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The Multiple Anxieties of Getting Older: Tranquilizers and the Ambivalence of Effect

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Abstract

Most studies on benzodiazepines emphasize overconsumption and warn of addiction, especially by older adults. This article is about the avoidance of benzodiazepine medications by ‘aging’ women living in a Brazilian village. This case study helps to support our central concern: to call attention to the ambiguities that exist in discussing these meds, and stress the importance of a multilayered understanding of effect. We argue that benzodiazepines, like other psychopharmaka, induce bodily sensations that, at least in part, correspond to and are shaped by the situated self-image of individuals in distress.
Anxiety is a common disorder and, after the World Mental Health Survey (2002), emerged as the “most prevalent mental health problem across the globe.” Psychiatrists generally explain anxiety as triggered, to different degrees, by a combination of personality (sometimes explained as based on genetic makeup and brain chemistry, e.g., Tye et al. 2011), life events, and environmental stressors (cf. Surgeon General n.d.). Epidemiological research on anxiety disorders in adults shows a great variety of prevalence rates (e.g. Wetherell, Lenze and Stanley 2005; World Mental Health Survey 2002). These differences either indicate that anxiety is contextual (i.e. some groups suffer more than others), or expose the difficulty of diagnosing a malleable state, which is sometimes seen as an emotion, sometimes a pathology; in some cases a symptom, in others a syndrome. Anxiety is, as psychiatrist George Makari (2012) so well explains, a signal of danger and a “possible symphonic interaction of DNA, hormones, neurons, anticipatory fantasies, memories and thoughts, as well as the constraints and opportunities of our culture.”

The prescription rates of anti-anxiety medications seem to reflect this general state of anxiety. In many countries around the world, the use of benzodiazepine, the most common anti-anxiety medication, is high, and is the target of government campaigns warning against the drugs’ addictive properties and side-effects (see below). Patterns of benzodiazepine consumption, though, vary. In England, the prescription of this anti-anxiety drug group is highest in the north-west of the country – “the reason for this
regional variation is unclear” (see MHRA 2011) – while in Brazil, the focus of this article, we will describe an atypical low use of these drugs in one particular place, which differs from a national pattern of high benzodiazepine consumption. Although a number of factors may influence regional and national differences in benzodiazepine use,\(^2\) one aspect has received too little attention so far: the ‘ambivalence of effect.’

By the ambivalence of effect we refer to the difficulty of coming to terms with the complexity of what medications do; part of this difficulty is the condensation of complex interactions into variables such as gender, race or, in this article, aging. Drugs do not simply act on and change the biological body; they are also implicated in creating new diagnostic connections among bodies and explanatory connections within bodies (cf. Leibing and Kampf, in press, Persson 2004), which, in return, also influence the sensations and physiological changes called ‘effect’. In this regard, Ashcroft (2002: 231) speaks about intrinsic and relational properties when he writes about clinical effectiveness, emphasizing that “these properties are not physical, but do supervene on physical properties.” Because of their specific physiologies, women and men react differently to certain medications, for example. This factor is rarely part of clinical trials or prescriptions, which most often conceive of effect as sex-independent (Brower 2002; Maker 2011). But men and women also embody gender-specific expectations of what medications do and therefore shape reactive bodies. This goes far beyond the symbolic, as Jonathan Metzl (2003a, 2003b) has shown for the gendered history of ‘mother’s little helpers’.
The multiple levels of effect are also relevant when it comes to lifecourse-related
categories such as aging. The biology of the aging body influences how medications act
on the body, although in highly different ways, depending on the individual phenotype.
Also, older people often take several medications, which can lead to drug interactions
influencing effect and effectiveness. Further, as we describe in this article, the variable
‘aging’, when ‘unpacked’ (cf. Trostle 2005), brings to new dimensions in which objects,
biological and social facts get mingled, questioning some of the most common
correlations found in the literature about aging and benzodiazepine use. Far from
disentangling this complex question, our more humble aim here is to call attention to the
socio-biological situatedness of benzodiazepines (and other medications).

In the most general terms, medications establish connections among bodies, artefacts and
technologies, re-ordering the world in which health-related interventions can be thought
of, experienced, and acted on (cf. Willems 1998). The ‘thingness’ of medications, its
concreteness in changing the social and the biological, results in the following Brazilian
example of the avoidance of the effect stemming from benzodiazepines, in contrast to the
findings in a number of studies around the world in which the ‘seducing’ effect of these
medications seems to be the reason for overconsumption.

In order to make our point we focus on the utilization of benzodiazepines by one sub-
group of anxious individuals: People who consider themselves old. Although a number of
studies show that anxiety declines with age (e.g., Hunt, Wisocki, and Yanko 2003),
others argue that anxiety disorders are underreported, and call anxiety a “silent geriatric
giant” (Cassidy and Rector 2008:150). Some believe that “anxiety symptoms and disorders are among the most common psychiatric ailments experienced by older adults” (Sheikh 1994: 281). Those who think that there is a strong association between anxiety and older age generally explain this with the biology of aging and the negative life circumstances of some seniors including social exclusion, dependency, stigma, solitude, and chronic disease.

