The medicalisation of shyness: from social misfits to social fitness

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Abstract   Shyness has become an 'unhealthy' state of mind for individuals living in contemporary Western societies. Insofar as its behavioural 'symptoms' imply a failure to achieve certain cultural values, such as assertiveness, self-expression and loquacious vocality, shyness is increasingly defined as a problem for which people can, and should, be treated. This paper first critically discusses the idea that we are witnessing a new 'cultural epidemic' of shyness, as evidenced by increasing rates of diagnosis for Social Phobia, Social Anxiety Disorder and Avoidant Personality Disorder. It then examines three main dimensions of the medicalisation of shyness: biomedical and genetic approaches, the therapeutic interventions of cognitive-behaviour therapy and 'shyness clinics', and the disciplinary regimes imposed by self-help books and websites. Within a cultural climate of pervasive anxiety and privatised risk, the medicalisation of shyness suggests a powerful new way of defining and managing certain kinds of deviant identities, but we can also find some evidence of resistance to this approach.

Keywords: medicalisation, shyness, social phobia, social anxiety, identity

Introduction

Shyness is a condition that is difficult to categorise, lying on the 'contested boundaries' between physical health, mental illness and social deviance (Busfield 1996). On the one hand, this is a relatively normal experience: many of us can identify with episodic feelings of shyness that arise in certain types of situation. On the other hand, some people identify so strongly with the 'shy' label that they feel constantly anxious, lonely and frustrated, and understand shyness to be a chronic and debilitating condition that interferes with their everyday lives. Over the past 50 years, this more extreme form of shyness has come to be seen as a mental illness: Social Phobia, Social

Anxiety Disorder and Avoidant Personality Disorder are all relatively new diagnoses that are implicitly differentiated from 'normal shyness' (Cunningham 2002). The boundary between these states of mind, however, is not easy to discern, not least because the classification of mental disorders reflects as much about social judgements about 'appropriate' forms of behaviour as it does about objective clinical knowledge (Conrad 2004). Elsewhere (Scott 2003, 2004a, 2004b, 2005), I have argued that shyness can be understood as a socially intelligible response to the dramaturgical dilemmas of interaction, revealing a commitment to self-presentation and teamwork, and yet, para-doxically, that it is often perceived as deviant behaviour. The argument of this paper is that the medicalisation of shyness is an extension of this pervasive social attitude of disapproval towards those who fail to conform to certain values of contemporary Western culture. This is not to deny the very real suffering and distress that 'shy' people may experience, or indeed the relief that some treatments can provide from the related symptoms of anxiety, depression and so on. Instead it is intended to sharpen our awareness of the ways in which the turn towards these treatments is being managed at a social level. This in turn reveals how medical and psychiatric knowledge is encroaching upon more and more everyday 'problems in living' (Szasz 1961), and so the case of shyness fits into debates about the medicalisation of society (Zola 1972, Illich 1975, Conrad 1992).

Sociologists of medicine have noted how various conditions enter and leave the realm of medical knowledge in line with changing ideas about socially desirable behaviour (Turner 1995, Porter 1997). Consequently, trends of both medicalisation and demedicalisation can be observed, although the former seems to be outpacing the latter (Williams 2003). As we shall see, the discourses of self-help books, websites, therapies and clinics portray shyness as a new social problem, of apparently epidemic proportions. However, the cultural and historical specificity of this social reaction suggests that it is closer to a moral panic than a rational appraisal of objective epidemiological trends. Shyness may represent the latest in a rapid succession of moral crusades against deviant behaviour (Thompson 1998), for in a culture obsessed with loquacious vocality as a means to success, the reticent stand out as modern-day folk devils (Cohen 1972). In the texts discussed below, we can see how the mass media propagate the idea that being shy is a barrier not only to personal relationships but also to career advancement and civil interaction with strangers, acquaintances and friends. As a neglect of *social* responsibilities, therefore, shyness is presented as a cause for public concern, fuelling the assumption that 'something must be done'. As Showalter (1997) argues, contemporary Western society has become a hotbed for a succession of 'hysterical' epidemics, which struggle for legitimacy as mental disorders but are ultimately symptomatic of *cultural* anxiety. As a reflection of changing social values, therefore, the medicalisation of shyness suggests that bashful modesty and reserve are no longer so acceptable and that to succeed we must be vocal, assertive and capable of gregariously participating in social life.

This negative definition of shyness as a lack of culturally valued attributes reminds us of how psychiatric knowledge serves the social function of pre-scribing normative codes of behaviour, and thus contributes to the 'regulation of rationality' (Busfield 1996, see also Foucault 1961).

Shyness: a new cultural epidemic?

The diagnostic category of Social Phobia (SP) first appeared in the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system in 1980. Since then, the diagnostic label has been applied to an increasing number of people who would once have been seen as 'just shy'. In the UK, the Mental Health Foundation (2005) suggests that one in 10 people will experience a 'disabling anxiety disorder' at some point in their lives, while SP in particular is thought to affect one to two per cent of the British population, with men and women showing similar rates of diagnosis (SANE 2004). Meanwhile in the USA, the National Institute for Mental Health (2005) estimates that around 3.7 per cent of the population aged 18–54 (or 10.1 million Americans) have received a diagnosis of the disorder in the past year. This incidence rate of one in 27 is higher than the prevalence rate of one in 51, (or 1.95 per cent of the population), which suggests that there may have been a sudden increase in the rates of diagnosis in recent years. These statistics are based on the rates of officially recorded diagnoses of SP as it is defined in the DSM-IV:

> a marked and 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 (American Psychological Association 1994: 416).

