PUTTING THE 'SOCIAL' IN 'SOCIAL ANXIETY DISORDER': EXPLORING WOMEN'S EXPERIENCES FROM A FEMINIST AND ANTI-PSYCHIATRY PERSPECTIVE

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ABSTRACT

This work interrogates the extent to which cultural values, namely norms of femininity, are implicit in the *DSM-5*'s diagnosis Social Anxiety Disorder (SAD). In order to do so, narratives of seven women diagnosed and/or self-diagnosed with SAD are obtained by means of individual, in-depth, semi-structured interviews. By privileging these accounts, this thesis shifts the power to define this 'disorder' from the medical professional to women with SAD themselves, and serves to illuminate the socially anxious woman's experience.

Participants' testimonies are placed into dialogue with *DSM-5* diagnostic criteria for SAD and associated 'co-morbidities' and the resulting interchange is viewed from a perspective informed by anti-psychiatry, feminism, and feminist science studies. In this way, the diagnosis and treatment of women with SAD is problematised, and, more broadly, psychiatry's position as an authority discourse on (women's) 'madness' is called into question.

Given participants' discussions of the effects upon them of external structural sexism and norms of femininity in their containing culture, this thesis theorises women's SAD as a 'culture-bound syndrome'. Moreover, in the spirit of the anti-psychiatrists, I ask whether these women's social anxiety is not a rational response to the circumstances in which they find themselves. By focussing on the significance of social, especially gendered, external conditions, this research departs from existing work on women's overrepresentation among those with SAD. In turn, it provides a corrective to biologically reductionist and gender biased accounts which have sought to explain this imbalance.

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INTRODUCTION

'But to be happy it is essential not to be too concerned with others.'[1]

Recognising the profound and multiple ways gender socialisation has shaped my life, I found myself asking: 'Why would my experience with Social Anxiety Disorder be any different?' In a bid to find answers, I delved into modern discourses surrounding mental health issues, which invariably led me to popularised notions of 'chemical imbalances', 'illnesses like any other', and 'brain diseases', terms which have mostly been deployed by the well-meaning with the purpose of de-stigmatisation. Perhaps my immersion in these discourses, which pervade not only popular thought but medicine too, is why I initially found it difficult to read the works of the anti-psychiatrists of the 1960s: I bristled at the more absolutist claims, such as those of Thomas Szasz, that there was 'no such thing as mental illness'.[2] Although I found merit in Szasz's tenet, maintained throughout his opus — the aptly named *The Myth of Mental Illness* — that many 'mental illnesses' were actually 'problems in living',[3] I did not feel as though I could tell people that their mental health issues did not in fact exist without upsetting them: not wanting to upset people is a hallmark of my own social anxiety, to be sure.

In spite of my discomfort, I kept reading and slowly came to see that it was possible to critique the framework which exists around diagnosing and treating mental health issues without dismissing distress. I discovered a body of work, a feminist legacy of anti-psychiatry, which theorises women's mental

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[1] Albert Camus, *The Fall [La Chute],* trans. Justin O'Brien (Penguin: Harmondsworth, 1957[1956]), p. 59.
[2] Thomas S. Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York: Harper and Row, 1974), p. 1.
[3] Ibid., throughout.

suffering without resorting to biologically reductive, 'low serotonin' explanations. In fact, it does quite the opposite in that it privileges the importance of structural inequalities and considers the material realities of the body without recourse to arguments based on hormones or reproductive processes. Reading analyses of other gendered diagnoses, such as Eating Disorders[4] and Depression,[5] I asked myself: 'Why had nobody yet taken this approach with women's social anxiety (disorder)?'

Thesis Overview

In this work I seek to expose the degree to which cultural values, namely norms of femininity, are implicit within the psychiatric diagnosis Social Anxiety Disorder (SAD)[6] in women. In so doing, I call the status of the socially anxious woman's experience as 'disordered' into question. This research finds a place within a broad field of critical work, informed by Michel Foucault and others, which shows how medicine broadly, and psychiatry in particular, have become authority discourses in modernity. The rise of biomedical psychiatry means that it increasingly emulates the natural sciences and exists behind a 'scientific patina'.[7] This in turn renders the interrogation of the extent to which normativities inform who is deemed to be 'ill' or 'well'; 'normal', or 'abnormal' — and thus in need of (pharmacological) treatment — more difficult.

To achieve the aims of this thesis, I harness the words of women (self-) diagnosed with SAD, imparted to me through depth interviews. Themes from their narratives are placed into dialogue with diagnostic

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[4] Patricia Fallon, Melanie A. Katzman, and Susan C. Wooley (eds.), *Feminist Perspectives on Eating Disorders* (New York: Guilford Press, 1996).
Susie Orbach, *Fat Is a Feminist Issue* (London: Arrow Books Limited, 1986).
Susie Orbach, *Bodies* (New York: Picador, 2009).
Susie Orbach, *Hunger Strike: Starving amidst Plenty* (London and New York: Karnac, 2005).
[5] Janet Stoppard, *Understanding Depression: Feminist Social Constructionist Approaches* (London: Routledge, 2014).
[6] Not to be confused with the diagnosis 'Seasonal Affective Disorder'.
[7] Carl I. Cohen, 'The Biomedicalization of Psychiatry: A Critical Overview', *Community Mental Health Journal*, 29.6 (1993), 509 –21 <doi: 10.1007/BF00754260> [accessed 25 September 2020], p. 517.

criteria and viewed through a feminist science studies and anti-psychiatry lens. The stories of my participants are at the very heart of my work: my theorising about SAD is grounded by their narratives. Through adopting a position of advocacy, my research bestows upon these women the power to define their 'disorder' for themselves. That is, listening to the often-silenced voices of the 'mad'[8] permits the forging of an alternative narrative on women and SAD to that espoused by the psy sciences. This provides a corrective to the extant psy science literature, since the latter has yet to take heed of women's subjective experiences.

It is worth noting at this juncture that my analysis will be limited to primarily the UK and, to a lesser extent, the US: my participants are drawn from the UK, and I deal only with the psychiatric diagnostic manuals of the UK and US. This is owing to the fact that both femininities[9] and psychiatric diagnoses[10] are culturally constructed and situated.

Context

Before elaborating on the rationale for this research, it is timely to chart briefly the history of what is now called 'Social Anxiety Disorder'. Considering this diagnosis necessitates some discussion of the notion of 'shyness'. Sociologist Susie Scott tells us that 'Social Phobia, Social Anxiety Disorder and Avoidant Personality Disorder are all relatively new diagnoses that are implicitly differentiated from "normal shyness".'[11] However, demarcating between the 'normal' and the 'disordered' is a fraught task.

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[8] Michel Foucault, *History of Madness,* ed. Jean Khalfa, trans. Jonathan Murphy and Jean Khalfa (London and New York: Routledge, 2006) [*Folie et Déraison: Histoire de la Folie à L'âge Classique,* 1961]).

[9] Elaine Showalter, *The Female Malady: Women, Madness, and English Culture* (New York: Pantheon, 1985).

[10] Laurence J. Kirmayer, 'Cultural Psychiatry in Historical Perspective', in *Textbook of Cultural Psychiatry*, ed. by Kamaldeep Bhui and Dinesh Bhugra (Cambridge: Cambridge University Press, 2007), 3–19.

[11] A. Cunningham, *Social Phobia or Just Shyness?* (2002) <https://serendip.brynmawr.edu/bb/neuro/neuro02/web3/acunningham.html> [accessed 5 August 2004] cited in Susie Scott, 'The Medicalisation of Shyness: From Social Misfits to Social Fitness', *Sociology of Health and Illness,* 28.2 (2006), 133–53, pp. 133–34 <doi: 10.1111/j.1467-9566.2006.00485.x> [accessed 3 January 2021].

On this issue, Scott argues that, rather than revealing 'objective clinical knowledge',[12] psychiatric diagnoses instead reflect 'social judgements about "appropriate" forms of behaviour'.[13]

On the history of shyness, literary critic Christopher Lane tells us that while 'anxiety' is fairly 'constant as it ripples through the ages',[14] the link between shyness and anxiety is not so ahistorical as we might at first assume.[15] In order to explore this further, it is pertinent to visit Robert Burton's seventeenth century work *Anatomy of Melancholy,* wherein his citing of Hippocrates describes a man in whom the linkage between shyness and anxiety is manifest:

> [T]hrough bashfulness, suspicion, and timorousness, [he] will not be seen abroad; 'loves darkness as life, and cannot endure the light,' or to sit in lightsome places; his hat still in his eyes, he will neither see nor be seen by his goodwill. He dare not come in company, for fear he should be misused, disgraced, overshoot himself in gesture or speeches, or be sick; he thinks every man observes him, aims at him, derides him, owes him malice.[16]

The next most notable mention of social anxiety is not to be found until very much later. The 'alienists' of the 1880s 'began viewing shyness as a morbid condition that bordered on pathology'.[17] Specifically, French psychiatrist Paul Hartenberg spoke of 'chronic shyness' in his 1901 work *Les Timides et la*

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[12] Peter Conrad, 'On the Medicalization of Deviance and Social Control', in *Critical Psychiatry: The Politics of Mental Health,* ed. by David Ingleby, 2nd edn (London: Free Association, 2004), cited in Scott, 'The Medicalisation of Shyness', pp. 133–34.
[13] Ibid.
[14] Christopher Lane, *Shyness: How Normal Behavior Became a Sickness* (Yale University Press, 2007) <https://ebookcentral.proquest.com/lib/bham/reader.action?docID=3420940> [accessed 6 January 2021], p. 11.
[15] Ibid.
[16] Hippocrates, quoted in Robert Burton, *The Anatomy of Melancholy: What It Is, with all the Kinds, Causes, Symptoms, Prognostics, and Several Cures of It* (London: William Tegg, 1854[1621]), p. 253, cited in Lane, *Shyness*, p. 12.
[17] Lane, *Shyness*, p. 14.

Timidité, which contains one chapter dealing with 'pathological shyness'.[18] Around the same time, French psychologist Pierre Janet began to work on the same topic, coming up with the name 'Social Phobia' (*Phobies Sociales*).[19]

As such, despite Hippocrates' very early writings on social anxiety, and Lane's claim that the Ancient Greeks did in fact recognise 'stage fright',[20] it was not until the 1900s that 'Social Phobia' began to be construed as a mental disorder.[21] It is salient to note that Western psychiatry assumed its current form around this time,[22] with madness being subsumed into medicine.[23] Following on from this, the 1930s witnessed the emergence of what was called 'Social Neurosis', which was characterised by 'shyness, inhibition of thinking and memory, and a tendency to withdraw from social activities [...] Physical symptoms observed [were]: sweating, blushing, inability to speak, and shaking'.[24] SAD was formally conceptualised as a distinct disorder in 1965 by psychiatrists Isaac M. Marks and Michael Graham Gelder who, in their small scale study, described individuals who 'became anxious primarily when required to participate in social situations'. This group 'tried whenever possible to avoid eating in public [...] Signs of

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[18] Pierre Janet, *Les Obsessions et la Psychasthénie* (Paris: Félix Alcan, 1903), 2 Vols., 1:210, cited in Lane, *Shyness*, p. 30.
[19] Janet, *Les Obsessions et la Psychasthénie* 1:205, cited in Lane, *Shyness*, p. 30.
[20] Lane, *Shyness*, p. 2.
[21] Thierry Haustgen, 'À Propos du Centenaire de la Psychasthénie (1903): Les Troubles Obsessionnels-Compulsifs dans la Psychiatrie Française: Revue Historique', *Annales Médico-psychologiques, Revue Psychiatrique,* 162.6 (2004), 427–40 <doi: 10.1016/j.amp.2003.09.012> [accessed 3 January 2021].
[22] Joel Kovel, 'The American Mental Health Industry', in *Critical Psychiatry*, ed. by David Ingleby (New York: Pantheon, 1980), 72–101.
[23] Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* [based on an abridged version of *Folie et Déraison: Histoire de la Folie à L'âge Classique*], trans. Richard Howard (London and New York: Routledge, 2001[1961]), 234–64.
[24] Paul Schilder, 'The Social Neurosis', *Psychoanalytic Review*, 25 (1938), 1–19 <https://psycnet.apa.org/record/1938-02478-001> [accessed 3 January 2021], p. 1.

their distress included “fears of blushing in public, . . . [of] going to dances or parties,” and “shaking when the center of attention”’.[25]

Subsequently, SAD entered the second edition of the American Psychiatric Association’s (APA) *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), the US’s psychiatric diagnostic manual, in 1968.[26] The *DSM* is of key importance in contemporary psychiatry insofar as it is used by mental health professionals in diagnosing, and treating, mental health issues. Indeed, the APA’s own website tells us that the fifth, and latest, edition of the *DSM* is ‘the handbook used by health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders’.[27]

What was perhaps most significant about the second edition of the *DSM* was that it turned ‘phrases like “schizophrenic reaction” into simple nouns (“schizophrenia”)’.[28] In so doing, ‘it altered at a stroke the very meaning of illness for clinicians and patients.’[29] The move away from conceptualising mental disorders as reactions served to posit them as ‘permanent, even innate conditions’.[30]

Returning to the trajectory of SAD in particular, this diagnosis was not developed a great deal further until the 1980s, when Social Phobia, as well as the closely related Avoidant Personality Disorder, were added to the revised third edition of the *DSM*.[31] Scott contends that, ‘[s]ince then, the diagnostic label [SAD] has been applied to an increasing number of people who would once have been seen as “just

[25] Isaac M. Marks and Michael Graham Gelder, ‘Different Ages of Onset in Varieties of Phobia’, *American Journal of Psychiatry,* 123.2 (1966), 218–21 <doi: 10.1176/ajp.123.2.218> [accessed 3 January 2021], cited in Lane, *Shyness*, p. 71.
[26] American Psychiatric Association [APA], *Diagnostic and Statistical Manual of Mental Disorders*, 2nd edn [*DSM-II*] (Washington, DC: American Psychiatric Association Publishing, 1968).
[27] American Psychiatric Association [APA], *DSM–5: Frequently Asked Questions* (2021) <https://www.psychiatry.org/psychiatrists/practice/dsm/feedback-and-questions/frequently-asked-questions> [accessed 17 Februaru 2021].
[28] Lane, *Shyness*, p. 38.
[29] Robert L. Spitzer, interview by Christopher Lane (February 22, 2006) cited in Lane, *Shyness*, p. 38.
[30] Lane, *Shyness*, p. 38.
[31] Ibid., pp. 2–3.

shy".'[32] Indeed, this 'transformation of shyness into a disease'[33] was facilitated 'behind closed doors of carefully vetted committee meetings'[34] by 'a small group of self-selecting American psychiatrists'.[35] Crucially, this reframing of shyness conceptualised it as stemming 'not from psychological conflicts or social tensions, but rather from a chemical imbalance or faulty neurotransmitters in the brain'.[36] There are links to be made here with the shift in terminology which occurred with the *DSM*'s second edition, as Lane explains: '[W]hen one anticipates that the *DSM-III* would soon render this as, in effect, "You have social phobia" or even "You are a social phobe," the impact of the revisions begins to hit home.'[37] This is a prime example of what Foucault describes as a 'specification of individuals' in his account of the history of the human sciences.[38] While Foucault tells us that homosexuality used to be 'a category of forbidden acts',[39] its classification constructed 'a personage, a past, a case history, and a childhood'.[40] Analogously, the move from a mental disorder as a *reaction* to something one *is* renders it 'everywhere present in him: at the root of all his actions because it [is] their insidious and indefinitely active principle […] It [is] consubstantial with him […] a singular nature'.[41] It is timely to mention here that Foucault's work informs this thesis more broadly. Chiefly, I draw on his opus *History of Madness* in discussing the evolution of contemporary psychiatry in Chapter 1 and his oeuvre *Discipline and Punish*[42] in analysing my participants'

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[32] Scott, 'The Medicalisation of Shyness', p. 135.
[33] Lane, *Shyness*, p. 2
[34] Ibid.
[35] Ibid.
[36] Ibid.
[37] Ibid., p. 38.
[38] Michel Foucault, *The Will to Knowledge, The History of Sexuality: I,* trans. Robert Hurley (Harmondsworoh: Penguin, 1998), pp. 42–43.
[39] Ibid.
[40] Ibid.
[41] Ibid.
[42] Michel Foucault, *Discipline and Punish [Surveiller et Punir]* trans. Alan Sheridan (Harmondsworth: Penguin, 1991[1975]).

experiences of self-surveillance in Chapter 5. I also make use of his notion of a 'reverse discourse',[43] which is explored in more detail later on in this introduction, as well as in Chapters 3 and 4.

Returning to SAD, prior to the publishing of the *DSM*'s revised third edition, this diagnostic category remained somewhat under-researched within the psy sciences, causing Michael R. Liebowitz et al. to term it the 'neglected anxiety disorder' in 1985.[44] The next eight years, including the publication of the revised third edition of the *DSM* in 1987, saw increasing interest in SAD, which led to its being named 'one of the most common psychiatric diagnoses in the Western world'.[45] Clinics researching and treating Anxiety Disorders proliferated, opening in the US, Canada, and the UK.[46] SAD was called the 'Disorder of the Decade' in the press,[47] with estimates of prevalence in the US population rising from 3.7%[48] to 18.7%.[49] More recently, in 2004, the Social Phobia/Social Anxiety Association stated the figure as being 7%, which still makes it the third most common mental health issue globally.[50] In the same year, co-directors of the Shyness Institute gravely described SAD as a 'public health danger that appears to be heading toward epidemic proportions'.[51] Kate Hilpern had already made a similar claim in 1998, telling us

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[43] Foucault, *The Will to Knowledge*, p. 101.
[44] Michael R. Liebowitz, Jack M. Gorman, Abby J. Fyer, and Donald F. Klein, 'Social Phobia: Review of a Neglected Anxiety Disorder', *Archives of General Psychiatry,* 42.7 (1985), 729–36 <doi: 10.1001/archpsyc.1985.01790300097013> [accessed 3 January 2021].
[45] Lane, *Shyness*, p. 6.
[46] Ibid., p. 4.
[47] Psychology Today, *Disorder of the Decade* (1993) <https://www.psychologytoday.com/intl/articles/199307/disorder-the-decade> [accessed 7 January 2021] cited in Lane, *Shyness*, pp. 4–5.
[48] National Institute of Mental Health <http://www.nimh.nih.gov/publicat/phobiafacts.cfm> [accessed June 8, 2006] cited in Lane, *Shyness*, pp. 4–5.
[49] Murray B. Stein, John R. Walker, and David R. Forde, 'Setting Diagnostic Thresholds for Social Phobia', *American Journal of Psychiatry,* 151.3 (1994), 408–12 <doi: 10.1176/ajp.151.3.408> [accessed 3 January 2021], p. 408, cited in Lane, *Shyness*, pp. 4–5.
[50] Social Anxiety Association, *Social Phobia* (2004) <http://www.socialphobia.org/> [accessed 27 July 2004] cited in Scott, 'The Medicalisation of Shyness', p. 136.
[51] Lynne Henderson and Philip Zimbardo, *The Shyness Home Page* (2004) <www.shyness.com/encyclopedia.html> [accessed 12 October 2006] cited in Lane, *Shyness*, p. 5.

that 'pre-millennial "shrinking violet syndrome"'[52] was 'reaching epidemic proportions'.[53] Meanwhile, psychiatrists wondered whether those seeking help were not merely 'the tip of the social phobic iceberg';[54] they pondered whether 'public speaking phobia should be classified separately from the other Social Phobias'.[55]

As dialogue surrounding SAD began to grow, so too did speculation as to how best to treat it. Dr Murray Stein, who was involved in shyness studies at the University of California, was often present on US television and in pharmaceutical literature alike, wherein he encouraged the public to seek treatment for their social anxiety.[56] Shyness had become subject to 'medicalisation' which, as academic Peter Conrad tells us, means 'to make medical'.[57] This reframing of shyness made headlines, in much the same way as prevalence had, with one article titled 'You're Not Shy, You're Sick'.[58] The *Wall Street Journal* featured an article on medicating for SAD, entitled 'Easing Stage Fright Could Be as Simple as Swallowing a Pill'. The pill in question was an antidepressant, or Selective Serotonin Re-uptake Inhibitor (SSRI), notably paroxetine.[59]

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[52] Kate Hilpern, 'You're too Shy, Shy', *Frank Magazine*, 150.3 (1998), p. 150, cited in Scott, 'The Medicalisation of Shyness', p. 137.
[53] Ibid.
[54] Richard G.Heimberg, Craig S. Holt, Franklin R. Schneier, Robert L. Spitzer, and Michael R. Liebowitz, 'The Issue of Subtypes in the Diagnosis of Social Phobia', *Journal of Anxiety Disorders*, 7.3 (1993), 249–69., cited in Lane, *Shyness*, p. 5.
[55] Robert L. Spitzer and Janet B. W. Williams, 'Proposed Revisions in the DSM-III Classification of Anxiety Disorders based on Research and Clinical Experience', in *Anxiety and the Anxiety Disorders,* ed. by A. Hussain Tuma and Jack Maser (Hillsdale, NJ: Lawrence Erlbaum, 1985), p. 769, cited in Lane, *Shyness*, p. 5.
[56] Lane, *Shyness*, pp. 4–5.
[57] Peter Conrad, 'Medicalization and Social Control', *Annual Review of Sociology,* 18 (1992), 209–32 <www.jstor.org/stable/2083452> [accessed 3 January 2021].
[58] Colby Cosh, '"You're not Shy, You're Sick: Psychiatrists Discover a Crippling "Social Anxiety Disorder" that Affects 13% of Us', *The Report* (June 19, 2000), 49–50, cited in Lane, *Shyness*, pp. 4–5.
[59] Robert Langreth, 'Drugs: Depression Pill may Help Treat the Acutely Shy', *Wall Street Journal* (May 3, 1999). Elyse Tanouye, 'Easing Stage Fright Could Be as Simple as Swallowing a Pill', *Wall Street Journal* (June 30, 1997; Eastern ed.), cited in Lane, *Shyness*, pp. 4–5.

Author Lisa Appignanesi has critiqued this medicalising of shyness in describing Columbia University's mental health screening programme, 'Teen Screen'. Her sentiment echoes Thomas Szasz's commentary of modern psychiatry's over-zealous medicalising, which he describes as 'the widespread passion to describe the most diverse human experiences and phenomena in medical or pseudomedical terms'.[60] Appignanesi describes how 'Teen Screen' exemplifies the way in which people 'learn the brackets and language into which they can wedge their often inchoate feelings. These are then arranged into today's fashionable diagnoses: panic disorder, social phobia, generalised anxiety, social anxiety disorder, for which Paxil has been widely sold'.[61] Crucially for my own work, she points out that '[t]he programme may indeed also have helped edge the common teenage "social anxiety" into the category of illness'.[62] On this point, Sasha Claire McInnes, in a parodic pharmaceutical advertisement, describes how psychiatry and big pharma have colluded in medicalising shyness, the treatment for which can now be found in pill form:

> <u>Are you shy? Having trouble feeling comfortable with people?</u>
>
> Don't despair. While you may have long considered shyness to be just another element of your personality, medical 'science' has decided that this trait is the expression of a chronic mental disorder. The American Psychiatric Association asserts that there are 35 million people adrift on a

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[60] Szasz, *The Myth of Mental Illness*, p. 87.
[61] Lisa Appignanesi, *Mad, Bad and Sad: A History of Women and the Mind Doctors from 1800 to the Present* (London: Virago, 2008), pp. 531–32.
[62] Ibid.

sea of morbid shyness (Social Phobia) and the US Federal Drug Agency (FDA), in May 1992, gave approval to SmithKlineBeecham to market Paxil as the fix.[63]

Although, arguably, pharmacological treatment is not marketed quite so aggressively in the UK as in the US, SAD persists today as a distinct mental disorder in psychiatric diagnostic manuals in both countries. The *DSM-5* boasts 'Social Anxiety Disorder (Social Phobia)'[64] and its UK counterpart, the 10th edition of the *International Classification of Diseases* (ICD) lists 'Social Anxiety Disorder'[65] as discrete diagnoses. The concordance between these two diagnostic manuals is to such an extent that, in 1999, the APA released a *DSM-IV International Version*,[66] in which the *DSM-IV* codes are given alongside their *ICD-10* 'equivalents'. The fifth, and latest, edition of the *DSM* also features this equivalency.[67] By extension, the two manuals' diagnostic criteria for SAD are largely concurrent.

The *DSM*-5's diagnostic criteria are as follows:

A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).

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[63] Sasha Claire McInnes, 'The Political Is Personal–Or, Why Have a Revolution (from within or without) when you Can Have Soma?' *Feminist Review,* 68.1 (2001), 160–66 <doi: 10.1080/01417780110042455> [accessed 3 January], p. 160.

[64] APA, *Diagnostic and Statistical Manual of Mental Disorders [DSM-5]* (Washington, DC: American Psychiatric Association Publishing, 2013) <https://ebookcentral.proquest.com/lib/bham/reader.action?docID=1811753> [accessed 6 January 2021].

[65] World Health Organization [WHO], 'Social Phobias', *International Classification of Diseases,* 10th edn [*ICD-10*] (2016) <https://icd.who.int/browse10/2016/en#F40.0> [accessed 25 September 2020].

[66] Gavin Andrews, Tim Slade, and Lorna Peters, 'Classification in Psychiatry: ICD-10 versus DSM-IV', *The British Journal of Psychiatry,* 174.1 (1999), 3–5 <doi: 10.1192/bjp.174.1.3> [accessed 4 January 2021], p. 3.

[67] APA, *DSM-5*, pp. xiii-xl.

Note: In children, the anxiety must occur in peer settings and not just during interactions with adults.

B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others).

C. The social situations almost always provoke fear or anxiety.

Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.

D. The social situations are avoided or endured with intense fear or anxiety.

E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.

F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.

J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.

Specify if:

Performance only: If the fear is restricted to speaking or performing in public.[68]

Throughout the thesis, I will critically engage with the *DSM-5*'s diagnostic criteria and its exposition of SAD, and related diagnoses, as well as dominant UK treatment protocols.[69] Having outlined the history of SAD, it is time to elaborate on the rationale behind this research.

Rationale and Conceptual Framework

Despite the past two and half decades bearing witness to an increase in SAD research within the psy sciences, the research outside of these disciplines and especially concerning women, among whom SAD is more prevalent,[70] is still lacking. As such, research which interrogates the extent to which female socialisation contributes to the experience of social anxiety is long overdue and crucial, especially since psy science explanations for this discrepancy have tended to fall back on biologically reductive arguments.[71] That is, hormones, genetics, and reproductive processes are frequently cited as causative agents. Theoretical approaches similar to my own, which I outline in more detail shortly, and more comprehensively in Chapter 2, have been applied to other mental health issues which are found more

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[68] APA, *DSM-5*, pp. 202–03.
[69] For a more detailed account, see 'Social Anxiety Disorder (Social Phobia)' in APA, *DSM-5*, pp. 202–08.
[70] David J. De Wit, Michelle Chandler-Coutts, David R. Offord, Gillian King, Janette McDougall, Jacqueline Specht, and Shannon Stewart, 'Gender Differences in the Effects of Family Adversity on the Risk of Onset of DSM-III-R Social Phobia', *Journal of Anxiety Disorders,* 19.5 (2005), 479–502 <doi: 10.1016/j.janxdis.2004.04.010> [accessed 4 January 2021].
Hans-Ulrich Wittchen, Murray B. Stein, and Ronald C. Kessler, 'Social Fears and Social Phobia in a Community Sample of Adolescents and Young Adults: Prevalence, Risk Factors and Co-morbidity'*, Psychological Medicine*, 29.2 (1999), 309–23 <doi: 10.1017/s0033291798008174> [accessed 4 January 2021].
Maya Asher, Anu Asnaani, and Idan M. Aderka, 'Gender Differences in Social Anxiety Disorder: A Review', *Clinical Psychology Review,* 56 (2017), 1–12 <doi: 10.1016/j.cpr.2017.05.004> [accessed 4 January 2021].
[71] E.g. Margaret Altemus, 'Sex Differences in Depression and Anxiety Disorders: Potential Biological Determinants', *Hormones and Behavior,* 50. 4 (2006), 534–38 <doi: 0.1016/j.yhbeh.2006.06.031> [accessed 4 January 2021].
Lisa S. Weinstock, 'Gender Differences in the Presentation and Management of Social Anxiety Disorder', *The Journal of Clinical Psychiatry*, 60 (Suppl9) (1999), 9–13 <https://psycnet.apa.org/record/1999-05175-002> [accessed 4 January 2021].

often in women. These include Eating Disorders,[72] Depression,[73] and, retrospectively, Hysteria.[74] However, SAD has hitherto not been met with the same scrutiny, despite research which positions it as the third most prevalent mental health issue globally.[75] More recently, Scott has explored the sociology of the related concept of 'shyness' using Goffman's theory of dramaturgy.[76] However, Scott does not focus on gender, nor does her approach draw explicitly on anti-psychiatry, feminist science studies, or critical and medical humanities perspectives.

By contrast, my approach is informed by the 'anti-psychiatry' movement, which has its roots in the 1960s. This movement formed as a critique of the emerging field of psychiatry, and sought to render 'mental illnesses' intelligible, or comprehensible as rational responses to one's circumstances. Ronald David Laing, one of the movement's forerunners, famously described insanity as 'a perfectly rational adjustment to an insane world'.[77] While the movement has primarily directed its attentions to schizophrenia and psychosis,[78] this thesis is novel in that it applies tenets of anti-psychiatry to SAD in women.

The second strand of my approach is informed by feminism, specifically feminist science studies. That is, I expose implicit gender biases in both diagnostic criteria and the way that medicine and psychiatry treat

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[72] Fallon et al., *Feminist Perspectives on Eating Disorders.*
[73] Stoppard, *Understanding Depression.*
[74] Showalter, *The Female Malady.*
[75] Ronald C. Kessler and T. Bedirhan Üstün (eds.), *The WHO World Mental Health Surveys: Global Perspectives on the Epidemiology of Mental Disorders* (New York: Cambridge University Press, 2008).
[76] Susie Scott, 'The Red, Shaking Fool: Dramaturgical Dilemmas in Shyness', *Symbolic Interaction,* 28.1 (2005), 91–110 <doi: 10.1525/si.2005.28.1.91> [accessed 4 January 2021].
Susie Scott, 'The Shell, the Stranger and the Competent Other: Towards a Sociology of Shyness', *Sociology,* 38.1 (2004), 121–37 <doi: 10.1177/0038038504039364> [accessed 4 January 2021].
Scott, 'The Medicalisation of Shyness'.
[77] Ronald David Laing, quoted in Larry Chang, *Wisdom for the Soul: Five Millennia of Prescriptions for Spiritual Healing* (Washington DC: Gnosophia Publishing, 2006), p. 412.
[78] Ronald David Laing, *The Divided Self: An Existential Study in Sanity and Madness* (London: Tavistock Publications Ltd., 1965).
David Cooper, *Psychiatry and Anti-psychiatry,* 2nd edn (St. Albans: Paladin, 1972).

women presenting with distress: distress which can often be understood as arising from women's position in a subordinated social role. I draw on thinkers such as Jane M. Ussher[79] and Phylis Chesler,[80] whose research provides a feminist response to anti-psychiatry. On why this response is needed, feminist literary critic Elaine Showalter notes that a number of Laing's case studies feature women who are struggling with resolving conflicting ideas about femininity, but 'these potential theories of gender are not developed in themselves'.[81] I explicitly address this absence in Chapter 5.

My intention is, chiefly, to critique the biological focus that pervades present-day discourses, both inside and outside of psychiatry, on mental health. However, it is worth noting that even when psychiatry is not biologically reductive, the focus is on changing the individual. Sociologists call this the 'social pathology'[82] or 'individual pathology' model, which states that the 'pathology' is within an individual, as opposed to their environment. In turn, this pathology, rather than the society in which they live, is presented as being the cause of the individual's distress. Scott critiques this model in saying that it is 'an extension of [the] pervasive social attitude of disapproval towards those who fail to conform to certain values of contemporary Western culture'.[83] Applying this to shyness in particular, she tells us that, in a society where 'loquacious vocality'[84] is highly prized, 'the reticent stand out as modern-day folk devils.'[85]

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[79] Jane M. Ussher, *Women's Madness: Misogyny or Mental Illness?* (London: Harvester Wheatsheaf, 1991).
[80] Phyllis Chesler, *Women and Madness* (London: Allen Lane, 1974).
[81] Showalter, *The Female Malady*, p. 231.
[82] Milena Büchs, 'Social Pathology', *The Blackwell Encyclopedia of Sociology* (2007) <doi: 10.1002/9781405165518.wbeoss173> [accessed 4 January 2021].
[83] Scott, 'The Medicalisation of Shyness', p. 134.
[84] Stanley Cohen, *Folk Devils and Moral Panics: the Creation of the Mods and Rockers* (London: MacGibbon and Kee 1972), cited in Scott, 'The Medicalisation of Shyness', p. 134.
[85] Ibid.

On the individual pathology model, P. Susan Penfold and Gillian Walker note that while society presents problems for individuals, so too does it mandate the solving of these problems *by individuals*.[86] Since these problems are much larger in scope than the individual in question, for instance, arising from structural inequalities such as sexism or racism, the individual has little chance of being able to action change, and hence solve their particular problem. Likewise, the psy sciences treat individuals, as opposed to seeking to change society. On this point, Lane positions Social Phobia, as well as the closely related Avoidant Personality Disorder, as 'complex, sometimes appropriate, signs of noncompliance with social norms — meaning the problem extends from the individual to the wider community and culture'.[87] As social psychologist Elliott George Mishler tells us, 'medical discourses may frame diseases as a deviation from normal functioning, but in some cases it is appropriate to ask, "deviant for whom?".'[88] It is worth entertaining the possibility that 'shyness is only a "problem" when others define it as such'.[89]

To explore why social anxiety could be construed as a form of deviance, it is salient to review Scott's exposition of shyness as a type of rule-breaking in interactions. '[I]n everyday life', Scott tells us, 'there is an expectation that "normal" (non-shy) people will display a certain level of interactional competence.'[90] The shy person presents 'a threat to this order in that their "moves" are unexpected and uncoordinated with those around them'.[91] Moreover, 'shyness in itself can be perceived as such a threat to the flow of interaction, insofar as it is sometimes misinterpreted as rudeness or aloofness.'[92] Building upon Scott's

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[86] P. Susan Penfold and Gillian Walker, *Women and the Psychiatric Paradox* (Milton Keynes: Open University Press, 1984), p. 49.
[87] Lane, *Shyness*, p. 168.
[88] Elliott George Mishler, 'Critical Perspectives on the Biomedical Model', in *Perspectives in Medical Sociology,* ed. by Phil Brown (Belmont, CA: Wadsworth, 1989) cited in Scott, 'The Medicalisation of Shyness', p. 139.
[89] Howard S. Becker, *Outsiders: Studies in the Sociology of Deviance* (New York: Free Press, 1963) cited in Scott, 'The Medicalisation of Shyness', p. 148.
[90] Scott, 'The Shell, the Stranger and the Competent Other', p. 128.
[91] Ibid.
[92] Scott, 'The Red, Shaking Fool', p. 92.

analysis, I argue that, since women are expected to be responsible for the feelings and emotions of others to a far greater extent than men,[93] their being perceived as a threat to the flow of interaction is doubly threatening by virtue of their contravention of gendered norms. Scott then tells us that, rather than 'reconfigure normative standards'[94] of interaction, '[i]t is easier and more socially facilitative to blame the individual' and label them 'shy'[95] or I would add, 'socially anxious'.

The individual pathology model is thus endorsed by the way that our society frames mental health issues such as SAD. In turn, these same mental health issues have been categorised as medical problems, and hence considered to be the domain of doctors. The effect of this medicalisation is that '[r]ather than seeing certain behavior as symptomatic of problems in the social system, the medical perspective focuses on the individual [by] diagnosing and treating the illness, generally ignoring the social situation'.[96] Medicalisation and the social pathology model thus work in tandem to 'absolve the individuals or community from blame for the problems in question'[97] and allow 'the rest of society to abdicate responsibility'[98] since it 'does not have to look for social causes or solutions'.[99]

The positioning of the socially anxious woman as ill, and in need of (pharmacological) treatment such that she can function in society, therefore maintains the very social conditions, the status quo, which

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[93] Jean Grimshaw, *Philosophy and Feminist Thinking* (Minneapolis: University of Minnesota Press, 1986), p. 196, cited in Jane M. Ussher and Janette Perz, 'PMS as a Gendered Illness Linked to the Construction and Relational Experience of Hetero-Femininity', *Sex Roles*, 68. 1–2 (2013), 132–50 <doi: 10.1007/s11199-011-9977-5> [accessed 4 January 2021], p. 136.
Dana Crowley Jack, *Silencing the Self: Women and Depression* (Cambridge, MA: Harvard University Press, 1991).
Helen O'Grady, *Woman's Relationship with Herself: Gender, Foucault, Therapy* (London: Routledge, 2005).
All cited in Ussher and Perz, 'PMS as a Gendered Illness', p. 136.
[94] Scott, 'The Shell, the Stranger and the Competent Other', p. 128.
[95] Ibid.
[96] Peter Conrad, 'The Discovery of Hyperkinesis: Notes on the Medicalization of Deviant Behavior', *Social Problems*, 23.1 (1975), 12–21 <doi: 10.2307/799624> [accessed 6 January 2021], p. 19.
[97] Penfold and Walker, *Women and the Psychiatric Paradox*, p. 147.
[98] Ibid., p. 25.
[99] Ibid.

likely contributed to her social anxiety in the first instance. I echo sociologist and psychologist Joan Busfield's thoughts on this, since she says that the individual pathology model is a 'major ground for disquiet concerning the present day regulatory apparatus surrounding mental disorder'.[100] Likewise, Scott implicitly critiques the shyness label in saying that it 'reveals as much about the underlying order of social interaction as it does about an individual's mind'.[101] Therefore, this thesis seeks to explore the 'social origins of mental disorder',[102] which have hitherto been given little attention in the case of women with SAD.

A Note on Terminology

At this juncture, I must be clear about terms I use throughout this thesis. Hereafter, 'SAD'and 'Social Anxiety Disorder' (capitalised) will be used when referring to diagnostic categories. By contrast, 'social anxiety' and 'socially anxious' (lower-case) will be used to describe the unpathologised phenomenon: that is, both discomfort or unease in interacting with others, and feelings of nervousness about being evaluated or judged in a negative light by others. This distinction in terminology is necessary since it provides a means by which I can describe these experiences without implicitly endorsing the psychiatric conception of them as illness.

In addition, as far as possible, I have attempted to de-medicalise the language around certain other characteristics and behaviours that have been pathologised by the psy sciences. Most notably, I deploy the terms 'sadness' and 'unhappiness', as opposed to 'depression'; eating *problems* as opposed to eating *disorders*; 'nervousness' and 'apprenhension' instead of 'anxiety', and so on. As with SAD, my use of the

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[100] Joan Busfield, *Men, Women and Madness* (Basingstoke: MacMillan, 1996), p. 234.
[101] Scott, 'The Shell, the Stranger and the Competent Other', p. 128.
[102] Busfield, *Men, Women and Madness*, p. 144.

medicalised terms is reserved for when I am writing about diagnostic categories and these will, like SAD, be capitalised.

Research Aims and Questions

The primary aim of this research is to interrogate how norms of femininity are implicit within the diagnostic category 'Social Anxiety Disorder'. Secondly, I aim to explore how external structural factors are implicated in women's SAD, since the increasing biomedicalisation of psychiatry has tended to neglect these contributors. In fulfilling these two aims, I seek to refute the notion that it is women with SAD who are pathological. Rather, in the spirit of Laing's sentiment, I question whether it is not the society in which they live that is 'insane'. In turn, I am advocating for a more holistic and embodied account of this mental health issue which is disproportionately represented in women.

Moreover, the psy sciences have hitherto not provided a space for women with SAD themselves to describe their own experiences. This thesis thus enables a sample of these women to describe what their lives with SAD are like and, in placing their narratives into dialogue with psychiatric diagnostic criteria, I explore the shortcomings, oversights, and gendered biases in the latter and, by extension, challenge psychiatry as an authority discourse on 'madness'.

My research questions are as follows:

- What problems are inherent in conceptualising SAD as a mental illness?
- How do my participants experience social anxiety, and how does this compare with how psychiatry conceptualises SAD?
- What are the effects of the traditional female gender role and ideals of femininity on my participants' experiences of SAD?

- How do my participants experience SAD and what insights do these experiences provide in relation to the external/social contributors to SAD?

Methodology

This thesis is based on the narratives of seven women, obtained through depth interviews. Interviews were recorded and transcribed, and the resulting transcripts were coded using general thematic analysis.[103] Participants were afforded the opportunity to amend their transcripts and provide their feedback on my analysis through member checking. Methodologically, my approach is informed by feminist standpoint theory,[104] science and technology studies and feminist scholar Donna Haraway's work on situated knowledges,[105] and reflexivity.[106] I give a more comprehensive account of my methodology in Chapter 3.

A Note on Inclusion Criteria

In order to be eligible, participants needed to be a woman with SAD, either self-diagnosed or diagnosed by a medical professional. A full discussion for the rationale behind this inclusion criterion can be found in Chapter 3, but I will summarise it here. Firstly, I am concerned with pragmatism: healthcare is not universally accessible.[107] Although the philosophy underpinning the UK's publicly-funded healthcare system, the National Health Service, is that healthcare is free at the point of delivery and available to all,

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[103] Virginia Braun and Victoria Clarke, 'Using Thematic Analysis in Psychology', *Qualitative Research in Psychology,* 3.2 (2006), 77–101 <doi: 10.1191/1478088706qp063oa> [accessed 4 January 2021].
[104] Nancy Hartsock, 'The Feminist Standpoint: Developing the Ground for a Specifically Feminist Historical Materialism', in *Feminism and Methodology,* ed. by Sandra Harding (Indiana University Press and Open University Press: Bloomington and Indianapolis; Milton Keynes, 1987), 157–80.
[105] Donna Haraway, 'Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective', *Feminist Studies,* 14.3 (1988), 575–99 <doi: 10.2307/3178066> [accessed 4 January 2021].
[106] Alvin W. Gouldner, *The Coming Crisis of Western Sociology* (London: Heinemann, 1971).
[107] Jennifer Vanderminden and Jennifer J. Esala, 'Beyond Symptoms: Race and Gender Predict Anxiety Disorder Diagnosis', *Society and Mental Health,* 9.1 (2019), 111–25 <doi: 10.1177/2156869318811435> [accessed 3 January], p. 113.
Sian Ferguson, 'Self-Diagnosing Mental Illness Isn't Perfect, but here's why It Can Be Necessary', *Everyday Feminism* (2017) <https://everydayfeminism.com/2017/02/self-diagnosing-mental-illness/> [accessed 7 January 2021].

this is not always the case in practice and indeed, access to services oftentimes varies geographically. Mental health services are a case in point, for investment therein has been found to drastically vary by region, with charity *Mind* likening mental health spending to a 'postcode lottery'.[108] In addition, the Covid-19 pandemic has seen the shutting down of non-Covid-19 services during the 'first wave'. This has reduced the availability of mental health services, creating a backlog,[109] and thereby increasing waiting times even further.[110]

A further contributor to my inclusion of self-diagnosed participants is that previous research indicates that one third of individuals are not explicitly told their diagnosis when seeking medical treatment in primary care — which is where the NHS recommends first seeking help for SAD in the UK[111] — irrespective of presenting complaint.[112] This decision was also made in light of the observation that psychiatric diagnoses, such as SAD, are merely descriptive,[113] as opposed to representing an underlying cause.[114] To insist upon an official diagnosis would risk endorsing the idea that the socially anxious

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[108] Mind, *NHS Figures Reveal Mental Health Spending Postcode Lottery* (2019) <https://www.mind.org.uk/news-campaigns/news/nhs-figures-reveal-mental-health-spending-postcode-lottery/> [accessed 19 February 2021].
[109] British Medical Association [BMA], *Pressure Points in the NHS* (2021) <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressure-points-in-the-nhs> [accessed 22 February 2021].
[110] NHS England, *Consultant-led Referral to Treatment Waiting Times Data 2020-21* (2020) <https://www.england.nhs.uk/statistics/statistical- work-areas/rtt-waiting-times/rtt-data-2020-21/> [accessed 22 February 2021], cited in Shaun Griffin, 'Covid-19: Waiting Times in England Reach Record Highs', *British Medical Journal* (2020) 370.m3557, 1 <doi: 10.1136/bmj.m3557> [accessed 22 February 2021].
[111] NHS, *Social Anxiety Disorder (Social Phobia)* (2020) <https://www.nhs.uk/conditions/social-anxiety/> [accessed 7 January 2021].
[112] John Heritage, 'Revisiting Authority', in *Diagnosis as Cultural Practice*, ed. by Judith Felson Duchan and Dana Kovarsky (Mouton de Gruyter, 2005) <https://r2.vlereader.com/Reader?ean=9783110199802> [accessed 6 January 2021], 83–102, p. 88.
[113] Stijn Vanheule, *Diagnosis and the DSM: A Critical Review* (Basingstoke and New York: Palgrave MacMillan, 2014). Kenneth S. Kendler and Josef Parnas (eds.), *Philosophical Issues in Psychiatry: Explanation, Phenomenology, and Nosology* (Johns Hopkins University Press, 2008) <http://ebookcentral.proquest.com/lib/bham/detail.action?docID=4398485> [accessed 6 January 2021], p. 373. Alison Faulkner and Vicky Nicholls, *Towards a Radically Different Mental Health System* (n.d.) <www.critpsynet.freeuk.com/Faulkner.htm> [accessed 7 January 2021].
[114] Robert West, Lee Kennedy, and Anna Carr, *The Rehabilitation of Speech, A Textook of Diagnostic and Corrective Procedures based upon a Critical Study of Speech Disorders* (Revised edn) (New York: Harper, 1947), p. 61, cited in

woman's experience is underpinned by something (biological), which not only has not been established, but runs counter to my problematisation of both the biological reductionism and subscription to the social pathology model in contemporary psychiatry.

As such, I shaped my inclusion criteria on the basis of my critical conception of psychiatric diagnoses. This involved problematising biological reductionism,[115] drawing on existing critiques of psychiatric diagnoses which describe them as disempowering,[116] stigmatising,[117] and diminishing of personhood.[118] With that said, diagnoses can also be empowering:[119] they can be used as a means by which to resist the pathological meaning originally ascribed to the given label. In writing of the 'homosexual', Foucault calls this phenomenon 'reverse discourse'.[120] Following Foucault, philosopher Ian Hacking tells us that the term 'homosexual' was originally 'applied by the knowers to the known,'[121] but was subsequently 'taken up' by those it sought to describe, resulting in gay liberation, gay pride, and coming 'out'.

Judith Felson Duchan, 'The Diagnostic Practices of Speech-Language Pathologists in American over the last Century', in Felson Duchan and Kovarsky, *Diagnosis as Cultural Practice*, 201–22, pp. 208–09.

[115] Philip Thomas and Patrick Bracken, 'Power, Freedom, and Mental Health: A Postpsychiatry Perspective', in *Liberatory Psychiatry,* ed. by Carl I. Cohen and Sami Timimi (Cambridge: Cambridge University Press, 2008), 35–54, p. 49.

[116] David C. Giles and Julie Newbold, 'Self- and Other-diagnosis in User-Led Mental Health Online Communities', *Qualitative Health Research,* 21.3 (2010), 419–28 <doi: 10.1177/1049732310381388> [accessed 4 January 2021], p. 427.

[117] Joseph L. Baird, Stephen P. Hinshaw, and Sheree L. Toth, *The Mark of Shame: Stigma of Mental Illness and an Agenda for Change* (Oxford University Press Incorporated, 2006) <http://ebookcentral.proquest.com/lib/bham/detail.action?docID=415914> [accessed 6 January 2021], p. 232.
Ramotse Saunders, Amjad Hindi, and Ipsit Vahia, 'A New Psychiatry for a New World: Postcolonialism, Postmodernism, and the Integration of Premodern Thought into Psychiatry', in *Liberatory Psychiatry,* ed. by Carl I. Cohen and Sami Timimi (Cambridge: Cambridge University Press, 2008), 205–34, p. 212.

[118] Barbara G. Bokhour, 'A Diagnosed Life in an Institutional Setting: Can the Dancer Walk?' in Felson Duchan and Kovarsky, *Diagnosis as Cultural Practice*, 33–63, p. 34.
Judith Felson Duchan and Dana Kovarsky, 'Introduction', in Felson Duchan and Kovarsky, *Diagnosis as Cultural Practice*, 1–14, p. 9.

[119] Baird et al., *The Mark of Shame*, p. 232.

[120] Foucault, *The Will to Knowledge*, p. 101.

[121] Ian Hacking, 'The Looping Effects of Human Kinds', in *Causal Cognition: A Multidisciplinary Debate*, ed. by Dan Sperber, David Premack, and Ann James Premack (Oxford: Oxford University Press, 1995) <doi: 10.1093/acprof:oso/9780198524021.003.0012> [accessed 6 January 2021], 351–83, p. 381.

In the spirit of relativising the power of psychiatry, my decision to include women who are self-diagnosed supports the idea that psychiatric diagnoses are useful insofar as they serve the individual, and individuals are free to choose the terms which they feel describe their experience.[122] Drawing on Hacking's idea of self-ascription[123] and feminist theorist and philosopher Sandra Harding's notion that women can be knowers,[124] I take the view that my participants are experts on their experience and therefore their self-diagnoses tell us just as much, perhaps more, than professional diagnoses.

My decision to include self-diagnosed women was also inspired by the interplay between popular and psychiatric discourses. That is, the latter filters into the former such that women's symptoms of psychological suffering are 'mimetic' in order to be intelligible.[125] This means that when official diagnosis is sought, self-diagnosis precedes it, and the official diagnosis is confirmatory.[126] Moreover, drawing on self-narrative theory,[127] women's self-concept is susceptible to cultural ideas about social anxiety which, whether the woman is officially diagnosed or not, function to position her as 'mentally ill'. Consequently, the effects of psychiatric, and popular, mental health discourse on women with SAD is explorable with or without an official diagnosis.

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[122] Disability Visibility Project, *Abolition Must Include Psychiatry* (2020) <https://disabilityvisibilityproject.com/2020/07/22/abolition-must-include-psychiatry/> [accessed 7 January 2021].
[123] Hacking, 'The Looping Effects of Human Kinds', p. 381.
[124] Sandra Harding, 'Introduction: Is there a Feminist Method?', in *Feminism and Methodology,* ed. by Sandra Harding (Indiana University Press and Open University Press: Bloomington and Indianapolis; Milton Keynes, 1987), 1–15, p. 3.
[125] Jane M. Ussher, 'Diagnosing Difficult Women and Pathologising Femininity: Gender Bias in Psychiatric Nosology', *Feminism and Psychology*, 23.1 (2013), 63–69 <doi: 10.1177/0959353512467968> [accessed 4 January 2021].
[126] Paul ten Have, 'Lay Diagnosis in Interaction', *Text and Talk,* 21.1–2 (2008), 251–60 <doi: 10.1515/text.1.21.1-2.251> [accessed 8 January 2021], p. 252, cited in Cindy Suopis and Donal Carbaugh, 'Speaking about Menopause: Possibilities for a Cultural Discourse Analysis', in Felson Duchan and Kovarsky, *Diagnosis as Cultural Practice*, 263–76, p. 267.
[127] Marya Schechtman, *The Constitution of Selves* (Ithaca, NY: Cornell University Press, 1996), p. 94, cited in Ginger A. Hoffman and Jennifer L. Hansen, 'Prozac or Prosaic Diaries?: The Gendering of Psychiatric Disability in Depression Memoirs', *Philosophy, Psychiatry, and Psychology,* 24.4 (2017), 285–98 <doi: 10.1353/ppp.2017.0041> [accessed 4 January 2021], p. 287.

Researcher Positionality

My positionality is salient in that my own identity as a woman with SAD has undoubtedly influenced my decision to research the topic of this thesis: it is a topic which 'means something' to me.[128] Other feminist researchers have noted that drawing on one's first-hand experience can prove valuable.[129] This is true not only in terms of theorising about other women's narratives, but in establishing rapport during interviews.[130] Although I do not extensively divulge my own experiences, my identity vis-à-vis SAD in women provides me with a privileged episteme from which to theorise this topic.

My approach to this research is also reflexive:[131] I acknowledge how my role as interviewer might have impacted upon my participants' responses and, in turn, shaped the research project. That is, '[e]pistemologically, the researcher and participant are interconnected, both influencing the inquiry

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[128] Anne Oakley, 'Interviewing Women: A Contradiction in Terms', in *Doing Feminist Research,* ed. by Helen Roberts (London: Routledge and Kegan Paul, 1981), 30–61.
Pamela Cotterill and Gayle Letherby, '"Weaving Stories": Personal Auto/biographies in Feminist Research', *Sociology*, 27.1 (1993), 67–80 <doi: 10.1177/003803859302700107> [accessed 4 January 2021].
Pamela Cotterill and Gayle Letherby, 'The "Person" in the Researcher', in *Studies in Qualitative Methodology, Vol. 4,* ed. by Robert G. Burgess, (London: JAI Press, 1994), 107–36.
Liz Stanley and Sue Wise, *Breaking Out Again: Feminist Ontology and Epistemology* (London: Routledge, 1993).
Jane Ribbens and Rosalind Edwards, *Feminist Dilemmas in Qualitative Research: Public Knowledge and Private Lives* (London: Sage, 1998).
All cited in Gayle Letherby, 'Dangerous Liaisons: An Auto/biography in Research and Research Writing', in *Danger in the Field: Risk and Ethics in Social Research,* ed. by Geraldine Lee-Treweek and Stephanie Linkogle (Taylor and Francis Group, 2000) <https://ebookcentral.proquest.com/lib/bham/reader.action?docID=166040> [accessed 6 January 2021], p. 95.
[129] Oakley, 'Interviewing Women'.
Cotterill and Letherby, '"Weaving Stories"'.
Cotterill and Gayle Letherby, 'The "Person" in the Researcher'.
Stanley and Wise, *Breaking Out Again.*
Ribbens and Edwards, *Feminist Dilemmas in Qualitative Research.*
All cited in Letherby, 'Dangerous Liaisons', p. 95.
Elizabeth Mollard, 'Exploring Paradigms in Postpartum Depression Research: The Need for Feminist Pragmatism', *Health Care for Women International*, 36.4 (2015), 378–91, p. 382.
[130] Letherby, 'Dangerous Liaisons', p. 97.
[131] Gouldner, *The Coming Crisis.*

process and the findings.'[132] I view my interviews as 'social and emotional interactive processes'[133] of knowledge production.

Thesis Structure

In addition to this introductory chapter, my thesis comprises six chapters. The first three describe my theoretical approach, provide a literature review of germane prior research, and detail my methodology regarding interviews and analysis, respectively. Chapters 4 and 5 focus on the empirical material, wherein I place my participants' narratives into dialogue with ideas from anti-psychiatry, feminist science studies, and psychiatric diagnostic criteria. The final chapter draws the thesis to a close and offers a brief summary, concluding remarks, directions for future research, and some personal reflections.

In Chapter 1, I set out the theoretical approach underpinning this research. In essence, this is informed by anti-psychiatry and feminist responses to this movement, as well as being influenced by feminist science studies. To begin, I historically situate modern-day psychiatry by briefly charting its evolution. Returning to the present day, I probe the relationship between psychiatry, big pharma, and cultural values. In closing the chapter, I offer some thoughts on the relationship between feminism and anti-psychiatry.

Chapter 2 examines critical scholarship informed by feminism or anti-psychiatry which has been used to problematise other psychiatric diagnoses. I focus on diagnoses that are overtly gendered, such as 'Pre-menstrual Dysphoric Disorder' (PMDD). I situate my approach to SAD in relation to this literature,

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[132] Mollard, 'Exploring Paradigms in Postpartum Depression Research', pp. 380–81.
[133] Christine Griffin and Ann Phoenix, 'The Relationship between Qualitative and Quantitative Research: Lessons from Feminist Psychology', *Journal of Community and Applied Social Psychology*, 4.4 (1994), 277–98 <doi: 10.1002/casp.2450040408> [accessed 4 January 2021], cited in Helen Malson, *The Thin Woman: Feminism, Post-structuralism and the Social Psychology of Anorexia Nervosa* (London and New York: Routledge, 1998), p. 103.

outlining both how I will borrow from previous work and how my research contributes to existing scholarship.

Chapter 3 is concerned with my methodology vis-à-vis the depth interviews I conduct. I outline how my participants' voices play a crucial and central role in this thesis as well as how my own positionality has shaped the research project. In forming my epistemological approach, I make use of feminist standpoint theory,[134] Haraway's situated knowledges,[135] and reflexivity.[136]

Chapters 4 and 5 are empirical chapters in which I theorise my participants' stories using perspectives informed by feminism, specifically feminist science studies, and anti-psychiatry. Chapter 4 deals with my participants' experiences of mental health diagnosis and treatment, both in terms of therapy and medication. 'Co-morbidities' form a backdrop to this entire chapter and indeed to the entire thesis. Chapter 5 deals with my participants' fears of negative evaluation, which is a cornerstone of the socially anxious woman's experience. I find strong resonance between my participants' narratives and the case studies of Laing, the gendering of which, until now, has not been fully examined. My participants' narratives open up an uncharted inner world of experiences which are made understandable by considering female socialisation. Furthermore, in much the same way that 'co-morbidities' form a backdrop to Chapter 4, the worrisome effects of social media form a motif in this chapter.

In what follows, I theorise SAD in women by exploring my participants' narratives. True to the aims of anti-psychiatry, I seek to render their experiences intelligible. Likewise, in the spirit of feminist analyses of other gendered diagnoses, I explore how female socialisation shapes the socially anxious woman's experience.

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[134] Hartsock, 'The Feminist Standpoint'.
[135] Haraway, 'Situated Knowledges'.
[136] Gouldner, *The Coming Crisis*.

CHAPTER 1

SOCIAL ANXIETY DISORDER: A DISEASE LIKE ANY OTHER?

In this chapter, I will outline the theoretical approach to be utilised throughout the thesis. Broadly, this is informed by the anti-psychiatry movement, feminist responses to this movement, and feminist science studies. Firstly, I will describe how madness came to be conceived and treated in medical terms. I will then explore the evolution of, and problematise, the dominant model used in psychiatry today: the biomedical or biological model. After this, I will examine the link between this model and the pharmaceutical industry, before discussing psychiatric medication and the strong interdependency between mental health issues and culture. In closing, I will offer some thoughts on combining a feminist and anti-psychiatry perspective in discussing women's mental health.

A History of (Anti-)psychiatry

It is usually taken for granted that what we call 'madness' has always been understood in medical terms, but this was not the case until around the nineteenth century.[137] In pre-modern times, Foucault tells us, madness was accepted as a different way of existing in the world: a mediator between order and chaos. Foucault likens sanity and madness to 'two threads' which were once 'intertwined',[138] however came to be separated by an 'act of scission'.[139] This led to their being regarded as opposites, a binary: to be sane was to be healthful and normal; to be mad was to be unwell and abnormal.

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[137] Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity* (London: Fontana Press, 1999), p. 493.
[138] Foucault, *History of Madness,* p. 25.
[139] Foucault, *Madness and Civilization*, p. xii.

Before madness became medicalised in the 1800s, doctors had only a minor role in treating the mad, whose duty of care rested with religion and common morality. Usually the community dealt with the mad by either keeping them confined indoors;[140] banishing them 'from inside the city walls, leaving them to run wild in the distant countryside';[141] committing them to the care of passing pilgrims or merchants; or throwing them into prison.[142] Foucault explains that the mad began to be confined to madhouses in the mid-seventeenth century,[143] and this extended into the 1700s. In addition to hosting the mad, madhouses were also home to the ill, those without work, and the destitute.[144] The institutionalised were thus those who posed a threat to social or financial stability and as such, their confinement met society's needs. It follows that what is called 'mental illness' could be something that is constructed, for the same purpose. This notion continues to threaten to permeate psychiatry today, and is an idea to which I will return later on in the chapter.

Since the institutionalisation of the mad involved the congregation of large numbers of mental patients in one place, it facilitated their classification and status as objects of research. Indeed, this provided fertile ground for the increasing interest in the study of madness as a medical phenomenon and patients were classified in much the same way as patients suffering from other diseases.[145] We can thus see how madness began to be medicalised.

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[140] Oliver Josef Dumolo Ralley, 'The Rise of Anti-psychiatry: A Historical Review', *History of Medicine Online*, 2012 <http://www.priory.com/history_of_medicine/Anti-Psychiatry.htm> [accessed 10 April 2019].
[141] Foucault, *History of Madness*, p. 9.
[142] Ibid., p. 10.
[143] Ibid., p. 47.
[144] Ibid., p. 66.
[145] Franz G. Alexander and Sheldon T. Selesnick, *A History of Psychiatry: An Evaluation of Psychiatric Thought and Practice from Prehistoric Times to the Present* (London: George Allen and Unwin, 1967), cited in Ralley, 'The Rise of Anti-psychiatry'.

Foucault explains in *History of Madness* that the early 1800s saw considerable strides towards psychiatry's inclusion in medicine. Figures that were viewed as being moral were entrusted with treating madness, despite lacking any expertise to this end. Examples include the doctor Phillipe Pinel, notable for his 'spectacular unchaining of the mad at Bicêtre',[146] and later the Quaker William Tuke. Indeed, the way that madness was treated around this time was not medical, and according to Foucault, both men's treatments featured a shift from physical confinement towards mental subjection. This shift is paralleled by the thoughts of anti-psychiatrist Laing, who discusses the control of psychiatric patients in the twentieth century. Whereas their confinement had previously been physical in nature, using tools such as locked doors, restraints, and straitjackets, newer methods, 'lobotomies and tranquillizers […] place the bars of Bedlam and the locked doors *inside* the patient.'[147]

In a reversal of the trend that we see today, the early-nineteenth century witnessed *men* being the majority of patients in asylums,[148] and this was something that continued until the middle of the century. Throughout the nineteenth century, however, the number of men in asylums began to decline, and by the end of the century more women were inpatients.[149] This shift, most marked between 1870 and 1910, coincided with middle-class women's organising for access to universities, jobs, and the vote.[150] The reason behind this coincidence is succinctly explained by Showalter: 'During an era when patriarchal culture felt itself to be under attack by its rebellious daughters, one obvious defence was to label women campaigning for access to the universities, the professions, and the vote as mentally disturbed.'[151]

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[146] Foucault, *History of Madness*, p. 372.
[147] Laing, *The Divided Self*, p. 12.
[148] Showalter, *The Female Malady.*
[149] Ibid., p. 51.
[150] Ibid., p. 18.
[151] Ibid.

Indeed, 'Victorian psychiatry silenced women' when they challenged the status quo.[152] On this point, McInnes, writing in 2001, speaks of proposed legislation in Canada which would subject individuals to forced treatment if they are 'non-compliant',[153] with one of the criteria for forced treatment vaguely cited as being 'inappropriate behaviour'.[154] There are echoes here of Nicola J. Smith's exposition of how, in Britian, the period between 1542 and 1736 saw both the criminalisation of sex workers and the witch trials. Women from both of these, sometimes overlapping, categories were 'positioned in opposition to honest women: like the common whore, the witch was the antithesis of the good wife and so represented a "warning to women" of the fate that could await them if they acted (or were seen to act) in noncompliant ways'.[155] Much like in the early modern and, later, the Victoria eras, we might question whether women's (non)adherence to their gender role is still given credence today when it comes to evaluating their mental health.

In terms of tracing the origins of the medicalisation of madness, Pinel encouraged viewing the mad as being ill. While differing from the views of the Tuke family, who claimed that medicine did not offer any efficacious treatments for madness,[156] Pinel's opinions were in line with the views of other prominent figures of the time, such as psychiatrist Wilhelm Griesinger. The latter believed mental ill health to be disease of the brain, namely brain lesions. He advocated for a medical model of treatment for madness, with the hope that science could provide a cure, and that the stigma-ridden label of 'mad' would be

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[152] Ibid., p. 98.
[153] McInnes, 'The Political Is Personal', p. 165.
[154] Ibid.
[155] Louise Jackson, 'Witches, Wives and Mothers: Witchcraft Persecution and Women's Confessions in Seventeenth Century England', *Women's History Review*, 4.1 (1995), 63–84 <doi: 10.1080/09612029500200075> [accessed 4 February 2021], p. 72, cited in Nicola J. Smith, *Capitalism's Sexual History* (New York, NY: Oxford University Press, 2020), p. 48.
[156] Roy Porter, *Flesh in the Age of Reason* (London: Allen Lane, 2003).

replaced by that of a medical condition.[157] The biomedical model of mental health issues, such as SAD, that is dominant today, has much in common with Griesinger's ideas. This is because, as I shall explore in due course, it attributes mental distress to biological causes, most notably a lack of particular neurotransmitters in the brain.

A number of treatments were practised in asylums throughout the 1800s, perhaps the most controversial of which included bloodletting and cold water therapy.[158] Female genital mutilation was also practised, with clitoridectomy advocated as the cure for all manner of ills, most notably by Isaac Baker Brown in his work *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy and Hysteria in Females.*[159] Indeed, women's sensitivity to mental illness[160] was often blamed on their reproductive systems and linked to pregnancy, menstruation, and menopause.[161] An example of this is reflected in an innately female disease: Hysteria, which was thought to be caused by a 'wandering womb'. Likely originating with Hippocrates,[162] this notion posited that the womb's movement around the body caused a number of diseases, ranging from shortness of breath, choking, paralysis, and palpitations.[163] Despite Greek physicians Galen's and Soranus of Ephesus' insistence that the uterus cannot move,[164] its supposed mobility remained linked to the idea of illness until the modern era.[165] A more recent example

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[157] Porter, *The Greatest Benefit to Mankind*, p. 509.
[158] Alexander and Selesnick, *A History of Psychiatry,* cited in Ralley, 'The Rise of Anti-psychiatry'.
[159] Isaac Baker Brown, *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy, and Hysteria in Females* (Dyke: Harwicke, 1866).
[160] Appignanesi, *Mad, Bad and Sad*, p. 119.
[161] Showalter, *The Female Malady,* pp. 55–56.
[162] Helen King, 'Once Upon a Text: Hysteria from Hippocrates', in *Hysteria Beyond Freud,* ed. by Sander L. Gilman, Helen King, Roy Porter, G. S. Rousseau, and Elaine Showalter (Berkeley and Los Angeles: University of California Press, 1993), 3–90.
[163] Edward Jorden, 'A Briefe Discourse of a Disease Called the Suffocation of the Mother', (1603) <https://quod.lib.umich.edu/e/eebo2/A04663.0001.001?view=toc> [accessed 3 January 2021].
[164] Laurinda S. Dixon, *Perilous Chastity: Women and Illness in Pre-Enlightenment Art and Medicine* (Ithaca and London: Cornell University Press, 1995), pp. 19–20.
[165] Gilman et al., *Hysteria Beyond Freud,* p. 118.

of the inherently feminine being implicated in mental disorder is given by Jane M. Ussher and Janette Perz in discussing Pre-menstrual Dysphoric Disorder (PMDD). They characterise this as

> [A]n archetypal example of normal female experience being positioned as mad, resulting in women taking up (or being given) a psychiatric diagnosis, with consequences for how their behaviour is subsequently judged. PMDD sits in the *Diagnostic and Statistical Manual of the American Psychiatric Association*, DSM-4 [sic],[166] officially categorising premenstrual mood or behaviour change as pathology.[167]

Returning now to the era of Baker Brown, amidst controversial and female-specific 'cures' and 'treatments', madness began to be integrated into medicine. There was a synchronous fall in the number of women who ran asylums,[168] likely because medicine was deemed to be an inappropriate vocation for women.[169] Consequently, 'Victorian psychiatry thus established lunatic asylums increasingly populated by women but supervised by men',[170] and the power to specify what constituted madness therefore lay with the male psychiatrist.[171] This provided yet more fertile ground for women being pathologised.

In addition to questionable therapies specifically for women, the nineteenth century and early-twentieth centuries saw the proliferation of even more controversial methods. These included insulin therapy; electroconvulsive therapy, which continued into the late 1930s; and lobotomies, with Egas Moniz

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[166] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders,* 4th edn [*DSM-IV*] (Washington, DC: American Psychiatric Association Publishing, 2000).
[167] Lisa Cosgrove and Paula J. Caplan, 'Medicalizing Menstrual Distress', in *Bias in Psychiatric Diagnosis,* ed. by Paula J. Caplan and Lisa Cosgrove (Northvale: Jason Aronson Inc., 2004) 221–32.
Jane M. Ussher, *Managing the Monstrous Feminine: Regulating the Reproductive Body* (London: Routledge, 2006).
[168] Showalter, *The Female Malady.*
[169] Ibid., pp. 52–53.
[170] Ibid., p. 54.
[171] Ibid., p. 78.

actually being awarded a Nobel Prize in 1949 for his performing a frontal leucotomy.[172] Criticism of the asylum, and its ineffective and inhumane methods, thus started to grow from the early twentieth century onwards. In the years 1905 to 1910, pressure groups such as the Mental Hygiene Movement began to form, which sought to improve both the conditions in asylums and the treatment of the mad.[173] Therefore, the move away from the asylum and its associated methods was beginning to gain momentum, especially in light of asylums being viewed as 'monuments of therapeutic failure'.[174] As a result, psychiatry sought to distance itself from mental hospitals by establishing itself in outpatient and mental hygiene clinics, centres for child guidance, and research centres.[175] Indeed, at the time of writing, those seeking help for SAD are typically treated on an outpatient basis.[176]

At the same time as the Mental Hygiene Movement was formed, there was a marked move in healthcare from 'home remedies and patent medicines' to 'professional care provided by physicians, hospitals, and pharmacists'.[177] This coincided with the Flexner Report of 1910, which placed restrictions on medical licensure and education. It also helped to establish the hegemony of allopathic medicine, at the expense of other forms such as osteopathy and homeopathy.[178] Simultaneously, psychiatry increased its dominance in terms of treating the mad. American author and academic Joel Kovel argues that American psychiatry assumed its modern form around this time.[179] This is in line with Foucault's description of how

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[172] Baker Brown, *On the Curability of Certain Forms of Insanity*.
Porter, *The Greatest Benefit to Mankind*, p. 520.
[173] Porter, *The Greatest Benefit to Mankind*, cited in Ralley, 'The Rise of Anti-psychiatry'.
[174] Gerald Grob, *Mental Illness and American Society, 1875–1940* (Princeton: Princeton University Press, 1983), cited in Cohen, 'The Biomedicalization of Psychiatry', p. 515.
[175] Andrew Scull, 'Deinstitutionalization: Cycles of Despair', *Journal of Mind and Behavior*, 11.3–4 (1990), 301–12 <https://www.jstor.org/stable/43854093> [accessed 4 January 2021].
[176] National Institute for Health and Care Excellence [NICE], *Social Anxiety Disorder: Recognition, Assessment and Treatment* (2013) <https://www.nice.org.uk/guidance/cg159> [accessed 11 June 2019].
[177] Cohen, 'The Biomedicalization of Psychiatry', p. 515.
[178] Ibid.
[179] Kovel, 'The American Mental Health Industry'.

the start of the twentieth century saw clinicians subsuming madness into medicine and thereby justifying the physician's power over the mad.[180] It is noteworthy that Social Phobia was first mentioned by psychiatry around this time.[181]

Psychiatry enjoyed a resurgence of sorts in the mid-twentieth century, which was precipitated by psychopharmacological discoveries. These occurred at the same time as the falling out of favour of 'desperate remedies' such as ECT and insulin therapy.[182] Lithium was introduced in 1939, and antipsychotics[183] and antidepressants[184] in the 1950s; and the benzodiazepine craze occurred throughout the 1960s and 1970s.[185] All of these were to become dominant modes of treatment for mental health issues, with antidepressants now most commonly used for SAD. Psychopharmacology also catalysed the move away from institutionalisation to a community-centred model. Moreover, it reinstated the public's trust in psychiatry as a science, with the capability to treat madness.[186]

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[180] Foucault, *Madness and Civilization*, pp. 234–64.
[181] Haustgen, 'À Propos du Centenaire de la Psychasthénie'.
[182] Porter, *The Greatest Benefit to Mankind*, p. 520.
[183] Caroline King and Lakshmi N. P. Voruganti, 'What's in a Name? The Evolution of the Nomenclature of Antipsychotic Drugs', *Journal of Psychiatry and Neuroscience,* 27.3 (2002), 168–75 <https://pubmed.ncbi.nlm.nih.gov/12066446/> [accessed 4 January 2021].
[184] David Healy, 'The Antidepressant Drama', in *The Treatment of Depression: Bridging the 21st Century*, ed. by Myrna Weissman (Washington: American Psychiatric Publishing Inc., 2001), 10–11.
[185] Hugh J. Parry, 'Use of Psychotropic Drugs by US Adults', *Public Health Reports,* 83.10 (1968), 799–810 <doi: 10.2307/4593420> [accessed 4 January 2021].
Hugh J. Parry, Mitchell B. Balter, Glen D. Mellinger, Ira H. Cisin, and Dean I. Manheimer, 'National Patterns of Psychotherapeutic Drug Use', *Archives of General Psychiatry,* 28.6 (1973), 769–38 <doi: 10.1001/archpsyc.1973.01750360007002> [accessed 4 January 2021].
Mitchell B. Balter, Jerome Levine, and Dean I. Manheimer, 'Cross-National Study of the Extent of Anti-Anxiety/Sedative Drug Use', *New England Journal of Medicine*, 290 (1974), 769–74 <doi: 10.1056/NEJM197404042901404> [accessed 4 January 2021].
All cited in Jonathan M. Metzl, '"Mother's Little Helper": The Crisis of Psychoanalysis and the Miltown Resolution', *Gender and History,* 15.2 (2003), 228–55 <doi: 10.1111/1468-0424.00300> [accessed 4 January], p. 228.
[186] Porter, *The Greatest Benefit to Mankind*, cited in Ralley, 'The Rise of Anti-psychiatry'.

Social Anxiety Disorder first entered the APA's diagnostic manual, the *DSM*, in 1968.[187] The *DSM*, as well as the *ICD*, arguably function to taxonomise madness, providing psychiatry with an air of scientific objectivity, and are perhaps a reflection of the discipline's wider tendency towards medicalising human experiences.[188] It is also worth noting that, in the US, patients are usually required to have a *DSM-5*-recognised diagnosis in order to be able to claim for the cost of their treatment on their insurance.[189] This means that the manual, and its diagnoses, occupy an important place in both medical, and popular, conceptions of mental health issues in the US. In turn, this has influenced conceptions of mental health issues in the UK.

Returning now to the evolution of the biomedical model, it might be said that the mid-twentieth century's boom in psychopharmacology 'restored psychiatry's wishful identity as a "hard" science'.[190] Consequently, the biomedical model, the focus of which was on 'internal mechanism rather than external social factors',[191] seemed to show promise. In framing human problems in medical terms, psychiatry was able to stave off encroachment from competing disciplines such as psychology.[192] However, despite being bolstered by psychopharmacology, the 1960s saw psychiatry subject to criticism from both Freudians, who did not subscribe to a biomedical model, and the anti-psychiatry movement. Both of these groups seemed to pose a threat to psychiatry's credibility and its status as a legitimate

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[187] APA, *DSM-II*.
[188] Szasz, *The Myth of Mental Illness*, p. 87.
[189] Kendra Cherry, *Diagnostic and Statistical Manual (DSM) Overview* (2019) <https://www.verywellmind.com/the-diagnostic-and-statistical-manual-dsm-2795758> [accessed 11 June 2019].
[190] Porter, *The Greatest Benefit to Mankind,* p. 521.
[191] Cohen, 'The Biomedicalization of Psychiatry', p. 516.
[192] Alvin Pam, 'A Critique of the Scientific Status of Biological Psychiatry: Part II: Errors in Conception', *Acta Psychiatrica Scandinavica,* 82.S362 (1990), 1–35 <doi: 10.1111/j.1600-0447.1990.tb06868.x> [accessed 4 January 2021], p. 28.

speciality of medicine.[193] American psychiatrist George Engel, who first established the 'biopsychosocial' model of mental ill health,[194] observed that, in response to these threats, 'many psychiatrists seemed to be saying to medicine, "Please take us back and we will never again deviate from the biomedical model."'[195] More recently, psychiatrist and president of the APA, Alan Schatzberg, gave the following advice in response to the questioning of psychiatry's legitimacy: 'We need to be more medical to be taken seriously.'[196] Indeed, the biomedical model has persisted since it serves psychiatry as a 'primary source of its legitimacy as a branch of scientific medicine'.[197]

Psychiatrist Carl I. Cohen has drawn attention to the way in which the biomedical model of psychiatry 'utilizes complex classifications and statistical procedures to render the appearance of objectivity'.[198] One example of this is the way in which the *DSM-III*'s (and subsequent editions') five digit diagnostic codes 'allow for two digits to the right of the decimal point' which gives 'the impression that diagnoses are precise to within one-hundredth of each other'.[199] In reality, since these diagnoses do not represent disease entities, their numbering is wholly arbitrary and has not been, nor can it be, empirically proven or mathematically derived. Szasz has also observed the way in which the psy sciences try to emulate positivism; that is, they have typically been viewed as analogous to physics or biology: empirical sciences.

