Everyone knows what it’s like to feel anxious or afraid—whether it’s before an important presentation, calling someone for a date, or anticipating bad news from the doctor. Among most members of the animal kingdom (including humans), the anxiety response involves three systems: an increase in physiologic arousal, a shift in attention toward the perceived threat, and the urge to fight or flee. A life-saving process for ancient humans who lived among their natural predators, the anxiety response is now mostly needed to help us rise to the occasion and do our best in social and other performance situations. Accordingly, this set of coordinated “fight-or-flight” responses is among the most natural and fundamentally
adaptive processes of the body and mind—even if it sometimes brings about intense physical and mental anguish, perhaps even escalating to panic attacks.

Although anxiety and fear are natural and highly adaptive responses, they are quite readily triggered by the mere perception of a threat. And humans—some more than others—are prone to perceiving threat where there is none (after all, this is a good survival strategy rather than the other way around). When a “false alarm” (the mistaken perception of threat) occurs, most of us correct our thinking when the perceived threat doesn’t materialize.

But for about 25 percent of adults, the overestimation of threat is a more habitual occurrence. Moreover, there are factors that may interfere with the ability to correct the overestimation, leading to a vicious cycle that is difficult to get out of without help. Of course, I am referring to people having what the Diagnostic and Statistical Manual of Mental Disorders (DSM) refers to as anxiety disorders. These problems, which can wreak havoc on one’s social, leisure, and work life, are the topic of Allan Horwitz and Jerome Wakefield’s book titled All We Have to Fear: Psychiatry’s Transformation of Natural Anxieties Into Mental Disorders.

The central thesis of this book is that anxiety disorders represent modern psychiatry’s pathologizing of the normal anxiety response into mental disorders that seem to require (in many cases) medical treatments such as pharmacotherapy. The book comprises nine chapters and is informed by the fields of psychiatry, evolutionary psychology, history, sociology, and anthropology.

To place All We Have to Fear in the proper context, a brief history lesson is in order. The 1970s were a turning point for American psychiatry. The field was mired in a serious image problem. Psychiatrists had low status and made less money compared with other medical practitioners. They relied on pseudoscientific theoretical models (e.g., psychoanalysis) and were seen as advocating for fringe and unconventional treatments (e.g., encounter groups). Growing fields such as clinical psychology and social work also threatened to intrude on psychiatry’s turf (Wyatt & Midkiff, 2006).

So leaders in the field of psychiatry held strategic planning conferences to generate strategies for improving the profession’s status and for increasing the number of people going into the field (which had declined by more than 50 percent during the 1970s; Nelson, 1982). Among these solutions was a plan to make psychiatry more “medical” (and therefore more “legitimate”) by improving the diagnostic reliability of, and promoting biological causation models for, psychiatric disorders—which would now be considered on par with “real” medical diseases such as diabetes, for example. Thus, work began during the late 1970s to revamp the DSM, which at the time suffered (and many would argue still suffers) from poor reliability.

Around the same time, pharmaceutical companies were looking for more ways to sell psychotropic medications, which had become increasingly popular since the 1950s. As it turned out, efforts to improve the diagnostic reliability and promote a biological causation
(e.g., chemical imbalance) theory of psychiatric disorders satisfied the business interests of both organized psychiatry (i.e., the American Psychiatric Association) and “Big Pharma.”

And so was born a mutually beneficial partnership that continues to this day (for a thought-provoking discussion about this association, see Wyatt & Midkiff, 2006). It is the playing out of this partnership that serves as a backdrop against which Horwitz and Wakefield take issue with the DSM and psychiatry’s claim that the anxiety disorders are truly “disorders” that require medical treatments (or any treatment at all).

Horwitz and Wakefield’s overarching contention is that the DSM’s symptom-based diagnostic system needlessly pathologizes normal everyday anxieties. They argue that presentations of anxiety that are actually within the range of ordinary (albeit unpleasant) human experience have been built up by organized psychiatry into “diseases.” The data are very much on Horwitz and Wakefield’s side: In the 1970s, less than 5 percent of the U.S. population were found to suffer from an anxiety disorder. Now, as mentioned previously, that prevalence rate is upward of 25 percent. It might be interesting to note that over the same period of time the use of psychotropic medication for anxiety in the United States has mushroomed as well.

Horwitz and Wakefield promise to shed light on these issues in their book, which begins with a discussion of the nature of “normal” and “abnormal” anxiety and fear. They then detail an evolutionary approach to understanding anxiety. The next set of chapters focuses on anxiety in the psychiatric nomenclature: The history and validity of DSM anxiety disorders are surveyed, and the presentation of anxiety in nonclinical samples is discussed.

