How Shyness Became an Illness and Other Cautionary Tales about the *DSM*

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When the American Psychiatric Association decided in 1980 to update its official list of mental disorders, it cited the existence of more than eighty new ones, many of them a source of ongoing controversy (American Psychatric Association: 1980).

Among the new disorders were Social Phobia and Avoidant Personality Disorder, preludes to modified illnesses such as Social Anxiety Disorder, with descriptions so broad and open-ended they gave rise to charges that the APA was turning widespread traits into treatable conditions. The effect of such moves, scholars and fellow psychiatrists warned, was not merely to redefine norms of social interaction, itself a dangerous move, but also to medicalize large swaths of behavior with no previous relation to psychiatry or medicine (see for example Karp 1997, Kutchins and Kirk 1997, Horwitz 2003, Conrad 2007, Horwitz and Wakefield 2007 and Lane 2007[1]). In 1968, to give weight to such charges, the association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM* for short), to which I'm referring, cited 180 categories of mental disorders. By 1987, that number had grown to 292 and, by 1994, with the publication of *DSM-IV,* to over 350. In just twenty-six years, that is, the number of official mental disorders almost doubled, an outcome occurring nowhere else in the history of medicine.

Having studied in detail how the DSM-III task force made such consequential decisions, from memos and correspondence held at the APA's headquarters near Washington, D.C., I will draw heavily on such material to assess the brief but fascinating history of Social Phobia/Social Anxiety Disorder, which, just a few years after being formally classified, became so widely diagnosed—especially in the United States—that *Psychology Today* dubbed it "the disorder of the decade" and the *Harvard Review of Psychiatry* determined that it had become "the third most-common psychiatric disorder [in the U.S.], behind only major depressive disorder and alcohol dependence" (Rettew 2000: 285). Two decades earlier, by contrast, the disorder did not formally exist.

1 From which parts of this essay have been adapted.

[From: M. Dellwing and M. Harbusch (eds.), *Krankheitskonstruktionen und Krankheitstreiberei: Die Renaissance der Soziologischen Psychiatriekritik* (Berlin: Springer-Verlag, 2013), 55-74.]

As Social Phobia was classed as a mental illness at a time when the move had surprisingly little professional support among psychiatrists not serving on the DSM-III task force,[2] my essay examines why the latter pushed for its inclusion and that of several near-identical illnesses, such as "Avoidant Personality Disorder" and "Introverted Personality Disorder" (the latter ultimately failing to gain approval). I also assess why Social Phobia was renamed "Social Anxiety Disorder" and why the threshold for diagnosing both it and Avoidant Personality Disorder was lowered dramatically in later editions of the *DSM* to include public-speaking anxiety and other routine fears usually seen as closer to social embarrassment than chronic phobia or acute anxiety. Social Anxiety Disorder is, I'll be arguing, a textbook example of how normal behavior and many human emotions, including grief and sadness, have been turned into disorders supposedly warranting the use of psychotropic medication (see Karp 1997, Harowitz and Wakefield 2007).

As millions of North Americans and Europeans have since taken antidepressant medication for SAD—in 2001 alone, 25 million new prescriptions were written in just the U.S. for the drug Paxil (Hawkins 1987: 241f.)—it is crucial to ask why the official symptoms of the disorder in one of the world's most-influential psychiatric manuals still include fear of public speaking, fear of hand-trembling while writing a check, and, amazingly, even dislike of eating alone in a restaurant. With the bar set so low that it includes such routine concerns, it is on the one hand unsurprising that so many people have been diagnosed with the condition. As two prominent Stanford psychologists recently determined, "nearly 50% (48.7% +/- 2%)" of North Americans (and most other nations and groups) self-identify as shy or introverted around the world (Henderson and Zimbrado in press). Concern about the overlap between shyness and social anxiety even led the DSM-IV task force to add a warning to the 1994 edition, urging psychiatrists not to confuse the two phenomena.[3]

On the other hand, the same task force not only retained in *DSM-IV* all prior symptoms of the disorder, but also managed to add to them, as I'll outline below. The psychotropic medication licensed to treat such behavior is also widely known to be riddled with adverse side effects, from nausea and sexual dysfunction to increased threat of suicide ideation, pregnancy problems, and an often-chronic withdrawal syndrome (see for instance Segraves 1998, Opbroek et al. 2002, Harvey et al. 2003, Warner et al. 2006). In October 2004, concern about

