An Anxious Society:

The French Importation of Social Phobia and the

Appearance of a New Model of the Self

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Abstract

This dissertation examines the introduction of social phobia into France. My analysis is concerned with how this diagnosis, which is inconsistent with the psychoanalytic model that dominates French psychiatry, is increasingly being accepted by French physicians and patients. I argue that the diagnosis social phobia offers physicians and patients a justification for life difficulties that was not provided by existing diagnoses such as phobic neurosis, obsessional neurosis or 'normal' shyness.

In 2003-4 I carried out one year of fieldwork in North America and France. During this time I conducted participant observation and interviews with clinicians and members of a social phobia support group. Throughout this thesis, it is my objective to understand the disorder from three perspectives: historical, ethnographic, and socio-cultural.

First, I examine French psychiatrists' claims that social phobia has existed in French psychiatric literature since the nineteenth century. I investigate the efforts of these French psychiatrists to prove that the diagnostic category has a legitimate place in French medicine. Second, I look at how a small group of Parisian psychiatrists who practice cognitive and behavioural therapy are fighting for greater awareness and acceptance of social phobia. Promoting social phobia is a means of spreading awareness of their therapeutic model. Their aim is to unseat psychoanalysis from its dominant position in French psychiatry. Many individuals prefer cognitive and behavioural therapists' explanations of social phobia symptoms to those of psychoanalysts because they are less stigmatizing and their predicted outcomes more optimistic. But many French clinicians reject the diagnosis social phobia and prefer psychoanalytic explanations for patients' symptoms. Some see it as a 'fashionable' disorder overly promoted by the pharmaceutical industry. Third, I investigate how social phobia is related to cultural behavioural ideals and societal expectations. I look at how these factors lead more people to become concerned about the symptoms of social phobia than in the past.

In the end, I explain that French physicians and patients are choosing social phobia from among other possible labels for this set of symptoms. The way that they describe this diagnosis, however, blends multiple therapeutic models and they create an explanation of the disorder which most thoroughly and positively describes patients' experiences.

Résumé

Cette thèse examine l'introduction de la phobie sociale en France. Mon analyse porte sur la façon dont ce diagnostic, qui est en contradiction avec le modèle psychanalytique encore dominant dans la psychiatrie française, est de plus en plus accepté par des médecins et des patients français. Je propose de montrer que le diagnostic de phobie sociale permet aux médecins et aux patients de justifier et donner un sens à des difficultés de vie de façon plus satisfaisante que des diagnostics existants tels que la névrose phobique, la névrose obsessionnelle ou la timidité 'normale'.

En 2003-2004 j'ai effectué une recherche en Amérique du Nord et en France. Pendant une année, j'ai fait de l'observation participante et ai réalisé des entretiens avec des cliniciens ainsi qu'avec les membres d'un groupe de soutien aux phobiques sociaux. Dans cette recherche, mon objectif est de comprendre le trouble à partir de trois perspectives : historique, ethnographique, et socioculturelle.

Certains psychiatres français affirment que la phobie sociale fait l'objet de discussions dans la littérature psychiatrique française depuis le dix-neuvième siècle. Je commence par étudier les efforts de ces psychiatres français pour légitimer l'existence de la catégorie diagnostique dans la médecine française. Ensuite, j'examine comment un petit groupe de psychiatres parisiens qui pratiquent la thérapie cognitive et comportementale luttent pour accroître la prise de conscience et l'acceptation de la phobie sociale. La promotion de la phobie sociale est un moyen d'informer médecins et patients de leur modèle thérapeutique. Leur but est d'affaiblir la position dominante de la psychanalyse dans la psychiatrie française. Beaucoup d'individus préfèrent voir expliquer leurs symptômes de phobie sociale par les thérapeutes cognitifs et comportementaux plutôt que par les psychanalystes, parce qu'ils sont moins stigmatisant et sont plus optimistes quant aux résultats du traitement. Mais de nombreux cliniciens français rejettent le diagnostic de phobie sociale et préfèrent les explications psychanalytiques des symptômes des patients. Certains considèrent la phobie sociale comme un trouble 'à la mode' qui fait l'objet d'une promotion excessive par l'industrie pharmaceutique. Enfin, j'analyse la relation qui existe entre phobie sociale, idéaux comportementaux culturels et attentes sociales. Je montre comment ces facteurs amènent un nombre croissant de personnes à se sentir porteurs de symptômes de phobie sociale.

En conclusion, j'explique ce qui amène les médecins et les patients français à préférer la phobie sociale à d'autres étiquettes possibles pour désigner cet ensemble de symptômes. La manière dont ils décrivent ce diagnostic, cependant, fait intervenir de multiples modèles thérapeutiques pour fournir à leurs problèmes une explication qui est à la fois plus proche de leur expérience et socialement acceptable.

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Introduction

Choosing social phobia

Contents

This thesis traces the introduction of social phobia into France. Throughout my research and analysis I have sought to understand why social phobia is now being accepted as a medical category in France, though it was ignored for the first 15 years of its existence in standardized psychiatric nosologies. In contrast with North America, where a biological, cognitive and behavioural model of mental illness is dominant, in France, most physicians rely most heavily on psychoanalytic models in their clinical practices. Social phobia[1], or social anxiety disorder, is inconsistent with the dominant French psychoanalytic model. To psychoanalytically-oriented clinicians, social phobia is invisible: people trained in psychoanalytic psychotherapy will not spontaneously detect social phobia. Social phobia is a disorder defined by its symptoms, not its etiology.

Psychoanalysts are primarily concerned with the psychological etiologies of mental illness. They believe that the same condition can be represented by a range of symptoms and that the same symptoms can relate to different psychological problems. Psychoanalytically-oriented clinicians see symptoms as malleable manifestations of an

[1] Throughout this text I have chosen to use the term social phobia rather than the now more popular term social anxiety disorder. I have done this for several reasons. First, despite the fact that social anxiety disorder is now the most common term used to describe the disorder, social phobia is the official name according to DSM-IV. In this edition of the manual, social anxiety disorder is only a parenthetic name for the condition. Second, in France, the disorder is almost exclusively referred to as *phobie sociale*, which is a direct translation of the term social phobia. Some specialists occasionally refer to it as *troubles anxiété sociales*, but this is rare and reflects a conscious effort on their part to mirror the North American use of 'social anxiety disorder'. When physicians used this updated terminology in interviews, they quickly lapsed back into using the term *phobie sociale*. Third, the use of the term is a personal choice. As will be described later in this thesis, some have charged that the pharmaceutical industry is the force driving the replacement of social phobia by social anxiety disorder (Birnbaum and Montero 1999; Healy 2001). The name-change was proposed by researchers who work very closely with these companies (Liebowitz et al. 2000). Many people have suggested that the name change was introduced more as a means of facilitating the marketing of the disorder than for any other medically necessary reason. So, to remove myself from this debate, I have opted to use the older name of the disorder.

underlying etiology. Because of this, psychoanalysts place little importance on patients' symptoms when assigning diagnoses. But now, an emergent group of French clinicians is arguing for the adoption of social phobia and the symptom-based approach that accompanies it. French patients, who learned to speak of their personal malaise in psychoanalytic terms throughout their education and as a result of their exposure to French popular media (whose perspective on psychiatry has been dominated by a psychoanalytic framework, though this is now changing), are increasingly adopting a the new model of the self, consistent with social phobia. These patients now identify themselves as 'social phobics' (*phobiques sociaux*). The category social phobia is increasingly adopted by physicians and patients alike to describe what used to be covered by the term 'neurosis' (*névroses phobiques, névroses obsessionnels*). The question at the heart of this thesis is: why are people *choosing* social phobia?

The inseparability of social phobia and cognitive and behavioural therapy

The acceptance of social phobia in France occurs together with the adoption of cognitive and behavioural therapy and the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. Taking on these frameworks renders social phobia comprehensible and visible. People working from this perspective automatically understand what social phobia is and it is obvious to them how it should be treated.

The DSM and a cognitive and behavioural therapy focus on patients' symptoms. The primary concern of clinicians working from these perspectives is using patients' symptoms to identify their problem. The goal of subsequent therapy, both chemical and psychotherapeutic, is the alleviation of these symptoms. Clinicians who rely on the DSM

and who practice cognitive and behavioural therapy presume that the ultimate origins of their patients' problems are biological. For this reason, the use of psychopharmaceuticals is recommended and the most contemporary treatment protocols suggest the use of SSRI (selective serotonin re-uptake inhibitor) antidepressants. However, in France, many clinicians, particularly general practitioners and psychoanalytically-oriented psychiatrists, still prescribe benzodiazepines, such as Valium, as an anodyne to treat the symptoms associated with social phobia. These medications are not thought to cure patients' problems. Instead, they are prescribed to calm patients so that that they can better benefit from the real cure, which they see as psychotherapy. Psychotherapy is an integral part of patient therapy by clinicians who use the DSM and cognitive and behavioural techniques. But this is not the long term psychoanalytic psychotherapy that has traditionally been used in France. The goal of cognitive and behavioural psychotherapy is not to find the ultimate cause of patients' troubles. Instead, it is to identify patients' irrational, conscious thought processes and behavioural traits, expressed as symptoms of their disorder, and to correct these through rational examination and behavioural re-training.

Psychoanalytically-oriented clinicians, by contrast, search for the psychogenic origins of patients' problems and seek to address these through a careful examination of suppressed or repressed thoughts and desires that may be anxiety-provoking. The focus of this therapy is understanding and acceptance of these thoughts and desires rather than the removal of symptoms through conscious re-training.

Interviewees

During my fieldwork I interviewed psychiatrists and general practitioners, the physicians who most often treat social phobia. Psychiatrists receive referrals from all types of physicians. General practitioners treat those patients who are unwilling or unable to consult a psychiatrist. Waiting lists for psychiatrists are long but half of all French physicians are general practitioners, making the latter an easily accessible group. With one exception, I did not interview psychologists because they cannot prescribe medicines. An analysis of medication prescription and consumption was important because the French consume a large number of psychopharmaceuticals per capita. Information about social phobia is often provided alongside the promotion of paroxetine (Paxil in North America, Deroxat in France) and other SSRI (selective serotonin reuptake inhibitors) antidepressants. Thus, attitudes toward the use of medications are a focus of my research.

Object of research

At the beginning of my research, my aim was to look at *social phobia*, i.e. diagnosed cases of the disorder that clearly meet the diagnostic criteria, including the criteria of disability as a result of the condition. I quickly decided that it would be necessary to look at the DSM-IV *symptoms of social phobia*. I asked clinicians about their patients who *could* meet the diagnostic criteria of the disorder, rather than those patients who were *diagnosed* with the disorder. This shift was necessary to take into account clinicians who recognized the symptoms of social phobia amongst their patient populations, but who preferred to use another name to describe patients' conditions.

General practitioners and psychiatrists gave these symptoms various names such as depression, 'normal' or 'useful' anxiety (some physicians described anxiety as a motor [*moteur*] that was useful in pushing people to meet life challenges), reaction to a pathological social environment, shyness (*timidité*), neurosis and narcissistic personality.

Had I limited my research to the prototypical form of the disorder often described in clinical research articles, or as described in the DSM, I would have found few cases of social phobia in France. Further, physicians who use the social phobia diagnostic label often employ a more inclusive diagnostic threshold that is lower than suggested in the DSM. This malleability of the diagnostic category was not entirely surprising. In clinical research articles, authors often draw attention to the fact that depending on how social phobia's diagnostic criteria are interpreted, very different rates of the disorder can be detected. Social phobia is not one 'thing'. Each person and physician I spoke to described it in a slightly different way, focusing on different elements of the disorder. For this reason, there is not a unitary 'social phobia' that I have investigated, but a variety of experiences rationalized by the DSM symptom list.

Social phobia as a social construction

My approach to social phobia resembles that of a social constructionist to the extent that I take the *disorder* social phobia to be an idea that has been constructed over the last thirty years or so. Social unease and social phobias may always have existed, but the disorder is something that was recently constructed and was officially made a psychiatric condition when it was defined by a list of symptoms in DSM-III. The disorder's definition in the DSM is the result of years of clinical research, the discussions

of expert committees and consensus statements from panels of specialists. These are the people who decided what the disorder is. I do not take the disorder to be something 'real' or 'natural', something that has continually existed as specific condition as it if now defined. In this sense I follow the examples of Allan Young (1995), Margaret Lock (2002), and Hacking (1999).

The 'social phobics', as they refer to themselves, that I spoke to had most often been serially diagnosed with different disorders over the years. Their symptoms were interpreted in different ways at different points in time. However, patients usually reported feeling continual anxieties since childhood. Each diagnosis highlighted particular aspects of their troubles, for example acute reactions to stress (highlighted by the diagnosis spasmophilia), mood (highlighted by the diagnosis of depression), or obsessive tendencies (highlighted by the diagnosis obsessive-compulsive disorder). Each time their condition was re-labelled, the disorder they were diagnosed with corresponded with prevailing medical beliefs and trends. During the 1970s and 1980s, many were diagnosed with a magnesium imbalance, which fit into a wave of French research on the effects of elemental deficiencies. Others were labelled as neurotics or as suffering from narcissistic personalities (not narcissistic personality disorders). These latter diagnoses fit into the psychodynamic framework. The serial (and sometimes concomitant) diagnoses of French social phobics underscores the ease with which a set of symptoms can be assigned different labels and the way that different disorders are socially constructed in different eras.

It is not only in response to changing medical practices and theories that diagnostic categories are created and become more widely known and used. Alain

Ehrenberg, a French medical sociologist, has described the way in which depression became such a prevalent diagnosis in France (1998). According to Ehrenberg, depression became more visible and widely diagnosed by virtue of the fact that it stands in opposition to valued traits in society such as a willingness to act and take on responsibility. He argues that the recognition of a particular psychiatric condition is strongly influenced by the way in which it is situated within its social and historical context. Such an argument suggests that behaviour must reflect, to some extent, culturally disvalued traits if it is to be identified and labelled as pathological.

Social scientists and journalists have suggested that social phobia is an increasingly recognized disorder because it reflects a culturally-inappropriate timidity on the part of those who suffer from the condition (Cottle 1999; Healy 2004b; Scott 2006; Talbot 2001). This shyness is less tolerated on the part of men. While women make up the majority of people diagnosed with social phobia in epidemiological studies world wide (Furmark 2002), men are treated for the condition in equal numbers as women. These treatment ratios indicate that while serious shyness is considered pathological for all, it is even less acceptable for men, reflecting cultural ideals of aggressive, dominant males (Goode 1998). The social scientists and journalists cited above argue that there is an increasing demand in Western societies to be assertive and extroverted. When people's behaviour fails to live up to these standards they may conclude that what they previously considered a harmless characteristic, 'normal' shyness, is a problem. Increasingly, these people are encouraged by physicians and the media to see their problem as a disease or a disorder, something in need of treatment.

Beyond seeing social phobia as a social construction, I also see the disorder as what philosopher of science Ian Hacking has referred to as an 'interactive kind'. This sets the disorder apart from what philosophers refer to as 'natural kinds', though Hacking prefers the term 'indifferent kind'. He describes indifferent kinds as objects that are indifferent to their own labelling, while he defines interactive kinds as objects that are influenced by how they are labelled. Using the example of a quark, Hacking argues that the quarks are unaware of their own labelling. Because of this, "our knowledge about quarks affects quarks (in the sense that we may experiment on them expressly because of their designation as quarks), but not because they become aware of what we know, and act accordingly" (Hacking 1999: 105). Interactive kinds, by comparison, are aware of how they are labelled and react to their label and to the 'matrix' of institutions and practices that are associated with the label. Hacking introduces the example of children, hyperactive children specifically, to make his point. Hyperactive children, he argues, respond to the label that has been assigned to them and they become different people as a result of how they are educated and treated by others. In this sense, the children's consciousness of their label and to their environment, make them interactive kinds (Hacking 1999: 103).

Social phobics are interactive kinds in this way. Like hyperactive children, they become enrolled in certain practices and institutions because of their label. The social phobics I spoke to became members of a support group where they learned about what it means to be a social phobic from the other group members. They share stories about the difficulties of being social phobics and discuss coping mechanisms used to survive day to day life with their disorder. Over time, their descriptions of their experiences as social

phobics become more homogenous (see the example of M. Vial in chapter eight). While Hacking suggests that hyperactive children react with the label that is assigned to them simply by virtue of knowing the label, he does not elaborate extensively on the consequences of this knowledge. My research with French social phobics indicates that people have very strong reactions to their label (whether it is assigned by a physician or the result of self-diagnosis). Most reported that from the moment they learned of the disorder, they realized what their problem had always been[2]. They rapidly adopt the identity of social phobics to justify the difficulties they have had in life and the failures they have been met with.

While I see social phobia as a social construction stemming from particular cultures, histories and professional frameworks, I do not question the suffering of the social phobics I have interviewed. My analysis of social phobia as a social construct is meant in no way to deny the reality of their experiences. These people clearly suffer from a debilitating condition. By taking a social constructionist stance, I wish only to describe and analyse how these people's experiences came to be labelled as social phobia rather than as another condition which may equally aptly describe their experiences and symptoms.

Selling social phobia

Much literature has been dedicated in recent years to the concept of disease mongering and how the marketing of disorders and their treatments to a certain extent dupes people into believing that they have a disease, when in fact, they are only suffering

[2] I have no way of knowing whether this was their reaction to all of their previous labels as well, since the people I spoke to had already rejected many of their past labels.

from a normal, if undesirable condition (for example, Diller 2001; Fishman 2004; Healy 2001; Lee and Mysyk 2004; Moynihan, Heath and Henry 2002). A recent issue of *Public Library of Science, Medicine* was devoted to a discussion of disease mongering. The editors of this issue define disease mongering as "the selling of sickness that widens the boundaries of illness and grows the markets for those who sell and deliver treatments" (Moynihan and Henry 2006: 1). American advertisements for Paxil (paroxetine), which include information about social phobia, have been identified by David Healy (2001) and Pat Fiske and Catherine Scott (2004 [in the documentary *Selling Sickness: An Ill for Every Pill*]) as an example of disease mongering. The Paxil advertisements urge viewers to consult their physicians if they suffer from "overwhelming anxiety and intense fear of social situations with unfamiliar people". They show people cringing in work and social situations because of their inability to deal with interpersonal encounters. The televised advertisements assure viewers that if they take Paxil to treat their social anxiety disorder, it will allow others to "see the real you". The wording of the television commercial duplicates portions of the DSM description of social phobia, referencing "overwhelming anxiety" and "intense fear" of social situations. However, the tone of the advertisement and the situations depicted mirror more ordinary social situations: the people in the commercials seem merely uncomfortable and anxious. Similar television advertisements for medications used to treat other conditions, such as premenstrual dysphoric disorder, have been pulled from the air by the Food and Drug Administration (FDA) because they were found to "trivialize" the severity of the disorder as it is defined in the DSM.

A recent marketing campaign for social phobia was prepared by GlaxoSmithKline's public relations firm Cohn and Wolfe. The firm prepared posters

which were displayed in bus shelters throughout the United States. They portray a dejected-looking man playing with a teacup. The text of the advertisement reads: "You blush, sweat, shake – even find if hard to breathe. That's what social anxiety disorder feels like". The posters bore the insignia of a group called the Social Anxiety Disorder Coalition and its three non-profit members, the American Psychiatric Association, the Anxiety Disorders Association of America, and Freedom From Fear. Brendan Koerner, a journalist, suggests that the coalition was not a grassroots alliance of patients in search of a cure. He argues that it was cobbled together by SmithKline Beecham (now called GlaxoSmithKline). When Koerner contacted the coalition's hotline, he was informed by a recording, "This programme has successfully concluded" (Koerner 2002). These marketing campaigns represent one way in which 'disease mongering' leads people to learn, and become concerned, about particular disorders. The effect of these advertisements is to lower the diagnostic thresholds of disorders and, therefore, to increase the number of people who identify with the disorder and seek help for their condition.

The American form of direct to consumer advertising, in which the name of the drug is presented alongside the name of a condition, is not is not permitted in France[3]. However, an increasing number of 'awareness campaigns' have been launched in France about social phobia. The disorder is often discussed in the popular media, such as in the lay magazine *Psychologies* (similar to the North American *Psychology Today*). Recent television and radio shows have been devoted to the problems of shyness and social phobia.

[3] This issue is under review by the European Union.

Medicalization and social phobia

Authors who discuss disease mongering are a part of a long history of medicalization researchers. The literature on medicalization suggests that an increasing number of experiences that were once considered 'normal' or seen as non-medical issues have been redefined as diseases[4]. Many Western social scientists suggest that we live in an over-medicalized society in which we define an increasingly number of experiences as pathological (for example, Conrad 2005). More recent literature on medicalization claims that we are now monitored not only by physicians for signs of pathologies, but also by ourselves (Clarke et al. 2003). These social scientists write that our self-surveillance has led us to believe that we are indeed quite sick and in need of medical care. A recent study supports this contention. It indicates that Americans report three times the illness frequency than is reported by people in India (Guyatt 2003). The proposed explanation for these findings is that Americans have learned to label certain conditions as diseases, such as irritable bowel syndrome, that would be considered a part of normal life in India.

In the case of social phobia, it is suggested that 'normal' shyness has become redefined as a disorder through a process of medicalization. Many of the reasons for this shift are mentioned in the previous section. However, looking at social phobia as the medicalization of normal shyness places a particular emphasis on the power and authority of the medical institution as well as on individuals' willingness to enrol themselves in a treatment regimen offered by the medical institution.

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[4] This literature will be discussed in greater detail in the conclusion of the thesis.

Not only have we learned to monitor ourselves for signs of illness, but we have also learned to monitory ourselves for the risk of future illness (Lock 1998; Novas and Rose 2000). In the case of social phobia, this occurs as a result of pharmaceutical marketing campaigns which encourage people to examine themselves for the symptoms of the disorder. Individuals diagnosed with social phobia are informed by physicians that they are now considered at risk for the development of depression. The connection between the two disorders also is mentioned in popular discussions of social phobia. The people I observed in a social phobia support group in Paris were aware of the connection between depression and social phobia and they feared the development of what they consider the much more serious disorder. Many of these people wished to convince me that they were entirely free of all symptoms of depression. They contrasted themselves to members of the support group whom they believed were depressed. Their vehement claims to a relatively low-level mental illness (social phobia) made it clear that they feared slipping into a state of more serious mental illness that they believed their social phobia placed them at risk of developing.

Enhancement and social phobia

In addition to discussions of disease mongering and medicalization in the media and academic literature, one encounters debates about enhancement. In these cases, ethicists ask whether physicians are treating true disorders or trying to make people "better than well", to use Peter Kramer's (1993) phrase. These commentators argue that people are using medications and medical interventions increasingly to perfect themselves, to make their minds and bodies conform to cultural ideals (for example,

Elliott 2003; Rothman and Rothman 2003). Some writers suggest that a "keeping up with the Joneses" mentality drives the use of enhancement technologies. They argue that as more people use medications to enhance their social or intellectual performance, collective expectations of performance will rise (Diller 2000; Wolpe 2002). Social phobia seems to fit this pattern. This was certainly the case among the members of the Parisian support group that I studied. One man stated that he decided to attend the group after diagnosing himself with social phobia. He explained that did not feel comfortable making presentations to large groups of people. While this had not been a problem for him in the past, he now wanted a promotion at work and the new position required that he regularly take a leadership position in group work and at meetings. At this point, he reconceived of his problem as a disorder. It is possible to argue that, for this man, treatment for social phobia amounted to an enhancement. However, I did not find enhancement concerns to play a major role in most individuals' decisions to identify themselves as social phobics. Thus, enhancement debates are marginal to my analysis of the introduction of social phobia into France.

While there are many ways in which social phobia is being 'sold' to French physicians and patients, there is also a trend toward these people seeking out social phobia as an explanation for particular symptoms of malaise. Part of this process relates to medicalization, as mentioned above, and the increasing tendency of people in Western societies to look for biological explanations for their medical problems. People want to put the name of a disorder or disease on their symptoms and personal problems. But the diagnosis of social phobia offers an explanation of individuals' problems that was not made available by prior explanatory frameworks. The individuals who identify

themselves as social phobics actively sought out this new label because of the new explanatory framework it offered (this applied to physicians as well). In this way, more than being 'sold' the idea of social phobia, these people are actively selecting among different therapeutic frameworks and opting to identify with the DSM and cognitive and behavioural principles associated with social phobia.

Choosing *French* social phobia

Throughout my research it became clear that while many factors are implicated in the increasing acceptance of social phobia in France, to a large extent, people are choosing social phobia. The category is used preferentially to explain symptoms that are accounted for by pre-existing diagnoses used in France. Many people, including French physicians and social phobics, have made a concerted effort to encourage the acceptance of social phobia.

The importation and adoption of the diagnosis is often justified by reference to its high prevalence in North America. Many proponents for the acceptance of social phobia argue that if it is so widespread overseas, it is only natural that one would expect to find it in France. Physicians and patients assert that the use of the diagnosis in North America has improved patients' outcomes and decreased the stigmatization associated with their symptoms. French physicians and patients want social phobia symptoms to be similarly destigmatized in France.

Patients and physicians seem eager to adopt a perspective of their symptoms that resembles what Nikolas Rose has referred to as the 'neurochemical self' (2003). While Rose is interested in disorders related to cravings and addictions, his discussion is

relevant to social phobia because, like the disorders he discusses, it is a 'disease of the will' (a phrase that Rose attributes to Mariana Valverde [1999]). Throughout my research, physicians and social phobics repeatedly stated that the diagnosis offers relief to those people who were previously considered shy and who were told that they should simply try harder to be extroverted. Overcoming shyness, these people say, is considered a matter of will. Social phobia, on the other hand, cannot be overcome in this way. It is believed to require medical attention and specific interventions such as antidepressants and cognitive and behavioural therapy. Rose argues that new information about the brain and its mechanisms, along with developments in treatments (such as psychopharmaceuticals), has encouraged a reconceptualization of diseases of will. Diseases of will have become, he suggests, diseases of the brain. Almost all of the French physicians and patients I spoke to who support the adoption of the diagnostic category social phobia described the disorder as a disease of the brain. Explanations of social phobia symptoms that are based on the 'neurochemical self' are increasingly preferred to explanations that focus on the psychogenic origins of mental illness.

There are a number of other factors pushing people to choose social phobia and the cognitive, behavioural and biological model that accompany the disorder. First, these treatments are faster (per session and in numbers of session) than psychoanalysis. Physicians are paid for each patient they see. This means that the most efficient mode of treatment will be preferred. Providing medications or brief sessions of cognitive and behavioural therapy will allow them to make more money than they would by providing lengthy sessions of psychoanalytic psychotherapy. The government is favourable to cognitive and behavioural therapy since it requires fewer (government reimbursed)

sessions to treat a patient than psychoanalytically-oriented therapies. Second, young physicians are trained in adherence with DSM and cognitive and behavioural, rather than psychodynamic, frameworks. This means that the next generation of doctors will be accustomed to looking for the symptoms of disorders such as social phobia and they will feel more comfortable offering assistance and explanations based on cognitive and behavioural principles. Third, patients increasingly research their medical conditions, or suspected medical conditions. As they learn more about social phobia in the popular press and on the internet, they are more likely to ask their physicians about this disorder and the treatments (such as antidepressants and cognitive and behavioural therapy) that are discussed in popular resources. Many clinicians, particularly general practitioners who work out of 'private' (not hospital based) clinics, are likely to treat patients according to their wishes, since competition is intense among these doctors. If they do not keep a large patient base, they can literally go out of business. The pharmaceutical industry is aware of this situation and GlaxoSmithKline markets paroxetine for the treatment of social phobia particularly intensively to these clinicians. Finally, many clinicians suggested to me that in contemporary France, lack of social ease and adaptation are considered particularly shameful. At the same time, French citizens are more isolated that ever before as more young people move far from their families to live in urban areas. A focus on problems of social adaptation and the imperative to improve social functioning is likely to make a disorder such as social phobia more visible. People may start to interpret their social unease as the primary root of a broader set of life difficulties. This would encourage individuals to conceive of themselves as social phobics. All of these factors push for the adoption of social phobia as a new way to explain one's

personal problems that may have previously been described as part of a neurotic condition.

The globalization of psychiatric diagnoses

The increasing acceptance of social phobia in France is part of a trend toward the more common use of American diagnoses (from the DSM). The commonness of this process, in which American diagnoses are assumed to be present world wide if only one searches for them, indicates that psychiatric diagnoses will continue to become more globalized and standardized. The DSM is increasingly the psychiatric nosology that is used world wide to diagnose mental disorders. The fact that social phobia has been imported into France along with an American-style therapy, cognitive and behavioural therapy, provides further evidence of this Americanization of French psychiatry. French patients will not only be diagnosed with DSM categories, they will also have their conditions treated and explained according to the dominant American therapeutic principles. This means that French experiences will increasingly be justified and comprehended as are experiences overseas.

Ilana Löwy and George Weisz have recently examined the question of standardization versus variation in Western medicine. They examined the widespread use of progestins in France and compared the French reasons for their use to those in the United States and Britain as a means of exploring national and local variability (Löwy and Weisz 2005). They conclude that variation is the rule in Western medicine, despite the fact that the proponents of evidence-based medicine (EBM) are pushing physicians and researchers worldwide to streamline their practices. Löwy and Weisz suggest that

variation, to EBM practitioners, is considered a problem to be solved by future consensus papers, meta-analyses or practice guidelines. Their findings suggest that guidelines and meta-analyses have not met their goals.

This is also the case with social phobia. There is a push for and from clinical researchers world wide to produce replicable, standardized studies on social phobia. This research is meant to produce guidelines that will be used by physicians in order to provide an internationally uniform treatment for social phobia. But clinical practices differ from the work of clinical researchers, including the work of French specialists[5]. In fact, when I interviewed several of the most frequently published French clinical researchers of social phobia, I found that even their practices often differed from the protocols they recommended in their scientific articles. These practices are described in detail in the following chapters.

French clinicians, including the clinical researchers mentioned above, rely on eclectic theories and treatment strategies to attend to their patients' social phobia symptoms[6]. While eclecticism in clinical practice is not limited to French physicians (Frank 1973 [1961]; Young 1988), the particular kind of eclecticism in French clinics reflects the professional history of French psychiatry, as well as the cultural milieu in which physicians practice. French clinicians combine cognitive, behavioural and biological explanations of social phobia with psychoanalytic explanations for patients' troubles. References to shyness and personality types, along with other psychoanalytic concepts such as neurosis, are mixed into clinical explanations of patients' social phobia

[5] This situation is very likely not limited to France. Clinical practices very often differ significantly from clinical research guidelines.
[6] Here I am referring to those French clinicians I spoke to who use the diagnostic category social phobia. Many refuse to use the diagnostic category.

symptoms. The result is that while the DSM-IV category of social phobia is diagnosed in France and cognitive and behavioural therapy is a part of its treatment, the disorder is explained and understood in a culturally-specific way. It reflects the historical dominance of psychoanalysis in France. While the two models (psychoanalysis on the one hand and cognitive, behavioural and biological therapies on the other) are combined partly as a result of the training most over-forty year old physicians have had in both psychoanalytic and biological psychiatry (including training in how to use the DSM), clinicians' tendency to blend the two models of mental illness also reflects their attempts to make disorders more understandable to patients.

Reference to these psychoanalytic concepts is commonplace in France and it is through this lens that most French citizens have been taught to understand many elements of mental illness. Psychoanalytic terms and concepts are regularly used to explain the everyday suffering that is characterized by the symptoms of social phobia. This type of everyday suffering or low level mental illness, including neurosis, is thought to differ from madness according to most of the social phobics I interviewed. Most of these people see madness as something much more serious than social phobia and as something that is associated with hospitals or asylums.

A particularly French social phobia

I have emphasized the extent to which French social phobics value their new diagnosis because it turns a 'disease of will', shyness, into a chemical imbalance that is beyond their control and therefore less stigmatizing. But while they identify strongly with the diagnosis of social phobia, this does not prevent French social phobics from

drawing on eclectic psychiatric etiologies to explain their psychic unease. Like French clinicians, these social phobics move seamlessly between contradictory medical models without being troubled by the inconsistency of the explanations for their difficulties. When they want to emphasize that their troubles are a real medical condition in need of medical treatment, they emphasize biological models of their illness, referring to the need to take medications to treat the underlying cause of their disorder. When they want to emphasize the treatability of their condition, they emphasize cognitive and behaviour models of social phobia, which suggest that the disorder can be effectively treated with six months of therapy and antidepressants (after which patients' symptoms are expected to have been relieved).

However, social phobics often admit that while six months of cognitive and behavioural therapy may alleviate their condition, they usually expect to have to manage their illness throughout their lives. They anticipate a life long struggle because they believe that social phobia is associated with an inborn temperament or personality. These integral characteristics, they believe, make them susceptible to social phobia. Yet informants indicated that this was not entirely bad, that their temperaments and personalities are associated with many positive character traits. At this point in our conversations, they abandoned discussion of their disorder. These French social phobics highlighted their sensitive temperaments and the need to understand the particularity of their own personalities deeply if they wished to manage their condition. Many of these people argued that psychoanalytic psychotherapy has helped them to understand important elements of their personalities and has given them an in depth comprehension of themselves that will provide them with a more durable and stable recovery. These

statements usually surfaced at the end of interviews, after social phobics had spent most of our conversation praising the DSM and cognitive and behavioural approach to their conditions. So, while these individuals have chosen to seek out physicians who will diagnose them with social phobia, in addition to firmly identifying themselves as social phobics, they nonetheless draw on a more eclectic, and particularly French, explanation for their experiences. In this way, the social phobia that they have chosen to identify with provides both a contemporary, American-style of justification for their condition, and at the same time they retain explanations that are consistent with the French psychoanalytic tradition. French social phobics have negotiated an identity that best explains their experiences given their cultural milieu. They have taken the most positive elements of multiple traditions and use these to create their new selves. It is a particular kind of social phobia that these people have chosen to identify with.

The acceptance of social phobia in France has broader implications than the introduction of one new disorder. Social phobia is a vehicle used by French cognitive and behavioural therapists in their efforts to promote their therapeutic framework and to unseat psychoanalysts from their dominant position in French psychiatry. The introduction of social phobia and cognitive and behavioural therapy (and the biological models of the brain that accompany cognitive and behavioural therapy) shapes the way that the self (*le soi*) is conceptualized in France. This new image of the self is blended with existing psychoanalytic theories and the result is a distinctively French hybrid of a psychoanalytic, cognitive and neurochemical self.

Issues related to the subject of this thesis

There are a number of interesting issues related to my research on social phobia that can be raised. Many of these have been addressed in my thesis. However, as in all research, it was necessary to limit the scope of my work and as a result, some avenues of inquiry remain unaddressed. It is nonetheless important to enumerate some of these related issues:

1. Where do personality disorders fit into French physicians' discussions of social phobia?

The DSM-IV (fourth edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association) category "avoidant personality disorder" is similar to social phobia and may sometimes be used alongside the diagnosis social phobia or in its place. In North America, using the category avoidant personality disorder is a means of using psychoanalytically-influenced concepts in patient assessment[7], while still working within the DSM framework. French physicians are trained to use both psychoanalytic theories and DSM categories, so one may expect that they would feel especially comfortable using personality disorder diagnoses to bridge the gap between these two therapeutic orientations. However, throughout my research, only one physician specifically referred to personality disorders. I suspect that French physicians use the foundational psychoanalytic concepts that personality disorders are based upon, rather than their DSM formulations, to understand their patients and explain particular concepts of personality to their patients. This psychoanalytic explanation is often provided alongside a DSM diagnosis. I note later in this text that the physicians I interviewed

[7] The relationship between psychoanalytic categories, personality disorders and the DSM will be examined in greater detail in chapter 1.

often use psychoanalytic concepts unproblematically alongside DSM categories even though the two systems of labelling are inconsistent with one another. The use of apparently conflicting explanations of patients' psychic unrest does not seem to concern most of the French clinicians I interviewed, and as a result, they do not use personality disorders to bridge the gap between these two therapeutic standpoints.

2. What is the role of pharmaceutical companies in the increasing acceptance of social phobia in France?

Throughout this text, I have pointed out certain ways in which the pharmaceutical industry is implicated in the rising profile and increasing acceptance of social phobia in France. However, a detailed examination of the activities of the pharmaceutical industry in France was not the objective of this thesis. Instead, I focused on changing therapeutic orientations of physicians, as physicians' therapeutic orientations to a large extent determine their willingness to accept the DSM-IV categories promoted by the industry (such as social phobia) as well as their interest in using the medications promoted by the industry. For instance, psychoanalytically-oriented physicians will be less likely to prescribe SSRI (selective serotonin re-uptake inhibitor) antidepressants than are cognitive and behavioural therapists. Psychoanalytically-oriented physicians believe that mental unrest is psychogenic, so they are naturally not as interested in the industry's claim that SSRIs are effective at treating the biochemical origins of psychic unrest in the case of social phobia.

Pharmaceutical companies are actively promoting information about social phobia and SSRI antidepressants in France. These drugs are still covered under patent protection

and are therefore very lucrative for the companies, unlike benzodiazepines, which are older drugs commonly used for the treatment of anxiety in France (including conditions sharing the symptoms of social phobia). The pharmaceutical industry, particularly GlaxoSmithKline, is in the process of trying to convince French physicians to abandon their habit of prescribing benzodiazepines. One of the ways they are doing this is to fund research on social phobia and other anxiety disorders because North American studies have demonstrated that SSRIs can effectively treat these conditions. It is most effective for the industry to promote information about disorders their medications can treat alongside information about the medications themselves.

Promoting information about disorders such as social phobia requires that the pharmaceutical industry teaches French physicians about the DSM, which defines disorders such as social phobia. The DSM is more commonly relied upon in North America than in France. Pharmaceutical companies are spreading information about a North American therapeutic model implicit in the DSM in their attempt to change French physicians' diagnostic and prescription habits. The North American model suggests that the ultimate origin of psychiatric disorders is biological rather than psychological. Using this model, the industry can argue that their drugs are cures for conditions such as social phobia. The industry funds symposia, which focus on disorders such as social phobia and where French medical opinion leaders discuss the treatment of these disorders (included among these treatments are SSRIs), to spread information about social phobia and SSRIs. Pharmaceutical companies also give physicians copies of the DSM free of charge in an attempt to convince them to use the manual's categories and their treatments.

The industry has lobbyists who succeeded in having the French government classify SSRIs as a reimbursable treatment for social phobia despite the state's initial refusal to do so. The industry is also lobbying the European Union in an attempt to have direct to consumer advertising permitted. Their efforts did not pay off in a 2004 vote that upheld the Union's anti-DTCA position, but they are continuing their efforts. Several physicians I interviewed reported that pharmaceutical companies circumvent the European Union's ban on DTCA by producing covert marketing campaigns for their drugs in the form of public health awareness campaigns on the television and radio.

Finally, GlaxoSmithKline pays for the promotional pamphlets distributed by a social phobia support group in Paris. The president of this support group hopes for more financial support from them in the future.

For all of these reasons, the industry is deeply implicated in the promotion of information about social phobia in France.

3. How is the widespread use of anxiolytics (e.g. benzodiazepines) in France related to the traditionally low recognition and treatment of social phobia (i.e. with the accepted North American treatment of antidepressants)?

Despite the fact that a growing number of French physicians are adopting DSM categories for use in their clinics and are beginning to use SSRIs for the treatment of these conditions, a large number of French clinicians still use benzodiazepines to treat their patients' anxiety. These physicians tend to use benzodiazepines non-specifically, meaning that they do not necessarily inform their patients of a specific DSM diagnosis (and they may not even decide upon a label themselves). Such physicians often believe

that assigning a specific diagnosis to patients is not beneficial. In fact, some say that this could be destructive for patients who would carry around their diagnostic label for the rest of their lives. These clinicians suggest that placing patients in the boxes defined by diagnoses does not improve their treatment or outcome. Because of the way that these physicians conceive of diagnosis and treatment, it is not easy for French psychiatric opinion leaders or the pharmaceutical industry, both of whom are promoting information about social phobia, to convince these physicians to change their diagnostic and treatment practices.

4. What kind of evidence is there that French physicians' understanding and treatment of mental unrest is changing (e.g. prescriptions, diagnoses) in such a way that cognitive and behavioural theories[8] about patients' problems are replacing psychoanalytic theories?

It is more difficult to track physician diagnosis patterns in France than in the United States, for instance. In the United States, one can access prescription rates of medications and the diagnoses for which they were given through statistics kept by health maintenance organizations and insurance companies. In France, statistics which link prescribed drugs to diagnoses are not available. However, there is evidence that sales of antidepressants have risen dramatically over recent years, while sales of benzodiazepines have fallen (Le Moigne 2002). This suggests that physicians have been influenced by arguments about the superiority of SSRIs' ability to treat the biochemical origins of anxiety and depression and it may indicate that they are beginning to conceive of the conditions they prescribe the drugs to treat differently as well (benzodiazepines are

[8] The link between cognitive and behavioural theories of the mind, the use of DSM categories, and reliance on biological models of mental illness are discussed at length in this text, so I will not go into detail about the relationship between them at this point.

considered anodynes used to allow patients and physicians to more easily address the psychological origins of mental illness – this clearly involves a different way of thinking about psychic unrest and its treatment). However, it is possible that physicians have simply changed their prescribing patterns without changing the way they conceive of the specific effects of the medications and the origins of mental illness. This would more likely be the case with general practitioners. It is this category of physicians who prescribe the greatest quantities of antidepressants and anxiolytics (such as benzodiazepines).

Most of the evidence I have of physicians' changing understanding and treatment of mental illness is anecdotal or based on the assumed effects of changing medical education. The anecdotal evidence comes from my interviews with French general practitioners and psychiatrists. Many of these physicians state that they have begun incorporating more cognitive and behavioural models and techniques into their practices. Many of them have taken continuing education courses that focus on these theories. Clinicians also noted that they believe their colleagues are increasingly interested in cognitive and behavioural therapies. Cognitive and behavioural models of the mind have replaced psychoanalytic ones in terms of the relative attention they are given in medical education: psychoanalytic models have become marginal. Recent medical school graduates and current medical students are more familiar with DSM categories and cognitive, behavioural and biological theories of the mind than are most of their senior colleagues. Physicians trained according to these principles will continue to grow in number over time and as older physicians retire, the theories that these younger

physicians are trained in will naturally become the dominant models used in French medicine and psychiatry.

5. To what extent is a new model of the self is appearing in France, one that is based on the desirability of an extroverted personality and the labelling of extreme shyness as a pathology?

It is difficult to furnish evidence of large scale cultural change. However, statements supporting this notion were repeated to me by 'social phobics' during interviews. These people all claimed that shyness and passivity is less accepted in contemporary French society. Extroverts, these people said, are considered to have more acceptable, and even more normal, personalities. Popular literature supports these claims. I found many articles which described French society's increasing preference for extroverts and the increasing difficulty of being shy in this milieu (André 2004; Halmos 2006; Sarfati 2004). In addition, I came across an article that argued for a greater appreciation of introverts (Huret 2002) by enumerating the contributions famous shy people had made to society. This article provides further evidence of the valour normally assigned to extroverts rather than introverts.

Physicians I interviewed stated that they have patients who previously considered their shyness acceptable but who have since begun to think of their condition as pathological because their shyness is increasingly incompatible with their aspirations: both social and professional. Physicians reported that their patients increasingly have difficulties meeting workplace expectations (e.g. group presentations and leadership roles) and establishing social networks and intimate relationships, which is exacerbated

by the growing necessity of moving to large urban centres to initiate or forward one's career.

Large scale distribution of questionnaires concerning social expectations and cultural norms would have provided more conclusive evidence of the social change I discuss in this thesis, but I did not have the means to carry out this type of research.

Chapter outline

I begin this thesis with an introduction of the object of study: social phobia. Chapter 1 describes the creation of the diagnosis social phobia as well as the evolution of the diagnostic category since its introduction into DSM-III in 1980. This chapter presents different etiological explanations of the disorder and epidemiological data about its prevalence. Chapter 1 concludes with a discussion of whether social phobia is a pathology, or whether it is simply the medicalization of a 'normal' condition. This section examines where thresholds are set to differentiate normal from pathological states and how new illness categories are created.

Chapter 2 describes the stake holders in social phobia: who is involved in its promotion and why. In this chapter, I examine changing attitudes toward mental illness and health, and how the acceptance of the diagnosis social phobia is affected by these trends. The methods that proponents of the category have used to spread awareness about the disorder are examined.

In Chapter 3, I examine the history of therapeutic interventions used in North America and France. In particular, I look at the rising popularity of psychogenic explanations of mental illness during the early twentieth century and how psychoanalytic

explanations of mental illness have been replaced by cognitive, behavioural and biological explanations in North American. The factors driving the acceptance of new etiological models of mental illness are examined as they relate to North America and France.

Chapter 4 examines different histories of social phobia. In this chapter I look at the different ways in which the history of social phobia can be told. I look at both Anglo-Saxon and French accounts of the history of the disorder, from descriptions of similar conditions in nineteenth century psychiatry to its present day format. By tracing the different stories of social phobia, and the people who are said to have played central roles in the definition of the disorder, I highlight how social phobia can be seen to have different national characteristics. French clinical researchers, for example, describe Pierre Janet as a founder of the diagnostic category while Janet is not mentioned at all in Anglo-Saxon histories of the disorder. The effect of the French account of the disorder is to create a specifically 'French social phobia'.

Chapter 5 is the first of three chapters that focus on the words of French clinicians. In this chapter, I outline the range of ways in which social phobia *symptoms* are described by French general practitioners and psychiatrists. This chapter focuses on the other diagnostic labels these physicians use to describe social phobia symptoms, as many of these doctors refuse to use the label social phobia.

Chapter 6 focuses on French cognitive and behavioural therapists. These clinicians are the primary proponents of the acceptance of social phobia in France. In this chapter, I relate their arguments concerning the importance of adopting this diagnostic category in France.

Chapter 7 outlines French clinicians' arguments concerning why the diagnostic category social phobia should be avoided. In this chapter I focus on why many French clinicians believe that using the diagnostic label social phobia, and treating patients' symptoms according to cognitive and behavioural principles, is a disservice to patients.

In Chapter 8, I focus on members of a Parisian social phobia support group. In this chapter, I provide a detailed account of who has social phobia in France. By doing so, I explain the demographics of this patient population and the treatments these people have been offered now and in the past. This chapter outlines the extent to which mental illness, and social phobia in particular, is accepted in French society. It also explains the multiple therapeutic recourses drawn upon by French individuals now diagnosed, or self-diagnosed, with social phobia.

Chapter 9 outlines patients' and physicians' sources of information about social phobia. This chapter concludes with a discussion of why it is that French individuals have become particularly receptive to information about social phobia. I use this discussion to address why it is that the French are now 'getting' social phobia.

Finally, Chapter 10 examines why it is that people want to be social phobics and why physicians want to use this label. In this chapter, I look at what the diagnostic category, and the new therapeutic system that accompanies it, offers to patients and physicians that were not provided by pre-existing treatments and labels. I focus on the individualistic factors that are driving the acceptance of this label.

A full description of the clinicians I interviewed is included in Appendix II. A description of my methodology is summarized in Appendix I.

Part I

Putting Social Phobia in Perspective

Chapter One

What is social phobia?

Contents

Modern social phobia

To begin this ethnography of social phobia, I will describe the object of study. My research focuses on the category social phobia and how the diagnosis has been adopted in different countries, particularly in France. While I examine the symptoms and experiences that constitute this disorder, my interest is not to trace people's experiences throughout the ages or to argue for or against the permanence of the disorder's symptomatic description. Instead, my objective is to explain why certain experiences are now called social phobia and how this labelling relates to the dominance of particular psychiatric frameworks. Much of this thesis will focus on social phobia in its most current form, as defined by the American Psychiatric Association (APA) in the fourth edition of the Diagnostic and Statistical Manual of Mental Illnesses (DSM-IV). However, an account of social phobia's history, tracing it from Isaac Marks and Michael Gelder's initial description in 1966 through its different forms in the DSM (third edition to present) will explain the changes the category has undergone over the last 40 years. Some psychiatrists argue that social phobia has existed in psychiatric literature for over 100 years[9], though its descriptions have been influenced by changing psychiatric frameworks (for example, Lépine and Pélissolo 1995; Marks 1970). However, most of these versions of the disorder disappeared over time and were never the base of substantial psychiatric literature. The diagnosis of social phobia that is used today has maintained a constant place in psychiatric literature for the past 40 years.

A description of the recent history of social phobia provides a background against which one can contextualize the disorder in its modern form, according to contemporary

[9] The long-term history of social phobia will be discussed in chapter four.

psychiatric theories and nosologies. Throughout this recent history, important, though small, changes have taken place in the characterization of the disorder that reflect trends within modern psychiatry as a whole. This history serves to contextualize social phobia within contemporary Western psychiatry.

The DSM, ICD and social phobia

I adopt standardized psychiatric nosologies for the definition of social phobia and as exemplars of the dominant theories in the field. Psychiatrists world wide employ two standardized nosologies to diagnose mental disorders. The Diagnostic and Statistical Manual of Mental Disorders (DSM) [10] of the American Psychiatric Association (APA), now in its fourth edition, is perhaps the most widely used psychiatric nosology world wide. The tenth edition of the International Classification of Diseases (ICD-10) of the

[10] Contemporary American psychiatric nosology was created with the DSM-III, published in 1980. The theoretical foundations of its predecessors, published in 1952 and 1968, are largely incompatible with the third edition and they never gained widespread acceptance. The first DSM was compatible with psychodynamic principles and described mental disorders as existing on a continuum from mental health to severe mental illness. Both these characteristics of the manual are problematic according to the DSM-III committee and beyond. The second DSM moved away from psychodynamic principles, in an attempt to align itself with its contemporary nosology, ICD-8. However, it retained the term neurosis, which refers to intrapsychic conflict that was considered responsible for creating anxiety. It also failed to establish clear boundaries for diagnostic categories. Both of these characteristics of the manual are problematic in terms of contemporary psychiatric diagnostic nosologies. With DSM-III, its creators sought to revolutionize the diagnostic criteria for psychiatric disorders. Each disorder was to be a distinct and delimited entity (Young 1995: 98-9). Diagnosis was to be "identified by criteria accessible to empirical observation and measurement" (Young 1995: 99).

DSM-III-R (1987) and DSM-IV (1994) include revisions and additions to the diagnostic categories included in DSM-III. This process of updating takes place using committees of experts, generally specialists of the disorder assigned to their committee. These committees review available studies and clinical information about the diagnosis assigned to them, and after this process, they make a recommendation as to whether or not a new disorder should be included and if so, where in the manual (Young 1995: 109).

World Health Organisation (WHO) is also employed outside the United States[11]. There is substantial overlap between the diagnostic symptoms and the codes for disorders in the manuals, to the point that they are now nearly identical.

Illnesses listed in the DSM are divided into "mental disorders" and "personality disorders", which are defined as axis I and axis II disorders respectively[12]. Mental disorders are further divided into categories based on the similarity of symptoms. These include mood disorders, somatoform disorders, substance-related disorders, eating disorders, and anxiety disorders. Social phobia is classified among the anxiety disorders.

The diagnosis of social phobia first appeared in the third edition of the DSM, which was published in 1980. DSM-III departed in many ways from the theories and traditions that had informed earlier versions of the manual which had been predominantly psychoanalytic. One of the most significant changes in the content of DSM-III was that the term neurosis no longer referred to an etiology, the cause of a person's neurosis. While it still appeared, it was now used parenthetically to label specific disorders that were defined by lists of symptoms whose origins cannot be known with certainty (APA 1980: 9-10). In DSM-II the term neurosis referred to the neurotic process, considered the etiology of the disorder, in which the symptoms of mental illness were considered an

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[11] The codes for mental disorder found in the ICD are officially used world wide. However, the editorial task force of the DSM introduced codes in their manual which are virtually identical to those in the ICD. Because of the similarity of the classifications in these manuals, American psychiatrists can rely solely on the DSM while still using the codes of the ICD.

[12] The DSM editorial task force recommends to doctors the use of a multiaxial patient evaluation system. Axis II includes personality disorders and specific developmental disorders, and axis I includes all other mental disorders. Axis III is used to identify physical disorders, axis IV is an assessment of the severity of psychosocial stressors, and axis V identfies the highest level of adaptive functioning in the patient's past year (APA 1980: 8).

adaptation to anxiety-inducing past experiences or thoughts. Within the new DSM-III framework, the re-shaped concept of neurosis was worked into several disorders, rather than being used as a single category[13]. Neurosis was split into affective, anxiety, somatoform, dissociative and psychosexual disorders.

It was not only the etiology of neurosis that the editorial task force of DSM-III rejected. They chose to exclude etiological information on all mental disorders, except for the rare cases in which a disorder's etiology was unequivocally agreed upon within the psychiatric field. An emphasis was placed on symptom-based differential diagnosis rather than on an overall etiological theory of illness development. With this change, the DSM-III editorial task force put forward a new way to think of and identify mental illness, one that prioritized symptoms and patient functioning. According to this new view, a mental illness is, "clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioural, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society" (APA 1980:6).

The editorial task force presented DSM-III as atheoretical. They hoped that their 'atheoretical', or theory-neutral, approach would be acceptable to psychiatrists of all theoretical positions. This atheoretical approach is the first of three major changes brought about by the introduction of DSM-III. A second change followed when DSM-III

[13] The DSM-III task force wanted to remove the term neurosis from the manual entirely, but psychoanalysts were successful in forcing the inclusion of the term (Shorter 1997). The term neurosis was removed entirely from DSM-IV.

became the mandatory nosology for clinicians. Beginning in the early 1980s, medical students' curriculum and standardized tests began to include DSM-III criteria and research clinicians' contributions to journals and research proposals had to conform to the language of the manual (Young 1995: 102). Clinicians also had to use the manuals' codes for record keeping purposes and to enable patients to make insurance claims[14]. The third difference between DSM-III and earlier editions of the manual is that while other classifications systems had been officially accepted before, they had failed to be widely adopted. DSM-III became a platform for diagnostic globalization. The ICD is still used around the world, but with the publication of DSM-III, international journals increasingly began to adopt it as a standard.

In contrast with DSM-II[15], DSM-III includes specific diagnostic criteria for each category of mental illness. These were introduced to "enhance interjudge diagnostic reliability", which meant that people of different professional backgrounds and levels of expertise should be able to independently diagnose patients with consistent labels (APA 1980: 8). For instance, in a blind clinical trial, a social worker, a psychoanalytic psychiatrist and a cognitive and behavioural therapist should assign the same diagnoses to a set of patients using the diagnostic criteria provided in DSM-III. According to the editorial task force of DSM-III, use of the manual's diagnostic criteria should allow people to reliably diagnose patients with the same disorder regardless of their theoretical

[14] The DSM-III diagnostic codes also became those used for statistical reporting and other official purposes. While a revised version of DSM-II had been used to track and report on disorder prevelance in the past, those of DSM-III became more widely accepted. Both of the coding systems are based on the codes used in the ICD, but with additional digits (the ICD codes with three digits, DSM-III usually had four, sometimes five) to provide more detailed reports of clinical diagnoses.
[15] And ICD-9.

training or degree of clinical experience. The diagnostic criteria included in the manual were based on experts' clinical experience and the detailed categories they created were supposed to obviate the need for others' expertise. These experts' compiled lists of symptoms that they agreed most accurately described particular disorders. Their expertise in identifying relevant symptoms was thought to result from their years of clinical practice and research. The reliance on clinical expertise in the creation of DSM-III categories, instead of theory, was meant to allow psychiatrists of different theoretical orientations to reliably identify disorders which were now identified by clear symptom descriptions.

The clinical usefulness of particular categories was another factor that influenced the decision to include certain disorders and exclude others. Each diagnosis was evaluated in terms of whether it offered a description that clinicians felt they needed, and that they would use, in the clinical encounter.

Committees were established to assess the reliability and validity of accepted diagnostic categories, as well as to review diagnoses considered for admission into DSM-III. Committee members included senior psychiatrists and psychiatrists who were specialists of the diagnosis being examined by the committee. In some cases, interest groups also influenced which disorders would be included in DSM-III. One of the most clearly documented cases involved the American Veterans' Association's successful lobbying for the inclusion of Post-Traumatic Stress Disorder (PTSD) in DSM-III despite resistance on the part of psychiatrists (Young 1995).

Since the editorial task force of DSM-III included social phobia in its manual, the American Psychiatric Association (APA) has published three supplemental books that

focus on anxiety disorders including social phobia (APA 1995, 1996, 2000). The earliest book is the only one to focus solely on the disorder. This book includes psychodynamic perspectives on social phobia and examines the role of personality in the development of the disorder. The subsequent books focus on cognitive, behavioural, biological and pharmacological therapies for all anxiety disorders included in the DSM-IV. The publication of these books, and the proliferation of journal articles focusing on social phobia, reflects the growing professional interest in social phobia and anxiety disorders more generally. These publications are also a sign of changing theoretical interests within the field of psychiatry, moving from psychoanalytic perspectives toward cognitive and biological explanations of mental illness.

The origins of modern social phobia

The modern diagnostic category social phobia was first proposed by Isaac Marks and Michael Gelder in 1966 (Marks and Gelder 1966; elaborated in Marks and Gelder 1970). They described the disorder as a condition in which a person becomes very anxious when scrutinized by others while performing a specific task (Hofmann, Heinrichs and Moscovitch 2004). However, their proposed diagnostic category was not widely used until it was included in DSM-III. In DSM-III (1980), social phobia is classified as an anxiety disorder alongside agoraphobia, post-traumatic stress disorder and panic attacks. No disorder comparable to social phobia had been included in DSM-I, DSM-II or in the ICD nosology commonly used outside of the United States. Even though social phobia received more attention once it was included in the DSM, it only became more frequently diagnosed and the subject of increased research once DSM-III-R and DSM-IV

were published. The early period of the disorder's 'life' in DSM-III was a time when psychiatrists were more interested in and concerned about depression (a mood disorder) than anxiety disorders (Healy 1997).

Social phobia in DSM-III

DSM-III[16] defines social phobia as a circumscribed fear of performance situations where one might be scrutinized or judged by others. People diagnosed with this disorder are described as generally fearing a single situation. In this sense, social phobia is similar to the diagnostic classification "specific phobia[17]" (for example, a fear of spiders). People who suffer from this disorder are described as fearing they will embarrass or humiliate themselves in situations such as speaking or performing in public, using public lavatories, eating in public, or writing in the presence of others. Patients' fears of others' judgements and their subsequent humiliation are at the basis of their "compelling desire to avoid" the phobogenic situation (APA 1980:228). People who suffer from social phobia are said to be aware that their persistent fears are irrational and excessive, which indicates that their reality testing is intact[18].

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[16] The DSM-III category social phobia is described as follows:

A. A persistent, irrational fear of, and compelling desire to avoid, a situation in which the individual is exposed to possible scrutiny by others and fears that he or she may act in a way that will be humiliating or embarrassing.
B. Significant distress because of the disturbance and recognition by the individual that his or her fear is excessive or unreasonable.
C. Not due to another mental disorder, such as major depression or avoidant personality disorder.

APA 1980: 228

[17] In DSM-III specific phobias are also referred to as simple phobias.

[18] Reality testing refers to one's capacity to differentiate self from non-self, intrapsychic from externally originated stimuli, and the capacity to maintain awareness of ordinary

DSM-III describes social phobia as being a relatively rare condition, less common than agoraphobia which was estimated to have a lifetime prevalence of 0.5% in the general population (APA 1980: 228).

Social phobia in DSM-III-R

DSM-III-R (1987) introduced a generalized subtype of social phobia[19]. Patients with this new subtype of the disorder are described as fearing many social situations, rather than as having one circumscribed fear, as the disorder was defined in DSM-III. Examples of these general fears include public speaking, saying something foolish in public or not being able to respond appropriately to questions in social situations (APA

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social criteria of reality. The presence of psychotic symptoms indicates loss of reality testing (Kernberg 1998).

[19] The official diagnostic criteria for social phobia in DSM-III-R are:

A. A persistent fear of one or more situations (the social phobic situations) in which the person is exposed to possible scrutiny by others and fears that he or she may do something or act in a way that will be humiliating or embarrassing. Examples include: being unable to continue talking while speaking in public, choking on food when eating in front of others, being unable to urinate in a public lavatory, hand-trembling when writing in the presence of others, and saying foolish things or not being able to answer questions in social situations.
B. If an Axis III or another Axis I disorder is present, the fear in A is unrelated to it, e.g., the fear is not of having a panic attack (panic disorder), stuttering (stuttering), trembling (Parkinson's disease), or exhibiting abnormal eating behaviour (anorexia nervosa or bulimia nervosa).
C. During some phase of the disturbance, exposure to the specific phobic stimulus (or stimuli) almost invariably provokes an immediate anxiety response.
D. The phobic situation(s) is avoided, or is endured with intense anxiety.
E. The avoidant behaviour interferes with occupational functioning or with usual social activities or relationships with others, or there is marked distress about having the fear.
F. The person recognizes that his or her fear is excessive or unreasonable.
G. If the person is under 18, the disturbance does not meet the criteria for avoidant disorder of childhood or adolescence.

Specify generalized type if the phobic situation includes most social situations, and also consider the additional diagnosis of avoidant personality disorder.

APA 1987: 243

1987: 241). Estimates of prevalence of the circumscribed disorder (only one fear) are described as "rare" whereas the prevalence of the generalized type is described as "common"[20]. In the DSM-III-R version of social phobia, the negative impact of the disorder on a patient's "usual" social or occupational routine is introduced as a symptom of the disorder. Another important change in the definition of the disorder is the replacement of the phrase "a compelling desire to avoid" the feared situation with "a marked distress" about having the fear. This rewriting of the diagnostic criteria increased the number of people who could be diagnosed with the disorder because the threshold of disability and distress was lowered (Lang and Stein 2001).

Social phobia (social anxiety disorder) in DSM-IV

In DSM-IV (1994), social phobia was given a parenthetic name, "social anxiety disorder"[21]. One of the reasons for this change was to disassociate this disorder from the

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[20] Specific values were not provided.

[21] The official diagnostic criteria for Social Phobia in DSM-IV are:

A. A marked or persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. **Note:** In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.
B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed panic attack. **Note:** In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.
C. The person recognizes that the fear is excessive or unreasonable. **Note:** In children, this feature may be absent.
D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.
E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine,

psychoanalytic concept of phobic neurosis. Leading the initiative to change the name of the disorder was Michael Liebowitz, a prominent anxiety disorder researcher[22], who argued in a letter published in the *Archives of General Psychiatry* that social phobia should be renamed social anxiety disorder (Liebowitz et al. 2000). He suggests that social anxiety disorder better conveys how pervasive and serious the disorder is. He further argues that the name of a disorder is important in determining how easily understood and accepted it will be[23].

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occupational (academic) functioning, or social activities or relationships, or there is a marked distress about having the phobia.

F. In individuals under age 18 years, the duration is at least 6 months.

G. The fear or avoidance is not due to the direct physiological effects of substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., panic disorder with or without agoraphobia, separation anxiety disorder, body dysmorphic disorder, a pervasive developmental disorder, or schizoid personality disorder).

H. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear is not of stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behaviour in anorexia nervosa or bulimia nervosa.

Specify if:

Generalized: if the fears include most social situations (also consider the additional diagnosis of avoidant personality disorder)

APA 1994: 416-417

[22] Michael Liebowitz was a member of the anxiety disorders committee for DSM-III-R and was a member of the editorial task force and anxiety disorders committee for DSM-IV. Liebowitz was singled out in a *New York Post* article as a psychiatrist who works closely with, and receives large sums of money from, the pharmaceutical industry (Birnbaum and Montero 1999). One of the companies he is listed as conducting experiments for is SmithKline Beecham (now GlaxoSmithKline), the makers of Paxil, which was licensed to treat social phobia in 1999 (in the United States and Canada). The impact of this association is unclear, though the article was written as an indictment of what the reporters saw as a conflict of interest. However, links between psychiatrists and the pharmaceutical industry today are common, and it is rare that a high-ranking research psychiatrist would not to receive funding from the pharmaceutical industry at some point in his or her career (Healy 2004).

[23] The importance of names for the acceptance of a disorder is also made clear by the renaming of impotence to erectile dysfunction, or ED, as it is now commonly referred.

A notable shift in the description occurred between DSM-III-R, in which the patients' are described as experiencing "intense anxiety" if they have to endure the phobic situation, and DSM-IV, in which "intense anxiety or distress" are sufficient for diagnosis. In DSM-IV the estimated prevalence of social phobia in the general population is between 3 and 13%.

Social phobia in ICD-10

Social phobia was first included in ICD-10, published in 1992[24]. Twelve years separate the entry of the disorder into the two diagnostic systems. The symptoms listed in this manual are similar to those in DSM-IV, though the diagnostic criteria of ICD-10 are more restrictive[25]. The symptom list places priority on avoidance of the phobic situation. In the text that accompanies the diagnostic criteria, it is stated that "social phobias are usually associated with low self-esteem and fear of criticism" (WHO 1992). This aspect of the disorder is highlighted in psychiatric literature on the disorder, though it is not explicitly mentioned in the DSM-IV diagnostic criteria. As is the case for DSM-IV, ICD-10 includes circumscribed and generalized versions of social phobia[26].

The latter name, and the acronym, sound more clinical and do not have the connotations of the word "impotence".

[24] All of the following criteria should be fulfilled for a definite diagnosis of social phobia according to ICD-10:
(a) the psychological, behavioural, or autonomic symptoms must be primarily manifestations of anxiety and not secondary to other symptoms such as delusions or obsessional thoughts;
(b) the anxiety must be restricted to or predominate in particular social situations; and
(c) avoidance of the phobic situations must be a prominent feature.
(WHO 1992)

[25] Epidemiological studies using ICD-10 criteria produce lower rates of social phobia in the general population than those studies using DSM-IV criteria.

[26] ICD-10, unlike DSM-IV, does not specifically use the word 'subtype'.

According to these definitions, a patient may fear only one situation or almost all social situations outside the family circle. The ICD-10 diagnosis of social phobia also includes the diagnoses anthropophobia and social neurosis as other possible names of the disorder.

The epidemiology of social phobia

The changing prevalence rates of social phobia reported in the successive DSM editions, from less than 0.5% to 13% of the population, make it appear as though the disorder is on the rise. A consensus panel paper reports that the more recent, and higher, prevalence rates are likely more indicative of how many people suffer from the disorder (Ballenger et al. 1998; also see Katzelnick et al. 2001). Consensus panels are groups of experts who are brought together to create a set of recommendations about the way a disorder should be identified or treated. In the case of the Ballenger et al. paper, their objective to was to provide primary care physicians with information about the prevalence of social phobia and to make recommendations about the appropriate pharmacotherapy. This particular consensus panel was supported by "an unrestricted educational grant from SmithKline Beecham Pharmaceuticals[27]" (Ballenger et al. 1998) and the consensus panel statement appeared in a supplement to the Journal of Clinical Psychiatry supported by SmithKline Beecham Pharmaceuticals[28]. According to Ballenger et al., the newer and more inclusive definition of social phobia is superior to the older ones because it correctly identifies people who suffer from the disorder who

[27] SmithKline Beecham Pharmaceuticals is now called GlaxoSmithKline. In 2000, Glaxo Wellcome merged with SmithKline Beecham to form GlaxoSmithKline. GlaxoSmithKline produces paroxetine, known as Paxil in North America.
[28] It is not uncommon for consensus panels and journal supplements to be supported by the pharmaceutical industry.

were previously defined as simply shy. Despite the rising prevalence rates of the disorder, which are a result of the creation of more inclusive diagnostic criteria, many clinical researchers argue that social phobia remains an under-recognized disorder, resulting in many people suffering in silence and remaining un- or under-treated (Lépine and Pélissolo 2000; Tharwani and Davidson 2001).

Since its inclusion in the DSM, epidemiological research on social phobia has increased significantly, particularly over the last 10-15 years. In the articles published on the disorder, social phobia is commonly described as highly prevalent, overlooked and under-treated (Bruce and Saeed 1999; Hidalgo, Barnett, Davidson 2001; Wittchen 2000; Zamorski and Ward 2000). It is also reported to be the most common anxiety disorder in the general population (Lydiard 2001; Walker and Kjernisted 2000). The authors of these articles argue that social phobia is often overlooked in the clinical setting. They underline the importance for physicians, especially general practitioners, to learn to recognize the symptoms of the disorder so that the rates of diagnosis will approach the prevalence rates reported in epidemiological studies[29].

[29] Articles in which researchers urge general practitioners to increase their vigilance in looking for a specific disorder amongst their patients are not uncommon and they are not restricted to articles on social phobia. However, researchers' attempts to increase the diagnosis rates of social phobia involves teaching people to understand their behaviour in new ways, which is different from doctors informing patients that they carry a 'risk factor' for a disorder that they were unaware of (each case has its own problematic elements). Many, if not most, people who meet the diagnostic criteria for social phobia never seek treatment for their 'symptoms'. A good number of these people may be too shy or embarrassed to come forward, and for them, the increased vigilance of physicians in looking for social phobia amongst their patients may provide an opportunity to speak about and be treated for, the condition they have suffered with silently. However, for many others who do not see themselves as mentally ill despite the fact that they may meet the diagnostic criteria for social phobia, physicians' vigilence and attempts to raise diagnosis and treatment rates may be counter productive and result in the pathologization of certain of their characteristics they once considered normal.

Researchers explain that people with the symptoms of social phobia rarely seek treatment for their troubles, and will usually only do so if they have a comorbid disorder (for example, see Dunner 2001)[30]. Once a comorbid mental illness appears, a patient's social phobia is thought to become more serious and resistant to treatment. This research finding is cited as another reason for general practitioners to learn to recognize the first symptoms of social phobia, so that the disorder is diagnosed at its early, more treatable stage. Researchers estimate that more than 80% of people diagnosed with social phobia suffer from another psychiatric disorder, most often depression, generalized anxiety disorder, panic attack, or avoidant personality disorder (Rapee and Spence 2004; Sareen and Stein 2000).

Ashok Raj and David Sheehan, well published psychiatrists on the subject of social phobia, report that when patients seek help or treatment for social phobia, general practitioners commonly trivialize patients' complaints and suggest that everyone experiences these problems from time to time, rather than interpreting their complaints as symptoms of this psychiatric disorder (Raj and Sheehan 2001). They argue that after such a dismissal, patients will rarely discuss their symptoms with a physician again. Raj and Sheehan argue that this is one of the reasons that physicians must learn to better recognize the symptoms of social phobia and to acknowledge them as part of a serious mental illness.

While prevalence rates of social phobia have generally increased over the last 20 years, disparate results are still reported in psychiatric literature, ranging from 1 to 20%

[30] The diagnosis of comorbid psychiatric disorders was not permitted according to DSM-III diagnostic criteria. However, in DSM-IIIR and subsequent editions of the manual, patients could be diagnosed with multiple comorbid diagnoses which may reflect the limitations of categorical analyses, as compared with dimensional ones.

(Furmark et al. 1999). The mostly frequently cited numbers are drawn from two large studies in the general population carried out in the United States: the National Comorbidity Survey (NCS) and the Epidemiological Catchment Area (ECA). Both of these projects drew on community, rather than clinical, populations. The ECA used DSM-III criteria and the Diagnostic Interview Schedule (Robins et al. 1981) and reported a 2.7% lifetime prevalence of social anxiety disorder (Robins and Regier 1991). The NCS used the DSM-III-R criteria along with the Composite International Diagnostic Interview (CIDI) and reported a lifetime prevalence of 13% (Magee et al. 1996)[31]. The range of these estimates is considerable, and researchers admit that the results reflect not only different populations but more likely, differences in study method (Furmark 2002). This refers to, among other factors, the diagnostic manual and scale used (Stein, Walker and Forde 1994).

Many researchers have argued that the wide range of prevalence rates reported for social phobia hinders attempts to define the disorder as a condition distinct from shyness (Chavira, Stein and Malcarne 2002; Furmark 2002; Marteinsdottir et al. 2003; Pélissolo et al. 2000). These researchers admit that people who suffer from shyness rather than social phobia are likely included in the higher prevalence rates reported in some studies. These shy people would be unlikely to seek treatment for the disorder even though certain clinical scales define them as having social phobia. There is no consensus concerning which scale most accurately diagnoses social phobia. Nevertheless, Ariel Lang and Murray Stein, among other clinical researchers, maintain that even if some estimates are inflated, the overall numbers of people are significant and social phobia

[31] Results for different countries also vary widely, depending on the study and the version of the manual and scale used.

should be defined as the most prevalent anxiety disorder (Davidson et al. 1994; Lang and Stein 2001). Timothy Bruce and Sy Saeed, also clinical researchers, staunchly support the high estimates reported and criticize those who favour lower estimates (Bruce and Saeed 2000). They argue that the researchers who support lower estimates, for example Steven Woolf and Carol Friedman (2000)[32], are using out of date classifications and psychiatric assessment tools. Bruce and Saeed accuse Woolf and Friedman of trivializing the gravity of social phobia (Bruce and Saeed 2000)[33].

The etiology of social phobia

There are many theories to explain the appearance of social phobia in patients. Several biological factors are thought to be involved in the development of the disorder including left hemisphere dysfunction (Bruder et al. 2004); an overactive frontolimbic system (Veit et al. 2002); and a gene on chromosome 16 (Gelernter et al. 2004). Most current articles on social phobia emphasize the underlying biological origins of the disorder. This reflects the biological orientation of today's dominant psychiatric framework.

Researchers have also identified psychological (developmental) factors that may be associated with the origins of social phobia. These factors involve early life experiences including referral for treatment with growth hormones, which may be

[32] By contrast, Woolf and Friedman argue that they prefer the more 'conservative' tools because they are more likely to prevent cases of shyness from being needlessly pathologized.

[33] Other researchers claim that the rate at which social phobia presented in these studies points to a rampant medicalization of existence (Prescrire 2003).

associated with a lowering of a child's self esteem[34] (Stabler 2001). The children of over-protective, controlling and relatively cold parents are reported to be statistically more likely to develop social phobia later in life (Rapee and Melville 1997; Rapee and Spence 2004) as are children who have undergone aversive life experiences such as the loss of a parent (Hackmann et al. 2000). Researchers report that children with inhibited temperaments are more likely to develop social phobia later in life (Neal, Edelmann and Glachan 2002). Researchers also associate children's likelihood of developing social phobia with the way that parents react to the children's inhibited temperaments (Hudson and Rapee 2004). They found that parents may be more likely to shelter an inhibited child, which may result in the child becoming more withdrawn.

Beyond the psychological factors that have been associated with the childhood origins of social phobia, researchers have linked many other factors to the continuation of social phobia symptoms. In one study, people suffering from social phobia and a control group were shown a series of photos of faces with various expressions. The people diagnosed with social phobia had a tendency to associate neutral social cues (faces with neutral expressions) with aversive outcomes (Hermann et al. 2002). This tendency would be likely to make an already inhibited, or mildly socially phobic, person feel rejected or judged poorly by others, which would only make them more withdrawn and fearful. Researchers have also reported that people with social phobia have biases and distortions in social-information processing and thoughts (Clark and McManus 2002). As in the case of misreading social cues, the people diagnosed with social phobia had a tendency to assume that others were negatively judging them. This finding would tend to support the

[34] Stabler points out that the development of social phobia is not associated with growth hormone treatment, only with the *referral* for treatment.

usefulness of cognitive and behavioural therapy in the treatment of social phobia, since it focuses on teaching the patient to re-assess social cues and test thought processes.

Researchers have hypothesized that social phobia may be the result of an intrusion complex, thought to be associated with both narcissistic and an oedipal complexes (Ogawa and Bouderlique 1994). Intrusion complexes are part of family complexes in which the child begins to identify a rivalry between him or herself and other members of the family. A child's identification with his or her parents becomes problematic through this process and other complexes may arise as a result. However, psychoanalytic perspectives of social phobia are extremely rare, as these clinicians would not normally use the category[35].

Finally, some researchers have linked social phobia to an evolutionary model in which submissive and retreating actions would be an asset to an individual in a non-dominant societal position (Stein and Bouwer 1997). This view is usually presented alongside biological theories of the disorder which explain how this trait has been passed from one generation to the next.