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[193] Brett J. Deacon, 'The Biomedical Model of Mental Disorder: A Critical Analysis of its Validity, Utility, and Effects on Psychotherapy Research', *Clinical Psychology Review,* 33.7 (2013), 846–61 <doi: 10.1016/j.cpr.2012.09.007> [accessed 4 January 2021].
[194] Scott A. Dowling, 'George Engel, M.D. (1913–1999)', *The American Journal of Psychiatry*, 162.11 (2005), 2039.
[195] George L. Engel, 'The Need for a New Medical Model: A Challenge for Biomedicine', *Science*, 196.4286 (1977), 129–36 <doi: 10.1126/science.847460> [accessed 4 January 2021], p. 129, cited in Deacon, 'The Biomedical Model of Mental Disorder', p. 848.
[196] Alan F. Schatzberg, 'Presidential Address', *The American Journal of Psychiatry*, 167.10 (2010), 1162–65, p. 1163 <doi: 10.1176/appi.ajp.2009.166.10.1105> [accessed 4 January 2021], cited in Deacon, 'The Biomedical Model of Mental Disorder', p. 848.
[197] Deacon, 'The Biomedical Model of Mental Disorder', p. 848.
[198] Cohen, 'The Biomedicalization of Psychiatry', p. 512.
[199] Phil Brown, 'Diagnostic Conflict and Contradiction in Psychiatry', *Journal of Health and Social Behavior*, 28.1 (1987), 37–50 <doi: 10.2307/2137139> [accessed 4 January], cited in Cohen, 'The Biomedicalization of Psychiatry', p. 518.

Szasz argues against the psy professions' inclusion in this category, since their remit is 'moral problems', which are outside the domain of science and, by extension, outside the domain of medicine.[200]

In discussing psychiatric inpatients, Chesler speaks to Szasz's point when she says that the psychiatrist 'lends a paternal air of scientific and legal efficiency' to the psychiatric facility.[201] The other professionals in the facility who are overseen by the psychiatrist, such as social workers or nurses, are, like the patients, more likely to be women.[202] The psychiatrist outdoes them all apropos of 'prestige, money and *ultimate* control over psychiatric policies'. As such, the power to determine who is mad, why, and what happens to them lies in the hands of the psychiatrist.[203] Showalter summarises the current situation rather succinctly in stating that: 'As long as women are over-represented among mental patients and family caretakers and under-represented among psychiatrists, administrators, and politicians, their lives will continue to be unhappily affected by decisions in which they take no part.'[204]

Having outlined psychiatry's origins, particularly in terms of the biomedical model, I now explore its relevance for women with SAD.

Biological Reductionism

My concern with the biomedical model arises from its being psychiatry's main approach to mental health issues, such as SAD, in the UK. Phillip Thomas, the co-founder of the Critical Psychiatry Network, an organisation of psychiatrists which has its roots in some of the ideas found in anti-psychiatry, seems to share my concern. In his paper, 'Challenging the Globalisation of Biomedical Psychiatry', Thomas and

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[200] Szasz, *The Myth of Mental Illness*.
[201] Chesler, *Women and Madness*, p. 60.
[202] Ibid.
[203] Ibid., p. 59.
[204] Showalter, *The Female Malady*, p. 249.

colleagues call Britain 'a bastion of biomedical psychiatry'.[205] The biomedical approach to mental health issues has also recently come under fire by the British Psychological Society's division of clinical psychology, who released a statement expressing scepticism regarding the emphasis placed on this model by psychiatry, as well as psychiatry's use of drugs.[206] Clinical psychologist Brett J. Deacon describes this model as 'an accepted reality' in the US,[207] where it seems to enjoy a more unquestioned position due to the commercialisation of healthcare and the power of 'big pharma'.

Cohen argues that it is not inherently problematic to explore the biological contributors to mental health issues like SAD since humans are, after all, biological beings.[208] However, problems do arise when 'psychosocial approaches to mental disorder are eschewed in favor of biological theories and treatments'.[209] This eschewing has been called 'biological reductionism': 'That is, explanations of phenomena occurring at several levels (e.g., social, psychological) that are sought at a single level (biology)'.[210] British medical doctor Bruce G. Charlton criticises the very basis of biological models of psychiatry in that they seek to explain the aetiology of mental health issues, which are multifaceted, by delving deeper into the brain.[211] Like Cohen, he calls this 'reductionism: the view that the bigger and

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[205] Philip Thomas, Patrick Bracken, Paul Cutler, Robert Hayward, Rufus May, and Salma Yasmeen, 'Challenging the Globalisation of Biomedical Psychiatry', *Journal of Public Mental Health,* 4.3 (2005), 23–32 <doi: 10.1108/17465729200500021> [accessed 4 January 2021], p. 30.
[206] The British Psychological Society: Division of Clinical Psychology, *The Power Threat Meaning Framework – Towards the Identification of Patterns in Emotional Distress, Unusual Experiences and Troubled or Troubling Behaviour, as an Alternative to Functional Psychiatric Diagnosis* (2018) <https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/PTM%20Framework%20%28January%202018%29_0.pdf> [accessed 10 June 2019].
[207] Deacon, 'The Biomedical Model of Mental Disorder', p. 847.
[208] Cohen, 'The Biomedicalization of Psychiatry', p. 509.
[209] Engel, 'The Need for a New Medical Model', cited in Deacon, 'The Biomedical Model of Mental Disorder', p. 847.
[210] Cohen, 'The Biomedicalization of Psychiatry', pp. 509–10.
[211] Bruce. G. Charlton, 'A Critique of Biological Psychiatry', *Psychological Medicine,* 20.1 (1990), 3–6 <doi: 10.1017/s0033291700013179> [accessed 4 January 2021], p. 5.

more complex is explained by the smaller and simpler; and that the smaller and simpler is more fundamental than the bigger and more complex'.[212]

Citing neuroscientist Steven P. R. Rose, Charlton calls these bigger or smaller ways of viewing things 'hierarchical descriptive levels'.[213] At the top of the hierarchy are disciplines such as social psychology and anthropology. Working down the hierarchy, we then have psychiatry and behavioural psychology and, as the levels become more fundamental, physiology, chemistry, materials physics, and particle physics. Charlton likens the idea of delving deeper into more fundamental disciplines to 'peeling off the skins of an onion to find a core of dense and dependable truth'.[214] He then challenges this scheme by questioning whether what he calls 'descriptive levels' are interrelated. Drawing on the thoughts of American philosopher Richard Rorty, Charlton argues that the descriptive levels are *not* related in a causal manner and indeed have no interrelationship, but rather, they are autonomous: '[T]hey are simply different ways of describing the same thing.'[215] This calls to mind Spinoza's thoughts on the mind-body relationship, which I explore in Chapter 4. Charlton argues that the lower levels cannot be called upon to explain the higher levels, because this involves invoking the methods of other levels, or disciplines, in order to solve problems or provide explanations. For the purposes of using biology to explain mental ill health, Charlton argues that

> [T]o explain psychiatric illness in terms of biochemistry (for example) is not to describe its underlying cause, but to redescribe it.[216] The individual human organism is in question. Either we

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[212] Ibid.
[213] Steven P. R. Rose, *Molecules and Minds* (Milton Keynes: Open University Press, 1987), cited in Charlton, 'A Critique of Biological Psychiatry', p. 5.
[214] Ibid.
[215] Richard Rorty, *Consequences of Pragmatism* (Brighton: Harvester, 1982), cited in Charlton, 'A Critique of Biological Psychiatry', p. 5.
[216] Rose, *Molecules and Minds*.

> can describe its abnormal behaviour and how to normalize it in terms of a medical vocabulary (equals psychiatry); or we can describe its cerebral structure, its neurochemical make-up, its pattern of heat distribution, its atomic structure, or whatever we want – but we are not talking about the cause of its behaviour, we are not explaining the behaviour. The organism is unchanged and nothing has been said about causes or explanations.[217]

Austrian psychiatrist and neurologist Viktor Frankl has made similar arguments in giving the example of a biologist who tries to explain the nature of being using only biology. Such a scientist 'has fallen prey to biologism' and, in the move from biology to biologism, 'science is turned into an ideology'.[218]

The biomedical model has been further problematised because it occludes other factors, as Engel argues: 'It assumes diseases to be fully accounted for by deviations from the norm of measurable biological (somatic) variables. It leaves no room within its framework for the social, psychological, and behavioral dimensions of illness.'[219] In unduly focussing on the biological, external factors which might contribute to the presentation of mental health issues in oppressed groups such as women — notably their existence in a subordinated position — are obfuscated. Moreover, conceptualising mental health issues as biological, 'caused by neurotransmitter dysregulation, genetic anomalies, and defects in brain structure and function',[220] and therefore innate, runs dangerously close to positing that the 'problem' lies within the woman, and not in the wider society.

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[217] Charlton, 'A Critique of Biological Psychiatry', p. 5.
[218] Viktor Frankl, 'Reductionism and Nihilism', in *Beyond Reductionism: New Perspectives in the Life Sciences,* ed. by Arthur Koestler and John Raymond Smythies (New York: MacMillan, 1970), 396–416, cited in Pam, 'A Critique of the Scientific Status of Biological Psychiatry', p. 23.
[219] Engel, 'The Need for a New Medical Model', p. 130.
[220] Deacon, 'The Biomedical Model of Mental Disorder', p. 847.

Yet, this might be the very reason why this model has enjoyed such popularity. Its occlusion of 'certain aspects of social reality'[221] is reminiscent of what sociologists call the 'social pathology' model.[222] This is the idea that pathology lies within an individual, as opposed to society, and is the cause of the given individual's distress. This is the tenet vis-à-vis SAD and women that I am seeking to refute in this research. Cohen makes a relevant argument in saying that one of the central problems with biological reductionism in psychiatry is its similarity to the social pathology model. That is, '[i]t deflects problems from social/contextual issues onto the individual.'[223] More specifically, it achieves this by attributing human behaviour to innate qualities, for instance, '"drives," instincts, neurochemicals, and genes'.[224]

As well as occluding external contributors to mental health issues,[225] biological reductionism provides a 'scientific patina' under which social issues are 'professionalized', 'removed from the realm of public discussion',[226] and placed into the domain of experts.[227] It has been argued that this is the method by which psychiatry has replaced religious devotion as a means of social control.[228] Indeed, it could be argued that this is one of the motivators for psychiatry's trying to emulate the natural sciences. As Cohen explains:

> With the decline of religious and political authority, science is one of the few remaining legitimate authorities. Any model that can emulate the scientific methods of the physical sciences lays claim

[221] Cohen, 'The Biomedicalization of Psychiatry', p. 512.
[222] Büchs, 'Social Pathology'.
[223] Cohen, 'The Biomedicalization of Psychiatry', p. 517.
[224] Ibid.
[225] Ibid.
[226] Ibid.
[227] Conrad, 'On the Medicalization of Deviance and Social Control'.
[228] Michel Foucault, *Ethics: Subjectivity and Truth: Essential Works of Michel Foucault 1954–1984, Vol. 1*, ed. by Paul Rabinow, trans. Robert Hurley and others (New York: New York Press, 1997), p. 313.

> to legitimacy. The use of nosological classifications, esoteric terminology, and statistical procedures give the appearance of objectivity, free of biases of culture or class.[229]

And, I would add, 'free of biases of gender', when, in reality, psychiatry is anything but. As American psychologist Inge K. Broverman and colleagues found, doctors' concept of the behaviours and characteristics of a 'healthy man' is the same as their concept of a 'healthy human'. By contrast, their definition of a 'healthy woman' is more emotional, dependent, and deferential while being less objective.[230] By definition, it seems that a woman cannot be a 'healthy human' or, by extension, 'mentally well'.

The relationship between biological reductionism and the social pathology model could perhaps explain why psychiatry has focused increasingly on the biomedical. In embracing the biomedical model, and being faced with social issues, society has no need to change, and extant structures which breed oppression are allowed to continue to thrive, unquestioned. American psychologist Alvin Pam has argued that this interplay has seeped into the very core of biological psychiatry, such that its practitioners engage in 'use of selected data which subtly and unwittingly may represent at times an apologia for existing social structures in the name of "science"'.[231] One such example is the prevalence of homelessness among people with severe mental health issues, which biological reductionism would posit as being the result of the mental health issues as opposed to a dearth of affordable homes.[232] Szasz perhaps sums up these apologias in saying that '[w]e now deny moral, personal, political, and social

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[229] Cohen, 'The Biomedicalization of Psychiatry', p. 511.
[230] Inge K. Broverman, Donald M. Broverman, Frank E. Clarkson, Paul S. Rosenkrantz, and Susan R. Vogel, 'Sex-Role Stereotypes and Clinical Judgments of Mental Health', *Journal of Consulting and Clinical Psychology*, 34.1 (1970), 1–7 <doi: 10.1037/h0028797> [accessed 4 January 2021], cited in Chesler, *Women and Madness,* p. 65.
[231] Pam, 'A Critique of the Scientific Status of Biological Psychiatry', p. 24.
[232] Cohen, 'The Biomedicalization of Psychiatry', p. 511.

controversies by pretending that they are psychiatric problems'.[233] My own research, which focuses on social and environmental factors which have hitherto not received enough attention, therefore acts as a corrective to the dominant psy science discourses relating to women's SAD.

As previously noted, despite its shortcomings, the biomedical model is still popular today. Cohen was arguing in the 1990s that the current trend was to view one's personality traits, such as shyness, as the result of one's biology: an expression of one's genes.[234] The phenomenon of attributing mental health issues purely to biology is perhaps even stronger today than when Cohen was writing. Michelle N. Lafrance argued in 2007 that since Depression has been conceptualised as resulting from 'chemical imbalances in the brain',[235] this explanatory model 'has taken hold and currently dominates public opinion of depression',[236] especially in the US.[237] Indeed, the media often 'uncritically'[238] endorses and draws upon this model, despite evidence as to its validity being lacking. A recent, and typical, example of such endorsement is found in British weekly *OK! Magazine*, wherein the Agony Aunt responds to a letter entitled 'I'm depressed':

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[233] Szasz, *The Myth of Mental Illness*, p. 182.
[234] Presidential Lecture, Society of Biological Psychiatry, *Clinical Psychiatry News*, 17.7 (July 1989), cited in Cohen, 'The Biomedicalization of Psychiatry', p. 513.
[235] Stanley W. Jackson, *Melancholia and Depression: From Hippocratic Times to Modern Times* (New Haven, CT: Yale University Press, 1986), cited in Michelle N. Lafrance, 'A Bitter Pill: A Discursive Analysis of Women's Medicalized Accounts of Depression', *Journal of Health Psychology,* 12.1 (2007), 127–40 <doi: 10.1177/1359105307071746> [accessed 4 January].
[236] Paula Gardner, 'Distorted Packaging: Marketing Depression as Illness, Drugs as Cure', *Journal of Medical Humanities*, 24.1–2 (2003), 105–30 <doi: 10.1023/A:1021314017235> [accessed 4 January 2021], cited in Lafrance, 'A Bitter Pill', p. 128.
[237] Christopher M. France, Paul H. Lysaker, and Ryan P. Robinson, 'The "Chemical Imbalance" Explanation for Depression: Origins, Lay Endorsement, and Clinical Implications', *Professional Psychology: Research and Practice,* 38.4 (2007), 411–20 <doi: 10.1037/0735-7028.38.4.411> [accessed 4 January 2021].
[238] Jeffrey R. Lacasse and Jonathan Leo, 'Serotonin and Depression: A Disconnect between the Advertisements and the Scientific Literature', *PLoS Medicine*, 2.12 e192 (2005), 1211–16 <doi: 10.1371/journal.pmed.0020392> [accessed 4 January 2021], cited in Deacon, 'The Biomedical Model of Mental Disorder', p. 849.

> [I]t does sound to me like you are suffering from genuine clinical depression. This can be caused by a chemical imbalance in the brain and lots of people experience it at some point so there is no need to feel ashamed.[239]

American Psychiatrist Peter D. Kramer has also commented on the permeation of biological materialism through our culture, observing that 'newspaper columns, sit-coms, comic strips, talk shows – our public banter is replete with corollaries of the thesis that biology is destiny'.[240] Related to the Agony Aunt's insistence that the depressed writer should not feel shame, the biomedical model has sought to de-stigmatise. This aim should be applauded, and it goes some way to explaining why the model has endured such popularity, especially in light of its lack of supporting evidence. That said, the chemical imbalance explanation for mental health issues has been subject to increasing scrutiny and questioning,[241] and has even been refuted by psychiatrists.[242] As a result, embracing this model has been

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[239] OK!, *Dear Jordan: I'm Depressed* (2009) <https://www.ok.co.uk/celebrity-news/342653/dear-jordan-im-depressed> [accessed 7 January 2021].
[240] Peter D. Kramer, *Listening to Prozac* (London: Fourth Estate, 1994), p. xiii.
[241] Marcia Angell, 'The Illusions of Psychiatry', *The New York Times Review of Books* (2011) <http://www.nybooks.com/articles/archives/2011/ jul/14/illusions-of-psychiatry/> [accessed 18 February 2012].
Marcia Angell, 'The Epidemic of Mental illness: Why?', *The New York Times Review of Books* (2011) <http://www.nybooks.com/articles/ archives/2011/jun/23/epidemic-mental-illness-why/> [accessed 18 February 2012].
Sharon Begley, 'The Depressing News about Antidepressants', *Newsweek* (2010) <http://www.thedailybeast.com/newsweek/2010/01/28/the-depressing-news-about-antidepressants.html> [accessed 18 February 2012].
Alix Spiegel, *When It Comes to Depression, Serotonin Isn't the Whole Story* (2012) <http://www.npr.org/blogs/health/2012/01/23/ 145525853/when-it-comes-to-depression-serotonin-isnt-the-whole-story> [accessed 18 February 2012].
Lesley Stahl, 'Treating Depression: Is there a Placebo Effect?' *60 Minutes* (2012) <http://www.cbsnews.com/830118560_162-57380893/ treating-depression-is-there-a-placebo-effect/> [accessed 6 March 2012].
All cited in Deacon, 'The Biomedical Model of Mental Disorder', p. 847.
[242] Thomas R. Insel, *Mental Illness Defined as Disruption in Neural Circuits* (2011) <http://www.nimh.nih.gov/about/director/2011/mental- illness-defined-as-disruption-in-neural-circuits.shtml> [accessed 18 February 2012].
Dr Joseph Coyle, quoted in Spiegel, *When it Comes to Depression,* cited in Deacon, 'The Biomedical Model of Mental Disorder', p. 852.

found to be ‘at best ineffective and at worst potentially stigmatizing’, according to the USA’s General Social Survey in 1996 and 2006.[243] Brett J. Deacon and Grayson L. Baird observe that this is because biological models of mental ill health ‘foster the perception that the mentally ill lack control over their behavior’.[244] As a result, ‘such individuals may be viewed by the public as unpredictable, dangerous, unable to care for themselves, requiring harsher treatment, and fundamentally different from those without mental disorders.’[245] On Deacon and Baird’s latter point, this effect could prove extremely dangerous for women: the relationship between women and psychiatry has historically been problematic, and the viewpoint that people with mental health issues are fundamentally different can only further the othering and pathologising of women by psychiatry.

Ronald W. Pies, ‘Psychiatry’s New Brain-Mind and the Legend of the “Chemical Imbalance”’, *Psychiatric News* (2011) <http://www. psychiatrictimes.com/blog/couchincrisis/content/article/10168/1902106> [accessed 18 February 18 2012].
All cited in Deacon, ‘The Biomedical Model of Mental Disorder’, p. 852.

[243] Bernice A. Pescosolido, Jack K. Martin, Scott Long, Tait R. Medina, Jo C. Phelan, and Bruce G. Link, ‘A Disease Like any Other? A Decade of Change in Public Reactions to Schizophrenia, Depression, and Alcohol Dependence’, *The American Journal of Psychiatry*, 167 (2010), 1321–30 <doi: 10.1176/appi.ajp.2010.09121743> [accessed 18 March 2021], p. 1327, cited in Deacon, ‘The Biomedical Model of Mental Disorder’, p. 852.

[244] Matthias C. Angermeyer and Herbert Matschinger, ‘Labeling – Stereotype – Discrimination: An Investigation of the Stigma Process’, *Social Psychiatry and Psychiatric Epidemiology*, 40.5 (2005), 391–95 <doi: 10.1007/s00127-005-0903-4> [accessed 6 January 2021] cited in Brett J. Deacon and Grayson L. Baird, ‘The Chemical Imbalance Explanation of Depression: Reducing Blame at What Cost?’, *Journal of Social and Clinical Psychology,* 28.4 (2009), 415–35 <doi: 10.1521/jscp.2009.28.4.415> [accessed 6 January 2021], pp. 430–31.
D. J. Hill and R. M. Bale, *Measuring Beliefs about where Psychological Distress Originates and Who Is Responsible for its Alleviation* (New York: Academic Press, 1981), cited in Deacon and Baird, ‘The Chemical Imbalance Explanation of Depression’, pp. 430–31.
Sheila Mehta and Amerigo Farina, ‘Is Being “Sick” Really Better? Effect of the Disease View of Mental Disorder on Stigma’, *Journal of Social and Clinical Psychology*, 16.4 (1997), 405–19 <doi: 10.1521/jscp.1997.16.4.405> [accessed 6 January 2021], cited in Deacon and Baird, ‘The Chemical Imbalance Explanation of Depression’, pp. 430–31.

[245] Angermeyer and Matschinger, ‘Labeling – Stereotype – Discrimination’.
Hill and Bale, *Measuring Beliefs about where Psychological Distress Originates.*
Mehta and Farina, ‘Is Being “Sick” Really Better?’
All cited in Deacon and Baird, ‘The Chemical Imbalance Explanation of Depression’, pp. 430–31.

While the biomedical model of mental ill health *has* been found to reduce blame,[246] Deacon argues that this comes at a price, since these models 'reinforce concerns about the chronic and untreatable nature of mental disorders'.[247] I would argue that a focus on exogenous factors is equally capable of reducing blame as biological models, and can do so without insisting on an inherent, fundamental, and potentially unchangeable dysfunction within the woman. In addition, the biomedical model is associated with worse prognoses and 'pessimism about treatment and recovery'.[248] This is likely because, by definition, this model is deterministic, or it suggests that the problem is ingrained and therefore that the woman is powerless to change it.

Another name for the biomedical model is the 'brain disease' model,[249] that is, the idea that 'mental disorders "are recognized to have a biological cause"[250] and are "real illnesses of a real organ, the brain, just like coronary artery disease is a disease of a real organ, the heart"'.[251] The 'brain disease' claim has been refuted on a number of counts. Appignanesi points out that post-mortem brains of 'the normal' are remarkably similar to those belonging to people who have experienced mental ill health.[252] Further to this, even if mental health issues *do* correlate with brain changes,[253] it is difficult, if not impossible, to establish which came first,[254] or which is the causative factor. Appignanesi gives the following example: 'I

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[246] Ibid.
[247] Ibid.
[248] Deacon and Baird, 'The Chemical Imbalance Explanation of Depression', pp. 430–31.
[249] Donald J. Kiesler, *Beyond the Disease Model of Mental Disorders* (Westport, CT: Praeger, 2000).
[250] Thomas R. Insel, 'Faulty Circuits', *Scientific American*, 302 (2010), 44–51, p. 5.
[251] Hyman at the 1999 White House Conference on Mental Health, quoted in George W. Albee and Justin M. Joffe, 'Mental illness Is NOT an "Illness Like any Other"', *The Journal of Primary Prevention*, 24 (2004), 419–36, cited in Deacon, 'The Biomedical Model of Mental Disorder', pp. 851–52.
[252] Appignanesi, *Mad, Bad and Sad*, p. 4.
[253] G. Claridge, 'Schizotypy as a Dimension of Personality', in *Personality Psychology in Europe, Vol. 3*: *Foundations, Models and Inquiries*, ed. by G. L. Van-Heck, S. E. Hampson, J. Reykowski, and J. Zakrzewski (Lisse, The Netherlands: Swets and Zeitlinger, 1990), 31–44.
[254] Ussher, *Women's Madness*, p. 217.

feel sad when my dog dies. That causes a change in my brain. The emotion isn't caused by the brain.'[255] As Pam contends, finding biochemical abnormalities in the brains of those with mental health issues does not prove that these abnormalities 'cause' the mental health issues.[256]

The World Health Organization has claimed that: 'We know that mental disorders are the outcome of a combination of factors, and that they have a physical basis in the brain.'[257] In response to this, Deacon makes the observation that 'scientists have not identified a biological cause of, or even a reliable biomarker for, any mental disorder'. [258] Pam, writing in 1990, described biological psychiatry's history, in the case of all mental health issues, as

> [A] tale of 'promising leads' […] that seem to always represent themselves as the long-awaited breakthrough in a steady stream of scientific progress […] many scholarly assurances that the elusive constitutional mechanism must exist and is just waiting to be discovered [...] rush to print on slender evidence, medication to deduce the etiology of a disorder, hyperbole as initial reception to new work, and ultimately unproductive results. With each failure, the faith remains undaunted, simply shifting direction in its quest by optimistic lurches from one idea to another. Heuristically, a lot of research has been generated but, following about a century of effort, a harsh assessment would be that no substantive results have been tendered for any 'functional' disorder's pathogenesis.[259]

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[255] Appignanesi, *Mad, Bad and Sad*, p. 4.
[256] Pam, 'A Critique of the Scientific Status of Biological Psychiatry', p. 20.
[257] World Health Organisation, *Mental Health Global Action Plan: Close the Gap, Dare To Care* (2002) <http://www.who.int/mental_health/media/en/265.pdf> [accessed 18 February 2005], cited in Thomas et al., 'Challenging the Globalisation of Biomedical Psychiatry', p. 25.
[258] Deacon, 'The Biomedical Model of Mental Disorder', p. 847.
[259] Pam, 'A Critique of the Scientific Status of Biological Psychiatry', pp. 12–13, 18.

If the fruit of biological psychiatry's labour are as lacking as Pam contends, why does biological psychiatry persist in its search? I have explored the notion that biological models are endorsed because they reduce stigma, but this is far from the whole story. Another reason has to do with the relationship between this model and the pharmaceutical industry.

'Big Pharma'

The US might be said to be the global capital of big pharma. Yet, the UK is perhaps not as far behind the US as one might think. The UK has the third highest percentage of pharmaceutical research and development expenditure in the world, behind only the US and Japan; one in five of the world's most popular drugs were developed in the UK; proceeds from the pharmaceutical industry form 0.6% of the UK's GDP; and the UK's domestic market is the fifth largest in the world, behind only the USA, Japan, Germany, and France. Moreover, a number of leading global pharmaceutical companies, such as AstraZeneca, GlaxoSmithKline, and Eli Lilly, are based in the UK.[260]

Although my focus in the forthcoming chapters will be primarily on the UK, it is pertinent to examine some aspects of big pharma in the US insofar as they influence those in the UK. Due to UK healthcare being nationalised and US healthcare being privatised, there are key differences between the two countries. With that said, some of the concerns that have been raised about the pharmaceutical industry in the US are applicable to the UK, since both are home to private pharmaceutical companies which are regulated in similar ways. One concern, raised by Danish Doctor Peter Gøtzsche, is that the past two decades have seen 'more commercially oriented drug approval policies', leading to 'substantial flaws in

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[260] The Association of the British Pharmaceutical Industry, *Did You Know?: Facts and Figures about the Pharmaceutical Industry in the UK – Second edn* (2011) <http://www.abpi.org.uk/our-work/library/industry/Documents/Did%20you%20know_Jan11.pdf> [accessed 13 March 2019].

the way that medical evidence is produced'.[261] Although this change has occurred mainly in the US, Gøtzsche contends that it is echoed in the rest of the world.

Of the drugs that pharmaceutical companies manufacture, antidepressants are of particular relevance since five of my seven participants disclosed that they had taken, or were currently taking, antidepressants for either SAD or other mental health issues. While antidepressants were discovered some decades earlier, this class of drugs first gained significant popularity after the USA's Food and Drug Administration (FDA) approved one particular antidepressant, fluoxetine, in 1987. Fluoxetine, whose trade name is Prozac, was subsequently marketed extensively by its manufacturer, Eli Lilly.[262] This surge in popularity could be said to have reached further afield than the US and extended to other SSRIs: in 2018, almost 71 million prescriptions for antidepressants were dispensed in the UK, almost double the number prescribed in 2008.[263] This example perhaps illustrates how the (US's) pharmaceutical industry influences both the public's, and doctors', conceptions of mental health treatment not only in the US, but further afield, such as in the UK. With that said, there are other reasons why this proliferation has occurred.

In the UK, guidelines to doctors state that the antidepressant class SSRIs are considered a 'second line' treatment for SAD, after cognitive behavioural therapy (CBT).[264] Despite this, it appears questionable

[261] Peter Gøtzsche*, Deadly Medicines and Organised Crime: How Big Pharma Has Corrupted Healthcare* (New York: Radcliffe, 2013), cited in James Dickinson, 'Deadly Medicines and Organised Crime: How Big Pharma has Corrupted Healthcare' [Book Review], *Canadian Family Physician,* 60.4 (2014), 367–68, p. 367.
[262] Blair T. Johnson and Irving Kirsch, 'Do Antidepressants Work? Statistical Significance versus Clinical Benefits', *Significance,* 5.2 (2008), 54–58, p. 54.
[263] BBC News, *Jump in Antidepressant Prescriptions in England* (2019) <https://www.bbc.com/news/amp/health-47740396> [accessed 10 June 2019].
[264] S. Pilling, E. Mayo-Wilson, I. Mavranezouli, K. Kew, C. Taylor, and D. M. Clark (Guideline Development Group), 'Recognition, Assessment and Treatment of Social Anxiety Disorder: Summary of NICE Guidance', *British Medical Journal (Clinical Research Ed.),* 346.f2541 (2013) <doi: 10.1136/bmj.f2541> [accessed 18 March 2021].

whether this is actually followed in practice. Lengthy waiting lists for therapies, such as CBT,[265] seem to be a factor: one in five patients waits longer than a year.[266] Even with the advent of the Improving Access to Psychological Therapies (IAPT) programme,[267] waiting lists can still be up to several months in some regions.[268] Moreover, the situation across the country is 'patchy',[269] with just 15% of UK residents with mental health issues such as Depression and Anxiety Disorders being able to access IAPT services in 2018.[270]

This situation has been compounded by the Covid-19 pandemic, which has seen waiting lists for NHS treatment grow dramatically. The increased demand on the NHS caused by a surge in Covid patients requiring hospitalisation has meant that most non-Covid services shut down during the 'first wave', in Spring 2020, creating a substantial backlog.[271] As such, the number of patients waiting longer than a year for treatment, including for mental health issues, increased 81-fold between 2019 and 2020.[272] In addition, the demand for mental health care has increased during this time, suggesting that the pandemic has had a deleterious effect on people's mental wellbeing. Indeed, mental health charity *Mind* reports that 'more people have experienced a mental health crisis during the coronavirus pandemic than ever previously recorded'.[273]

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[265] Mind, *We Need To Talk: Getting the Right Therapy at the Right Time* (n.d.) <https://www.mind.org.uk/media/280583/We-Need-to-Talk-getting-the-right-therapy-at-the-right-time.pdf> [accessed 10 June 2019].
[266] Ibid.
[267] NHS England, *Adult Improving Access to Psychological Therapies Programme* (n.d.) <https://www.england.nhs.uk/mental-health/adults/iapt/> [accessed 7 January 2021]
[268] Mind, *We Need To Talk.*
[269] Ibid.
[270] NHS England, *Adult Improving Access to Psychological Therapies Programme.*
[271] BMA, *Pressure Points in the NHS*.
[272] NHS England, *Consultant-led Referral to Treatment Waiting Times.*
[273] Mind, *Mind Warns of 'Second Pandemic' as it Reveals More People in Mental Health Crisis than ever Recorded and Helpline Calls Soar* (2020) <https://www.mind.org.uk/news-campaigns/news/mind-warns-of-second-

Hence, the wherewithal for providing talking therapies in primary care, or referral to secondary care, seems to be limited. As such, GPs report that they often feel as though they are left with no choice but to prescribe medication when the only alternative is a long waiting list.[274] These factors, combined with the fact that UK healthcare is nationalised, create a unique situation in the UK.[275] Moreover, the NHS has recently been subject to budget cuts,[276] which have seen mental health services being badly affected.[277] In such a climate of austerity, and with the added pressure that the Covid-19 pandemic has presented, sociologist Allan Horwitz's observation is cruelly fitting: '[D]rugs [are] clearly both faster and cheaper than years of psychoanalysis.'[278] That is, I add, if and only if patients are able to access primary care in a timely manner, for the pandemic has seen a 33% reduction in GP appointments.[279]

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pandemic-as-it-reveals-more-people-in-mental-health-crisis-than-ever-recorded-and-helpline-calls-soar/> [accessed 22 February 2021].

[274] Julia Hyde, Michael Calnan, Lindsay Prior, Glyn Lewis, David Kessler, and Deborah Sharp, 'A Qualitative Study Exploring how GPs Decide To Prescribe Antidepressants', *British Journal of General Practice,* 55.519 (2005), 755–62 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1562347/> [accessed 25th September 2020], pp. 759–60.
Royal Pharmaceutical Society, 'Most GPs are Over-prescribing Antidepressants', *The Pharmaceutical Journal Online*, 272.7293 (2004), 407 <https://www.pharmaceutical-journal.com/pj-online-news-most-gps-are-over-prescribing-antidepressants/20011591.article?firstPass=false> [accessed 10 June 2019].
Emily Wooster on behalf of the We Need To Talk campaign, *While We are Waiting: Experiences of Waiting for and Receiving Psychological Therapies on the NHS* (2019) <https://www.mentalhealth.org.uk/publications/while-we-are-waiting [accessed 10 June 2019], p. 8.

[275] Anvishka Patel, *Government Must Stop Cutting Funding for 'Deteriorating' Public Health Services* (2019) <http://www.pulsetoday.co.uk/news/hot-topics/public-health-cuts/government-must-stop-cutting-funding-for-deteriorating-public-health-services/20038466.article> [accessed 10 June 2019].
British Medical Association, *Prioritising Prevention for Population Health* (2019) <https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/prioritising-prevention-for-population-health> [accessed 7 January 2021].

[276] British Medical Association, *Prioritising Prevention for Population Health.*

[277] Trade Union Congress, *Breaking Point: The Crisis in Mental Health Funding* (2018) <https://www.tuc.org.uk/sites/default/files/Mentalhealthfundingreport2_0.pdf> [accessed 10 June 2019].

[278] Allan V. Horwitz, *Creating Mental Illness* (London: University of Chicago Press, 2002), cited in Olivia Goldhill, *30 Years After Prozac Arrived, We Still Buy the Lie that Chemical Imbalances Cause Depression* (2019) <https://qz.com/1162154/30-years-after-prozac-arrived-we-still-buy-the-lie-that-chemical-imbalances-cause-depression/> [accessed 10 June 2019].

[279] This reduction occurred between between March and April 2020. See NHS Digital, *Appointments in General Practice* (2020) <https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/april-2020> [accessed 22 February 2021], cited in UK Parliament, *Waiting Times and Managing the Backlog of Appointments* (2020)

While some women's testimonies describe how antidepressants have helped them, which is something I explore in Chapter 4, Cohen problematises psychiatric medication. He argues that the actual act of prescribing in psychiatry infers that the problem is solely a biological one. This essentially erases environmental contributors, both in the mind of the patient and the clinician.[280] On this point, McInnes discusses women's 'Post Traumatic [sic] Stress Response' to gender-based violence.[281] Rather than being a biological problem, McInnes conceptualises it as '[w]omen's responses to men's violence and the stresses we face living under Patriarchy'.[282]

For the purposes of my own work, I argue that the act of prescribing or medicating is problematic insofar as it seeks solely to remedy something *within* the woman, as opposed to espousing a more holistic approach which would involve dealing with external factors. It is thus problematic in the same way as the biomedical model: that is, if it posits mental health issues as *only* internal, or innate. The notion that social anxiety in women arises solely because of inherent pathology is the idea I am challenging in this work.

We have so far seen that Pam likened biological psychiatry's search for answers to a never-ending quest, with the next breakthrough seemingly always around the corner.[283] This is reminiscent of the remarks of psychiatrist William Sargant in the mid-twentieth century, when pharmacological therapies started to take off. Sargant predicted that such drugs 'would enable doctors to "cut the cackle" of mental illness by the 1990s'.[284] Much like the many promises of the biomedical model which have yet to come to fruition,

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<https://publications.parliament.uk/pa/cm5801/cmselect/cmhealth/320/32006.htm#footnote-294-backlink> [accessed 22 February 2021].

[280] Cohen, 'The Biomedicalization of Psychiatry', p. 517.

[281] McInnes, 'The Political Is Personal', p. 161.

[282] Ibid., p. 162.

[283] Pam, 'A Critique of the Scientific Status of Biological Psychiatry'.

[284] Porter, *The Greatest Benefit to Mankind*, p. 521.

psychiatric drugs such as antidepressants are not the panacea Sargant had hoped. I want to remind the reader that in the UK, the number of prescriptions for antidepressants dispensed between 2008 and 2018 has doubled.[285] In spite of this, the prevalence of Depression and Anxiety in the UK is, at best, staying the same[286] at a rate of one in four,[287] or, at worst, increasing,[288] especially in the case of women.[289] It is salient to note that a recent study by the Institue of Fiscal Studies found that

> Mental health in the UK worsened substantially as a result of the Covid-19 pandemic – by 8.1% on average and by much more for young adults and *for women* which are groups that already had lower levels of mental health before Covid-19.[290]

At this juncture, before exploring big pharma in any more detail, it is apt for me to talk a little about the relative rates of mental health issues in men and women.

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[285] Gareth Iacobucci, 'NHS Prescribed Record Number of Antidepressants Last Year', *British Medical Journal,* 364.1508 (2019), <doi: 10.1136/bmj.l1508> [accessed 25 September 2020].
[286] Mind, *Mental Health Facts and Statistics* (2013) <https://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/#one> [accessed 10 June 2019].
[287] S. McManus, H. Meltzer, T. S. Brugha, P. E. Bebbington, and R. Jenkins, *Adult Psychiatric Morbidity in England, 2007: Results of a Household Survey* (2009) <https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-in-england-2007-results-of-a-household-survey> [accessed 10 June 2019], cited in Mind, *Mental Health Facts and Statistics.*
[288] J. Evans, I. Macrory, and C. Randall, *Measuring National Well-being: Life in the UK* (2016) <https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/measuringnationalwellbeing/2016#how-good-is-our-health> [accessed 3 October 2016] cited in Mental Health Foundation, *Fundamental Facts about Mental Health 2016* (2016) <https://www.mentalhealth.org.uk/publications/fundamental-facts-about-mental-health-2016> [accessed 10 June 2019], p. 14.
[289] S. Stansfeld, C. Clark, P. Bebbington, M. King, R. Jenkins, and S. Hinchliffe, 'Common Mental Disorders' in *Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014*, ed. by S. McManus, P. E. Bebbington, R. Jenkins, and T. Brugha (Leeds: NHS Digital, 2016) <https://openaccess.city.ac.uk/id/eprint/23646> [accessed 6 January 2021], cited in Mental Health Foundation, *Fundamental Facts about Mental Health,* p. 14.
[290] James Banks and Xiaowei Xu, 'The Mental Health Effects of the First Two Months of Lockdown and Social Distancing During the Covid-19 Pandemic in the UK', Institute of Fiscal Studies Working Paper W20/16 (2020) <doi: 10.1920/wp.ifs.2020.1620> [accessed 22 February 2021]. My emphasis.

It could be argued that, today, mental ill health is very much ‘a female malady’:[291] women form the majority of those subject to psychiatric hospitalisation; the majority of those receiving treatment from GPs for mental health; and community surveys find that a greater number of women have poor mental health compared to men.[292] More specifically, women are found to have ‘higher rates for all the neurotic disorders’:[293] that is, mental disorders ‘involving distress but not delusions or hallucinations’.[294] Anxiety Disorders are also twice as prevalent in women as in men.[295] One reason for these trends is likely to be differences in socialisation. Men are taught that they should be able to handle their problems independently, without divulging them to others. This then leaves them susceptible to other ways of coping, for instance, alcohol use, instead of seeking mental health treatment.[296] Conversely, women are taught that they can have faith in doctors and that they should communicate their problems. Hence, the chances are higher that they will seek psychiatric treatment.[297] Another reason could be that women are socialised to internalise their distress, whereas men are socialised to externalise it. While the amount of distress someone experiences has been found to be independent of their gender,[298] differing socialisation leads to differing ways of coping. It is more probable that boys will exhibit signs of antisocial

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[291] Mental Health Foundation, *Fundamental Facts about Mental Health*, pp. 3–4.
[292] Walter R. Gove and Jeannette F. Tudor, ‘Adult Sex Roles and Mental Illness’*, American Journal of Sociology,* 78.4 (1973), 812–35 <doi: 10.1086/225404> [accessed 6 January 2021].
[293] Pauline M. Prior, *Gender and Mental Health* (Basingstoke: MacMillan Press, 1999), p. 38, 44.
[294] Semel Institute for Neuroscience and Human Behaviour, *Neurotic Disorders* (2018) <https://www.semel.ucla.edu/research-condition/neurotic-disorders> [accessed 11 June 2019].
[295] Prior, *Gender and Mental Health*, p. 44.
[296] Lynne M. Cooper, Marcia Russell, Jeremy B. Skinner, Michael R. Frone, and Pamela Mudar, ‘Stress and Alcohol Use: Moderating Effects of Gender, Coping, and Alcohol Expectancies’, *Journal of Abnormal Psychology,* 101.1 (1992), 139–52 <doi: 10.1037//0021-843x.101.1.139> [accessed 6 January 2021].
Irene Gianakos, ‘Predictors of Coping with Work Stress: The Influences of Sex, Gender Role, Social Desirability, and Locus of Control’, *Sex Roles,* 46.5–6 (2002), 149–58 <doi: 10.1023/A:1019675218338> [accessed 6 January 2021].
[297] Debra J. Rickwood and Valerie A. Braithwaite, ‘Social-Psychological Factors Affecting Help-Seeking for Emotional Problems’, *Social Science and Medicine,* 39.4 (1994), 563–72 <doi: 10.1016/0277-9536(94)90099-x> [accessed 6 January 2021].
[298] Bruce Philip Dohrenwend and Barbara Snell Dohrenwend, *Social Status and Psychological Disorder: A Causal Inquiry* (New York: Wiley-Interscience, 1969), cited in Chesler, *Women and Madness*, p. 37.

behaviour, whereas girls are more likely to feel apprehensive and have decreased self-confidence – which might lead to diagnoses of Depression or Anxiety – and this trend is apparent from a young age.[299]

Although it is likely that gender socialisation is a factor in women's over-representation among those with poorer mental health, this is only true if certain diagnoses are considered. Glibly, women *do* have higher rates of mental health issues than men, yet this could be a product of the way that they are conceptualised. Personality Disorders and Substance Abuse are often excluded, considered to be 'badness', not 'madness', particularly in men.[300] As academic and social worker Pauline M. Prior notes, taking the aforementioned into account resolves the gender asymmetry.[301]

Moreover, women are over-represented among people with SAD,[302] but under-represented in the case of Anti-social Personality Disorder.[303] Several authors have noted that the latter could be conceptualised as a 'caricature' of the masculine gender role.[304] On the other hand, it could be said that SAD is an exaggeration of the stereotypically feminine gender role. Indeed, Showalter tells us that the diagnoses that psychiatry has traditionally given to men and women, who exhibit the same symptoms, are contingent on gender.[305] That is, men's diagnoses are linked to their 'intellectual and economic pressures', whereas women's diagnoses are functions of their 'sexuality and essential nature'.[306] The root of this could be the way that psychiatry has conceived of 'woman': recall that Broverman et al.

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[299] Ibid., p. 39.
[300] Prior, *Gender and Mental Health*, p. 49.
[301] Ibid., pp. 131–32.
[302] Kessler and Üstün, *The WHO World Mental Health Surveys.*
Wittchen et al., 'Social Fears and Social Phobia'.
[303] Jeremy Coid, Min Yang, Peter Tyrer, Amanda Roberts, and Simone Ullrich, 'Prevalence and Correlates of Personality Disorder in Great Britain', *The British Journal of Psychiatry,* 188.5 (2006), 423–31 <doi: 10.1192/bjp.188.5.423> [accessed 6 January 2021].
[304] Philip R. Slavney, 'Histrionic Personality and Antisocial Personality: Caricatures of Stereotypes?' *Comprehensive Psychiatry*, 25.2 (1984), 129–41 <doi: 10.1016/0010-440x(84)90001-4> [accessed 6 January 2021].
[305] Showalter, *The Female Malady.*
[306] Ibid., p. 7.

found that physicians' definitions of 'healthy man' and 'healthy woman' were informed by traditional gender roles.[307]

Having briefly outlined the ways in which women are over-represented among those with mental health issues, I will now return to my discussion of mental ill health in the UK. Not only are mental health issues seemingly on the rise, but people with these issues, who are more likely to be women, are increasingly using self-harm and experiencing suicidal thoughts. This indicates that, despite the proliferation of pharmaceuticals, people are coping with mental health issues in increasingly harmful and ineffective ways.[308] Perhaps then, pharmaceuticals such as antidepressants are not appropriate, or effective, treatments for mental health issues.

This idea gains more credence when the evidence behind pharmaceuticals' efficacy is reviewed: it is scanty, especially given that industry-sponsored trials are of poor quality, and are up to 20 times more likely to show higher efficacy than independent and placebo-controlled trials.[309] British physician Ben Goldacre has written an extensive critique of big pharma in the UK, where poor quality clinical trials are commonly performed by the same people who manufacture the drugs being trialled. Often, the trials are performed in such a way as to skew the results in favour of the drugs' efficacy.[310] Goldacre describes such skewing as 'wily tricks, close calls, and elegant mischief at the margins of acceptability'.[311] Oftentimes, he continues, statistics will be manipulated to make the trials' outcomes seem more

[307] Broverman et al., 'Sex-Role Stereotypes and Clinical Judgments'.
[308] McManus et al., *Mental Health and Wellbeing in England,* cited in Mind, *Mental Health Facts and Statistics.*
[309] Michael E. Thase, 'Do Antidepressants really Work? A Clinicians' Guide to Evaluating the Evidence', *Current Psychiatry Reports,* 10.6 (2008) 487–94 <doi: 10.1007/s11920-008-0078-2> [accessed 6 January 2021].
Lisa Bero, Fieke Oostvogel, Peter Bacchetti, and Kirby Lee, 'Factors Associated with Findings of Published Trials of Drug-Drug Comparisons: Why Some Statins Appear More Efficacious than Others', *PLoS Medicine,* 4.6 (2007) e184 <doi: 10.1371/journal.pmed.0040184> [accessed 6 January 2021], cited in Ben Goldacre*, Bad Pharma* (London: Fourth Estate, 2012), p. 2.
[310] Goldacre*, Bad Pharma*, p. xi.
[311] Ibid., p. 171.

promising than they actually are.[312] It is also not unusual for trials to be of inappropriate lengths and sizes; and new drugs are compared to drugs not used for the same purpose, in the same way, at the correct dose, or drugs which are known to not be effective.[313] Results from trials which do not show the 'correct' outcome are simply not published[314] and Goldacre contends that academic papers on a given drug are often written by employees of the companies that manufacture that drug, although this is seldom disclosed.[315] Clearly, there are conflicts of interest here, and this is also something which plagues the way that the pharmaceutical market is regulated, as I will explore later on in the chapter. On the topic of trials, I want to examine the notion of the placebo effect in the case of antidepressants; ask whether these drugs cause harm; and discuss their supposed mechanism(s) of action.

One of the 'wily tricks' Goldacre cites is examined in depth by author and academic Irving Kirsch.[316] Kirsch has said that a myriad of data, some of which are hidden by drug companies, demonstrate that antidepressants do not have a clinically significant benefit over placebo. When benefits *have* been found, they are small enough that they are below the criterion of 'clinical significance' set by the National Institute for Health and Care Excellence (NICE). NICE writes treatment guidance, including on mental health issues such as SAD,[317] for the NHS in the UK. Kirsch tells us that when antidepressants seem to show slightly more efficacy than placebos, this is because doctors and/or patients in most clinical trials 'break blind'.[318] Although antidepressants are reported, by both doctors and patients, to work well, we

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[312] Ibid., pp. 216–17.
[313] Ibid., p. 176, 180–87, 191–93.
[314] Ibid., p. 12, 407.
[315] Ibid.
[316] Irving Kirsch, 'Antidepressants and the Placebo Effect', *ZeitschriftfürPsychologie,* 222.3 (2014), 128–34 <doi: 10.1027/2151-2604/a000176> [accessed 5 January 2021], p. 128.
[317] NICE, *Social Anxiety Disorder.*
[318] Ibid.

never see how a patient improves with mere placebo.[319] As well as their efficacy being questionable, antidepressants have a number of unpleasant side effects and can cause withdrawal symptoms, if stopped.[320] Perhaps more concerning is that people who have been treated with antidepressants have a greater risk of relapsing than people who have had other treatments,[321] such as talking therapies.

Not only is it purported that antidepressants are harmful, it is questionable whether they actually work.[322] Further to this, it is still not actually understood *how* they are supposed to work. They are said to work by 'correcting the neurotransmitter imbalances that cause mental disorders'.[323] The main neurotransmitter concerned in cases of mental health issues is overwhelmingly serotonin, or more specifically, a lack of serotonin.[324] Despite the permeation of this idea into lay conceptions of mental ill health, the consensus in the scientific community seems now to be that the 50 year-old 'low serotonin' model of mental ill health is not the whole story[325] and is too simplistic.[326] Moreover, Kirsch points out

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[319] Johnson and Kirsch, 'Do Antidepressants Work?', p. 56.
[320] Kirsch, 'Antidepressants and the Placebo Effect', p. 132.
[321] Paul W. Andrews, J. Anderson Thomson, Jr., Ananda Amstadter, and Michael C. Neale, 'Primum Non Nocere: An Evolutionary Analysis of whether Antidepressants Do More Harm than Good', [Review], *Frontiers in Psychology*, 3.117 (2012) <doi: 10.3389/fpsyg.2012.00117> [accessed 6 January 2021].
M. A. Babyak, J. A. Blumenthal, S. Herman, P. Khatri, P. M. Doraiswamy, K. A. Moore, and K. R. Krishnan, 'Exercise Treatment for Major Depression: Maintenance of Therapeutic Benefit at 10 Months', *Psychosomatic Medicine*, 62 (2000), 633–38 <doi: 10.1097/00006842-200009000-00006> [accessed 6 January 2021].
Keith S. Dobson, Steven D. Hollon, Sona Dimidjian, Karen B. Schmaling, Robert J. Kohlenberg, Robert Gallop, Shireen L. Rizvi, Jackie K. Gollan, David L. Dunner, and Neil S. Jacobson, 'Randomized Trial of Behavioral Activation, Cognitive Therapy, and Antidepressant Medication in the Prevention of Relapse and Recurrence in Major Depression', *Journal of Consulting and Clinical Psychology*, 76.3 (2008), 468–77 <doi: 10.1037/0022-006X.76.3.468> [accessed 6 January 2021].
All cited Kirsch, 'Antidepressants and the Placebo Effect', p. 132.
[322] Kirsch, 'Antidepressants and the Placebo Effect', p. 128.
[323] Deacon, 'The Biomedical Model of Mental Disorder', p. 846.
[324] Kirsch, 'Antidepressants and the Placebo Effect', p. 128.
[325] Kenneth S. Kendler and Kenneth F. Schaffner, 'The Dopamine Hypothesis of Schizophrenia: An Historical and Philosophical Analysis', *Philosophy in Psychiatry and Psychology*, 18.1 (2011), 41–63 <doi: 10.1353/ppp.2011.0005> [accessed 6 January 2021].
Irving Kirsch, *The Emperor's New Drugs: Exploding the Antidepressant Myth* (New York: Basic Books, 2010).
Lacasse and Leo, 'Serotonin and Depression'.
All cited in Deacon, 'The Biomedical Model of Mental Disorder', p. 852.

that the benefits of antidepressants have been found to be the same regardless of whether they increase or decrease serotonin levels, or act on another neurotransmitter altogether.[327] On this point, he asks: 'What do you call pills, the effects of which are independent of their chemical composition? I call them "placebos."'[328]

Another facet of antidepressant use that is rather suspect is the way that they are used to suggest diagnoses. As Appignanesi has said, 'the girl is said to suffer from depression because she responds to antidepressants, a line of reasoning that drug-based therapies too readily employ, offering a diagnosis tailored to a response to a drug.'[329] This reasoning has been characterised as 'backwards'[330] and 'circular':[331] the diagnosis necessarily came first in order to administer a given drug. As such, it is almost inevitable that the response to the medication should match up with that diagnosis.

Not only are antidepressants used to diagnose, but they are also used, erroneously, to deduce aetiology.[332] The implication of therapeutic effect being garnered from a drug is taken to mean that the drug is providing something (usually the neurotransmitter serotonin) which was hitherto missing and thus causing the mental health issue.[333] This is problematic because we do not know whether a given drug is acting indirectly or directly on the mental health issue,[334] or in another way altogether.[335] As such, therapeutic effect does not prove the aetiology or mechanism of action of a given mental health issue,

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[326] Philip J. Cowen and Michael Browning. 'What Has Serotonin To Do with Depression?' *World Psychiatry,* 14.2 (2015), 158–60 <doi: 10.1002/wps.20229> [accessed 6 January 2021], p. 160.
[327] Kirsch, 'Antidepressants and the Placebo Effect', p. 128.
[328] Ibid., p. 131.
[329] Appignanesi, *Mad, Bad and Sad*, p. 448.
[330] Pam, 'A Critique of the Scientific Status of Biological Psychiatry', p. 11.
[331] Kramer, *Listening to Prozac*, pp. 44–45.
[332] Pam, 'A Critique of the Scientific Status of Biological Psychiatry', p. 12.
[333] Ibid., p. 11.
[334] Ibid., p. 21.
[335] Ibid., p. 12.

nor does it prove that the mental health issue has a biological cause.[336] Even the actual act of administering a drug and measuring the response in order to make a diagnosis presupposes that the 'problem' has a solely biochemical basis, when this has not been proven.[337]

Despite this, the 'low serotonin' model has persisted as a convenient explanatory model for doctors to use when commencing pharmaceutical treatment or, as I have previously examined, for attempting to reduce stigma.[338] Moreover, the idea of serotonin as the sole cause of mental health issues has, like the notion of the 'chemical imbalance', seeped into popular discourse: serotonin molecule jewellery[339] and tattoos,[340] both intended to symbolise a person's struggle with mental health issues, have become more popular in recent years.

In spite of this, the drug categories 'selective serotonin reuptake inhibitors' and 'mood stabilisers' were borne out of pharmaceutical marketing as opposed to reflecting the drugs' mechanisms of action.[341] The widespread use of these terms gives the false impression that the 'etiology and pathophysiology'[342] of mental health issues are known. Indeed, some have posited that the low serotonin hypothesis 'has been

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[336] Ibid.
[337] Ibid., p. 11.
[338] Kendler and Schaffner, 'The Dopamine Hypothesis of Schizophrenia'.
Kirsch, *The Emperor's New Drugs.*
Lacasse and Leo, 'Serotonin and Depression'.
All cited in Deacon, 'The Biomedical Model of Mental Disorder', p. 852.
[339] Pam Pastor, *Jewelry-Hunting? Check Out these Homegrown, Indie Brands* (2019) <https://lifestyle.inquirer.net/323928/jewelry-hunting-check-out-these-homegrown-indie-brands/> [accessed 11 June 2019].
[340] Arianna Rebolini and Tracy Clayton, *24 Beautiful Tattoos Inspired by Mental Illness* (2015) <https://www.buzzfeed.com/ariannarebolini/beautiful-tattoos-inspired-by-mental-illness> [accessed 11 June 2019].
Mark at 'Everybody Has a Brain', *Before You Get that Serotonin Tattoo...* (2016) <http://everybodyhasabrain.com/before-you-get-that-serotonin-tattoo/> [accessed 11 June 2019].
[341] David Healy, *Pharmageddon* (Berkeley, California: University of California Press, 2012).
[342] Deacon, 'The Biomedical Model of Mental Disorder', p. 850.

misused by the pharmaceutical industry to promote a simplistic biological model of depression to market selective serotonin reuptake inhibitors (SSRIs) to medical practitioners and the public'.[343]

Similarly, Dr Joanna Moncrieff, a leading figure in the Critical Psychiatry Network, explores an unnamed how-to guide on pharmaceutical marketing. Moncrieff finds therein that strategies such as creating 'dissatisfaction in the market', establishing 'a need' and creating 'a desire' are advocated.[344] These terms do not seem compatible with the idea of treating legitimate diseases. Rather, they seem more akin to medicalising problems which are complex and multi-faceted, thus not purely medical, for economic gain. The words of Paxil's product director, Barry Brand, are a case in point, for he once said that '[e]very marketer's dream […] is to find an unidentified or unknown market and develop it. That's what we were able to do with social anxiety disorder'.[345]

Goldacre has also problematised the medicalisation of what are arguably normal phenomena. He contends that pharmaceutical companies 'widen the boundaries of diagnosis',[346] and then proffer the 'remedies' in medicinal form. One example that he cites is a study on what has been termed 'Female Sexual Dysfunction' (FSD). The study claimed that 43% of women were 'affected' by this condition.[347] It later became known that two out of the three authors of the paper had worked for the pharmaceutical company Pfizer, which was about to release 'female Viagra'. Their conflict of interest had, of course, not

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[343] Philip J. Cowen, 'Serotonin and Depression: Pathophysiological Mechanism or Marketing Myth?' *Trends in Pharmacological Sciences,* 29.9 (2008), 433–36 <doi: 10.1016/j.tips.2008.05.004> [accessed 4 January 2021].
[344] Joanna Moncrieff, *Is Psychiatry for Sale? An Examination of the Influence of the Pharmaceutical Industry on Academic and Practical Psychiatry.* Maudsley Discussion Paper (London: Institute of Psychiatry, 2003).
[345] Barry Brand, quoted in Shankar Vedantam, *Drug Ads Hyping Anxiety Make Some Uneasy* (2001) <https://www.washingtonpost.com/archive/politics/2001/07/16/drug-ads-hyping-anxiety-make-some-uneasy/8fe2eea2-b780-48cd-9872-1d3802e83147/> [accessed 7 January 2021], cited in Lane, *Shyness*, p. 105.
[346] Goldacre, *Bad Pharma*, pp. 261–62.
[347] Edward O. Laumann, Anthony Paik, and Raymond C. Rosen, 'Sexual Dysfunction in the United States: Prevalence and Predictors', *Journal of the American Medical Association*, 281.6 (1999), 537–44 <doi: 10.1001/jama.281.6.537> [accessed 4 January 2021].

been declared. As well as drawing attention to big pharma's medicalising of arguably normal phenomena, science reporter Denise Grady alludes to the way that this is gendered. In this case, women who do not want sex 'enough' are pathologised, the solution to which can be found in a pill.[348]

An example of Grady's point can be found on the social media accounts of women's beauty, skincare, and vitamins brand, *hers*. One post states that '[a] low libido is one of the most common female sexual complaints. It's not weird, what's weird is we had no options'.[349] Much like Pfizer, the solution to this 'problem' is purported to be medication. The difference is that, with *hers*, the pills are packaged in faux-feminism and empowerment. Another post features a screenshot of a reminder on a mobile phone to prepare for a presentation.[350] The caption reads, '[i]f notifications like this make you anxious AF, set a reminder to check our IG tm @ 12.' For a shy person, feeling 'anxious AF' at the prospect of public speaking is all too real. The post that appears peddles the prescription-only beta-blocker propanolol for performance anxiety:

> Feeling anxious is *the worst* — but you don't have to struggle in silence. Meet Propranolol, a beta-blocker that can help control the physical symptoms of performance anxiety. Check out the link in bio to see if this Rx is right for you.[351]

hers has a counterpart for men called *hims*. Journalist Emily Reynolds calls *hims* and *hers'*s marketing 'perniciously gendered':[352] previous *hers* advertisements for propanolol claimed that the beta-blocker

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[348] Denise Grady, *THE NATION: BETTER LOVING THROUGH CHEMISTRY; Sure, We've Got a Pill for That* (1999) <https://www.nytimes.com/1999/02/14/weekinreview/the-nation-better-loving-through-chemistry-sure-we-ve-got-a-pill-for-that.html> [accessed 11 June 2019], cited in Goldacre, *Bad Pharma*, pp. 261–62.
[349] hersfirst, *A Low Libido…* (2018) <https://www.instagram.com/p/Bq28u0FnJWV/> [accessed 11 June 2019].
[350] hersfirst, *Prep for Presentation…* (2019) <https://www.instagram.com/p/BuZrk3gnro8/> [accessed 11 June 2019].
[351] hersfirst, *Feeling Anxious Is…* (2019) <https://www.instagram.com/p/Bubt-VeHEc7/> [accessed 11 June 2019].

would 'cure first-date nerves'. *hims'*s adverts for propanolol 'promised it would help deal with board meetings and public speaking'.[353] Moreover, Reynolds observes that *hers* seems to 'play on the "badass woman" tropes of neoliberal feminism'. The image of the latter, Reynolds contends, has been 'cleaned up' and 'used to sell us things'.[354] Journalist Eva Wiseman notes how the notion of mental health has undergone a similar shift: 'From squishy toys to colouring books to blankets, the anxiety business is worth billions.'[355] A particularly relevant example of this can be found in 'The Wallflower Box'. This is 'a subscription box for introverts and social anxiety sufferers', filled with copious amounts of lavender; vegan cosmetics; and lots of rhetoric reassuring the purchaser that it really is okay to be an introvert, 'despite society telling you that you need to be a social butterfly'.[356] It might be said then, that brands like *hers* and products like The Wallflower Box represent a fusion of the commercialisation of feminism and mental health.

Much like the pharmaceutical industry, Reynolds observes that 'the advertising industry likes to create problems in order to sell us their solutions'.[357] In the case of *hers*, nervousness at the prospect of an important presentation in front of a large audience is somewhat common and I daresay normal. Related to this, McInnes has described the ever-increasing pervasiveness of psychotropic drugs as the 'move to pathologize and medicalize every human emotion and behaviour'.[358] Recall Appignanesi's remarks on

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[352] Emily Reynolds, *Marketing Medication as his and hers? This Is 'Anxiety Economy' at its Worst* (2019) <https://www.theguardian.com/commentisfree/2019/mar/14/marketing-antidepressants-his-hers-anxiety-economy-at-its-worse> [accessed 11 June 2019].
[353] Ibid.
[354] Ibid.
[355] Eva Wiseman, *Feel Better Now? The Rise and Rise of the Anxiety Economy* (2019) <https://www.theguardian.com/global/2019/mar/10/feel-better-now-the-rise-and-rise-of-the-anxiety-economy> [accessed 11 June 2019].
[356] Anxiety Gone, *A Subscription Box for Introverts and Social Anxiety Sufferers* (2017) <https://anxiety-gone.com/subscription-box-introverts-social-anxiety-sufferers/> [accessed 11 June 2019].
[357] Ibid.
[358] McInnes, 'The Personal Is Political', p. 162.

‘Teen Screen’ and McInnes’s parodic pharmaceutical advertisement on shyness. McInnes follows this by calling pharmaceutical companies ‘legal drug pushers […] [who] profit from women’s reality’[359] and lays out a plethora of ‘conditions’ for which women — since, she says, 70% of those receiving psychiatric drugs and labels are women — receive treatment. These include PMS, Post-Traumatic Stress Response to gender-based violence, Anxiety and, bizarrely, SSRIs for those among us — 90% of which, apparently, are women — ‘who can’t stop shopping’.[360]

hers appears, on the surface, very different to pharmaceutical companies. Its products are targeted specifically at women and packaged in rhetoric about self-empowerment; its subtle foray into pharmaceutical sales, from beauty and skincare, represents a more accessible, contemporary, and friendlier face of big pharma. As one of their Tweets says, ‘the site is “so chill” it’s like “shopping for leggings, not prescription meds”.’[361]

Brands like *hers* exemplify the way that big pharma not only shapes how psychiatrists, but also the public, conceive of mental health issues, leading to the widespread internalisation of the medical model. This links to regulation. The pharmaceutical industry is regulated by the Medicines and Healthcare Products Regulatory Agency (MHRA) in the UK and the FDA in the US. Goldacre contends that regulators do not act in the interest of the population, but rather, of the pharmaceutical companies. This ‘regulatory capture’ is due to the crossover of employees between pharmaceutical companies and regulators.[362] There is clear conflict of interest here, and Pam has argued that a similar conflict of interest

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[359] Ibid., p. 160.
[360] Ibid., p. 161.
[361] hers, *The hers Site* (n.d.) <https://twitter.com/wearehers/status/1088527526199205888> [accessed 11 June 2019], cited in Reynolds, *Marketing Medication as his and hers?*
[362] Goldacre, *Bad Pharma*, p. 123.

exists between biological psychiatry research and the pharmaceutical industry.[363] He calls this a '"sleaze" factor' which is introduced into biological psychiatry's research by 'drug money'. For instance, the APA allows pharmaceutical companies, for a price, to sponsor talks at its conferences.[364] As such, the 13th World Congress of Psychiatry in 2005 was sponsored by Otsuka Pharmaceutical, Bristol-Myers Squibb, and Eli Lilly.[365] Arrangements such as these have been questioned repeatedly[366] and these challenges are perhaps best summarised by asking the question: '[H]ow is it that nobody points out the current economic arrangements are inconsistent with scientific objectivity?'[367]

These conflicts of interest mean that the influence of the pharmaceutical industry on psychiatry is pervasive. Big pharma has thus shaped psychiatry's conceptions of mental health issues, with some arguing that mental health diagnoses and symptoms have 'tailored' themselves to big pharma.[368] Concordant with this view, psychiatrist Kramer confesses that the symptoms or 'disease' the clinician

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363 Pam, 'A Critique of the Scientific Status of Biological Psychiatry', p. 28.
364 Robert Whitaker, *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America* (New York: Crown, 2010), cited in Deacon, 'The Biomedical Model of Mental Disorder', p. 848.
365 Thomas et al., 'Challenging the Globalisation of Biomedical Psychiatry', p. 23.
366 1 Boring Old Man, *Not a Toy...* (2012) <http://1boringoldman.com/index.php/2012/06/09/not-a-toy/> [accessed 7 January 2021].
Dx Revision Watch, *Three Professional Organization Responses to Third and Final DSM-5 Stakeholder Review* (2012) <http://dxrevisionwatch. wordpress.com/2012/06/21/three-professional-organization-responses-to-third-and-final-dsm-5-stakeholder-review> [accessed 25 June 2020].
Allen J. Frances and Thomas Widiger, 'Psychiatric Diagnosis: Lessons from the DSM-IV Past and Cautions for the Future', *Annual Review of Clinical Psychology,* 8 (2012), 109–30 <doi: 10.1146/annurev-clinpsy-032511-143102> [accessed 4 January 2021].
Brent Robbins, *Open Letter to the DSM-5* (n.d) <http://www.ipetitions.com/petition/dsm5/> [accessed 4 February 2013].
Brian C. Pilecki, J. W. Clegg, and D. McKay, 'The Influence of Corporate and Political Interests on Models of Illness in the Evolution of the DSM', *European Psychiatry*, 26.3 (2011), 194–200 <doi: 10.1016/j.eurpsy.2011.01.005> [accessed 4 January 2021].
All cited in Deacon, 'The Biomedical Model of Mental Disorder', p. 852.
367 Peter Schrag, *Mind Control* (New York: Pantheon, 1978), cited in Pam, 'A Critique of the Scientific Status of Biological Psychiatry', p. 28.
368 Appignanesi, *Mad, Bad and Sad*, p. 506.

looks for in examining a patient are contingent on which drugs are available.[369] This is likely because 'physicians prefer to diagnose conditions they can treat rather than those they can't',[370] so will prefer to diagnose something for which there already exists a pharmaceutical 'cure'. A prime example of how this relates to gender can be found by considering Eli Lilly's drug Sarafem. Far from being a new medication, Sarafem is the pre-existing antidepressant Prozac, repackaged in pink and purple casing and marketed to women for Pre-menstrual Syndrome/Pre-menstrual Dysphoric Disorder.[371] Psychologist Paula J. Caplan points to the explanatory materials for Sarafem including 'a list of mood problems from the PMDD list that virtually every human being experiences'. This 'category creep,' she contends, is 'a way of deeming increasing numbers of people mentally ill'[372] and, I add, is a means by which pharmaceutical companies can sell more pills.

The pharmaceutical 'revolution' of sorts, particularly the proliferation of antidepressants in recent decades, while rife with problems, has brought to attention the interplay between what constitutes 'mental illness' and cultural values. It is appropriate now for me to discuss the notion of the 'culture-bound syndrome', and how this relates to psychiatric medication.

Culture-Bound Syndromes and Cosmetic Pharmacology

In *Listening to Prozac*, psychiatrist Kramer chronicles his observations after prescribing the antidepressant Prozac to several patients over a number of years. He discusses the idea that what is categorised as 'mental illness' is strongly contingent on the norms and demands of the prevailing culture:

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[369] Kramer, *Listening to Prozac*, p. 35.
[370] Edward Shorter, *A History of Psychiatry* (New York: John Wiley and Sons, 1997), p. 5, cited in Appignanesi, *Mad, Bad and Sad*, p. 524.
[371] Paula J. Caplan, 'Pathologizing your Period', *Ms. Magazine,* 18.3 (2008), 63–64, p. 64.
[372] Ibid.

> Seeing how poorly patients fared when they were cautious and inhibited, and how the same people flourished once medication had made them assertive and flexible, I developed a strong impression of how our culture favors one interpersonal style over another.[373]

Some people, Kramer argues, only 'need' psychiatric or pharmacologic treatment because their environments do not favour their traits or temperament.[374] Of particular relevance is that a lot of Kramer's case studies' traits are consistent with social anxiety. For instance, he speaks of one patient's having experienced rejections, which Kramer characterises as not arising due to the patient's ability, but due to 'various institutions' prejudice in favor of extraversion and "assertiveness"'.[375] On this point, Lane questions 'whether "social phobia" and "avoidant personality disorder" may at times represent a type of noncompliance with our culture's demand for extroversion'.[376] Another of Kramer's patients 'became more energetic and more assertive socially' after taking Prozac,[377] while another still said of Prozac 'It makes me confident.'[378] A further patient 'became socially capable, no longer a wallflower but a social butterfly'.[379]

In brief, Kramer observes that Prozac seems to be able to make people 'socially attractive';[380] it can turn 'a shy and conservative member of a human troop into a gregarious risk-taker'[381] and is able 'to give social confidence to the habitually timid, to make the sensitive brash, to lend the introvert the social

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[373] Kramer, *Listening to Prozac*, p. xv.
[374] Ibid., p. 246.
[375] Ibid., p. 174.
[376] Lane, *Shyness*, p. 9.
[377] Kramer, *Listening to Prozac*, p. 237.
[378] Ibid., p. 9.
[379] Ibid., pp. 10–11.
[380] Ibid., p. xvi.
[381] Ibid., pp. 166–67.

skills of a salesman'.[382] In discussing one particular patient, Sally, Kramer entertains the idea that her distress arises from an aspect of her temperament, namely social inhibition, as opposed to 'illness'. This then begs the question as to what Prozac is actually medicating when it is administered to such an individual, and Kramer questions whether it is not the very personality of the individual that is being changed by the medication.[383] If this is the case, we must ask: does medicating for SAD medicalise a 'normal' personality trait, in this case, shyness? This leads into my discussion of what Kramer calls 'cosmetic psychopharmacology',[384] that is, the 'reshaping of personality traits by medication'.[385]

The recognition that medications like Prozac might be altering aspects of personality 'that might have succeeded in a different, and not especially distant, culture'[386] means that we ought to question what psychiatric medication is actually for: is it to cure, to treat, or to make people conform to what the dominant culture values? Kramer points out that a significant number of the people he has found to be rendered 'better than well'[387] by Prozac have had what he calls 'mild degrees of impairment: minor depression, minor compulsiveness, sensitivity to loss, personality styles fallen from favour'.[388] These people 'need' treatment because of 'how exigent our culture is in its behavioral demands'.[389] As such, it could be argued that to medicate such people 'is just to tamper with normal minds'.[390] Although I think this argument has merit, Kramer's choice of words is perhaps a poor one. Since my position is one which advocates for embracing different ways of being and eschews the imperative to adhere to normative standards, I would problematise the idea of a 'normal' mind.

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[382] Ibid., p. xv.
[383] Ibid., p. 162.
[384] Ibid., p. xvi.
[385] Ibid., p. 143.
[386] Ibid., p. 41.
[387] Ibid., p. xv.
[388] Ibid., p. 108.
[389] Ibid., p. 41.
[390] Ibid., p. 246.

Following Kramer, it can be seen that what are called 'mental illnesses' are strongly rooted in cultural norms. A prime example of this is addressed by psychiatrist Richard S. Schwartz in discussing the use of antidepressants for 'prolonged' bereavement.[391] In the US, 'prolonged' is classed as being a year after the bereavement occurred; in rural Greece, it is the norm for relatives of the deceased to grieve for five years. This points to the arbitrary nature of prescribing antidepressants for grief, and how the acceptable time-frame is wholly reliant on culture. Indeed, Schwartz suggests that medicating with 'mood brighteners' has the potential to be used to justify and reinforce oppressive cultural norms and expectations: those who do not conform are pathologised and hence 'treated'. Given that mental health issues and their pharmacologic treatment are embedded in culture, the concept of the 'culture-bound syndrome' (CBS) is of particular relevance.

Academic Ivan Crozier defines CBSs as follows: '[A] group of symptoms (mental, physical, social) that is recognized within a specific culture, with accepted treatments within these cultures.[392] Such illnesses are not universal; they are not caused by other neurological or psychiatric conditions.' The idea of a CBS, though not called by the same name, had been discussed for many years prior to its inclusion in the *DSM* in 1994. It has its roots in the colonial psychiatry of the nineteenth and early-twentieth centuries, owing to figures such as Emil Kraepelin's observations of phenomena such as *Koro* (briefly, the belief and resulting panic that the penis is shrinking into the abdomen) in East Asia. Kraepelin understood CBSs not to be 'separate diseases'.[393] Rather, he believed that all people suffered from the same diseases, but that 'culture' altered a disease's presentation. Kraeplin's legacy is still visible in contemporary psychiatry in

[391] Richard S. Schwartz, 'Mood Brighteners, Affect Tolerance, and the Blues', *Psychiatry,* 54.4 (1991), 397–403 <doi: 10.1080/00332747.1991.11024568> [accessed 4 January 2021], p. 401, cited in Kramer*, Listening to Prozac*, p. 254.
[392] Ivan Crozier, 'Making up Koro: Multiplicity, Psychiatry, Culture, and Penis-Shrinking Anxieties', *Journal of the History of Medicine and Allied Sciences,* 67.1 (2011), 36–70 <doi: 10.1093/jhmas/jrr008> [accessed 4 January 2021], p. 65.
[393] Ibid., p. 43.

the way that many psychiatrists conceptualise CBSs.[394] Presumably in response to criticisms of the way that CBSs had been included in the *DSM*, the APA released an addendum to the *DSM-5* in 2013. The document speaks of how the 'DSM-5 [sic] updates criteria to reflect cross-cultural variations in presentations',[395] with the following given as an example: '[U]ncontrollable crying and headaches are symptoms of panic attacks in some cultures, while difficulty breathing may be the primary symptom in other cultures.'[396] Although the document claims that the *DSM* 'incorporates a greater cultural sensitivity',[397] it is clear that it endorses Kraepelin's viewpoint that CBSs are, at root, the same 'disorders', with 'culture' having the role of moderating their presentations. Rather than situating all mental health issues in their cultural contexts, the *DSM* seeks to define CBSs in terms of Western 'equivalents', and subsume the former into the latter. An example of this is the Japanese phenomenon of *Taijin Kyofusho*, which concerns a person's 'fear that they will displease or embarrass others'.[398] The *DSM-5*'s addendum points to the incorporation of 'fear of "offending others"' into the *DSM-5*'s criteria for SAD, 'to reflect the Japanese concept in which avoiding harm to others is emphasized rather than harm to oneself'.[399] The *DSM-5* thus effectively subsumes *Taijin Kyofusho* into the category of SAD, implicitly saying that they are the same disease entity, manifested differently due to 'culture'. As Charles C. Hughes has argued of the *DSM-IV*, culture should not merely be '"taken into account" off-handedly as

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[394] Ibid., p. 44.
[395] American Psychiatric Association, *Cultural Concepts in DSM-5* (2013) <www.psychiatry.org%2FFile%2520Library%2FPsychiatrists%2FPractice%2FDSM%2FAPA DSM Cultural-Concepts-in-DSM-5.pdf &usg=AOvVaw3_HkTBYb4VAOy0SY3yoZOS> [accessed 7 January 2021], p. 1.
[396] Ibid.
[397] Ibid.
[398] Katsuaki Suzuki, Nori Takei, Masayoshi Kawai, Yoshio Minabe, and Norio Mori, 'Is Taijin Kyofusho a Culture-Bound Syndrome?' *American Journal of Psychiatry,* 160.7 (2003), 1358 <doi: 10.1176/appi.ajp.160.7.1358> [accessed 4 January 2021], p. 1358.
[399] APA, *Cultural Concepts in DSM-5,* p. 1.

a side issue (as repeatedly suggested in DSM-IV [sic])'.[400] Hughes's critique is especially salient if we consider that in both the *DSM-IV*[401] and the *DSM-5*,[402] CBSs are relegated to an appendix. As opposed to being an 'add-on', Hughes argues that culture is 'embedded in the culturally structured scenario between the patient and clinician, no matter where it occurs'.[403] Crozier makes a case along similar lines, suggesting that culture is very much a part of modern psychiatric discourses, since mental health issues are 'performed in specific cultural settings'.[404]

Indeed, psychiatry deals with human behaviour, a notion in which ideas of roles and norms, which are informed by culture, are inherent. Despite this, culture does not seem to have a great deal of importance in the biomedical model of psychiatry, a model which has insisted on its 'objective nature'.[405] On this point, Cohen invites the reader to imagine the decisions and assessments a clinician needs to make before diagnosing a patient as being paranoid. The clinician needs to assess the patient's behaviour contextually, and in light of cultural norms and practices, in order to ascertain whether it is reasonable.[406] Moreover, given that diagnosing somebody with a mental health issue is grounded in cultural understanding, as opposed to being born of 'neutrality' or 'objectivity', an 'intersubjective dialogue'[407] is arguably a more apt diagnostic tool than the 'objectifying gaze'[408] that the *DSM* demands — a further point of concern given feminism's problematisation of women's objectification.