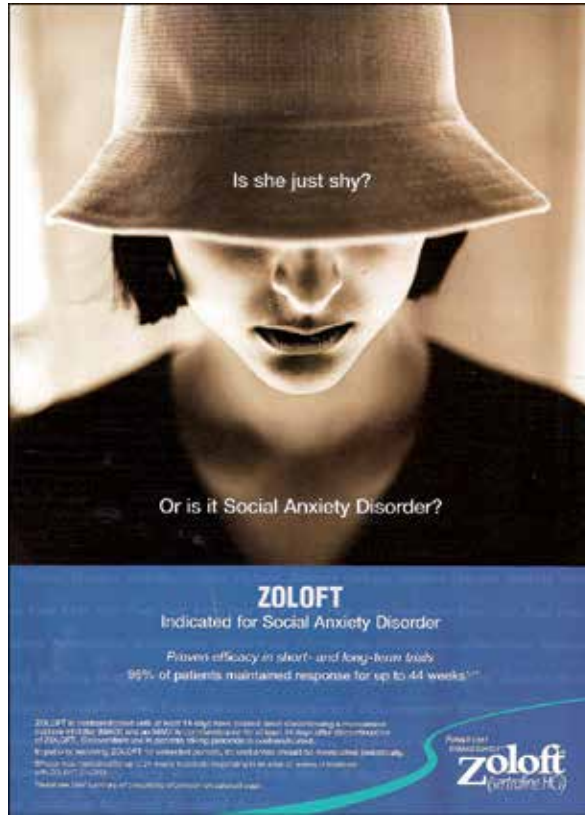
2 Isaac Marks, interview with Christopher Lane (November 1, 2005), quoted in Lane 2007: 105. See also David Healy's remarks on the same page.

3 *DSM-IV* (300.23) (1994), 416: "Performance anxiety, stage fright, and shyness in social situations that involve unfamiliar people are common and should not be diagnosed as Social Phobia unless the anxiety or avoidance leads to clinically significant impairment or marked distress."

increased suicidal ideation among adolescents prescribed Paxil and other SSRI (serotonin-specific reuptake inhibitor) antidepressants led the U.S. Food and Drug Administration to add a black-box warning to that class of drugs, drawing official attention to the problem.

The following advertisement, published the year before (August 2003) in the *American Journal of Psychiatry,* is a striking illustration of such diagnostic confusion, with Pfizer, makers of the drug in question (Zoloft), capitalizing on it by asking of a young woman with a downward glance: "Is she just shy? Or is it Social Anxiety Disorder?" (fig. 1). That the two phenomena could be confused in such a way is, I shall argue, both the point and the problem.

Image 1:



The term "Social Phobia" dates to 1903, when the French psychiatrist Pierre Janet, writing about agoraphobia, referred to "social phobias or those with phobias of society" (originally, "*phobies socials ou des phobies de la societé"*) (Janet 1903: 210); but the term didn't catch until 1966, when Isaac Marks and Michael Gelder at the Maudsley Institute, London, published a review article sketching several different forms of panic they witnessed in patients (10 male, 15 female) who became anxious primarily in social settings (Marks and Gelder 1966: 218). Signs of the patients' distress, Marks and Gelder wrote, included "fears of blushing in public, … [of] going to dances or parties," and "shaking when the center of attention" (ibid: 218).

As the second edition of the *DSM* (1968) referred only to "anxiety neurosis," a holdover from American psychiatry's previously strong support for Freudianism, the distinctions Marks and Gelder noted in their small group couldn't be registered formally. But nor did either psychiatrist want them to be. Their article, "Different Ages of Onset in Varieties in Phobia," published in the *American Journal of Psychiatry,* neither lamented that situation nor recommended breaking up the overarching, diagnostic term. On the contrary, Marks and Gelder concluded: "behaviorist and psychoanalytic views favor unitary explanations of phobias, and attempts to subdivide the[m] have proved fruitless" (ibid.: 220). Four years later, in a report scholars have since said was instrumental in ensuring the inclusion of social phobia in *DSM-III,* Marks restated his position more firmly. "Evidence is lacking that [social phobia] is a coherent group." He warned, "We need to know more about social phobics before definitely classifying them on their own" (Marks 1970).