As we describe, the results of a study conducted by the first author in one context in Brazil diverge in several important points from the research in which the second author was involved in Québec, Canada. Because of limited space, but also because different methodologies and research objectives were involved, we will not directly compare the two studies. However, our arguments resulting from the data in Brazil will be constructed against recurring arguments stemming from research about anxiety in older individuals in many so-called western countries (including urban Brazil), into which the second author’s study falls. By doing this, the peculiarities of the Brazilian research can be elucidated, enabling us to make our central argument concerning the situatedness of effect of medications and, as a by-product, the situatedness of the life course.

**BENZODIAZEPINES**

The epidemiology of the use of anti-anxiety drugs, especially those belonging to the benzodiazepine group, confirm that anxiety is a widespread problem in many societies. This is especially true for older individuals: A study from Québec (Voyer et al. 2010; see also Voyer et al. 2004; Collin 2001; Perodeau et al. 2003), for instance, shows that 25%
of the community-dwelling seniors use benzodiazepines on a regular basis. These high numbers exist despite the fact that health authorities recommend their use for a maximum of two weeks in order to avoid addiction and, more recently, have started to recommend the prescription of anti-depressants – SSRIs – for the treatment of anxiety (e.g. NIMH n.d.). Not all seniors suffer from anxiety, and “the pharmaceuticalization of sleep” (Wolf-Meyer 2009; see also Rogers et al. 2007) is an important part of the phenomenon. A US study conducted by Simon and Ludman (2006) shows that in their sample, the most common indications for benzodiazepine prescription were insomnia (42%), followed by anxiety (36%).

In urban Brazil, the picture resembles the North American one: One study in one major city shows that 21% of community-dwelling seniors were using benzodiazepines regularly (Alvarenga et al. 2008); another found that 25% of older adults in a smaller city received a prescription for a drug from this medication group (Firmino et al. 2011; see Kapczinski et al. 2001 for an overview of the general population).

Since the 1960s, benzodiazepines have been widely used in many countries, and by the 1970s they were the most prescribed medication group worldwide (Marks 1983). After their initial heyday, benzodiazepines became strongly associated with warnings against addiction (see Metzl [2003a, b] and Tone [2005, 2009] for a more extensive history of benzodiazepine use and abuse in North America). As historian of medicine Edward Shorter and psychiatrist Peter Tyrer (2003: 159) observe, “[d]espite clear evidence that benzodiazepines were effective, they were dismissed as drugs for neurotic women, who
then become addicted.” The demonization of benzodiazepines since the end of the 1970s has been so strong that some researchers now contest this condemnation, some of them fearing that benzodiazepines, which have fewer side-effects than the majority of psychiatric drugs, will not reach those patients who need them (e.g., Cloos and Ferreira 2009; Douki 1991; Marks 1983). Further, Robert DuPont (quoted in Balestra 2009), the former director of the American National Institute on Drug Abuse, maintains that 90% of benzodiazepine users do not appear to become addicted, questioning the degree of fear and stigmatization associated with benzodiazepine use.

If people around the world fear but still take benzodiazepines, there must be something about their effect that interacts with the notion of risk in such a way that the effect for some is preferable to exploring alternative paths of healing. The immediacy of results and their affordability, especially compared to SSRIs, certainly play a role. The efforts of the pharmaceutical industry to maintain a market is a further factor that is shaping perceptions of doctors and patients regarding effect (Healy 2004a: 5-7). And although individuals taking high doses over a long time complain about memory loss, flattened mood, slurred speech, weight gain, agoraphobia, impotence, and claustrophobia, others using lower doses often have a positive perception of benzodiazepines, and a pragmatic use pro re nata – when the need arises – seems to be a common attitude towards these medications (see North, Davis, and Powell 1995). While not denying the possibility of addiction and negative side-effects of long-term use (cognitive impairment is another recent association, cf. Wu et al. 2011), it might also be that psychiatrists who are often the authors of articles warning against benzodiazepines are more in contact with patients
who are already prone to an addictive behavior (cf. Tone 2005). This is not the place to resolve the question of whether and how benzodiazepines should be taken. Nor are we able here to provide the fascinating history of anxiety and its interrelatedness with depression (e.g., Shorter and Tyrer 2003; Healy 2004b; Ehrenberg 2008; Flint 2009)—although the following observations clearly show that anxiety and depressive states often cannot be separated. For the moment, we only want to call attention to the fact that discussions involving both anxiety and benzodiazepines are ambiguous and seem to depend on how effect is shaped by a number of factors, something that one of the authors has called elsewhere “embodied molecules” (Leibing 2009 and in press).