One chapter focuses on posttraumatic stress disorder, which Horwitz and Wakefield argue exemplifies the problem with transforming normal anxious responses into clinical disorders. Specifically, they contend that it is difficult to distinguish normal from pathological responses to traumatic or extremely stressful events. The arguments are generally data based, although in spots, I found the writing redundant and at times dense and challenging to weave through. There were a few passages that I had to reread in order to properly digest.

Chapter 8 is perhaps the most intriguing of the book’s nine chapters. Here Horwitz and Wakefield discuss sociohistorical aspects of anxiety and depression as they relate to treatment—particularly pharmacotherapy with the use of antidepressant and anxiolytic medications. They address issues such as why depression is the most treated psychiatric problem whereas anxiety disorders (taken as a whole) are actually the most prevalent. Readers will find the influence of the marketplace (and the pharmaceutical industry) at once fascinating yet at the same time very disturbing.

In the final chapter, the authors return to the discussion of whether fear and anxiety are “normal” occurrences versus being indicators that something inside the person (i.e., the brain) is “defective” or “broken.” This relates to the questions of whether (or when) treatment is necessary and when treatment represents crossing a boundary from good
medical/psychological care into the realm of dictating adherence to social norms. The authors’ expertise on the sociological aspects of these issues makes for interesting reading.

I find myself agreeing in principle with Horwitz and Wakefield, which is why I was excited by what seemed to be the book’s central message. Indeed, there is no biological test to confirm the diagnosis of any anxiety disorder (or any mental disorder, for that matter). And there is little evidence that anxiety disorders result from dysfunctional neurotransmitter or neurological processes. The biological reductionist language used in explaining anxiety disorders has little (if any) empirical basis (Deacon & Lickel, 2009). Further, it is not understood how medications such as SSRIs affect anxiety.

Yet, in the end, this book came up somewhat short of my expectations. For one thing, the idea that organized psychiatry is creating mental illness out of normal psychological experiences, leading to the rise in prevalence rates of psychiatric disorders, is not a new one. Numerous authors have observed the growth of the DSM (in its number of pages and in the number of diagnoses; Follette & Houts, 1996). Problems such as child bipolar disorder and attention deficit disorders (in children and adults) have become epidemics, whereas only a quarter century ago they were considered more or less rare . . . and treatable. Thus, many of the arguments presented here can be found elsewhere (e.g., Whitaker, 2011).

I also found the book’s discussion of the influence of evolutionary psychology an unfortunate aspect, especially in light of more empirically sound arguments for the authors’ thesis. I am referring, of course, to cognitive-behavioral models of anxiety—which are regrettably absent from this text. The advantages of cognitive-behavioral approaches over evolutionary psychology include that the former are empirically verifiable and have given rise to the most effective ways of helping individuals overcome problems with anxiety that do not assume the presence of any underlying dysfunction or disease (e.g., Abramowitz, Deacon, & Whiteside, 2011; Barlow, 2002).

Cognitive-behavioral models acknowledge the universality and (evolutionary) adaptiveness of anxiety. Empirical research supports cognitive-behavioral explanations for how perceptions of threat (real or imagined) become associated with objectively safe situations and stimuli, and then are maintained via the very cognitive biases and safety-seeking responses (e.g., escape, avoidance) that are inherent in the fight-or-flight response itself, leading to the self-perpetuating vicious cycle alluded to above.

Moreover, cognitive-behavioral models, as well as cognitive-behavioral treatments, do not assume the presence of disease processes within the individual (e.g., dysfunctional neurochemical or brain function, bad genes). In fact, these models account for the signs and symptoms of DSM anxiety disorders without appealing to disease processes. Cognitive-behavioral treatment merely helps patients use logic (education and cognitive restructuring) and their own experiences (i.e., exposure and response prevention) to correct their mistaken perceptions of danger so that they are only as anxious as the facts warrant.

There are many points at which All We Have to Fear reads as if the authors have tried to stretch what could suffice as a long journal article into a full-length book. The chapters
are at times dense, meandering, and repetitive, with similar arguments used over and over and varying only slightly with the specific subject matter. These criticisms aside, Horwitz and Wakefield, to their credit, illuminate the field of psychiatry’s monumental failure to understand and classify human nature—at least insofar as the experience of anxiety is concerned. This, I believe, is the main value in their book.

References