Robert Spitzer's DSM-III taskforce welcomed the review, I discovered much later from a detailed review of its memoranda, taking such preliminary findings as evidence that the phobia existed and adopting them wholesale in 1980 as justification for listing the phobia as a distinct illness (see also Cheleby 1987: 167). Yet as knowledge of social phobia remained largely unchanged throughout the 1970s, the task force had ignored Mark's final proviso. It also had glided over two of his and Gelder's major conclusions: the number of patients affected is proportionately small, and anxiety's various facets are so entwined that it's a mistake to split them into separate disorders.

Of the few reports that *did* appear between the 1966 review and the 1980 publication of *DSM-III,* moreover, two sided with Marks in voicing serious doubts that social phobia was a distinct syndrome. In 1969, Eliot Slater and Martin Roth signaled clearly in *Clinical Psychiatry* that "on the present evidence there is no very clear line of demarcation" between those with social anxiety and those with

agoraphobia, for instance, a position almost identical to R. P. Snaith's lengthy report on the two types of anxiety, appearing the previous year (Slater and Roth 1969 and Snaith 1968).

Disregarding such caveats, the task force went ahead and formalized social phobia as a distinct mental disorder. It also broke "anxiety neurosis" into five other disorders—simple anxiety, generalized anxiety, OCD, panic disorder, and post-traumatic stress disorder – in effect multiplying by six (rather than dividing by the same number) the populations of mentally ill patients whom drug companies would soon target with SSRI antidepressants. American academics and the U.S. media also swooned over the latter, with international bestsellers such as *Listening to Prozac* offering near-euphoric testament about the drug's pharmaceutical benefits for the worried well (Kramer 1997). News magazines such as *Newsweek* and *Time* also wrote rashly about the benefits of "personality sculpting" and "mood brightening" from SSRIs—all without side effects, of course (Begley 1994). One June 2000 article for *The Report* captures the enthusiasm and press that neuropsychiatry could command, carrying the unironic title, "You're Not Shy, You're Sick: Psychiatrists Discover a Crippling "Social Anxiety Disorder" That Affects 13 % of Us" (Cosh 2000: 49f.). Other, scholarly articles put that figure at 18.7 % North Americans – close to one in five (Stein et al. 1994: 408). (That higher number was reached, it's worth adding, by researchers polling several hundred urban Canadians and asking them to rate their fear of going to parties, figures of authority, and calling strangers.)

One reason the DSM-III task force was so successful in devising this and more than eighty other mental disorders in 1980, Marks told me in 2005, is that "the consensus [for supporting them] was arranged by leaving out the dissenters" (Lane 2007: 74)[4] Marks himself was not invited to crucial follow-up *DSM* discussions about panic disorder, one of them sponsored by Upjohn Pharmaceuticals, maker of Xanax, because, though he was committed to treating panic, he did not think it represented a bona-fide disorder in the way that, say, depression did. Robert Spitzer, chair of the task force and editor of *DSM-III* and *-IIIR*, has since admitted that he picked only "kindred spirits" (his term) with near-identical diagnostic assumptions to join the task force, which met for four years before it even occurred to some of its members to include other voices and perspectives (Wilson 1993: 404)[5].

The person (John Frosch) later added to the task force to correct this imbalance subsequently resigned, complaining of an "Alice in Wonderland feeling"

4 Marks, interview by Lane, quoted in Lane 2007.
5 Spitzer, interview by Mitchell Wilson, quoted in Wilson 1993.

(Lane 2007: 59)[6]. Small wonder, one might think, after an influential member of the Personality Disorders Subcommittee asked colleagues to review his proposal for "Emotionally Unstable Character Disorder" by announcing rather breezily, "You'll note that this syndrome has been repeatedly described by me," with drug and follow-up studies "attesting to the reality of this syndrome, which is more than can be said about a number of the syndromes in DSM-III" (Lane 2007: 44)[7]. Another active consultant to *DSM-III* went public to the *New Yorker* magazine in 2005, conceding: "There was very little systematic research [in what we did], and much of the research that existed was really a hodgepodge – scattered, inconsistent, ambiguous" (Spiegel 2005: 59)[8].