[400] Charles C. Hughes, 'The Glossary of "Culture-Bound Syndromes" in DSM-IV: A Critique', *Transcultural Psychiatry,* 35.3 (1998), 413–21 <doi: 10.1177/136346159803500307> [accessed 4 January 2021], p. 420.
[401] Ibid.
[402] APA, *Cultural Concepts in DSM-5,* p. 1.
[403] Hughes, 'The Glossary of "Culture-Bound Syndromes"', p. 420.
[404] Crozier, 'Making Up Koro', p. 40.
[405] Cohen, 'The Biomedicalization of Psychiatry', p. 512.
[406] David Ingleby, 'Understanding Mental Illness', in *Critical Psychiatry,* ed. by David Ingleby (New York: Pantheon, 1980), cited in Cohen, 'The Biomedicalization of Psychiatry', p. 512.
[407] Cohen, 'The Biomedicalization of Psychiatry', p. 518.
[408] Kovel, 'The American Mental Health Industry'.

Crozier is critical of another implication of the way in which the *DSM* conceptualises CBSs, namely, that the CBSs' placement and description therein reveals an ethnocentrism in the way that Western psychiatry conceives of mental health issues.[409] Moreover, he points out 'the privileged position' of Western psychiatry': that is, it thinks of itself as being 'beyond culture'.[410] This is evident in the way that psychiatry has conceptualised cases of *Koro* in the West: namely, by positing that *Koro* is possible 'out of cultural context',[411] which suggests that the West does not have a cultural context. Crozier also points out the way in which psychiatry has tended to explain non-western *Koro* using 'a standpoint that seems to advocate that culture is elsewhere (i.e., nonwestern)'.[412]

In line with this refutation, Hughes suggests that Western issues such as Anorexia Nervosa and Bulimia Nervosa should be classed as CBSs.[413] Likewise, Crozier argues that a number of CBSs are found in Western societies, such as 'neurasthenia, anorexia, bulimia, abduction phenomenon, and Gulf War syndrome'.[414] As such, Hughes makes the argument that culture cannot be ignored in making a diagnosis, since it is 'just as much a factor in shaping particular patterns of symptomatology in Western societies as it is everywhere else'.[415] He therefore makes the suggestion that *all* diagnostic categories should address cultural context, 'even' in the case of Western cultures. Of particular importance for my own research, Hughes makes the case that what have been called 'women's diseases' — such as Anorexia Nervosa, Bulimia Nervosa, and Body Dysmorphic Disorder — be considered in light of 'cultural beliefs about ideal

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[409] Crozier, 'Making Up Koro', pp. 67–68.
[410] Ibid.
[411] Ibid., p. 50, cited in German Berrios and Stephen Morley, 'Koro-Like Symptoms in a non-Chinese Subject', *British Journal of Psychiatry*, 145 (1984), 331–34 <doi: 10.1192/bjp.145.3.331> [accessed 21 January 2021], p. 333.
[412] Crozier, 'Making Up Koro', p. 69.
[413] Hughes, 'The Glossary of "Culture-Bound Syndromes"', p. 419.
[414] Crozier, 'Making Up Koro', p. 66.
[415] Hughes, 'The Glossary of "Culture-Bound Syndromes"', p. 420.

body shape, sexuality and women's societal roles in Western societies'.[416] Also of relevance is Hughes's recommendation that we move away from using 'culture' as a tool for othering, and towards including it in diagnoses. The end result, he tells us, is the inclusion of other mental health issues under the heading 'Western CBSs', such as 'post-traumatic stress disorder, dissociative identity disorder' and, most relevant for my own work, 'social phobia'.[417]

Having discussed the CBS, I want to now look at how culture interacts specifically with mental health issues which affect women. Crozier concludes, from considering *Koro*, that some mental health issues are 'transient', that is, they exist 'only at a certain time and place'.[418] This idea relates to Kramer's observation that distress can result from possessing certain personality traits, which may have been rewarded in a bygone era, but which are not currently valued by our culture. Kramer observes that our culture prefers certain personality traits, such as 'the contemporary fastidiousness' and 'the business advantage conferred by mental quickness'.[419] Not only does our culture prefer certain personality types, it prefers certain personality types *in women*. Before exploring this idea in any more depth, I will trace the roots of current styles of femininity. 'Femininity' encompasses both appearance and personality. I will discuss appearance in Chapter 5. For now, I wish to focus on personality.

The type of personality style which is in favour for women today has undoubtedly been influenced by Victorian conceptions of ideal femininity. A succinct representation of the latter can be found in the concept of 'The Angel in the House', and is based on the poem by the same name.[420] This describes an

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[416] Ibid.
[417] Ibid.
[418] Crozier, 'Making Up Koro', pp. 40–41.
[419] Kramer, *Listening to Prozac*, p. 270.
[420] Coventry Patmore, *The Angel in the House*, ed. Henry Morley (2014 [1891]) <https://www.gutenberg.org/files/4099/4099-h/4099-h.htm> [accessed 26 September 2020].

ideal Victorian woman: wife, mother, and cornerstone of family life. Virginia Woolf, in criticising the Angel, describes her as:

> [I]mmensely sympathetic, immensely charming, utterly unselfish. She excelled in the difficult arts of family life. She sacrificed herself daily [...] if there was a draught she sat in it [...] she was so constituted that she never had a mind but preferred to sympathize always with the minds and wishes of others [...] Her purity was supposed to be her chief beauty.[421]

Femininities, of course, are many and contingent on time and place; ideal notions of femininity have evolved since the time of the Angel. However, the legacy of ideal Victorian femininity can be seen in UK and US contexts in the late-twentieth and early-twenty-first centuries. In 1974, Sandra Bem compiled traits which were 'judged to be more desirable [in American society] for a woman than for a man'[422] in forming the Bem Sex Role Inventory.[423] Bem deemed a person to be 'feminine' if they could be described as the following: affectionate, cheerful, childlike, compassionate, does not use harsh language, eager to soothe hurt feelings, feminine, flatterable, gentle, gullible, loves children, loyal, sensitive to the needs of others, shy, soft spoken, sympathetic, tender, understanding, warm, and yielding.[424] There is significant overlap between Bem's conceptions of femininity and the Victorian Angel. Indeed, Kramer's description of Victorian femininity echoes both of these, for he describes the Victorian ideal as 'emotionally

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[421] Virginia Woolf, 'The Professions of Women', in *Norton Anthology of Literature by Women,* ed. by Sandra Gilbert and Susan Gubar, 2nd edn (W.W. Norton and Company, 1996), pp. 134–36.
[422] Sandra L. Bem, 'The Measurement of Psychological Androgyny', *Journal of Consulting and Clinical Psychology*, 42.2 (1974), 155–62 <doi: 10.1037/h0036215> [accessed 4 January 2021], p. 156.
[423] Bem, 'The Measurement of Psychological Androgyny'.
[424] Ibid., p. 156.

sensitive, socially retiring, loyally devoted to one man, languorous and melancholic, fastidious in dress and sensibility, and histrionic in response to perceived neglect'.[425]

Considering Bem compiled her Sex Role Inventory some 45 years ago, the feminine ideal has evolved still further. Writing in 1993, Kramer alludes to the personality style in favour for women in citing '[v]ivacious women's attractiveness to men' and 'men's discomfort with anhedonia in women'.[426] In contrast with the Victorian ideal, Kramer tells us that the 1990s saw traditionally 'masculine' traits valued in women such as 'resilience, energy, assertiveness, an enjoyment of give-and-take'.[427] This is reflective of wider social change such as more individualistic politics and more women working outside of the home in the late 1970s and early 1980s. As Rosalind Gill notes, it was in this era that 'notions of male and female equality and the basic similarity of men and women took hold in popular culture'.[428]

The feminine ideal has since evolved even more, perhaps due in part to the feminist movement's call for parity with men. Indeed, a woman exhibiting masculine traits is now more acceptable than ever.[429] As such, when I speak of current femininity, I am speaking of a personality style whose legacy is Victorian femininity, but bears closer resemblance to the femininity described by Kramer: I will call this 'masculine femininity'. Broadly, this can be thought of as traditional femininity with the addition of certain traits, which have typically been deemed masculine, which contemporary UK and US culture values. These include being ambitious, assertive, independent, competitive, individualistic, self-reliant, self-sufficient,

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[425] Kramer, *Listening to Prozac*, p. 270.
[426] Ibid.
[427] Ibid., p. 271.
[428] Rosalind Gill, 'Postfeminist Media Culture: Elements of a Sensibility', *European Journal of Cultural Studies*, 10.2 (2007), 147–66 <doi: 10.1177/1367549407075898> [accessed 4 January 2021], p. 158.
[429] Lori B. Girshick, 'The Social Construction of Biological Facts', in *Transgender Voices: Beyond Women and Men,* ed. by Lori B. Girshick (Hanover, New Hampshire: University Press of New England, 2008), p. 48.

and having leadership abilities.[430] In considering this new type of feminine ideal, the unreasonable nature of the expectation that women display opposite, and incompatible, traits becomes clear.

It is perhaps pertinent here to examine just why trends in femininity have moved in this direction and to do so I would like to review some of the thoughts of the trans theory writer Julia Serano. Serano observes that in our patriarchal society, masculinity is more valued than femininity. Hence, women wanting to espouse these characteristics is seen as understandable. On the contrary, men's wanting to exhibit feminine traits is counter to the idea that men are superior, and so tends to not be tolerated. One of the examples Serano uses to support her claim is parental responses to children playing with toys which are not gender-normative: for instance, girls playing with cars is much more likely to be tolerated than boys playing with Barbie dolls.[431]

In light of Serano's observations, I argue that women's exhibiting masculine traits is not merely tolerated, but it is *expected*. With that said, the Victorian legacy of femininity still bears weight. As such, women must now live up to previously contradictory expectations of masculinity, such as assertiveness, and femininity, such as modesty and shyness. Moreover, it is worth considering that the standards to which women are held have become more focused on the body since the Victorian era: indeed, this is exactly what Naomi Wolf contends in *The Beauty Myth*.[432] I will revisit the thoughts of Wolf in focussing on the role of appearance and the body in Chapter 5; and I will discuss contemporary representations of femininity more fully in subsequent chapters.

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[430] Bem, 'The Measurement of Psychological Androgyny', p. 156.
[431] Julia Serano, *Whipping Girl: A Transsexual Woman on Sexism and the Scapegoating of Femininity* (Berkeley: Seal Press, 2007), pp. 284–92.
[432] Naomi Wolf, *The Beauty Myth: How Images of Beauty are Used against Women* (London: Vintage Books, 1991).

Relating my discussion of femininity to the thoughts of Kramer, one of his contentions is that women with traits reminiscent of the Victorian ideal today are not likely to be rewarded. I would argue that this is a little simplistic, since I have outlined how Victorian styles of favoured femininity have influenced our conceptions of appropriate femininity in the present day. Even so, I think that Kramer's argument still has merit, for he tells us that today, society values traditionally 'masculine' traits in women. Fundamentally, he claims that the 'problem' occurs when there is a 'mismatch between women's coping style and the requisites for finding reward in this culture',[433] which begs the question: should this mismatch be treated as an illness and thus be medicated? In seeing his patients' personality traits altered by Prozac, Kramer contends that the drug has the ability to change the personality of a woman with 'overly-feminine'[434] traits, such as passivity, to a more assertive and spirited personality style: a personality style more consistent with what the culture values and rewards. One can see how this could play out in the case of a socially anxious woman.

However, Kramer questions whether, in 'curing' women of 'feminine' traits such as passivity and thereby instilling in women a personality style which is more in line with the feminine ideal *du jour*, we are not endorsing 'a certain sort of social conformity'.[435] Further to this, he questions whether Prozac does not bring women into line with '"masculine" capitalist values'[436] and thereby serves the economic needs of society. I will revisit this question when I discuss postfeminist and neoliberalist representations of ideal femininity later on in the thesis. In light of this question, Kramer wonders whether Prozac is akin to drugs such as Miltown, Librium, and Valium, the 'mother's little helpers' of the 1960s and 1970s. These drugs were used to keep women in their place in society and make them content with the drudgery of

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[433] Kramer, *Listening to Prozac*, p. 170.
[434] Ibid.
[435] Ibid. p. 271.
[436] Ibid.

housework. As American psychiatrist Jonathan M. Metzl explains, 'the pills became known as the treatments of choice for the pressures of motherhood, single-hood and other historically specific forms of essentialised womanhood.'[437] By contrast, Kramer cites the experience of one particular patient, Julia, for whom Prozac 'got [her] out of the house and into the workplace, where she was able to grow in competence and confidence'.[438] Kramer thus describes antidepressants as 'feminist drugs, liberating and empowering […] in this scenario, it is the failure to prescribe medication that keeps the wife trapped'.[439] I would however, question whether Prozac is actually the opposite of the mother's little helpers of yesteryear: is it really the antithesis of these drugs, or just more insidious? Have the demands to which women are now subject changed? In attempting to answer these questions, it is worth considering that psychopharmaceuticals have been described as a 'woman's best friend' in terms of 'dealing with the pressures of working in a man's world'.[440] Perhaps then, pharmaceuticals are used to enable women to cope in a man's world, as opposed to changing society to accommodate more diverse behaviours.

Schwartz acknowledges studies which have found that people who are depressed are better at predicting probabilities than people who are not depressed: indeed, people who are not depressed have been found to be 'too optimistic'.[441] As such, it could be inferred that people who are depressed have a more realistic perspective of the world. Medicating these people then reduces their ability to predict probabilities, and by extension, serves to disconnect them from what is arguably the bleakness of reality. McInnes also alludes to this effect in drawing on a passage from the Jeanette Winterson novel, *Art and Lies*: '"Take this," says the Doctor, "you'll soon feel better." They do "feel" better, because little by little,

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[437] Metzl, '"Mother's Little Helper"', p. 228.
[438] Kramer, *Listening to Prozac*, p. 40.
[439] Ibid.
[440] Jaqueline Susann, *Valley of the Dolls* (New York: Random House, 1966).
Barbara Gordon, *I'm Dancing as Fast as I Can* (New York: Harper and Row, 1979).
All cited in Metzl, '"Mother's Little Helper"', p. 228.
[441] Schwartz, 'Mood Brighteners', cited in Kramer, *Listening to Prozac*, p. 253.

they cease to feel at all.'[442] McInnes also likens pharmacological interventions such as antidepressants to Aldous Huxley's 'soma':

> And if ever, by some unlucky chance, anything unpleasant should somehow happen, why, there's always soma to give you a holiday from the facts. And there's always soma to calm your anger, to reconcile you to your enemies, to make you patient and long suffering.

Similarly, Kramer imagines a dystopian society, whose medication of 'normal' emotions and personality traits in order to ensure its citizens' adherence to norms, has been taken to the extreme:

> 'Why such a long face? Can't you take a MoodStim before work?' A family doctor warns the widow, 'If you won't try AntiGrief, we'll have to consider hospitalization.' And a parent urges the paediatrician to put a socially anxious child on AntiWallflower Compound.[443]

While Kramer's and McInnes's examples are of course extreme (and fictional), I am rendered a little uneasy by the fact that the principles underlying them are akin to what are oftentimes the reasons for medicating social anxiety in women.

In closing this chapter, I want to draw together the two schools of thought which inform my theoretical approach: anti-psychiatry and feminist responses to anti-psychiatry. McInnes alludes to the separateness of the feminist and anti-psychiatry movements when she tells of a community of which she is a part, going by the name of *UnrulyWomen.*[444] This, she says, is an 'example of a re-birth of the Consciousness-Raising groups of the 1960s and 1970s'.[445] One of its objectives is to bring 'the principles of women's

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[442] McInnes, 'The Political Is Personal', p. 162.
[443] Kramer*, Listening to Prozac*, p. 273.
[444] McInnes, 'The Political Is Personal'.
[445] Ibid., p. 164.

liberation to mental health policy'[446] and she states that she is for mental health support for women which is free from labels and about choice. Perhaps the best example of McInnes's melding of these two movements is when she says: 'Remember our slogan, "Keep Your Laws off Our Bodies"? Let's bring it all together by adding "And Out of Our Minds!"'[447] On the other hand, she points out that, just as psychiatry (and I would argue, anti-psychiatry), as a whole, has not acknowledged feminism, '[t]he feminist movement had not yet embraced "madwomen"'[448] and that, in light of the large number of women affected by mental health issues, this has to change.

[446] Ibid.
[447] Ibid., p. 165.
[448] Ibid., p. 164.

CHAPTER 2

PROBLEMATISING (GENDERED) DIAGNOSES

Having outlined my theoretical approach in the previous chapter, in this chapter I will examine a number of critical methods and ideas informed by feminism, feminist science studies, and/or anti-psychiatry that have been used to discuss other gendered psychiatric diagnoses: my focus will be diagnoses that are *overtly* gendered. I will situate my approach to SAD in terms of these methods and ideas, outlining both how I will borrow from existing work and how my work contributes to existing scholarship.

A thread which ran through the previous chapter, particularly in my discussion of the thoughts of Kramer, was the idea that cultural norms are implicit within psychiatric diagnoses: it is this that I consider first.

Psychiatry and Cultural Values

In exploring women's experiences of SAD, I am aligning myself with a social constructionist approach. That is, what constitutes '(mental) illness' is contingent on, and shaped by, culture.[449] This approach has previously been used to examine other mental health issues affecting women, notably Pre-Menstrual Syndrome (PMS), an exaggerated version of which features in the *DSM-5* as Pre-Menstrual Dysphoric Disorder (PMDD).[450] Sociologist Kathy Kendall has argued that probing the scientific institution which uses a 'disease model' to conceptualise women's monthly cycles reveals that said institution 'is a social,

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[449] Jane M. Ussher, 'Premenstrual Syndrome: Reconciling Disciplinary Divides through the Adoption of a Material-Discursive Epistemological Standpoint', *Annual Review of Sex Research*, 7.1 (1996), 218–51 <doi: 10.1080/10532528.1996.10559914> [accessed 4 January 2021], p. 225, 235.
[450] APA, *DSM-5*, p. 171.

political and gendered institution which reflects cultural concepts, values, ideologies and practices'.[451] Likewise, academic Elizabeth Mollard contends that a feminist analysis of Postpartum Depression (PPD) reveals that this diagnosis is replete with 'societal and cultural bias'.[452] What we can glean from these works is that science 'contains and maintains perspectives of the social order'.[453] It is precisely this ideological influence that I am seeking to expose in my examination of the way that contemporary UK and US psychiatry conceptualises SAD in women.

In a similar vein, Ussher proposes that the diagnoses PMS and PMDD serve to attribute women's distress to their bodies and reproductive processes.[454] SAD is perhaps not as readily attributable to reproductive processes or the body since it is a 'disorder' which has to do with relations with others, as opposed to a relation with one's own body. With that said, some of the psy science literature on women and SAD has sought to make links between women's overrepresentation among those with Anxiety Disorders — including SAD — and reproductive processes such as breastfeeding and hormonal changes.[455] As such, Ussher's critiques of PMS/PMDD, which debunk the attribution of women's distress to their bodies, are relevant to my research on women's SAD insofar as my work attempts to act as a corrective to the biological reductionism and implicit sexism within the extant psy science literature.

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[451]Kathy Kendall, 'Dangerous Bodies', in *Offenders and Victims: Theory and Policy British Criminology Conference 1991, Selected Papers, Vol. 1,* ed. by David P. Farrington and Sandra Walkate (The British Society of Criminology and the Institute for the Study and Treatmentof Delinquency, 1992), p. 48, cited in Kirsten K. Johnson and Mary Anne Kandrack, 'On the Medico-Legal Appropriation of Menstrual Discourse: The Syndromization of Women's Experiences', *Resources for Feminist Research*, 24.1/2 (1995), 23–27 <https://search.proquest.com/openview/a3bf7eed440b78ae140a9651bfc06402/1?pq-origsite=gscholar&cbl=43888> [accessed 4 January 2021], p. 26.
[452] Mollard, 'Exploring Paradigms in Postpartum Depression Research', p. 383.
[453] Johnson and Kandrack, 'On the Medico-Legal Appropriation of Menstrual Discourse', p. 23.
[454] Evelyn Fox Keller, *Reflections on Gender and Science* (London: Yale University Press, 1985).
[455] E.g. Altemus, 'Sex Differences in Depression and Anxiety Disorders'.
Weinstock, 'Gender Differences'.

A further point made by Ussher is that, in attributing women's distress to their bodies and reproductive processes, the interplay between science and the social order, especially the gendered nature of science, is occluded, as are the social aspects of women's realities.[456] Drawing on Foucault,[457] Ussher suggests that arguments akin to her own have been made regarding other diagnoses, 'leading to a deconstruction of expert diagnosis and to a questioning of the existence of many "syndromes"'.[458] In later chapters, I will discuss the link between science and the social order in the case of psychiatry's conceptualisation of women's SAD and thereby deconstruct this diagnosis. Moreover, in listening to the narratives of my participants, I will bring to the fore the social aspects of women's lives that contribute to their SAD: that is, the contributory factors to this mental health issue in women that the attribution of their distress to their bodies has rendered invisible.

In addition to Ussher, other authors have interrogated the social construction and gendering of PMS.[459] Women's health activist and writer Esther Rome has explored the way in which even PMS's specific *symptoms* 'take on a value influenced by society'. For instance, bloating, she argues, 'can be painful in and of itself, but it would not carry a social stigma if we all [...] believed fatness was beautiful'.[460] Applying this to SAD, I invite the reader to imagine if the physical symptoms of social anxiety, such as blushing and hand tremor,[461] were viewed as attractive by society: this would doubtless affect whether socially anxious women deemed their experiences to be problematic, and would likely impact their

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[456] Keller, *Reflections on Gender and Science.*
[457] Michel Foucault, *The Birth of the Clinic* (London: Penguin, 1989).
Peter Sedgewick, *Psychopolitics* (London: Pluto Press, 1987).
[458] Ussher, 'Premenstrual Syndrome', p. 225.
[459] Sophie Laws, *Issues of Blood: The Politics of Menstruation* (London: MacMillan, 1991).
Mary Brown Parlee, 'The Social Construction of PMS: A Case Study of Scientific Discourse as Cultural Contestation', *The Good Body: Asceticism in Contemporary Culture* conference (Institute for the Medical Humanities, Texas University, Galveston, 1991).
[460] Esther Rome, 'Premenstrual Syndrome (PMS) Examined through a Feminist Lens', *Health Care for Women International*, 7.1-2 (1986), 145–51 <doi: 10.1080/07399338609515729> [accessed 4 January 2021], p. 145.
[461] WHO, 'Social Phobias'.

decisions regarding treatment seeking. This speaks to Ussher's contention that we 'do not experience symptoms in a sociocultural vacuum'.[462] Indeed, symptoms are contingent on cultural and historical context,[463] and cannot be understood separately from these contexts.[464] This contingency on culture evokes the idea of a CBS that I discussed in the previous chapter and, indeed, several authors have concluded that PMDD is a CBS.[465] In theorising SAD thus, my work seeks to transform our understanding of this mental health issue in women.

Having outlined how the interplay between illness and cultural values has been examined in previous work, and how I will apply this to women's SAD, I want now to explore the way that certain mental health issues have been conceptualised as being on a spectrum with the 'normal'.

(Ab)normality

In addition to the notion of what is 'normal' varying with culture and time period, psychologists Joan C. Chrisler and Paula J. Caplan,[466] in their analysis of PMS, question whether the line between what constitutes 'normal' and 'abnormal' can ever definitively be drawn. Similarly, in a feminist critique of

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[462] Lynn Payer, *Medicine and Culture* (New York: Henry Holt and Company, 1988).
Sedgewick, *Psychopolitics*, cited in Ussher, 'Premenstrual Syndrome', p. 228.
[463] Ibid.
[464] Ussher, 'Premenstrual Syndrome', p. 228.
[465] Joan C. Chrisler and Ingrid Johnston-Robledo, 'Raging Hormones?: Feminist Perspectives on Premenstrual Syndrome and Postpartum Depression', in *Rethinking Mental Health and Disorder: Feminist Perspectives,* ed. by Mary Ballou and Laura S. Brown (New York: Guilford Press, 2002), 174–97, cited in Ussher, 'Diagnosing Difficult Women', p. 66.
Tamara Kayali Browne, 'Is Premenstrual Dysphoric Disorder Really a Disorder?' *Journal of Bioethical Inquiry*, 12.2 (2015), 313–30 <doi: 10.1007/s11673-014-9567-7> [accessed 4 January 2021].
Thomas M. Johnson, 'Premenstrual Syndrome as a Western Culture-Specific Disorder', *Culture, Medicine and Psychiatry,* 11.3 (1987), 337–56 <doi: 10.1007/BF00048518> [accessed 4 January 2021].
Joan C. Chrisler, 'PMS as a Culture-Bound Syndrome', in *Lectures on the Psychology of Women,* ed. by Joan C. Chrisler, Carla Golden, and Patricia D. Rozee (New York: McGraw-Hill, 1996), 106–21, cited in Joan C. Chrisler and Paula Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde: How PMS Became a Cultural Phenomenon and a Psychiatric Disorder', *Annual Review of Sex Research*, 13:1 (2002), 274–306 <doi: 10.1080/10532528.2002.10559807> [accessed 4 January 2021].
[466] Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', p. 276, 292.

Postnatal Depression, Natasha Mauthner argues that the medical establishment's conceptualisation of this mental health issue as an 'illness' presents it as 'an objective, clinical entity'.[467] This functions to produce 'a false dichotomy': on the one hand, there is a 'normal' mental state, wherein motherhood is a wholly positive experience, without unhappiness. On the other hand, there is a 'pathological' mental state: that of Postnatal Depression.[468] I would make a similar argument regarding women's social anxiety. That is, psychiatry's construal of it creates a binary: on the one hand, there is the 'normal', social anxiety-free existence; on the other, there is the 'pathological' state of SAD. Instead of this false dichotomy, Chloë Taylor makes the case that 'the pathological is on a hazy continuum with the banal';[469] just as philosopher Cressida Heyes contends that 'there is no "bright line" between Body Dysmorphic Disorder and "normal" feminine preoccupations with physical appearance'.[470]

Applying the idea of a spectrum to SAD begs the following question: at what point, if ever, does shyness or social anxiety become pathological? This dilemma is illustrated by considering what occurred in the wake of the *DSM* task forces collating the SAD diagnosis in the 1980s. That is, '[a] few experts insisted they wanted to treat only "extreme shyness,"[471] but others admitted they were unable to distinguish

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[467] Shelley Day, 'Puerperal Insanity: The Historical Sociology of a Disease', unpublished Doctoral Thesis, Cambridge University, 1985), cited in Natasha Mauthner, 'Towards a Feminist Understanding of Postnatal Depression', *Feminism and Psychology,* 3.3 (1993), 350–55 <doi: 10.1177/0959353593033006> [accessed 4 January 2021], p. 351.
[468] Mauthner, 'Towards a Feminist Understanding', p. 351.
[469] Chloë Taylor, 'Female Sexual Dysfunction, Feminist Sexology, and the Psychiatry of the Normal', *Feminist Studies*, 41.2 (2015), 259–92 <doi: 10.15767/feministstudies.41.2.259> [accessed 4 January 2021], p. 286.
[470] Susan Bordo, *Unbearable Weight: Feminism, Western Culture, and the Body* (Berkeley: University of California Press, 1993).
Cressida Heyes, 'Diagnosing Culture: Body Dysmorphic Disorder and Cosmetic Surgery', *Body and Society*, 15.4 (2009), 73–93 <doi: 10.1177/1357034X09347222> [accessed 4 January 2021].
All cited in Taylor, 'Female Sexual Dysfunction', p. 286.
[471] Lynne Lamberg, 'Social Phobia— Not Just another Name for Shyness', *Journal of the American Medical Association*, 280.8 (1998), 685–86 <doi: 10.1001/jama.280.8.685-JMN0826-3-1> [accessed 4 January 2021].
Claudia Kalb, 'Challenging "Extreme" Shyness', *Newsweek* (2003) <https://www.newsweek.com/challenging-extreme-shyness-139679> [accessed 7 January 2021].

between that trait and Social Anxiety Disorder.'[472] So, they were put on the same hazy continuum, with the co-authors of *Social Anxiety Disorder: A Guide* explain with surprising nonchalance, '[w]here shyness ends and social anxiety disorder begins isn't clear. Some social anxiety is expected in everyone.'[473]

On the notion of a spectrum or continuum, Taylor suggests that traditionally 'feminine' traits are deemed to be abnormal when they are in the extreme. That is, 'the pathological is not so much opposed to the norm as the norm exaggerated.'[474] This is because feminine traits are already deemed to be abnormal, as masculine traits are seen as the default. When feminine traits are exaggerated, they are seen as being doubly aberrant. Social anxiety, or shyness, is arguably a typically feminine trait, thus there is scope for Taylor's argument to be applied to women's SAD. That is, shyness is already deemed to be abnormal, since the more masculine trait of assertiveness is seen as the default. Extreme shyness, or SAD, is then seen as doubly aberrant.

This brings us to the idea of norms of femininity, and previous work which has highlighted how these norms interact with different diagnoses: it is to these interactions, and what they mean for women's SAD, that I now turn.

Gendered Norms

Several authors have discussed the extent to which certain psychiatric diagnoses hinge on ideals of femininity. For instance, Ussher explores the relationship between PMDD and gendered traits. PMDD can, she tells us, be diagnosed in women with the following 'feminised' pre-menstrual symptoms:

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[472] See Franklin R. Schneier, Carlos Blanco, Smita X. Antia, and Michael R. Liebowitz, 'The Social Anxiety Spectrum', *Psychiatric Clinics of North America*, 25.4 (2002), 757–74 <doi: 10.1016/s0193-953x(02)00018-7> [accessed 4 January 2021].
[473] John H. Greist, James W. Jefferson, and David Katzelnick, *Social Anxiety Disorder: A Guide* (Madison: Information Centers, Madison Institute of Medicine, 2000), p. 7.
[474] Taylor, 'Female Sexual Dysfunction', p. 286.

'[A]nxiety, tearfulness, and depression'.[475] Similarly, what started life as 'hysterical personality disorder', and was renamed 'histrionic personality disorder in 1980',[476] has been described by Mary Ann Jimenez as being 'essentially a caricature of exaggerated femininity'.[477] Its symptoms consist of 'excitability, emotional instability, over-reactivity and self-dramatisation'.[478] A person likely to be diagnosed with this might be 'someone who is "typically attractive and seductive ... overly concerned with physical attractiveness" as well as interested in "control(ling) the opposite sex or enter(ing) into a dependent relationship (and continuously demanding) reassurance, approval or praise".[479] Ussher asks, '[i]sn't this how we are taught to "do girl" through teenage magazines, romantic fiction, and "chick flicks? [sic]'[480] In a cruel contradiction, women are socialised into behaving according to ideals of femininity and in doing so are pathologised. The relevance of this to SAD is made apparent by examining the thoughts of sociologist Erving Goffman, who has claimed that women are 'socialized […] to project "shyness"' and '"reserve"'.[481] Indeed, *masculinity* is considered the benchmark for normalcy so femininity, its opposite, is already deviant. Performing to the expectations of femininity is therefore deemed abnormal, even though this is what is expected. This interplay will form a portion of my analysis in later chapters.

While Ussher's aforementioned argument concerns PMDD and Personality Disorders, Mollard writes on PPD. Specifically, she advocates for a feminist constructivist approach in examining this mental health

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[475] Ussher, 'Diagnosing Difficult Women', p. 66.
[476] Mary Ann Jimenez, 'Gender and Psychiatry: Psychiatric Conceptions of Mental Disorders in Women, 1960–1994', *Affilia*, 12.2 (1997), 154–75 <doi: 10.1177/088610999701200202> [accessed 4 January 2021].
[477] Jimenez, 'Gender and Psychiatry', p. 65.
[478] Ussher, 'Diagnosing Difficult Women', p. 65.
[479] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edn [*DSM-III*], Washington DC: American Psychiatric Association Publishing, 1980), p. 348, cited in Ussher, 'Diagnosing Difficult Women', p. 65.
[480] Jane M. Ussher, *Fantasies of Femininity: Reframing the Boundaries of Sex* (London/New York: Penguin/Rutgers, 1997), cited in Ussher, 'Diagnosing Difficult Women', p. 65.
[481] Erving Goffman, *The Presentation of Self in Everyday Life* (New York: Anchor, 1959), cited in Kathryn A. Ziegler, *'Formidable-Femininity': Performing Gender and Third Wave Feminism in a Women's Self-Defense Class* (Saarbrücken: LAP LAMBERT Academic Publishing, 2010), p. 10.

issue due to the centrality of the construct of 'mother'.[482] Pointing to the rigidity of the idealised notion of motherhood as being a contributor to PPD, she makes the case for interrogating this rigidity.[483] I would argue that similarly interrogating the rigid idealised notion of *woman*hood would feature in a feminist constructivist approach to women's SAD. Relatedly, Joan C. Chrisler and Ingrid Johnson-Robledo tell us that 'good women [...] are always soft-spoken, patient, receptive, nurturing, and kind. Any woman who is turned inward or otherwise unapproachable is thought to have something wrong with her'.[484] Their latter sentence is particularly salient for the socially anxious woman, for whom 'turned inward' and 'unapproachable' are accurate descriptors. Chrisler and Johnson-Robledo's characterisation of 'good womanhood' therefore tells us a great deal about how the socially anxious, 'turned inward', and 'unapproachable' woman is 'thought to have something wrong with her' in our culture. By extension, this not only tells us why shyness in women might not be valued, but also tells us why women exhibiting these attributes are positioned as 'mentally ill', both within and without the psy sciences.

Having outlined how previous work has demonstrated that a number of diagnostic categories rest on norms of femininity, and indeed operate through femininity's relationship to masculinity, I want to now focus on the notion of the 'normal' and review work which questions the validity of certain psychiatric diagnoses.

Prevalence and the Normal

Ussher contends that one of the ramifications of naming PMS 'Pre-Menstrual *Syndrome*' is that it 'implies the existence of a clinical condition which is statistically abnormal'.[485] In spite of this, the

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[482] Mollard, 'Exploring Paradigms in Postpartum Depression Research', p. 386.
[483] Ibid., p. 384.
[484] Chrisler and Johnston-Robledo, 'Raging Hormones?', cited in Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', p. 285.
[485] Ussher, 'Premenstrual Syndrome', p. 226.

prevalence of PMS symptoms suggests that it is actually statistically *normal*. Community surveys have found that 'the world's commonest disease'[486] affects around 50% of women, and between 10 and 40% have symptoms which disrupt their lives.[487] Other sources estimate PMS among women in North America, Australia, and Western Europe occurs at a rate of 75%,[488] while 13-19% satisfies the diagnostic criteria for PMDD.[489] In light of these statistics, the following remark from Emily Martin is particularly relevant: '[H]ow is it that "a clear majority of all women are afflicted with a physically abnormal hormonal cycle"?'[490]

Taylor's thoughts are similar to those of Martin in that she questions the disease model status of female sexual problems, such as Female Orgasmic Disorder,[491] Female Sexual Interest/Arousal Disorder,[492] and Genito-Pelvic Pain/Penetration Disorder,[493] which come under the umbrella 'Female Sexual Dysfunction' (FSD). Specifically, she turns to statistics in seeking to question the validity of this umbrella of diagnoses. Taylor points out that the National Health and Social Life Survey of 1999 claimed that 32% of women had

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[486] Katherina Dalton, *Once A Month* (Pomona, CA: Hunter House, 1979), p. 193, cited in Rome, 'Premenstrual Syndrome (PMS) Examined through a Feminist Lens', p. 145.
[487] Joseph F. Mortola, 'Assessment and Management of Premenstrual Syndrome', *Current Opinion in Obstetrics and Gynaecology*, 4, 877–85 <https://pubmed.ncbi.nlm.nih.gov/1450353/> [accessed 4 January 2021] cited in Ussher, 'Premenstrual Syndrome', p. 226.
[488] Meir Steiner and Leslie Born, 'Advances in the Diagnosis and Treatment of Premenstrual Dysphoria', *CNS Drugs*, 13 (2000), 287–304 <doi: 10.2165/00023210-200013040-00005> [accessed 4 January 2021] cited in Ussher and Perz, 'PMS as a Gendered Illness', p. 132.
[489] Uriel Halbreich, Jeff Borenstein, Terry Pearlstein, and Linda S. Kahn, 'The Prevalence, Impairment, Impact, and Burden of Premenstrual Dysphoric Disorder (PMS/PMDD)', *Psychoneuroendocrinology*, 28 (2003), 1–23 <doi: 10.1016/s0306-4530(03)00098-2> [accessed 4 January 2021] cited in Ussher and Perz, 'PMS as a Gendered Illness', p. 132.
[490] Emily Martin, *The Woman in the Body: A Cultural Analysis of Reproduction* (Boston: Beacon, 1987), cited in Anne E. Figert, 'Premenstrual Syndrome as Scientific and Cultural Artifact', *Integrative Physiological and Behavioral Science,* 40.2 (2005), 102–13 <doi: 10.1007/BF02734245> [accessed 4 January 2021], p. 106.
[491] APA, *DSM-5*, p. 429.
[492] Ibid., p. 433.
[493] Ibid., p. 437.

Hypoactive Sexual Desire Disorder[494] and that, in the case of women over forty, '"more than half" […] are sexually "disordered"'.[495] While FSD is treated as a psychiatric disorder, Taylor uses the numbers cited above to make the case that these women's 'symptoms' are, in a statistical sense, normal.[496] Moreover, she tells us that, in women over forty, it is actually the *majority* that 'have' FSD.[497] If FSD is *statistically* normal, Taylor questions whether it is a psychiatric disorder at all.[498] In considering its treatment by psychiatry, she proposes that FSD has been conceptualised as being 'abnormal in some *other* way — such as ideologically'.[499] '[T]he ideological norm in question,' she tells us, 'is a medical construction of female sexuality tailored to appeal to modern, Western, heterosexual men'.[500] Taylor's thoughts speak to the conflation of normality with illness, and follow Foucault's remark that

> [I]f you are not like everybody else, then you are abnormal, if you are abnormal, then you are sick. These three categories, not being like everybody else, not being normal and being sick are in fact very different but have been reduced to the same thing.[501]

Relating these arguments to my own work, the *DSM-5*'s definition of SAD states that it is characterised by '[m]arked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others'.[502] An example of this situation writ large is arguably public speaking, and

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[494] Laumann et al., 'Sexual Dysfunction in the United States', cited in Taylor, 'Female Sexual Dysfunction', pp. 261–62.
[495] Taylor, 'Female Sexual Dysfunction', p. 282.
[496] Ibid., p. 265
[497] Ibid., p. 282.
[498] Ibid., p. 285.
[499] Ibid., p. 282.
[500] Ibid., pp. 283–84.
[501] Michel Foucault, 'Je Suis un Artificier', in *Michel Foucault, Entretiens,* ed. by Roger-Pol Droit (Paris: Odile Jacob, 2004), p. 95.
[502] APA, *DSM-5*, p. 202.

this phobia has been construed within the psy science literature as a subtype of SAD.[503] Indeed, the *DSM-5*'s diagnostic criteria state that physicians should '*[s]pecify* if: Performance only: If the fear is restricted to speaking or performing in public'.[504] In much the same way that Martin and Taylor point to the prevalence of PMS and FSD, respectively, in questioning these phenomena's validity as illnesses, it is pertinent to point out that the rate of nervousness about public speaking has been found to be 20.6% in a US community sample;[505] one in three in another US community sample;[506] and 55% in a US community survey.[507] If we are not to restrict ourselves to the exclusive consideration of public speaking, author of *Shyness: What It Is, what To Do about It* Philip G. Zimbardo suggests that around 90% of people have experienced social anxiety symptoms.[508] It is also worth pointing out that none of the studies I have cited above differentiate between genders; when considering that SAD is more common in women,[509] its prevalence among women is likely higher than these studies indicate. Recall the thoughts of Kramer cited in the previous chapter, wherein he discussed the way in which our culture prefers certain traits in women, namely '[v]ivacious women's attractiveness to men'[510] and 'resilience, energy, assertiveness, an enjoyment of give-and-take':[511] socially anxious women are perhaps not likely to exhibit these traits. In

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[503] Anke W. Blöte, Marcia J. W. Kint, Anne C. Miers, and P. Michiel Westenberg, 'The Relation between Public Speaking Anxiety and Social Anxiety: A Review', *Journal of Anxiety Disorders*, 23.3 (2009), 305–13 <doi: 10.1016/j.janxdis.2008.11.007> [accessed 4 January 2021].
[504] APA, *DSM-5*, p. 203.
[505] Alec C. Pollard and Gibson J. Henderson, 'Four Types of Social phobia in a Community Sample', *Journal of Nervous and Mental Disease*, 176.7 (1988), 440–45 <doi: 10.1097/00005053-198807000-00006> [accessed 4 January 2021].
[506] Murray B. Stein, John R. Walker, and David R. Forde, 'Public-Speaking Fears in a Community Sample: Prevalence, Impact on Functioning, and Diagnostic Classification', *Archives of General Psychiatry*, 53.2 (1996), 169–74 <doi: 10.1001/archpsyc.1996.01830020087010> [accessed 4 January 2021].
[507] Stein et al., 'Setting Diagnostic Thresholds for Social Phobia'.
[508] Philip G. Zimbardo, *Shyness: What It Is, what To Do about It* (Reading, MA: Addison-Wesley, 1977).
[509] De Wit et al., 'Gender Differences in the Effects of Family Adversity'.
Wittchen et al., 'Social Fears and Social Phobia'.
Asher et al., 'Gender Differences in Social Anxiety Disorder'.
[510] Kramer, *Listening to Prozac*, p. 270.
[511] Ibid., p. 271.

light of this, I would argue, in much the same way as Taylor posits regarding women and FSD, that SAD in women is not statistically or biologically abnormal, but *ideologically* abnormal. Moreover, in treating SAD in women, it could be argued that doctors are enforcing adherence to dominant norms, or practising 'social hygiene'.[512]

On the topic of prevalence, I want to draw on the thoughts of Caplan, and revisit Eli Lilly's Sarafem. As previously mentioned, Sarafem is Prozac, repackaged in pink and purple casing and marketed to women for PMS/PMDD. Caplan tells us that, in the explanatory materials for Sarafem, Eli Lilly has

> [A]dded a list of mood problems from the PMDD list that virtually every human being experiences. Even the National Institute of Mental Health website muddies the distinction between PMS and PMDD. This is called 'category creep,' a way of deeming increasing numbers of people mentally ill.[513]

It is worth asking whether, like the problems from the PMDD list that Caplan cites, nervousness about public speaking is also something that almost every human being has experienced at some point; and whether shyness is also subject to category creep, facilitated by the pharmaceutical companies that peddle its 'cure'.

Taylor makes an argument related to category creep concerning FSD. I contend that her point could equally be made regarding other mental health issues, including SAD. She argues that the treatment of

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[512] See Michel Foucault, *The History of Sexuality: An Introduction* (New York: Vintage, 1978).
Michel Foucault, *Abnormal: Lectures at the Collège de France 1974–1975* (New York: Picador, 2003).
Michel Foucault, 'Confinement, Psychiatry, Prison', in *Michel Foucault: Politics, Philosophy, Culture: Interviews and Other Writings, 1977–1984,* ed. by Lawrence D. Kritzman (New York: Routledge, 1988), 178–210.
Michel Foucault, *History of Madness* (1961; repr., New York: Routledge, 2006).
Michel Foucault, *Psychiatric Power: Lectures at the Collège de France 1973–1974* (New York: Palgrave MacMillan, 2006).
All cited in Taylor, ', 'Female Sexual Dysfunction', p. 284.
[513] Caplan, 'Pathologizing your Period', p. 64.

FSD is a means by which psychiatry is able to target greater numbers of people,[514] since those with FSD 'do not even stray from an ostensible statistical norm'.[515] Just over a century ago, she tells us, psychiatry 'dispensed with illness', thereby increasing its remit of control.[516] That is, it began treating not only the pathological, but also the abnormal.[517] Recall my citing of Foucault above, wherein he points to the conflation of not being like everybody else, being abnormal, and being sick. What Taylor argues is that, in much the same way that psychiatry broadened its 'web of control' over a hundred years ago,[518] it now not only concerns itself with the *ab*normal, but with the *normal*.[519] Perhaps then, this could explain why it now concerns itself with the socially anxious (woman).

Certainly, category creep is a way in which diverse behaviours are increasingly medicalised and conceptualised as problems. In the case of social anxiety, such behaviours might include general shyness; lack of eye contact; disliking going to parties or social gatherings;[520] or finding it difficult to start and/or maintain conversation.[521] I now want to explore the medicalisation of diverse behaviours.

Medicalising Difference

On PMS, Rome has criticised what she sees as the tendency of some feminists to claim that the majority of women are 'normal', with but a few experiencing disruption pre-menstrually. This, she claims, 'only serves to separate those who "pass" in our male regulated society from those who can't or won't pass, rather than to examine the broader issues of societal rules not classifying a wider range of human

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[514] Taylor, 'Female Sexual Dysfunction', p. 264.
[515] Ibid., p. 265.
[516] Michel Foucault, *The History of Sexuality: An Introduction* (New York: Vintage, 1978), p. 308.
[517] Taylor, 'Female Sexual Dysfunction', p. 282.
[518] Foucault, *The History of Sexuality*, p. 308.
[519] Taylor, 'Female Sexual Dysfunction', p. 282.
[520] Mayo Clinic, *Social Anxiety Disorder* (2017) <https://www.mayoclinic.org/diseases-conditions/social-anxiety-disorder/symptoms-causes/syc-20353561> [accessed 26 September 2020].
[521] Schneier et al., 'The Social Anxiety Spectrum'.

experience as acceptable'.[522] On a related note, bioethicist and philosopher of medicine Tamara Kayali Browne points to the tendency for people to be 'uncomfortable with biological variation',[523] citing the recent trend of vulval surgery as an example. While this 'discourages acceptance of variations in vulva appearance', she argues, analogously, 'so too does the feminine ideal also discourage acceptance of variations in female behaviour'.[524]

While Rome writes about PMS, her argument is equally applicable to other mental health issues. In the case of women's SAD, I posit that it is important to examine what society sanctions as acceptable or permissible behaviour, especially in light of 'appropriate' behaviours for women and the feminine ideal, as Browne contends. Following Rome, I advocate a move away from separating women into 'normal' and 'abnormal', the socially anxious women and the non-socially anxious women; and, by extension, those women who 'pass', and those who do not.

On the thoughts of Browne, it is the label of 'disorder', she tells us, which aids in legitimising treatments. If, she posits, a given *difference* were to be regarded as simply that, as opposed to a pathology, then 'treatment' would be seen as being unethical, even harmful.[525] Applying this to socially anxious women, we must ask: if we were to view women's social anxiety as a difference, not a disorder, would SAD be treated with psychotherapy and medication as it is at the moment?

It is also pertinent to point out that several authors have suggested that difference should not merely be tolerated, but that it might be actually positive, or even advantageous. For instance, Browne cites cases of Depression, brought on by a heightened sensitivity to external factors, which have been credited by

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[522] Rome, 'Premenstrual Syndrome (PMS) Examined through a Feminist Lens', p. 145.
[523] Browne, 'Is Premenstrual Dysphoric Disorder Really a Disorder?', p. 320.
[524] Ibid.
[525] Ibid.

some people as being a ‘catalyst for change in their lives’.[526] That is, their unhappiness acted as a sign that something in their lives had ‘gone awry’.[527] Most importantly for my own work, Browne adds that ‘[a] similar argument has been made for anxiety in social situations and suffering due to trauma — that such reactions are normal and can even be useful’.[528] Indeed, I outlined earlier on in the chapter how nervousness in performance situations, giving public speaking as an example, is extremely common and thus arguably normal. Nervousness surrounding such a situation might mean that a socially anxious woman makes ample preparation, anticipates audience questions, and ultimately this might mean that she delivers a higher quality speech than her less nervous counterpart.

Erica Leibrandt, a psychotherapist and author who identifies as a ‘Socially Anxious Person’, describes some of the benefits of social anxiety. These include saving energy for ‘things that are really important to us’, namely social gatherings; a tendency to be compassionate, empathetic, and tolerant of others’ ‘quirks’, owing to our own; being incredibly loyal once we find friends that we trust; having learned to enjoy solitude; and, owing to the fact that we find a lot of situations stressful, not taking things for granted.[529] Leibrandt’s narrative stands in stark contrast to the rather hopeless picture presented when

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[526] Arthur W. Frank, *At the Will of the Body: Reflections on Illness* (Boston: Houghton Mifflin, 1991).
Rita Schreiber, ‘(Re)defining my Self: Women’s Process of Recovery from Depression’, *Qualitative Health Research* 6.4 (1996), 469–91 <doi: 10.1177/104973239600600402> [accessed 4 January 2021].
Damien Ridge and Sue Ziebland, ‘“The Old Me Could never Have Done that”: How People Give Meaning to Recovery Following Depression’, *Qualitative Health Research,* 16.8 (2006), 1038–53 <doi: 10.1177/1049732306292132> [accessed 4 January 2021].
All cited in Browne, ‘Is Premenstrual Dysphoric Disorder Really a Disorder?’, p. 320.
[527] Frank, *At the Will of the Body.*
Schreiber, ‘(Re)defining My Self’.
Ridge and Ziebland, ‘“The Old Me Could Never Have Done that”’.
All cited in Browne, ‘Is Premenstrual Dysphoric Disorder Really a Disorder?’, p. 320.
[528] Richard G. Tedeschi, Crystal L. Park, and Lawrence G. Calhoun, *Posttraumatic Growth: Positive Changes in the Aftermath of Crisis* (Mahwah, NJ: Lawrence Erlbaum Associates, 1998), cited in Browne, ‘Is Premenstrual Dysphoric Disorder Really a Disorder?’, p. 320.
[529] Erica Leibrandt, *The Surprising Benefits of Having Social Anxiety* <https://www.elephantjournal.com/2016/05/the-surprising-benefits-of-having-social-anxiety/> [accessed 6 September 2019].

consulting psy science sources on SAD, such as the Royal College of Psychiatrists's resource on 'Shyness and Social Phobia', which tells us that

> Many sufferers cope by arranging their lives around their symptoms.
> This means that they (and their families) have to miss out on things they might otherwise enjoy. They can't visit their children's school, can't do the shopping or go to the dentist. They may even actively avoid promotion at work, even though they are quite capable of doing a more demanding and more financially rewarding job.
> About half of those with a severe phobia, particularly men, will have difficulty in making long-term relationships.[530]

Philosopher Jacquelyn Zita draws attention to a similar narrative when considering women's monthly cycles. Consideration, she tells us, tends to be wholly given to the negative aspects of the peri- and pre-menstrum.[531] In spite of this, she cites studies which have found that many women purport that their midcycle is a time of heightened mood, productivity, and creativity.[532] The positive aspects of PMS, Zita contends, are not given attention.[533] Chrisler and Caplan also observe this phenomenon across both the popular and academic literature.[534] It exists, they argue, because this 'time of the month' is

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[530] Royal College of Psychiatrists, *Shyness and Social Phobia* (2016) <https://www.rcpsych.ac.uk/mental-health/problems-disorders/shyness-and-social-phobia> [accessed 6 September 2019].
[531] Jacquelyn N. Zita, 'The Premenstrual Syndrome: "Dis-easing" the Female Cycle', *Hypatia*, 3.1 (1988), 77–99 <doi: 10.1111/j.1527-2001.1988.tb00057.x> [accessed 4 January 2021].
[532] M. Altmann, E. Knowles, and H. Bull, 'A Psychosomatic Study of the Sex Cycle in Women', *Psychosomatic Medicine,* 3.3 (1941), 199 –225 <doi: 10.1097/00006842-194107000-00001> [accessed 4 January 2021].
Melville E. Ivey, M. E. and Jurdith M. Bardwick, 'Patterns of Affective Fluctuation in the Menstrual Cycle', *Psychosomatic Medicine*, 30.3 (1968), 336 –45 <doi: 10.1097/00006842-196805000-00008> [accessed 4 January 2021].
All cited in Zita, 'The Premenstrual Syndrome'.
[533] Zita, 'The Premenstrual Syndrome'.
[534] Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', p. 276.

conceptualised in the literature 'as a time of illness and dysphoria':[535] positivity and advantage do not fit the dominant narrative of PMS. Considering social anxiety, I would argue that its benefits, some of which are outlined by Leibrandt, are ignored in much the same way as the positive aspects of the pre-menstrum: they do not fit the dominant narrative of SAD as a biologically-rooted, psychiatric disease that needs to be corrected.

In considering narratives of illness, it is pertinent to entertain the idea that these narratives not only work to occlude aspects of women's experiences of mental health issues, but shape the way that women experience these mental health issues: it is this that I now discuss.

Dominant Narratives

The way that women experience distress seems to be affected by the existence of diagnostic boundaries, as well as psychiatric and popular descriptions of these boundaries. I touched on this earlier in justifying my decision to include self-diagnosed participants. In Ussher's research on women and PMDD, she found that when her participants were asked to describe their PMS, they

> [R]e-produced the key symptoms found in academic and popular texts on PMDD […] describing, and simultaneously interpreting, their premenstrual bodily and psychological experiences within the narrow symptom checklist model of PMDD presented by the psychiatry/psychology professions.[536]

Conversely, Ussher notes that when the women were asked to 'present their own interpretations of their premenstrual experiences in the open ended narrative interview', a 'much richer and

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[535] Ibid.
[536] Jane M. Ussher, 'The Role of Premenstrual Dysphoric Disorder in the Subjectification of Women', *Journal of Medical Humanities,* 24 (2003), 131–46 <doi: 10.1023/A:1021366001305> [accessed 4 January 2021], p. 136.

contextualised picture of their symptomatology' emerged.[537] As such, Ussher concludes that the symptom framework sanctioned by medicine has an undeniable effect on how women 'interpret and categorise experiences as PMDD'.[538] Although Ussher is writing about PMDD, it is reasonable to suppose that her argument would equally well apply to other mental health diagnoses, such as SAD. In attempting to counteract the reproducing of dominant narratives of SAD, my participant interviews followed a similar format to Ussher's in that they were semi-structured and participant-led. For this reason, it is likely that my interviews similarly yielded a more rich and contextualised account of my participants' experiences than other methods of data collection. I will elaborate on this in the next chapter.

On women's reproducing of the dominant narratives of PMS/PMDD, Chrisler and Caplan suggest this is owing to the figure of the pre-menstrual woman being prominent in popular culture since around 1980. As such, women's narratives of their own experience are almost inevitably influenced by this stereotype.[539] While the figure of the socially anxious woman is not as ubiquitous in popular culture, the figure of the woman with mental health issues, which arise either due a chemical imbalance or other biological factors, is perhaps becoming more prevalent in popular culture. The existence of this figure will thus inevitably influence the way that socially anxious women conceptualise their own distress as well as the cause to which they attribute it. Chrisler and Caplan cite multiple studies which have observed that women tend to attribute negative experiences (e.g., stress, discrimination, harassment,

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[537] Ibid.
[538] Ussher, 'The Role of Premenstrual Dysphoric Disorder', p. 136.
[539] Chrisler, 'PMS as a Culture-Bound Syndrome', cited in Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', p. 279.

abuse) to cyclical changes,[540] irrespective of 'whether or not they actually correspond to cyclical changes in any measurable way'.[541] It is reasonable to suggest that women also might attribute negative experiences to their social anxiety, as opposed to external factors.

Science and Technology Studies scholar Judy Segal, in discussing psychiatry's identification and treatment of FSD, makes a similar point to Chrisler and Caplan. She notes that professional,[542] corporate,[543] and popular[544] forces are confluent in working to 'persuade women that low desire is abnormal and may be a sign of biological disease'.[545] Perhaps, I would suggest, these forces also work to persuade women that shyness is abnormal, and may too be a sign of a biological disease. On the notion of popular forces, or discourses, Segal notes that

> We all experience distress in the terms available for us to experience it in [...] We are surrounded by professional and public discourses — rhetorics — about health and illness. These rhetorics are

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540 Sharon Golub and Denise M. Harrington, 'Premenstrual and Menstrual Mood Changes in Adolescent Women', *Journal of Personality and Social Psychology*, 41.5 (1981), 961–65 <doi: 10.1037//0022-3514.41.5.961> [accessed 4 January 2021].
Diane N. Ruble, 'Premenstrual Symptoms: A Reinterpretation', *Science*, 197.4300 (1977), 291–92 <doi: 10.1126/science.560058> [accessed 4 January 2021], cited in Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', pp. 280–81.
541 Rome, 'Premenstrual Syndrome (PMS) Examined through a Feminist Lens', p. 145.
542 Laumann et al., 'Sexual Dysfunction in the United States', cited in Judy Z. Segal, 'The Rhetoric of Female Sexual Dysfunction: Faux Feminism and the FDA', *Canadian Medical Association Journal*, 187.12 (2015), 915–16 <doi: 10.1503/cmaj.150363> [accessed 4 January 2021], p. 916.
543 Sprout Pharmaceuticals, *Home Page* (2019) <www.sproutpharma.com> [accessed 29 June 2015] cited in Segal, 'The Rhetoric of Female Sexual Dysfunction', p. 916.
544 Mara Schiavocampo, Jackie Jesko, and Lauren Effron, 'Fight over "Little Pink Pill" Raises Sexism Questions', *ABC News* (2014) <https://abcnews.go.com/Health/fight-pink-pill-boosting-womens-sex-drive-raises/story?id=23813586> [accessed 7 January 2021].
All cited in Segal, 'The Rhetoric of Female Sexual Dysfunction', p. 916.
545 Segal, 'The Rhetoric of Female Sexual Dysfunction', p. 916.

> imbued with values [...] We absorb these values and draw on them in interpreting our own experience of health and illness.[546]

Although Segal's discussion is limited to FSD, I contend that it is applicable to women's SAD: professional and public discourses, and the values they contain, are inevitably going to affect the way that women interpret their experiences of social anxiety. Segal also proposes exploring the means by which our distress is presented to us as being 'best thought of as contained in our individual bodies, expressing a disease, in need of a drug'.[547] Indeed, this is exactly what I am exploring with respect to women's SAD: I am interrogating the notion that it arises due to individual pathology, that it is a biological disease, and that it warrants (pharmaceutical) treatment.

Segal's remarks on discourses and rhetorics surrounding mental ill health somewhat speak to the idea that what are called 'mental illnesses' are socially constructed: it is this that I will now address.

'Mental illnesses' Are Socially Constructed

Positing that mental illnesses are socially constructed does not mean denying women's distress or dispossessing them of their experiences. To this end, I agree with academic Lisa Cosgrove's theorising of PMS. That is, she advocates a constructivist analysis while acknowledging that PMS is 'both a constructed and a lived experience': '[T]he materiality of premenstrual change [is] discursively constructed and experienced as PMS or PMDD in particular socio-cultural contexts, and premenstrual distress [develops] in the context of women's lives.'[548] Similarly, women's distress arising from particular personality traits,

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[546] Ibid.
[547] Ibid.
[548] Lisa Cosgrove, 'Crying out Loud: Understanding Women's Emotional Distress as both Lived Experience and Social Construction', *Feminism and Psychology*, 10.2 (2000), 247–67 <doi: 10.1177/0959353500010002004> [accessed 5 January 2021] cited in Ussher and Perz, 'PMS as a Gendered Illness', p. 133.

such as shyness, develops in the context of my participants' lives; it is discursively constructed and experienced as SAD in the UK at the time of writing.

Although I do not wish to diminish my participants' experiences of distress, it is simultaneously worth examining *why* psychiatry posits certain traits and patterns of behaviour as pathological. In the case of PMS, Ussher posits that this 'disease' emerged in the wake of greater gender equality in the West, with 'the belief that women are erratic and unreliable premenstrually serving to restrict women's access to equal opportunities'.[549] Sociologist Anne Figert points out that this belief has been implemented as a barrier to women entering certain occupations, notably as presidents,[550] doctors, and pilots.[551] The notion that women are at the mercy of their hormones once a month, Ussher tells us, also furthers the idea that they cannot be trusted in roles which carry responsibility.[552] Arguably then, PMS being conceptualised as a mental disorder at the aforementioned time served a purpose: chiefly, to maintain the status quo regarding women's inequality. Ussher points out that mental illnesses, more broadly, have previously been theorised as 'social constructions that regulate subjectivity'.[553] It is thus worth considering whether social anxiety in women could be described as threatening the status quo by contravening present ideals of femininity — ideals which serve our neoliberal, postfeminist society.

In addition to feminist writers such as Ussher and Figert drawing links between the status quo and what constitutes a psychiatric disease, PMS has been described by other feminist writers as a diagnostic

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[549] Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', cited in Ussher, 'Diagnosing Difficult Women', p. 67.
[550] Figert, 'Premenstrual Syndrome as Scientific and Cultural Artifact', p. 67.
[551] Mary B. Parlee, 'The Premenstrual Syndrome', *Psychological Bulletin*, 80.6 (1973), 454–65 <doi: 10.1037/h0035270> [accessed 5 January 2021] cited in Ussher, 'Diagnosing Difficult Women', p. 67.
[552] Ussher, 'Diagnosing Difficult Women', p. 67.
[553] Ussher, 'The Role of Premenstrual Dysphoric Disorder', pp. 132–33.

category which pathologises the reproductive body.[554] I suggest that, along with PMS/PMDD, other overtly gendered mental health diagnoses, such as PPD and FSD, could be described as pathologising women's responses to their reproductive function. Similarly, what are commonly understood as 'women's diseases', such as Eating Disorders and Body Dysmorphic Disorder, pathologise women's responses to their bodies. SAD differs markedly from both of these categories in that it could be described as a 'disorder' of relationality. That is, it is the pathologisation of women's responses to *other people, or social norms*. Even if there *is* some contingency on the body, it is to do with how other people view it or make judgements about it, or in light of our culture's bodily ideals. Social anxiety, as applied to the body, has been previously explored using the construct 'Social Physique Anxiety', but only one study outside of the psy science literature has sought to explore this construct using women's narratives, and from an explicitly feminist perspective.[555] Although my work *does* consider social anxiety arising as a result of concerns about appearance and the body, my analysis does not hinge on this consideration alone.

Returning to the idea of mental illnesses being socially constructed, Ussher and Figert contend that PMS has arguably been positioned as pathology to preserve the status quo. Likewise, Rome argues that anger

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[554] Paula J. Caplan, Joan McCurdy-Myers, and Maureen Gans, 'Should "Premenstrual Syndrome" Be Called a Psychiatric Abnormality?' *Feminism and Psychology*, 2.1 (1992), 27–44 <doi: 10.1177/0959353592021003> [accessed 5 January 2021].
Parlee, 'The Social Construction of PMS'.
Heather C. Nash and Joan C. Chrisler, 'Is a Little (Psychiatric) Knowledge a Dangerous Thing? The Impact of Premenstrual Dysphoric Disorder on Perceptions of Premenstrual Women', *Psychology of Women Quarterly*, 21.2 (1997), 315–22 <doi: 10.1111/j.1471-6402.1997.tb00115.x> [accessed 5 January 2021].
Jane M. Ussher, 'Women's Madness: A Material-Discursive Intra-Psychic Approach', in *Psychology and the Postmodern: Mental Illness as Discourse and Experience,* ed. by Dwight Fee (London: Sage, 2000), 207–30.
Jane M. Ussher, 'Processes of Appraisal and Coping in the Development and Maintenance of Premenstrual Dysphoric Disorder', *Journal of Community and Applied Psychology*, 12 (2002), 1–14 <doi: 10.1002/casp.685> [accessed 5 January 2021].
All cited in Ussher, 'The Role of Premenstrual Dysphoric Disorder', p. 132.
[555] Tara-Leigh F. McHugh, Kent C. Kowalski, Diane E. Mack, Peter R.E. Crocker, Sarah E. Junkin, Lisa K. Lejbak, and Stephanie Martin, 'Young Women's Experiences of Social Physique Anxiety', *Feminism and Psychology*, 18.2 (2008), 231–52 <doi: 10.1177/0959353507088593> [accessed 5 January 2021].

expressed during the pre-menstrual stage of women's cycles being positioned as 'illness' is 'a handy way of not looking at what women are upset about and why. It is a way of "keeping us in our place"'.[556] The idea of SAD being conceptualised as illness so as to obscure the causes of women's social anxiety is something I will explore in subsequent chapters. Related to this is the idea that mental health issues are a way of releasing suppressed feelings, and this is what I will now explore.

Me, not Me: False and Real Selves

Several feminist writers have posited that women 'allow'[557] themselves to display emotions such as frustration, listlessness, and anger but once a month,[558] since the pre-menstrual period is a time in which the display of such emotions is 'culturally sanctioned'.[559] This is because, during this time, such emotions can be blamed on biological factors such as hormones, 'biological malfunction',[560] 'a medical condition' (PMS)[561] or 'pathology',[562] rather than bringing to the fore 'social conditions'[563] which might provide good reason for women to experience distress.[564] As Caplan succinctly points out, '[i]t seems less

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[556] Rome, 'Premenstrual Syndrome (PMS) Examined through a Feminist Lens', p. 145.
[557] Susan H. McDaniel, 'The Interpersonal Politics of Premenstrual Syndrome', *Family Systems Medicine*, 6.2 (1988), 134–49 <doi: 10.1037/h0089741> [accessed 5 January 2021].
Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', p. 276, 288.
[558] Figert, 'Premenstrual Syndrome as Scientific and Cultural Artifact', pp. 104–05.
Anne L. Stout and John F. Steege, 'Psychological Assessment of Women Seeking Treatment for Premenstrual Syndrome', *Journal of Psychosomatic Research*, 29.6 (1985), 621–29 <doi: 10.1016/0022-3999(85)90071-6> [accessed 5 January 2021], cited in Ussher and Perz, 'PMS as a Gendered Illness', p. 135.
[559] Johnson and Kandrack, 'On the Medico-Legal Appropriation of Menstrual Discourse', p. 25.
[560] Elizabeth Sheehy, *Personal Autonomy and the Criminal Law,* Background Paper (Ottawa: The Canadian Advisory Council on the Status of Women, 1987), p. 42, cited in Johnson and Kandrack, 'On the Medico-Legal Appropriation of Menstrual Discourse', p. 25, 26.
[561] Diane N. Ruble and Jeanne Brooks-Gunn, 'Menstrual Symptoms: A Social Cognition Analysis', *Journal of Behavioral Medicine,* 2.2 (1979), 171–94 <doi: 10.1007/BF00846665> [accessed 5 January 2021] cited in Loes Knaapen and George Weisz, 'The Biomedical Standardization of Premenstrual Syndrome', *Studies in History and Philosophy of Science. Part C: Studies in History and Philosophy of Biological and Biomedical Sciences,* 39.1 (2008), 120-34 <doi: 10.1016/j.shpsc.2007.12.009> [accessed 5 January 2021], p. 126.
[562] Ussher and Perz, 'PMS as a Gendered Illness', p. 136.
[563] Johnson and Kandrack, 'On the Medico-Legal Appropriation of Menstrual Discourse', p. 25, 26.
[564] Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', p. 276, 288.

daunting to say, "It must be hormonal!" than to begin the frightening process of looking at underlying causes and realising, for instance, "I need to leave this job — or relationship."'[565] As a result, not only are external contributors to distress ignored but, as Ussher tells us, a woman's turning inward to seek the root of her anger protects her impression of her circumstances, e.g. relationships, as 'good'. Not only this, but these biological explanations for PMS also protect a woman's view of her*self*: positioning 'premenstrual negative affect as "not me"'[566] allows her to 'avoid an assault on the self'.[567]

In the case of PMS, Chrisler observes the use of 'dualistic discourse', such as 'Jekyll & Hyde, "me/not me," "PMS-self/real-self"' that is prevalent in self-help books for PMS.[568] Moreover, a number of studies have found this same discourse in the narratives of (heterosexual) women themselves.[569] It is noteworthy that this parallel echoes the same parallel observed by Ussher in women's descriptions of their PMS symptoms, discussed earlier.

Marion Pirie, 'Women and the Illness Role: Rethinking Feminist Theory', *Canadian Review of Sociology and Anthropology,* 25.4 (1988), 628–48 <doi: 10.1111/j.1755-618X.1988.tb00123.x> [accessed 5 January 2021], p. 642, cited in Browne, 'Is Premenstrual Dysphoric Disorder Really a Disorder?', p. 320.
McDaniel, 'The Interpersonal Politics of Premenstrual Syndrome', cited in Ussher and Perz, 'PMS as a Gendered Illness', p. 135.
[565] Caplan, 'Pathologizing your Period', p. 64.
[566] Ussher, 'The Role of Premenstrual Dysphoric Disorder', cited in Ussher and Perz, 'PMS as a Gendered Illness', p. 140.
[567] Ibid.
[568] Joan C. Chrisler, 'How To Regain your Control and Balance: The "Pop" Approach to PMS', Manuscript under review (2001), cited in Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', p. 276, 288.
[569] Cosgrove, 'Crying out Loud'.
Lee and Sasser-Coen, *Blood Stories.*
Jane M. Ussher, 'Premenstrual Syndrome and Self-Policing: Ruptures in Self-Silencing Leading to Increased Self-Surveillance and Blaming of the Body', *Social Theory and Health*, 2 (2004), 254–72 <doi: 10.1057/palgrave.sth.8700032> [accessed 5 January 2021].
Jane M. Ussher, Myra S. Hunter, and S. J. Browne, 'Good, Bad or Dangerous To Know: Representations of Femininity in Narrative Accounts of PMS', in *Culture and Psychology,* ed. by Corinne Squire (Falmer: Routledge, 2000) 87–99.
All cited in Ussher and Perz, 'PMS as a Gendered Illness', p. 136.

Positioning negative affect or distress as 'not me' is arguably applicable to other mental health issues, such as SAD. Firstly, it has relevance for how my participants conceptualise their own mental health issues, as I shall discuss in Chapter 5. Secondly, I have discussed the experiences of women with SAD in these terms in previous research.[570] That is, these women alluded to their selves being divided into a 'false self' and a 'real self'. In the interests of building on my previous research and providing a more in-depth analysis, it is pertinent to examine existing work which has observed a separation of selves in relation to other mental health diagnoses.

By citing Ussher, I have outlined how positioning negative affect, pre-menstrual or otherwise, protects a woman's sense of self. Chrisler and Caplan make a similar argument in linking this positioning to ideals of femininity. Attributing 'unfeminine' traits or behaviours to PMS, they tell us, allows women 'to hold onto a self-definition of "good/proper" woman'.[571] In doing so, PMS 'allows women to aspire to the ideal without having to admit that it is impossible to achieve'.[572] While Chrisler and Caplan conceptualise this attribution as a coping mechanism, Ussher and Perz write of something very different. The dissonance between reality and 'idealised cultural constructions', they tell us, is actually a *contributor* to women's Depression.[573] Mauthner makes a related point regarding PPD, proposing that it 'arises out of the

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[570] Katie Masters, 'An Analysis of Women and Social Anxiety Disorder from the Perspectives of Feminism and Anti-Psychiatry', Unpublished MRes dissertation, University of Birmingham, 2015.
[571] Sophie Laws, 'The Sexual Politics of Premenstrual Tension', *Women's Studies International Forum*, 6.1 (1983), 19–31 <doi: 10.1016/0277-5395(83)90084-5> [accessed 5 January 2021] cited in Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', p. 276, 288–89.
[572] L. Cosgrove and B. Riddle, 'Constructions of Femininity and Experiences of Menstrual Distress', *Women and Health,* (in press).
Laws, 'The Sexual Politics of Premenstrual Tension', cited in Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', p. 276, 288–89.
[573] K. Berggren-Clive, 'Out of the Darkness and into the Light: Women's Experiences with Depression after Childbirth', *Canadian Journal of Community Mental Health*, 17.1 (1998), 103–20 <doi: 10.7870/cjcmh-1998-0006> [accessed 5 January 2021].
Natasha Mauthner, '"I Wasn't Being True to Myself". Women's Narratives of Postpartum Depression', in *The Depression Epidemic: International Perspectives on Women's Self-Silencing and Psychological Distress,* ed. by Dana Crowley Jack and Alisha Ali (Oxford: Oxford University Press, 2010), 459–84.

discrepancy' that mothers experience 'between the mother they want to be and the mother they feel they are'.[574] Not only would I posit that Mauthner and Ussher and Perz's arguments could be made equally well by swapping 'mother' with 'woman', but it can be seen how ideals of femininity foster an aspiring to an 'ideal self'. Traits which do not fit this ideal may then be attributed to PMS, or other mental health issues, which functions as a coping mechanism. These traits are then positioned as 'my Depression', 'my Anxiety', 'my SAD', or 'not me'. We can thus begin to see how ideals of femininity and mental health issues can work in tandem to create multiple selves.

In discussing PMDD, Ussher cites the tendency to position difficult emotions as 'not me'.[575] Moreover, calling experiences 'symptoms', or 'things', portrays them as something divorced from ourselves and something that needs to be corrected. As such, Ussher writes, 'we foster a sense of alienation or distance from ourselves.'[576] In turn, this facilitates women measuring themselves against 'an idealised construction of femininity'.[577] This measuring or comparison manifests by means of self-surveillance, a phenomenon which I have linked to women's experiences of SAD in previous research,[578] and which I analyse in relation to my participants' narratives in Chapter 5. In brief, social anxiety, or concern with how one is perceived, promotes a continuous watching, or surveillance, of the self. It is pertinent for me now to chart the origins of this concept before exploring its relevance for other mental health diagnoses affecting women.

All cited in Ussher and Perz, 'PMS as a Gendered Illness', p. 137.

[574]Mauthner, '"I Wasn't Being True to Myself", p. 470, cited in Ussher and Perz, 'PMS as a Gendered Illness', p. 137.

[575] Ussher, 'The Role of Premenstrual Dysphoric Disorder', pp. 137–38.

[576] Mark Epstein, *Thoughts without a Thinker: Psychotherapy from a Buddhist Perspective* (London: Duckworth, 1996), p. 144, cited in Ussher, 'The Role of Premenstrual Dysphoric Disorder', pp. 137–38.

[577] Ussher, 'The Role of Premenstrual Dysphoric Disorder', pp. 137–38.

[578] Masters, 'An Analysis of Women and Social Anxiety Disorder'.

Self-surveillance

While I have drawn upon Foucault's *History of Madness*[579] in the previous chapter, it is to another of his works, *Discipline and Punish,*[580] that I now turn. It is worth considering that the original title of *Discipline and Punish* is *Surveiller et Punir*. As Lisa Downing has pointed out, this title is more reflective of 'the importance of the spectacle and the role of the visual in the operations of power and punishment' than the English translation, and connotes the idea of being looked at.[581] On this point, Foucault uses Jeremy Bentham's Panopticon, or 'perfect prison', to explore self-surveillance. This is a cylindrical building comprised of abutting cells about a central watchtower. There is an inmate in each cell, however they cannot see each other; thus an inmate is unable to be a 'subject of communication'.[582] This prevents mutiny because organising such requires communication and, as a result, the inmates' compliance is ensured.

Because only the central observation point, and not what or who is inside, is visible from the cells, the inmates do not know whether they are being observed at any given time. The configuration is thus 'a machine for dissociating the see/being seen dyad'.[583] The Panopticon thus gives rise to the inmates' behaving as though they are being observed, irrespective of whether they are or not. The result is a very effective and efficient disciplinary model, since the tower can be unstaffed. Consequently, the inmates effectively watch themselves, or engage in self-surveillance and, by extension, self-regulation. The inmates have, Foucault tells us, internalised the 'inspecting' gaze of the surveyor: '[A] gaze which each individual under its weight will end by interiorising to the point that he is his own overseer; each

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[579] Foucault, *History of Madness,* p. 25
[580] Foucault, *Discipline and Punish*.
[581] Lisa Downing, *The Cambridge Introduction to Michel Foucault* (Cambridge and New York: Cambridge University Press, 2008), p. 75.
[582] Foucault, *Discipline and Punish,* p. 200.
[583] Ibid., p. 202.

individual thus exercising the surveillance over, and against, himself. A superb formula, power exercised continuously.'[584] I will employ the concepts of self-surveillance and Panopticism in my analysis of my participants' testimonies in later chapters. For now, I want to further examine previous work which has related these ideas to other mental health diagnoses.