The following example, taken from a study the first author conducted in a small village in Brazil, is also about ambiguities. However, unlike in an urban context in Brazil, where similar patterns to North American benzodiazepine consumption exist, different kinds of ambiguity—both regarding benzodiazepine use and aging—can be observed.

**BENZODIAZEPINES AND THE BRAZILIAN CONTEXT**

*A vida é combate,*

*Que os fracos abate,*

*Que os fortes, os bravos,*

*Só pode exaltar.*

(Gonçalves Dias, 1944, *Obras Poéticas* II)

(“Life is a battle that destroys the weak people, that only fortifies the strong and brave ones.” (Our translation)
Epidemiological studies in Brazil show that at the end of the 1980s and the beginning of the 1990s, 85% of psychotropic medications prescribed were anxiolytic drugs. Researchers also found a north-south increase for these medications, which after Kapczinski et al. (2001) can be explained by the fact that in southern Brazil, people generally have a higher living standard and therefore better access to medical services. These numbers – which are higher than in other countries (ibid.) – are nevertheless lower than those taken from the end of the 1970s in Brazil: In 1986 and 1987, new legislations from the Ministry of Health were introduced to require medical prescriptions for benzodiazepines, limiting their over-the-counter use (ibid.).

Despite these cautions, and an initial decline in the use of benzodiazepines, a 2010 study, published by IMS Health (a private company doing worldwide health markets research), again alerted to the abusive practice of prescribing benzodiazepines in Brazil, which, after the contraception pill, was the country’s most frequently prescribed medication. One drug in particular, Rivotril (clonazepam), has become a blockbuster medication (cf. Collucci 2011): Between 2006 and 2010, sales of Rivotril increased from 13.7 million to 18.45 million boxes. The reasons for the success of this specific medication are its low price ($5 per box), and high popularity, using, for example, social media for its advertising. Rivotril’s widespread use seems to be the result of insufficient control by the state, in combination with the marketing practices of the manufacturing enterprise that targets one of the largest markets for psychopharmaca in the world (Collucci 2011; Pfeifer 2006).
A number of interrelated factors explain why so many Brazilians seem to be in need of an anti-anxiety medication. A generally positive attitude towards medical technologies – also explaining, at least partly, the extremely high numbers of caesarean births and plastic surgery in the country (e.g. Sicoli 2009; Edmonds 2010) – facilitates the marketing practices of pharma concerns and other for-profit health providers. Further, the high rates of violence generate a climate of constant fear and distress in most areas of Brazil and, for many, result in traumatic life events. Although recent ‘pacification measures’ have resulted in a less violent environment in certain areas, especially in Rio de Janeiro, surrounding areas have become more violent. Other parts of the country have also suffered from an increase in violent crimes, where recent higher prosperity has gone hand-in-hand with growing drug violence (Barrionuevo 2011).

A common association is the one between urban life, modernity and anxiety (e.g. Schuster 2011; Oppenheim 1991). This argument could be used in Brazil, where a number of socio-economic factors make urban life in particular very demanding in a highly consuming society with high costs for basic needs. For psychoanalyst Jurandir Freire Costa (2004), the extreme level of consumerism in Brazil – where identity is linked to the possession of consumer goods (which includes the highly malleable body of many Brazilians) – accompanies a loss of tradition. Costa’s argument – like Friedrich Nietzsche’s ‘death of god’ and Paul Tillich’s ‘anxiety of meaninglessness’ – is that this loss of tradition is a major source of anxiety.
If modern urban life is so generally accepted as a source of anxiety, what about life in an isolated and apparently bucolic village, the site of a study undertaken by the first author. We present this in the following section.

DISTRESS IN A BRAZILIAN VILLAGE

Some years ago, Santo André – as we call this village of about 120 inhabitants – was an isolated place situated between the ocean and the agricultural land of a north-eastern state in Brazil. While more recently a street has been built that links the village to larger places, at the time of the fieldwork, it could only be reached by private boat, or by truck on sand trails that were not always passable. Most people in Santo André were too poor to own either a truck or a boat. The surrounding towns were at that time starting to develop as a major touristic area, which also affected Santo André because consumer goods, entertainment, and new work and education opportunities became more easily available. In the village, however, everyday life appeared to continue as before, especially for the women, who rarely traveled.

I (AL) had discovered the village by chance, and wondered how a community that had such a complicated access to larger towns with medical services might organize care and self-care when medical attention were needed. After several visits to Santo André, a clearer picture emerged about the women living there, who, with few exceptions, were my only informants: The contact between men and women was restricted and supervised, regularly commented on and judged regarding gender-specific moral conduct and codes.
Since my first visit, I was astonished to note that many women complained about nervous disease – in a village that I had initially perceived as the perfect place for relaxing, where nothing seemed to go on, where the natural beauty was enchanting, and where most people were poor, but not miserable. Because of the isolated geography of Santo André, I imagined that local herbs and prayer would be the favored health interventions for nervous disease. These were the therapeutics provided by the local healer I had met during my first stay, an old woman who, with the help of a spiritual entity, performed mainly healing ceremonies and prayers.