In 1987, however, seven years after Social Phobia entered the stage, it acquired a new name, Social Anxiety Disorder, and with it, even-more dramatically expanded parameters and everyday symptoms, including public-speaking anxiety – one so prevalent among the general public that it's often put higher than even fear of death (Greist et al. 2000: 2). Among the DSM Anxiety Disorders Working Group members, there was also considerable discussion about whether the disorder should include test anxiety among schoolchildren and teenagers, and even anxiety about going on dates. Michael Liebowitz, a prominent Columbia University psychiatrist who chaired the committee and was instrumental in giving Social Phobia its more patient-friendly name, wrote to Spitzer in concern about individuals who "may have difficulty with speaking or auditioning, eating, drinking or writing in public, or in social activities [such] as dating, actual conversations, [and] going to parties" (Lane 2007: 99)[9]. As a result of his intervention, several of those concerns – including, amazingly, even a fear of sounding foolish – were written into *DSM-IIIR and –IV,* with the latter edition going on to sell more than a million copies and influencing diagnostic trends around the world. The wording of SAD's major criteria was also greatly adjusted so that merely *anticipating* fear or anxiety became grounds for diagnosis. As *DSM-IIIR* put it, "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 and embarrassing"[10]. The manual had deleted language stipulating that the fears had to be "irrational," multiple," and actual – simply anticipating them was enough.

One might at this point wonder how fear of eating alone in restaurants came to be listed as an official symptom of such a devastating anxiety disorder. As far

6 John Frosch to Robert Spitzer, quoted in Lane 2007.
7 Klein to Spitzer, quoted in Lane 2007.
8 Theodore Millon, quoted in Alix Spiegel 2005.
9 Michael L. Liebowitz to Spitzer, quoted in Lane 2007.
10 "Social Phobia," DSM-IIIR, 241.

as I can tell from the archive, the matter arose because Donald Klein, another Columbia University psychiatrist serving on the task force, wrote in July 1985 about "a patient with panic disorder who also avoided restaurants because of fear that he may drop some food on his necktie and look ridiculous. I don't think the cure for these complex situations," Klein added," is in the construction of [diagnostic] hierarchies, but rather in multiple diagnoses" (Lane 2007: 77f.)[11].

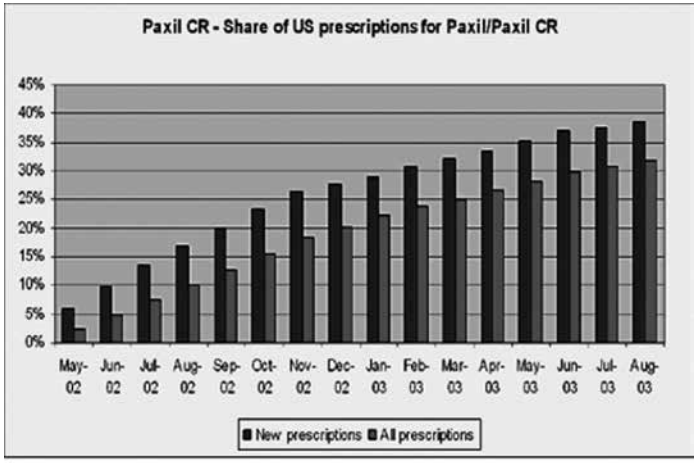
In their aptly named study *Making Us Crazy: DSM: The Psychiatric Bible and the Creation of Mental Disorders,* sociologists Stuart Kirk and Herb Kutchins write: "By simply altering slightly the wording of a criterion, the duration for which a symptom must be experienced in order to satisfy a criterion, or the number of criteria used to establish a diagnosis, the prevalence rates in the United States will rise and fall as erratically as the stock market" (Kutchins and Kirk 1997: 244).

Not surprisingly, given the accuracy of that observation, the radical expansion of the official symptoms of SAD and the dramatic lowering of its threshold, the American Psychiatric Association was forced to add a warning to *DSM-IV* in 1994, urging that the psychiatrists, doctors, social and healthcare workers, courts, prisons, and schools that routinely consult the manual *not* confuse the disorder with shyness.[12] Yet the same edition added fresh language about Social Anxiety Disorder in children, advising the same large constituency: "Crying, tantrums, freezing, clinging or staying close to a familiar person … may be present."[13]

Shortly after the manual published these lower thresholds, the U.S. Food and Drug Administration (FDA) gave the Anglo-American pharmaceutical giant GlaxoSmithKline a green light to license its spotty antidepressant Paxil for the revised and renamed disorder. With more than $92 million spent on marketing the condition in the year 2000 alone, it's no surprise that between 3,000 and 5,000 North Americans soon began a course of drug treatment for the disorder every day (fig. 2).[14] The numbers in Europe were lower only because direct-to-consumer pharmaceutical advertising for psychiatric conditions is not permitted in the European Union.