As I noted earlier, Ussher writes on self-surveillance in the case of women with PMS. She observes the rigidity of feminine ideals in Western culture and the fact that contraventions of these ideals are pathologised.[585] This then works in tandem with 'negative constructions of menstruation' to foster self-surveillance:[586] that is, women monitor their 'moods and behaviour in relation to often unrealistic ideals'.[587] Similarly, Ussher and Perz interview women with PMS and find that some of these women are 'engaging in self-surveillance'.[588] That is, these women measure their own needs against cultural constructions of the ideal woman who is 'responsible, self-renunciating, and always able to offer unlimited care and attention to others'.[589] One can already see the overlap with women's social anxiety: concern with how one is perceived, especially in light of cultural ideals of womanhood, might lead to a constant monitoring of how one measures up to that ideal.

On Ussher and Perz's point concerning women and care, it might be said that women in our society are expected to carry out the bulk of emotional labour in relationships. Women are positioned, either by

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[584] Michel Foucault, ed. Colin Gordon, *Power/Knowledge: Selected Interviews and other Writings, 1972–1977* (New York: Pantheon Books, 1980), p. 131.
[585] Joan C. Chrisler, '2007 Presidential Address: Power, Perfectionism and the Psychology of Women', *Psychology of Women Quarterly*, 32.1 (2008), 1–12 <doi: 10.1111/j.1471-6402.2007.00402.x> [accessed 5 January 2021].
Ussher, *Managing the Monstrous Feminine*, cited in Ussher and Perz, 'PMS as a Gendered Illness', p. 133.
[586] Ussher, 'Premenstrual Syndrome and Self-Policing', cited in Ussher and Perz, 'PMS as a Gendered Illness', p. 133.
[587] Ibid.
[588] Ussher and Perz, 'PMS as a Gendered Illness', p. 138.
[589] Ussher, 'Premenstrual Syndrome and Self-Policing'.
Ussher and Perz, 'PMS as a Gendered Illness', p. 138.

themselves or others, as being solely responsible for their relationships.[590] In turn, this might lead to women feeling guilty or overly concerned with preserving them. The words of feminist philosopher Jean Grimshaw are relevant here, for she astutely observes that, for women, 'not upsetting people must always be given priority.'[591] This remark's salience for socially anxious women is quite clear, since concern with how one is perceived, concern with others' opinions of oneself, and being liked are all central to the socially anxious experience.

The interplay between women's mental health and their relationships is especially pertinent since SAD is very much a 'disorder' of relationality. In their study on women with PMS, Ussher and Perz note that it is within women's relationships, especially when women express negative emotions therein, that they are subject to their 'inner critics': that is, a self that is 'surveillant, judging […] vigilant'.[592] Not only are there links to be drawn here with self-surveillance, there is a clear association with the division between selves — 'me, not me' — on which I touched earlier. In addition to self-surveillance and division of selves, there is a third concept which emerges from the literature on women's mental health and has relevance for women's social anxiety: self-silencing.

Self-silencing

Rather than questioning why some women become angry or irritable once per month, Ussher and Perz suggest that we should look to why these women suppress such emotions for the rest of the month.[593]

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[590] Jack, *Silencing the Self: Women and Depression.*
O'Grady, *Woman's Relationship with Herself.*
Ussher and Perz, 'PMS as a Gendered Illness', p. 136.
[591] Grimshaw, *Philosophy and Feminist Thinking*, p. 196, cited in Ussher and Perz, 'PMS as a Gendered Illness', p. 136.
[592] Ussher and Perz, 'PMS as a Gendered Illness', p. 136.
[593] Ibid.

They call this suppression ‘self-silencing’, and conceptualise PMS as ‘ruptures’ in this self-silencing.[594] The concept of self-silencing has been employed elsewhere, and has even been made into a scale by psychologist Dana Crowley Jack,[595] who has linked this phenomenon to Depression in women. Rather than use the scale to quantify self-silencing, it is the terms used within this scale that are of particular interest for my work. In Jack’s schema, ‘silencing the self’ is described as ‘the inhibition of thoughts and feelings to avoid relationship conflict and loss’.[596] This is undeniably linked with the socially anxious experience, which comprises concern with how one is perceived, or concern with being liked: silencing the self might well function to preserve either relationships or a favourable impression of the self. However, what is most relevant is what Jack, along with fellow psychologist Diana Dill, calls the ‘divided self’: ‘[B]ehaving in a compliant manner to live up to female role imperatives whilst feeling angry inside.’[597] There is resonance here with the division of selves which I discussed earlier on in the chapter. The female role imperatives about which Jack and Dill write are also reminiscent of the cultural constructions of womanhood that Ussher and Perz mention, and which foster self-surveillance. Jack and Dill’s ‘divided self’, I contend, is arguably alluding to an external self that the socially anxious woman cultivates in order to be liked and accepted in society. Finally, and perhaps most crucially, this self is

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[594] Janette Perz and Jane M. Ussher, ‘Women’s Experience of Premenstrual Change: A Case of Silencing the Self’, *Journal of Reproductive and Infant Psychology*, 24.4 (2006), 289–303 <doi: 10.1080/02646830600973883> [accessed 5 January 2021].
Ussher, ‘Premenstrual Syndrome and Self-Policing’.
Jane M. Ussher and Janette Perz, ‘Disruption of the Silenced-Self: The Case of Pre-Menstrual Syndrome’, in Jack and Ali, *The Depression Epidemic*, pp. 435–58.
[595] Jack, *Silencing the Self: Women and Depression.*
[596] Dana Crowley Jack and Diana Dill, ‘The Silencing the Self Scale: Schemas of Intimacy with Depression in Women’, *Psychology of Women Quarterly*, 16.1 (1992), 97–106 <doi: 10.1111/j.1471-6402.1992.tb00242.x> [accessed 5 January 2021], p. 98.
Ussher and Perz, ‘PMS as a Gendered Illness’, p. 135.
[597] Jack and Dill, ‘The Silencing the Self Scale’, p. 98.
Ussher and Perz, ‘PMS as a Gendered Illness’, p. 135.

reminiscent of Laing's conception of the self in his opus of the same name.[598] Indeed, I have linked Laing's 'divided self' to women's social anxiety elsewhere,[599] and I will explore his work in more depth in Chapter 5.

As one of the forerunners of the anti-psychiatry movement, Laing famously noted, as previously referenced, that insanity could be thought of as 'a perfectly rational adjustment to an insane world'.[600] It is to this sentiment that I will now turn.

'Mental Illnesses' as Rational Responses

In problematising PMDD, Browne draws on the British Psychological Society's critical remarks regarding the *DSM-5*, arguing that the manual medicalises 'normal/natural responses to experiences […] "which do not reflect illnesses so much as normal individual variation"'.[601] Relatedly, Janet Stoppard has conceptualised women's Depression as 'a result of the gendered power imbalance in a patriarchal society',[602] while Ussher reframes the irritability of women with children, supposedly arising due to PMS, as 'a legitimate response to lack of partner support in the home'.[603] While Depression, PMS, and PMDD have been reframed as normal responses to external events and circumstances, SAD has yet to be reframed in this manner. By exploring the lived experience of women with SAD, this project examines the stressors to which these women are subjected in their daily lives under heteropatriarchy.

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[598] Laing, *The Divided Self.*
[599] Masters, 'An Analysis of Women and Social Anxiety Disorder'.
[600] Laing, quoted in Chang, *Wisdom for the Soul,* p. 412.
[601] British Psychological Society, *Response to the American Psychiatric Association: DSM-5 Development* (2011) <http://apps.bps.org.uk/_publicationfiles/consultation-responses/DSM- 5%202011%20-%20BPS%20response.pdf> cited in Browne, 'Is Premenstrual Dysphoric Disorder Really a Disorder?', p. 317.
[602] Stoppard, *Understanding Depression*, cited in Browne, 'Is Premenstrual Dysphoric Disorder Really a Disorder?', p. 323.
[603] Ussher and Perz, 'PMS as a Gendered Illness', p. 140.

On the subject of gendered lived experience, Browne tells us that since '[w]omen experience disproportionate levels of stress and trauma in comparison to men […] it is not surprising that they suffer from disproportionate levels of psychological distress'.[604] Ussher has written on a particularly gendered example, sexual violence, from which many women diagnosed with Borderline Personality Disorder have suffered as children.[605] Far from being pathology, Ussher posits, these women's anger is a justifiable response to what has happened to them, in much the same way as 'their "difficulty" with men in positions of power over them — the therapists who give out diagnoses'.[606] McInnes has conceptualised Post-Traumatic Stress Response along these lines: that is, as women's rational responses to men's violence.[607] Chrisler and Johnston-Robledo also speak to this tenet in asking us to acknowledge the role that 'the stress of women's busy, overburdened lives and, in some cases, traumatic events' play in PMS.[608] In light of these examples, we must ask whether other mental health issues, such as SAD, could also be rational responses to women's gendered experiences. These might include attempting to measure up to societal ideals of femininity; or negative evaluation, bodily and otherwise, by others. Concern with what other people think is central to these contributors, and it can thus be seen how social anxiety might arise from the experience of living as a woman in Western society.

Central to the analyses described above, which posit mental health issues as legitimate responses, is the idea that justifiable distress is not a disease. In the case of PMS, Zita argues that speaking of 'symptoms'

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[604] Alisha Ali, Paula J. Caplan, and Rachel Fagnant, 'Gender Stereotypes in Diagnostic Criteria', in *Handbook of Gender Research in Psychology, Vol. 2: Gender Research in Social and Applied Psychology,* ed. by Joan C. Chrisler and Donald R. McCreary (New York: Springer, 2010), 91–109, cited in Browne, 'Is Premenstrual Dysphoric Disorder Really a Disorder?', p. 322.
[605] Jane M. Ussher, *The Madness of Women: Myth and Experience* (London: Routledge, 2011).
[606] Ussher, 'Diagnosing Difficult Women', p. 66.
[607] McInnes, 'The Political Is Personal'.
[608] Chrisler and Johnston-Robledo, 'Raging Hormones?', cited in Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', p. 276, 277.

detracts from the fact that a woman 'might be furious with someone, and justifiably so'.[609] Indeed, Chrisler and Caplan tell us that when direct-to-consumer advertisements for Sarafem began to air, many women were aghast that their 'daily frustrations and irritations of life' were being 'portrayed as symptoms of a psychiatric disorder'.[610] By extension, I invite the reader to imagine a television advertisement depicting a woman's nervousness about delivering a speech, wherein her apprehension is portrayed as a psychiatric disorder in need of pharmaceutical treatment. Or similarly, an advertisement portraying her concern with how she is perceived, in light of the unattainable ideal of hegemonic femininity, being portrayed as a mental illness in dire need of medication. In reviewing the above authors' work, we can see that they have problematised the tendency of psychiatry to conflate legitimate responses with mental disorders, or to 'medicalise' phenomena.[611] Having already discussed the idea of medicalising difference, I now turn my attention to the medicalisation of distress.

Medicalising Distress

I have previously explored how the word 'syndrome', as in the case of PMS, itself connotes the existence of an abnormality. Indeed, Figert notes that this word implies the existence of 'an underlying disease process in women's bodies'.[612] Further to this, Chrisler and Caplan observe that, in labelling a problem thus, 'it is taken more seriously and seen as needing medical attention.'[613] Sociologist Georgiann Davis also argues along these lines, telling us that the way certain phenomena are named is of utmost importance since 'history has shown that there are implications to defining conditions as disorders'.[614]

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[609] Zita, 'The Premenstrual Syndrome', p. 90.
[610] Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', p. 276, 296.
[611] Conrad, 'Medicalization and Social Control', cited in Vanderminden and Esala, 'Beyond Symptoms', pp. 113–14.
[612] Jane M. Ussher, *The Psychology of the Female Body* (London: Routledge, 1989), p. 73, cited in Figert, 'Premenstrual Syndrome as Scientific and Cultural Artifact', pp. 104–05.
[613] Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', p. 283.
[614] E.g. Phil Brown, 'The Name Game: Towards a Sociology of Diagnosis', *The Journal of Mind and Behavior*, 11.3/4 (1990), 385–406 <https://www.jstor.org/stable/43854099?seq=1> [accessed 5 January 2021].

Citing Conrad, she invites the reader to consider the case of Attention Deficit Hyperactivity Disorder (ADHD).[615] The 1990s saw this diagnostic category broaden to include adults who had not hitherto been diagnosed. This subsequently affected, post-diagnosis, how these people 'understood and explained their behaviours' in lasting ways.[616] Similarly, it is worth considering whether the naming of certain experiences, feelings, and behaviours as 'Social Anxiety *Disorder*' might also have an enduring effect on the way that women understand and explain their experiences, and construe these experiences as abnormal, disordered, or illness.

A number of authors have problematised what they have called the conflation of women's problems with illness. In the case of women who are mothers, social work scholar Susan Gair contends that the 'sick label' inherent in the PPD diagnosis dismisses 'the impossible workload, the loss of uninterrupted sleep, and the overwhelming responsibility of motherhood'.[617] Likewise, feminist activist Sophie Laws and colleagues tell us that the PMDD label separates women from the sociocultural context of their lives,

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Phil Brown, 'Naming and Framing: The Social Construction of Diagnosis and Illness', *Journal of Health and Social Behavior*, 35 (1995) 34–52 <doi: 10.2307/2626956> [accessed 5 January 2021].
Phil Brown, *Toxic Exposures: Contested Illnesses and the Environmental Health* Movement (New York, NY: Columbia University Press, 2007).
Peter Conrad, *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders* (Baltimore, MD: Johns Hopkins University Press, 2007).
Elizabeth C. Cooksey and Phil Brown, 'Spinning on its Axes: DSM and the Social Construction of Psychiatric Diagnosis', *International Journal of Health Services*, 28.3 (1998), 525–54 <doi: 10.2190/1C4D-B7XT-BLLY-WH4X> [accessed 5 January 2021].
Annemarie Jutel, *Putting a Name to It: Diagnosis in Contemporary Society* (Baltimore, MD: The Johns Hopkins University Press, 2011).
All cited in Georgiann Davis, 'The Power in a Name: Diagnostic Terminology and Diverse Experiences', *Psychology and Sexuality*, 5.1 (2014), 15–27 <doi: 10.1080/19419899.2013.831212> [accessed 5 January 2021], p. 18.
[615] Conrad, *The Medicalization of Society.*
[616] Davis, 'The Power in a Name', p. 18.
[617] Susan Gair, 'Distress and Depression in New Motherhood: Research with Adoptive Mothers Highlights Important Contributing Factors', *Child and Family Social Work,* 4.1 (1999) <doi: 10.1046/j.1365-2206.1999.00098.x> [accessed 5 January 2021] p. 56.

calling the latter 'the unfair burdens and circumstances in which women can find themselves'.[618] Mollard's analysis of narratives of mothers experiencing PPD reveal that these mothers' own conceptualisations of their experiences are in line with the ideas of Laws et al. and Gair. That is, they view their PPD not as mental illness, but as 'psychosocial experience[s] related to their material and social conditions'.[619]

By contrast, labelling women's distress as a medical issue such as PMS, Chrisler and Caplan suggest, not only disempowers women[620] but also pathologises[621] them and places 'a biological or medical label on their rebellion or discontent, and thereby dismisses it'.[622] Analogously, naming women's social anxiety as (biological) pathology serves to dismiss the environmental factors which might give rise to it. Their subsequent disempowerment is what I am attempting to reverse by providing a platform on which they can share their narratives and talk about the sociocultural contexts of their lives.

In tandem with ignoring environmental causes of women's distress,[623] several feminist scholars have posited that medicalisation positions the pathology, and therefore the blame,[624] as being within the

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[618] Karen B. Levy, *The Politics of Women's Health Care: Medicalization as a Form of Social Control* (Mesquite, TX: Ide House, 1993).
Catherine K. Riessman, 'Women and Medicalization: A New Perspective', *Social Policy*, 14.1 (1983), 3–18 <doi: https://pubmed.ncbi.nlm.nih.gov/10264493/> [accessed 5 January 2021].
Susan S. M. Edwards, *Women on Trial: A Study of the Female Suspect, Defendant and Offender in the Criminal Law and Criminal Justice System* (Dover: Manchester University Press, 1984).
Sophie Laws, Valerine Hey, and Adrea Egan, *Seeing Red: The Politics of Pre-menstrual Tension* (London: Hutchinson, 1985).
[619] Laura S. Abrams and Laura Curran, '"And You're Telling Me not To Stress?" A Grounded Theory Study of Postpartum Depression Symptoms among Low-Income Mothers', *Psychology of Women Quarterly*, 33.3 (2009), 351–62 <doi: 10.1177/036168430903300309> [accessed 5 January 2021], p. 360, cited in Mollard, 'Exploring Paradigms in Postpartum Depression Research', p. 385.
[620] Shirley Lee, 'Health and Sickness: The Meaning of Menstruation and Premenstrual Syndrome in Women's Lives', *Sex Roles*, 46 (2002), 25–35 <doi: 10.1023/A:1016033517659> [accessed 5 January 2021], cited in Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', p. 276, 287.
[621] Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', p. 298.
[622] Laws, *Issues of Blood*, cited in Ussher, 'Premenstrual Syndrome', p. 225, 235.
[623] Browne, 'Is Premenstrual Dysphoric Disorder Really a Disorder?', p. 318.

individual woman or, in the case of PPD, the individual mother.[625] Kendall, in discussing PMS, has called this 'the medical management of women's oppression' and decries the way that it positions women's conduct as 'individual pathology, rather than as a collective social issue'.[626] Karen Levy is similarly critical of the label 'PMS', since it 'tells women that their problems are internal and individual'.[627] It is worth considering whether the label 'Social Anxiety Disorder' communicates to women a similar message.

While Browne agrees with Levy and Kendall, she also notes that the label 'mental illness' adds 'another layer' to one's suffering, since it entails 'the associated stigma and discrimination and their follow-on consequences'.[628] One of these consequences, Browne notes, is that 'individuals diagnosed with a mental illness are less likely to have their physical complaints taken seriously'.[629] Thus, even amidst recent attempts to mitigate stigma associated with mental health issues through positioning them as biological illnesses like any other, there is still stigma associated with mental health issues such as SAD. Therefore, in following Browne, this label has the potential to compound the socially anxious woman's distress.

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[624] Mauthner, 'Towards a Feminist Understanding', p. 352.
Ussher, 'The Role of Premenstrual Dysphoric Disorder', p. 140.
[625] Mauthner, 'Towards a Feminist Understanding', p. 352.
[626] Kathy Kendall, 'The Politics of Premenstrual Syndrome: Implications for Feminist Justice', *The Journal of Human Justice,* 2.2 (1991), 77–98 <doi: 10.1007/BF02636788> [accessed 5 January 2021], p. 91, cited in Johnson and Kandrack, 'On the Medico-Legal Appropriation of Menstrual Discourse', p. 25.
[627] Levy, *The Politics of Women's Health Care,* cited in Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', p. 276, 300.
[628] Browne, 'Is Premenstrual Dysphoric Disorder Really a Disorder?', p. 317.
[629] Peter Byrne, 'Psychiatric Stigma: Past, Passing and To Come', *Journal of the Royal Society of Medicine*, 90.11 (1997), 618–21 <doi: 10.1177/014107689709001107> [accessed 5 January 2021].
Beate Schulze and Matthias C. Angermeyer, 'Subjective Experiences of Stigma. A Focus Group Study of Schizophrenic Patients, their Relatives and Mental Health Professionals', *Social Science and Medicine*, 56.2 (2003), 299–312 <doi: 10.1016/s0277-9536(02)00028-x> [accessed 22 March 2021].
Simon Jones, Louise Howard, and Graham Thornicroft, '"Diagnostic Overshadowing": Worse Physical Health Care for People with Mental Illness', *Acta Psychiatrica Scandinavica*, 118.3 (2008), 169– 71 <doi: 10.1111/j.1600-0447.2008.01211.x> [accessed 5 January 2021].
All cited in Browne, 'Is Premenstrual Dysphoric Disorder Really a Disorder?', p. 317.

While feminist scholars have been critical of labelling women's distress as illness, since doing so hides external contributors, Mauthner is critical of existing work which attempts to examine external factors in women's PPD. Oftentimes, she tells us, the analysis 'nonetheless fails to go beyond the level of the individual to address the wider sociopolitical and ideological context and structures in which these mothers' experiences are embedded'.[630] Ussher observes a similar tendency in PMS literature, which presents PMS as very much 'an individual problem', a 'disorder affecting an individual woman […] on whom […] psychosocial factors impact and produce symptomatology'.[631] In light of these feminist critiques of existing work on women's mental health, it is important that my attention to the external factors influencing women's SAD is not merely an adjunct to my analysis. Instead, I will explore the wider societal context of my participants' experiences of social anxiety through listening to their testimonies.

While construing women's distress as individual pathology obscures external contributors, what warrants further discussion is how scholars have been critical of this trend insofar as it facilitates the ignoring of the root causes of women's distress such that they continue to be unaddressed.[632] These contributors might include 'abusive relationships, stressful life circumstances, poverty, trauma, and harassment'.[633] Trauma, abusive relationships, and harassment are particularly salient to women's SAD, since the victim-blaming narratives surrounding these phenomena might cause the woman to question, or dwell on, how she was perceived at the time of the event, and how this might have rendered her to 'blame' for its occurring.

This idea can perhaps be made clearer when considering the particular example of a woman subject to abuse. Browne tells us that diagnosing the victim with a 'disorder' ultimately blames her and diverts

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[630] Mauthner, 'Towards a Feminist Understanding', p. 352.
[631] Ussher, 'Premenstrual Syndrome', p. 226.
[632] Browne, 'Is Premenstrual Dysphoric Disorder Really a Disorder?', p. 316.
[633] Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', p. 298.

attention away from the abuser.[634] Not only that, she continues, but medicating a woman in such a situation with biological treatments not only fails to address the root cause of her distress,[635] but could well facilitate its continuation.[636] Browne draws parallels with such situations and using drugs and alcohol 'as self-medication in order to tolerate otherwise intolerable situations'.[637] It is worth considering whether Browne's argument could be applied to women's being medicated for mental health issues, such as SAD, with pharmaceuticals such as antidepressants: do these drugs make women able to tolerate otherwise intolerable situations, namely: intense scrutiny of their bodies, behaviours, and characters, as part of being continually measured against, and measuring themselves against, an impossible hegemonic ideal of Western heterofemininity?

On the topic of medication, and in discussing PMS, Figert comments that there has been a 'movement in modern society to assign a medical label or explanation for human behaviors'.[638] This then means, as Chrisler and Caplan observe, that both doctors and the public have begun to consider medication a panacea for all manner of problems.[639] Rome contends that women's PMS is emblematic of medicalisation: it entails 'the labeling of increasing numbers of normal life events as appropriate for medical "expertise" and treatment'.[640] This places these women under the control of the medical profession which enables doctors to 'redefine real conflicts and tensions in our lives as sickness, and put

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[634] Browne, 'Is Premenstrual Dysphoric Disorder Really a Disorder?', p. 317.
[635] Riessman, 'Women and Medicalization'.
Edwards, *Women on Trial.*
Laws et al., *Seeing Red*, cited in Browne, 'Is Premenstrual Dysphoric Disorder Really a Disorder?', p. 320.
[636] Ibid., p. 317.
[637] Qing Li, Xiaoming Li, and Bonita Stanton, 'Alcohol Use among Female Sex Workers and Male Clients: An Integrative Review of Global Literature', *Alcohol and Alcoholism*, 45.2 (2010), 188–99 <doi: 10.1093/alcalc/agp095> [accessed 5 January 2021], cited in Browne, 'Is Premenstrual Dysphoric Disorder Really a Disorder?', p. 318.
[638] Figert, 'Premenstrual Syndrome as Scientific and Cultural Artifact', pp. 107–08.
[639] Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', p. 276, 299.
[640] Rome, 'Premenstrual Syndrome (PMS) Examined through a Feminist Lens', p. 145.

pressure on us to conform'.[641] Chrisler and Caplan give an example of this in the case of a woman reporting severe PMS her psychotherapist. In this scenario, the psychotherapist

> [M]ay find it easier to help a woman try to change herself in order to fit the feminine ideal than to figure out how to help her resist the social and cultural pressure to be an ideal woman. Taking medication may provide apparent serenity to individual women, but it does nothing to alleviate the oppressive conditions that contributed to the stress and tension that caused them to report severe PMS.[642]

It is particularly relevant that Chrisler and Caplan speak of stress and tension arising as a result of societal pressure on women to fit the feminine ideal. Concern with how well one is perceived as meeting this ideal is consistent with social anxiety. In terms of medicating distress, which might arise from attempting to live up to this construction of femininity, I agree with Chrisler and Caplan insofar as it is 'easier' to medicate this distress, as opposed to facilitating women's resisting the pressure to conform to, and to measure themselves against, ideals of femininity.

If we are to be critical of medicating distress, as opposed to addressing its underlying causes, it is perhaps now pertinent to ask *how* the underlying causes can be addressed: can women's distress be alleviated without recourse to medicalisation? It is here that I want to draw on the work of New York sexologist Leonore Tiefer, whose remit is female sexual problems. Tiefer's take on FSD is analogous to the approach I am endorsing with respect to women's SAD insofar as she focuses on external, contextual contributors and is critical of biological reductionism. Tiefer's *New View Campaign* seeks to challenge

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[641] Jackson in Laws et al., *Seeing Red,* p. 7, cited in Figert, 'Premenstrual Syndrome as Scientific and Cultural Artifact', p. 107.
[642] Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', p. 301.

‘the medicalisation of sex’:[643] that is, the conflation of issues — which are arguably of a political, contextual, social or relational nature — with issues that are medical.[644] Echoing many of the thoughts of the critics of psychiatry cited in the previous chapter, Tiefer challenges dominant FSD discourse which, she argues, conceptualises it as purely biological; arising from cerebral, vascular, or hormonal

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[643] Ellyn Kaschak and Leonore Tiefer (eds.), *A New View of Women’s Sexual Problems* (New York: Haworth Press, 2001).
Also see Leonore Tiefer, *The New View Manifesto* (2000) <http://www.newviewcampaign.org/manifesto.asp> [accessed 26 September 2020].
All cited in Katherine Angel, ‘Contested Psychiatric Ontology and Feminist Critique: “Female Sexual Dysfunction” and the Diagnostic and Statistical Manual’, *History of the Human Sciences*, 25.4 (2012), 3–24 <doi: 10.1177/0952695112456949> [accessed 5 January 2021], pp. 11–12.

[644] Thea Cacchioni, ‘Heterosexuality and the “Labour of Love”: a Contribution to Recent Debates about Female Sexual Dysfunction’, *Sexualities*, 10.3 (2007), 299–320 <doi: 10.1177/1363460707078320> [accessed 5 January 2021].
Annie Potts, ‘”The Essence of the Hard On”: Hegemonic Masculinity and the Cultural Construction of “Erectile Dysfunction”’, *Men and Masculinities,* 3.1 (2000), 85–103 <doi: 10.1177/1097184X00003001004> [accessed 5 January 2021].
Annie Potts, Nicola Gavey, Victoria M. Grace, and Tiina Vares, ‘The Downside of Viagra: Women’s Experiences and Perspectives’, *Sociology of Health and Illness*, 25.7 (2003), 697–719 <doi: 10.1046/j.1467-9566.2003.00366.x> [accessed 5 January 2021].
Annie Potts, Victoria Grace, Nicola Gavey, and Tiina Vares, ‘Viagra Stories: Challenging “Erectile Dysfunction”’, *Social Science and Medicine,* 59.3 (2004), 489–99 <doi: 10.1016/j.socscimed.2003.06.001> [accessed 5 January 2021].
Margaret Ramage, ‘Female Sexual Dysfunction’, *Psychiatry,* 6.3 (2006), 105–10 <doi: 10.1016/j.mppsy.2006.12.003> [accessed 5 January 2021].
Margaret Ramage Fell, ‘Female Sexual Dysfunction’, *Women’s Health Medicine,* 3.2 (2006), 84–88 <doi: 10.1383/wohm.2006.3.2.84> [accessed 5 January 2021].
Jennifer R. Fishman, ‘Manufacturing Desire: The Commodification of Female Sexual Dysfunction’, *Social Studies of Science,* 34.2 (2004), 187–218 <doi: 10.1177/0306312704043028> [accessed 5 January 2021].
Paula Nicolson and Jennifer Burr, ‘What Is “Normal” about Women’s (Hetero)Sexual Desire and Orgasm? A Report of an In-depth Interview Study’, *Social Science and Medicine*, 57.9 (2003), 1735–45 <doi: 10.1016/S0277-9536(03)00012-1> [accessed 5 January 2021].
Kaschak and Tiefer, *A New View of Women’s Sexual Problems.*
Annie Potts, ‘The Female Sexual Dysfunction Debate: Different “Problems”, New Drugs – More Pressures?’, in *Contesting Illness: Processes and Practices,* ed. by Pamela Moss and Kathy Teghtsoonian (Toronto: University of Toronto Press, 2008), 259–80.
Jennifer Drew, ‘The Myth of Female Sexual Dysfunction and its Medicalization’, *Sexualities, Evolution and Gender*, 5.2 (2003), 89–96 <doi: 10.1080/14616660310001632563> [accessed 5 January 2021].
Ray Moynihan and Alan Cassels, *Selling Sickness: How the World’s Biggest Pharmaceutical Companies Are Turning Us all into Patients* (New York: Nation Books, 2005).
Ray Moynihan and Barbara Mintzes, *Sex, Lies and Pharmaceuticals: How Drug Companies Plan to Profit from Female Sexual Dysfunction* (Vancouver: Greystone Press, 2010).
All cited in Angel, ‘Contested Psychiatric Ontology’, p. 12.

malfunctions; and in need of treatment by pharmaceuticals.[645] Instead, Tiefer argues that female sexual problems are highly contingent on context, and may arise due to a number of cultural, political, and social contributors which specifically affect women. She cites the following as examples, which are all, except perhaps the first, more likely to affect women than men: '[L]ack of communication between partners; exhaustion due to inequalities in child-rearing and housework; anxieties about body image; violence from sexual partners; and misunderstandings of female anatomy'.[646] In the spirit of Tiefer's approach, in this work I am critical of what I see as psychiatry's biological reductionism regarding SAD in women. In order to provide a corrective to dominant narratives on women's SAD, I wish to focus on cultural, social, and political contributors which specifically affect women, and which might give rise to this mental health issue. In drawing this section to a close, I will cite the Boston Women's Health Collective's stance regarding the medicalisation of women's problems. They state that 'the cure for PMS may lie in resocialization and societal change, not medicine'.[647] I propose that the cure for social anxiety, similarly, perhaps cannot be found in psychiatry, but may instead lie in women's collective resistance to, and a resulting change in, societal attitudes and views regarding what constitutes 'appropriate' femininity.

Holistic Perspective

In outlining the prevalence of explanations for women's mental health issues that rely on a model of individual pathology, it is unsurprising to learn that the extant literature on this topic, especially SAD, focuses almost completely on biological factors. Zita has problematised this in the case of PMS, calling

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[645] Tiefer, *The New View Manifesto,* cited in Angel, 'Contested Psychiatric Ontology', pp. 11–12.
[646] Ibid.
[647] Boston Women's Health Collective, 'How Real Is PMS?', *Ms.,* III.4 (1992), 75–76, cited in Figert, 'Premenstrual Syndrome as Scientific and Cultural Artifact', p. 107.

the recourse to a hormonal imbalance 'overly simplistic'.[648] This recourse echoes the proposed cause of other mental health issues touted by popular and psychiatric discourse, namely, that they arise from a *chemical* imbalance in the brain. In a similar vein to Zita, Mauthner acknowledges the changes inherent in the body during pregnancy, birth, and the postpartum period but is critical of the tendency to attribute PPD entirely to hormones.[649]

In rejecting the idea that women's distress arises from internal, individual pathology, it is tempting to think that, by extension, I am denying the effect of biological factors. As Ussher has observed in the case of PMS, while this denial could be seen as 'understandable as a reaction to biological reductionism',[650] it is a problem inherent in advocating a social constructionist stance: the body and its effects are not irrelevant. As such, I am adopting a holistic perspective on women's SAD, or what Mollard has called '[a] truly feminist viewpoint' in her analysis of PPD. Such a viewpoint examines the cultural, biological, psychological, economic, and social aspects of a woman's life, as well as her experiences.[651] This is what I am doing by exploring my participants' stories through depth interviews. Moreover, I advocate for an analysis of SAD within its 'social and ideological context',[652] as Zita endorses in exploring PMS. Such a holistic perspective is necessary since mental health issues occur on many levels. Writing of PMS, Ussher cites bodily, social, and psychological levels which, she says, cannot be disentangled from each other.[653] Another way of considering this is by using the concept of embodiment, as employed by Mollard[654] and

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[648] Zita, 'The Premenstrual Syndrome', p. 94.
[649] Mauthner, 'Towards a Feminist Understanding', p. 351.
[650] Ussher, 'Premenstrual Syndrome', p. 238.
[651] Mollard, 'Exploring Paradigms in Postpartum Depression Research', pp. 378–91, 382–83, 385, 386.
[652] Zita, 'The Premenstrual Syndrome', p. 90.
[653] Ussher, 'Premenstrual Syndrome', p. 244.
[654] Mollard, 'Exploring Paradigms in Postpartum Depression Research', p. 388, 383.

Margaret Jane Radin[655] in their research on PPD. Specifically, these authors espouse the idea that women cannot be divided up into parts, and emphasise the link between the biological and the psychological. Further to this, Mollard, drawing on a pragmatist approach, observes that the 'way an individual thinks and experiences the world is related to one's biological makeup'.[656] Building on this and applying it to women with SAD, I would add 'and how others react to one's biological makeup' and, in turn, 'how one reacts to and processes others' reactions'.

Although SAD is dissimilar from PPD or PMS in that it is not a woman's reaction to her body, but a 'disorder' based upon relationality with others, it encompasses physical symptoms as a result of anxiety. These include 'blushing, hand tremor, nausea, or urgency of micturition'.[657] These physical manifestations can then become the focus of the anxiety themselves in that the woman may be concerned that others notice them.[658] As such, the concern with how she is perceived is then shifted to include these aspects of her physicality. Echoing Radin, Mollard, Ussher, and Zita, this example is illustrative of the entanglement of the biological with the psychological which is characteristic of mental health issues. In turn, I propose that a holistic understanding of women's SAD is essential, and this very understanding is what I will deliver in subsequent chapters.

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[655] Margaret Jane Radin, 'The Pragmatist and the Feminist', *Southern California Law Review*, 63 (1989), 1699–1855 <https://heinonline.org/HOL/LandingPage?handle=hein.journals/scal63&div=47&id=&page=> [accessed 5 January 2021].
[656] Ibid., p. 388.
[657] WHO, 'Social Phobias'.
[658] Social Anxiety Institute, *DSM-5 Definition of Social Anxiety Disorder* (2020) <https://socialanxietyinstitute.org/dsm-definition-social-anxiety-disorder> [accessed 26 September 2020].

CHAPTER 3

INTERVIEWING WOMEN WITH SOCIAL ANXIETY DISORDER

Overview

Having set out my theoretical approach in Chapter 1, and, in Chapter 2, reviewed studies which problematise psychiatric diagnoses from a feminist, feminist science studies, and/or anti-psychiatry perspective, this chapter will be concerned with my methodology vis-à-vis the depth interviews I conducted. This entails the interviews themselves, analysis, recruitment, sampling, research ethics, and limits.

I will now briefly remind the reader what I am investigating. My research is concerned with women's experiences of Social Anxiety Disorder. Specifically, it focuses on the sociological underpinnings of, and social contributors to, the experiences which constitutute this mental health diagnosis — which disproportionately affects women[659] — by using women's own words. Existing psy science research on women and SAD has tended to rely on quantitative analyses[660] and has sought to explain SAD's overrepresentation in women using chiefly genetic, hormonal, and evolutionary arguments.[661] My

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[659] DeWit et al., 'Gender Differences in the Effects of Family Adversity'.
Wittchen et al., 'Social Fears and Social Phobia'.
Asher et al., 'Gender Differences in Social Anxiety Disorder'.
[660] E.g. Klaus Ranta, Riittakerttu Kaltiala-Heino, Anna-Maija Koivisto, Martti T. Tuomisto, Mirjami Pelkonen, and Mauri Marttunen, 'Age and Gender Differences in Social Anxiety Symptoms during Adolescence: The Social Phobia Inventory (SPIN) as a Measure', *Psychiatry Research*, 153.3 (2007), 261–70 <doi: 10.1016/j.psychres.2006.12.006> [accessed 5 January 2021].
Yang Xu, Franklin Schneier, Richard G. Heimberg, Katherine Princisvalle, Michael R. Liebowitz, Shuai Wang, and Carlos Blanco, 'Gender Differences in Social Anxiety Disorder: Results from the National Epidemiologic Sample on Alcohol and Related Conditions', *Journal of Anxiety Disorders*, 26.1 (2012), 12–19 <doi: 10.1016/j.janxdis.2011.08.006> [accessed 5 January 2021].
[661] E.g. Altemus, 'Sex Differences in Depression and Anxiety Disorders'.

research thus addresses a conspicuous gap in the literature. Through conducting depth interviews with women who have SAD, my work provides a space for them to describe their lived experiences. In so doing, these women are able to conceptualise SAD for themselves, rather than have the psy sciences do it for them.

Research Questions and Design

In brief, my methodology was as follows: women with SAD described their experiences in their own words in individual, semi-structured, in-depth interviews. My approach was reflexive[662] as well as being informed by feminist standpoint theory[663] and Haraway's work on situated knowledges.[664] After all interviews had been completed and transcribed, interview transcripts were analysed using general thematic analysis.[665] Transcripts and resulting analyses were fed back to participants to give them the opportunity to amend their transcripts and check that each of them agreed with my interpretation of their narratives.

My research questions were as follows:

- What problems are inherent in conceptualising SAD as a mental illness?
- How do my participants experience social anxiety, and how does this compare with how psychiatry conceptualises SAD?

Weinstock, 'Gender Differences'.
For a critique of such work, see Katie Masters, 'Tending to the "Neglected Anxiety Disorder": A Critique of the Psy Science Literature on Women and Social Anxiety Disorder', on the panel 'Alternative Perspectives: Humanities Methodologies within Science and Technology Studies', *Nordic Science and Technology Studies Conference 2019*, University of Tampere, 13th-14th June 2019.

[662] Gouldner, *The Coming Crisis.*

[663] Hartsock, 'The Feminist Standpoint'.

[664] Haraway, 'Situated Knowledges'.

[665] Braun and Clarke, 'Using Thematic Analysis in Psychology'.

- What are the effects of the traditional female gender role and ideals of femininity on my participants' experiences of SAD?
- How do my participants experience SAD and what insights do these experiences provide in relation to the external/social contributors to SAD?

The Centrality of Women's Voices

In both of the previous chapters, I have made it clear that I am aligning myself with a feminist perspective. In terms of my research methodology, my approach is a feminist one insofar as my work brings to light the voices of women with SAD. Academic Tara-Leigh McHugh and colleagues take a similar stance. While they recognise that a 'feminist perspective' is by no means singular or absolute,[666] common themes, such as the centrality of women's experiences, are found in feminist research.[667] I therefore align myself with these scholars since they cite their study on women's Social Physique Anxiety as having 'supported the feminist goal to highlight young women's voices'.[668] Building on this, I seek not only to highlight my participants' voices, but to render them central to my work. Mauthner's approach echoes this in her research on women's experiences of PPD. Therein, she notes a gap in the existing literature in asking: 'Where are the voices of *women* in this debate and, in particular, the voices of distressed mothers? What are *their* accounts of their experience? How do *they* speak of their suffering?'[669] In order to fill this gap, Mauthner advocates 'listening to women's voices' and 'attempting

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[666] Shulamit Reinharz, *Feminist Methods in Social Research* (New York: Oxford University Press, 1992), cited in McHugh et al., 'Young Women's Experiences of Social Physique Anxiety', p. 234.
[667] Heidi Gottfried, 'Engaging Women's Communities: Dilemmas and Contradictions in Feminist Research', in *Feminism and Social Change,* ed. by Heidi Gottfried (Urbana, IL: University of Illinois Press, 1996), 1–20.
Niobe Way, 'Using Feminist Research Methods To Explore Boys' Relationships', in *From Subjects to Subjectivities: A Handbook of Interpretive and Participatory Methods,* ed. by Deborah L. Tolman and Mary Brydon-Miller (New York: University Press, 2001).
All cited in McHugh et al., 'Young Women's Experiences of Social Physique Anxiety', p. 234.
[668] McHugh et al., 'Young Women's Experiences of Social Physique Anxiety', p. 247.
[669] Mauthner, 'Towards a Feminist Understanding', p. 354.

to understand women's lives on their own terms'.[670] In the spirit of Mauthner's work, I note that the voices of women with SAD are likewise conspicuously absent from the extant literature. In this respect, my work addresses a crucial shortcoming in existing scholarship.

My work also provides a space for my participants to speak about their experiences. On this point, the work of psychology scholars Jenna M. MacKay and Alexandra Rutherford, which features interviews with feminist women diagnosed with depression, aims to provide space in which their participants 'construct their own experiences'.[671] I borrow from this area of their methodology in that my research acts as a platform for my participants' voices: in adopting a position of advocacy, I not only provide a space for them to speak about their experiences, but also amplify their accounts and viewpoints.

Further rationale for the centrality of women's voices in my research can be found by considering how one understands social anxiety. Since it is something which is rooted in subjective experience, and has no definitive 'test' in the way that a lot of physical health issues do, clinicians rely on women's descriptions of their 'symptoms' in order to make diagnoses and decide on treatment. It is thus disappointing that psychiatry has traditionally not been receptive to listening to women's voices regarding mental health issues broadly, and specifically concerning SAD. Mauthner tells us that '[w]ithin a medical perspective', which is the dominant mode of viewing SAD in the UK at the time of writing,

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[670] Liz Stanley and Sue Wise, '"Back into the Person" or: Our Attempt To Construct "Feminist Research"', in *Theories of Women's Studies,* ed. by Gloria Bowles and Renate Duelli Klein (London: Routledge and Kegan Paul, 1983) 192–209.
Jane Ribbens, 'Acounting for our Children: Differing Perspectives on "Family Life" in Middle Income Households', unpublished Doctoral Thesis, South Bank Polytechnic, 1990.
Cited in Mauthner, 'Towards a Feminist Understanding', p. 354.
[671] Jenna M. MacKay and Alexandra Rutherford, 'Feminist Women's Accounts of Depression', *Affilia*, 27.2 (2012), 180–89 <doi: 10.1177/0886109912443959> [accessed 5 January 2021], p. 180.

> [T]here is no place for listening to the views, the words, the voices of women themselves. No space is created in which they might share and speak out about their experiences, their feelings, their knowledge. Women's voices are disregarded and silenced.[672]

Ussher makes a parallel point concerning PMS, telling us that its symptoms 'are not visibly apparent, they have to be observed through the interface of subjective accounts'.[673] My work thus seeks to put forward my participants' subjective accounts such that we can understand what the lives of socially anxious women are really like.

While I have mentioned that the voices of women with SAD are largely missing from the literature, it is salient to note that there are also few or no studies which explore external contributory factors to SAD. My work, in exploring exogenous contributors to SAD in women by listening to the women themselves, can thus potentially transform our understanding of this mental health issue as it is experienced by women. Ussher has an analogous approach in her research on PMS, wherein she argues that 'the distinctive features of women's social situations, in a gender-stratified society, may be directly utilised as theoretical and research resources'.[674] In tandem with this, she advocates viewing 'the world "through our participants' eyes"',[675] and 'valorizing the accounts of women'.[676] Employing ideas akin to Ussher's, my work explores structural factors, such as gender inequality, which might contribute to women's SAD. Much like Ussher, I do this by listening to the stories of my participants; presenting to the reader what

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[672] Mauthner, 'Towards a Feminist Understanding', p. 353.
[673] Ussher, 'Premenstrual Syndrome', p. 227.
[674] Sandra Harding, 'Rethinking Standpoint Epistemology: "What Is Strong Objectivity?"', in *Feminist Epistemologies,* ed. by Linda Martín Alcoff and Elizabeth Potter (London: Routledge, 1993), 63–78.
Catherine J. Swann, 'Psychology and Self-Reported PMS: An Evaluation of Different Research Strategies', Unpublished Doctoral Thesis, University of London, 1996, cited in Ussher, 'Premenstrual Syndrome', p. 243.
[675] Harding, 'Rethinking Standpoint Epistemology'.
Sandra Harding, *Whose Science? Whose Knowledge? Thinking from Women's Lives* (Milton Keynes: Open University Press, 1991), cited in Ussher, 'Premenstrual Syndrome', p. 243.
[676] Ussher, 'Premenstrual Syndrome', p. 243.

the world is like through their eyes; and revealing how they feel about the relationship between their social circumstances and experiences of social anxiety.

A final reason for my privileging of my participants' voices is that I deem them to be experts on women's experiences of SAD, since these experiences form their lived realities. When discussing body image, McHugh et al. likewise mention that women are 'experts on their own body experiences'.[677] In common with this, Mollard, in her feminist approach to PPD, argues that '[a]s people experience the world with their body and mind, they are viewed as experts of their own life'.[678] It is this sentiment that I channelled throughout my data collection and analysis.

Following on from my discussion of prioritising women's voices, I will now take the opportunity to explain how my interviews achieved this.

Interviews

As noted above, my analysis is based on a series of individual, semi-structured, in-depth interviews. Qualitative research interviews were the most appropriate method for this research since they are focused on elucidating 'meanings that life experiences hold for the interviewees'.[679] This mode of interview also seeks to encourage participants 'to share rich descriptions of phenomena'.[680]

Semi-structured interviews were an apt choice for this research since, unlike more scripted interviews, they allow for the participants to lead the discussion, describing their experiences 'in their own

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[677] McHugh et al., 'Young Women's Experiences of Social Physique Anxiety', p. 248.
[678] Mollard, 'Exploring Paradigms in Postpartum Depression Research', p. 382.
[679] Barbara DiCicco-Bloom and Benjamin F. Crabtree, 'The Qualitative Research Interview', *Medical Education*, 40.4 (2006), 314–21 <doi: 10.1111/j.1365-2929.2006.02418.x> [accessed 5 January 2021], p. 314.
[680] Carol A. Warren and Tracy Xavia Karner, *Discovering Qualitative Methods: Field Research, Interviews and Analysis* (Los Angeles: Roxbury, 2005), 115–35, cited in DiCicco-Bloom and Crabtree, 'The Qualitative Research Interview', p. 314.

words';[681] they are conducive to my aim of amplifying participants' voices; and they help to prevent the researcher from dominating the narrative.[682] The objective of this method is to reduce the researcher/researched dichotomy as well as lessen any problematic power dynamics so as to not undermine the participant.[683] Interviews which are less structured render the interviewee 'a participant in meaning making'.[684] Specifically, semi-structured interviews are commonly used in feminist research since they 'convey a deeper feeling for or more emotional closeness to the persons studied'.[685]

In the spirit of the feminist interview, Ussher, in her work on PMDD,[686] uses *un*structured interviews. She begins interviews by asking her participants what PMS means to them, thereby providing a space for them to define PMS for themselves, without recourse to 'official' diagnostic criteria. Rather, the focus is directed towards these women's experiences of PMS, in their own words, and is reminiscent of what I sought to do in terms of SAD. After asking this first question, Ussher states that she then 'followed the woman's lead, asking questions of clarification as and when necessary'.[687] Although my own interviews were semi-structured, thus slightly more rigid in their format than Ussher's, I drew on her approach in that my interviews were very much participant-led. Ussher states that her interviews take the form of 'a dialogue between two people, rather than a question and answer situation'.[688] As readers will see at

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[681] Hilary Arksey and Peter T. Knight, *Interviewing for Social Scientists: An Introductory Resource with Examples* (London and Thousand Oaks, California: Sage Publications, 1999), p. 82.
[682] Ibid.
[683] Ann Oakley, *The Sociology of Housework* (London: Martin Robertson, 1974).
Oakley, 'Interviewing Women'.
Toby Jayaratne, 'The Value of Quantitative Methodology for Feminist Research', in *Theories of Women's Studies*, ed. by Bowles and Klein, 140–62.
Liz Stanley and Sue Wise, 'Method, Methodology and Epistemology in Feminist Research Processes', in *Feminist Praxis,* ed. by Liz Stanley (London: Routledge, 1990), 20–60.
[684] DiCicco-Bloom and Crabtree, 'The Qualitative Research Interview', p. 314.
[685] Jayaratne, 'The Value of Quantitative Methodology', p. 145.
[686] Ussher, 'The Role of Premenstrual Dysphoric Disorder', p. 134.
[687] Ibid.
[688] Ibid.

certain points in Chapters 4 and 5, my own interviews echoed this. Moreover, this format lent itself particularly well to my project owing to my own positionality regarding SAD. This is something about which I will speak in more depth later on in this chapter.

Although I drew on Ussher's approach, the reason for my choosing semi-structured over unstructured interviews needs to be addressed. Due to the fact that both my participants and I are socially anxious, unstructured interviews would have been more likely to lead to periods of silence, awkwardness, and stunted discussion than semi-structured interviews. The latter format, while still allowing space for the participant to speak freely and for the interviewer to explore areas raised by the participant spontaneously, provided an interview schedule on which the interviewer could fall back, as well as ensuring that the topics covered in the interview were pertinent to the research questions.[689] That is, while each interview was participant-led, the interviewer could still 'stage-manage' it,[690] guiding the interviewee back to material which was relevant to the research questions when necessary.[691]

The questions in a semi-structured interview are usually between five and ten in number and 'sufficiently focused so that a relatively homogenous group will have shared experiences about the topic'.[692] My interview schedule featured five questions, one of which comprised two parts and one of which comprised three parts. The questions in a semi-structured interview are usually open-ended, and other, follow-up questions are likely to emerge during the interview.[693] This was also typical of the questions in

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[689] Robin Legard, Jill Keegan, and Kit Ward, 'In-depth Interviews' in *Qualitative Research Practice: A Guide for Social Science Students and Researchers,* ed. by Jane Ritchie and Jane Lewis (London, Thousand Oaks, New Delhi: SAGE Publications, 2003), 138–69, p. 141.
[690] Ibid., p. 144.
[691] Ibid., p. 147.
[692] William Miller and Benjamin F. Crabtree, 'Depth Interviewing', in *Doing Qualitative Research,* ed. by Benjamin F. Crabtree and William Miller, 2nd edn (Thousand Oaks, California: Sage, 1999), 89–107, cited in DiCicco-Bloom and Crabtree, 'The Qualitative Research Interview', p. 316.
[693] DiCicco-Bloom and Crabtree, 'The Qualitative Research Interview', p. 315.

my interview schedule, which were broad. For instance, my first question was: ‘Can you give me a personal history, including any mental health issues?’ This question allowed for multiple avenues to be explored, in accordance with the participant’s response. Indeed, John M. Johnson advocates being prepared to depart from the predetermined set of questions, since ‘digressions can be very productive as they follow the interviewee’s interest and knowledge’.[694] My interview schedule can be found in Appendix I.

Individual interviews were chosen over other possible alternatives such as focus groups, which are sometimes used in feminist research with similar aims to my own work.[695] This is because it is likely that socially anxious women would have found speaking in a larger group distressing and, as a result, focus groups would not have been conducive to open discussion. Individual interviews were also selected since their focus is on the individual’s views and experiences,[696] which is concordant with my aim to amplify my participants’ voices. Moreover, they permit the interviewer to delve ‘deeply into social and personal matters’.[697] Indeed, my small sample size meant that I had the scope to obtain deep narratives from each of my participants.

Following on from this, I chose the in-depth interview because it allows the interviewer to fully explore subjective experiences.[698] Moreover, participants are able to ‘express deep feelings and give rich detail

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[694] John M. Johnson, ‘In-depth Interviewing’, in *Handbook of Qualitative Research,* ed. by Jaber F. Gubrium and James A. Holstein (Thousand Oaks, California: Sage, 2002), 103–19, cited in DiCicco-Bloom and Crabtree, ‘The Qualitative Research Interview’, p. 316.
[695] E.g. McHugh et al., ‘Young Women’s Experiences of Social Physique Anxiety’.
[696] DiCicco-Bloom and Crabtree, ‘The Qualitative Research Interview’, p. 314.
[697] Ibid., p. 315.
[698] Victoria Healey-Etten and Shane Sharp, ‘Teaching Beginning Undergraduates how To Do an In-depth Interview: A Teaching Note with 12 Handy Tips’, *Teaching Sociology*, 38.2 (2010), 157–65 <doi: 10.1177/0092055X10364010> [accessed 5 January 2021], p. 157.

about specific experiences' therein.[699] This type of interview is intended to 'elicit detailed narratives and stories'[700] in the participant's own words,[701] which is very much in alignment with my aim to amplify my participants' accounts. I have outlined the purpose of my using in-depth interviews on an individual level, but it is worth noting that the purpose of this kind of interview, on a collective level, is to 'discover shared understandings of a particular group':[702] in this case, of women with SAD in the UK at the time of writing.

Sociologists Viven Marie Palmer[703] and Jack D. Douglas[704] both advocate the quick establishment of a rapport at the beginning of an in-depth interview. This entails respect and trust for the participant, as well as the story she shares, and involves creating a comfortable and safe environment for her such that she is able to reveal candidly 'personal experiences and attitudes as they actually occurred'.[705] No doubt my own positionality as a fellow socially anxious woman was conducive to establishing positive relationships with my participants during my interviews.

I interviewed seven women in total; three of these interviews were face-to-face. One interview was conducted over the telephone and two were conducted by video call, due to geographical constraints. One interview was conducted via email, at the request of the participant. Semi-structured in-depth interviews are usually carried out once per individual and typically last for between half an hour and

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[699] Healey-Etten and Sharp, 'Teaching Beginning Undergraduates', p. 159.
[700] DiCicco-Bloom and Crabtree, 'The Qualitative Research Interview', p. 317.
[701] Sara Owen, 'The Practical, Methodological and Ethical Dilemmas of Conducting Focus Groups with Vulnerable Clients', *Journal of Advanced Nursing*, 28.2 (2001), 345–52 <doi: 10.1046/j.1365-2648.2001.02030.x> [accessed 5 January 2021] cited in DiCicco-Bloom and Crabtree, 'The Qualitative Research Interview', pp. 316–17.
[702] DiCicco-Bloom and Crabtree, 'The Qualitative Research Interview', p. 317.
[703] Viven Marie Palmer, *Field Studies in Sociology: A Student's Manual* (Chicago: University of Chicago Press, 1928), cited in DiCicco-Bloom and Crabtree, 'The Qualitative Research Interview', p. 316.
[704] Jack D. Douglas, *Creative Interviewing* (Beverly Hills, California: Sage, 1985), cited in DiCicco-Bloom and Crabtree, 'The Qualitative Research Interview', p. 316.
[705] DiCicco-Bloom and Crabtree, 'The Qualitative Research Interview', p. 316.

several hours.[706] My own interviews reflected this: they were carried out once per participant and lasted between thirty five minutes and two hours, with the average being around an hour and twenty minutes. After my interviews were conducted and transcribed, they were analysed using psychologists Virginia Braun and Victoria Clarke's six steps of general thematic analysis.[707] That is, the transcripts were read and re-read, and preliminary codes were noted down. Preliminary codes were subsequently refined and turned into initial codes. A full list of initial codes can be found in Appendix II. The data that corresponded to each of these initial codes were collated. Codes were then collated into possible themes, and data corresponding to these possible themes were also collated. It was then ascertained whether the themes chosen were appropriate in relation both to coded extracts and to the rest of the data. Links between themes were established, generating a 'thematic "map"' of the data.[708] Performing ongoing analysis refined each theme as well as the overarching narrative of the analysis. The final themes I operationalised were as follows: co-morbidities, diagnosis, treatment, physical health, appearance and the body, surveillance, and the false self. The final stage, the production of this thesis, was characterised by '[s]election of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis'.[709]

In addition to using general thematic analysis, I borrowed elements from MacKay and Rutherford's study on objectification and Depression in women, which also uses semi-structured interviews.[710] The transcripts from these interviews are coded such that themes are developed from the women's narratives, as opposed to pre-existing theory. McHugh et al. treat their interview transcripts in a similar

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[706] Ibid., p. 315.
[707] Braun and Clarke, 'Using Thematic Analysis in Psychology'.
[708] Ibid., see Figure 2, p. 90.
[709] Ibid., p. 97.
[710] MacKay and Rutherford, 'Feminist Women's Accounts of Depression'.

manner, in that their analyses are 'grounded in the experiences and stories of women'.[711] I note that these methods of analysis have elements in common with grounded theory, which informed my own analysis. Grounded theory stands in stark contrast with most scientific research, which uses a deductive model. That is, data collected are used to either prove or disprove an existing hypothesis. Grounded theory *uses the themes from the data collected in order to produce a new hypothesis*: it is inductive.[712] I did not begin this research with a hypothesis about women and SAD that I attempted to either prove or disprove. Rather, I began with broad research questions, such as: 'What does "Social Anxiety Disorder" mean to you? In what ways do you identify as having SAD?' Through talking to women with SAD about their lives and experiences, I used the themes from their narratives in order to theorise women's SAD in new ways.

The Value of Centralising Women's Voices

I will now take the opportunity to state specifically what my harnessing of my participants' voices achieved. In this thesis, I forge a critique, informed by feminism, especially feminist science studies, and anti-psychiatry, of the psychiatric diagnosis 'Social Anxiety Disorder' in women. In order to do this, my participants' narratives, in the chapters that follow, are placed into dialogue with SAD's diagnostic criteria. Mauthner has conducted similar work in talking to women with experience of Postnatal Depression, and uses material from her interviews 'to support feminist critiques of the medical model of "postnatal depression".'[713] What I add to Mauthner's approach is that my critique is also informed by

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[711] McHugh et al., 'Young Women's Experiences of Social Physique Anxiety', p. 235.
[712] George Allan, 'A Critique of Using Grounded Theory as a Research Method', *Electronic Journal of Business Research Methods*, 2.1 (2003), 1–10 <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.464.1384&rep=rep1&type=pdf> [accessed 5 January 2021].
[713] Mauthner, 'Towards a Feminist Understanding', p. 350.

anti-psychiatry. Moreover, though I am critical of the medical model of SAD, my focus is on the psy sciences, especially psychiatry.

It is also worth stating who my research is *for*. Ultimately, my thesis is for women with SAD, especially those women, my participants, who have shared their stories with me and therefore made this research possible. Mauthner, in studying PPD, also cites the importance of 'carrying out research for women'.[714] It is of utmost importance, she tells us, 'that the findings are comprehensible, accessible and relevant to women, especially to those women who have contributed to the search'.[715] My use of general thematic analysis fulfils Mauthner's requirements since it generates results which are, in the main, 'accessible to [the] educated general public'.[716] In addition, Braun and Clarke note that it lends itself well to research in which participants are collaborators.[717] On this point, I ensured the accessibility of my own findings, and invited participants to collaborate in a limited way, by employing member checking.[718] That is, my participants were given access to their transcripts as well as my analysis of what they had said. They were given the opportunity to alter their transcripts and check that I had interpreted their narratives as they intended.

The member checking I employed also provides a corrective to the extant literature on women and SAD, which has yet to feature women's own accounts, in their own words. Mauthner explains the need for

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[714] Rosalind Edwards, 'Connecting Method and Epistemology: A White Woman Interviewing Black Women', *Women's Studies International Forum*, 13.5 (1990), 477–90 <doi: 10.1016/0277-5395(90)90100-C> [accessed 5 January 2021], cited in Mauthner, 'Towards a Feminist Understanding', p. 354.
[715] Edwards, 'Connecting Method and Epistemology'.
S. Sharpe and J. Jefferson, 'Moving out of Psychology: Two Accounts', in *Feminists and Psychological Practice,* ed. by Erica Burman (London: Sage, 1990), cited in Mauthner, 'Towards a Feminist Understanding', p. 354.
[716] Braun and Clarke, 'Using Thematic Analysis in Psychology', p. 97.
[717] Ibid.
[718] Linda Birt, Suzanne Scott, Debbie Cavers, Christine Campbell, and Fiona Walter, 'Member Checking: A Tool To Enhance Trustworthiness or Merely a Nod to Validation?', *Qualitative Health Research*, 26.13 (2016), 1802–11 <doi: 10.1177/1049732316654870> [accessed 24 March 2021].

research such as mine in stating that 'women's personal accounts of their experience of distress, and the meaning that they attribute to it, are rarely taken into account, let alone presented, in the academic literature'.[719] Moreover, even when women's views *are* considered, 'they are invariably "rewritten", as health professionals have tended to interpret information from people whom they consider to be "disturbed" as a distortion of reality.'[720] Through my own positionality as a woman with SAD, and by employing member checking and elements from grounded theory, I have endeavoured to remain wholly true to my participants' accounts and views.

A Note on Knowledge

Having detailed the type of interview I used, why, and the aims in so doing, I will now outline my own positionality regarding women and SAD as well as how I anticipate that this has shaped the research project. Social psychologist Helen Malson, in her analysis of women's experiences of Anorexia, takes up a stance similar to mine, as evidenced by her description of her research's remit. She tells us that 'analysing academic or clinical texts about anorexia or analysing interviews with women diagnosed as anorexic involves treating the accounts not as more or less objective, but as versions which actively construct certain realities or representations of the world'.[721] Applying this to women with SAD, I am seeking to understand, and present to the reader, my participants' lived realities as well as this group's ways of viewing the world.

Since I am considering the experiences of an oppressed group, I have adopted an approach informed by the feminist epistemology of Sandra Harding. Harding says that historically, relativism appears as a

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[719] Mauthner, 'Towards a Feminist Understanding', p. 353.
[720] Erving Goffman, *Asylums* (New York: Doubleday, 1961), cited in Mauthner, 'Towards a Feminist Understanding', p. 353.
[721] Malson, *The Thin Woman,* p. 7.

‘problem’ when the validity of the views of the dominant group is being challenged.[722] As such, Harding advocates critically examining ‘analyses produced by members of the oppressor group’.[723] In my case, such analyses would be the diagnostic criteria for SAD which I will examine with a critical eye in due course.

I also utilise ideas from feminist standpoint theory:[724] namely, that marginalised groups have access to knowledge that others cannot access. Feminist epistemology scholar Nancy Hartsock says that ‘women’s lives make available a particular and privileged vantage point on male supremacy’.[725] It is this knowledge, from a particular vantage point, for which I am providing a platform in this thesis. Hartsock continues by saying that a standpoint speaks of women’s experience at a specific time, place, and within specific social relations.[726] By adopting a feminist standpoint I am illuminating women’s experiences of SAD in the UK at the time of writing.

I wish to add further nuance to my approach by discussing Haraway’s work on situated knowledges. This work stems from Haraway’s problematising of ‘objectivity’ in science. In her reading of Haraway’s work, philosopher Monika Rogowska-Stangret contends that this ‘impartiality’ or ‘neutrality’ actually ‘hides a very specific position (male, white, heterosexual, human)’ — and I would also add ‘not socially anxious’ — ‘and thus makes this position universal’.[727] Haraway calls this ‘the god trick’.[728]

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[722] Harding, ‘Introduction’, in *Feminism and Methodology,* ed. by Harding, 1–15, p. 10.
[723] Ibid., p. 11.
[724] Hartsock, ‘The Feminist Standpoint’.
[725] Ibid., p. 159.
[726] Ibid., p. 174.
[727] Monika Rogowska-Stangret, *Situated Knowledges* (2018) <https://newmaterialism.eu/almanac/s/situated-knowledges.html> [accessed 26 September 2020].
[728] Haraway, ‘Situated Knowledges’, p. 581.

Situated knowledges, Haraway argues, offer a path to objectivity without recourse to 'the god trick'. It is worth noting that some of Haraway's sympathies are in alignment with that of standpoint theorists'. For instance, she observes that the standpoints of the subjugated are often preferred in feminist thought 'because they seem to promise more adequate, sustained, objective, transforming accounts of the world'.[729] Moreover, she notes the tendency within feminist thought to trust 'the vantage points of the subjugated; there is good reason to believe vision is better from below'.[730]

By 'situated', then, Haraway is advocating for knowledges that are located and positioned, 'where partiality and not universality is the condition of being heard to make rational knowledge claims'.[731] She also makes the case for knowledges that are embodied, in arguing for 'the view from a body, always a complex, contradictory, structuring, and structured body'.[732] What she is arguing *against* is 'the view from above, from nowhere, from simplicity'.[733] Indeed, she is arguing against knowledges that are 'unlocatable, and so irresponsible'.[734]

In espousing these principles, Haraway posits that situated knowledges, by means of their inherent partial perspective,[735] offer 'sustained, rational, objective inquiry'[736] or 'feminist objectivity'.[737] Situated knowledges are able to offer this kind of objectivity because they demand that 'the object of knowledge be pictured as an actor and agent, not as a screen or a ground or a resource'.[738] Moreover, situated knowledges demand 'a practice of positioning that is about carefully attending to power relations at play

[729] Ibid., p. 584.
[730] Ibid., p. 583.
[731] Ibid., p. 589.
[732] Ibid., p. 583.
[733] Ibid., p. 589.
[734] Ibid., p. 583.
[735] Ibid.
[736] Ibid., p. 584.
[737] Ibid., p. 581.
[738] Ibid., p. 592.

in the processes of knowledge production'.[739] In my research, this involved attempting to reduce the power relations at play during the knowledge production that was my interviews.

Adopting an approach informed by Haraway's situated knowledges has several ramifications for my research. Attending to 'partial sight' and 'limited voice' has the potential to reveal 'connections and unexpected openings' that would otherwise remain unexplored.[740] In addition to this, Haraway states that situated knowledges are concerned with communities: in this case, women in the UK with SAD. Haraway calls feminist objectivity 'positioned rationality',[741] which is particularly salient given my conceptualisation of women's SAD as their rational responses to their life circumstances. The images of this positioned rationality, Haraway tells us, are 'the joining of partial views and halting voices into a collective subject position'.[742] Likewise, my work seeks to harness the (partial) viewpoints and (halting) voices of women with SAD into a collective subject position, with the intention of using this position to provide a corrective to diagnostic criteria. Such a position, Haraway argues, 'promises a vision of the means of ongoing finite embodiment, of living within limits and contradictions — of views from somewhere'.[743] Further to this, Haraway suggests that situated knowledges are conducive to 'the loving care people might take to learn how to see faithfully from another's point of view, even when the other is our own machine'.[744] This is what this thesis intends to do with respect to the perspectives of women with SAD.

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[739] Rogowska-Stangret, *Situated Knowledges.*
[740] Haraway, 'Situated Knowledges', p. 590.
[741] Ibid.
[742] Ibid.
[743] Ibid.
[744] Ibid., p. 583.

Positionality

Having explained my epistemological approach, I will now elaborate on my own positionality, and how it has shaped this research project. One author who is candid about her own positionality relative to her work is sociologist Gayle Letherby. Letherby indicates that her own life experiences have played a role in her chosen area of research.[745] Like Letherby, my own identity as a woman with SAD has undoubtedly influenced my decision to research the topic of this thesis. Indeed, Letherby tells us that '[s]everal feminist researchers have noted that women researchers often choose topics which mean something to them'.[746] In so doing, 'drawing and theorising on one's own personal experience is valuable.'[747] Similarly, in speaking of women's experiences of PPD, Mollard argues that 'this phenomena [sic] is not fully understood by those who do not have first-hand experience'.[748] I posit that Letherby's and Mollard's arguments could be made regarding my own positionality with respect to the topic of this thesis: that is, my own experience fosters a greater understanding of the issue I am researching, and drawing on my own insights has proven most valuable.

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[745] Letherby, 'Dangerous Liaisons', p. 91.
[746] Oakley, 'Interviewing Women'.
Cotterill and Letherby, '"Weaving Stories"'.
Cotterill and Gayle Letherby, 'The "Person" in the Researcher'.
Stanley and Wise, *Breaking Out Again.*
Ribbens and Edwards, *Feminist Dilemmas in Qualitative Research.*
All cited in Letherby, 'Dangerous Liaisons', p. 95.
[747] Oakley, 'Interviewing Women'.
Cotterill and Letherby, '"Weaving Stories"'.
Cotterill and Gayle Letherby, 'The "Person" in the Researcher'.
Stanley and Wise, *Breaking Out Again.*
Ribbens and Edwards, *Feminist Dilemmas in Qualitative Research.*
All cited in Letherby, 'Dangerous Liaisons', p. 95.
[748] Mollard, 'Exploring Paradigms in Postpartum Depression Research', p. 382.

A further advantage resulting from the researcher's positionality can be illustrated by considering sociologist Janet Finch's work, wherein she interviewed clergymen's wives.[749] Finch found that 'revealing her own identity as a clergyman's wife greatly improved her interviews. Once respondents had placed her as "one of them" they were happy to talk'.[750] Letherby made a similar discovery in her own research on women's experiences of miscarriage and 'involuntary childlessness', with participants' typical responses being in the vein of, '[i]t's nice to talk to someone who understands', and '[h]ad I known of your own personal involvement in the issue I would have got in touch sooner'.[751]

Although I have not extensively divulged my own experiences as one would in autoethnographic research, my positionality and identity vis-à-vis SAD in women has provided me with a privileged episteme from which to theorise this topic. Letherby echoes my sentiments in stating that although she does not view her own experiences 'as an essential ingredient' in her approach,[752] they are significant in that they are conducive to 'a critical reflexive research process'.[753] It is to the idea of reflexivity as applicable to my research that I now turn.

In stating that my approach is reflexive,[754] I mean that I have acknowledged how my role as interviewer might have impacted upon my participants' responses. To quote Mollard in her study on women's experiences of PPD, reflexivity is the idea that '[e]pistemologically, the researcher and participant are

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[749] Janet Finch, '"It's Great To Have Someone To Talk to": The Ethics of Interviewing Women', in *Social Researching: Politics, Problems, Practice,* ed. by Colin Bell and Helen Roberts (London: Routledge and Kegan Paul, 1984), 70–87, p. 79, cited in Letherby, 'Dangerous Liaisons', p. 97.
[750] Letherby, 'Dangerous Liaisons', p. 97.
[751] Ibid.
[752] Ibid., p. 95.
[753] Tracey L. Hurd and A. McIntyre, 'The Seduction of Sameness: Similarity and Representing the Other', in *Representing the Other: A Feminism and Psychology Reader*, ed. by Celia Kitzinger and Sue Wilkinson (London: Sage, 1996), p. 78, cited in Letherby, 'Dangerous Liaisons', p. 95.
[754] Gouldner, *The Coming Crisis.*

interconnected, both influencing the inquiry process and the findings'.[755] Relatedly, Malson, in her work on women's experiences of Anorexia, views her interviews as 'social and emotional interactive processes[756] in which we discussed experiences and ideas about "anorexia" and about femininity and in which my own subjectivities both as interviewer and as fairly thin woman were also significant'.[757] The interviews I conducted were inevitably shaped by my subjectivity as researcher and socially anxious woman, a subjectivity which fostered interrelatedness between me and my participants.

On the notion of interrelatedness, I want now to discuss the idea that the researcher and interviewee should be 'matched': that is, have 'key socio-demographic criteria' in common.[758] Specifically, the importance of matching on the grounds of gender has been noted by feminist researchers. Such researchers have argued that women's shared 'subordinate social status' gives rise to 'cultural affinity',[759] resulting in a 'closer relationship'.[760] Most pertinent to my own work, the importance of the researcher having 'experiences in common with those they interview' has also been noted.[761] In my work, these 'experiences' were 'experiences of social anxiety as a woman in the UK'.

As such, matching can be advantageous. Shared background can give the researcher deeper insight into the participants' narratives, 'of the language they use and of nuances and subtexts'.[762] Matching can also

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[755] Mollard, 'Exploring Paradigms in Postpartum Depression Research', pp. 380–81.
Although Mollard is not speaking explicitly about reflexivity here, her comment encapsulates the reflexive approach I have employed in this research.
[756] Griffin and Ann Phoenix, 'The Relationship between Qualitative and Quantitative Research', cited in Malson, *The Thin Woman*, p. 103.
[757] Malson, *The Thin Woman,* p. 103.
[758] Jane Lewis, 'Design Issues', in *Qualitative Research Practice,* ed. by Ritchie and Lewis, pp. 48–76, p. 65.
[759] Finch, '"It's Great To Have Someone To Talk to"'.
Oakley, 'Interviewing Women', cited in Lewis, 'Design Issues', p. 65.
[760] Virginia L. Olesen, 'Feminisms and Qualititive Research at and into the Millennium', in *Handbook of Qualitative Research*, ed. by Norman K. Denzin, Yvonna S. Lincoln*,* 2nd edn (Thousand Oaks, CA: Sage, 2000), cited in Lewis, 'Design Issues', p. 65.
[761] Lewis, 'Design Issues', p. 65.
[762] Ibid.

help the researcher to ask appropriate follow-up questions[763] as well as helping to avoid reproducing power imbalances, which exist in society, in the interview. If reproduced in the interview, these power imbalances are 'unlikely to be conducive to open discussion, particularly if issues of oppression or discrimination are highly relevant to the research question'.[764] In the case of women's experiences of SAD, oppression and discrimination are central, both on the grounds of gender and mental ill health. As such, my own positionality as a woman with SAD was key in reducing power imbalances and thereby fostering open dialogue.

Following on from matching, other authors, such as McHugh et al., draw on a body of feminist research[765] which has sought to reduce power dynamics which might arise between the researcher and participants.[766] This is something towards which I have also striven and indeed, my positionality facilitated this. Malson makes a similar argument in theorising as to how sharing her own subject position might have shaped her own research involving interviews with her participants:

> [T]he sharing of various subject positions may have diminished the inevitable power differential that exists between researcher and researched. And these shared discourses, subjectivities and experiences will have had some effect on the dynamics of the interview process, on the ways in

[763] Ibid.
[764] Ibid.
[765] Joan Alway, 'The Trouble with Gender: Tales of the Still-Missing Feminist Revolution in Sociological Theory', *Sociological Theory*, 13.3 (1995), 209–28 <doi: 10.2307/223297> [accessed 5 January 2021].
Verta Taylor, 'Feminist Methodology in Social Movements Research', *Qualitative Sociology,* 21 (1998), 357–79 <doi: 10.1023/A:1023376225654> [accessed 5 January 2021].
Way, 'Using Feminist Research Methods To Explore Boys' Relationships'.
All cited in McHugh et al., 'Young Women's Experiences of Social Physique Anxiety', p. 235.
[766] McHugh et al., 'Young Women's Experiences of Social Physique Anxiety'.

which the interviewees articulated their ideas and experiences and later on the ways in which I analysed the interview transcripts.[767]

My sharing of my own experiences has undoubtedly shaped my interviews, and thus my thesis, in a similar manner to that which Malson describes.

Inclusion Criteria: Self-diagnosis Rationale

Before continuing, it is timely to outline my rationale for including participants who are either diagnosed or self-diagnosed. The first reason for this choice has to do with the accessibility of healthcare in the UK at the time of writing. As sociologists Jennifer Vanderminden and Jennifer Esala note, diagnosis 'is not equally accessible across social groups, which represents a critical form of social inequality'.[768] Even though, as I mentioned previously, healthcare is supposed to be universally accessible in the UK, with this ethos underpinning the NHS, the variation in mental health service investment by region means that delivery is 'patchy'.[769] Moreover, what were already extremely long waiting lists for mental health treatment, of years in many cases,[770] have been lengthened further by the Covid-19 pandemic.[771] This is due to both reduced availability[772] and increased need[773] of mental health services during this time. In

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[767] Malson, *The Thin Woman*, p. 103.
[768] Vanderminden and Esala, 'Beyond Symptoms', p. 113.
[769] Mind, *NHS Figures Reveal Mental Health Spending Postcode Lottery* (2019) <https://www.mind.org.uk/news-campaigns/news/nhs-figures-reveal-mental-health-spending-postcode-lottery/> [accessed 19 February 2021]. NHS England, *Adult Improving Access to Psychological Therapies Programme.*
[770] Mind, *We Need To Talk: Getting the Right Therapy at the Right Time* (n.d.) <https://www.mind.org.uk/media/280583/We-Need-to-Talk-getting-the-right-therapy-at-the-right-time.pdf> [accessed 10 June 2019].
[771] NHS England, *Consultant-led Referral to Treatment Waiting Times Data 2020-21* (2020) <https://www.england.nhs.uk/statistics/statistical- work-areas/rtt-waiting-times/rtt-data-2020-21/> [accessed 22 February 2021], cited in Shaun Griffin, 'Covid-19: Waiting Times in England Reach Record Highs', *British Medical Journal,* (2020) 370.m3557, 1 <doi: 10.1136/bmj.m3557> [accessed 22 February 2021].
[772] British Medical Association [BMA]*, Pressure Points in the NHS* (2021) <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressure-points-in-the-nhs> [accessed 22 February 2021].
[773] Mind, *Mind Warns of 'Second Pandemic' as It Reveals More People in Mental Health Crisis than ever Recorded and Helpline Calls Soar* (2020) <https://www.mind.org.uk/news-campaigns/news/mind-warns-of-second-

such a climate, it cannot be denied that obtaining a diagnosis, and getting treatment, is easier for those who are able to seek mental health care privately. An article from the Royal College of Psychiatrists, decrying long waiting lists for access to mental health services, outlines this situation rather well in sharing Evangeline's story, 'who *had to get private treatment* after waiting months on the NHS':

> My mental health spiralled out of control after my dad's suicide. I saw a mental health specialist at CAMHS but didn't hear anything from them for months despite my anxiety and depression getting much worse. *Things got so bad that my family had no option but to book me in for private treatment.* I'm feeling much better now, but my illness could have been sorted much sooner if I hadn't been left in limbo waiting for my CAMHS appointment.[774]

In reading Evangeline's story, I am left wondering about the many others who are not as fortunate: that is, whose families do not have the wherewithal to book them in for private treatment. These individuals not only do not get the *treatment* that they need, but do not get a *diagnosis* either. As such, the words of *Everyday Feminism*'s Sian Ferguson ring true, for she tells us that 'professional diagnoses are usually only available for the privileged'.[775] In turn, Ferguson, who is self-diagnosed with Post-Traumatic Stress Disorder (PTSD), tells us that self-diagnosis can facilitate those who cannot access professional diagnoses talking about, and understanding, their mental health. In not requiring an official diagnosis, this project therefore provides a platform for such women to tell their stories when they might otherwise not have

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pandemic-as-it-reveals-more-people-in-mental-health-crisis-than-ever-recorded-and-helpline-calls-soar/> [accessed 22 February 2021].