SP is often referred to as Social Anxiety (SA), and this anxiety is said to be triggered by social situations that involve any kind of public performance (from giving a formal speech to signing a cheque in the supermarket) and being watched, observed and evaluated, particularly by people in a position of authority. It is often accompanied by physical and behavioural 'symptoms' such as blushing, sweating, trembling and avoiding eye contact. A related condition is Avoidant Personality Disorder (APD), which is depicted as something more stable and enduring that shapes the sufferer's reactions to all social situations. This involves a 'pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation' (American Psychiatric Association 1994: 665) that results in a lack of interpersonal contact, an unwillingness to get involved in social activities for fear of criticism, disapproval and rejection, and a view of oneself as socially inept or unskilled. Both of these conditions are viewed by psychologists as something

more than 'just shyness', insofar as they occur at a later age, are more chronic or long standing, and may involve a more pervasive degree of functional impairment (Beidel and Turner 1998).

There is currently a great deal of coverage of shyness, SP and SA in the mass media. This is evidenced most clearly in the wide range of internet websites devoted to the subject: typing the name of one of these conditions into an Internet search engine produces over 200,000 hits, including factual information from mental health organisations, support groups and forums, and personal websites about living with the conditions. Many of these sites aim on the one hand to provide support and advice for people who have SP/SA, and, on the other hand, to raise awareness of the condition in the general population. The National Institute of Mental Health, for example, emphasises that SP is 'a real illness' affecting 3.7 per cent of the American population (NIMH 2005), while the Social Phobia / Social Anxiety Association puts the figure at seven per cent and tells us that this represents the third largest mental health problem in the world today (SP/SA 2004). Ironically, some psychologists have explained this in terms of the rise of internet-based communication, which is presumed to provide a poor substitute for face-to-face interaction and a dearth of opportunities for practising social skills (Sussman 1996, Shotton 1988).

Perhaps the most influential commentary, however, has come from Philip Zimbardo and his colleague Lynne Henderson at Stanford University. Zimbardo (1977) conducted a pioneering study of shyness, using a questionnaire that he distributed to American college students. The results of this Stanford Shyness Survey were that 40 per cent of respondents described themselves as chronically shy, with a further 15 per cent saying that they were shy in some situations but not in others and only five per cent saying that they had never felt shy. Since then, the survey has been replicated by these social psychologists on various college populations, and appears to be tracking a trend of increasing shyness: Henderson and Zimbardo (2005) estimate that the proportion of chronically shy people has now reached nearly 50 per cent. They suggest that the consequences of shyness are 'deeply troubling' in that shy people may be painfully self-conscious, fail to take advantage of social situations and see themselves as awkward, inhibited and lacking in 'basic social skills'. Furthermore, whilst identifying the psychological basis of shyness as a set of negative cognitive biases in some people's attitudes towards interaction, Henderson and Zimbardo point to a changing cultural climate in which shyness is *socially produced* at an accelerating rate. They make a bold statement about the epidemiology of shyness as a 'new' social disease:

> We would like to propose that the recent increases in statistics of shyness prevalence may be diagnostic not only of the extent of personal social anxiety, as viewed within the framework of a traditional medical model, but as diagnostic of societal pathology, within a public health model. As such, we may want to take note of increasing levels of shyness as a

warning signal of a public health danger that appears to be heading toward epidemic proportions (Henderson and Zimbardo 2005: 10).

Meanwhile, broadsheet and magazine journalists have begun to document this apparently new cultural epidemic, creating something of a moral panic (Cohen 1972) about its social consequences. Writing in the late 1990s, Kate Hilpern (1998) identified a pre-millenial 'shrinking violet syndrome', which appeared to be reaching epidemic proportions (1998: 150). Extreme shyness continues to be depicted as a barrier to achieving many of the markers of social success in our culture, such as close friendships, romantic relationships and career advancement. For example Annabelle Thorpe (1999) points to the problems caused by shyness in the workplace, as colleagues may misperceive the shy demeanour as one of arrogance or aloofness, while Christina Odone (2001) suggests that shyness takes to an extreme the stereotypical British demeanour of modesty, reserve and 'social autism'; she blames an increasingly work-centred culture for our lack of enthusiasm for collective activities. Jane Feinmann (2001) similarly suggests that shyness could be reaching 'epidemic proportions as quiet, introspective types increasingly see themselves as having a problem in a competitive, pushy culture' (2001: 47).