11 Donald Klein to Spitzer, quoted in Lane 2007.
12 DSM-IV (300.23) (1994), 416, quoted above.
13 DSM-IV, 413.
14 Hawkins, "Paxil Is Forever," n.pag.

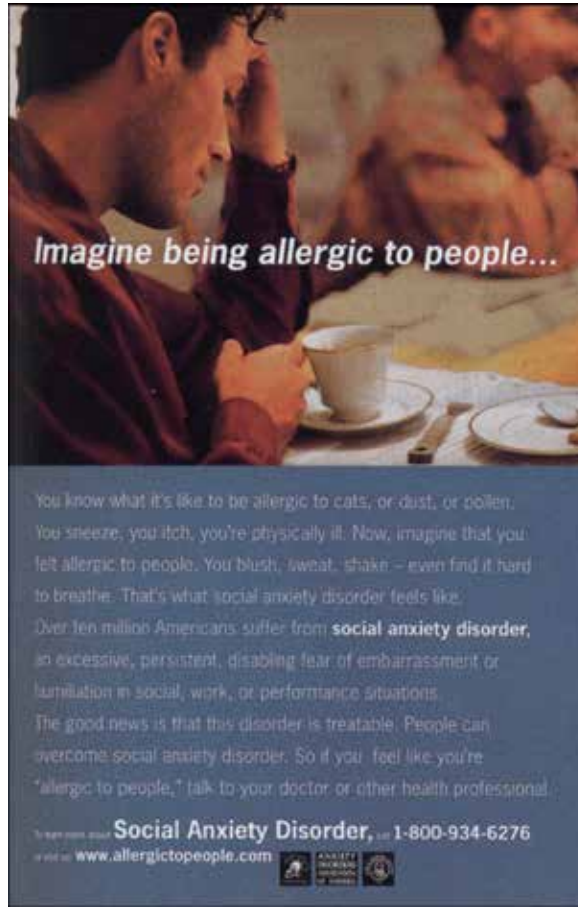
Image 2:



GlaxoSmithKline decided to call its promotional campaign "Imagine Being Allergic to People," adhering to the principle that if you want to sell a drug, you must first sell the disease it is said to treat. On bus shelters across the U.S., the company – through its hired PR consultants Cohn and Wolfe – plastered ads depicting an attractive young man staring forlornly into a teacup, detached from those around him (fig. 3). The copy exhorts:

> You know what it's like to be allergic to cats, or dust, or pollen. You sneeze, you itch, you're physically ill. Now, imagine that you felt allergic to people. You blush, sweat, shake – even find it hard to breathe. That's what social anxiety disorder feels like. . . . The good news is that this is treatable. People can overcome social anxiety disorder. So if you feel like you're "allergic to people," talk to your doctor or other health professionals.

Image 3:

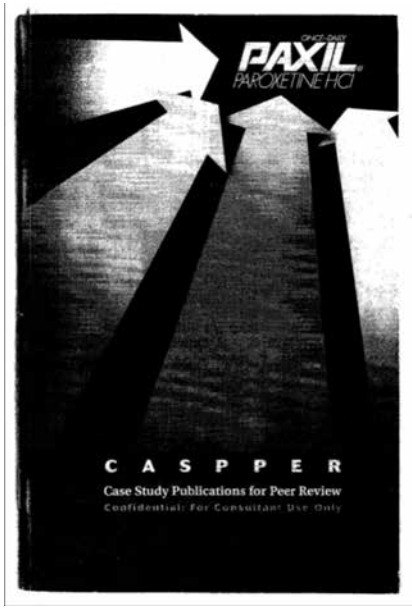


Meanwhile, the latter groups were bombarded daily, sometimes hourly, by smiling but pushy pharma reps "just stopping by" on busy working days to ensure that the colleague in question had enough free samples on hand if a patient came inquiring about the ad.