[774] Royal College of Psychiatrists, *Two-fifths of Patients Waiting for Mental Health Treatment Forced To Resort To Emergency or Crisis Services* (2020) <https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2020/10/06/two-fifths-of-patients-waiting-for-mental-health-treatment-forced-to-resort-to-emergency-or-crisis-services> [accessed 23 February 2021]. My emphases.

[775] Ferguson, 'Self-Diagnosing Mental Illness'.

been afforded the opportunity. In addition, my not requiring a professional diagnosis facilitates having a diverse sample of women, with intersecting identities, contribute to my research.

Another consideration underpinning my inclusion criteria relates to whether women with SAD are explicitly told their diagnosis. General Practitioners Patrick Byrne and Barrie Long,[776] in their analysis of over 2000 patient consultations with doctors in a primary care setting — which is where the NHS recommends first seeking help for SAD in the UK[777] — found that the encounters in their sample fell into one of seven diagnostic styles. Specifically, in 31% of cases in their sample, 'no diagnosis was given at all.'[778] Instead, '[t]he physician makes a decision about the patient and his treatment and then instructs the patient to see some service;'[779] that is, '[d]iagnosis is not named, treatment is not explained.'[780] In these cases, patients are not told, and thus do not know, their diagnosis.

Sociologist John Heritage notes that this type of patient-physician interaction is characteristic of 'physician-centered styles of diagnosis', that is, 'those that involve little or no explanation to patients, and that invite little or no participation from them'.[781] On the other hand, '[p]atient-centered styles involve more of both'[782] and are arguably conducive to research, and practice, which is more user-led insofar as it privileges service users' knowledge and experience and thereby seeks to empower them — I will expand upon this approach shortly. By contrast, the ideology which underpins physician-oriented styles of diagnosis, that is, the conception of the medical professional, in the case of mental health, as an arbiter of madness, is what I am interrogating. To exclude women who have been subject to this sort of

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[776] Patrick Byrne and Barrie Long, *Doctors Talking to Patients* (London: Her Majesty's Stationary Office, 1976) cited in Heritage, 'Revisiting Authority', p. 87.
[777] NHS, *Social Anxiety Disorder (Social Phobia).*
[778] Heritage, 'Revisiting Authority', p. 88.
[779] Ibid.
[780] Ibid.
[781] Ibid.
[782] Ibid.

diagnostic process, and thus do not know their diagnosis, would be counter to the aims of this research project.

It is also salient to question what diagnosis means when considering the experience of social anxiety. Clinical psychologist Stijn Vanheule tells us that 'DSM [sic] diagnoses do not *explain* anything beyond [...] idle descriptive classification'.[783] Given this reliance on description, psychiatrists Kenneth S. Kendler and Josef Parnas note that the *DSM* is 'actually remarkably thin, descriptively',[784] thus pointing to the lack of rigour that a professional diagnosis actually entails. On descriptive classification, the thoughts of Robert West, Lou Kennedy, and Anna Carr are relevant.[785] In their research on speech defects, these authors make an important distinction between 'diagnosis' and 'description':

> After we have definitely decided that the only possible cause of a given speech defect is a real pathology or abnormality, then, and only then, do we venture to undertake what can properly be called a *diagnosis*. When we *describe* a case of speech defect, we think in terms of the several *abilities* necessary to speech; when we diagnose it, we think in terms of causes. The two studies, description and diagnosis, differ largely in approach. Description is concerned with the *phenomenology* of the case being studied, diagnosis with its *etiology.* The one deals with the development of that condition in the past, and traces it, if possible, to its beginning and its fundamental cause.

The division between diagnosis and description has relevance for SAD, whose aetiology is unknown. We must therefore question what its official diagnosis actually represents, or tells us, over a given woman's

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[783] Vanheule, *Diagnosis and the DSM,* p. 22.
[784] Kendler and Parnas, *Philosophical Issues in Psychiatry*, p. 373.
[785] Robert West, Lou Kennedy, and Anna Carr, *The Rehabilitation of Speech, A Textook of Diagnostic and Corrective Procedures based upon a Critical Study of Speech Disorders* (Revised edn) (New York: Harper, 1947)., p. 61, cited in Felson Duchan, 'The Diagnostic Practices', pp. 208–09.

own description. Its diagnosis, like those of other psychiatric disorders, is performed based on ‘the internal experiences inherent in mental health problems’.[786] Therefore, these diagnoses are ‘not amenable to objective measurement’ and are ‘based solely on personal accounts and observation’.[787] Thus, what are called ‘psychiatric “diagnoses”’ are more akin to West, Kennedy, and Carr’s ‘descriptions’. If I were to require an official diagnosis, I would be tacitly supporting the idea that a diagnosis indicates something *more* than a description, and tells us about something causative which (biologically) underpins the participant’s experience. In turn, this would run counter to my aim to explore external contributors to SAD in women as well as my aim to problematise the biological reductionism inherent in contemporary psychiatry.

While some scholars such as West and colleagues, and Vanheule, have questioned the validity of psychiatric diagnoses, other scholars have provided critical commentary on these diagnoses for other reasons. Psychiatrist Claire L. Pouncey and academic Jonathan M. Lukens tell us that psychiatric diagnosis is a pre-requisite for involuntary hospitalisation and that this diagnosis is therefore ‘used to justify coercion’.[788] Both inside and outside of the hospital, psychiatric diagnosis, owing to its imposing ‘behaviors and experiences on individuals’, has been described as ‘inauthentic, not to say disempowering’.[789] Moreover, psychiatrist Ramotse Saunders and colleagues tell us that ‘[p]sychiatric diagnoses are often stigmatizing, pejorative, and most importantly, enduring’,[790] while Joseph Baird and colleagues also write of their stigmatising nature.[791] Psychiatrists Philip Thomas and Patrick Bracken

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[786] Faulkner and Nicholls, *Towards a Radically Different Mental Health System.*
[787] Ibid.
[788] Claire L. Pouncey and Jonathan M. Lukens, ‘Madness versus Badness: The Ethical Tension between the Recovery Movement and Forensic Psychiatry’, *Theoretical Medicine and Bioethics*, 31.1 (2010), 93–105 <doi: 10.1007/s11017-010-9138-9> [accessed 5 January 2021], p. 99.
[789] Giles and Newbold, ‘Self- and Other-diagnosis’, p. 427.
[790] Saunders, Hindi, and Vahia, ‘A New Psychiatry for a New World’, p. 212.
[791] Baird et al., *The Mark of Shame*, p. 232.

describe psychiatric assessment, diagnosis, and treatment as 'very often being experienced as limiting and oppressive'[792] as well as harbouring biologically reductionist underpinnings.[793] In light of these critiques, insisting on an official diagnosis does not at all seem fitting for my research project.

In addition, researcher Barbara Bokhour, in her case study of 'Mr Weinberg', a man diagnosed with Alzheimer's, illustrates how '[i]ndividuals suffering from diseases such as Alzheimer's may subsequently be defined as the diagnosis itself, thereby limiting the ways in which others interact with them, view their potential and make decisions on their behalf'.[794] In Bokhour's analysis, diagnosis replaces Mr Weinberg's personhood, that is, his case study represents 'a classic illustration of how the disease becomes the focus of treatment rather than the person who needs support for his symptoms'.[795] While my participants have shared experiences, my aim is to explore each of their stories and regard them as individuals, as opposed to defining them by their mental health issues.

However, while there are doubtless negative consequences to psychiatric diagnoses, this is not the whole story. As Baird and colleagues point out, 'the labeling of mental disorder is an important aspect of stereotyping, prejudice, discrimination, and stigma. On the other hand, labels in the form of accurate diagnoses can be empowering, bespeaking the complexity of this entire issue.'[796] This brings me to the next segment of the rationale underpinning my inclusion criteria, which is my stance regarding psychiatric abolition.

My viewpoint is in alignment with that of the Disability Visibility Project's (DVP) views on psychiatric abolition. This does not mean, as the Project tells us, 'that no one is allowed to identify with psychiatric

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[792] Thomas and Bracken, 'Power, Freedom, and Mental Health', p. 49.
[793] Ibid.
[794] Bokhour, 'A Diagnosed Life in an Institutional Setting', p. 34.
[795] Felson Duchan and Kovarsky, 'Introduction', p. 9.
[796] Baird et al., *The Mark of Shame*, p. 232.

diagnoses that they feel serve them'.[797] This tenet evokes Foucault's idea of a 'reverse discourse',[798] and is something I explore in relation to my participants' testimonies in Chapter 4. 'Reverse discourse' is the idea that while psychiatric diagnoses can be used to pathologise and medicalise, they can also be empowering:[799] they can be used as a means by which to resist and refute the pathological meaning originally ascribed to the given label by, for instance, making one's own positive meanings from the label or by reaching out to others with the same label and creating communities. Following Foucault, Hacking tells us that the term 'homosexual' was originally 'applied by the knowers to the known'.[800] Hacking describes how this term was subsequently 'taken up' by those it sought to describe, the result of which was gay liberation, gay pride, and coming 'out'; the 'homosexuals' were transformed from pathologised perverts to gay communities of pride and pleasure.

While I wish to recognise the experience of those women who are officially diagnosed, equally, I am inspired by the idea of a reverse discourse. As a result, I am espousing the idea that psychiatric diagnosis should be used as a tool only insofar as it serves the individual. This is what has fuelled my inviting self-diagnosed participants to participate in this research and indeed, this decision follows the DVP's insistence that '[y]ou get to choose the language for your own experience'.[801]

Building on the idea of a reverse discourse, the second half of the twentieth century has seen a move away from the division between the 'knowledge and the known',[802] and the idea that '"[w]e" know about "them"',[803] towards what Hacking calls 'self-ascription'. Again using the 'homosexual' as an

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797 Disability Visibility Project, *Abolition Must Include Psychiatry.*
798 Foucault, *The Will to Knowledge*, p. 101.
799 Baird et al., *The Mark of Shame*, p. 232.
800 Hacking, 'The Looping Effects of Human Kinds', p. 381.
801 Disability Visibility Project, *Abolition Must Include Psychiatry.*
802 Hacking, 'The Looping Effects of Human Kinds', p. 381.
803 Ibid.

example, Hacking describes how individuals so labeled 'took up' the label, resulting in gay pride and liberation. As such, '[i]t became a moral imperative for people of the kind to identify themselves, to ascribe a chosen kind-term to themselves. That way they also became the knowers, even if not the only people authorized to have knowledge.'[804]

Hacking's last line resonates with Harding's work on feminist epistemologies. Traditional epistemologies, Harding contends, 'exclude the possibility that women could be "knowers" or agents of knowledge'.[805] By contrast, feminist epistemologists 'have proposed alternative theories of knowledge that legitimate women as knowers'.[806] In allowing women to define themselves as they wish, my work embraces Harding's principles of feminist epistemology. Specifically, I seek to subvert the hegemony of psychiatry and its exclusive power to diagnose and classify. In so doing, in the words of Hacking, women with SAD 'may rise up against the experts. The known may overpower the knowers'.[807]

Following on from this, I take the view that my participants, officially diagnosed or not, are experts on SAD by virtue of their experience. A similar idea is expressed by social justice movement the Health Justice Commons, who, in their vision statement, tell us that '[h]ealth […] cannot be […] easily or entirely defined by health experts. Health must be defined and informed by us and our wisdom, grounded in the totality of our own experiences'.[808] I build upon the HJC's vision in that I apply their ethos to *mental* health.

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[804] Ibid.
[805] Harding, 'Introduction', in *Feminism and Methodology,* ed. by Harding, 1–15, p. 3.
[806] Ibid.
[807] Hacking, 'The Looping Effects of Human Kinds', pp. 360–61.
[808] Health Justice Commons, *Health Justice: Beyond Reform* (n.d.) <https://www.healthjusticecommons.org/our-vision> [accessed 7 January 2021].

The notion that experience is conducive to expertise has begun to filter into scholarship in the form of 'user-led research'. In writing on this emerging field, Alison Faulkner and Vicky Nicholls, both of London's *Mental Health Foundation*, share concerns akin to my own, as well as Bokhour's, on the deleterious effect of psychiatric diagnoses:

> The current emphasis on evidence-based medicine and the need to demonstrate measurable outcomes results in a narrow understanding of illness and treatments, one that frequently fragments experience and reduces the person to a disease or a cluster of symptoms. Our aim is to challenge the scientific emphasis of this approach and to assert that the evidence from service users is equally valid.[809]

Likewise, I deem the testimonies of my participants, irrespective of whether they are self-diagnosed or officially diagnosed, to be valid narratives of SAD. That is, their lived experience endows them with expert status on this mental health issue in women.

A further strand of the rationale behind my inclusion criteria has to do with the reciprocal relationship between psychiatric discourse and popular discourse. Ussher, in writing of each iteration of the *DSM* and the new diagnoses therein, tells us that 'details of the necessary symptoms for diagnosis are circulated through interactions with the psy- professions, or through pharmaceutical company advertising, media discussion of madness, and "self-help" diagnostic websites'.[810] She notes that, as a result, women's psychiatric diagnoses are 'mimetic': that is, 'we signal our psychic pain, our deep distress, through culturally sanctioned "symptoms", which allows our distress to be positioned as "real".'[811] What is key about these 'mimetic' diagnoses is that they are contingent on women's exposure to 'pharmaceutical

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[809] Faulkner and Nicholls, *Towards a Radically Different Mental Health System.*
[810] Ussher, 'Diagnosing Difficult Women', p. 64.
[811] Ibid.

company advertising, media discussion of madness, and “self-help” diagnostic websites’[812] in addition to interactions with psy science, and other medical, professionals. As such, *mimesis can occur whether the given woman has been officially diagnosed or not*.

In light of the circulation of the *DSM*’s symptoms, Ussher asks the reader whether it is ‘surprising that so many women self-diagnose with these disorders and then come forward for professional confirmation of their pathological state?’[813] In this account, the symptoms which represent or signal the woman’s distress, and with which she presents to her doctor, are determined by popular discourses on mental health. The official diagnosis, Ussher proposes, is but the final confirmatory step. By this line of reasoning, the way that the distress felt by socially anxious women manifests will be similar regardless of whether she holds a professional diagnosis or a self-diagnosis.

Anthropologist and sociologist Paul ten Have speaks to a similar phenomenon in conceptualising ‘lay diagnosis as an “essential precondition” for “first visits”’ to medical professionals.[814] Indeed, this precondition was borne out in scholars Cindy Suopis and Donal Carbaugh’s research on women’s experience of menopause, wherein ‘[a] preliminary diagnosis or curiosity’ preceded the medical consultation.[815] These works draw links with the overarching argument made by Judith Felson Duchan and Dana Kovarsky in their edited volume, *Diagnosis as Cultural Practice*, that is, ‘diagnoses do not exist as a piece of objective, decontextualized, problem solving done only by health professionals, but are deeply embedded in cultural practices of everyday life.’[816] In addition to being performed by

[812] Ibid.
[813] Ibid.
[814] ten Have, ‘Lay diagnosis in Interaction’, p. 252, cited in Suopis and Carbaugh, ‘Speaking about Menopause’, p. 267.
[815] Suopis and Carbaugh, ‘Speaking about Menopause’, p. 267.
[816] Felson Duchan and Kovarsky, ‘Introduction’, p. 2.

professionals, they argue, diagnosis 'is practiced [sic] by lay people as well' who 'frequently engage in diagnostic reasoning as they come to grips with their own ailments or the symptoms of others'.[817]

Returning to the thoughts of Ussher on the circulation of the *DSM*'s symptoms, her work resonates with the ideas of philosophers Ginger A. Hoffman and Jennifer L. Hansen on narrative theory. This is a theory of the self which holds that 'a person's identity…is constituted by the content of her self-narrative'.[818] What is pertinent about this narrative is that it 'absorbs elements from surrounding cultural scripts'.[819] This has salience for women's mental health in that 'cultural stories about both psychiatric disability and gender can have concrete and sometimes troubling effects on who we are as individuals'.[820] As such, exploring cultural ideas about women's social anxiety (disorder), and the ensuing effects of these ideas on women's sense of selves, is equally possible whether the given woman is diagnosed or self-diagnosed.

Inclusion Criteria, Recruitment, and Sampling

In light of the above discussion, my seven participants were a mixture of those professionally diagnosed and self-diagnosed with SAD. Particiapants all resided in the UK at the time of interview: a corollary of the recruitment process being carried out from the UK. Due to psychiatric diagnoses and femininity being culturally specific, participants were required to have lived in the Anglosphere for at least three years at the time of recruitment and, indeed, all had lived in the UK for this duration. Hence, my analysis

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[817] Ibid., p. 1.
[818] Schechtman, *The Constitution of Selves*, p. 94, cited in Hoffman and Hansen, 'Prozac or Prosaic Diaries?', p. 287.
[819] Françoise Baylis, 'The Self in Situ: A Relational Account of Personal Identity', in *Being Relational: Reflections on Relational Theory and Health Law,* ed. by Jennifer J. Llewellyn and Jocelyn Downie (Vancouver: UBC Press, 2011).
Hilde Lindemann, *Damaged Identities, Narrative Repair* (Ithaca, NY: Cornell University Press, 2001).
Şerife Tekin, 'Self-Concept through the Diagnostic Looking Glass: Narratives and Mental Disorder', *Philosophical Psychology*, 24.3 (2011), 357–80 <doi: 10.1080/09515089.2011.559622> [accessed 5 January 2021].
Şerife Tekin, 'How Does the Self Adjudicate Narratives?' *Philosophy, Psychiatry, and Psychology*, 20.1 (2013), 25–28 <https://muse.jhu.edu/article/511267/pdf#info_wrap> [accessed 5 January 2021].
Şerife Tekin 'Self-Insight in the Time of Mood Disorders: After the Diagnosis, Beyond the Treatment', *Philosophy, Psychiatry, and Psychology*, 21.2 (2014), 135–37 <doi: 10.1353/ppp.2014.0019> [accessed 5 January 2021].
All cited in Hoffman and Hansen, 'Prozac or Prosaic Diaries?', p. 285.
[820] Hoffman and Jennifer L. Hansen, 'Prozac or Prosaic Diaries?', p. 285.

is primarily concerned with the UK, however I devote some consideration to the US insofar as the latter influences the former.

Participants were recruited by a variety of methods. Some were women who I knew had SAD, who were asked if they wished to participate, whereas some participants were recruited through events at my institution. Others were recruited via my email signature and university research page, both of which featured a link to my research blog which displayed the recruitment advertisement[821] and participant information sheet.[822] These documents can be found in Appendices III and IV, respectively. Further participants were recruited using snowball sampling.[823] Most of the prospective participants met the inclusion criteria and agreed to contribute to the research; one prospective participant did not in fact meet the inclusion criteria, while two other prospective participants became unresponsive to my attempts to enlist them, and thus were not recruited.

Research Ethics

Participants were given access to their transcripts in case they wished to make any amendments. After this, they were invited to give their feedback on my analysis of their narratives — they had access to full write ups — and this feedback was then used in order to refine and alter analysis. In addition, when the research project was complete, participants received a copy of the thesis.

Participants were reminded throughout the recruitment and interview processes, verbally and via both the consent form and the participant information sheet, that they had the right to withdraw during or

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[821] Katie Masters, *Call for Participants* (n.d.) <https://katiemastersresearch.wordpress.com/call-for-participants/> [accessed 26 September 2020].

[822] Katie Masters, *Information for Participants* (n.d.) <https://katiemastersresearch.wordpress.com/information-for-participants/> [accessed 26 September 2020].

[823] Lucy Gibson, '"Type Me Your Answer." Generating Interview Data via Email', in *Collecting Qualitative Data: A Practical Guide to Textual and Virtual Techniques,* ed. by Virginia Braun, Victoria Clarke and Debra Gray (Cambridge, UK and New York, NY: Cambridge University Press, 2017), 213–34, p. 223.

after the interview process. They were also informed of the deadline by which they had to say they wanted to withdraw, which was, initially, 28th February 2021, a date upon which I had to insist due to my maximum period of registration ending on 31st March 2022.

Prospective participants were provided with an information sheet and, after consulting this, were given the opportunity to ask me any questions. If they were happy to participate, they were asked to sign a consent form, which can be found in Appendix V. Hence, informed consent was obtained in all cases. After data collection, I wished to revise the date by which participants had to say if they wanted to withdraw to six months prior to my minimum period of registration, that is, 31st July 2020. Approval was sought, and granted, for this change by the University of Birmingham's Ethical Review Board. Subsequently, all participants were sent an adjunct to their consent form, featuring this change, which they all signed and returned. The adjunct to the consent form can be found in Appendix VI. Interviews were recorded and transcribed. A number of measures were taken to ensure confidentiality and anonymity. As soon as transcription had taken place, transcripts were stored in an encrypted file and the audio recordings of the interviews were destroyed, in line with the University of Birmingham's guidelines. Participants were initially given an ID number such that, once I had interpreted their narratives, this interpretation could be fed back to the appropriate participant. Once the participant had expressed that they were happy with my interpretation of their narrative, this ID number was removed, and hence is not present in this thesis. All traces of digital communication with a given participant were also removed. In the transcriptions, all identifying details have been changed. Where they do not add any context or meaning, my own interjections have also been removed to render the participants' narratives more readable and fluid. Each participant's ID number has been replaced with a pseudonym

both in the interests of readability and retaining their humanity in the reader's mind's eye. Pseudonyms were chosen at random from a web resource for baby names.[824]

The interview recordings were stored on my personal computer and USB drive (both of which were encrypted) for a time period of three months — this is the time it took me to transcribe the interviews. Only my supervisory team and I had access to the USB drive and computer on which the audio recordings were stored. Once the interviews had been transcribed, I deleted the audio recordings from my computer and USB drive and subsequently saved new data to these devices, such that the audio recordings were not recoverable.

When conducting interviews, I ensured that I was safe by letting a friend or family member know when and where I was meeting a participant, when meeting face-to-face. Meetings with participants were held in a mutually agreed public place.

Participants were given the option of having me discuss with them in advance the topics to be covered in the interview and were asked if there were any topics that they would like to avoid. As a further safeguard, participants were reassured that they could request that the topic of the interview be changed, and they could terminate the interview, at any time. During interviews, when discussing a topic that I thought may have been potentially distressing for the participant, such as other mental health issues, I sought assurance from the participant that they were happy to continue.

One participant withdrew after interview. Accordingly, the audio recording of her interview, her transcript, and analysis involving her narrative were all destroyed immediately in line with ethical guidelines. Owing to the length of the interviews, and richness of narratives, of the remaining

[824] BabyNames.com (2021) <https://www.babynames.com/> [accessed 18 February 2021].

participants, it was not deemed necessary to recruit an additional participant in lieu of the withdrawing one.

Full approval was granted for this research project by the University of Birmingham's Ethical Review Board.

Limits

In drawing this chapter to a close, I want to reflect on the limits of this research. While I have previously explained how my positionality has likely shaped this project in terms of interviews and analysis, it is likely also to have influenced how I formulated my research questions as well as how and where I collected my data and recruited my participants.

In considering the limits of this project, I wish to draw on the thoughts of Morag MacSween, as articulated in her study in which she interviews women about their experiences of Anorexia Nervosa:

> Obviously this material in no way allows me to draw generalized conclusions about anorexia: the sample is non-random and fairly small. So this material is not intended to 'prove' a hypothesis, but is used to explore and exemplify a theoretical argument.[825]

Much like MacSween, my sample is also small and purposive. Thus, I am not endeavouring to prove a hypothesis. Instead, by using the material I have gathered from interviewing my participants, I am seeking to explore new ways of understanding how women experience SAD in the UK at the time of

[825] Morag MacSween, *Anorexic Bodies: A Feminist and Sociological Perspective on Anorexia Nervosa* (London and New York, Routledge, 1993), p. 8.

writing. In acknowledging the remit and scope of this work, I agree with Nicola J. Smith,[826] who tells us that

> To openly acknowledge the incomplete and bounded nature of the research is not to abandon commitments to scholarly rigor but, quite the opposite, is to recognise — as both queer and feminist scholars urge us to do[827] — that being partial (in both senses of the word) is the 'precondition of a politically engaged critique'.[828]

I have previously mentioned that while the majority of my interviews were face-to-face, some were conducted by video call, by telephone, and via email. I want to briefly outline difficulties inherent in each method. I will begin by reviewing difficulties which were common to all methods, before dealing with difficulties specific to each method.

On the topic of my own positionality, I previously discussed 'matching' of participant and interviewer demographics, and the potential benefits in so doing. It must also be said that matching carries with it some potential drawbacks. For one, the interviewer might assume that they know what the participant

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[826] Smith, *Capitalism's Sexual History*, pp. 6–7.
[827] J. Ann Tickner, 'Gendering a Discipline: Some Feminist Methodological Contributions to International Relations', *Signs: Journal of Women in Culture and Society,* 30.4 (2005), 2173–88 <doi: 10.1086/428416> [accessed 3 February 2021].
Mary Hawkesworth, *Feminist Inquiry: From Political Conviction to Methodological Innovation* (New Brunswick, NJ: Rutgers University Press, 2006).
Celine-Marie Pascale, *Making Sense of Race, Class, and Gender: Commonsense, Power, and Privilege in the United States* (New York, Routledge, 2007).
Kath Browne and Catherine J. Nash, 'Queer Methods and Methodologies: An Introduction', in *Queer Methods and Methodologies: Intersecting Queer Theories and Social Science Research,* ed. by Kath Browne and Catherine J. Nash (Farnham, UK: Ashgate, 2010), 1–23.
Laura Sjoberg, 'What's Lost in Translation? Neopositivism and Critical Research Interests', *Millennium: Journal of International Studies*, 43.3 (2015), 1007–10 <doi: 10.1177/0305829815581632> [accessed 3 February 2021].
All cited in cited in Smith, *Capitalism's Sexual History*, pp. 6–7.
[828] Judith Butler, 'Contingent Foundations: Feminism and the Question of "Postmodernism"', in *Feminists Theorize the Political*, ed. by Judith Butler and Joan Wallach (New York: Routledge, 1992), p. 6, cited in Smith, *Capitalism's Sexual History*, pp. 6–7.

means, and avoid seeking further elaboration where it might be warranted.[829] Likewise, participants might rely 'on the interviewer to draw on their own background rather than giving a full and explicit account'.[830]

Another limitation that may have been exacerbated by my own investment in this research topic is the intrusion of analysis upon the interview process. Robin Legard and colleagues advise that any consideration of analysis is best left for outside of the interview, and should not be entertained during the interview itself. During the interview, 'the researcher needs to be totally dedicated to interviewing. Their attention should be focused on listening and responding.'[831] Attempting to consider the interviewee's narrative in terms of analysis can therefore detract from the interview process; can result in leading questions; and can interfere with the participant telling their own story, in their own words.[832] With that said, it was sometimes hard to avoid thinking of how my participants' words, as they were speaking, fitted into my analysis. While I tried to ensure that I did not delve into analysis during the interview, I found that I had to, at least at a surface level, consider how my participants' narratives linked both to one another and to the research questions: this required some degree of thought directed towards analysis. Engaging in analysis during the interview was a lesser concern during email interviewing, but it may still have had an impact on the follow-up questions I chose to ask.

It is worth briefly mentioning difficulties with transcription, which were applicable to all interview formats except for email. The main difficulties encountered here arose from background noise and

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[829] Robert G. Burgess, *In the Field: An Introduction to Field Research* (London: Allen and Unwin, 1984).
Martyn Hammersley and Paul Atkinson, *Ethnography: Principles in Practice*, 2nd edn (London: Routledge, 1995).
Paul Richard Thompson, *The Voice of the Past: Oral History*, 2nd edn (Oxford, Oxford University Press, 2000).
All cited in Lewis, 'Design Issues', p. 65.
[830] Lewis, 'Design Issues', p. 65.
[831] Legard et al., 'In-depth Interviews', p. 144.
[832] Ibid.

audibility,[833] and difficulty deciphering speech in instances where the interviewee and I spoke at the same time.

I will now deal with problems particular to individual interview formats, beginning with those that were face-to-face. Besides the background noise and disruptions particular to conducting interviews in public places,[834] the main limitation regarding face-to-face interviews was my own lack of experience in doing so, especially given that discussing experiences of SAD had the potential to be distressing for both myself and the participant. As sociologist Lucy Gibson says, '[f]ace-to-face interviewing is a skill and can be demanding on qualitative researchers; it is potentially really challenging for *inexperienced* researchers, especially for sensitive topics.'[835] Moreover, Gibson tells us that '[n]ervous or anxious researchers don't necessarily make great interviewers, and can fail to put participants at ease, or establish rapport, which often reduces data depth and quality'.[836] Given both my own positionality regarding SAD and my relative inexperience, the interviews brought with them a certain degree of nervousness for me, particularly when I did not know the participant well, or at all. In spite of this, I argue that once I divulged my own positionality regarding SAD to a given participant, it helped to put them at ease, reassure them of the absence of any judgement on my part, and facilitated the establishment of a rapport.

After face-to-face interviews, the next most common interview was via video call and telephone: several of the difficulties encountered in conducting virtual interviews are shared by these formats. For instance,

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[833] Blake D. Poland, 'Transcription Quality', in *Handbook of Interview Research: Context and Method,* ed. by Jaber F. Gubrium and James Holstein (Thousand Oaks, CA: Sage Publications, 2002), 629–49, cited in Gibson, '"Type Me Your Answer."', p. 216.
[834] Alan Bryman, *Social Research Methods*, 2nd edn (Oxford: Oxford University Press, 2004) cited in Paul Hanna and Shadreck Mwale, '"I'm not *with* You, yet I Am…" Virtual Face-to-Face Interviews', in *Collecting Qualitative Data, ed. by Braun et al.,* 256–74, p. 259.
[835] Gibson, '"Type Me Your Answer."', p. 216.
[836] Ibid.

both of these formats entail a 'lack of personal contact'[837] as well as the 'intersubjective "feel"' which arises from being in the same physical space as another person.[838] Telephone interviews in particular are missing 'information conveyed through body language',[839] 'facial expressions',[840] and 'visual cues'.[841] The absence of these factors might impact on the building of trust and the establishment of a rapport.[842] Additionally, state of mind is oftentimes conveyed by means of these non-verbal cues.[843] The absence of such cues, such as during a telephone interview, might mean that the researcher does not respond to the interviewee in an appropriate way. For instance, the researcher might not know when to interject, or may talk over the interviewee.[844]

Legard and colleagues perhaps best sum up the shortcomings of telephone and video call interviews in saying that

> Qualitative interviews are almost always conducted face-to-face. It would be extremely difficult to conduct really detailed in-depth interviewing over the telephone. The interview is an intense experience, for both parties involved, and a physical encounter is essential context for an interview which is flexible, interactive and generative, and in which meaning and language is explored in depth.[845]

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[837] Alison Evans, Jonathan Elford, and Richard D. Wiggins, 'Using the Internet for Qualitative Research', in *The SAGE Handbook of Qualitative Research in Psychology,* ed. by Wendy Rogers and Carla Willig (London: Sage Publications, 2008), cited in Hanna and Mwale, '"I'm not *with* You, yet I Am…", pp. 259–60.
[838] Ibid., p. 271.
[839] Ibid.
[840] Ibid.
[841] Evans et al., 'Using the Internet for Qualitative Research', cited in Hanna and Mwale, '"I'm not *with* You, yet I Am…", pp. 259–60.
[842] Ibid.
[843] Legard et al., 'In-depth Interviews', p. 157.
[844] Hanna and Mwale, '"I'm not *with* You, yet I Am…", p. 271.
[845] Legard et al., 'In-depth Interviews', p. 142.

Another limitation of these interview formats is that the interviewee may be in an environment, or in the vicinity of other people, which might either constrain their responses or be a distraction — or both.[846] A final factor which is specific to video call interviews is the quality of the connection. A poor connection can mean interruptions and a disjointed conversation. Interviews can take longer than anticipated and not be of the intended depth. For these reasons, a poor Internet connection can also result in difficulty establishing a rapport.[847]

I want now to mention some of the limitations with interviewing via email, which was a method requested by one of my participants. Asynchronous emailing was used: I sent the participant a list of questions, and the participant was able to respond in her own time.[848] In a similar manner to video call and telephone interviews, the lack of voice inflections and non-verbal cues are a drawback to this type of interviewing.[849] Likewise, there is greater potential for misreading, for misunderstandings to arise, and for incorrect assumptions to be made than in a face-to-face interview: these pitfalls can be made both on the part of the researcher and the interviewee.[850]

A further concern that has been raised in the case of online participants who have not met the researcher is that their identity cannot be verified. That said, it would be rather difficult for participants to produce a fake identity for such in-depth, qualitative research which relies on their experiences.[851]

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[846] Hanna and Mwale, '"I'm not *with* You, tet I Am…", pp. 268–69.
[847] Ibid., p. 267, 268.
[848] Gibson, '"Type Me Your Answer."', p. 214.
[849] Roberta Bampton and Christopher J. Cowton, 'The E-Interview', *Forum Qualitative Sozialforschung [Forum: Qualitative Social Research]*, 3.2 (2002) <http://nbn-resolving.de/urn:nbn:de:0114-fqs020295.> [accessed 5 January 2021].
Susan Crichton and Shelley Kinash, 'Virtual Ethnography: Interactive Interviewing Online as Method', *Canadian Journal of Learning and Technology*, 29.2 (2003) <https://www.learntechlib.org/p/43044/> [accessed 5 January 2021], cited in Gibson, '"Type Me Your Answer."', p. 229.
[850] Bampton and Cowton, 'The E-Interview', cited in Gibson, '"Type Me Your Answer."', pp. 229–30.
[851] Gibson, '"Type Me Your Answer."', pp. 223–44.

Despite the shortcomings of email interviews, they are immensely important to this research in that they have provided a means by which one of my interviewees was able to participate in my project and tell of her lived experiences as a woman with SAD: a prospect which she might otherwise have found too daunting.

A final limit of note was the late withdrawal of a participant. Since her withdrawal occurred after I had begun to analyse participants' testimonies, this necessitated substantial revisions to my empirical chapters. Her late withdrawal was, in part, through my adherence to ethical research practices: I had wanted to provide interviewees with the longest time period possible during which they were able to withdraw, after interview. However, this participant's late withdrawing presented a significant concern, namely due to my having my own deadline by which I had to submit this thesis. In light of this, after her withdrawal I sought, and was granted, ethical approval to bring forward the withdrawal deadline for the remainder of my participants by 6 months. While still giving participants a substantial amount of time to withdraw, upwards of a year after interview in most cases, this new deadline helped to ensure the timely submission of my thesis if further participants were to withdraw.

Having detailed my methodology in this chapter, the next two chapters are my empirical chapters. That is, these chapters place my participants' testimonies into dialogue with the *DSM-5*'s diagnostic criteria for SAD and, where appropriate, other mental health diagnoses. The resulting interchange is then viewed from the perspectives I laid out in Chapters 1 and 2, that is: anti-psychiatry, feminism, and feminist science studies.

CHAPTER 4

MEDICINE AND MEDICAL ISSUES

Overview

In this chapter, I explore the words of my participants in relation to medicine and medical issues. This comprises their experiences of both seeking and not seeking help for their mental health, as well as the role that co-occurring conditions play in women's SAD. Although I devote a specific subsection to what psychiatry calls 'co-morbidities', this concept forms a backdrop to the entire chapter, and indeed to the entire thesis. Meanwhile, I bring to the fore several topics about which my participants spoke, including the usefulness of diagnosis, how they conceptualise their SAD, and their experiences with therapy. I conclude by discussing their opinions on psychiatric medication, the pharmaceutical industry, and drug use more widely.

(Not) Seeking Help and 'Co-Morbidities'

My participants disclosed that they had all sought medical help for their mental health, although none of them had sought help for social anxiety in isolation: only Olivia and Farah mentioned this to their doctors. It follows that all of my participants told me that they experienced, or had experienced, other types of psychological distress — which psychiatry would term 'co-morbidities' — and these formed the basis of their help-seeking. For instance, Ria and Daniella sought help for problems with eating, Phoebe sought help for feelings of nervousness, Amy sought help for feelings of nervousness and sadness, and Ellen sought help for listlessness. As such, my participants' experiences of 'co-morbidities' will form a

cornerstone of this chapter as well as of the whole thesis. This is because, as I will argue in due course, these non-normative ways of being can actually *give rise* to social anxiety.

As I have explored elsewhere,[852] my participants expressed significant reluctance regarding seeking help for their mental health: not just for nervousness about social interaction, but more generally. I have theorised that this could be due to women's socialisation, which discourages them from wanting to 'bother' medical professionals or leads to them not believing their distress to be 'severe' enough.[853] Indeed, a number my participants only sought help when their distress was prolonged and/or debilitating. On struggling with eating problems, Daniella told me that her 'first two and a half years of the PhD were really low [...] I couldn't function properly [...] I could not get out of bed', while Phoebe told me how she often used to wake up panicked: '[I]t's like crushing on your chest [...] like [gasps] "Oh my God! [...] I can't breathe."' The reluctance among my participants to seek help was evidenced by some of them only doing so when persuaded to by others. Ellen only sought help 'because my dad dragged me to the doctors'. Similarly, Olivia told me how 'it was my boyfriend who encouraged me to seek help'. As I have discussed elsewhere,[854] Ellen's and Olivia's testimonies evoke feminist psychotherapists Susie Orbach and Luise Eichenbaum's thoughts on women in our society: '[S]he must *defer* to others — follow their lead, articulate her needs only in relation to theirs.'[855]

In theorising the help-seeking of socially anxious women, I have posited that the very nature of shyness itself presents a further barrier to describing distress, especially to doctors.[856] In addition, I have proposed that women do not seek help for their shyness because they might well refute its

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[852] Katie Masters, 'Subscribing to, and Resisting, Authority Discourses on Mental Health: Women with Social Anxiety Disorder and the Forging of Alternative Narratives', Unpublished paper, (n.d.).
[853] Ibid.
[854] Ibid.
[855] Susie Orbach and Luise Eichenbaum, *Understanding Women* (Harmondsworth: Penguin, 1985), p. 7.
[856] Masters, 'Subscribing to, and Resisting, Authority Discourses on Mental Health'.

characterisation as a disorder,[857] as Ellen told me: 'I've never said I have "Social Anxiety Disorder", I've just said I would [be] anxious with certain things.' Farah's narrative goes a step further in that she speaks to the idea that social anxiety should be viewed as just another element of one's personality:[858]

> Why should I [...] Be calm, all the time [...] Maybe it's not a bad thing if I have this experience […] we can really embrace different images in society [...] and we don't need [...] to have just one good image of a successful person [...]

Ellen's and Farah's narratives could suggest why most of my participants did not seek help for their social anxiety, but sought it for other forms of psychological distress. I will revisit the notion of not seeking help specifically for social anxiety later on in the chapter, in discussing gendered expectations of care.

Having established that there is reluctance among socially anxious women to seek help, and that help is often sought on the basis of other mental health issues, the interplay between social anxiety and these 'co-morbidities' warrants further examination. The clinical literature posits that 'SA sufferers present for help only after the development of one of these co-existing disorders',[859] and this is echoed by the *DSM-5* which states that 'the onset of social anxiety disorder generally precedes that of the other disorders'.[860] The pre-supposition that social anxiety comes first, and thus *causes* unhappiness, nervousness, or eating problems, is something that I wish to question. As I demonstrate in due course, it is more probable that a nervous or subdued temperament, or indeed, exhibiting any characteristics which society views as non-normative, might expose a woman to the social conditions which contribute to feeling nervous about others' evaluations of oneself. Divergence from normativity in our society can

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[857] Ibid.
[858] Ibid.
[859] Jean Gallagher and Declan Lyons, 'When Anxiety Strikes', *Psychiatry* (2005), 29–30 <https://www.inmo.ie/MagazineArticle/PrintArticle/5316> [accessed 5 January 2021], p. 30.
[860] APA, *DSM-5*, p. 208.

often bring ridicule and humiliation, undue attention, feelings of being watched, and a sense of being an outsider or not belonging. This calls to mind a remark made by protagonist Meursault in Albert Camus's *L'Étranger*: 'I felt the urge to reassure him that I was like everybody else, just like everybody else.'[861]

Consequently, having a non-normative identity might create concern with how one appears to others. Drawing on the thoughts of the anti-psychiatrists,[862] I wonder whether SAD might be best conceptualised as an intelligible phenomenon arising from how society treats women with a prior 'co-morbidity' that renders them non-normative. In refuting the idea that social anxiety is inherent pathology, we must consider whether society has a larger role to play in the development of SAD than traditional psychiatry would have us believe.

In order to illustrate this, I want to discuss Phoebe, who told me that she suspects that she is autistic. The diagnosis 'Autism Spectrum Disorder' (ASD) is distinct from what are classified as 'psychiatric disorders', such as Anxiety, Depression or SAD, in that it is characterised as a 'Neurodevelopmental Disorder': that is, it is said to affect the brain and central nervous system.[863] The words of scholars Erika Dyck and Ginny Russell are of note here, for they tell us that

> Autism is not currently identified by neurological markers as none are reliable enough to create diagnostic tests [...] it is behavioural inventories that are used to diagnose ASD, not brain scans, and these use a dimensional scale of impairment with a cut-off rather than a dichotomous distinction. In the diagnostic process, the point at which individual differences in behaviour

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[861] Albert Camus, *The Stranger [L'Étranger]*, trans. Matthew Ward (New York: Vintage International, 1989 [1942]), p. 37.
[862] Laing, quoted in Chang, *Wisdom for the Soul,* p. 412.
Laing, *The Divided Self.*
Cooper, *Psychiatry and Anti-psychiatry.*
[863] Anita Thapar, Miriam Cooper, and Michael Rutter, 'Neurodevelopmental Disorders', *The Lancet Psychiatry,* 4.4 (2017), 339–46 <doi: 10.1016/S2215-0366(16)30376-5> [accessed 24 September 2020].

constitute autism is based on clinical decisions which may depend on resources that diagnosis will trigger, the meaning of diagnosis to the patient or clinicians' own ideas about signs and signifiers of autism. Thus, a somewhat arbitrary cut-off is used on the autism spectrum to define autism as a diagnosed disorder. This process is heavily influenced by culture, context, and values.[864]

As such, despite ASD's categorisation as a neurodevelopmental disorder, the lack of evidence for any biomarker in those diagnosed renders it subject to the same criticisms as other psychiatric diagnostic categories. These are, namely, that while the *DSM-5* proposes that ASD arises from biological malfunction in the brain, its diagnosis hinges on cultural norms. It is perhaps then rather fitting that Neurodevelopmental Disorders come under the remit of psychiatry: they feature in the *DSM-5*[865] and *ICD-10*,[866] and diagnosis and management of ASD will involve a psychiatrist in the UK.[867] My stance vis-à-vis ASD thus echoes my view on other psychiatric diagnoses. That is, in contrast to the *DSM-5*'s conception of ASD as a disease entity or 'a deficit-based description of a person',[868] I follow the neurodiversity movement's conception of this diagnosis. That is, I contend that it 'should not be considered as pathological, i.e. in terms of a medical condition, but in terms of the normal variation of

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[864] Courtenay Frazier Norbury and Alison Sparks, 'Difference or Disorder? Cultural Issues in Understanding Neurodevelopmental Disorders', *Developmental Psychology*, 49.1 (2013), 45–58 <doi: 10.1037/a0027446> [accessed 10 March 2021], cited in Erika Dyck and Ginny Russell, 'Challenging Psychiatric Classification: Healthy Autistic Diversity and the Neurodiversity Movement', in *Healthy Minds in the Twentieth Century: In and beyond the Asylum,* ed. by Steven J. Taylor and Alice Brumby (Cham, Switzerland: Palgrave MacMillan, 2020), 167–187, p. 172.
[865] APA, *DSM-5*, p. 50.
[866] WHO, 'Pervasive Developmental Disorders', *ICD-10* (2016) <https://icd.who.int/browse10/2016/en#/F84> [accessed 7 January 2021].
[867] National Autistic Society, *Professionals Involved in a Diagnosis* (2020) <https://www.autism.org.uk/about/diagnosis/professionals-involved.aspx> [accessed 24th September 2020).
[868] Dyck and Russell, 'Challenging Psychiatric Classification', p. 171.

the human population'. [869] To this end, I agree with autistic activist Jim Sinclair, who describes autism as 'inseparable from the person [...] and as a valid way of being'.[870]

It is worth noting that 'about 70% of individuals with autism spectrum disorder may have one comorbid mental disorder, and 40% may have two or more comorbid mental disorders',[871] examples of which include Anxiety Disorders.[872] Phoebe implicitly speaks about the intertwined nature of social anxiety with other 'disorders', in this case ASD, in saying that: 'I think all my anxiety stems from like relationships with other people [...] I actually think maybe [...] I'm autistic.'

As I discussed in Chapter 2, SAD is very much a 'disorder' of relationality, since it could be described as the pathologisation of women's responses to others. This is to what Phoebe is alluding — relationships with other people are at the root of her anxieties, and yet, she seems not to attribute this to her SAD, but rather to her autism. This calls into question the idea that feeling socially anxious triggers the development of 'co-morbid' psychiatric disorders. Phoebe's narrative supports the idea that social anxiety instead arises as a result of something about a given individual that society views as non-normative. This could be something which has a physical basis, such as a health condition, or a particular type of temperament — for instance, subdued or, as psychiatry would have it, 'depressed' — both of which I will explore in due course. Given Phoebe's testimony, I wonder if we should also add what are called 'Neurodevelopmental Disorders', such as ASD, to this list of non-normativities. On this point, Phoebe told me that her ASD makes her feel like an outsider in that she feels fundamentally different from others: 'I don't feel like my brain is like the same as other people's.'

[869] Ibid., p. 176.
[870] Ibid., p. 179.
[871] APA, *DSM-5*, p. 58.
[872] Ibid., pp. 58–59.

Although she did not disclose whether or not she was autistic, Amy spoke of a similar experience. Specifically, she explained how everything is coloured by her mental ill health:

> It permeates every part of your life [...] My mental illness is inside my friendships and it's in my home and it's in my work, but–no, it's not in any of those, it's inside my brain and it just feels like it's everywhere because I have to filter my experience of life through my brain.

Amy's and Phoebe's narratives both support the idea that their lived experiences of mental health issues and Neurodevelopmental Disorders, and by extension social anxiety, constitute a specific way of viewing the world to which only this group of marginalised women have access. In other words, these women's narratives speak to the core tenets of feminist standpoint theory. Amy and Phoebe allude to their social anxiety, no matter from which other 'condition' or 'disorder' it arises, influencing everything in their lives. Their narratives thus draw on partial and underrepresented knowledges. Indeed, '[h]ow one views the world [...] serves as a prism from which data and information are filtered.'[873] In light of this, if they experience the world differently from other people, this might well foster a sense of estrangement from others. This is something which resonated with Olivia's testimony, wherein she told me that 'I have always felt socially anxious since I was little, especially experiencing discomfort around groups of strangers'. Phoebe spoke similarly, telling me, '"Oh, I was anxious as a kid." But I thought that that was just how everyone felt.'

In assuming that others think in ways akin to us, when in reality they might not, Phoebe's alluding to feeling alienated as a child brings to mind author and psychoanalyst Marion Milner's exposition of experiments in childhood development:

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[873] Derald Wing Sue, *Microaggressions in Everyday Life: Race, Gender, and Sexual Orientation* (John Wiley and Sons Incorporated, 2010) <https://ebookcentral.proquest.com/lib/bham/reader.action?docID=487711> [accessed 24 September 2020], p. 45.

> [A] child is not born knowing that what goes on in his own mind has not the same sort of independent existence as what goes on around him. He does not know that a feeling in his own mind is only his feeling, he has no means of telling, for instance, that the whole world is not darkened with his misery.[874]

Milner tells us that '[a] child gradually discovers […] that what is in his mind is not necessarily in other people's'.[875] I cannot help but wonder whether, at least for somewhat non-normative women like Phoebe, this discovery remains unearthed for longer than is typical. Perhaps women like Phoebe go on believing that others think in the same way that they think and thus they struggle to comprehend why others behave in seemingly incomprehensible ways. In turn, this fosters estrangement, alienation, and might lead to fear of negative evaluation. On the above mentioned experiments in childhood development, Milner states that although they 'dealt only with children, I felt certain that they had a very important bearing upon my own problems'.[876] Likewise, given Phoebe's story, these ideas are clearly useful in theorising about women's non-normative ways of being and social anxiety.

Staying with the theme of interacting with and relating to others, Professor of Counselling Psychology Derald Wing Sue notes that people from minorities consistently experience 'microaggressions'. Sue defines microaggressions as 'the constant and continuing everyday reality of slights, insults, invalidations, and indignities visited upon marginalized groups by well-intentioned, moral, and decent family members, friends, neighbours, co-workers, students, teachers, clerks, waiters and waitresses,

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[874] Jean Piaget, *Language and Thought of the Child (and other Later Works)* (Abingdon: Kegan Paul, 1926).
Susan Isaacs, *The Nursery Years* (Abingdon: Routledge, 1929).
All cited in Marion Milner, *A Life of One's Own* (Taylor and Francis Group, 2011).<https://ebookcentral.proquest.com/lib/bham/reader.action?docID=672403> [accessed 24 September 2020] p. 84.
[875] Milner, *A Life of One's Own*, p. 85.
[876] Ibid.

employers, health care professionals, and educators'.[877] Sue explains that the harm from microaggressions is often psychological in nature, is implicated 'in restricting career and job choices, in creating a lower standard of living for them [women], and in perpetuating inequities in employment and health care'.[878] For the purposes of this work, *gender* microaggresions are defined by Sue as 'brief and commonplace daily verbal or behavioral indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative gender slights and insults that potentially have a harmful impact on women'.[879] Sue contends that when people with marginalised identities experience microaggressions, they use their prior experience 'to add meaning to interpersonal encounters: that is, they evaluate similar experiences they have encountered over time and in different places'.[880] When individuals do this, Sue argues, they often conclude that the linkage between the multiple experiences is the aspect of their identity that defines them as a minority: for our purposes, gender.[881] Phoebe's and Ria's testimonies spoke to this in that they both featured examples of gender microaggressions. These experiences are germane to social anxiety in that they centre on others' opinions of them, or what other people say about them:

> Ria: [I]f you went round to someone's house and you were really agreeable and helpful [...] you'd feel as though it would be noted [...] you hear it being talked about [...] I'll chat to my auntie and

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877 Sue, *Microaggressions*, p. xv.
878 H. Rubin, *Sexism* (2008) <http://www.portfolio.com/executives/features/2008/03/17/Sexism-in-the-Workplace?.> [accessed 19 May 2009].
Derald Wing Sue and David Sue, *Counseling the Culturally Diverse: Theory and Practice*, 4th edn (New York: John Wiley and Sons, 2008).
US Bureau of the Census*, Poverty in the United States* (Washington, DC: US Government Printing Office, 2002).
All cited in Sue, *Microaggressions*, p. 164.
879 Sue, *Microaggressions*, p. 164.
880 John F. Dovidio and Samuel L. Gaertner, 'Aversive Racism and Selective Decisions: 1989–1999', *Psychological Science*, 11.4 (2000), 315–19 <doi: 10.1111/1467-9280.00262> [accessed 24 September 2020], cited in Sue, *Microaggressions*, p. 54.
881 Sue, *Microaggressions*, p. 54.

> she'll mention the fact that my cousin hasn't sort of got into contact with her in a while [...] that [...] wouldn't even figure for a guy [...] they're cut a bit more slack [...]

> Phoebe: 'The fucking boys at our school were such misogynistic little pricks.' [...] I remember there was this girl called Lindsey [...] And I remember them [...] making like stomping noises and like shouting at her and then telling her to like, 'Go back to the canteen,' because that's where she should be, kind of thing, because she just wants to eat [...] I remember thinking, 'Oh, if they say that about her, what do they say about me?'

Crucially, Phoebe told me that incidents like these have had an enduring effect on her:

> Phoebe: And the way they would talk to us, and the other girls, was so disgusting, and you look back and you're like, 'Fuck, no wonder I'm really anxious', because these boys just thought they could talk about girls however they wanted and you just felt like you had to take it [...] you internalise that misogyny and then you carry that with you throughout your life [...] I just think like stuff like that and I'm like, 'No wonder women are so anxious,' [...]

One can see, based on Phoebe's and Ria's anecdotes, that these external events might cause them to care about others' impressions of them, hence fostering social anxiety. This also points to a wider cultural phenomenon: that women are to be discussed and evaluated.

Recall that Sue attests that oftentimes marginalised individuals will link experiencing microaggressions to their marginalised identities. Diverging from Sue's analysis, I contend that it is possible that women attribute the consistency with which they encounter microaggressions not to their gender but to themselves *as individuals*. This is especially probable when microaggressions are not readily linked to gender, as is often the case for microinvalidations and microinsults. Microinvalidations are demeaning,

conveying ‘rudeness and insensitivity’, while microinsults ‘exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality’ of those to whom they are aimed.[882] This is particularly relevant during childhood, when girls are not necessarily equipped with the critical thinking skills to understand that what happens to them might be the result of institutionalised sexism, as opposed to individual faults. Following Phoebe’s recalling of her school days, several of my participants shared stories from their childhood:

> Daniella: I remember going to my first year at school [...] I really didn’t get along and I got bullied [...]
>
> Farah: [M]y sister […] [was] 13 year[s] […] older… And my brother [was] 8 years older and all of my cousins were around that age, so I […] [wasnt’] accepted easily in[to] that teenager group [...] I was a sort of outsider [...]

These narratives all centre on feeling alienated. It is perhaps not surprising then, that its reverse, belonging, was central to my participants’ conceptions of social anxiety. For instance, Farah told me that her ‘anxiety is related to the feeling of belonging’. Daniella’s discussion of changing schools as a teenager spoke to feeling like she did not belong: ‘[H]abits were different and kids were different and mentality-wise it was different [...] I always felt out of place.’ And Ria gave the following example related to public speaking: ‘[Y]ou might stand up [...] to give a talk–and you get this awareness that maybe you don’t belong there.’ It is possible that, while mental ill health or what are called ‘Neurodevelopmental Disorders’ might foster a sense of not belonging, so too do prior experiences — both those that are readily linked to systemic sexism and those that are not — such as the experiences my participants discussed above. In turn, as Ria told me, ‘the idea that you don’t belong, I think, can feed social anxiety.’

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[882] Sue, *Microaggressions*, p. 29.

Returning to ASD, I have proposed that it may work in a similar way to other mental health issues insofar as it shapes experiences. The *DSM-5* lists 'high-functioning autism' as a 'co-morbidity' with SAD,[883] and I suggest that the link between social anxiety and this diagnosis is more obvious than the link between experiencing social anxiety and other non-normative temperaments or feelings — or, what psychiatry would call 'co-morbidities', such as Depression or Anxiety. This is because ASD, like social anxiety, has a strong component which has to do with relating to others. For instance, the NHS lists 'getting very anxious about social situations' as being among common signs of ASD in adults.[884] Other signs include 'seeming blunt, rude or not interested in others without meaning to' and 'not understanding social "rules", such as not talking over people'.[885] Exhibiting these signs is likely to provoke a negative reaction from others, particularly for women who are, as Phoebe said, 'always told to be like polite and good'.

As such, I ask the reader to imagine a woman exhibiting some of the NHS's above quoted non-normative ways of interacting. When her behaviour garners negative reactions from others, she would be left wondering why. Such reactions are likely to create apprehension around possible further negative reactions in the future: one can see how this might cultivate social anxiety. Given this, especially in the case of women, it is reasonable to suggest that, as in Phoebe's case, social anxiety is understandable as a response to how *others* respond to non-normative ways of interacting.

Another 'co-morbidity' of SAD that the *DSM-5* cites is Selective Mutism (SM).[886] All but one of my participants — Olivia — were happy to be interviewed verbally, so it follows that none of them divulged to me that they had experienced barriers in speaking. However, Farah's account of experiencing

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[883] In the case of children only. See APA, *DSM-5*, p. 208.

[884] NHS, *Signs of Autism in Adults* (2019) <https://www.nhs.uk/conditions/autism/signs/adults/> [accessed 24 September 2020].

[885] Ibid.

[886] Also in the case of children only. See APA, *DSM-5*, p. 208.

difficulty communicating in an unfamiliar circumstance has relevance:[887] '[I]n the class, I couldn't participate and whenever I wanted to say something, my heartbeat was… In a way that I couldn't breathe, so you can't even talk.' Farah's narrative gives rise to the idea that the inability to speak in certain situations is best understood not as a binary, but, evoking ideas I discussed in Chapter 2, as a spectrum to do with difficulties in communication. On this point, previous research has hypothesised that such difficulties might arise from social anxiety,[888] or indeed be an extreme manifestation of fear in social situations.[889] Given this, and the overlap between the two, we return to the idea, as I explored in Chapter 1, that these diagnoses are often not as discrete as the diagnostic criteria set out in the *DSM-5*'s schema imply. Indeed, their overlap suggests that they are not distinct disease entities that reflect underlying pathology, as the biomedical model underpinning the *DSM-5* would have us believe. Moreover, through phenomenology, these 'pathological' experiences can be rendered comprehensible.

In order to do this in the case of Farah's being unable to speak, I note that she echoes an idea running through the narratives of people with SM having to do with the expectations of others. Aaron S. Walker

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[887] It is worth noting that the example she gave related to recently moving to the UK from another country and as such, could be construed as, in part, relating to language competence: the *DSM-5* states that this is not constitutive of an SM diagnosis.

[888] Bruce Black and Thomas W. Uhde, 'Psychiatric Characteristics of Children with Selective Mutism: A Pilot Study', *Journal of the American Academy of Child and Adolescent Psychiatry,* 34.7 (1995), 847–56 <doi: 10.1097/00004583-199507000-00007> [accessed 25 September 2020].
E. Steven Dummit III, Rachel G. Klein, Nancy K. Tancer, Barbara Asche, Jacqueline Martin, and Janet A. Fairbanks, 'Systematic Assessment of 50 Children with Selective Mutism', *Journal of the American Academy of Child and Adolescent Psychiatry,* 36. 5 (1997), 653–60 <doi: 10.1097/00004583-199705000-00016> [accessed 25 September 2020].
All cited in Aaron S. Walker and Jane Tobbell, 'Lost Voices and Unlived Lives: Exploring Adults' Experiences of Selective Mutism Using Interpretative Phenomenological Analysis', *Qualitative Research in Psychology*, 12.4 (2015), 453–71 <doi: 10.1080/14780887.2015.1054533> [accessed 5 January 2021], p. 453.

[889] Josh M. Cisler, Bunmi O. Olatunji, Matthew T. Feldner, and John P. Forsyth, 'Emotion Regulation and the Anxiety Disorders: An Integrative Review', *Journal of Psychopathology and Behavioural Assessment*, 32.1 (2010), 68–82 <doi: 10.1007/s10862-009-9161-1> [accessed 25 September 2020].
Samantha Scott and Deborah C. Beidel, 'Selective Mutism: An Update and Suggestions for Future Research', *Current Psychiatry Reports,* 13.4 (2011), 251–57 <doi: 10.1007/s11920-011-0201-7> [accessed 25 September 2020].
All cited in Walker and Tobbell, 'Lost Voices and Unlived Lives', p. 453.

and Jane Tobbell,[890] in their exploration of the narratives of individuals with SM, discuss 'the expectations of others who had adapted to, and in doing so reinforced, the silence of the child'.[891] Farah spoke about the weight of others' expectations when visiting her home country, and how these function in causing her to embrace a personality more reminiscent of her past self: '[I]n my mind, I have this memory of myself, that I was like that in this environment, so, unconsciously I would be the same again.' She experienced a similar feeling when seeing childhood friends, telling me

> [W]hen I started to visit them again, after years […] I could see that it was a bit hard for them to see me differently […] I've changed a lot […] I try to be… A bit like twenty years ago, when I'm around them […]

Farah, in trying to emulate the personality style to which her friends are accustomed, is describing trying to meet their expectations. This is reminiscent of how individuals with SM in Walker and Tobell's study 'negotiated their identities with regards to [sic] the expectations and behaviours of others'.[892] Indeed, feeling as though they would be 'unable to handle the reactions of others if they were to suddenly begin speaking' was cited as a reason for the perpetuation of SM in Walker and Tobell's work.[893] Scott cites a similar reason for the perpetuation of the shy identity in saying that 'it may be easier for a person to live up to the label they have been given than to try and change the opinions of others'.[894] Farah posited a possible reason for Scott's observation in telling me about her friends' reactions to seeing how she had changed: 'I could see that it was a bit uncomfortable for them.' A remark that Amy made revealed just

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[890] Walker and Tobbell, 'Lost Voices and Unlived Lives', p. 456.
[891] Ibid.
[892] Ibid., p. 461.
[893] Heidi Omdal and David Galloway, 'Interviews with Selectively Mute Children', *Emotional and Behavioural Difficulties*, 12.3 (2007), 205–14 <doi: 10.1080/13632750701489956> [accessed 25 September 2020] cited in Walker and Tobbell, 'Lost Voices and Unlived Lives', pp. 462–63.
[894] Scott, 'The Shell, the Stranger and the Competent Other', p. 133.

why Farah might have behaved in accordance with her friends' expectations, in order to not make them uncomfortable: 'My social anxiety is probably tied to what I have been programmed to think, as a woman [...] that my responsibility is to make other people comfortable.' An unwillingness to make others uncomfortable, or being unable to handle others' reactions in light of change or unexpectedness, keeps individuals with SM silent. In the same manner, the need to make others *comfortable* functions to constrain the behaviours, or degree of assertiveness, that socially anxious women exhibit.

I now want to address another diagnosis: Avoidant Personality Disorder (APD). The *DSM-5* lists this as being 'co-morbid' with SAD,[895] but none of my participants mentioned it explicitly. Like Neurodevelopmental Disorders, 'Personality Disorders' are somewhat distinct from other psychiatric diagnoses but still remain within the remit of psychiatry. A Personality Disorder is defined as 'an enduring pattern of inner experience and behavior that *deviates markedly from the expectations of the individual's culture*, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment'.[896] Given this definition, we might posit that Personality Disorders are pathologisations of behaviours which challenge cultural ideals. APD is described as 'a pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation'.[897] As I have explored in greater depth elsewhere,[898] some of the sentiments held by a number of my participants evoke this diagnostic category in that they feature 'feelings of inadequacy'[899] and 'low self-esteem'.[900] Daniella told me that she has experienced feelings of this nature from the ages of '6 or 7': 'I would always have this feeling of being inadequate [...] I always feel, like, inferior to everyone else.'

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[895] APA, *DSM-5*, p. 208.
[896] Ibid., p. 645. My emphasis.
[897] Ibid.
[898] Katie Masters, 'Women, Social Anxiety Disorder, Microaggressions, and Imposter Syndrome'. Unpublished paper (n.d.).
[899] APA, *DSM-5*, p. 673.
[900] Ibid.

These feelings persisted throughout her teenage years and right through to when she graduated from a respected university with an upper-second-class-honours degree. She downplayed this accomplishment, instead telling me that she 'managed' and 'did alright'. Farah alluded to her own feelings of inadequacy when she told me that, although she had won a scholarship to study at her university, 'I still think that they didn't realise that I'm not good.' Similarly, Amy divulged that she also experienced these sentiments in the context of her academic research in telling me that 'I'm probably fooling everybody else [...] fewer people are working on that so they won't know that it's all a lie'.

That these sentiments featured so prominently in a number of my participants' narratives suggests two things. Firstly, we have the idea that there is significant slippage between the diagnostic categories 'APD' and 'SAD'. The *DSM-5* concedes this, noting that there is 'a great deal of overlap between avoidant personality disorder and social anxiety disorder (social phobia), so much so that they may be alternative conceptualizations of the same or similar conditions',[901] or indeed on the same 'spectrum'.[902] Likewise, Robert Spitzer, who led the task-force which updated the *DSM* into its third edition, 'is prepared to concede that between generalized social anxiety disorder and avoidant personality disorder there is almost "total overlap"'.[903] Even Liebowitz, who was one of the pioneering researchers on SAD, says that 'it doesn't make sense to have these two separate categories — social phobia and avoidant personality'.[904] The lack of distinction between these diagnoses is a prime example of why Cohen is so critical of the *DSM*'s attempting to objectively catalogue supposed disease entitles, with codes which 'allow for two digits to the right of the decimal point', giving 'the impression that diagnoses are precise

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[901] Ibid., p 674.
[902] Ibid., p. 648.
[903] Robert L. Spitzer, interview by Christopher Lane, 22 February 2006, cited in Lane, *Shyness*, p. 96.
[904] Lane, *Shyness*, pp. 96–97.

to within one-hundredth of each other'.[905] While I am writing on the poor demarcation between these 'disorders', this is not the extent of my critique: as noted previously, my stance is abolitionist as opposed to revisionist. My contention is that these poorly defined diagnoses are a *reflection*, a *symptom* of the notion I am arguing against in this thesis, more broadly. That is, the idea that these diagnoses are discrete disease entities, caused by biological malfunction. Rather, I argue that the slippage between them exposes the fact that they are arbitrary categories which have been created and that function to pathologise non-normativity.

The feelings of inadequacy present in my participants' narratives might lead us to a second conclusion. These feelings, which promote apprenhension about others' evaluation, are something entwined with being a woman in our society. As I have argued elsewhere,[906] a prime example of women's propensity to feel inadequate in their professional lives can be found by considering 'Imposter Syndrome', that is, 'an internal experience of intellectual phoniness, which appears to be particularly prevalent and intense among a select sample of high achieving *women*.'[907] I will revisit women's feelings of inadequacy later on in the chapter in exploring my participants' experiences of 'microaggressions'. For now, I will note that these feeings are oftentimes a result of female socialisation, which calls their pathologisation into question. As Phoebe said: 'I don't think you can ever remove [...] your gender from social anxiety because that frames the way we see ourselves.'

Another commonality that was present between the 'co-morbidities' reported by the *DSM-5* and four of my participants' experiences was an association with feelings of nervousness, not restricted to social

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[905] Brown, 'Diagnostic Conflict and Contradiction', cited in Cohen, 'The Biomedicalization of Psychiatry', p. 518.
[906] Masters, 'Women, Social Anxiety Disorder, Microaggressions, and Imposter Syndrome'.
[907] Pauline R. Clance and Suzanne A. Imes, 'The Impostor Phenomenon in High Achieving Women: Dynamics and Therapeutic Intervention', *Psychotherapy: Theory, Research and Practice*, 15.3 (1978), 241–247 <doi: 10.1037/h0086006> [accessed 26 February 2021], p. 241. My emphasis.

situations, and feelings of sadness. In psychiatric terms, these emotional states are named as Generalised Anxiety Disorder[908] and Major Depressive Disorder,[909] respectively. In order to continue my discussion of 'co-morbidities', it is appropriate to think about the interplay between these emotional states. Amy described how her mental health issues 'kind of bounce off of each other':

> My logic brain is going, 'Hey, you seem like you're in a depression rut. The main thing you could do to help get out of that would be to reach out to your friends [...].' But my social anxiety goes, 'What if a depressed person is not a palatable person to hang out with?'

Amy's view on unhappiness and social anxiety suggests that she conceptualises their interplay as mutually reinforcing. That is, in feeling sad, she is uneasy about interacting with others. Her isolation, in turn, deepens her unhappiness. Amy's account certainly challenges the psy sciences' conception of neatly separated disease entities, a conception implied by the *DSM*'s five-digit diagnostic codes.[910] Phoebe's account presented a similar challenge, for she characterised the interaction between her mental health issues thus: '[T]hey all like kind of blur into one, don't they? [...] you don't know which is which, often [...] they come under quite a broad umbrella.'

This way of viewing one's mental health could also suggest why my participants may not have sought help for social anxiety specifically. Earlier on, Farah's and Ellen's narratives refuted social anxiety's conception as a 'disorder'. While some of my other participants' narratives were not as absolute, they posited that SAD was not a distinct mental health issue in its own right. The *ICD-10* defines 'Generalised Anxiety Disorder' as '[a]nxiety that is generalized and persistent but not restricted to, or even strongly

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[908] APA, *DSM-5*, p. 208.
[909] Ibid., p. 160.
[910] Brown, 'Diagnostic Conflict and Contradiction', cited in Cohen, 'The Biomedicalization of Psychiatry', p. 518.

predominating in, any particular environmental circumstances (i.e. it is "free-floating")'.[911] If feelings of nervousness pervade all areas of life, and are equally distressing in social situations as in other areas, the attempt to cleave this emotional state into 'GAD' and 'SAD' seems somewhat arbitrary. Amy offered an alternative way of theorising this in describing her social anxiety as 'the social aspect, the social anxiety sect of generalised anxiety'.

The *DSM-5*'s diagnostic criteria for GAD, and its overlap with SAD, are emblematic of the slippage between diagnoses which I have discussed in this chapter. The criteria for GAD actually include some elements which could be viewed as elements of SAD: 'Social worries are common in generalized anxiety disorder, but the focus is more on the nature of ongoing relationships rather than on fear of negative evaluation.' Some of my participants' testimonies problematised this distinction in speaking about fear of negative evaluation *within* their ongoing relationships:

> Phoebe: I get really anxious about when I see my friends. I will obsess afterwards [...] 'Oh [...] do they just not like me anymore? [...]'

> Ellen: [I]f I haven't seen a group of people for a while then I'll be really anxious [...] I'm like, '[...] what are we going to talk about? [...]'

> Olivia: Sometimes I'm absolutely fine around the people I'm close to, but other times I feel anxious [...] worrying about how I am being perceived and [...] worrying if I'm going to ruin the relationship somehow and not meet their expectations of me!

[911] WHO, 'Social Phobias'.

> Amy: [D]inner with my friends [...] my social anxiety, it gets in there and it convinces me that they're just putting in the time because they feel like they have to [...] 'You're annoying people [...].'

It is not clear whether each of these narratives falls into 'GAD or 'SAD', again calling into question the *DSM-5*'s assertion that these experiences are constitutive of separate illnesses, each reflecting underlying (biological) sickness. By contrast, and as I argue in due course, societal, and gendered, factors are implicated in these forms of psychological distress to a far greater degree than the psy sciences would have us believe.

It is now worth examining the interrelatedness of general nervousness and nervousness pertaining to social situations in terms of something upon which I touched earlier in the chapter: why women often do not seek treatment for social anxiety in particular. It may be that viewing social nervousness as a subset of nervousness, more broadly, as Amy told us, is conducive to the impression that treatment for the latter will also alleviate distress arising from the former. In other words, and as I have alluded to elsewhere,[912] if one form of psychological distress is alleviated, the other might iron itself out. Olivia articulated this in describing her own help-seeking, wherein she told me that she was 'visiting the GP primarily for depression, but since I knew that anxiety is often linked with depression I also mentioned struggling with social anxiety'. The social anxiety was mentioned in passing and, through articulating the linkage between depression and anxiety, Olivia has implicitly suggested that treating one might improve the other.

There is another reason, however, why I believe that help is often not sought for social anxiety specifically, but rather, for another form of psychological distress, and this reason is pertinent especially

[912] Masters, 'Subscribing to, and Resisting, Authority Discourses on Mental Health'.

in the case of women. In order to explain this, I would like to call upon the reasoning of Amy and Olivia, who both told me that their gender socialisation mandates that they put others' feelings first — something which others, and thus society, are unlikely to see as a problem:

> Amy: [W]omen are more susceptible to Social Anxiety Disorder, probably on the basis that we're conditioned to be more concerned with other people's feelings than our own [...] and that puts the burden of other people's mental states on us [...] it makes every social interaction terrifying, if you walk into it feeling responsible for the feelings and experiences of everyone around you.
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> Olivia: I'm always trying to be pleasing and nice and untroublesome and thoughtful of how others might feel or respond to what I've said — traditionally feminine characteristics.

Given this, psychiatrist Siegfried Kasper's description of SAD as 'characteristically discreet',[913] to which he attributes its under-diagnosis, is ironically fitting. While he is writing of its relative invisibility compared to Panic Disorder and GAD, I argue that SAD's being 'discreet' in women is precisely due to its being imbued with norms of femininity.

Olivia's and Amy's narratives above echo a point concerning women and care that I cited in Chapter 2. That is, women in our society are expected to be solely responsible for their relationships,[914] and 'not

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[913] Siegfried Kasper, 'Anxiety Disorders: Under-diagnosed and Insufficiently Treated', *International Journal of Psychiatry in Clinical Practic*e, 10.1 (2006), 3–9 <doi: 10.1080/13651500600552297> [accessed 24 February 2021], p. 3.
[914] Jack, *Silencing the Self: Women and Depression.*
O'Grady, *Woman's Relationship with Herself.*
All cited in Ussher and Perz, 'PMS as a Gendered Illness', p. 136.

upsetting people must always be given priority'.[915] Indeed, women in our society are expected to carry out the bulk of emotional labour in relationships,[916] and this is something of which Ria was aware:

> [T]here's a pressure for women to not only go to work, but sort of still be primary caregivers [...] even if you don't have children [...] to be the person who sort of holds the social unit or the family unit together.

The way that society places others' emotional wellbeing in the hands of women, as Ria and Amy have noted, puts a tremendous amount of pressure on women. Cast in this way, one can see how women might be conscious about how their behaviours affect others' wellbeing or how these behaviours cause them to be perceived: in other words, their positioning as the gatekeepers of others' emotional states promotes feeling nervous about social interaction. This resonates with the words of Orbach, who notes that '[w]e grow up to be concerned with others and often feel guilty if we notice that we have our own needs, desires and concerns which really come first'.[917] The source of this guilt is made more evident by considering the words of Lisa Downing, who notes that, for men, being selfish is but a 'minor infraction'. By contrast, 'it is a far more serious transgression to be selfish while a woman – indeed it is a category violation of identity.'[918]

According to Olivia and Amy, the way that social anxiety manifests in women is in accordance with the gender role expectations that society places upon them. Conceptualised in this way, since it is *not* a contravention of expected gender norms, unlike selfishness, social anxiety is unlikely to be construed as

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[915] Grimshaw, *Philosophy and Feminist Thinking*, p. 196, cited in Ussher and Perz, 'PMS as a Gendered Illness', p. 136.
[916] Jack, *Silencing the Self: Women and Depression.*
O'Grady, *Woman's Relationship with Herself.*
All cited in Ussher and Perz, 'PMS as a Gendered Illness', p. 136.
[917] Orbach, *Fat Is a Feminist Issue*, p. 88.
[918] Lisa Downing, *Selfish Women* (Abingdon, Oxon; New York, NY: Routledge, 2019), p. 1.

offensive, a disorder, or a medical issue that desperately needs to be cured. Hence, it is not likely to be viewed as problematic by others — the same others who persuade women to seek help for their mental health — in fact, quite the opposite, for others stand to benefit from women's selflessness. This is in contrast to other mental health issues such as feelings of depression which, as Amy notes, renders her not a 'palatable' person to be around. On this point, psychiatrist Kramer observes that 'men's discomfort with anhedonia in women' reflects current styles of femininity.[919] Having discussed the idea of ideal femininity, its Victorian roots, and the evolution into its current form in Chapter 1, I will elaborate on the relevance of these notions for women's SAD later on in this chapter. Having reviewed co-occurring mental health issues and Neurodevelopmental Disorders, and their interplay with SAD, I now wish to shift my focus somewhat in addressing the role of the physical and the body.

Physical Health

One of my participants in particular, Amy, spoke at length about the interplay between her physicality and her mental health. Amy was born with a heart defect which has meant that she has thus far undergone three open heart surgeries. She told me that 'a big portion of my mental health is probably tied to the infant trauma that I had when I had the first heart surgeries, when I was born'. Following this remark, it might be said that Amy's nervous disposition is an intelligible response to trauma and, as such, its being pathologised or medicalised is certainly questionable. Amy's experience calls to mind one of the central tenets espoused by the anti-psychiatry movement and perhaps most succinctly articulated by Laing's aforementioned notion of insanity as 'a perfectly rational adjustment to an insane world';[920] the latter being, in Amy's case, a world which insists upon norms surrounding health and illness. In turn, Amy's heart defect positions her as non-normative. In Amy's case, and following Laing, her nervousness

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[919] Kramer, *Listening to Prozac*, p. 270.
[920] Laing, quoted in Chang, *Wisdom for the Soul,* p. 412.

can perhaps be thought of as a perfectly rational adjustment to the trauma resulting from her heart defect which entails, as she told me, 'a lifetime of facing mortality'.