However, a second and related observation was as astonishing as the first one: When I started to be invited into the houses of the women, to chat over a coffee or while helping them with some of their tasks, I also saw and admired the altars most families had built in the back of their houses. Altars are used for praying and protect the household against negative forces, but also for worshipping objects linked to the identity of the family (see Duarte 2006). On these altars – often a table or some bricks covered with a table cloth - a range of religious objects could be found, which were mostly of Catholic origin, but also stemmed from the African-Brazilian religion Candomblé and other religious manifestations (for example, a statue of Buddha placed beside the Virgin Mary). The astonishing part was that several altars also displayed a box of tranquilizers: Benzodiazepines. When asked about the meds, most women seemed to be embarrassed and just commented, saying “I didn’t like to take these pills” or “one day I might.” It took a while, and long, repeated conversations, to understand the role these medications played in the women’s lives.
'Dust Fighters’ Or A Special Kind Of Aging

A third astonishing observation challenged my own cultural expectations. These women – the core group on which most of the data are based – were between 22 and 51 years-old, and they considered themselves to be old. The women referred to themselves as “not young anymore” or stated that “my youth is over.” There was something absolute about the women’s place within the life course: They were neither part of the group of the deeply wrinkled, grey-haired seniors who, unlike what the studies had revealed about seniors and benzodiazepines in other places, did not consume these drugs; nor were they part of the ‘younger people,’ who in some cases were the same age as my interviewees. The women did not consider themselves just adults, like the men they were living with; they were, as one woman described it, “just dust-fighters: We broom and broom until we die.”

FEMALE ANXIETIES

The life course is a malleable category linking age groups to specific historical and geographical contexts (e.g. Holstein and Gubrium 2000; Katz 2005; Cole 1992). Age groups can be ‘invented’, just like adolescence (which became something to worry about around 1900; see Bakan 1972) or the ‘third age’, a more recent concept perceived as a life period situated between adulthood and old age (generally through ‘active aging’, consumerism, and a general denial of death), which appeared in the 1960s in France and became a major movement of empowerment in many countries (e.g., Laslett 1991; Katz 2005; Leibing 2005 for Brazil). For the women in Santo André, being ‘old’ or ‘dust
fighters’ was linked to a number of norms that at this specific point in time resulted for
many in major distress. Aging for the women interviewed in Santo André was often
linked to appearance in combination with a less functional, tired body, although this
association was less linked to a numeric age than to working hard and being (unhappily)
mARRIED: “One gets married and thinks, now everything will be wonderful. And then
come the children. Only children, working all day long. One works and gets a body like
this [points to her body]. An ugly body” (woman with four children, 35-years-old).

Other factors that could be subsumed under the category of ‘social change’ were
intertwined with their distress as married – and therefore old – women.10 The women’s
narratives particularly reflected the major changes the village was undergoing (Kottak
2006 describes a similar process for a village in Bahia) – changes to which the women
had only indirect access. Men were free to go to the larger cities to sell their agricultural
products, and to visit relatives, doctors, and supermarkets. It was they who often brought
the medications to the village, either using a prescription or, most often, through an
illegal over-the-counter transaction. Men from Santo André had access to something that
could be called ‘modernity’ (see Inkeles 1969), such as entertainment, different kinds of
food, and other women in the surrounding cities. Other women and better job
opportunities had led to some of the men leaving the village behind, and some abandoned
their families; sometimes new women moved into the village. Some of the younger
unmarried women also left to study in the nearby cities, but for most of them, this was
not an option. The temptations of ‘modernity’ were a major threat to the women living in
the village, since they had to live following a strict moral code that was different from the
Women were restricted to their houses: Those who spent too much time outside their homes could easily be judged as immoral. The fear of men of becoming *cornos* (a cuckold) resulted in sometimes violent acts of control. During one of my stays in Santo André, a house was burned down that belonged to a woman who had come to the village only some years ago, and whose boyfriend did not accept her independence.