Shyness has not always been seen as a social problem, however. In a recent review of 191 popular advice books and etiquette manuals from the 1950s to the 1990s, McDaniel (2001) demonstrates the cultural and historical specificity of our perceptions and the discursive framing of the condition. She argues that high levels of concern about shyness arise during times when it is perceived as a barrier to the emotional labour needed to achieve intimacy in heterosexual relationships. Thus whereas in the 1950s, women were encouraged to be 'good wives' by deferring modestly to men, by the 1980s and 1990s, self-help books were defining shyness in terms of a failure to practise the skills of self-disclosure, empathic listening and assertiveness. As well as discursively constituting the 'shy' identity in various ways, therefore, these cultural representations have traditionally been gendered: shyness has been depicted as yet another 'female malady' (Showalter 1985) that is associated with hyper-feminine behaviour. For example, shyness is included as a 'feminine' trait in the Bem Sex Role Inventory (Bem 1974), alongside compassion, gullibility, soft-spokenness, moodiness and unpredictability. Insofar as notions of adult mental health implicitly refer to stereotypically 'masculine' rather than 'feminine' traits (Broverman *et al.* 1970), this would explain why shyness has been seen as an undesirable attribute, particularly in men. Thus, whereas shyness in women and children has traditionally been seen as 'cute' and endearing (see Scott 2004a), men may feel under more pressure to avoid being labelled as shy. Media representations of shy male characters, too, focus on the barriers this poses to success at work and in personal relationships (Scott 2003), where the problem of 'love shyness' (Gilmartin 1987, see below) implies a tragic failure to assert one's masculinity.

However, perhaps as we enter the 21ˢᵗ century, the boundary between male and female shyness is breaking down. In this arguably post-feminist era of late modernity, the cultural pressure to manage the reflexive project of the self (Giddens 1991) has made shyness a more widely acknowledged social problem for both men and women. Insofar as the emotional labour of intimacy is a shared burden in the 'pure relationship' (1991), an inability to articulate one's needs, desires and grievances can pose a serious threat to the 'life politics' of both partners. In the self-help resources I discuss below, we generally find a gender-neutral form of discourse that on the one hand seems progressively inclusive and politically correct, while, on the other, perpetuates the idea that shyness is an insidious cultural epidemic with the potential to affect us all.

Dimensions of the medicalisation of shyness

In contemporary Western society, therefore, shyness is emerging as a 'new' social problem: the increasing pressure to be ambitious, assertive and communicative, together with a growing sense of introspective anxiety, make this a more widely experienced and/or recognised state of mind. The medicalisation of shyness may then represent a reaction to this concern about the alleged 'shyness epidemic', and an attempt to control its social effects. We can identify three main dimensions of this process: biomedical approaches and the development of drugs to treat shyness, the application of cognitive-behavioural therapies, and the disciplinary regimes of self-help books and websites.

Biomedical approaches

The first of these dimensions of medicalisation is a turn towards biomedical explanations and pharmacological treatments as a relatively fast and efficient way of dealing with shyness symptoms. As Williams (2003) argues, this trend towards 'cosmetic psychopharmacology' and the production of 'chemically assisted selves' reveals an important feature of medicalisation in the 21ˢᵗ century. Ahuja (2003) has documented the increasing tendency for the 'worried well' to consult their GPs about emotional issues such as mourning, financial stress and shyness, all of which would previously have been accepted as normal 'problems in living' (Szasz 1961, see also Craib 1994), and these conditions have been deemed amenable to pharmacological treatments.

The drugs most commonly prescribed for SP/SA fall into four main categories: monoamine oxidase inhibitors (MAO-Is) such as phenelzine; betablockers such as atenolol; benzodiazepines such as clonazepam and alprazolam; and selective serotonin reuptake inhibitors (SSRIs) such as Prozac, Zoloft, Paxil and Seroxat (Crozier 2001). The periodic 'discovery' of these various drugs attracts a great deal of media coverage, as journalists consider the social benefits of a miracle cure for shyness (see for example a

BBC news report about the new 'shyness pill', the anti-depressant Escitalopram (26th November 2001)). Shyness is depicted as a crippling affliction from which its 'sufferers' are longing to be released, and while it may be true that that shyness causes some people considerable distress, one cannot help but question whose interests these 'magic bullet cures' really serve. As Mishler (1989) puts it, medical discourses may frame diseases as a deviation from normal functioning, but in some cases it is appropriate to ask, 'deviant for whom?'. The biomedical approach to treating shyness, as with many other conditions, focuses on the alleviation of *symptoms* at a rather superficial level, the aim being to help the patient return to 'normal' levels of social functioning as quickly as possible. Thus while MAO-Is, betablockers, benzodiazepines and SSRIs may help to reduce the levels of anxiety that prevent 'shy' people from participating in social activities, or the depression that results from feelings of isolation, they do not really tackle 'shyness' as an all-encompassing, embodied and emotional state (Bendelow and Williams 1998). This neglect of these *social* dimensions of the shy self reinforces the belief that this is a problem of individual minds rather than a reflection of social norms and values.