The physical is also salient in Amy's story in that her heart defect actually facilitated her mental health diagnoses. That is, the latter came about as part of 'the therapy that I went into in a run up to heart surgery'. After having gone through the surgery, she described how she expected her mental health issues to disappear. By contrast, she told me, 'I was like, "Uh, my brain still doesn't really work though."' In her words, 'physical health, in a weird sort of roundabout way, ended up paving the way for an acknowledgement of my mental health, because it gave a tangible reason to investigate my mental health.'

Amy spoke of how she believed her mental health issues had arisen due to childhood trauma related to her heart defect. However, she noted that this is not a simple one-way relationship. That is, 'my mental health is its own thing and it's not just a symptom of physical health.' I will explore the way that Amy characterises her mental health as being 'its own thing' in due course. For now, I want to focus on Amy's comment that the mental is not merely a symptom of the physical. Indeed, they interact and are entangled. As an example of this, Amy spoke of how her feelings of anxiety and depression manifest physically:

> [A]nxiety affecting your appetite [...] getting physical nausea in an anxiety standpoint [...] in terms of physical symptoms of depression, like physical lethargy is a big one, I tend to get quite cold in that as well [...] just a general slowing kind of melancholic kind of space [...]

What is significant about Amy's perspective, and what speaks to the idea of the mental and the physical being entangled, is that her mental health and physical health oftentimes produce the same symptoms:

> '[...] [A]m I palpitating because I have anxiety, or am I palpitating because there's blood physically backed up in my heart as a result of my problematic mechanical valve?' [...] these like very like tangible, mechanical, anatomical problems having the same symptoms, in some cases, as my less tangible mental health [...]

This experience has given Amy insight into the interconnected nature of the entire body, since 'it makes it difficult to determine which symptoms are coming from which things and sometimes it's both'. Much like the feminist literature I drew upon in Chapter 2, Amy's narrative suggests that considering the mind and body separately is not helpful for understanding women's mental health.[921] Amy emphasises 'the significance of acknowledging that the whole body is interconnected and the psychological stuff affects the physical and vice versa'.

While Amy spoke about how her heart defect and her feelings of nervousness oftentimes produce the same physical symptoms, it is of note that a number of my participants spoke about the physical effects of their social anxiety, and this echoes Amy's exposition of the idea that the whole body is interconnected. Farah explained how social anxiety brings about physical symptoms, such as

> [M]y heartbeat was… In a way that I couldn't breathe […] I'm getting… red […] So hot [...] I can feel exactly the […] moving, blood […] Shaking hands […] trembling hands! […] when I get stressed […] I feel sick [...] sweating […]

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[921] Ussher, 'Premenstrual Syndrome', p. 244.
Radin, 'The Pragmatist and the Feminist'.
Elizabeth Mollard, 'Exploring Paradigms in Postpartum Depression Research: The Need for Feminist Pragmatism', *Health Care for Women International*, 36.4 (2015), 378–91 <doi: 10.1080/07399332.2014.903951> [accessed 25 September 2020], p. 383, 388.

Daniella described similar phenomena in saying that her nervousness causes her to 'feel queasy and nauseous, and dizzy'. Crucially, and most pertinent to the idea of the interplay between the mental and the physical, Daniella proposed that SAD is 'not just, you know, a mental disorder, it's kind of a physical disorder because obviously it affects everything: your body, your blood pressure can go up and your heart rate can go up'. Daniella's narrative goes a step further in that she described how these physical symptoms, arising from her emotional state, then affect how she feels: 'You actually feel like you're ill inside.'

Daniella's testimony links to something I discussed in Chapter 2, that is, how feeling socially anxious can have physical manifestations,[922] as my participants have described. These physical manifestations can then become the focus of the social anxiety, in that one may be concerned that others notice these physical symptoms.[923] As such, concern with how one is perceived is then shifted to include these physical symptoms, which arise from mental discomfort. In other words, the physical symptoms, which arise from a woman's emotional state, then play a role in the emotional state which, in turn, might trigger further physical symptoms. This exemplifies the interconnectedness of mind and body to which my participants have alluded.

Ellen's narrative includes a similar idea in that she told me she has joint hypermobility syndrome. This is characterised by flexible joints, often leading to injuries such as strains and sprains:[924]

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[922] WHO, 'Social Phobias'.
[923] Social Anxiety Institute, *DSM-5 Definition of Social Anxiety Disorder*.
[924] NHS, *Joint Hypermobility Syndrome* (2017) <https://www.nhs.uk/conditions/joint-hypermobility-syndrome/> [accessed 25 September 2020].

I have like chronic joint pain which is linked to the depression and anxiety [...] exercise is how I kind of battle the pain, but [...] I'm more prone to injury [...] so then I'm less likely to be able to exercise and then I get anxious. So it kind of all links in [...] it like goes round in circles.

For Ellen, exercising is beneficial for both her mental health and her joint pain, but the resulting chronic pain from exercise-induced injury, to which she is more susceptible, prevents her from exercising and is therefore conducive to poorer mental health and worse chronic pain. Here we have another example of the interrelation, indeed the reciprocal relationship, between the physical and the mental. Again, this echoes Amy's thoughts: '[T]he body and the mind are connected to each other [...] the whole body is so interconnected [...] Mental health has physical symptoms and physical health can affect mental health.'

At this point, it is necessary to very briefly touch on the concept of mind-body dualism. This topic is still a matter of debate within psychiatry today[925] and the concept itself has a long history, perhaps being most closely associated with the work of Descartes, beginning in the 17th century.[926] Some feminist thinkers, such as Genevieve Lloyd and Moira Gatens,[927] have used the work of philosopher Baruch Spinoza as an alternative way of theorising about the mind and the body. Specifically, they have found his tenets that

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[925] Hane Htut Maung, 'Dualism and its Place in a Philosophical Structure for Psychiatry', *Medicine, Health Care and Philosophy,* 22.1 (2019), 59–69 <doi: 10.1007/s11019-018-9841-2> [accessed 25 September 2020].
Florence Thibaut, 'The Mind-Body Cartesian Dualism and Psychiatry', *Dialogues in Clinical Neuroscience,* 20.1 (2018), 3 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6016047/> [accessed 25 Septepmber 2020].
Joachim Raese, 'The Pernicious Effect of Mind/Body Dualism in Psychiatry', *Journal of Psychiatry*, 18.1 (2015), 219–26 <doi: 10.4172/1994-8220.1000219> [accessed 25 September 2020].
[926] Rene Descartes, *The Philosophical Writing of Rene Descartes. 3 Vols*, trans. J. Cottingham, R. Stoohoff, D. Murdoch, and A. Kenny (Cambridge, UK: Cambridge University Press, 1984–1991).
Justin Skirry, *Descartes and the Metaphysics of Human Nature* (London and New York: Thoemmes-Continuum Press, 2005).
All cited in Thibaut, 'The Mind-Body Cartesian Dualism', p. 3.
[927] Susan James interviews Genevieve Lloyd and Moira Gatens, 'The Power of Spinoza: Feminist Conjunctions', *Hypatia – Going Australian: Reconfiguring Feminism and Philosophy,* 15.2 (2000), 40–58 <doi: 10.1111/j.1527-2001.2000.tb00313.x> [accessed 5 January 2021], p. 41.

the mind is 'the idea of the body'[928] and that 'the mind and body are one thing, viewed in two irreducibly different ways'[929] useful insofar as they offer a different paradigm to that of Cartesian dualism.[930] Laing is also implicitly critical of Cartesian dualism in writing that:

> The most serious objection to the technical vocabulary currently used to describe psychiatric patients is that it consists of words which split man up verbally in a way which is analogous to the existential splits we have to describe here.[931]

I will explore Laing's 'existential splits' and link this with the way that women are taught to view themselves in the next chapter. For now, it is of note that Laing is alluding to the way that language itself places constraints on how we express and conceptualise different aspects of our lived experience, and 'verbally split' us up into 'mind' and 'body'. Like Laing, Amy expressed criticism vis-à-vis mind-body dualism:

> [D]on't get me started on the mind-body stuff [...] a huge, huge, huge element of medicine is understanding how this part of the body affects that part of the body, and even down to the split between mental health and physical health. That's a fallacy [...]

Amy's critique of mind-body dualism echoes a body of feminist work on women's mental health that I reviewed in Chapter 2. Of particular note is the work of Ussher on PMS. Ussher argues that women's bodily, social, and psychological levels cannot be disentangled from each other.[932] This evokes Amy's thoughts on the interconnectedness of the mind and body, and her take on separability:

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[928] Ibid.
[929] Ibid., p. 47.
[930] Ibid., p. 41.
[931] Laing, *The Divided Self*, p. 19.
[932] Ussher, 'Premenstrual Syndrome', p. 244.

It's a fallacy and a human construct of medicine that we think of the body as a series of layered systems that can be separated out from each other. Because you can't, you can't separate them out from each other [...] the body is a big, messy, organic thing [...]

Amy's narrative also calls to mind feminist critiques of Cartesian dualism which posit this school of thought as creating a series of binary oppositions that devalue women, emotion, and the body in relation to man, reason, and the mind. Social psychologist Mary Gergen describes this as 'a hierarchy within which the rational (mind/soul) elements are designated as the masters of the inferior body (emotions)'.[933] In turn, Cartesian dualism 'reproduces the male/female dichotomy'.[934]

In terms of Amy's narrative, we can think of the brain and the body (and also the mind, if we wish) as, in Amy's words, 'big, messy, organic' things which cannot be separated or disentangled from one another. Another way of considering this is by using the concept of embodiment, which Simon J. Williams tells us is a means by which we can 'tackle, head on, the traditional division between biology and society, mind and body'.[935] Williams advocates abandoning mind/body splits and instead, tells us that we must

[C]onfront the question of how the social realm itself is *embodied*: a notion which can give form to the relationship between the social structural milieu in which humans live, their subjective experience, and the *flesh* through which that existence is lived.[936]

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[933] Mary Gergen, 'Postmodern, Post-Cartesian Positionings on the Subject of Psychology', *Theory and Psychology,* 5.3 (1995), 361–68 <doi: 10.1177/0959354395053003> [accessed 25 September 2020].
[934] Ibid.
[935] Simon J. Williams, 'Reason, Emotion and Embodiment: Is "Mental" Health a Contradiction in Terms?', *Sociology of Health and Illness,* 22.5 (2000), 559–81 <doi: 10.1111/1467-9566.00220> [accessed 25 Septepmber 2020], p. 565.
[936] M. Lyon, 'C. Wright Mills Meets Prozac: The Relevance of "Social Emotion" to the Sociology of Health and Illness', *Health and the Sociology of Emotions,* ed. by Veronica James and Jonathan Gabe (Oxford: Blackwell, 1996), 55–78, p. 96, cited in Williams, 'Reason, Emotion and Embodiment', p. 566.

Radin[937] and Mollard[938] also use the concept of embodiment in their research on women's PPD. They espouse the idea that women cannot be divided up into parts and emphasise the link between the biological and the psychological in much the same way that Amy's testimony emphasises the link between mental and physical health.

In the interests on building on these works, and applying them to women with SAD, I contend that not only are the biological and psychological linked and interconnected, as Amy attests, but have a reciprocal relationship. This is exemplified by the relationship between Ellen's joint pain and her mental health as well as my participants' descriptions of how their social anxiety manifests physically. Reconceptualised in this way, although social anxiety might be, at least in the first instance, experienced in mental terms, it is something which is experienced by the woman in her entirety. Williams makes a related point in making the case for the importance of emotions in life, wherein he describes the body as

> [T]he active, emotionally 'expressive' body, in sickness and in health, as the basis of self, sociality, meaning and order, set within the socio-cultural realms of everyday life and the ritualised forms of interaction and exchange they involve.[939]

Medical humanities scholar Elizabeth Donaldson advocates for a similar position in telling us that 'theories that pay attention exclusively to the social causes and construction of mad identity while overlooking the material conditions of the body, and the body as a material condition, have a limited political scope'.[940] The embodied self is thus a key part of the socially anxious woman's experience. Related to this idea are specifically female experiences or constitutions and their connection to mental

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[937] Radin, 'The Pragmatist and the Feminist'.
[938] Mollard, 'Exploring Paradigms in Postpartum Depression Research', p. 383, 388.
[939] Williams, 'Reason, Emotion and Embodiment', p. 567.
[940] Donaldson, 'The Corpus of the Madwoman', p. 102.

health issues:

> Ria: [W]e do have a hormonal fluctuation sort of in-built into our being as well, and that's a legit thing, isn't it?
>
> Daniella: Hormones play a role in a sense. Because you've got lots of hormones that are fluctuating throughout the... Month.
>
> Ellen: [T]here's definitely points in my like cycle, of the month, as well, that I'm worse.

In Ellen's case, she went on to tell me that it was not necessarily hormonal changes *per se* that affected her mood, but changes in her body which accompanied these hormonal changes:

> I was reading, and it was like, 'You can put on up to 5lbs,' and I'm like, 'I am that person that puts that on.' [...] I can't do any of my clothes up when I'm on my period [...] I'm like, 'I hate myself,' and none of my clothes fit [...]

Ellen is alluding to temporary weight gain having a negative effect on her self-esteem, likely due to thinness in women being prized in our culture. In this case, it is not her body, by itself, which is implicated in her lower mood, but rather society's ideals pertaining to female bodies. Although her body *does* play a role in her concern with how she is perceived, I am doubtful whether this concern would exist without her being exposed to social conditions which mandate female slenderness. As such, in acting in tandem with the physical, society plays a larger role than we perhaps might think in affecting mental health. While my discussion here has been focused on hormonal changes, I will explore bodily ideals in greater depth in the next chapter.

Since I am discussing hormones in relation to mental ill health, I must be clear about my repudiation of biologically reductionist accounts which attribute the heightened prevalence of Depression and Anxiety

Disorders in women solely to their hormonal profiles, which I have discussed elsewhere.[941] With that said, although my overarching focus is on the under-researched social contributors to women's SAD, this does not mean that I am dismissing the effects of the body. In spite of this, the tension between espousing a social constructionist approach and acknowledging the role of the body persists and indeed, this is something about which Ussher speaks in her work on PMS:

> One of the main problems is that in adopting a social constructionist perspective, or in arguing that PMS exists entirely at a discursive level, we are implicitly denying the influence of biology — of factors such as menstruation, hormonal changes, or endocrine changes — or we may appear to relegate the body to a passive subsidiary role, which has meaning or interpretation imposed upon it. Whilst the emphasis on social and discursive phenomena is understandable as a reaction against biological reductionism, positioning the body as irrelevant in the etiology, interpretation, or meaning of PMS or premenstrual symptomatology is clearly inappropriate.[942]

Catherine Prendergast speaks of a similar dilemma in the case of schizophrenia:

> For an academic like myself with generally poststructuralist leanings, to think of schizophrenia as a 'disease' makes me sound at best conservative and at worst theoretically unsound. I am therefore left wandering far from my usual terrain to find language with which I can address the dilemmas and gaps in understanding that mental illness presents.[943]

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[941] Masters, 'Tending to the "Neglected Anxiety Disorder"'.
[942] Ussher, 'Premenstrual Syndrome', p. 238.
[943] Catherine Prendergast, 'On the Rhetorics of Mental Disability', in *Embodied Rhetorics: Disability in Language and Culture,* ed. by James C. Wilson and Cynthia Lewiecki-Wilson (Carbondale: Southern Illinois University Press, 2001), 45–60, p. 46, cited in Donaldson, 'The Corpus of the Madwoman', p. 116.

As such, although my focus on social contributors to women's SAD *is*, in part, a response to biological reductionism, this focus does not necessitate the exclusion of considering the role of the body. Ellen perhaps best sums up this perspective in saying: '[Y]es, I can be a bit more anxious on my period, but also, I'm mostly more anxious because of the way that men have spoken to me, in the past.'

To further outline the importance of the body in women's SAD, I would like to explore the thoughts of Gatens's reading of Spinoza as well as the work of Haraway. Haraway tells us that 'bodies are perfectly "real," and nothing about corporealization is "merely" fiction. But corporealization is tropic and historically specific at every layer of its tissues'.[944] Similarly, Gatens tells us that, according to Spinoza, the body is 'not identical with itself across time [...] its meaning and capacities will vary according to its context'[945] and 'can only be revealed by the ongoing interactions of the body and its environment'.[946] This latter point is especially salient, since it is through interacting with the environment, chiefly other people, that social anxiety is experienced. Similarly, Donaldson endorses the idea that 'bodies are not simply born, but made'.[947] And Haraway tells us that 'bodies as subjects of knowledge are material-semiotic generative nodes. Their boundaries materialize in social interactions; "objects" like bodies do not pre-exist as such'.[948] To take the liberty of appropriating Simone de Beauvoir's famous remark for my own purposes:[949] 'One is not born, but rather becomes, a socially anxious woman.' Haraway's focus on social interaction in the shaping of the body is especially key in the case of social anxiety. Indeed, every

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[944] Donna Haraway, *Modest_Witness@Second_Millennium. FemaleMan_Meets_OncoMouse: Feminism and Technoscience* (New York: Routledge, 1997), p. 142, cited in Donaldson, 'The Corpus of the Madwoman', p. 110.
[945] Moira Gatens, 'Towards a Feminist Philosophy of the Body', *in Continental Feminism Reader,* ed. by Ann J. Cahill, and Jennifer Hansen (Lanham, Maryland: Rowman and Littlefield, 2003) 275–86, p. 284.
[946] Ibid.
[947] Donaldson, 'The Corpus of the Madwoman', p. 112.
[948] Donna Haraway, 'The Biopolitics of Postmodern Bodies: Determinations of Self in Immune System Discourse', in *Feminist Theory and the Body: A Reader*, ed. by Janet Price and Margrit Shildrick (New York: Routledge, 1999), 203–14, p. 208.
[949] Simone de Beauvoir, *The Second Sex* (New York: Vintage Books, 1973), p. 301.

interaction has an effect on the woman as a whole. This was something that arose in my interview with Ria, when she spoke about instances of being undermined, patronised, and underestimated in the workplace in a male-dominated field: '[I]t doesn't help, does it? [...] when it happens more than once and you're aware of it [...] eventually, it's going to chip away at you, isn't it?'

The 'chipping away' to which Ria alludes has much in common with 'microaggressions'. Recall Sue's definition of gender microaggressions cited earlier: '[B]rief and commonplace daily verbal or behavioral indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative gender slights and insults that potentially have a harmful impact on women.'[950] Two subtypes of gender microaggressions are of particular note, since they are most relevant to Ria's narrative. These are 'microinsults' and 'microinvalidations,' which I also discussed earlier, and which Sue tells us are 'less obvious' and more subtle than overt sexism, their invisibility rendering them 'so powerful' and 'insidious'.[951]

Ria's testimony suggests that our reaction to outside stimuli, namely repeated unfair treatment in the form of microaggressions, causes negative emotions and, by virtue of these emotions being rooted in our brains, they are rooted in our bodies. Similarly, Williams tells us that 'society affects us, both emotionally and physically, deep within the recesses of the human body'.[952] On this point, Ria had this to say:

> [I]nstinctually, I'd sort of say the social/environmental would be the sort of, the base of it [social anxiety] [...] Biology obviously is a thing, but yeah, it's kind of carefully cultivated, isn't it? Maybe

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[950] Ibid., p. 164.
[951] Derald Wing Sue and Christina M. Capodilupo, 'Racial, Gender, and Sexual Orientation Microaggressions: Implications for Counseling and Psychotherapy', in *Counseling the Culturally Diverse: Theory and Practice,* ed. by Derald Wing Sue and Christina M. Capodilupo (Hoboken, NJ: John Wiley and Sons, 2008), 105–30, cited in Sue, *Microaggressions*, p. 169.
[952] Williams, 'Reason, Emotion and Embodiment', p. 569.

> due to a mix of all these biologies coming together [...] I think it is the result of lots of little interactions building up over time [...] a lone instance that suddenly makes you socially anxious: I don't think that's a thing. And I think things just sort of lead on and on and on that you sort of feel a sense of your lack of worth being reinforced with little things — sometimes possibly very little things.

Ria's 'careful cultivation' could be viewed as repeated social interactions of a similar kind having effects on our emotions and, by extension, our bodies. On this point, Sue gives an anecdote about a time when he, an Asian American man, and his colleague, an African American woman, both felt discriminated against because of their race. Sue begins to ask himself, 'why were we being singled out? Were we being singled out because of our race? Was this just a random event with no racial overtones? Were we being oversensitive and petty?'[953] Sue tells us that after the incident, he and his colleague both 'felt resentment, irritation, and anger'.[954] Ria alluded to the idea that these emotional states, which arise from experiencing microaggressions as a woman, have an effect on our biology. This is borne out in Sue's anecdote, for he tells us that '[w]hile I kept telling myself to drop the matter, I could feel my blood pressure rising, my heart beating faster, and my face flushing with anger'.[955] In the spirit of both Spinoza's account of the body and Haraway's work, we are beginning to see how the body of the socially anxious woman is made.[956] In turn, we can acknowledge the effects of the biological without resorting to harmful biological reductionism which posits mental health issues, such as SAD, as being innate and thereby ignoring harmful structural inequalities which are conducive to psychological distress.

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[953] Derald Wing Sue, Christina M. Capodilupo, Gina C. Torino, Jennifer M. Bucceri, Aisha M. B. Holder, Kevin L. Nadal, and Marta Esquilin, 'Racial Microaggressions in Everyday Life: Implications for Clinical Practice', *American Psychologist,* 62.4 (2007), 271–86 <doi: 10.1037/0003-066X.62.4.271> [accessed 5 January 2021], p. 275, cited in Sue, *Microaggressions*, p. 43.
[954] Sue, *Microaggressions*, p. 43.
[955] Ibid.
[956] Donaldson, 'The Corpus of the Madwoman', p. 112.

In problematising mind-body dualism, we might also question other splits. In her interview with philosopher Susan James, Gatens tells us that she first began reading Spinoza because she was interested in the mind-body problem 'and its relation to the reason/passion split and the nature/culture split'.[957] Similarly, Williams tells us that the mind/body split 'spawns a number of other dualisms such as nature/culture, reason/emotion, public/private'.[958] The nature/culture dualism has salience for my participants' narratives insofar as they spoke about their SAD arising from a combination of nature and nurture:

> Daniella: [T]he way you're brought up, has an effect [...] I think it depends [...] on your personality as well, so it's nature and nurture.
>
> Amy: It's sort of the nature vs. nurture question, isn't it, at a certain point? [...] our experiences are a bit of both.
>
> Olivia: I think what 'causes' SAD may be a combination of predisposition to social anxiety in genetics and personality, mixed with environmental and social upbringing within cultural norms of gender/femininity. The contributing factors for me were a mixture of nature and nurture.

These narratives all point to the influence of both culture and biology on social anxiety. On this idea, Gatens tells us that traditional political theory 'takes the body [...] as virtually given'.[959] That is, the way that the body then 'takes up' culture is contingent on this *a priori* biology. This traditional viewpoint was present in Amy's narrative in that she alluded to a pre-existing biology which is then affected by external

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[957] James interviews Lloyd and Gatens, 'The Power of Spinoza', p. 43.
[958] Williams, 'Reason, Emotion and Embodiment', p. 561.
[959] Gatens, 'Towards a Feminist Philosophy', p. 284.

factors: '[H]aving a mental illness is genuinely a condition of chemical imbalances. So that's an internal space that could then be exacerbated by external influences.'

Gatens departs from this in advocating for a 'nondichotomized view of nature and culture' which requires 'acknowledging the cultural and historical specificity of bodies'.[960] That is, 'the body is always already in a social context, and the context in which a body grows makes a real difference to the powers and capacities of the individual it becomes.'[961] Elements of Gatens's reading of Spinoza found echoes in both Phoebe's and Olivia's stories, particularly in the idea of the role of the biological and its relation to social context in the development of social anxiety:

> Phoebe: [Yo]u have to be like prone to it, but I think that contextually [...] the way in which society is structured massively has an impact on our brains [...]
>
> Olivia: I think I'm predisposed to be on the quiet and shy side, and feminine cultural norms only cemented these traits and boxed me in rather than nurture me to feel more empowered.

We are thus seeing how the interrelation of culture and the body creates the socially anxious woman.

Up until this point, I have problematised the diagnostic category 'SAD', as well as its associated 'co-morbidities'. I now wish to shift my focus somwewhat and consider my participants' views and experiences of diagnosis.

Diagnosis

As I outlined in the Introduction, my participants were a mixture of diagnosed and self-diagnosed with both SAD and other mental health issues. Nonetheless, a number of them had opinions, positive and

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[960] Ibid.
[961] James interviews Lloyd and Gatens, 'The Power of Spinoza', p. 47.

negative, on diagnosis. Amy spoke about the importance of her own diagnosis and in so doing mentioned people who have not received an official diagnosis:

> [T]his is not to undercut anyone who identifies–mental health that hasn't been officially diagnosed–because obviously that gets into the difficulty of accessing healthcare, which is a whole other issue [...] So those people are obviously valid as well, I'm just speaking from my own personal experiences.

Amy's astute observation that there are difficulties accessing healthcare is something on which my decision to include self-diagnosed participants was based. Moreover, this issue is a prominent one in terms of diagnoses such as ASD which, especially in women, are often not made in childhood: recent years have seen a growing number of women diagnosed in later life.[962] And, unlike 'garden variety' mental health issues like Generalised Anxiety Disorder[963] and Depression,[964] diagnoses for which can be given and treated by a GP, other diagnoses such as ASD can only be made via referral to a specialist.[965] As with the case of talking therapies, waiting times are often long[966] and provision can vary depending on area.[967] As discussed earlier, all of these barriers to diagnosis have been buttressed by the Covid-19 pandemic. Phoebe, who believes she has ASD, spoke about her experience of not being diagnosed, as well as how she feels a diagnosis would benefit her:

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[962] Sarah Bargiela, Robyn Steward, and William Mandy, 'The Experiences of Late-diagnosed Women with Autism Spectrum Conditions: An Investigation of the Female Autism Phenotype', *Journal of Autism and Developmental Disorders,* 46.10 (2016), 3281–94 <doi: 10.1007/s10803-016-2872-8> [accessed 25 September 2020].
[963] NHS, *Do I Have an Anxiety Disorder?* (2018) <https://www.nhs.uk/common-health-questions/lifestyle/do-i-have-an-anxiety-disorder/> [accessed 7 January 2021].
[964] NHS, *Diagnosis: Clinical Depression* (2019) <https://www.nhs.uk/conditions/clinical-depression/diagnosis/> [accessed 7 January 2021].
[965] NHS, *How To Get Diagnosed* (2019) <https://www.nhs.uk/conditions/autism/getting-diagnosed/how-to-get-diagnosed/> [accessed 25 September 2020].
[966] Ibid.
[967] National Autistic Society, *Pre-Diagnosis Support – A Guide for Adults Who Think They Might Be Autistic* (2020) <https://www.autism.org.uk/about/diagnosis/adults.aspx> [accessed 25th September 2020].

> I've never been diagnosed with it but I've been reading up a lot about it recently and I actually think that I am, it just makes so much sense to me [...] I'm thinking about going to try and get a diagnosis, just because it would [make] things feel like they fit in more, in my mind.

Amy spoke in similar terms about how her diagnoses of Depression and Anxiety had benefited her, allowing her to make sense of how she feels:

> [H]aving that diagnosis changed a lot for me, because it allowed me to acknowledge it as a separate part of me and not just this weird, ambiguous, 'Why do I feel like this today?' [...] and that gives me something to hang onto [...] and a thing to look up [...]

Amy's and Phoebe's views on the utility of diagnosis mirror the typical liberal feminist position on PTSD, as articulated by clinical social worker Susan H. Berg. Berg contends that this position maintains that this diagnosis is helpful to women insofar as it facilitates the development of a treatment plan which 'helps patients continue to develop resources, both internal and external, to aid in their growth and fulfilment'.[968] By extension, diagnosis more generally is good for women because it identifies, names, and explains a particular type of experience.

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[968] Sandra Bloom, *Creating Sanctuary* (New York: Routledge, 1997).
Judith Lewis Herman, 'Complex PTSD: A Syndrome in Survivors of Prolonged and Repeated Trauma', *Journal of Traumatic Stress*, 3 (1992), 377–91 <doi: 10.1002/jts.2490050305> [accessed 25 September 2020].
Irene P. Stiver, 'The Meaning of Care: Reframing Treatment Models', in *Women's Growth in Connection,* ed. by Irene P. Stiver, Judith V. Jordan, Jean Baker Miller, Janet Surrey, and Alexandra G. Kaplan (New York: Guilford, 1991), 250–67.
Lenore E. Walker, *Abused Women and Survivor Therapy: A Practical Guide for the Psychotherapist* (Washington, DC: American Psychological Association, 1994).
All cited in Susan H. Berg, 'The PTSD Diagnosis: Is It Good for Women?', *Affilia,* 17.1 (2002), 55–68 <doi: 10.1177/088610990201700104> [accessed 5 January 2021], p. 58.

As such, psychiatric discourses need not only pathologise and medicalise different ways of being, though they might do so, but can make possible, ‘the formation of a “reverse” discourse’.[969] Historian Rebecca Jennings draws on this Foucauldian idea in discussing *female* homosexuals who, in the nineteenth century, were termed ‘inverts’.[970] Jennings challenges ‘[t]he idea that sexological categories were imposed on unwilling women by the hostile body of “experts”’.[971] She evidences this by citing several letters to the sexologist Edward Carpenter which ‘suggest that individual women found the ideas of some sexologists helpful in thinking about their sexuality, but often as part of an ongoing process which had started prior to reading the literature’.[972] One woman ‘described reading Carpenter’s *The Intermediate Sex* as “like being given sight”’.[973] Another example, identified by sociologist Liz Stanley, is the case of a woman who pseudonymously called herself Frances Wilder.[974] In a letter, Wilder tells Carpenter that reading *The Intermediate Sex* ‘had made her realise “that I myself belong to that class and [it] made everything fall into place”’.[975] This echoes Phoebe’s testament that she feels as though an ASD diagnosis would make things feel like they ‘fit in more’. As such, it is becoming clear that while diagnoses such as SAD are a way to medicalise non-normative behaviours or ways of being, or intelligible responses

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[969] Foucault, *The Will to Knowledge,* p. 101.
[970] Rebecca Jennings, *A Lesbian History of Britain: Love and Sex between Women Since 1500* (Oxford/Westport, Connecticut: Greenwood World Publishing, 2007), p. 77.
[971] Ibid., pp. 86–87.
[972] Ibid., p. 87.
[973] George Meredith, *Diary of the Crossways* (London: Virago, 1980 [1885]), p. 41, 132, cited in Sally Ledger, *The New Woman: Fiction and Feminism at the Fin de Siècle* (Manchester: Manchester University Press, 1991), p. 135, cited in Jennings, *A Lesbian History of Britain*, p. 88.
[974] Liz Stanley, ‘Romantic Friendship? Some Issues in Researching Lesbian History and Biography’, *Women’s History Review*, 1.2 (1992), 193–216 <doi: 10.1080/0961202920010201> [accessed 6 January 2021] pp. 206–08, cited Jennings, *A Lesbian History of Britain*, p. 87.
[975] Jennings, *A Lesbian History of Britain*, pp. 87–88.

to gender-based trauma, they can equally be helpful in 'providing a name and framework'[976] for self-understanding and, as Amy says, treatment.

By contrast, Farah's perspective on being diagnosed with Anxiety is perhaps more reflective of Berg's conceptualisation of the radical feminist position on the PTSD diagnosis. Farah told me that she felt that her diagnosis pathologised her and, in turn, this increased her psychological distress:

> [T]hat kind of categorisation [...] When they pathologise you, it actually increase[s] maybe, that anxiety [...] Because you feel that, ok, you have [a] problem [...] And thinking about solving that problem [...] Increase[d] my anxiety.

Berg tells us that radical feminism believes that both diagnosis, and treatment, pathologises women, for it 'adds to the victim's belief in her defectiveness'.[977] Farah described why her own diagnosis made her feel a similar way:

> Farah: [T]he doctor told me, 'Oh, why did you suffer this much? You could come sooner and we could solve it for you. By just using this medicine, 70% of this problem would be solved,' [...] Lack of some–some er… Stuff in your body [...]
> K:[978] Oh, serotonin in your brain?
> Farah: Yeah, you know, and then, it's not all about your characteristic[s] or [...] personality [...] You would think that, ok, there's something different… There's something wrong with your body as well.

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[976] Meredith, *Diary of the Crossways,* p. 41, 132, cited in Ledger, *The New Woman,* p. 135, cited in Jennings, *A Lesbian History of Britain,* p. 88.
[977] Berg, 'The PTSD Diagnosis', p. 61.
[978] The researcher and interviewer.

It is also worth noting that this pathologisation, or a fear of it, might prevent some women from seeking help expressly for their social anxiety. As I mentioned earlier on in the chapter, as well as elsewhere,[979] this might particularly be the case if women deem their social anxiety to be another facet of their personality as opposed to an illness in need of (pharmacological) treatment. While I have hitherto focussed on pharmacological remedies in discussing treatment, a number of my participants' divulged their experiences with therapy: it is to these experiences that I now turn.

Therapy

Of the seven women I interviewed, four disclosed to me that they had had some sort of therapy for their mental health. For one of these women, this was during her time spent living in the US, while the other three engaged in therapy while living in the UK. That only three women in my sample, of the five who had lived in the UK for their entire lives,[980] had received therapy goes some way to supporting the idea, as I discussed in Chapter 1, that therapy provision in the UK is patchy[981] and waiting lists are lengthy[982] — and even more so owing to the Covid-19 pandemic. By contrast, five of the seven women in my sample had taken medication for their mental health issues, although one of these was during her time living in Western Asia. This reinforces a related idea that I set out in Chapter 1: faced with long waiting lists and no alternative, GPs are prescribing more and more antidepressants.[983] This is perhaps a shame, since all of the women in my sample who had had therapy expressed positive feelings about it and described how

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[979]Masters, 'Subscribing to, and Resisting, Authority Discourses on Mental Health'.
[980] In terms of my participants who had moved to the UK from other countries, at the time of interview, one had lived in the UK for seven years, while another had lived in the UK for at least three years.
[981] Mind, *We Need To Talk*, p. 7.
NHS England*, Adult Improving Access to Psychological Therapies Programme* (n.d.).
[982] Hyde et al., 'A Qualitative Study Exploring how GPs Decide To Prescribe Antidepressants'*,* pp. 759–60.
Royal Pharmaceutical Society, 'Most GPs are Over-prescribing Antidepressants'.
Wooster, *While We Are Waiting*, p. 8.
[983] Ibid.
Iacobucci, 'NHS Prescribed Record Number of Antidepressants Last Year'.

it had helped them. Most commonly, they spoke of therapy providing tools or techniques to deal with psychological distress in helpful ways. Olivia shared her experience: 'The counselling helped with dealing with depression a little. I didn't do many sessions but the ones I did, I felt were helpful in just talking to someone about how I felt and being reminded of little self-care techniques.'

Amy's experience of therapy, which was with an art therapist and was undertaken during her time living in the US, was similar:

> I had a really good therapist for a couple of years there who gave me a lot of good resources [...] even just the awareness of like diagnostics [...] knowing what it is that makes your brain do what it does is a helpful tool to go, 'Oh, that's not really just me losing my mind, that's what Anxiety looks like.' Now let's acknowledge it, take steps to see what you can do to curb it.

With that said, some feminists have been critical of therapy. That is not to suggest that my participants are wrong for engaging in it or for finding it helpful: if it aids in alleviating distress, then this method should be applauded. Rather, some feminists have contended that therapy colludes with the psy sciences insofar as it focuses on mental health issues as being innate or resulting from a fault within the individual woman. Instead, some feminists propose that the focus should be shifted towards the social contributors to mental ill health. Their contention is therefore that therapy 'provides individual approaches to collective problems... [so that] each woman comes to see her problems as unique'.[984] As I reviewed in Chapter 2, Chrisler and Caplan make a similar argument regarding the use of medication for PMS in saying that '[t]aking medication may provide apparent serenity to individual women, but it does

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[984] Arches, cited in J. A. Nes and P. Iadicola, 'Toward a Definition of Feminist Social Work: A Comparison of Liberal, Radical and Socialist Modes', *Social Work*, 34.1 (1989), 12–21 <doi: 10.1093/sw/34.1.12> [accessed 5 January 2021], p. 18, cited in Berg, 'The PTSD Diagnosis', p. 61.

nothing to alleviate the oppressive conditions that contributed to the stress and tension that caused them to report severe PMS'.[985]

In the UK, guidelines for doctors recommend a type of therapy called cognitive behavioural therapy (CBT) for mental health issues germane to my participants' experiences: SAD,[986] Depression,[987] Generalised Anxiety Disorder,[988] as well as 'eating-disorder-focused cognitive behavioural therapy' for Bulimia Nervosa.[989] Psychologist Ricki E. Kantrowitz and feminist therapist Mary Ballou make a number of relevant points in their feminist critique of CBT. The first is in alignment with my prior argument that therapy places the onus to adapt to the environment squarely on the shoulders of the individual.[990] Within this framework, the environmental conditions to which people are exposed remain unchallenged.[991] In turn, the imperative to adapt serves to reinforce these environmental conditions or the 'dominant social standards'.[992] The requirement that it is the individual who should change was apparent in both Olivia's and Amy's narratives. Both women spoke about being given tools with which to help themselves; neither woman spoke about having addressed environmental issues during their

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[985] Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', p. 301.
[986] NICE, *Interventions for Adults with Social Anxiety Disorder* (2013) <https://www.nice.org.uk/guidance/cg159/chapter/1-Recommendations#interventions-for-adults-with-social-anxiety-disorder-2> [accessed 25 September 2020].
[987] NICE, *Depression in Adults: Recognition and Management* (2009) <https://www.nice.org.uk/guidance/cg90/chapter/1-Guidance#treatment-choice-based-on-depression-subtypes-and-personal-characteristics> [accessed 25 September 2020].
[988] NICE, *Principles of Care for People with Generalised Anxiety Disorder (GAD)* (2019) <https://www.nice.org.uk/guidance/cg113/chapter/1-Guidance#principles-of-care-for-people-with-generalised-anxiety-disorder-gad> [accessed 25 September 2020].
[989] NICE , *Treating Bulimia Nervosa* (2017) <https://www.nice.org.uk/guidance/ng69/chapter/Recommendations#treating-bulimia-nervosa> [accessed 7 January 2021].
[990] Ricki E. Kantrowitz and Mary Ballou, 'A Feminist Critique of Cognitive Behavioral Therapy', in *Personality and Psychopathology: Feminist Reappraisals*, ed. by Laura S Brown and Mary B. Ballou (New York: The Guilford Press, 1992), 70–87, p. 77, 79, 83.
[991] Ibid., p. 79.
[992] Ibid.

therapy, which is perhaps surprising given that both women told me that they believed their female socialisation had played a role in the development of their social anxiety.

Given these problems with CBT, Kantrowitz and Ballou outline how it could be made more feminist. They advocate for the recognition of the importance of context. By this, they mean that the following aspects of women's lives should be considered: '[S]ociety, culture, class, race, developmental status, and individual experiences.'[993] They also emphasise the importance of environmental factors such as 'social and economic class, gender, ethnicity, political structures, and religion'.[994] Instead of these factors existing as 'environments to which individuals adapt' within the current schema,[995] they argue that CBT 'must also attend to and develop programs aimed at altering the natural setting instead of changing the individual'.[996]

Given the shortcomings of mainstream CBT, which is what patients are currently offered on the NHS, both for SAD and the additional diagnoses I discussed above, it is worth considering whether interventions outside of the psy sciences' remit might confer benefits to the wellbeing of women experiencing social anxiety. One example might be talking with other socially anxious women. Recall that Olivia, in discussing the positive effects of counselling, stated that 'just talking to someone about how I felt' was beneficial for her. Similarly, Ria explained why she thought talking through one's problems with somebody else, or writing them down, might be helpful:

> Ria: [I]t's kind of hard to apply logic to yourself [...] unless you write things down, to spot patterns. But when you talk to someone else [...] you can spot patterns in the outward behaviour [...]

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[993] Ibid., p. 82.
[994] Ibid., p. 84.
[995] Ibid.
[996] Ibid., p. 86.

> K: You mean like in terms of therapy?
>
> Ria: I think just generally, just generally conversing with someone you can pick things up [...] with yourself, you've kind of got your whole id and your inner world to contend with as well.

Given these testimonies, the therapeutic benefit offered by speaking with someone trusted should not be underestimated. This might be cathartic, as in the case of Olivia, or aid in spotting negative thought patterns which can cause distress, as in the case of Ria. I also propose that speaking to someone who has similar experiences to oneself has the potential to mitigate distressing feelings associated with social anxiety such as loneliness, being an outsider, or being different to other people. In a quasi-consciousness-raising group for mental health, the solidarity that speaking to others might confer could also remind these women that their problems are not as individual as psy science conceptions would often have them believe.

I have previously mentioned that SAD treatment in the UK follows two strands: talking therapy and medication.[997] Having reviewed some of my participants' perspectives on the former, it is now timely to discuss the latter.

Medication and Femininity

In Chapter 1, I discussed the pertinence of serotonin, a lack of which is purported to be the neurotransmitter at the root of a large proportion of mental health issues and the basis on which antidepressants work. This is relevant in that a lot of my participants had been prescribed antidepressants and had viewpoints on the chemical imbalance model. On this point, Kirsch suggests that antidepressants, which work by increasing serotonin levels, are no more effective than placebo in

[997] Ibid.

treating mental health issues.[998] Kirsch also contends that antidepressants' efficacy seems to be independent of whether they function to increase or decrease serotonin or act on a completely different neurotransmitter altogether.[999] Studies have since tried to debunk Kirsch's claims,[1000] but Kirsch, in response, argues that the efficacy that this research demonstrates is only a small amount above placebo.[1001] On this point, psychiatrist James Warner suggests that '[l]ooking at mean responses irons out those that don't respond at all and those that respond quite well'.[1002] This meshes with the observations of Kramer, who characterises a number of his patients, whom he treated with antidepressants such as Prozac, as 'good responders'.[1003] Considering the women I interviewed, their experiences with antidepressants are quite varied with respect to their perceived efficacy. Although Daniella later talks about ways that she feels antidepressants have helped her, she initially gave an account in alignment with the thoughts of Kirsch, telling me, 'I started getting help from the GP and they put me on–they made me try medication, which, a year or so later, still doesn't really [laughs] [is] still not having a massive effect.'

Farah's account was ambivalent. She was unsure whether taking Zoloft[1004] helped her, or whether the improvement she felt could be attributed to other lifestyle changes she employed at the same time:

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[998] Kirsch, 'Antidepressants and the Placebo Effect', p. 128.
[999] Ibid.
[1000] E.g. Andrea Cipriani, Toshi A. Furukawa, Georgia Salanti, Anna Chaimani, Lauren Z. Atkinson, Yusuke Ogawa, Stefan Leucht, Henricus G. Ruhe, Erick H Turner, Julian P. T. Higgins, Matthias Egger, Nozomi Takeshima, Yu Hayasaka, Hissei Imai, Kiyomi Shinohara, Aran Tajika, John P. A. Ioannidis, and John R Geddes, 'Comparative Efficacy and Acceptability of 21 Antidepressant Drugs for the Acute Treatment of Adults with Major Depressive Disorder: A Systematic Review and Network Meta-Analysis', *Focus,* 16.4 (2018), 420–29 <doi: 10.1176/appi.focus.16407> [accessed 25 September 2020].
[1001] Clare Wilson, 'Nobody Can Agree about Antidepressants: Here's What You Need To Know', *New Scientist* (2018) <https://www.newscientist.com/article/mg23931980-100-nobody-can-agree-about-antidepressants-heres-what-you-need-to-know/> [accessed 25 September 2020].
[1002] Ibid.
[1003] Kramer, *Listening to Prozac*, p. 236.
[1004] The generic name for which is 'sertraline', an SSRI.

> K: [T]he medication, did you think it helped?
>
> Farah: I really don't know because […] at the same time, lots of things changed in my life […] at the same time I started to go to [the] gym...

Olivia's account was different in that she told me that the antidepressant sertraline 'has had a much more noticeable effect in helping my depression than in helping my social anxiety'. Like Olivia, Ria's experience with antidepressants has been mixed:

> I went on citalopram, briefly [...] it didn't jive with me that well [...] then went on fluoxetine. Jived a little better, found it was taking me a bit… Manic [...] But I was better [...] and it got to the point where [...] I felt convicted of the decision to not take the tablets any further, so I just didn't–but it worked [...] And the Bulimia sort of sorted itself out [...]

Meanwhile, Ellen spoke about how she has found the antidepressant fluoxetine to be very helpful:

> I found one that I like [...] if I'm ok, I'll forget to take it and then I'll go like shit again, then I'm like 'Why am I shit?' and I'm like, 'Oh, it's because I've been okay, so I forgot to take the tablets.'

Given these viewpoints, antidepressants are by no means inherently anti-feminist or necessarily opposed to conceptions of mental health issues informed by anti-psychiatry. As evidenced here, for some women, they can be immensely helpful. What is objectionable is the viewpoint, arguably espoused by the biomedical model in psychiatry and big pharma, that mental health issues are solely biologically based and that antidepressants are a panacea for all manner of social and environmental problems, including distress arising from gender-based oppression.

As I am discussing antidepressants, it is pertinent to revisit the 'low serotonin' model of mental health issues. This model is commonly used by mental health professionals and has seeped into popular

parlance around mental ill health. What has come along with this notion is the idea that mental illness is an illness 'like any other'.[1005] Ellen's narrative evoked this notion when she discussed her somewhat uneasy relationship with, and how she rationalised, taking antidepressants, telling me, '"I don't want to be reliant on these." But then I'm like, "Ah, well if I was in pain I'd just be taking paracetamol." There's no difference.' Despite her seeming to endorse the idea that mental illness is akin to physical illness, Ellen is also aware that her mental health has a social component in saying that 'my insecurities are the result of what is going on in the world. Therefore, is it biological? No. I wouldn't feel this way if this wasn't happening'.

Regarding the chemical imbalance hypothesis, a number of the women to whom I spoke had something to say apropos of this explanatory model. Amy had faith in this model, as evidenced by our exchange:

> K: [P]eople talk about mental health issues as a chemical imbalance in the brain or, kind of, low serotonin. I wondered what your take on that was, what you thought about that?
> Amy: I mean, I agree with science, if that's what you're asking [...] Yeah, definitely.

The faith that Amy puts in this model, on account of its being 'science', speaks to the Foucauldian idea that science has replaced religion as a tool of population control.[1006] However, Amy's testimony goes further in that she explained specifically *why* she finds this model helpful. For her, it has provided a means by which she can explain how her mental health issues affect her without causing her to feel ashamed or apportioning blame to herself:

[1005] Hyman, quoted in Albee and Joffe, 'Mental illness Is NOT an "Illness Like Any Other"', cited in Deacon, 'The Biomedical Model of Mental Disorder', pp. 851–52.
[1006] Foucault, *Ethics*, p. 313.

> [T]he chemicals in the brain are what make me feel things and when they get out of whack, that's how depression and anxiety happen. That goes back to that burden of responsibility and that sort of shame that comes from, you know, 'I shouldn't feel sad, so why do I feel sad? I shouldn't feel anxious, so argh, why is this happening? [...]' And then I get mad at myself for feeling 'wrong'. So removing that burden of responsibility is a really important element, and chemical imbalance in the brain is literally the answer to that, right?

In discussing her mental health, Amy mentioned how she 'should' and 'shouldn't' feel. For her, the chemical imbalance model provides a reason, which is out of her control, as to why she feels 'wrong', or, I suggest, perhaps why she is made to feel 'wrong' by society.

Olivia seemed to have mixed feelings on the chemical imbalance model. While she attributed her mental ill health to it in part, she also viewed it as one of many causative factors affecting her mental wellbeing in telling me, 'I'm still unsure if the depression is caused by chemical imbalances in the brain or by contraception or by environmental factors, or a mix of these.' As Amy spoke about feeling 'wrong', Olivia told me that 'the medication worked quickly in helping me feel more "normal" again, which really made me think my depression must be caused by a chemical imbalance in the brain'. Perhaps then, for Olivia, as for Amy, this model provides a way of avoiding self-blame. While Amy's and Olivia's perspectives on the chemical imbalance model differ, it is interesting that they both speak of there being a 'wrong' or 'normal' way of being or feeling. We have here the idea that one must feel a certain way, such as 'happy', lest they are abnormal which, following Foucault, is conflated with being mentally sick. Williams discusses the conflation of happiness with emotional health in saying that

> [F]ar from being 'unhealthy' or 'pathological', it is indeed quite normal if not healthy to feel dissatisfied, disillusioned or even downright depressed at times; not simply due to prevailing

> ideologies of happiness and personal fulfilment, but also because of the embodied dilemmas and existential predicaments we all, qua human beings, inevitably face. We must not, in other words, confuse or equate issues of emotional health with happiness and wellbeing. Emotional health, in this sense, may indeed run the gamut of emotions, including those currently deemed 'treatable' by whatever means.[1007]

Olivia's and Amy's narratives also speak to what society sanctions as appropriate or permitted mental or emotional states. If we are to apply Williams's tenets to my participants' narratives, then Olivia's return to feeling 'normal', facilitated by her medication, might not represent a return to emotional health, but rather, to happiness and wellbeing. In Chapter 1, I discussed the work of psychiatrist Kramer in exploring how definitions of psychiatric disorders rest upon cultural norms.[1008] Indeed, Kramer tells us that some people 'require' psychiatric treatment because of a mismatch between their environment and their temperament.[1009] One cannot help but wonder if this is what Amy's and Olivia's narratives suggest. That is, they feel 'wrong', not how they 'should', or not 'normal' because society values certain traits in women, and the current feminine ideal is not nervous, socially anxious, or listless.

Returning to Amy's narrative and the idea of a chemical imbalance, one can see why Amy might find this model helpful in terms of avoiding blame: the fact that her personality style and the currently *en vogue* more 'masculine femininity', which I outlined in Chapter 2, might not match up, or our culture does not reward these traits, does not mean that there is something 'wrong' with her own personality style. Indeed, the discord which makes her feel 'wrong', or causes her to experience emotions that she feels she 'shouldn't', is certainly not her fault.

[1007] Williams, 'Reason, Emotion and Embodiment', p. 572.
[1008] Kramer, *Listening to Prozac*, p. xv.
[1009] Ibid., p. 246.

In the case of Olivia in particular, her testimony that taking antidepressants made her feel 'normal' again has relevance to Kramer's argument. Kramer contends that an antidepressant has the potential to alter the personality style of the person to whom it is administered. In so doing, this prescription could be viewed as bringing the patient into line with the current 'masculine feminine' ideal and thereby endorsing 'a certain sort of social conformity'.[1010] If there is no longer a discord between how a woman feels and how she is persistently told by society that she ought to feel, she might well feel 'normal' again, as Olivia described.

Although Daniella did not speak about a chemical imbalance, her experience of starting to take antidepressants bears resemblance to that of Olivia. Daniella told me how she used to feel prior to taking the antidepressant sertraline:

> I used to be really obsessed about what people thought of me [...] if I was in an awkward situation, I would feel like I was cringing inside [...] I would get really anxious [...] I would feel really bad if I made a mistake, or if I had to explain myself [...] Dwell on it massively, I could not have a conversation without like [...] crying [...] I used to care far too much about absolutely everything.

Before taking antidepressants, Daniella's temperament was somewhat in accordance with what Kramer describes as Victorian femininity, elements of which include being 'emotionally sensitive', 'fastidious', and 'melancholic';[1011] as well as Bem's conceptions of femininity: being shy, soft spoken, and sensitive to the needs of others.[1012] Daniella described the changes that she feels taking medication has made to her temperament: '[T]he abrupt mood changes have gone [...] It's more stable in the sense that I don't like cry for no reason all the time [...] I don't care as much.'

[1010] Ibid., p. 271.
[1011] Ibid.
[1012] Bem, 'The Measurement of Psychological Androgyny', p. 156.

Now, Daniella's personality style is closer to what Kramer describes as the current feminine ideal, or what I have called the more 'masculine femininity': that is, a personality style that features traditionally 'masculine' traits,[1013] such as 'resilience, energy, assertiveness, an enjoyment of give-and-take';[1014] being vivacious and mentally quick;[1015] and being analytical.[1016] Her personality style is also reminiscent of sociologist Anita Harris's exposition of modern young adult femininity in the early twenty-first century, which comprises the 'can-do' girl. This type of girl is characterised by confidence and resilience — 'they have "the world at their feet."'[1017] This brand of femininity has much in common with the 'the ideal late modern subject [...] who is flexible, individualized, resilient, self-driven, and self-made and who easily follows nonlinear trajectories to fulfillment and success'.[1018] The 'can-do' girls, therefore,

> [A]re identifiable by their commitment to exceptional careers and career planning, their belief in their capacity to invent themselves and succeed, and their display of a consumer lifestyle. They are also distinguished by a desire to put off childbearing until 'later'.[1019] […] This is a sexy, brash, and individualized expression of ambition, power, and success […] drawn from a wide range of areas: girls' educational success; their consumption, leisure, and fashion practices; apparent rejection of institutionalized feminism; sexual assertiveness; professional ambitions; delayed motherhood, and so on.[1020]

[1013] Kramer, *Listening to Prozac*, p. 271.
[1014] Ibid.
[1015] Ibid., p. 270.
[1016] Bem, 'The Measurement of Psychological Androgyny', p. 156.
[1017] Anita Harris, *Future Girl: Young Women in the Twenty-first Century* (Taylor and Francis Group, 2003) <https://ebookcentral.proquest.com/lib/bham/reader.action?docID=182880> [accessed 25 September 2020], p. 13.
[1018] Ibid., p. 16.
[1019] Ibid., pp. 13–4.
[1020] Ibid., pp. 16–7.

The construction of this particular kind of femininity, Harris argues, creates ‘docile good girls who can uncomplainingly participate in meeting the needs of the marketplace’.[1021] This is something which resonates with Daniella’s experience of the changes she felt on taking medication: ‘[T]he medication has helped for some things. I’m definitely able to do some work [...] whereas before, I just could not’. On this point, Kramer questions whether medicating women with antidepressants does not enforce adherence to ‘“masculine” capitalist values’ in order to serve the economic needs of society.[1022] Daniella’s testimony exemplifies this point. She described being reprimanded at work after starting to take antidepressants, and compared how this made her feel with how she imagined she would have felt in the same situation prior to taking medication: ‘[W]hen they told me off at work, if that was before medication, I would have cried on the spot for ages and I would’ve felt like crap for [...] the rest of the day.’

On a related note, Harris, citing cultural and feminist theorist Angela McRobbie, tells us that feminine success now extends from the body and appearance to success in the workplace. Indeed, ‘[t]he processes of working on the self […] to be perfect in self-presentation have been extended so that improving oneself is necessary to success in the labor and consumer markets.’[1023] Focusing on self-presentation in order to garner favourable evaluation from others is something I discuss in relation to social anxiety in the next chapter. For now, I note that concern with self-improvement in the context of work was evident in Daniella’s narrative, where she elaborated upon being reprimanded at work:

> I care, obviously, because it’s something that I need to change and I have to work on, blah blah blah, but it’s not going to ruin my day. And [...] I’m going to take action of this meeting, work on it,

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[1021] Ibid., p. 18.
[1022] Kramer, *Listening to Prozac*, p. 271.
[1023] Harris, *Future Girl*, p. 19.

> do whatever they say that I have to do, but [...] before medication, it would have been, 'Oh, I'm a failure. That's it. There's nothing you can do about it: you suck.'

Another area where the 'can-do' feminine ideal functions to meet the demands of the labour market is found in the pressure to put off childbearing until later on in life. This has required 'a reshaping of traditional conservative family values around mothering to accommodate the neoliberal agenda that calls for young women to function as high-status workers'.[1024] Women must therefore walk the fine line of acceptable femininity: they must 'delay childbearing until their careers are established but not […] renounce motherhood altogether'.[1025] The pressure to have children later on in life was present in the narrative of Farah, who was in her late thirties at the time of our interview:

> My mum, each time that she calls me, always tells me that, 'You should have children' […] occasionally some friends […] they would say, ok, because my husband also is younger than me […] if one day he wants [children], then maybe he would leave you […]

On having children, Harris tells us that women are 'simultaneously told that they must pursue careers and at the same time factor in children before it is "too late"',[1026] thus speaking to the somewhat contradictory nature of 'can-do' femininity. Downing has written on the 'double-bind' that women face in terms of having children. That is, '[t]he childless or childfree woman is othered as abnormal while the obediently reproductive woman, whose role is to provide infinite love, will be endlessly monitored, critiqued, and policed.'[1027] She continues:

[1024] Ibid., p. 21.
[1025] Ibid.
[1026] Ibid., p. 23.
[1027] Downing, *Selfish Women*, p. 101.

> [W]hile childfree women are routinely demonized for rejecting the role that has traditionally been seen as a woman's 'proper' one, women who do become mothers are not exempt from similar charges and also face grueling amounts of cultural surveillance regarding their level of commitment to motherhood, measured by the various associations that accrue to staying at home or working outside of the home in the popular cultural and media contexts and, in psychiatric and psychological ones, by suspicions of narcissistic mothering and 'helicopter parenting.'[1028]

The contradictory expectations about which Harris and Downing write are at the very heart of feminine ideals at the time of writing this thesis. Women must walk the thin line between exhibiting 'desirable' masculine traits, as exemplified by 'masculine femininity', while still being seen as feminine 'enough'. In light of this, fear at the prospect of not getting this balance quite right, thus being negatively evaluated and, in turn, experiencing social anxiety, is understandable.

While this tension is very apparent today, it is arguably a legacy of a comparable tension between Victorian femininity and the femininity of the 'New Woman' of the *fin de siècle*. In contrast with Victorian femininity, the New Woman had feminist politics; was independent, career-minded, and educated;[1029] and her riding of bicycles was reflective of both her contravention of the traditional female gender role and her ability to engage with the world beyond the domestic sphere.[1030] Incidentally, the New Woman was also associated with nervous illness.[1031] On the subject of this tension, but in the twentieth century, Penfold and Walker note that women participating in consciousness-raising groups might feel 'torn

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[1028] Ibid., p. 3.
[1029] Hugh Stevens, *Henry James and Sexuality* (Cambridge: Cambridge University Press, 2008), p. 27.
[1030] Jacob Roberts, 'Women's Work', *Distillations*, 3.1 (2017), 6–11 <https://www.sciencehistory.org/distillations/womens-work> [accessed 25 September 2020].
[1031] Showalter, *The Female Malady,* p. 137.

between a pull to remain with traditional ties and a pull to move onward'.[1032] Olivia explained how this tension is still very much an issue in the twenty-first century:

> [G]rowing up I received confusing mixed messages about gender roles. It was seen as 'normal' and 'natural' in media, culture and everyday life that as a girl I would show attributes of being quiet, self-conscious, sensitive, thoughtful, sweet and caring, rather than confident, independent and assertive. Yet, at the same time there was the 'girls can do anything' narrative – messages that I think only superficially attempted to empower girls, because the traditional feminine roles of passivity and beauty were and are still very much alive.

The shallow rhetoric about which Olivia spoke is visible in media in campaigns such as Sport England's *This Girl Can*[1033] and Caryl Hart's book *Girls Can Do Anything!*[1034] Although these are well-meaning, their rhetoric is somewhat shallow because it does not match up with most women's socialisation. This creates a difficult situation: women are socialised to behave in a particular way, and yet come to feel that they need to exhibit behaviour that is quite different. One can see how this might stir up concern with being 'good enough', and especially create concern about what others think. The leap from this to social anxiety is a small one.

The tension between exhibiting traditionally 'masculine' and 'feminine' characteristics is something which is especially present in the workplace, as Sue explains:

> These double standards create no-win situations for women. While men are valued for their assertiveness, an attribute of leadership, women evidencing these traits are described as 'bitchy'.

[1032] Penfold and Walker, *Women and the Psychiatric Paradox*, p. 219.
[1033] Sport England, *This Girl Can* (n.d.) <https://www.thisgirlcan.co.uk/> [accessed 25 September 2020].
[1034] Caryl Hart, *Girls Can Do Anything!* (Southam: Scholastic, 2018).

> Ironically, women are also aware that they must conform to masculine roles or behavior standards in order to be perceived as credible leaders. They are told to be wary of showing emotions or social sensitivities to others or they will be perceived as being 'weak' or 'too emotional' to deal with the rough and tumble of logical decisions.[1035]

I am reminded here of Broverman et al.'s[1036] study, wherein physicians' definition of the 'healthy man' and 'healthy adult' were one and the same, and stood in contradistinction to the 'healthy woman'. Sue cites this very same study in exploring femininity in the workplace:

> If 'male characteristics' denote health and effectiveness in the workforce, it means that 'healthy female traits' connote dysfunction and ineffectiveness in work situations. However, if women exhibit assertiveness at a work site (healthy male and healthy adult traits) she runs the risk of being perceived as an unhealthy female ('bitchy' or being 'butch').[1037]

American business executive Sheryl Sandberg also speaks to this phenomenon in pointing out 'the unfairness of women leaders being perceived as "unlikeable,"[1038] while "men are continually applauded for being ambitious and powerful"'.[1039] Moreover, as Downing notes, '"not being nice" is a feature of being human for which women are particularly harshly punished.'[1040]

One can see how this 'no-win' situation might stoke up fear regarding self-portrayal, and thus feed social anxiety. This was something to which Phoebe alluded:

[1035] Sue, *Microaggression*s, p. 163.
[1036] Broverman et al., 'Sex-Role Stereotypes and Clinical Judgments', cited in Chesler, *Women and Madness*, p. 65.
[1037] Sue, *Microaggressions*, pp. 165-66.
[1038] Sheryl Sandberg, *Lean In: Women, Work and the Will To Lead* (New York: WH Allen, 2013), loc. 2400, cited in Downing, *Selfish Women*, p. 119.
[1039] Sandberg, *Lean In,* loc. 253.cited in Downing, *Selfish Women,* p. 119.
[1040] Downing, *Selfish Women*, p. 152.

K: [W]hat do you think makes women vulnerable to social anxiety, especially? [...]

Phoebe: [...] I think... Especially is that women kind of can't win.

Gill observes a similar conflict to that which Sue describes in discussing contemporary media culture which, she tells us, simultaneously espouses pro- and anti-feminist sentiment.[1041] Olivia spoke about the effect that these conflicting discourses around femininity have in producing social anxiety, telling me that 'I think these messages about your prescribed gender role are overwhelming and make you set ridiculously high standards for yourself which are unattainable and that makes you feel personally inadequate'. Olivia's point about being made to feel 'personally inaedquate' also resonates with the feelings of inadequacy which ran through many other of my participants' narratives, which I discussed earlier on in the chapter. It is therefore becoming clear how female socialisation fosters these feelings in women.

In addition to harbouring contradictions, Harris's 'can-do' femininity comprises the idea that success is something 'achieved through personal effort alone',[1042] namely, 'strategic effort and good personal choices'.[1043] Conversely, failure is punished, for it represents nothing but 'individual weakness'.[1044] Problems then, are construed as personal in both 'cause and solution'.[1045] That is, perceived shortcomings are presented as being down to the individual, as opposed to either the way that society has socialised them or structural inequalities. This is analogous to the way that the psy sciences endorse the individual pathology model in their conceptions, and treatments, of mental health issues. Ria

[1041] Gill, 'Postfeminist Media Culture', p. 161.
[1042] Harris, *Future Girl*, p. 19.
[1043] Ibid., p. 31.
[1044] Angela McRobbie, 'Good Girls, Bad Girls? Female Success and the New Meritocracy', unpublished keynote address presented at *A New Girl Order?* conference, London, November 14th– 16th 2001, cited in Harris, *Future Girl,* p. 19.
[1045] Ibid., p. 33.

articulated the effects of these discourses in discussing her feeling that she ought to be good at public speaking:

> [I]f I know I'm not good at something, I have to try and be better [...] that kind of feeds it because I suppose you're more likely to put yourself in situations, perversely, that might stoke up a bit of social anxiety.

Present in both Olivia's and Ria's narratives are feelings of inadequacy and being uncomfortable with having weaknesses. This speaks to Harris's observation that the literature for and about girls is 'chock-full of workbook things you can do to improve yourself',[1046] with magazines targeted at teenage girls starting 'from the supposition that girls need fixing'.[1047] And whereas the pressures on girls prior to the advent of 'can-do' femininity might have said 'you're not thin enough or pretty enough',[1048] they now seem to be saying 'you're not strong enough or confident enough'.[1049] We can see that the particular set of characteristics which women, even younger women, are expected to exhibit is no longer limited to physicality but extends to incorporate the girl, and later, the woman, in her entirety. The result is that we have, as is evident in Ria's and Olivia's narratives, 'the never-good-enough girl who must perpetually observe and remake herself',[1050] and I would add, 'in order to stave off apprehension about how others perceive her'.

On the point that a narrow feminine ideal now extends beyond physicality, Harris notes the imperative for young women to perform well academically. This has, she tells us, 'become the key to safeguarding

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[1046] Ibid., p. 32.
[1047] Ibid.
[1048] Jennifer Baumgardner and Amy Richards, *Manifesta: Young Women, Feminism and the Future* (New York: Farrar, Straus and Giroux, 2001), p. 191, cited in Harris, *Future Girl,* p. 32.
[1049] Ibid.
[1050] Harris, *Future Girl,* p. 32.

the future'.[1051] Not only is it regarded as beneficial for the woman herself insofar as it facilitates her obtaining 'an appropriate adult professional and consumer life-style',[1052] but it is portrayed as preventative of all manner of evils such as 'disaffection, criminality, and disenfranchisement'.[1053] The imperative to achieve academic success, coupled with more established imperatives surrounding physicality, was something which ran through Farah's narrative when she spoke about others' evaluations of her, as a child: 'I didn't consider as an important kid in that family. Not beautiful, not important, and that beauty and smartness was important in that family.' Recall that, in citing Harris, I previously discussed the idea that perceived shortcomings are construed as being an individual problem in 'can-do' femininity. This links to another area of Harris's analysis: the notion that the self is a project on which one should work.[1054] I will discuss this more fully in the next chapter. For now, I wish to return to my discussion of psychiatric medication: specifically, how (gendered) normativities inform its use.

Drugs

In order to more fully explore medicating for one's mental health, I wish to again draw on the thoughts of Kramer. In retelling his observations of treating a number of patients with the antidepressant Prozac, Kramer notes that oftentimes people's motivation for taking street drugs is to 'feel normal'.[1055] I want to remind the reader here of Olivia's testimony about commencing the antidepressant sertraline: '[M]edication worked quickly in helping me feel more "normal" again.'

[1051] Ibid., p. 27.
[1052] Ibid.
[1053] Ibid.
[1054] Ibid., p. 32.
[1055] Kramer, *Listening to Prozac*, p. 16.

Kramer then questions whether street drugs and antidepressants are not 'morally indistinguishable in terms of the reasons they are taken and the results they produce'.[1056] He questions 'whether street-drug abusers are self-medicating'[1057] their mental distress and 'whether prescribed-drug users are, with their doctors' permission, stimulating and calming themselves in quite similar ways'.[1058] The key difference might be that the latter is an instance of drug (ab)use having 'sneaked through the back door',[1059] the reason being that 'entering the middle class carries the privilege of access to socially sanctioned drugs that are safer and more specific in their effects than street drugs'.[1060] Given Olivia's testimony, I think Kramer's questions are certainly ones that should be asked.

The *DSM-5* states that 'Substance Abuse' is often 'co-morbid' with SAD,[1061] but only one of the women I interviewed mentioned drug use.[1062] An interesting gendered assumption is that substance (mis)use is more likely to occur in men than women, owing to its being considered a risk-taking activity. The *DSM-5* subscribes to this assumption, reporting that rates of Alcohol Use Disorder 'are greater among adult men (12.4%) than among adult women (4.9%)'.[1063] The *DSM-5* also cites men as being 'more likely' to 'use alcohol and illicit drugs to relieve symptoms' of SAD,[1064] but the gendering of these activities remains characteristically unexplored.

[1056] Ibid.
[1057] Ibid.
[1058] Ibid.
[1059] Ibid.
[1060] Ibid.
[1061] APA, *DSM-5*, p. 208.
[1062] It is worth noting that while only Farah spoke about the interplay between drug use and her SAD, the illegality of substances in the UK at the time of writing, coupled with the lack of social acceptability of women engaging in this gendered activity, may have precluded other participants from disclosing their experiences in this regard.
[1063] APA, *DSM-5*, p. 493.
[1064] Ibid., p. 206.

Despite this, Farah mentioned having used a non-prescribed substance recreationally, although this does not seem to have been for the express purpose of alleviating social anxiety, nor was the usage something that was ongoing, but had occurred a number of years ago:

> Farah: I was so comfortable with using drugs as well when I was young to help myself […] For a short time, for example, I used opium, and opium is, you know, nice.
>
> K: Oh, really? Okay… Did it help?
>
> Farah: Very much so! [laughs] […] other drugs [weren't] helpful […] grass or these kind of… Weed […] they are mostly considered as a kind of… 'Hyper' drug, it makes you hyper… So this is not good for me […] I need something like opium, that category, that makes me… Calm and opium is the best one… And, of course, whenever I've used, I've done it among my friends so it's a very nice environment […]

As opposed to fitting the *DSM-5*'s narrative, namely, '[s]elf-medication with substances is common (e.g., drinking before going to a party),'[1065] Farah's previous opium use, among friends, seems akin to normative alcohol use at parties. On alcohol, Farah also had an interesting perspective insofar as it allayed her social anxiety, for she told me, 'I'm much comfortable in speaking when I'm drunk.' Interestingly, it was others' expectations upon learning that Farah had drunk alcohol that alleviated her social anxiety, as opposed to the effects of the alcohol on her:

> I know that when people think that you are drunk, sometimes I even pretend that I am drunk, more than what I am, because people's expectations become lower [...] and you are more comfortable to […] [say] what you want to say. You have more freedom if people think that you are drunk [...]

[1065] Ibid., p. 204.

There are echoes here of my discussion of Selective Mutism earlier on in the chapter, in which Farah's narrative also featured. Recall that others' expectations that people with SM will not speak buttressed the barriers to speaking that they experienced. In much the same way, others' evaluations of Farah become altered when they believe her to be intoxicated. As such, if their evaluations are negative, as the socially anxious fear, then the intoxication offers a way out: the negative evaluation is not a reflection of, as she feels, a defect in her personality, as would usually be the case. Rather, the evaluation is attributable to her inebriation. While individuals with SM feel shackled by others' expectations of them, Farah is describing alcohol use as a means by which one can circumvent the restrictions on her behaviours that others' expectations present.

Since Substance Abuse is reported by the *DSM-5* as being 'co-morbid' with SAD, it is worth mentioning other relevant 'co-morbidities', one of which is Body Dysmorphic Disorder (BDD).[1066] Ellen very briefly mentioned BDD by name in discussing her body image issues, though did not identify with it explicitly. Despite this, almost all of my participants spoke about their body image during their interviews and a number had experienced struggles with eating. I will begin the next chapter by discussing these body-centric mental health issues in tandem with society's prescriptions around the female body, as well as what this means for concern with how one is perceived and, by extension, social anxiety.

[1066] Ibid., p. 208.

CHAPTER 5

FEAR OF NEGATIVE EVALUATION, NORMS OF FEMININITY, AND FALSE SELVES

Overview

For all of the women I interviewed, fear of negative evaluation was central to their social anxiety. For several of them, this fear centred on their appearance, their bodies, and their size. As I mentioned in Chapter 2, social anxiety, as applied to the body, has been previously explored using the terminology 'Social Physique Anxiety', but only one study outside of the psy science literature has sought to explore this label using women's narratives and from an explicitly feminist perspective.[1067] It is in the first part of this chapter that I build upon this work.

Following on from this, a number of my participants divulged that their social anxiety extended to how they were perceived as a whole person. The second part of this chapter frames social anxiety as fear of negative evaluation of women's entire performance and explores the resulting cultivation of an acceptable outward self. It is also worth noting that for a number of the women to whom I spoke, social media compounded and were intertwined with the difficulties that they faced. Therefore, at different points, I will discuss the impact of social media.

I draw this chapter to a close in examining how women experience and make sense of their social anxiety in terms of cultivating a false self and experiencing an 'inner critic'. I find significant overlap with

[1067] McHugh et al., 'Young Women's Experiences of Social Physique Anxiety'.

diagnostic categories which have hitherto not been widely linked to the diagnostic category 'SAD'. In so doing, I contend that the inner world of the socially anxious woman is a vastly under-researched area and one that warrants greater attention if we are to render this position understandable and, in turn, help to alleviate the socially anxious woman's distress.

Appearance Norms

A common thread about which many participants spoke was that of a physical norm or ideal against which all women are evaluated. Olivia told me that '[s]ince women are objectified in our patriarchal culture, girls and women face far more pressures than boys and men of being expected to always look a certain way'. Similarly, Ellen alluded to this norm in also speaking of the 'pressure to look a certain way' and the imperative to 'conform to being a petite feminine lady'. She described her own social anxiety as being 'about how I look', telling me, 'it will be fear of being judged [...] that's why I'm anxious going somewhere where I don't look like what I think I should look like.'

Olivia also spoke about being 'self-conscious and hyper-conscious of my appearance', to the extent that she expressed a preference for telephone interactions over in-person interactions, the latter being 'where I know that a judgement is being formed about me and how I look'. Likewise, Phoebe revealed the significance of her body image, telling me of a point in her life several years ago when she 'just felt really like just disgusting [...] like I was just the ugliest thing ever [...] so I guess that in itself is social anxiety, isn't it?'

The existence of a bodily norm for women is now established, and rendered more visible, by social media. Valerie Steeves makes a similar observation in saying that social media entails 'a clear and

vigorously enforced set of social rules about acceptable ways of being a girl'.[1068] This resonates with Ellen's testimony, wherein she told me about how her teenage cousin — as well as young women in general — uses social media:

> [I]t's the influencers as well, like, everyone is like, 'I need to get this, I need to look like this person.' I'm like, 'Oh, just look like yourself.' [...] They are told how to dress [...] that's why everyone–you go outside and everyone looks the same because it's social media [...]

Recall that in the previous chapter I discussed how women in the workplace seemingly cannot win and must walk the fine line between being 'too feminine' and 'not feminine enough'. Steeves posits analogous constraints on femininity in terms of how women portray themselves on social media. That is, social media is

> [A] place where girls are open to criticism because they are […] too made up, not made up enough, expose too much cleavage (and are therefore 'sluts'), don't expose enough cleavage, have too many friends (and are therefore 'desperate'), and/or don't have enough friends (and are therefore 'losers').[1069]

This double-bind is exemplified by Chimamanda Ngozi Adichie, who has described girls' socialisation thus: 'We say to girls, you can have ambition, but not too much. You should aim to be successful, but not too successful.'[1070]

[1068] Valerie Steeves, '"Pretty and Just a Little Bit Sexy, I Guess": Publicity, Privacy, and the Pressure To Perform "Appropriate" Femininity on Social Media', in *EGirls, ECitizens: Putting Technology, Theory and Policy into Dialogue with Girls' and Young Women's Voices,* ed. by Valerie Steeves and Jane Bailey (Ottawa, Ontario: University of Ottawa Press, 2015) 153–73, p. 158.

[1069] Ibid., p. 163.

[1070] Chimamanda Ngozi Adichie, *We Should All Be Feminists* (London: Fourth Estate, 2014), p. 27.

Returning to Steeves, implicit in her discussion is the idea of cultivating a particular kind of online image: one that is 'just right'.[1071] Failure to do so, Steeves tells us, can often result in 'harsh judgment'.[1072] It is also salient that the right kind of online image is not only restricted to the way that the body is stylised, but extends to enacting 'highly gendered behavioural norms',[1073] thus suggesting that regulation of appropriate femininity extends beyond appearance and in fact concerns the whole woman. As such, social media engenders a need for young women to be 'very careful' about how they represent themselves,[1074] with an eye to conforming to '"appropriate" femininity'.[1075] Otherwise, they face the prospect of being unable to attain the approval of their peers: something which Steeves tells us 'plays an inordinately important role' in girls' socialisation.[1076] The requirement that young women present themselves in a very particular way, or else face rejection or ridicule from their contemporaries, is a prime example of the very real and damaging consequences women face if they fail to match up to the narrow norm. With so much at stake, their anxiety pertaining to how they appear online is understandable.

The narratives given by Ellen, Phoebe, and Olivia, above, all harbour a fear of judgment pertaining to their bodies. Going beyond social media, women's appearance and bodies are used to infer all manner of facts about their characters and personalities, often leading to discrimination if they are seen to fall short. John Berger comments on the importance of appearance in stating that how a woman appears to others, 'and ultimately how she appears to men, is of crucial importance for what is normally thought of

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[1071] Steeves, '"Pretty and Just a Little Bit Sexy, I Guess"', p. 163.
[1072] Ibid., p. 161.
[1073] Ibid., p. 159.
[1074] Ibid.
[1075] Akane Kanai, in the same edited volume, 'Thinking beyond the Internet as a Tool: Girls' Online Spaces as Postfeminist Structures of Surveillance', pp. 83–108, cited in Steeves, '"Pretty and Just a Little Bit Sexy"', p. 170.
[1076] Meenakshi Gigi Durham, 'Articulating Adolescent Girls' Resistance to Patriarchal Discourse in Popular Media', *Women's Studies in Communication*, 22.2 (1999), 210–29 <doi: 10.1080/07491409.1999.10162421> [accessed 5 January 2021], p. 222, cited in Steeves, '"Pretty and Just a Little Bit Sexy, I Guess"', p. 169.

as the success of her life.'[1077] Orbach speaks to why this makes women so ill at ease in writing that '[t]his emphasis on presentation as the central aspect of a woman's existence makes her extremely self-conscious'.[1078] Building on this, I argue that since so much hinges on the acceptability of a woman's appearance, one can understand how she might be concerned with how this aspect of her is evaluated by others, the latter being the cornerstone of social anxiety.