Purity (of moral conduct) was reflected in the cleanliness of the houses (Mary Douglas comes to mind). The women’s constant brooming was a Sisyphean work, since the dust and sand that was everywhere in the village, due to its proximity to the beach, immediately came back through the open windows and the cracks in the wooden walls of which the poorer houses were made. While a married woman was considered morally pure as long as she stuck to the house (and worked hard), a single woman always carried the potential stigma of sexual impurity, making abandonment a much-feared stressor in the women’s lives. And once a couple had children, the status of motherhood could turn the woman into an almost asexual, saint-like being (DaMatta 1987); as a result, other women became sexually more attractive. The anxiety of these women revealed a hopeless situation, a lack of control over their lives that some psychiatrists would probably link to a diagnosis of depression. The extreme anxiety stemming from being imprisoned between the moral need to be married and the growing insecurity of marital bonds, worsened by the new possibilities of life men found in the surrounding cities, resulted in a search for medical interventions in the form of drugs. In this case, neither prayers nor herbs were strong enough.
Benzodiazepines In Santo André

The question remains why the benzodiazepines were put on the altars of the women’s houses. The medications – at the same time adored and feared – were rarely taken, despite the strong distress experienced as nervousness (nervoso) or anxiety (ansiedade), but neither were the pills thrown away. Some of the women had taken the pills over a period of several days and then abandoned the treatment; a few took them sporadically, when suffering became too strong, and some had not even tried their medication after they had heard from other women of the undesired side-effects. What the women explained was that psychiatric medications were too strong for them; their bodies were weak due to their prolonged suffering, their nervousness. Also, they considered themselves weak because they were poor, and psychiatric medications were incompatible with their lifestyle since they were part of the world of the rich and with their strong bodies.

As an example, 51-year-old Maria, the oldest woman in the Santo André sample, explained her situation:

Whenever I get upset or receive a sad message, I get nervous. Sometimes I cry, can’t sit still and cannot sleep. (...) Then I take these pills here. (...) The doctor prescribed them and he said I should take them every day. But I only take them when my heart beats so strongly. Sometimes I think I will die. It’s too much, everything. It can’t be good to take something so strong all the time. The doctor told me to do so, but he is not weak. (...) I was already nervous as a child. But it became really bad when my husband started to
drink and have other women. (...) And then (...) I went to the doctor. I couldn’t work anymore, take care of my kids. No one helps me. Sometimes the fruits get rotten, because I can’t carry them by myself. And I don’t take care of my grandchildren anymore. They crawl on the floor and get worms. That makes me even more nervous.

Maria’s suffering is constructed around her medication – including issues regarding compliance and trust (Leibing 2010), purity (Douglas 1988) and what Joseph Dumit (2002) has described as “drugs for life”. However, what is different from drugs-for-life prescriptions that are based on a reasoning presupposing a chemical imbalance in the body, here the prescription pattern suggested by the doctor shows that life itself is seen as pathological and in need of daily medication. As one doctor, interviewed in a surrounding town, said:

These people are nervous, because they are poor. They don’t eat well and live without hygiene. Some little issue and they are sick. (...) What can I do? They want these meds. And these pills are not so bad – maybe better than finding out that you belong to the miserable people. (...) I don’t have time for long discussions, in front of my door many are waiting.

The pathologization of social life is also reflected in the underlying logic of ‘weak and strong’, which in some parts of Brazil is a substitute for the well-known hot-cold classification system in Latin America and other places around the world, probably having its origins in ancient humoral medicine (Foster 1987). Unlike the hot-cold
system, the division of health, food, individuals, medications, and plants into strong and weak always bears a reference to social status and power relations (DaMatta 1997; Scheper-Hughes 1992). Locally available herbal and religious medicines were, however, too weak to treat the women’s strong anxiety, which, at least in part, had its origins in and was associated with the world that was made up of strong people. Consequently, the women were in need of powerful medications, but were not strong enough to take them. The embodiment of power relations explains one part of the impossibility of taking benzodiazepines in Santo André.

The ‘thingness’ of the medications exposed on the altar, its effect and concrete impact, is a further aspect. The exposed benzodiazepines – a ‘technology of hope’ (Leibing and Tournay 2010) – acts on both the individual and the social body. Placing medications on the altar means the avoidance of the molecules acting on the women’s bodies; it also means the hope of one day achieving the strength to use them, and at the same time receiving some of the meds’ powers as a result of their adoration. When placed on the altar, benzodiazepines finally become a clear symbol of the women’s suffering, fully in the sight of the men, other family members, and visitors, and therefore not only acting on the individual (who, in most cases, is not taking them).

The avoidance of the active molecules in the pills needs a closer examination; it is the ambiguity of effect that we see as another factor for explaining differences in how these meds are being taken and experienced in most studies around the world, versus the specific pattern in Santo André. In fact, the complexity of anxiety, reflected in the Makari
quotation in the introduction of this article, paired with the complexity of effect, becomes a major challenge to any explanatory system.