Is social phobia a pathology?

There is no consensus regarding how many people suffer from social phobia, nor how it should be treated. Some clinicians argue that social phobia is a medicalization of shyness and a reflection of low self esteem (Healy 2004; Woolf and Friedman 2000). These researchers suggest that the personality traits represented in social phobia diagnostic categories should not be equated with a psychiatric illness. It has been

[35] This theme will be elaborated on throughout the rest of the thesis.

suggested that were it not for pharmaceutical companies' interest in social phobia[36], the disorder would not receive nearly the attention it has from clinicians and the public (Healy 2004; Prescrire 2003; interviews for this thesis). For these critics of the diagnostic category, social phobia (or at least not all of the cases reported by epidemiological research) is not a pathology. Rather, it is an example of the medicalization of existence in which 'normal' behaviours and traits become pathologized.

Conclusion

The rising prevalence numbers of and increased expert attention to social phobia in the last 25 years can be seen as part of a "looping effect" (Hacking 1999: 34). Ian Hacking has used the concept to describe how an idea or category can take on a life of its own once it has been created and applied to a group of people. By labelling someone with a mental disorder, that person will change his or her perception of him or herself. Patients' behaviour, once they have this disorder will 'loop back' and influence physicians' understandings of the disorder. As more and more patients are diagnosed with the condition, the disorder seems more real to physicians. The disorder is deemed something that is important to look for in the clinical encounter. This has been the case with social phobia. Once the diagnosis began to be used, patients and physicians began to see it more and more, in themselves and in others (Hacking 1999: 111-115, 160). Over time, this may have contributed to the broadening of the diagnostic category. Once the

[36] Many companies received extensions of their patents on SSRI (selective serotonin reuptake inhibitors) antidepressants after receiving licenses to market these products as treatments for social phobia.

core idea of the diagnosis had been accepted, it would become easier to see people who lie at the diagnostic limits of the disorder and who might not have previously been thought to suffer from a psychiatric condition.

Hacking compares the looping effect to a positive feedforward cycle. He sees this cycle, originally put forward by C.K. Li, as analogous to the looping effect (Hacking 1999: 160). According to the positive feedforward cycle, more research generates more experts generates more cases generates more research. It could be argued that this cycle is reflected in the proliferation of research over the past couple of decades on social phobia and has functioned to make the disorder appear more prevalent to clinicians, who then diagnose more people with the disorder. The end result is that social phobia becomes better known and is seen as a widespread disorder.

Discussions of social phobia in psychiatric journals and the popular media often focus on where the line should be drawn between the normal and the pathological, between shyness and social phobia (Chavira, Stein and Malcarne 2002; Cottle 1999; Heiser, Turner and Beidel 2003; Talbot 2001). Officially, psychiatrists now work with a categorical rather than a dimensional nosology[37]. According to this categorical

[37] Hans Eysenck put forward a dimensional theory of mental illness. According to this theory, there is no strict line between the normal and the pathological, instead, personality traits are placed on a continuum, and the poles at each end represent a pathological state. However, there is not set line where a personality trait becomes pathological. Treatment according to this premise would focus on working with the patient's constitutional temperament, modifying this to create a more 'normal' personality. The dimensional view of mental illness was also supported by psychodynamic perspectives, which are less interested in determining a patient's categorical diagnosis and more interested in understanding a patient's personality and neurotic tendencies, for example. A dimensional view fell out of fashion around in the early 1960s when the new antidepressant, Imipramine, appeared to bring patients from a clearly pathological state to a normal one, which supported a more categorical view of mental illness. A dimensional

framework, a line is clearly drawn between one disorder and another, and between the normal and the pathological. However, these lines are not always clear in studies of social phobia, as is reflected in discussions about the blurriness of the line between shyness and social phobia. The blurry edges of social phobia include people who, according to certain psychiatric scales suffer from the disorder while other scales classify them as 'normal'. The more inclusive social phobia scales have come under attack for being too broad, and it is argued that certain 'normal' people's experiences have been pathologized (Prescrire 2003). The lack of certainty about where the lines should be drawn to delineate social phobia puts it at odds with current theories about the categorical nature of mental disorders[38]. In psychiatric literature, social phobia is often discussed in a way that is more consistent with dimensional rather than categorical principles.

Another factor makes social phobia a blurry category is that it most often appears with a comorbid conditions. The diagnosis of comorbid psychiatric disorders has been permissible, according to APA regulations, since DSM-IIIR (1987). People with social phobia have a higher than usual rate of psychiatric comorbidity: more than eighty percent

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view of mental illness was officially left behind with the publication of DSM-III (Healy 1997: 237).

[38] This is certainly not the only mental illness whose boundaries are blurred, or which is discussed in a dimensional way. The different possible intensities of depression, from dysthymia (sub-syndromal depression), to mild depression to major depression are an example of this. The firm lines between boundaries are also beginning to blur, as more and more people receive multiple diagnoses for comorbid psychiatric disorders. Categorical theories of mental illness have also been undermined to a certain extent by the current use of psychotropic medications. 'Antidepressants' are now used to treat social phobia, post-traumatic stress disorder, generalized anxiety disorder, bulimia, pre-menstrual dysphoric disorder, along with depression. Whereas early psychotropic drugs were seen as acting on specific chemical states associated with specific mental illnesses, this no longer seems to be the case with new psychotropic drugs.

of those people who fit the diagnostic criteria for social phobia also fit the criteria for at least one other psychiatric disorder (Rapee and Spence 2004).

Aside from its high comorbidity, social phobia is an unusual disorder in that on one end of its spectrum it is indistinguishable from 'normal' shyness, and at the other end, it is virtually the same as generalized anxiety disorder or agoraphobia, two conditions often diagnosed alongside social phobia. With research findings such as these, one might question the necessity of the diagnostic category if it is used so commonly alongside others. In some cases, researchers argue that part of the clinical importance of social phobia is that it provides an early warning about the possible development of other psychiatric diagnoses such as depression and alcoholism. The blurriness of social phobia's category lends itself well to an analysis of the line between normal and pathological, and the social, cultural, historical and economic factors that make certain personality traits eligible for definition as pathological.

Once a category has been created, it takes on a new life in the people who are labelled with the disorder. The dominant psychiatric nosology of our time tells us what social phobia is, and the theoretical orientation of those people who created the framework for DSM-III and later issues tells us how to think about it and treat it. As Tanya Luhrmann argues in *Of Two Minds* (2000), the dominant psychiatric perspective in North America, which is now taking hold in France, tells us much about our brains.

Brains are now at the centre of psychiatry, as the origins of most mental illnesses are presumed to have a biological component, even if this is only considered to be one of many factors implicated in the illness. Biochemical processes are often described as the root of psychiatric problems, as susceptibilities that makes one person more likely than

another to develop a psychiatric disorder. However, an overemphasis on the brain obscures that fact that there remains a place for the mind in contemporary psychiatry. Cognitive and behavioural views of mental illness gained dominance in North American psychiatry beginning in the 1960s. They represent a rationalist approach in which the mind is seen as exacerbating mental illness symptoms. According to therapists of this perspective, people's biased thoughts and perceptions of the world are believed to contribute to their symptomatic behaviour. Therapy is aimed at correcting thought processes, allowing patients to live more comfortably and improve their day to day functioning.

But this contemporary view of the mind differs from older psychiatric theories of the mind and mental illness. In the modern perspective, the mind is not seen as the origin of mental illness, this role is attributed to biochemical processes. The mind is a secondary factor that is implicated in patients' ability to be more or less functional in spite of their biochemical state, considered the root cause of mental illness. This primary biological factor of mental illness will often be treated by psychopharmaceuticals.

According to older psychiatric theories, such as psychoanalysis, the mind is seen as the origin of mental illness. Anxiety was thought to lead to pathological behaviours and conceptions about the world. In order to improve, a patient's basic anxiety needed to be identified and treated. These theories were based on psychological, rather than biochemical, origins of mental illness, which implicated the mind rather than the brain. What Luhrmann and other anthropologists have emphasized is that of the myriad ways that we could understand ourselves and our experiences, a dominant psychiatric theory

limits explanations. Understanding our current explanations of mental illness tells us a lot about the society we live in and who we think we are.

Chapter Two

Who cares about social phobia?

Contents

Social phobia in society

Social phobia, or social anxiety disorder, is a mental illness that, over the last 24 years, has become widely diagnosed in North America. Twenty years ago many of those people now diagnosed with the disorder would have been referred to as neurotic or shy. Others may have been described as depressed or suffering from another anxiety disorder. Social phobia, according to some people, accounts for un-employment, under-employment and personal misery, and is considered a serious risk factor for major depression, other psychiatric disorders, and even suicide. Researchers claim that problems linked to social phobia were previously given too little attention and they must now be closely examined to prevent minor cases of social phobia from becoming more serious (for example, Bruce and Saeed 2000).

Social phobia, on one end of its spectrum, has been described as 'pathological' shyness, and on the other end, as a condition similar to major depression or generalized anxiety disorder (APA 1996: 507-8). Those diagnosed with the disorder often describe a strong fear of others' judgement and are uncomfortable in social and performance situations. Many of these feelings are, to one degree or another, widespread in society. As the name of the disorder and the description of the symptoms suggest, the condition is social in its nature and in its origins. It is brought on by social interactions. Some of the clinicians I interviewed argued that social phobia is a normal response to contemporary social expectations and refused to diagnose the disorder, though they would often provide medications to ease patients' anxieties. Other clinicians and members of social phobia support groups argued that the disorder is a serious mental illness and that it is largely the

result of biochemical processes and should be treated with psychotherapy and medications.

Parties interested in social phobia

Support groups

'Lay people' make up at least three groups who have an interest in social phobia. These include patients, support groups and advocacy groups. All three groups overlap in their members, and the last group is a subgroup of support groups[39]. Of all three groups, it is in support groups that these people most often meet. Support group members share information about different therapies and practices (psychotherapies and day to day coping mechanisms[40]) as well as experiences and resources (web sites, 'good' doctors, books, television or radio programmes). Most of these people are patients in the sense that they are diagnosed with and being treated for social phobia, however some support group members are self-diagnosed "social phobics"[41]. While the mandates of many support groups prioritize mutual support, there are several members of these groups, often members of the executive councils, whose actions resemble those of advocacy

[39] While there are advocacy groups for certain disorders, such as HIV/AIDS, no such groups yet exist for social phobia. Therefore, it is members of the support group who take on this role.

[40] The use of medications is discussed, though officially the support group has no opinion concerning this type of treatment, since only physicians or researchers are legally permitted to recommend these modes of treatment.

[41] In contrast to professional literature which avoids linking a patient's identity with his or her disorder, for example referring to someone as a social phobic rather than as someone who suffers from social phobia, the members of the support group almost unanimously referred to themselves as social phobics. This reflected their willingness to make the disorder a central element of their identities.

group members[42]. The actions of these support group members reach audiences beyond the support group and they work to disseminate information about and promote understanding of social phobia. These people strive to decrease the stigma associated with the disorder and to emphasize the importance of its early recognition as well as the necessity of appropriate medical care. These support group members also publicize reports of the widespread and treatable nature of social phobia. They promote a message of a common disorder that is only dangerous is left untreated. Support groups are much more numerous and wide spread in North America than in France, and it is still relatively rare that these groups are formed in the latter region. This reflects lingering taboos about discussing mental illness in France. While public opinion is changing, to admit to a mental illness is still considered by some an admission of madness. Because of this, many people are still reticent to discuss their psychological problems, preferring to reveal their condition only to a clinician and, perhaps, some family members.

Advocacy groups organized by mental health workers

The information promoted by advocacy members of support groups often overlaps with the message put forward by mental health professionals' advocacy groups. The mental health professionals' groups are primarily made up of clinicians, along with some pharmacists and other health professionals. Professional advocacy groups include the Anxiety Disorders Association of America (ADAA), the Association des Troubles Anxieux du Québec (ATAQ) and the Association Française des Troubles Anxieux

[42] In support groups that are run by paid staff, it is most often these staff members to take on the advocacy role. There were no paid staff members in the support group that I attended in Paris and so it was the executive members who took on these tasks.

(AFTA). Of these three groups, the ADAA was formed first, in the early 1980s, followed 10 years later by ATAQ and nearly 20 years later by AFTA. The time differences between the founding of these groups reflect order in which interest in social phobia developed in these countries.

These groups argue that increased recognition and treatment of social phobia is required. In France, the doctors who founded AFTA are also those who practice cognitive and behavioural therapy. Advocacy groups like AFTA serve the double purposes of spreading information about the seriousness of anxiety disorders and about these physicians' cognitive and behavioural perspectives and treatment strategies. Through meetings and educational resources (for example, CDRoms[43], leaflets, and other information packages), the professional members of AFTA teach psychiatrists and general practitioners how to recognize social phobia amongst their patients. The founding members of AFTA are deeply involved in research on social phobia, authoring a large proportion of the articles on the disorder, including the first two to appear in *Encephale*[44] in 1995 (André and Légeron 1995; Pélissolo and Lépine 1995). Many AFTA members are highlighted on GlaxoSmithKline's French website, part of which was created to spread information about social phobia. AFTA clinicians also publish popular books about social phobia and other mental health issues (see André and Légeron 1995a).

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[43] These CD-Roms are created with funds from GlaxoSmithKline and promoted on the company's website (http://www.gsk.fr/gsk/mediasgp/dp/2003/2602.html).

[44] *Encephale* focuses on biological psychiatry and publishes a proportion of French articles on social phobia.

Since 1980[45], the ADAA has taken on the role of advocate for patients, clinicians and researchers interested in anxiety disorders. They describe themselves as the only national, non-profit organization dedicated solely to informing the public, healthcare professionals and legislators that anxiety disorders are real, serious and treatable mental illnesses. They promote early diagnosis and treatment of anxiety disorders and they aim to promote professional and public awareness of anxiety disorders and to teach people about the impact of these disorders on people's lives. Another of their goals is to encourage the advancement of scientific knowledge about the causes and treatments of anxiety disorders. The ADAA seeks to assist individuals suffering from anxiety disorders find appropriate treatment[46] and to develop self-help skills. Finally, they aim to reduce the stigma of anxiety disorders. Membership in the ADAA is open to mental health professionals and students. The board of directors and scientific advisory board of this advocacy group are made up of a large number of the top clinical research publishers on social phobia[47]. The members are also well represented on DSM committees.

ATAQ was created in 1991 as a professional, non-profit group devoted to anxiety disorders and comorbid conditions (including depression). Since that time, they have spread information about anxiety disorders in public and professional forums (conferences, television programmes). They have also established support groups for people suffering from anxiety disorders. Their name is known not only in Quebec, but

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[45] The ADAA was founded in 1980 as the Phobia Society of America. The group broadened its scope to all anxiety disorders in 1990 and renamed themselves the Anxiety Disorders Association of America.

[46] Member physicians have the opportunity to place their names on the ADAA's "find a therapist" online listing.

[47] The corporate advisory board is made up of Astra Zeneca, Eli Lilly and Company, Forest Laboratories, Janssen Pharmaceutica, Pfizer, Inc., and Wyeth Pharmaceuticals.

also in France, where people rely on information provided on their website. As is the case for the ADAA and AFTA, ATAQ's literature focuses on patient treatment by medication and by cognitive and behavioural therapy.

The pharmaceutical industry and 'big pharma' critics

Pharmaceutical companies are interested in raising awareness about social phobia. American general population studies indicate that the lifetime prevalence of the disorder is over 13% (Kessler et al. 1994). Even though French estimates are smaller, 6-8% of the general population (Furmark 2002), this still represents a potentially large market for anti-anxiety medications (anti-depressants and traditional anxiolytics, or tranquilizers, such as benzodiazepines[48]). The rising prevalence rates of the disorder in the United States provide some evidence that social phobia is a diagnostic category open to market expansion. Clinical researchers' use of updated rating scales that reflect the DSM-IV's diagnostic criteria means that the number of 'affected' individuals has risen significantly as these rating scales, like the DSM-IV criteria, are more inclusive than previously used scales and diagnostic manuals (Furmark 2002; Lang and Stein 2001). It is with this kind of disorder, whose category can be effectively broadened, that pharmaceutical companies

[48] The benzodiazepines appeared in the 1960s and were described as tranquilizers. They worked by reducing the anxiety of those using them, making them anxiolytic medications (Healy 2004), which is how I will refer to them throughout this text to reflect how they are most commonly known today. All references to tranquilizers are avoided to distance them from the stigma associated with the benzodiazepines that developed throughout the 1970s and 1980s (Tone 2005). The generation of antidepressants that appeared alongside Prozac is now being marketed for its anxiolytic properties.

can increase sales and profits and for which they can hope to create[49] a 'blockbuster' drug[50].

Pharmaceutical companies have increasingly come to rely upon blockbuster drugs to secure their financial stability (Healy 2004). In the case of GlaxoSmithKline's paroxetine[51], which is the only SSRI (selective serotonin reuptake inhibitor) antidepressant licensed in France for the treatment of social phobia[52], social phobia is the third condition the medication has been licensed to treat in France. First licensed by the Agence Française de Sécurité Sanitaires des Produits de Santé (AFSSAPS) to treat depression in 1992, the agency added the indications of panic attacks with or without agoraphobia and obsessive-compulsive disorder in 1996[53]. In 2003 paroxetine was licensed to treat social phobia, with generalized anxiety disorder added as an indication later in the same year (Prescrire 2003a). By acquiring these additional indications, GlaxoSmithKline was able to extend its position as the only producer of paroxetine in France by 1 year for each new indication. This is added to the 10 years a company is

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[49] These drugs can be created in the traditional sense of synthesizing a new compound. Recently it has become more common for pharmaceutical companies to create blockbuster markets for drugs that are already on the market to treat another disorder. They can do this by applying for new indications for these drugs. If accepted, these additional indications can also extend companies' patents on their products. By seeking additional indications for existing medications, the number of people eligible for treatment with a particular medication can rise substantially.

[50] In 2002 "blockbuster drugs" were defined by IMS-Health (a large market intelligence firm for pharmaceutical and healthcare industries) as products with sales of $1 billion (IMS 2002). "Mega-blockbuster drugs" have $1 billion of sales in their first year on the market. More recent articles describe blockbuster drugs as having *annual* sales of $1 billion (IMS 2005).

[51] Paroxetine is marketed as Paxil in North America and Deroxat in France.

[52] In the United States, four other SSRIs have been licensed to treat social phobia. Paroxetine (Paxil) was the first to be licensed, in 1999.

[53] http://64.233.187.104/search?q=cache:eAc2vBZ_4VkJ:afssaps-prd.afssaps.fr/html/has/sgt/htm/avis/data/ct010087.pdf+AMM+deroxat&hl=en

granted as the only producer of their product, which means that during this time, no generic form of the medication can be sold (Prescrire 2004). Some versions of generic paroxetine became available in 2004.

Pharmacovigilance groups, who critically and independently[54] examine the licensing of new medications, have described the "creation[55]" of social phobia as an example of the "medicalization of existence" driven by various groups, foremost by the pharmaceutical industry (Prescrire 2003b). By the medicalization of existence, these groups refer to what they see as the conversion of normal states into diseases that are often treated with psychopharmaceuticals. Their targets include attention deficit and hyperactivity disorder, social phobia and low level depression, among other conditions. *Revue Prescrire*, a financially independent[56] medical journal run by physicians, pharmacists and others has analysed the evidence supporting GlaxoSmithKline's successful application for a license to offer paroxetine as a treatment for social phobia. From their assessment of placebo controlled studies[57] submitted to the French government by GlaxoSmithKline using paroxetine to treat people diagnosed with social

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[54] Their most marked independence is from the pharmaceutical industry, though they try to distance themselves from any interested parties, such as the government, by operating almost exclusively on subscription fees.

[55] *Prescrire* articles have referred to the 'creation' of certain disorders, like social phobia, by the pharmaceutical industry. However, when I discussed these comments with one of their representatives, the interviewee clarified their statement, noting that the use of the phrase 'creation of social phobia' was misleading. What they meant was that a market had been created for social phobia treatments.

[56] The journal depends almost solely on subscription fees for their financial support. Their primary customer base is general practitioners. They assert that theirs is the only French medical journal that is completely independent of pharmaceutical company funding.

[57] *Prescrire* criticized the studies' methodologies, arguing that a comparison of paroxetine to other antidepressants and to cognitive and behavioural therapy would have provided more useful data than a comparison only to placebo.

phobia, they conclude that paroxetine provides at most a modest, and short term, improvement for patients, all of whom remained symptomatic (Prescrire 2003a). They suggest that cognitive and behavioural therapy may be more effective for many people, though some patients may also benefit from paroxetine. The contributors to *Revue Prescrire* caution their readers not to confuse shyness with social phobia. They draw attention to the blurriness of the boundaries between 'normal' social discomfort and social phobia.

While some French physicians I interviewed see *Revue Prescrire* as too rigorous in their assessment of new medications and too critical of the pharmaceutical industry, just as many argued for the importance of this journal in providing an independent, critical analysis of new medications and a forum to discuss the intrusive role of the pharmaceutical industry in their daily practices. *Revue Prescrire* sees itself as responsible for encouraging physicians to critically examine the benefits of new drugs and increasingly, of 'new[58]' diagnostic categories.

Popular attitudes toward mental illness in France

Throughout the last twenty years in France, physicians and the public have changed their attitudes considerably toward mental illness. Before this time, to speak of mental illness was to breach a taboo. Psychiatry's place was seen as asylums or

[58] I include social phobia in this group of 'new' psychiatric diagnoses since it is only relatively recently that physicians and the public became more widely aware of the diagnosis and more interested in using the category. In interviews, physicians often referred to social phobia as a new mental illness category.

hospitals, and its object as madness[59]. Though medications were used during this time, particularly anxiolytics, these would most often be prescribed by general practitioners who would recommend their use for 'nerves', sleeping troubles, or somatic symptoms. Recourse to psychoanalysts was relatively common, especially by the wealthy, but these people were seen as suffering from a psychological disturbance, or psychic conflict. They were not thought to be suffering from an organic disease or serious mental illness; while they may have been neurotic, they were not viewed as 'crazy'.

Over the past decade in France, there has been increasing attention to the concept of *mieux-être* (well-being). News articles (Huret 2003) suggest that it seems everyone now has their "*psy*[60]" to attain psychological equilibrium. These claims may be inflated, but they reflect a trend: the stigma once attached to seeking psychiatric treatment, especially a non-psychoanalytic psychiatrist, has been significantly reduced. While certain serious mental illnesses (for example, schizophrenia or bipolar disorder) are still feared, the diagnosis of disorders such as depression are now widely used and references to depressed feelings has become commonplace[61]. Other disorders, such as agoraphobia, and panic attack or obsessive-compulsive disorder, have reached the ears of the general public and are now spoken of with relative ease.

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[59] Resort to psychoanalysts, whether psychiatrists or psychologists, was more acceptable and common.

[60] Informal name for *psychiatre* (psychiatrist).

[61] While in Paris I heard references to neighbourhoods being 'depressed' or 'depressive', certain bakery products being of poor enough quality to be depressing, the weather as depressing, etc. These everyday statements were common, but references to more serious depressions and other states of mental illness had also become more common. Obsessive-compulsive disorder was relatively widely discussed or referenced as well.

Despite their historical reluctance to discuss mental illness, the French have nonetheless been high consumers of psychotropic medications[62]. European studies suggest that they are more heavily medicated than the citizens of other European countries and one of the more heavily medicated societies world wide (Alonso et al. 2004). The French are the highest consumers of anxiolytics globally (Zarifian 1996), they consume these medications at a rate of 2-3 times that of other Western countries (Pélissolo et al. 2001). In recent years, their consumption pattern has changed, moving away from anxiolytics and tranquilizers and toward antidepressants (Le Moigne 2002). Because of this, the attention of the medical and popular press and the government has turned to rates of depression and anxiety disorders treated by these medications (Blanchard 2004; Bovard-Gouffrant 2004; Dartigue et al. 1998; Prieur 2004).

The destigmatisation of mental illness

The destigmatisation of psychiatric disorders began earlier in North America than in France. There are at least three factors that have influenced this process. First, psychoanalysis became very popular and was highly regarded in North America from the 1920s to the 1970s (Hale 1995: 6, 25-37, 157-166, 276-344; Luhrmann 2000: 203, 212-217, 220-226; Metzl 2003: 56-63; Shorter 1997: 305-7, 309-13). Its acceptance among psychiatrists and the public was more widespread and influential than in France, whose psychiatric system remained more eclectic, though psychoanalysis was widely accepted in France as well (Ohayon 1999: 9-13, 60-1, 80-6, 113-5, 193-220, 229-30, 241-3, 251-2,

[62] While statistics report that the French purchase large quantities of medications, there is no way to know if people take any or all of the medications they buy. This argument can be made for any society but may be particularly applicable to France, where the cost of medications is particularly low (and largely reimbursed by the state).

277-86, 290-1, 302-8, 336, 338-42, 365-414). Large numbers of North Americans chose to undergo psychoanalysis, and psychoanalytic theories, or at least a popularized version of these theories, became relatively well known in the United States (Hale 1995: 6, 28, 74-8, 211, 276-99, 380-90; Healy 2002: 143; Luhrmann 2000: 213-214). This acceptance of psychoanalysis as a means of treating psychological distress or unease was an initial step toward the destigmatisation of mental illness, if only those forms described and treated by psychoanalysts[63] (Hale 1995: 75-6, 278, 339, 358; Luhrmann 2000: 214). This was the beginning of the treatment of 'everyday ills' by medical/psychiatric intervention.

Second, beginning in the 1960s, when psychoanalytic theories started to fall from favour in North America, other psychological theories began to capture the interest of psychologists, psychiatrists and psychiatric social workers (Healy 1997: 237, 239; Shorter 1997: 293, 305). Cognitive-behavioural, rational-emotive and interpersonal therapies began to influence the way that clinicians and the public understood mental illness (Hale 1995: 354-6). These therapies were increasingly used to treat much of the same patient population that had once been treated by psychoanalysts, people suffering from anxiety and relatively low-level psychological distress (Healy 1997: 241; Shorter 1997: 293-5). The new therapies focused on the role of the conscious mind in 'thinking oneself out of' one's problems and correcting distorted patterns of thinking (Luhrmann 2000: 207). In these new therapies, patients' thoughts, experiences and social behaviour were psychologized in a new way. There was a shift from psychoanalytic explanations based on subconscious forces toward explanations that focused on conscious thought

[63] While some patients in psychiatric hospitals, suffering from serious mental illnesses, were treated according to psychoanalytic principles, psychoanalysts were primarily interested in treating people for neurotic or anxious conditions (Shorter 1997).

processes. This new way of explaining unease and psychological stress made intuitive sense to the public (Shorter 1997: 293). Straight forward methods were proposed to correct faulty thought processes, which made the management of these psychological troubles appear uncomplicated. The cumulative effects of the acceptance of psychoanalytic theories of anxiety and nerves and the acceptance of the new rational theories of the mind, meant that psychologized accounts of 'stress' and nerves were increasingly normalized in North American society. It was less and less abnormal to talk about these disorders or to admit that one experienced them. The treatment of anxiety, nervous and depressive conditions, for which these therapies were most often used, increasingly seemed a common place type of therapy, something which need not be feared or stigmatized.

A third factor is implicated in the destigmatisation of mental disorders in North America. During the 1970s, a group of psychiatrists worked to promote the idea that mental illness has a biological basis. According to the 'broken brain' models of mental illness, the roots of psychological disturbances are organic and out of control of the person who suffers from the disturbance. A person should not be subjected to moral judgements or personally faulted because of his or her problems. By the 1980s, this biological model had become the dominant means of understanding mental illness in North America (Andreasen 1984), which has been referred to by some as the "bacteriological model of mental illness" (Healy 1997: 28, 257). In France, my informants referred to this as the "diabetes model of mental illness". Such statements refer to the tendency to see mental illness as just another physical disease to be regulated.

This understanding of mental illness has now been largely accepted by the general North American population and it is becoming more influential in France.

National trends in the use of psychopharmaceuticals

Americans, like the French, are significant consumers of pharmaceuticals and are the highest per capita users of antidepressants world wide. Anxiolytics are not used to the same extent as they are in France, largely because of fears that arose in the late 1960s[64] about the addictive potential of these drugs (Healy 1997; Tone 2005). Nonetheless, many physicians continue to prescribe them and continue to believe that anxiolytics are useful for lowering states of anxiety, including those brought on by SSRI (selective serotonin reuptake inhibitors) antidepressants like Paxil (paroxetine) or Prozac (fluoxetine) (Bakalar 2005).

Social phobia, or social anxiety disorder, is much more widely known and is reported to be more prevalent in the United States than in France. However, the symptoms of the disorder are widely known and experienced in both countries. Explaining why the symptoms[65] are described and treated differently in the two countries will be one of the objectives of this thesis.

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[64] Despite concerns that arose about the addictiveness of tranquilizers and anxiolytics in the late 1960s, Valium reached the height of its sales in 1978, selling 2.3 billion pills (Bakalar 2005).

[65] The basic symptoms of social phobia, such as excessive shyness, fear of others' judgements and social unease are the object of self-help books in both countries. People in both countries are familiar with these feelings and most have experienced them first hand to some degree, at some point in their lives. These symptoms are sometimes referred to as social phobia. In many instances, these feelings and experiences are not referred to as symptoms, a term which medicalizes the sentiments. I use the term symptom in this text to make it clear that I am referring to the experiences listed in the

How social phobia arrived in France

French clinicians did not show a great deal of interest in the category of social phobia when it entered DSM-III in 1980. It was not until the mid 1990s that some hospital-based, academic researchers began to publish articles on the disorder. Publications began to appear semi-regularly around the turn of the century, at least in some journals. *Encephale*, a biologically-oriented medical journal regularly publishes articles on the topic[66].

The clinicians who publish on social phobia in France are generally based out of academic hospitals. Many of these psychiatrists undertook at least a part of their training in the United States. They primarily practice cognitive and behavioural therapy and are interested in the biological bases of mental illness. Their approaches are consistent with the DSM-III and later versions, though in interviews, these clinicians distance themselves from the DSMs to a certain extent. They charge American physicians with using the DSM too rigidly, and as a result almost mechanically addressing patients' symptoms and assigning diagnoses. When these French clinicians draw a comparison with their overseas colleagues, they explain that while they use the DSM category of social phobia in their research and practice, they use a much richer information base to inform their doctor-patient interactions and their treatment of patients. They rely on clinical

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DSM definition of social phobia. I am not arguing that these experiences ought to be, or ought not to be, seen as clinical signs of mental illness.

[66] A Pubmed search for the key words "social phobia" or "phobie sociale", limited to articles in French returned a list of articles that were published almost exclusively in *Encephale*. Articles have also appeared in *Revue Médicale de Liège* and *Annales Médico-psychologique*.

experience and draw on a wide range sources and theories, even if they use DSM diagnostic categories and prioritize cognitive-behavioural theories[67].

For certain social phobia research clinicians, their use of cognitive and behavioural theories is part of a conscious move away from, or break with, psychoanalytic theory. These clinical researchers widely promote information about social phobia. They are using their specialization in this disorder to spread awareness of their clinical approach more generally. Through their explanations of social phobia and its treatment, physicians and the public are learning more about the principles of the therapy that they offer. This is a part of their efforts to establish a new norm, or at least option, for psychiatric treatment in France aside from psychoanalysis.

Social phobia now 'exists' in France, in the sense that it is acknowledged as a valid category in official diagnostic manuals and in the medical institutions described above. Awareness of the concept has trickled down to other clinicians, including generalists, who encounter articles about the diagnosis in medical journals or who learn about it during their continuing education[68]. While the category remains only loosely understood by most of these non-psychiatric clinicians, they are nonetheless aware of its existence.

Christophe André, a psychiatrist at a public hospital in Paris, has been particularly active in spreading information about social phobia to the French general population. He is the author (with Patrick Légeron) of *La peur des autres: Trac, timidité et phobie sociale*, published in 1995. The book describes how common the symptoms of social

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[67] The extent to which this caricature they draw of North American psychiatrists differentiates them from their overseas colleagues is uncertain.

[68] As in North America, French continuing medical education (CME) is heavily sponsored by the pharmaceutical industry.

phobia are and how misunderstood it is as a disorder. The book sets out to assure his symptomatic readers[69] that they are not crazy and that there are clear ways of improving their symptoms and quality of life. *La peur des autres* is quite popular, informing many people about the disorder. Dr. André speaks regularly about the disorder through various media including in 'pop psychology' magazines[70], on television[71] and on the radio[72].

Cognitive and behavioural therapists, whose therapy has been demonstrated as effective for the treatment of social phobia (Davidson et al. 2004), is gaining institutional power in France, though this type of psychotherapy is available virtually only in Paris. Despite the growing visibility of cognitive and behavioural therapy, most other clinicians tend to describe themselves as influenced by psychoanalytic principles[73] and because of this, they are less likely to use the diagnostic category social phobia[74]. This is not the case in North America, where cognitive and behavioural therapy and other

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[69] The readers of this book are presumably those people who identify with the idea of social phobia or have experienced at least some of its symptoms.

[70] *Psychologies* is the best-selling pop psychology magazine in France (André 2004). Pop psychology articles also appear in magazines and 'women's' magazines such as *Elle* (Fohr 2003; Sarfati 2004).

[71] Dr. André was interviewed about his book on phobias and anxiety on France 1. In this interview he discusses the biological origins of these fears (http://news.tf1.fr/news/sciences/0,,900689,00.html). During another interview about his book on the psychology of phobias, he discusses the usefulness of cognitive and behavioural therapy in alleviating one's symptoms (http://plurielles.tf1.fr/plurielles/psycho/moi/0,,3178491,00.html).

[72] Wednesday 8 November 2000, "Alter ego" on France Inter. Theme of the show: "Comment vaincre ses peurs". Christophe André appeared along with Frédéric Fanget, who has written the book *Affirmez-vous*, and a member of Médiagora Paris, a self-help group for people suffering from phobias. This particular member suffers from social phobia.

[73] This includes most clinicians I interviewed, who cited this as their own bias and suspected that it was the tendency of most other clinicians as well.

[74] The ethnographic section of my thesis explains that physicians who are not in accord with cognitive and behavioural principles are unlikely to use the diagnosis of social phobia. If they do, the disorder is often explained using psychoanalytic principles that do not reflect the DSM definition of the disorder.

psychotherapies quickly gained popularity starting in the 1960s and where cognitive-behavioural models have been dominant theoretical frameworks in psychiatry since the 1980s.

Televised efficacy

In North America since the early-1990s, clinicians, medical researchers and the general public have become aware of the diagnostic category social phobia. The number of psychiatric publications on the topic has increased since the early 1990s and estimates of the number of people affected continue to rise. The number of articles in newspapers and magazines about social phobia has also risen throughout this time, though the appearance of these articles has lagged behind the increase in scientific publications by a few years.

In the United States, direct to consumer advertisements (DTCA) for the medications used to treat social phobia have been identified by clinicians and ethicists as a possible reason for an increased interest in the diagnostic category and the medications used to treat the disorder. Many clinicians believe that DTCAs encourage patients to seek unnecessary medical treatments (for example, Berndt 2005). While some argue that the information in the ads can increase the dialogue between physician and patient (Bonaccorso and Sturchio 2002; Gonul, Carter and Wind 2000; Menon et al. 2004), many others claim that the biased nature of the information in the ads is insufficient to provides patients with useful knowledge (Lyles 2002; Mintzes 2002) and that it creates undue concerns among their healthy patients or the unnecessary use of the advertised drugs (Berger et al. 2001; Hollon 2004; Mintzes et al. 2003). Barbara Mintzes (2002), a social

scientist who has studied the impact of DTCA, claims that the advertisements for prescription medications have increased the numbers of the "worried well" in the general population. Communications researchers have explored the means by which pharmaceutical companies stretch the Federal Drug Association's (FDA) regulations in their promotional activities, both to physicians and to the public (Moynihan, Heath and Henry 2002). Researchers have argued that statistics are decontextualized to make products look as effective as possible, while minimizing side effects (Oldani 2002). Additionally, the mode of action of medications is simplified in visual presentations to physicians and patients with the intention of convincing viewers that the advertised medication has a lock and key fit with the origin of the psychiatric problem[75] (Healy 2004 [4S presentation]). Researchers have also argued that disorders are trivialized in advertisements in such a way that they can be more easily related to by a larger proportion of the general population, thereby creating a larger market for pharmaceutical companies' products (Greenslit 2003).

Along with the increased attention to social phobia in DTCAs and advertisements for physicians, the profile of the disorder has also increased in the popular press. This increased attention to social phobia has created a heightened awareness of the disorder, which has led a growing number of people identifying with the disorder and seeking treatment for social phobia.

In France, as noted above, social phobia has only recently been more widely accepted by medical professionals, even if they still do not regularly use the term or know

[75] In the case of the effects of antidepressants, these 'lock and key' illustrations are far from the status of scientific information about the way in which the medications work on the symptoms of depression or anxiety.

all of its symptoms in detail. It is generally understood to be a set of problems that affect the ease of one's social interactions. The disorder is considered to be particularly treatable by cognitive-behavioural therapy. The diagnosis is more commonly accepted by physicians who recently graduated from medical school for whom the DSM (III and later editions) would have been a part of their curriculum.

Psychological problems are an increasingly popular topic of discussion in the French media. Television shows have special episodes dedicated to conditions such as obsessive-compulsive disorder and social phobia. On the radio, special segments present information about health troubles, often mental health problems. Magazines, particularly, but not exclusively, 'women's magazines', publish many articles on personal problems, including social phobia. A relatively new magazine, *Psychologies*, is dedicated to self-improvement. *Psychologies*, which is classified as a women's magazine despite estimates that men make up one third of its readership, often publishes stories and letters about social phobia. The advice they offer is usually from a cognitive and behavioural therapy perspective. The internet is also a source of information about social phobia, though websites in French are far fewer in number than those in English[76]. Support groups, chat groups and pharmaceutical companies are amongst the most easily accessible sources of information, and it is through these resources that many people initially 'discover' that they are 'social phobics'[77].

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[76] People in France often rely on the websites from Québec for information.

[77] While sitting in on a support group for people who suffer from phobias, it became clear that these people most often describe themselves not as suffering from social phobia, but as being a social phobic. This latter mode of identification is generally avoided by professionals. The introduction to DSM-III recommended that such descriptors should not be used (APA 1980).

As a result of the attention that is now being directed toward social phobia, it has the potential to become a new mental illness phenomenon, like obsessive-compulsive disorder several years ago and depression more recently.

From shyness to social phobia

Alain Ehrenberg, a French sociologist, has argued that the increased recognition of depression in France is intimately tied to societal pressures focusing on the imperative of action and personal responsibility (Ehrenberg 1998). In a certain sense, depression is the foil to a properly performing and responsible individual. This type of explanation of mental illness attributes the appearance of particular disorders to changing social and cultural norms.

In the case of social phobia, the increasing appearance of 'pathological shyness' may reflect social expectations of extroversion and forwardness. It reflects a growing acceptance of the medicalization and biologization of mental 'health'. In France, these changes in society have significantly changed the lived experiences of my interviewees, some of whom used to think that their shyness had "spoiled" their lives. These people now explain that their problems result from a mental illness, a pathological condition that has made them the way they are. It is something that the psychiatric system can help them overcome. For them, the transition from shyness to social phobia has profoundly changed the way they think of who they are.

Chapter Three

Changing therapeutic principles in North America and France

Contents

> The history of psychiatry shows that many ideas and concepts that once had attained the status of incontrovertible facts were later discarded as nothing more than myths or superstitions. We are forced to the realization that the study of the nature and treatment of the neuroses – or emotional disorders – does not rest on any proven theorems or generally shared assumptions. (Aaron Beck 1976: 6-7)

From psychiatric disease to mental health

The origin of psychiatry, over 200 years ago, was in asylums and the discipline was concerned with the severely mentally ill, who displayed signs of psychosis (Shorter 1997: 1, 5, 291-2). Today we might describe these people as suffering from schizophrenia, bipolar disorder or an organically based psychosis (for example, resulting from syphilis). Gradually, the scope of psychiatrists' and neurologists' work broadened to include those people who suffered from what could be called neurotic disorders (Shorter 1997: 113-9, 291-2). These cases were treated in private offices. The creation of psychoanalysis, about a hundred years ago, and the popularity it gained throughout the first half of the twentieth century made out-patient clinical consultation a more common practice (Hale 1995: 74-8, 211, 276-99, 380-90). Psychoanalytic treatment of neurosis shifted the focus of large numbers of psychiatrists toward the management of everyday psychological ailments and life problems. Even after psychoanalytic theory passed from dominance, at least in North America, treatment of moderate anxiety and psychological difficulties remained a part of psychiatrists' and psychologists' practices[78] (Healy 1997:

[78] Psychoanalysis began to lose its position of dominance in North America beginning in the 1960s. In France, where it was never as dominant as in North America but where it nonetheless still has a great deal of institutional power, other psychiatric theories are beginning to displace psychodynamic theories. Institutional positions are starting to be given to psychiatrists who specialize in other forms of psychotherapy, such as cognitive

241; Shorter 1997: 293-5). The names and explanations for these troubles have changed over time, but the 'symptoms', or complaints, being treated in out-patient clinics throughout the twentieth century have remained largely consistent. Everyday psychological difficulties are now firmly embedded within the domain of psychiatry and psychology (Shorter 1997: 289, 293-5).

These changes did not, and could not, take place only at the professional level. During the twentieth century, North Americans and the French came to use the language of the dominant psychological theory of their day to describe what might have previously been referred to as social or moral problems (Hale 1995: 3-9; Shorter 1997: 96). People throughout much of the Western world are increasingly comfortable resorting to psychological or psychiatric consultations to find solutions to their personal troubles (Hale 1995: 312-3, 340, 358-9; Shorter 1997: 295).

Throughout the last 20 years, professionals and the general public have become increasingly interested in the subject of mental health. Mental health maintenance involves taking the steps to avoid a broad range of disorders and concerns that, although less serious than severe mental illness, still might lead to personal limitations. These steps include monitoring oneself for potential symptoms of illness and caring for one's health. Interest in mental health is tied to contemporary concerns about personal functioning, and an increased attention to overcoming performance limitations. Many of the disorders that are included in mental health concerns are grouped in the DSM under three categories: disorders of motivation (for example, social phobia or subsyndromal/borderline depression); disorders of action regulation (for example,

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and behavioural therapy. This shift is bringing the French psychiatric system more in line with the North American one.

attention deficit and hyperactivity disorder or premenstrual dysphoric disorder); disorders of language and cognitive development (for example, high-functioning autism). Each of these mental illness categories is a reflection of the society in which it was created and/or accepted and that society's expectations of functioning and performance.

The seriousness of 'pathological' mental processes is increasingly described in terms of 'losses of productivity' (personal and professional). The 'cost' of these problems is presented in both economic (often, missed work days and unemployment) and personal (well being) terms. These figures are promoted by governments, international bodies (for example, the World Health Organisation) and other groups interested in promoting awareness of mental illness, such as support or patient advocacy groups. These calculations and analyses move mental illness beyond consideration as a personal concern, to a social issue. Such concerns recall early twentieth century anxiety about degeneration. By this time, populations had become sufficiently urbanized that large scale comparisons of the superior versus the degenerate became possible (Pick 1989: 20-1). Army recruitment and education systems also provided data about the apparently increasingly degenerate populations in Western Europe[79] and North America (McLaren 1990: 91; Schneider 1990a: 85, 93). Primary among people's concerns were feeblemindedness; alcoholism; immorality, which was often assumed to go hand in hand with immigrant populations; criminality; and the poor. Fears about the imminent effects of degeneration were publicized in the media (Mazumdar 1992: 3-4; Reilly 1991: 8-11; Schneider 1990a: 70, 73), as are concerns about rising rates of mental illness today. Similar to contemporary worries about personal functioning and mental illness, the

[79] Concerns were the greatest in north-western Europe. Natives of these countries were worried about the unhealthy influences of people from the South.

degenerate features that were identified in the early 1900s reflected social ideals. These were expressed using scientific jargon and pseudo-scientific research (Kevles 1985: 3, 102-3, 149; Searle 1981: 239; Soloway 1990: xviii; Wilson 2002: 63). The Jew's flat foot was criticized in Germany as were immigrants in North America for scoring low on IQ tests, which were administered in English regardless of the immigrant's fluency in that language (Kevles 1985: 80-3; McLaren 1990: 92; Nelkin and Michaels 1998: 37-8; Selden 2000: 241; Gilman 1991: 39, 49, 55). French Canadians were also seen as a threat to the rest of Canada because of their high birth rate and Catholicism (McLaren 1990: 11). Societal ideals were based on the preferences of countries' middle class and influenced by their religious and racist biases and economic concerns (Allen 1997: 83; Kevles 1985: 46; McLaren 1990: 11, 155, 163; Nelkin and Michaels 1998: 37; Thurtle 2002: 46; Weindling 1999: 219; Weiss 1990: 10, 12). In most countries, for example, compulsory sterilization, and worse, of degenerates/the eugenically unfit was only instituted in times of economic collapse, such as the Great Depression (Allen 1997: 85; Weiss 1990: 37-9). Before this time, institutionalization had been the principles means used for segregating the degenerate and eugenically unfit (Soloway 1990: 107). The cost of institutionalization and the general draining of a country's resources by the eugenically unfit were, like mental illness today, expressed in economic terms (Allen 1999: 8; Reilly 1991: 12-29). Degeneration then and mental illness now are both described as social concerns that need to be addressed for the benefit of society as a whole.

Contemporary populations are analysed for their rates of mental illness. These rates are compared to the likely impact that these illnesses will have on the future of countries. It is in this way that the concept of risk is mixed into the discourse on mental

health. With increasingly popular events such as depression screening day, we are reminded to monitor ourselves for symptoms of potential mental illness and we learn to interpret feelings and thoughts in psychological terms. We are also reminded that if we fall ill, and are not responsible enough to seek treatment, we will be a drain on society. While mental health has become a social issue, it remains one's personal responsibility to recognize and treat one's individual problems.

Trends in therapeutic principles

Psychiatry as a discipline has its roots in the late eighteenth century amid growing concerns about serious mental illness (Klerman 1990). Before this time, while the insane had been institutionalized, care was not the objective of their confinement (Shorter 1997: 4). Early therapeutic psychiatrists worked in asylums and treated psychotic patients (Shorter 1997: 5). While the term psychiatry was invented in 1808, until the twentieth century, these specialists were referred to as alienists, those who treated mental alienation (Shorter 1997: 17). Early nineteenth century alienists laid the foundations for the development of modern day psychiatry (Weisz 2003: 554). By late in the eighteenth century, neurology had developed as a field specializing in problems with nerves and other mental illnesses believed to be of organic cause (Shorter 1997: 22-3). In France, neurology and psychiatry were recognized as independent medical specializations from early in the twentieth century onward, but it was only in 1934 that the state instituted exams to license these physicians, thereby making them official medical specializations (Weisz 2002: 471). In the 1950s, the two specializations came together under the name neuropsychiatry (Weisz 2002: 476).

Early in the nineteenth century, European and American psychiatrists[80] were to a certain degree biologically oriented. Neurologists and psychiatrists looked for the organic causes of mental illness and psychotherapy, or a talking cure, was not of interest to these specialists (Shorter 1997: 26-9). Interventions were made on a physical level, which included bleeding, purging and giving of emetics (Shorter 1997: 9). Introducing a structured time table, isolation (from the outside world) and compassion into the inmates' environment was also considered therapeutic. These latter interventions reflect the attention of early psychiatrists to the non-biological factors involved in the development of mental illness.

Early figures included Philippe Pinel in France, William Battie in England, Vincenzio Chiarugi in Italy and Johann Reil in Germany. Pinel is perhaps the most famous of the four for having ordered the removal of chains from the madmen at Bicêtre and later from the women at the Salpêtrière. For this, his name remains associated with the 'freeing' of the insane, who had to that point been left chained or locked up in cramped quarters. With the sympathetic treatment and isolation of these individuals, Pinel hoped to restore their faculties of reason.

Edward Shorter (1997), a historian of medicine, argues that it was not Pinel but Battie who was the first psychiatrist to promote the therapeutic benefits of institutionalizing patients. Battie was the owner of two private 'madhouses', the founding medical officer of a London asylum that opened in 1751, and the author of the *Treatise on Madness* (1758), which specifically attributed therapeutic virtues to the asylum. In Italy, Chiarugi successfully petitioned Austrian administrators in Tuscany for

[80] The term psychiatrist will be used in place of alienist.

the creation of a hospital for mentally ill patients, which opened in 1788. Chiarugi also published a three-volume work *On Insanity* (1793-4) which outlined how to run such an institution. The work of Reil influenced psychiatric reform in Central Europe with his *Rhapsodies on the Application of the Psychological Method of Cure in Mental Alienation* (1803). Reil suggested that patients be offered physical therapy and psychological stimulation in settings that soothed their minds. He suggested building "healing facilities", as he referred to asylums, amid brooks and lakes, hills and fields (Shorter 1997: 14, 18).

These early psychiatrists created the foundations upon which the treatment of psychotic inpatients would be undertaken by later psychiatrists. The therapies they describe spread throughout European institutions and were used, and further developed, throughout the nineteenth century. While specific psychotherapies were not described, physicians' compassion and "the comfort of the spoken word" were included as parts of the patient's treatment regimen (Shorter 1997: 22).

It was not until the early nineteenth century that psychiatrists' interest turned to non-psychotic conditions, which were lumped together under the name neurosis[81], or nerves. Before this time, the nervous illnesses had been treated by either neurologists catering to the upper classes or spa physicians. Though some neurotics sought the help of psychiatrists, the treatment of nervous conditions was primarily the occupation of early neurologists. Nervous illnesses were thought to affect the nerve fibres in patients' brains creating an array of difficulties for patients including obsessional thoughts, anxiety, melancholy, dullness, among a wide variety of other difficulties. These conditions were

[81] The term 'neurosis' was coined by the British physician Thomas Wilkes in the seventeenth century.

considered entirely different from psychotic madness, which were considered much more severe and associated with greater stigma. This stigma affected more than the psychotic individual as insanity was often thought to be hereditary in nature. Adding to the stigma was the fact that madness was associated with asylums, and despite efforts of asylum keepers to introduce more civilized therapeutic techniques into their institutions, much of the general population still saw these therapeutic institutions simply as madhouses. Perhaps because of the public's fear of psychosis and asylums, over the years, the term 'nerves' became more and more widely used. It was even used to diagnose psychotic patients, particularly of wealthy families, in an attempt to avoid the stigma associated with psychotic mental disorders. The exact meaning of nerves became blurred and it began to be associated with greater stigma as a result of its potential use for the diagnosis of psychosis. Because of this, many patients reacted negatively to physicians' diagnoses of nervous conditions (Shorter 1997: 26-9). Nineteenth century treatments for nerves focused on rest and relaxation, with the occasional use of electrotherapy or hydrotherapy. These therapies continued into the twentieth century (Weisz 2001).

In the late nineteenth century, neurologists and psychiatrists, notably Jean-Martin Charcot and Pierre Janet, became interested in the concept of hysteria. Charcot examined how memories of traumatic events could lead to the symptoms of hysteria among his female patients at the Salpêtrière. Janet, a student of Charcot, investigated how memories, or what he referred to as subconscious thoughts, could create the symptoms of mental illness (Ohayon 1999: 51). The work of Charcot and Janet influenced a generation of young psychiatrists and neurologists, and laid the foundation of a psychologized view of the mind, which focused on psychogenic illnesses (Young 1995:

21). During this period, hypnosis was often used as a means of accessing patients' pathological thoughts (Healy 2002: 41-2).

Sigmund Freud was one of the young neurologists who were influenced by Charcot's research[82]. When Freud turned his attention from the biological to the psychological origins of mental illness, the history of psychiatry was ultimately changed. While his theories about the role of subconscious ideas creating mental illness were similar to Janet's, he did much more to promote himself and his ideas than did Janet, and his theories therefore reached many more ears than did those of his French colleague (Ohayon 1999: 48). Freud's psychodynamic theories of the mind were spread world wide, passed down through 'generations' of therapists, the first generation of whom he analysed himself. Freud's theories became influential in France in the 1920s, and psychoanalysis remains a well-accepted means of dealing with one's neurotic difficulties. However, Freud's psychodynamic theories never achieved the dominance they did in North America. (While psychoanalytic theories became dominant in France, it was an eclectic, rather than a strictly Freudian, version of these theories that was adopted.) In North America, psychoanalysis became the principle means of understanding and addressing mental illness and psychic unrest[83]. Its terms permeated professional and lay language, and it was a significant factor in people coming to understand their thoughts and experiences in a 'psychologized' way. Psychoanalysis made it more commonplace to seek recourse in a psychiatrist, psychologist or neurologist for treatment of anxiety.

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[82] While Charcot influenced Freud's work, he was only one among many other influences of the Viennese physician.

[83] Many of the patients treated in psychodynamic psychotherapy did not meet the diagnostic criteria for a mental illness. These people often went to see therapists because of low level anxiety or existential worries.

While theories have changed over time, with the arrival of psychoanalysis, the door to the psychologization of the mind was opened for future generations of mental health clinicians.

The psychoanalysts to the biological psychiatrists

Psychoanalysis arrived in the United States in the 1920s. Psychoanalytic theory was introduced to Americans by visiting European specialists and a number of European psychiatrists who emigrated to the United States during the 1930s and 40s. Psychoanalysts were readily accepted into the American mental health system and throughout the 1940s and 50s, many obtained high ranking positions in academic and professional institutions. The representation of psychoanalysts in these positions of authority was substantial considering the relatively small number of these psychiatrists; in 1953, psychoanalysts made up only 7% of American psychiatrists. By 1968 the number of psychoanalysts had increased, but still only 8% of American psychiatrists were psychoanalysts. Many of the others were biologically oriented[84] (Shorter 1997: 173-5). Biological and psychoanalytical psychiatrists worked in different domains. Private psychiatric clinics were primarily set up by psychoanalysts while biologically-oriented psychiatrists worked in research units, hospitals or in institutions for the mentally ill where they treated psychotics, schizophrenics and other serious mental illnesses[85].

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[84] Biologically-oriented psychiatrists used chemical and surgical techniques, among others.

[85] However, biologically-oriented psychiatrists did not have exclusive control over these institutions. Perhaps the most well known example of psychoanalysts treating serious mental illnesses is the Osheroff case, in which a doctor, later diagnosed as suffering from

In the 1950s the landscape of psychiatric psychotherapy began to change. A theoretical shift took place in psychiatry that was influenced by the relatively new field of social work and by the related field of psychology. By the 1950s, these professionals greatly outnumbered licensed psychiatrists. While the practice of psychoanalytic psychotherapy was outside of their reach, since the American Psychoanalytic Association required practitioners to complete a residency in psychiatry, several new forms of psychotherapy were introduced in the 1960s and 1970s that they could practice[86]. These professionals believed that the new psychotherapies, including cognitive and behavioural therapy and rational-emotive therapy[87] provided valuable tools for the treatment of their patients and clients. Cognitive and behavioural therapy[88], rational-emotive therapy and interpersonal therapy were relatively easily introduced into the clinical setting because of the degree to which the therapy had been structured and organized in manuals (Beck 1967, 1976; Ellis and Grieger 1977; Klerman, Weissman, Rounsaville and Chevron 1984); this meant that people with a relatively basic set of professional skills (not necessarily an M.D. or an advanced degree) could learn to provide these therapies in a

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bipolar disorder, was treated for 7 months according to psychoanalytic principles at the Chestnut Lodge. Seeing no results, his family removed him from the institution and moved him to another where he was given medications, which immediately produced significant results. He later sued Chestnut Lodge for not offering the possibility of other therapies, including pharmacotherapy (Healy 1997: 246-7).

[86] Interpersonal therapy was created by a social worker, Myrna Weissman, for use by non-physician therapists (Healy 1997).

[87] These theories came from both psychology and psychiatry. In the case of Ellis and Beck, the former was a psychologist, the latter a psychiatrist.

[88] Psychiatrists and highly trained psychologists tried to exercise control over who could practice cognitive and behavioural therapy, trying to restrict its use (Healy 1997). However, its principles were included in the eclectic therapy practiced by most psychotherapists (Healy 1997; Young 1995) since Beck's manual describing the practice and the theory behind it was straightforward enough to be understood by health professionals and the lay public (Healy 1997).

manner that would be comparable to the therapy offered by other mental health professionals[89].

Throughout the years that the number of psychologists and social workers had risen, the number of psychiatrists had fallen; fewer medical students were choosing psychiatry as a clinical specialization (Shorter 1997). Since the decline of psychoanalysis, psychiatry had lost some of its stature and therefore its draw for new physicians. Psychiatrists saw the new psychotherapies as too basic to warrant their specialized training, so most psychiatrists had turned their attention to specialization in drug therapy. Because of this, there were no longer enough psychiatrists to meet patients' demand for psychotherapy, which had increased considerably during the years in which psychoanalysis had been popular. Psychologists and psychiatric social workers increasingly began to take over the practice of psychotherapy to meet patient demand[90].

While psychiatrists still offered psychotherapy, including psychoanalysis, they began to re-establish themselves within what was beginning to be a post-psychoanalytic field. Psychiatrists could no longer expect to base a lucrative practice solely on psychodynamic psychotherapy; patients wanted new forms of psychotherapy, such as cognitive and behavioural therapy, rational-emotive therapy and interpersonal therapy[91]. However, psychiatrists were not interested in practicing the new forms of 'low skill' psychotherapy, such as interpersonal therapy. Since psychiatrists were losing, or

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[89] The performance of these therapies were comparable in two senses. First, outcomes could be measured and compared with tools such as the Beck Depression Index. Second, there were set techniques and practices for each of the therapies which were structured, providing, at least theoretically, comparable outcomes.

[90] Patients wanted access to psychotherapists, but they had grown wary of psychoanalysis and were interested in the new therapies created beginning in the 1950s.

[91] Patients also wanted access to newly developed psychotropic medications.

abandoning, their role as psychotherapists they sought out new niches. The biologically oriented psychiatrists, who had outnumbered psychoanalytically oriented psychiatrists even at the height of psychoanalysts' popularity, encouraged new psychiatrists to take up their specialization. In the 1960s and 70s, biologically oriented psychiatrists were doctors who were interested in the use of psychotropic drugs, and surgical methods, in the treatment of mental illness. The apparent effectiveness of medications in particular made these psychiatrists increasingly certain that psychiatric illnesses could be split into different categories reflecting different disease processes, as drugs like antidepressants worked on one group of patients while anti-psychotic drugs worked on another group of patients. David Healy has described the effects of the synthesis, and demonstrated effectiveness, of the first antidepressants. The creators of these drugs, he says, believed that "what was to be seen was not an antidepressant effect so much as the outlines of a disease – whose existence had been proposed before but which was now being revealed by a pharmacological scalpel" (Healy 1997: 56). The decline of psychoanalysis created an opportunity for biological psychiatrists to take a more central role in psychiatry and redefine the practice of this discipline. These psychiatrists began arguing for the reincorporation of psychiatry into biologically-based medicine.

Biologically-based psychiatrists began to promote scientific research as the appropriate centrepiece of a new incarnation of psychiatry around the same time that new psychotherapies were being developed in the United States. This was the beginning of a neo-Kraepelinian movement in psychiatry whose leaders were pushing for the classification of mental illnesses as discrete disease categories. According to this new perspective, mental illness categories were presumed to have biological origins that

would be uncovered with sufficient time and research. As noted above, this presumption was at least partially informed by research findings which indicated that drugs could be used to effectively treat specific psychiatric disorders. The most influential contribution of neo-Kraepelinian psychiatrists to the shaping of their discipline was the DSM-III and subsequent editions.

As had been the case for the creators of new psychotherapeutic techniques, these biologically oriented clinicians had begun to doubt the ability of psychoanalysis to work effectively for the treatment of certain mental illnesses. The biological psychiatrists were particularly motivated by the finding that newly developed medications could sometimes stabilize[92] a psychotic patient within days, while psychodynamic psychotherapy could take months or years to produce the same result, if it was able to at all. The new medications seemed to be disease-specific since they worked on patients with relatively uniform symptoms. This made it appear as though discrete mental illness categories existed at a biological level. This perspective cast doubt on psychoanalytic descriptions of mental illness which included broad, dimensional categories, and which considered patients' symptoms relatively unimportant[93]. For example, phobic symptoms are not immediately seen as symptoms of a particular disorder. They can appear in anxiety hysteria or phobic neurosis, both of which are conditions which clinicians have described to me as similar to social phobia, but they may also be related to a variety of neurotic and psychotic conditions (Laplanche and Pontalis 1974: 37-8). To psychoanalysts symptoms are not correlated with a disorder to the extent that they are in the DSM.

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[92] By stabilize, I do not mean long term stabilization. I am referring only to the short term reduction of violent or self-destructive psychotic behaviours.

[93] This statement will be elaborated upon in the ethnographic section of this thesis.

The focus of psychiatrists on research and the surgical[94] and, primarily, chemical treatment of patients increasingly left psychotherapy to psychologists and social workers. The low level anxiety and psychic malaise, for which patients had previously sought the help of psychoanalysts, now became the work of non-medical professionals. In addition to cognitive and behavioural therapy, rational-emotive therapy and interpersonal therapy, many other psychotherapies became well known and popular. These ranged from Eriksonian therapy, to more controversial varieties such as rebirth ceremonies and hypnosis/regression therapy. Certain of these became mainstream, others remained marginal. These theories of mental illness causation became well known and were incorporated into the fabric of popular culture; a new psychologisation of lived experiences was the outcome. The origins of one's present problems were no longer sought in repressed memories. The conscious mind became the focus of therapy, emotions and relationships were analyzed for insight into one's problems. These symptoms of mental illness became the object of intervention rather than being pushed aside as polymorphous markers of underlying psychic conflict. With this change, daily experiences and thoughts were psychologized as symptoms, and their significance changed according to the new theory applied[95].

The introduction of a 'rational' psychotherapy

By the 1960s, North American therapists were eager to take a more active-directive role in the psychotherapeutic encounter, rather than waiting what they saw as excessive

[94] I include electroshock therapy in this category.
[95] For instance, workplace contentment or dissatisfaction is now described in psychological terms in popular psychology magazines, such as a healthy work environment, anxiety or trauma (Psychology Today 1993, 2003).

and painful amounts of time for patients to understand the origins of their difficulties, according to psychoanalytic principles. Free-association itself was considered a part of the problem since patients often required a long time to *learn* to perform this task, some never mastering the technique (Ellis 1963). Albert Ellis and Aaron Beck, among other therapists, believed that the origins of patients problems were more self evident and easily accessible than the pathogenic, unconscious memories sought through free association.

As a result of this discontent with psychodynamic psychotherapy, in the 1960s and 1970s American psychologists and psychiatrists set out to create a new theoretical basis for psychotherapy, one that could be compared and validated through clinical studies. Two of the foundational therapies proposed were rational-emotive therapy[96] and cognitive behaviour therapy. These therapies were introduced by Albert Ellis and Aaron Beck, respectively, as alternatives to psychodynamic psychotherapy (Amador and David 1998). With rational-emotive therapy and cognitive and behavioural therapy, Ellis and Beck sought to create logic-driven approaches toward the understanding and treatment of mental disorders. Their frameworks placed insight within the conscious grasp of patients and privileged outcomes that were 'objectively' measurable[97]. Both Ellis and Beck identify the Greek Stoics as influential in the creation of their theories. Like them, the Stoics "considered man's conceptions (or misconceptions) of events, rather than the

[96] Rational-emotive therapy is at times referred to as rational emotive behavioural therapy (Ellis 1999).

[97] For instance, Aaron Beck created the Beck Depression Index based on this cognitive theories of the disorder, which is used to diagnose depression and to quantify patients' improvement. This scale quickly became popular and is still widely used. Compared to Beck, Ellis placed less of an emphasis on the measurability of patients' outcomes.

events themselves, as key to his emotional upsets" (quote taken from Beck 1976: 3; Ellis presents similar ideas 1963: 17).

The creation of rational-emotive therapy precedes that of cognitive and behavioural therapy; rational-emotive therapy in some ways provided a theoretical base on which cognitive and behavioural therapy could expand. The latter form of therapy has become a clinically proven treatment for depression and social phobia (Davidson et al. 2004) and both rational-emotive therapy and cognitive and behavioural therapy have influenced, to one extent or another, the way in which social phobia is currently understood.

According to rational-emotive and cognitive and behavioural principles, patients are thought to have learned to interpret the world around themselves defectively; they have distorted ideas about reality[98] that must be modified in order to improve their personal functioning (Beck 1976). Examples of these distorted ideas include how they imagine others perceive them or what they expect of themselves (their expectations are usually unrealistically high). These therapists suggest that such faulty beliefs can lead to negative self-thoughts which undermine patients' confidence and give rise to mental illness. According to cognitive-behavioural and rational therapists, humans are rational creatures in possession of common sense[99]. Emotional upset and irrational behaviour are thought to arise only as a result of faulty premises held by the patient (Beck 1976). From this perspective, humans can be described as reasoning logically at all times. When

[98] Though these people are described as working with distorted views of reality, they are still able to see the reality of their situation, if challenged by a therapist to do so. This separates them from people who do not have intact reality testing. In this second case, people are described as incapable of differentiating between hallucinations, for example, and reality.

[99] These clinicians consider common sense to be one of human beings' most powerful tools.

patients' behaviour and beliefs seem maladaptive or irrational, these instances are interpreted as rational but simply following from the erroneous premises. The goal of cognitive and behavioural therapy and rational-emotive therapy is to correct faulty premises and after this the patient's common sense can take over, which will now based be upon the 'correct' understanding of reality (Beck 1976).

Rational-emotive therapy, and, even more so, cognitive and behavioural therapy, are highly systematized forms of therapy. Patients are assigned "homework" at each session with the intention of having them put into action the ideas discussed during that session of therapy (Andrews 1993; Ratto and Capitano 1999). Following a successful course of cognitive and behavioural therapy, the focus of the therapist and patient is reoriented toward maintaining the patient's improved condition. In order to prevent a relapse, patients are taught to look for prodromal symptoms of their disorders (Fava et al. 1998). Should these appear, patients are taught to put into practice the coping techniques they learned in therapy, such as correcting negative automatic thoughts or self-statements (Beck 1976; Ellis 1963).

Rational-emotive therapy and cognitive and behavioural therapy share a self-conception of humans with folk psychology. This psychological framework calls upon the act of self-observation in order to gain insight into mental disorders (Kirmayer and Corin 1998). By placing an emphasis on the patient's understanding of his or her conscious mind and behaviour, rational and cognitive therapies set themselves apart from psychodynamic theory. Cognitive and behavioural therapy and rational-emotive therapy created a new conception of the patient, a new self, being treated in psychotherapy (Amador and David 1998).

Rational-emotive behavioural therapy

While rational-emotive therapy and cognitive and behavioural therapy share much in common, they differ to some extent in their approaches, particularly in terms of their creators' efforts to create replicable, quantifiable and scientifically-proven bases for their therapy.

Albert Ellis created the foundations of rational-emotive therapy during the 1950s (Ellis 1963). Ellis doubted the efficacy of psychoanalysis in removing patients' symptoms and allowing them to get on with their lives. Even once a patient's current troubles had been traced to a specific memory, Ellis was not certain of that the patient was cured; an outcome which he measured at least partially in terms of reduced fear and anxiety (Ellis 1963). Symptom alleviation is central to rational and cognitive psychotherapies. Ellis came to the conclusion that what caused the patient's on-going difficulties in their day-to-day lives was not their original bad experience, but what he referred to as "twice-told tales". Ellis suggested that it was patients' "imagined" fears, which are continually mentally re-played as "twice-told tales", that are at the root of most neuroses[100] (Ellis 1963). According to this theory, the imagined fears would lead patients to habitually make negative internal self-statements based upon the repeated tales. This view is differentiated from the psychodynamic perspective by the role attributed to the *conscious* self-statements that perpetuate the effects of the patient's original experience. Ellis came to believe that he had previously been erroneously stressing "what to undo

[100] While rational-emotive therapy was initially used to treat primarily depression and neuroses, it is now most often used to treat depression and anxiety disorders, reflecting changes in psychiatric nosologies.

rather than what to unsay or unthink" (Ellis 1963). With this shift of focus, the curative powers of therapy moved from the past to the present, from memories to thinking.

Ellis' rational theory of the mind describes emotions as "nothing more nor less than a certain kind – a biased, prejudiced, or strongly evaluative kind of thought" (Ellis 1963: 41). Ellis defines sustained negative emotions as pathological and suggests that these are based upon irrational thoughts, or 'negative self-talk[101]' (Ellis 1963). Self-talk results in a patient holding biased and strongly personalized perceptions of the world based upon previous experiences that may have little in common with the patient's present circumstances. According to Ellis' theory, such disturbances must be corrected by changing the internalized phrases or thoughts which accompany patients' experiences. This is done with the help of the therapist by "unmasking the past and illogical thinking" of the patient in order to show how he is "causing and maintaining his disturbances. The therapist's role is in "demonstrating what the illogical links in his (the patient's) internal sentences are, and teaching him to rethink" (Ellis 1963: 58). Ellis' objective was to prove that people suffering from neurotic or other mental illnesses, were not altogether different from 'normal' people. He argued that simple changes could allow these patients to function as well as their 'normal' counterparts.

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[101] Self-talk includes the things that we say to ourselves as we go through day to day life. It is not the same thing as talking to oneself out loud, though some self-talk may be verbalized. Negative self-talk is thought to prevent people from finding solutions and can be immobilizing. Examples include: "I can't do this", "they can see how incompetent I am". Rational and cognitive therapists suggest that negative self-talk be replaced with positive statements. Self-talk is related to internalized phrases or thoughts. These are the things we say repeatedly to ourselves, or ideas that arise automatically, which may be negative. Internalized phrases or thoughts are similar to 'knee-jerk' reactions to specific situations. For example, some people may automatically assume in certain situations that people dislike them, are hostile towards them, or are judging them in certain ways. These reactions lead to emotional responses.

Ellis based his theories on subjective observations of patients and his explanations emphasized subjective interpretations, focusing on philosophical and multifactorial explanations. Though some of his later works fleetingly refer to the influence of biological processes on psychological difficulties, he does not describe particular neurological pathways or specific biological causes (Ellis 1997). Ellis' research has been largely theory-driven and rational-emotive therapy is not well represented in empirical, scientific literature.

This last factor is perhaps the most important difference between rational-emotive therapy and cognitive and behavioural therapy. To a certain extent, Ellis' rational-emotive therapy provided the ground work for rational and cognitive theories of the mind. But, in a new era of psychiatry and psychology founded on quantifiable results and scientific theories, Ellis' theories failed to be as influential as Beck's research on the effects of cognitive and behavioural therapy, in which Beck went to great lengths to quantifiably demonstrate efficacy and replicability of his therapy.

Cognitive and behavioural therapy

Aaron Beck introduced cognitive and behavioural therapy in 1967. As Ellis had become suspicious of psychoanalytic theory, so too had Beck. What he specifically opposed was what he saw as the premise shared by neuropsychology, psychoanalysis, and behaviour therapy, namely that "the emotionally disturbed person is victimized by concealed forces over which he has no control" (Beck 1976: 2). He saw these approaches as "glossing" over the patient's consciousness, which he believed to be the very part of a patient's mind responsible for his or her "emotional upsets and blurred thinking" (Beck

1976: 3). Not only did Beck believe that the sources of a patient's difficulties were consciously available to him or her, he also believed that there were rational techniques to deal with the "disturbing elements of the consciousness". According to Beck:

> Man has the key to understanding and solving his psychological disturbance within the scope of his own awareness. He can correct the misconceptions producing his emotional disturbance with the same problem solving apparatus that he has been accustomed to using at various stages in his development. (Beck 1976: 3)

In drawing upon the patient's everyday 'problem solving apparatus' in therapy, he hoped to bring "the understanding and treatment of emotional disorders closer to the patient's everyday experiences" (Beck 1976: 13). In cognitive and behavioural therapy individuals are expected to have conscious access to the "core structures" responsible for their dysfunctional feelings and conduct (Beck and Freeman 1990). The aim of the therapy is to train a person to have greater access to his or her cognitive schemata which produce biased judgements and to correct the patient's individual functioning (Beck 1976). In Beck's view, cognitive dysfunction boils down to 'defective learning', and the therapists role is to unravel the 'distortions' within the patient's thinking and to help him "learn alternative, more realistic ways to formulate his experiences" (Beck 1976: 3). He argues that common sense has been disvalued in psychiatry and psychology, as have been the "profound and intuitive understandings that people have of themselves" (Beck 1976: 13).

According to Beck, emotional reactions must be understood in terms of the difference between public meaning and private meaning. Whereas public meaning is the "formal, objective definition of the event – devoid of personal significance or

connotation", private meanings are associated with "special meanings" which are "evoked when an event touches on an important part of a person's life" (Beck 1976: 48-9). Put another way, public meanings of events have few implications for an individual. Private meanings of events, on the other hand, are the significations that an individual reads into an event, which may involve the individual making generalizations from this event. For example, if a person places a bet on horse X at a race and that horse does not win, the public meaning would be that a horse faster than horse X was in the race. The private meaning of this event could be, "I never win, I'm always the loser". Irrational reactions are thought to derive from private meanings. For every event, there is at least one of each meaning. Beck suggests that personal meanings are often unrealistic because people do not test their validity, as a therapist does in the clinical encounter. He argues that private meanings explain why a person's reaction to an event may seem inappropriate or excessive: he or she has attached a "web of incorrect meanings" to the event, and it is this web that creates the cognitive distortions (Beck 1976: 49). Beck conceives of dysfunctional emotional behaviour and thoughts as problems of an "attributional response bias" and believes that one is cured by becoming aware of these incorrect attributions of meaning and changing them (Beck 1990: 5). By attributional response bias Beck means that patients tend to interpret the world around them in a personal and biased way. They use their interpretations to create causal explanations for why things happen. Since these explanations are based on biased premises, they are thought to be incorrect or irrational.

In his writings, Beck elaborates on the concept of a rule-based, schema-driven brain that is described by cognitive scientists[102]. Beck organizes mental experiences into symptom structures, the manifest problems, and the underlying schemata that are the presumed causal cognitive structures. The schemata, or cognitive structures, have the function of organizing experience and behaviour, and contain the beliefs and rules that determine thinking, affect, and behaviour (Beck and Freeman 1990:4). Schemata act as processors of information, helping to organize and give shape to information from the external world. According to Beck, patients can learn to correct their schemata as a part of an individual learning process that is performed with the assistance of the therapist (Beck 1976; Ratto and Capitano 1999). To achieve this, an individual is expected to draw on and learn from his or her personal history (Beck 1976; also see Ellis 1963). Through this process, Beck believes that patients can modify the attribution of negative thoughts, in order to have a more 'normal' understanding of, and behaviour in, the world (Guidano 1991).

Beck introduced the Beck Depression Index in 1979 to quantitatively assess changes in patients' symptoms brought about by cognitive and behavioural therapy. His goal was to introduce a tool for psychiatrists to gauge patients' experiences in therapy and to measure therapeutic outcomes so that patients' improvements and therapists' effectiveness could be 'objectively' compared (Beck and Freeman 1990: 5). Ellis, on the other hand, maintains that personality change, though feasible, is difficult to measure and as far as he knows, "it has never been assessed accurately" (Ellis 1997: 334). With the introduction of DSM-III in 1980, quantitatively-based assessment became the norm.

[102] Ellis touches upon such explanations but does not develop them.

Those not willing to work within this framework became marginalized and it was Beck's, rather than Ellis', theories that most closely fit into the new framework.

Cognitive behaviour therapy has been successfully integrated into North American psychiatry and psychology, to the point that it is now one of the most prevalent therapies offered for mood and anxiety disorders. Its efficacy has be demonstrated in comparison with other therapies (Otto and Deveney 2005; Scott, Mughelli and Deas 2005), including pharmacotherapy (Davidson et al. 2004). Some of these papers link the outcomes of cognitive and behavioural therapy to the effect of this therapy on patients' hormone levels or the underlying structures and activities of their brains (Joffe, Segal and Singer 1996; Schwartz 1998). This evidence has led cognitive and behavioural therapy, along with certain medications, to be the most recommended treatment for social phobia.