On the importance of appearance in the case of women, author and academic Deborah L. Rhode has this to say:

> Beginning at birth, those who are viewed as physically appealing are also more likely to be viewed as smart, likeable and good. The ridicule and ostracism that unattractive children experience can result in lower self-confidence and social skills, which leads to further disadvantages later in life. Appearance also influences judgements about competence and job performance, which, in turn, affect income and status. Résumés get a less favorable assessment when they are thought to belong to less attractive individuals. These individuals are also less likely to get hired and promoted, and they earn lower salaries [...] Women face greater pressures than men to look attractive and pay greater penalties for falling short. [1079]

In light of Rhode's observations, women's fears that they do not match up to society's definition of attractiveness seem quite logical, since 'failing' in this arena could mean barriers to success in a myriad of other domains. Although Rhode's focus is on women's professional lives, she does briefly mention interpersonal relationships. Orbach elaborates on such relationships in saying that '[g]irls […] seek

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[1077] John Berger, *Ways of Seeing* (Harmondsworth: Penguin, 2008) pp. 40–41.
[1078] Orbach, *Fat Is a Feminist Issue*, p. 30.
[1079] Deborah L. Rhode, *The Beauty Bias: The Injustice of Appearance in Life and Law* (Oxford: Oxford University Press, 2010), pp. 6–7.

connection with others and learn that this connection, especially with men, depends on the acceptability of their bodies'.[1080] Farah's narrative evokes this idea in that she wondered whether her appearance was culpable in the demise of a romantic relationship: '[He] didn't continue his relationship with me [...] I thought that it might be related to my appearance […] because he was in [a] relationship with [an]other person, and the fact that she's more beautiful than me.'

Having established that not matching up to the physical ideal means tangible disadvantage in multiple spheres of life for women, I wish to draw the reader's attention to one element of the *DSM-5*'s diagnostic criteria for SAD. That is, '[m]arked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others;' 'fear or anxiety' must be 'out of proportion to the actual threat posed by the social situation and to the sociocultural context'.[1081] Given that women's success in their personal and professional lives rests on their ability to match up to norms of femininity pertaining to appearance,[1082] I ask: is her fear and anxiety about how her appearance, and therefore her character and abilities, is evaluated by others 'out of proportion'?

During her interview, Olivia articulated another deleterious consequence of society's focus on women's appearance: 'For many girls and women, their worth and value is placed on their appearance by those around them (by individuals in their lives and by society and media at large), so that their self-worth becomes based on their looks.' Feminist philosopher Sandra Lee Bartky alludes to Olivia's point in stating

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[1080] Orbach, *Hunger Strike.*
[1081] APA, *DSM-5*, p. 203.
[1082] Rhode, *The Beauty Bias*, pp. 6–7.
Orbach, *Hunger Strike.*

that '[t]he sense of oneself as a distinct and valuable individual is tied […] to the sense of how one is perceived'[1083] — I add, 'as meeting the feminine bodily ideal'.

On the feminine bodily ideal, Bartky characterises it as elusive in nature. She describes it as 'a "setup": it requires such radical and extensive measures of bodily transformation that virtually every woman who gives herself to it is destined in some degree to fail'.[1084] As Bartky contends that this fosters shame[1085] and erodes women's sense of value,[1086] following Olivia, I propose that it fosters low self-worth. There are links to be made here with the feelings of inadequacy that my participants reported in Chapter 4. If women are perceived to be failing — and they inevitably will — to reach the feminine bodily ideal, they face feelings of low self-worth, which are distressing. The prospect of this distress might bring about anxiety. As such, in order to stave off the negative evaluation which leads to this distress, women might, as Olivia tells us, spend 'lots of time on their appearance'. On this point, feminist writer Naomi Wolf contends that women engage in three 'shifts'. The first and second of these are work outside of the home and domestic work, respectively. The 'third shift' consists of beautifying their bodies.[1087] The standards to which women are held thus function to discipline their bodies and behaviours.

Bartky makes this point in her feminist reading of Foucault. In *Discipline and Punish*, Foucault coins the term 'docile bodies' in describing our disciplinary society. To illustrate this concept, Foucault tells us that in pre-modernity, men were chosen as soldiers based on pre-existing traits. By contrast, modernity saw the soldier first being chosen and then being 'constructed' into a 'machine' that then exhibits the desired

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[1083] Sandra Lee Bartky, 'Foucault, Femininity, and the Modernization of Patriarchal Power', in *The Politics of Women's Bodies: Sexuality, Appearance, and Behavior,* ed. by Rose Weitz (New York and Oxford: Oxford University Press, 1998), 25–45, pp. 38–39.
[1084] Ibid, pp. 33–34.
[1085] Ibid. p. 34.
[1086] Ibid., pp. 38–39.
[1087] Wolf, *The Beauty Myth.*

traits such that the requirements of society are met.[1088] He continues: ‘A body is docile that may be subjected, used, transformed and improved.’[1089] As such, the body is ‘an object and target of power’.[1090]

Bartky observes that Foucault does not devote enough attention to the idea of a *female* docile body.[1091] In exploring this, she tells us that, at the time of writing, the trend for women’s bodies is ‘of a slimness bordering on emaciation’.[1092] She nuances this point by noting that ‘the current fitness movement has permitted women to develop more muscular strength and endurance than was heretofore allowed; indeed, images of women have begun to appear in the mass media that seem to eroticize this new muscularity’.[1093] In the time that has elapsed since Bartky was writing, the feminine bodily ideal’s evolution has assumed a trajectory in accordance with that which Bartky describes. In much the same way as the ideal feminine personality style, the feminine bodily ideal has come to incorporate traditionally masculine traits: it has evolved from being simply thin to now being thin and muscular.[1094] This might be attributed to a rise in ‘gym culture’ which has accompanied, and been precipitated by, the popularisation of social media.[1095] As I stated previously, social media now functions as one of the main methods by which bodily ideals are disseminated. In talking to Ellen, it became clear that these ideals were more far-reaching than the body and extended to lifestyle. She told me how the Instagram accounts that she followed affected how much she cared about her appearance, her body, and the

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[1088] Foucault, *Discipline and Punish,* p. 135.
[1089] Ibid., p. 136.
[1090] Ibid.
[1091] Bartky, ‘Foucault, Femininity, and the Modernization of Patriarchal Power’.
[1092] Ibid., p. 28.
[1093] Ibid., p. 35.
[1094] Frances Bozsik, Brooke L. Whisenhunt, Danae L. Hudson, Brooke Bennett, and Jennifer D. Lundgren, ‘“Thin Is in? Think Again: The Rising Importance of Muscularity in the Thin Ideal Female Body’, *Sex Roles*, 79.9–10 (2018), 609–15 <doi: 10.1007/s11199-017-0886-0> [accessed 5 January 2021].
[1095] Roberta Sassatelli, ‘Fitness Culture’, *The Blackwell Encyclopedia of Sociology* (2007), 1–3 <doi: 10.1002/9781405165518.wbeosf083.pub2> [accessed 5 January 2021].

standards to which she held herself: ‘I think because I do follow all of that [gym culture and fitness accounts] on Instagram [...] I am like, “[...] she can do a pull up. Why can’t I do a pull up?”’

What was interesting about Ellen’s testimony was that she had a degree of awareness that social media contributed towards her having high expectations of herself and that these expectations were not necessarily realistic. Following her previous remark, she told me, ‘actually, she’s like 5’ and really tiny and I’m not, so I’ve got a lot more weight to lift.’ Moreover, she seemed aware of what steps she would need to take in order to promote a healthier body image and higher self-esteem, telling me, ‘I reckon if I removed all of that [fitness accounts on Instagram] and all I followed was like fat activists like Lizzo or like Tess Holliday, I think I’d be fine, I think I would stop caring.’ Ellen is not alone in being aware of the harms caused by consuming mainstream social media pages. In Steeves’s research on social media use in young women, one of her participants ‘felt that the ubiquitous presence of diet ads, weight loss tips, and other “beauty aids,” on social media, as well as pages posted by models and clothing companies, created an overwhelming desire to “change my body”’.[1096]

On the other hand, Ellen alluded to social media being used to celebrate different physiques and to promote body positivity. To focus on the figures that Ellen mentioned, Tess Holliday made headlines in 2015 for becoming the largest plus-sized model to be contracted by a mainstream agency[1097] and founded the online body positivity movement *EffYourBeautyStandards*.[1098] Ellen told me about Lizzo:

[1096] Steeves, ‘“Pretty and Just a Little Bit Sexy, I Guess”’, pp. 166–67.
[1097] Pearl Gabel, ‘Plus-Size Model Tess Holliday Busts out of Stereotype’, *Daily News* (2015) <http://www.nydailynews.com/life-style/plus-size-model-tess-holliday-busts-stereotype-article-1.2090500> [accessed 1 February 2015].
[1098] Tess Holliday, *EffYourBeautyStandards* (n.d.) <https://www.instagram.com/effyourbeautystandards/?hl=en> [accessed 26th September 2020].

> [S]he was in an interview where someone said to her like, 'Oh, you wouldn't look good skinny anyway,' she's like, 'Honey, I look good any size.' [...] she's a rapper and a singer [...] basically like a fat activist and she's just really cool.

Despite Ellen's insight into what she ought to follow on social media in order to improve her body image and wellbeing, I sensed reluctance in her to actually commit to what she was proposing: she held an unwillingness to fully renounce the body and lifestyle ideals espoused by the fitness and gym culture Instagram accounts in question. The principle here is similar to that of a number of women in the fat acceptance movement, and one which strikes a chord with Ellen's narrative later on in this chapter: 'I'm totally smart and a feminist…and yet I want to be a waif.'[1099]

Returning to Bartky's argument about the thin ideal female body, she contends that in order to achieve it, most women have to diet, and '[d]ieting disciplines the body's hungers'.[1100] In addition, I would argue that, now, in order to achieve the ideal thin and muscular body, most women also have to exercise. As such, both diet and exercise serve to discipline the body, its size, and the space it takes up.

Taking up Space

Underlying many of my participants' discomfort with their body size was the idea of taking up space. Ellen spoke about this several times during her interview:

> I find myself trying to shrink myself and it's horrible [...] we're meant to care about our size and not taking up too much space [...] I'm always paranoid about my height. I'm like, 'I take up too much space for a woman.'

[1099] Ngaire Donaghue and Anne Clemitshaw, '"I'm Totally Smart and a Feminist… And yet I Want To Be a Waif": Exploring Ambivalence towards the Thin Ideal within the Fat Acceptance Movement', *Women's Studies International Forum*, 35.6 (2012) <doi: 10.1016/j.wsif.2012.07.005> [accessed 5 January 2021], p. 415.

[1100] Bartky, 'Foucault, Femininity, and the Modernization of Patriarchal Power', p. 28.

Phoebe also spoke about feelings of panic resulting from her body size: ‘I remember once I had a massive panic attack because I was having to budge through chairs [...] I got really anxious that I wasn't going to fit.’ Bartky describes similar narratives of women in her own work as being indicative of deep shame,[1101] that is, ‘a measure of the extent to which all women have internalized patriarchal standards of bodily acceptability’.[1102] In addition to body size, Bartky, citing political scientist Iris Young, notes that women's body comportment is more restricted than men's. Along with body size, ‘[w]oman's body language speaks eloquently, though silently, of her subordinate status in a hierarchy of gender.’[1103] Feminist photographer Marianne Wex's work corroborates this idea further, wherein she examines photographs of men and women in public areas.[1104] When sitting and waiting for trains, women tend to sit with their legs together and their hands in their laps: they seem to aim to take up as little space as they can. This resonates with Amy's narrative, in that she spoke about

> [F]eeling like I'm not allowed to take up space and that I should be conscientious of the space that I'm taking up [...] I definitely see that as a gendered problem [...] the female programming is that like low-key instinct not to take up space.

By contrast, Wex noted that men, unconcerned with taking up space, sit with their arms out to their sides and their legs apart.[1105] I am reminded here of Lily Myers's poem ‘Shrinking Women’,[1106] in which

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[1101] Ibid., p. 38.
[1102] Ibid.
[1103] Iris Marion Young, ‘Throwing like a Girl: A Phenomenology of Feminine Body Comportment Motility and Spatiality’, *Human Studies*, 3.1 (1980), 137–56 <doi: 10.1007/BF02331805> [accessed 5 January 2021], cited in Bartky, ‘Foucault, Femininity, and the Modernization of Patriarchal Power’, p. 36.
[1104] Marianne Wex, *Let's Take Back our Space: Female and Male Body Language as a Result of Patriarchal Structures* (Frauenliteratur Verlag Hermine Fees, 1979) cited in Bartky, ‘Foucault, Femininity, and the Modernization of Patriarchal Power’, p. 30.
[1105] Ibid.
[1106] Lily Myers, *Shrinking Women* (n.d.) <https://genius.com/Lily-myers-shrinking-women-annotated> [accessed 26 September 2020].

Myers imagines saying to her brother, '[w]e come from difference, Jonas, you have been taught to grow out, I have been taught to grow in.' Myers's words strongly resonate with Phoebe's testimony, wherein she stated that 'you're told to like shrink in–both physically and mentally, I think, and then that plays out in like your social life'. As Amy had noticed that women tended to be aware of, and minimise, the space that they take up, following Wex, she had also noticed that men were not subject to such restrictions in telling me about 'the men around me unabashedly taking up space'. She also shared with me how men taking up an inordinate amount of space made her feel, and why: '[I]t makes me really mad [...] because I don't have that privilege [...] it's almost a jealously thing, like, "How dare you take up all of this space [...]?"' Amy's narrative tells us that public spaces are implicitly male spaces, as is evidenced by the extent to which women endure street harassment on a daily basis.[1107] Nicola J. Smith also speaks to this idea in telling us that '[f]eminist scholars have illuminated how public space has been historically constituted (and privileged) as the "masculine" sphere of economic production'.[1108]

Ellen's experience is also relevant here, yet she told me something a little different, that is, 'I'm scared of the "man area" at the gym.' In his work on gender and gym culture, sociologist Thomas Johansson notes that while late modernity has seen the body become a project, the gym has become a place where 'the body is cultivated'.[1109] Johansson's work links with Ellen's narrative in that he tells us that '[t]he gym is a gendered space, where certain body techniques and locations are related to the female body and others with the male body [...] where the bodybuilding culture meets the aerobics culture'.[1110] Ellen's apprehension about entering the 'man area' of the gym could thus be construed as anxiety about transgressing gender norms by entering what is implicitly a male space. Indeed, Johansson tells us that

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[1107] Laura Bates, *Everyday Sexism Project* (n.d.) <https://everydaysexism.com/> [accessed 26 Septempber].
[1108] Smith, *Capitalism's Sexual History*, pp. 3–4.
[1109] Thomas Johansson, 'Gendered Spaces: The Gym Culture and the Construction of Gender', *Young,* 4.3 (1996), 32–47 <doi: 10.1177/110330889600400303> [accessed 5 January 2021], p. 32.
[1110] Ibid.

‘women often feel like aliens when stepping into the male space’.[1111] Ria gave an example which resonates with Johansson’s latter remark, but this referred to a space being gendered in a figurative sense. She spoke about standing up to deliver a speech, an arguably masculine activity demanding assertiveness and aplomb. This scenario precipitated in her the ‘feeling like you don’t have any ownership in the space you’re in’. Following on from this, Amy explained how ‘my social anxiety makes me even more aware of the space I take up’. She then pondered: ‘[I]s my social anxiety spatial awareness part of or driven by the female programming that says “don’t take up space”? They’re probably interconnected.’

Amy elaborated on this by telling me that men’s taking up space is reflective of a wider problem in society:

> [Y]ou’d be frustrated if somebody was standing in your way, right? And then you’d be more frustrated if that person was a man who was clearly like completely blanking on how he’s affecting other people. And then you’d be more frustrated when you realise that that’s a systematic problem [...] That’s how society has taught men that they’re allowed to be. Or, more specifically, that’s how society’s taught women they’re not allowed to be. And then it goes, ‘Oh, actually, is the man doing the wrong here or has society done me the disservice of convincing me I have to be aware of the space I take up?’

Amy’s awareness that the gendering of space is a systemic problem serves to compound her distress surrounding this issue. Sue’s discussion of microaggressions is relevant here, since the gendering of public space could certainly be construed as a form of microaggression. Sue also tells us that

[1111] Ibid., p. 35.

microaggressions operate ‘on a systemic and macro level’.[1112] Speaking about people of colour, he argues that they ‘do not just occasionally experience racial microaggressions. Rather it is a constant, continuing, and cumulative experience’.[1113] Crucially, microaggressions are not only a reminder of greater structural inequalities, but arise from the same institutional biases that ‘affect [...] quality of life and standard of living’ as well as ‘denying equal access and opportunities in education, employment, and health care [...] for marginalized groups in our society’.[1114] Although Sue is discussing people of colour, the same argument could be made in the case of women. Is being undermined in the workplace not a reminder that women still earn, on average, 9% less than men for doing the same job?[1115] Does ‘harmless’ street harassment not arise from the same misogyny which leads to one in five women over the age of 16 being sexually assaulted?[1116] Ellen’s perspective resonates with this latter point: ‘[I]t constantly happens to women. Like, you will be cat called [...] it’s an everyday battle, so therefore why would you not internalise [...] take that with you and worry about it the next day? Because it’s every day.’

My participants’ experiences all speak to phenomena which make navigating public spaces and domains difficult for women. In turn, their narratives all suggested that these experiences stoke, and interact with, their social anxiety. Another issue which played a role in my participants’ social anxiety was that of weight: I will now discuss this in greater depth.

[1112] Sue, *Microaggressions*, p. 16.
[1113] Ibid., p. 52.
[1114] Ibid., p. 16.
[1115] Brigid Francis-Devine and Doug Pyper, *The Gender Pay Gap, House of Commons Library Briefing Paper Number 7068*, (2020) <https://commonslibrary.parliament.uk/research-briefings/sn07068/> [accessed 18 March 2021].
[1116] Rape Crisis, *About Sexual Violence* (2020) <https://rapecrisis.org.uk/get-informed/about-sexual-violence/statistics-sexual-violence/> [accessed 26 September 2020].

Weight

Weight warrants specific discussion for a number of reasons: it features in many of my participants' testimonies and it is an attribute tied more strongly to oppression than other metrics of body size. Indeed, discrimination against people who fit the criteria for obesity has been dubbed 'an acceptable prejudice'.[1117] Much like body comportment, as Wex tells us,[1118] the imperative for women to be thin and therefore not take up space is an indicator of their subordinate social position.

Moreover, our culture relates weight more closely to female beauty than other aspects of body size, such as height, and the thin body forms a cornerstone of the bodily ideal for women. Ellen tells me about her own experience with losing weight and how this put her closer to this ideal:

> [W]hen I was dumped, I lost like 2 stone really quickly, but that was just the fact that I was sad and I couldn't eat [...] I got to a point where I was like, 'I look great,' and [...] all of my friends were like, 'Yeah, but you're sad, you're really sad.' And I was like, 'But I'm skinny!'

Ellen's sentiment in this excerpt of her narrative reflects society's mandate that the importance of attaining a thin body trumps mental wellbeing. I am reminded here of one of the fat acceptance movement's tenets, commonly employed in response to 'fake concern' regarding the health ramifications of being a given weight. Fat activist Victoria Welsby sums this up rather well in saying 'if you actually cared about fat people's health then you would care about their mental health'.[1119]

[1117] Michael S. Kavic, 'Obesity – An "Acceptable" Prejudice', *Journal of the Society of Laparoendoscopic Surgeons*, 5.3 (2001), 201–02 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3015454/> [accessed 26 September 2020].
[1118] Iris Marion Young, 'Throwing like a Girl: A Phenomenology of Feminine Body Comportment Motility and Spatiality', *Human Studies*, 3.1 (1980), 137–56 <doi: 10.1007/BF02331805> [accessed 5 January 2021], cited in Bartky, 'Foucault, Femininity, and the Modernization of Patriarchal Power', p. 36.
[1119] Victoria Welsby, *About the BBC Show 'Who Are You Calling Fat?'* (2019) <http://fiercefatty.com/blog/about-the-bbc-show-who-are-you-calling-fat> [accessed 26 September 2020].

Earlier on in the chapter, I discussed the existence of an appearance-based norm for women. The prospect of failing to reach this norm, I argued, brings about justifiable anxiety, and this was something about which Phoebe spoke in relation to her weight. She told me, 'when I went to university I became really like aware of my weight and very like self-conscious.' The existence of a bodily norm thus serves to create a feeling of one's body not fitting in, quite literally, or of being 'wrong'. Recall my discussion of normativity in the previous chapter, wherein belonging was a common thread in my participants' testimonies. On this point, Orbach tells us that, for a number of women, Anorexia Nervosa arises from pursuing 'thinness in order to feel acceptable. Acceptance may have at first meant fitting in'.[1120] An acceptable body is pursued because our culture tells us that this acceptability is a ticket to entering the world.[1121] On acceptability, Ria spoke about literally being an outlier as precipitating her problems with eating:

> [W]hen I thought my eating disorder started, I was about 9 years old. And we were in a maths class, and we were doing scatter plots. And we were plotting height vs. weight. And I was a little bit of an outlier [...] I remember people pointing at the outlier, and, 'Who's that?' [...] and then [...] at that point, I was like, 'Ok, maybe I could do with losing a few pounds.'

There are links to be drawn here with what I discussed in the previous chapter regarding personality style: recall that some of my participants reported feeling 'wrong' in light of their personality style not matching up with that which is currently in fashion for women. We are thus beginning to see that social anxiety is experienced at the prospect of multiple aspects of a woman's identity being perceived by others as non-normative and thus incorrect.

[1120] Orbach, *Hunger Strike*, p. 68.
[1121] Ibid., p. 85.

Daniella also spoke about weight, namely, that she felt as though she needed to lose weight upon moving to the UK: 'I didn't know anyone [...] I kind of felt like [...] I had to show a better appearance of myself [...] So, at that time, I started losing a lot of weight.' Daniella's apparent motivation for losing weight was to look 'better' or, indeed to fit in. Implicit in Daniella's narrative is the idea that she would have been better equipped to secure new relationships if she had a thin body, which strongly echoes Orbach's tenet that women's relationships with others are contingent on the acceptability of their bodies.

In citing Rhode earlier on in the chapter, I argued that women's appearance, which extends to the acceptability of their bodies, affects many different areas of their lives. What arose from a number of my participants' testimonies was the interplay between their relationships and their weight. Daniella gave her account:

> [T]he reason why [...] I don't want to see people is because I don't want them to see me at this size [...] when I was trying to like rationalise the fact that I didn't want to meet people, it was like, 'Would that be different if I were thin?' And the answer is, 'Yes [...] it wouldn't bother me as much.' [...] that's why I'm refusing to go home [...] I haven't seen my family in a long time [...] especially my mum's side, they would say things [...] they're [...] very upfront. So it'll be like, 'Oh, you chunked up.'

Whereas Daniella told me how she imagines that her family will react to her body, Phoebe tells me about comparable exchanges which actually came to pass with her family:

> [T]hat side of my family are like massively like fat-phobic [...] I remember my uncle said to me, '[....] you've got a real blubbery layer and you really need to like get rid of it.' [...] I remember

asking my cousin, '[...] do you think I do?' [...] and she was like, '[...] you do [...] but you can like get rid of it [...].'

These narratives both gel with Bartky's observation that '"people" – friends and casual acquaintances alike – act to enforce prevailing standards of body size'.[1122] Phoebe's experience demonstrates that perhaps Daniella is rational in fearing what her family will say about the changes in her body since last seeing her, and how this might make her feel. Indeed, Phoebe said that her conversation with her cousin, '[...] made me really sad because I was like, [...] "I just really needed you to be kind in that moment because I felt really vulnerable" [...]'. Daniella's resulting avoidance of visiting her family could hence be construed as quite understandable.

On this point, Daniella reflected on whether losing weight would solve some of her problems, telling me, 'they always say, "Oh, if you lose weight, it's not going to solve your problems."' Orbach talks about this idea in saying that '[g]irls from the age of nine right through to women in their sixties have absorbed the message that they *can* solve emotional problems, sexual problems, family problems, relationship problems, work problems—all through the transformation of their body size'.[1123] While Szasz argues that '[w]e now deny moral, personal, political, and social controversies by pretending that they are psychiatric problems',[1124] it might be said that we now deny a plethora of women's problems by conflating them with body size 'problems'. Daniella speaks to this dominant cultural message in telling me that losing weight 'might solve a few of mine [problems]. Because a lot of mine are related to weight'. Based on her earlier remarks, Daniella's problems seem related not to her weight *per se*, but

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[1122] Bartky, 'Foucault, Femininity, and the Modernization of Patriarchal Power', p. 36.
[1123] Orbach, *Fat Is a Feminist Issue*, p. 20. My emphasis.
[1124] Szasz, *The Myth of Mental Illness*, p. 182.

related to how others are likely to react to it. Ellen's narrative also revealed this sentiment, but in terms of her height:

> I'm 6ft [...] I've internalised the fact that I'm like, 'Oh, I'm masculine, people are going to look at me because I look like a man, they're going to be judging me for my height and then [...] I'll get called big.'

Returning to Daniella, her expectations of how others will react to her weight are, given Phoebe's experience, educated predictions. They are also based on prior experience, for she told me that 'I was always chunky, I mean, as a kid: the reason why I was bullied'. Her concerns with how others perceive her body seem quite justifiable, therefore calling into question whether women's fear of being negatively evaluated, or social anxiety, is best framed as a mental disorder. Would it not be better framed as a rational response to how society treats non-normative female bodies?

Given my participants' concerns with their bodies and appearance, a number of them had something to say about eating and exercising. Indeed, three of them had experiences with eating problems and this was tied to wanting to change their appearance and rooted in concern with others' perceptions. I posit that, far from being inherent pathology, these experiences of 'disordered' eating arise because of the importance that society places on women's appearance.[1125] The effort to change the body to fit the prescriptive norm might then lead to the adoption of eating behaviours which are deemed pathological. Due to female socialisation, the modification of food intake to achieve a socially-sanctioned body is a largely female-specific experience which the *DSM-5*'s categories of discrete Eating Disorders — Anorexia

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[1125] Fallon et al., *Feminist Perspectives on Eating Disorders*.
Orbach, *Bodies*.
Orbach, *Hunger Strike.*

Nervosa,[1126] Bulimia Nervosa,[1127] — not only fail to encapsulate, but conceptualise what I would argue are rational responses to female socialisation as illness.

Eating and Exercising

On eating and exercising, Phoebe divulged her own experience:

> It was never diagnosed but I think I probably had some sort of eating disorder[1128] where I would like exercise kind of like compulsively [...] I would eat but in a way where only if I could counterbalance it with exercise [...] so I was like that for a few years [...] I never had a day off, for months. [...] I would run like a half marathon everyday [...]

While Phoebe's narrative draws links with the diagnostic criteria for Anorexia Nervosa, which are characterised by 'strict rituals around eating'[1129] and 'energy intake restriction',[1130] it is salient that a large proportion of women could be said, to varying degrees, to have strict rituals around eating in light of cultural ideals about thinness. This evokes the idea of mental (ill) health being on a spectrum, as opposed to a binary, as I outlined in Chapter 2. Indeed, Malson tells us that dieting is now 'more prevalent and therefore more "normal" or normative than *non*-dieting amongst women and girls'.[1131] That energy intake restriction is engaged in by a large proportion women problematises the *DSM-5*'s

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[1126] APA, *DSM-5*, pp. 338–345.
[1127] Ibid., pp. 345–350.
[1128] As I explored in Chapter 4, Phoebe told me that she believed she was autistic. It is interesting to note that 'eating disorders', especially 'anorexia nervosa', have been linked to autism in women. See Janina Brede, Charli Babb, Catherine Jones, Mair Elliott, Cathy Zanker, Kate Tchanturia, Lucy Serpell, John Fox, and Will Mandy, '"For Me, the Anorexia Is just a Symptom, and the Cause Is the Autism": Investigating Restrictive Eating Disorders in Autistic Women', *Journal of Autism and Developmental Disorders*, 50 (2020), 4280–96 <doi: 10.1007/s10803-020-04479-3> [accessed 5 January 2021].
[1129] NHS, *Symptoms: Anorexia Nervosa* (2018) <https://www.nhs.uk/conditions/anorexia/symptoms/> [accessed 26 September 2020].
[1130] APA, *DSM-5*, p. 339.
[1131] Janet Polivy and Peter C. Herman, 'Diagnosis and Treatment of Normal Eating', *Journal of Consulting and Clinical Psychology*, 55.5 (1987), 635–44 <doi: 10.1037/0022-006X.55.5.635> [accessed 5 January 2021].
Cited in Malson, *The Thin Woman*, p. 90.

tenet that these behaviours constitute illness, as opposed to comprehensibe reponses to female socialisation and a narrow bodily norm.

On this point, I argue that social anxiety is intertwined with eating problems insofar as both experiences centre around one's body being normative, or, quite literally, fitting in. In turn, eating is modified in order to alter the body's appearance such that it better approximates the ideal. Given this, the *DSM-5*'s conceptualisation of Anorexia Nervosa as merely 'an intense fear of gaining weight or becoming fat'[1132] is wildly reductive. No attention is devoted to why women might have this very rational fear, given the way that society treats fat female bodies. I mentioned earlier that prejudice against people who fit the criteria for obesity could be construed as the last acceptable prejudice.[1133] Indeed, the Reddit community 'fat people hate' was only banned relatively recently, in 2015.[1134] On this point, psychoanalyst Marilyn Lawrence cites a study by Lenore F. Monello and Jean Mayer in which the authors contend that 'the prejudice against fat people is similar to that directed against certain racial minorities'.[1135] Lawrence summarises the study thus:

> [F]at people themselves suffer the same damage to their self-esteem and share the same resistance to achievement as that found amongst racial minorities who are subject to social hatred and discrimination. The effect of these negative images and associations with fat is to make us overvalue thinness.[1136]

[1132] APA, *DSM-5*, p. 339.
[1133] Kavic, 'Obesity – An "Acceptable" Prejudice'.
[1134] Adi Robertson, 'Reddit Bans "Fat People Hate" and other Subreddits under New Harassment Rules', *The Verge* (2015) <https://www.theverge.com/2015/6/10/8761763/reddit-harassment-ban-fat-people-hate-subreddit> [accessed 7 January 2021].
[1135] Lenore F. Monello and Jean Mayer, 'Obese Adolescent Girls: An Unrecognised "Minority" Group?', *American Journal of Clinical Nutrition*, 13.1 (1963), 35–39 <doi: 10.1093/ajcn/13.1.35> [accessed 5 January 2021].
[1136] Marilyn Lawrence, *The Anorexic Experience* (London: The Women's Press Ltd., 1984), p. 39.

Given this, the fear of negative evaluation, which is a hallmark of the socially anxious experience, from inhabiting a fat female body is rendered intelligible.

On the topic of eating problems, a common thread which I found in my participants' testimonies was control. Daniella shared her experience: '[W]hen I had Anorexia, the only satisfying thing about it was that I was in control [...] when I binge, I don't have measure, I don't have control, I lose control and that makes me super anxious.' Although Ria spoke of Bulimia Nervosa, her narrative told a similar story, since she stated that, 'I guess the eating, and as it started, I think it probably was a control thing.' Lawrence's conceptualisation of the anorexic experience is relevant here, namely, what she calls the 'control paradox'. Lawrence describes this as

> [V]ery powerful control which anorexics exert in the area of food and weight and their own experience of themselves as utterly out of control. Anorexics are attempting to solve the problem of their own powerlessness and denigration as women by engaging in an internal struggle for self-control.[1137]

Lawrence contends that women feel unable to address issues in their environment, which renders control an internal issue:[1138] '[W]omen are encouraged to locate any difficulties they feel inside themselves rather than in the world.'[1139] MacSween conceptualises Anorexia Nervosa similarly in saying that '[t]he anorexic "solution" […] is an indirect and individualized response to a *social* issue'.[1140] This is salient if we consider others' reactions to women's bodies: it is the society which values women based on their adherence to an arbitrary norm, not the women themselves, that is at fault. Lawrence tells us

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[1137] Marilyn Lawrence, 'Anorexia Nervosa – The Control Paradox', *Women's Studies International Quarterly*, 2.1 (1979), 93–101 <doi: 10.1016/S0148-0685(79)93118-X> [accessed 5 January 2021], p. 93.
[1138] Ibid., p. 99.
[1139] Lawrence, 'Anorexia Nervosa', p. 100.
[1140] MacSween, *Anorexic Bodies,* p. 4.

that self-control substitutes for control of the self in the environment.[1141] Orbach makes a related argument in saying that '[w]e translate life problems into food problems or body problems':[1142] fixing these problems serves as a proxy for solving life problems which, owing to women's social subordination, is not so easily done.[1143] Solving life problems also requires 'interaction with other people':[1144] the difficulty therein is evident if we consider socially anxious women. Applying these ideas to my participants' narratives, eating problems are conceptualised as a means of control. This can be construed as a woman's struggle to mould her body to the norm, in an effort to avoid negative evaluation from others, in the absence of being able to affect the norm itself.

On the topic of eating, Daniella told me about her experience with binge eating: 'So that's a massive part of my mental health [...] it's the main thing that contributes to my mood swings. So, if I'm eating right, my mood is up, if I'm eating wrong, my mood is low.' This echoes the idea of a woman's personality, the way that she feels, or her appearance being 'right' or 'wrong'. It also draws links with the morality that is bestowed upon food. Lawrence, in conversation with a patient undergoing therapy, describes how she came to realise that food is indeed a moral issue.[1145] She discusses the morality that our culture assigns to food by citing the oft-repeated 'it's illegal, it's immoral or it makes you fat'.[1146] She continues: 'Self-denial in the area of food will therefore bring with it some fairly far-reaching moral kudos, and will be an indicator of moral worth.'[1147] As such, being a good and attractive woman in our culture means having the right personality style, the right body type, and having the ability to deny oneself.[1148] Failure on the

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[1141] Lawrence, 'Anorexia Nervosa', p. 94.
[1142] Orbach, *Fat Is a Feminist Issue*, p. 24.
[1143] Ibid.
[1144] Lawrence, 'Anorexia Nervosa', p. 99.
[1145] Lawrence, *The Anorexic Experience*, pp. 18–9.
[1146] Lawrence, 'Anorexia Nervosa', p. 95.
[1147] Ibid.
[1148] Ibid., p. 96.

part of women to exercise any kind of restraint in terms of their food intake, therefore, is likely to garner negative evaluation from others. The *DSM-5*'s diagnostic criteria for Anorexia Nervosa state that 'individuals may feel humiliated or embarrassed to be seen eating in public, as in social phobia'.[1149] What this fails to encapsulate is that this concern is explicable if we consider that food is tied to morality. Somebody seen to be indulging, as opposed to restraining their appetite, is likely to be frowned upon[1150] — especially if this person is a woman, and especially if she is fat.[1151]

The idea of food and restraint as moral issues is linked to the notion that physical health and (what are seen as) healthy behaviours are virtuous. Exhibiting these behaviours and possessing this kind of body are thus pre-requisites for being evaluated positively by others. Daniella alluded to this in explaining to me the reasons behind wanting to lose weight: 'It's not just that I want to look thin, it's not just an appearance line, but it's a physical thing as well [...] it's health.' Conrad suggests that 'health can be a moral discourse and the body a site for moral action'. He goes on to the talk about a 'moral world of goods, bads and shoulds'. Engaging in the pursuit of wellness, of which physical health is a part, 'becomes seen as a good in itself'.[1152] On this point, Lawrence tells us that:

[1149] APA, *DSM-5*, p. 344.
[1150] Richard I. Steim and Carol J. Nemeroff, 'Moral Overtones of Food: Judgments of Others Based on What They Eat', *Personality and Social Psychology Bulletin,* 21.5 (1995), 480–90 <doi: 10.1177/0146167295215006> [accessed 8 March 2021].
[1151] Ga-Eun Grace Oh and Young Eun Huh, 'Judge Me for What I Eat: Women Choose Low-Calorie Labeled Food To Signal Competence', *14th Association for Consumer Research Gender, Marketing and Consumer Behavior Conference,* 10th-11th October 2018, Hilton Anatole, Dallas, Texas, USA.
[1152] Peter Conrad, 'Wellness as Virtue: Morality and the Pursuit of Health', *Culture, Medicine and Psychiatry,* 18.3 (1994), 385–401 <doi: 10.1007/BF01379232> [accessed 5 January 2021].

> We behave as though the body is indeed the mirror of the soul. Fat people, simply by virtue of their shape and size, seem to be telling us that they are careless, indolent, lacking in self-control and even in sensitivity. We know this is not true, but we behave as though it is.[1153]

What is perhaps ironic about slenderness being tied to health is that, in order to attain such thinness, it is necessary for most women to diet, a state which Wolf calls 'semistarvation'.[1154] Wolf cites a body of work which has linked 'chronic dieting' to 'irritability, poor concentration, anxiety, depression, apathy, lability of mood, fatigue and social isolation'.[1155] Chronic dieting, this suggests, is thus clearly very bad for our mental health, and this again speaks to the relation between the physical and the mental which I discussed in the preceding chapter. Ria's narrative also relates to the idea that chronic hunger can affect women's emotional state, in that she told me that she had noticed that 'women seem to get "hangry" more than men do [...] is that the socialisation [...] the fact that women don't eat to be full?' Most pertinent to Ria's observation is Wolf's citing of a study which took a number of volunteers and placed them on a diet which halved their usual caloric intake. After losing one quarter of their starting bodyweight, Wolf notes that the subjects started to experience 'emotional disturbances' such as 'depression [...] hysteria, angry outbursts [...]'.[1156] All of the subjects were young men. It is quite plausible

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[1153] Lawrence, *The Anorexic Experience*, p. 18.
[1154] Wolf, *The Beauty Myth*, pp. 193-94.
[1155] Cecilia Bergh Rosen, 'An Explorative Study of Bulimia and Other Excessive Behaviours', King Gustav V Research Institutue, Karolinska Institutute, Stockholm, and the Department of Sociology and the School of Social Work, University of Stockholm, Sweden (1988), p. 77.
Daniota Czyzewski and Melanie A. Suhz (eds). *Hilde Bruch, Conversations with Anorexics* (New York: Basic Books, 1988).
David M. Garner, Paul E. Garfinkel, Donald Schwartz, and Michael Thompson, 'Cultural Expectations of Thinness in Women', *Psychological Reports*, 47.2 (1980), 483-91 <doi: 10.2466/pr0.1980.47.2.483> [accessed 5 January 2021].
Ilana Attie and J. Brooks-Gunn, 'Weight Concerns as Chronic Stressors in Women', in *Gender and Stress, ed. by Rosalind Barnett, Lois Biener, Rosalind C. Barnett, and Grace K. Baruch* (New York: Free Press, 1987), 218-54.
All cited in Wolf, *The Beauty Myth*, p. 195.
[1156] Robert Pollack Seid, *Never Too Thin: Why Women Are at War with their Bodies* (New Work: Prentice Hall, 1989), cited in Wolf, *The Beauty Myth*, pp. 193–94.

then, that, ironically, in engaging in the chronic dieting which the pursuit of the ideal female body requires, women might render themselves more (socially) anxious than they might otherwise be.

Returning to Lawrence's idea that one's body is seen as reflecting one's character, Orbach makes a salient point in characterising the body as being entwined in the search for identity.[1157] The body is, she tells us, one's 'calling card, vested with showing the results of our hard work and watchfulness or, alternatively, our failure and sloth'.[1158] Gill argues that this is emblematic of postfeminist media culture, wherein the female body

> [I]s constructed as a window to the individual's interior life. For example, in Bridget Jones's Diary[1159] when Bridget Jones smokes 40 cigarettes a day or consumes 'excessive' calories, we are invited to read this in psychological terms as indicative of her emotional breakdown.[1160]

Orbach contends that now, people 'believe that their bodies are a physical enunciation of their true state of being'.[1161] This extends to the body being an indication of one's membership to a given 'class, a group, a sexual practice, an aspiration'.[1162] This positioning of the body represents a legacy, or more modern version, of physiognomy: that is, the belief that facial features 'are accurate manifestations of inner moral character and identity'.[1163] Ellen's testimony further cements the links between appearance and behaviour, in that she told me that women are 'surveyed on how we behave as well'.

On this point, Gill tells us that 'monitoring and surveying the self have long been requirements of the performance of successful femininity — with instruction in grooming, attire, posture, elocution and

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[1157] Orbach, *Bodies*, p. 150.
[1158] Ibid., p. 6.
[1159] Helen Fielding, *Bridget Jones's Diary* (London: Picador, 1997).
[1160] Gill, 'Postfeminist Media Culture', p. 150.
[1161] Orbach, *Bodies*, p. 171.
[1162] Ibid., p. 175.
[1163] Donaldson, 'The Corpus of the Madwoman', p. 103.

“manners” being “offered” to women to allow them to emulate more closely the upper-class white ideal’.[1164] We can understand the extension of concern with how one is perceived from the body to other aspects of the self by reviewing the thoughts of Malson. Malson tells us that ‘[h]umanistic discourse dictates that it is the inner self, an individual’s character rather than their appearance, which is important and should be valued’.[1165] I contend that, in the age of postfeminism, the requirement to regulate extends from the body to body comportment, behaviour, and character. I would echo Gill, who tells us that

> [I]t is not only the surface of the body that needs ongoing vigilance — there is also the self: what kind of friend, lover, daughter, or colleague are you? Do you laugh enough? How well do you communicate? Have you got emotional intelligence? […] the self has become a project to be evaluated, advised, disciplined and improved or brought ‘into recovery’.[1166]

Indeed, ‘women are required to work on and transform the self, regulate every aspect of their conduct.’[1167] In the previous chapter I explored the way that current femininity views the body as a project. Given the thoughts of Malson and Gill, it seems that this way of thinking about the body extends to the whole self. The imperative for women to work on the self is perhaps most visible on social media, and it is to this that I now turn.

‘Be the Best Version of Yourself’

In my interview with Ria, we spoke about the rhetoric of personal betterment with which social media is now awash:

[1164] Gill, ‘Postfeminist Media Culture’, p. 155.
[1165] Malson, *The Thin Woman*, p. 155.
[1166] Gill, ‘Postfeminist Media Culture’, p. 156.
[1167] Ibid., p. 164.

K: [I]t's like continuous betterment [...] 'Oh, you have to be the best version of yourself,' just like in–

Ria: Oh! 'Be your best self,' I hate that! I hate that phrase! [...] 'Be my best self.' Shut up! [...] I think it's one of the worst–it–I think it epitomises what's terrible now.

The rhetoric of which Ria is so critical is now commonplace on social media, the usual format being a background of a sunset or something equally scenic, over which is written an inspirational or motivational quote. For example, the Instagram account 'Motivation_Mondays' boasts a post which states 'I'm working on myself, for myself, by myself',[1168] and '6amsuccess' tells us that '[Y]our biggest opponent is yourself'.[1169] This rhetoric represents a shift from the idea that we should all strive to be like the successful, beautiful woman on our Instagram feed, and a move towards the idea that our goal should be to achieve 'the best version of ourselves', evoking a fictional and idealised image of ourselves that is in reach, if only we put in the work to get there. I am reminded here of the following quote, attributed to an anonymous source: 'Someone once told me the definition of hell; on your last day on earth, the person you could have become will meet the person you became.' Failure to measure up to this ideal self therefore stokes feelings of inadequacy — which were so prominent in my participants' narratives in the previous chapter — and perhaps the fear that others will look upon us unfavourably: the links with social anxiety are clear.

Harris's conceptualisation of modern-day femininity, in her work on the 'can-do' girl, also links to this rhetoric. Harris tells us that 'can-do' femininity has its beginnings in the 'grrrl' movement of the 1990s which, with 'its punk philosophy of DIY (do it yourself) and individual responsibility for social change lent

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[1168] Motivation_Mondays, *I'm Working on Myself, for Myself, by Myself* (2020) <https://www.instagram.com/p/CAIrN9MhKqf/> [accessed 27 September 2020].

[1169] 6amsuccess, *Your Biggest Opponent Is Yourself* (2020) <https://www.instagram.com/p/CAXGbi7jsFI/> [accessed 27 September 2020].

itself easily to its transformation into a discourse of choice and focus on the self'.[1170] Inherent in this movement was the concept of 'girlpower'. This incorporated ambition, confidence, outspokenness, self-belief and, most notably, 'power through and control over one's own identity invention and re-invention'.[1171] We are thus seeing how the present-day femininity expressed on social media has come to feature the self as a 'DIY project' on which a woman should work.[1172]

Implicit in this rhetoric is the idea that what happens to us is completely under our control. Indeed, Gill tells us that postfeminist discourses contain an 'emphasis upon empowerment and taking control that can be seen in talk shows, advertising and makeover shows'[1173] and, I would add, on social media. In being critical of the emphasis on self-determination, personal choice,[1174] and the idea that women are 'free to shape their own destiny',[1175] I am not suggesting that women do not have agency. Rather, I am making the case that this self-betterment rhetoric peddles the idea that if one works hard enough to better oneself, one can achieve *absolutely anything,* regardless of the world one lives in and irrespective of any adverse circumstances, such as structural inequalities. On this point, Gill argues that inherent in postfeminist discourse is '[t]he notion that all our practices are freely chosen' and that women are 'autonomous agents no longer constrained by any inequalities or power imbalances whatsoever'.[1176] Indeed, '[a] grammar of individualism underpins all these notions — such that even experiences of

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[1170] Harris, *Future Girl*, p. 16.
[1171] Susan Hopkins, 'The Art of "Girl Power": Femininity, Feminism and Youth Culture in the 1990s', in *Australian Youth Subcultures: On the Margins and in the Mainstream*, ed. by Rob White (Hobart: Australian Clearinghouse for Youth Studies, 1999), p. 95, cited in Harris, *Future Girl*, p. 17.
[1172] Harris, *Future Girl*, p. 18.
[1173] Gill, 'Postfeminist Media Culture', p. 153.
[1174] Ibid.
[1175] Ibid.
Maria Adamson, 'Postfeminism, Neoliberalism and a "Successfully" Balanced Femininity in Celebrity CEO Autobiographies', *Gender, Work and Organization*, 24.3 (2017), 314–27 <doi: 10.1111/gwao.12167> [accessed 22 March 2021]. p. 317.
[1176] Gill, 'Postfeminist Media Culture, p. 153.

racism, homophobia or domestic violence are framed in exclusively personal terms in a way that turns the idea of the personal-as-political on its head.'[1177]

In this climate of social media which is brimming with postfeminist discourses, there are no excuses for not being able to reach the idealised, fictional version of yourself which this rhetoric evokes. It is this self, which women are called upon to incessantly improve and manage, that McRobbie calls 'a dangerous fiction',[1178] not least, I argue, because the perceived failure to fulfil this fiction is conducive to distress arising from the prospect of being evaluated unfavourably by others. Ria was aware that the notion of an idealised self was indeed a fiction. That is, she refuted this discourse's demand that women cultivate a particular image of themselves — an image that is perfect to the extent of being almost non-human. In response to this demand, she told me: '[A]nd you're just like, "No. Sometimes, I want to sit in my pyjamas, with a big, fat ice cream" [...].' Despite her seeming resistance, Ria seemed to still feel the pressure to be her 'best self', since she followed the above remark with 'I shouldn't care that people know that'.

Revisiting the concept of the thin female body, Malson warns that 'the deployment of humanistic discourse does not necessarily lessen the imperative to be thin'[1179] or, I add, to adhere to society's bodily ideal. She continues in telling us that 'i[t] may instead result in a negative interpellation of the subject as irrational and superficial, as being too concerned with appearance'.[1180] This creates a sort of conflict: one wants to adhere to the bodily ideal, but feels guilty for doing so. I alluded to this conflict earlier in exploring Ellen's narrative, and it is to her words that I now return. She told me, 'it's weird, because I

[1177] Ibid.
[1178] Angela McRobbie, 'Notes on the Perfect: Competitive Femininity in Neoliberal Times', *Australian Feminist Studies,* 30.83 (2015), 3–20 <doi: 10.1080/08164649.2015.1011485> [accessed 5 January 2021], p. 6.
[1179] Malson, *The Thin Woman*, p. 155.
[1180] Ibid.

don't care what other people think, I care–I'm like, "Oh, I want to look like that." But [...] why do I want to look like that?' She also told me how this conflict extends to thoughts surrounding the newer, more fringe imperative of body positivity:

> I constantly battle with myself, I'm like, 'All bodies are amazing,' and I'm like, 'Apart from mine.' [...] I've never ever looked at anyone else and thought, 'You shouldn't wear that.' [...] But to myself, I'm like, 'Hmm... You can't wear that.'

Ellen acknowledges, on some level, that the existence of a bodily norm is harmful for women. Alongside this, she experienced difficulty in 'resisting the "thin ideal" that has become such a normative requirement of successful western femininity',[1181] particularly when it came to her own body. Psychologists Ngaire Donaghue and Anne Clemitshaw note a comparable feeling among women within the fat acceptance movement, which I cited earlier: 'I'm totally smart and a feminist…and yet I want to be a waif'.[1182]

Orbach's point about both achieving and rejecting 'a perfect body-image',[1183] citing 'eating problems' as a result,[1184] is salient here. Ellen told me how she experiences an analogous conflict about attitudes towards food and the expectation that women self-deny, telling me,

> I find myself challenging people every day that are like, 'Oh, I'm not going to–' I'm like, 'No food is bad.' [...] even though in my own head I'll go home and be like, 'I can't have a bite of that.'

Ria articulated a similar conflict in telling me that she had noticed that she liked to eat 'a nice big portion in front of people and they're like, "Ooh, how do you stay so slim?" [...] "How amazing!" And I think part

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[1181] Donaghue and Clemitshaw, '"I'm Totally Smart and a Feminist…"', p. 415.
[1182] Ibid.
[1183] Orbach, *Hunger Strike*, pp. 49–50.
[1184] Ibid., p. 173.

of me really liked that'. Alongside this, Ria experienced guilt about cultivating an enviable image of herself as a slim woman who regularly eats large portions and manages to not gain weight, since she also said: 'I'm going to try and stop myself [...] I shouldn't do it [...] it's not good.' While Ellen and Ria told of how they experienced conflict regarding the body and food, they also both alluded to the idea of critiquing oneself. Before I delve into the notion of self-critique any further, I would first like to address an idea closely linked to bodily and appearance norms, and this is the notion that women are watched. I would ask the reader to retain the idea of self-critique in the back of their mind, for, in due course, my exposition will address how these two factors combine in socially anxious women.

Being Watched

Many of my participants shared concerns with being watched, both on a personal level and in terms of an awareness that women as a group are watched. When they personally experienced this, it made a number of them anxious:

> Ellen: I have that panic of, 'Oh, that's why I'm being looked at,' and that will make me anxious [...]
>
> Phoebe: I would feel really anxious in social situations because I would feel like people were looking at me [...]
>
> Olivia: I don't like being looked at because I over-worry about how I'm being perceived […]

For Phoebe, this anxiety made her reticent about leaving her home:

> [I]f there's someone that I'm embarrassed of my behaviour from when I was younger [...] guys I've slept with or whatever [...] I would get so anxious about seeing them [...] to the point where I would like avoid leaving my flat, if I could, because I would get worried [...] in case I saw them.

While Phoebe spoke about feeling apprehensive about *seeing* certain people around her city, we might understand this as her fear of *being seen*, and hence negatively evaluated, especially given the apprehension about being watched noted by a number of my participants, including Phoebe. On being seen, Orbach mentions how social media can be used to 'post unflattering pictures of individuals which are then "snarked" and negatively commented on'.[1185] In the UK, particularly on university campuses, a prominent example of this phenomenon is the proliferation of 'Spotted' pages on Facebook, where users can anonymously post candid photographs of students on which other users can comment. As *Everyday Sexism Project* founder Laura Bates writes in a piece for *The Guardian* newspaper, these comments usually take the form of evaluating the (female) subject's appearance and are often both highly sexualized, objectifying, and sexist.[1186] A similar online community, not limited to university campuses, was found on Reddit in the (recently removed) community 'CreepShots', wherein users posted candid photographs of women without their consent.[1187] The ensuing discussion followed a similar format to that on 'Spotted' pages. These are just two examples of how social media compounds women's nervousness about being seen, and hence evaluated, by others. Given that being in the public domain entails scathing evaluations of every aspect of a woman's identity, social media pages akin to those I have described above intensify this fear and immortalise the whole endeavour. With this in mind, I am sure I am not alone when I say that I can understand why Phoebe sometimes feels apprehensive about being seen, and the evaluation that will ensue, when she leaves her home.

[1185] Hannah Seligson, 'The Rise of Bodysnarking', *Wall Street Journal*, 16 May 2008, cited in Orbach, *Bodies*, p. 7.

[1186] Laura Bates, 'Facebook's "Spotted" Pages: Everyday Sexism in Universities for All To See', *The Guardian*, (2014) <https://www.theguardian.com/lifeandstyle/womens-blog/2014/jan/31/facebooks-spotted-pages-everyday-sexism-universities> [accessed 29 July 2020].

[1187] Andrea Walling, *Explainer: What Are 'Creepshots' and What Can We Do about Them?* (2017) <https://theconversation.com/explainer-what-are-creepshots-and-what-can-we-do-about-them-80807 [accessed 30 July 2020].
Justin Gray, 'Teacher Allegedly Posts Pictures of Students on "CreepShot" Website', *FOX 5 Atlanta* (2012) <https://web.archive.org/web/20130601231618/http://www.myfoxatlanta.com/story/19650823/teacher-allegedly-posts-pictures-of-students-on-site> [accessed 30 July 2020].

Within Phoebe's narrative there are links with the diagnosis 'Agoraphobia,' which the *DSM-5* lists as being commonly 'co-morbid' with SAD.[1188] It distinguishes between the two thus: 'Agoraphobia should be differentiated from social anxiety disorder based primarily on the situational clusters that trigger fear, anxiety, or avoidance and the cognitive ideation. In social anxiety disorder, the focus is on fear of being negatively evaluated.'[1189]

Echoing the first researchers to categorise SAD, Marks and Gelder, I posit that where SAD ends and Agoraphobia begins seems 'rather arbitrary',[1190] especially when considering a woman like Phoebe, whose fear of being negatively evaluated *causes* her to avoid public spaces. As before, I am not advocating for a revision of diagnostic criteria, but rather drawing attention to there being 'no very clear line of demarcation'[1191] between these diagnoses. In turn, this slippage indicates a fundamental flaw with the *DSM-5*'s tenet that these diagnoses are separate, biologically-rooted pathologies. By contrast, listening to the accounts of women like Phoebe, and exploring social contributors to their psychological distress, can render their experiences understandable and, in turn, problematise the notion that they are 'mental illnesses'.

Returning to the idea that women are watched, thus far my discussion of this phenomenon has largely concerned women's bodies. Ellen's narrative departs from this in that she felt that being watched went

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[1188] APA, *DSM-5*, p. 221.
[1189] Ibid.
[1190] Lane, *Shyness*, pp. 71–72.
[1191] Eliot Slater and Martin Roth, *Clinical Psychiatry*, 3rd edn (Baltimore: Williams and Wilkins, 1969), pp. 95–96.
See also: R. P. Snaith, 'A Clinical Investigation of Phobias', *The British Journal of Psychiatry,* 114.511 (June 1968), 673–97 <doi: 10.1192/bjp.114.511.673> [accessed 5 January 2021].
Frederick Kräupl Taylor*, Psychopathology: Its Causes and Symptoms*, Revised edn (Baltimore: Johns Hopkins University Press, 1979 [1966]), p. 160.
All cited in Lane, *Shyness*, p. 72.

beyond her appearance, telling me, ‘we’re like surveyed on how we behave as well’. I ask the reader to retain this idea in the back of their mind, for I will explore this notion in greater depth in due course.

As well as their own personal experiences of being watched, some of my participants revealed that it is women as a group who are surveyed. Indeed, Farah told me ‘women are watched’ and Phoebe was aware that women’s being watched was something gendered, since she spoke about ‘the pressures of gender and like femininity, feeling like you’re being watched, feeling like people are talking about your body’. In interviewing my participants, it was clear that they understood that women are not merely watched by men but learn to watch one another and in turn, judge one another. Daniella explained:

> [Y]ou know women are very judgy of each other? Especially in a group [...] if they’re not, you always think that other people are. So you always have the thing, ‘Oh, other people are judging me’ [...] women care more about what other people think [...]

The pull of this culture of judgement was made evident when Daniella told me that she does not want to care what others think, but is unable to shake this concern completely: ‘I really don’t care, but [...] subconsciously, I do, and it’s really annoying.’ There are echoes here of Ellen’s ambivalence regarding body positivity vis-à-vis social media, and her attitudes towards food.

In describing a culture of judgement, Daniella also alluded to the prevalence of comparison and competition, evoking the words of McRobbie. Citing Foucault, McRobbie tells us that ‘competition is a defining feature of the rise of neoliberal society’.[1192] Both Daniella and Phoebe spoke about their own experiences of competition:

[1192] McRobbie, ‘Notes on the Perfect’.

Daniella: I don't want to say that women are bitchy, you know, about each other, but they tend to converse more about each other than men do [...] I feel like there is a lot of competition [...] They're always the topic of conversation of each other. And always, vic–well, not victim, but, object of scrutiny, of each other.

Phoebe: [W]hen I went to university [...] I'd always like look at my smaller friends and be really jealous [...]

In discussing the culture of competition which exists among women, Daniella later alluded to the idea that social anxiety is not a binary, but rather, it exists on a spectrum with the 'normal'. I mentioned this idea in relation to FSD[1193] and BDD[1194] in Chapter 2, and also concerning dieting earlier on in this chapter. Related to dieting, Orbach notes that 'there is a painful continuity between most women's daily experience and that of the anorectic woman. Nearly all women feel the necessity to restrain their appetites and diminish their size'.[1195] Speaking of unease about others' evalautions and the culture of competition in which women find themselves, Daniella alluded to an analogous continuity in saying that 'even in the most, you know, confident woman, it's still a source of a bit of anxiety [...] if a woman has social anxiety, I think that's a big part of it. Because it is for me'.

Ellen and Phoebe made points akin to Daniella's in noting that these feelings of unease likely extend to all women, to an extent:

[1193] Taylor, 'Female Sexual Dysfunction', p. 286

[1194] Bordo, *Unbearable Weight.*

Heyes, 'Diagnosing Culture'.

All cited in Taylor, 'Female Sexual Dysfunction', p. 286.

[1195] Orbach, *Hunger Strike*, p. 78.

Ellen: [M]y cause of social anxiety is that [...] I do not look like what the ideal, sexy, pretty, beautiful woman would look like. And then I'm just paranoid that people are looking at me, thinking, 'Tall,' or whatever [...] I would imagine it's similar for other women.

Phoebe: I think a lot of my anxiety stems from kind of restrictive understandings of what femininity should be, and how that's like impacted me. I think a lot of women would probably say that as well.

Following Daniella's, Ellen's, and Phoebe's remarks, if most women experience some social anxiety owing to the way that they are treated by society, we return to the question of whether it is an experience that is best framed as a mental disorder.

Just as Daniella mentioned earlier that women judge one another, Phoebe made a related point: 'I think that we internalise so much misogyny [...] in social occasions because you feel watched and then you watch yourself.' Phoebe's remarks call to mind the thoughts of Sue in discussing women's objectification and resulting self-objectification. Sue explains:

The more women report being gazed at, encountering remarks about their appearance, garnering unwanted sexual attention, and experiencing sexual harassment, the more they also objectified themselves and other women as separate sexual beings.[1196] Thus women, who are evaluated in an objectified culture regarding physical appearance, come to evaluate their own worthiness or self-

[1196] Melanie S. Hill and Ann R. Fischer, 'Examining Objectification Theory: Lesbian and Heterosexual Women's Experiences With Sexual- and Self-objectification', *The Counseling Psychologist*, 36.5 (2008), 745–76 <doi: 10.1177/0011000007301669> [accessed 5 January 2021].
Janet K. Swim, Lauri L. Hyers, Laurie L. Cohen, and Melissa J. Ferguson, 'Everyday Sexism: Evidence for its Incidence, Nature, and Psychological Impact from Three Daily Diary Studies', *Journal of Social issues*, 57.1 (2001), 31–53 <doi: 10.1111/0022-4537.00200> [accessed 5 January 2021].

esteem based upon appearance and physical attributes. Self-objectification has been found to be negatively related to mental health, happiness, and subjective well-being.[1197]

Phoebe's comment above on watching herself, which alludes to self-objectification, is reminiscent of Foucauldian ideas in *Discipline and Punish*. In brief, Foucault uses Jeremy Bentham's Panopticon to explore self-surveillance. In this 'perfect prison', since only the central observation point therein, and not what or who is inside, is visible from the cells, the inmates do not know whether they are being observed at any given time. The Panopticon thus gives rise to the inmates' behaving as though they are being observed, irrespective of whether they are or not. Consequently, they effectively watch themselves, or engage in self-surveillance and, by extension, self-regulation. They have internalised the 'inspecting' gaze of the surveyor.[1198]

Watching the Self

In speaking about women watching themselves, Phoebe alluded to a phenomenon that can be understood through Foucault's conceptualisation of self-surveillance. Berger makes a concordant point in explaining that a woman is aware of herself as 'an object of vision',[1199] incessantly accompanied by 'her own image of herself'.[1200] Indeed, Berger tells us that '[w]omen watch themselves being looked at'.[1201] Drawing on Berger, Orbach remarks that 'women are taught to see themselves from the outside

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[1197] Barbara L. Fredrickson and Tomi-Ann Roberts, 'Objectification Theory: Toward Understanding Women's Lived Experiences and Mental Health Risks', *Psychology of Women Quarterly*, 21.2 (1997), 173–206 <doi: 10.1111/j.1471-6402.1997.tb00108.x> [accessed 5 January 2021].
Cited in Sue, *Microaggressions,* p. 170.
[1198] Foucault, *Power/Knowledge*, p. 131.
[1199] Berger, *Ways of Seeing*, p. 41.
[1200] Ibid., p. 40.
[1201] Ibid., pp. 40–41.

as candidates for men'.[1202] Orbach also contends that the phenomenon of women watching themselves being looked at morphs into the phenomenon of women 'assuming the gaze of the observer'.[1203]

In the spirit of exploring more contemporary manifestations of self-surveillance, I wish to briefly mention social media. Steeves, in discussing young women's social media usage, tells us that this demographic is 'under a high degree of social pressure to conform to "the norms of femininity" and typically judge themselves through the lens of peer acceptance'.[1204] Steeves is writing about women's surveillance of their own online profiles. In turn, we can garner from her remarks that women might now feel compelled to live their lives with their social media accounts never far from their minds. Ellen mentioned this in saying that 'even my little cousin–so she's [...] eleven, twelve, thirteen, and she is constantly [...] I can see how she lives her life through social media'. Ellen's words echo the idea that, in daily life, there is the imperative for women to be accompanied by, in Berger's words, 'her own image of herself'[1205] — or, considering social media, one might say, 'her own Instagram feed'. I invite the reader to recall how many times they have been at a party, on holiday, or even at the gym, and witnessed others taking photographs or videos which seem not to be for posterity or to immortalise a cherished memory or special occasion, though these certainly may form part of the motivation. Rather, these photographs and videos serve primarily as fodder for one's social media accounts, usually Instagram. Ria has observed this while on holiday:

> [W]e climbed up one of the Mayan pyramids, and at the top, you saw people like getting selfies like on the edge [...] And then the other thing as well [...] we saw this woman: really, really

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[1202] Orbach, *Fat Is a Feminist Issue*, p. 30.
[1203] Orbach, *Bodies*, p. 108.
[1204] Durham, 'Articulating Adolescent Girls' Resistance', p. 222, cited in Steeves, '"Pretty and Just a Little Bit Sexy, I Guess"', p. 169.
[1205] Berger, *Ways of Seeing*, p. 40.

> stunning woman in like a bikini [...] she was taking like a selfie and she had like a friend next to her with like a big metal sheet, to get the lighting right [...] And you're like, 'Gosh, that is a thing.'

With the rise in popularity of social media, we can see that women, such as the bikini-clad woman in Ria's narrative, increasingly live their daily lives governed by what will look favourable on social media, as opposed to living in the moment and experiencing life through their own eyes. Not only do women survey themselves from a distance, as Berger and Orbach tell us, but, now that social media has risen to such prominence in people's daily lives, they also now survey their *virtual selves* once removed. Ria perhaps best summed up this phenomenon in saying, 'that one minute of the day where I might be doing a stretch [...] "Oh gosh, we've got to make you do it in the sunset now" [...] and make sure it makes a good photo.'

Susan Sontag has said that 'the camera makes everyone a tourist in other people's reality, and eventually in one's own'.[1206] If we replace 'the camera' with 'social media', we have a descriptor for the way that social media fosters a detachment from one's day-to-day life in our time. In their daily lives, women are accompanied by the questions, '[h]ow am I looking today? How are my knees, my breasts, my buttocks, etc.?'[1207] Now, we are increasingly accompanied by the additional question, 'how can I portray what I am doing in the best possible light on my social media accounts?' For Ria, this imperative stirred up a conflict in her and, although she was able to resist the pressure to engage in this practice, she still felt this pressure nonetheless:

[1206] Susan Sontag, *New York Review of Books*, 18 April 1974.
[1207] McRobbie, 'Notes on the Perfect', p. 7.

> [I]t really like frustrates me, because I think there's a part of me as well that goes, 'Should I be joining in with that?' You know, like, there's this genuine bit of conflict, and then I'm like, 'No, don't be stupid.'

Continuing with the theme of self-surveillance, anti-psychiatrist Laing notes that one of his case studies, Joan, told him that she could 'only be good if you saw it in me. It was only when I looked at myself through your eyes that I could see anything good'.[1208] The idea that women self-survey with male eyes is reminiscent of feminist film theorist Laura Mulvey's term 'the male gaze', which was originally coined to describe the role of the passive female and active male in narrative film: the viewer is assumed to be male, and women are looked at or displayed. This 'male gaze' is then internalised.[1209]

Janet Holland et al.'s thesis of the 'male-in-the-head', which emerges from their work on young poeple's narratives on heterosexuality, is also relevant to my discussion. The 'male-in-the-head' is defined as 'the surveillance power of [...] male-dominated and institutionalised heterosexuality'.[1210] A woman, therefore,

> Through her subordinated participation in his performance she is inducted into the world of heterosexual sexuality, where she has to manage her femininity according to the 'male-in-the-head' or take the consequences of resistance. Under this gaze, her sexual identity, subjectivity and desire are silenced.[1211]

[1208] Laing, *The Divided Self*, p. 174.
[1209] Laura Mulvey, 'Visual Pleasure and Narrative Cinema', *Screen*, 16.3 (1975), 6–18 <doi: 10.1007/978-1-349-19798-9_3> [accessed 30 July 2020].
[1210] Janet Holland, Caroline Ramazanoglu, Sue Sharpe, and Rachel Thomson, *The Male in the Head: Young People, Heterosexuality and Power* (London: The Tufnell Press, 1998), p. 11.
[1211] Ibid., p. 188.

In turn, women's self-definition is contingent on the opinions of others, particularly men. One might say that Laing's case study Joan is alluding to this. Indeed, one of Holland et al.'s participants 'comments on a sense of being assessed by someone else's standards [...] Another comments on the way sexual reputation impresses conformity to normative femininity'.[1212] This could tell us why women might be concerned with how they are perceived: their very identity rests on it. Viewed in this way, social anxiety, which entails a fear of being perceived in a negative light, becomes quite rational.

It is pertinent now to revisit Bartky's work, wherein she tells us that 'a panoptical male connoisseur resides within the consciousness of most women'.[1213] That is, women learn to look 'at themselves from the outside'.[1214] Novelist Margaret Attwood's words echo this idea in that she speaks of 'the ever-present watcher peering through the keyhole [...] in your own head [...] You are a woman with a man inside watching a woman'.[1215] In the section that follows, I will outline how our culture fosters in women a detachment from their bodies insofar as they are conditioned to internalise others' standards. In turn, they watch themselves from afar as a means by which they can ascertain how well they reach these standards: a strategy as a safeguard against others' negative evaluation and a means by which to allay social anxiety. This detachment is something which warrants further unpacking and it is to this that I now turn.

The Body and the Self

Orbach writes on how women are socialised to view their bodies. She describes how, in adolescence, a girl develops 'a split between her body and her self': 'Her body is rapidly being presented to her and

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[1212] Ibid., p. 173.
[1213] Bartky, 'Foucault, Femininity, and the Modernization of Patriarchal Power', p. 34.
[1214] Orbach, *Bodies*, p. 108.
[1215] Margaret Attwood, *The Robber Bride* (London: Bloomsbury, 1993), p. 392, cited in Holland et al., *The Male in the Head*, p. 19.

being perceived by her as an artifact.'[1216] I mentioned earlier, in discussing weight, that our culture views the body as being reflective of one's personality or character. Orbach refines this notion in observing that our culture demands that a woman's body 'expresses both her oneness with the culture and her individuality';[1217] '[h]er body is a statement about her position in the world.'[1218] For Orbach, a woman's body is therefore 'both divorced from and yet reflective of who and what she is'.[1219] This conceptualisation of the body promotes careful curation and is analogous to how current norms of femininity promote the self as project.

The importance that society places on the body, the existence of a stringent norm, and the demand that the body should reflect who the woman is all mean that women learn to view 'their bodies from the outside, as if they were commodities'.[1220] In doing so, a woman 'measures how far from the projected norm she is'.[1221] As Olivia noted, 'these norms encourage girls to feel more cripplingly self-conscious than boys in how they must present themselves'. Orbach further characterises self-surveillance of the body as 'visual acuity turned in on itself. It operates almost as a third eye'.[1222] A woman thus surveys her body 'almost as one removed'.[1223] The young women in Holland et al.'s research echoed this idea, since

> [T]hey are under pressure to construct their bodies into a model of femininity which is both inscribed on the surface, through such skills as dress, make-up and dietary regimes, and

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[1216] Orbach, *Hunger Strike*, p. 28.
[1217] Ibid., p. 16.
[1218] Ibid., p. 28.
[1219] Ibid.
[1220] Ibid., p. 16.
[1221] Ibid., p. 28.
[1222] Ibid., p. 16.
[1223] Ibid., p. 28.

disembodied, in the sense of detachment from their sensuality and alienation from their material bodies.[1224]

These ideas evoke the depersonalisation in what the *DSM-5* calls 'Depersonalization/Derealization Disorder'. This is described as 'clinically significant persistent or recurrent depersonalization (i.e., experiences of unreality or detachment from one's mind, self, or body)'[1225] or feeling 'as if one were an outside observer of one's mental processes or body'.[1226] On this point, Martin argues that women 'see their bodies as separated from themselves, as needing to be controlled. She reports "a fair amount of fragmentation and alienation in women's general conceptions of body and self" of which they did not seem to be aware'.[1227] Following Martin, Anglo-American culture mandates that women view their bodies in this way and, what is more, this is normalised. Rather than being a discrete psychiatric disorder in its own right, which is *not* reported as being 'co-morbid' with SAD by the *DSM-5*,[1228] I posit that this phenomenon is not only a logical facet of the socially anxious woman's experience, but I question whether it constitutes a discrete mental disorder, or even a mental disorder at all. In much the same way that mental health issues such as eating problems and BDD are 'on a hazy continuum with the banal',[1229]

[1224] Holland et al., *The Male in the Head*, p. 109.
[1225] APA, *DSM-5*, p. 291.
[1226] Ibid., p. 273.
[1227] Emily Martin, *The Woman in the Body* (Milton Keynes: Open University Press, 1989), p. 89, cited in Holland et al., *The Male in the Head*, p. 109.
[1228] The extant literature provides no reference to any link between the 'Dissociative Disorders' and 'SAD' aside from one qualitative study and one psychological study. These are, respectively:
Matthias Michal, Johannes Kaufhold, Ralph Grabhorn, Karsten Krakow, Gerd Overbeck, and Thomas Heidenreich, 'Depersonalization and Social Anxiety', *The Journal of Nervous and Mental Disease*, 193.9 (2005), 629–32 <doi: 10.1097/01.nmd.0000178038.87332.ec> [accessed 30 July 2020].
Juergen Hoyer, David Braeuer, Stephen Crawcour, Elisabeth Klumbies, and Clemens Kirschbaum, 'Depersonalization/Derealization during Acute Social Stress in Social Phobia', *Journal of Anxiety Disorders,* 27.2 (2013), 178–87 <doi: 10.1016/j.janxdis.2013.01.002> [accessed 30 July 2020].
[1229] Taylor, 'Female Sexual Dysfunction', p. 286.

for women, some degree of dissociation from the body is almost inevitable if we consider how society treats female bodies. It follows that this experience should not be pathologised.

I will revisit what are called the 'Dissociative Disorders' later on in the chapter. For now, I wish to return to women's experiences of division or separation from the body. These experiences, which our culture fosters, represent a sort of specifically feminine Cartesian dualism. Although some of my participants, both explicitly and implicitly, rejected this dualism, they also spoke in such a way as to endorse it. This suggests on the one hand that this way of conceptualising ourselves is so ingrained in our culture that it is difficult to rid ourselves of it completely. On the other hand, it suggests a problem with the language available for us to speak about ourselves. As I noted previously, Laing states that this is the case for psychiatric patients, since our language 'consists of words which split man up verbally'.[1230] Phoebe alluded to this in telling me that 'our language is kind of imbued with the like disciplining of women'.

One of the manifestations of this dualism, Orbach tells us, is that women 'routinely judge our appearance through a hyper-critical lens, objectifying our faults'.[1231] This was evident in the words of Ellen, who told me about a number of areas of her body with which she was unhappy: 'When I lost weight and they were really small I was like, "This is great!" [...] Now, back to normal boobs [...] I only want a bigger arse [...] my arse is flat as a pancake.'

Orbach also notes that many women view their body as 'an "it" rather than their home',[1232] which was reflected in Phoebe's narrative when she remarked that 'my body wasn't kind of maybe as thin as it "should" have been'. Echoing the conceptualisation of the body as a project, Orbach also contends that

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[1230] Laing, *The Divided Self*, p. 19.
[1231] Orbach, *Bodies*, p. 111.
[1232] Ibid., p. 151.

women often view their bodies in this way,[1233] that is, as 'a product we manufacture and create'.[1234] It was evident in Ellen's testimony that she, at least in part, viewed her body as something on which she needed to work: 'My Instagram feed is literally, "How to get like the perfect arse at the gym."'

In her theorising about women's experiences of Anorexia Nervosa, Orbach speaks to the notion of the body as project in describing this mental health issue as 'the excruciating spectacle of women actually *transforming* their bodies'.[1235] The reason for this transformation, Orbach tells us, is 'to deal with the contradictory requirements of their role in late twentieth-century America and England'.[1236] Phoebe cited a similar contributor to her social anxiety in speaking about the way that gender interacts with capitalism: '[W]hen you throw in like fucking capitalism and how that fucks everyone up, but especially women, because it profits off women's anxieties anyway [...] in the sense of beauty aesthetics and how that creates anxiety.' For Phoebe, the interaction between gender and capitalism has shaped her, as a socially anxious woman:

> [T]he way that gender and capitalism interlink has had a massive impact on me as a person [...] I definitely think it impacts all of us [...] I think that you can't ever like remove yourself from those structures, because it's kind of what shape us.

Phoebe's narrative evokes Orbach's theory that Anorexia can be understood as 'a metaphor of our times – an especially poignant statement of the way that the predicaments of life in late twentieth-century capitalism can be experienced by the individual woman'.[1237] Building on Phoebe's narrative, we might

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[1233] Ibid., p. 51.
[1234] Ibid., p. 168.
[1235] Orbach, *Hunger Strike*, p. 4.
[1236] Ibid.
[1237] Ibid., p. 107.

conceptualise women's SAD as 'a statement of the way that the predicaments of life in twenty-first century capitalism can be experienced by the individual woman'.

Having discussed self-surveillance pertaining to the body, and how the body is seen to be a representation of the self, it is timely now to focus on self-surveillance, but extended to the woman in her entirety. I would like to remind the reader of Ellen's remark from earlier in the chapter, where she stated that women are 'surveyed on how we behave as well'. MacSween links being watched, and watching the self, with femininity and the idea of control, specifically self-control, and behaviour. Recall that control was something which a number of my participants linked to their experiences of eating problems. '[S]elf-control is,' MacSween tells us, 'an essential feature of femininity and of women's relationship with their bodies: women watch what they eat, how they dress, talk, sit, walk and behave'.[1238] MacSween's statement follows Ellen's narrative insofar as it expands the idea of self-surveillance from one's body to incorporate one's body comportment and behaviour: in other words, self-surveillance extends to the woman in her entirety. Olivia alluded to this being a core part of her heightened self-awareness in telling me that 'I identify as having SAD in that I feel self-conscious and hyper-conscious of my appearance, body language, mannerisms, what I say and how I sound whenever I'm in a social situation'.