**BENZODIAZEPINES AND EFFECT**

The women in Santo André are not part of the culture of condemnation found in North America (and elsewhere) regarding benzodiazepines. They have negative expectations regarding allopathic medications in general (as being too strong), and seem to experience benzodiazepines as reinforcing their anxiety, without the benefit of sedation responsible for the high numbers of benzodiazepine sales in other places. The women in Santo André did not receive any warnings of the dangers associated with benzodiazepines from their doctors or from other sources of information (such as the Internet or the printed media) outside their immediate peer group. The central site of effect were those women’s bodies who had experienced these meds. Effect is shaped by bio-cultural learning (Latour 2004; Leibing 2009), triggered by sensations, rumours, and expectations. However, practices of benzodiazepine consumption in Santo André are not completely free of the influence of the marketing of medications and dominant biomedical paradigms; Santo André and its surroundings can be described as marginally connected to the global flux of biomedical knowledge and the specific Brazilian trend of overprescribing these meds, without which benzodiazepines would not be available.

The bodily responses of the women in Santo André to the medications are not comparable with those we mentioned in articles about seniors and benzodiazepines. The biology of aging leads to a special biological vulnerability of seniors to benzodiazepines
(Dailly and Bourin 2008). This is mostly absent from Santo André due to the women’s younger age. We can only speculate about other biological factors that might influence how benzodiazepines are experienced. For example, a specific biological make-up of this Caboclo population (a mix of Afro-Brazilians with Native Indians), and a greater sensitivity to the drugs’ effects due to other underlying factors (malnourishment for instance), is possible, but not proven.

Independent of context, both seniors in most benzodiazepine studies and the women in Santo André experience a strong ambivalence regarding these drugs, although with a striking difference: Seniors generally take too many benzodiazepines, which cannot only be explained as addiction, while the women in Santo André keep the pills on an altar, showing a positive relation with its effects as a possibility located in the future.

Another ambiguity is the merging of effect and symptoms stemming from the medications and the symptoms of anxiety itself: When talking about benzodiazepines, the women in Santo André most often spoke about side effects. Their accounts of heart palpitations, headaches, restlessness, dizziness, insomnia, crying, and the feeling of falling down are difficult to separate from each other as psychiatric symptoms (of anxiety/depression) or as side-effects (of the medication). For example, Caboca, a 30-year-old mother of three, described taking the medications and being unable to work afterwards: “I felt so dizzy and my heart was beating; I was all the time afraid of falling down.” Maria, mentioned above, also talked about heart palpitations and restlessness, but
as a sign of her suffering, just as her neighbour Lourdes who, after her husband had left her, complained about falling down, dizziness, and the inability to work.

The United Kingdom NHS list of symptoms associated with GAD (General Anxiety Disorder) consists of psychological symptoms (“restlessness, a sense of dread, feeling constantly ‘on edge’, difficulty concentrating, irritability, impatience, being easily distracted”), and physical symptoms (“dizziness, drowsiness and tiredness, pins and needles, irregular heartbeat (palpitations), muscle aches and tension, dry mouth, excessive sweating, shortness of breath, stomach ache, nausea, diarrhoea, headache, (...) difficulty falling or staying asleep [insomnia]).” This list strongly resembles the list for benzodiazepine side-effects; for instance, the Canadian Centre for Addiction and Mental Health (CAMH 2009) warns that, “[c]ommon side-effects are drowsiness, sedation, dizziness and loss of balance. At higher doses, side-effects can include confusion, disorientation, amnesia, breathing difficulties and depression.” The question of how clinical trials can be conducted that assess the merging of symptoms and (side-)effects does not seem to have been answered yet.

Some symptoms and sensations of anxiety may disappear naturally, so it is also difficult to define what the effect is. A similar phenomenon has been observed regarding behavioral and psychological symptoms of dementia (BPSD): As McShane and Gormley (2002: 241) warn, "[d]rugs are widely and often excessively used to manage BPSD. The placebo response rate is high in randomized studies. This may be because of the increased attention of triallists and the natural tendency of BPSD to resolve.”
Benzodiazepines certainly do something to people, which may be felt as positive or negative, but effect is not as helpful when it comes to explaining what is going on; effect is a confusing and unspecific concept.

DIFFERENCES AND SIMILARITIES

We have offered several interrelated reasons for the situatedness of effect of benzodiazepines in ‘older’ individuals. While not offering a final explanation, our objective was to call attention to the ambiguities that exist in discussing these drugs, and to emphasise the importance of a multilayered understanding of effect. Older, poorer, gendered, and other bodies react differently to drugs. These differences are further shaped by the historical moment and local medical landscapes. For example, the historical situatedness of benzodiazepines can be found in the general appreciation of this medication group in its early years and its general condemnation more recently. Martin and colleagues (2007:780), in a meta-analysis, conclude that, “the more recent the study, the smaller the positive effect seemingly found in favour of benzodiazepines: in contrast, the longer ago the publication of the study, the greater the effect in favor of benzodiazepines.” The authors explain this variation over time as due to selected (positive) reporting and expectations, paired with imprecise (small) sampling in the first trials.