Measuring the mind

The new psychotherapies developed in the United States throughout the 1960s-1980s were rapidly adopted by American and Canadian social workers and psychologists. Several of these therapies have become the standard form of therapy offered to patients. Of all those introduced, cognitive therapy may be the most widely used. Cognitive and behavioural therapy has been shown quantitatively to stably improve the functioning of depressed patients (Hollon et al. 2004), evidence of its efficacy that is valued in North American psychology and psychiatry, which prioritizes standardization and measurable results[103].

[103] In contrast, psychoanalysts are resistant to the measurement of their patients' improvement, arguing that for each patient a different outcome could be considered

Interest in the quantification and comparison of psychological tests developed early in the twentieth century. Psychologists' interest was piqued by the results of quantified intelligence and functioning assessment tests given to army recruits during the First World War. Tests had been used before and after this in eugenic studies of the general population and on immigrants as part of the North American eugenics movement, but the assessment of army recruits was the first collection of data of such a large scale. The use of psychological scales became more common to assess personality, among other traits during the interwar period and has since remained a central feature of psychology and clinical social work. During the interwar period, psychologists were eager to promote the use of these tests as evidence of the scientific nature of their field. But the tests were also used in accordance with social ideals of the day and contributed to eugenic research by identifying people of greater or lesser morality (Nicholson 1998). Cognitive therapists catered to continuing interest in measurability of psychological traits and this facilitated their acceptance in Canada and the United States.

While standardized tests have long been a part of psychological research in France, this has not favoured the acceptance of cognitive and behavioural therapy to the same extent as in North America. French psychologists and psychiatrists have held staunchly to a therapeutic eclecticism, of which psychoanalysis is a central feature. French clinicians remain wary of the short term psychotherapies[104] that became popular in North America in the late 1970s and early 1980s. Cognitive and behavioural therapy

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positive; their therapy and therapeutic results are considered too individualized to be assessed by a standardized questionnaire.

[104] Most of these short term psychotherapies were cognitive or behavioural, though short term psychoanalytic techniques in which the therapist is more active, were also created.

in particular has been described by French clinicians[105] as shallow and possibly delaying patients' recovery since it focuses on symptom alleviation without concentrating on the psychogenic origins of symptoms. Cognitive therapists are gaining respect within French psychiatry and psychology, but this change is relatively recent and they still hold fewer academic and senior hospital positions than psychoanalytically-oriented psychologists and psychiatrists. While North Americans seem to have whole-heartedly embraced the quantitative outcomes[106] that are possible with short term psychotherapies and medications, the French seem reluctant to accept this idea as they were to accept Freudian psychodynamic theories[107]. According to physicians that I interviewed, the French are sceptical compared to people of other nationalities and are more likely to criticize a new theory than accept it. This may have played a role in the French remaining unconvinced by a 2004 study released by the Institut national de la santé et de la recherche médicale (INSERM) indicating that cognitive and behavioural therapy is superior to psychoanalytic psychotherapy (Benkimoun 2004). Apart from cognitive and behavioural therapists, most French clinicians rejected the findings of the study, which they expressed in letters to newspapers and magazines. Newspaper and magazine articles were also devoted to the issue ([this list includes both letters and articles] André 2004; André 2005;

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[105] This idea was repeatedly presented during interviews with French clinicians.

[106] Both medications and short term psychotherapies, such as cognitive and behavioural therapy, have been tested in clinical research. These studies provide quantitative measurements of patients' improvement. Psychoanalysis, in contrast, has rarely been studied in clinical trials. Recent studies have been carried out, but most psychoanalysts claim that the effectiveness of their therapy cannot be understood within the rigid confines of a clinical trial. Because of this, there are few quantitative studies supporting the effectiveness of psychoanalytic psychotherapy.

[107] The French did not rapidly accept Freudian psychological concepts. While many of his ideas eventually became influential in France, this took a long time. In addition, psychodynamic concepts used in France often come from French psychoanalytic theorists rather than from the Freudian psychoanalysis that was rapidly adopted in North America.

Blanchard 2005; Cottraux 2004; Danion and Etiemble 2005; Favereau 2004; Fischetti 2005; Holden 2005; Huret and Olivier 2004; Keller 2004; Miller 2004; Pélissolo 2004; Prieur 2005; Roudinesco 2005; Servan-Schreiber 2005; Tort 2004; Vincent 2005). The French certainly have an interest in the measured mind. After all, the first IQ test was developed in France. However, they have not embraced quantifiable results offered by short term therapies to the same extent that North Americans have[108]. This position has allowed more eclectic, and not easily measured, therapies to maintain a more central position in France than in North America.

Economic factors affecting therapeutic recourse

The acceptance of modern, short-term therapies has been influenced by many factors. In the United States, economic factors encouraged the use of brief psychotherapy. Health Maintenance Organisations (HMOs) wanted to place limits on the amount of money spent on psychotherapy and they wanted a means to confirm that the therapy was working, to ensure that their money was being well spent (Luhrmann 2000). HMOs decided to place limits on the number of psychotherapy sessions available to their clients. This decision meant that for those people who were not in a position to pay for long term psychotherapy, brief psychotherapy, such as cognitive and behavioural therapy, would become the standard method of treatment in the United States.

[108] This will be the focus on the ethnographic sections of this text.

In Canada and France, medically-mandated recourse to psychiatrists is paid for by the government in the same manner as other visits to physicians[109]. Psychiatrists perform many types of psychotherapy including cognitive and behavioural therapy and psychoanalysis. However, because these professionals are paid by the act, per patient that they see, they are unlikely to spend long periods of time with their patients. There is an exception to this, certain French psychiatrists, along with other physicians, have the right to charge more for their services than others. The state only reimburses their services at the normal rate, so patients end up paying more money to see these physicians. Such psychiatrists may be more likely to engage in elongated psychotherapy sessions with their patients. Nonetheless, for most Canadian and French psychiatrists, a large part of their work involves assessment and prescription of medicines, though all types of psychotherapy remain a part of their work.

Psychologists and other mental health professionals also offer psychotherapy to patients, including cognitive and behavioural therapy and psychoanalysis. The Canadian and French governments do not pay for psychotherapy performed by psychologists and other psychotherapists. Some people have private insurance, often through their jobs, which pays for a limited number of sessions, but generally people must pay out of pocket for these psychotherapists. This means that when patients are not seeking psychotherapy from a psychiatrist, they will likely favour short term psychotherapy and those who choose long-term psychotherapy are liable more affluent than those who do not. Wealthy

[109] In Canada this means that the patient does not pay at all. In France, the patient is reimbursed at the same rate as for other trips to the doctor, which results in the patient only paying a small fee.

Parisians are the primary clients of psychoanalytic psychologists in France[110]. Many psychoanalysts in France also offer sliding-scale fees, so that their services are available to individuals of lower socio-economic status. In general, however, in the U.S., Canada and France the current financial set up of the health system most favours the treatment of mental illness with medications. Short term psychotherapy (often in the form of cognitive therapy) is the second most favoured treatment, followed by long term psychotherapy.

Psychiatric critiques of the rational self

Patrick Bracken, a British clinical psychiatrist, argues that cognitive psychological theories draw upon a particular view of the self. Patients are assumed to be willing and capable of verbalizing the details of their psychological problems. The sort of self analysis advocated in cognitive and behavioural therapy, where one reflects "upon oneself in a detached and 'objective' manner has become something of a moral imperative" in contemporary societies adhering to these principles (Bracken 1998: 53). Rationality and objectivity hold privileged places in these contemporary psychological theories.

The lack of emphasis on the social and relational factors in the cognitive therapy literature may not be surprising, considering the overwhelming importance placed on the individual by cognitive and rational theorists (Young 1988). If it is believed that all change should arise from internal mental schemata of the individual patient, then

[110] A pair of social scientists in Paris mapped out the location of psychoanalysts in the city. The numbers increase as one follows the Seine from east to west; this reflects the trends in affluence in the city, with the west being more affluent than the east (Françoise Champion and Xavier Briffault, unpublished).

environmental and situational factors are necessarily of less interest or consequence. Bracken argues that in the post-Enlightenment preoccupation with a "search for causal, scientific accounts of the mind and its disorders... cognitive models and therapies involve the clearest expression of this cultural quest to use reason and scientific techniques in an exploration of the subjective realm" (Bracken 1998: 43). The cognitivist schemata models of the mind associated with cognitive and behavioural therapy have implications for the way that therapy will be offered. Their models suggest that if the "meaningful nature of reality is something 'conferred' on it by the schemata, or programs, running in individual minds", then "cognitive restructuring" in the therapeutic encounter is all that is necessary to correct the patient's thinking (Bracken 1998: 49, 55). Bracken suggests that the end result of such an approach is that one ends up with documented accounts about the effects of 'internal change' on patients while potentially meaningful life factors are set out on the periphery (Bracken 1998: 51).

Vittorio Guidano[111], an Italian psychiatrist, created a post-rationalist approach to cognitive theory. This approach grew out of constructivist therapy which began to be used in the 1970s as a response to cognitive and behavioural therapy. These two approaches criticize the assumption in cognitive and behavioural therapy that emotional adjustment is a simple matter of making one's cognitions more realistic and in line with the observable world. Guidano's approach introduces the influence of life events and unconscious thoughts into cognitive therapy. Guidano argues that even after a 'successful' outcome in cognitive and behavioural therapy, the patient has not come to understand the content of his or her 'strange' over-sensitivity, instead the "critical

[111] Guidano's post-rationalist approach is not widely cited on Medline. However, he is widely recognized for his contributions to constructivist psychological theories.

emotions remain alien to the subject who has acquired skills in controlling them from the outside" [112] (Guidano 1991: 94). He argues that because cognitive therapists consider emotions to be no more than personalized thought, emotions are not examined at length or in depth. Instead, the goal of therapy is to re-conceptualize or abandon these thoughts. In cognitive and behavioural therapy, he argues, the full weight of change is placed on the individual and his or her ability to rationalize his or her feelings.

Guidano argues that cognitive therapists assume there exists a true or objective external reality which patients experience correctly or incorrectly (rationally or irrationally). Therefore, treatment of mental dysfunction involves, at some level, "identifying 'wrong' beliefs and irrational automatic thoughts, comparing the client's behaviour with a set of standard rational axioms taken to be universally valid" (Guidano 1991: 3, 93). Guidano argues that rather than creating a wholly rational person, this approach to understanding the self may instead alienate a certain self-awareness; distanced is an 'irrational' way of "experiencing and explaining the self and reality" (Guidano 1991: 94) that deviates from cognitive and behavioural therapy's rational norm.

Practicing cognitive and behavioural therapies

From the 1960s onward, but especially since the appearance of DSM-III, psychotherapies have been promoted as disorder-specific. Before this time, there had been fewer clearly delineated categories of mental illness, which reflected the influence of psychoanalytic theories. Psychodynamic therapists were not as interested in defining discrete disease categories and tended to see therapy as specific to an individual rather

[112] These ideas were echoed by a number of members of a social phobia support group in Paris, who has already followed a six month course in cognitive and behavioural therapy.

than a disorder. Therapy sought to understand the etiology of patients' problems, which meant that their unconscious conflicts and anxiety needed to be examined. The same therapeutic technique would be used regardless of a patient's diagnosis. In this context, specific targeted interventions made less sense. In contrast to this approach, since its creation, cognitive and behavioural therapy has been promoted as an effective treatment for depression[113]. Cognitive and behavioural therapy and other rational psychotherapies are now considered particularly effective for mid-level or chronic depression and certain anxiety disorders[114]. Social phobia is one of the disorders that are shown to be particularly effectively treated by cognitive and behavioural therapy. Because of this, cognitive therapists have promoted it as one of the 'success stories' brought about by the introduction of this form of therapy. The attention of cognitive therapists to social phobia has increased other therapists' awareness of the disorder and encouraged them to look for the disorder amongst their patients.

Miracle drugs

The appearance of psychopharmaceuticals has contributed to the way that mental illnesses are understood and treated. The first drug described as an antidepressant reached the market in 1955. This drug created the impression that drugs could be

[113] David Healy suggests that this statement holds true for therapies and medications alike. He argues that we are currently in an era in which there is the "impression that drugs like Prozac and therapies like cognitive therapy are treating specific disorders, such as depression, in contrast to Valium and psychoanalysis, which many thought were begin used inappropriately to manage what were seen as existential problems. The change in perceptions, so that it is thought that real illness rather than distress is now being treated, owes a great deal to a revolution by committee, which was effected by the developers of a new classification for psychiatric disorders unveiled in 1980 – DSM-III" (1997: 231).
[114] Cognitive and behavioural therapy is also considered a useful therapy for the treatment of schizophrenia.

disorder and symptom specific, which encouraged clinicians and researchers to see psychiatric disorders as associated with discrete sets of symptoms. At the same time, the first tranquilizers were being produced. While their effects were not considered to be as targeted at those of the antidepressants, these drugs were widely consumed. The social implication of their use was that it became acceptable to medicate low to moderate anxiety. The large scale use of the tranquilizers (also called anxiolytics) indicated that large markets exist for psychotropic medications. The world markets were now ready for blockbuster drugs such as Prozac. Throughout this time, mental illnesses were transformed. They started out as psychologically-based disorders, but became discrete diseases associated with chemical imbalances and identified by lists of symptoms. Furthermore, they were no longer to be treated solely by psychotherapy. Drug treatments for low grade mental illness became as commonplace as the chemical treatment of serious mental illness.

The first antidepressant, imipramine, became available in 1955 (Healy 1997: 52). Early prescriptions for the medication were limited to inpatients, but once the medication was accepted by clinicians, it made the outpatient treatment of depression possible. The side effects of imipramine, and other tricyclic antidepressants, include a "dry mouth, a tendency to sweat more profusely and sometimes paroxysmally, some constipation, possible drops in blood pressure, and possible confusional conditions in subjects with other brain disorders" (Healy 1997: 53). The presence of these side effects generally meant that only people with more serious depression were willing to take the medications to treat their condition. For low grade depression, the benefits of the drug did not necessarily outweigh the costs. Roland Kuhn, a German psychiatrist who conducted

studies of imipramine for the pharmaceutical company Geigy, believed that the antidepressant effects of this compound on depressed patients was proof that depression exists as a discrete disease (Healy 1997: 49-52, 56). While others did not necessarily share this view when imipramine was initially promoted as an antidepressant, over time more drugs were shown to have symptom-specific effects. Kuhn's perspective was eventually was adopted by other clinicians. They began to think of mental illnesses as discrete sickness categories (Healy: 163).

Anxiolytics, or tranquilizers, were created in 1955 when meprobamate (Miltown) reached the market (Tone 2005: 376). The medications were easy to take. The original version had few side effects, some sedation resulted, and produced virtually immediate results: a reduction in anxiety. Within 5 years, new anxiolytics with fewer side effects reached the market. Of these, Librium (chlordiazepoxide), was the first to be released in 1960. This was the first benzodiazepine, a category of anxiolytic drugs that rapidly expanded the psychotropic drug market already opened up by Miltown (Tone 2005: 377). For the first time, general practitioners became comfortable prescribing this class of medications, which opened the gateway for people with moderate mental health problems to seek recourse in prescription drugs. A trip to a psychiatrist's office was no longer necessary.

When the SSRI (selective serotonin re-uptake inhibitor) antidepressants reached the North American market in 1987 (Healy 1997: 133), they were marketed as having few side effects compared to other antidepressants. Because of this, they seemed as harmless to take as had anxiolytics when they were initially marketed. Recent concerns about suicidal or violent behaviour by people taking these drugs have to some extent

tainted the harmless reputation of these drugs. Nonetheless, the sales of these drugs remain high, with social phobia as one of the drugs' indications. Many SSRI antidepressants are currently licensed to treat social phobia in North America and in France. In all areas concerned, paroxetine (sold under the brand name Paxil in North America, Deroxat in France) was the first SSRI licensed to treat the disorder.

Social phobia is currently treated with both antidepressants and anxiolytics, at times separately, at times together. The use of benzodiazepine anxiolytics is more common in France[115] than in North America. While the drugs are still used in North America, there was a significant backlash against the benzodiazepine anxiolytics in the 1970s and 1980s resulting from fears about their addictive quality (Tone 2005: 378). The backlash against these anxiolytics and the aggressive advertising campaigns by the pharmaceutical industry (to the public and health professionals) promoting the use of SSRIs to treat social phobia has helped to make SSRIs the medication of choice for social phobia in North America.

Changing theories of the mind in the domain of psychotherapy have influenced the way that mental illness, and social phobia, has been conceptualized by professionals and the public. The revolution in psychotropic medications has had at least an equal impact on the way that the Western self is envisaged, increasingly as a neurochemical being (Rose 2003). Mental illness is also being reconceived, more and more as a disease of the brain rather than a problem in the mind. Our happiness or sadness, anxiety or calm can now be seen as chemical, rather than existential, states. These new conceptions of the self and mental illness are appealing to many, as will be discussed in the ethnographic

[115] The French are the largest consumers of anxiolytics world wide.

sections of this thesis (see also Luhrmann 2000 for debates on this issue as well as Harmon 2004).

If moods and experiences are chemically determined, or at least strongly influenced, they are somewhat out of the control of individuals. This means that a person can not be held responsible or blamed for his or her emotional states. Of course, it is equally possible that cognition or emotion may influence chemistry. But as the ethnographic sections of this thesis will explain, people often draw on multiple and conflicting explanations of mental illness without being bothered by the apparent contradictions in their arguments. They use multiple explanations as evidence of their beliefs and justification of their experiences. Regardless of acknowledgements of the bidirectional causal arrow between affect and chemistry, chemical explanations of mental illness have contributed to the reduction of stigma associated with mental illness. Patient support and advocacy groups often promote the 'broken brain[116]' (Andreasen 1984) image of mental illness to reduce the stigma, guilt and blame that have historically accompanied mental illness. This image of mental illness has also been promoted by many mental health professionals and the pharmaceutical industry. The use of a biological model of mental illness is a comfort to many, which perhaps accounts for its popularity. It also lends authority to biological psychiatrists. The biological model of mental illness likely contributes to increasing the rate at which psychotropics are taken, despite the fact that they have not been demonstrated uniformly to be more effective than psychotherapy in the treatment of social phobia (Davidson et al. 2004).

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[116] "*Broken brain*" is the title of a book by psychiatrist Nancy Andreasen, published in 1984. The book applauds the advances of biological psychiatry, and explicitly argues against the stigmatization of the mentally ill.

The idea of chemically dependent moods is not accepted by everyone. Some patient groups reject the broken brain model of mental illness and argue that it does not do justice to their experiences. They assert that their 'illness' is intrinsic to their character. Rather than considering their mental illness as simply a chemical imbalance, they believe that their disorder is essential to their person (Luhrmann 2000). However, in both popular and professional literature, this view reflects a minority position.

Conclusion

Throughout the past hundred years or so, theories of the mind and brain have changed substantially. Radical changes have taken place even within the last 50 years, moving from the apogee of one therapeutic paradigm's dominance to that of another. In each era, the therapy of choice is lauded and vilified reflecting the embeddedness of mental illness in societal norms of behaviour and performance ideals. Tanya Luhrmann, a medical anthropologist, suggests that psychiatric paradigms also reflect a society's morals. Psychiatry, she says, "is inevitably entangled with our deepest moral concerns: what makes a person human, what it means to suffer, what it means to be a good and caring person" (Luhrmann 2000: 23). It is in this way that mental illness differs from many other physical ailments. The definition of mental illness cannot be separated from cultural values and societal norms and ideals. It is these norms and ideals that determine what is accepted as normal behaviour, functionality and performance. The mental illness categories that are accepted in different eras inform us which thoughts and emotions are normal enough and which stray far enough from rationality to be considered pathological. This means that our current era's norms to some extent dictate what will be defined as

mental illness. Many of my informants supported this argument and suggested that social phobia has become recognized as a disorder only because society now places greater value on extroversion than introversion.

Alarm has been expressed by many about the widespread use of psychotropic medications today, including in popular media representations of drug use. Many of these people have pointed to the chemical control increasingly mild versions of socially unacceptable behaviour. Peter Breggin makes this argument in his book *Toxic Psychiatry* (1994). His work chronicles criticisms of psychiatry beginning with the anti-psychiatry[117] movement in the 1960s, which described this branch of medicine as a form of social control. Anti-psychiatrists believed that psychiatric diagnoses were being used to label and pathologize behaviour that society was unwilling to accept. The unnuanced arguments of the anti-psychiatrists have largely been left behind (Luhrmann 2000: 10-17), but questions about why certain behaviours are characterized as pathological remain (Luhrmann 2000: 17-24). Today, rather than being locked up in asylums or enrolled in long term psychotherapy, pathological behaviour is increasingly treated through chemical interventions. Because psychopharmaceuticals are now central to contemporary treatment of mental illness, Breggin and others now claim that we live in an era of the "chemical straitjacket" (Breggin 1994 and as discussed in Sappell and Welkos 1990).

[117] The anti-psychiatry movement emerged in the 1960s in the United States. Among its most prominent theorists were Erving Goffman, R.D. Laing, Thomas Scheff and Thomas Szasz. These men argued that psychiatric illness was a myth. Those who are labeled as mentally ill, they asserted, were simply nonconformists or people who had learned to act mentally ill as a result of their psychiatric institutionalization. Peter Breggin could be described as a second generation anti-psychiatrist.

Chapter Four

Histories of social phobia

Contents

A historiography of social phobia

There is general agreement among clinicians that feelings of extreme self-consciousness and shyness, now described as the symptoms of social phobia, have always existed (for example, André 1995; Klerman 1990). What has changed is the way people's experiences are explained. Psychiatric nosologies have influenced the way that clinicians approach the people who suffer from these symptoms and the way the disorder will be treated. Concepts similar to contemporary definition of social phobia have been discussed in medical literature for over 100 years. These concepts outline different types of social phobias and social anxieties.

Different histories of the disorder emphasize different intellectual lineages. These explanations vary across national borders. While the North American and British histories of social phobia tend to overlap to some degree, those from France emphasize different origins of the contemporary concept of social phobia. All accounts of the history of social phobia mention certain key specialists in the field, but different countries' accounts emphasize their own psychiatric culture.

This chapter examines the different stories of social phobia. It looks at why different histories of social phobia are told. In particular, I focus on how the French 'story' of social phobia emphasizes the role of French clinicians in the creation of the diagnostic category, despite the fact that these clinicians do not appear in non-French histories of the disorder. The French origins of social phobia have been emphasized by French cognitive and behavioural therapists, I argue, in order to make social phobia appear less an 'American' disorder and more a traditional French malady. I suggest that

this story of social phobia is being used to facilitate the acceptance of social phobia in France.

Anglo-Saxon accounts of the history of social phobia

Anglo-Saxon accounts of the origins of classifications of phobias and social phobia generally emphasize the roles of British and German psychiatrists. They trace a line from German neurologist Carl Westphal's early definitions of agoraphobia, through Freud to Kraepelin and up to British psychiatrist, Isaac Marks', definition of social phobia. This history of social phobia emphasizes the key figures and theories that have been dominant in Anglo-Saxon psychiatry. These differ, as will be shown in the second half of this chapter, from the key figures and theories that appear in the French history of social phobia. The Anglo-Saxon account of social phobia has the effect of making social phobia appear to be completely in line with the dominant theoretical frameworks that have influenced Anglo-Saxon psychiatry.

What follows is a history of social phobia taken from contemporary psychiatric texts. I am not attempting to report an exhaustive history of everything that has influenced the diagnosis over time. Rather, I am reporting the history of social phobia as it is drawn by Anglo-Saxon clinicians.

The British psychiatrist Isaac Marks is usually credited with having first described the category of social phobia as it exists today[118]. Before this time, the diagnosis, or several versions of the diagnosis, had been discussed, but none had maintained a place in psychiatric literature. In his foundational paper on the classification of phobic disorders

[118] The diagnosis has changed over time, but it was Marks' version of social phobia that was introduced into DSM-III in 1980.

(1970)[119], Marks describes the history of this category of mental illnesses. He argues that "although morbid fears have been described by doctors from Hippocrates onwards, the word phobia has only been used on its own since the beginning of the nineteenth century", (Marks 1970). During that century, the term gradually gained acceptance. It had the same meaning that it does today: an intense fear which is out of proportion to the apparent stimulus. Avoidance of the feared situation or object whenever possible was described as the outcome of these phobias. These fears were seen as unexplainable and it was not believed that they could be reasoned away.

Early accounts of phobias: agoraphobia

Marks (1970) argues that systematic descriptions of phobic disorders appeared with increasing frequency in psychiatric literature from 1870 onwards. Into this history of social phobia he brings Carl Westphal and Henry Maudsley, both of whom were influential figures in the history of British psychiatry, particularly Maudsley.

Agoraphobia, Marks suggests, was one of the first commonly used diagnoses within the category of phobias. He identifies Westphal as the first clinician to describe agoraphobia, in 1871 (see also Beck, Emery and Greenberg 1985[120]). At this time, it became common to split the phobias into subgroups rather than lumping all phobias together, which led to a rapid increase in the number of defined syndromes. Henry

[119] Modern day social phobia was first described in a brief paper about the age of onset of different phobias (animal phobias, agoraphobia, social phobia and miscellaneous specific phobias) (Marks and Gelder 1966). However, it is in Marks' 1970 paper that the disorder is described in greater detail.

[120] Beck outlines a similar history of the phobias as does Marks. He notes that the clinical syndrome of agoraphobia had not changed since radically since Westphal first described it (Beck, Emery and Greenberg 1985).

Maudsley, considered by many to be the founder of British psychiatry, incorporated Westphal's definition of agoraphobia in his 1879 edition of *Pathology of Mind*, though he removed it in the 1895 edition[121]. Maudsley criticized what he found to be the excessive splitting of phobic disorders. He found that most phobic disorders co-occur or occur successively in the same person, so he was reluctant to accept that they were distinctive disorders. Instead, he thought that they might be the expression of a single condition. Despite its removal from Maudsley's psychiatric diagnosis manual, agoraphobia continued to be diagnosed. Agoraphobia plays a role in the history of social phobia because the two disorders share several features, notably the avoidance of social spaces. Many people who are now diagnosed with social phobia would have been diagnosed with agoraphobia in the past.

Freud on phobias and neuroses

Freud's role in American psychiatry has been outlined in earlier sections of this thesis. While his theories have largely been abandoned in Anglo-Saxon psychiatry, his influence on the history of the profession is undeniable. Isaac Marks and Gerald Klerman bring Freud into their accounts of the history of social phobia.

In 1895, Marks reports, Freud distinguished between common phobias that almost all people fear to some extent (for example, death, illness and snakes) and specific phobias which inspire no fear in the 'normal' man (for example, agoraphobia) (Marks 1970). He created the category 'phobic neurosis[122]' which, along with 'anxiety neurosis', is the category that would most likely be used to describe someone who experiences the

[121] In the 1895 edition, Maudsley listed all phobias under the heading of melancholia.
[122] Also referred to as anxiety hysteria.

symptoms of DSM-IV social phobia. Freud was the first clinician to describe anxiety neurosis as a separate nosologic condition (Freud 1894/1957).

In his initial description of this disorder, Freud had not yet developed his psychodynamic theory of the psychogenic origins of mental illness. Instead, he focused on 'actual neuroses' (Klerman 1990). Actual neuroses are distinguished from psychoneuroses by the origin of the patient's problem. Actual neuroses do not result from infantile conflicts, but from problems in patients' present, usually in their sex lives. The symptoms are described as the direct outcome of the absence of adequate sexual satisfaction, rather than as symbolic expressions of anxiety (Laplanche and Pontalis 1973: 10). In the case actual neuroses, such as anxiety neurosis,

> The mechanism of symptom-formation is taken to be somatic in the actual neuroses (as when there is a direct transformation of the excitation into anxiety); so that 'actual' connotes the absence of the mediations which are to be encountered in the symptom-formation of the psychoneuroses (displacement, condensation, etc.) (Laplanche and Pontalis 1973: 10)

Klerman explains that it was only later in his career that Freud introduced his theory about the role of psychic mediation development of symptoms (Klerman 1990). This fits the description of anxiety hysteria, which is also called phobic neurosis[123] (Laplanche and Pontalis 1973). Anxiety hysteria refers to a neurosis whose central symptom is a phobia. Phobic symptoms are encountered in a wide variety of neurotic and psychotic conditions (from obsessional neurosis to schizophrenia) and Freud wanted to distinguish between these types. The terms anxiety hysteria and phobic neurosis were

[123] Laplanche and Pontalis point out that anxiety hysteria and phobic neurosis are not exactly synonymous terms, but the two are nonetheless very similar (Laplanche and Pontalis 1973: 38).

created in order to specify a certain type of phobic symptom (Laplanche and Pontalis 1973: 37). It was Freud's analysis of little Hans, a five year old boy with a range of phobias including horses, that persuaded the clinician to propose phobic neurosis as a specific entity. Freud considered this neurosis, in which the principle symptom is a phobia, to have a similar structure as conversion hysteria. The basis of this similarity is that in both cases, repression functions to separate affect from ideas. The difference between conversion hysteria and anxiety hysteria/phobic neurosis is that in the latter, "the libido which has been liberated from the pathogenic material by repression is not converted [...] but is set free in the shape of anxiety" (Freud quoted in Laplanche and Pontalis 1973: 38). Freud believed that phobias appear in anxiety hysteria/phobic neurosis because the mind is constantly trying to psychically bind the anxiety which has been liberated. This process of trying to rein in anxiety leads to the development of a phobia as anxiety tends to become displaced and focused on a phobic object (Laplanche and Pontalis 1973: 38).

Freud developed these theories in the early twentieth century and it is with these theories of anxiety that social phobia-like symptoms would be explained using a psychodynamic model today.

Kraepelin on phobias

Most histories of social phobia do not place much of an emphasis on the work of Kraepelin compared to the emphasis that is placed on others' contributions, particularly Freud. However, in 1860 Kraepelin described a condition resembling social phobia, anthropophobia (Chang 1997; King 1999). Anthropophobia was not a commonly used

diagnosis in the nineteenth century and it virtually disappeared from psychiatric literature, but it is now known as a parenthetic name for *tai-jin kyofusho*, a specifically Japanese version of social phobia. Both conditions describe a fear of interpersonal relations (Matsunaga 2001). In 1913, Kraepelin included in his textbook a brief chapter on irrepressible ideas and irresistible thoughts, though he did not separate social phobia from these other phobias (Marks and Mataix-Cols 2004).

Introduction of phobic disorders into official psychiatric nosologies

Phobias received a separate diagnostic label in the 1952 edition of the DSM. They appeared slightly earlier in the ICD, included in the 1947 edition of the manual (Marks and Mataix-Cols 2004).

French accounts of the history of social phobia

Few French clinicians or researchers have bothered to write a history of social phobia, reflecting the fact that the condition does not have a central place in French psychiatry. The only histories I have found of social phobia published by French researchers are written by French cognitive and behavioural therapists. These are essentially the only clinicians who are interested in the disorder. Others may use the category in their clinical practices, but it is only cognitive and behavioural therapists who actively promote the disorder. The most systematic French history of social phobia was written by Antoine Pélissolo and Jean-Pierre Lépine, two leading French researchers of the disorder. Christophe André and Patrick Légeron, also leading French researchers of social phobia and cognitive and behavioural therapists, provide a condensed history of

social phobia (1995). However, the primary concern of André and Légeron is to identify examples of social phobia in literature throughout time, starting with the Odyssey. By doing this, they attempt to show the timelessness of social phobia and to prove that it is not a new disorder. According to André and Légeron, social phobia has always existed (André and Légeron 1995: 25-7). Because of the scarcity of other literature, this section of the chapter will focus on the history of social phobia described by Pélissolo and Lépine. By tracing their version of the disorder's history, I will highlight the differences between their account of the disorder and Anglo-Saxon accounts of social phobia's history. The French clinicians rely to a much greater extent on French, or French-speakers', contributions to the history of the disorder. This has the effect of making social phobia appear to be a French disorder, in the sense that it was defined primarily by French clinicians. French cognitive and behavioural therapists' history of social phobia counters the widespread belief, which was repeated to me during interviews, that social phobia is an 'American' disorder.

Pélissolo and Lépine (1995) identify two key early contributors to the concept of social phobia, Paul Hartenberg and Pierre Janet. Hartenberg is now described in both Anglo-Saxon and French literature as having produced some foundations ideas about the disorder. Janet, in contrast, is generally ignored in non-French accounts of social phobia. Pélissolo and Lépine identify an earlier social phobia-like classification not mentioned by British and American scholars, erythrophobia[124]. As described below, while the French

[124] This classification, which describes the fear of blushing, is another disorder, in addition to anthropophobia, that is quite similar to the Japanese diagnosis *tai-jin kyôfu*. *Tai-jin kyôfu* was introduced in 1930 by the Japanese psychiatrist Morita. The syndrome describes a fear of upsetting others as a result of one's anxiety being noticed, which is usually manifested in the reddening of one's face, inappropriate responses, or trembling

include a few British and German psychiatrists in their history of social phobia, there is a strong emphasis on the place of French psychiatrists in shaping the history of the disorder.

***Erythrophobia* (also called eureutophobia)**

J.L. Casper, a German psychiatrist, was the first clinician to describe erythrophobia in an 1846 case report[125] (Pélissolo and Lépine 1995). The term erythrophobia was used to describe the condition of a patient who fears blushing in front of others, and the embarrassment blushing would cause him or her. He described the experiences of a 21 year old medical student whose fear of blushing in front of others drove him into a deep depression and eventually to suicide. Casper was incapable of finding an explanation for the young man's problems, and asked "Must one see in this case a punishment of God, an effect of the original sin?" (quoted in Pélissolo and Lépine 1995).

By the end of the nineteenth century, several disorders similar to erythrophobia had been described in the psychiatric literature. Albert Eulenberg described *rougeur essentielle* and then *rougeur emotive* (Claparède 1902). Boucher[126] described a disorder that had similarities with erythrophobia, *érythémophobie,* but the term referred more to a

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(Kirmayer 2001; Takahashi 1989). The disorder very is similar to social phobia, although until recently, it was most common that *tai-jin kyôfu* would be diagnosed rather than social phobia (Takahashi 1989). Social phobia and other DSM-IV diagnoses are now beginning to replace *tai-jin kyôfu* in Japan as the diagnosis used to describe these symptoms (Clarvit, Schneier and Liebowitz 1996; Tajima 2001). The chemical treatment of this condition is also changing. Anxiolytics were and still are popular in Japan, but young psychiatrists are increasingly beginning to prescribe SSRI antidepressants for anxiety disorders (Tajima 2001). This reflects a further shift toward a 'Western' view of mental illness and treatment and a further globalization of approaches toward emotions and experiences (Kirmayer 2002).

[125] The case report was translated into French in 1902.

[126] I have been unable to find any reference that provides Boucher's first name.

fear of the colour red rather than a fear of blushing. Boucher's term failed to be adopted by many other psychiatrists. However, Casper's original description of erythrophobia was an increasingly popular diagnosis and in 1897 French psychiatrists Albert Pitres and Emmanuel Régis adopted the term (they used a slightly different spelling, *éreutophobie*), though they classified it among obsessions rather than phobias (Pitres and Régis 1897, 1902). The diagnosis was nonetheless not without its critics. Alfred Hoche stated that he found it of no use to create a clinical label for the condition, since he did not believe that it was a morbid entity. Hoche believed the disorder described a relatively normal sentiment. Erythrophobia nonetheless became quite a widely accepted disorder.

Edouard Claparède, a Swiss psychologist and student of Alfred Binet, an influential French experimental psychologist, discussed the social dimension of erythrophobia (1902). He described how all the stimuli for and the reactive behaviours of blushing have a social nature. To prove this point, he provided specific examples of his patients' experiences: an innocent child who blushes in school if his or her teacher is looking for a guilty classmate; an adult who dares not show him or herself in public, who flees from the opposite sex or who hides behind newspapers in restaurants. Claparède also described the tactics that erythrophobics use to hide their blushing from others, such as umbrellas, hats, moustaches and make up. He reported that recourse to alcohol was also quite common for people suffering from this condition (Claparède 1902: 309). Claparède claimed that erythrophobia was frequently an inherited disorder; 83% of his patients suffering from this disorder had parents who suffered from some mental disorder. He also discussed the possible pathophysiological mechanisms of the disorder. He asked whether there were perhaps two forms of the disorder, one in which it was the

reddening itself that was the problem for patients and the other in which the fear of the blushing was the problem. In his analysis of the causes and mechanisms of the disorder, Claparède drew on emotional theories of James-Lange, since they had been introduced by other clinicians writing about erythrophobia. He outlines other clinicians' arguments that the mechanisms of erythrophobia either prove or disprove James-Lange's theories of emotion and reflexes. However, he sides with neither side of these debates and concludes that theories about erythrophobia have little consequence for James-Lange's theories (Claparède 1902: 319-20). Claparède also presented physiological studies of cardiac and respiratory difficulties in his explanations of erythrophobia. Pélissolo and Lépine suggest that many of Claparède's theories are not very distant from modern cognitive theories used to explain social phobia (Pélissolo and Lépine: 1995).

The term erythrophobia is still used in psychiatric literature (for example, Laederach-Hofmann et al. 2002; Stein and Bouwer 1996). It is often used to explain one of the ways in which social phobia is manifested. In this way, erythrophobia can be seen as one component of social phobia, since a large number of social phobics suffer from a fear of blushing. However, social phobia encompasses a greater variety of fears than does erythrophobia.

Janet on situational phobias

In 1903, Pierre Janet proposed a systematic classification of four types of phobias: body function phobias, situational phobias, phobias of objects and phobias of ideas (Janet 1908 [orig. 1903]). Among the situational phobias, Janet describes phobias related to physical situations (agoraphobia, acrophobia, claustrophobia) and phobias of social

situations. In his description of phobias of social situations, Janet explains that the source of the phobia is the necessity to act or participate in public situations. He notes that these same people have no fear of reddening, paling, making faces, laughing when they are alone. Because of this, he concludes that, "One can then call these phenomena social phobias or phobias of society." Janet also used the word erythrophobia (*éreutophobie*), which he employed in a broad way to describe marriage phobias, phobias of giving classes or phobias of domestic workers.

Shyness

Shyness (*timidité*) has also been associated with social phobia (Heiser, Turner and Beidel 2003; Tignol et al. 1994; Turner, Beidel and Townsley 1990[127]), but it is a much older category (Pélissolo and Lépine 1995). Pélissolo and Lépine describe shyness as a term that has been used in field of psychopathology, but which has always existed in common language. In psychiatry, shyness has been used as a synonym for social anxiety[128].

In recent years, a text by Paul Hartenberg (1901) has become increasingly well known among researchers interested in social phobia[129]. His book is dedicated to the concept of shyness (*timidité)*, which he uses to describe a condition that is strikingly similar to modern definitions of social phobia and social anxiety (Fairbrother 2002). Hartenberg proposed a symptomatic description of social phobia which is virtually the

[127] These researchers focus on the relationship between shyness and social phobia. They are interested in identifying a distinction between the two states. They consider shyness to be normal and social phobia to be pathological.
[128] This will be elaborated upon in the ethnographic sections of this thesis.
[129] This text is only drawn upon in recent Anglo-Saxon accounts of social phobia.

same as that found in DSM-IV (Fairbrother 2002; Pélissolo and Lépine 1995). He argued that to be shy, one must be inclined to experience a certain emotion in certain circumstances (1901: 2). Hartenberg described the emotions in question as made up in variable parts of fear, which will be primarily expressed somatically (for example, heart palpations, cold sweats and trembling), and shame (which may be expressed in confusion, the reddening of one's face or anxiety [*angoisse*]) (1901: 3; 11-40). Hartenberg argued that these emotions are attached to one particular circumstance: the presence of another person (Hartenberg 1901: 6). He explained that a shy person dreads and avoids presenting himself before others while speaking or walking. The shy person avoids the gaze of others and their responses to him. Hartenberg insisted on the subjective dimension of the fear of others, which for the shy person is based on being unappreciated or to be seen by others as inferior or ridiculous (Hartenberg 1901:49-58).

Hartenberg identified several varieties of shyness which resemble performance anxiety, or stage fright [*trac*]. He provided examples of artists, conference presenters, professors, lawyers, and musicians (Hartenberg 1901: 158). He divided stage fright into two phases, the anticipatory anxiety and the anxiety during the event. Hartenberg further identified three degrees of stage fright intensities: first, a simple emotional reaction; second, stage fright, accompanied by psychological and somatic symptoms; and third, severe stage fright in which one is paralyzed or flees[130]. The last degree of stage fright resembles contemporary definitions of specific, rather than generalized, social phobia. This third degree of stage fright would be considered 'pathological' today, which is how Hartenberg conceived of it in his time (Hartenberg 1901: 161-4).

[130] Claparède references Hartenberg's three steps in his 1902 article on erythrophobia (1902: 309).

Hartenberg examines the characters of shy people by analysing certain personality profiles considered associated with shyness. He describes on the one hand, the sensitivity of these people in terms of their morals and scruples, and on the other their tendency toward sadness, pessimism, misanthropy and excessive pride[131] (Hartenberg 1901: 47-121). Hartenberg notes that while some of these characteristics may appear contradictory, they are expressions of fundamental and superficial feelings that easily co-occur in the same person. For example, the feelings of misanthropy, pride and the desire to live up to unreachable ideals are superficial traits of someone whose basic personality is shy. At the same time, this person may have fundamental sentiments of humility, pride and kindness. The apparent conflict of these emotions and characteristics arises from the all or nothing personalities of these people. Even if they are naturally humble, their thoughts and imaginations drive them to be prideful. These people are ambitious in their dreams, but in reality modest. This internal conflict gives rise to their timid natures (Hartenberg 1901: 67-8).

Pélissolo and Lépine are struck by the similarity of Hartenberg's description of the symptoms of shyness to those presented in contemporary nosologies (1995). The physiological symptoms he describes are virtually the same as those described today[132] . Pélissolo and Lépine draw attention to the line Hartenberg draws between 'normal' shyness and its pathological form. According to Hartenberg, an emotion is pathological when [1] its physiological effects are presented with an extraordinary intensity, [2] it

[131] He notes that most shy people who are from a cultivated class have excessive pride.
[132] Cardiovascular reactions (palpitations, measured by a sphygmographe, objective measurements of peripheral vasoconstriction, paleness, shivering), respiratory problems, smooth muscle spasms (sweating, nausea, vomiting, vascular tetanus, intestinal troubles), contraction of the facial muscles, trembling, and incoordination extending as far as total paralysis.

appears without sufficient cause, [3] its effects are extended or spread out beyond an expected period.

The last chapter of Hartenberg's book focuses on treatment. In a section entitled "prophylaxis", Hartenberg outlines his belief in the hereditary origins of shyness. Earlier in his book, he explained that most of his shy patients have ancestors who could be defined as shy as well (Hartenberg 1901: 136). He concludes that "the fewer congenitally affected (*taré*) individuals there are, the fewer extremely shy people (*grandes timides*) there will be." This statement reflects Hartenberg's belief that pathological shyness is hereditary. His statement also reflects the era he was writing in. This was a time when eugenics was on the rise throughout Western Europe. It was increasingly common to think of negative personal traits as hereditary and as characteristics that should be selected against in society. However, Hartenberg was neither a eugenicist nor a member of the French eugenics society. His comments nonetheless reflect the (weakly) positive eugenic thinking in France in the early twentieth century, in which the health of parents, particularly mothers, and children were monitored. Unlike other countries in Western Europe, the French focused not only on encouraging eugenically 'fit' people to reproduce, but also on providing health services to improve the wellbeing and fitness of all members of society. Included in this weak eugenic programme were beliefs that large scale traits, such as shyness, could be passed along hereditarily.

Hartenberg advocated what Pélissolo and Lépine refer to as more "modern" techniques for the prevention and treatment of shyness, such as teaching children public speaking techniques, teaching patients methods to interact with and present to others.

Hartenberg suggested that physicians accompany patients while they practice these techniques taught in the clinic. He also described behavioural modification forms of therapy in which patients are taught to modify their non verbal behaviour to facilitate social interactions. For example, Hartenberg suggested that patients undergo training in how to look people in the eye while speaking, speak in a strong and clear voice, and use firm and decisive gestures (Hartenberg 1908: 234). He believed that once these behaviours became natural to patients, their social comfort would improve since they no longer had to worry about their mannerisms betraying their social unease. Today, French and Anglo-Saxon clinicians argue that the treatment Hartenberg offered to his patients over 100 years ago was the earliest form of cognitive and behavioural therapy known within medical literature (Fairbrother 2002; Pélissolo and Lépine 1995).

Hartenberg claimed that his book is a work of scientific psychology, rather than a philosophically or spiritually-influenced psychology. Empirical research, symptomatic descriptions and etiological explanations of psychological problems are at the heart of his work. The approach he takes to mental illness is consistent with DSM-IV and cognitive and behavioural principles. These similarities make his work important to contemporary researchers who see in him a founder of the field and an early researcher of French social phobia.

Efforts to make a specifically French social phobia

The French have historically had a psychiatric system that has a specific national character. For instance, when Freud's theories dominated Anglo-Saxon, and particularly American, psychiatric discourse, the French expressed only minimal interest in his

theories. Neurologists such as Charcot, psychiatrists such as Pierre Janet and Henri Wallon, as well as psychologists such as Alfred Binet, Henri Piéron and Jean Piaget were the key figures in the French 'psychiatric[133]' system in the late nineteenth century and early twentieth[134]. All these men were scientifically oriented, in the sense that they were interested in clinical and experimental research[135]. The neurologists amongst them were interested in the brain lesions or other physical abnormalities that they believed to be at the based of mental illness, the psychiatrists were interested in psychopathology, and the psychologists were interested in conducting experimental research to examine normal and abnormal behaviour (Ohayon 1999; Thomas 2002: 27, 31). In addition to their scientific, and often biological, interests, certain of them also expressed interest in psychogenic nervous conditions and conditions which arise from a combination of psychological and organic origins, but none believed that *all* mental illness arose from purely psychological factors as certain psychodynamically-oriented clinicians did (Thomas 2002: 32). These are the men who held the most important positions in Paris hospitals and universities, decided who would be hired in these institutions, and which theories would be focused on. While clinicians from other countries had positions and influence in France, the most renowned clinicians were French[136]. Great French clinicians, such as Janet, are still

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[133] I will use the term 'psychiatric system' to refer to the mental health system that includes neurologists, psychiatrists and psychologists.

[134] Théodule Ribot has been described as the psychologist who first sought to 'liberate' psychology from philosophy and to create a new science of the mind (Ohayon 1999: 17).

[135] They were scientifically-oriented to varying degrees. Of all of the men listed, Janet was the most (psychoanalytically) psychologically oriented, in the sense that he believed that certain mental illnesses such as hysteria and neurosis could have entirely psychological origins. This was a view he shared with Freud (Ohayon 1999: 48).

[136] The case of Eugénie Sokolnicka is illustrative of this trend. Sokolnicka arrived in Paris in 1921after having been analysed by Freud, making this Poland native the first Freudian analyst to arrive in France. While she initially had a place at Saint Anne's

honoured in French psychiatry and they are attributed with making significant contributions to modern psychiatry. This is the case with social phobia. Even though non-French historical accounts of social phobia do not mention Janet, he, along with Hartenberg, are portrayed by French cognitive and behavioural therapists as having played essential roles in the classification of the disorder. The influence ascribed to these renowned French physicians gives French psychiatry, and social phobia, the appearance of a distinctly French national character.

Most French clinicians excluded Freud's psychoanalytic theories from their practices in the early twentieth century. Even at the height of their popularity in North America, around the 1950s, Freud's theories failed to be very influential in French psychology. Janetian psychology held this place until the end of the 1960s[137] (Ohayon 1999: 47). In the 1920s that Freud's theories began to be discussed in France, though the 'Freudian' theories that they taught were distant derivatives of Freud's original writings, much changed by early physicians' interpretations of his German language texts which were not translated into French until the early to mid 1920s (Thomas 2002: 350). After the translation of the texts, more accurate discussions of Freud's theories became possible, but influence of earlier interpretations of his work remained.

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hospital, she eventually left after being continually humiliated in clinician meetings by Henri Claude. Claude, who was the director of the psychiatric department, did not believe she should have a place in the hospital since she did not have a medical degree (she was a 'lay' psychoanalyst). He reportedly bombarded her with medical questions she could not answer and gave her cases that were not well suited to her talents. She did not fit the model of a French mental health clinician. Nonetheless, she analysed several important French psychiatrists and psychologists, including Édouard Pichon, from the private practice that she established after leaving Saint Anne (Ohayon 1999: 62-7).

[137] Another particularly influential clinician in French psychiatry during this period was Henri Ey, who brought together psychoanalytic principles with biological theories (Healy 2002: 85-7).

Saint Anne's hospital was one of the few public institutions that began training psychoanalysts in France. Training was restricted to medical doctors[138] (Ohayon 1999: 76). Here Freud's work was accepted primarily as a type of Janet-like theory, since Janet had already written about the role of fixed subconscious ideas in the creation of psychiatric symptoms and about their treatment by using hypnosis access memories and the analysis of dreams (Ohayon 1999: 51; Thomas 2002: 352). Freud's theories about the origins of mental problems in repressed sexual desires were not well received. Many clinicians misunderstood the sexual etiology discussed in his work and believed that he was returning to ancient ideas about hysteria symptoms resulting from a wandering womb. Others criticized it for resulting from either a too puritanical or libertarian view of sexuality. In all cases, it was seen as a 'German' theory[139], not a French one (Thomas 2002: 353-4). French versions of psychodynamic theories have become well known in France and most clinicians I spoke to drew on eclectic psychodynamic principles rather than strictly Freudian ones.

French histories of social phobia focus on different clinicians than do Anglo-Saxon accounts of the disorder. The French accounts of the disorder focus on renowned clinicians in the history of French psychiatry. This history reflects the tendency of French psychiatry to promote a national image of mental illness. French psychiatrists, not included by any other commentators, are considered key figures in the development of this category, thereby making it a 'French' disorder. History shows that disorders that

[138] The exclusion of 'lay', meaning non-physician, psychoanalysts reflects a long battle between psychiatrists/neurologists and psychologists in France for institutional control and power (Ohayon 1999).
[139] Despite the fact that he was Austrian.

are seen as too American, such as panic attacks, will not be accepted in France[140]. Making French psychiatrists appear to have a foundational role in the classification of social phobia may be a tactic of French cognitive and behavioural therapists to facilitate the acceptance of the disorder in France. If French cognitive and behavioural therapists successfully integrate social phobia into French psychiatry and society more generally, a cognitive and behavioural perspective would be introduced at the same time, since social phobia is primarily explained from a perspective that is consistent with cognitive and behavioural principles. This would smooth the progress of the acceptance of cognitive and behavioural therapy in France. In this way, social phobia is a tool used by cognitive and behavioural therapists in the institutional battles they are waging with psychoanalysts to control French psychiatry.

[140] The French tended to describe the symptoms that would be called panic attacks in North America, as spasmophilia. This is a French 'culture-bound syndrome' that was based on a theory in which a deficit of magnesium was thought to lead to a range of symptoms from fatigue, to muscle tension, to hyperventilation.

Part II

The Physicians

Chapter Five

Debating the label 'social phobia'

Contents

In this chapter the voices and ideas of my informants will take centre stage. It draws on the interviews that I conducted with psychiatrists, general practitioners and one psychologist[141]. I present the span of these clinicians' attitudes toward social phobia. Most of these clinicians do not often use the diagnosis of social phobia and many are quite critical of the category. This chapter describes their positions concerning the disorder as well as the labels they would assign to DSM-IV *symptoms* of social phobia. The perspectives of physicians who promote the use of the diagnostic category will be the focus on chapter six.

I chose to seek out psychiatrists and general practitioners because they are the people who most often see the people who suffer from the symptoms of social phobia and they can prescribe drugs. It was important for me to interview potential prescription-writers because current discourses on mental illness are so closely tied to discourses about psychotropic drug use. General practitioners (GPs) act as gate-keepers. Potential social phobia patients will see them before moving onto a specialist. But, GPs may treat the disorder, whether by their choice, the patient's choice (or unwillingness to see a psychiatrist) or because a psychiatrist is unavailable[142]. Waiting lists for psychiatrists are long and GPs must make a case to try to 'sell' the patients they deem in need of treatment to psychiatrists. This involves patients writing letters of motivation to psychiatrists and GPs maintaining a good rapport with psychiatrists and confirming their patients' needs

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[141] Throughout this and later chapters I use familiar names for physicians. Rather than reintroducing them every time I make reference to them, I have compiled an appendix with all physicians' name, their medical specialization as well as their attitudes toward social phobia. This appendix can be found at the end of this text.

[142] Several physicians I interviewed suggested that general practitioners increasingly have to care for patients with small neuroses and depression because there are not enough psychiatrists available.

and determination to improve. GPs are not happy with this situation. Dr. Jacob[143] notes that it is so difficult to find a qualified psychiatrist, many patients end up resorting to what he calls charlatans[144]. He describes the situation as "really worrying". He says,

> It has meant that us, general practitioners, have had to do more psychotherapy, because there is a specific 'general medicine psychotherapy'... but we can only do a few small things well. A therapist has to do more of a detailed therapy, and there are theoretical differences too. Ten years ago, once you had diagnosed any kind of problem, 'social phobia' or depression, the big problem was making them [patients] realize that there is a problem until they come and say, "I should go and see someone and talk about it don't you think?", and you go, "Ah, good". And you pick up the phone [to call the psychiatrist]. Now when they do that, you have to tell them, "Look we've gone a long way, that's a great decision, but unfortunately I'll have to tell you that the hard part starts now". Finding one [a therapist], getting into therapy...I have to call, I have to call myself, call and call again until they call me back. I have to sell them a patient, because I have a good relationship with them [psychiatrists], and they know that I'll do a first screening, and that the people that I send to them are motivated, and so they do it, and I tell the patient, "You can now call him and say you were referred by Dr. Jacob, ...and do keep calling back..." And so it's much harder than it used to be.

In contrast to the dearth of psychiatrists, GPs make up one half of all physicians in France.

Psychiatrists see many patients with the symptoms of social phobia and the majority of these see them in 'private' clinics[145]. These clinics are not private in the

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[143] All names, unless otherwise mentioned, are pseudonyms.
[144] There are many 'alternative' therapists in France who practice a wide range of psychotherapies and physical therapies. These are likely the people to whom Dr. Jacob is referring.
[145] This idea was supported by physicians' statements, such as those of Dr. Villette and Dr. Begot.

sense that patients pay for the full cost of therapy, but because 'private' physicians do not work in public institutions. Patients are reimbursed for their visits to private clinics at the standard rate of seeing physicians. Those psychiatrists who work in public institutions tend to see more serious cases of mental illness compared to those who work in private clinics, unless they do clinical research on social phobia or conditions similar to social phobia. However, this rule is not set in stone. Some hospitals have staff psychiatrists whose clienteles suffer from the same range of disorders as do people who are treated in private clinics. It is difficult to generalize because patients, theoretical orientations and treatment options vary from institution to institution. In order to try to get a representative cross-section of physicians, I interviewed both public and 'private' psychiatrists and GPs.

This chapter focuses on one issue: why French clinicians employ so many different explanations for the symptoms of social phobia, most of which do not involve labelling the symptoms as social phobia. French physicians' explanations of these symptoms will be at the heart of this chapter. The differences in physicians' explanations result from different theoretical perspectives, many of which reject the symptom-based nosology that is responsible for the definition of social phobia. Many of the clinicians with whom I spoke stated that they would not usually use, or use at all, the term 'social phobia' to describe the symptoms that correspond with the DSM-IV definition of the disorder. This is despite the fact that almost all of these clinicians reported that they had seen social phobia symptoms among their patient populations. They cited many reasons to avoid the term social phobia. Some preferred classic psychoanalytic explanations of the symptoms, using Freudian theories to explain patients' conditions. Other clinicians

did not use classic psychoanalytic explanations, but presented an eclectic and psychoanalytically-informed[146] explanation of the disorder that referred to such concepts as personality and relational difficulties. Others stated that they avoid the term social phobia because they believe it is over-used and that the truly incapacitating form of the disorder is extremely rare. Still others avoided the term social phobia because they believe that it is another psychiatric 'fad', like obsessive-compulsive disorder before it, that is currently used to explain relatively normal anxiety.

French psychiatry has undergone significant changes in the last 40 years. Prior to the Second World War, psychiatry was still a part of neuropsychiatry, and confinement to asylums was a common means of treatment. Psychiatry, in the form of neuropsychiatry, was fully a part of scientific medicine and psychology was considered as scientific a discipline as physiology (Ohayon 1999). The pre-Second World War clinicians have since been criticized as paternalistic, and the methods of treatment used, including confinement in asylums, contributed to a significant fear of asylums amongst the general population. This orientation slowly changed in the post Second World War era. Psychoanalytic clinicians began to grow in number and gain a stronger position within the field. It was the events of May 1968 that brought about greater changes in the field (Ohayon 1999: 413-4). The student protests that initiated general strikes, bringing up to one million people onto the streets of Paris in protest (Le Monde 2006; Perromat 2006[147]), did not produce a systemic revolution in France, but it brought about changes in education and in the way that psychiatry was practiced. The paternalistic bases of these

[146] Many clinicians drew on psychoanalytic theories, but not necessarily classical Freudian psychoanalysis. Some GPs clearly had no profound training in psychoanalysis but drew on their basic understandings of psychoanalytic theory in their explanations.
[147] See also http://en.wikipedia.org/wiki/May_1968.

institutions began to weaken. In schools, students began asking questions of their teachers rather than simply complying with demands, as they had previously been expected to do. Neuropsychiatry split into two branches: neurology and psychiatry (Ehrenberg 1998: 195). The former remained wedded to the scientific model and kept its base in hospitals. The latter also retained its position in hospitals as a branch of medicine, and psychoanalytic psychiatrists began to take positions of institutional power in universities (Ohayon 1999: 413-4). However, there was a large migration of psychoanalysts into private clinics, which was seen by the general population as evidence of psychiatry's (particularly psychoanalysts') break with a paternalistic and hegemonic state. In private clinics, the number of types of therapies proliferated[148] opening up more therapeutic options and giving patients different choices for therapeutic recourse. These new types of therapy were viewed as having a greater distance from the government, hospital and asylum, than had previous therapeutic options. This shift gave psychiatric consultation a new and less intimidating tone. Along with a new variety of psychotherapies, therapists grew in numbers[149]. Recourse to these therapists became more commonplace, reducing the stigmatization in the past which had resulted from the

[148] Annick Ohayon, a French historian, has noted that Lacanian theory became more popular around this time (Ohayon 1999: 413).

[149] A cognitive-behavioural therapist working in a Parisian hospital told me that he believes that the training of this wave of therapists was a little thin – either in fringe sorts of therapies or weak training in psychoanalysis. However, he also pointed out that these people are now nearing the age of retirement, so they will soon be out of the system. While he seemed to think that this demographic shift was positive, he also feared more problems because in recent years training of psychiatrists has become much more rigorous which has resulted in there being fewer clinicians available. He suspects that this will be a significant problem in the future (Dr. Duclaux).

equation of psychiatrists to asylums and serious mental illness[150]. But despite increasingly open discussions about psychiatric problems, there is still a tendency today among certain classes, particularly the bourgeois, to keep mental illness hidden[151]. People from this class are less likely to discuss their illnesses with others, preferring to hide their illness (and any therapeutic interventions they undergo) or to speak only of their condition with their family[152]. The result of the changes that have occurred since 1968 is a more eclectic field of psychiatric practitioners, though many of these people adhere to psychoanalytic principles. This eclecticism has contributed to the fact that today patients' symptoms and experiences are interpreted from an array of perspectives.

Psychoanalytic perspectives

Social phobia, as defined by DSM-IV, is of little interest to psychoanalysts because it describes a list of symptoms rather than explaining the etiology of the disorder. Psychoanalysts' interpretation of patients' conditions is based on the neurotic process, in which they look for patients' underlying psychic conflict or their adaptation to this

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[150] From interview with Dr. Villette, Dr. Lalande, Dr. Marsault and others. Many people I interviewed, clinicians and patients alike, compared French versus American attitudes toward psychiatry. Some hoped that the French would increasingly move toward the American model, in which they presume that everyone takes medicines and talks freely about their psychiatrists, as they see in films (Mlle. Hébert, president of a French support group for anxiety disorders in Paris). But resistance remains in France to the acceptance of psychiatric explanations for as many life experiences as are presumed to be pathologized in the United States. Dr. Delaporte mentions: We have the impression that we consume much less (medications) than in the United States. Surely our consumption rises, yes, there are many pathologies tied to work, real pathologies, and maybe people speak more easily about their problems than 30 years ago when they have a depression. But we cannot make it commonplace, normalize it. Then it becomes normal to have a disease and to speak of psychiatric pathologies. Because then people will do something about it. It's more open now, but...

[151] From an interview with Dr. Mignot.

[152] This tendency will be further discussed in later chapters.

anxiety. From this perspective, symptoms are seen as polymorphous indicators of the etiological process, but are uninformative by themselves. Symptoms only provide a glimpse at the underlying neurotic process. This is how psychoanalysts would at 'social phobia[153]' symptoms.

Dr. Fortin is a psychoanalytically-oriented psychiatrist who is the head of a psychiatric hospital on the outskirts of Paris. When asked for his opinion of what causes social phobia he stated:

> I'm going to answer your question in a little bit of a caricatured manner. The origin of social phobia is the first fear of a stranger when a baby is in the hands of his mother. As soon as they are separated, the baby begins to get nervous to see a face that he doesn't know and which he interprets as menacing. He no longer has the security that he knew in the arms of his mother. Social phobia, at its origin, is something very natural. We are all sensitive and nervous with someone different, a stranger, because we don't know if he could be hostile toward us... It evolves according to education, life experiences, and [these factors will determine] whether he is able to get over it and integrate into society, or whether, because of neurotic reasons or other sicknesses, he becomes fixed on the fear of others. It's a little simple to reduce it to a trouble with serotonin, even if serotonin helps, as alcohol and cannabis also reduce the symptoms of social phobia[154]...

This type of explanation makes clear psychoanalysts' conviction that social anxieties are born in early infancy and then develop over one's life depending on one's particular

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[153] Throughout this text I often refer to social phobia between single quotation marks. I do so to indicate that certain people would not label the DSM-IV symptoms of social phobia as social phobia. I have done this to avoid repeatedly referring to 'social phobia' symptoms as "the symptoms that might otherwise be referred to as social phobia", which is much wordier.

[154] Though the last sentence of this quote moves away from the classic psychoanalytic perspective which is being described in this section, I have left it in because it is reflective of the regular criticisms that physicians like Fortin would make of what they describe as the simplistic perspectives of biological psychiatry.

situation. But phobias are also interpreted in a particular manner by psychoanalysts. Unlike in the fearful and anxiety-inducing situation described above, the object of fear in a phobia is often considered to have a distant relationship with a patient's basic problem. Psychoanalysts argue that a phobogenic object is often a symbol for the 'real' source of a person's fear. Dr. Fortin continued on to explain this feature of phobias:

> Often in phobias, we know that this fear masks another fear, a real fear much more profound, much more archaic... When we say "phobia", it evokes to us a phobic mental structure.

Dr. Fortin explains that phobias of different severity exist and will have very different impacts on the life of the sufferer:

> First, there are people who are not necessarily sick, who may have phobias during a period of their lives, for a year, or two years, because they aren't well. They have natural challenges in their lives and they defend themselves like that [the development of phobias]. We can also find phobias that we *believe* to be phobias, but that are based on a different mental structure like paranoiacs, etc. This is also common. They are afraid to plunge into the world because they are afraid of persecution or to be hated. This is not a real phobia in the sense of its structure. And, there is a third category where the social phobia corresponds truly to a mental structure of phobic neurosis. In this situation there is a total coherence. That is to say that this social phobia corresponds to a way to live in the world and in relation to others. It's the phobic neurosis of Little Hans [as described by Freud]... It's a little bit like this that we understand things.

At this point he described Freud's famous case study of Little Hans. This boy's intense fear of horses was thought to be the result of several factors, including the recent birth of a little sister, repressed erotic longings and a fear of punishment by his father. The case has been studied in detail over the years. Other psychoanalytically-oriented clinicians presented similar psychoanalytic explanations of 'social phobia'. Most indicated that

they see the symptoms of social phobia largely as an indicator of neurosis[155]. Several other clinicians also suggested patients' problems vary in degree and at their most severe will resemble a phobic neurosis or, according to Dr. Mignot and Dr. Hervé (a psychologist who practices psychoanalysis), obsessional neurosis.

It is clear from the above accounts that the psychoanalytic perspective shares little in common with the 'atheoretical' approach presented in the DSM from the third edition (1980) onwards. To psychoanalysts, etiology is everything, to the adherents of a DSM approach, symptoms are primary. The two groups of clinicians do not have the same object at the base of their clinical view.

Eclectic perspectives

> I think that what I've seen are people who have relational difficulties and who retreat in their relational life. It's another way to describe a social phobia, but I never used to see it defined as a phobia with avoidance behaviours. I never saw it as an anxiety disorder. What I've seen more is a personality disorder, a psychic functioning that underlies the strictly behavioural aspect. (Dr. Picard)

Psychoanalytic influences

French psychiatry is strongly eclectic, but most clinicians are still influenced by psychodynamic principles. Because of this, explanations based on personality and other psychoanalytic concepts loom large in clinicians' descriptions of their patients' troubles.

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[155] From an interview with Dr. Cohen. Many other physicians concurred with this idea, including Dr. Begot who pointed to the greater interest of French clinicians in the anxio-nervous problems of patients, referring to the neurotic process that has been eliminated from standard North American psychiatric manuals. It is interesting that despite Dr. Begot's statement that French clinicians, including herself, are more interested in the neurotic process, she still identifies herself as primarily a practitioner of cognitive and behavioural therapy.

These perspectives were put forward by both general practitioners and psychiatrists. Alongside these psychoanalytically-influenced explanations, many clinicians described patients' problems in terms of relational or communicative problems. They suggested that helping patients to understand and address their relational problems was more important than addressing their individual symptoms whose causes are interpersonal encounters.

When clinicians introduced the concept of personality to account for the difficulties experienced by patients, they did so by discussing personality disorders, which are Axis II DSM disorders rather than Axis I diagnoses like social phobia. Axis I disorders generally take precedence over axis II disorders, which tend to be seen as secondary or exacerbating factors. As explained in the first chapter, personality disorders represent the last remnant of psychoanalytic concepts in the modern versions of the DSM. Personality disorders are considered chronic conditions rooted in patients' characters, often resulting from early childhood experiences. The diagnostic criteria of avoidant personality disorder[156] are probably the most similar to those of social phobia and there is

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156 The DSM-IV-TR defines avoidant personality disorder as a "pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection
2. Is unwilling to get involved with people unless certain of being liked
3. Shows restraint within intimate relationships because of the fear of being shamed or ridiculed
4. Is preoccupied with being criticized or rejected in social situations
5. Is inhibited in new interpersonal situations because of feelings of inadequacy
6. Views self as socially inept, personally unappealing, or inferior to others
7. Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

considered to be significant overlap between the two disorders (Tignol et al. 2001). The clinicians with whom I spoke did not refer to specific personality disorders, and others, such as Dr. Clavel, used the more vague term of a "pathological personality". Dr. Picard, a psychoanalytically-oriented but eclectic psychiatrist, prefers to focus on personality disorders rather than social phobia because she believes that they underline the importance of the psychological factors that are precursors for symptomatic behaviour[157]. This position is reflective of many psychoanalytically-oriented clinicians, who do not think that symptoms should be the primary focus of therapy, but rather, that an individual's character or personality should be central to analysis. Dr. Picard laid out a hierarchy of 'biological' disorders, in which she placed personality disorders at the bottom, and social phobia only slightly above this, compared to something she considered more biological, such as depression. She used this hierarchy to explain that although she uses medications, she does not believe that antidepressants will solve everything, particularly in these 'less biological' cases. They do not address the psychological root of patients' problems.

The psychoanalytic concept of narcissism was also introduced by eclectic therapists. Dr. Picard explained that narcissism, from a psychoanalytic perspective, is considered to underlie what might otherwise be called social phobia. According to this point of view, narcissism is a lack of substance or solidness, a lack of an internal force and a lack of self esteem. She prefers this explanation of patients' problems to that of social phobia, though she praises the development of the latter category because it draws

[157] Dr. Picard noted that while she tends to see people with the symptoms of social phobia as having personality disorders, patients fight against this point of view. This point will be addressed in a later section.

a broader audience's attention to disorders that drive people to avoid self-exposition. Dr. Picard believes that it is patients' narcissistic tendencies that drive them to become members of a social phobia support group. Because these people have so little self-assurance, it is particularly important for them to know they are not alone with their problems. In this way, she finds them to be similar to adolescents who search for a group to give them a sense of identity. On the whole, she does not think that these groups will help patients, since they are likely to fall into a rut of self-labelling and group identification. In fact, her words seem applicable certain members of the support group, who will be focused on later in this text. While some group members purposefully weaned themselves off of their relative dependence on the support group, others have been members for years without significant improvement in their condition. For these people, the support group and their diagnosis with social phobia are central to their identities and the support group is their primary social circle.

Many other clinicians suggested that they find the term neurosis apt to describe 'social phobia'. As in the explanations above, this explanation tends to emphasize the personalities underlying the condition rather than focusing on patients' symptoms. Dr. Delaporte emphasized the significance of such a position. While social phobia is seen, like most phobias from a modern DSM-influenced perspective, to be limited to a circumscribed set of situations, neurosis is not avoidable by simply avoiding public speaking, for example. It is something that will broadly affect one's life.

Dr. Delaporte, like many French clinicians, is not a strictly psychoanalytically-oriented doctor. She is a GP, who has training in psychotherapy, taught largely from a cognitive, symptom-based perspective. She argued that if a patient has what she

classifies as 'real' social phobia, which she describes as extremely rare and which she defines as something very similar to agoraphobia, antidepressants and cognitive and behavioural therapy are probably the best first therapies to alleviate symptoms. Nonetheless, she tends to adhere to a much more 'French' perspective which emphasizes the psychogenic origins of mental illness. This is reflected in the fact that she claims psychoanalysis provides more in-depth help to patients in the long term. But in the end, choosing a therapy, she said, depends on one's goals. Much like her openness to psychoanalytic principles does not make her adverse to cognitive and behavioural therapy, neither does it prevent her from using DSM-IV diagnoses. She simply uses them moderation alongside other explanatory frameworks.

There is a constant thread that runs through Dr. Delaporte's explanations, which is common to many French clinicians. Like neurosis, she tends to see social phobia as associated with a particular temperament, rather than seeing it as a list of symptoms perhaps caused by a chemical imbalance. A significant point here is that a temperament is often serious and likely permanent, whereas social phobia is usually considered transient. Dr. Delaporte argued that the French are much less likely to see people's temperaments as sicknesses or diseases, such as social phobia, than are Americans. Dr. Delaporte suggests that the French are generally more wary of using disease labels compared to Americans and also that the threshold of sickness is much higher for the French than Americans. She believes that Americans are much more likely to pathologize experiences such as shyness, whereas the French are more likely to describe such a condition as simply normal. Dr. Lalande, also a GP, concurred with Dr.

Delaporte's argument that the French are more likely to talk about timidity than social phobia, thereby refusing to pathologize the feelings and behaviours.

While several of the clinicians I interviewed mentioned a biological predisposition as a possible factor in the development of social phobia, most people who used this explanation were cognitive and behavioural therapists. The positions of these therapists differed significantly from those of most other French clinicians I interviewed, and more closely reflected what other clinicians characterized as an 'American' approach to psychiatry. French cognitive and behavioural therapists are deeply involved in evidence-based medicine research and use DSM categories to guide their work. The therapeutic framework that they use is the dominant model used in North American psychotherapy. French cognitive and behavioural therapists will be discussed in detail in the next chapter. The typical eclectic approach used by French general practitioners is reflected in Dr. Delaporte's words:

> In France, there are many discourses, psychoanalysis, behaviouralism, systemic therapies. And each has their own therapies. Doctors will say it's a problem with serotonin or something, psychoanalysts will say that it comes from paraexcitation in their very early youth, that they [patients] weren't sufficiently secured. The behaviouralists will say that it's their relations with others[158]. I don't know. If we listen to the discussions, we don't know. Maybe a little bit of each. ... I don't waste time finding solutions [she tries to meet patients' immediate needs instead]... There is without a doubt several factors involved. In psychiatry it's

[158] This reference to behaviouralists' interest in relations is different from the discourses on relations that will appear later in this section. Concerning relations, behaviouralists tend to take an individual approach toward overcoming unease in social situations, often through behavioural re-training. Other people who focus on social relations often do so by looking for the root of social unease or by looking for problems that exist between peoples' social relations, rather than the problems of only one person. It is these last two groups that I will be examining later in this chapter.

often like that… There are often susceptibilities at the base and they develop depending on the life. This is undoubtedly true.

S.L.: You mentioned that French psychiatry is becoming more American. Do you think it is necessary to maintain a 'French psychiatry'?

Not especially French, but not too DSM-IV, [which is to say] American. You know that I am critical of the DSM-IV, the DSM-IV is a tool that is used to do research and it's necessary. You have to use it. But the Americans have a tendency to use it not just as a tool, but as a dogma, a rule, into which people must fit. If there is a pathology, it's necessary that it fits into a category in DSM-IV. And then you give them the medication for that category. In France, we are not in agreement with that, the psychiatrists, the general practitioners… There can't be a rigorous rule, a strict rule. It can't be rigid. The American method is too rigid and we don't agree with it. But this, it's not necessarily French. Things are not so simple in life. We can't frame everything… It's also true that there's a bit of nostalgia. Because the French, well, a lot of Europeans, but a good number of French [psychiatrists] were quite powerful at the beginning of the 20th century. So, we were at the height of the thinking and styles in psychiatry, but now we don't produce too many things in that domain, the French. I'm not nostalgic. For me, things must remain individual for the patient.

Dr. Delaporte was not the only clinician to point to a certain nostalgia on the part of French physicians, and especially psychiatrists, for the days when Charcot and Janet were at the pinnacle of world psychiatry. Dr. Fourciers, a cognitive and behavioural therapist, also drew attention to this tendency to reminisce among French psychiatrists and argued that it was responsible for the French refusing to take on new American models of the mind. He suggested that most French clinicians were still hoping that psychoanalysis would bring them back to the top of psychiatry's intellectual tradition. But more

clinicians concurred with Dr. Delaporte's statement that rather than trying to maintain a 'French' psychiatry, they believe it is more important to take into account individual patients' needs.

Many clinicians echoed Dr. Delaporte's suggestion that a more 'individual' approach to the patients is of prime importance in the clinic. Some proposed that it is ridiculous to think of social phobia as a uniform category at all and argued that these symptoms could be brought on by myriad factors and therefore should have as many interpretations and treatments. Dr. Clavel, a general practitioner, suggested that while categories can be useful and reassuring, the problem is that you almost need one different category per patient, because people are so different[159]. Dr. Cohen, a psychiatrist at a psychoanalytically-oriented hospital, used the example of a banker whose symptoms of social phobia appeared after a significant personal loss. Referring to this man, he argued that it would be inappropriate not to take into account the immediate cause of his problems, and to address his general symptoms rather than his feelings and reaction to his situation. Dr. Villette, also a psychoanalytically-oriented psychiatrist, presented a very similar point of view, which he summed up as, "as many people as there are, as many reasons there are for the appearance of symptoms." He does not feel that offering a structured form of cognitive and behavioural therapy can adequately address patients' concerns. Dr. Bouchet, a general practitioner, pointed out that the concept of neurosis more appropriately addresses individual patients' problems, which she believes should be

[159] Dr. Clavel added that he refuses to classify people in categories. He argued that it is the people who create psychiatric categories who have to be treated, in his opinion. It's them, he said, who have a problem. While Dr. Clavel was certainly a contrarian, he describes himself as a "black sheep" within medicine, his thoughts were echoed by many clinicians who doubt the motivations of the researchers to who create categories. Most echoed Dr. Clavel's insistence that categories are to be avoided.

the focus of therapy. She also believes that focusing on neurosis more clearly ties patients' problems to society more than a diagnosis of social phobia would.