The "Allergic to People" campaign did not mention Paxil – it didn't need to, since it was the only pharmaceutical remedy approved for the disorder at the time. The ad referred only to a group called Anxiety Disorders Association of America,

whose two nonprofit members include the American Psychiatric Association and Freedom from Fear, an advocacy group the drug maker was quietly sponsoring and financing on the side (Koerner 2002: 61). In a thoroughly postmodern turn, then, where companies simply fabricate the feedback they want for their product, Glaxo was funding Freedom From Fear to supply a steady pool of contented "patients" willing to rhapsodize about their experience on the antidepressant and to stress how debilitating their social anxiety was. (The same groups are paid to post comments on Internet articles that are critical of the drug companies.)

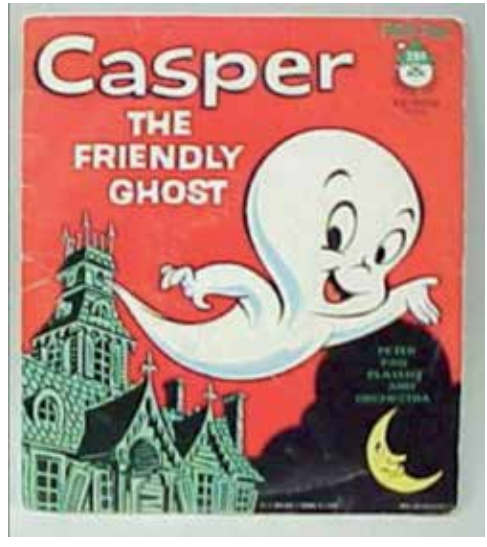
Image 4:



GlaxoSmithKline, reporters have since unearthed, also sponsored its own ghost-writing program to land favorable articles with fabricated evidence in influential scholarly journals. It called the program "CASPPER" – short for "Case Study Publications for Peer Review" (fig. 4), an acronym the drug-maker seems to have chosen also as an inside-joke, as it invokes the cartoon ghost Casper, popular among American children – as in "*CASPPER, the friendly ghost*-writing agency" (fig.

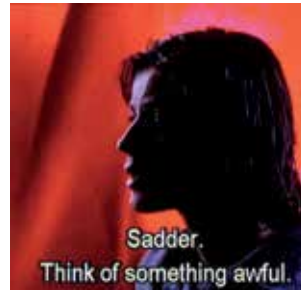
5). GSK's Philadelphia office published and circulated the confidential brochure "for consultant use only," noting that its "PAXIL Product Management" team had "budgeted for 50 articles in 2000" (SmithKline 2000: 11).

Image 5:



Just one other example can suffice to convey the rampant marketing of disorders and drugs in the 1990s and 2000s. After the Polish-French filmmaker Krzysztof Kieślowski released his *Trois couleurs* series, with the final film *Rouge* (1994) expressing an interest in generalized anxiety, GlaxoSmithKline blatantly plagiarized it and him. In the film, an ethereal model Valentine (Irène Jacob) ultimately connects with her handsome neighbor Auguste (Jean-Pierre Lorit), but only after a half-dozen near-miss encounters and a traumatic rescue from a ferry accident in the English Channel.

Image 6:

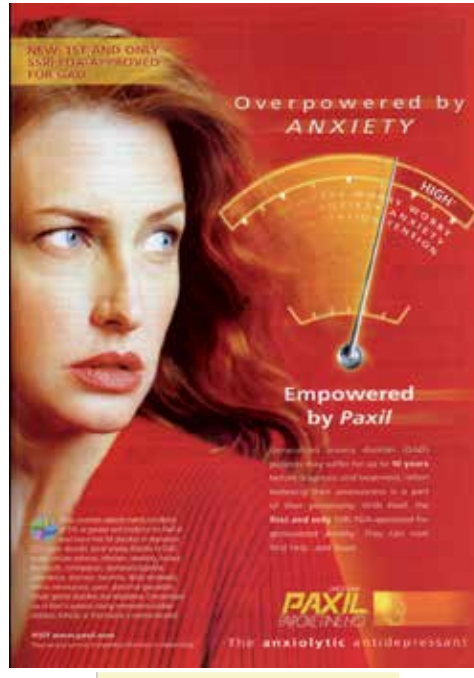


"Be sad," Jacob's character is implored earlier in the film as she tries to get into character to sell some chewing gum. "Think of something awful" (fig. 6).[15] It's a strange, slightly over-the-top scene in the film, not least because, for reasons never explained, the product, gum, never appears in the final ad, even though the image in question (fig. 7) strongly anticipates the final shot of Valentine leaving the almost-collapsed ferry. GlaxoSmithKline later cribbed from the film, very obviously, when using its concept and color scheme to promote Paxil for Generalized Anxiety Disorder (fig. 8). No more than a month after 9/11, when America was trying to recover from the shock of the attacks, the same company also ran ads for Generalized Anxiety Disorder featuring a woman saying, "I'm always thinking something terrible is going to happen"[16]. Subtle it was not – whether as timing, plagiarism, or naked opportunism.

Image 7:

15 Krzysztof Kieślowski (dir.), Trois couleurs: Rouge (1994).
16 Hawkins, "Paxil Is Forever," n.pag.

Image 8:



Paxil, *American Journal of Psychiatry* 158 (July 2001)

Whether plagiarizing Polish-French films, fabricating evidence in influential medical journals, or funding vast and expensive promotional campaigns for antidepressants that become the basis for a new (if medicated) sociability (fig. 9), drug companies have exercised a strong, often heavy-handed influence on the medicalization of emotions and common behaviors. (The caption here, below a group of laughing friends, is "Paxil – Your *Life* Is Waiting," as if life itself were waiting for the medication.) Especially in the U.S., where the same corporations sponsor most of the academic research that is undertaken and published on their products, one grasps quite quickly why there's been a scandalous delay in studying the withdrawal syndrome that frequently ensues when drug treatment ends (see for instance Segraves 1998, Opbroek et al. 2002, Harvey et al. 2003, Warner et

al. 2006) – it's simply not in the drug companies' interests to fund such studies, despite the millions of people affected (Turner et al. 2008)[17].

Image 9:

As for the American Psychiatric Association, which devised and formally approved so many of the conditions for which such drugs are now approved treatments, the organization is trying to reform the *DSM* by pushing for the adoption of a "dimensional model" that will diagnose conditions based on their frequency and severity, in recognition that the intensity of symptoms may fluctuate across the lifespan, rather than remain, as frequently marketed, a constant neurochemical risk. The hope is that the dimensional model will dampen the pressure to diagnose and medicate, because it will erase black-and-white distinctions between normalcy and pathology, leaving clinicians with greater or lesser shades of gray.

The problem with such a model isn't simply how variously the physician in question can apply it (a particular issue when, as the APA implicitly recognizes, shyness and Social Anxiety Disorder are so easily confused); it's also that the pressure to add more conditions to the *DSM hasn't* gone away. If anything, it's greatly intensified in recent years, with colleagues urging for the adoption of "Internet ad-

17 Turner et al. determined that a publication bias skewing to positive reporting of SSRI antidepressants was owing less to the efficacy of the drugs themselves than to the non-publication of clinical trials showing unfavorable results and the recasting of ambiguous, mixed results as mildly positive in publication.

diction disorder," "apathy disorder," "compulsive shopping disorder," "hypersexual disorder," "psychosis risk syndrome," "binge eating disorder," "premenstrual dysphoric disorder," and even "temper dysregulation disorder," which sounds impressive until one asks how many childhood tantrums would be the basis for yet-more pathologization of the very young. After pressure to recognize juvenile bipolar disorder mounted from psychiatrists, schools, some parents, and of course affected drug companies, diagnoses among infants and children in the U.S. skyrocketed 4,000 % (Frontline 2008).

As for Internet addiction disorder, how many people—particularly those spending long hours on the web for work—would be eligible for diagnosis? The question almost answers itself, yet one 2008 editorial published in the *American Journal of Psychiatry* did more than call for recognition of the "common disorder" (Block 2008: 306f.). Referencing a single conference paper, its author, Jerald J. Block, argued that the disorder presents three subtypes: "excessive gaming, sexual preoccupations, and email-text messaging." Ominously, even surreally, given the amount of texting that teenagers, in particular, favor, he added: "About 80 % of those needing treatment [for overuse of the Internet] may need psychotropic medications, and perhaps 20 % to 24 % require hospitalization" (ibid.).