This demand for these pharmacological 'quick fixes' is in part a reflection of the emotional climate (de Rivera 1992) of late modernity. As Giddens (1991) argues, the social, economic and political changes associated with advanced capitalism have created a sense of widespread ontological insecurity and existential anxiety. His idea of the self as a reflexive project suggests that we have become preoccupied with monitoring the boundaries between self and other, constantly rehearsing and dissecting our experiences of interaction: so where can we draw the line between this normalised caution and excessive shyness? Similarly, Lasch's (1984) comments on the 'minimal self' suggest that social withdrawal and ambivalence about interaction might be quite a logical response to rapid cultural change. Theories like these suggest that, as well as reflecting the historically and culturally specific social perceptions that McDaniel (2001) has described, the current moral panic about shyness may have been fuelled by an actual increase in the experience of anxiety, uncertainty and risk perception (*cf.* Beck 1992, Marris 1996). Indeed, Wilkinson (2001) identifies anxiety as a peculiarly modern problem that has itself come to be interpreted within the language of risk: as well as featuring heavily in the discourses of psychiatry, this condition is having a far more pervasive effect on society, and is expressed in various ways. Thus, his argument, that we should see anxiety 'not so much as a particular problem for unusual individuals who are perceived as having something "wrong" with them but, rather . . . as an occasional experience that affects us all' (2001: 16), is one that can be usefully applied to shyness as a pervasive new form of *social* anxiety. In a culture obsessed with self-expression and communication, it is perhaps not surprising that more and more people can identify with some experience of shyness, and it is even less surprising that they should interpret this as a 'problem' to be solved as quickly as possible.

Meanwhile, tentative steps have also been made towards the geneticisation of shyness, an issue that is likely to become contentious if it ever receives the same amount of media coverage as drug treatments. The discovery of a 'shyness gene' might on the one hand lend credence to essentialist theories of the condition as something to which a distinct minority group are predisposed, thus reinforcing the pathologisation of shyness. On the other hand, those living with SP/SA might welcome a genetic, asocial account of their 'problem' insofar as it exonerates them from personal responsibility for it: a legitimate disease label underpinned by credible scientific knowledge is arguably preferable to stimatising attributions of social deviance. In a similar way, people who suffer from extreme shyness may actively seek out a diagnosis of SP or SA because this allows them to adopt the 'sick role' (Parsons 1951) and gain access to treatments (see Scott 2003). However, the evidence for a genetic basis of shyness remains limited and inconclusive: even the most biologically inclined psychologists have avoided genetically-determinist accounts of shyness, citing heritability estimates of between 20 and 50 per cent (Plomin 1990, Crozier 2001). There have been reports of the discovery of a gene for shyness, but upon closer inspection we find that these refer to tangential aspects of the condition. Hamer and Copeland (1998), for example, have suggested that a shorter version of the DRD4 gene is responsible for a reluctance to seek out novel stimuli – a behavioural correlate of shyness, perhaps, but not something that is synonymous with it. It is also significant that the gene in question is one that controls the levels of serotonin and dopamine in the brain, both of which are amenable to the drug treatments described above: we can see how the geneticisation and pharmacological regulation of shyness could develop hand in hand.

The rise of CBT and other 'psy' therapies
The limited role of these biomedical and genetic approaches to shyness exists alongside the more widespread treatment of SP, SA and APD through the 'psy' disciplines of psychiatry, psychotherapy and counselling. It is arguably an iatrogenic effect of the pharmacological revolution that this gap in the market of healthcare provision exists: the very existence of drugs such as Seroxat and Paxil and their partial effectiveness in treating SP/SA-related *symptoms* has reinforced the idea that these conditions exist as objective disease entities, and thus the psychiatric labels used to describe them have been reified. Furthermore, the very inclusion of SP and APD in the DSM-IV over the past 25 years may have led to an increase in their rates of diagnosis (as the statistics cited earlier would suggest). With demand for psychiatric services far outstripping supply, there is now a growing market for the 'psy' disciplines and user-led support groups to provide a therapeutic alternative.

The turn towards psychotherapeutic measures as a complement to or replacement for drug treatments can be understood within the 'therapeutic culture of the self' (Rose 1990) in contemporary Western society. As Giddens (1991) argues, our cautious distrust of abstract expert systems such as

medical science and technology has led to an increased focus on the self and the internal world of the emotions. We are now keen to perform reflexive biographical work on the self, and learn to account for our lifestyle choices through the confessional 'emotion talk' of an interview society (Atkinson and Silverman 1997, Shattuc 1997). In the late modern age, self-identity has become an object of scrutiny for the reflexive social actor, and we have become preoccupied with managing our emotions and embodiment as ongoing projects (Giddens 1991, Shilling 1993). Paradoxically, however, we are turning more and more to sources of expert knowledge in the 'psy' professions, drawing on therapeutic discourses to learn ways of managing the emotional self (Lupton 1998). Shyness, in particular, may be something that we want to understand at the level of personal experience as well as biology and genetics, because this is such an all-encompassing state of embodied, emotional and socially-oriented discomfort.