Dr. Bouchet's assertion may seem surprising, since psychoanalysis is traditionally a very individual-oriented therapy, but French clinicians argue that the emphasis on symptoms and biological predispositions in DSM-IV influenced psychiatry provide an even more narrow explanation of patients' disorders than does a psychoanalytic approach. At the very least, psychoanalysis does not situate a patient's problem within his or her biochemistry. Explanations of neurosis, when used in a broader, not strictly psychoanalytic framework, open the door to external causes of neurosis and patients' ongoing problems with the world around them as a result of their neurotic character. Dr. Bouchet spoke particularly of certain groups of individuals, such as young mothers and the old, who were vulnerable in society and who may fit the diagnostic criteria for social phobia. But she believes that if one looks at the social factors in their lives that may have led to their marginalization, the diagnosis of social phobia becomes inappropriate. Dr. Bouchet said that this marginalization should not be considered a sickness. She believes that the goal instead should be to address the factors in their lives that leave them isolated, such as lodging conditions or other practical factors. She added that there are certain personalities that react poorly to situations, and these people will need psychological interventions[160]. These clinicians' words describe an interesting eclectic approach, in which they will use DSM categories for research and statistical purposes and will at times send their patients to cognitive and behavioural therapists for symptom

[160] Dr. Bouchet suggests that certain people want to be seen as having a handicap, but she did not consider this to be the driving force in most cases. She believes that this small subset of her patients want a medical excuse for the problems in their lives.

alleviation, but in their basic explanations of patients' disorders they rely on psychoanalytic concepts. These concepts are used for their personal comprehension of patients' problems as well as in the explanations they offer to patients[161].

Social explanations

Many clinicians suggested that it is in social relations, rather than symptoms of social phobia, that physicians should look to better understand patients' problems. Some of the clinicians who presented this point of view drew attention to their training in Balint therapy[162]. This type of therapy, created by Michael Balint, is influenced by psychoanalytic theory and is a part of object relations theory. According to this perspective, the ego only exists in relation to other objects/persons. It is thought that the feelings and reactions that one has to others are fundamental factors in the development of one's personality. For people trained in this perspective, the diagnosis of social phobia would offer a less rich description of what is happening when the symptoms of social phobia arise, since these people would look for the origin of the problem in terms of a person's relationships, rather than in individual behaviour or cognitions. Certainly there is some overlap between the more individual, cognitive and behavioural perspective and that of a relational perspective. However, the orientations of the two are different enough that different origins of patients' problems would be sought out and different treatments would be recommended. Different explanations and labels would also be applied.

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[161] However, the former is more common than the latter. Most clinicians expressed their reticence to pass along the names of disorders to patients, preferring to use more open-ended, less definitive explanations rather than labels.

[162] For instance, Drs. Arnaud and Clavel.

Many other clinicians, who did not attribute their explanations to training in Balint therapy, nonetheless suggested that it is more appropriate to explain social phobia symptoms as relational problems. To these clinicians, it seems more natural to think of patients having general relational problems rather than circumscribed problems in either one or more social situations, as social phobia is described in DSM-IV. While their perspectives may seem to reflect a diagnosis of generalized social phobia, their view of the disorder would be broader in its focus and in its search for the ultimate causes of patients' problems. Clinicians argued that explaining peoples' disorders in terms of relational problems is more useful to patients than focusing on symptom alleviation, which is the primary approach according to cognitive and behavioural therapy. They believe that the former explanation offers more depth to patients' understandings of their problems than does the latter.

Several clinicians specifically emphasized family interactions. For example, Dr. Mignot, a psychoanalytically-oriented psychiatrist, noted that social phobia-like symptoms often cluster in families, which may indicate that there is a genetic element. However, he also suggested that family relations are often implicated in several family members developing social phobia. Because of this, he often recommends family therapy to his patients to encourage family members to learn together more "efficacious" ways of living. Dr. Petit, a family therapist, argued that because of the specificity of his approach, in which problems are seen as the result of family dynamics, he has never found it necessary to use the diagnostic category of social phobia. Instead he focuses on 'pathological relationships' and the way that this affects all people involved. He represents a therapeutic orientation in which social phobia might barely exist. While

most physicians expressed clear reasons for focusing on relational problems, I had the impression that some clinicians' references to 'relational' or 'communication problems' was simply an attempt to avoid other, more serious-sounding labels, which they feared patients would adopt and carry with them throughout their lives.

In contrast to the physicians just mentioned, who believe that a focus on social relations will most effectively treat social phobia, Dr. Picard suggests that physicians' emphasis on social relations has contributed to the visibility of social phobia. She argues that in a certain sense physicians have encouraged patients to consider that they suffer from something like social phobia. Dr. Picard outlined discourses of control that have recently appeared in France. She reported that during a visit to New York about 15 years ago, she was struck by the pervasive rhetoric about learning to be the master of oneself, controlling one's difficulties, managing oneself and one's stress. This rhetoric appeared alongside discussions of the need to master one's relationships with others. This is the rhetoric that she now sees in France. But she does not think that this discourse has helped people to manage social interactions and social relations, instead it has only made them more self conscious of their perceived failures. She believes that social relations are much less structured and less sure than they were in the past, and people's failure to be able to control them as they would like has drawn attention to social phobia. While both she and the clinicians arguing for increased discussions about social relations believe that the term social phobia should be avoided, they believe that the concept of relations should be used and, sometimes, problematized in different ways.

Evolutionary explanations

One clinician presented an evolutionary explanation for the symptoms of social phobia, arguing that "a certain number of the problems in our functioning are tied to the fact that we live in large cities with a brain that has been the same for five thousand years." This clinician, a general practitioner, Dr. Clavel, was the only physician with whom I spoke who claimed to be influenced by evolutionary psychology. Other clinicians do not precisely share his opinions, but some, such as Drs. Bouchet, Mignot and Lefebvre, argue that the social world we live in has a large role in explaining the appearance of what could be called social phobia. Dr. Clavel argued that fifteen thousand years ago we could know all of humanity. Using the example of Versailles, where he lives and works, Dr. Clavel argued that five thousand years ago, there were only 150 people in his local area, so each person could know everyone else. Now, it is impossible to know everyone and he identifies this as a probable generator of anxiety and frustration. Based on these factors, he thinks that social phobia is a normal reaction to society.

Dr. Picard believes that there are often sociological explanations for the recognition of mental illnesses during a particular time period. Referencing Alain Ehrenberg's book on depression, *La Fatigue d'être Soi*[163], Dr. Picard explained her position. She believes that there is a relationship between certain eras and the way that mental disorders that will be expressed and how they will be seen by others. She believes that social environments influence the manifestations of mental illness. This echoes Ehrenberg's argument that depression has become more prevalent in France because it is the opposite of the French ideal of action and responsibility. This ideal makes the

[163] The title of this book can be roughly translated as *The Weariness of being Oneself.*

inaction and social withdrawal of depressed people more visible. Dr. Picard does not believe that this is the sole explanation to account for the appearance of social phobia, but she is convinced that it accounts for the changes of clinical frameworks over time.

Dr. Cohen referred to the changing eclectic make up of French psychiatry. He noted that explanations for mental disorders are changing. Psychoanalysis, which used to be the primary therapeutic approach taught at medical school, has become less central. He asserted that "psychoanalysis is no longer in fashion and the balance of the eclectic approach is shifting from psychoanalysis to other approaches, often more consistent with the DSM." His statement points toward changes similar to the shift that American psychiatry underwent in the 1970s and 1980s. According to Tanya Luhrmann, a medical anthropologist, the shift in American psychiatry from a psychoanalytic to a more biological and DSM-consistent approach profoundly changed the way that Americans learned to see the mind and its troubles (2000). The conditions that drove this change in the United States are now visible in France. This possible transition will be addressed in later chapters.

Doubts concerning the prevalence of social phobia

In general, most clinicians concurred that they have seen the symptoms of social phobia among their patients, but they also asserted that the 'real' and serious form of the disorder is very rare. Dr. Begot, for example, argues that the 6-8% of French people who are reported to suffer from social phobia according to epidemiological studies (Alonso 2004a; Furmark 2002) must only fall into this category because of the inclusiveness of the scales used in the studies and the efforts of researchers to find people who may fit

these criteria. She does not believe that all of these people suffer from the serious and incapacitating form of the disorder that she sees only very rarely in her office. Dr. Picard suggests that when people usually complain to her about the symptoms of 'social phobia', such as a fear of being watched by other people, it is usually a part of a depressive episode, which she does not consider a true social phobia. She argues, "A real social phobia is a relatively permanent disorder, chronic and independent of a thymic disorder, for example. It can eventually be aggravated by a depressive episode, but it persists beyond these episodes." Dr. Picard state that she rarely sees this 'real' version of the disorder, and she thinks that this is not uniquely tied to the fact that she does not look for it. She, like Dr. Begot, does not think that it is as widespread as epidemiological studies suggest. She does not even think that social phobia is present in 5-6% of her patients, a group in which one would expect to see more of the disorder than in the general population[164]. Dr. Picard reasons that these estimates are produced by looking across the population and finding all the people who, at that instant have social phobia-like behaviour or who have a regressive moment in their functioning, perhaps linked to a depressive episode. She reports that she does not really use the diagnosis because she finds that the set of symptoms most often occurs with depressive episodes and if the depression is treated, the other symptoms disappear spontaneously. In essence, Dr. Picard believes that social phobia symptoms are usually a sign of another disorder.

[164] Especially because social phobia is so often co-morbid with other conditions, it would be likely found at higher rates in clinical populations, in which people have already sought assistance for some disorder, as opposed to the general population, in which the majority of people would not consider themselves mentally ill.

Many physicians concur with Dr. Picard's argument that 'real' social phobia is very rare. Dr. Gitton, a GP, expresses the point of view of many other clinicians when he argues that:

> I would say that it's [*social anxiety* is] a disorder that is sufficiently prevalent, that one sees a certain number of people who present this sort of disorder. After that, it's a problem of classification. The patients who have *real social phobia*, with an important reticence, we don't have many of those. I would say that *phobic traits* are frequent enough in all patients who are followed for diverse and varied neurotic disorders, to more or less significant degrees. *Social phobia*, when it's really that, it's a disorder organized around this theme, it's very structured, and very identifiable. Like a neurotic organization, it's not that frequent. Neurotic traits relevant to social phobia are common enough. One is confronted at once with people who one does characterize in terms of social phobia, but who have neurotic traits that can range from a fear of speaking in public to a real neurosis and to have repercussions in terms of their professional future, social relations, emotional relations and professional relations. There is a whole spectrum. In general medicine, we are confronted with the recruitment of the entire spectrum... (emphasis added)

Dr. Gitton added that if one defined social phobia as the condition at less affected end of the spectrum, "one could put everyone in that category". I had already informed Dr. Gitton that I was interested in his opinions of patients who fit the DSM-IV diagnostic criteria for social phobia regardless of whether he would normally use that diagnostic category. His reaction was similar to that of most physicians with whom I spoke when he said that the symptom list of the disorder provides little certainty about the type of people who will be included in the category. Each of the symptoms has a broad enough range of intensities, Dr. Gitton suggested, that if someone was looking for the disorder, it would be possible to see it in everyone. He and other clinicians argue that most of the people

who match the symptom list do not truly suffer from a pathological condition. They suffer from a problem, but not a full disorder. It is not something that ought to be medicalized.

Dr. Agasse, a general practitioner, is in accord with such a view. He agrees that there are some long-term, very serious cases that should be called social phobia, but there are many people who suffer only from stage fright, or unease[165]. I asked him about where social phobia stands between pathological shyness on the one hand and depression or generalized anxiety on the other hand. Dr. Agasse replied that to him, this is one of the most important questions in general medicine: where to draw the line between the normal and the pathological? He believes that patients and other physicians often define a condition as pathological which he would describe as normal.

> By the way one draws a line, one is the creator or not of a professional discourse… [one can say] 'you are in good health and what you feel is normal, bravo… I wish you anxiety[166], you are anxious, it's normal, it's a motor'. I say that to patients. I tell them, 'listen, the principle of anxiety, it's a motor, it doesn't have to be a break. I take an example that they understand well enough: the stage fright of an actor. Does the actor need an anxiolytic or beta blocker to get on stage? The answer is no, it's obvious. And all the good actors say that consciousness of this is indispensable for their work.

He recounted a story of his own experience with this type of anxiety, when he worked as a physician answering calls on a radio talk show. From his experience, he concludes that this anxiety helped him and was a part of the pleasure of his job. He finds this kind of

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[165] The word Dr. Agasse used was "*trac*". This word translates as stage fright but also refers to a number of similar feelings that a person feels in many different situations. It has a much broader meaning compared to stage fright.

[166] When physicians speak of anxiety, they often use the word *angoisse*, as was used in this case by Dr. Agasse. This word can be translated as either anxiety or anguish. Most often I have used the term anxiety, but it can be thought of as a strong form of anxiety.

anxiety normal and useful, "If you ask me, is it pathological? The response is no. It is tied to a particular situation... and when that situation is over, the feeling is gone." Partly because of his experiences with 'stage fright', Dr. Agasse believes that much of what is called social phobia by other clinicians would be better described as normal, and useful, anxiety.

On a similar line of argument, Dr. Clavel suggested, as did other clinicians, that "there are people for whom it causes real suffering, but there are not many..." He compares the range of social phobia to that of impotence, "for those who suffer and for whom it's a permanent condition, they are in the category and they will look for solutions. And then there are other people, they'll be impotent from time to time, and they don't make a big deal about it. They say to themselves, 'it's not serious, the next time it will go better'". Dr. Clavel believes that it is very difficult to say when something becomes a 'real' disorder, and argues that one must not be dogmatic.

Historical changes and fashionable explanations

Many of the clinicians I spoke with voiced the same opinion as Dr. Begot when she said that, depending on your therapeutic orientation, you will see what you want. These clinicians believe that social phobia only exists, or at least to any significant degree, for those who look for it. Clinicians made reference to several other disorders that at a given time, were suddenly thought to be widespread in society, but which have since either ceased to 'exist' or which are no longer thought to be so prevalent. These

disorders include: panic attacks[167], obsessive-compulsive disorder (OCD) and spasmophilia, a French culture-bound syndrome[168]. Other clinicians made reference to trends in psychiatry or in information sources that they also think account for the recent acceptance of social phobia world wide, and increasingly in France.

Dr. Picard suggests that the importance of medications in psychiatric treatment today makes one look for symptoms, to take an increasingly symptom-based approach. Other physicians, especially general practitioners, concurred. There are many reasons that medications have gained such a central role in psychiatric care. First, French patients see prescriptions as the natural outcome of a visit to one's clinician[169]. Second, the low costs of medications, negotiated between the French government and the pharmaceutical industry, along with the government's reimbursement[170] of medications, make it likely that patients will purchase the drugs prescribed. So, the ease of access to medications also encourages the acquisition of drugs, though whether patients consume the medications purchased is another issue[171]. Third, physicians repeatedly noted that because doctors are paid by the act, which means for each patient they see, the most efficient means of treatment will generally be used. This encourages clinicians to quickly

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[167] Dr. Villette was the only physician to mention panic attacks as a 'fashionable' and passing diagnosis in France. This is perhaps because most French physicians shunned the diagnostic category as an 'American' trend, preferring to use the diagnostic category of spasmophilia instead.

[168] A full description of spasmophilia is provided in a few pages.

[169] While I was in France, the government had launched a marketing campaign to counteract patients' expectations. Throughout Paris signs reading "Antibiotics are not automatic" were posted in an attempt to begin changing prescription practices and patient expectations.

[170] Most medications are reimbursed at a rate of 35% or 65%. Patients are reimbursed for 65% of the cost of psychotropic medications such as SSRIs.

[171] The physicians I spoke to estimated that between 1/3 and ½ of their patients probably do not take the medications they are prescribed and often buy.

assess patients' problems and to prescribe a medication, rather than taking the time to discuss patients' problems and perhaps offer some form of psychotherapy. Fourth, marketing campaigns for SSRIs have been directed most intensely at clinicians who work out of private offices[172]. Dr. Cohen noted that these physicians have to prescribe because of to the competition to keep patients. If a physician in private practice does not prescribe a medication to a patient, he or she risks losing that patient. If a physician is unable to keep a large patient base, which involves seeing many patients for rapid consultations, a doctor can literally go out of business. Dr. Petit, a family therapist, concurred with the view that physicians in private practice are more likely to prescribe medications to please and keep their patient populations. Dr. McDermott, an Irish physician who worked for some years in the Strasbourg area, compared the way that French clinicians are paid, by the act, versus how they are paid in Britain, which is by the number of their registered clients. In the British system, the emphasis is on the physician's ability to please the patient in general, rather than to see as many patients as possible in a given day. Dr. McDermott argued that the British system may not promote the prescription of medications to the degree that prescription is promoted in France.

The increasing attention to patients' symptoms suggests to Dr. Fortin, a psychoanalytic psychiatrist, that the psychological causes of patients' disorders will be given less and less attention:

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[172] This information is taken from a free, educational CD-ROM created by GlaxoSmithKline (GSK) and disseminated to French clinicians. While they do not mention the name of their product paroxetine, known as Deroxat in France and Paxil in North America, a parallel campaign was also undertaken to spread information to physicians about this medication and the symptoms it is thought to treat. GSK sent me the CD-ROM at the request of a French cognitive and behavioural therapist who works closely with this company and whose work is used on the CD-ROM.

> In the 20-25 years I've worked as a psychiatrist, a lot has changed. Practices have been modified along with the prescription of psychotropic drugs... The classifications of 20 years ago are no longer the same, that is to say that we respond much more to the reduction of symptoms now... So the diagnosis no longer has the same importance and it's because of that that we can have a nosological system such as DSM-III – very descriptive for the symptoms but without a reflection on [disease] structure. That is to say, what type of personality does the person have?

The passing of an etiologically-based nosology has left the door open to a system in which mental illness is known by its superficial traits. Symptoms become the focus on physicians' attention. In an age when the widely-used SSRI antidepressants are increasingly marketed as treatments for the symptoms of anxiety (Healy 2004b), anxiety disorders, such as social phobia, begin to be of more interest to doctors. Physicians look for what they can treat. New, symptom-based diagnoses are applied and what was once the result of a neurotic process becomes a symptom of a serotonin imbalance.

Dr. Cohen, a psychiatrist at a psychoanalytically-oriented psychiatric hospital, suggested that the type of education that physicians now receive encourages them to take a symptom-based approach; to look for symptoms and match them to a medication treatment. He mentioned that the changing training environment in schools, from a more in-depth psychoanalytic approach to a DSM-based approach is shifting physicians' focus. They are no longer interested in the basic psychological factors in mental illness, and instead look for superficial symptoms and biological factors. Dr. Cohen is also frustrated by the influence of the pharmaceutical industry in teaching physicians to read particular symptoms as treatable by a particular medication. He sees the relationship between drugs and mental illness as much more complex than this. Dr. Cohen finds this new approach

troubling, particularly since it appeals to many physicians and patients who are looking for short-term solutions to problems, to accompany, for example, six months of cognitive and behavioural therapy[173]. He does not think that these short term solutions work very well, and he believes that the industry is aware of this despite their claims that six months of psychopharmaceuticals is often enough to treat a patient's problem. Dr. Cohen argues that the pharmaceutical industry has a vested interest in encouraging medication for life, even if this is not the message that is initially promoted with the use of SSRIs[174]. Once patients are on medications, with the intention of only taking the drugs for six months to a year, he says that they are encouraged to stay on the drugs 'just in case'. Warnings regularly appear about the danger of discontinuing therapy too soon (for example, GSK 2004).

It was common among the physicians I spoke with to compare social phobia to OCD and spasmophilia, describing them as disorders that have been 'fashionable' in France. Physicians claim that these disorder appear to come out of nowhere at a particular moment and suddenly grab the attention of professionals and the public alike. Most physicians presented the view that in all of these disorders anxiety is at the base, and that this anxiety can be expressed in many ways and moulded into many frameworks. Dr. Cohen stated that there is no difference between social phobia and spasmophilia, both are simply fads. The patients who experience these types of anxiety are seen as neurotics, which classifies them as people who are more likely than most to 'see'

[173] This treatment protocol is often promoted as the best for people suffering from social phobia.
[174] Dr. Villette argued that long-term use of SSRIs is also a result of the strong severance problems associated with the medications.

themselves in medical diagnoses more than other patients. This would make the process of label-changing easier than one might otherwise expect.

Spasmophilia can be described as a French culture-bound syndrome. The disorder was first defined in 1948 by Dr. Henri-Pierre Klotz[175], who believed that the disorder, which could cause muscular spasms and hyperventilation, was caused by a deficiency of magnesium and calcium (Payer 1988: 63-4). Other symptoms or disorders thought to be brought on by magnesium and calcium deficiency include: cramps, convulsions, loss of memory, insomnia, migraines, stress, anxiety, the "neurotic triad" of hypochondriasis, depression and hysteria, and other personalized symptoms (Durlach and Bara 2000: 98-9, 129). Magnesium and calcium are not seen as the sole factor in all of these problems, but as an exacerbating element that can contribute to their appearance or worsening. The diagnosis rate of this disorder increased sevenfold between 1970 and 1980, and by 1982 the clinical test for this disorder was the twenty-ninth most commonly performed procedure in France. It had become a part of a typical day in medical practice and the diagnosis of spasmophilia was as frequent as that of hearing problems (Payer 1988: 63). Dr. Lalande recalled that spasmophilia diagnoses probably reached their peak around 1994 or 1995 and since then, diagnostic rates have been on the decline.

The symptoms associated with this disorder are broad enough that they can be associated with the diagnostic criteria of many medical problems. Most clinicians with whom I spoke suggested that the diagnosis would now be considered to overlap most closely with panic attacks, but that people who were once thought to be spasmophiles could likely meet the diagnostic criteria for several other psychiatric disorders. Dr. Fortin

[175] Klotz is not a pseudonym.

put forward an explanation to account for why social phobia has replaced spasmophilia as the latest 'fashionable' disorder:

> Without a doubt that there is movement in our society that wants to see adaptation to the social world as more important than before. In the past there were periods of research on the metabolic problems of certain psychological or psychiatric disorders and there were disappointments that we didn't find an answer for these disorders on a biological level. We now consider that the most embarrassing handicap in our society is a social handicap, and this was because our era is more concerned with seeing good communication, good harmony, a good spiritual togetherness and social adaptation than in the past... So, there is first an aspect of disappointment because of an absence of biological discoveries for psychiatric symptoms and secondly, we are very concerned now with social adaptation than maybe 50 or 100 years ago.

These changes would seem to make social phobia a natural choice to take the place of spasmophilia, whose popularity was already waning. Dr. Vézinet, a prominent French clinician who is a specialist in magnesium research and who has undertaken a great deal of research suggests that the diagnosis fell out of use because it became a catch-all term to refer to almost any medical condition or minor ailment. He is particularly critical of the overuse of the diagnostic category to act as a euphemism for mental illnesses. This use of a 'physical' problem to explain 'psychic' unrest recalls the use of the term nerves in the nineteenth and early twentieth centuries to avoid the stigma of being labelled as 'mad'.

The appearance of some disorders has been tied to the development of new drugs. At times, a treatment is created for which doctors will then look for a condition it treats well. The publicity surrounding the licensing of a new treatment will also, at times, turn

doctors' attention toward the disorder it treats, even if it was of little interest to them before. Dr. Fortin noted:

> Our great desire to discover something ensures that we end up always finding what we want, at least partially. We have to always control what we call counter-transference in a relationship. If you want to work on social phobia, you will interrogate all the population and you will find that 90% of people have a social phobia. That's what happened for OCD. At one time, the pharmaceutical companies that launched the SSRI antidepressants to work on the symptoms of OCD asked us to undertake epidemiological research. In the end, we noticed that practically everyone had OCD. That's what the industry was looking for, for sure. That is to say that when one wants to find something, one finds it. I'm exaggerating, but it's a bit like that. So, in every era, there are interested parties, whether it's the pharmaceutical industry, funding sources... In France we had a professor who absolutely wanted to leave his name on a syndrome and also to leave his name in pharmacological research on the metabolism of calcium in spasmophilia. And so, he was able to find all the necessary arguments [to make the disorder appear widespread]... This shows that the work of a researcher is very difficult because one has to always be self-critical. In our profession of psychiatry, given that we work on mental issues which are immaterial, insubstantial, it's necessary to be doubly vigilant about self-criticism. It's a lack of self-criticism that that allows us during a certain era to treat spasmophilia with calcium while now the same disorder is treated with a serotonin re-uptake inhibitor.

Dr. Clavel had a more cynical interpretation of what happens in research. He, too, believes that if you look for a disorder you can find it anywhere. But he thinks that even if it can be seen everywhere, it does not mean that it should necessarily be treated medically:

> Me too, I had a social phobia at one time. I read this morning that 15% of men are impotent, plus those who have social phobia, plus those who are overweight,

> plus those who can't sleep, plus those who pick their nose, plus those who have bad hair, plus those who drink too much, smoke too much, don't have wives, whose wives have just left them, listen... all are possibilities to make diagnoses. But to have a social phobia, from time to time to find humanity damn annoying and intolerable, it doesn't seem that dramatic, it's not a reason to take someone into care medically or socially. I find it normal to find society intolerable.

Dr. Clavel points to what he sees as the over-pathologization of what he considers normal life events. This does not mean, however, that he will deny treatment to his patients. He said this would be unkind. He states that if he thinks someone is truly suffering, he will offer him or her a medication. This is different, he suggests, than explaining to the patient that he or she has a medical or psychiatric problem.

Dr. Clavel, like many other physicians, believes that 'fad' disorders are simply different names for similar types of anxiety. A few symptoms may be different, but he believes that they are essentially the same experiences, labelled differently. He thinks that asking people certain questions and performing certain studies allows researchers to place people in different categories over time. His argument goes beyond what many physicians stated: that researchers will see what they want. He says that it is known that since long ago, scientists have cheated. Dr. Clavel referred to *La Souris Truquée: Enquête sur la Fraude Scientifique* (originally published as *Betrayers of the Truth: Fraud and Deceit in the Halls of Science* [Broad and Wade 1982]), which traces the story of a scientist who surreptitiously moved mice from cage to cage in his study, according to their colour, to prove his theories. He says that this is common practice in science, "First, scientists have a theory, then they search to verify it. Everything that doesn't verify their theory, they throw in the garbage, everything that verifies their theory, they keep." He explains that there have been accounts of this since the seventeenth century. To him, this

accounts for why so many new disorders and categories are able to be verified from one era to the next.

Conclusion

Whether names change because of different education systems, treatments or people of influence, most clinicians suggested that the names used to describe moderate anxiety over the past 50 years, such as OCD, spasmophilia or social phobia, have often failed to truly describe patients' problems. In his analysis of these changing names, Dr. Fortin notes that something is missing from these diagnoses.

> Something always escapes us. It's the true understanding behind a manifestation which is that of fear, dread, the fear of something imaginary. That is, anxiety, a phobia. When we say the word phobia, what we mean to say that there is an object of fear, but which is exaggerated: crowds or groups of people. In social phobia, that brings together many things. For one of my patients, who was a paranoiac, he had a fear of a surprise aggressor, discovery and aggression [but it was expressed as a social phobia]. I have another person, she is afraid of others seeing her because she has a dysmorphic phobia. That is, the social phobia hides a phobia of her face, she had acne which left scars, she has a face that is a bit deformed, her nose, her ears don't please her, etc. The same social phobia covers at once someone who has a fear of being unattractive and the other that she is pursued by persecutors. The third, it's the fear of being looked at, to be recognized and to be isolated like someone who did something bad, who has a sense of guilt. In consolidating social phobia, one absolutely does not take into account the fine analysis of what is behind it. To treat someone with serotonin who is persecuted or someone who is a little uncomfortable in public because he had a very severe education by his parents, it's not the same thing.

While his perspective is influenced by his psychoanalytic training, he points to something that was raised by many physicians: that there is something underlying the experience of social phobia that is not taken into account in the explanation offered by the DSM. Post 1980 DSM diagnoses do not provide an explanation for why a person suffers from social phobia, for example. It addresses only the expression of patients' problems. Because of this, many clinicians I spoke to suggested that DSM diagnoses lack substance. These clinicians believe that DSM diagnoses are deficient because they do not address interpersonal or individual factors that are implicated in the etiology of social phobia.

Overall, this is why most French clinicians of almost all therapeutic orientations found social phobia to be an inappropriate diagnosis for patients' symptoms. It labels, but does not fully describe patients' problems. Even if physicians use the term social phobia, they will introduce other explanatory systems, such as psychoanalysis, to explain patients' troubles. They believe that these supplementary explanations are necessary to address deficiencies in the explanations provided by the DSM.

Despite these criticisms of the DSM, social phobia and the manual are increasingly being adopted by French physicians. This reflects ongoing changes in the French psychiatric system. It is becoming more in line with an increasingly standardized world-wide diagnostic system. But at this point, standardization is far from complete and the French psychiatric system retains many of the characteristics that make it distinct.

Chapter Six

Clinicians promoting the adoption of social phobia

Contents

French cognitive and behavioural therapists are the primary group of clinicians advocating acceptance of social phobia. Their arguments for the recognition of the disorder often focus on patient need. They believe their patients have suffered greatly over the years because their troubles were either interpreted as 'only' shyness or they were offered long-term psychoanalytic treatment, which the cognitive and behavioural therapists believe does little to help these people. But there is a larger battle going on in French psychiatry between cognitive and behavioural therapists and psychoanalysts for control of psychiatric institutes. Because of this, cognitive and behavioural therapists' arguments must be understood as coming from a very different context than in North America, where this type of therapy has virtually become the norm. French cognitive and behavioural therapists have fought for their positions in renowned Parisian hospitals and this is reflected in their professional histories. Dr. Roux recounted the trajectory that led him to be one of the top social phobia researchers in France. His experiences tend to overlap with many other French cognitive and behavioural therapists, who often have close connections with American researchers, have lost patience with psychoanalytic techniques, and want to more aggressively help patients. He, and other early French cognitive and behavioural therapists, was very much in the minority when he began his research. Below is his story:

> I've been interested in social phobia for a long time. At the beginning of my training in cognitive and behavioural therapy, it was the end of the 1970s. I was in the United States at UCLA where I had a government research grant to study psychiatry at the medical school. I trained in cognitive and behavioural therapy and was working on a research project on schizophrenia, on the social skills of schizophrenics, with Professor Robert Lieberman. So very quickly I became interested in social behaviour and personal affirmation training. I returned to

> France in 1980, and I worked a little bit on schizophrenia, but I preferred to study neurotic patients. Plus, it [studying neurotic patients] involved behavioural affirmation and social relations. Very soon after that, evidently, the DSM-III came out in the United States, and it was then that they identified the category of social phobia. Quickly enough I found that self affirmation was interesting to use with social phobia. I started with self affirmation and assertiveness with these patients and I became more interested in anxiety disorders in general, and most particularly, social phobia.

When asked to explain his use of the term neurotic, which is uncommon for cognitive and behavioural therapists, and if it meant that during the early period of his practice he was still using a psychoanalytically-influenced model, Dr. Roux replied:

> Not at all, I said neurotic disorders, but I meant to say anxiety disorders... From my training in cognitive and behavioural therapy in the 1970s onwards, I was always working with that framework. I was the president of the French association of cognitive and behavioural therapy and I was editor in chief of the journal *Cognitive and Behavioural Therapy*. I am uniquely in the domain of cognitive and behavioural therapy.

Recalling his early days working according to this therapeutic framework, Dr. Roux explained:

> It was very complicated. In the 1980s, cognitive approaches were at once very much at the fringes of psychiatry, and very, very few people worked from this approach. There were twenty, maybe thirty of us, and there was a very, very strong opposition to it that still exists today. There was the very, very strong opposition of psychoanalysts who were very, very widespread and who monopolized all psychological discussions of anxiety. So, it was very complicated... It's easier now. The proof is that there are specialized consultations in all university hospitals, therapy services that are officially cognitive and behavioural therapy. Back when we started, there were people who

> worked in hospitals, but there was nothing very official, it had not been put in place. Now, in university hospitals, in psychiatry, it's something that is relatively well accepted. The problem is that in psychology, not psychiatry[176], cognitive and behavioural therapy is still very poorly accepted. The majority of psychology faculties in France don't teach this therapy. And the second problem is that there are an insufficient number of people trained in cognitive and behavioural therapy, so there are not enough people to treat patients in this way.

According to Dr. Roux, it is not easy for new therapeutic frameworks to be accepted into clinicians' practices. He argues that eclectic approaches have not been as thoroughly integrated in France as in the United States. While multiple forms of therapies exist in France, they are not blended by individual therapists. Instead each therapy will be used in a different clinic. He believes that this differs from the practices of American therapists:

> In France, it's not like in the United States, the eclecticism. What really shocked me in the United States was that the three large currents of modern psychiatry: pharmacology, psychoanalysis and cognitive and behavioural therapy, they co-existed and were almost equal[177]. A psychiatrist could prescribe medications, use psychoanalytic techniques and use cognitive and behavioural therapy. It wasn't shocking. In France, we're not in the same state. In France, the approaches are more separated. The cognitive and behavioural therapists don't have a problem with pharmacology, for example. I prescribe a lot in addition to giving psychotherapy. Psychoanalysts are more complicated. Many almost refuse the ideas of medications and many psychoanalysts refuse to prescribe medications. And, in terms of using the two psychotherapies, it's very rare, I don't know any,

[176] This does not mean that cognitive and behavioural therapy is widely accepted by French psychiatrists, only that it is now routinely taught to psychiatric interns and residents.

[177] While this may have been the case in the late 1970s, it is difficult to say whether all three streams remain on equal footing, particularly psychoanalysis which has lost a large number of proponents in the last 25 years.

> well, I know a couple of therapists, but it's really very exceptional for someone to use the two. It's only in the last few years that some people use a little bit of the two aspects. The French are a people that are more into controversy than consensus[178]. But that's also in the history of the country and the mentality of the people. Consensus in France is rare... It's true that in hospital clinics like this one, there is a little bit of cohabitation, but this department is quite rare. In this department we have a strong history of research in pharmacology, but it also has an enormous number of psychoanalysts, so it has quite a psychoanalytic tendency. When I arrived here more than a dozen years ago, I was all alone, but since then there have been other doctors that have joined me like Dr. Fourciers and now there is a whole team. In a department like this one, there is at once pharmacology, psychoanalysis and cognitive and behavioural therapy. So it's not that patients who are looking for both can't find it, it's just that it's more of a coming together of the currents rather than eclecticism; cohabitation rather than eclecticism.

It is clear, from Dr. Roux's story that cognitive and behavioural clinicians are fighting for a lot more than the acceptance of the category of social phobia. They are fighting for the acceptance of the validity of their therapeutic approach and for a new trajectory to be created for the future of French psychiatry. This may partially account for their strong reactions to those who deny the existence of social phobia.

Clinicians who argue that social phobia must be recognized suggest that those who do not use the diagnostic category do not understand the disorder. If they did, the social phobia supporters argue, it would be very easy for them to see the disorder and clearly separate it from other disorders or conditions. The vast majority of clinicians who argue that social phobia is a prevalent and seriously incapacitating disorder that requires

[178] Dr. Roux was not the only clinician to describe the French in this way. Dr. Lefebvre stated similar things using stronger terms and Dr. Jacob described the French as natural sceptics.

treatment have been trained in a cognitive and behavioural framework. Many of them are actively involved in clinical research and they have often worked for the pharmaceutical industry[179]. Their theoretical frameworks, including their psychotherapeutic and biological orientations, are consistent with DSM-IV diagnoses, which are explained according to patients' behaviour and which are often presumed to have biological origins. Social phobia is almost exclusively written about from these two perspectives (cognitive-behavioural and biological). The ideal treatment for social phobia is considered a combination of medications and cognitive and behavioural therapy (Sareen and Stein 2000), which are thought to symbiotically address different factors involved in the development of the disorder. For people trained in these models, it is easy to 'see' social phobia.

Increasing awareness of social phobia in France

Unlike the vast majority of clinicians in France, psychiatrists trained in a cognitive and behavioural model have discussed social phobia since the diagnostic category was introduced in DSM-III (1980). Dr. Duclaux asserts that little by little, clinicians have become aware of the disorder and now, he suggests, most psychiatrists[180] know about it. But, even among these specialists, he estimates that less than half of them are really familiar with the research on social phobia. Dr. Duclaux notes that his

[179] Working with funds from or directly for the pharmaceutical industry is not exclusive to the doctors who accept social phobia, but there is a tendency for these physicians to be more 'industry-friendly'.

[180] Dr. Duclaux stated that the hospital-based psychiatrists know about the disorder partly because of discussions that took place in hospitals about the pharmaceutical industry, the difficulties that the industry had (GlaxoSmithKline in particular) getting authorization to have their drugs recognized as treatments for social phobia, and about the way that social phobia would fit into their diagnostic coding system.

statements concerning psychiatrists being more knowledgeable about social phobia are not applicable to psychoanalysts. Psychoanalytic psychiatrists, of which he says there are still many in France, Dr. Duclaux asserts, are not interested in social phobia, which means their patients will never be treated as cognitive and behavioural therapists think they should. In practice, he concludes, psychiatrists who work in hospitals know what social phobia is, especially those who work in university hospitals. These are quite different from other hospitals because it is there that students are taught. The clinicians at university hospitals perform research and are aware of contemporary nosological systems. Awareness of social phobia tends to diminish beyond these boundaries. But, Dr. Duclaux anticipates that in ten years the situation will be quite different, and the average theoretical approach will have changed in French medicine, bringing it close to his own position. He notes with regret, however, that there are resistances to this process of change. There are still young interns who begin psychiatry and move immediately toward psychoanalysis because they find it more interesting and it sets them apart from others. They find an approach in line with cognitive and behavioural theory, as well as in line with the DSM, to be too 'American'. Even if the disorder is not as well known as he would like, he believes that social phobia will become increasingly well know as it is now included in medical school classes and it is at university hospitals where these students are educated.

Dr. Duclaux's description of professional awareness of social phobia is in line with what most other clinicians reported, though, as noted in the previous chapter, clinicians' familiarity with the disorder does not necessarily mean they will use the diagnostic category. In terms of how information about social phobia has been

distributed among different groups of clinicians, Dr. Duclaux emphasizes that while more non-psychoanalytic psychiatrists know about the disorder, this is not necessarily the case for general practitioners, though he noted that there are many who are interested in psychiatric issues and these people are likely to know more about the disorder. Most general practitioners, he reports with regret, have done little to expand their understanding of psychology, and they know particularly little about anxiety disorders. Dr. Duclaux says that generalists search in a somewhat preventive way for signs of depression, but the same is not true for anxiety disorders.

Anxiety disorders have historically been of little interest to French clinical researchers[181]. Psychosis research has a rich history in French and European psychiatry, richer he thinks than in the United States, which he says is reflected in the poor treatment it gets in the DSM classification system. The French are proud of their clinical research history and he believes that this is partly to blame for their lack of interest in anxiety. Looking at anxiety, he believes, necessitates the importation of American cognitive and biological models of these disorders since it is in the United States that the most research has been undertaken on these disorders. Another factor that made French clinical researchers wary of new theoretical models of anxiety, Dr. Duclaux continued, is that the hospitals that were great institutions in the history of French psychiatry do not want to let

[181] Clinical researchers are, of course, quite a different group of professionals than are psychoanalysts. Throughout the history of French psychiatry, clinical psychology or psychiatry research has been far removed from psychoanalytic practice. It is the latter group that have tended to treat patients suffering from anxiety of different sorts, rather than clinical researchers in hospitals. But psychoanalytic models of anxiety are incompatible with those put forward by modern clinical researchers. So, cognitive and biological models of anxiety have traditionally been ignored both by the vast majority of clinical researchers as well as psychoanalysts because the former group has little interest in anxiety and the latter groups therapeutic orientation is incompatible with that of cognitive and behavioural therapists.

the pharmaceutical industry influence their future. They know that what they describe as the 'American pharmaceutical industry', despite the fact that most companies are multinational, has an increasing influence on classifications and the direction that psychiatry is taking. Pharmaceutical companies support much of the research on social phobia, and presumably other anxiety disorders, that is currently undertaken in France. Dr. Duclaux has worked with funds from the industry. He does not deny the industry's influence and points to it as one of the negative factors in the development of his profession, even though he by no means thinks that the industry is entirely a negative influence. It is, after all, one of the biggest promoters of social phobia in France.

Cognitive and behavioural therapists are well aware of what other clinicians think of social phobia, in particular that the category should not exist, that it is an invention of the pharmaceutical industry or the DSM committees[182]. Dr. Duclaux casts aside these arguments, saying that other clinicians are simply out of touch with contemporary psychiatry and are afraid of change. Dr. Fourciers concurs with Dr. Duclaux's statement and adds that the fact that French psychiatrists are unwilling to accept that they are no longer at the top of world research further encourages them to ignore new research produced elsewhere. Dr. Fourciers stated that he is not able to explain why so many French clinicians reject social phobia and the DSM. He says that it is too difficult a question, but:

> basically, in France we are a country that is easily anti-American because we are an old force in the world that has become a small force world wide and we have become jealous of Americans, that's the first point. More specifically, French medicine was for a long time said to be the best in the world, this was always a

[182] These ideas will be addressed in greater detail in the next chapter.

> part of the superiority complex of the French. When I was a medical student I heard a thousand times that French medicine was the best in the world. It was crazy! French psychiatrists also think they are the best in the world and do not easily accept that they are not only not the best in the world, but they are, in all of the West, the worst psychiatrists. So that holds us back. It's stupid.

Cognitive and behavioural therapists are frustrated by the very slow rate that psychiatry is changing in France. While some clinicians have become more open to new approaches, others cling to a past that cognitive and behavioural therapists judge would be best to leave behind.

How French cognitive and behavioural therapists define social phobia

The basic contention of clinicians who study and treat social phobia is that it exists. Dr. Fourciers, a leading researcher of the disorder, contends that social phobia has always existed. He suggests that the feelings expressed by patients have been recounted in literature and biographical accounts for as long as these things have been recorded. He points to Homer's *Odyssey*, and the intimidation of Ulysses in the face of the king Alkinoos, along with anecdotes from Rousseau's *Confessions*, in which Rousseau admits to the shame he felt in response to his extreme self-consciousness in public and his avoidance of household servants and local salesclerks. The diagnostic category, Dr. Fourciers argues, has existed for more than a century, after first being described by Casper 1846 using the name ereutophobia[183]. When asked about the effects of changing eras and social environments, Dr. Fourciers agrees that while the cultural environments

[183] This account of the history of social phobia is taken partly from an interview with Dr. Fourciers, but is supplemented with information from a book he published on social phobia. I have not cited it since this would reveal Dr. Fourcier's real name.

were completely different in all cases described, he maintains that the disorder described is constant. The patients experience the same problems, he says; the same disease has always existed. This argument flies directly in the face of those who suggest that social phobia either does not exist at all as a discrete category or that it is simply a 'fad', a way of explaining certain feelings that will disappear in time.

Cognitive and behavioural therapists conceive of social phobia as something whose onset is early in life. Dr. Lefebvre believes that the age of onset is a particularly important factor to distinguish between social phobia and other disorders. He explained that there are:

> Authentic social phobics who will first experience the disorder in primary school because of such or such a thing. Then you have people who are not social phobics to begin with, but who suffer serious humiliations... We find it [social phobia] among patients between 18 and 25 years of age, after 25 there are complications.

When asked about the older people who make up a good portion of the social phobia support group in Paris, Dr. Lefebvre replied:

> What is happening with the older people is that they weren't diagnosed earlier. Social phobics[184] who appear after 30 or 40 years of age, who never had it before, when that happens, in general it's a manifestation of a disorder that's part of a major depression. You have a patient who has a major depression and they suddenly become incapable of easily developing a relationship and because they are depressed people who have persecution ideas, a fear of judgement develops. So, they can pass for a social phobics, but in fact it's a depression. So, social phobics appear between 15 and 25 years of age, and after 20 year of age, after 25

[184] At this point Dr. Lefebvre corrected himself and replaced social phobics with social phobia.

> years of age, the people who present a social phobia who have never had something like this before, it's something else entirely.

When asked why he believes that social phobia is mostly likely to develop among 18-25 year olds, Dr. Lefebvre stated:

> Well, 18, because they are legally adults and from that point onward we can include them in clinical trials and it's because of that that we see few patients who are less than 18 years old. The reality is, when we ask them to look retrospectively, we find that it's often between 7 and 12 years of age that it sets in. In the end, it's Lépine[185], in his epidemiological study that speaks about an onset between 15 and 25 years. But, it's adolescence more broadly defined.

Dr. Lefebvre's statement concurs with much of the scientific literature published on social phobia. Many studies suggest that social phobia is something that is most likely to appear during one's teens, but these studies also indicate that the disorder often dissipates over time (Chartier, Hazen and Stein 1998; Rapee and Spence 2004; Wittchen and Fehm 2003). This statement is at times presented alongside assertions that social phobia will not improve without treatment (Keller 2003), a factor which is thought to differentiate it from shyness. These factors lead to a certain amount of ambiguity concerning the trajectory and predicted outcome of the disorder.

Reasons for categorical confusion

Cognitive and behavioural therapists told me that while some general practitioners are able to refer cases of social phobia with accuracy, there remains a great deal of confusion about the disorder on the parts of physicians and patients. Dr. Duclaux, also a

[185] Jean-Pierre Lépine is a clinician and researcher who publishes widely on social phobia. This is his real name, not a pseudonym.

leading researcher of social phobia, says that "there are many people who come to see me who say, 'I have a social phobia', when in fact they are agoraphobics most often." People make mistakes, he says. But, Dr. Duclaux points out that:

> When they have seen detailed things [descriptions of social phobia], in general they don't make mistakes. But... there are even doctors [who don't know the difference]. Recently I received a letter from a psychiatrist, someone who is supposed to know, who told me, "I have a patient who has social phobia", when in fact, it was an agoraphobic. It's not that complicated... These are people whose knowledge is not very great. It's a problem in France that they don't know [the diagnoses] very well. For the general public, it's normal.

The implication of this statement is that while he can see that a lack of understanding of psychiatric categories is "normal" on the part of the public, this is not normal or acceptable for psychiatrists.

The frustration of Dr. Duclaux and many other physicians, whose therapeutic approaches are similar to his, comes through in their statements. They believe that psychiatrists who do not understand modern DSM classifications are stuck in a psychiatric framework whose time has passed. They consider this lack of current knowledge not simply a failure to keep up with contemporary psychiatry, but also a failure to do what is best for their patients. But they admit that there are exacerbating factors. Dr. Duclaux suggests that the name of the disorder is partially responsible for people's lack of understanding of the disorder:

> *Phobie sociale* [social phobia], in French, is a sort of word construction that is not very clear. Maybe in English it works better. P*hobie sociale*, is like *trouble d'anxiété généralisée* [generalized anxiety disorder]. In French it means nothing, it's a direct translation from English. *Phobie sociale*, that means you are afraid to go in the metro, or if there are a lot of people, so you say: I have *phobie sociale*.

> For us, it's not the same thing. We speak more easily of shyness in France. We [he and other cognitive and behavioural therapists] were on a television show with journalists and we talked about shyness, because then people understand better, even if it's more severe than that...

Dr. Duclaux does not find there to be too much confusion between shyness and social phobia, despite the fact that one is considered much more serious a condition than the other. In practice, he says, the two are easily separable because there are diagnostic criteria for social phobia, which prevent it from being confused with shyness. Dr. Fourciers also points out that it is a question of degree, and that it is clear when someone crosses the line from shyness to a sickness (social phobia). Drs. Duclaux and Fourciers believe that the use of clinical judgement should make the distinction between the two states clear.

Separating shyness from social phobia

Dr. Lefebvre, a psychiatrist whose office is in a medium-sized clinic in the suburbs of Paris, argued very firmly that social phobia is a "real" psychiatric disorder, easily distinguishable from shyness. He emphasizes some subjective differences between the patients' experiences of shyness versus social phobia that Dr. Duclaux does not highlight. He argues that the anxiety involved in social phobia is set off by close contact with other people. He says that French patients, perhaps more than others, speak a lot about judgement, as though they are in a tribunal. This, he says, is very different from shyness. When asked specifically to explain this position, Dr. Lefebvre stated:

> It's people who don't know social phobia [who say things like this]. I'll explain the difference to you. If I'm shy, I will be intimidated by you, who I don't know.

> And on the other hand, I will be completely reassured by my secretary who I know well. If I am socially anxious[186], I will be completely at ease with you, who I don't know. But I will be ill at ease with my secretary because she knows me, she knows my faults, my weaknesses, she might judge me…

The implications for a person's life are substantial, according to this definition. Presumably shy people will be able to overcome their unease as they get to know people, which will allow them to eventually carry on 'normal' social and professional relations. Someone with social phobia, on the other hand, will be unable to develop relationships in their personal or professional lives. Such a person will be constantly plagued by the fear that he or she is not good enough, or is somehow ridiculous in the eyes of others. Dr. Duclaux concurs and argues that social phobia, unlike shyness, is not something a patient simply 'gets over'. He states that it often starts very early, and last a long time. Comparing people with social phobia to those who are shy, he says that for shy people certain experiences will be very difficult the first time, but the second time it will be easier: to speak in public or meet someone, for example. For shy people, he suggests, normally after two or three times attempts at exposing themselves to a feared situation, their unease will fade or be cast aside. But for anxious people, he says, it is practically more difficult every time. He believes that therapy and treatment with medication are necessary for socially anxious people to overcome their problems.

Dr. Duclaux says that what he and other cognitive and behavioural therapists tell social phobia patients is that social phobia is a shyness that becomes severe. He tells them that it has to be taken seriously and that cognitive and behavioural therapists have

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[186] The phrase used by Dr. Lefebvre was "anxieux sociaux". This is the equivalent of saying social phobic, though out of the base diagnostic phrase of social anxiety disorder rather than social phobia, which assigns the disorder as the person's identity.

clinical means to evaluate the extent of their pathology, its severity and its history. He tells patients that a shy person will generally get better with age, but that for serious cases of social phobia avoidance mechanisms may be built up over time and lead to serious suffering[187]. He explains to patients, "You have a social phobia that corresponds to a serious shyness, but it's a disorder that is rather different than shyness." When asked if they thought that speaking of shyness might make too many people worry that they have social phobia, Drs. Duclaux and Fourciers both emphasized that they believe it is okay to cast the diagnostic web too wide. They are more comforted by being able to turn patients away, telling them that they have no clinical problem, than by believing that there are people suffering who will not seek out treatment. Dr. Roux concurs. He and Dr. Fourciers wrote a book about social phobia aimed at the general public, and he reports that a great many people have since called him, certain that they suffered from social phobia. Many people identify with this disorder, he said, though some turned out to be paranoid schizophrenics, for example. But he agrees with the words of Dr. Fourciers, that he would rather have "false-positives" than "false-negatives". He would rather have people over-identify with the disorder than under-identify with it, and therefore seek no help. He argues that this is one of the positive effects of public campaigns[188] to the general public. He compares the effects of public information campaigns to the effects of medications:

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[187] As noted above, there is some disagreement among social phobia researchers concerning whether the disorder improves with age.

[188] Dr. Fourciers has been involved in television and radio programmes about social phobia and has also published widely in the self-help domain, in addition to continuing his contributions to scientific literature about the disorder. Other cognitive and behavioural therapists have also been involved in these activities.

> there are positive effects and then there are negative or undesirable effects as well. It is a therapeutic effect of these campaigns that people come in. There are also collateral effects – schizophrenics and people who may or may not have other problems may also come in too. Then it becomes a bit more complicated. As soon as you do something, there are imperfections.

But from the point of view of these clinicians, these imperfections are much less objectionable than not reaching out to a public that they believe is in need.

"The label social phobia reduces a patient's suffering"

French cognitive and behavioural therapists think that it is important to recognize social phobia because it is real. Dr. Roux explains that he and several colleagues have done research on the disorder for years and when they see the patients arrive, they are doing very, very badly. They are suffering and in distress. For those for whom a diagnosis of social phobia is evident, he argues, it is obvious very quickly that it is a disease. He said, "We see the point to which these people are afflicted, the point to which they suffer." Dr. Roux cites epidemiological studies and reports that people with social phobia are at a higher risk of committing suicide, they over-consume alcohol and they can eventually become depressed. He underlines that it is well proven epidemiologically. "So", he stated, "to deny the reality of this disease is a complete aberration." At this point he specifically pointed to people who deny the existence of social phobia or who say that it is a creation of the pharmaceutical industry. He acknowledges, however, that depending on the way an epidemiological study is conducted, the line between normal and pathological will differ. Dr. Roux stated that: "Certainly, the criteria [for social phobia] can be defined on a continuum, that it is a

disease at its most extreme, to discomfort and shyness. To be uneasy or uncomfortable in certain situations is normal. The continuum exists." He suggests that depending on where the line is drawn between normal and pathological you can get studies that report that 2-3% of the population have social phobia, up to 12-13% of the population. "If you have very extensive criteria, you are in the area of about 20% of the population, which must be the dream of the pharmaceutical industry to have 20% of the population on their medication. So it's true that you can have a range, and I think you have to pay attention to this, psychiatrists have to." But Dr. Roux thinks it is "shameful" to say that social phobia doesn't exist. He compares it to saying that sadness has been medicalized, pointing to arguments about the over-diagnosis of depression. He underlines that he finds it "scandalous" that certain people think that social phobia was created by the pharmaceutical industry. These arguments about social phobia and the pharmaceutical industry will be addressed in chapter seven.

The acceptance of social phobia in France is important enough to French cognitive and behavioural therapists that they were willing to stand up against the French government, which has resisted acceptance of the diagnosis. Dr. Duclaux outlined the role of French cognitive and behavioural therapists in convincing the French government to officially acknowledge the diagnosis of social phobia. The French government's agency that authorizes drug makers to sell their medications for specific disorders refused for quite some time to allow GlaxoSmithKline's paroxetine (Deroxat/Paxil) to be prescribed for social phobia. They argued that social phobia was not unmistakably a distinct disease and that the risk was too high that the drug would be prescribed to all shy

people in the country[189]. Denying a drug to be licensed to treat this disorder effectively denied the existence of the problem. According to Dr. Duclaux, the drug was finally given a license in 2003 as a result of pressure from the pharmaceutical industry in addition to cognitive and behavioural therapists' arguments that, "there are patients who are sick, to whom we prescribe, it (paroxetine) works and it would be unfortunate to not validate this disorder, though limits must be given to it." Because of their lobbying of the French government, French cognitive and behavioural therapists are implicated in the official governmental acceptance of social phobia in France.

Cognitive and behavioural therapists consider it is very important that patients are informed of their diagnosis, rather than being told they are simply shy, given another diagnosis, or told nothing at all. Dr. Fourciers says that it makes an enormous difference to patients to be told what they suffer from:

> Before, if doctors said it's just shyness, there was nothing to be done except to say "force yourself" [to confront the patient's feared situation]. Make an effort to do public presentations, etc., look people in the eye. That might work for shy people, but not for people with social phobia. It's too serious. It's impossible for them to do that.

He said that he saw the importance of giving a name to patients' problems when he published a book (with Dr. Roux) on social phobia that was directed toward the general public. He reports that he got hundreds of letters from patients thanking him because before, they had believed their difficulty was a problem of will. Dr. Fourciers argues that, "It's as absurd to ask a social phobic or a panicker to control their nervousness as it

[189] While the government's position may have been driven by a desire to control the over-medicalization of life experiences, it is at least as likely that they were afraid of the potential costs of the treatment, since drugs like paroxetine are reimbursed by the government at 65% of their cost to the patient.

is to ask an asthmatic to control their asthma attacks." He believes that psychotherapy and medications are necessary for a patient to improve. Patients' responses to Dr. Fourciers' book indicate that they consider this argument to be very reassuring.

Dr. Fourciers believes that a diagnosis of social phobia should not make a person feel abnormal. When he describes the disorder to his patients, the message he emphasizes is that they are not abnormal. He explains that, "they are people with social anxiety like everyone else, they just have a problem regulating it. The point of therapy and medications is to learn to control it and to have a level of social anxiety like everyone else." This is why he does not have a problem talking about shyness and performance anxiety alongside social phobia, he sees them as dimensional problems and believes that people with social phobia must simply learn to master their level of anxiety. Dr. Fourciers points out that he is the type of clinician who thinks that, "everyone has a little bit of something", and that psychiatrists are there to help people to regulate their problems. This perspective differs from those of other clinicians, such as Dr. Lefebvre who points to clear, categorical differences in the nature of anxiety experienced by people with shyness versus social phobia. While the reasons given by French experts to differentiate shyness from social phobia are not uniform, they are in agreement that the two states must be recognized as subjectively different and must be cared for in different ways. One can be improved through will, the other needs medical interventions.

Dr. Roux suggests that diagnosing social phobia according to the DSM is very important. His reasons are that the DSM has an epidemiological base, clear diagnostic

criteria and explanations of symptomotology and etiology[190], so it presents clinicians with solid categories that have been verified. He thinks that it is important to use DSM diagnoses because:

> they permit patients to have diseases, to have what we call disorders, more than being a sick person. I think that the word 'disorder'[191] is very important, it's a sickness rather than a sick person. I think that's important... The French approaches talk more about sick people than sicknesses. We [cognitive and behavioural therapists and people who use the DSM] don't talk about a schizophrenic, but about a disease, schizophrenia. We talk about anxiety disorders rather than anxious people, we talk about sicknesses. From that moment forward, a disease is a disease, and we are not responsible for it. It's a disease like any other.

When asked what he thought of the fact that I often heard people at a social phobia support group identifying themselves as "social phobics", he responded:

> You're right, the attitude remains. I think that in medicine it's the same, "I'm a diabetic", "I'm an asthmatic"... I think it's more reasonable to say "I have asthma", I'm afflicted with a disease, "I have cancer" rather than "I am cancerous". Because, "I am cancerous", is definitive, like "I am a man", or "I am a woman". That can't change. But a disease is a trouble that exists at one point in time, nothing permits us to say that it will exist forever. So, there is the issue of de-stigmatization...

Dr. Roux's argument echoes that of North American biological psychiatrists in the 1970s and onward: that patients should not be held responsible for mental illness any more than

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[190] At the time, I did not ask him what he meant by saying that the DSM includes etiology. It is likely that he simply meant that it has a strong stance toward etiological theories, because he noted at other points in the interview that psychiatrists must accept their lack of understanding of the causes of mental disorders. At that point, he approvingly made reference to the DSM for taking this approach.

[191] Dr. Roux emphasized his point by saying the word disorder in English.

for any other medical problem. Dr. Roux believes that this approach to mental illness will benefit his patients and reduce the stigma associated with mental illness.

Dr. Roux noted the importance of recognizing social phobia in assuring that patients are treated appropriately. He read aloud a letter from a patient wishing to be seen by him. This patient had had problems for four years; he started psychoanalysis and then stopped because he wanted a more pragmatic, fast-paced therapy. Dr. Roux said this letter, which he had received the morning of our interview, it typical of letters that he gets all the time and he used it as proof that patients are not effectively treated by clinicians who do not recognize their social phobia. Dr. Roux said that patients must know what they suffer from in order to be directed toward a cognitive and behavioural therapist who will be able to most successfully treat them. He also explained that most patients want results quickly and he does not think that they will find these using other types of therapies. Patients often come to him, Dr. Roux explained, after following a therapy that they judge ineffective. He recounted the story of a man who wrote to him six months ago requesting therapy. The man had completed four years of psychoanalysis, and while it was not all negative, for instance he said that it helped him to understand certain things about himself, his social phobia remained entirely unaddressed.

Dr. Roux believes the recognition of social phobia and the discovery of cognitive and behavioural therapy are closely related. The acceptance of one will lead to the acceptance of the other. He believes that social phobia patients and cognitive and behavioural therapy clients are a new type of consumer in the French medical system. More than other patients/consumers, they are looking to increase their cost-benefit rates in psychiatric treatment. He says that they are comparison shoppers in a certain sense.

He referred to a report that had recently been released by a government-funded body, INSERM (*Institut national de la santé et de la recherche médicale*), which suggested that for many disorders, including social phobia, cognitive and behavioural therapy was more effective than psychoanalysis. Dr. Roux believes that these types of studies will encourage more patients to consider cognitive and behavioural therapy and encourage more physicians to refer their patients to this type of therapist. He wrote an editorial on the subject of this report in which he put forward the idea that evidence-based medicine is beginning to be recognized, but still needs to be further recognized in France in order to ensure that treatments are validated empirically and so that patients can know which type of therapy will be best for them. He believes that if French medicine and psychiatry move in this direction, it will greatly benefit patients who suffer from social phobia.

The putative causes of social phobia

The majority of psychiatrists discussed in this chapter have published widely on social phobia, in particular, Drs. Duclaux, Fourciers and Roux. They have all published on the causes, course and outcome of the disorder. The theories they present are consistent with those presented in the first half of the thesis, where contemporary research on social phobia is outlined. In interviews with clinicians who argue for the acceptance of social phobia, broader discussions about causation were introduced and these are the ideas presented in this section.

Dr. Lefebvre recounted many of the widely discussed 'causes' of social phobia in our interview. He pointed to a combination of social, individual and biological factors that interact in the development of the disorder. Dr. Lefebvre asserts that most

contemporary literature incorporates a genetic vulnerability into the development of the disorder, which he believes is a just explanation. He believes that this genetic component combines with personal, traumatic experiences among individuals to create social phobia. He argues that the genetic component of the disorder has been proven by family studies, which show that "there are many more social phobics among the ascendants of social phobics, than among those who are not social phobics[192]." His focus on the genetics of social phobia places him among clinicians who tend to think that biological factors are central in the development of the disorder. All in all, however, Dr. Lefebvre suggests that the precipitating factors for social phobia are very heterogeneous.

Dr. Nouri, an Iranian psychiatrist now living in France and working at a psychoanalytically-oriented psychiatric hospital in the suburbs of Paris, has been treated for social phobia. Perhaps as a result of his personal experience with the disorder, he tends to see a particular set of factors involved in social phobia, factors that were present in the development of his problems. In contrast to Dr. Lefebvre, Dr. Nouri accentuates the effects of stress, family problems, war and embargoes in his development of social phobia. He thinks that it is stressors like these that are central to the development of most cases of social phobia. Dr. Nouri sees social phobia as a relatively common disorder, and suggests that almost all male medical students who he studied with in Iran suffered from the disorder. In this case, he pointed to the stress of exams, social life and uncertainty as the most important factors in the development of social phobia. He is one of the only clinicians I spoke to who, on the one hand, recognized social phobia as a 'real' mental

[192] There is another possible interpretation of these findings, which might suggest that social and psychological factors lead the children of 'social phobics' to become 'social phobics' themselves. Papers explaining these hypotheses were discussed in the first half of the thesis.

disorder and who, on the other hand, did not allude to biological factors at the base of this disorder. In this respect, his discourse reflects that of the members of the social phobia support group I attended more than the discourses of other physicians. This is perhaps because, to people who suffer from the disorder, it often seemed enough to believe that the disorder was 'real' and recognized to justify their pain. After that, it was the social factors in their life, whether these were precipitating causes of social phobia or results of the disorder, that tended to take centre stage. Most of the time, they did not need to make explicit reference to the biology at the bottom of the disorder to further support its 'realness'. Their personal experiences had more meaning to them than the medical discourse that has been produced to explain their difficulties.

While Dr. Roux agrees that the potential causes of social phobia mentioned by Dr. Lefebvre are widely recognized, Dr. Roux argues that psychiatrists must be modest when discussing the causes of mental illness. His position is very clear concerning the necessity of this modesty and he thinks that psychiatrists must be frank about their lack of understanding of mental illness etiology. Dr. Roux indicates that there is some understanding of a few mental disorders, but he is critical of the people who say, "voilà, this is the cause of social phobia". He describes these types of statements as scandalous. But:

> There are models. There are biological, evolutionary, psychodynamic and cognitive and behavioural models. It's normal. Models are interesting because they give you room to understand, even therapeutic models. We have cognitive and behavioural therapy models, but they're not explanations... With this much modesty, the discipline is in the middle ages. Unlike other disciplines like cardiology, dermatology, etc., we don't have explanations for mental disorders. Perhaps we don't have [definitive] explanations because they are complex, multi-

> factorial. Possibly it's that. The difficulty is that we have lots of explanations. This is why we must be very modest. Unfortunately, this modesty is not maintained. In particular, I find that psychoanalysts are extraordinary in explaining why you are like that... giving explanations.

The conflict between cognitive and behavioural therapists and psychoanalysts is routinely visible in statements given by clinicians of both therapeutic orientations, reflecting what both groups feel is at stake in a changing composition of French psychiatry.

Alongside arguing for modesty in etiological explanations of mental disorders, Dr. Roux also argues for ambition in therapeutic approaches. He asserts that it is now possible to be ambitious because psychiatric therapies have become relatively efficacious. He explains:

> I've been practicing psychiatry for 30 years now, and during this time, to treat obsessive-compulsive disorder, depression or social phobia, I can tell you that we now have much better results. It's not 100%, but... But unfortunately, the discourse suggests that we have to understand in order to heal. This is not misguided, but there are tonnes of diseases that are relatively well understood, like AIDS, but is it well treated? That's another story. We can treat what we don't understand. [Whereas] understanding a disorder is not a guarantee that it will be perfectly treated. That's not to say that we shouldn't try, but, and this is a personal position... If we find good treatments they can make psychiatry efficacious. I've known an inefficacious psychiatry... Psychiatry is still in its infancy.

Dr. Roux's statements suggest his hopes for the future of psychiatry, that it can become closer to other medical disciplines in its treatment efficacy. His words also reflect a common position of cognitive and behavioural therapists, which is that psychiatrists must have pragmatic, result-oriented goals. It is only by taking this approach, he believes, that

psychiatric care can improve. Research on causation is important to continue improving understandings of mental illness, but it must not be the sole focus, if only because cognitive and behavioural therapists believe that current understandings of mental illness lend little to the clinical encounter and they know that they must do their best to treat patients nonetheless. This discourse reflects the chasm that separates cognitive and behavioural, from psychoanalytic perspectives. To the latter, understanding the etiology of a patient's problem is the central goal of therapy. To the former, this goal is currently impossible and it is therefore not the focus of therapy. Dr. Roux believes that cognitive and behavioural therapy perspectives must become the base of modern psychiatry, "To explain diseases you have to be honest. You cannot tolerate aberrant discourses." These aberrant discourses, according to Dr. Roux, include psychoanalysis and other therapies whose efficacy is not proven by clinical trials using evidence-based medicine standards.

How cognitive and behavioural therapists treat social phobia

Dr. Roux believes that treatment of social phobia must begin with a DSM-IV-influenced assessment of patients. He points out that this belief puts him in the minority among other French psychiatrists. According to him, "I don't have the statistics, but in my opinion, less than one psychiatrist out of two in France", supports the DSM. This means that more than half of the fifteen thousand[193] psychiatrists in France reject the DSM. But Dr. Roux points out that even for him, the DSM "is not a bible". He describes the categories as a little artificial. While he agrees that a descriptive approach is the best means of classifying patients, given psychiatrists' very incomplete understanding of

[193] This number came from Dr. Roux.

psychiatric disorders, he also believes that descriptions have limitations. These limitations are reflected in the fact that so many traits of anxiety disorders are present across categories. So, while he thinks that the DSM is very useful, he recognizes it as limited and the overlapping diagnostic criteria make diagnosis "complicated". When he sees a patient, he reflects on the diagnostic criteria in the DSM, but he is most interested in what he calls a functional analysis. That is, to "understand their [patients'] difficulties and to see how, in a cognitive and behavioural approach, we can help them to resolve their problems." He asserts that cognitive and behavioural therapists do not get hung up on isolating just one diagnosis, because he and other cognitive and behavioural therapists know that there is often a great deal of co-morbidity when one uses the DSM. So, Dr. Roux reports, multiple diagnoses are not a problem to him, what he finds more interesting and important is how he uses these diagnoses to help his patients.

Dr. Lefebvre's assessment of ideal treatment concurs with much of the literature published today on social phobia: a combination of antidepressants and cognitive and behavioural therapy. He suggests that these combined therapies offer the greatest help to patients. Dr. Lefebvre initially hesitated to identify antidepressants as the medication of choice, because he also knows of a new-generation anxiolytic created by Pfizer, pregabalin, which is under assessment for a license to treat social phobia in France. According to a group of researchers studying this drug, it is able to treat anxiety disorders but does not have the severance problems associated with the benzodiazepines (Pande et al. 2003). As someone who is involved in research for the pharmaceutical industry, both in terms of presently conducting trials for them and also having worked for two years at Wyeth Ayerst, Dr. Lefebvre is quite knowledgeable of the new drugs entering the French

market. He pointed to GlaxoSmithKline's successful campaign to promote Deroxat for the treatment of social phobia as well as Wyeth Ayerst's efforts to obtain a license for venlafaxine[194] (marketed as Effexor in North America) as a treatment for social phobia. Dr. Lefebvre believes that in the near future, many medications will receive indications for the treatment of social phobia, and so will enter the physician's arsenal of potential treatments. Dr. Lefebvre's history of working closely with the pharmaceutical industry might be considered problematic from the point of view of other French clinicians, but compared to other cognitive and behavioural therapists, his closeness to the industry is quite average.

When patients with social phobia arrive in his clinic, Dr. Duclaux suggests psychotherapy, which is most often offered in the form of group therapy. He finds that patients are quite open to this type of treatment. In addition to psychotherapy, he suggests the use of medications. Dr. Duclaux reports that patients do not usually seek out psychotropic drugs, and that many even refuse them. This contradicts what several other clinicians told me, though these contradictory statements often came from general practitioners. I found that general practitioners envision patients to be more positive toward, less afraid of and more likely to use antidepressants than do psychiatrists. Most psychotropic drugs are prescribed, in fact, by general practitioners rather than psychiatrists (Le Moigne 2002) and this leads general practitioners to be blamed for what is seen as an over-consumption of all medications and especially anxiolytics. Dr. Duclaux suggests that general practitioners likely prescribe at the rate they do because

[194] Throughout this text, I have capitalized the market name(s) of different drugs, while presenting the name of the compound uncapitalized.

writing a prescription is easier than organizing psychotherapy[195]. Dr. Duclaux stated that while the anxious and depressed easily take anxiolytics, it is not necessarily as easy to get them to take antidepressants. Most often, however, they end up agreeing to take the medications if he takes the time to explain the way that the drugs work. However, it is not the patients, he says, that initially ask for the antidepressants. He also prescribes benzodiazepines alongside antidepressants, which differs from the treatment recommended in North America and in international publications (Davidson 2003; Kripke 2005). This reflects the fact that in France there was never a backlash against the benzodiazepines to the extent that there was in North America. While there is a conscious effort on the part of psychiatrists and general practitioners to reduce the number of benzodiazepines being prescribed, often to be replaced with antidepressants, the anxiolytics medications are still used. As in North America, the benzodiazepines are beginning to be seen as taboo, but also as in North America, the drugs are still being prescribed. An article appeared in the New York Times last year which reported that despite a highly visible rejection of benzodiazepines by American psychiatrists, the drugs are still "widely" used in the United States (Bakalar 2005). However, the French remain the highest per capita users of this class of drugs, the anxiolytics, world wide.

Dr. Duclaux explains that some patients diagnosed with social phobia undergo psychoanalysis, a practice which he attributes partially to the fact that there are not enough cognitive and behavioural therapists to offer therapy to all social phobia patients (One might question whether this is a reasonable claim. In Paris, there are likely enough

[195] As noted in chapter 5, because there are not enough psychiatrists to meet the demand for psychotherapy in France, waiting lists are often long and many hurdles must be crossed, on the part of general practitioners and their patients, to get a patient into therapy.

cognitive and behavioural therapists to treat Parisian social phobics if they wish to seek this kind of treatment and they are willing to wait to see these specialists. So, those Parisians who see psychoanalysts for their social phobia have probably either chosen to seek this type of therapy, not wished to wait to see a cognitive and behavioural therapist or have never heard of this last type of therapist. In other regions of France, where cognitive and behavioural therapists are far fewer, it is likely true that if a patient wanted to see this type of therapist, it would be quite difficult to find one). In addition to seeking the help of therapists of other therapeutic orientations, Dr. Duclaux suggests that patients also seek help in popular literature. Recent books on psychiatry, or self-help books, he claims, have brought about great improvements for many patients. On the side of self-help, he also believes that the relatively new appearance of self-help, or support, groups in France has been beneficial. He points in particular to the support group that I attended in Paris, for people with phobias and anxiety disorders[196]. The hospital where he works provides this group with space for their meetings free of charge, since the group does not have the means to rent meeting facilities. Dr. Duclaux believes that the most beneficial aspect of this group is the support they provide for each other so that patients know they are not alone. He thinks that their political, or broader, influence is not significant because they are not professionals. However, he believes that the support they provide, along with the information provided at meetings and on the internet, is enough. Dr. Duclaux hopes that these types of groups proliferate.

[196] This support group describes itself as specifically providing help to people with anxiety disorders, and in particular for people suffering from social phobia, agoraphobia, panic attacks, and generalized anxiety disorder.

Aside from the therapy offered by clinicians working in public hospitals or 'private' clinics[197], other types of therapy such as "coaching" (in France the English word is used) are available. These services are purely private – the client pays out of pocket with no governmental reimbursement. According to Dr. Duclaux, these private clinics were among the first providers of cognitive therapy for anxiety in France, approximately twenty years ago. The therapists working at these clinics, of which there are three in Paris, slowly moved more toward personal coaching. While individuals still use these centres for personal therapy, businesses are among the top clients of at least two of these centres. The patients who seek help at these centres do not necessarily suffer from anxiety disorders, but rather seek treatment for the management of stress or coaching for personal betterment. It is unlikely that these centres see a substantial number of the people suffering from social phobia in Paris. The cost of therapy alone would make this unlikely. Nonetheless, it is one of the options available to patients.

From a North American perspective, it seems necessary to address the question of self-medication with psychotropic drugs purchased on the internet. However, this is not a significant factor in France. As noted throughout these chapters, physicians, and especially general practitioners, prescribe psychotropic medications readily. In addition, general practitioners, who make up one half of French physicians, are easy to access and are inexpensive to see[198]. Lastly, there is little impetus for the French to purchase medications online, since the drugs cost them so little when purchased legitimately by prescription: the French government negotiates medication prices with the

[197] As noted in chapter 5, these clinics are not private in the sense that they are paid for by clients, but because they are not based out of public institutions. Patients are reimbursed by the government at a standard rate.
[198] Patients are almost entirely reimbursed for trips to physicians.

pharmaceutical industry that are much lower than in other countries, and patients are reimbursed for these medications at a rate of 65% of their cost. Even patients who are not diagnosed with social phobia, but who believe themselves to suffer from the disorder, would likely not find it difficult to be prescribed psychotropic drugs for their anxiety, whether a specific diagnosis was given or not.

Self-medication with other substances is another issue. Many clinicians pointed to the high consumption of alcohol in France as proof of the amount of self-medication for anxiety, and likely social phobia, that occurs. Associations between alcoholism and social phobia have been addressed repeatedly in psychiatric literature, so it is likely that self-medication is likely to occur in this way. However, it is something that I did not examine carefully as a part of my research.

Reasons for the delayed recognition of social phobia in France, according to cognitive and behavioural therapists

Most cognitive and behavioural therapists complain that the recognition of social phobia in France has been held back by several factors. At the top of this list are psychoanalysts and the French government. As described earlier in this chapter, the French agency that licenses medications refused for some time to grant GlaxoSmithKline a license to sell paroxetine for social phobia. At that time, the French government agency, AFSSAPS (Association française de sécurité sanitaire des produits de santé) argued that the disorder was not different enough from other disorders, such as depression, and that approving a drug for its treatment could lead to all shyness in France being medicalized. This would come at a great cost for the French government, Dr.

Duclaux notes, because according to some epidemiological studies 50% of the population qualifies as shy.