Given the almost-identical ways in which putative psychiatric conditions are "introduced" to clinicians and the general public, to say nothing of how they're held up as urgent problems meriting inclusion in the next edition of the *DSM,* Internet addiction disorder can be considered an exemplum representing all the other minor disorders the *DSM-5* task force is currently reviewing, with massive implications for public health and, just as predictable, the likelihood of overdiagnosis and overmedication.

One sign of how zealously American psychiatrists will fight for such additional changes (and defend against the adjustment or removal of existing ones) became clear in 2003, when Harvard-based psychiatrist Ronald Kessler and his team published in the *Archives of General Psychiatry* an article called "Mild Disorders Should Not Be Eliminated from the *DSM-V"* – eight years *before* the edition was slated to appear (Kessler et al. 2003: 1117-22). It's not that anyone had formally proposed such a move; Kessler and his colleagues were merely lining up an argument in case anyone tried. The article indeed reads like a pre-emptive attack, designed to stop the DSM-5 task force and its working groups from second-guessing earlier decisions. It even singles out Darrel Regier, a man "expected to play a prominent role in the development of *DSM-V*," and warns that he would be wrong to "support … similar restrictions" on the calculation of mild disorders, such as Social Anxiety Disorder. The latter disorder's problem, Kes-

sler nonetheless concedes, is that it and similar ones "appear not to have meaningful thresholds"—by which he means, they lack "consistent" and "wholly reliable" ones (ibid.). Such elasticity allows the disorder to be adjusted as much as tenfold, depending on where one sets its variables and parameters, as the *American Journal of Psychiatry* discovered in 1994 (Stein et al. 1994).

Despite such very *un*reassuring signs of confidence from Kessler, however, he singled out such disorders as needing to remain unchanged in a manual eight years before it was even due to appear. He also, one should add, served as chair of a National Comorbidity Study suggesting that fully 28.8 percent of the American public – almost one in three – met the threshold for an anxiety disorder, with 12.1 percent of them exhibiting signs of social anxiety disorder (Kessler et al. 2005: 593).

Although the latter "appears not to have meaningful thresholds," as Kessler's team conceded (Kessler et al. 2003: 1118), the number of chronically ill patients said to be afflicted is very much at stake as evidence and confirmation of the disorder's severity. More than careers, research lines, and blockbuster drugs are on the line. If the criteria for such disorders were appropriately tightened, not consistently relaxed, millions of patients would no longer be defined as ill. Whole segments of the population, in Europe and the States, currently buoying up the drug companies and their annual returns (fig. 10), would disappear at a stroke, to reemerge beyond their nets as something like the "worried well" or the "simply shy." Nor would Kessler's team be able to state, as it does with remarkable casualness, "About half of Americans will meet the criteria for a *DSM-IV* disorder sometime in their life" (Kessler et al. 2005: 593). The number of people seemingly afflicted by mental disorders would nosedive. It would be as if the *DSM-5* task force took a corrective pin to the manual's bloat and hype, leaving it suitably deflated to focus once more on those who are chronically ill.

Image 10:

I have tried to demonstrate, nonetheless, how quickly and easily a common behavioral trait, shyness, was turned into a psychiatric condition, with millions of Europeans and North Americans given powerful psychotropic medication for it and suffering chronic adverse side effects as a result. Such radical redefinitions of behavior not only pathologize large numbers of people formerly classed as "the worried well"; they also shrink the parameters of normalcy (including "normal" sociability), making it a great deal easier to be grouped among the mentally ill and increasingly more-difficult to be viewed as lacking in pathology. The second edition of the *DSM* even anticipated that move when it included, in 1968, a diagnostic code for those lacking any mental disorder: "318: No mental disorder."[18]

When influential psychiatrists publish editorials in the flagship *American Journal of Psychiatry* advising that, for overuse of the Internet and excessive texting, "About 80% of those needing treatment may need psychotropic medications, and perhaps 20% to 24% require hospitalization,"[19] one does however perceive the pressure amassing behind these diagnostic endeavors and the public health risks affecting us all if, as looks likely, more of them are formally approved.

18 DSM-II (318: No mental disorder) (1968), 52.
19 Block, "Editorial: Issues for DSM-V: Internet Addiction," 306.

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