When it comes to treating SP, SA and APD, cognitive-behavioural therapy (CBT) is a lucrative business in the Western world. The status of these conditions as officially designated anxiety disorders means that their symptomatology is defined in terms of 'irrational' thought patterns and negative beliefs about social situations, which are viewed as habitually learned responses. By training patients to stop these 'automatic negative thoughts' and replace them with more 'realistic' attitudes, the CBT practitioner aims to return the socially phobic person to a more 'normal' level of social functioning. This typically involves a six to 12-week course of CBT combined with group therapy, role-play workshops and social-skills training – usually for a substantial fee. The New York Institute for Cognitive and Behavioral Therapies, for instance, claims to educate, coach and retrain the shy mind, weakening the connection between 'troublesome situations' and 'habitual reactions' to them. Its director, John Winston Bush (2001), argues that CBT is more effective than drug treatments at avoiding 'relapses' into shyness and creating 'permanent changes' in behaviour. Meanwhile, the London Shyness Centre uses a combination of psychotherapy to identify 'the deeply rooted causes that underlie the individual shyness factor' alongside 'bio-energetic therapy' and neuro-linguistic programming to tackle the 'behaviour patterns that reinforce the problem'. In the opinion of its director, Linda Crawford (2004), shyness is 'the crippling and hidden emotion of the century' which 'wreaks havoc in many people's lives'.

Despite providing these miraculous solutions to shyness, the proponents of CBT emphasise that it is the client's responsibility to do the mental and emotional work of changing. While they can provide the tools and encouragement needed to retrain the shy mind, they say, this can only be achieved if the individual is prepared to accept the authority of the therapists and obey their instructions. As the website of Anxiety Network International (2004) puts it, 'We do not want you to come unless you are ready, willing and motivated to get better!'. Meanwhile, many of the clinics point to the rational efficiency of a short course of CBT as opposed to several years of

intense psychotherapy. The aim of such organisations is to create a dramatic and observable change in the client's behaviour and self-reported feelings, which is taken as evidence that shyness levels have been reduced. For example, the Social Anxiety/Social Phobia Association provides a short course of 16–24 sessions of CBT that is apparently enough to create such an effect and maintain a high rate of client turnover:

> What socially anxious people do not need is years and years of therapy or counselling . . . [those] taught to 'analyze' and 'ruminate' over their problems usually make their social anxiety and fears worse (Social Anxiety/Social Phobia Association 2004).

Here we find a clear example of the 'McDonaldization' of emotion (Mestrovic 1997, *cf.* Ritzer 1996). Metaphorically speaking, there is a long line of customers waiting to be 'cured' of their shyness, and the most rational and efficient way of processing them is to hand out snack-sized portions of CBT and close the door. The managers of these 'shyness clinics' have little time for people who want to indulge in a little navel-gazing and explore the deeper roots of their personalities; it is more important to maintain a steady flow of satisfied customers who can be returned to work and family life. As Busfield (1996) argues, one of the key social functions that psychiatric services provide is the regulation of rationality; and so, in what is perhaps a late modern variant of the civilising process (Elias 1994), we are taught that such 'irrational' and socially disruptive acts as shyness must be either hidden or eradicated. This colonisation of the emotional lifeworld (Crossley 2000) by the 'psy' industry reinforces the idea that we must depend upon professional experts to teach us how and what to feel; such denial of patients' autonomy and self-knowledge in managing their health was identified by Illich (1975) as a central dimension of social iatrogenesis and medicalisation. As Furedi (2004) suggests, this new 'therapy culture' relies for its success upon the idea of emotional vulnerability being an affliction, insofar as clients are positioned as victims who can be taught to strive towards 'recovery'.

In their approach to dealing with shyness, then, these therapies appeal to the 'communicatively rational' side of emotions (Crossley 1998, 2000), demanding that clients be accountable for their feelings and attempting to reason them out of inappropriate responses. Shy people are taught that their tendency towards quietness, passivity and withdrawal to the margins of social situations simply will not do, and represents a pattern of faulty cognition that must be unlearned. Furthermore, it is presumed that there is a definitive set of 'social skills' which socially-phobic people currently lack but which can be learned through hard work and determination: assertiveness, making small talk, 'working the floor' at parties and gatherings, and initiating romantic encounters. Yet ironically there is little tolerance of what I would argue is the true communicative rationality of shyness: that it can be understood as a socially intelligible response to dramaturgical stress (*cf.* Freund 1998,

Goffman 1959). Elsewhere (Scott 2004a) I have suggested that the shy self involves an internal dialogue between the Shy 'I' and the Shy 'Me' (following Mead [1934]), in that feelings of shyness arise when one perceives oneself as relatively incompetent at interaction, and fears being exposed as a poor team player. If we anticipate that we will say or do 'the wrong thing' and face embarrassment, surely it makes perfect sense to defend oneself emotionally by remaining quiet and avoiding the spotlight of a frontstage performance (*cf.* Goffman 1959)? Furthermore, the very fact that shy actors feel shame and frustration at not being able to 'pull their weight' as they would wish in social encounters suggests that they are highly committed to maintaining the interaction order. It is therefore deeply ironic that shy people should be misconstrued as being wilfully disengaged or ignorant about their social obligations.