Dr. Lefebvre also believes that financial interests were at the origin of the French government's initial refusal to acknowledge social phobia as a disorder in need of pharmacological treatment. He added that this represented a lack of concern for the French citizens. On a more cynical note, Dr. Lefebvre suggested that there is an interest[199] in France in keeping people with social phobia untreated, because this ensures that they will remain obedient. He did not expand on this explanation. Returning to the government's financial interests in denying people with social phobia access to paroxetine, Dr. Lefebvre suggests that these difficulties were a part of larger political problems in the country. He argues that the government unions have too much power over governmental decisions, and it was their lobbying that was at the root of the initial denial of paroxetine's new indication. They undertook this lobbying because of their desire to keep government costs for medications down. He lumps the staff at the journal *Prescrire* together with these government workers. *Prescrire* was against the licensing of paroxetine for the treatment of social phobia. The employees of *Prescrire* agreed with the government that the licensing of paroxetine could lead to the medicalization of shyness. They took these arguments further and in 2003 they ran several articles about this case in particular as a part of the "medicalization of existence" (for example, *Prescrire* 2003a, 2003b). This journal is directed toward general practitioners, though it is also read by other clinicians. Many physicians I spoke to found the journal's position to be too militant, though most subscribers, including those who described the journal as

[199] He did not specifically name this interest, but alluded to the government.

too militant, were happy that the journal exists because it is the sole medical journal in France whose funding is completely independent of the pharmaceutical industry. Dr. Lefebvre does not share these physicians' admiration for the journal and he feels as though they are a part of the problem that prevents French medicine and psychiatry from becoming modern.

The arguments of *Prescrire* and others about the medicalization of shyness and over-prescription of medications (for example, Zarifian 1996) have been cited as factors that have slowed the acceptance of social phobia. Dr. Duclaux carefully addressed the question of medicalization during out interview. He realizes that fears about the medicalization of shyness were behind early attempts to prevent paroxetine from being used for social phobia. Dr. Duclaux pointed to the strong pressure of the pharmaceutical industry to make everything into a disease. He believes this has happened to a certain extent in the United States and he believes that this is a risk anywhere. But he does not think that there is necessarily a risk of this happening in France, because he says that the power of the industry is a lot more limited. Using the example of Ritalin prescription for hyperactive children in the United States, Dr. Duclaux drew attention to prudence of the French in comparison to that of Americans. He pointed to several syndromes that are often treated with psychotropic drugs in the United States, but which are rarely treated this way in France. Despite what he sees as France's conservative approach toward the acceptance of medicalization, he thinks that people still commonly fear that psychiatry's definition of disorders will change 'normal' life events or 'normal' ways of doing things into diseases. He does not think that this will happen, however, and he trusts psychiatric

nosologies to prevent this from happening by differentiating clearly enough the normal from the pathological. The issue of medications is a more difficult one, he believes.

On the one hand, Dr. Duclaux suggests, it is said that the French consume too many medications. But on the other hand, he believes that patients who are truly sick often do not take sufficient medications. The question of medicalization, he believes, is far from simple. While he says that 7% is clearly too high a number of people to be using benzodiazepines in France, he argues that the over consumption of these medications is due to the fact that they are not used in targeted ways. They are not being used for specific disorders; instead they are simply used for general anxiety. He believes that if clinicians understood the indications for which medications should be used, many problems would be solved. People who need drugs would receive prescriptions and those who use them without justification would have their prescriptions cut off. But for the moment, this is not the case and so France remains a country in which too many drugs are prescribed, but not enough disorders are properly treated, according to Dr. Duclaux.

While psychoanalysts are most often the group within psychiatry that cognitive and behavioural therapists blame for having stalled the introduction of social phobia and cognitive and behavioural therapy into France, they also point to the lack of scientific rigour in French psychiatry as a whole. This implicates French psychologists and psychiatrists of all therapeutic orientations other than cognitive and behavioural therapists. Dr. Lefebvre offered what he described as an "emotional" response to a question I posed about the journal *Encephale*, a biological psychiatry French journal. He had initially complained that in some of the networks of clinicians he belongs to, the doctors have very little interest in discussing diagnoses. But he mentioned that it was in

Encephale where one could find good research on social phobia. I told him that this was the only place I had found articles on social phobia and asked him if this was because the editors were more open to DSM-style psychiatry. To this, he had two responses:

> The emotional response… is that they are the only ones who know how to work. And now I'll give you the rational response. The rational response is that in France, there are two schools. One school that wants to keep psychiatry in a medical approach, with the justifications that we know: the head is a part of the body, the interactions, etc. So, that school supports itself effectively on a diagnostic classification, even if it isn't perfect, even if there is a lot of comorbidity… And beside that is a school that wants to give psychiatry its own identify, it is part of a European tradition, psychoanalysis, Freud and all of that. So, the only journal, well, one of the principle journals because it's not the only one, that keeps psychiatry in the medical sector is *Encephale*. It publishes things that are precise and comprehensible. When I read *Encephale*, I retain what they have written. When I read an article in another journal of psychiatry, so-called traditional psychiatry, I have a hard time understanding it. I have to read it ten times, and I don't like it, I find it very disagreeable.

When asked whether it is the primarily the psychoanalytic tendency in France that he sees as responsible for social phobia not being known, he responded that he is not sure. He replied by referring more broadly to the French mentality as a limiting factor to change in psychiatry:

> I believe that it's very much a specialty of the French mentality. The French are undisciplined, the react, but they don't discuss… Things are in the process of working themselves out. The young people want to have a discussion. We had a [psychiatric] meeting in France and a meeting in the United States. At the end of the meeting in the United States, the speaker asked if there were any questions, and there were tonnes. Because asking questions, to an American, is to show interest in the person who just spoke. At a meeting in France, at the end of the

> presentation, the speaker asks if there are questions, no one asks any questions, because asking questions is to show a lack of respect for the person who has just spoken who is presumed to have said all there is to be said in the presentation. I think it's because of this that social anxiety has a place in French culture, it's because people don't contest, in fact. When they contest, it's *en masse*...

Dr. Lefebvre moves beyond psychoanalysis to address why the "traditional" psychiatric approaches have not been significantly challenged in France in addition to suggesting why social phobia is not seen as a pathology. Without discussion, it is not possible for there to be change in psychiatry. Dr. Lefebvre introduced similar concepts throughout our interview, criticizing the socialist tendencies of the French government and repeatedly complaining about unions and strikes. He tends to lump together the character of the state with the psychoanalytic character of psychiatry, both of which he finds outdated and irrational.

Dr. Roux expressed hope for the future of a scientific psychiatry, but pointed out that it is only recently that psychiatry became a part of scientific medicine. "Medicine itself has been scientific for a century and a half, well, 130 years. In France, Claude Bernard wrote an introduction to experimental medicine in 1865, so we can say that the second half of the 19th century was the entry of medicine into a scientific discipline. Before, it hadn't been scientific. Psychiatry entered scientific medicine pretty late, at the end of the 20th century. It was in the 1970s and 1980s, a century behind the rest of medicine." So while psychiatry has had a delayed introduction into a scientific paradigm, Dr. Roux believes that the discipline is moving in the right direction.

According to the cognitive and behavioural therapists whose words are presented in this chapter, the reasons for the delayed acceptance of, and continuing opposition to,

social phobia and their clinical perspective arise from a wide range of factors in French society: economic, political, and professional, among others. While these factors may seem a formidable opposition, cognitive and behavioural therapists nonetheless believe that changes in French society as a whole will open people's minds to their perspective. For instance, GlaxoSmithKline was successful in influencing the French government to provide a new indication for paroxetine. New medical students are being educated their therapeutic perspective instead of being encouraged to adopt psychoanalytic principles. Young people, including medical students and the general public, are questioning the medical establishment more than ever. They are increasingly aware of the therapeutic options available and are willing to discuss these, as the taboo that prevented discussions of psychiatric illness is abandoned. These factors do not necessarily indicate that everyone will move toward cognitive and behavioural therapy, but the seat of power in psychiatry is shifting, and psychoanalysis is losing its dominance. Examples from around the world indicate that biological, along with cognitive and behavioural, approaches in psychiatry appeal to doctors and patients alike. It is too early to ascertain whether France will follow the example of the United States, but at the very least, change is in the air: social phobia and cognitive and behavioural therapy are increasingly a part of the norm, the way of understanding the self and the mind, in France.

Chapter Seven

Why many French clinicians reject the label 'social phobia'

Contents

Unlike cognitive and behavioural therapists, many French clinicians do not spontaneously detect social phobia amongst their patient populations. As described in chapter five, many of the physicians I interviewed chose to see other diagnoses or life problems (pathological or not) where social phobia may otherwise have been found. In this chapter I focus on clinicians' reasons for avoiding the diagnosis social phobia. Some believe that social phobia is a co-construction of physicians and patients, discussed out of a desire to avoid speaking of more serious mental illnesses. Others believe that cognitive and behavioural explanations of social phobia offer little to patients and that this kind of therapy may prevent them from becoming truly well. Finally, others claim that social phobia is the result of collusion between cognitive and behavioural therapists and the pharmaceutical industry.

Versions of this last argument were quite prevalent among the clinicians with whom I spoke and many self-consciously constructed their arguments to reflect Philippe Pignarre's *Comment la dépression est devenu une epidémie*[200] (2001). Pignarre worked for 17 years in the pharmaceutical industry and has now turned to writing exposés about the industry from an 'insider's' perspective. He argues that depression would not exist if it were not for the pharmaceutical industry's efforts to sell their antidepressant drugs. While Pignarre introduces some secondary factors to account for the increasing rates of depression in France, the pharmaceutical industry is at the base of his argument. An independent medical journal, *Prescrire*, has presented a similar argument. Some physicians who are sympathetic to this perspective have nonetheless criticized Pignarre's thesis because they feel that it oversimplifies a complex situation that needs to be

[200] The title of the book can be translated as: How Depression became an Epidemic.

examined closely. This debate about the relationship between the pharmaceutical industry and the incidence of psychiatric complaints creates a forum for the expression of dissent about the industry in French medicine. This type of dissent does not have an official base in North American in either the form offered by *Prescrire*, or in the unofficial networks of physicians who are sympathetic to Pignarre's argument. Pignarre has an academic position at a Paris university (VIII) and he runs a publishing house, *Empêcheurs de Penser en Rond*, out of which he launches books whose ideological bases he agrees with[201]. *Prescrire* is a medical journal that provides independent reviews of new medications that enter the French market[202] and they claim to be the only medical journal in France that does not receive funding from the pharmaceutical industry. *Prescrire* has 27 000 subscribers and they estimate that about 40 000 physicians read it, including those who buy it off of the newsstand, find it in libraries and through other outlets. The journal is well known and is discussed in the media, thereby increasing its impact (90 Minutes 2005). Neither Pignarre nor *Prescrire* are marginal. Each has a large readership: *Prescrire* in terms of its physician base and Pignarre in terms of the large public audience who read his books and those which he publishes. Both the journal and Pignarre are capable of having their messages heard and they are often involved in public debates and contribute to media attention to medical issues.

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[201] Not all of these books are about pharmaceuticals, but they fit within a circumscribed range of perspectives. Alain Ehrenberg, for instance, would not be invited to publish here as Pignarre and his intellectual allies have attacked Ehrenberg's book on depression (1998) for having missed the 'real' cause of depression. This is a slight caricature of the exchange, but it addresses many of its central points (Ehrenberg 2002; Mikkel Borch-Jacobsen 2002)

[202] *Prescrire* provides an independent analysis of the clinical trials, and other data, submitted by the pharmaceutical industry to the French government in order to receive a license for their medications.

While there are individuals who have criticized the pharmaceutical industry's practices in North America, for instance psychopharmacologist David Healy, haematologist Nancy Olivieri and former *New England Journal of Medicine* editor Marcia Angell, the institutional basis for dissent is not comparable. The French have different system in place for the open discussion of dissenting views and these views make up a large part of this chapter.

"Social phobia is a phenomenon constructed by a patient and her physician"

> We recognize what we know, and we only look for what we know. So, you get to the point pretty quickly: what were you taught? What have you learned to recognize? Knowledge, recognition. (Dr. Agasse)

Many physicians I spoke to argued that social phobia is something that only exists because certain clinicians search for it. Because of this, they do not warrant that it should be recognized as a legitimate diagnostic category as it offers little that was not addressed by pre-existing diagnoses. These clinicians argue that social phobia has no obvious place in medicine and many suggest that the diagnosis provides a less apt description of patients' problems than the diagnoses it is meant to replace. Physicians who proposed these arguments identified cognitive and behavioural therapists as those responsible for making the disorder appear real and prevalent.

Some clinicians point to clinical research as a means of making the disorder visible. They suggested that the questionnaires and protocols of studies that cite a high prevalence of the disorder should be examined closely. They believe that the highly

inclusive scales used in these studies are responsible for making the disorder visible and making it appear to be widespread. In response to studies which report that 13% of Americans suffer from social phobia, Dr. Petit said that he is pretty sure that 13% of the population may suffer from *something*, but it is not necessarily a discrete category called social phobia, and it is not necessarily even something pathological. Dr. Petit's comments resemble psychopharmacologist David Healy's assessment that 10-20% of the population[203] suffers from 'everyday nerves'. He believes that the number of these people remains constant over time, but that their diagnosis (if they are diagnosed with a disorder at all) will change according to medical trends. For instance, from about 1950 to 1980 most of these people would have been described as suffering from anxiety. During the 1980s and 1990s these same people were described as suffering from depression, and from the mid 1990s onward, they were re-evaluated, this time as suffering from anxiety once again (Healy 2004: 220-3). What both Dr. Petit and Healy suggest is that there exists a sizable portion of the population who suffer from a low to moderate level of psychological distress. These people can meet the diagnostic criteria of many mental disorders, and because of the prevailing interests in psychiatry, they are currently being labelled as social phobics.

Dr. Agasse suggested that the appearance of a medication that is said to be a specific treatment for social phobia (and here he paused to criticize the marketing strategies of the pharmaceutical industry stating that it is a joke to argue that a specific treatment for a specific disorder exists) will make it appear that the disorder is everywhere. The appearance of a 'specific' medication, he continued, will create a

[203] Healy does not identify which population, for instance American, British, etc., he is speaking about.

discourse about the disorder it treats, about the symptoms it is supposed to relieve, as well as how to recognize these symptoms. This, Dr. Agasse suggests, will increasingly make it appear as though social phobia is a disorder distinguishable and separate from others.

None of these factors, these clinicians argue, justify the acceptance of social phobia as a valid category. Dr. Petit's assertion that he does not see social phobia because as a family therapist he is not as interested in looking for individual pathology, was described in chapter five. He confirms many other clinicians' statements that one's therapeutic orientation will determine the disorders that one sees. He also suggests that social phobia is a construction that arises out of interactions between clinicians and patients. Clinicians look for symptoms and patients act in a way that will confirm their presence. Dr. Petit did not elaborate on this process, but it sounds quite a bit like what Ian Hacking has referred to as the looping effect (Hacking 1999).

Aside from clinicians' assertions that some sort of a looping effect has led to many French clinicians recognizing social phobia, a looping effect was also visible in the social phobia support group I attended. To assist new members in finding treatment for their problems, whether they are diagnosed with the disorder or only suspect they suffer from it, the executive council of Les Phobiques provides a list of 'social phobia friendly' physicians who new members are recommended to see. These are clinicians who regularly treat patients with social phobia, meaning that they are not among the large number of French clinicians who either do not know about social phobia or who deny its existence. So, they are much more likely to confirm people's suspicions that they suffer from the disorder than are other therapists. In addition, at support group meetings,

routine discussions of symptoms, daily problems and therapeutic resources (e.g. books) encountered by members tended to create homogenous discourses about social phobia. Members' stories become more and more similar over time and they learn to describe themselves and their disorder according to its hallmark symptoms. In this way, potential social phobics learn to present themselves as such, and physicians who are looking for the disorder are more often met with clinical cases that confirm their suspicions that the disorder is widespread in France.

The physicians I interviewed were largely of the opinion that this 'looping effect' was proof that the disorder is not 'real', that it is simply a construction that certain people recognize for their own vested interests. The majority of the clinicians I spoke to did not believe that just because social phobia *can* be seen and diagnosed, it *should* be recognized.

"Cognitive and behavioural therapy and antidepressants offer only ephemeral help to patients"

During interviews, most clinicians, even the most strictly psychoanalytic ones, did not deny that the 'gold standard' treatment for social phobia, which is short-term (six months) cognitive and behavioural therapy and antidepressant use, could usually help patients in certain respects. Dr. Fortin, a psychoanalytically-oriented psychiatrist, explained:

> I think that you have to take everything into account. There is something [for people with these symptoms] that is morbid in the sense that it is very painful and handicapping for them. This can't be denied... It's not possible to leave these people in this sort of distress. So, there is really something to be done and something to be done with medications because medications are starters. They

> interrupt the vicious cycle and thanks to them, we can take them [patient] by the hand, get them into the outside world and work at overcoming their fears, etc. So, chemical and behavioural therapies have a certain place.

But Dr. Fortin is not convinced that these should be the primary interventions used for patients. He believes cognitive and behavioural therapy and antidepressants are too shallow in their effects to have a lasting impact on patients. He added to his above statement:

> On the other hand, these treatments have an ephemeral effect, one also has to understand what one's problems represent in order to treat something in the long run and avoid relapses. I don't deny the morbid side of these problems, but it's not enough to make a disease exclusively out of something that is only a symptom. One can't approach people so naively as to think that the social is nothing but a serotonin receptor. One mustn't be so stupid as that. One shouldn't say either that: as spasmophilia was tied to calcium, social phobia is a sickness that is tied to serotonin... Social phobia is a symptom that one finds in many sicknesses, which are more complex sicknesses. The reality is much more complicated than certain scientists or researchers want us to think. They want us to think in terms of some abstract ideal where we can organize everything in boxes so that everything is perfect. Life has shown us that it is not that simple.

Dr. Fortin clearly questions the utility of the structured, rational approach most commonly used[204] to treat social phobia, once it has been diagnosed as such. He believes that this approach does not address the root of patients' problems and will not, in the long term, help them. Patients' symptoms may be temporarily relieved, but their inner turmoil will remain. This is not the only failure he sees in the symptom-based diagnosis of social

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[204] Cognitive and behavioural therapy and antidepressants are the most common treatments in North America and they are also the most common treatment recommended in France by physicians who diagnose patients with social phobia, an act that expresses at least openness to cognitive and behavioural perspectives.

phobia and its treatment. He does not think that a diagnosis of social phobia, with its emphases on biological susceptibilities and patient behaviour, is able to address the broader social environment in which social phobia exists. If anything, it simply confirms a problem without looking for its roots:

> … society has changed, and we pay a lot more attention to social integration than before. We are worried to see that our gadgets isolate adolescents in their corner with their walkmans, videogames, etc. Everyone is playing solitaire with their little machines. On the other hand, we want to bring together people in clans because, in effect, society needs to have, despite everything, a certain unity. For example, we are very worried to see the European elections, people are no longer mobilized, people are alone with their television, video games, family, and there is no sense of the collectivity. It's worrying. I believe that currently, we are very concerned about the spirit of this community. Right now, people are working for this, for example patients, families of patients who gather, which have a kind of political force and, at the same time, takes into account that society has many problems, such as exclusions, suffering, in particular, social phobia.

Dr. Agasse agrees with this assessment. He thinks that by using the term social phobia, patients' symptoms are only solidified rather than helped, and the social conditions that may have led to patients' troubles remain unaddressed. Dr. Fortin believes that looking solely at patients' problems through the lens of cognitive and behavioural therapy or biological psychiatry misses too much and will leave a patient ill-treated by his or her therapist. Examining social phobia from this perspective, he believes, too narrowly focuses physicians' interventions. He judges social phobia to be a symptom of a larger problem in contemporary psychiatry, which is an overemphasis on certain biochemical processes at the expense of explanations. He suggests that the pharmaceutical industry is at the bottom of this problem:

> I have been trained in several streams [psychoanalysis and clinical research] and I think that everyone should have the right to undertake his own research, with the condition that one does not step on others' feet or become tyrannical to the point of destroying others' research. That is what is intolerable. If in every case we say: it's associated with serotonin, this means that it's not necessary to search for other hypotheses, which is not right.

Dr. Fortin is unhappy with the trend in psychiatry to make explanations more and more narrow and to increasingly look for biological origins of mental unrest. He does believe that these approaches serve patients well, so he opposes this trend by refusing to use the category of social phobia and by encouraging the maintenance of eclecticism in French psychiatry.

Dr. Jacob argues along the same lines as Dr. Fortin, but takes his arguments further. As a starting point, Dr. Jacob questions whether social phobia exists as a discrete syndrome. He believes that if one desired, the category could be seen everywhere, but he does not see it because he chooses not to. He argues that psychiatric explanations have moved too far away from the Freudian theories he was taught in school, and too much toward the tendency to say, "Oh, I recognize it [social phobia] and I'll give you this drug and everything will be good." Like Dr. Fortin, he sees a social component in the disorder that is not addressed in its treatment by cognitive and behavioural therapy and medications. He asks:

> Is it social phobia when a woman is afraid of going out, is afraid of going back to work… or is it just that she is the victim of moral harassment? When you say social phobia it's so nice because you've got peace and quiet socially. I mean, there is no need to have any kind of political drive behind it. "Oh my! You've got social phobia? Take this drug and everything will be okay". If instead you reject the definition, say that it's mental or moral pain, felt by an individual in

> reaction to the situation, and that the situation itself may be pathogenic, that it creates pathological anxiety, you are now in a completely different ball game.

While cognitive and behavioural therapy and antidepressants may make patients feel better in the short term, he believes that a more socially engaged explanation of social phobia will help patients much more than teaching them to accustom themselves, whether through medication or behavioural re-training, to the "pathological" conditions they may experience. He believes that calling these experiences social phobia is a cop-out that neglects patients' real problems.

Dr. Jacob is frustrated by the increasing popularity of disorders such as social phobia and obsessive-compulsive disorder, which he sees as fashionable labels for more profound problems. In particular, he is irritated by the portrayal of these disorders on certain television shows that are widely watched in France. The show he pointed to in particular, *Ça se discute*, hosted by Jean-Luc Delarue is one of these. *Ça se discute* is very popular and web forums exist to discuss themes presented on the show. Every member of the social phobia support group I interviewed told me that they had been introduced to the idea of social phobia, or learned more about it, through this programme. They recommended it to me as a resource to understand how social phobia is typically discussed in France. Dr. Jacob describes Delarue as the "epitome of the television showman" who wanders around his set with a clip board speaking to members of his audience and diagnosing their disorders. One of the most common disorders he discussed for some time was obsessive-compulsive disorder, but he has discussed many other anxiety disorders and phobias on his show. Dr. Jacob recounted a moment on one of Delarue's shows in which he 'diagnosed' (Delarue is not a clinician) a woman with obsessive-compulsive disorder because she often goes to see if the door is well-locked.

Dr. Jacob retorted, "Well, she might just have had a near miss with a rapist or something, she might have some kind of anxiety that has nothing to do with obsessive-compulsive disorder." Dr. Jacob describes Delarue as knowing "nothing about anything" and as "knowing zilch about medicine, about the human mind". He thinks that this type of show presents exactly the wrong type of information about mental illness, encouraging people to seek out information about "fashionable" disorders rather than initiating an exploration of their troubles, whether these have personal or social elements. He is careful to point out that he is "obviously not saying that mental illness or sickness or moral unwellbeing does not exist". But he thinks that it is necessary to look at who is promoting the disorder, and why. In the case of Delarue, Dr. Jacob believes that he may be discussing these new and 'fashionable' disorders to increase the shock-value of his show and increase his ratings. But Dr. Jacob also believes that there is another group that has good reason to promote disorders such as obsessive-compulsive disorder and social phobia: the pharmaceutical industry. He believes that this industry is behind marketing initiatives to convince people that they are not well and to profit from the doubt they induce in the public. He believes that it is almost solely because of the pharmaceutical industry that disorders like social phobia, obsessive-compulsive disorder and depression are believed to be so wide spread. And, Dr. Jacob added, the pharmaceutical industry is pushing short-term medication and cognitive and behavioural fixes.

Dr. Jacob recommended that I look at two books that provide a good explanation of his position concerning the disorders just mentioned and his opinion of the pharmaceutical industry. Both of the books are by Philippe Pignarre: *Comment la dépression est devenu un épidémie* (2001) and *Le grand secret de l'industrie*

pharmaceutique (2003). It is onto arguments focusing on the influence of the pharmaceutical industry that I will now move.

"Social phobia in France is the product of the pharmaceutical industry"

Almost all of the clinicians I spoke with, even those who often work closely with the pharmaceutical industry, described negative impact of the industry's power. Clinicians suggest that pharmaceutical companies encourage too many people to take their medications and that they manipulate information about their products and the disorders they are licensed to treat. Physicians also believe that the pharmaceutical industry has too much power over governmental bodies and that this has influenced legislation about the licensing of medications. Some physicians also noted the powerful role that the industry has in lobbying the European Union. Finally, some clinicians believe that the pharmaceutical industry is involved in "creating" mental disorders.

The industry and physician education

Many clinicians feel that the pharmaceutical industry has been given too much license to spread 'educational' information and control physicians' continuing medical education (CME). Dr. Petit identified this as the biggest problem facing physicians. He believes that physician training has essentially been left to the industry. In reaction to their fears about the independence of physicians' CME, a group of French doctors created MG Form (which stands for *médecin généraliste formation*, or, general practitioner education), which offers training to physicians throughout the country. It is associated with MG France, the union of French general practitioners. I interviewed several

physicians who work with MG France, most of whom were involved in teaching CME sessions or organizing these, such as Drs. Lallier and Lalande. MG Form aims to provide continuing education which is free of the influence of the pharmaceutical industry. I was never given a clear answer about how much of their money comes from the industry, as opposed to the government and their other sources of financing, but they indicated that the amount was minimal. However, I interviewed a medical journalist near the end of my stay in France, Catherine Saczuk, and she laughed at the claims that this group operated at a distance from the industry, casting into doubt the independence of MG Form. Whether or not MG Form has been successful in providing independent CME, it at least represents a concern and a will to do something to counteract the pharmaceutical industry's increasing influence on education (in CME and through the information they disseminate about their medications) and to provide unbiased information to physicians so that they will not only receive education about medical conditions for which a new drug has been licensed to treat.

A number of clinicians I spoke to are very selective about the information sources on which they rely to keep on top of medical and pharmaceutical developments. Much of this selectivity was aimed at limiting the influence of the pharmaceutical industry on their ongoing professional education (formal and informal). They most frequently tried to do this by reading the journal *Prescrire*, rather than the information provided either directly from the pharmaceutical industry or from journals that are known to be heavily influenced by the pharmaceutical industry. Concerning this last type of journal, I was told that while France has been successful in limiting the influence of the pharmaceutical industry on certain fronts, such as direct to consumer advertising, they have a lot less

control over the influence of the industry on medical journals. Many physicians informed me that the influence of the industry on many journals goes well beyond the advertisements they publish. I was told by several clinicians that authors routinely do not state conflicts of interest, texts from the pharmaceutical industry are published as unbiased articles and the industry, most importantly, has a great deal of editorial control over the content and direction of journals. The industry's control over medical journals is facilitated by the fact that most French clinicians feel that it is their right not to have to pay for journals, so few journals with subscription fees survive. Because of this, most journals end up receiving a large part of their funds from the pharmaceutical industry. *Prescrire* is an exception to this trend.

Not all clinicians see reading *Prescrire* as an effective means of balancing their information sources. Some of these were psychiatrists, who explained that they do not bother with *Prescrire* because it is for general practitioners, not them. Others avoided *Prescrire* for a variety of reasons. For example, Dr. Lefebvre rarely reads the journal, unless he gets a free copy, because he believes they are too critical in their assessment of medications[205]. Dr. Marsault, a general practitioner in the outskirts of Paris, said that she does not read *Prescrire* because she finds it boring. She finds the free information packages left by the pharmaceutical sales representatives more appealing. While I

[205] Dr. Lefebvre argued that France is generally too difficult on the pharmaceutical industry, and suggested that they be given a lot more freedom to exercise their businesses and marketing. The day I visited Dr. Lefebvre in the clinic that he shares with 27 other doctors, there were no less than 3 to 4 pharmaceutical sales representatives in the waiting room that served him and 3 or 4 other physicians. I only counted the reps that were clearly identifiable. When I asked him why there were so many waiting, he said that it is the only day of the week that they see them. Whatever the reason for the presence of the pharmaceutical sales representatives, of all the clinicians I interviewed, Dr. Lefebvre was the most pro-industry.

interviewed many clinicians who take critical perspectives of the pharmaceutical industry and of their field, I had the sense that Dr. Marsault might be quite typical of general practitioners in France.

Another way that clinicians try to control the information they receive is to refuse 'medical visitors', which is what they call pharmaceutical sales representatives. Some refuse all pharmaceutical sales representatives. This is the position taken by Dr. Jacob. When I suggested that he must have frequent visits from these people, he replied, "You suppose wrongly because the last one, as Hannibal Lecter said, 'I ate his liver with a nice Chianti'." While a couple of other clinicians I interviewed refused all pharmaceutical sales representatives, many more suggested that they only accepted visitors from 'ethical' companies. It was difficult to know in all these cases where physicians set thresholds of 'ethical' or what they identified as undue influence of the companies on their positions. Most of these physicians' judgements of ethical behaviour on the part of the industry were based on their personal experiences with the companies in question.

On a similar line of reasoning, many physicians said that they avoid big pharmaceutical events, such as distant trips, which they see as more influential on their practices than the dinners, day-long events and close range trips they participate in. But recent studies suggest that the type of gift from or contact with the pharmaceutical industry does not matter. Any kind of contact with the pharmaceutical industry tends to change physicians' prescribing practices (Adair and Holmgren 2005; Caudill et al. 1996; Chew et al. 2000; Chren and Landefeld 1994). An interesting study was published several years ago that reported a bias on the part of physicians. The study asked physicians if, [1] they believed they were influenced by the pharmaceutical industry, and

[2] if they believed their colleagues were. 61% of physicians responded that they believe they are not influenced by the industry, but only 16% believed that their colleagues were similarly unaffected (Steinman, Shlipak and McPhee 2001). These results indicate that physicians likely over-estimate the degree to which they can filter information and control their reactions to the pharmaceutical industry. It would seem that it is only reactions as resolute as Dr. Jacob's that can hope to remove the influence of the industry[206].

The industry and the popular media

Many clinicians are also concerned about the information presented about medical illnesses in the popular media. Dr. Jacob suggested that there are journalists who are paid by the pharmaceutical industry to write stories about particular companies' products or the diseases their products are meant to treat. These articles, in effect, would act as advertisements for particular companies' medications. They would be a covert version of direct to consumer advertising. If what Dr. Jacob says it true, these types of articles would provide a means for the pharmaceutical industry in France to get past the European Union's prohibition of direct to consumer advertising. When I spoke with Catherine Saczuk she did not mention that journalists write the articles that Dr. Jacob suggests they do, but she explained the process whereby pharmaceutical companies host lavish press releases where they provide essentially ready-for-publication articles about their products for journalists' use. They make reporters' jobs easy and this make it all the more likely

[206] However, even with his firm position, it is unlikely that he is able to avoid contact with the industry in medical journals, CME, etc.

that the industry's news will make it into newspapers and magazines. However, Ms. Saczuk says that events like these have become less lavish in recent years.

The industry and opinion leaders

Dr. Petit does not think that articles aimed at professionals or the public are what matters most. He argued that it is no longer scientific literature, or stories based on this literature, that changes medication prescription. Instead it is opinion leaders. He suggests that these opinion leaders are created by the pharmaceutical industry and are used to promote the company's message. This message includes not only information about the company's products, he says, because companies cannot make money any longer by simply creating molecules, they also have to promote the disease the product is meant to treat. As an example of this practice, Dr. Petit referred to the creation of Dr. Fourciers as an opinion leader about social phobia, who Dr. Petit believes is used to promote information about the disorder and GlaxoSmithKline's paroxetine. Dr. Picard concurs, at least concerning the fact that pharmaceutical companies promote the disorders that their molecules are meant to treat. She believes that they are responsible for creating discussions that will encourage people to identify with the disorders for which their medications are licensed. For example, she believes that they have worked to promote discourses about self control, self-mastery and the importance of social relations. As more and more people pick up these discourses, a disorder like social phobia will be of more concern and will also be more readily visible. Presenting a similar argument, Dr. Cohen suggests that the pharmaceutical industry turns a more general discourse about individuals' problems into a disease by teaching people to see symptoms, read them as a

disease and then match them to medications. Once this successfully occurs, the disorder seems not only real, but treatable, and patients are physicians alike will be more likely to look for it.

Dr. Nouri noted that in the process of teaching physicians about new drugs and the disorders they treat, pharmaceutical companies often manipulate clinicians. In particular, he recounted stories in which drug company representatives made presentations at the psychoanalytically-oriented psychiatric hospital where he works. In these presentations, they played on what the physicians know and what they do not know, particularly in the case of the analysts. Dr. Nouri reported that the presenters would often speak 'over the heads' of the analysts, using references to biochemical processes with which they may not be entirely familiar. He said that this approach was often successful, and many of the people listening to these presentations were impressed and blindly accepted what they did not understand.

Critics of the pharmaceutical industry concerning social phobia

Of all the doctors I spoke to, Drs. Jacob and Arnaud were the most critical of the pharmaceutical industry. Their words very closely echoed those of Philippe Pignarre, particularly from his book *Comment la depression est devenue une épidémie* (2001). They agree with Pignarre that if it were not for the pharmaceutical industry, people would not suffer from what we call depression, obsessive-compulsive disorder or social phobia. While there is a logic to some of their arguments, at their base, their claims usually go too far, which weakens them. They agree with Pignarre when he introduces and just as quickly dismisses sociological factors such as social suffering and insecurity,

epidemiological arguments such as modified diagnostic tools, and psychodynamic arguments which point to the effects of contemporary rates of ruptured childhoods, to account for the apparent rise of depression rates in France. Pignarre believes that all of these arguments fail to account for why more French people have been diagnosed with the disorder. The only factor that really explains the increase, he believes, is the pharmaceutical industry and the creation and promotion of their drugs to treat the disorder. Basically, depression would not exist if it the industry did not want it to be treated by their drugs (Pignarre 2001: 15-19). Pignarre makes similar arguments about obsessive-compulsive disorder (among other disorders), which Drs. Jacob and Arnaud refer to and apply to the example of social phobia. The history of obsessive-compulsive disorder is intimately associated with the therapeutic reforms that allowed drug testing to become a part of the industry's marketing tactics: to promote one drug for one condition, and use the tests to prove its efficacy. This is a fairly well known story and one that David Healy (1997) and historians of science have outlined quite clearly. It is with this story that Dr. Jacob began his attack on the diagnosis of social phobia:

> I would start by questioning the concept [of social phobia] itself. I'll have to start at the beginning, which is the pharmaceutical industry: the way it looks for new drugs, the way it releases new drugs and the way it markets new drugs. Basically, until the 1950s or something like this, the pharmaceutical industry could do what it wanted. I mean they could go into an American or French hospital and say, "we have this new drug which seems interesting", and doctors were willing to try it out on patients and see what happened. Obviously this led to great breakthroughs and discoveries and also pathetic and cruel failures for which the patients were the guinea pigs. In the 1950s and 1960s, after some of these human catastrophes, therapeutic reformers pushed for control of this process. And the FDA in America established the basis of the way that new drugs would be tested, clinical

> research tests, and so on. But once this had been done by the therapeutic reformers, only half the progress had been accomplished. Once this had been done, the government, the FDA and all of this, should have had enough money to implement public research. You had the guidelines, you get public funding, you get public research and the results you get are socialized. But obviously this isn't the way it works, especially in a private system. So, the pharmaceutical industry found itself with something that was supposed to curb them, but which had in the end been given to them as a tool. They now knew what was expected of them so that their drugs would be well received by the establishment and given a quick seal of approval. They had to go through these little hoops and very quickly they became very adept at finding drugs that would go through these little hoops and come out on top. And how did they do that? Well they changed their descriptions of what was happening a little bit, and instead of trying new drugs, they tried drugs that were just slightly different from what they already had. And it went on until they started inventing not new drugs, but new conceptions of illness.

At this point he referred me to Pignarre's book, *Comment la dépression est devenue une épidémie*, which he described as "very interesting and profound". He continued on to describe the relatively recent backlash against Ritalin and Prozac, which he describes as driven by fears that the drugs are being over-used. But Dr. Jacob suggests that more than fearing the overuse of drugs, people should be even more sceptical of the pharmaceutical industry, their drugs and the disorders they treat:

> It goes much deeper than that to: Do these diseases that we've been told about, do they exist? I will move a bit away from social phobia to talk about another disorder, obsessive-compulsive disorder... [this is the one in] which the guy checks that the water is not running in the bathroom, goes to bed, and five minutes later says, "is it running?" And he goes and fiddles with the faucet and goes to bed and says, "yes, it was off, but I fiddled with it, did I really put it back?" This is very painful when it happens, but let's face it, it's ludicrous to

> believe that it is widespread. I haven't seen one in 20 years of practice, okay? So, we are led to believe in the last five years that obsessive-compulsive disorder doesn't exist because those *stupid* general practitioners do not diagnose it correctly. So, "how do you know, Mr. So and so, that you do not have obsessive-compulsive disorder", and you can switch that for social phobia, "and that your doctors haven't noticed it?" When you start to get this kind of information in magazines and things saying, "if you wake up at night, if you feel anxious [you may have obsessive-compulsive disorder]", and when you look at these things, one person out of two will have these things, like me. So there was a technique of marketing obsessive-compulsive disorder, first, in general magazines, then in magazines and newspapers for doctors saying, "are you not over-looking obsessive-compulsive disorder?" Which will create panic and guilt in the doctors, saying, "shit! Obsessive-compulsive disorder, I thought that it was just two lines in my psychiatry studies twenty years ago, and now they're saying it's completely under-diagnosed and this professor, who is paid a very large amount by the industry, is coming on TV and saying, "it's a medical, psychic scandal in France to see that all these people are suffering from this disease", and obviously, if you're marketed a drugs that is *just* another anxiolytic[207], another tranquilizer that is only slightly different from Valium, and you have these fantastic studies to show that you've got a 95% success rate for social phobia, which is not hard to do for obsessive-compulsive disorder, since it was created where there was a vacuum, you create a market. Offered by doctors, demanded by patients, the whole thing is taken care of.

Dr. Jacob's rapid switching back and forth between his references to social phobia and those to obsessive-compulsive disorder is at times confusing. But beyond the superficial difficulties it creates, his efforts to use parallel arguments for the two disorders is a little forced, if only because the two disorders were borne out of such different contexts. It is

[207] I am not sure which drug he is referring to at this point. I would have expected him to make reference to an antidepressant rather than an anxiolytic.

indicative of the simplicity of these physicians' arguments that they believe they can so easily switch from one disorder to another.

Dr. Jacob's statement outlines the marketing tactics that he believes were used to make obsessive-compulsive disorder a recognizable, diagnosed and medicated disorder in France. Within his account there are certain aspects, and contradictions, that warrant further examination. While on the one hand, Drs. Jacob and Arnaud, along with Pignarre, argue that the pharmaceutical industry "created" these disorders. I was careful to confirm with the physicians that "created" was the word they really wanted to use. Drs. Arnaud and Jacob verified that they believe that the pharmaceutical industry created these disorders (obsessive-compulsive disorder, depression, and social phobia) and they would not exist without the industry's presence. But these statements are belied by the fact that Drs. Jacob and Arnaud usually pointed to the rare 'real' cases of these disorders, or to the existence of these disorders that preceded the pharmaceutical industry's interest in them. Dr. Jacob noted that obsessive-compulsive-like disorders had been a part of his psychoanalytic training in medical school, pointing to the fact that early versions of these diagnostic categories and these behaviours were not a pure fabrication of the industry. However, despite the apparent contradictions, this is what these physicians wanted to argue: that these behaviours would disappear if the pharmaceutical industry stopped promoting them. I have mentioned Drs. Jacob and Arnaud by name, because they were the physicians who most obviously echoed Pignarre's texts. However, themes of Pignarre's thesis appeared in the words of other physicians, some of whom knew of his work, others who either picked the ideas up elsewhere or who had perhaps run across his

work and adopted some of his arguments without attributing them to the author. In any case, Pignarre's views, in their moderate form, are shared by many French clinicians.

Part of Pignarre's argument, and those who most faithfully endorse his work, hinges on the idea that certain behaviours have always existed, and at a certain point in history, the pharmaceutical industry gave them a new name, promoted them widely, and suddenly many people were diagnosed with the new disorder. This argument is perhaps the most convincing in the case of obsessive-compulsive disorder. David Healy has also pointed out how the diagnostic category of obsessive-compulsive disorder was virtually a creation of the pharmaceutical industry. In 1958, scientists at Geigy synthesized a new drug that they believed might work on depressed patients. The problem was, however, is that it did not have a therapeutic profile that was substantially different from other tricyclic antidepressants. Geigy feared that it may fail to be given a licence if it was seen as a 'me too' drug. George Beaumont was put in charge of finding a market for this new compound, clomipramine. Years had passed by this point. Beaumont was interested in what a French psychiatrist had noted in 1967: that the drug may be of use in the treatment of obsessive-compulsive disorder. Geigy scientists soon began studying the effectiveness of clomipramine on obsessive-compulsive disorder, though while doing so they had to "invent the methodology of drug trials for obsessive-compulsive disorder" (Healy 1997: 201), because the disorder had previously been considered too rare to warrant study. As a result of these studies, Geigy was able to sufficiently prove the effectiveness of clomipramine on phobic and obsessional states to have it licensed in the UK in 1975. After this, Geigy essentially lost interest in the drug. However, George Beaumont still believed that a wider market could be found. It was possible to market the drug as a

treatment for phobias in the United States, but this market was already well-treated by another class of antidepressants (MAOIs). And the market for obsessive-compulsive disorder seemed too small to matter and it was usually treated by behavioural therapy. Beaumont nonetheless organized several studies of the treatment of obsessive-compulsive disorder with clomipramine, compared to behavioural therapy and the placebo. Over the years, the results were not astounding, but something else had changed. In 1989, Judith Rapoport published the book *The Boy Who Couldn't Stop Washing*, which contained clinical vignettes about obsessive-compulsive disorder. The book was widely read. Suddenly, it seemed as though there might be a market for an obsessive-compulsive disorder treatment. The industry stepped in and started hosting symposia about the disorder and they widely disseminated Rapoport's book. In 1990, clomipramine was granted a licence for the treatment of obsessive-compulsive disorder in the United States (Healy 1997: 199-207). The rise of obsessive-compulsive disorder is a striking, but unusual, case in the history of psychiatry. It seems one of the clearest examples of the industry finding a disorder for which their drug can be used. This is the only example of which I am aware where this process has been so clear, when the pharmaceutical industry has been so centrally implicated. However, even in this case, obsessive-compulsive disorder pre-existed the industry's interest in it. When Pignarre or French physicians try to apply this story to other disorders, the situation becomes even more muddied. While the industry may have promoted the diagnoses of obsessive-compulsive disorder, depression and social phobia, the classifications were already established by the time the industry became interested in them. It is true that if the industry provides money to researchers to investigate and speak about these disorders,

they will become better known, and will often become more recognized in patient populations. But this does not amount to the creation of a disorder.

The most difficult part of Pignarre's thesis to accept is that the pharmaceutical industry is the only factor that accounts for high rates of depression, and for the creation of this and other disorders. As noted above, Pignarre rejects the idea that sociological, epidemiological and individual factors are implicated in the increased appearance of depression and the appearance of other mental disorders, such as obsessive-compulsive disorder and other anxiety disorders. The pharmaceutical companies, from his point of view, are the only constant and influential factor that matters. Pignarre goes so far as to argue that he sees his book as a remedy for depression, suggesting that if people understand his perspective, they will avoid doctors and medications and so avoid the sickness (Pignarre 2001: 8-9). Dr. Jacob implicitly endorsed this thesis, by expressing his whole-hearted support for Pignarre's arguments. He is the only physician to do so. Even Dr. Arnaud, who supported Pignarre's argument, only described himself as agreeing in "large part" with Pignarre.

The fact that so many French physicians are sympathetic to Pignarre's argument, even if they do not agree with the full extent of it, is reflective of their distrust of the pharmaceutical industry and their fears that they are losing control of the way medicine and psychiatry are practiced. Their response is to reject the industry, and the biological psychiatry and cognitive and behavioural therapists they see as its allies. This means that the diagnosis of social phobia will also be rejected as a symptom of the larger problems in French psychiatry. But by allowing themselves to be convinced by so narrow an explanation for the rise in the rates of certain illnesses, these physicians turn their

attention away from a more multi-factorial, and profound explanation for the changes they are seeing in French psychiatry. They overlook possible reasons to explain why disorders such as social phobia may appeal to French physicians and the general population at this point in time.

"Blaming the pharmaceutical industry for the existence of 'new' mental illnesses has become a crusade"

Dr. Clavel believes marketing has a substantial influence on how symptoms are labelled and how well particular disorders are known. This is reflective of the positions of many physicians I interviewed, but it is different from the position presented in the previous section, in which physicians claim that the industry is responsible for literally creating these disorders.

During my interview with Dr. Gitton, a general practitioner, he presented a rather well thought out, multi-factorial explanation of the factors involved in the appearance of 'new' mental illnesses. He included the pharmaceutical company as one of several of these factors. However, he also said things from time to time such as "the pharmaceutical industry invents diseases". Because of the contradiction in his statements (when he switched from naming the industry as only one factor to then describing it as the primary factor in the appearance of 'new' mental illnesses), and perhaps because I had grown tired of listening to physicians repeat Pignarre's thesis, I asked him what he thought of Pignarre's uni-factorial explanations. Our conversation did not focus on social phobia. It began with a question about what leads to the widespread use of a diagnostic category, but the factors he mentions are applicable to many disorders:

Labels are at the crossroads of several determinants. Spasmophilia is a typical example. It's always easier to use a sickness label that does not have too many connotations or too many personal implications or psychological connotations, than to say: you have symptoms tied to anxiety. Now, spasmophilia is a little bit less fashionable, now chronic fatigue and fibromyalgia are diagnosed more often. On top of this, it's also related to the people who publish, because spasmophilia was published on notably in France [explaining why it was better known there]... If one wants to advance one's university career, one has to publish. Even if one publishes on whatever, it doesn't matter, one just has to publish. Fibromyalgia is very Anglo Saxon and there are people who have made careers publishing on it. In the United States, to give credit where credit is due, it's necessary to publish so they publish on fibromyalgia, on things that don't exist, but it's they think its fine[208]. The third determinant is the pharmaceutical industry because they invent diseases. It's very practical to have treatments for diseases because that permits them to sell the medications that they would otherwise not be able to sell because they did not serve a particular disease. So, one creates a sickness and after you create the treatment for that sickness. Disorders have to please patients, doctors, hospital doctors [researchers] and the pharmaceutical industry, it happens like that. So, at one period spasmophilia had its moment of glory, now it is other things, evidently diseases that don't exist. Fibromyalgia is still fashionable and now it's restless leg syndrome. There is a real neurological disease associated with that disease but it doesn't affect a large number of people. But now, there are millions of people who have restless leg syndrome... if you can't sleep, if you can't find a good position to sleep, it's restless leg syndrome. And the numbers are rising. It's the same [as spasmophilia]. There are people who publish on it, and they are presented in the media to explain to everyone what restless leg syndrome is. People are watching the television and they say: oh yes, I have that. The doctor says: I see, maybe I will give you a treatment...

[208] These types of criticisms of Americans and American medicine were rather common during interviews with French physicians.

At this point in our conversation, I explained to Dr. Gitton that many physicians I interviewed, particularly general practitioners, had indicated that they believe the pharmaceutical industry creates new diseases. I asked him if he thought this was a result of Pignarre's book:

> No, I don't think that we waited for Philippe Pignarre to make this claim. It's true that he has, given his past position in the pharmaceutical industry, he has gotten his view well covered in the media. Yes, he popularized the idea, but it was evident before Philippe Pignarre. The typical example, which is old, is spasmophilia... For the vendors of magnesium, spasmophilia was ideal. So, it's not a new mechanism... The other big means at this time [to promote a disorder], the target is no longer doctors, it's the patients directly. When you create diseases or put medications on the market, and this has changed in the last five years, you are no longer going to condition health professionals to look for it, you are going to condition patients. When you speak about the medication, you are not going to invite the people from *Quotidien du Médicin*[209] or the physicians themselves, you're going to invite journalists from the lay press to go to Seychelles[210] for a seminar about medications. And so, you will have the popular press [on your side]... The best example is the COX-2 inhibitors, Vioxx, Celebrex... In the popular press, it was crazy, and people came [to his office asking for it]. It's the first time I'd seen it on that scale, patients came to see me saying: I want Celebrex or Vioxx, I saw in the paper that they're good. We had never experienced that before. So, we can see that strategies are changed over time, that they're always getting more sophisticated so that they [the industry] can get past the barriers that we set up against them.

I asked him to clarify where the symptoms come from in these 'newly created' diseases:

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[209] Le *Quotidien du Médicin* is a free newsletter provided to physicians.
[210] Seychelles is an archipelago in the Indian Ocean renowned for its turquoise waters and beautiful beaches.

> The symptoms are pre-existing and the challenge is to create an entity that pulls a certain number of elements together to make a new syndrome. That's how it works.

According to his statements above, these "elements" included many factors other than the pharmaceutical industry. He includes social factors like the media, patient interest and other factors like physicians' careerism. I asked him what he thought about social factors being excluded from Pignarre's thesis:

> It's a bit reductive [Pignarre's thesis]. It's a crusade now, it's a crusade against the pharmaceutical industry. Like I said to you a little while ago, there are a certain number of determinants, and they aren't random. It's not only a triangulation, but a quadri-angulation between patients, primary care physicians, physicians at hospitals [researchers] and the pharmaceutical industry. It's not random. It is not enough for the industry to create a disease... I believe that it's [a new diagnostic category is] at the crossroads of all of these determinants. The industry can't do it alone. On the other hand, it sees very well what is going on and it is organized enough to use that information... But it's also the patients... they are also a mediating factor. [They want] to name things, it's very reassuring. When you provide the name of a disorder that explains to people why they can no longer meet social expectations, professional expectations, etc. and when we explain to them that it's not that they can't do these things anymore, it's that they have chronic fatigue syndrome or something, it reassures them completely. So all of these elements are a part of the whole story.

I raised similar issues in an interview with a representative of *Prescrire* near the end of my stay in Paris. By this point, I had already met with several representatives of the journal and they had provided me with many contacts for interviews, along with allowing me access to their governmental and professional documents. I asked the representative why *Prescrire* would use words similar to Pignarre's and refer to the "creation" of new

disorders. I indicated to her that it seemed to me that their knowledge of the industry and of the history of psychiatry was inconsistent with the use of such simple arguments. The representative agreed. She concurred that "creation" was not the best word to use to explain the industry's role in the rise of disorders such as social phobia. She explained that the journal uses these words mostly to draw attention to their arguments, but they also arise out of their frustrations with the industry. They feel as though they have little power compared to pharmaceutical companies and their powerful lobbyists. *Prescrire* has close ties with European Union representatives and they know that even though the EU has maintained a rather strong front against the industry, this will likely not last. So, she summarized, she thinks that words like "creation" enter into articles published in the journal because of their annoyance with the industry and out of their efforts to try to catch people's attention, to make them care about the need to regulate the pharmaceutical industry. These tactics, they hope, will encourage their readers to become engaged in the more political aspects affecting medicine and will eventually make a difference on the regulation of the industry.

This last section has moved away from the theme of the chapter: why that the term social phobia should be avoided. But it points to some of the larger reasons that explain why so many French physicians refuse to use the diagnostic category. It is not just the diagnosis itself that they shun; it is the people and groups who they view as responsible for its promotion and increasing recognition. Physicians believe that pharmaceutical companies and the opinion leaders they prop up (or clinicians whose research they fund) are trying to hijack French medicine and psychiatry to make it conform to their goals of selling more drugs and creating a new dominant therapeutic

regime. Many physicians believe that psychoanalysis and more profound, and better, theories of the mind are being replaced by less appropriate theories and practices. For this reason they reject the category social phobia. Other physicians, who do not see the need to use the diagnosis of social phobia very often, believe that a much more complex set of factors are involved. These changes implicate French cognitive and behavioural therapists and the pharmaceutical industry, but they also implicate French society more broadly. People, including patients, are interested in new explanations of psychic discomfort and personal unease. The more inclusive explanations for these changes present an even less controllable set of circumstances than people like Pignarre would like to believe. Middle class French citizens are interested in these new models and are playing a strong role in their acceptance and proliferation. It is not possible to stop all of these groups simply by virtue of tightening legislation on the pharmaceutical industry.

Addendum: The place where social phobia does *not* exist

The strength of this middle class factor was strikingly apparent during an interview I had with one physician in the suburbs of Paris. Dr. Vincent is the only clinician I interviewed in France who firmly and frankly stated that he had never seen a patient who seemed to suffer from this disorder. It is to this case that I now turn.

Many physicians I interviewed said that they rarely or never use the diagnosis of social phobia either because they see it as linked to a larger "pathological personality", in the words of Dr. Clavel, or because their therapeutic orientations simply do not provoke them to look for the disorder. Dr. Petit, a family therapist, is an example of a physician with this latter opinion. He reported that he has heard of the disorder throughout his

professional training and has read about it in papers distributed by the pharmaceutical industry. However, in his practice he tends to see troubles as resulting from the interactions of people, rather than from a single person. Only certain physicians search for the symptoms he suggested and he added that he was not one of these. Many similar perspectives have been presented in the previous chapters.

However, I only interviewed one physician who candidly stated that he had never encountered a patient with social phobia. By this point in my research, I had grown accustomed to this sort of response and knew that if I asked about the symptoms themselves he would likely recall several patients who fit this profile and who, were in fact being treated for the disorder, or something like it, regardless of whether he used the name social phobia to describe the condition. However, Dr. Vincent stuck to his position that none of his patients had ever suffered from social phobia while under his care.

This made me wonder what was so different about him or his practice. It was not a question of lack of experience. This 56 year old general practitioner had been practicing at least as long as most physicians I interviewed. He did not express any particularly negative attitudes toward the pharmaceutical industry or cognitive and behavioural therapists, which were common reasons among other physicians to not use the diagnosis of social phobia. His only comment about the industry was that he only gives company representatives one day a year to show him new products. His explanation was presented in a matter of fact tone. He said that he believes it is more important to spend time with his patients than it is to spend time with pharmaceutical representatives. His attitude toward cognitive and behavioural therapy was rather positive and he believes it is a useful form of therapy. Because of this, he often refers his

patients to cognitive and behavioural therapists if needed. When he offers therapy to patients himself, he said that it is usually loosely based on the principles of cognitive and behavioural therapy, though he noted that it was more apt to call what he offers accompaniment since it was quite basic in its nature. His positions concerning the pharmaceutical industry and cognitive and behavioural therapy would indicate his reasons for failing to spontaneously detect social phobia were different from those cited by other French clinicians.

Dr. Vincent practices medicine in a poor suburb of Paris. The city where he works is included in the Yvelines district, an area in which many of the cities have at least a moderate degree of economic prosperity. Many of the more wealthy towns of the region are not far from where Dr. Vincent practices. But where he works, the financial situation appears quite grim. The road sides were newly planted with trees and flowers and the service centres (for example, youth and community centres) had been recently constructed, but the area seemed barren. A crowded strip mall with an open-air market was a flurry of activity, but the road that led to the clinic had very little development on it. The new service centres looked like they were waiting for a subdivision to appear around them. Instead, dust swirled around empty lots. Dr. Vincent's clinic was at the base of a small cluster of densely inhabited high-rise apartment buildings that were crowded with people of every age group. The population appeared to be almost exclusively made up of immigrants. Dr. Vincent estimated that 50% of the population came from North Africa, specifically from the Maghreb. Much of the rest of the population comes from the French Antilles. While other physicians I interviewed have

patient populations from a wide array of economic and social classes, Dr. Vincent works with the most uniformly poor and new-immigrant dense group of patients.

He reported that his patients do not complain of psychiatric symptoms. In his practice he focuses on public health issues, working in teams with other physicians to reach out to obese paediatric populations at risk of developing diabetes, for example. He reported that he spends a lot of his time following patients with AIDS, addiction issues and diabetes (in the general population). The diseases he described treating were often closely related to poverty, and purely physical in their nature. Much of his patient population was chronically ill. Other than serious cases of mental illness, which he passes along to psychiatrists, he said that these types of problems simply do not take up much time in his practice.

He explained that perhaps he does not see many signs of mental illness because of the tendency of his patients to somatize, to complain about insomnia, pain or stomach problems rather than psychological distress. Dr. Agasse also pointed to this tendency among the immigrant populations he treats. Dr. Vincent noted that his patients were rarely interested in hearing psychological explanations for their troubles either. So, his patients were neither interested in complaining about these problems nor learning about them. This lack of interested was highlighted by Dr. Vincent's report that his patients sometimes come in with information about physical diseases, but never about psychological ones. The clearest theme that ran through Dr. Vincent's words, however, was that mental illness, especially minor ones like social phobia, were simply not something his patients deliberated on. Daily concerns about poverty and physical disease

more than overshadowed psychological concerns, they obliterated them. It seemed that social phobia was the least of Dr. Vincent's and his patients' worries.

The interview I conducted with Dr. Vincent left me with a lot of questions. Why is it that social phobia does not appear to exist in the poor suburb where he works? Many of the factors cited by other clinicians as having a role in the development of social phobia symptoms were no doubt there: social isolation, low self esteem, crowded and stressful living environments, life disruptions, etc. I mulled over several hypotheses that might account for the lack of social phobia reported by Dr. Vincent and his patients. First, it is possible that there was something peculiar about Dr. Vincent. However, I could find nothing that set distinguished him as a serious outlier from the other physicians I had interviewed. If anything, Dr. Vincent seemed remarkably 'normal'. He took part in similar public health networks as other physicians I interviewed and most of his opinions were commonly expressed by other physicians.

Next I looked at Dr. Vincent's patient population. One notable difference about his patient population was that they were almost exclusively immigrants. Many other physicians I interviewed had worked in areas with a large proportion of immigrants, but these physicians still reported seeing patients with the symptoms of social phobia[211], so I was unsure to what extent this set Dr. Vincent's patient population apart from others. Several physicians I spoke to, including Drs. Vincent, Mignot and Agasse, referred to the different ways that new immigrant populations express malaise compared to the 'French[212]' or assimilated immigrants. Dr. Vincent's assertion that his patients somatize,

[211] However, it is possible that these social phobia patients were not a part of the immigrant community.
[212] By French they meant white people of French origin.

meaning that they would be unlikely to express psychological symptoms of any mental disorder, was mentioned above. Dr. Mignot, a psychoanalytically-oriented psychiatrist, said that he communicates differently with different members of his patient population depending on their social positions. For the bourgeois class, he focuses on reassuring them and he draws his therapeutic strategies from psychoanalytic principles. For his patients from the countryside, he focuses on making the disorder and its treatment seem as solid and 'real' as possible. For his immigrant patients, he said that he tries to describe their problems using their cultural references. He suggested that there were certain symbols that have great resonance in these communities, compared to the ones he could offer from a Western psychiatric tradition. He noted that immigrants from the Maghreb often see mental illness as others' punishment of them and they often present with a fear of demons. Because of this, he was more likely to listen closely for patients' references to these fears and to discuss mental illness in these terms. Dr. Mignot's attempts at culturally-specific treatments did not prevent him from seeing mental illnesses amongst this population. However, he did not specifically point to any of his immigrant patients suffering from social phobia. Dr. Agasse, a general practitioner, also pointed out how new immigrants' modes of expression and ways of describing illness differ when compared to his other patients. I was unsure of how much to trust these physicians' statements: how much of this reportedly different presentation style of new immigrants was simply a result of doctors exoticizing their clientele? Or, a result of their desire to be culturally sensitive in their explanations? Dr. Agasse, in particular, described himself as an anthropologist or at least knowledgeable of anthropological issues, though as far as I know he has no training in this area. Dr. Mignot and Agasse's responses made me

wonder if I was not simply being told what they thought an anthropologist would want to hear. Because of this, it was difficult to ascertain the impact of immigrants' presumed different modes of clinical presentation on the apparent prevalence of social phobia.

Another difference in Dr. Vincent's patient population compared to that of many other physicians I interviewed is poverty. The level of poverty seemed more pronounced here than in any of the other regions that I interviewed physicians. The middle class was not at all represented in the crowded high-rise dwellers that made up Dr. Vincent's patient community. These people were isolated because of their relatively long distance from any commuter trains that could provide access to Paris. A substantial bus ride was necessary to reach the train system that covers the Paris suburbs for hours outside of the city. While there were other towns within a reasonable walking distance, in which the ethnic make up of the population shifted dramatically with white people making up most of the residents, the immediate surroundings of this community offered very few opportunities. This isolation likely left most of Dr. Vincent's patient population with high unemployment and little hope of moving up and out of their current situation. The likelihood of basic personal and economic hardship was probably quite elevated among this population. Dr. Vincent's patients' stood in stark contrast with the members of the social phobia support group, who were largely white, overwhelmingly middle class and mostly employed and university educated.

My very speculative answer to explain why social phobia does not exist among Dr. Vincent's patients is that they simply do not have the time or energy to develop a disorder that is based on a profound self-centredness. This answer seemed to be supported by the types of people who are interested in social phobia and provides a

tentative explanation to account for why social phobia is appearing in certain pockets of the French population. Perhaps it takes a middle class patient group to describe their concerns in a way that physicians will read as social phobia. As much as I tried to find other explanations to account for the fact that Dr. Vincent has never seen a case of social phobia, it is this last explanation that has remained convincing to me.

Part III

The Support Group

Chapter Eight

Conversations with members of a Parisian social phobia support group

Contents

This chapter focuses on the people who suffer from social phobia. It outlines their experiences, their paths through the medical and psychiatric fields, and their thoughts about the disorder and its reception in French society. I compare the words of physicians to the experiences of 'social phobics', as they call themselves, in order to clarify the overlaps and the divergences of their view points. My objective is to show the extent to which these social phobics have been accepted by the medical community and how they believe social phobia has affected their lives. This chapter provides examples of trajectories leading people to the diagnosis of social phobia, and I consider how this reflects more generally on the place of social phobia within the French medical system. Through the words of support group members, the place of psychiatric illness in French society also becomes clearer.

Support group members often report feeling liberated by the relatively non-stigmatizing diagnosis of social phobia. Most say that it is a relief to know they are not "crazy". Yet because of their reluctance to tell others about their problems, their liberation is only a personal matter and their diagnosis is rarely used to publicly justify their behaviour. Few social phobics speak openly about their disorder, and while there is an increasing audience for confessional-style literature and television and radio shows, this practice is much less widespread than in North America. The French have become more open to discussions of mental illness, but it is still not something that is not often spoken of beyond the bounds of a family, or now, a support group. Fears of mental illness linger and social phobics still fear they will be stigmatized if others know about their secret. So, for social phobics, their new identity is a personal transformation, rather than a social transformation.

All of the people I spoke to who suffer from social phobia[213] are members of a support group for this and several other anxiety disorders, Les Phobiques de Paris[214]. At the beginning of each of their meetings, which occur on a monthly basis, all attendees introduce themselves and explain what they suffer from and why they joined the group. Most identify themselves as "social phobics". The group is heterogeneous in terms of the degree to which attendees are affected by their disorder or disorders. Some appear barely affected and they are usually eager to explain this during their introduction. For instance, one man explained that his troubles do not extend much past discomfort while giving presentations. He added, however, that this had become a problem because he was seeking a promotion at work and knew that he had to improve his public speaking skills and interpersonal comfort level to achieve his goal. He, like many others in the group, decided that he suffers from social phobia after undertaking some research on the internet. He plans to attend the support group and carry out personal exercises until he feels ready to meet the demands of his desired work position.

Other members come across as minimally affected, but as a little bit cold or 'off' in some way. During more in depth discussions and presentations in the group, it becomes clear that their inner turmoil and reactions to and means of dealing with everyday situations set them far apart from 'normal' people. For example, one woman who appeared composed and functional explained the extent to which she hates engaging in small talk with colleagues or people in her apartment building. She outlined the new

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[213] The only exception is Dr. Nouri, who I met because of his occupation as a psychiatrist. He suffers from social phobia and has been treated for the disorder.
[214] This is not the real name of the group. Les Phobiques de Paris is primarily a support group for sufferers of social phobia, but the group also welcomes people suffering from agoraphobia, panic disorder and generalized anxiety disorder. Members' names are also pseudonyms.

tactic she created in order to deal with these people: she said that the previous week, while taking her residential elevator, a woman who shared the elevator with her said something about the weather. The member of Les Phobiques said that she found this so troubling, offensive and intrusive that she blatantly ignored the woman and continued to stare fixedly at the changing floor numbers. She refused to look at the other woman for the duration of their elevator ride. According to this support group member, her actions were an appropriate way to show intrusive extroverts how inappropriate their behaviour is. She related this story during a small group exercise and most other members of the group approved of her actions. These exercises make up about one third of each meeting of Les Phobiques.

Finally, other members of the group are clearly very much affected by social phobia and sometimes other disorders. These people are barely able to speak during group introductions, they laugh uncontrollably when they make group presentations, they cannot make eye contact with others and they will avoid talking to people they do not know. When they engage in such activities their difficulty is obvious it is clear that interacting with others is a personal exercise for them. These are people who would stand out in society as having something clearly wrong with them. This was not only my perception as an outsider to the group. Similar assessments of support group members' relative disabilities were raised by members of Les Phobiques during individual interviews. A perceived hierarchy in the group was revealed to me during one-on-one interviews, in which the more functional members of the group looked down upon, and were often fearful of, the less functional members of the group. The people making judgements about hierarchies most often described functional behaviour as the ability to

maintain a job (preferably a good job), have a 'normal' life (for example, be married or date) and hide one's troubles enough to appear 'normal' to one's friends. Functionality, to these people, usually entailed being able to hide one's emotions and keep up an image of being calm and 'normal' in front of one's friends, colleagues and sometimes even one's close family, including one's spouse. The more functional members of Les Phobiques saw less functional support group members as pitiful and pathetic. They used them as examples of what they feared could happen to themselves.

Members of Les Phobiques often report that they suffer from a variety of anxiety disorders, though many assess their other diagnoses as cases of mislabelling. At least a couple of members have been diagnosed with obsessive-compulsive disorder, but the support group is not oriented toward the treatment of these people. Group exercises and session themes are chosen to most benefit those people with social phobia. Many of the members of this group have multiple diagnoses from clinicians, which will be described in greater detail later in this chapter, but it is their diagnosis of social phobia that they cling to most tightly[215]. It is with this diagnosis that they most closely identify, casting the others aside as less important in terms of understanding who they are. They discuss literature about the disorder and the virtues of social phobics.

In addition to the members of the support group with multiple diagnoses, there are other members who have never been diagnosed with a psychiatric disorder but who

[215] This is particularly telling in the case of the president of the group, Mlle. Hébert. She has suffered from depression, social phobia and obsessive-compulsive disorder. It is the last condition that has perhaps been the most severe of the three, according to her statements. Nonetheless, she chose to create a support group for social phobia, which is the disorder she talks about the most and which she speaks to the media about most frequently. The largest psychiatric support group run by patients in France is for obsessive-compulsive disorder, so she could have easily become a member of that group rather than creating one primarily for people with social phobia.

nonetheless identify themselves as social phobics. These are people who have taken stock of their personal or professional short comings, done some research (normally on the internet) and who have decided that social phobia accounts for their problems. They take a pragmatic approach and usually have specific life goals in mind about how they wish to be once they have improved.

Almost all of the members of Les Phobiques de Paris can be placed into three categories: [1] people diagnosed with social phobia only by a medical expert; [2] people who have self diagnosed with social phobia; [3] people who have been professionally diagnosed with several disorders (these people may only have self diagnosed with social phobia). These people come from a variety of backgrounds[216], but are largely white and middle class. Most are educated and employed. Even the most affected members of the group usually have jobs which they maintained throughout the worst phases of their illness, though there are exceptions[217]. However, group members are commonly dissatisfied with their jobs. They reported keeping their present positions only because of their fear of change. The application process involved in finding a new position exposes them to others' judgements to a greater extent than usual.

The rest of this chapter is devoted to the stories of social phobics. I present their experiences in detail: how they came to be social phobics, how the disorder has changed their lives, what they think the future holds for them and other social phobics. These

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[216] The people who contacted me to offer to undertake interviews were from a more multi-cultural background than is reflective of the entire support group.

[217] One of these exceptions is the president of the group. I suspect that she could find a job, as she has more than a bachelor's degree, but she spends most of her time planning the group and speaking in the media about the support group and about social phobia. She appears happy that the support group is her primary 'job'. She lives at home and receives social assistance.

stories are taken from long, in depth, individual interviews. I chose to include detailed accounts to give the readers of this text a thorough understanding of individuals' experiences and also to cast light on the position of mental illness in France. The individuals I interviewed repeatedly pointed to the effects that broader society has on the development of their disorder and also on their ability to speak about social phobia and accept their condition. These people represent an array of different backgrounds and experiences with the disorder, in addition to representing the spectrum of the disorder, from mildly to seriously handicapping. Most of the people I interviewed are white and middle class, which is representative of the membership of Les Phobiques. When this is not the case, I have drawn attention to interviewees' ethnicity and social class. Their stories go a long way toward explaining a French experience of social phobia.

Social, professional and academic withdrawal

Social phobics' accounts of their lives at times closely resembled clinicians' descriptions of the withdrawal that is a common element of the disorder. Physicians often describe "real social phobia" as a condition in which people can no longer insert themselves into life, whether social, professional or academic. M. Béguin is an example of this. Even though he was able to remain employed throughout his most difficult years with social phobia, which was perhaps because his job requires very little social interaction, he says that he withdrew entirely from his social life. This started when he was in university. It became especially hard for him to be around groups of people and this led to his initial social withdrawal. While his problems have now lessened, it is still hard for him to speak in the presence of others and he finds many specific social

situations difficult[218]. Like many other members of the support group, all of whom I interviewed in public spaces, M. Béguin warned me that he would not be able to be interviewed in a crowded café. He finds others' gazes to be intolerable, largely because of the judgements he presumes they are making. To interview members of Les Phobiques, I had to find cafés that were not busy at the time of day we planned to meet and that offered quiet and secluded corners.

M. Béguin has had problems for quite some time. He is now in his mid-40s, but he only went to a therapist in 1997. At the time M. Béguin first saw a therapist, he says that he had become depressed, an assessment which his therapist does not seem to have challenged. Before that, he had managed his problem with anxiolytics prescribed by his GP, but he had not put a name to the mental illnesses from which he suffered. At this period of his life, he says that he was taking so many anxiolytics that he was almost in a vegetative state. While he took many anxiolytics, he did not self-medicate in any way[219]. He specifically said that he does not drink and he alluded to his fear that if he did, he may become addicted. So, he believes it is best avoided entirely. M. Béguin found his first therapist, who was psychoanalytically-oriented, by word of mouth. He reports that psychoanalysis had no effect on his problems and he soon stopped seeing the therapist. About three to four years ago, he heard about cognitive and behavioural therapy. He sought out a therapist and started individual therapy. With this therapist he worked on some of his social fears such as speaking on the phone. It was this psychiatrist who

[218] I was not surprised that almost all of the social phobics that contacted me for interviews chose to do so by email, though on the information sheets I left at their meetings, both my email and phone numbers were included. M. Béguin and other members of Les Phobiques describe speaking on the phone as a task they dread.
[219] Many social phobics are thought to self medicate with alcohol, among other drugs. These include people who have been diagnosed and those who have not yet been.

diagnosed M. Béguin with social phobia. After having undertaken individual therapy, he enrolled in group therapy where he practiced encountering some of his most feared social situations. The group therapy involved a lot of role playing, during which time he practiced reading in public and walking into a room full of people. As a result of this therapy he says that his depression has now passed. He reports that when he was depressed he believed himself to be "almost autistic", a condition which he described as unable to interact at all with other people. He says he could not get out of his shell.

From M. Béguin's account, he clearly suffered from a wide range of social anxieties and it is just as clear that he still lacks social comfort, despite his reports that he is now doing much better. I had the impression that agreeing to an interview with me was an exercise for him, and that, while he was open in describing his past and present problems, the process was not at all easy for him. Nonetheless, he says that he now "feels much better in his skin". His cognitive and behavioural therapist recommended that he attend Les Phobiques and he says that this group has helped him a great deal. He began attending the group in 1999 and attended regularly until early 2003. He says that he has gotten to know many of the social phobics and considers them to be "almost friends". They go out together on organized events and he credits them with bringing him out of his isolation. He says that he is now trying to establish a little distance from the group to become more independent. He joined a hiking group where he has met new people and he is trying to further diversify his activities. M. Béguin considered attending another support group in Paris, À la phobie, but like most other members of Les

Phobiques, he chose not to since À la phobie is a pay-for-service support group[220]. The director organizes events which people pay a fee to participate in such as group picnics, theatre workshops, etc.

While M. Béguin was seeing his cognitive and behavioural therapist, the therapist encouraged him to replace his anxiolytics with SSRIs. This change-over has been largely successful. He was told that the SSRIs would be better able to regulate his "humours". Reference to humours is not a common occurrence among cognitive and behavioural therapists, as it refers to Galenic theories of health and illness. Cognitive and behavioural therapists normally pride themselves on working with contemporary theories and treatments that have been tested according to evidence-based principles. However, my interviews with cognitive and behavioural therapists indicate that the techniques and theories that they use in the clinic are more eclectic than their publications would suggest. When M. Béguin began taking SSRIs he took anxiolytics concomitantly, but he has managed to significantly reduce his use of these medications, though he carries the drugs at all times in case of a sudden need. M. Béguin no longer sees his psychiatrist, his therapy came to its predetermined end[221], but he is still on SSRIs and he believes that it will be difficult to stop taking these drugs. He did not voice any hope of eventually living drug-free.

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[220] There is a small fee to be a member of Les Phobiques, but is it substantially less than the fees attached to individual events at À la phobie. The fees at Les Phobiques are used to cover the cost of the production of newsletters and administrative functions.

[221] Unlike psychoanalytic psychotherapy, which can continue indefinitely, cognitive and behavioural therapy is usually only carried out for six months or some other predetermined period of time. The goal is to move patients quickly through therapy towards their presumed cure.

M. Béguin does not talk to many people about his problems aside from members of Les Phobiques. He says that he has not talked to his friends about his social phobia, though he has spoken to his mother about his troubles. Despite his general reticence to discuss his disorder, he says that French society is now more open to the idea of mental illness and that it is easier to talk about one's problems with others. Like many other people I spoke to, M. Béguin reported that until the 1980s and '90s if you went to a psychiatrist, you were already considered mad. He alluded to the events of 1968 as the apex of the French anti-psychiatry movement. Since then, he believes that psychiatry has been increasingly accepted, though the process has been very slow.

Being diagnosed with social phobia was a turning point in his life. M. Béguin says that once he learned about social phobia, he understood his symptoms, and he knew why he finds any social contact so difficult and why he stays in a job he does not like. For him social phobia provides an explanation for why his life turned out as it has. He says that he now knows why he has "wasted" his life.

Most of the people I interviewed indicated that they have discussed their problems with family members and a few have discussed social phobia with their close friends. This practice was not shared by all members of Les Phobiques and many people reported that they prefer to keep their problem hidden. Several described keeping up a façade with their friends, so that others would only perceive them as shy and would not suspect the depth of their problems. This seemed to be an indicator of the degree to which mental illness is still taboo in France and also of the extent to which many of the social phobics I interviewed were functional. This last point is important as many physicians' definitions of social phobia are dependent on the degree of patients' functioning. As noted in

previous chapters, many physicians suggested that "real" social phobia involves such a retreat from life that it virtually resembles agoraphobia. Many physicians expect these people to have no friends and not be able to work or go to school. This definition does not apply to most people I interviewed, many of whom are quite functional, at least superficially. Even M. Béguin was able to maintain employment.

