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Shyness is not a sickness

***Shyness is not a sickness**, Interview to **Christopher Lane**, Storic Archives of Psicolinea*

Read the Italian Version: La timidezza non è una malattia

by Giuliana Proietti,

Interview

GP First of all, please introduce yourself to the Italian public: your latest book has not been translated yet and not everybody knows about the theories you expressed in it about shyness and sickness.

CL Well, I'm a London-born scholar now based in Chicago. I was educated and trained in England as a specialist of Victorian literature, but ever since I began my career in my twenties (I'm now in my early forties) I've been fascinated by nineteenth-century psychology and psychoanalysis. All four of my books have looked at Victorian fiction through the lens of such psychological theories. In the past few years, as "Shyness" hopefully demonstrates, I've broadened my interests to include intellectual history. What I'm trying to do, then, is use the topic of "shyness" to document major changes in Ameri-

can and European psychiatry, particularly the shift in the last three decades from talk-related therapy to neuropsychiatry and its emphasis on medication.

GP Why did you become interested in shyness and why did you write your latest book, "SHYNESS: How Normal Behavior Became A Sickness"?

CL After I finished a book on antisocial behavior in Victorian literature and culture (Hatred and Civility, 2004), I wanted to examine what happened to mavericks, the idiosyncratic, and, indeed, the shy in the 20th and 21st centuries. When I asked several leading psychiatrists about this, invariably they hinted that these people had been medicated. I grew concerned that medication was being used to eradicate key aspects of our humanity—emotions and behavioral traits that may be extreme, but that remain vital parts of us we can't simply dismiss or medicate away. Above all, who was determining which emotions and behaviors could stay and which should go?

Having reviewed so much of the psychiatric literature on the various personality, anxiety, and mood disorders, I've grown far more concerned about this question and underlying trend. Contemporary psychiatry is in many respects deeply conservative, conformist, and narrow in what it views as "normal behavior," a category that has shrunk quite dramatically in recent years, so that fewer and fewer of us manage to squeeze into it. Indeed, growing numbers of us are persuaded that there's something fundamentally wrong with us that drugs can and must fix. That trend frankly worries me. While it's true that many people are anxious and concerned about how they fit in and how the world is changing, medication often is not the solution, but actually something that can make things a great deal worse—by introducing a large number of troubling side effects, for instance, and by not addressing the underlying issues that are causing such anxiety in the first place.

GP How is the book selling and where has it encountered the greatest interest and success? According to the feedback you surely receive, could you tell us if your readers are mostly doctors and psychiatrists or the general public?

CL My editor tells me the book is selling very well (several thousand copies in the first months since release). The reviews generally have been very positive, too, with most recognizing that the book brings to light an important and largely ignored chapter of American psychiatry. It's gratifying to see that most reviewers consider it vital that that moment be examined, and that we ask, very seriously, whether all of the changes introduced in the 1980s were necessary and precise. I don't happen to think they were, and 99% of the extensive feedback I've received, largely as email but also as a few voicemails, has been from the general public agreeing with me.

When my piece about the book and the overemphasis on drug treatments appeared in the New York Times and reprinted the same day in the International Herald Tribune, I received dozens of emails from all around the world—from France to New Zealand, Canada to Guatemala, indeed from Italy too, and of course from all across the States. It was a little overwhelming, but made me realize that the column and the book tapped what I believe is widespread public concern about the overdiagnosis and overmedication of especially young children. I've since heard from quite a lot of doctors and psychia-

trists, too, almost all of them voicing support and relief. They're genuinely grateful that someone is airing these matters.

GP In your book you say that when you examine the track record of drugs promoted as efficient, speedy, and accurate, you quickly discover that they're anything but. What drug do you examine most closely in your book?

CL The drug that I examine most closely in my book is Seroxat ("Paxil" in the States): it can't in fact discriminate between routine stress and chronic anxiety, so it ends up blocking almost all such signals from the brain and central nervous system, with worrying health risks for patients.