The idea of retraining recalcitrant outsiders with programmes of CBT resonates strongly with Foucault's (1975) notion of disciplinary power. Personality inventories are frequently used in the initial stages of assessment in shyness clinics, and clients are then usually given an individualised programme of therapy according to their particular 'needs' or 'deficiencies'; it is against this grid of perceptions (Foucault 1963) that their progress can be monitored. Furthermore, the very techniques used to administer this mode of surveillance are evocative of the disciplinary regimes Foucault describes in his account of military and prison yard drills. Perhaps the best example of this can be found in The Palo Alto Shyness Clinic, run by Lynne Henderson and Philip Zimbardo in California. While Zimbardo's pioneering research in the 1970s was genuinely groundbreaking in drawing people's attention to shyness as a widespread social 'problem', the treatment regime now offered by the clinic focuses more on the individual's responsibility to learn more socially facilitative forms of behaviour. Using an explicitly penological analogy, Henderson and Zimbardo (2005) call their approach the Social Fitness Model, which consists of:

> education and training in positive social behavior, exercises to convert maladaptive thoughts, attributions and self-concept distortions to more adaptive cognitive patterns, and training in effective communication skills, including healthy assertiveness and negotiation. People move from social dysfunction, withdrawal, passivity, and negative self-preoccupation to adaptive functioning, increased social participation, a proactive orientation, and empathy and responsiveness to others, that taken together is referred to as 'social fitness' (2005: 11).

Clients at the Palo Alto Shyness Clinic are expected to take an active role in developing their levels of 'social fitness', by engaging in various drills, exercises and treatment procedures. The six-month programme begins with a 12-week series of group therapy sessions, involving 'social skills' coaching and simulated exposures to shyness-inducing situations in role-play workshops.

This is followed by 10 weeks of training in communication skills and assertiveness, using the techniques of 'in-vivo exposures' and 'cognitive restructuring'. Having thus learned how to manage their anxiety in social situations, the erstwhile shy client is then expected to practise their newfound skills in a series of homework tasks, such as making small talk in a supermarket or inviting a colleague out for coffee. Their progress is monitored not only verbally, in the group-therapy sessions, but also using instruments of surveillance such as videotaped feedback and shyness surveys. Using these Foucauldian grids of perception, the aim of the therapeutic regime is to reduce clients' scores on certain variables and ensure that they 'move into the normal range on standardized questionnaires' (Henderson and Zimbardo 2005; see also the related website of 'The Social Fitness Center'). In the longer term, one might argue, the ultimate aim of a shyness clinic is to retrain and resocialise deviant individuals towards more normative modes of behaviour.

This orderly production of cheerful, gregarious and socially integrated selves reflects a more general pattern within contemporary forms of psychotherapy. Craib (1994) has presented a scathing critique of the claims made by the 'psy' industries to eradicate what he sees as normal human misery. He suggests that the image of a perfect self, devoid of all negative emotions and unpleasant social experiences, is a myth that serves to perpetuate the omnipotent status we have accorded to psychotherapy. In particular, the psy industries make untenable and dangerous claims to be able to 'cure' us of what may be natural and inevitable features of human existence: suffering, anxiety and isolation. Neat packages of counselling, group therapy and cognitive behavioural techniques may help the clients to come to terms with the internal conflicts that we all face, Craib argues, but they cannot prevent us from feeling angry, sad, envious, unhappy or indeed shy at some points in our lives. Insofar as we can identify shyness as having an emotional component (of anxiety, frustration and loneliness), therefore, it is perhaps unrealistic to assume that a shyness clinic could, and indeed should, aim to produce non-shy social selves. By producing a steady flow of resocialised, conformist 'gingerbread men' (Craib 1994), these therapeutic regimes perpetuate the idea that non-shyness is both a normal and a desirable state to be in, and that 'shy people' have an obligation to change themselves. They ultimately serve a social function by reinforcing the values of individual achievement, competitive success and self-actualisation that underlie contemporary Western culture.

Self-help and self-surveillance
The clinical management of SP/SA might then be seen as a form of social control, but this is not to suggest that there is a dominant group of professionals in the psy disciplines who cynically exploit their vulnerable clients. Instead, the notion of disciplinary power suggests a more pervasive, impersonal and blameless image of certain forms of powerful knowledge operating within a wider network of cultural values. Here I want to argue that the principles upon which shyness treatments are based have become so embedded

in the values of late-modern society that we have come to take them for granted as prerequisites of the healthy self, turning the clinical gaze onto ourselves through our consumption of self-help books and online resources. Within a wider context of discourses about public health and health promotion, Lupton (1995, 1998) argues that physical, mental and emotional wellbeing have been represented as cultural imperatives, to be sought out and consumed as objects of moral value. Health has become a commodity that is constantly pursued but never fully achieved by the 'worried well', and this involves a range of disciplinary practices to cultivate both the inner and outer selves (Crawford 1984, 2000). This can be understood as one dimension of the trend towards surveillance medicine (Armstrong 1995) that has developed in contemporary Western societies, directing the Foucauldian clinical gaze onto the spaces between bodies and encouraging us to monitor our own health (Hughes 2000). Thus while extreme shyness can be conceptualised as a *social* problem because it poses a threat to the dynamics of interaction and social order at a micro level, it tends to be depicted as an *individual* problem, involving deviant minds and bodies that must be brought back into line. This in turn makes it the individual's responsibility to recognise when their behaviour interferes with 'normal' everyday routines and to take measures to adapt accordingly.