Physicians' definition of "real social phobia" is more apt for M. Pelletier. He is in his mid twenties and lives at home with his family. He is not currently employed and has had a hard time continuing his studies. When I asked him if he discusses his problems with family or friends, he responded that he does not have any friends and has not had any since he graduated from the equivalent of North American high school[222]. He does not believe that his social phobia has become worse since his graduation, but said that it was easier to meet people in high school. To account for his lack of friends, he explained that French society is closed and other people are defensive, which makes it difficult to meet new acquaintances. He pointed to the fact that more people are single in Paris than in the past and he believes that this is a significant cause of loneliness. Even though conversation seemed easier for M. Pelletier than M. Béguin, and M. Pelletier was clearly more relaxed in a social context such as a café, he plainly met physicians' expectations of the social retreat common in social phobia. With the help of his psychiatrist, however,

[222] During interviews with social phobics I had initially shied away from asking people about whether they discussed social phobia with their friends, since I was not sure they would have any. By the time I interviewed M. Pelletier, I had already interviewed many people, all of whom had specifically mentioned either avoiding discussions of social phobia with their friends or engaging their friends in conversations about their psychological problems – all of them had mentioned having some friends. This is why I did not hesitate to ask M. Pelletier about his friends, alongside my inquiry into his family discussions, particularly since he did not seem any more impaired than the other people I had interviewed.

M. Pelletier believes his condition is improving. He believes that his psychiatrist understands him better than anyone else and he appreciates the support offered by his therapist. Because of this therapy, he said that he has become less passive. He now dares to oppose others, such as his father, which is something he said he did not attempt in the past. M. Pelletier believes this is a sign that he is becoming more socially competent and that he will eventually be able to re-insert himself back into 'normal' life.

M. Bonet has spent most of his adult life quite withdrawn socially, but he is hoping that this will soon change as a result of his therapy. He reports that as an adolescent he was shy, but that over time his shyness intensified enough to become a handicap. He said that when he left home to go to university his problems became worse. The negative impact of such disruptions was a common theme among the people I spoke to. M. Béguin, M. Perrin, Mlle. Bryuère and M. Bouvier all reported that moves, either to Paris from elsewhere or from Paris to other places, had made their problems worse. M. Bonet reported that his move to university caused him such anxiety that his inhibitions increased dramatically, he did not do well at school and eventually had to leave university. He tried another university but had to leave that one as well because of his discomfort. His area of study was computers and accounting and he eventually found a private school with a student body of only 15 people that offered a similar programme. Under these conditions, he says, his studies went well[223].

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[223] M. Bonet's, and other members of Les Phobiques', descriptions of social phobia differ from Dr. Lefebvre's account of social phobia. He is a psychiatrist who has conducted research on social phobia for pharmaceutical companies. He argued that the difference between shyness and social phobia is that the shy person will fear large groups of people who he or she does not know. A social phobic, on the other hand, will fear those people he or she sees on a regular basis (his example was one's secretary). According to this definition, most people I interviewed, even the most impaired, should be classified as shy

He attributes many of his problems to the fact that at the age of six, he changed schools mid year. It was around this time that M. Bonet believes that his shyness intensified and slowly started to become handicapping. Something was set off, he believes. It was a long time, however, before he acted on his concerns. After finishing his programme in computers and accounting, he had to undertake his mandatory military service. His mental stability degraded and he was soon diagnosed with a psychiatric disorder and released for medical reasons. He did not seem willing to disclose the specific diagnosis he was given during his military service, so I did not force the subject. He only said that he was assessed as having serious mental problems. At this point, his parents urged him to go to a psychologist. He says that he went twice, but only to please his parents. He hinted that his parents believe he was depressed, though throughout the interview he repeatedly and adamantly stated that he is not depressed and has never been depressed. He used his purported lack of depression as a means of distinguishing himself from people who are 'really' mentally ill, or even crazy.

After leaving the military he arrived in Paris at the age of 25 to take on a job. He was once again alone, which he found hard, and he started to believe that something was wrong with him. Relationships with women and interactions with kids were and remain particularly difficult for him. In fact, he found most contact with others to be

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rather than as social phobics as they prefer to be amongst small groups of people who they know. Most of the social phobics I spoke to most fear public situations such as walking past crowded café terraces, and, as in the case of M. Bonet, attending places like university where there are a large number of unknown people. This would tend to either undermine Dr. Lefebvre's definition of social phobia, or it would indicate that the members of Les Phobiques are either 'only' shy or that they are shy but suffer from some other psychiatric disorder. This reflects the contested nature of social phobia, since many people argue that it is the medicalization of a normal condition (shyness) or that there is no need for such a diagnosis, as people's conditions can be aptly described by other diagnostic categories.

uncomfortable. At this point he began to see a psychologist or psychiatrist, he cannot remember which except that the therapy was reimbursed. This was about 10 years ago. He describes the experience as relatively positive, but complained that the therapist was rather psychoanalytically-oriented and sessions were made up of a great deal of silence while the therapist waited for him to speak. After leaving this therapist, he went to a second one, a psychiatrist, who he describes as "not very good" and who he did not see for very long. Three years later, he began seeing another one. He liked this therapist, who put an emphasis on the conscious mind, but he nonetheless did not improve. He has been with his fourth therapist, a psychiatrist, for 2-3 years now. It is this therapist who first talked to him about social phobia, which suggests that his current psychiatrist is a cognitive and behavioural therapist. He says that having a name assigned to his disorder has helped him. This therapist recommended that he attend Les Phobiques and he has been going to the support group's meetings ever since. He says that being a part of this group and working with his current therapist are the types of interventions he has always been looking for. In addition to attending regular meeting of Les Phobiques, M. Bonet also attended some programmes at À la phobie, which he described as useful.

As a result of his current therapeutic programme, M. Bonet says that he now finds it much easier to talk about himself, which was very difficult before. Even though he believes that he has improved and that he is better able to tolerate isolation, a development which he attributes to Les Phobiques rather than his psychiatrist, he says that nothing extraordinary has changed in his life. He still has many social difficulties and has not managed to reintegrate himself entirely into society.

He emphatically identifies himself as a social phobic and as someone with an avoidant personality. The latter designation may reflect a diagnosis he was given during his time spent in psychoanalysis. M. Bonet uses these labels to differentiate himself from other members of the support group who he has diagnosed with depression[224]. Some of these people, he says, even suffer from bipolar disorder and because of this he says that they do not suffer from real social phobia. He explained that social phobia, as opposed to depression or bipolar disorder, is not so much a disease as a learned behaviour. He describes social phobics, including himself, as perfectionists who become upset when their ideals cannot be reached. This, he thinks holds social phobics back in life. M. Bonet also says that social phobia is partly a result of French culture and ideals. Because extroverts are preferred in society, others stand out. Another cultural factor he pointed to was the over-individualization of French society, which he argued led to the isolation of people thereby contributing to feelings of social unease and social phobia.

Despite the fact that he points to many societal contributors to social phobia, M. Bonet believes that the resolution of social phobia must be self-initiated. He sees psychotherapy as a sort of coaching to help him along the path to recovery. His current psychiatrist finally talked him into taking Deroxat, which he resisted for some time because he associates taking this medication with having a disease, something he firmly denies having. He says that he did not see much of a change after beginning Deroxat and decided to try another SSRI which he said helped him somewhat.

M. Bonet's current objectives are to live his daily life as others do, to live a 'normal' life. He hopes to have a girlfriend for the first time. He has worked in the same

[224] It is also possible that some people may have admitted to him or the group that they suffer from depression or other psychiatric illnesses.

job for 15 years and says that he would like to change this too, but he has not yet made a final decision. He says that his free time is more enjoyable now. In an effort to integrate himself into society, he has tried volunteering with different groups. He initially joined a group that helps to repair things for others who are unable to do so, but he left the group because he found no relational depth in his interactions with other members. M. Bonet says that he still has a hard time concentrating on things and that he finds it difficult to invest himself in people or activities. It is easier for him to move onto new things all the time. He says that he is has never been passionate about anything and that his treatment has not changed this aspect of his personality. Even so, he says he is going to keep looking for ways to engage in life and trying to improve his social ease.

"You're just shy"

From the interviews I conducted with physicians in France, it appears as though French physicians are reluctant to assign a diagnosis to conditions that they feel are a part of normal life, even if they are undesirable conditions. They argue that they set the threshold of pathology higher than their American colleagues. This does not mean that they will not offer medications to patients with psychic distress, it means that they will usually not offer a medical diagnosis to explain the patients' symptoms. Physicians may recommend that these patients take benzodiazepines as needed, seek a therapist to educate them in relaxation techniques, or encourage them to learn to live with their discomfort. The result of this perspective is that French patients are less likely to suffer from diagnoses such as social phobia, simply because they will not have been assigned a label. Patients are encouraged to see their symptoms in ways that are quite different from

patients in North America, so they will interpret their experiences in different ways. What follows is a description of how social phobics managed years of being told that they were "only" shy.

Several of the social phobics I spoke to complained that their physicians prevented them from getting the early treatment that could have helped them to nip the effects of their disorder in the bud. Mlle. Arcier is a 22 year old who reports that she suffered from social phobia since the age of 14. She now believes herself to be cured and insists that she would have suffered less if she had been properly diagnosed with social phobia, rather than shyness, earlier in her life. Mlle. Arcier first saw a psychiatrist at the age of 16. He was psychoanalytically-oriented and her therapy consisted of dream analysis. She says that this helped her a little and at the very least, the therapist taught her some useful relaxation techniques. However, this therapist told her that she was only shy and even once her shyness had been identified, he did not specifically address her shyness-related symptoms. Mlle. Arcier's timidity grew worse over time and she began to develop other shyness-related phobias. Her extreme self-consciousness made her extremely uncomfortable sitting at a table to eat with others and she blushed at the slightest provocation, even when only with her parents. At this point she began to fear that she was going crazy. Her problems led her to become socially withdrawn, though she never lost touch with all of her friends.

Eventually Mlle. Arcier heard about cognitive and behavioural therapy and began group therapy for social phobics in which they role played feared situations. She describes the work she did with this group of eight people as very hard but valuable. For her, the therapy was fast and effective and she credits it with the complete cessation of all

of the problems she once suffered as a result of her social phobia. In her current job, at Euro Disney, she works directly with the public and says she enjoys this position. She believes that it is very important to recognize social phobia early in its development and as early as possible in life. She is adamant that it not be confused with shyness because this confusion will lead to either no therapy or an ineffective treatment. She believes that the longer one waits to treat it, the more difficult it will be to "cure" the disorder.

No other members of Les Phobiques recovered as swiftly as Mlle. Arcier once their diagnosis was changed from shyness to social phobia. In fact, most were critical of her claim that a definitive cure is possible. Nonetheless many others reported that they had been described as "only shy" early in their lives and they believe that had they been diagnosed with social phobia instead, their problems would have been much more easily treated. In addition, they assert that they would not have wasted so many years of their lives searching for what was wrong with them and not 'properly' treating their condition. M. Sabbah has been shy for as long as he can remember, but he was only recently diagnosed with social phobia. His story differs significantly from Mlle. Arcier's and when we spoke he focused on the ups and downs he has experienced throughout his treatment for social phobia.

M. Sabbah is a master's student in mathematics in Paris. He believes that he has been a social phobic for a long time, but it was only recently that he was able to put a word to his problems. Before, he simply felt useless and had an inferiority complex because of this. At the time of our interview, he had been diagnosed with social phobia for one and a half years. M. Sabbah explained that he had moved to France from

Morocco two and half years ago[225] for his studies. In Morocco, he says, there were not many psychiatrists. He says that most conditions like his would have been interpreted as the result of a demon having been sent to do harm to an individual, as a result of the actions of saints or old family members, or because rituals had been overlooked. He says that in Morocco he was shy, but he did not analyse its source. He ran away from his problems and became isolated because he was ashamed to show his weakness. He believed that he simply had a tired character.

When he arrived in Paris, he wanted to meet new people, but it was too difficult for him. He was always tired and had neck problems. He went to a GP who told him that he suffered from depression and social phobia. After this, he began seeing what he described as a psychologist, in November 2002. It is likely that this therapist was a psychiatrist because M. Sabbah reports that the therapist prescribed some antidepressants to help him to deal with his problems, which had become handicapping. Among other things, he found that he could no longer study. In December 2002 he went to see a second psychiatrist who had him do some tests and they discussed his fears of being judged. However, it was the first therapist he had met that he continued to see for some time and this clinician helped to, in M. Sabbah's words, re-educate him. While he found the therapy useful, he was uncertain that the antidepressants were helping, so he decided to try another type. He found their effectiveness to be about the same as that of the other drug.

Around this time, he heard a radio broadcast featuring the president of Les Phobiques. She discussed her own problems with social phobia and described the

[225] This was two and a half years before our interview.

support group. He was intrigued and he eventually decided to attend a meeting of the group. He first went to a meeting in April, 2003. His initial encounter in the group was very difficult for him, but he forced himself to continue attending. After the second or third time, he was able to talk, and once he began talking, M. Sabbah says that he talked a lot. He declares that that day, he changed a lot. He believes that his break-through at the support group gave him the motivation to change. He began trying harder to escape from his isolation and he soon thought that he was doing better, so he stopped taking his antidepressants. This triggered a relapse of his problems. Once again he was tired and he felt very uncomfortable around others and became more withdrawn. When people spoke to him he would freeze up and find himself unable to respond. This state lasted until September 2003.

That month he began working an overnight shift at a hotel. Slowly, this responsibility and the contact he had with others improved his self confidence. After a couple of months he started to feel better. He started to volunteer as a math tutor at school but when his own exams came around he felt that he had taken on too much and his exam results suffered. In response to his poor performance on his exams, he quit his job at the hotel but kept tutoring. However, in the workshops he offered, he was tired and could not concentrate. By now it was December 2003. He took a trip to Belgium with his sister and hoped that this would help him to surmount the fatigue that was once again taking over his life. The trip did not offer a resolution to his problems and he found it increasingly difficult to express himself. He pointed out that he had stopped seeing his psychiatrist the month before this trip because he thought he no longer needed him.

By January 2004 he realized anew that he had a problem and he started to see a different psychiatrist. He was pleased that after a couple of months he had already improved substantially. Les Phobiques meetings once again became easier for him and he reported to me that he had been feeling much better for 2-3 months. He still takes his medications, even though he does not think that they help much, because he is afraid that if he stops his fatigue will return and he will be unable to get out of bed. It was the end of April that we spoke. He says that his contact with the students he tutors is much better now and that about 50% of the time he can joke around with them, even if the other 50% of the time he feels shy. It helps him, he says, to see that the students he tutors have improved and he now sees them as friends.

Despite all of his improvements, he says that he is still tired. He is hopeful that because he has come this far, the "real improvement" will soon begin. He is starting to seek out a social life and to become more involved with others. His humours, he says, still depend very much on his context, for instance who he meets, the shows he watches, and because of this he knows that he still has to be careful. Even so, he is optimistic that he can cure his problems. He knows that ensuring that he is in contact with other people will help him and it allows him to become more tolerant of others and more open with them. If he gets through his social phobia, he says, he will be a better person for it. He continues to seek out new types of therapy and says that he is about to start cognitive and behavioural therapy. He compared the situation in France to that in Morocco. In France social phobia and other psychiatric diagnoses are much better known. To account for this, he suggested that in Morocco there are more material problems. There is neither the time nor the means to think about things like social phobia. In France, he says, people

have enough basic comforts, so they have can turn their attention to mental illnesses. He wishes that he had known about his social phobia earlier, that he had put a word to his problems. This would have made his problem easier to resolve, he believes.

Patients with multiple comorbidities choose to identify themselves as social phobics

Epidemiological studies report that 80% of patients who suffer from social phobia have at least one co-morbid psychiatric condition. These studies were conducted in the United States and they reported that patients were most likely to have a co-morbid anxiety or mood disorder, which, like social phobia, are defined by the DSM. There is no reason to believe that the situation is different in France, in terms of most patients' symptoms extending beyond a diagnosis of social phobia. However, the disorders with which French patients are diagnosed may differ. Social phobics may be diagnosed with French culture bound syndromes, such as spasmophilia or they may also be given psychodynamic explanations for account for particular elements of their disorder. These diagnoses may be given by several physicians (for example, each physician a patient sees may explain the disorder in a different way) or by one physician who is drawing on eclectic therapeutic paradigms. Many members of Les Phobiques have also been assigned different diagnoses over the years.

Regardless of whether social phobics' other diagnoses were assigned in a sequential or parallel manner, I found that these people preferred to identify with their diagnosis of social phobia rather than their other psychiatric labels. Some people accepted their other diagnoses, but simply stated that they believe that they most closely identify with their social phobia diagnosis. Others argued that their other diagnoses were

not correct and that social phobia is the only diagnosis that is relevant to their experiences. In all of these cases, the introduction of social phobia into France has offered these people a new identity, one which they now cling to fiercely.

The social phobics of Les Phobiques reported that they suffer from fears of public transit, panic attacks, agoraphobia, depression or spasmophilia. Physicians reported similar comorbidities among their patient populations and often said that patients would be better served by being identified by one of their comorbid conditions rather than social phobia. Nonetheless, the people who attend the support group tend to identify themselves primarily as social phobics, even if they have comorbid conditions or, in some instances, have never been diagnosed with the condition. Social phobic is the primary identity they choose. As noted at the beginning of this chapter, most of these people speak about their condition only to members of the support group and family members. Some choose to discuss their social phobia with their friends, but this makes up the minority of support group attendees. Because of this, being a social phobic, for most of these people, is a private identity, but one that informs the way that they relate to the world around them. M. Vial is among these people who have chosen to identify themselves as social phobics. He had identified himself as a social phobic for approximately one year when we spoke, but I believe that this was a self-diagnosis. This self-diagnosis led him to attend meetings of Les Phobiques. At the time that we spoke, he had just begun seeing a cognitive and behavioural therapist. This therapist was treating M. Vial for social phobia, which confirmed his self-diagnosis. When I arrived at the café where we had agreed to meet for an interview, M. Vial was reading over informational pamphlets that he had picked up at Les Phobiques that described the

symptoms and problems associated with social phobia. The sheets explained the disorder according to cognitive and behavioural theories[226]. It seemed as though he wanted to get his explanations and answers 'correct' during our interview.

M. Vial explained that he has had the same problems, which he now attributes to social phobia, since infancy. He says that he has always feared others, remained distant from them and felt uncomfortable in his own skin. As a child, he even went through a phase of mutism. His problems became worse following his divorce in 1993. At this time, he believed that he suffered from agoraphobia, was afraid to take the highway, and had what he described as panic attacks[227]. He was also diagnosed with spasmophilia. One year prior to our interview, he decided to make a concerted effort to change. He looked on the internet and found the term social phobia. To him, this disorder seemed to explain all of the symptoms he had experienced throughout his life. He had never heard of the disorder before but he immediately identified with it. From that point forward, he says, he knew that he was no longer alone. He had found the words to describe his suffering. Once he discovered his diagnosis, he was able to find support and help in the form of online resources and Les Phobiques.

Though he decided to make serious changes to his life a year prior to our discussion, he had already been in psychotherapy for three years. He wanted to change for a woman he is dating. For many years, he had felt stagnated at work and being at his

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[226] This is one of the ways that the members of the support group end up adopting the language of DSM and cognitive and behavioural therapy in their explanations of their troubles.

[227] Fear of driving on highways, under tunnels and particularly taking the metro seem to be rather common fears in Paris. Several physicians listed them as frequently occurring problems that were manifestations of deeper disorders and several support group members I spoke to mentioned suffering from these troubles.

place of employment caused him a great deal of anxiety especially when he had to make presentations. To deal with these problems he had sought means of calming himself, including thalassotherapy[228], phototherapy, and Californian and shiatsu massage therapy. These techniques helped somewhat but he wanted to continue to improve and to continue "working on" himself. Part of this self-work included cosmetic changes and he saw an orthodontist who straightened and aligned his teeth. One year prior to our discussion, he discontinued his treatment with the psychiatrist he had been seeing for 3 years and stopped taking psychotropic medications. He had taken medications for quite some time, having started antidepressants and neuroleptics in 1979. Despite his assertion that he has stopped all medications, he says that he still takes something to calm himself at night but other than that only takes natural medications.

The psychiatrist that he left was a psychoanalyst who had never put a name to his problems, which displeased M. Vial. Before seeing this psychoanalyst he had also undergone hypnosis and Ericksonian therapy. When I interviewed M. Vial he had only attended one meeting of Les Phobiques, though I saw him at subsequent meetings. The first day he went was difficult for him. He lives in a suburb just beyond the boundary of Paris which is separated from the city by a series of tunnels. Driving through tunnels is one of M. Vial's phobias[229]. In order to go to the meeting, he worked up the courage to drive through the tunnels. For him, this was part of the challenge and a therapeutic aspect of attending Les Phobiques. He explained this in the meeting, during his introduction,

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[228] Thalassotherapists use sea water and sea products, such as seaweed, in their treatments which aim to calm and relax their clients.

[229] He did not explain what it is that he fears about driving through tunnels. He did not seem to think that this phobia in any way undermined his identity as a social phobic. M. Vial sees this problem as something that is secondary to his primary problem, which he identifies as social phobia.

and was applauded for his efforts. The challenges he has faced over the last few years have been difficult for him, but he says that his pride pushes him along because he is determined to work on his social phobia, driving phobia and other problems.

He says that his anxiety still remains, but that it has lessened and he continues to improve. He can live better now, he stated. One year ago he changed jobs, which is something he claims he would never have dared to do before. The interview process is difficult for him, but he says that it was good for him to face his fears. M. Vial is now seeing a cognitive and behavioural therapist, who he says is helping him a lot. He has attended three sessions and has six months of therapy left. He works with his therapist to undertake tasks that he is afraid of.

His family is largely unaware of his problems, which is not uncommon among members of Les Phobiques. Even if members choose to discuss their problems with their families, it is usually only with select family members, such as a favoured sibling or the parent they see as most sympathetic to their difficulties. M. Vial says that his family has never seen him have a panic attack despite the fact that he describes these self-diagnosed episodes as being his most early indicator of mental unrest. Unlike many of the other members of Les Phobiques, M. Vial does not believe that the French have become significantly more accepting of mental illness. He says that if you go to a psychiatrist, you are already seen as crazy, a statement which reflects how most people described French attitudes to psychiatry more than 10 years ago. He compares this to the situation in Canada, which he believes he understands quite well from visiting websites and chat groups based in Quebec. He believes that mental illness is much more readily accepted in Canada compared to France. This idea that North Americans readily acknowledge

mental illness as a part of everyday life was a common theme throughout my interviews with members of Les Phobiques. This perceived difference is important to them as they believe that they have the right to be accepted into French society as 'normal' people who simply suffer from a low level psychiatric disorder. They believe that they would be accepted this way if they lived in North America. It seems that their adoption of the label 'social phobic', which is considered an American mental disorder, is part of an effort to immerse themselves in an 'American' discourse that is free of blame, stigma and references to madness. I suspect that this is one of the reasons that French social phobics are often so supportive of the cognitive and behavioural explanation of their condition, since this orientation reflects the 'American' model of mental illness. In this way, becoming a social phobic is an act of resistance against a society that the social phobics believe would otherwise have them hidden away in asylums.

Over the past few years, M. Vial says that his capacity to adapt to people and situations has improved, allowing him to be much more functional. He believes that recognizing himself as a social phobic was an important step in his progress because it allowed him to begin working on his difficulties in a more targeted manner. He is optimistic that he will eventually fully master his problems. While he is doing much better now, he describes what he has gone through over the years as "horrible" and he says that he would not wish it on anyone else. However, he believes that because he has managed to largely surmount his problems, he is a better person because of it.

Several other members of Les Phobiques had been given multiple diagnoses over the years, or have diagnosed themselves with multiple disorders, including spasmophilia, recovered memory syndrome, depression, obsessive-compulsive disorder and panic

attacks. As was the case with M. Vial, these other people now identify themselves as social phobics. Among these people are Mlle. Hébert, the president of Les Phobiques, and Mlle. Jabin. Mlle. Jabin has seen many different physicians and therapists over the years and they diagnosed her with spasmophilia and depression. She also believes that she suffers from social phobia, agoraphobia and recovered memory syndrome. The symptoms of this last problem appeared about a decade ago when she was between 30 and 32, and began to remember what she believes are traumatic memories from her childhood. Mlle. Jabin did not offer any further details about the content of her recovered memories or about the process of their appearance. In addition to these disorders, she is also afraid of driving in cars and being near water. Like M. Vial, Mlle. Jabin does not believe that these phobias conflict with her self-diagnosis of social phobia. She believes, as does M. Vial, that these phobias (for example, of cars, tunnels and water) are secondary to her primary problem of social phobia. Both Mlle. Jabin and M. Vial appear to believe that if they address their social phobia, these other anxieties and phobias will simply fade away or will at least be easy to treat. Both seem to believe that many of their other problems result from the anxiety tied to their social phobia. They seem to believe that their social anxiety leads to their more generalized anxiety[230].

Mlle. Hébert has been diagnosed with depression, obsessive-compulsive disorder and spasmophilia alongside social phobia. Both Mlle. Hébert and Mlle. Jabin have been diagnosed over the years with what many physicians described to me as "fashionable" disorders. These diagnoses appeared both sequentially and simultaneously. Neither woman suggests that her symptoms changed significantly over the years, though at

[230] By generalized anxiety, I do not mean generalized anxiety disorder. No one I spoke to mentioned this diagnosis.

certain times, they may have been more concerned with one symptom or another. This pattern, of multiple names being given to a relatively constant set of symptoms, supports physicians' arguments that while people's basic anxieties change little over time, new labels will be applied to these symptoms. The choice of new labels, according to these clinicians, depends on which diagnosis researchers and the pharmaceutical industry choose to promote at a particular moment in time.

Mlle. Jabin first heard about social phobia and treatments for the disorder offered in France in the magazine *Marie Claire*. She had previously heard about the disorder while living overseas. She has closely identified with the disorder for about one year and it was this disorder that brought her to Les Phobiques. Mlle. Jabin grew up in France with a traditional family from the Maghreb. She reports that many members of her family suffered from phobias, but that they were not discussed amongst her family members and certainly not with people from outside of her family. She believes that her brother suffers from social phobia. She describes her childhood and youth as surrounded by fear and phobias. Girls were not supposed to go out, and she was raised with a fear of men and taught that the occidental world was her enemy. Though she did not explicitly state her belief that her parents also suffer from mental illnesses, she asserted that she does not think that sick people should have kids. While some of her experiences were related to cultural issues, many of the members of Les Phobiques stated that they believe their parents and siblings suffer from mental disorders. Most of these people indicated that their parents' problems are at least partially responsible for their current difficulties. Some of these people point to nature. They believe that their disorder has a genetic or biological basis that is passed from one generation to the next. Others point to nurture

and blame their parents for having passed along their anxieties and phobias by setting bad examples for them and by creating an environment of anxiety in the home. Mlle. Jabin seems to adhere to the latter perspective.

She left home for good at the age of 20 and has since placed a great deal of distance from between herself and the community she grew up in. She moved around a lot, living in England and the United States, where she initially heard about social phobia. During our interview, she drew attention to the differences she perceives between France and the United States, where she said that it seems everyone has a therapist. She criticized Americans, however, for using too many medications, specifically pointing to the use of Ritalin for attention deficit and hyperactivity disorder. As discussed earlier in this chapter, many members of Les Phobiques suggested that mental illness is much more readily accepted in North America and that in the United States recourse to a therapist is commonplace. Far fewer support group members criticized the overmedication of Americans. In all cases, however, I understood these French-North American comparisons to express support group members' wishes concerning how mental illness should be understood in France. For the most part, they hoped that mental illness will soon be more readily accepted in France. While almost all support group members told few people about their disorder, it seemed that most would prefer to be able to openly discuss their problems without being judged. Whether or not their comments about how social phobia is accepted in North America are accurate, it seems that by describing a utopian acceptance of mental illness in North America, French social phobics are expressing their own desire to be able to speak openly and without shame about their disorder.

Over the years Mlle. Jabin has had many problems ranging from guilt to self-punishment and feels that these sentiments have often led her to do the opposite of what she wants. To deal with these problems, she has read many books on self-victimization. Mlle. Jabin now attributes these self-destructive behaviours to social phobia and believes that she has lost years of her life to the sickness. She says that for years she misidentified her problems and thought she was alone with no one to talk to. She has been on antidepressants for 10 years because of what she describes as her "shyness". This interview stood out among the others I conducted. Mlle. Jabin did not seem to me to be at all shy. She agreed to meet me near my apartment and suggested that we meet on a busy street in a crowded café. She was also the only social phobic to contact me by phone rather than by email. The drugs have been prescribed by GPs, never by psychiatrists, she reports. She described GPs as more human and as having a more diverse set of therapies to offer. Perhaps because she does not see a therapist, she describes the support group as an important part of her therapy and says that it is very important to her.

At support group meetings, Mlle. Jabin discussed the radio show she hosts on a community radio station and repeatedly tried to get members of the support group to participate in it, to share their experiences on air. I got the impression that most members were not pleased with her relatively aggressive efforts to get them involved in her show. I did not notice her at many meetings beyond those at which she promoted her show. This show, she said, is something that she is very proud of, since she had always wanted to be a performer, specifically a singer. She said that speaking on the radio is easier and more natural for her than speaking to people in person. She sees her show as a way to

help others. I was initially reluctant to meet with Mlle. Jabin because I got the impression that she may simply want to meet with me to collect information on social phobia for herself or for her radio show. I was never fully convinced that she was not simply trying to do 'underground' reporting for the show. Nonetheless, she seemed certain that she had suffered from all the disorders she named and I figured if nothing else, she was an interesting example of someone who has serially self-diagnosed.

This was a relatively common theme among several people at the support group as well as on online forums. There was almost a competition to 'help' new or vulnerable members at the support group and on the online forum. Help was usually offered by people who believed themselves to be cured of social phobia, or at least substantially improved, and who now wanted to offer assistance to other social phobics. They wanted to use their experiences to guide other people through their problems.

Mlle. Jabin, like many other members of the support group, believes that people with social phobia have a richness of experience that is incomparable to others'. She believes that social phobics are more sensitive to the human condition and that they give more of themselves than others. Echoing the comments of other support group members, she compared social phobics like herself to non-social phobics who tend to take advantage of others and who take without giving. Creating and repeating these 'us versus them' statements seemed to be a central factor in the establishment of people's identities as social phobics. The disorder became a means of setting themselves apart from others and creating a cohesive group identity[231].

[231] This argument is developed in chapter 12.

Mlle. Hébert primarily identifies herself as a social phobic, though she also describes herself as a spasmophile who still works to control her obsessive-compulsive disorder. She has suffered from every disorder that the French clinicians I interviewed identified as "fashionable". Mlle. Hébert reported that her problems prohibit her from working, though she has advanced degrees in library studies which would likely make her employable. She lives at home and is financially supported by the state. Her time is dedicated to the management of Les Phobiques de Paris and promoting acceptance of cognitive and behavioural therapy and social phobia. I do not know if she identified as closely with her past diagnoses as she does with social phobia, but her most recently identified disorder has become the focal point of her life. Mlle. Hébert has used her identity as a social phobic to establish a new 'career' as the volunteer president of Les Phobiques. She could have joined an existing support group for people who suffer from obsessive-compulsive disorder, but she would simply have been a member in this group rather than the founder and president. She has also used her position as a social phobic treated according to cognitive and behavioural principles to act as an expert commentator concerning the relative value of cognitive and behavioural therapy versus psychoanalysis, because she has been a patient within both therapeutic systems. She takes every opportunity possible, whether at support group meetings or on radio shows, to criticize psychoanalytic psychotherapy. She sees herself as having an important role in changing the French therapeutic system, replacing psychoanalysis with cognitive and behavioural therapy. She portrays herself as an expert who is able to knowledgably criticize the inaccurate explanations psychoanalysts provided for her problems over the years. She

believes that she now knows what has caused her difficulties and she credits cognitive and behavioural therapists for having shown her the truth.

M. Bouvier was never diagnosed with the fashionable French disorder of the 1970s-1990s, spasmophilia. His primary diagnosis for quite some time was panic disorder, which was more rarely diagnosed in France than in North America. He now believes that social phobia is at least partially at the root of his problems with panic disorder. When I spoke with him, he had attended Les Phobiques a couple of times. He was careful to point out that although he certainly has some difficulties, he is not badly off compared to many other members of the group. M. Bouvier appears to be a successful, upper middle class business man who works in one of the industries at La Défense, where we met at a restaurant for an interview[232]. M. Bouvier says that his problems go back to his childhood. He had his first panic attack at the age of four and then several others at the age of seven. His dad was a doctor, but he did not do anything about his son's problems and M. Bouvier believes that this is why his problems became more pronounced: because they were ignored at their early stages when they could have been more easily treated.

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[232] M. Bouvier's interview was one of the two that I conducted in English. In M. Bouvier's case, he requested that we do so to prevent his colleagues or acquaintances from overhearing us, should they happen to appear in the same restaurant during our meeting. The other interview that I conducted in English was Dr. Jacob, though the interview moved between the two languages. He assumed we would conduct the interview in English because he had undertaken much of his education in England and so is fluently bilingual. He knew that I am an Anglophone.

After childhood panic attacks[233], he had no problems until the age of 30. At this time he was working in Africa and he had a severe panic attack which he attributed to a work overload. As a result of his panic attack, he spent two days in the hospital. He was alone at this time in Africa, as his wife had relocated back to France. Nonetheless, M. Bouvier did not identify his isolation as a pertinent factor in the onset of his problem. While in the hospital, he reports that he thought his problems would be over by the end of the week, but he says they have never gone away. His panic attacks and constant anxiety persist. After this episode, he returned to France for a vacation and never went back to Africa.

He left his job and dedicated three months to searching for the root of his problems, during which time he underwent many medical tests, including heart tests. At this point he began taking Xanax somewhat regularly as well as a medication for heart palpitations. This was the beginning of more than a decade of benzodiazepine use for the treatment of his anxiety. He has found it very difficult to stop taking these medications.

While his benzodiazepine use and his use of the term panic attack indicate that he was aware of the psychological components of his problem, he was still partly looking for a biological origin for his problems, as indicated by his focus on potential heart problems.

He began a new job and was subsequently free of panic attacks. He thought that he was better. He had begun to see a pragmatic psychiatrist in Bordeaux, who was a

[233] While many people I spoke to reported that they suffered from panic attacks, M. Bouvier was the only support group member who had been diagnosed with panic disorder. All other members who described having suffered from panic attacks were usually diagnosed with spasmophilia rather than panic disorder. Spasmophiles often suffer from panic or anxiety attacks, but the etiology of their condition is considered to be completely different from those people who suffer from panic disorder.

friend of his father's. After six months, he believed that he was "almost fine" and he stopped taking medications. His decision to see a psychiatrist was likely difficult for him since he grew up in a household run by a man who he describes as an anti-psychiatrist. His father joked about psychiatrists, calling them crazy, and he suggested that if you went to one, you were also abnormal or crazy. M. Bouvier says that there was a taboo against seeing psychiatrists and that as long as you did not go, you were safe and not one of 'them', the crazy people. Despite his upbringing, he was relieved to go to this therapist and was pleased with the results. However, on a vacation to Portugal, he had another panic attack. He started using anxiolytics again to cope with his ongoing problems. His cure had not been definitive.

Some years later, his employers transferred him to Houston. While he was there, he underwent a one year programme in cognitive therapy. He loaned me the books and exercises that accompanied this therapy. The content of the books focused on general cognitive and behavioural techniques, rather than on specific disorders such as social phobia or panic attacks. The documents were oriented more generally toward the management of anxiety. However, the psychotherapy that accompanied the literature may have targeted specific disorders. He did not mention having been diagnosed with social phobia at this time. Nonetheless, it was around this time that he seems to have been told, or at least that he became convinced, that he suffered from social phobia. M. Bouvier continued to feel anxious, particularly at work, even when he could not identify a particular stressor. He noted that in the United States, anxiety is seen as a disease, whereas it is not in France. He believes that this disease-based approach to anxiety has contributed to the greater acceptance of mental illness and anxiety disorders in the United

States. Like most members of Les Phobiques, this is a model that he wishes would be widely adopted in France. He said that he was initially shocked by the relative absence of American taboos about mental illness as well as the widespread acceptance of the use of many types of psychotropic drugs. This acceptance of medications, however, did not extend to benzodiazepines[234]. His American physician urgently wanted him to stop taking benzodiazepines and convinced him to try Zoloft, but he stopped taking the SSRI because he found there were too many side effects. He said his worst problem while on SSRIs was that he no longer recognized himself. He also tried Paxil at this time but did not like it either. So, he continued taking anxiolytics. Recently, in another attempt to reduce his benzodiazepine use he tried Effexor, but did not like its effects and stopped taking it. He says that he has now been on Deroxat[235] for two days and does not know if it will work, but he is eager to stop taking tranquilizers.

A recent request by his company to transfer him to Moscow triggered more anxiety and panic attacks and he said that the possibility of a move initiated the return of a number of problems that had not bothered him for some time. Because of his continuing difficulties, he decided to try going to a support group and he found information about Les Phobiques online. He hesitated before going and this is likely because he still seems to harbour some fear of "crazy" people as was evident by his reaction to the group. It is also perhaps because he does not seem entirely comfortable

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[234] M. Bouvier said that his pharmacist treated him like a drug addict because of his benzodiazepine use. When M. Bouvier was in Houston, the backlash against tranquilizers/anxiolytics had already taken place, so these drugs were no longer considered appropriate treatments for anxiety. The SSRIs had been re-branded as anxiolytics and they had become the treatment of choice. This change-over is only beginning to happen in France.

[235] He did not seem to be aware that Paxil and Deroxat are different market names for the same drug.

speaking about his troubles. Like many members of Les Phobiques, he has discussed his problems with few people. He says that he speaks to his wife as little as possible about his difficulties and only speaks of them on occasion to one of his sisters.

M. Bouvier's impression of the group, after having attended his first meeting of Les Phobiques, was that he had been surrounded by crazy people. He believed that these people had nothing in common with him. At the same time, he said that the meeting made him wonder whether he was as crazy as the other members. His attention was divided between the "crazy" group members and those whom he identified as more normal, such as M. Vial. Even though he believed himself to be much more normal than most people at the meeting, he said that the first part of the morning, when people introduce themselves to the other members of the group, was difficult for him. He had seated himself at a place in the room which ended up making him the last person to introduce himself. He found this to be a very difficult position. During his introduction, he drew attention to the anxiety that the experience of waiting to introduce himself had caused him. The mid-morning coffee break, he says, was when he started to benefit from the group. At this point he spoke to a couple of other members, including M. Vial and another woman with a severe case of agoraphobia. He said that he could relate to M. Vial and that he felt a certain empathy for the agoraphobic woman, though he did not feel that this empathy should make him feel committed to a friendship. Despite his ambivalence about the support group members, he said that when he spoke to these people, he felt as though they were his brothers and sisters and that they shared similar experiences at a deep level.

M. Bouvier attributes his ongoing panic attacks and social phobia to two basic factors. First, he thinks that there is a genetic factor, and second, he thinks that because his problems were ignored during his childhood, they became much worse than they would have otherwise. He then added that the second factor likely accounts for "65-70%" of his problems. He said that lack of early treatment leads to feelings of abandonment and that there is no safety around, which exacerbates the original problems. He reiterated that treating psychological disorders was not "à la mode" when he was a child.

He now believes that he will have to deal with the symptoms of his panic attacks and social phobia for the rest of his life. He says that the origin of his problems is deep and he does not expect success out of therapy. He thinks that therapy can only help in the management of his problems but that it cannot offer a cure. Nonetheless, he says that 5% of the time, he wants to believe that a miracle will make his problems go away. He says that this accounts for why he tried magical therapies to treat his problems when he was in Africa and why he has tried looking for repressed memories that might be causing his difficulties. Concerning the last attempt at therapy, he says that he did not uncover anything he did not already know, which was as he expected. He says that he remembers having a happy childhood. Ninety-five percent of the time, he says, he believes that the only thing that can keep his problems under control is his own mind, which reflects his belief that people are at least partly responsible for the course of their own mental illnesses.

A repeated theme throughout our interview was his assertion that he is not crazy. He has a normal life, even if he is somewhat affected by his troubles. He says that he

hides his problems well and he does not expect that anyone else would guess the extent of his disorders. The only thing he really avoids is presentations. Over the years, he has come to identify with social phobia as well as panic attacks, and it seems as though social phobia may now be the disorder he most closely identifies with. Like most other members of the support group, he believes that people with anxiety disorders have certain positive qualities, particularly social phobics. He says that people with social phobia are sensitive, that they have "above average personalities". M. Bouvier did not elaborate on what he considers an above average personality to be. From his other comments, however, he seems to attribute to social phobics a more developed capacity for empathy and sensitivity toward others. This is likely what he believes makes these people better than the average person who has never suffered from the symptoms of social phobia. He says that despite the problems the disorder has caused him, his experiences have in some ways been great. He believes that because he is a social phobic he is capable of great empathy for others and that this brings a richness to the personalities of social phobics. Many other social phobics I interviewed referred to the richness of experiences they have had as a result of their disorder. They believe that this has made them better people than they would otherwise be and many often suggested that this makes them better people than non-social phobics. This theme is elaborated upon in chapter ten.

Socially phobic, but not crazy

M. Bouvier insisted that although he suffers from social phobia, he is not crazy. This argument was echoed at length by M. Pelletier and M. Perrin and it was a fairly common theme among most of the social phobics that I interviewed. While they

recognize that they suffer from a mental illness, they are adamant that this does not make them like other crazy people. Most members of the support group made a point of saying that what they suffer from is not at all similar to serious mental illnesses and they argue that they are much better off than depressed people, for instance, though a minority of members admit that they suffer from this disorder. Support group members' statements resemble those of cognitive and behavioural therapists. These physicians, as reported in chapter 6, make a point of telling their patients that just because they suffer from social phobia, they are not different from other people. Cognitive and behavioural therapists often describe social phobia in a dimensional manner, in which social phobia is simply seen as a severe form of shyness. They assure their patients that they are not crazy. Physicians who are critical of the diagnosis of social phobia suggested that social phobia is a disorder that seems safe to patients because it allows them to access therapies and treatments for the mentally ill, but it is relatively distant from disorders that are seen as serious mental illness. These critical physicians argue that there is a lot less stigma associated with being overly sensitive than there is with most other mental illnesses.

These ideas came out in the words of M. Perrin. He said that he could relate to M. Bouvier more than the other members of the support group. This underscored the hierarchy within Les Phobiques, in which some people feel that they are considerably better off psychologically than others and undertake a ranking of support group members. After having compared himself to the other members of Les Phobiques at the support group meeting, M. Perrin said that he felt better because he now knew that there are many people who are much more affected by their social phobia than is he. In comparison with many support group members, he seemed quite normal and functional. In addition to

being more functional than many support group members, he and M. Bouvier seemed more affluent than many of the other middle class members. M. Perrin and M. Bouvier also seemed to be more gainfully employed than other members, thereby placing them in a different socio-economic class.

M. Perrin reported that his troubles started in his teens, though he noted that he thinks that people are often born with this condition. He describes his adolescent crisis as acute and he says that it cost him a lot. He implied that he measured these costs in terms of anxiety and the limitations that anxiety put on his lifestyle. He is now in his late twenties. He did not do anything about his fears until he was a visiting student at McGill University. At this time, he developed persistent stress headaches that lasted for two and a half months. What he would later recognize as his social phobia symptoms became much more acute as well.

This was a common theme among the members of Les Phobiques. They often suggested that while they believe they had always suffered from the disorder, once they found themselves in a new place, somewhat isolated, their symptoms became much more pronounced. M. Perrin said that it was very hard living alone in Montreal. He went for months without speaking to anyone at all. Eventually, he moved in with eight roommates and he credits these living conditions with the significant improvement of his condition. While he attended McGill, he says that he was always nervous, he constantly bit his nails and he was excessively shy. Nonetheless, by the end of his trip, he said that he had made new friends. He also had never lost contact with his friends in France. Because of these factors, he never became as isolated from others to the extent reported by other members of Les Phobiques.

While in Quebec, M. Perrin obtained information about social phobia, but never underwent any specific therapy for the disorder. Part of the reason he did not seek therapy is because he believed that when he returned to France his problems would go away, but they persisted. A French GP offered him medications and conducted several tests, but found nothing wrong with him. He began to take anxiolytics, which he still takes. Despite his GP's attestation that he was fine, M. Perrin decided to see a psychologist to help him better understand and accept his difficulties. It was at this time that he was diagnosed with social phobia. During the year that he saw the psychologist, M. Perrin discussed his family with the therapist. He believes they are also anxious people, particularly his dad from whom he thinks he 'got' social phobia. He did not indicate the mechanisms of generational transmission, for example, genetic versus behavioural. He told me that he learned a lot from his therapist but that he tried other interventions at the same time, such as sophrology[236], to further tackle his symptoms and anxiety. His sophrologist, he says, taught him relaxation techniques and helped him to master some of his superficial symptoms. He said that learning these body control techniques helped him to get by in day to day life. M. Perrin also saw an osteopath to help him deal with certain manifestations of his anxiety.

He attended Les Phobiques only once and said that he found the people strange. He pointed out that there is a great deal of variety in the gravity of people's problems and reiterated that his problems are not that severe compared to others'. His problems, he says, do not prevent him from living fairly normally. However, he believes that everyday

[236] Sophrologists aim to help patients regain their equilibrium between their thoughts, emotions and behaviour. Most of the techniques used in therapy are meant to encourage patients to relax and meditation and hypnosis are a part of this therapy.

life takes more out of him than it does people who do not suffer from social phobia. He said that he has nonetheless always been a good student and has always tried to prove himself at school and at work. He has persistent fears that he will not succeed at work but also explains that he has always been too hard on himself and that he constantly worries of failure.

M. Perrin has told his parents about his disorder though he says that he still does not express a lot of his feelings or concerns. He does not talk to his friends about his problems and instead he says that he keeps up a façade to convince them that he is like everyone else. He says that he would rather overcome social phobia rather than discuss it with his friends and he believes that the front he maintains has been successful. Part of his reluctance to discuss his problems stems from the taboo he still feels is associated with mental illness. This sentiment reflects the words of several psychiatrists I spoke to who noted that the taboo against mental illness is still particularly evident among the bourgeois and upper classes.

In spite of all of the therapeutic interventions he has sought out, M. Perrin still finds it hard to make presentations and he feels a great deal of shame about this and his other weaknesses. He does not think that the disorder will ever fully go away and he has resigned himself to hoping only for its management. The only way of dealing with the disorder, he believes, is to use one's internal resources, so everyone's solution will be a little different. As the other social phobics pointed out, he believes that people with this disorder are sensitive and are more apt to be interested in music, for example[237]. He has been involved in acting in the past and sees it as a personal challenge and a form of

[237] Almost every social phobic I spoke to suggested that people with this disorder are more likely to be artists, with interests in music, theatre, etc.

therapy. This seems to be his most commonly-used means of combating social phobia: to challenge himself by engaging in tasks and behaviours that he fears and by trying to live like a 'normal' person.

It is extremely important to M. Perrin to believe, and have others believe, that social phobia is not a disease. He asserts that 80% of the disorder is just a sensitivity. He says that is it not a disease, just a discomfort. This does not mean that the problem is neither real nor serious, only that it is different from craziness, which he views as a disease. M. Pelletier shares this view and noted that learning the name of his problems was very important to him specifically because of the implication that he is not crazy. He said that he can get through life with the problems he has. It was necessary for him to know that he is "not like the people at Ville Évrard", referring to a psychiatric asylum in the Paris region. On a similar line of reasoning, M. Perrin firmly noted that he did not want to become depressed because this is something completely different from social phobia, much more severe, a disease. Like M. Bonet, who claims that he is not depressed despite his parents' belief that he may suffer from the disorder, M. Perrin suggests his lack of depression is an important factor in differentiating him from the other support group members. Perhaps their fear of depression, or other mental 'diseases', stems from the fact that the symptoms of social phobia, at their more severe end, are quite similar to those of depression. The comorbidity of the two disorders is very high. Depression is very close to social phobia and at the same time, the worse case scenario of their disorder. Depression to these men is a frightening, stigmatizing disease compared to the *relatively* stigma-free diagnosis of social phobia that they so fiercely identify with. They would much rather be social phobics than diseased or 'crazy' people.

Competitions to be social phobia 'experts'

The members of Les Phobiques who identify themselves as social phobics often want to use their experiences with the disorder to help others. In this way, even once they feel better, they still retain their identity as social phobics and they also benefit from having a sense of mastery of their problems, and others' admiration of their mastery. 'Recovered social phobics' often see themselves as more or less normal, but as more sensitive than others. Mlle. Hébert is one of these people. Being the president of the support group is Mlle. Hébert's primary occupation, although it is only a volunteer position[238]. She is largely responsible for making final decisions about the themes that will be discussed in meetings and it is usually her who leads presentations at group meetings. Her resources for these discussions are primarily books and articles written by cognitive and behavioural therapists aimed at a lay audience. In her presentations to the group her desire for control of the message about social phobia is evident. She quite firmly believes that cognitive and behavioural therapy is the only valid therapeutic intervention for the disorder and that the disorder should be described using cognitive and behavioural language. When others occasionally led full-group presentations, she

[238] It seemed evident when I interviewed Mlle. Hébert that she was hoped to one day create a job out of her volunteer position. During the time that I interacted with the support group they had no external funding and relied on membership fees and the generosity of the hospitals to support almost all of their room rentals, actions and literature. All members of the executive council, including Mlle. Hébert, are volunteers. GlaxoSmithKline paid for the production of their glossy pamphlet which describes social phobia and which is given to each new member of the group. Mlle. Hébert said that beyond providing their pamphlets, GlaxoSmithKline does not support the group in any other way. However, it seemed to be her hope that they would do so.

repeatedly interrupted them to correct their descriptions of the disorder or even to re-explain administrative details of the group.

Mlle Hébert made it more than clear that she improved only after she started cognitive and behavioural therapy and she tells any audience she finds herself in front of that this is the only intervention that will help them. These audiences include support group members and people who listen to radio shows on which she has been a guest. When others challenged her about her perspective of the disorder, her clear bias toward cognitive and behavioural therapy and her anti-psychoanalysis position, she becomes quite agitated. One meeting effectively fell apart after she had an elongated, heated exchange with a member who felt that she was not accurately representing support group members' views to a broader audience when she publicly states that psychoanalysis can offer nothing to social phobics. Mlle. Hébert eventually started crying and left the meeting. Other days, in the absence of challenges by other members, she would make snide comments that were clearly aimed at specific members who had made suggestions in the past about other possible explanations for the disorder's symptoms, lodged complaints about her control over the topics discussed or the way the group is run or represented. She clearly wanted to be *the* person to help social phobics and to represent them in Paris and she did not accept others offering an alternative voice for these people.

Mlle. Hébert wrote letters to *Le Monde* for publication from time to time, but it is only recently that one of her letters has been published in *Libération*, a left-leaning Paris newspaper[239]. She has also been promoting her role in the newly published *Livre Noir de la Psychanalyse* (2005), an edited volume which is part of an ongoing effort to supplant

[239] I have not included the reference since this would provide Mlle. Hébert's real name. The letter was published in October 2005.

this type of psychotherapy. A section of the book focuses on patient testimonials and in this section she describes her years enrolled in psychoanalysis and the lack of improvement she saw during this period.

Because of her role as the president of Les Phobiques, Mlle. Hébert usually represents social phobics in Paris. It is she who writes letters to newspapers, most often participates on television and radio shows and decides how Les Phobiques will be represented (for example, on their website). Sometimes other members of Les Phobiques were recruited to provide testimonials of their experiences with social phobia on radio or television shows, or to be case studies on instructional CD ROMs (for example, on GlaxoSmithKline's *Les Phobies Sociales* [nd]). When other people were selected to represent Parisian social phobics, Mlle. Hébert seemed disappointed not to have been chosen for these positions.

As a result of Mlle. Hébert's desire to be the sole representative of Parisian social phobics, there was tension when Mlle. Jabin tried to get members of Les Phobiques to discuss their problems on her radio show. Her actions introduced competition to be the voice of Les Phobiques, a role that Mlle. Hébert carefully guards. Other members of the group seemed to suspect that Mlle. Jabin joined their group simply to seek out contributors to her show. These were likely factors that contributed to Mlle. Jabin not being warmly welcomed by the group.

Similar types of competition were visible in online discussions about social phobia. At social phobia online discussion forums, it was not uncommon for 'recovered' social phobics to take part in discussions and to offer their advice, expertise and assistance. While reading these online forums, I was struck by the high ratio of people

offering help to the number of people seeking help. It seemed that a large number of people participated in these groups primarily to offer help, and 'expert' advice, to others. Their advice was based on their own experiences with social phobia. Many even offered one-one-one advice to others and provided contact information so that they could have more intimate, off-forum discussions with social phobia sufferers. In addition to individuals offering assistance to others, executive members of Les Phobiques also participated in these online forums offering advice of their own. The executive members would at times try to intervene in the situations described above, of recovered social phobics offering help to 'new' social phobics. The Les Phobiques members would recommend that new social phobics attend their support group meetings to learn more about the disorder, rather than accepting help from people who were not members of Les Phobiques. These exchanges made it appear as though there were almost as many amateur social phobia therapists, whether individual recovered social phobics or support group members, as there were people interested in learning about social phobia.

Mlle. Bruyère joined Les Phobiques to help others. She began attending the group in December 2003 to share her experiences and to let others know that improvement is possible. Despite the fact that she has a desire to help others, which she sees as a sign of her own recovery, she has much less at stake in this role compared to Mlle. Hébert. Mlle. Bruyère is also much less aggressive with her offers of assistance, compared to most others at the support group or in online forums. She seems more stable than some of the other people who are eager to offer help. While Mlle. Hébert came across as someone who was still very edgy and for whom communication with others remained difficult, Mlle, Bruyère seemed to be within the 'normal' register of quiet and

shy. Mlle. Bruyère did not particularly care whether anyone followed the same path to recovery as she did, she simply decided to go to Les Phobiques when she felt personally prepared to share her story and she sees her participation in the group as an ongoing benefit for her self esteem and personal development.

She believes that her social phobia began around the age of 15 and that since then, it comes and goes. It became worse at about the age of 25, which is the same year that she moved to Paris from the north of France. By this time, however, she had already gotten some information on social phobia from a patients' association in Lille, which was likely the Lille branch of Les Phobiques[240]. Once in Paris work became a challenge for her, she found it hard to integrate and ended up leaving her first job. One of her biggest problems was a fear of reddening. Despite her problems, Mlle. Bruyère found a new job and since that time, always maintained employment and a social life. She describes her disorder as primarily job related, though she said that she feels anxious when meeting new people. She says that she now finds it much easier to find new friends, but that she still needs to find activities to engage in with them to feel at ease. Aimless social events remain anxiety-inducing.

Mlle. Bruyère began looking for a therapist when she was 27 or 28 and she found a psychologist who practices individual cognitive and behavioural therapy. She got the name of this therapist through an association, AFTCC (Association Française de Thérapie Comportementale et Cognitive). She chose to seek a therapist through this group because, she said, she believed that psychoanalysis would not be of use to her. She never

[240] There are branches of Les Phobiques in Lille, which was the first one to be established in 1995, followed by the branch in Paris, then Rouen, Lyon, Rennes, and finally Toulouse. The most recent branch was established in 2004.

took any medications for her disorder because she was ashamed to tell a physician about her problems. She is nonetheless aware that many people with social phobia take medications to calm their anxiety. Even without recourse to medications, she improved substantially in therapy. She credits her therapy for the disappearance of her symptoms, though she still describes herself as more sensitive than average.

Mlle. Bruyère hesitated before going to a meeting of Les Phobiques, but she now says that she is glad she went. She had been interested in attending earlier, but at that point she did not want to see depressed people. She assumed that these people, who she presumably feels have a more serious mental illness than herself, would not be able to provide her with any assistance. She believes that being around these people would have been too much for her to take. Now that she considers herself more stable, she was willing to take a chance on the group. She says that sharing her experiences and talking to the other members has made her feel as though she is less alone. She likes the group and says that she was welcomed straight away. It was immediately easy to for her to talk at meetings and she finds the other members of the group interesting.

Other than with the people at Les Phobiques, Mlle. Bruyère has not discussed her problems with many others. This is partly because she believes that psychiatry, and those who see psychiatrists, is looked down upon in France. She has not told her friends about her disorder. She only told her sister the month before we spoke and was not pleased with her sibling's reaction. Her sister told her that she does not believe Mlle. Bruyère has the disorder because she does not know her to be like a social phobic. Her sister essentially told her that she is normal. This response annoyed Mlle. Bruyère because to her it was a clear sign that her sister does not understand her and did not want to hear

about her problems. The only person she really talks to about her problems with social phobia is her boyfriend, someone she described as an introvert like herself.

In most ways, Mlle. Bruyère considers herself cured and she no longer sees her psychologist. She is more able to meet new friends, she is more at ease at work, though she still finds it a challenge to eat with colleagues. Other people now react to her differently, she thinks, and she sees this as another sign that she is better. Both she and others see her as a 'normal' person. She points out, however, that she does not see this cure as definitive. She expects that social phobia will come and go throughout her life. She recognizes that although she has become more open, adaptable and tolerant, there are still areas of her life that are destabilized and she still searches for more ways to insert herself into new areas of life. Currently, for example, she is looking for a sport to become involved in.

Despite the doubts she expressed about the efficacy of psychoanalysis at the beginning of our interview, at the end of our interview she said that she is about to begin psychoanalytic psychotherapy. This does not entail a rejection of cognitive and behavioural therapy, however. She believes that she is a lot better as a result of her cognitive and behavioural therapy, but she also believes that the therapy has left her vulnerable to future destabilization because she does not think that the therapy delved very deeply into her problems. She says there is still too much about herself that she does not know and she believes that she needs to better understand her memories and inner self to have a more enduring improvement. She believes that psychoanalytic psychotherapy will provide these insights.

Before attending Les Phobiques, she considered the message that she had to offer others about social phobia. She decided that the perspective that she wanted to bring to Les Phobiques was one of guarded optimism. She thinks that social phobia can be overcome to the extent that it can become a well-managed part of a person's life. But, she does not think that she or anyone else is likely to free themselves entirely of the disorder and, she believes, one always has to be prepared for its resurgence. Nonetheless, it is not a disorder that she believes has to prevent a person from living as they want to live. She believes that other members of Les Phobiques have benefited from learning of her experiences and this makes her feel better. Helping out as a 'recovered social phobic' is now a part of her identity that increases her self esteem and makes her proud of the fact that she has largely taken control of her disorder.

Mlle. Arcier attended a meeting of Les Phobiques specifically to tell the group's members about the process of how she was "cured" and to give other members hope based on her experiences. She made a long introductory presentation, describing the history of her problems and her complete recovery from the disorder. During the mid-morning coffee break she talked with a large number of people who approached her and she reiterated that cognitive and behavioural therapy group therapy is capable of completely curing social phobia if one is motivated enough. For her, all it took was six months and her social phobia was gone. Mlle. Arcier sees herself as one of the lucky people who were young enough, motivated enough and who has the right personality to be "cured". Being a 'survivor' of or 'victor' over social phobia is a part of her identity and she wants to use stories of her improvement to spread hope and offer assistance to people who she believes have the same aptitude to be cured as she did.

To cure a disease or manage a temperament?

Most of the members of Les Phobiques who I spoke to, aside from Mlle. Arcier, were very hesitant to say that there is a cure for social phobia. If they suggested such a thing, they would usually add that while they might be able to master their problems in the short term, they anticipate that they will struggle with the disorder for the rest of their lives. M. Pelletier's words are representative of what many people in the group felt: that he expects to experience ups and downs throughout his life as a result of social phobia. Many support group members were very critical of Mlle. Arcier's words and said that they simply do not believe her. M. Bouvier, who has experienced relapses of panic disorder and social phobia throughout his life, said that he feels sorry for her and he believes that she will be surprised one day in the future when she experiences a relapse. Her insistence that she is cured, he believes, will leave her less prepared to deal with what he believes is the inevitable return of social phobia symptoms. M. Bouvier was upset by her presentation and said that her insistence that a cure exists for social phobia annoyed him. He claims that it is an insult to those who have struggled with the disorder for many, many years and who he believes are much more knowledgeable about the effects of social phobia than is Mlle. Arcier. He is now in his early fifties. He does not think that her outspoken naiveté will end up helping anyone in the group. He does not believe that it will help Mlle. Arcier either, since it leaves her with what he believes are unrealistic expectations about the future.

M. Béguin, who has struggled with depression and social phobia, is also doubtful of Mlle. Arcier purported full and permanent recovery. He agrees with most members of

the group that it is only realistic to be prepared for relapses. Even though he would like to believe that a cure is possible for the disorder, he is doubtful of her claims. This commonly held belief of the members of Les Phobiques, that social phobia can be largely controlled but that it will never go away, supports the idea that social phobia is not a disease. At least, it is not an acute or temporary disease as it is often described by cognitive and behavioural therapists. Most support group members do not see it as something that overlays one's personality and which can be made to disappear if only one can find the appropriate therapy. Like Dr. Fourciers, these patients believe that they have a low level sensitivity that will last a lifetime, but unlike the well known cognitive and behavioural therapist, the members of Les Phobiques generally do not believe that cognitive and behavioural therapy will help them master their sensitivity definitively. They expect that more serious bouts of timidity and full scale social phobia will always threaten to return. The support group members express hope that cognitive and behavioural therapy will offer a cure, but in the end, they often convey views that reflect psychoanalytic beliefs that a temperament is something that one must manage in the long term. This is an instance in which social phobics move back and forth between drawing on cognitive and behavioural and psychoanalytic explanations. In this case, the cognitive and behavioural explanation provides hope while the psychoanalytic explanation more closely reflects their lived experiences.

Many of the members of Les Phobiques are not nearly as pro-cognitive and behavioural therapy as Mlle. Hébert's public statements would suggest. Few members would argue that cognitive and behavioural therapy has nothing to offer, particularly in terms of symptom alleviation, but many believe that psychoanalysis is a very appropriate

therapy to help them deeply address their problems. However, unlike the man who loudly argued with Mlle. Hébert about the validity of psychoanalysis at a Les Phobiques gathering, most members keep their ideas about psychoanalysis to themselves during group meetings. During interviews, though, most people I spoke to suggested that they had seen a psychoanalytically-oriented therapist at some point in their lives and almost all said that this type of therapist helped them to understand a lot about themselves and improved their situation.

M. Dinh is one member who prefers psychoanalytic perspectives to cognitive and behavioural ones. M. Dinh is a student and was born and raised in Paris. During our interview he described growing up at the centre of cultural clashes between his Japanese mother and Vietnamese father in the midst of a French society. Like many people I interviewed, he reported that he has suffered from social phobia for as long as he can remember. It became worse as he approached adolescence but he felt that it was not something he could discuss with his family. His parents were very strict and for this and other reasons he felt somewhat distanced from them and did not feel comfortable discussing his problems. It is only recently, once M. Dinh was in his twenties, that he sought help for his problems. He had already found information on social phobia and believed this is what he suffered from. He briefly saw a cognitive and behavioural therapist, but he did not think that this therapy addressed the origins of his problems, which is what he saw as the appropriate focus of therapy.

Despite his appreciation of psychoanalytic psychotherapy, M. Dinh does not discuss his experiences in therapy with the members of Les Phobiques. One reason, he says, is that what happens in therapy is too personal to discuss with anyone else, but he

also knows that this is not the 'language' of Les Phobiques. The therapeutic language at the support group is quite strictly cognitive and behavioural so he works according to those terms during meetings. M. Dinh's position is similar to other members who draw on multiple therapeutic resources that explain their difficulties in many different ways, but who learn and use the support group language as a means of presenting themselves. In this way, they become fluent 'social phobics', capable of describing their problems according to DSM symptoms and cognitive and behavioural explanations even if these are not their only, or even primary, explanatory models of the disorder.

The members of Les Phobiques often focus on their problems with the symptoms of social phobia in spite of their diagnoses with other psychiatric disorders and regardless of whether they have ever been officially diagnosed with the disorder. It is less interesting to me whether they officially 'have' social phobia. I am more interested in why they have now chosen to identify with this disorder, what it offers them and why it appeals to them. If it did not have something to offer, they have other therapeutic tracks open to them: they can be treated by a psychoanalyst, receive medications from a GP or use a number of relaxation therapies that are popular in France. However, if people choose these other therapeutic recourses, they will likely not be diagnosed with social phobia. The coming chapters address where social phobics first learn about social phobia and how they come to identify with the disorder.

Chapter Nine

Patients' and physicians' sources of information about social phobia

Contents

Physicians and patients have many sources of information about social phobia. While professional and lay sources differ, there are some overlaps in the types of information these groups draw upon. This chapter will present the most commonly cited sources of information used by the public and professionals.

The most contentious professional source of information about social phobia is the pharmaceutical industry. The information they provide is widely believed to be biased and their promotion of the disorder is believed to be motivated by self-interest. Distrust of these companies, and specifically GlaxoSmithKline, has led some physicians to reject the disorder because they believe that the industry has virtually created social phobia[241]. Most physicians assume that the industry is interested in making social phobia look as widespread as possible in order to sell drugs.

Information disseminated by cognitive and behavioural therapists, in their public appearances, participation in symposia on social phobia and in their popular literature on the disorder, is also seen as suspect. This is primarily because their therapeutic perspective is believed to be an inappropriate means of assessing and treating patients' problems. Examining the origins of physicians' sources of information makes it easier to understand why many French doctors reject the concept of social phobia.

I will also outline patients' sources of information to explain how these individuals first encounter the concept of social phobia. While physicians are among their sources of information, many of the people I spoke to learned about the disorder outside of the medical establishment. The media and popular culture books have played a significant role in introducing social phobia to the French public, so for many people,

[241] Some clinicians believe that the industry literally created social phobia.

their first steps toward identification with the disorder will occur far from a physician's clinic.

Physicians' sources of information

Two of the primary sources of information cited by the physicians I interviewed were the journal *Prescrire* and the pharmaceutical industry. These sources present information about social phobia from very different perspectives and treat the disorder as different objects. *Prescrire* describes social phobia as a new disorder that is part of a trend toward the medicalization of existence (*Prescrire* 2003b). The journal describes paroxetine, the first drug licensed in France to treat social phobia, as often having too many side effects for patients to complete treatment. Staff at the journal argue that paroxetine's efficacy should have been compared to that of cognitive and behavioural therapy before a license was granted to the product (2003a). Instead, a license was granted to paroxetine's manufacturer, GlaxoSmithKline, based solely on the efficacy of paroxetine compared to that of a placebo. Most clinicians described the information in *Prescrire* as very reliable and portrayed the journal as one of the only sources that provide critical, independent assessments of new medications. Other clinicians, however, describe the journal as intolerant, too critical and uninformed. The position physicians took toward *Prescrire* was reflective of their attitude toward social phobia. If they rejected the diagnostic category of social phobia, they tended to be more sympathetic toward *Prescrire*, whereas if they used the diagnostic category, they tended to describe *Prescrire* as being generally overly critical and biased.

In contrast to *Prescrire*, the pharmaceutical industry presents social phobia as a serious disorder that is under-diagnosed and under-treated. These companies argue that social phobia needs to be recognized so that it can be treated, ideally with the use of medications and psychotherapy (GlaxoSmithKline nd). This is the message that they conveyed to physicians in an educational CD-ROM that provides clinicians with lessons on how to identify and treat the disorder. Not many physicians I spoke to had yet to receive this CD-ROM when I was in contact with them, but they reported that pharmaceutical sales representatives from GlaxoSmithKline had given them literature promoting the use of Deroxat (paroxetine), the licensed treatment for social phobia. In addition to the information disseminated by pharmaceutical sales representatives in physicians' offices, some physicians said that they get they learned about social phobia at lectures and colloquia supported by the pharmaceutical industry. Dr. Duclaux noted that the pharmaceutical industry helps cognitive and behavioural therapists to disseminate information about cognitive and behavioural therapy. The company will fund medical symposia or colloquia at which cognitive and behavioural therapists present papers about their therapeutic orientation and social phobia. In return, the physicians talk about the company's medication licensed to treat social phobia, since it is a part of the recognized treatment for social phobia, Dr. Duclaux added.

Many physicians I spoke to describe the information offered by the pharmaceutical industry as of poor quality and as biased. Dr. Bouchet[242], a Parisian general practitioner, described the industry as selling needs, indicating that she does not trust the information they provide and would not consider it to be in the best interest of

[242] For more information on individual physicians, please see the second appendix to this text.

her patients if she were to do so. Many physicians did not consider information from the pharmaceutical industry to be of good scientific quality. But a good number of physicians I spoke to nonetheless take the information and free drug samples offered by pharmaceutical sales representatives. This apparent contradiction, in which physicians suggest that the industry provides biased information and yet argue that can work closely with pharmaceutical companies because they are immune to the industry's influence, is not uncommon among physicians. A recent study of medical residents reported that 61% of these physicians believe that industry promotions and contacts do not influence their own prescribing, while only 16% believe that other physicians were similarly unaffected (Steinman, Shlipak and McPhee 2001).

A couple of physicians I interviewed spoke highly of the information they get from the pharmaceutical industry. Dr. Lefebvre, a psychiatrist who works in the suburbs of Paris, believes the industry's research to be of high calibre, which is probably influenced by the fact that in the past he worked in the research department of a pharmaceutical company. He still conducts clinical trials for different pharmaceutical companies. Dr. Marsault, a general practitioner working at the outskirts of Paris, did not assess the quality of information from the industry, but she reported that she prefers information that comes from pharmaceutical companies, such as pamphlets and information packages, to *Prescrire*, for example, because she finds the industry information "less boring". Dr. Marsault describes the industry as her sole source of information about new drugs and medical conditions. The format and content of information from pharmaceutical companies probably appeals to many physicians similar to Dr. Marsault because it is easy to digest and presents seemingly uncomplicated

solutions. Dr. Fourciers, a well-known Parisian cognitive and behavioural therapist, described the industry as very helpful in spreading information about social phobia. He credits them with the organization of large congresses, which are often attended by a thousand physicians, where clinicians are taught about the disorder, its diagnosis and treatment. Dr. Fourciers speaks on behalf of GlaxoSmithKline and appears in their promotional literature. He describes his relationship with the pharmaceutical industry as a partnership in which he uses them to disseminate information about social phobia, while they get to improve their image in the eyes of physicians[243] and promote their medications. He believes that the relationship is mutually beneficial.

An information source that is closely related to the pharmaceutical industry is the *grands professeurs* who become famous for their research and treatment of particular disorders. Drs. Petit and Arnaud, a family therapist and general practitioner respectively, argue that opinion leaders are made by the pharmaceutical industry, which provides the funds to support events and research that increase the stature of these specialists. Alongside Drs. Petit and Arnaud, other physicians argue that the *grands professeurs* have more impact on other physicians' practices than do published articles. The opinion leaders' thoughts are both widely disseminated and influential. Dr. Petit pointed specifically to Dr. Fourciers as an opinion leader who has a great deal of influence on French attitudes toward social phobia. Social phobia opinion leaders have a significant impact on the lay population as well as on their professional colleagues.

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[243] Pharmaceutical companies often try to improve their image by supporting an issue or a medical problem. In this case, Dr. Fourciers believes that GlaxoSmithKline will be able to improve their image by acting as a generous supporter of the under-recognized problem of social phobia.

It is at continuing medical education events that a number of physicians I spoke to initially heard about social phobia. Despite efforts to keep this education independent of the industry, pharmaceutical companies still have a great deal of influence over continuing medical education because of the lack of independent funds to support these courses. While many of the physicians I interviewed were critical of the information provided at continuing medical education meetings, they did not necessarily expect the average attendee of these events to be critical of what they heard, especially if a new therapy was being promoted. Dr. Agasse noted, "it seems to me that if I were a bit harsh, I would say: there is a suspicious credulity in the medical community." He said that this extended into all areas of medicine but that physicians' credulity concerning claims about psychotropic medications surpassed their gullibility in all other areas.

Continuing medical education events that focus on cognitive and behavioural therapy are also places where physicians learn about social phobia. Drs. Debru and Delaporte[244], both general practitioners, reported that they had learned about social phobia at continuing medical education training sessions that they undertook to learn

[244] Dr. Delaporte had initially described her continuing medical education in psychiatric skills for general practitioners as having no theoretical position because it was taught be physicians. Though she later acknowledged that they had spent most of their time on practical and cognitive and behavioural therapy approaches, her initial comment underlines an important factor in medical training and continuing medical education. If a session is led by a doctor, rather than another sort of specialist or representative of the pharmaceutical industry, many doctors will probably assume, as did Dr. Delaporte, that the information presented is objective and neutral. This would add to the power of opinion leaders, who are physicians, but who present information that is favourable to the group that funds them. These opinion leaders and other externally-funded physicians will be seen as presenting unbiased information, though the topic they speak about and the elements their discussions focus on will often be selected for strategic purposes for the benefit of the group funding the talk.

more about cognitive and behavioural therapy. During the meetings, they learned about cognitive and behavioural therapy as a technique that is effective in treating the disorder.

Some physicians recalled hearing about social phobia in their original medical training, but at the time most of the physicians I interviewed were educated[245], the disorder would have been little know and little attention would likely have been paid to it. This is very different from contemporary medical training, Dr. Duclaux, a cognitive and behavioural therapist, pointed out. Students are trained in the environments in which cognitive and behavioural therapy has the most influence, university hospitals. At the hospitals, students will now be given detailed information about psychiatric practices such as cognitive and behavioural therapy, which is likely to make them 'see' the disorder, in addition to being taught explicitly about social phobia.

The DSM, which now has a more central role in medical education, is also a source of information about social phobia for new and older physicians alike. As Dr. Villette, a psychoanalytically-oriented psychiatrist, pointed out, the pharmaceutical industry gives out free copies of the DSM to physicians, so it is likely to be a text that doctors have at their fingertips and to which they can easily refer to find an explanation for patients' symptoms. Despite the fact that the manual was little accepted for a long time in France and some still fight against its integration, it is now more widely known and used. Dr. Jacob reported that 15 years ago, when he was a young general practitioner, he did not understand why the DSM received such bad press. In his opinion, it seemed advantageous to have an organized classification system. But now he and others argue that the classification is not based on science, as they had previously

[245] Almost all of the physicians I interviewed were between the ages of 30 and 50.

thought. It can be manipulated by many people, he says, including representatives of the pharmaceutical industry.

Professional associations are also a source of information about social phobia and several physicians reported that they had recently discussed social phobia at a professional association meeting. Professional associations include groups like the Yvelines network[246] which I joined. These groups pull together professionals with similar interests. For instance, the Yvelines network is an association that brings together health professionals (for example, physicians, psychologists, nurses, social workers, etc.) with a particular interest in mental health issues. It came to my attention towards the end of an Yvelines weekend retreat in Normandy that the event had been paid for by Eli Lilly. Apparently one of their representatives had been there throughout the weekend and though I tried to find him to inquire into the company's role in the network, I was unable to find him. Other associations bring together physicians involved in clinical research, public health campaigns or specialized juvenile healthcare.

Medical journals are also a source of information about social phobia, though as noted earlier in this text, *Encephale* is one of the few French language journals to publish detailed articles about the disorder. *Encephale* is a biologically-oriented medical journal and its readers are often those physicians who take part in pharmaceutical clinical trials along with cognitive and behavioural therapists. Social phobia is given some attention in other journals[247] but it is still not a common topic in most French medical journals.

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[246] The Yvelines network is described in both appendices to this text. It is a network of health professionals who meet at least once or twice a year to discuss the treatment of patients suffering from mental illness.

[247] As mentioned in chapter two, these include *Revue Médicale de Liège* and *Annales Médico-psychologique*.

Of course, physicians, like patients, also hear about social phobia through popular sources. Doctors reported hearing about the disorder on the radio and television both in terms of shows being devoted to a discussion of social phobia in addition to advertisements focusing on mental health issues[248].

Patients' sources of information

Patients have a wide variety of information sources and most physicians I spoke to report that people arrive in their offices with more information now than they did in the past. According to Dr. Delaporte, patient activism and involvement in choosing their own therapeutic interventions has risen significantly since HIV/AIDS patient groups were first mobilized. Patient mobilization had led to more people actively researching the implications of their symptoms and self-diagnosing their problems. All the members of Les Phobiques to whom I spoke indicated that they had read about social phobia in books, magazines or on the internet, and were acquainted with the disorder through the television and radio. They often tuned in to shows hosted by psychologists or dedicated to psychological issues. Doctors did not uniformly report that their patients self-diagnosed, but most said that the incidence of this practice has increased and that many patients probably self-diagnosed without informing their physicians of their personal conclusions. Dr. Arnaud said that young patients, as well as young physicians, prefer to use labels compared with their senior counterparts. He believes that this has further encouraged patients to seek out the name of their (potentially self-diagnosed) condition.