These differences influence and provide the cultural references that shape individuals’ experiences of the symptoms and side-effects of drugs. Both groups – seniors in most benzodiazepine studies and the women from Santo André – are at a standstill, a state of
marginalization combined with the almost inescapable ambiguity related to their lives and the effects of benzodiazepine medications. In the most general terms, they could be described as being in a state of ‘sedation’. However, in the Brazilian example, negative expectations were predominantly linked to the consumers themselves (they were too ‘weak’), while in most studies around the world, the medications and their addictive features are the reasons for warnings and restrictions. This difference might explain the different patterns we describe: avoidance versus overconsumption.

The medications act on central issues and social expectations related to what makes a good citizen. In the North American studies (and elsewhere), benzodiazepines used to counter insomnia produce senior citizens who then are able to be active and engage with the world in which they live; however, if the same medication is taken to fight anxiety, another image of calming down and acceptance is produced and another group is targeted (Collin and Leibing 2012). This second group co-exists with the one of the active senior, despite all attempts to ban it by the third-age movements around the world, and comprises older individuals who are part of the older gerontological ideal of disengagement (cf. Achenbaum 1995).

In most ‘western’ contexts, the metaphor of ‘decline’ is the central trope relating to aging (Gulette 2004). In most studies on older individuals and benzodiazepine side-effects, a general slowing down and sedation are the most prominent symptoms reported. According to interviewees in Québec (Collin 2001), older people on anti-anxiety drugs, whatever their background and social characteristics, view themselves as fragile and frail.
To various degrees, they define aging as a simultaneous process of experiencing the deterioration of their body and the dissolution of their social networks and ties. Most of them feel that their ability to cope with everyday life is getting very thin. They see themselves as having problems controlling their emotions and their nerves, and often feel overwhelmed by the pressures that arise from the pace and obligations of everyday life. Most of them find it difficult to cope with too many activities at the same time, but they also can be very anxious about not having any activities at all.

Most of these users of benzodiazepines (in Québec) have hypertension or coronary heart disease. They feel strongly that they have to avoid stress and control their nerves in order to prevent heart attacks. Anti-anxiety drugs are seen to work in two ways: by “slowing them down inside,” as one of them put it, and by somewhat dulling their sensations and perceptions of the outside world. In both cases, benzodiazepines are seen to contribute to lowering the pressure (and stress) they experience from the outside, and to lowering their blood pressure, while at the same time, the drugs are seen as helping them to cope with their emotional and physical frailty, which they see as a “deficit.”

Benzodiazepines therefore induce bodily sensations that correspond to the self-image of many older persons. Their agitation and emotional fragility find expression in feelings of dullness, of being anesthetized, and of being removed from the outside world. The sense of dislocation and slowing down – at odds with the performance and consumption ethics that characterize late-modern societies – is a tangible reflection of their marginalization, and serves to strengthen it. Nevertheless, marginalization has to be accompanied by the
maintenance of autonomy among older people, which for some can only be achieved with psychotropic drugs.

The women in Santo André were different: Those seniors who were old in years did not take these medications, perhaps because they still had a role that included certain tasks (grand-mothering, for example), while at the same time a certain disengagement was seen as positive. The women (‘dust-fighters’) who were anxious and did not take benzodiazepines, so as to be good citizens, needed to work hard; the sedative effect of the medication would make this impossible.

The molecules of anti-anxiety medications in many cases act like ‘cultural brokers’; their action on the body is shaped by the attempt to mediate between different, sometimes contradictory cultural spheres, which, without the drugs, could hardly be articulated. In the case of the women in Santo André, the mediation took place with the rather radical claim that the effect of sedation is contradictory to the cultural ideal of a hard-working and therefore morally acceptable woman. Sedation was therefore increasing anxiety.

Most studies conducted around the world reveal that the sedating effect of benzodiazepines is considered desirable to achieve either the cultural ideal of an active citizen by inducing sleep, or the calming-down of anxious seniors who are not able to participate in an active lifestyle (Collin 2001, Hunt, Wiesocki and Yanko 2003). The effect on anxious individuals is a meaningful, though often ambiguous, way of negotiating the gap between the individual’s distress and the resources available in a given society. Benzodiazepines can be seen as vital elements in contemporary biopolitics,
enabling the paradox of marginalized individuals sometimes becoming active citizens through sedation and others becoming more anxious because of sedation – for better and for worse.

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NOTES

1. The Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR) incorporates within anxiety disorders generalized anxiety disorder (GAD), social anxiety disorder (or social phobia), specific phobia, panic disorder with and without agoraphobia, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), anxiety secondary to medical condition, acute stress disorder (ASD), and substance-induced anxiety disorder (APA 2000). The more inclusive criteria accepted for the forthcoming DSM-5 will, Frances Allen (2012) suggests “obscure[s] the already fuzzy boundary been Generalized Anxiety Disorder and the worries of everyday life. Small changes in definition can create millions of anxious new 'patients' and expand the already
widespread practice of inappropriately prescribing addicting anti-anxiety medications”
(no page).