We find this message saliently displayed within self-help books and online resources about shyness, SP and SA. These texts provide clear-cut guidelines and advice for 'overcoming' extreme shyness, delivered in a tone that is at once disciplinary, authoritative, condescending and motivational. Readers are advised both that SP/SA is a cripplingly abnormal mental disorder, and that this is something they have the power to change. By dangling the carrot of various culturally-valued attributes as evidence of 'normal' success (a good job, a loving relationship, an active social life and so on), the self-help materials encourage individuals to take responsibility for aligning themselves with normative codes of behaviour through regimes of self-surveillance. Furthermore, the 'technologies of the self' (Foucault 1988) that are employed to achieve these goals are represented as enormously empowering to the individual. Appealing to the idea of the self as a reflexive project (Giddens 1991), these instruments of disciplinary power work by teaching us that it is really in our best interests to change. As Rose (1990) puts it, the psy disciplines are internalised as 'therapies of freedom', helping us towards the goal of self-actualisation. When shy people consume self-help resources, therefore, they do so willingly and with the belief that learning to be non-shy is a choice that they are free to make.

In a tantalisingly-titled book, *Overcoming Shyness and Social Phobia: a Step-By-Step Guide*, Rapee (1998) argues that these conditions can be mastered through willpower, motivation and practice. Breaking SP/SA down into an array of mental, physical and behavioural responses, Rapee claims that we can teach ourselves new social skills and ways of appraising social situations more realistically. Similarly, Orr (1997) refers to his technique as

the 'assertiveness training of the self', and argues that it is possible to learn more effective interpersonal skills which simply need to be practised in order to become habitual. He encourages readers to take control of their own programme of therapy, by combining these cognitive and behavioural drills with periods of relaxation, confidence boosting and diary keeping to monitor one's progress. Meanwhile, Gilmartin (1987) focuses on one particular culturally-valued attribute – the romantic relationship – as a goal against which SP/SA can impose a serious barrier. His book about the disastrous epidemic of 'love shyness' that is apparently gripping America employs the language of a moral panic, pointing to the growing numbers of heterosexual single men who have never married because of their shyness around women. Gilmartin suggests a number of possible routes out of love shyness, such as practising dating with sympathetic peers, visualisation techniques and positive affirmations to be repeated to oneself regularly.

Shyness in children, meanwhile, is depicted as a cause for almost pitiful concern: the shy child is seen to be at risk of growing up to be a shy adult, unable to make friends, form relationships and succeed at work, and so on. Insofar as such children are not deemed morally responsible for their own behaviour, disciplinary power operates by proxy, as self-help materials are directed at parents, offering them tips and advice about 'successfully' rearing a non-shy child. The magazine *Twins* (Henderson 1999), for instance, raises the question of what should be done when one twin is shy and the other is outgoing. This apparent 'problem' can be solved by teaching the shy twin to be more like their sibling, the author argues: parents should provide positive examples of non-shy behaviour and 'gently encourage' the shy child to confront new social situations when they are afraid. Similarly, Malouff (2002) considers what parents and teachers can do to 'help' children overcome shyness: he suggests showing empathy and talking to the child about one's own experiences of shyness, whilst firmly setting targets and monitoring 'progress' towards the goal of outgoing behaviour.

The range of self-help materials available online is staggering, but appears to revolve around a number of common themes. Carducci's (2000) account of 'the eight habits of highly popular people', for instance, suggests that shy people are different from non-shy people, that they lack the social skills that these more emotionally healthy individuals possess, but that if they practise hard enough, the shy can learn sufficient tricks and strategies to 'pass' (Goffman 1963). It is therefore the shy person's responsibility to ensure that they think positively, learn to handle 'failure' in social situations, and 'laugh a little' to defuse negative responses. Similarly, Nancy Wesson (2004) claims that it is possible to 'overcome' the shy response by training oneself not to indulge in 'negative self-talk' and arming oneself with a set of 'counter-arguments' that anticipate success in interaction. Meanwhile, the Social Anxiety Institute offers a comprehensive self-administered course of CBT in the form of 10 audiotaped therapy sessions, which claim to teach us how to stop 'automatic negative thoughts' and replace them with more 'reasonable'

and 'realistic' alternatives. The consumer is expected to engage actively with the tapes, not just by listening to them but also by enthusiastically practising the techniques at home. The assumption here is that shyness is an irrational response that we can be reasoned out of, if we are only given the right tools; again, these materials appeal to the 'communicative rationality' of emotions (Crossley 1998, 2000). The ninth tape, for example, tackles the questions of 'Why "feelings" can be wrong. Why they "lie" to us, and why we must stop believing irrational feelings' (Social Anxiety Institute 2004). From these texts we learn that shyness is not only socially unacceptable but also invalid as an emotional response, a betrayal of the rational self that we could, and should, become.

Demedicalisation and resistance: 'Shy Pride'?

This discussion would not be complete without a consideration of the effects of these cultural representations of shyness upon their intended audiences. As Showalter (1997) argues, hysterical epidemics only take hold if there is a critical mass of would-be patients who are willing to comply with the inter-pretation of their experiences in medical terms, and insofar as lay attitudes can prove highly resistant to the authoritative tone of health-promotion materials (Davison *et al.* 1991), it is important to be aware of the limits of medicalisation (Williams and Calnan 1996).