[248] Among other television shows, *Tout le monde en parle* was mentioned by name, but I was unable to find the specific episode the physician was referring to.

The primary sources of information for patients include physicians, the media, the internet, books and support groups.

Physicians as *sources of information*

In chapters five, six and seven, I described French clinicians' opinions concerning social phobia and how they explain the symptoms of the disorder to their patients. They present a wide range of explanations of the disorder. Some describe the symptoms as natural and even beneficial anxiety, while others describe the symptoms as part of a serious medical condition needing multiple therapeutic interventions. But patients who eventually become diagnosed as social phobics must find a physician who uses the diagnostic category. As explained in chapter five, many physicians avoid using the label social phobia. If patients do not find a physician who accepts social phobia as a valid diagnostic category, they will not be assigned the label and will perhaps be prescribed antidepressants or anxiolytics for a different disorder or be given very little explanation for their troubles.

Physicians who use the diagnostic category provide patients with different amounts of information. There are general practitioners such as Dr. Marsault, who believe that the disorder is very widely prevalent and who associate it with a very wide range of conditions and levels of impairment. These general practitioners will likely diagnose many people with the disorder. However, Dr. Marsault appears to know little about the disorder aside from what she reads in pharmaceutical pamphlets and she seems to know very little about psychiatric theories. Physicians of her kind, of whom there are probably many in France, particularly considering the large proportion of general

practitioners (general practitioners comprise one half of all French physicians), will tend to provide patients with little information other than the name of their disorder and the name of the drug used to treat it. On the other hand, there are some general practitioners who provide patients with detailed accounts of the disorder and how they believe it can best be treated. There are some psychoanalytically-oriented clinicians who will talk to their patients about social phobia, but who will emphasize the personality traits and developmental issues involved in the appearance of the disorder. These physicians are unlikely to provide patients with much information about social phobia as it appears in North American or biologically-oriented French medical literature. Finally, there are cognitive and behavioural therapists who give patients a detailed description of the disorder that fits their theoretical and therapeutic frameworks. The information that patients get from these clinicians will concur most closely with North American and DSM definitions of social phobia. It is only from these physicians that patients will learn about the official, DSM version of the disorder.

The information that patients get from clinicians is heterogeneous, but if patients believe that they suffer from the disorder or if they want to know specific information about it, it is very easy for them to shop around for a physician who will provide them with the type of information or label they want. They can get the names of therapists who specialize in the treatment of social phobia and other anxiety disorders from either Les Phobiques or the French Association of Cognitive and Behavioural Therapists. Many members of the support group noted that they had seen different therapists for years and had often been assessed as 'normal' or diagnosed with other disorders before

they found a physician who diagnosed them with social phobia. They reported being happy to finally learn what they suffered from.

Almost all of the support group members had experience with cognitive and behavioural therapy or planned to begin therapy with a cognitive and behavioural therapist. So, almost all of these people had heard the DSM explanation of social phobia from a physician. Once in therapy with a cognitive and behavioural therapist, most patients participate in group therapy, so they learn about social phobia not only from their therapist, but also from other patients. As in support group meetings, contact with other social phobics increases patients' knowledge of the manifestations of social phobia and re-affirms their belief that social phobia is a real and common mental illness.

The media as a source of information

Most of the social phobics I spoke to mentioned television and the internet as their primary sources of information. Physicians concurred that these were the most popular sources of information about medical disorders amongst their patient populations. Several patients and physicians noted that social phobia has become prominent in the media and patients often report that they had heard about the disorder this way before they were diagnosed. Dr. Fourciers compares the publicity that social phobia is now receiving to the attention given to obsessive-compulsive disorder by the media about 10-15 years ago. At that time, he says, patients who had heard about the disorder crowded his office[249]. Dr. Fourciers and other cognitive and behavioural therapists report that they

[249] Like almost everyone who mentioned obsessive-compulsive disorder, Dr. Fourciers referred to the effective role of Judith Rapoport's book *The Boy Who Couldn't Stop*

are now deluged by letters from patients who believe they are social phobics. But, like other cognitive and behavioural therapists, he does not think that this is an undesirable situation. He believes that it is better to cast the net too broadly for social phobics, at which point he or his colleagues may have to inform certain patients that they do not suffer from the disorder, than it is to risk failing to attract potential social phobics to his office for treatment.

Almost all of social phobics I interviewed informed me that the weekly television programme *Ça se discute,* hosted by the popular television personality Jean-Luc Delarue, was one of their regular sources of information on mental illness and its treatments. Delarue has discussed various phobias, including social phobia on his popular talk-show style programme. Members of the support group I attended in Paris have appeared as guests on his show to share the details of their experiences with the disorder. People I interviewed said that watching the show and hearing about other people's problems with mental illness gives them hope about their ability to master their own problems. Shows such as *Ça se discute* also make them feel less alone in their experiences with mental illness. Physicians confirm that it is from this show that their patients often report getting their information. Other television shows that focus on psychological issues were also mentioned by physicians and members of Les Phobiques, such as *Psychologies* which is hosted by another popular television personality, Maïtena Biraben.

Dr. Delaporte informed me that there are now advertisements on French television that discuss medical conditions. She has seen ones about migraines and problems with being overweight. Like their North American counterparts, the advertisements first

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Washing (1988) in spreading information widely about the disorder to patients and physicians alike.

describe a condition and then suggest that if the viewer can relate to the description of the disorder, he or she should see a physician for more information. While these advertisements do not mention any medicines by name, Dr. Delaporte describes these as hidden advertisements for medications and says that they bring people into her office looking for drugs. She says that she has not yet seen any that focus on social phobia, but she does not see why they would not appear in the future. She pointed out that these advertisements do not amount to direct-to-consumer-advertising[250], but she says there is a lot of pressure from the pharmaceutical industry to allow this type of marketing. Nonetheless, she says she is an optimist and says she has hope that direct to consumer advertising will never appear in France. I did not own a television throughout my field work, so I did not see any of these advertisements first hand. The advertisements were not discussed in my meetings with European Union representatives or pharmacovigilance groups, as I had specifically asked about commercials with references to drugs. During my stay in France I heard similar advertisements on the radio. Such commercials sounded much more like public service announcements than the direct to consumer advertisements that air in Canada or the United States.

Dr. Duclaux pointed to the appearance of "institutional" advertisements in France, which appear on the television and in print formats. In these commercials, pharmaceutical companies publicize the name of their company and generally describe the research that they are undertaking. The companies use these advertisements to inform

[250] Direct to consumer advertising, as it commonly used in the United States today for pharmaceuticals, involves advertising a prescription medication on the television, radio or print media. The condition the medication is used to treat is also described in the commercial so that the viewer at once learns about a disorder and its pharmaceutical treatment.

the public of how their company is working to improve the health of the French people. However, the companies cannot provide the names of their medications or describe the disorders their medications treat.

Physicians were divided concerning whether they think that direct to consumer advertising would eventually be permitted in France and whether it provides good information. Some felt that the European Union will end up giving in to pressure from the pharmaceutical industry, while others believed, without stating a specific reason, that something like direct to consumer advertising could never appear in France. Some physicians argued that the French government would never allow direct to consumer advertising because the government pays most of the cost of medications. In countries where direct to consumer advertising is permitted (United States, New Zealand), the consumption of advertised drugs has been shown to increase (Mintzes et al. 2003). But statements that put responsibility on the French government to prevent the appearance of direct to consumer advertising did not take into account the fact that it is the European Union, rather than the French government, that will make the decision about whether to allow these types of advertisements. The European Union recently reaffirmed its stance prohibiting direct to consumer advertising. However, the European Union representatives that I interviewed indicated that concessions had been made to have this legislation pass. They stated that it is far from certain that the Union will maintain its current level of control, which is generally more stringent than in North America, of the pharmaceutical industry.

Most physicians believe that direct to consumer advertising is a bad idea because the information in the advertisements is biased or incomplete. However, Dr. Lefebvre

believes that patients deserved to have this type of information and suggested that it allows them to engage more easily in conversation with their physicians. This argument is similar to that most often presented by the pharmaceutical industry to justify direct to consumer advertising (for example, Bonaccorso and Sturchio 2002).

Whether it is good or bad, direct to consumer advertising and the other advertisements describe above, will play an increasing role in informing patients of new medications and the health conditions they treat.

Private and public French radio stations have aired programmes that focus on social phobia and social anxiety. A relatively recent (December 2004) show on "Le Bistrot de la Vie" (Radio Notre Dame) examined the ubiquity of social anxiety, arguing that 58% of the French population suffers from these troubles. The psychologist specializing in cognitive and behavioural therapy who was a guest on the episode emphasized, however, that this anxiety was different from the more serious and rare social phobia[251]. The therapist explained to listeners the history of this type of therapy and the efficacy it has been shown to have in American and French clinical trials. The president of the support group I attended was also a guest on the programme where she discussed her experiences with the disorder[252]. She described the activities and members of the support group and provided information to reach Les Phobiques. It is through shows such as this one that many support group members either first hear about Les

[251] This format of naming the respective conditions, social anxiety, which almost 6 in 10 people can relate to, versus social phobia, which is considered a more serious disorder, is interesting in light of the recent debates over suggestions to change the name of social phobia to social anxiety disorder. It is clearly the latter that more people can relate to and could possible encourage the broadening of the diagnostic category.

[252] Because the name of the support group and its president are mentioned, I have not added a link to this programme.

Phobiques and social phobia. Many also use these shows to increase their knowledge about the disorder. M. Sabbah, a member of Les Phobiques, for example, reported listening to a radio show hosted by a psychologist, Caroline Dublanche, on the Europe 1 station. This show focuses on psychiatric and personal problems "large and small", from problems in listeners' love lives to people suffering from serious psychiatric disorders. Like many of the other shows that support group members are fond of, this show includes many personal account of mental illness from people who call in and share their experiences. M. Sabbah says that hearing about other people's experiences gives him confidence in his ability to talk about his own problems. He first learned about Les Phobiques when the president of the support group was a guest on a radio show.

Finally, magazines and online magazine resources are also popular sources of information about psychiatric problems for members of Les Phobiques[253]. The most common type of magazine cited by both support group members and physicians as providing lay information about social phobia were 'women's' magazines (*les féminins*). These magazines focus on fashion, general interest stories and psychologically-related issues. Dr. Clavel's opinion of these magazines was somewhat representative of the physicians I spoke to. He said that because of these women's magazines, people are increasingly aware of the existence of social phobia and other disorders. Many people first learn about the disorder in magazine articles. He says that while patients do not necessarily know what to do with the information they read in these magazines, he considers it beneficial that at least the public is becoming better informed. Specific

[253] Dr. Jacob believes that articles in magazines such as *L'Express* or *Le Point*, which have focused on disorders like obsessive-compulsive disorder or social phobia, only appear because journalists are paid by the pharmaceutical industry.

magazines that support group members identified as sources of information include *Marie Claire* and especially *Psychologies*, which a large number of Les Phobiques members read. *Psychologies* is an increasingly popular magazine in France. In the last eight years its sales have increased more than any other women's magazine. In 1997 just over 75 000 copies were sold annually. By 2005 this number had risen to almost 325 000 copies (http://images.psychologies.com/publicite/performances.pdf).

These media resources introduce the French population to the category of social phobia and new ways of interpreting their experiences, fears and weaknesses. These resources provide the public with explanations for their personal and career failures, fears of performance, lack of self esteem. *Psychologies* magazine alone offers 130 tests for readers to analyse their personalities, relationships and lives. The magazine also provides medical experts' responses to readers' letters. Among the magazines regular experts is the well know cognitive and behavioural therapist, Christophe André, co-author of the book *La peur des autres: Trac, timidité et phobie sociale* (André and Légeron 1995b). Articles have appeared in both *Psychologies* and *Marie Claire* about shyness and social phobia. By describing the signs and symptoms of social phobia, these resources encourage people to examine their own feelings and behaviours for signs of the disorder.

The internet as a source of information

The internet is a major source of information for almost all of the members of the support group. They can access online discussion forums, medical advice, pharmaceutical company websites and popular or professional literature. Although there is a lot of information available online, several support group members and physicians

mentioned that there is not nearly as much available on the internet in French as in English. A few support group members who could read English noted that they used Anglophone resources more than the French ones because they are more numerous. For those who can only read French, some use Québec web sites, which they say offer a different range of information from that available in France. Physicians agreed that the internet appears to be one of their patients' major sources of information. However, Dr. Delaporte worried that almost any information can make it onto the internet so she does not believe that the people who use this resource are getting the best quality information. Dr. Lefebvre, on the other hand, thinks that this information is useful nonetheless. He is pleased by patients' interest in seeking out information and he believes that he can correct the inaccuracies patients stumble across once they arrive in his office. He believes that discussing the information that patients have sought out on the internet is a good way to initiate conversations about patients' problems.

M. Perrin is one of the support group members who has searched widely on the internet for information about social phobia. He is bilingual as a result of his one-year exchange to McGill University. He reported to me that he gets information from sites such as Doctorissimo.com. While he was in university, he used the school's online resources to access professional literature about social phobia. He says that he has used primarily English-language resources because he knows that this is where he can find more information. M. Bouvier, who is fluently bilingual, also relies on English-language websites, which he has used to find information about disorders but also about medication use. One of the British sites he visits is Benzo.org.uk, which is a virtual

support group for people addicted to the benzodiazepines. M. Bouvier also found out about Les Phobiques on the internet.

Most of the support group members use only French websites. M. Bonet is one of these people. He says that he uses primarily online forums where concrete cases of social phobia are described. He said that such sites made him feel less alone and they also provide him with a great deal of the information about the disorder as well as techniques for coping with his symptoms. He has also used interest-specific forums, such as ones that encourage participants to get involved in artistic endeavours. Through one of these forums, he became involved in a couple of theatre productions. Like many of the support group members, M. Bonet also heard about Les Phobiques for the first time on the internet. M. Vial reported that it was on the internet that he first heard about not only about Les Phobiques, but also social phobia. Before this, he had never heard the term and but as soon has he read about it, he immediately believed that this was the disorder he suffers from. In seeking further information about the disorder, he says that he selects websites according to the amount of technical information and mutual support they offer. This is why he has used French Canadian websites, which he describes as offering more information about symptoms, therapies and treatments than French websites.

Books as sources of information

Psychology and self-help books are also well-used sources of information about social phobia. Many such books exist, but by far the most widely read book among the people I interviewed was Christophe André and Patrick Légeron's *La Peur des Autres: trac, timidité et phobie sociale* (1995b). The authors are two of the most well-known

French psychiatric researchers of social phobia. Among the support group members I spoke to, Dr. André's name was the best known of any other authors who have written about social phobia and at least a couple of the people I spoke to had been treated by him. Dr. André is a psychiatrist at St. Anne's hospital in Paris. Dr. André has also written several other similar books and for one of these he collaborated with a well known French graphic artist, Muzo. M. Béguin, a member of Les Phobiques, specifically mentioned this latter book, *Petites Angoisses and Grosses Phobies* (2002), as one which had taught him a lot about how to deal with social phobia. Dr. André says that he sees his books as aimed not only at patients, but also physicians. He describes them as psycho-education books and includes many references for his readers to further inform themselves about the conditions he writes about[254]. While self-help books are not as widespread in France as in North America, Dr. Lefebvre pointed out, bookstores are dedicating an increasingly large amount of space to books of this genre. Dr. Jacob pointed out that there is "loads of money" to be made selling these types of books, which have become quite popular.

In addition to reading books specifically about social phobia, support group members also reported reading related books about self-victimization (Mlle. Jabin), shyness (Mlle. Bruyère), the inability to ever be satisfied, feelings of guilt, and of never being good enough (M. Béguin). Dr. Delaporte complained that although most of the self-help books are good, it is relatively easy for people to publish books in France, so quality is not necessarily assured. In this respect, she compared the quality of some books to that of the internet.

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[254] Dr. André explained this to me during our interview. Throughout the rest of this text, I have used a pseudonym for Dr. André.

A book that none of the support group members reported reading but which has become a best seller in France is David Servan-Schreiber's[255] *Guérir le stress, l'anxiété et la dépression sans médicaments ni psychanalyse* (2003). This book has been translated into English and published in North America in 2004 as *The Instinct to Heal: Curing Stress, Anxiety and Depression without Drugs or Talk Therapy*, and in Britain as *Healing without Freud or Prozac* (2004). He has established a website to elaborate on content of his book (www.nofreudnoprozac.org). This book promotes seven 'natural' ways of overcoming life's problems including exercise, taking omega fatty acids, acupuncture and eye-movement desensitization and reprocessing. It is likely that some members of the support group have read this book, but no one commented on it, so I am unable to report on the effect it may have had on social phobics. Dr. Duclaux was the only person I interviewed who mentioned the book, which he referred to derisively as an American-style publication. He explained that Servan-Schreiber comes from a famous French family[256], for example his uncle operates the magazine *Psychologies*, who have a significant impact on French media and publishing. Dr. Duclaux said that the book could probably help people with small problems. Dr. Duclaux's description of David Servan-Schreiber indicated that he is not an author that Dr. Duclaux takes seriously nor does he believe that other French psychiatrists would take him seriously. By describing the powerful family that Servan-Schreiber comes from, Dr. Duclaux seemed to suggest that Servan-Schreiber would not be where he is today (a best-selling author and well known psychiatrist) without his family's support and power.

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[255] Dr. Servan-Schreiber is a clinical psychiatrist who is affiliated with the University of Pittsburgh and the Faculty of Medicine in Lyon.

[256] His father is Jean-Jacques Servan-Schreiber, a well known French economist and founder of the weekly magazine *L'Express*.

From the reports of both doctors and support group members, self-help books are one of their primary sources of information and they will probably be used even more in the future as the self-help culture advances in France.

Support groups as sources of information

There are few places that Parisians suffering from phobias can go to access peer-support. While the internet provides virtual support systems, websites often act largely as referral systems guiding participants to live support groups, written materials, or 'good' physicians[257]. There are two active support groups in Paris for the treatment of phobias and anxiety. One of these, À la phobie[258], provides organized events, training and group meetings for a fee, but does not hold regular group meetings open to the public. The woman who established this group used to be an executive member of the other support group in Paris, Les Phobiques, and some friction exists between the two groups, or at least between the executive members of Les Phobiques and À la phobie. Most of the members of Les Phobiques who I interviewed were aware of À la phobie's programmes, and some had attended the group's events. But while most said that the activities this group offered might be helpful, they complained that it was expensive to participate. Cost was the primary reason cited by members of Les Phobiques to explain why they do not attend the activities of À la phobie.

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[257] 'Good' physicians, according to self-help websites and groups, are those who practice cognitive and behavioural therapy and are experienced in treating social phobia.
[258] This is the real name of the group, not a pseudonym, as I never had any interaction with the group. The woman in charge of the group did not respond to my attempts to contact her.

The second support group in Paris, Les Phobiques, was established in 1998 as a local branch of a network of support groups established in Lille (1995) for people suffering from phobias and anxiety. Branches have subsequently been established in Rouen (1999), Lyon (2002), Rennes (2002) and Toulouse (2004). The Paris branch of these support groups is a member of the National Federation of Psychiatric Patients' Groups (*Fédération Nationale des Associations de Patients en Psychiatrie [FNAP-Psy]*). Many members of Les Phobiques initially learned about the group on the internet or radio, while others were referred to the group by their physicians. Most doctors I interviewed believed that attendance in a support group would likely help their patients[259]. As Dr. Delaporte said, "It's good. They [patients] take their own care in their hands. We're doctors, but we don't have social phobia and I think it's good that they can talk amongst themselves and give advice to each other." Most physicians believe that there should be more of these groups, as there are in North America, and several physicians I spoke to treated patients who were members of Les Phobiques.

Many of the cognitive and behavioural therapists I interviewed helped to establish Les Phobiques and they provide space to the group in the hospitals where they are employed, free of charge. One Parisian cognitive and behavioural therapist is the honorary president of the group. Dr. Duclaux pointed out that while these patients offer help to each other, they have a limited power beyond their group because they are not professional. Most people, he said, would not put as much faith in the voices of support group members as they would in professionals, who have a greater authority. This hierarchy between professionals and non-professionals is reflective of the French society,

[259] Dr. Picard is a notable exception to this trend.

where senior professionals' voices carry substantially more weight than their juniors and non-professionals. Hierarchies are more strictly respected compared to in North America.

It is at meetings of Les Phobiques that many people learn the 'language' of social phobia, as explained in chapter nine. At meetings, cognitive and behavioural therapy and DSM terms are used to describe members' symptoms and new members learn from old ones how to describe their problems in ways that are consistent with the language used in the group. M. Vial, for example, sat studying hand-outs from Les Phobiques which described social phobia from a cognitive and behavioural framework, as he waited for our interview to begin. Many patients reported to me that before attending the support group, they did not know how to put their problems into words. But after attending the group, they explained that they were much more able to explain their social phobia.

People also learn coping skills and tactics to get along better in daily life at Les Phobiques. Many members credit this group with teaching them how to begin re-inserting themselves into life as well as how to cope with their solitude. Most members I spoke to reported feeling immediately better once they attended the group because it gave them immediate assurance that they are not alone in suffering from their troubles.

Support group members rely on information about how social phobia and other psychiatric disorder are treated in other countries, or at least how they imagine they are treated there, to assess how social phobia is perceived and treated in France. Most members, even those who have never been to the United States and who cannot read English, believe that Americans much more openly discuss psychiatric disorders than do the French. Several of these people had been to North America, or who had at least

visited North American social phobia websites, report that the disorder is accepted as a disease overseas and that it is seen as something that can be easily treated and spoken about. They compare this to the situation in France where it is only in the past decade that seeing a psychiatrist would not lead one to be labelled as crazy, though some believe that this assumption remains. However, most are hopeful that this situation is changing and that their problems will be more easily understood by others in the future. The members of Les Phobiques used the foil of North American acceptance of social phobia to argue that it should be more easily accepted in France.

Disseminating information about social phobia is the first step in its integration into French psychiatry and society. Once people hear about social phobia, the possibility of them identifying with the disorder is raised. My research has shown that social phobia is a disorder that many individuals are eager to learn about and it is an easy disorder for them to relate to. Cognitive and behavioural therapists' explanations of the disorder appeal to many patients and it provides them with a medical justification for their shy behaviour that may have held them back in life. This argument is developed in chapter 11. Regardless of whether many physicians reject the disorder, the more it is discussed, the more people will hear about it. The next chapter examines the process of becoming a social phobic.

Addendum: How the French become social phobics

The dissemination of information about a 'new' disorder in no way ensures that patients or physicians will either adopt or diagnose the label. In this addendum to chapter 10, I address why it is that the French are 'getting' social phobia.

There is no biological marker to confirm or disprove a person's diagnosis with social phobia. Because of this, diagnosis must be based on the results of psychological tests and clinical interviews in which patients report the symptoms of social phobia and physicians interpret patients' symptoms as proof of the disorder. Physicians must be willing to detect social phobia, rather than interpreting patients' problems as signs of another condition (for example, shyness, neurosis or depression). For patients to become social phobics, they must be willing to interpret their personal experiences as signs of the disorder. In the case of many French social phobics, this involves a reinterpretation of their experiences. What they may have once thought of as simply unwelcome character traits, such as shyness and social unease, must be identified as a problem. This problem must be disturbing enough that they are willing to accept that it is a disease. The adoption of the diagnostic label means that French individuals acquire a new way to account for their personal and professional failures, fears of performance and lack of self esteem. Below, I present several explanations of why this process occurs. These explanations were provided by the social phobics and physicians I interviewed.

Social phobics and physicians suggested that modern French life, especially urban life, is conducive to social isolation. This social isolation, they say, worsens people's social skills and increases their social unease. These are both factors, they say, in the rise of people identifying with the label social phobia. People are more often spatially separated from their families, as they move to major urban centres to find employment. In big cities, a large proportion of people live alone in bachelor apartments[260], which

[260] It was quite uncommon for people in Paris to live with room mates, a practice that is must more prevalent in North America. I knew several North Americans who attempted to find housing to share with a group of people, and they were often met with suspicion

further increases their isolation. People are living longer in these bachelor apartments, as people tend to marry later in life now than they did in the past. Further, social phobics and doctors pointed to the role of technology in encouraging social isolation. They said that computers, television and the internet all contribute to people staying at home alone, rather than going out to socialize. These technologies, they say, have made it easier for people who are uncomfortable in social situations to isolate themselves, thereby worsening their condition. Using these arguments about social isolation, physicians and patients blame environmental factors for creating social phobics out of people who they believe would otherwise be more socially at ease, perhaps 'normal', if their living conditions were different.

Several physicians I spoke to suggested that people are beginning to accept the label of social phobia more easily because social ease and adaptation have become greater concerns in modern day France. If people do not believe that they can perform adequately in society, whether at social engagements or in accordance with job related responsibilities such as giving presentations, they are now more likely to see their failures as signs of pathology. One doctor went so far as to say that being shy has become a source of shame in French society. His statement supported those of other physicians and patients who noted that there is a growing pressure in French society to be extroverted. Introversion is no longer considered a valuable trait. Because of these changes, people are increasingly concerned about their ability to meet social expectations and will more quickly label social failures or shyness as problematic or pathological. What was in the past a normal degree of social unease, becomes a problem in need of treatment. The

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by landlords, who did not understand why a group of friends, rather than a family, would want to rent a large apartment.

physicians who put forward these arguments suggest that social anxiety and discomfort are now sentiments that must have a justification and even a medical explanation. They suggest that these factors make the use of the label social phobia.

According to most of the psychiatrists I spoke to, the type of people who identify with social phobia tend to suffer from low self esteem or narcissistic personalities. For these types of people, support groups offer a group identity, something that provides them with a sense of belonging. Because of this, psychiatrists suggest that these people would be drawn to Les Phobiques as it would provide them this with group identity. In this case, the support group might act as a driving factor in these people eventually identifying themselves as social phobics. Individuals may have first attended the group with a loose set of symptoms and complaints, but over time, they may learn to identify themselves according to the language of the group, which is primarily that of social phobia symptoms and cognitive and behavioural approaches to the mind.

Many physicians I spoke to argued that most people who are now diagnosed with social phobia are actually neurotics. However, the doctors added, these individuals easily 'get' social phobia because they are highly suggestible. They consider suggestibility to be a distinguishing feature of neurotics, making these people likely to 'see' themselves in other diagnostic categories. This process may occur with or without a physicians' diagnosis. Because social phobia is receiving a considerable amount of attention in the popular media, physicians suggested that this makes it a diagnosis that neurotics will likely adopt. It is not uncommon, they say, for neurotics to experience social unease, which means that they can often meet the diagnostic criteria of social phobia. The physicians who made this point did not believe that these people should be diagnosed

with social phobia, only that they could fit the diagnostic criteria. They believed that these individuals would be better treated if they were cared for as neurotics. The general point that these physicians made was that social phobia seems to be the newest "fashionable" mental disorder. Because of its increased profile, more neurotics will likely hear about the disorder. These clinicians believe that hearing about social phobia is almost enough for neurotics to identify with it. The availability of a support group would only further augment neurotics' identification with social phobia because of the strong group identity it offers to what physicians describe as somewhat decentred people looking for clues to their own identity in others.

Arguing from another point of view, several physicians suggested that people become social phobics because it is their preferred diagnosis. The rate of co-morbidity of individuals with social phobia is estimated to be 80% (Rapee and Spence 2004; Sareen and Stein 2000), so this disorder most often appears alongside at least one other. The disorders it most commonly appears alongside include anxiety disorders (for example, generalized anxiety disorder, obsessive-compulsive disorder, panic disorder), or a mood disorder such as depression. As I explained in previous chapters, social phobia is viewed as both a 'real' and serious mental disorder, but it is also less stigmatizing than many others. So people who suffer from multiple anxiety disorders including social phobia or social phobia plus a mood disorder may prefer to identify with social phobia rather than their other diagnoses.

It is not just people diagnosed with other anxiety or mood disorders who may prefer the label of social phobia to other designations. Many patients I spoke to said that they much preferred the diagnosis of social phobia to psychoanalytic labels. Regardless

of the other labels that had been given to them by psychoanalytically-oriented physicians over the years, once patients' received a diagnosis of social phobia (or if they self-diagnosed the disorder) they often distanced themselves from the psychoanalytic labels that they had found stigmatizing. Patients generally found that the psychoanalytic labels offered them little hope of a cure and provided no clear cut path to improvement. Physicians, particularly psychiatrists, agreed that patients often prefer the label social phobia to psychoanalytic labels. These doctors suggested that patients' prefer non-psychoanalytic labels such as social phobia, because they do not require patients' to examine their sentiments and experiences at as profound as level as do psychoanalytic approaches to psychic suffering. Patients' labelling preferences thereby increase the number of proclaimed social phobics compared to those who identify with another disorder.

Social phobia seems to be a disorder that the French population finds increasingly easy to identify with. The cognitive, behavioural and biological perspectives are the ones that French social phobics are eager to draw on to explain their problems, though they combine these explanations with references to their sensitive personalities. While some support group members choose to delve further into psychoanalytic explanations for their difficulties, most make only superficial references to these theories and the use of the term personality is as close as many come to psychoanalytic explanations. Dr. Picard, a psychoanalytically-oriented psychiatrist, suggests that it is common among her patients who could meet the diagnostic criteria for social phobia to fight against more purely

psychoanalytic explanations of their problems[261]. This suggests that there will likely be more social phobics in the future, compared to 'neurotics'. It is increasingly patients' preferred identity. The next chapter addresses what it is that an identification with social phobia offers to patients.

261 Dr. Picard : *Je pense qu'on (psychanalystes) a davantage tendance à considérer la phobie sociale comme constitutive de la personnalité... Et les patients luttent contre ça.*

Part IV

Assessing Social Phobics

Chapter Ten

Why some people want to be social phobics

Contents

Much of this thesis has focused on why certain people are struggling to have a particular set of clinical symptoms recognized as social phobia, rather than as phobic neurosis, other diagnostic labels or 'normal' shyness. I have examined why many French physicians refuse to use the label social phobia and why they argue that patients with these symptoms are equally, if not better, attended to when other diagnostic labels are applied. Some physicians suggest that the category should not exist and argue that its use by others is ethically suspect.

This chapter moves beyond debates about whether social phobia is the most appropriate name for pathological shyness and fear of judgement. It brings together observations and comments scattered throughout this text to focus on what the diagnosis of social phobia offers to patients and physicians. I will examine why certain people *want* to be social phobics and why an increasing number of physicians prefer this label to others.

Critics of social phobia

Most of the physicians I spoke to said that they would not use the diagnosis of social phobia, either because they believe that psychoanalytically-oriented explanations are more apt, this type of anxiety is normal, or using the diagnosis makes them complicit with pharmaceutical companies' efforts to sell more SSRI antidepressants. However, clinicians suggested many reasons to account for why the disorder appeals to patients and other physicians. Professionals who are critical of social phobia argue, somewhat cynically, that patients and other physicians like the diagnosis because it is uncomplicated to use and easy to relate to. As Dr. Lalande told me, "There is still some

fear or discomfort with the idea, but it is not heavy in signification." He argues that the discomfort with the idea of social phobia results from lingering French fears of psychiatric illness, which interviewees described as greater than Americans' fears[262]. The French described American's approaches to mental illness as nonchalant and believe that Americans can discuss mental illness as easily as any other medical disorder. My interviewees suggested that discussing one's psychiatrist is a part of everyday small talk in the United States. In comparison, the French still have the tendency to equate resort to a psychiatrist with "madness", my informants told me. It is not possible, they believe, to speak freely about their problems. While discomfort with the idea of social phobia remains, Dr. Lalande's assertion that the disorder is not heavy in signification relates to the fact that social phobia is a DSM disorder defined by its symptoms, unlike psychoanalytic categories which are defined by an etiological process that implicates a person's essential character. The behaviour and thoughts that constitute the diagnostic criteria of social phobia are usually treated with antidepressants and cognitive and behavioural therapy. This psychotherapy does not focus on patients' pasts (Spiegel 2006), but instead on how to alleviate their symptoms by teaching them to interpret and react differently to their environments. Dr. Lalande and similarly minded clinicians consider this symptom-based approach to be superficial compared to their own psychoanalytic, or psychoanalytically-oriented, practices. They suggest that people like to be diagnosed with social phobia because it allows them to identify with a disorder,

[262] Many of the people I interviewed used the United States as a reference for everything that they think is good or bad about French psychiatry. The people cited above were critical of the pressure they felt to keep mental illness a secret in France. Others took a different angle and criticized the over-prescription of drugs in the United States and Americans' pathologization of everyday life events, to show how prudent French physicians are in comparison.

which provides an explanation for their problems in everyday life. But at the same time, the diagnosis does not implicate what these clinicians refer to as the psychological root causes of their troubles, which they consider the most important part of addressing a mental illness. So, these critics argue, a profound process of self-interrogation is not necessary for the treatment of social phobia. These clinicians believe that patients are often resistant to the self-inquiry involved in psychoanalysis, which they say makes the cognitive and behavioural approach associated with the treatment of social phobia more appealing to many patients.

Why physicians are comfortable diagnosing social phobia

Physicians who are critical of social phobia argue that in addition to making it an easy label for patients to relate to, the superficial nature of the diagnosis makes it easier for physicians to assign the category. They believe that other physicians like the category social phobia because using it makes their jobs easier. This belief was reflected in the explanation of the disorder offered by Dr. Gitton. He drew a comparison between the diagnosis of social phobia and the once widespread use of the term spasmophilia. Dr. Gitton argues that it is easier for physicians to assign patients a disease label that has fewer personal or psychological implications. He suggests that using a term such as spasmophilia or social phobia allows physicians to avoid explaining to patients that their symptoms are tied to anxiety or personal anguish, which he believes is often uncomfortable for physician and patient alike. He credits physicians' reticence to use diagnoses loaded with personal or psychological meaning to the rise of diagnoses including spasmophilia and social phobia, and also disorders like chronic fatigue

syndrome, fibromyalgia and restless leg syndrome[263]. Dr. Gitton's statements implicate physicians in the endorsement of social phobia, through their use of the diagnosis, for reasons that are almost as personal as are social phobia patients' for identifying with the disorder.

Other critics of social phobia concurred with Dr. Gitton's assertion that physicians prefer to diagnose patients with social phobia, rather than other disorders, because it does not require them to discuss the deep personal or psychological implications of patients' problems. These clinicians argue that social phobia is an easy diagnosis to assign because social phobics, from DSM and cognitive and behavioural perspectives, are in essence healthy, sound of mind individuals who have a 'chemical imbalance' and a few inappropriate perceptions about the world which can be cleared up with six months of cognitive and behavioural therapy and antidepressant use. The cognitive and behavioural therapists I spoke to, who use the label of social phobia, counter that this is a ridiculous assertion because much of their work, even with social phobics, focuses on the personal problems experienced by their patients[264]. However, more than half of French physicians are GPs with little or no training in psychotherapy. I think that critics' suggestion that physicians prefer diagnoses that require little in-depth engagement with their patients

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[263] Dr. Gitton said that for a very small group of people have this neurological disease. However, the name has been much more broadly used to explain to people why they might not be able to sleep or relax, thereby explaining what could be psychological symptoms in biological terms.

[264] During interviews with cognitive and behavioural therapists, they were careful to address this often used criticism of their work. They agree that their therapy is directed toward symptom alleviation, but they argue that this does not preclude them addressing their patients' deep seated problems. The difference between their therapy and psychoanalysis, cognitive and behavioural therapists argue, is that they focus on the conscious mind rather than on patients' unconscious memories, for example. This does not mean, they say, that their therapy is superficial.

might be more persuasive in the case of GPs. For these doctors, a 'chemical imbalance' explanation, along with a referral to a cognitive and behavioural therapist may be easier than introducing a potentially more psychologically-loaded, psychoanalytic diagnosis. The fact that French physicians are paid by the act, which means that the more patients they see, the better their incomes will be, may encourage clinicians to avoid profound, lengthy discussions with their patients. Physicians who have their own practices, rather than working out of public institutions, told me that if they do not see large numbers of patients, it is quite possible for them to go out of business.

Nonetheless, the critics' argument assumes that physicians will necessarily offer less feedback when assigning a diagnosis of social phobia compared to other categories. Individual physicians are likely to explain the diagnosis to their patients in very different ways, some providing more feedback while others systematically engaging less with their patients. When I asked physicians how they explained the disorder to their patients, they had a divergent set of theories ranging from minimal references to relationship difficulties, to more profound explanations of sensitivities and personality types[265]. It seemed that by claiming that social phobia is an easy category for physicians to use, many of the critics of the disorder sought to position themselves as superior to other 'lazy' physicians who are unwilling to deal with patients 'true' problems.

[265] References to personalities are not consistent with DSM definitions of social phobia and reflect the tendency of French clinicians to blend together cognitive and behavioural with psychoanalytic theories. So while a strictly DSM, symptom-based approach to social phobia may appear shallow, the way the disorder is used and explained in clinical practice varies considerably. All physicians I spoke to, even those who regularly conduct clinical research using DSM categories, asserted that the DSM is a text that it useful, but which is distant from their clinical practices.

The preferred version of social phobia

Cognitive and behavioural therapists are fighting to reduce stigma and bring French therapy in line with global evidence based medicine (EBM) standards. As explained in previous chapters, the promotion and acceptance of social phobia is closely tied to the acceptance of cognitive and behavioural therapists' therapeutic principles. Like the critics of social phobia described above, cognitive and behavioural therapists describe the disorder in a way that is easy for people to relate to. But while critics of social phobia suggest that social phobia is portrayed as easy to relate to in order to 'sell' the disorder more effectively, cognitive and behavioural therapists earnestly describe social phobia in terms that are easy to relate to because they believe it is a widespread disorder that should be better known and more often diagnosed.

Every cognitive and behavioural therapist I spoke to compared the treatment of social phobia to that of diabetes, or a similarly 'medical' disorder. In these disorders, it is assumed that there are chemical imbalances in the body that need to be stabilized by medications so that the patient can be returned to his or her 'normal' state. According to these explanations, social phobia does not impact on a patient's 'real' person, it is conceived of as something separate from a person's essential being that can be overcome or managed with appropriate treatment. This description of social phobia, which is one of the portrayals of the disorder most widely publicized by cognitive and behavioural therapists, seem nearly identical to the caricature of cognitive and behavioural therapy and social phobia drawn by critics of the disorder.

Cognitive and behavioural therapists are aware of others' criticisms and argue that these people do not understand the extent of their multi-faceted approach to social

phobia. One cognitive and behavioural therapist, Dr. Roux, in response to criticisms of cognitive and behavioural therapy, sought to differentiate social phobia from other disorders that have been described as minimizing the psychological component of patients' conditions by placing an emphasis on their physical problems or presumed biochemical particularities. The disorder to which Dr. Roux compared social phobia was spasmophilia[266]. His criticisms of the disorder resemble other physicians' criticisms of social phobia. Dr. Roux asserted that spasmophilia became a popular diagnosis because of its biological explanatory model, which is considered less frightening than a psychological explanation for patients' troubles. He argues that a diagnosis of spasmophilia does not require the anxious and emotional components of the disorder to be deeply examined. At its base, Dr. Roux thinks that spasmophilia was simply another way of describing panic attacks, though he believes that social phobics might once have been described as spasmophiles, whether these people have co-morbid panic attacks or not[267]. Whereas he believes that the treatment of spasmophiles with magnesium was ineffective, he thinks that these same people respond well to treatment with cognitive and behavioural therapy and antidepressants. Dr. Roux argues that spasmophiles were not adequately treated because no part of their therapy addressed the psychological origins of their problems. In contrast, he believes that cognitive and behavioural therapy and antidepressants sufficiently treat the psychological roots of social phobics' problems.

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[266] Spasmophilia was introduced so often into interviews I conducted with physicians and patients that I eventually began asking people's opinions of it in all interviews, if it was not raised spontaneously. References to spasmophilia tended to polarize physicians into those who accept social phobia and those who believe it is just a "fad", like spasmophilia.

[267] 80% of people with social phobia have other co-morbid disorders, often anxiety disorders such as panic attacks, or mood disorder, such as depression. Dr. Roux noted that the relationship between panic disorder and social phobia is complicated, and that the two overlap in terms of patients' fears and sentiments.

As hinted at in their responses to critics, cognitive and behavioural therapists present explanations of social phobia in interviews and their publications[268] which extend beyond the bounds of their specialized therapeutic orientation (guided by the DSM and cognitive and behavioural principles), thereby contributing to a more complex picture of the disorder than is presented above. These types of accounts focus on the sensitive natures of social phobics. Dr. Fourciers reported that despite his frequent reliance on the DSM, which is a categorical description of mental illnesses, he sees social phobia as a dimensional disorder. He argues that social phobics are not categorically different from normal people, though they may be more sensitive and shy than others and have failed to manage their anxieties. While this means that they may be less functional than many people, there is no reason why they cannot learn to manage their anxieties as effectively as do others. Dr. Fourciers describes social phobia as a disorder that relates to an inborn, sensitive temperament. But the temperament he describes can be corrected or managed with a moderate amount of work on a patient's behalf.

The different descriptions of social phobia that cognitive and behavioural therapists promote seem to be at odds with each other. On the one hand, they describe it in terms of a "diabetes model of mental illness", as described by their detractors, which is consistent with North American models of the illness. This chemical imbalance description of the disorder works well with the idea that social phobia is something like a cold. It is something that one is afflicted with. It is not really a part of that person, but

[268] The cognitive and behavioural therapists I am referring to publish everything from advice columns in popular magazines, to self-help books on shyness and social phobia, to peer-reviewed clinical research on the disorder.

something that has thrown the 'real them' off balance[269]. Re-equilibrium is the promised outcome of therapy. On the other hand, cognitive and behavioural therapists describe social phobia as something similar to shyness, as a disorder related to a sensitive *temperament*. These types of explanations implicate a person's essential being, and recall psychoanalytic theories from which cognitive and behavioural therapists are usually so careful to dissociate themselves. It is cognitive and behavioural therapists' attention to patients' shyness and sensitivity that adds an element to their therapy that is not recognized by many other physicians[270], even though cognitive and behavioural therapists promote this view of social phobia as much as they do the first. French cognitive and behavioural therapists walk a fine line when bringing together these two perspectives of social phobia, one that is a modern, American approach and the other that draws on a psychoanalytic perspective that cognitive and behavioural therapists are trying to supplant.

But neither cognitive and behavioural therapists nor their patients seem to view the explanations as contradictory. In fact, together, they seem to provide them with an ideal account of the illness. The 'diabetes model' gives them hope that social phobia is short term disorder that is highly curable and while biologically-based[271], it is not too serious. The temperamental explanation of social phobia seems to correspond with

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[269] This idea that social phobia masks the "real you" is promoted in American direct to consumer advertisements for Paxil.

[270] The physicians who discuss the relationship between shyness and social phobia most often do so as a criticism. They argue that cognitive and behavioural therapists and the pharmaceutical industry are working toward the market expansion of SSRIs and that if these people have their way, eventually all shy people will be diagnosed with social phobia and treated with antidepressants.

[271] As in North America, biological explanations of mental illness are used to reduce patients' responsibility for mental illness.

patients' usually long term experiences with their troubles. It also accords them a special identity, one that they believe gives them qualities that they believe others lack, such as sensitivity. The pictures that cognitive and behavioural therapists draw of social phobia are at once simple and easy to relate to, but they also point to a side of social phobia and its treatment that is more profound. Cognitive and behavioural therapists believe that this should be the new model of mental illness in France and they are eager to promote it.

What patients like about social phobia

The explanations of social phobia offered by patients, cognitive and behavioural therapists and critics of the disorder often overlap. However, the descriptions of social phobia that cognitive and behavioural therapists use in earnest are what critics of the disorder depict as easily manipulated explanations that patients contort to make themselves look better or special. Patients are attracted by cognitive and behavioural therapists' medicalized explanation of social phobia, but they also appreciate the more subtle aspects of the disorder. Critics of social phobia say that patients selectively use cognitive and behavioural therapists' explanations of the disorder to reassure themselves and even inflate their self images. According to these critics, patients are comforted by the label of social phobia because it means that they are not 'mad', a sentiment that was echoed by many support group members[272]. Patients are appreciative of the diagnosis of social phobia, physicians argue, because the diagnosis allows them to have their problems

[272] Almost all of the 'social phobics' I spoke to specifically said that their diagnosis with social phobia was a relief because it meant that they were not losing their minds, that they did not have anything more serious. Many of the social phobics I interviewed had been diagnosed with many disorders other than social phobia, such as obsessive-compulsive disorder and depression among others, but they cast aside these other labels and identified themselves as social phobics.

recognized, and verifies that they have a medical disorder which gives them something to fight against, but it does not imply that they are profoundly different from 'normal' people. At the biological base of their disorder, they are thought to have a poorly regulated serotonin system. At the psychological base, they may simply be more sensitive than other people and sensitivity is not an altogether bad trait. In fact, one psychoanalyst argued, it might even make social phobics feel superior to others. Throughout my interviews with social phobia support group members and in group meetings, their sensitivity was continually referred to as an asset, something that set them apart from insensitive extroverts. They also often mentioned that their sensitivity gives them more natural talent as artists[273].

Cognitive and behavioural therapists and support group members alike suggested that social phobics are more self-critical than others, a tendency which is at the root of their problems. This is another way in which social phobics separate themselves from what increasingly come to look like brash, unreflective 'normals'. Social phobics, according to such descriptions, look like "nice" people in the words of one psychoanalyst. Critics of the diagnostic category argue that all of these 'positive' elements of the disorder make it an easy diagnosis to identify with and one that is likely to create a strong sense of group identity. Dr. Picard believes that the support group these people attend has a lot to do with why they are willing to fight for recognition of social phobia. She suggests that the people who are either diagnosed with the disorder, or who

[273] This was so widely believed among the social phobics I spoke to that the one man who said that he does not have artistic inclinations expressed his disappointment in himself for lacking these qualities. He saw himself as the exception to the rule.

have self-diagnosed with the disorder[274], often have feelings of inner weakness. She believes that finding a group of people with similar problems gives them a sense of comfort. Like adolescents, this new group identity is something that they cling to and are willing to defend, she argues.

Critics of social phobia contend that they have seen the label used as a justification for lives wasted. One physician compared social phobics to adults who arrive in her office asking for Ritalin because they believe that their self-diagnosed hyperactivity has prevented them from getting to where they wanted to in life. Her statements were echoed in the words of several of the support group members. For example, M. Béguin, a regular attendee of the social phobia support group in his late forties, told me that he had been looking for this diagnosis all of his life. When he first heard the name and description of social phobia, he says it was "a beginning. After that, I knew what my problem had always been." He says that he now knows why he "spoiled[275]" his life. He was not the only member of the support group to react to his diagnosis in this way. It gave him a new identity and a justification for why his life has not turned out as he would have liked. Many of the support group members attributed the fact that they had long stayed in jobs they did not like and some had never had a

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[274] Many of the members of the social phobia support group told me that they had never officially been diagnosed with social phobia. It is something that they had heard of, and believed that it applied to them, and began attending the support group. Most of these people were diagnosed with other disorders, though some were not. This latter group tended to see the group as an opportunity for self improvement, to learn how to better manage their fears of presentation in order to get a promotion at work, for example. Dr. Picard believes that there are many people in France who self-diagnose with social phobia.

[275] The term M. Béguin used was "raté". The translation to the word "spoiled" does not necessarily convey M. Béguin's sentiment, because "raté" is more severe than "spoiled". It could also be translated as wasted, screwed up, or some stronger term.

boyfriend or girlfriend[276] to their status as social phobics. They reason that with therapy, these other aspects of their lives will change.

The cognitive and behavioural and support group view of social phobics differs greatly from how certain psychoanalysts I interviewed assess social phobics. Social phobics may have previously been told by psychoanalysts that their problems are rooted either in their personalities or characters. These are the types of explanations, Dr. Picard suggests, that patients fight against. She says that instead, these people are increasingly picking up the cognitive and behavioural and DSM rhetoric to describe their problems. In comparison to purely personality-based labels, the typical explanation of social phobia describes it as a disease or sickness. The implications of this are that, as opposed to a character or personality, a disease is something that someone can overcome. Drs. Picard and Fortin agree that in contrast to psychoanalytic the explanations that these patients may have previously been given to explain their difficulties, the discourses that surround social phobia suggest that they are in essence healthy[277], sound of mind individuals. They say that patients prefer the idea that they have a sickness superimposed on their healthy person. Drs. Picard and Fortin argue that this explanation exists because of the cognitive and behavioural descriptions of the disorder, but also the neurobiological discourse that surrounds it. Dr. Picard argues that these frameworks allow people to consider the trouble as exterior to themselves rather than considering it as something that is an intrinsic character trait. According to these discourses, to improve, they need only removed this sickness that is not considered to be a part of the 'real' them.

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[276] These were people in their thirties and forties.

[277] The word that Dr. Picard used was "*sain*", which can be translated as health, sound or sane.

Dr. Fortin focused on the stigma associated with different types of mental disorders to explain why the diagnosis of social phobia is important to many patients. In contrast to cognitive and behavioural therapists, who tend to emphasize the biological origins of mental illness to lessen patient responsibility and stigma, Dr. Fortin emphasized the psychological basis of social phobia and how that could be used to reduce the stigma of a patient's condition. Like most critics of social phobia, he believes that patients identify with this disorder because it offers them a more positive explanation for their troubles, compared to how they would be described in psychoanalytic terms. He explains:

> I think that it is not shameful to have social phobia, it's something that's easy to admit to having. It's not shameful. On the contrary, it denotes perhaps a character that is sensitive, sensitive in a way that renders someone susceptible to the aggression of crowds.

And throngs of people are never given good press, he points out. In demonstrations, they devastate stores and lead to destruction. At its base, it is legitimate to be afraid of uncontrollable movements of humans. Dr. Fortin continued:

> Crowds are not reasonable, we know they are capable of murder, lynching, they are capable of blind destruction, even if they started out having a good argument... So in the end, it's not that bad [to fear these groups], it could even be valorising to say: I'm afraid of them. I'm afraid of madness, it's kind of like saying that.

To have social phobia is to be almost the opposite of this 'mad' crowd. And the diagnosis of social phobia does not put into question a person's sanity. Dr. Fortin adds, "A person is absolutely protected in saying that [that is, he or she suffers from social phobia]." He describes it as similar to saying that one is depressive. It can simply mean

that these people are more sensitive than others, that they have the sensitivity of an artist. Both disorders are open to a certain amount of romanticization, he says. According to Dr. Fortin, identifying with social phobia is like saying that "we are a lot more sensitive than others who are like big brutes". Social phobia has an element of a fear of being among others, among masses, which Dr. Fortin describes as "so much the better". It makes the experience of the disorder much more positive in a certain sense. This is why he believes that patients seek out social phobia explanations for their problems because it provides them with the best possible justification of their condition.

Social phobia versus phobic neurosis (and other psychoanalytic explanations)

To understand the appeal of a label of social phobia to patients, it is useful to take into the account alternative explanations for their troubles. Some psychoanalysts told me that people prefer to be social phobics and to have cognitive and behavioural explanations for their problems rather than come to terms with the 'real' origins of their problems, which they believe can only be identified using psychoanalytic theories. These analysts argued that people who identify with social phobia are conceited and their problem lies in the fact that they have very elevated self images which they cannot live up to. Their 'sensitivity' is a result of their fear that people will see their faults and shortcomings and that their overly developed sense of pride makes them embarrassed to be seen as vulnerable. Analysts believe that patients would prefer to be social phobics rather than admit to having these deeper problems.

Dr. Fortin suggested that the term social phobic, on the surface, seems to be an inoffensive type of disorder, as described in detail above. Superficially, he explained,

"there is always something nice about phobics. For example, they are not prideful." Or at least this is the way they are often seen. They are seen as "self-critical, they know their faults, that they are not perfect. That's nice. It's the opposite of megalomania and from paranoia because they are reasonable people. So, there is always a nice side to these people." But he argues, when these people are observed more closely, it becomes clear that they are prideful, their "nice" side hides a self-importance, an ideal of themselves that is very elevated, and a desire to be perfect. It is this, he argues, that leads to the self-criticism because they are disappointed in themselves for not living up to their own standards. For these people:

> there is at once a prideful desire to be perfect and a consciousness that it is not really possible. In the phobias, as in the case of little Hans[278], there is a consciousness that there is something in oneself that is not good, which is can not be admitted, and which must be hidden. There is a fear of having one's subconscious revealed. That is, that people will see that I want to be mean, that I want to be libidinous, that they will see all my faults and weaknesses. Phobias, it's when someone is afraid to be without defences before others. He has lost all of his defences, that is to say that he is going to be a being who is very weak, very fragile and very vulnerable.

Dr. Fortin paints a different picture of people with social phobia than is presented from a cognitive and behavioural perspective. The people he describes seem obsessed with putting forward an inoffensive persona beyond criticism. The forces behind this 'nice' outward persona seem less nice from a psychoanalytic perspective. When given the choice between the cognitive and behavioural or psychoanalytic perspectives, it seems to

[278] Dr. Fortin refers to Freud's famous case study of little Hans. This case is an example of the etiology of phobic neurosis according to Freud's psychoanalytic model (Laplanche and Pontalis 1974: 37).

Drs. Fortin and Picard that patients often prefer the former, which implicates their person at a much different level than the latter explanation. The cognitive and behavioural (social phobia) explanation of patients' troubles assures them that they are good people experiencing a period of unmanaged sensitivity or shyness. The psychoanalytic (phobic neurosis) explanation of these people's problems challenges them to come to terms with their deep seated short comings and unattractive elements of their characters. Increasingly, it seems as though patients are choosing the former explanation for their problems.

Why social phobia is a "nicer" label than other conditions

According to the critics of social phobia, it is as easy for doctors to tell their patients that they have social phobia as it is to tell them that they have a cold. Critics also argue that the disorder is equally easy for patients to accept, for the same reasons: social phobia is described as a passing chemical glitch in one's normal life. This caricature of social phobia ignores the complexity of cognitive and behavioural therapists' description and treatment of social phobia. However, physicians and patients are able to draw on the spectrum of cognitive and behavioural therapists' explanations to describe social phobia in such a way that it both accounts for patients' often long term and serious problems, while at the same time, highlighting the positive and transitory aspects of the disorder and the accompanying temperament. Compared to the more responsibility-laden descriptions of these troubles presented by psychoanalysts that assign negative qualities to these people which must be understood and accepted if patients want to move on, it is clear why patients might prefer cognitive and behavioural interpretations of their problems.

Perhaps it is the cognitive and behavioural explanations of social phobia that has allowed people to begin banding together to support and even celebrate being social phobics, or at least the best qualities that they see in themselves. Sitting in on social phobia support group meetings, I at times felt as though they were celebrating their neuro-diversity and their superiority over "neuro-typicals" in the same way that Asperger's patients have done in the United States (Harmon 2004a, 2004b). While the social phobics in this group still worked to overcome their most incapacitating problems, almost all of them stated that they felt they have special qualities as a result of their disorder. The fact that a diagnosis of social phobia allows people to see themselves in this light, and allows physicians to explain the disorder in this way to their patients, may be one of the reasons that a growing number of people are seeking out this diagnosis to account for their previously 'mislabelled' problems.

Chapter Eleven

Conclusion

Contents

This thesis has described the process by which social phobia is being introduced into French society. More than that, I have sought to explain why people are choosing the label social phobia over other labels used in France to describe the same symptoms.

I have argued that the introduction of social phobia affects more than just this one disorder, and that social phobia is implicated in cognitive and behavioural therapists' efforts to displace the psychoanalysts from their dominant position in French psychiatry. The introduction of social phobia and cognitive and behavioural therapy shapes the way that the self (*le soi*) is conceptualized in France. The result is a distinctively French hybrid of psychoanalytic and cognitive views and the self.

Continuing efforts to unseat psychoanalysts

What will the eventual effect of this movement be? I have traced the infancy of cognitive and behavioural therapy and social phobia's introduction into France. Already, some people's self perceptions have changed as a result. But the force of the movement driving cognitive and behavioural therapy's introduction into France is strengthening. The publication of *Le Livre Noir de la Psychanalyse* in September 2005 has been a landmark even in challenging the dominance of French psychoanalysis. The 831-page book urges its readers to "live, think and be better without Freud" (Meyer 2005). In the introduction, the book's editor, Catherine Meyer, begins by describing the pervasiveness of psychoanalytic language in France and how the French population has been indoctrinated with its principle tenets by the educational system. Meyer draws attention to the fact that France and Argentina are the two countries the most influenced by psychoanalysis, and she points out that the theory has become marginal elsewhere

(Meyer 2005: 7-8). The implication is that France has been left in the dark ages of psychiatry.

The book challenges its French readers, professional and lay, to think about life after Freud, and suggests that there are superior means of learning about the self and living in the modern world. The contributors to the book include well-known French cognitive and behavioural therapists, Antoine Pélissolo and Patrick Légeron; the American founder of cognitive and behavioural therapy, Aaron Beck; the founder of rational emotive behavioural therapy, Albert Ellis; and internationally-known historians and critics of psychoanalysis including Mikkel Borch-Jacobsen, Frederick Crews, Frank Sulloway and Edward Shorter. There are also chapters by former psychoanalysts and patients who provide testimonials of the ineffectiveness of psychoanalytic psychotherapy. One of these patients is the president of Les Phobiques. The aim of the book is to unmask and undermine the mythology of psychoanalysis and expose the ineffectiveness of this treatment. The contributors repeatedly draw attention to the exceptionalism of France in its adherence to the analytic paradigm; 70% of French psychiatrists are said to have been 'seduced' by the paradigm. Psychoanalysis is portrayed as an unscientific tradition that must be replaced if French patients are to be truly helped.

Le Livre Noir de la Psychanalyse has not been ignored. Since its publication, two books have been published in response: *Pourquoi tant de haine? Anatomie du Livre noir de la psychanalyse* (Roudinesco 2005) and *L'anti-livre noir de la psychanalyse* (Miller 2006). In addition, magazines and newspapers were filled with debates about the book and its implications (e.g. André 2005; Baccaria 2005; Birnbaum 2005; Castel 2005; Charles 2005; Charles [interview with Roudinesco] 2005; Coen 2005; Gauthier 2005;

Gruyer 2005; Lanez 2005; Le Nouvel Observateur 2005; Le Nouvel Observateur [letters] 2005; Le Nouvel Observateur, van Rillaer, de Mijolla 2005; Martineau 2005; Miller 2005; van Rillaer 2005). The debate is not only taking place at a professional level, nor is it confined to the literature of intellectuals. The books listed above are aimed at a general audience; the magazines and newspapers that published letters and articles about the books are 'popular'; most of these publications are left-leaning politically.

The publication of and response to the *Livre Noir* highlights the contentiousness of the changes taking place in French medicine. The debate that surrounds *Livre Noir de la Psychanalyse* reflects the passions stirred by the prospect of the loss of psychoanalysis in France. Social phobia is the canary in the mine, providing evidence of the 'superiority' of cognitive and behavioural models. The degree to which this disorder is accepted is a sign of to the extent to which cognitive and behavioural models can expect to be adopted. My research has shown that even though social phobia and its cognitivist therapies were initially received with suspicion, acceptance is now increasing.

Both physicians and the public seem aware that the introduction of social phobia and cognitive and behavioural therapy entail a new notion of personhood. This type of personhood has been, in part, 'sold' to physicians and the public through promotions of the disorder in articles in psychiatric journals and popular magazines, televised discussions of the disorder, radio discussions of the disorder, professional colloquia dedicated to the disorder, and lay websites offering help for social phobics by social phobics. Promotion of information about the disorder has encouraged an increasing number of people to identify themselves as social phobics, and this development has encouraged physicians to look for this treatable disorder amongst their patients.

Many people *want* to be social phobics. The label provides them with an appealing justification for their experiences – an option unavailable from psychoanalytic or non-medical (for example, shyness) accounts of their condition. The diagnosis, and the proposed therapeutic treatment of cognitive and behavioural therapy and antidepressants, appeals to physicians who hope to provide their patients with fast, effective alleviation of their symptoms.

Medicalization and biomedicalization

This combination of the promotion of new medical categories along with the increasingly large role of patients researching and identifying their own medical problems has been highlighted as central to contemporary medicalization practices[279] (Clarke et al. 2003). The concept of medicalization was introduced in the 1960s. It refers to a process whereby 'normal' human conditions are transformed into disorders and enter the domain of medical control.

The concept of medicalization is applicable to social phobia in the sense that many people who are now diagnosed with the disorder were once considered normal, but shy. Others may have been described as neurotic, if they had previously sought the help of a psychoanalytically-oriented clinician. Neurosis, while considered a problematic condition, is not a disease associated with a chemical imbalance. For these shy or neurotic people, becoming social phobics has involved a re-examination of their feelings and thoughts. Character traits are re-identified as problems and symptoms.

[279] Clarke et al. use the term biomedicalization to discuss this process.

Early critics of the process of medicalization focused on psychiatry (for example, Goffman 1963; Szasz 1970) and on medical imperialism more generally (for example, Illich 1975). Medicalization was described by Zola (1972, 1991) as the extension of medical jurisdiction, authority and practices into increasingly broad areas of people's lives. These critics of the medical establishment suggested that physicians and the state were responsible for moving morally problematic social concerns that affected the body from the jurisdiction of law to that of medicine (for example, homosexuality and alcoholism). Conrad and Schneider (1980) described this transformation as a movement from "badness to sickness". The point of these authors was that what was once considered morally, or legally, wrong or mistaken, had become redefined as disease. Thomas Szasz argued that usual or morally objectionable acts ought not to be under the surveillance of the medical community. Instead, he believed that they should be in the domain of social institutions, such as the legal system that had previously had jurisdiction over such behaviours.

More contemporary descriptions of medicalization attribute increasing amounts of agency to individuals. This has corresponded with a reduced emphasis on medical hegemony. While the medical establishment is still presumed to have a significant amount of power over patients, greater distribution of power and the influence of patients on physicians is increasingly taken into account. Individuals have more access to information than in the past and are more involved in the selection of elective interventions such as plastic surgery. In this sense, the patient has become more of a consumer (Conrad 2005). Individuals are also increasingly called upon to make decisions about their medical care based on physician-calculated risk assessments

concerning their likelihood of developing particular diseases (Lock 1998)[280]. Many writers focusing on medicalization emphasize the extent to which we have been taught to monitor ourselves for the development of diseases and that we have been encouraged to be responsible for managing our own risk (for example, Lupton 1995; Nye 2003; Vuckovic 1999). Some have argued that this constitutes a new way of knowing the self (Novas and Rose 2000). Lay people are also involved to a greater extent in social movements and interest groups related to their particular medical conditions (or those of their family members). Pharmaceutical companies often provide funds to these groups (Conrad 2005). These lay associations, in the form of support or advocacy groups, are increasingly involved in spreading information about particular medical conditions. Physicians are bypassed in this process and power is shifted away from the medical institution and into the hands of motivated individuals (and those who fund their activities).

Recent publications on medicalization also draw attention to the increasingly distributed power within medicine. For example, the pharmaceutical industry and biotechnological companies have greater influence on what is studied and published on due to the fact that they fund an increasingly amount of medical research (Conrad 2005). In some cases, this means that particular, and sometimes new, disorders will be given a large amount of attention as companies publicize disorders for which they have created medicines to treat it (Fishman 2004; Greenslit 2003; Healy 2001, 2004b).

[280] This has also been discussed concerning women's decisions about whether to continue with pregnancies when the foetus is calculated as at risk of developing particular disorders (Rapp 1999).

In an attempt to draw attention to the changes that have occurred in the process of medicalization, Adele Clarke and several of her colleagues coined the term biomedicalization (Clarke et al. 2003). While the account that Clarke et al. provide of biomedicalization does not differ greatly from many recent accounts of medicalization, it brings together a discussion of many elements of medicalization that had previously not been analysed in combination, notably concerning the dissemination of information about medical conditions. Clarke et al. believe that the shift from medicalization to biomedicalization occurred around 1985. The concept of biomedicalization accurately describes the history of social phobia in France over the last decade in several ways. In addition to providing funds to social phobia patients groups, the French pharmaceutical industry, notably GlaxoSmithKline, has played a leading role in funding research on social phobia. GlaxoSmithKline also funds colloquia and other events where social phobia and its SSRI antidepressant paroxetine (sold under the brand name Deroxat in France and Paxil in North America) are discussed. The power that pharmaceutical companies wield because of their financial resources is a feature of the changing power structure in French medicine. As companies increasingly set research and educational agendas, it becomes more evident that physicians are only one voice of authority among many. Medical researchers, as well, have less power to control what they investigate and are obliged to choose projects that coincide with the interests of their patrons. Research funds increasingly come from interested private groups and industries rather than governmental agencies[281]. Because of this, the interests being served by clinical research

[281] Particularly in the sciences, even governmental funds are increasingly offered as part of public-private partnerships, in which the industry offers to co-sponsor grants that could lead to developments in their field.

increasingly coincide with those of the pharmaceutical industry, for example. French citizens are seeking out information on their conditions in greater numbers than in the past, through various forms of the media (television, radio, magazines) and the internet. Their research, and sometimes subsequent self-diagnosis, circumvents medical professionals. Individuals' new sources of information are likely to be influenced by the private interests described above.

Biomedicalization highlights the extent to which the risk of disease is becoming a disorder unto itself (Rose 2001). Individuals are increasingly encouraged to undergo treatments and therapies to prevent future sicknesses. In scientific and lay literature, social phobia is presented both as a disorder and as a risk factor for the development of other, more serious, psychiatric disorders. The French clinicians I interviewed adopted a similar position. They noted that once social phobics develop comorbid depression, for instance, patients' conditions become more resistant to treatment. Whether social phobics learned to understand social phobia as a risk factor for other disorders from their physicians or from other sources, they seemed almost unanimously aware of the 'risks' of being social phobics. These individuals monitor themselves for prodromal signs of deterioration. This may account for the fierceness with which many social phobics I interviewed stated that they are *not* depressed. They are aware that this is something to be avoided and that by virtue of not being depressed they remain relatively 'normal' social phobics with only a minor mental illness.

Clarke et al. suggest that new identities are often formed as a result of biomedicalization. Some of these identities are collective and some are personal. They suggest biomedicalization may result in a collective identity that resembles Paul

Rabinow's concept of biosociality (1996). According to Rabinow and Clarke et al., a complex set of research and support practices will arise out of interest in and identification with a particular disorder. 'Genetic' disorders take a central place in Rabinow's discussions of biosociality. In the case of social phobia, research has been published which examines the possibility of genetics playing a role in the etiology of social phobia, as predicted by biosociality. But while there is a place for discussions about the role of genetics and heredity, these do not take centre stage when it comes to group identification with the disorder. As is also predicted by the concept of biosociality, researchers and patients work together to raise public and professional awareness of social phobia. However, most public discourse about the disorder focuses on the problems of daily living and the need to treat the disorder appropriately. Among patients, in particular, there is a 'them versus us' mentality that promotes the positive aspects of social phobics' personalities and disparages others for their relative insensitivity.

The concept of biomedicalization is useful to analyse how and why social phobia has been adopted in France. But there are limitations to this concept. While it draws attention to individual agency and the active comparisons that people make between themselves and technoscientific and biomedical[282] norms (often resulting in decisions to change themselves), Clarke et al. do not satisfactorily address the question of choice: how and why people choose to identify themselves in one way or another. Choice plays an

[282] Clarke et al. use Latour's term "technoscientific" to refer to the increasing closeness of science and technology, and argue that the two domains are co-constitutive. They use the term "biomedical" to emphasize the increasingly biological scientific aspects of clinical medicine. They argue, "the technoscientific practices of basic life sciences ('bio') are increasingly also part of applied clinical medicine – now biomedicine" (Clarke et al. 2003: 162). A good example may be Joseph Dumit's discussion of PET scans as a means of showing people's mental states (Dumit 2003).

essential role in the adoption of social phobia in France. As I explained in chapter ten, the diagnosis of social phobia has much to offer physicians and patients alike. In most cases of social phobia, alternative diagnoses could be given to social phobics due to the use of eclectic psychiatric models and the widespread co-morbidities of social phobics. So, when social phobia is diagnosed, or when people begin to identify with the disorder, it is often a choice to use this diagnosis rather than others. Most often, it appeals to people because of the relatively low stigma attached to the diagnosis (because it is largely considered to be the result of a chemical imbalance, but not as serious as the chemical imbalances that cause depression or other, more serious, mental illnesses) and the optimistic therapeutic outcome (cognitive and behavioural therapists consider it largely curable within six months of psychotherapy and antidepressant use). People have also been drawn to the diagnosis, and the cognitive and behavioural framework that accompanies it, because of their frustration with other psychiatric treatments. Some of these people simply want to try to new approach to managing their psychic unrest. The essential point is that while many external factors are pushing people toward identification with social phobia, as predicted by biomedicalization literature, to a large extent, becoming a French social phobic is part of a strategic decision to choose the most favourable (and least stigmatizing) account of one's problems. It is an active decision that makes the most out of existing therapeutic frameworks and cultural ideals.

Conclusion

I have tried to show in this thesis that while a new identity and a new way of knowing the self have been introduced in France with the increasing acceptance of social

phobia and cognitive and behavioural therapy, it is a distinctively French version of the disorder that has been adopted. Shyness (*timidité*) is a term that is intimately associated with social phobia in France. Physicians and patients use this term to describe the temperament that they believe accompanies the more pathological traits of social phobia. Their references to shy temperaments highlight the fact that they believe that the disorder is more than a passing difficulty that overlays a person's 'normal' self. It is in the latter way that social phobia is commonly described in North America. In France, the shy temperament associated with social phobia is seen as a part of individuals' essential person. This type of explanation is reflective of psychoanalytic theories and makes their description of social phobia particularly French; it reflects a distinctively French psychiatric eclecticism. Aside from references to shy personalities and temperaments, most French social phobics I spoke to combine an array of psychoanalytic explanations of their condition with those provided by their cognitive and behavioural therapists. They mix and match therapeutic explanations in ways that suit their interests. When they want to emphasize their normality, they use cognitive and behavioural explanations, when they want to explain their enduring character traits, they often draw on psychoanalytic concepts. These people are not concerned by the contradictions between the explanatory models they use. They simply use different models to describe isolated aspects of their disorders in ways that most closely correspond to their experiences. They selectively use different models to highlight the most positive aspects of their disorder.

This thesis attempts to bring together an analysis at two levels: changing nosological classifications and professional practices, with patient experiences. I have tried to show how the introduction of new governmental policies, pharmaceutical

company regulations and professional standards impact on the lives of individuals. These different actors each play a role in the introduction of social phobia into France.

The fact that social phobia, and the cognitive and behavioural framework that supports it, is being increasingly accepted in France represents a significant change in the way that mental unrest is understood. Narcissistic neurotics become social phobics and this changes their identities. Signs of psychological unrest become re-written as symptoms of a mental disorder. The era of psychoanalysis is waning and a globalized view of the mind is on the rise. Only time will tell where a balance between these two forces will be found.

Part V

Appendices

Appendix I

Methodology

The research for this thesis was conducted out of Paris. Most interviews took place in Paris or close to Paris (within 1.5 hours by train). My doctoral research included one-on-one interviews and participant observation. I conducted interviews with 49 people, some of whom I interviewed on several occasions (though I only include their names once on the interview list). Interviews were conducted with clinicians (general practitioners, psychiatrists and one psychologist), social phobia support group members, European Union (EU) representatives (ex-deputies and the representative of deputies), science journalists, and people engaged in pharmacovigilance. These people, and the groups they represent, are described below. At the end of this section, I have included a table listing all interviewees' names (pseudonyms), the date interviewed, the name of the person or group who recommended that I contact the interviewee (specific names are usually pseudonyms), and where they are located. Following the list of interviewees' names are the interview protocols that I used for clinician and support group member interviews.

To access interviewees, I relied to a large extent on a 'snowball' method: once I had a contact, I would ask that person if he or she could recommend other people I might want to interview. I started with several contacts and branched out from them to try to access the networks of people most relevant to my research. My initial contacts included a Swedish specialist of social phobia, a Canadian researcher of pharmaceuticals and economics, a British physician and poet who has written about spasmophilia, researchers

at CESAMES (the research unit out of which my research was based) as well as a number of other personal contacts (from whom I did not seek to develop networks of informants).

The Swedish clinician, Tomas Furmark, is not listed among my interviewees, as I only corresponded with him. I contacted him after reading one of his articles on social phobia. He put me in touch with a French cognitive and behavioural therapist who conducts research on social phobia. This French psychiatrist, is identified in the thesis as Dr. Duclaux, referred me to other leading French cognitive and behavioural therapists.

The Canadian researcher of pharmaceuticals and economics was Barbara Mintzes. She provided me with the names of people who track pharmaceutical use in Europe and France. I spoke with Mintzes about my research but have not included her in my interview list. I contacted the people whose names Mintzes provided. Of these contacts, Mme. Boulogne (a pseudonym) was the most informative interviewee. She works at *Prescrire*, a French journal that assesses new pharmaceuticals licensed in France. This journal is promoted as being the only French medical journal to be financially independent of the pharmaceutical industry. *Prescrire* receives governmental funding, which supplements the money they raise through subscription fees. These are their two primary sources of financing. The journal targets general practitioners and these clinicians make up the majority of their readership. There is no comparable English-language journal, perhaps because of lack of funding. The people who work at *Prescrire* describe their actions as 'pharmacovigilance' (the same word is used in French). The journal critically examines the role of pharmaceutical companies in encouraging physicians and patients to use drugs that the journal often considers to be inessential. Mme. Boulogne provided me with the names of EU representatives and science reporters.

While I was in France a vote was carried out to establish the Union's position concerning direct to consumer advertising (DTCA) of prescription pharmaceuticals. The vote re-affirmed the EU's position that DTCA should be prohibited. I wanted to interview people who had been involved in this decision to better understand the position of the Union and the lobbying practices that accompanied the final decision.

I was interested in speaking with science journalists to understand how pharmaceuticals are represented in the media. Additionally, several physicians had mentioned to me that the pharmaceutical industry often plants articles in the paper, or at least provides press releases that are virtually copied and pasted into newspapers. I wanted to ask reporters their opinions of these comments. Science reporters did not necessarily agree with all of the physicians' claims, but they informed me that versions of these practices occur.

I contacted a British physician, 'Dr. McDermott', after reading an article he had written about his experiences working in France and, more specifically, the French culture-bound syndrome spasmophilia. Dr. McDermott put me in touch with some of his Anglophone colleagues working in Paris. They were helpful in providing the perspective of outsiders working within the French medical community.

Researchers at CESAMES put me in touch with several clinicians with whose assistance I was able to create informant networks. One of these clinicians introduced me to the Yvelines Network (this is not a pseudonym) of clinicians. These doctors work in the Yvelines region surrounding Paris, a suburban area that includes Versailles. The Yvelines Network is a professional association that includes health professionals interested in psychiatric problems. I attended a weekend retreat with this group and sat in

on their discussions of how patients should be diagnosed and treated. There was little consensus among the members of this group concerning which diagnostic manuals to use and even if diagnoses should be used for the identification of mental unrest. Through researchers at CESAMES I was also introduced to several psychiatrists at a psychoanalytically-oriented psychiatric hospital on the outskirts of Paris. I interviewed several doctors at the hospital and sat in on discussions of patient cases presented from a psychoanalytic framework. Finally, I was introduced to a Parisian general practitioner, 'Dr. Agasse', by a CESAMES researcher. This GP holds an institutionally powerful position and knows many other networks of general practitioners. After I interviewed him, he sent an email to several of his colleagues asking them to think of a list of ten of their colleagues who might meet me and discuss their attitudes toward social phobia. In this way, I was able to meet many other general practitioners.

I obtained access to a social phobia support group in Paris by contacting the president of the group through their website. She was initially not very responsive to my request to sit in on support group sessions, but eventually gave me permission. I attended the support group for over six months and conducted individual interviews with many of the group's members. I left informational leaflets at group meetings describing my research and interested members of the group were encouraged to pick up the leaflets and contact me, which they did.