2. In a recent study, King and Esseck (in press) found that three factors influence regional
differences for psychotropic medication use in the US: access to health care, insurance
coverage and pharmaceutical marketing. This may also explain the differences regarding
regional differences in British prescription patterns of benzodiazepines, given that there
are no significant differences in the prevalence of mental health problems across the
country (Weich et al. 2003). In Brazil, it would explain the North-South difference (better
financial capacities of the households and better access), but not the importance
benzodiazepines have in Santo André with its difficult access and restricted financial
resources of its inhabitants. National politics regulating benzodiazepine prescriptions are
another factor, although they depend on the implemented systems of control, such as
electronic administration of patient files. There are many legal and illegal possibilities of
ignoring those regulations such as visiting different MDs, illegal selling either on
Internet or in pharmacies, using the black market, and others.

3. See, for example, NIA (National Institute of Aging) (2012)

4. Today, major health organizations such as the American Psychiatric Association or the
British NICE (National Institute for Health and Clinical Excellence) principally
recommend using the newer antidepressants, SSRIs (selective serotonin reuptake
inhibitors), for the treatment of anxiety disorders. However, SSRIs often take several
weeks until any benefits are felt, and benzodiazepines, because of their immediate effect,
are still being recommended for acute and short-term interventions (e.g. Cloos and
Ferreira 2009). The current recommendations, privileging the use of SSRIs, mirror a more recent change in the history of anxiety drugs. Depression and anxiety are conceived as comorbid in most cases, just as Sigmund Freud suggested, and SSRIs are found to treat both anxiety and depression. One of the strategies for the acceptance of SSRIs as the new *non plus ultra* in mood-disorder treatment was that warnings against dependency-creating benzodiazepines should be incorporated into the marketing strategies (Horwitz 2010; Rose 2006; Lakoff 2005). It was later found that SSRIs also cause physical addiction (and so-called ‘discontinuation syndrome’), although this is not widely known (Healy 2002: 169-171; Murray 2006). Also, the controversial possibility of a higher rate of suicide associated with SSRI consumption means that SSRIs are not necessarily the ideal alternative to benzodiazepines. And, finally, SSRIs may cause anxiety in some cases, despite that they are marketed as acting against anxiety (Brambilla, Cipriani, Hotopf, and Barbui 2005).

5. The authors conclude: “The community-based participants were not passive recipients of benzodiazepines; they regularly weighed up the costs, the risks of side-effects, dependence, and potential social alienation against the benefits, and most decided that benzodiazepines improved their quality of life” (ibid.: 643). Social psychologist Joke Haafkens (1997) disagrees. He calls these practices “rituals of silence:” Pharmaceutical companies take advantage of fragile individuals (mostly women), while prescribing doctors, even after having recognized the potential dangers of this drug group, and knowing about the social stigma associated with benzodiazepines, continue to prescribe and promote these drugs to (addicted) patients.
6. “The term ‘embodied molecules’ describes the experienced ‘cultural chemicality’ of medications … Effects stemming from group experiences consequently influence how the informed individual experiences the medication he or she takes [through] … the materiality of the drug (its molecules), the reacting body, and the socio-cultural context in which the effect takes place” (Leibing, in press).

7. São Paulo and Rio de Janeiro are respectively the 10th and 12th most expensive cities in the world (Heatley 2011).

8. The data about Santo André are the result of an ethnography: AL stayed on four occasions in the village, each visit lasting around one month. Informal interviews with the nervous women, some men, local healers and two doctors (MDs) in the closest major town, as well as observations, sometimes participant observations, were the main methods used to understand local practices of care and self-care at the beginning, while later the focus was on the women’s nervousness.

9. All quotes from individuals living in Santo André, and those stemming from the Brazilian literature, were translated by AL.

10. With the arrival of the DSM-III in 1980, depression and anxiety were distinguished as diagnostic entities, and drug treatment was separated accordingly. Shorter and Tyrer (2005) observe that this “obscured the notion that certain drug classes were effective for both anxiety and depression, particularly the benzodiazepines. With the decline of the benzodiazepines in the 1980s, anxiolytic therapy was placed on the back burner and antidepressants rushed into the spotlight, in the form of selective serotonin reuptake inhibitors. In the world of pharmacotherapy, anxiety and depression had become as different as chalk and cheese” (159). The current recommendation privileging the use of
SSRIs mirrors a more recent change in the history of anxiety drugs. Depression and anxiety are once more believed to be concurrent in most cases, but different from the pre-DSM III period, now they are treated with antidepressants: “Because they so often go hand in hand, anxiety and depression are considered the fraternal twins of mood disorders,” writes a health reporter (HealthyPlace.com 2009; emphasis added).

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