   To put this in a wider context, we might refer back to the theories of late modernity outlined above. While a cultural climate of anxiety might be encouraging more and more people to search for medical labels and treatments for their shyness, it may also be expressed in concerns about medical risks and dangers. As Giddens (1991) argues, the decline of traditional institutions has forced us to put our trust in more abstracted, 'expert systems', but we do so with a degree of caution. Lay attitudes towards science and technology, he suggests, are infused with a mixture of 'reverence and reserve, approval and disquiet, enthusiasm and antipathy' (1991: 7), which may reflect our growing awareness of the revisable nature of scientific knowledge. Media-fuelled concerns about the anti-depressant/anti-anxiety drug paroxetine (Paxil and Seroxat), for example, suggest that shy people are not prepared to take their medication lying down, and that alternative messages may be getting through. Thus, a recent episode of *Panorama* (BBC1 13th October 2003) reported on 'the darker side' of Seroxat, alleging that this was a dangerously addictive drug that had led some patients towards self-harm and suicide. Correspondingly, websites such as 'Psych Drug Truth' present alarmingly long lists of the side effects of drugs like Paxil (including disorders of the cardiovascular, lymphatic and respiratory systems), and encourage readers to file lawsuits against the drug manufacturers. Broadsheet journalists have also been reporting on the shrewd plans of a large pharmaceutical company to market Seroxat for conditions other than clinical depression, including Social Anxiety Disorder (Doward and McKie 2004). The corporate context

of this is explored in an Australian documentary film, *Selling Sickness* (2004), which reports on the way in which drugs like Seroxat, Paxil and Zoloft are marketed. The advertisements for these drugs depict 'normal', healthy people facing everyday stresses at work or at home, and proffer the drugs as a means of boosting personal effectiveness in these contexts. By widening the net of potential consumers from the most psychologically distressed to those with mere 'problems in living', the film-makers argue, the drug companies manage to create new mental disorders, new types of patient, and new ways of making money.

Elsewhere (Scott 2003, 2004a, 2004b) I have presented data from my own research with self-defined 'shy' people, who revealed attitudes of resistance as well as conformity to the medicalisation of shyness. Thus, alongside those who are willing to try new shyness pills or undergo courses of CBT, there may be others who take pride in their shy identity, emphasise the positive connotations of shyness (such as modesty, sensitivity and conscientiousness), and resent the way that other, non-shy people define the terms of interaction. We can detect further evidence of this undercurrent of resistance in websites, internet forums and online support groups about SP and SA. In this context, the counter-discourse (Foucault 1976) of what I shall call 'Shy Pride' relies on two main lines of argument. First, New Age philosophies and Romanticist ideals can be evoked to depict shyness as a positive, life-affirming experience. The *Shy and Free* website, for example, talks about exploring shy feelings as a means of 'finding the real you' and reaching a deeper understanding of the self. While it is not specified how exactly one might 'transform shyness to work for you', the idea that we can achieve personal growth by surviving psychological distress reminds us of Laing's (1967) influential remarks about schizophrenia as a voyage of self-discovery, and suggests that shyness represents a more 'authentic' mode of being. The second line of argument draws implicitly on labelling theories of deviance and the social model of disability (see Oliver 1990). Proponents of this view attempt to shift the responsibility for shyness back from the individual to society, arguing that shyness is only a 'problem' when others define it as such (*cf.* Becker 1963). The newsgroup *alt.support.shyness*, for example, suggests that the behaviours we associate with shyness are those that cause *other* people discomfort and disquietude: 'extroverted' people may feel awkward around shy people, and project their uncertainty onto them in the form of defensive anger (Arends 1998). These attempts to demedicalise shyness as a relatively normal 'problem in living' (Szasz 1961) suggest that shy people are capable of thinking sociologically about their condition, even if those around them are not.

Conclusion

The medicalisation of social deviance is a theme that recurs within medical sociology, and which can currently be seen in the case of shyness. I have

argued that despite being a socially intelligible response to the dramaturgical stresses of everyday interaction, this condition has come to be seen as a cause of increasing public concern within contemporary Western society. This may in part be a reflection of a genuine increase in the experience and recognition of shyness as 'social anxiety', insofar as the Giddensian self of late modernity is becoming increasingly anxious and self-reflexive. The idea of a 'shyness epidemic', however, also points to the way in which this experience is defined and managed as a social problem. The stereotypical 'symptoms' of quietness, timidity and social withdrawal pose a significant challenge to the values of assertiveness, emotional literacy and vocal self-expression that pervade contemporary Western culture. Consequently, as shyness becomes less and less socially acceptable, the 'shyest' people are finding that their erstwhile deviant identities are being recast in biomedical terms and subjected to psychiatric treatment. We can identify at least three main sites in which the medicalisation of shyness is taking place: in pharmacological remedies and genetic theories, in the therapeutic regimes of shyness clinics, counselling and CBT, and in the disciplinary practices advocated by self-help books and internet resources. We have yet to discover the full impact of all this upon 'shy' people's everyday lives, but already we can detect attitudes of both conformity and resistance to the medicalisation of shyness.

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Acknowledgements

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