Once back in Canada, I conducted two interviews. One was with an administrator at a social phobia support group in Montreal, and the other with a Toronto-based physician and pharmacovigilance researcher.

Interview list

NAME (pseudonym)	**#**	**SPECIALTY**	**DATE**	**SOURCE**	**INSTITUTION**	**LOCATION** (practice/home)
Dr. Levy	1	Psychiatrist (1/14)	30 December 2003	CESAMES referral	Primarily public, at a psychiatric hospital	Outskirts of Paris
Dr. Duclaux	2	Psychiatrist (2/14)	28 January 2004	Thomas Furmark	Public (at a large Parisian hospital)	Paris
Dr. Debru	3	General practitioner (1/14)	17 March 2004	Yvelines	Private clinic	Paris suburb
Dr. Clavel	4	General practitioner (2/14)	17 March 2004	Yvelines	Private clinic	Versailles
Dr. Jacob	5	General practitioner (3/14)	19 March 2004	Mme. Boulogne (Revue Prescrire)	Private clinic	Paris suburb
Mlle. Hébert	6	President of social phobia support group, Les Phobiques (1/12)	29 March 2004	Personal contact	N/A	Paris
Dr. Lefevbre	7	Psychiatrist (3/14)	6 April 2004	Yvelines	Private clinic	Paris suburb
Dr. Petit	8	Psychiatrist (4/14)	9 April 2004	Yvelines	Public (at a psychiatric hospital)	Paris suburb
Dr. Begot	9	Psychiatrist (5/14)	9 April 2004	Yvelines	Primarily public, at a psychiatric hospital	Paris suburb
Mr. Dinh	10	Member of Les Phobiques (2/12)	21 April 2004	Les Phobiques meeting	N/A	Paris
Dr. Delaporte	11	General practitioner (4/14)	22 April 2004	Yvelines	Private clinic	Paris suburb
Dr. Mignot	12	Psychiatrist (6/14)	22 April 2004	Yvelines	Private clinic	Paris suburb
Dr. Vincent	13	General practitioner (5/14)	22 April 2004	Yvelines	Private clinic	Paris suburb

Dr. Agasse	14	General practitioner (6/14)	28 April 2004	CESAMES referral	Public	Paris and suburbs
Mr. Sabbah	15	Member of Les Phobiques (3/12)	28 April 2004	Les Phobiques meeting	N/A	Paris
Mr. Vial	16	Member of Les Phobiques (4/12)	29 April 2004	Les Phobiques meeting	N/A	Paris suburb
Dr. Hervé	17	Psychologist (1/1)	30 April 2004	CESAMES referral	Private clinic	Paris
Mlle. Bruyère	18	Member of Les Phobiques (5/12)	30 April 2004	Les Phobiques meeting	N/A	Paris
Dr. Moreau	19	Psychiatrist (7/14)	6 May 2004	Head of Yvelines	Public, at a hospital	Paris suburb
Dr. Villette	20	Psychiatrist	6 May 2004	Yvelines	Private clinic	Paris suburb
Mlle. Jabin	21	Member of Les Phobiques (6/12)	14 May 2004	Les Phobiques meeting	N/A	Paris
Dr. Fourciers	22	Psychiatrist (9/14)	17 May 2004	Dr. Duclaux	Public (at a large Paris hospital)	Paris
Dr. Roux	23	Psychiatrist (10/14)	2 June 2004	Dr. Duclaux	Public (at a large Paris hospital)	Paris
Dr. Nouri	24	Psychiatrist (11/14)	4 June 2004	Dr. Hervé	Public (at a psychoanalytically-oriented psychiatric hospital)	Outskirts of Paris
Dr. Fortin	25	Psychiatrist	11 June 2004	Dr. Hervé	Public (at a psychoanalytically-oriented psychiatric hospital)	Outskirts of Paris
Dr. Cohen	26	Psychiatrist	11 June 2004	Dr. Hervé	Public (at a psychoanalytically-oriented psychiatric hospital)	Outskirts of Paris
Mlle. Arcier	27	Old member of Les	14 June 2004	Les Phobiques	N/A	Paris suburb

		Phobiques (7/12)		meeting		
Dr. McDermott	28	General practitioner (7/14)	15 June 2004	Personal contact	Not currently practicing	Britain
Dr. Lalande	29	General practitioner (8/14)	16 June 2004	Dr. Agasse	Private clinic	Paris suburb
Dr. Marsault	30	General practitioner (9/14)	16 June 2004	Dr. Agasse	Private clinic	Paris suburb
Dr. Picard	31	Psychiatrist (14/14)	17 June 2004	Yvelines	Public, at a hospital (used to have a private clinic)	Paris suburb
Dr. Lallier	32	General practitioner (10/14)	30 June 2004	Dr. Agasse	Private clinic (in the south west of France)	South west of France
M. Pelletier	33	Member of Les Phobiques (8/12)	2 July 2004	Les Phobiques meeting	N/A	Paris
M. Perrin	34	Member of Les Phobiques (9/12)	5 July 2004	Les Phobiques meeting	N/A	Paris
M. Bouvier	35	Member of Les Phobiques (10/12)	6 July 2004	Les Phobiques meeting	N/A	Paris
Dr. Arnaud	36	General practitioner (11/14)	6 July 2004	Dr. Agasse	Private clinic	Paris
M. Bonet	37	Member of Les Phobiques (11/12)	8 July 2004	Les Phobiques meeting	N/A	Paris
Dr. Gitton	38	General practitioner (12/14)	13 July 2004	Dr. Agasse	Private clinic	Outskirts of Paris
Dr. Bouchet	39	General practitioner (13/14)	6 August 2004	Dr. Agasse	Private clinic	Paris
Mme. Boulogne	40	Pharmacist (1/1)	19 August 2004	Barbara Mintzes	Revue *Prescrire*	Paris
Mlle.	41	Journalist	30 August	Mme.	*Que Choisir ?*	Paris

Saczuk		(1/2)	2004	Boulogne		
M. Béguin	42	Member of Les Phobiques (12/12)	30 August 2004	Les Phobiques meeting	N/A	Paris
Mlle. Barré	43	Journalist (2/2)	3 September 2004	Mme. Boulogne	Freelance journalist	Paris
Dr. O'Connell	44	General practitioner (14/14)	8 September 2004	Dr. McDermott	Private clinic	Paris
M. Deslauriers	45	Assistant of EU deputy[283]	9 September 2004	Mme. Boulogne	European Union legislature	Brussels
M. Mattei	46	EU ex-deputy	13 September 2004	Mme. Boulogne	Pharmaceutical company	Paris
Dr. Vézinet	47	Magnesium specialist	13 September 2004	Personal contact	Retired	Paris
IN CANADA						
Mrs. Henry	1	Programmer of events	30 September 2004	Personal contact	Ami Québec	Montreal
Dr. Martin	2	Emergency room physician and community health professor	9 October 2004	Personal contact	University of Toronto hospital network and York University	Toronto

[283] The term 'assistant' does not do justice to M. Deslauriers' position. He works hand in hand, virtually as a peer, with the deputy he represents. He is planning to run for a position as a deputy soon.

Clinician interview protocol

1. Age ?
2. Specialization ?
3. Training (where, with whom, DSM/Henri Ey/psychoanalysis, and cognitive/behavioural) ?
4. Current affiliations (liberal, public, working where, linked to what networks) ?
5. What have been your sources of information about social phobia (medical school, training <by whom ?>, pamphlets, articles <where ? by whom ?> ?
6. How would you describe this disorder ? What is it ?
    a. What are its origins ?
    b. What is the ideal treatment for it ?
    c. Does it often pass on its own ? When and with what types of cases ?
    d. How does it present (comorbidities) ?
7. Have you used this diagnostic category before (why or why not) ?
    a. Often ?
    b. If you don't use it, why not ?
8. How widely do you think it is used ? Is this rate of diagnosis warranted (too high ? too low ?) ?
    a. What clinical specialities would be most likely to diagnose someone with this disorder ?
    b. Is there dissidence between subspecialties regarding how often it is / should be diagnosed ?
9. Social phobia is more widely recognized and diagnosed in North America. Why would you say this is so ?
    a. Does this amount to a different way of seeing the self in these two regions ?
    b. What would you suggest could account for the differences (e.g. history of the field, culture, ads) ?
10. No matter who is describing this disorder, it is always pointed out that the borders of the disease are blurry on one hand with « normal » timidity, and with major depression and/or agoraphobia on the other. What is your reaction to such statements ?
    a. What does it mean if so much overlap and / or comorbidity is possible ?
    b. How do you ensure that an 'accurate' diagnosis is given ?
    c. Do you use psychological scales at all ? Which ?

11. What do you think about those who would argue that social phobia is one of a subset of disorders that constitute a foray into the 'medicalization of existence' ? Is this accurate ?
    a. Revue *Prescrire* has been one of the voices citing this criticism of certain diagnosed and treated cases of social phobia. What is your opinion of this role they have taken ? Do this have influence in this regard ? What about generally ?
    b. Any other critics (e.g. Zarifian) ?

12. To what extent do you think that the available treatments for this disorder have influenced its diagnosis (therapy and medications) ?
    a. What about the relative ease of taking a pill ?

13. As far as patients are concerned, does it seem as though they have heard of this disorder ? What do they seem to know about it ?
    a. How do they react to the diagnosis ?
    b. What is their reaction to treatment ?
    c. Do they have a preference in their treatment (including behavioural, cognitive, or psychodynamic psychotherapy, medications, other) ? Why ?

14. What are their sources of information about social phobia ?
    a. Do they mention any books ? Magazines ? Websites ? Television ? Radio ? Are you familiar with these sources of information ?
    b. Do patients seem to be well informed about the disorder / psychiatry ?

15. One of the most contested forms of 'education' about health conditions, here and elsewhere, it that provided by (or funded by) pharmaceutical companies.
    a. What forms of this 'education' are you aware of ?
    b. What is your opinion of them ?
    c. What do you think about the EU's decision to limit pharmaceutical company marketing / 'education' to the public ? Do you think that this is a sustainable decision ?
    d. What *is* the role of pharmaceutical companies in research and education (ref. Yvelines meeting funded by Lilly) ? How does this relate to the role of the state ?

16. Have you heard of the new speciality clinics that are appearing (Pluralis, etc.) ? What is your opinion of these speciality centres with acupuncture, psychotherapy, general practitioners, all together ?
    a. Does this reflect to a new attitude toward health « consumption » (as rates of use of medications *and* therapy continue to rise) ?
    b. Who is driving this ?
    c. What will be the impact ?

17. What does the acceptance of this disorder, or not, mean for the future of a DSM-style psychiatry in France ? What is the future of a distinct, French psychiatry ?

Support group member interview protocol

1. How long have you suffered from the symptoms associated with social phobia (e.g. speaking in public, fearing that others are looking at you, etc.)?

2. When did you decide to seek treatment for these symptoms (i.e. when did the condition become a problem, then a disease requiring treatment)?

3. What precipitated this action (problems at work, home, at the request of others, hearing about the disease)?

4. When were you given the diagnosis of social phobia?

5. Who made this diagnosis?
    a. How did you come to see this person?
    b. What did he or she tell you about the disorder? What was his or her opinion of it?
    c. Was he or she the first person you had sought out as a result of your troubles?
        i. What had other diagnoses had you previously been given? Or, what had been other physicians' reactions to your symptoms.

6. What has/have been the treatments you have been offered to ease your symptoms (e.g. cognitive and behavioural therapy, psychoanalysis, group therapy, medications)?
    a. Which of these have you followed up on?
    b. With what effects?
    c. Which treatments did you find to be the most effective?
    d. How long did you follow each of these therapies / are you still using them?

7. Have you taken any other steps to treat your condition, aside from the above treatments (e.g. naturopathy)?

8. When you were given the diagnosis of social phobia, was this the first you had heard of the disorder?
    a. (if yes) What information were you given about the disorder?
    b. (if no) Where had you previously heard about it?
        i. Where did you get the information?

9. What did you think of this baseline information?
    a. What sources do you prefer?
    b. Do you feel that you are missing information?
    c. What type of information would you like to have access to?
    d. Where do you think you are most likely to find this sort of information?

10. What is your impression of the reception of social phobia in France? Is it well accepted? How does it fit in with French culture?

11. How have your understandings of your condition/symptoms changed over time?

12. Why have your understandings changed (what has influenced your understanding)?

13. In what ways (positive or negative) have your experiences with social phobia changed over time?

Appendix II

List of clinicians interviewed and description of their practices

NAME (pseudonym)	#	SPECIALTY	DATE	SOURCE	INSTITUTION
Dr. Levy	1	Psychiatrist (1/ 14)	30 December 2003	CESAMES referral	Public (more or less), at a psychiatric hospital
Dr. Duclaux	2	Psychiatrist (2/ 14)	28 January 2004	Personal contact	Public (at a large Parisian hospital)
Dr. Debru	3	General practitioner (1/ 14)	17 March 2004	Yvelines[284]	Private clinic
Dr. Clavel	4	General practitioner (2/14)	17 March 2004	Yvelines	Private clinic
Dr. Jacob	5	General practitioner (3/ 14)	19 March 2004	Revue *Prescrire*	Private clinic
Dr. Lefevbre	6	Psychiatrist (3/ 14)	6 April 2004	Yvelines	Private clinic
Dr. Petit	7	Psychiatrist (4/ 14)	9 April 2004	Yvelines	Public (at a psychiatric hospital)
Dr. Begot	8	Psychiatrist (5/ 14)	9 April 2004	Yvelines	Public (more or less), at a psychiatric hospital
Dr. Delaporte	9	General practitioner (4/ 14)	22 April 2004	Yvelines	Private clinic
Dr. Mignot	10	Psychiatrist (6/ 14)	22 April 2004	Yvelines	Private clinic
Dr. Vincent	11	General practitioner (5/ 14)	22 April 2004	Yvelines	Private clinic
Dr. Agasse	12	General practitioner (6/ 14)	28 April 2004	CESAMES referral	Public

[284] The Yvelines network of clinicians is made up of doctors (GPs, psychiatrists, etc.), nurses, social workers and others who are charged with the treatment of the mentally ill. This network was established to improve communications between these groups of professionals to improve patient care. I attended a meeting of this network, which happen at least once per year, and was made a member. At the meeting I attended, I was able to make many contacts for future interviews and all members were informed that I might contact them to participate in my research.

Dr. Hervé	13	Clinical psychologist (1/ 1)	30 April 2004	CESAMES referral	Private clinic
Dr. Moreau	14	Psychiatrist (7/ 14)	6 May 2004	Head of Yvelines	Public (at a hospital)
Dr. Villette	15	Psychiatrist (8/ 14)	6 May 2004	Yvelines	Private clinic
Dr. Fourciers	16	Psychiatrist (9/ 14)	17 May 2004	Dr. Duclaux and several others	Public (at a large Paris hospital)
Dr. Roux	17	Psychiatrist (10/ 14)	2 June 2004	Pelissolo	Public (at a large Paris hospital)
Dr. Nouri	18	Psychiatrist (11/ 14)	4 June 2004	Dr. Hervé	Public (at a psychoanalytically-oriented psychiatric hospital)
Dr. Fortin	19	Psychiatrist (12/ 14)	11 June 2004	Dr. Hervé	ditto
Dr. Cohen	20	Psychiatrist (13/ 14)	11 June 2004	Dr. Hervé	ditto
Dr. McDermott	21	General practitioner (7/ 14)	15 June 2004	Personal contact	Not currently practicing
Dr. Lalande	22	General practitioner (8/ 14)	16 June 2004	Dr. Agasse	Private clinic
Dr. Marsault	23	General practitioner (9/ 14)	16 June 2004	Dr. Agasse	Private clinic
Dr. Picard	24	Psychiatrist (14/ 14)	17 June 2004	Yvelines	Public (at a hospital), used to have a private clinic
Dr. Lallier	25	General practitioner (10/ 14)	30 June 2004	Dr. Agasse	Private clinic (in the south west of France)
Dr. Arnaud	26	General practitioner (11/ 14)	6 July 2004	Dr. Agasse	Private clinic
Dr. Gitton	27	General practitioner (12/ 14)	13 July 2004	Dr. Agasse	Private clinic
Dr. Bouchet	28	General practitioner (13/ 14)	6 August 2004	Dr. Agasse	Private clinic
Dr.	29	General	8 September	Dr.	Private clinic

O'Connell		practitioner (14/ 14)	2004	McDermott	
Dr. Vézinet	30	Magnesium specialist (1/1)	13 September 2004	Personal contact	Retired

Details about clinicians interviewed

Dr. Levy is a psychoanalytically-oriented psychiatrist who works out of a public institution in the proximate suburbs of Paris. He was a valuable resource, particularly during the early phases of my research, in terms of clearly laying out psychoanalytic explanations of the phobias. Dr. Levy referred me to Freud's classic case study of Little Hans. He also introduced me to the Yvelines network of physicians. I attended one of their conferences where I was able to meet many clinicians to discuss my research, as well as conduct participant observation to learn how clinicians of different backgrounds approach psychiatric issues. At this meeting, there was an overwhelming disagreement about how diagnoses should be used (for example, whether the patient should be informed of the diagnosis, which diagnostic framework should be used, etc.), though the general consensus was that they should be avoided. I became a member of their network and was introduced at the meeting, at which point a brief description of my research was provided to other members. This introduction permitted me to freely contact other members to request interviews. This network was my primary means of finding clinicians outside of Paris. Speaking with these doctors was important because as soon as you leave the city, access to cognitive and behavioural specialists is reduced and because of this, therapeutic approaches to social phobia change.

Dr. Duclaux is a specialist in cognitive and behavioural therapy and works at a renowned university teaching hospital in Paris. He carries out a considerable amount of research on social phobia and has published widely on the disorder. I contacted him before my departure to France at the suggestion of a Swedish social phobia researcher. Dr. Duclaux referred me to other social phobia experts in Paris who I may not have had access to without his help.

Dr. Debru is a general practitioner who is a member of the Yvelines network of physicians. He has a private office in a quiet town about 40 minutes outside of Paris. I believe that he is probably representative of an 'average' French GP. He uses the diagnosis of social phobia from time to time, but has only basic information about the disorder. He is not particularly interested in the larger social, economic, political or historical issues surrounding the adoption of the diagnostic category social phobia that were of interest to other clinicians I interviewed.

Dr. Clavel is a general practitioner and member of the Yvelines network of physicians. His private office is based in Versailles. He is a self-described "black sheep" who is undaunted by presenting unpopular views or going out on a limb in his explanations. He is the only clinician I interviewed who used evolutionary psychology theories to explain the apparent increasing prevalence of social phobia in France. He rejects the use of almost all diagnostic categories. This is partly because he believes that researchers routinely lie and fabricate evidence to confirm their hypotheses. He prefers to respond to the suffering of his patients by explaining their problems in terms of anxiety, discomfort

or suffering. He sends his patients to specialists if they experience more acute cases of mental illness and he prescribes medications as needed.

Dr. Jacob's contact information was provided to me by members of the journal *Prescrire*. He is a general practitioner who has a private office in the outskirts of Paris. He takes a militant position concerning the pharmaceutical industry. He believes that the industry is responsible for the high rates of a number of modern illnesses, such as depression, obsessive-compulsive disorder and social phobia, and that the diagnoses would virtually disappear if it were not for the pressure of these companies. He believes that the most appropriate interventions are on a deeply personal level (in the form of psychoanalysis) and on a social level, to address "pathological" social conditions. He is also a strong proponent for the recognition of the value of GPs in French society. He recently published a 'day-in-the-life' account of his experiences as a generalist, which was based on real cases he has seen throughout his career. I am not including the reference, since that would violate our confidentiality agreement. Another physician wrote a similar book at about the same time as his. I heard rumours that the other physician's book may be in the process of being turned into a movie.

Dr. Lefebvre is a psychiatrist and a member of the Yvelines network. He has an office in a clinic of 28 doctors in a suburb of Paris. Dr. Lefebvre worked for several years for the pharmaceutical company Wyeth Ayerst, and still performs clinical research for this company and others. He is a member of a network of active clinical researchers in France. Because of this, he tends to know more than the average psychiatrist about new

drugs 'in the pipeline'. He believes that the French government exerts far too much control over the pharmaceutical industry. He believes that they should be given a lot more freedom to undertake research and market their products. Dr. Lefebvre identified governmental unions and the socialist state as the bodies responsible for the difficulties encountered by the pharmaceutical industry in France.

Dr. Petit is a psychiatrist and family therapist who is a member of the Yvelines network. He works out of a psychiatric hospital in the suburbs of Paris. He reported that as far as he is concerned, social phobia does not exist, but specified that this is likely because he has never looked for it. Dr. Petit suggests that the only reason that social phobia is presumed to exist is because doctors look for it in patients and patients respond to the physicians' expectations. He believes that most cases of social phobia are people who suffer from some sort of anxiety, but that this anxiety could be described by a number of names and it is not necessarily pathological.

Dr. Begot is a psychiatrist who works out of a public hospital at the outskirts of Paris. She is a member of the Yvelines network of physicians. She is trained in cognitive and behavioural therapy and family therapy. She works as a part of a network of physicians who specialize in the treatment of people with alcohol addiction. If any physician in my study should have seen a lot of people with social phobia, aside from the social phobia experts in Paris, it should have been her. However, she describes the condition as relatively rare, adding that she would usually see these symptoms as part of a larger diagnosis of an anxio-nervous or hystero-phobic type. Nonetheless, she said that if she

started to look for the disorder, she could probably find it in the rates reported by epidemiological studies, though she had no intention of doing so. She believes that what a clinician sees depends on his or her therapeutic orientation. Her eclectic training, even though it was informed by cognitive and behavioural therapy, was not enough to make her 'see' social phobia.

Dr. Delaporte is a general practitioner who has a private office in a suburb near the edges of Paris. She has taken supplemental training in psychotherapy through a continuing education programme for GPs, which focused on cognitive and behavioural therapy. Despite her training, which one might expect would make her look for the symptoms of social phobia, she believes that "real" cases of social phobia are quite rare. She classifies real cases of the disorder as those causing significant handicaps in a patients' life. When she described examples of these significant handicaps, they sounded close to behaviours associated with agoraphobia. Dr. Delaporte prefers to focus on patients' temperaments, since these are what she considers to be at the base of most of their problems. She tends to see social phobia-like symptoms as falling into a range of neurotic disorders. She says that cognitive and behavioural therapy is often useful for symptom alleviation, but if your goal is long term improvement, psychoanalysis is usually necessary.

Dr. Mignot is a psychoanalytic psychiatrist who has an office in the suburbs of Paris. His office is situated in an area that brings together the bourgeois, rural dwellers, and a large number of new immigrants. He is also a part of the Yvelines network. Dr. Mignot

has worked in many domains throughout his career, having been employed for many years by the pharmaceutical industry in addition to working for 20 years a public institution. He believes that social phobia is a disease, but he places it among the neuroses and would usually treat it as such. However, he said that in cases where patients need immediate assistance (symptom alleviation), he directs them to a cognitive and behavioural therapist. He has mixed feelings about the pharmaceutical industry in France. While he finds some companies to be ethical, he thinks that something resembling a *Michelin Guide* to the industry is needed. Here he refers to the guide book that is famous for their restaurant rankings and reviews in France.

Dr. Vincent is a general practitioner who works out of a clinic in a very poor suburb of Paris in which most of the residents are immigrants. He is a member of the Yvelines network. Dr. Vincent is the only physician I spoke to who said that he had never seen a case of social phobia. He did not suggest that he could find a case if he looked, he simply said it was something he has not detected amongst his patients. Unlike some of the other physicians I interviewed, he was not denying the existence of social phobia for political, economic or social reasons. He simply had never seen a case. Instead, he said his time is spent treating patients' diabetes or HIV infections. An appendix to Chapter 7 focuses on Dr. Vincent.

Dr. Agasse is a general practitioner who works in the outskirts of Paris. Like most physicians I spoke to, he finds little use for the term social phobia. He thinks that a lot of what we now classify as mental pathology used to be considered acceptable anxiety. He

thinks that anxiety can be of great use to people. It provides a rush of adrenalin which can allow people to do things they otherwise would not be able to do. He councils his patients to try to make the most of their anxiety.

Dr. Hervé is a psychoanalytic psychologist. He and I had several discussions about psychoanalytic perspectives of social phobia-like conditions. I attended clinical discussions he presented at a psychoanalytically-oriented psychiatric hospital near the edge of Paris about a patient suffering from obsessional neurosis. Dr. Hervé suggested that this is one of the disorders that most closely resembles social phobia. He introduced me to several other psychiatrists at this hospital, who I was later able to interview.

Dr. Moreau is a senior representative in the Yvelines network and practices psychiatry in a hospital in a wealthy suburb of Paris. She was one of the creators of the network, which she established to improve communication between different types of physicians so that patients' psychiatric care would improve. Dr. Moreau believes that clinical practices have changed a lot in psychiatry over the course of her career, which has spanned about 20 years. She suggests that the DSM has been more fully integrated into the practice of French medicine and psychiatry than the dominant discourse, which tends to focus on psychoanalytic concepts, would indicate. She believes that discourse changes after practice. Nonetheless, she thinks that there are still a large number of theoretical perspectives influencing French psychiatry other than the DSM.

Dr. Villette is a psychoanalytically-oriented psychiatrist who is a member of the Yvelines network and practices psychiatry out of an office in a small town outside of Paris. He believes that social phobia has become better known and more widely diagnosed because it is an "easy" diagnosis to use. People believe that its treatment does not require profound personal exploration, which he thinks is an appealing aspect of the disorder (to patients and physicians). He also believes that it is increasingly accepted by physicians, along with the DSM. Dr. Villette noted that the pharmaceutical industry is trying to promote the acceptance of the DSM and that they distribute free copies to physicians with the hope that they will use it. Dr. Villette believes that social phobia is at its base a low level anxiety that probably used to be treated by GPs, but which is increasingly seen as something that needs to be taken seriously as a disease. His would treat this condition by examining the fundamental origins of patients' problems.

Dr. Fourciers is a psychiatrist and cognitive and behavioural therapist. He is a social phobia specialist and has published widely on the disorder (both popular and professional literature). He is a public psychiatrist and works out of an esteemed Paris hospital. Dr. Fourciers also works alongside GlaxoSmithKline to promote information about the disorder. For instance, he participated in the creation of an educational DVD to teach physicians how to diagnose the disorder. Though he realizes that his collaborations with this company are likely to increase the prescription rates of paroxetine, the most important thing to him, he argues, is that physicians and patients learn about the disorder so that they will have the chance to be appropriately treated.

Dr. Roux is a psychiatrist and cognitive and behavioural therapist. He was the first psychiatrist of this therapeutic orientation to be hired on staff at a prestigious Paris hospital. Over the years, he has seen, and fought for, the development of a specialized cognitive and behavioural therapy clinic at this hospital. Dr. Roux believes that the French psychiatric system is divided and that while one group of psychiatrists wants to move forward and to make psychiatry a scientific field, another group (psychoanalysts) holds the discipline back by trying to maintain a traditional, French psychiatry. He believes that a shift in power is imminent in psychiatry and that cognitive and behavioural therapists will soon have a more dominant position.

Dr. Nouri is the only person who I interviewed who is at once a psychiatrist, who has treated social phobia, and who was also a social phobia patient. Dr. Nouri is an Iranian psychiatrist who now works out of a psychoanalytically-oriented psychiatric hospital near the edge of Paris. He believes that the disorder is largely the result of social factors and that it is quite widespread in society, or at least societies where these factors exist (he referred to stress, war and embargoes in Iran).

Dr. Fortin is the senior psychiatrist at a psychoanalytically-oriented psychiatric hospital at the outskirts of Paris. To explain mental illnesses, he prefers psychoanalytic models to cognitive and behavioural ones. In his practice, however, he draws on several models, using certain to undertake clinical research and others in his encounters with patients. Dr. Fortin believes that the diagnostic category social phobia is shallow and offers little explanation for development of the disorder. But this is why he believes that many

physicians and patients like the term. It implicates the self at a much less profound level and is thus easier to discuss. Social phobia also designates a disorder that is not considered to be an integral part of the self. He thinks that patients are drawn to the diagnostic category because it suggests that they are normal, good people, who need only undergo a small amount of treatment and therapy to be cured. In the long term, he thinks that cognitive and behavioural therapy offers patients little.

Dr. Cohen is a psychiatrist at a psychoanalytically-oriented psychiatric hospital at the edge of Paris. He believes that the pharmaceutical industry is largely behind the increasing recognition of social phobia. He prefers psychoanalytic concepts to the diagnosis social phobia, but thinks that patients find the term social phobia reassuring for reasons similar to Dr. Fortin's. Dr. Cohen laments the fact that the composition of French psychiatry is changing, and that younger students now know little about psychoanalytic theories. He thinks that French psychiatry is becoming much more DSM-centric.

Dr. McDermott is a British general practitioner who used to have an office in Strasbourg. He has now returned to Britain. He has written about some of the culturally-specific disorders in France, such as spasmophilia. He thinks that the French medical system, in which physicians are paid by the act (for the number of patients they see), has encouraged the over-prescription of medications.

Dr. Lalande is a general practitioner who has an office at the outskirts of Paris. He teaches general medicine at a Parisian university and is involved in MG Form, a group of physicians who are trying to create a system of continuing medical education for doctors which is in large part independent of the pharmaceutical industry. They still take money from this industry, but try to provide a more balanced type of education.

Dr. Marsault is a general practitioner who has an office near the edge of Paris. She works as a member of an outreach programmes for patients who are HIV positive as a part of her practice. Dr. Marsault has several patients who she considers to have social phobia, and as our conversation progressed, she thought of more and more people for whom diagnosis was applicable. In contrast to other physicians, she did not take this ability to see 'everything' as a sign of the disorder, to be a reason to doubt the specificity or validity of the category. She was the only GP I interviewed who does not read *Prescrire* and who said that her primary reading material comes from the pharmaceutical industry because she finds this literature more appealing. I suspect that she is representative of a typical GP in France.

Dr. Picard is a psychoanalytically-oriented, but eclectic psychiatrist who works in a hospital in a wealthy suburb of Paris. She is a part of the Yvelines network of physicians. Dr. Picard succinctly put into words what many other physicians alluded to about social phobia – why an increasing number of patients and physicians are interested in the diagnostic category. Dr. Picard sees social phobics as insecure people who search for a diagnostic category that will provide them with a sense of identity but which will not lead

to their stigmatization. In her explanations for the rise of social phobia in France, she included social (and sociological), individual, professional and economic factors.

Dr. Lallier is general practitioner who works in the south of France. I met with him to speak about MG Form and his role in this organization. He rarely sees the need to use the diagnosis of social phobia and notes that outside of Paris, it is difficult to find cognitive and behavioural therapists should a physician seek to send one of his or her patients to one of these specialists.

Dr. Arnaud is a general practitioner who, along with Dr. Jacob, was the strongest promoter of Philippe Pignarre's work (2001, 2003). His office is in central Paris. He believes that the pharmaceutical industry is largely responsible for the existence of social phobia, a disorder which he says they created. Dr. Arnaud thinks that the threshold for many mental illnesses has been placed too low and he only uses medications for quite serious cases of mental illness.

Dr. Gitton is a general practitioner whose office is in the outskirts of Paris. He is critical of the pharmaceutical industry, and during our interview he referred to the creation of mental disorders by the pharmaceutical industry. However, he explained that the adoption of any new diagnostic category requires the support of four different groups: clinicians, researchers, the pharmaceutical industry and patients. It is not possible, he argued, for one of these groups to force the other groups to adopt a new diagnostic category. All groups have to express and interest in it and a willingness to work with the

category. New, or newly accepted, diagnostic categories must have something to offer to all four of these groups.

Dr. Bouchet is a general practitioner who has an office in central Paris. She believes that the diagnosis of social phobia has little to offer patients compared to pre-existing diagnostic categories. Instead, she prefers to use psychoanalytic concepts in combination with an analysis of the social factors that might lead to social isolation and a condition resembling social phobia. It is on these social factors that she thinks it is most important to intervene.

Dr. O'Connell is an Irish general practitioner who practices in central Paris. He uses the diagnosis of social phobia in his practice. He readily discusses social phobia with his patients and believes that they easily understand and accept the diagnosis. Dr. O'Connell refers most patients he diagnoses with social phobia to cognitive and behavioural therapists.

Dr. Vézinet is a specialist in magnesium research. He is now retired from clinical practice, though he still publishes (or did at the time of our interview). He lives in Paris. Over the years he has conducted a great deal of research on problems associated with magnesium deficiencies, including spasmophilia, a disorder to which Dr. Klotz (his mentor) dedicated a great deal of his career. Dr. Vézinet, however, now avoids the use of the word spasmophilia because he believes it became much overused at a certain point in its history. He believes that it has become a catch-all phrase to refer to almost any

disorder, and it has been particularly often used as a euphemism for mental illnesses when patients and physicians want to avoid psychological explanations.

Bibliography

90 Minutes. L'industrie pharmaceutique, les médecins, les médias et l'argent . *Canal +*. 2005. Paris, Canal +.

Adair R, Holmgren L. 2005. Do drug samples influence resident prescribing behavior? A randomized trial. *American Journal of Medicine* 118(8):881-4

Allen GE. 1997. The social and economic origins of genetic determinism: a case history of the American eugenics movement, 1900-1940 and its lessons for today. *Genetica* 99:77-88

Alonso J, Angermeyer MC, Bernert S, Bruffaerts R, Brugha IS, Bryson H, De Girolamo G, De Graaf R, Demyttenaere K, Gasquet I, Haro JM, Katz SJ, Kessler RC, Kovess V, Lepine JR, Ormel J, Polidori G, Russo LJ, Vilagut G, Almansa J, Arbabzadeh-Bouchez S, Autonell J, Bernal M, Buist-Bouwman MA, Codony M, Domingo-Salvany A, Ferrer M, Joo SS, Martinez-Alonso M, Matschinger H, Mazzi F, Morgan Z, Morosini R, Palacin C, Romera B, Taub N, Vollebergh WAM. 2004a. Prevalence of Mental Disorders in Europe: Results From the European Study of the Epidemiology of Mental Disorders (Esemed) Project. *Acta Psychiatrica Scandinavica* 109(Supplement 420):21-7

Alonso J, Angermeyer MC, Bernert S, Bruffaerts R, Brugha IS, Bryson H, De Girolamo G, De Graaf R, Demyttenaere K, Gasquet I, Haro JM, Katz SJ, Kessler RC, Kovess V, Lepine JP, Ormel J, Polidori G, Russo LJ, Vilagut G, Almansa J, Arbabzadeh-Bouchez S, Autonell J, Bernal M, Buist-Bouwman MA, Codony M, Domingo-Salvany A, Ferrer M, Joo SS, Martinez-Alonso M, Matschinger H, Mazzi F, Morgan Z, Morosini P, Palacin C, Romera B, Taub N, Vollebergh WAM. 2004b. Psychotropic Drug Utilization in Europe: Results From the European Study of the Epidemiology of Mental Disorders (Esemed) Project. *Acta Psychiatrica Scandinavica* 109(Supplement 420):55-64

Amador XF, David AS. 1998. *Insight and Psychosis*. New York: Oxford University Press.

America Psychiatric Association. 1996. *DSM-IV Source Book Volume 2*. Washington: American Psychiatric Association.

American Psychiatric Association. 1952. *Diagnostic and Statistical Manual of Mental Disorders*. Washington: American Psychiatric Association.

American Psychiatric Association. 1994. *Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition)*. Washington: APA.

American Psychiatric Association. 1966. *Diagnostic and Statistical Manual of Mental Disorders (Second Edition)*. Washington: American Psychiatric Association.

American Psychiatric Association. 1980. *Diagnostic and Statistical Manual of Mental Disorders (Third Edition)*. Washington: APA.

American Psychiatric Association. 1987. *Diagnostic and Statistical Manual of Mental Disorders (Third Edition - Revised)*. Washington: APA.

André C. L'affront a l'Inserm, par Christophe Andre. 2005. Paris, *Le Monde*.

André C. La profession doit se plier au devoir d'inventaire. *L'Express*. 2004. Paris, L'Express.

André C. Qui veut renverser la statue de Freud? 2005. Paris, *Le Monde*.

André C. Réponse d'expert. *Psychologies*. 2004. Paris.

Andreasen NC. 1984. *The Broken Brain: The Biological Revolution in Psychiatry*. Philadelphia: Harper and Row.

Andrews G. 1993. The Essential Psychotherapies. *British Journal of Psychiatry* 162:447-51

André C, Légeron P. 1995b. *La Peur des autres: Trac, timidité et phobie sociale*. Paris: Odile Jacob.

André C, Légeron P. 1995. Social Phobia - Clinical and Therapeutic Approaches. *Encephale-Revue De Psychiatrie Clinique Biologique Et Therapeutique* 21(1):1-13

Atran S. 1990. *Cognitive foundations of natural history towards an anthropology of science*. Cambridge England, New York, Paris: Cambridge University Press. Editions de la Maison des sciences de l'homme.

Bakalar N. A Host of Anxiety Drugs, Begat by Valium. 2005. New York, *New York Times*.

Ballenger JC, Davidson JR, Lecrubier Y, Nutt DJ, Baldwin DS, den Boer JA, Kasper S, Shear MK. Consensus Statement on Panic Disorder From the International Consensus Group on Depression and Anxiety. [Review]. *Journal of Clinical Psychiatry,* 59 Suppl 8, 47-54. 1998.

Ballenger J, Davidson J, Lecrubier Y, Nutt D, Bobes J, Beidel D, Ono Y, Westenberg H. 1998. Consensus statement on social anxiety disorder from the International Consensus Group on Depression and Anxiety. *Journal of Clinical Psychiatry* 59(Supplement 17):54-60

Battie W. 1758. *Treatise on Madness*. London: Whiston.

Beccaria L. Droit de réponse de Laurent Beccaria a L'Express ; Droit de réponse a Elisabeth Roudinesco ; Lettre adressée a Denis Jeambar (Directeur de la rédaction de L'Express). *L'Express*. 2005.

Beck A, Emery G, Greenberg RL. 1985. *Anxiety Disorders and Phobias: A Cognitive Perspective*. New York: Basic Books.

Beck AT. 1976. *Cognitive Therapy and the Emotional Disorders*. New York: International Universities Press.

Beck AT. 1967. *Depression: Causes and Treatment*. Philadelphia: University of Pennsylvania Press.

Beck AT, Freeman A. 1990. *Cognitive Therapy of Personality Disorders*. New York: The Guidford Press.

Benkimoun P. L'Inserm propose une évaluation contestée des psychothérapies. 2004. Paris, *Le Monde*.

Berger JT, Kark P, Rosner F, Packer S, Bennett AJ. 2001. Direct-to-consumer drug marketing: public service or disservice? *Mount Sinai Journal of Medicine* 68(3):197-202

Berndt ER. 2005. To Inform or Persuade? Direct-to-Consumer Advertising of Prescription Drugs. *New England Journal of Medicine* 352(4):325-9

Birnbaum G, Montero D. Analyze this: Docs get drug company money. *New York Post*. 1999. New York.

Birnbaum J. Catalogue de la détestation antifreudienne. 2005. Paris, *Le Monde*.

Blanchard S. Pourquoi les Français consomment toujours plus de psychotropes . 2004. Paris, *Le Monde*.

Blanchard S. "Psys": l'Inserm se dit "choque" par la desaveu du ministre. 2005. Paris, *Le Monde*.

Bobes J. 1998. How Is Recovery From Social Anxiety Disorder Defined? *Journal of Clinical Psychiatry* 59:12-9

Bonaccorso S, Sturchio JL. 2002. Direct to consumer advertising is medicalising normal human experience: against. *BMJ* 342(13 April):910-1

Borch-Jacobsen M. 2002. Prozac notion. *London Review of Books,* (9 July).

Bovard-Gouffrant M. 2004. Prise en charge des troubles anxio-dépressifs. *Le Quotidien du Médecin*

Bracken PJ. 1998. Hidden Agendas: Deconstructing Post Traumatic Stress Disorder. In *Rethinking the Trauma of War*, ed. Bracken PJ, Petty C, London: Free Association Books.

Breggin P. 1994. *Toxic Psychiatry: Why Therapy, Empathy and Love Must Replace the Drugs, Electroshock, and Biochemical Theories of the "New Psychiatry"*. New York: St. Martin's Press.

Broad W, Wade N. 1982. *The Betrayers of the Truth: Fraud and Deceit in the Halls of Science*. New York: Simon and Schuster.

Bruce TJ, Saeed SA. 2000. Social Anxiety Disorder / In reply. *American Family Physician* 61(11):3245

Bruder GE, Schneier FR, Stewart JW, Mcgrath P, Quitkin F. 2004. Left Hemisphere Dysfunction During Verbal Dichotic Listening Tests in Patients Who Have Social Phobia With or Without Comorbid Depressive Disorder. *American Journal of Psychiatry* 161(1):72-8

Canguilhem G. 1966. *Le Normal et le pathologique*. Paris: Presses universitaires de France.

Castel P-H. Un livre, un divan et un débat. 2005. Paris, *Le Monde*.

Caudill T, Johnson M, Rich E, McKinney W. 1996. Physicians, pharmaceutical sales representatives, and the cost of prescribing. *Archives of Family Medicine* 5:201-6

Chang SC. 1997. Social Anxiety (Phobia) and East Asian Culture. *Depression and Anxiety* 5(3):115-20

Charles G. 2005. La guerre des psys. *L'Express,* (5 September)

Charles G. (entretien avec Elisabeth Roudinesco). 2005. Elisabeth Roudinesco, contra-attaque. *L'Express,* (5 September)

Chartier MJ, Hazen AL, Stein MB. 1998. Lifetime patterns of social phobia: a retrospective study of the course of social phobia in a nonclinical population. *Depression and Anxiety* 7(3):113-21

Chavira DA, Stein MB, Malcarne VL. 2002. Scrutinizing the Relationship Between Shyness and Social Phobia. *Journal of Anxiety Disorders* 16(6):585-98

Chew L, et al. 2000. A Physician Survey of the Effect of Drug Sample Availability on Physicians' Behavior. *Journal of General Internal Medicine* 15:478-83

Chiarugi V. 1793. *On Insanity and its Classification*. Florence: L. Carlieri.

Chren M, Landefeld C. 1994. Physicians' behavior and their interaction with drug companies. *JAMA* 271:684-89

Claparède E. 1902. L'obsession de la rougeur. *Archives de Psychologie de la Suisse Romande*(April):307-34

Clark DM, Mcmanus F. 2002. Information Processing in Social Phobia. *Biological Psychiatry* 51(1):92-100

Clarke AE, Shim JK, Mamo L, Fosket JR, Fishman JR. 2003. Biomedicalization: Technoscientific transformations of health, illness and U.S. biomedicine. *American Sociological Review* 68(2):161-94

Clarvit SR, Schneier FR, Liebowitz MR. 1996. The Offensive Subtype of Taijin-Kyofu-Sho in New York City: The Phenomenology and Treatment of a Social Anxiety Disorder. *Journal of Clinical Psychiatry* 57(11):523-7

Coen L. Peut-on encore croire Freud? Review of Le Livre Noir de la Psychanalyse. 2005. Suisse, *Le Temps.*

Conrad P. 2005. The Shifting Engines of Medicalization. *Journal of Health and Social Behaviour* 46 (March):3-14

Conrad P, Schneider J. 1980. *Deviance and Medicalization: From Badness to Sickness.* St. Louis: C. V. Mosby.

Cottle M. 1999. Selling Shyness. *New Republic,* (2 August)

Cottraux J. Le patient doit savoir ce qu'on lui propose. *L'Express.* 2004. Paris, L'Express.

Danion J-M, Etiemble J. Pourquoi et comment evaluer l'efficacite des psychotherapies. Quotidien du medicin . 2005. Paris, *Quotidien du medicin.*

Davidson JR. 2003. Pharmacotherapy of social phobia. *Acta Psychiatrica Scandinavica* (Supplement 417):65-71

Davidson JRT, Hughes DC, George LK, Blazer DG. 1994. Boundary of Social Phobia - Exploring the Threshold. *Archives of General Psychiatry* 51(12):975-83

Davidson J, Foa E, Huppert J, Keefe F, Franklin M, Compton J, Zhao N, Connor K, Lynch T, Gadde K. 2004. Fluoxetine, comprehensive cognitive behavioral therapy, and placebo in generalized social phobia. *Archives of General Psychiatry* 61(10):1005-13

Deshpande A, Menon A, Perri M, Zinkhan G. 2004. Direct-to-consumer advertising and its utility in health care decision making: a consumer perspective. *Journal of Health Communication* 9(6):499-513

Diller LH. 2001. An end run to marketing victory. *Salon,* October

Diller LH. 2000. Extreme Ritalin. *Salon* (31 March)

Dumit J. 2003. *Picturing Personhood: Brain Scans and Biomedical Identity*. Princeton: Princeton University Press.

Dunner DL. 2001. Management of Anxiety Disorders: The Added Challenge of Comorbidity. *Depression and Anxiety* 13:57-71

Durlach J, Bara M. 2000. *Le magnésium en biologie et en médicine*. Cachan: Editions Médicales Internationales.

Ehrenberg A. 1998. *La fatigue d'être soi dépression et société*. Paris: O. Jacob.

Ehrenberg A. 2002. Psychotropicana. *London Review of Books* 24(15 (8 August 2002)): letters

Elliott C. 2003. *Better than well American medicine meets the American dream*. New York: W.W. Norton.

Ellis A. 1997. Extending the Goals of Behavior Therapy and of Cognitive Behavior Therapy. *Behavior Therapy* 28:333-9

Ellis A. 1963. *Reason and Emotion in Psychotherapy*. New York: Institute for Rational Living, Inc.

Ellis A. 1999. Why rational-emotive therapy to rational emotive behaviour therapy? *Psychotherapy* 36(2):154-9

Ellis A, Grieger R. 1977. *Handbook of Rational-Emotive Therapy*. New York: Springer Publishing Company.

Fairbrother N. 2002. The Treatment of Social Phobia -- 100 years ago. *Behaviour Research and Therapy* 40:1291-304

Fava GA, Rafanelli C, Grandi S, Canestrari R, Morphy MA. 1998. Six Year Outcome for Cognitive Behavioral Treatment of Residual Symptoms of Major Depression. *American Journal of Psychiatry* 155(10)

Favereau E. Une expertise de l'Inserm contestée notamment par les psychanalystes. Bons points douteux pour les thérapies comportementales. *Libération* . 2004. Paris, Libération.

Fischetti A. La guerre des divans. 2005. Paris, *Charlie Hebdo*.

Fishman JR. 2004. Manufacturing Desire: The Commodification of Female Sexual Dysfunction. *Social Studies of Science* 34 (April):187-218

Fohr A. Vaincre l'anxiété. *Nouvel observateur,* 1998, [20 fevrier]. 2003. Paris.

Frank J. 1973. *Persuasion and Healing: A Comparative Study of Psychopathology.* Baltimore: Johns Hopkins University Press.

Furmark T, Tillfors M, Everz P-O, Marteinsdottir I, Gefvert O, Fredrikson M. 1999. Social phobia in the general population: prevalence and sociodemographic profile. *Social Psychiatry and Psychiatric Epidemiology* 34(8):416-24

Furmark T. 2002. Social phobia: overview of community surveys. *Acta Psychiatrica Scandinavica* 105:84-93

Gauthier U. 2005. Un livre-événement relance la guerre entre pro et anti: Faut-il en finir avec la psychanalyse? *Le Nouvel Observateur* (1 September)

Gelernter J, Page GP, Stein MB, Woods SW. 2004. Genome-Wide Linkage Scan for Loci Predisposing to Social Phobia: Evidence for a Chromosome 16 Risk Locus. *American Journal of Psychiatry* 161(1):59-66

Gilman SL. 1991. *The Jew's body.* New York: Routledge.

GlaxoSmithKline. *Les Phobies Sociales: Anxiete Sociale Pathologique* (free educational CD-ROM and written guide). nd. Marly-le-Roi, France, GlaxoSmithKline.

GlaxoSmithKline. 2004. *Pour diffusion immédiate: un nouveau médicament contre la dépression et les troubles anxieux contribue à réduire le taux d'abandon du traitement. L'arrêt prématuré du traitement antidépresseur est un problème très répandu.* GlaxoSmithKline, Montreal

Goffman E. 1963. *Stigma: Notes on the Management of Spoiled Identity.* New Jersey: Spectrum.

Gonul FF, Carter F, Wind J. 2000. What kind of patients and physicians value direct-to-consumer advertising of prescription drugs. *Health Care Management and Science* 3(3):215-26

Goode E. Old as Society, Social Anxiety is Yielding its Secrets. 1998. New York, *New York Times.*

Greenslit N. Depression and Consumption: Psychopharmaceuticals, branding, and new identity practices. *Vital Politics.* 2003. London.

Gruyer A. Le débat sur la psychanalyse laisse peu entendre les premiers concernés: La souffrance sans voix. 2005. Paris, *Libération.*

Guidano VF. 1991. *The Self in Process: Toward a Post-Rationalist Cognitive Therapy.* New York: The Guilford Press.

Guyatt G. 2003. How to keep a healthy state of mind. Have we gone too far in medicalizing our lives? *Straight Goods* (3 June)

Hacking I. 1999. *The Social Construction of What?* Cambridge: Harvard University Press.

Hackmann A, Clark DM, Mcmanus F. 2000. Recurrent Images and Early Memories in Social Phobia. *Behaviour Research and Therapy* 38(6):601-10

Hale NG. 1971. *Freud and the Americans: The Beginnings of Psychoanalysis in the United States, 1876-1917* . New York: Oxford University Press.

Hale NG. 1995. *The Rise and Crisis of Psychoanalysis in the United States*. New York: Oxford University Press.

Halmos C. 2006. Timide un mot qui fait mal. *Psychologies* (janvier)

Harmon A. Neurodiversity Forever; The Disability Movement Turns to Brains. 2004. New York, *New York Times*.

Hartenberg P. 1901. *Les Timides et la Timidité*. Paris: Félix Alcan.

Healy D. Have Drug Companies Hyped Social Anxiety Disorder to Increase Sales. Yes: Marketing Hinders Discovery of Long-Term Solutions. *Western Journal of Medicine* 175 [6], 364. 2001.

Healy D. 4S (Society for Social Studies of Science) Presentation. 2004.

Healy D. 1997. *The Anti-Depressant Era*. Cambridge: Harvard University Press.

Healy D. 2002. *The Creation of Psychopharmacology*. Cambridge: Harvard University Press.

Healy D. 2004a. *Let Them Eat Prozac: The Unhealthy Relationship between the Pharmaceutical Industry and Depression*. New York: New York University Press.

Healy D. 2004b. Shaping the intimate: Influences on the experience of everyday nerves. *Social Studies of Science* 34(2):219

Heiser NA, Turner SM, Beidel DC. 2003. Shyness: Relationship to Social Phobia and Other Psychiatric Disorders. *Behaviour Research and Therapy* 41(2):209-21

Hermann C, Ziegler S, Birbaumer N, Flor H. 2002. Psychophysiological and Subjective Indicators of Aversive Pavlovian Conditioning in Generalized Social Phobia. *Biological Psychiatry* 52(4):328-37

Hidalgo RB, Barnett SD, Davidson JRT. 2001. Social Anxiety Disorder in Review: Two Decades of Progress. *International Journal of Neuropsychopharmacology* 4(3):279-98

Hofmann SG, Heinrichs N, Moscovitch DA. 2004. The nature and expression of social phobia: Toward a new classification. *Clinical Psychology Review* 24:769-979

Holden C. French Psychoflap. *Science* 307 [25 February 2005]. 2005.

Hollon MF. 2004. Direct-to-consumer marketing of prescription drugs: a current perspective for neurologists and psychiatrists. *CNS Drugs* 18(2):69-77

Hollon SD, Jarrett RB, Nierenberg AA, Thase ME, Trivedi M, Rush AJ. 2004. Psychotherapy and medication in the treatment of adult and geriatric depression: which monotherapy or combined treatment? *Journal of Clinical Psychiatry* 66(4):455-68

Hudson JL, Rapee RM. From Anxious Temperament to Disorder - An Etiological Model. Generalized Anxiety Disorder: Advances in Research and Practice. 51-74. 2004.

Huret M. 2002. La revanche des timides. *L'Express* (22 August)

Huret M. Les psys peuvent-ils tout guérir? Mode d'emploi. 2003. Paris, *L'Express*.

Huret M, Olivier V. Peut-on evaluer les psychotherapies? *L'Express*. 2004. Paris, L'Express.

Illich I. 1975. *Medical Nemesis: The Expropriation of Health*. London: Calder and Boyars.

IMS Health. Blockbusters Blast a Highway through Pharma Sales. *Market Insight. 2002*. IMS Global.

IMS Health. IMS Reports 2004 Global Pharmaceutical Sales Grew 7 Percent to $550 Billion. *Press Room*. 2005. IMS Global.

Janet P. 1908. *Les Obsessions et la psychasthénie (volume 1)*. Paris: Félix Alcan.

Janet P. 1908. *Les Obsessions et la psychasthénie (volume 2)*. Paris: Félix Alcan.

Joffe R, Segal Z, Singer W. 1996. Change in Thyroid Hormone Levels Following Response in Cognitive Therapy for Major Depression. *American Journal of Psychiatry* 153 (3):411-5

Katzelnick DJ, Kobak KA, DeLeire T, Henk HJ, Greist JH, Davidson JRT, Schneier FR, Stein MB, Helstad CP. Impact of Generalized Social Anxiety Disorder in Managed Care. *American Journal of Psychiatry*, 158 [12], 1999-2007. 2001.

Keller MB. 2003. The Lifelong Course of Social Anxiety Disorder: a clinical perspective. *Acta Psychiatrica Scandinavica* 108 (supplement 417):85-94

Keller P-H. L'etat actuel des connaissances sur la souffrance psychique ne permet pas d'evaluation. Un rapport premature et dangereux. 2004. Paris, *Libération.*

Kernberg OF. 1998. The diagnosis of narcissistic and antisocial pathology in adolescence. *Adolescent Psychiatry*

Kevles D. 1985. *In the Name of Eugenics: Genetics and the Uses of Human Heredity.* New York: Alfred A. Knopf.

King LJ. 1999. A Brief History of Psychiatry: Millennia Past and Present. *Annals of Clinical Psychiatry* 11(1):3-12

Kirmayer L, Corin E. 1998. Insider Knowledge: Cultural Constructions of Insight in Psychosis. In *Insight in Psychosis*, ed. Amador XF, David AS, New York: Oxford University Press.

Kirmayer LJ. 2001. Cultural Variations in the Clinical Presentation of Depression and Anxiety: Implications for Diagnosis and Treatment. *Journal of Clinical Psychiatry* 62 (Supplement 13):22-8

Kirmayer LJ. 2002. Psychopharmacology in a Globalizing World: The Use of Antidepressants in Japan. *Transcultural Psychiatry* 39(3):295-322

Klerman GL, Weissman MM, Rounsaville B, Chevron ES. 1984. *Interpersonal Therapy of Depression.* New York: Basic Books.

Klerman GL. 1990. History and Development of Modern Concepts of Anxiety and Panic. In *Clinical Aspects of Panic Disorder*, ed. Ballenger JC,3-12 pp. New York: Wiley-Liss. 3-12 pp.

Koerner BI. 2002. Disorders made to order. *Mother Jones* (July/August)

Kramer P. 1993. *Listening to Prozac.* New York: Penguin.

Kripke C. 2005. Is pharmacotherapy useful in social phobia? *American Family Physician* 71(9):1700-1

Laederach-Hofmann K, Mussgay L, Buchel B, Wilder P, Ruddel H. 2002. Patients with Erythrophobia (fear of blushing) ShowAbnormal Autonomic Regulation in Mental Stress Conditions. *Psychosomatic Medicine* 64:358-65

Lanez EeaCA. 2005. Interview de Christophe André «Si la psychothérapie n'est pas un soin, il faut le dire! Si elle en est un, elle doit être évaluée». *Le Point* (29 September (1724))

Lang AJ, Stein MB. 2001. Social Phobia: Prevalence and Diagnostic Threshold. *Journal of Clinical Psychiatry* 62:5-10

Laplanche J, Pontalis J-B. 1973. *The Language of Psychoanalysis*. New York: W.W. Norton and Company.

Le Moigne P. 2002. *La Dépendance aux médicaments psychotropes: Enquête auprès des usagers et des prescripteurs*. CESAMES, Paris

Le Monde. En mai 68, les accords de Grenelle. 2006. Paris, *Le Monde*.

Le Nouvel Observateur. 2005. Haro sur Freud et ses émules: Ce qui dit «le Livre Noir de la Psychanalyse» (extraits du livre). *Le Nouvel Observateur* (1 September)

Le Nouvel Observateur. 2005. Retour sur "Faut-il en finir avec la psychanalyse?"; Lettres (selection of 15 letters in response to "Faut-il en finir avec la psychanalyse?"). *Le Nouvel Observateur* (15 September):3

Le Nouvel Observateur, Van Rillaer J, de Mijolla A. 2005. Deux personnalités acceptent le débat: L'un y croit, l'autre pas. *Le Nouvel Observateur* (1 September)

Lee S, Mysyk A. 2004. The Medicalisation of Compulsive Buying. *Social Science and Medicine* 58:1709-18

Lépine J-P, Pélissolo A. 2000. Why take social anxiety disorder seriously? *Depression and Anxiety* 11(3):87-92

Liebowitz MR, Heimberg RG, Fresco DM, Travers J, Stein MB. Social Phobia or Social Anxiety Disorder: What's in a Name? Archives of General Psychiatry 57[2], 191-192. 2000.

Lock M. 1998. Breast Cancer: Reading the Omens. *Anthropology Today* 14(4):7-16

Lock M. 2002. *Twice Dead: Organ Transplants and the Reinvention of Death*. Berkeley: University of California Press.

Luhrmann TM. 2000. *Of Two Minds: An anthropologist looks at American psychiatry*. New York: Vintage Books.

Lupton D. 1995. *The Imperative of Health: Public Health and the Regulated Body*. London: Sage Publications.

Lydiard RB. 2001. Social Anxiety Disorder: Comorbidity and Its Implications. *Journal of Clinical Psychiatry* 62:17-24

Lyles A. 2002. Direct Marketing of Pharmaceuticals to Consumers. *Annual Review of Public Health* 23:73-91

Marks IM. 1970. The Classification of Phobic Disorders. *British Journal of Psychiatry* 116:377-86

Marks IM, Gelder MG. Different Ages of Onset in Varieties of Phobia. *American Journal of Psychiatry* 123 [2], 218-21. 1966.

Marteinsdottir I, Tillfors M, Furmark T, Anderberg UM, Ekselius L. 2003. Personality Dimensions Measured by the Temperament and Character Inventory (Tci) in Subjects With Social Phobia. *Nordic Journal of Psychiatry* 57(1):29-35

Martineau C. 2005. Vers la fin du psychanalytiquement correct. *Le Quotidien du Médecin* (27 September)

Matsunaga H, Kiriike N, Matsui T, Iwasaki Y, Stein DJ. 2001. Taijin kyofusho: a form of social anxiety disorder that responds to serotonin reuptake inhibitors? *International Journal of Neuropsychopharmacology* 4:231-7

Maudsley H. 1879. *The Pathology of Mind.* London: Macmillan.

Mazumdar PMH. 1992. *Eugenics, Human Genetics and Human Failings: The Eugenics Society, its sources and its critics in Britain.* London: Routledge.

McLaren. 1990. *Our own master race: eugenics in Canada, 1885-1945* . Toronto: McClelland & Stewart.

Menon AM, Deshpande AD, Zinkhan GM, Perri M. 2004. A model assessing the effectiveness of direct-to-consumer advertising: integration of concepts and measures from marketing and healthcare. *International Journal of Advertising* 23(1):91-117

Metzl JM. 2003. *Prozac on the Couch: Prescribing Gender in the Era of Wonder Drugs.* Durham: Duke University Press.

Meyer C. 2005. *Le Livre Noir de la Psychanalyse.* Paris: Editions des Arenes.

Meyer C. 2005. Pourquoi un livre noir de la psychoanalyse? In *Le Livre Noir de la Psychanalyse*, ed. Meyer C, Paris: Editions des Arenes.

Miller J-A. 2006. *L'anti-livre noir de la psychanalyse.* Paris: Seuil.

Miller J-A. Autodialogue imaginaire sur la vraie question des thérapies comportementales: Le marché du mental. 2005. Paris, *Libération.*

Miller J-A. Une auto-evaluation par le patient lui-meme. *L'Express* . Paris, L'Express.

Mintzes B, Barer ML, Kravitz RL, Bassett K, Lexchin J, Kazanjian A, Evans RG, Pan R, Marion SA. 2003. How does direct-to-consumer advertising (DTCA) affect

prescribing? A survey in primary care environments with and without legal DTCA. *CMAJ* 169 (5):405-12

Mintzes B. 2002. For: Direct to consumer advertising is medicalising normal human experience. *BMJ* 324 (13 April):908-9

Moynihan R, Heath I, Henry D. 2002. Selling sickness: the pharmaceutical industry and disease mongering. *BMJ* 324 (13 April):886-91

Moynihan, Ray and Henry, David. *Public Library of Science Medicine* 3 [4]. 2006.

Neal JA, Edelmann RJ, Glachan M. 2002. Behavioural Inhibition and Symptoms of Anxiety and Depression: Is There a Specific Relationship With Social Phobia? *British Journal of Clinical Psychology* 41:361-74

Nelkin D, Michaels M. 1998. Biological categories and border controls: the revival of eugenics in anti-immigration rhetoric. *International Journal of Sociology and Social Policy* 18(5/6):34-61

Nicholson IAM. 1998. Gordon Allport, Character, and the "Culture of Personality," 1897-1937. *History of Psychology* 1(1):52-68

Novas C, Rose N. 2000. Genetic Risk and the Birth of the Somatic Individual. *Economy and Society* 29(4):485-513

Nye RA. 2003. The Evolution of the Concept of Medicalization in the Late Twentieth Century. *Journal of History of the Behavioural Sciences* 39(2):115-29

Ogawa T, Bouderlique J. 1994. L'Anthropophobie: Approche Psychopathologique des Interactions Entre Corps, Intersubjectivite et Langage. *The Japanese Journal of Psychiatry and Neurology* 48(3):527-32

Ohayon A. 1999. *L'Impossible Rencontre: Psychologie et psychanalyse en France 1919-1969*. Paris: La Découverte.

Oldani MJ. 2002. Tales from the 'Script': an insider/outsider view of pharmaceutical sales practices. *Kroeber Anthropological Society Papers* 87(spring):147-76

Otto MW, Deveney C. 2005. Cognitive-behavioral therapy and the treatment of panic disorder: efficacy and strategies. *Journal of Clinical Psychiatry* 66(Supplement 4):28-32

Pande A, Crockatt J, Feltner D, Janney C, Smith W, Weisler R, Londborg P, Bielski R, Zimbroff D, Davidson J, Liu-Dumaw M. 2003. Pregabalin in generalized anxiety disorder: a placebo-controlled trial. *American Journal of Psychiatry* 160(3):533-40

Selling Sickness: An Ill for Every Pill. Pat Fiske. 2004. Australia, Paradigm Pictures/Australian Film Finance Corporation Ltd.

Payer L. 1988. *Medicine and Culture: Varieties of Treatment in the United States, England, West Germany and France*. New York: Henry Holt.

Pelissolo A, Andre C, Moutard-Martin F, Wittchen HU, Lepine JP. Social Phobia in the Community: Relationship Between Diagnostic Threshold and Prevalence. *European Psychiatry* 15[1], 25-28. 2000.

Pelissolo A, Gourion D, Notides C, Bouvard M, Lepine JP, Mouren-Simeoni MC. 2001. Familial Factors Influencing the Consumption of Anxiolytics and Hypnotics by Children and Adolescents. *European Psychiatry* 16(1):11-7

Pelissolo A, Lepine JP. 1995. Social Phobia - Historical and Conceptual Views. *Encephale-Revue De Psychiatrie Clinique Biologique Et Therapeutique* 21(1):15-24

Pelissolo A. Reponse aux critiques faites au rapport de l'Inserm sur l'evaluation des psychotherapies. Plus de clartes sur les therapies. 2004. Paris, *Liberation.*

Perromat P. Le débat français à la « une » de la presse étrangère. 2006. Paris, *Le Monde.*

Pick D. 1989. *Faces of Degeneration: A European Disorder, 1848-1918*. Cambridge: Cambridge University Press.

Pignarre P. 2001. *Comment la dépression est devenue une épidémie*. Paris: La Découverte.

Pignarre P. 2003. *Le grand secret de l'industrie pharmaceutique*. Paris: Editions la Découverte.

Pitres A, Régis E. 1902. L'obsession de la rougeur ou éreutophobie (note additionnelle). *Archives Neurologique* 13:177

Pitres A, Régis E. 1897. L'obsession de la rougeur (éreutophobie). *Archives Neurologique* 3:1

Prescrire. 2004. Europe et Médicament: Les succès obtenu par les citoyens. *Revue Prescrire* 252(24):542-8

Prescrire. 2003a. Paroxétine (Deroxat). *Revue Prescrire* 237(Mars):167-70

Prescrire. 2003b. Point de vue de la Rédaction: Gare a la médicalisation pharmacologique de l'existence. *Revue Prescrire* 237(Mars):169-71

Prieur C. Et Philippe Doust-Blazy declara sa flamme a la psychanalyse. 2005. Paris, *Le Monde.*

Prieur C. Antidépresseurs : enquête sur un inquiétant succès. 2004. Paris, *Le Monde*.

Rabinow P. 1996. *Essays on the anthropology of reason*. Princeton, N.J: Princeton University Press.

Raj BA, Sheehan DV. 2001. Social Anxiety Disorder. *Medical Clinics of North America* 85(3)

Rapee RM, Melville LF. Recall of Family Factors in Social Phobia and Panic Disorder: Comparison of Mother and Offspring Reports. *Depression & Anxiety* 5[1], 7-11. 1997.

Rapee RM, Spence SH. 2004. The etiology of social phobia: Empirical evidence and an initial model. *Clinical Psychology Review* 24:737-67

Rapoport JL. 1988. *The Boy Who Couldn't Stop Washing: The Experience and Treatment of Obsessive Compulsive Disorder*. Boston: E. P. Dutton.

Rapp R. 1999. *Testing Women, Testing the Fetus: the social impact of amniocentesis in America*. New York: Routledge.

Ratto CL, Capitano DL. 1999. New Directions in Cognitive Therapy: A Schema-Focused Approach. *Cognitive and Behavioral Practice* 6:68-73

Reil J. 1803. *Rhapsodies on the Application of the Psychological Method of Cure in Mental Alienation* .

Reilly PR. 1991. *The Surgical Solution: A History of Involuntary Sterilization in the United States*. Baltimore: Johns Hopkins University Press.

Robins LN, Helzer JE, Croughan J, Ratcliff KS. 1981. National Institute of Mental Health Diagnostic Interview Schedule - Its History, Characteristics, and Validity. *Archives of General Psychiatry* 38(4):381-9

Robins LN, Regier DA. 1991. *Psychiatric Disorders in America*. New York: The Free Press.

Rose N. 2003. The Neurochemical Self and Its Anomalies. In *Risk and Morality*, ed. Ericson R, Toronto: University of Toronto Press.

Rose N. 2001. The Politics of Life Itself. *Theory, Culture and Society* 18(6):1-30

Rothman SM, Rothman DJ. 2003. *The Pursuit of Perfection: The Promise and Perils of Medical Enhancement*. New York: Pantheon Books.

Roudinesco E. La fin d'une evaluation, par Elisabeth Roudinesco. 2005. Paris, *Le Monde*.

Roudinesco E. 2005. *Pourquoi tant de haine? Anatomie du Livre noir de la psychanalyse*. Paris: Navarin.

Sappell J, Welkos RW. The Scientology Story, a six-part series. 1990. Los Angeles, *Los Angeles Times*.

Sareen L, Stein M. A Review of the Epidemiology and Approaches to the Treatment of Social Anxiety Disorder. [Review]. *Drugs* 59[3], 497-509. 2000.

Sarfati A-C. Coups de Blues: Comment les surmonter? *Elle* [12 avril], 83-86. 2004. Paris.

Schneider WH. 1990. The Eugenics Movement in France, 1890-1940. In *The Wellborn Science: Eugenics in Germany, France, Brazil, and Russia*, ed. Adams MB, New York: Oxford University Press.

Schneider WH. 1990. *Quality and Quantity: The Quest for Biological Regeneration in Twentieth Century France*. Cambridge: Cambridge University Press.

Schwartz JM. 1998. Neuroanatomical Aspects of Cognitive-behavioural therapy response in obsessive-compulsive disorder. *British Journal of Psychiatry* 173(Supplement 35):38-44

Scott RW, Mughelli K, Deas D. 2005. An overview of controlled studies of anxiety disorders treatment in children and adolescents. *Journal of the National Medical Association* 97(1):13-24

Scott S. 2006. The medicalisation of shyness: from social misfits to social fitness. *Sociology of Health & Illness* 28(2):133-53

Searle GR. 1981. Eugenics and Class. In *Biology, Medicine and Society, 1840-1940*, ed. Webster C, Cambridge: Cambridge University Press.

Selden S. 2000. Eugenics and the social construction of merit, race and disability. *Journal of Curriculum Studies* 32:235-52

Servan-Schreiber D. 2003. *Guérir le stress, l'anxiété et la dépression sans médicaments ni psychanalyse*. Paris: Robert Laffont.

Servan-Schreiber D. Monsieur le ministre, ne méprisez pas la souffrance des patients! *Psychologies* . 2005. Paris, Psychologies.

Shorter E. 1997. *A History of Psychiatry: From the era of the asylum to the age of Prozac*. New York: John Wiley & Sons.

Soloway RA. 1990. *Demography and Degeneration: Eugenics and the Declining Birthrate in Twentieth-Century Britain*. Chapel Hill: The University of North Carolina Press.

Spiegel A. More and More, Favored Psychotherapy Lets Bygones be Bygones. Health. 2006. New York, *New York Times*.

Stabler B. 2001. Impact of Growth Hormone (Gh) Therapy on Quality of Life Along the Lifespan of Gh-Treated Patients. *Hormone Research* 56:55-8

Stein DJ, Bouwer C. 1996. Blushing and social phobia: a neuroethological speculation. *Medical Hypotheses* 49:101-8

Stein DJ, Bouwer C. 1997. A Neuro-Evolutionary Approach to the Anxiety Disorders. *Journal of Anxiety Disorders* 11(4):409-29

Stein MB, Walker JR, Forde DR. 1994. Setting Diagnostic Thresholds for Social Phobia - Considerations From a Community Survey of Social Anxiety. *American Journal of Psychiatry* 151(3):408-12

Steinman M, Shlipak M, McPhee SJ . 2001. Of principles and pens: attitudes and practices of medicine housestaff toward pharmaceutical industry promotions. *American Journal of Medicine* 110(7):551-7

Szasz T. 1970. *Manufacture of Madness*. New York: Dell.

Tajima O. 2001. Mental Health Care in Japan: Recognition and Treatment of Depression and Anxiety Disorders. *Journal of Clinical Psychiatry* 62(Supplement 13):39-44

Takahashi T. 1989. Social Phobia Syndrome in Japan. *Comprehensive Psychiatry* 30(1):45-52

Talbot M. The Shyness Syndrome. New *York Times Sunday Magazine* [4 June], 11-12. 2001. New York, New York Times. 2001.

Tharwani HM, Davidson JRT. 2001. Symptomatic and Functional Assessment of Social Anxiety Disorder in Adults. *Psychiatric Clinics of North America* 24(4)

Thomas GM. 2002. *Post-Traumatic Nation: Medical Manifestations of Psychological Trauma in Interwar France*. Thesis. University of California, Berkeley.

Thurtle P. 2002. Harnessing Heredity in Gilded Age America: Middle Class Mores and Industrial Breeding in a Cultural Context. *Journal of the History of Biology* 35:48-73

Tignol J, Martin C, Auriacombe M, Grabot D, Pujol H, de Grove H, Gorse F, Gouget J. 2001. Case study--relationship between prevalence of shyness, social phobia and avoidant personality in male sexual disorders. *Encephale* 27(5 (Sep-Oct)):418-22

Tignol J, Martin C, Gorse F, Gouget JF. 1994. Social Phobia, Shyness and Male Sexual Disorders. *Current Therapeutic Approaches to Panic and Other Anxiety Disorders* 8:192-200

Tone A. 2005. Listening to the Past: History, Psychiatry, and Anxiety. *Canadian Journal of Psychiatry* 50(7):373-80

Tort M. Pour en finir avec le Père. *Nouvel Observateur*. 2004. Paris, Nouvel Observateur.

Turner SM, Beidel DC, Townsley RM. 1990. Social Phobia: Relationship to Shyness. *Behavior Research and Therapy* 28(6):497-505

Valverde M. 1999. *Diseases of the Will*. Cambridge: Cambridge University Press.

van Rillaer J. 2005. Enfin un bilan critique de la psychanalyse. *Elle* (5 September):50

Veit R, Flor H, Erb M, Hermann C, Lotze M, Grodd W, Birbaumer N. 2002. Brain Circuits Involved in Emotional Learning in Antisocial Behavior and Social Phobia in Humans. *Neuroscience Letters* 328(3):233-6

Vincent C. Psychotherapies, le défi de l'evalutation. 2005. Paris, *Le Monde*.

Vuckovic N. 1999. Fast Relief: Buying Time with Medications. *Medical Anthropology Quarterly* 13(1):51-68

Walker JR, Kjernisted KD. 2000. Fear: the Impact and Treatment of Social Phobia. *Journal of Psychopharmacology* 14(2):S13-S23

Weindling P. 1999. A virulent strain: German bacteriology as scientific racism, 1890-1920. In *Race, Science and Medicine, 1700-1960*, ed. Ernst WHB, London: Routledge.

Weiss SF. 1990. The Race Hygiene Movement in Germany, 1904-1945. In *The Wellborn Science: Eugenics in Germany, France, Brazil, and Russia*, ed. Adams MB, New York: Oxford University Press.

Weisz G. 2003. The Emergence of Medical Specialization in the Nineteenth Century. *Bulletin for the History of Medicine* 77:536-75

Weisz G. 2002. Regulating Specialties in France during the First Half of the Twentieth Century. *Social History of Medicine* 15(3):457-80

Weisz G. 2001. Spas, Mineral Waters, and Hydrological Science in Twentieth-Century France. *Isis* 92:451-83

Wilson PK. 2002. Harry Laughlin's eugenic crusade to control the 'socially inadequate' in Progressive Era America. *Patterns of Prejudice* 36(1):49-67

Wittchen HU. 2000. The Many Faces of Social Anxiety Disorder. *International Clinical Psychopharmacology* 15:S7-S12

Wittchen HU, Fehm L. 2003. Epidemiology and natural course of social fears and social phobia. *Acta Psychiatrica Scandinavica* 108(supplement 417):4-18

Wolpe PR. 2002. Treatment, Enhancement, and the Ethics of Neurotherapeutics. *Brain and Cognition* 59:387-95

Woolf SH, Friedman CL. 2000. Social Anxiety Disorder. *American Family Physician* 61(11):3245-+

Young A. 1995. *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*. Princeton: Princeton University Press.

Young A. 1988. Unpacking the Demoralization Thesis. *Medical Anthropology Quarterly* 2(1):3-16

Zamorski M, Ward R. 2000. Social Anxiety Disorder: common, disabling, and treatable. *Journal of the American Board of Family Practitioners* 13 (Jul-Aug)(4):251-60

Zarifian E. 1996. *Le prix du bien-être. Psychotropes et société*. Paris: Editions Odile Jacob.

Zarifian E. 1996. *Mission générale concernant la prescription et l'utilisation des médicaments psychotropes en France*. Paris: Odile Jacob.

Zola IK. 1991. Bringing our Bodies and Ourselves Back In: Reflections on a Past, Present and Future Medical Sociology. *Journal of Health and Social Behaviour* 32:1-16

Zola IK. 1972. Medicine as an Institution of Social Control. *Sociological Review* 20:487-504