When shyness is rebranded as "social phobia," moreover, all psychological, social, and even environmental factors causing reticence in people can fall out of the picture. They're replaced by questionable language about "chemical imbalances" in the brain and "biological dysfunctions" leading to "maladaptive" behaviors.

I find much of that emphasis troubling and questionable. For one thing, it's not an accurate way of talking about shyness or anxiety. Yet it seems to settle complex matters by suggesting that biology and genetics are able to pinpoint precisely what's going on, and no-one else need trouble themselves about such matters. Still, no-one can really say when the brain is "chemically balanced," because, for instance, its levels of serotonin, dopamine, and norepinephrine fluctuate all the time. And while many U.S. commentators love to speculate that there's a gene or even hormone for shyness, this is simply conjecture hardly worth the amount of time and space devoted to it. It's one thing to say that genes are responsible for things like eye-color; it's quite another, of course, to assert that they cause widespread and entirely unremarkable behavioral traits.

GP DSM is widely considered the "bible" of psychiatrists, but you don't seem to think the manual is "highly scientific." Why?

CL Well, the American Psychiatric Association was generous in giving me unprecedented access to its archives, so I was able to review all the letters, memos, documents, and even votes that circulated behind the scenes, before the creation of DSM-III. That was the crucial third edition that appeared in 1980 with 112 new disorders. Believe me, when you study such correspondence—I reproduce a lot of it in the book—you quickly lose any impression that what was going on was highly scientific or driven by careful clinical research. The correspondence instead reveals extraordinary lapses in professional judgment, embarrassing haste in cobbling together vague and questionable lists of symptoms, turf battles and interpersonal rivalries among the psychiatrists, a sometimes appalling poverty of group intelligence, frequently tiny case studies, and a general sense that anyone with friendly ties to the key task force members could get their pet theory formalized as a major disorder. It isn't a pretty picture, which surely is a key reason this embarrassing chapter of American psychiatry was buried behind a façade of rhetoric about hard science and pristine research. But, as I show in the book, that façade isn't accurate. Quite the contrary, it hides a reality that people really need to know about.

GP Is there any difference, according to you, between "shyness" and "social phobia"? Where should we draw the line between the two?

CL Yes, there are—or should be—key differences between them. Shyness is a common personality trait that's perfectly normal. Roughly half of any given population (including that of the U.S.) considers itself shy. Social phobia, by contrast, is meant to refer only to those suffering from chronic amounts of anxiety about interacting with other people. The problem is, the psychiatric literature on the two repeatedly confuses them (as, indeed, does the DSM), so ordinary shyness is now easily seen as a mental disorder.

Most psychiatrists that I interviewed told me, however, that the cut-off point between shyness and social phobia is relatively clear: on the order of 2% of seriously anxious patients they saw, as opposed to the unbelievable figure of one in five Americans (almost 19% of the U.S. population), which some psychiatrists have claimed is the correct figure.

GP And what about the "social anxiety disorder"? Why, according to you, have psychiatrists provided another definition so similar to that of "social phobia," which meets more or less the same criteria of it?

CL That's a good question. In 1987, when several psychiatrists were appointed to revise DSM-III, they argued that "social anxiety disorder" was a better name for "social phobia," because it reflected more accurately behaviors that they were seeing in the general population, including public speaking anxiety, dating anxiety, and even anxiety about dealing with figures in authority. To my mind, none of those common fears amounts to a mental disorder. On the contrary, they're so widespread as to be part of everyday psychology. But the psychiatrists updating the manual didn't see it that way. They thought they were helping everyone by calling such behaviors symptoms of social anxiety disorder. They also pressed for "social phobia" to be renamed so that it would include a great many more of us. And they succeeded. The list of official symptoms of social anxiety disorder grew accordingly, and many more people (over 18.5 million North Americans and 3 million Britons) were prescribed Seroxat/Paxil as a result.

GP In the New York Times you warned about overmedication and/or medicalization of society: what did you mean exactly?