Farah's experience is also salient here. While a number of my participants had experiences with eating problems and their testimonies expressed particular concern with how their physicality was perceived, Farah relayed something that was somewhat distinct. That is, her own social anxiety was expressly to do with her character: 'It wasn't about […] The image of my body, but it was about the image that generally as a person I have […] maybe intellectually.' Farah's testimony supports my contention that, much as

[1238] MacSween, *Anorexic Bodies*, p. 193.

eating problems can arise as a response to a narrow and prescriptive bodily norm, social anxiety can arise due to both this bodily norm *and* narrow and prescriptive gendered norms pertaining to personality and behaviour. While Orbach contends that anorexic women are in ‘a struggle to reshape themselves physically and emotionally’,[1239] socially anxious women are analogously engaged in a struggle to reshape, and cultivate, their entire selves.

In the interests of unpacking this analogy further, I invite the reader to recall that earlier in the chapter I explored how Ellen felt that social media affected her relationship with her body. Ria’s narrative drew a parallel with Ellen’s account in that she divulged that social media affected her sense of self. Whereas Ellen followed public figures and ‘influencer’ accounts, and her concerns centred on her body and her lifestyle, Ria told me how she had often compared herself to people that she knew, or had known in the past. Rather than physicality and lifestyle, Ria’s concern was more to do with accomplishments or advancement in life. She explained:

> I used to do that kind of thing where I’d go online — I guess this might feed into social anxiety to some extent [...] looking at where people were, and I still do that, I compare where I am in life to where other people are [...] ‘Ooh, so and so’s got kids,’ and, you know, they’re doing this and doing this.

Considering Ellen and Ria’s narratives alongside one another lends credence to the idea that whereas ‘pathological’ ways of eating are often precipitated by concern with attaining a bodily norm, social anxiety is also often precipitated by this very concern, but expanded to incorporate norms of behaviour and personality: it extends to all aspects of the self.

[1239] Orbach, *Hunger Strike,* p. 95.

On the excerpt from Ria's testimony cited above, social media renders all facets of users' lives visible. Oftentimes, these facets assume the form of a highlight reel, with the viewer then comparing this to their own lives: inevitably, the latter fails to match up. Above, Ria is describing engaging in 'passive use' of Facebook, wherein the user observes others' highlight reels, but does not interact with them nor engage in content production of their own. This phenomenon has been associated with higher levels of social anxiety[1240] and what has been termed 'Facebook envy': that is, 'a hostile evaluation of others from their social information' on social networking sites. In turn, this has been linked with poorer mental health.[1241] Passive Facebook use is also connected to increased frequency of social comparison,[1242] that is, 'where individuals compare themselves as having more positive (downward comparison) or negative (upward comparison) qualities than others'.[1243] Ria describes her own positioning of herself among her

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[1240] Ashley M. Shaw, Kiara R. Timpano, Tanya B. Tran, and Jutta Joormann, 'Correlates of Facebook Usage Patterns: The Relationship between Passive Facebook Use, Social Anxiety Symptoms, and Brooding', *Computers in Human Behavior*, 48 (2015), 575–80 <doi: 10.1016/j.chb.2015.02.003> [accessed 30 July 2020].
Cited in Elizabeth M. Seabrook, Margaret L. Kern, and Nikki S. Rickard, 'Social Networking Sites, Depression, and Anxiety: A Systematic Review', *JMIR Mental Health,* 3.4 (2016), e50 <doi: 10.2196/mental.5842> [accessed 30 July 2020], p. 5.
[1241] Edson C. Tandoc Jr., Patrick Ferrucci, and Margaret Duffy, 'Facebook Use, Envy, and Depression among College Students: Is Facebooking Depressing?' *Computers in Human Behavior*, 43 (2015), 139–46 <doi: 10.1016/j.chb.2014.10.053> [accessed 30 July 2020].
Helmut Appel, Jan Crusius, and Alexander L. Gerlach, 'Social Comparison, Envy, and Depression on Facebook: A Study Looking at the Effects of High Comparison Standards on Depressed Individuals'*, Journal of Social and Clinical Psychology,* 34.4 (2015), 277–89 <doi: 10.1521/jscp.2015.34.4.277> [accessed 30 July 2020].
Sang Yup Lee, 'How do People Compare Themselves with Others on Social Network Sites?: The Case of Facebook', *Computers in Human Behavior,* 32 (2014), 253–60 <doi: 10.1016/j.chb.2013.12.009> [accessed 30 July 2020].
Seabrook et al., 'Social Networking Sites', p. 8.
[1242] Lee, 'How do People Compare Themselves with Others'.
Seabrook et al., 'Social Networking Sites', p. 10.
[1243] Katerina Lup, Leora Trub, and Lisa Rosenthal, 'Instagram# Instasad?: Exploring Associations among Instagram Use, Depressive Symptoms, Negative Social Comparison, and Strangers Followed', *Cyberpsychology, Behavior, and Social Networking,* 18.5 (2015), 247–52 <doi: 10.1089/cyber.2014.0560> [accessed 31 July 2020].
Mai-Ly N. Steers, Robert E. Wickham, and Linda K. Acitelli, 'Seeing Everyone else's Highlight Reels: How Facebook Usage Is Linked to Depressive Symptoms', *Journal of Social and Clinical Psychology*, 33.8 (2014), 701–31 <doi: 10.1521/jscp.2014.33.8.701> [accessed 31 July 2020].
Lee, 'How Do People Compare Themselves with Others'.

peers and, by extension, how others might perceive her to sit in the 'social hierarchy' of sorts: '[T]here's always that slight sort of, "Oh, there's where I am, that's where they are."'

Ria's concern with how she is perceived is embedded in the extent to which, and exactly where, she feels she belongs among her peers, echoing the importance my participants placed on 'belonging'. Social media makes this sort of comparison easier and indeed facilitates it: this is a prime example of the interplay between social media and mental health issues. Indeed, Ria seemed aware of this interaction, telling me that her passive use of social media 'might feed into social anxiety to some extent'. Even so, this awareness did not completely allay her feelings of inadequacy that viewing others' highlight reels stirred up, since she told me that 'there is this idea that, you know, "Oh yeah, I've got to look like I'm, you know, managing everything beautifully and– [...] Ooh, this person's managing everything beautifully so I should also be doing the same."'

The sense of falling short to which Ria alluded might lead to fears of being negatively evaluated by others. In an effort to stifle this fear, one might argue that women have learned to live their lives with their self-presentation on social media always in the back of their minds. I touched upon this earlier on in the chapter in discussing the notion that one should 'be the best version of themselves'. I ask the reader to hold this idea in the back of *their* mind, for I will revisit it later on in the chapter.

On a related note, but departing from considering social media, I wish to return to the notion of the body as a project and discuss '[t]he postmodern myth of self-invention',[1244] that is, the way that our culture advocates a kind of 'cultivation' of the whole self. The normalisation of cosmetic surgery and its

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Brian A. Feinstein, Rachel Hershenberg, Vickie Bhatia, Jessica A. Latack, Nathalie Meuwly, and Joanne Davila, 'Negative Social Comparison on Facebook and Depressive Symptoms: Rumination as a Mechanism', *Psychology of Popular Media Culture*, 2.3 (2013), 161–70 <doi: 10.1037/a0033111> [accessed 31 July 2020].
Seabrook et al., 'Social Networking Sites', p. 8.
[1244] Orbach, *Bodies*, p. 166.

presentation as a 'quest […] to construct a different body'[1245] exemplifies this cultivation. Indeed, Orbach predicts that 'people will soon ask why you haven't remodelled your body, as though it were a shameful old kitchen'.[1246] Recall that psychiatrist Kramer termed medicating mental health issues with antidepressants, 'cosmetic pharmacology': according to Kramer, antidepressants are to the self what cosmetic surgery is to the body.

The continued working on the body and the self that our culture mandates therefore necessitates a continued watchfulness, the motivation for which is controlling others' perceptions. This watching of the self is conducive to a division of the self into the watcher and the watched. As Berger tells us, a woman thus constantly feels the imperative to watch herself such that 'she comes to consider the surveyor and the surveyed within her as the two constituent yet always distinct elements of her identity as a woman'.[1247] There is a deep resonance between Berger's remarks and the work of anti-psychiatrist Laing, and it is to the latter that I now turn.

The False Self

In what is perhaps Laing's most famous opus, *The Divided Self,*[1248] he tells us how persons labelled 'schizoid' experience a split of their self between a true and false self. Laing's exposition of the development of these selves has much in common with that of psychoanalyst Donald W. Winnicott, whose words Orbach cites in her theorising about women's Anorexia Nervosa. Orbach's use of these concepts in rendering this mental health issue explicable draws parallels with my own exposition of the socially anxious woman's split into a true and false self. Orbach's deployment of this concept therefore

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[1245] Catherine Baker-Pitts, 'Symptoms or Solution? The Relational Meaning of Cosmetic Surgery for Women', unpublished dissertation, New York University, 2008, cited in Orbach, *Bodies*, pp. 102–03.
[1246] Orbach, *Bodies*, pp. 102–03.
[1247] Berger, *Ways of Seeing*, p. 40.
[1248] Laing, *The Divided Self*.

gives credence to my contention that 'pathological' ways of eating, as related to striving for a normative body type, and SAD are related 'disorders' which centre on fear of negative evaluation of different aspects of one's identity.

Citing Winnicott, Orbach tells us that if, in infancy, the baby girl's needs remain unmet, for instance, 'if [...] she has been left crying',[1249] then she thinks that 'it must be because of some action on [...] her part, some failure of [...] hers. It is the baby rather than the care-giver who feels at fault or inadequate'.[1250] As a result, in the case of the baby, 'a kind of split takes place inside their mind. A part of them stays eager and attentive to the mother, while another part is watchful for what it is about themselves that will be received rather than rejected.'[1251] As such, the baby, 'in bringing forward parts of [...] herself that suit the mother',[1252] develops 'a false self'[1253] which is 'more pleasing'[1254] and features 'an overdevelopment of certain aspects of the self at the expense of other aspects':[1255] it comprises the aspects that the caregiver will respond to favourably.[1256] The true self, by contrast, 'remains undeveloped'[1257] because it has been 'split off and repressed'.[1258] Crucially, the development of a false self arises because the baby girl is 'wary of what emanates from [...] herself'.[1259] This wariness is reminiscent of the self-surveillance in which socially anxious women engage due to being concerned with how they are perceived by others.

[1249] Orbach, *Bodies*, pp. 81–82.
[1250] Ibid., p. 81.
[1251] Ibid.
[1252] Ibid., p. 82.
[1253] Ibid.
[1254] Orbach, *Hunger Strike*, p. 70.
[1255] Orbach, *Bodies*, p. 82.
[1256] Ibid.
[1257] Ibid.
[1258] Orbach, *Hunger Strike,* p. 70.
[1259] Orbach, *Bodies*, p. 82.

To delve into the infancies of my participants would be a difficult, if not impossible, endeavour, and to do so is beyond the scope of this work. However, while Laing contends that the first year of life is important, he tells us that childhood and adolescence 'may still have great effect one way or the other'.[1260] I go a step further than Laing and suggest that girls', and later women's, unrelenting socialisation across the entirety of their lifetimes, as opposed to socialisation in infancy and adolescence, causes women to view themselves in the way that Laing describes. To support my assertion, I would like to examine Laing's tenets regarding the body in relation to the false self in light of Orbach's contention that women come to view their bodies as external objects. That is, Laing tells us that an individual with a false self 'experiences himself as being more or less divorced or detached from his body […] the body is felt more as one object among other objects in the world than as the core of the individual's own being'.[1261]

Laing elaborates on this notion in telling us that the body is 'felt as the core of the false self, which a detached, disembodied, "inner", "true" self looks on at with tenderness, amusement, or hatred'.[1262] The latter's 'functions come to be observation, control, and criticism'.[1263] Laing's description evokes one of the *DSM-5*'s Dissociative Disorders: that is, Dissociative Identity Disorder (DID), wherein one becomes a depersonalised observer 'of their "own" speech and actions'.[1264] His description is also reminiscent of a related diagnosis on which I touched earlier: Depersonalization/Derealisation Disorder, wherein '[t]he depersonalization experience can sometimes be one of a split self, with one part observing and one participating, known as an "out-of-body experience" in its most extreme form'.[1265] The depersonalisation described in the *DSM-5* is an experience of being 'an outside observer with respect to one's thoughts,

[1260] Laing, *The Divided Self,* p. 190.
[1261] Ibid., p. 69.
[1262] Ibid.
[1263] Ibid.
[1264] APA, *DSM-5*, p. 293.
[1265] Ibid., p. 303.

feelings, sensations, body, or actions'.[1266] Far from being constitutive of women's 'pathology', through considering Foucault's self-surveillance and Berger's division of the woman into surveyor and surveyed, we can begin to understand exactly why and how socially anxious women might have these experiences. Laing tells us that:

> This *identification of the self with the phantasy of the person by whom one is seen* may contribute decisively to the characteristics of the observing self [...] this observing often kills and withers anything that is under scrutiny. The individual now has a persecuting observer in the very core of his being […] he retains his awareness of himself as an object in the eyes of another by observing himself as the other […][1267]

I am reminded here of Amy who, when recounting how she oftentimes feels socially anxious when with her friends, recalled asking of herself, 'how do I appear to them?' Laing continues:

> [H]e lends the other his eyes in order that he may continue to be seen; he then becomes an object in his own eyes. But the part of himself who looks into him, has developed the persecutory features he has come to feel the real person outside him to have.[1268]

As such, Laing is describing an individual who becomes 'compulsively preoccupied with the sustained observation of his own mental and/or bodily processes'.[1269] The true self is 'extremely aware of itself, and observes the false self, usually highly critically'.[1270]

[1266] Ibid., p. 302.
[1267] Laing, *The Divided Self,* p. 117.
[1268] Ibid.
[1269] Ibid., p. 112.
[1270] Ibid., p. 74.

Orbach's work is further testament to the idea that female socialisation, not restricted to infancy, is conducive to the development of a false self in the case of women. She describes how the anorexic *woman*, in an effort to create a new self that will be more accepted, develops a Winnicottian false self.[1271] Both Olivia's and Ria's testimonies were in line with this insofar as they spoke about the way that their female socialisation had instilled in them the imperative to please others and win their approval:

> Olivia: [G]irls are socialised to think that being feminine involves being […] pleasing to be in the company of […] girls are made to feel like it is in their role to please others and be agreeable […]
>
> Ria: [T]he idea that you've got to be nice and agreeable [...] you've got to, you know, basically be on-tap for these men.

In a similar vein, Downing notes that women are 'supposed […] to be life-giving, to be nurturing, to be *for the other,* and therefore literally *self-less*'.[1272] In turn, women have the experience of never constructing a self that is meaningfully true.

One of the means by which women might respond to the imperative to be 'self-less' is noted by Holland et al., who observe that '[y]oung women can become conscious of their image as a construction when they make a distinction between the presentation of themselves that men respond to'[1273] — which I would liken to a 'false self' — 'and what they think of as their "real self"'.[1274] Throughout Olivia's interview, she alluded to the fact that the gendered imperative to please others made her conscious of how she presented herself and, in turn, made her socially anxious. One might say then, that norms surrounding femininity, particularly pertaining to the expectation that women please others and are

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[1271] Orbach, *Hunger Strike*, p. 87.
[1272] Downing, *Selfish Women*, p. 1.
[1273] Holland et al., *The Male in the Head*, p. 112.
[1274] Ibid.

'self-less', foster the cultivation of a *false* self — at the expense of the true self and all of its wants and needs — that will fulfil this demand.

Moreover, Orbach tells us that the real self, owing to not having its needs met, views itself as 'bad': as such, it feels 'the necessity to protect others from its presence'.[1275] The idea of protecting others, especially by means of putting others before oneself, was evident in the previous chapter, where I discussed women only seeking help for their mental health issues at the behest of loved ones or as a means by which to allay loved ones' worries. This sentiment was also present in the words of Amy, who told me that she felt that her 'responsibility [...] to make other people comfortable' was something that 'society has really ingrained in me as a woman'. Having discussed the expectation that women please others and render them comfortable, I now wish to shift the focus of my analysis to the related concept of approval-seeking.

Seeking Approval

Related to approval-seeking is the tenet that the real self's needs can only be articulated if they are in accordance with the needs of others. Hence, following Orbach, a woman's creation of a false self 'is an attempt to take up and meet the projections of others'.[1276] Following Laing, the false self is contingent on others for its definition.[1277] Laing's and Orbach's remarks evoke the words of Farah, whose narrative resonated with those of people with Selective Mutism. These individuals felt, due to being accompanied by their own memory of themselves in given situations, compelled to be the selves they were many years ago in accordance with others' expectations. In the spirit of Farah's narrative, Orbach tells us that

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[1275] Orbach, *Hunger Strike*, pp. 143–44.
[1276] Ibid., p. 70.
[1277] Laing, *The Divided Self,* p. 98.

rather than developing our own identities, women learn to 'tune our antennae to adjust to others' expectations'.[1278] Ria's testimony also espoused this idea:

> [T]here's a social pressure [...] the idea that you want to sort of make your parents proud [...] your grandparents proud and have them be able to sort of show off about you [...] I'm a bit of an approval so and so [...]

Inherent in Ria's narrative is the wish to gain others' — her parents and grandparents' — approval. Orbach contends that this wish arises from society's insistence that women suppress their own needs — or, following Downing, are '*self-less*'[1279] — which causes them to 'not feel good within themselves'.[1280] In an attempt to remedy this, 'the approval of others temporarily quiets the uneasy feelings inside.'[1281] Approval-seeking was also something Phoebe recalled from her youth, in telling me that 'some boys in my school, who I was friends with [...] and I kind of wanted them to like me'.

On this point, Orbach speaks about a hypothetical woman who, having not been 'encouraged to develop her initiating part and draw a sense of authenticity and strength from that […] is victimized by a constant need for affirmation from external sources'.[1282] Steeves's research on young women's use of social media represents a more contemporary take on Orbach's contention, for Steeves tells us that the 'peer surveillance' inherent in social media teaches women 'to look for external male validation, and the easiest way to attain that validation [is] to conform to gendered stereotypes'.[1283] Though she did not speak explicitly of male validation, the need for external validation was something which came to the

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[1278] Orbach, *Fat Is a Feminist Issue*, p. 88.
[1279] Downing, *Selfish Women*, p. 1.
[1280] Orbach, *Hunger Strike,* p. 24.
[1281] Ibid.
[1282] Ibid., p. 63.
[1283] Steeves, '"Pretty and Just a Little Bit Sexy"', p. 165.

fore when I was talking to Ria, who told me that this was something she saw in her sister who is ‘teaching, and she recently got a promotion and she’s now like head of year. She’s doing really, really well. But I know with her, she still needs to hear it from other people’. Ria’s sister, who, to my knowledge, does *not* experience social anxiety, having an apparent need for external validation would suggest that the need for approval is common to a lot of women. Ria seemed aware of this in saying, ‘that comes back to kind of like a whole, “Do women need that external validation more and, if so, why?”’ We return to the idea that social anxiety, to an extent, is something which seems to befall most women due to the way that they are socialised, thus calling into question whether it is best described as a mental disorder.

Returning to the ‘external sources’ which provide women with validation, Ria suggested that these sources need not always be other *people*. We talked about how, during our school and university years, we had found validation in other ways:

> Ria: In our class, for example, we’d take a test, and the guys would come out, ‘It was easy, that was easy.’ And then the results would come out and I’d done better than any of them.
>
> K: And I came out of the test going, ‘Bloody terrible, I’ve failed that.’ Yeah, yeah!
>
> Ria: [...] because now we don’t go by exams, do we? That’s gone now, so we don’t have the reassurance of, ‘Oh, it’s ok, I’m good,’ in a sense–
>
> K: There’s not a number backing you up.
>
> Ria: Yeah, yeah, you’ve just got things that you’ve got to put yourself forward for. And, you know, you’re not getting the praise that you probably would have done in a school system [...] after a while, it’s going to be a bit like, ‘Ok, maybe they [boys/men] are as good as they say they are and I’m not as good.’

K: [...] you've not got an objective measure, like to position yourself relative to them anymore, have you?

Ria: [...] what is it–maybe not women, maybe not all women [...] what is it that stops people, maybe like us, from sort of accepting that the record states that we're ok, in general? [...] because like once the 'safety mechanism' of external feedback's gone [...]

Ria's discussion of hard numbers as a means by which one can obtain validation calls to mind the function inherent in many social media platforms: the 'like' function. This, Steeves tells us, 'means that each image they [young women] post is judged by their peers'.[1284] What this has in common with Ria's narrative is that it represents a quantification of external approval: just as Ria's test scores used to provide indisputable evidence that she was doing well academically, the number of 'likes' on a woman's photograph tells her that she is doing femininity well, or not, as the case may be.

Ria's words also call to mind the thoughts of Milner, who notes that 'this might explain why I was so desperately dependent upon what people thought of me [...] the fact that something had been said made it true'.[1285] We find resonance here with Orbach's contention that women's socialisation is conducive to them having a shaky sense of self and, in order to remedy this, they need reassurance from others, for their very identities depend on this validation. On the other hand, negative remarks can have devastating effects.

Conflicts and the False Self

In the interests of developing my discussion regarding a very gendered aspect of Laing's false self, I now want to explore the idea of conflicts. Showalter has noted that a number of Laing's case studies feature

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[1284] Ibid.
[1285] Milner, *A Life of One's Own*, p. 89.

women who are struggling with resolving conflicting ideas about femininity. Yet, she notes, 'these potential theories of gender are not developed in themselves.'[1286] It is this absence that the following section begins to remedy. In the spirit of Showalter's observation, my participants reported feeling inner conflicts relating to femininity. This is something which Orbach tells us arises from women being 'pushed and pulled in opposing directions'.[1287] In a similar vein, Ellen told me that she felt conflicted about being a *gourmand* on the one hand and society's insistence that she should self-deny in order to work towards attaining the body ideal on the other:

> My Instagram feed is literally, 'How to get like the perfect arse at the gym,' and then the next one down will be like, 'How to make the cheesiest pizza.' I'm like, 'I'm just going to constantly be battling this.'

Recall that, earlier in the chapter, Ellen told me that she outwardly expressed sentiment that was pro-body positivity and was critical of diet culture in the case of others. Yet, internally, she struggled to apply these concepts to herself. The thoughts that Ellen thus reveals to the world are quite different from those she holds within. I propose that she keeps certain thoughts hidden for fear that their disclosure might garner unfavourable evaluation from others. Olivia spoke of an analogous conflict regarding femininity. In the previous chapter, she spoke about the existence of a 'girls can do anything' narrative which then jars with the way that girls are socialised. She explained: 'I struggle being assertive and speaking my mind because it seems contradictory when at the same time I'm always trying to be pleasing and nice and untroublesome and thoughtful of how others might feel.'

[1286] Showalter, *The Female Malady*, p. 231.
[1287] Orbach, *Hunger Strike*, p. 9.

Given this, being 'pleasing and nice' could be described as Olivia's false self, which she feels society expects her to exhibit, and which she shows to the world to stave off negative evaluation. By contrast, being assertive and speaking her mind is how she 'really' wants to behave. Similarly, Ellen's false self is body positive, whereas her real self has internalised some of the fatphobia with which our society is replete. Olivia's, and to some extent, Ellen's, words epitomise a phenomenon described in the work of Jack and Dill, who, in discussing self-silencing, employ the concept of a 'divided self', that is, 'behaving in a compliant manner to live up to female role imperatives whilst feeling angry inside'.[1288] This is reminiscent of Laing's 'divided self', wherein '[t]he basic split in his being is along the line of cleavage between his outward compliance and his inner withholding of compliance'.[1289]

The concept of a divison of the self also echoes the work of psychoanalyst Joan Riviere. In *Womanliness as a Masquerade*, Riviere begins by observing that the homosexual man might overplay his heterosexuality as a compensatory mechanism.[1290] Likewise, Riviere tells us that women who 'wish for masculinity' employ femininity as a sort of façade with the aim of averting anxiety, concealing traits which are not acceptably feminine, and escaping negative consequences from men.[1291] Olivia's experiences of struggling to be assertive, in light of the imperative for her to be passive owing to her gender, resonates with Riviere's work. In addition, her narrative parallels McRobbie's thoughts on postfeminist femininity: 'Both the post-feminist masquerade and the perfect display highly normative and ultimately pleasing femininity where any aggression is entirely inner-directed.'[1292] McRobbie calls

[1288] Jack and Dill, 'The Silencing the Self Scale', p. 98, cited in Ussher and Perz, 'PMS as a Gendered Illness', p. 135.
[1289] Laing, *The Divided Self*, p. 99.
[1290] Ferenczi, 'The Nosology of Male Homosexuality', *Contributions to Psychoanalysis,* (1916), cited in Joan Riviere, 'Womanliness as a Masquerade', *International Journal of Psychoanalysis,* 10 (1929), 303–13, p. 303.
[1291] Riviere, 'Womanliness as a Masquerade', p. 303, 306.
[1292] McRobbie, 'Notes on the Perfect', p. 17.

this the ‘split-self desire for “perfection”’.[1293] These notions can also be found in Arlie Russell Hochschild’s opus *The Managed Heart*. That is, oftentimes, we are confronted by a discontinuity between what we feel and what we feel we ‘should’ feel. We negotiate this disconnect by appealing to ‘feeling rules’ in terms of what we owe to those around us[1294] and, I would add, such that we do not invite negative evaluation from others. What I add to Hochschild’s thesis is that women are particularly vulnerable to experiencing a disconnect between what we feel and what we ‘should’ feel in light of ‘the enduring power of the expectation that women should *be for others*’.[1295]

On an outward self that is pleasing to others, the remarks of one of Laing’s case studies, Joan, are particularly germane. Joan says that ‘[w]ith everyone else I was trying to change myself to please them’.[1296] Scott notes this sentiment in one of her shy case studies, Georgia, who, in her efforts of ‘“tailoring” herself to fit in with other people […] [she] found it increasingly difficult to retain a coherent sense of identity and ontological security, feeling as if the different faces of her social self were fragmenting’.[1297] In discussing Georgia, Scott cites another of Laing’s case studies, Julie, who ‘felt that she was “tailor-made” to meet the demands of others’.[1298]

Remaining with Laing’s case studies, *The Divided Self* deals primarily with the ‘schizoid’ person’s deployment of a false self persona: a strategy that this type of individual adopts because of not fitting in. While I do not subscribe to the *DSM-5*’s conception of ‘Schizoid Personality Disorder’ as a ‘mental

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[1293] Ibid., p. 15.
[1294] Arlie Russell Hochschild, The *Managed Heart: Commercialization of Human Feeling*, 3rd edn (University of California Press, 2012) <https://ebookcentral.proquest.com/lib/bham/reader.action?docID=870020&query=Hochschild%2C+the+Managed+Heart> [accessed 31 July 2020].
[1295] Downing, *Selfish Women*, p. 102.
[1296] Laing, *The Divided Self,* p. 166.
[1297] Scott, ‘The Shell, the Stranger and the Competent Other’, p. 125.
[1298] Laing, *The Divided Self*, p. 192, cited in Scott, ‘The Shell, the Stranger and the Competent Other’, p. 125.

illness', it is pertinent to note that its diagnostic criteria describe a person who is patently non-normative. This diagnosis is characterised by a preference for being alone; a lack of desire for close relationships; anhedonia, indifference, and emotional detachment.[1299] While none of my participants explicitly identified as 'schizoid', or with the aforementioned *DSM-5* diagnosis, a number of them divulged that, for one reason or another, and as I explored in the previous chapter in discussing 'co-morbidities' and personality types, they did not fit into mainstream society: adopting a false self allowed them to belong. It is pertinent to note here that I am not the first to have made links between social anxiety and the 'schizoid' position. I echo Lane's point made in his opus on the medicalisation of shyness, in which he discusses the arbitrary nature of the *DSM*'s divisions between diagnoses. He asks: 'Where, for instance, did schizoid personality disorder end and social phobia begin?'[1300]

On the idea of fitting in, Phoebe, who told me that she believed she was autistic, spoke of copying or mimicking others in order to fit in better and, by extension, to please others. When she was younger, she told me, 'I would copy my sister when she would socialise, because I didn't know how to socialise.' As Orbach notes, 'a girl grows up learning to turn much of her attention outside herself [...] to achieve approval of others by mirroring their projections.'[1301] In mimicking her sister's normative behaviour, Phoebe is arguably mirroring the projections of others. In so doing, she has taken steps towards 'the creation of a new person'[1302] which is visible to the world, which fits in with society's expectations, and which therefore allays others' negative appraisals and thus tamps down her own worries about social interaction. On the idea of cultivating a false self, I would now like to briefly make a link between this notion and social media.

[1299] APA, *DSM-5*, p. 653.
[1300] Lane, *Shyness*, p. 92.
[1301] Orbach, *Hunger Strike,* p. 59.
[1302] Ibid., p. 131.

Despite some scholars' contention that the Internet allows people to express their 'true selves' more easily,[1303] academics Brooke Erin Duffy and Ngai Keung Chan note that '[s]ocial media users are routinely counseled [sic] to cultivate their online personae with acumen and diligence' as well as engage in 'impression management'.[1304] Ria was well aware of how social media presented the opportunity to create an online persona:

> [T]he advent of things like Instagram [...] you're presenting a truth [...] you're presenting particular aspects, aren't you? Or, you're only seeing particular aspects [...] you're essentially making like an avatar, a projection, and it's like your idealised self [...]

Creating a virtual self has much in common with creating a false self that others will find pleasing. Orbach has commented on the creation of virtual selves, noting that since the virtual world dispenses with embodiment, it dematerialises people's existence[1305] and hence facilitates the creation of 'identities, personalities and bodies that have existed until now only in one's mind's eye'.[1306] In the context of this research, the virtual self could be construed as the digital counterpart to the false self, as Ria describes above.

On the false self, while I have hitherto explored my participants' experiences of this notion particularly with regard to the thoughts of Orbach and Winnicott, I would now like to visit Laing's false self in more detail.

[1303] John A. Bargh, Katelyn Y. A. McKenna, and Grainne M. Fitzsimons, 'Can You See the Real Me? Activation and Expression of the "True Self" on the Internet', *Journal of Social Issues*, 58.1 (2002), 33–48 <doi: 10.1111/1540-4560.00247> [accessed 5 January 2021].
[1304] Brooke Erin Duffy and Ngai Keung Chan, '"You Never really Know who's Looking": Imagined Surveillance across Social Media Platforms', *New Media and Society,* 21.1 (2019), 119–38 <doi: 10.1177/1461444818791318> [accessed 5 January 2021].
[1305] Orbach, *Bodies*, p. 97.
[1306] Ibid.

Laing's False Self

The area of an individual's life which is arguably most pertinent to theorising social anxiety is their relationships and interactions with others. In order to participate in life without experiencing anxiety, Laing contends that 'being like everyone else, being someone other than oneself, playing a part, being incognito, anonymous, being nobody (psychotically, pretending to have no body) are defences that are carried through with great thoroughness in certain schizoid and schizophrenic conditions'.[1307] He continues to describe a person of this type, who

> [I]s, therefore, driven compulsively to seek company, but never allows himself to 'be himself' in the presence of anyone else. He avoids social anxiety by never really *being with* others. He never quite says what he means or means what he says. The part he plays is always not quite himself. He takes care to laugh when he thinks a joke is *not* funny, and look bored when he is amused. He makes friends with people he does not really like and is rather cool to those with whom he would 'really' like to be friends. No one, therefore, really knows him, or understands him. He can be *himself* in safety only in isolation, albeit with a sense of emptiness and unreality. With others, he plays an elaborate game of pretence and equivocation. His social self is felt to be false and futile.[1308]

In the case of women with social anxiety, the false self functions as a sort of disguise and shield: if it is negatively evaluated, it does not matter, since it is not the 'real' self. Laing's case studies feature the recurring notions of a real, true, or inner self which stands in contradistinction to a 'personality' or false self. The true self typically remains hidden from others, whereas the false self is usually the part of the self that interacts with the world, and others.

[1307] Laing, *The Divided Self*, p. 11.
[1308] Ibid., p. 114.

With that said, a number of Laing's case studies found that their real self need not remain hidden if they were with people they did not know.[1309] Laing tells us that this is because being among strangers, where the self is not known, renders the real self 'safe from penetrating remarks'.[1310] By extension, if the individual were to travel to a place where they were not known, they would not experience any kind of self-consciousness or social anxiety.[1311] This phenomenon was apparent when I spoke to Phoebe, who had no problem being among strangers:

> [M]eeting new people doesn't bother me [...] if I walk into a room of new people: doesn't bother me at all [...] I can go to like new hobbies and that doesn't bother me [...] I went to this like choir thing last night, and there was like no people I knew there: didn't bother me, at all.

Recall that, by contrast, Phoebe, Ellen, and Amy all told me that they feared being negatively evaluated by their *friends* rather than by people with whom they were unfamiliar. In a similar vein, Olivia had this to say:

> I think I'm the most socially anxious around people I know a little. They have some unknown preconceived idea of me which makes me anxious and then I'm anxious about how I'm adding to that and if it's negative.

One reason for these women's anxiety around friends and, in Olivia's case, acquaintances, is that in these scenarios the real self is known and, as such, negative evaluation is a slight upon their *actual* selves, as opposed to their outward personae. With that said, it is worth entertaining the idea that a 'real

[1309] Ibid., p. 73.
[1310] Ibid., p. 139.
[1311] Ibid., p. 128, 139.

self' is not actually possible and indeed, that several 'selves' co-exist within each of us. I will revisit this idea later on in the chapter when I discuss 'plurality'.

Returning to social anxiety in different situations, Laing notes that some people who are self-conscious in their everyday lives lose this trait when in a performance situation, such as acting: '[T]he very situation, on first reflection, one might suppose would be most difficult for them to negotiate.'[1312] This situation, as I have noted elsewhere,[1313] represents the adoption of a false self, but writ large. Phoebe's narrative strikes a chord with this idea in that she told me that she is 'okay with public speaking'. Indeed, some of Scott's shy case studies divulged that they enjoyed acting in the theatre, since 'performing was easier when it was explicitly acknowledged that all the participants were playing parts inconsistent with their backstage selves'.[1314]

While some of my participants experienced greater unease among friends than among strangers or acquaintances, this was not completely the case for Daniella, for she told me that she deployed her false self when in the company of everyone except her boyfriend, because 'with everyone else I need to put up a face'. She found this exhausting and told me how it took a huge toll on her:

> [W]hen I'm talking to people, like when I'm [...] having coffee with someone [...] I get a massive headache [...] another sign of social anxiety is [...] that you feel drained. It doesn't have to be that you're not enjoying it [...] Because it's an effort.

Daniella's thoughts on putting up a front are reminiscent of autistic woman Rose Hughes's testimony in a National Autistic Society article on autism in women, wherein she states that 'I am the master of

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[1312] Ibid., p. 107.
[1313] Masters, 'An Analysis of Women and Social Anxiety Disorder'.
[1314] Scott, 'The Red, Shaking Fool', p. 100.

disguise. I have always worn a mask'.[1315] In a similar vein, 'pretending to be normal' has been found to be a common experience of women diagnosed with autism.[1316] That is not to suggest that Daniella does in fact have undiagnosed autism. Rather, it speaks to the idea that having a prior physical or mental health issue, or indeed personality type, which then renders a woman non-normative, is conducive to experiencing social anxiety. In order to allay this anxiety, our non-normative woman adopts a mask, a false self, a disguise, in order to function in the world and fit in.

While Daniella spoke about 'putting up a face,' Farah spoke more explicitly about adopting a mask, which was a scheme that she had devised as a way of concealing her shy inner self. She told me that she was unable to talk at length in gatherings amongst her peers: 'I wasn't able to talk and just to speak, because I hate my shaking voice […] Being [a] sort of shy person, it was a bit hard.' As such, she told me that she adopted 'a kind of strategy' where she would deliver a '[g]ood sentence, and then I couldn't say anything else, because I was shy': 'I [would] just ask a question and then get silent and make […] chaos among people. Because you [can] always ask a kind of problematic question [laughs] and then listen to people.' Farah's 'strategy' functioned to divert people's attention away from herself as well as conceal her shyness. Indeed, on the latter point, she tells me that 'I could cover my shyness by […] This mask of... Wisdom'. Contrary to her quietness causing people to 'think that I'm stupid, or I don't have anything to say' or that her reserve is 'something that's imposed on me because of... My lack of ability', Farah's strategy functioned to convey the image that her quietness was 'just my style': '[I]t was like a mask […] To pretend that it's a personality that I've chosen […] masking, and you would be silent, and pretend that you are a good listener and just [a] kind of wise person.' In her work on shyness, Scott noted a similar

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[1315] National Autistic Society, *How do Women and Girls Experience Autism?* (2018) <https://www.autism.org.uk/about/what-is/gender/stories.aspx> [accessed 31 July 2020].
[1316] Bargiela et al., 'The Experiences of Late-diagnosed Women with Autism'.

strategy in one of her respondents who would ask 'an open-ended question that encouraged others to talk', a 'question that I know is going to take a long time to answer and is going to cause a big old debate around the table, where everyone gets involved. . . . So then I can sit back'.[1317] In doing so, this respondent 'could move the spotlight onto them [other people] and avoid the dangers of saying the wrong thing under scrutiny'.[1318]

Returning to Farah's narrative, she is describing a kind of cultivation of a wise façade which hides how she feels on the inside, that is, ill at ease and thus unable to speak at length. This again evokes Scott, who speaks of a 'discrepancy between what they [the shy] perceive as their "real," backstage selves, who are hopelessly incompetent, and the impression of being poised and in control that they would like [to] portray'.[1319] Initially, Farah told me that she 'wasn't comfortable at all' in adopting this strategy. However, 'after a while you get used to it and I was happy about it'. This contentment with her false self quite possibly results from it allowing her to participate in life in ways she would otherwise feel unable. Similarly, Laing cites one of his case studies as being uncomfortable until he could turn himself 'into some role or part which was not him, and which he felt was a suitable disguise. This enabled him to "uncouple" his "self" from his actions, and function smoothly, without anxiety'.[1320] Farah's strategy achieves something akin to this. As she told me, 'each time that you are forced to be silent, it means that you are not yourself. I mean, it's like pretending that you are someone else […] to avoid conflict or whatever.' In adopting her 'mask of wisdom', and remaining silent, like Laing's case study, who had

[1317] Scott, 'The Red, Shaking Fool', p. 104.
[1318] Ibid.
[1319] Ibid., p. 101.
[1320] Laing, *The Divided Self,* p. 127.

‘always felt shy, self-conscious and vulnerable’,[1321] she finds ‘reassurance in the consideration that whatever [s]he was doing [s]he was not being [her]self’.[1322]

Considering Laing’s latter remark, recall that Daniella told me that she only felt as though she was herself when she was with her boyfriend, ‘[w]hereas it’s really hard for me to be myself with anyone else.’ Daniella’s case suggests that the false self only gets deployed when the socially anxious woman is with people whose negative evaluation she fears. In contrast to Ellen, Phoebe, Olivia, and Amy, who experienced social anxiety among friends, owing to fearing their friends’ negative evaluation, Daniella does not seem to fear the negative evaluation of the people to whom she is particularly close. Hence, in these situations, the façade is dropped.

Following on from this, then, is my next point. Laing notes that an individual may be split into ‘two *or more* selves’.[1323] Among her shy respondents, Scott notes ‘an acute awareness of the discrepancy between their private and public selves’,[1324] sometimes to the extent that ‘no one ever saw their “true,” backstage selves because they adapted their behavior to the demands of each situation’.[1325] I am also reminded here of Scott’s interviewee Georgia. In her efforts of ‘“tailoring” herself to fit in with other people, Georgia found it increasingly difficult to retain a coherent sense of identity and ontological security, feeling as if the different faces of her social self were fragmenting’.[1326] This was something which came to mind during my exchange with Farah, who noted that the selves she exhibited with different people were all slightly variable but, unlike Scott’s respondents, had common elements. By dint of this variation, she preferred to interact with her friends individually and to keep them separate:

[1321] Ibid., p. 71.
[1322] Ibid.
[1323] Ibid., p. 17. My emphasis.
[1324] Scott, ‘The Red, Shaking Fool’, p. 98.
[1325] Ibid.
[1326] Scott, ‘The Shell, the Stranger and the Competent Other’, p. 125.

[T]here's something — a shared thing, that's going on — but yes, I would also sometimes decide to share something with this person, and then share other things with [an]other person, rather than share everything with one person […] I would always try to have my friends separately […]

Farah's thoughts on many selves is reminiscent of philosopher William James's statement that one has 'as many different social selves as there are distinct groups of persons about whose opinion he cares'.[1327] While Farah notes that her various selves have in common 'a shared thing', if we are to draw on James and the poststructuralist tenet of the 'death of the subject', we might consider that 'people are socially constituted as social selves, and these social selves are historically variable rather than being a natural or fixed essence of self'.[1328] Drawing on Morthaur's refutation of the idea that one's self is 'a fully-constituted "subject" that stands outside context',[1329] it is through interacting with others and our environment that our self (or selves) are made. That is, the many selves of the socially anxious woman 'are produced through the discourses and practices of femininity [...] of our time'[1330] and, I would add, these many selves are constituted through our relationships with different others, as Farah tells us.

Having explored my participants' experiences of false selfhood, I now wish to turn to a phenomenon which follows on from the division of the self: that is, an inner dialogue or inner critic.

[1327] Théodore Flournoy, *The Philosophy of William James*, authorised trans. By William James Jr. (London: Constable, 1917), cited in Erving Goffman, *The Presentation of Self in Everyday Life* (Harmondsworth: Penguin, 1959), p. 57, cited in Scott, 'The Shell, the Stranger and the Competent Other', p. 125.
[1328] Holland et al., *The Male in the Head*, p. 28.
[1329] Morthaur, *One Year on the Web: Some Thoughts on Fractalus* (2015) <http://fractalus.org/essays/one_year_p0.php.> cited in Kristin Bumiller, 'Quirky Citizens: Autism, Gender, and Reimagining Disability', *Signs: Journal of Women in Culture and Society*, 33.4 (2008), 967–91 <doi: 10.1086/528848> [accessed 5 January 2021], p. 984.
[1330] Holland et al., *The Male in the Head*, p. 28.

The Inner Worlds of Women with SAD

I discussed the notion of an inner critic in relation to the work of Ussher and Perz in Chapter 2, wherein they identified this phenomenon in women with PMS.[1331] The self-critique of these women was understood using self-surveillance.[1332] In connection with this, I noted the imperative for women to carry out most of the emotional labour in relationships and the importance of 'not upsetting people'.[1333] Both of these threads were evident in Phoebe's testimony:

> I'd worry so much about like if I'd upset anyone [...] I get so obsessed about things I've said and things I've done, all like, 'Oh God, why did I say that? [...] I bet they hate me now.'

By its very nature, self-critique necessitates a degree of distance from the self that interacts with others. One might then say that we can understand socially anxious women's self-critique if we think about their possessing a true and false self. Recall that Laing tells us that the true self is 'extremely aware of itself, and observes the false self, usually highly critically'.[1334] This conceptualisation was evident in Farah's self-critique concerning how she appeared to others:

> I remember that there was lots of moments that when I was forced to speak and I couldn't and […] I wasn't satisfied about my presentation, for example, even among my friends. After that I had lots of — in an obsessive way — I would think about the whole scene, a thousand times […] to remember it, and analyse it, and […] just check [to] people's gesture[s] to guess what they think about me […]

[1331] Ussher and Perz, 'PMS as a Gendered Illness', p. 136.
[1332] Ibid., p. 138.
[1333] Grimshaw, *Philosophy and Feminist Thinking*, p. 196, cited in Ussher and Perz, 'PMS as a Gendered Illness', p. 136.
[1334] Laing, *The Divided Self*, p. 74.

In a related vein, she also told me that she had

> Imaginary dialogue with people in my mind a lot […] and sometimes in an obsessive way I would try to analyse what I've said, for example, what I could say… Or continue the conversation that I'm not satisfied about [...] when it happened in the past […]

While Berger tells us that a woman is split into the surveyor and the surveyed, with the former watching the latter, his exposition is focused on the body. Using Laingian selves, we can understand how the socially anxious woman's true self both surveys and critiques every aspect of the false self, as Farah told me, in accordance with the demands of society, in an attempt to fit in, and to ward off negative evaluation by others.

Having earlier alluded to the Dissociative Disorders,[1335] I now wish to revisit this diagnostic group. While I have previously problematised Depersonalization/Derealization Disorder[1336] in theorising about women's detachment from their bodies as understandable, given how our culture treats their bodies, the diagnosis Dissociative Identity Disorder[1337] is most relevant in exploring women's inner critics. Specifically, this diagnosis features 'recurrent, inexplicable intrusions into their conscious functioning and sense of self',[1338] such as 'perceptions of voices'.[1339] These voices are described as sometimes 'experienced as multiple, perplexing, independent thought streams over which the individual experiences no control'.[1340] They may be 'persecutory and derogatory'[1341] and 'personified, internally

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[1335] APA, *DSM-5*, pp. 291–308.
[1336] Ibid., pp. 302–06.
[1337] Ibid., pp. 291–98.
[1338] Ibid., p. 292.
[1339] Ibid., p. 293.
[1340] Ibid.
[1341] Ibid., p. 297.

communicative inner voices'.[1342] The Dissociative Disorders comprise 'recurrent disruption of conscious functioning and sense of self'[1343] as well as the 'fragmentation'[1344] or 'division'[1345] of identity which is 'characterized by two or more distinct personality states'.[1346] Daniella, in speaking about her interactions with other people, invoked the idea of fragmentation in her sense of self:

> And you believe that you want to do it, it makes you happy, like, 'Ooh, that's a great idea.' Or sometimes, I would ask them, so I would be like, 'Let's go for coffee,' and then I would pull out [...] I always feel like I've got a split personality. Not a 'split personality' in the medical sense [...] I always have a rational side and an irrational side [...] the line is so defined, like so you can feel it.

Daniella's narrative echoes another facet of the Dissociative Disorders, namely that they incorporate 'loss of personal agency'[1347] and 'feeling like one's body or actions are not one's own'.[1348] Indeed, this altered sense of self[1349] can be 'accompanied by a feeling that these attitudes, emotions, and behaviours — even one's body — are "not mine" and/or are "not under my control"'.[1350] There are links to be made here with Ussher and Perz's exposition of how women experience pre-menstrual negative affect as 'not me', as discussed in Chapter 2.[1351] Daniella's testimony further resonated with these ideas when she spoke about struggles with binge eating:

[1342] Ibid., p. 296.
[1343] Ibid.
[1344] Ibid., p. 291.
[1345] Ibid., p. 296.
[1346] Ibid., p. 292.
[1347] Ibid., p. 293.
[1348] Ibid., p. 292.
[1349] Ibid.
[1350] Ibid., p. 293.
[1351] Ussher, 'The Role of Premenstrual Dysphoric Disorder', p. 140.

> [W]hen I want to binge. My irrational side — I can feel the difference. So my rational side is trying to fight against it and the irrational side, it just goes, 'Nah, mate.' [...] you can feel the two clashing.

In addition to the work of Ussher and Perz, this aspect of Daniella's story relates to other feminist work on women with PMS. Recall from Chapter 2 that Chrisler found that the narrative '"me/not me," "PMS-self/real-self"' was present in PMS self-help books.[1352] In addition, several studies have found the tendency among heterosexual women to position 'PMS as something separate from themselves, as "not me", or as the "PMS self"'.[1353] Amy conceptualised her mental health issues in this way, calling compartmentalisation 'an important element of coping [...] a coping mechanism'. For Amy, compartmentalisation facilitated 'understanding which responses and behaviours and thoughts are coming from the anxiety place, are coming from the depression place'. In turn, she told me that she found herself referring to 'depression brain' and 'anxiety brain' in contradistinction to her 'logic brain', telling me 'that's another way of thinking about it [...] internally it's as separate brains'. This conceptualisaton of her mental health issues as 'a separate part of me' allowed her to cope and work through difficulties:

> It gives me an opportunity to say, 'Right, that's the illness talking, so let's put it over here and acknowledge it but also recognise that [...] it's not coming from my logic brain' [...] And then I can use my logic brain to work through it.

[1352] Chrisler, 'How To Regain your Control and Balance', cited in Chrisler and Caplan, 'The Strange Case of Dr. Jekyll and Ms. Hyde', p. 276, 288.
[1353] Cosgrove, 'Crying out Loud'.
Janet Lee and Jennifer Sasser-Coen, *Blood Stories: Menarche and the Politics of the Female Body in Contemporary US Society* (New York: Routledge, 1996).
Ussher, 'Premenstrual Syndrome and Self-Policing'.
Ussher et al., 'Good, Bad or Dangerous To Know'.
All cited in Ussher and Perz, 'PMS as a Gendered Illness', p. 136.

As is evident in the preceding quotation, and relevant for my discussion of DID, Amy told me that her mental health issues have voices. For instance, '[m]y depression said I couldn't get out of bed today [...] Depression says: don't do anything. And anxiety says: you need to do everything!'

In a similar manner to Daniella when describing her binge eating, Amy evoked another characteristic of DID, namely the lack of control over an aspect of one's identity, when she spoke about how she experienced her mental health issues. That is, she described them as having their own agency. Her social anxiety, she told me, 'shows up wherever it wants to'. Moreover, she described her depression and anxiety as being

> [L]ike a monster, just like hanging out with you, like a demon on your shoulder, kind of thing, where sometimes it just decides, 'This is what today is going to be,' and sometimes you just have to listen to it [...]

While Amy's narrative is reminiscent of the diagnostic criteria for DID, her testimony has much in common with women's positioning of pre-menstrual symptoms as separate from themselves. For these women, this way of positioning their symptoms served the purpose of avoiding 'an assault on the self'.[1354] Perhaps this is also the case for Daniella, who, in light of norms surrounding sociability, feels compelled to agree to attend social events. Attributing her reneging on the plans she has made to her 'irrational side' also allows her to avoid viewing her personality as wrong, in light of cultural norms. Amy explained how '[c]ompartmentalising into "anxiety brain" or "depression brain"' serves an analogous purpose. Much like her subscription to the chemical imbalance model, this strategy allowed her to avoid self-blame, since it makes her mental health issues 'separate from my conscious brain. And that is a tool

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[1354] Ussher, 'The Role of Premenstrual Dysphoric Disorder', cited in Ussher and Perz, 'PMS as a Gendered Illness', p. 140.

for removing the burden of responsibility from my own logical thoughts. And it allows me a distance to not shame myself'. Far from Amy's separation from certain parts of herself being pathological, as the *DSM-5*'s conception of the Dissociative Disorders would suggest, she seems to experience this dissociation as positive. That is, it is something which helps her to cope and ensure that ultimately she does not blame herself for her feelings being out of kilter with those which society deems normative.

Having reviewed my participants' narratives pertaining to their inner critics, splits in their sense of selves and, earlier, feelings of detachment from their bodies, it becomes clear that there is patent overlap between that which they report and the diagnostic criteria for the Dissociative Disorders. I have previously stated that, given women's socialisation and our culture's attitude towards women, especially towards their bodies, it is questionable whether dissociation and depersonalisation are not understandable responses. This supposition becomes even more viable if we consider that most women learn to view their bodies, and their selves, from the position of an outsider. In light of this, we must question whether these 'disorders' are really pathological. On this point, author and academic Meg-John Barker notes that DID, which used to be called 'Multiple Personality Disorder' in psychiatry, can often be experienced negatively, since

> [I]t's stigmatised to the extent that it's listed in the books of 'psychiatric disorders' [...] and represented in hugely stigmatising ways in popular culture: movies and TV shows almost exclusively depict it as a form of madness and as dangerous. Pretty much any plural person shown in the mainstream media has a self who is a serial killer. Think about movies like *Identity* and *Split*.[1355]

[1355] Meg-John Barker, *Plural Selves FAQ* (2019) <https://www.rewriting-the-rules.com/self/plural-selves-faq/> [accessed 31 July 2020].

Recall that Daniella sought to distance herself from this representation of DID in telling me that 'I always feel like I've got a split personality. Not a "split personality" in the medical sense'. Barker thus advocates for a more positive reframing of this diagnosis and renames it 'plural selves' or 'plurality', noting that those who identify thus 'generally find [it] a pretty positive experience'.[1356] Barker even identifies one of their selves as their 'inner critic', which they call 'Beastie'.

While Barker's thoughts on plurality are innovative, they do not make reference to social anxeity and nor do the *DSM-5*'s diagnostic criteria for DID, whereas I have outlined clear parallels between these diagnostic categories and SAD. That is not to say that all of my participants in fact have a Dissociative Disorder. Rather, the overlap between SAD and a purportedly unrelated diagnostic category again points to the arbitrary nature of these diagnostic categories themselves, bespeaking the central flaw in the *DSM-5*'s contention that these diagnostic categories represent *diagnoses*, as opposed to *descriptions*. Moreover, in bringing my participants' narratives to the fore, this work suggests that the inner worlds of women with social anxiety; how they experience social anxiety; how they make sense of it; and how they conceptualise it, are not well understood and have hitherto not been platformed. Indeed, psy science discourses make no attempt to render these gendered experiences explicable. It is in this work that I have begun to remedy this absence.

[1356] Ibid.

CONCLUSION

Throughout this research project, I was struck by, and even sometimes surprised at, the extent to which my participants' narratives resonated with my own experiences. Perhaps, until completing this research, I had little understanding of how other women experience social anxiety.

The linkage between my participants' stories and my own perspective has undoubtedly been brought to the fore by my own positionality, which has shaped the research project as a whole. For instance, my own perspective has influenced the questions I asked during interviews, the points on which I chose to follow up, how I interpreted my participants' narratives, and even my choice of research questions. With that said, while my participants' testimonies mirrored my own in some ways, their viewpoints diverged from mine in others, such as in their subscription to the chemical imbalance model, as I explored in Chapter 4. Yet, regardless of whether their testimonies concurred with my own views, for each point that they made I have endeavoured to remain true to their accounts and render their narratives central to this research. I also note that, irrespective of my involvement in shaping the research project, the continuity which ran through all of my interviewees' stories cannot be ignored: at times, they all seemed to relay similar experiences but in different ways.

Overview of Thesis

In this thesis, I have conceptualised SAD in women as a culture-bound syndrome, whose (pharmacological) treatment rests on cultural values, particularly norms of femininity. My research is situated alongside other work which problematises gendered psychiatric diagnoses using critical methods.[1357] Participants' narratives spoke to the idea that their social anxiety was an understandable

[1357] E.g. Ussher, 'Premenstrual Syndrome', p. 235.

response to their respective situations and that it was on a spectrum with what was regarded as 'normal' in our society. Their difference, in some cases arising from their personality styles comprising more traditional norms of femininity, is medicalised. While a SAD diagnosis was, in some cases, felt to pathologise, in other cases it formed a 'reverse discourse',[1358] that is, a means by which this pathologisation was turned on its head, as well as a useful tool which facilitated these women's self-understanding.

This thesis has seen the development of three central arguments, which I will reiterate here. Firstly, non-normativity is central to the socially anxious woman's experience. This non-normativity can take many forms, and ranges from what psychiatry calls 'co-morbid' mental health issues as well as 'Neurodevelopmental Disorders', physical health issues, temperament, through to body type. In contrast to what psychiatric discourses tell us, we can understand why these non-normativities are conducive to experiencing social anxiety as a woman by exploring how society treats non-normative women.

My second argument, which follows on from the first, is that SAD is not a disease entity in the way that the *DSM-5* presents. For women, the socially anxious experience invokes elements from the *DSM-5*'s descriptions of many of its other diagnostic categories, including Eating Disorders, Selective Mutism, Generalised Anxiety Disorder, Avoidant Personality Disorder, the Dissociative Disorders, and Major Depressive Disorder. The lack of clear cut demarcation between these diagnostic catergories is significant since it supports my contention that these diagnoses are not discrete illnesses which are caused by underlying (biological) pathology, as psychiatry would assert. By contrast, their messy

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Mollard, 'Exploring Paradigms in Postpartum Depression Research'.
Browne, 'Is Premenstrual Dysphoric Disorder Really a Disorder?'.
Mauthner, 'Towards a Feminist Understanding'.
Taylor, 'Female Sexual Dysfunction', pp. 261–62.
[1358] Foucault, *The Will to Knowledge*, p. 101.

entanglement, as demonstrated by my participants' testimonies, problematises the notion of a discrete diagnostic category of 'Social Anxiety Disorder'. By extension, it problematises the *DSM-5*, and psychiatry, as arbiters of (women's) madness.

Thirdly, this thesis sheds light on the ways that gender inequalities and ideologies contribute to social factors which have a more significant role to play in women's experiences of social anxiety than psychiatric discourses tell us. Specifically, female socialisation fosters feelings of inadequacy in tandem with creating separateness from the self. This necessitates the cultivation of a pleasing, gender-role-conforming outward self in order to stave off negative evaluation. Bringing to light the impact of social factors aids in refuting the individual pathology model as applied to women with SAD.

Impact and Significance

In providing a platform for the voices of women with SAD, and placing their narratives into dialogue with diagnostic criteria, the discord I have ascertained between the former and the latter calls the diagnosis and treatment of women with SAD into question. In addition, the power to define this 'disorder' is shifted from the medical professional to women with SAD themselves. By focussing on the significance of social factors in the development of women's SAD, this research departs from existing work on women's overrepresentation among those with this mental health issue. In turn, it provides a corrective to biologically reductionist and gender biased accounts which have sought to explain this gender imbalance.

As such, my research on this already 'neglected anxiety disorder'[1359] makes an important contribution to existing scholarship. It sits alongside a body of research which views gendered psychiatric diagnoses through a feminist lens. In addition, it makes a significant contribution to the sociology of mental health

[1359] Liebowitz et al., 'Social Phobia'.

insofar as my focus has been on the social, external, and structural factors contributing to SAD — and, to a lesser extent, other associated mental health issues — in women.

My work also represents a revival of anti-psychiatry. Beginning in the 1990s, the movement has found a successor in critical psychiatry,[1360] whose essential position is described by founding member of the Critical Psychiatry Network Duncan Double in stating that 'functional mental illness should not be reduced to brain disease'.[1361] The Network represents a nuanced marriage of key ideas within anti-psychiatry applied within the framework of mainstream psychiatry. That is, on the one hand, the Network distances itself from the absolutist strands of Szasz's work which deny mental illness. On the other hand, the Network, while not opposed to the use of psychotropic medication, adopts a sceptical approach, echoing my critique of the pharmaceutical industry in Chapter 1.

Crucially, the Network's focus 'is on understanding the person and why they have presented with the problems they have in the context of their life situation'.[1362] Given that my work seeks to understand women's social anxiety within the context of their social conditions, it aligns with the mission of the Network and provides insight for critical psychiatrists seeking to improve the lives of women presenting with distress arising from, or linked to, social anxiety.

It is also worth noting at this juncture that my epistemological position, namely feminist standpoint theory, is concerned with bringing about social change and empowering women. Harding tells us that these two ends can be achieved by focussing 'on women's agency and by providing new accounts of

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[1360] Hugh Middleton and Joanna Moncrieff, 'Critical Psychiatry: A Brief Overview', *BJPsych Advances*, 25.1 (2019), 47–54 <doi: 10.1192/bja.2018.38> [accessed 5 January 2021].
[1361] Duncan Double, 'Twenty Years of the Critical Psychiatry Network', *The British Journal of Psychiatry*, 214.2 (2019), 61–62 <doi: 10.1192/bjp.2018.181> [accessed 7 January 2021], p. 61.
[1362] Ibid., p. 62.

women's experience'.[1363] The centring of my participants' voices, which have too often been ignored by the psy sciences, does just that. Furthermore, my research is conducive to empowering my participants and, by extension, other women with SAD, since it has served as a space in which they could talk about their experiences and define SAD for themselves. Harding makes the argument that in listening to women, research can 'challenge the status quo and [...] provide the material to bring about change'.[1364] This project is in line with Harding's statement and, as such, brings to light considerations for mental health professionals and policymakers seeking to improve the lives of women with SAD.

Remit and Future Directions

In her writing on women's eating problems, Orbach delimits the remit of her work by noting that 'the overwhelming evidence' for these mental health issues' aetiologies 'lies in the direction of social and psychological explanations'.[1365] That is, she chooses not to entertain biomedical theories since they cannot account for 'the rise in anorexia, the incidence of episodic bulimia and the Western cultural obsession with thinness'.[1366] In a similar manner, I have chosen to distance myself from biological and evolutionary accounts of SAD, which often rely on implicit sexism, since they give no attention to the impact of postfeminist and neoliberal discourses which demand continuous self-betterment; the imperative for women to adhere to gender role expectations, no matter the cost to their mental wellbeing; and the myriad social factors which my participants have cited as contributors to their social anxiety. Instead, I have developed a holistic, embodied account of how women experience social anxiety in twenty-first century Britain.

[1363] Harding, 'Rethinking Standpoint Epistemology', cited in Ussher, 'Premenstrual Syndrome', p. 221. Ussher, 'Premenstrual Syndrome', p. 225, 243.
[1364] Harding, 'Rethinking Standpoint Epistemology', p. 225, 243.
[1365] Orbach, *Hunger Strike*, p. 162.
[1366] Ibid.

Orbach also notes that 'psychological symptoms express the ideas a culture has at any given time about itself'.[1367] I wonder then, what my participants' narratives can tell us about our culture. Perhaps, they tell us that our culture is one in which being 'normal' is prized; our society mandates a particular type of body and subjectivity; and neoliberal, postfeminist individualism reaches right into the minds of its inhabitants, for distress is construed as very much an individual problem. As Silvia Federici once said of female socialisation: 'If you don't like it, it is your problem, your failure, your guilt, and your abnormality.'[1368]

With that said, I am concerned that our culture, with its increasing move to medicalise, and medicate, emotions and different ways of being, is becoming more and more intolerant of any emotional state which could be described as less than pleasant. Williams is critical of the dominant perspective that emotions are 'failures in instrumental reasoning' and posits that a world without emotions would be 'a dull, empty affair without doubt'.[1369] Lane speaks similarly on the notion of 'mood brightening' and treating personality traits as medical issues: 'The sad consequence is a vast, perhaps unrecoverable, loss of emotional range, an impoverishment of human experience.'[1370] That is not to say that women with social anxiety that is distressing should not seek help, but that, as a society, I am worried by our move towards 'cauteriz[ing] pain […] averting any incident that would give us even a foretaste of it'.[1371] Indeed, perhaps *some* 'suffering is *sometimes* edifying'.[1372]

[1367] Ibid., p. 47.
[1368] Silvia Federici, *Wages against Housework* (London: Power of Women Collective, 1975), p. 3, cited in Smith, *Capitalism's Sexual History*, p. 101.
[1369] Williams, 'Reason, Emotion and Embodiment', p. 562.
[1370] Lane, *Shyness*, p. 8.
[1371] Ibid., p. 170.
[1372] Sally Satel and Christina Hoff Sommers, 'Therapy Nation: Really, We're OK', *Orlando Sentinel* (19 June 2005), cited in Lane, *Shyness*, p. 205. My emphasis.

Scott cites a web resource on shyness which presents ‘exploring shy feelings as a means of “finding the real you” and reaching a deeper understanding of the self’.[1373] Most pertinently for the approach I have espoused in this thesis, Scott tells us that ‘the idea that we can achieve personal growth by surviving psychological distress reminds us of Laing’s influential remarks about schizophrenia as a voyage of self-discovery, and suggests that shyness represents a more “authentic” mode of being’.[1374]

As well as perhaps revealing implicit cultural messages, my research has revealed a plethora of unexplored areas pertaining to women’s SAD and, as such, it has not been possible to explore them all fully within the scope of this thesis. I will visit these in turn here and suggest how future research might build upon each of these themes.

An unexpected finding was the resonance between my participants’ narratives and the Dissociative Disorders. I briefly drew on Barker’s work on ‘plurality’ in Chapter 5, wherein they frame multiple selves as another way of being and, on the whole, a positive experience. Barker makes brief mention of psychiatry’s classification of what used to be called ‘Multiple Personality Disorder’ and its representation in the media which, they tell us, is often very negative and involves criminality. Barker’s own experience of plurality stands in contradistinction to this, since they view their multiple selves in a positive light. This echoes some of the sentiments of my participants, such as Farah, as well as psychotherapist Leibrandt who I cited in Chapter 2. In contrast to psychiatric discourses on SAD, Leibrandt notes the advantages of having social anxiety. Likewise, recall that in Chapter 4, Farah said of her social anxiety, ‘[m]aybe it’s not a bad thing if I have this experience.’ Since my approach throughout this work has been to reframe and critique psychiatric discourse on SAD, an analogous approach would be apt for exploring the gendered

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[1373] Shy and Free, *Shyness Self-Help How-To* (2004) <http://www.shyandfree.com> [accessed 27 July 2004], cited in Scott, ‘The Medicalisation of Shyness’, p. 148.

[1374] Ronald David Laing, *The Politics of Experience and the Bird of Paradise* (Harmondsworth: Penguin, 1967), cited in Scott, ‘The Medicalisation of Shyness’, p. 148.

nature of plurality, engaging with the narratives of women with DID, and providing a corrective to psychiatric and popular discourses on multiple selves.

A further diagnosis which drew links with SAD was that of autism, particularly autistic women's accounts of wearing a 'mask'[1375] or 'pretending to be normal'.[1376] Gender bias in diagnostic criteria has meant that autism in girls and women has tended to be underdiagnosed.[1377] Future research might engage with autistic women's narratives in order to provide a corrective to the masculine bias inherent in current diagnostic criteria, in an analogous manner to how this thesis has unearthed the interplay between norms of femininity and the diagnostic criteria for SAD.

I was also struck by how significant a role social media played in the way my participants experienced social anxiety. While some of the women I interviewed spoke about their concern with their online image, and how ideals they saw online caused feelings of inadequacy in real life, I was left wondering whether social media might not also be used for good. In much the same way that this thesis has sought an alternative narrative on women and SAD, this would mean a rejection of mainstream social media. This would involve, as Ellen mentioned in Chapter 5, stopping following Instagram 'influencers' whose online personae reinforce feelings of inadequacy. Instead, socially anxious women could embrace relatively anonymised forms of online contact, such as the Reddit community 'social anxiety',[1378] in order to communicate with other socially anxious women: a sort of feminist consciousness-raising group on mental health issues in the technological age. The presence of other subcultures, such as the body positivity movement, might also provide refreshing ways of engaging with social media that have

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[1375] National Autistic Society, *How do Women and Girls Experience Autism?*
[1376] Bargiela et al., 'The Experiences of Late-diagnosed Women with Autism'.
[1377] Jolynn L. Haney, 'Autism, Females, and the DSM-5: Gender Bias in Autism Diagnosis', *Social Work in Mental Health,* 14. 4 (2016), 396–407 <doi: 10.1080/15332985.2015.1031858> [accessed 25 September 2020].
[1378] Reddit, *Social Anxiety* (n.d.) <https://www.reddit.com/r/socialanxiety/> [accessed 27 September 2020].

positive effects on body image and create less distressing relationships with others' perceptions. It remains to be seen whether these avenues could prove therapeutic for women with SAD.

Personal Reflections

Throughout this thesis, I have espoused Mary Crawford and Jeanne Marecek's tenet that the research process should be 'one of mutual collaboration in which the research participant is acknowledged as the primary interpreter of her or his experience and the research initiator is acknowledged as emotionally involved and as changed by the process of doing the research'.[1379] In rendering the voices of my participants central, acknowledging my own positionality, and adopting a reflexive approach, I have met the first two of Crawford and Maracek's criteria. What remains is the question of whether I have been changed by the research process.

Drawing on Milner, I have come to realise that, when confronted with a research question, the most satisfactory and nuanced solution or explanation is often 'a marriage between the two protagonists, not an either/or solution'.[1380] I have evidenced this merging in drawing on the work of anti-psychiatrists, philosophers, psychologists, psychotherapists, social workers, psychoanalysts, feminist scholars, medical doctors, journalists, sociologists, and psychiatrists alike in formulating my alternative narrative on women's SAD.

Finally, through listening to the stories my participants told, I came to realise that their distress, and perhaps mine too, is manifold. For one, we deal with the distress arising from how society treats us by dint of our non-normativity. By 'non-normativity', I mean a pre-existing 'co-morbidity' or

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[1379] Mary Crawford and Jeanne Marecek, 'Psychology Reconstructs the Female: 1968–1988', *Psychology of Women Quarterly*, 13.2, 147–65 <doi: 10.1111/j.1471-6402.1989.tb00993.x> [accessed 7 January 2021], p. 159, cited in Berg, 'The PTSD Diagnosis', p. 62.
[1380] Milner, *A Life of One's Own*, p. 178.

‘Neurodevelopmental Disorder’, or another characteristic that renders us non-normative such as temperament or body type, in addition to our non-normative ways of interacting with others: the latter often cause us to experience social anxiety. Our distress is then compounded by the compulsion we feel to conceal our non-normativity, our resulting distress, *and* our social anxiety. In the case of socially anxious women, the following words from Camus encapsulate our experience rather well: ‘Nobody realizes that some people expend tremendous energy merely to be normal.’[1381]

[1381] Albert Camus, *Notebooks, 1942–1951 [Carnets, Janvier 1942 – Mars 1951],* trans. Justin O’Brien (Chicago: Ivan R. Dee, 2010), p. 80.

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APPENDIX I

INTERVIEW SCHEDULE

- Can you give me a personal history, including any mental health issues?

- Do you think women are more likely to suffer from Social Anxiety Disorder (SAD)? Why/why not?

- What does 'Social Anxiety Disorder' mean to you? In what ways do you identify as having SAD?

- What do you think makes women vulnerable to SAD especially?

- What do you think 'causes' SAD? What do you feel were contributing factors for you specifically, and do you think these are true for most women who identify as having SAD? What is your opinion on the social and/or environmental causes of SAD?

APPENDIX II

INITIAL CODES

- Link between mental and physical health.
- Physical health issues in childhood.
- Constraints of female gender role.
- Inner voice/interior monologue.
- Capitalism.
- Norms and mental health.
- Family.
- Fathers.
- Medication/antidepressants.
- Belonging.
- Friendships.
- Experiences with mental health professionals/doctors.
- Dwelling.
- Weight issues.
- Others' perceptions.
- Judgement.
- Mind/body split.
- Perfectionism.
- Intelligence/being high achieving.
- Other mental health issues.

- Social media.
- Workplaces.

APPENDIX III

RECRUITMENT ADVERTISEMENT

Are you a woman with experience of social anxiety?

Do you...?
- Identify as having social anxiety disorder (either currently or in the past), and this need **not** have been diagnosed by a medical professional: I'm interested in how *you* identify.
- Identify as a woman (either currently, or in the past).

Then I would love to talk to you

Because...
- I'm interested in listening to the stories and experiences of women with SAD in order to understand how gender and SAD interact.
- I want to explore how living as a woman in our society affects experience of SAD.

What next?
- If you think you might like to get involved in my research, would like to know more, or have any questions then I would love to hear from you – please get in touch using the details below.
- There is **absolutely no obligation** to take part in the research at this stage.
- We can communicate in any way that you choose, both at this stage and later on (if you should decide you'd like to be involved), e.g. email, Skype, etc.

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APPENDIX IV

PARTICIPANT INFORMATION SHEET

Research Project: An Analysis of Women and Social Anxiety Disorder from the Perspectives of Feminism and Anti-Psychiatry

Researcher: Katie Masters

The Research Project

This research project is my thesis for a PhD in Sexuality and Gender Studies. The project will look at social anxiety disorder (SAD) using ideas taken from feminism, focusing on women's inequality, and from a perspective that aims to critique traditional psychiatry. In this research, I hope to use women's experiences to explore the the social and environmental factors which might give rise to their SAD.

While acknowledging the distress of women who identify as having SAD, I want to question the idea that SAD arises from pathology within the woman; and consider that it could be a rational response to her circumstances: circumstances which, in part, arise through living in a society with inequality. In order to produce an alternative view of SAD, I will critique the psychiatric literature surrounding gender and SAD, in addition to analysing the experiences of women who identify as having SAD.

What the Research Involves for Participants

I am hoping to provide a platform for women who identify as having SAD, such that they are free to define the 'disorder' for themselves. In order to achieve this, I am keen to listen to the stories and experiences of SAD women in participant-led interviews. The interviews will be semi-structured: that is, I will have an idea of what I would like to ask you and talk about, but the interview plan will be completely flexible in order for us to discuss unexpected topics of interest which may arise. I also hope that, in attempting to make the interview more participant-led, any power dynamic which might arise between myself and the participant will be minimised.

Once I have interviewed you, I will perform an analysis on your narrative. This analysis will then be sent back to you in order to ensure that you agree with my interpretation. If you do not agree, you will be encouraged to give feedback and thus suggest how it can be modified. This feedback will then be used by myself in order to refine/alter the analysis and this process will be repeated until you agree with my interpretation of your narrative. Until your approval is achieved, my analysis of your interview will not be included in the final dissertation. You will also be given access to your interview transcript in case you wish to make any amendments.

Potential Benefits of Participating

In carrying out this research, my aim is to provide a platform for the views of women who identify as having SAD, to act as a corrective to the 'official' view of psychiatry. I hope to amplify the voices of women, such as yourself, who perhaps have not had the opportunity to give their opinion on their

experience of SAD within the framework of traditional Western psychiatry. Moreover, in attempting to overcome the researcher/researched boundary that often exists in research with live participants, I plan to invite participants to be co-authors of any papers/journal articles which may result from this research project.

Reassurance

I understand that the social interaction inherent in the interview process has the potential to be stressful. In order to minimise this, you will have complete control over the interview format. For example, we could carry out the interview via video call, instant messaging, phone call, email or face-to-face. You will also be able to specify the interview time, date, duration and location (so long as this is a public place, since we both have to ensure that we are safe). Moreover, reliving unpleasant experiences could prove stressful for you. Thus, if you wish, we can discuss beforehand the topics to be covered in the interview and hence you can specify any topics that you would like to avoid, and I will do my utmost to honour this. At any time during the interview, you can request that the topic be changed and/or terminate the interview.

Please be advised that you also have the right to withdraw from the study at any time before 28/02/2021, a date which I must insist upon due to having a deadline, six months after this, by which I must submit my PhD thesis. If you decide to withdraw, your data will not be used: it will be destroyed.

Confidentiality and Anonymity

You interview will be recorded and later transcribed. As soon as transcription has taken place, transcripts will be stored in an encrypted file and the audio recordings of the interviews will be destroyed. The encrypted files will be stored on a password-protected computer to which only myself and my supervisory team have access. Your transcription will initially be given an ID number, such that, once I have interpreted your narratives, this interpretation can be fed back to you. The file which links you name to your ID number will also be encrypted. Once you have expressed that you are happy with the my interpretation of your narrative, this ID number will be removed and any linkage of it to yourself will be destroyed. As such, you will not be identifiable in the final thesis.

Inclusion Criteria

The first requirement for participating in the study are that you currently identify, or have identified at some point in the past, as having social anxiety disorder. This need not have been diagnosed by a medical professional – I'm interested in how you identify yourself. The second requirement is that you identify as a woman, either currently, or at some point in the past, at the same time as you identified as having SAD. Finally, since femininity and psychiatric diagnoses are dependent on culture, you will need to have lived, at some point in your life, in an English-speaking country for at least three years.

Contact

If you should have any questions, queries or concerns, no matter how small, I would be more than happy to help – please contact me, in any format that is comfortable for you, using the details below:

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APPENDIX V

PARTICIPANT CONSENT FORM

Research Project: An Analysis of Women and Social Anxiety Disorder from the Perspectives of Feminism and Anti-Psychiatry

Researcher: Katie Masters

I have read and understood the Participant Information Sheet. ☐

I have had the opportunity to ask any questions about the project and my involvement therein. ☐

I understand that I can withdraw from the study at any time before 28/02/2021, a deadline which the researcher must insist upon due to having her own deadline by which her PhD must be submitted. ☐

I understand that my withdrawal will incur no repercussions and I need not give a reason for it. ☐

I understand that I can elect to not answer any of the questions in the interview and that I am free to change the topic of the interview, or terminate the interview, at any time. ☐

I understand that my participation in the study is voluntary. ☐

I understand that my data will be stored securely and will be accessed by the researcher and, in anonymised form, her supervisors. ☐

I understand that my data which features in the final thesis will be anonymous and I will not be identifiable. ☐

I agree for my data to be used in future research. ☐

I agree to participate in the study. ☐

Please initial the boxes alongside each statement before signing below:

Name of participant ______________________ Signed _________________ Date ________

To be signed in the presence of the participant:

Name of researcher ______________________ Signed _________________ Date ________

APPENDIX VI

PARTICIPANT CONSENT FORM – ADJUNCT

Research Project: An Analysis of Women and Social Anxiety Disorder from the Perspectives of Feminism and Anti-Psychiatry

Researcher: Katie Masters

Due to a change to the expected delivery date of this research project, I have had to revise the deadline by which you can withdraw from the study (originally set for 28th February 2021). The new deadline for withdrawal has been set for 31st July 2020.

By signing this form you confirm that you consent to these changes.

Name of participant _____________________ Signed ________________ Date ________

To be signed in the presence of the participant:

Name of researcher _____________________ Signed ________________ Date ________