CL As the above example hopefully shows, many people are taking medication they don't really need. Indeed, large numbers of psychiatrists prescribing drugs have I think come to accept a blurred distinction between chronic anxiety and routine fears, meaning they'll offer medication in either case. We've even reached the point in the U.S. and Britain where very young children—sometimes as young as four and five—and being given psychiatric drugs, with the hope that their childhood traits can be medicated away before they grow, apparently, into adult disorders. To my mind, that's a very troubling picture.

When Rebecca Riley, a 4-year-old girl from Hull, Massachusetts, died last year from psychiatric medi-

cation, there was an outcry from the public demanding to know what on earth was going on. In Boston, Massachusetts General Hospital admitted with some embarrassment that, in its care, 955 children under the age of 7 were taking the same antipsychotic medication. In fact, that's really just the tip of the iceberg, because it represents just one U.S. hospital, but it hopefully gives your readers a sense of the scale of the problem and the kind of thinking we're up against.

In some quarters, the belief that drugs are necessary to stamp out childhood traits amounts to a kind of fundamentalism. The psychiatrists are so adamant that what they're doing is correct and necessary that they continue to say even-larger numbers of children and adults should be on medication. I find that approach extremely worrying and arrogant. Almost none of the experts will talk about the well-documented side effects of medication—lists of symptoms so long they could fill several paragraphs. Still, the mindset that assumes that drugs are always necessary and the right course, no matter how small the problem, is what "medicalizes" our society. We lose any ability to think about behaviors in other ways.

GP If shyness is so common among human beings (in Philip Zimbardo's research, for instance, it is clear that the majority of people "are" or "were" or "are on some occasions" shy), why do many people still consider it as a "problem"? Why can't people cope with it?

CL Especially in North America today, people are encouraged to be highly extroverted and outgoing. I'd say that it's almost gotten to the point where the shy and introspective are considered abnormal, even quite suspect, because they're perceived as "brooding," "unresponsive," even "antisocial." Meanwhile, the only type of personality the culture seems to admire is one that's "perky": always "up" and "on" and ready to work articulately, with great zeal, at the drop of a hat. Europeans are, in my experience, more suspicious, even ironic, about such standards. Let's be clear: It's not that gregariousness and enthusiasm are in themselves problems; both can be very welcome and appealing. It's more, as you say, that vast numbers of people don't fit that general picture and, indeed, mind that the culture doesn't view their thoughtful, even quiet, interactions with other people as acceptable.

But it's also more than that. If we're ready to call dating anxiety and public speaking aspects of a mental disorder, as the DSM encourages, then we're also creating a norm that's not only undesirable for a great many of us; it's also quite unattainable. The model of American "perkiness" on offer is more than unattractive, one-dimensional, and emotionally limited; it's also in some cases the cause of fresh suffering, because it represents an ideal that most of us can't hope to live up to. Quite honestly, in today's world, with so much suffering on display and so many justifiable grounds for concern, to be perky all the time could look as if it was a fraction out of touch with reality. Certainly, it's difficult to maintain that outlook after one opens a newspaper or watches the world news.

GP Do you think there might be cases in which a drug is a relief for a shy person, or at least a valid support to psychotherapy?

CL I'm often asked this question, and it's not easy to answer, because the circumstances vary so much

from one person to the next. In general, yes, to the surprise perhaps of some of your readers, I am prepared to say that drug treatments—combined with psychotherapy—may on occasion be useful, even necessary, for people with truly chronic and impairing anxiety. I'm not, then, a fundamentalist of another stripe: the kind that opposes medication on all grounds, regardless of its advantages. Medication can in general keep many people alive and protects us from harmful, sometimes deadly, diseases and viruses; one can't dismiss that fact because it doesn't fit our vision of humanity or society.

But psychiatric medication is a different matter, and while its advantages in cases such as schizophrenia are relatively easy to quantify (though still open to debate), its side effects are well-documented, its long-term effects largely unknown, and its placebo effect very substantial. The data submitted by the drug companies to the FDA about such antidepressants was highly inconclusive. Placebo effect is responsible for at least 80% of the drugs' perceived advantages.

But we're not at a point where we can rule out the possible benefits of the remaining 20%. Until we can, it seems necessary to keep an open mind about such medication while underscoring the risks of taking it and the need to draw a firm diagnostic line between acute anxiety or depression and routine fears and sadness. As Freud put it, there's a clear distinction between "hysterical misery" and "common unhappiness."

GP Having said that psychiatric research and DSM are practically handled by Big Pharma, have you received any response, attack, intimidation?

CL Basically, no, and I hope it stays that way! All that I've received are a couple of angry emails from people who edit websites about social anxiety, but their main complaint—that I'm ignoring or downplaying the plight of those with social anxiety—is easy to rebut, because I am concerned about those with chronic anxiety and would never trivialize what they're experiencing. It's more that I disagree with the way social anxiety disorder was created and pushed, including the list of routine symptoms that it's come to include. At points like that, it's useful to recall, as I do in the book, that the man responsible for recognizing social anxiety (Isaac Marks, now emeritus professor of psychiatry at the University of London) strongly argued against its being listed as a separate anxiety disorder. He added that it was, in general, a perfectly normal reaction to the stress of interacting with other people. In other words, we're abnormal if we don't experience some amount of it. Those two factors, it seems to me, are crucial to keep in mind.

GP Did you imagine, while writing this book, that it would create such a fuss all over the world?

CL I honestly couldn't have predicted how widespread the response would be. Certainly, I knew I was dealing with provocative, even incendiary material that would upset many of the leading figures. When you see in black-and-white what they were arguing and how they were behaving, they really don't come off looking very good. But my guiding impulse throughout was that this material was more a matter of public interest: We need to know a lot more about the disorders that were pushed so aggressively in the 1990s as widespread problems and the drugs that were pushed with equal zeal as

their remedies.

Above all, then, I wanted people to know the back-story to the creation of the new disorders so that they could judge for themselves whether the conditions had been overblown or described with appropriate alarm. My book doesn't pull any punches on this: Based on all the evidence to hand (and there's lots I reproduce in the book), I think it's clear the problems have been exaggerated and hyped out of all proportion, with experts declaring quite seriously that we're now witnessing an "epidemic" of shyness. But people need to make up their own minds about this, after seeing all the facts presented and weighing both sides of the story.

GP Are you going to publish your book in Italian?

CL I very much hope so. It's coming out in French next year with Editions Flammarion, and I gather that Yale Press is fielding interest from other European publishers. Having published one essay with Editore Feltrinelli, I'd be delighted if they or a comparable press wanted to publish the book in Italian.

Giuliana Proietti

Who is Christopher Lane?

Christopher Lane is the Pearce Miller Research Professor at Northwestern University, Chicago. He teaches and writes about mostly Victorian and modern British fiction. In addition to Shyness: How Normal Behavior Became a Sickness (2007), his books include The Ruling Passion (1995), The Burdens of Intimacy (1999), and Hatred and Civility: The Antisocial Life in Victorian England (2004). He is also editor of The Psychoanalysis of Race (1998), and a co-editor of Homosexuality and Psychoanalysis (2001), and he contributed the essay "L'estetica transessuale di Mieli" to Mario Mieli: Elementi di critica omosessuale, nuova edizione (Milano: Feltrinelli, 2002).
Chris has been awarded fellowships by the Andrew W. Mellon Foundation, the British Academy, the Emory University Research Council, the Centre for Twentieth Century Studies, the Alice B. Kaplan Humanities Institute, and the Guggenheim Foundation.
He has been published in numerous journals, and is on the boards of Nineteenth-Century Gender Studies, Literature and Psychology, Discourse, The Journal for Lacanian Studies, and the Journal for the Psychoanalysis of Culture and Society, and can be reached at "clane@northwestern.edu".

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