Psychiatric Conceptions of "Social Phobia": A Comparative Perspective

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1   Introduction

Psychiatry has been an important domain in the sociological literature on health and illness as well as the sociology of knowledge. However, very little research has been conducted on the relatively recent emergence of the condition alternately referred to as "social phobia" (SP) or "social anxiety disorder" (SAD), a diagnosis for individuals with an excessive fear of people or social situations. As I will attempt to show in this article, there are some differences as to how SP/SAD has been represented in the two globally dominant psychiatric manuals, the DSM and ICD, which in turn tend to dominate the professional practices of particular countries. Given that cross-national variations in medical and psychiatric beliefs and practices are probably not uncommon (e. g. Kendell et al., 1971, in Sands, 1983; Oliverio and Lauderdale, 1996; Den Boer and Dunner, 1999), an international comparison may provide a fruitful social scientific account of social phobia.

In the following analysis, I will examine SP/SAD by juxtaposing Swiss psychiatry to that of the United States. In Switzerland, the use of the ICD is widespread and it has a centralized body of psychiatric certification, which, as I will discuss later, promotes a relatively holistic psychiatric practice (seeking to combine psychoanalytic, social and biological psychiatry). The United States, by contrast, is the country in which the DSM originates and dominates in practice. Psychiatric certification is less centralized there, while a shift away from psychoanalytic towards biological and medical views of mental illnesses has also been observed (Weissman and Thurnblad, 1987; Oliverio and Lauderdale, 1996; Glucksman, 1997). In order to explore SP/SAD in those psychiatric contexts, I will focus on historical changes and current differences in the conception of the "behavioral" and "emotional" aspects implied by the disorder. This will be done by presenting an account of recent changes in DSM and ICD manuals and the associated professional discourse in psychiatric journals, which will provide the context for survey data on SP/SAD based on a small Swiss and American sample of psychiatrists.

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2   Theoretical Background

2.1   From the Medicalization of Behavior to the Medicalization of Emotions

Sociological theory about mental disorders has traditionally focused on the social construction of illness, including the process of "labelling" (Becker, 1963), or psychiatry as a system of social control and social reactions to deviance as norm-violating behavior (Foucault, 1965; Jodelet, 1991; Scull, 1991). "Medicalization" theories deal with the processes through which biological, psychological or social phenomena, such as deviant behavior, enter the control of medicine or psychiatry (Conrad and Schneider, 1980). Attention Deficit Hyperactivity Disorder has been a prime example of the medicalization of unwanted behavior (Conrad, 1975; Oliverio and Lauderdale, 1996; Dore and Cohen, 1997; Lloyd and Norris, 1999).

More recently, however, the medicalization of "life stresses," "everyday life" or "normalcy" has become a subject of academic discourse (e. g. Gabe and Lipshitz, 1984; Radelet, 1979). Increasing attention has been paid to the medicalization of emotional problems, such as depression or anxiety. Unlike ADHD or schizophrenia, for example, the diagnosis of "mental illness" related to anxiety is less behaviorally-based. In the American diagnostic manual for psychiatry, the DSM, "anxiety disorders" (formerly "neuroses") are defined as a category of "emotional problems" marked by behavior which "does not actively violate gross social norms" (DSM-III, 1980, page 10). One such disorder, social phobia, is diagnosed among individuals who have an excessive and irrational fear of the negative evaluation or scrutiny by others, leading to strong anxiety or even avoidance of social situations.[1] SP-related studies have mostly been done by American medical and psychological researchers.[2] In North America and Europe, treatment for the illness has included medication, mostly anti-depressants, and cognitive-behavioral therapy (Agras, 1990; Montgomery et al., 1996).

Rare but notable sociological theories on social phobia have incorporated sociohistorical explanations about the emergence of the condition depending on the nature of social systems (Swanson, 1986; Gomperts, 1991, 1993 and 1994). Cross-culturally oriented studies are usually restricted to (often West vs. Non-

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1   The designation of 'social phobia' probably constitutes some degree of a medicalization of "normalcy." Humans may be "biologically prepared" to fear scrutiny by others, which is perceived as an external "threat" (Rosenbaum et al., 1994; Stravynski et al., 1995). In sociological terms, shame or humiliation could be a "natural" part of a system of social control (Scheff, 1988, 396).

2   Genetic, family, environmental and developmental factors alike have been identified as its causes (Hudson and Rapee, 2000). Estimates put the lifetime prevalence of social phobia anywhere between 0.5 and 22.6% worldwide (Montgomery et al., 1996; Fones et al., 1998). Concerns about an underrecognition of the disorder have also been voiced (Montgomery et al., 1996; Fones et al., 1998), influenced by the perception of symptoms as simply an exaggeration of shyness (Harris, 1984; Montgomery et al., 1996) and the social stigma of mental disorders (Montgomery et al., 1996).

West) comparisons of differential *expressions* of the condition (Okano, 1994; Prince, 1993) or differences in the *prevalence* of shyness or SP (Heimber et al., 1997; Pines and Zimbardo, 1978). The diagnosis and *conception* of SP and its symptoms in the medical profession has not yet been researched in social scientific circles. Den Boer and Dunner (1999) studied physician and psychiatrist attitudes about and awareness of the diagnosis and treatment of SP/SAD in Europe and North America. However, the survey was primarily conducted in order to address medical issues of diagnostic consistency. It did not address medicalization issues as part of national professional contexts of psychiatry, medical discourses or psychiatric ideologies.

2.2   Cross-National Differences in Psychiatry

In the case of Attention Deficit and Hyperactivity Disorder (ADHD), it has been argued that the American "competitive" corporate (i. e. privatized, profit-based and decentralized) health care system, along with a lack of American unity in therapeutic perspectives due to a split between medically-oriented psychiatry and psychotherapy, may lead physicians to more frequently prescribe medication as a cost-effective short-cut for psychological problems. This may be aided by U. S. culture's privileging of "immediate solutions to problems" (358).[3] In some European "nationalized" (i. e. regulated and subsidized by the government) systems, by contrast, underlying emotional problems are more often addressed (Diller, 1996; Sergeant and Steinhausen, 1992; Oliverio and Lauderdale, 1996) through long-term interventions. As a result, different ideologies and conceptualizations of a psychiatric disorder may develop:

> *[E]ach of the diagnostic and treatment avenues facilitated by either a nationalized or competitive health care system appear to favor a different research orientation and/or agenda. Thus, the nature of "symptomatology" is emphasized differently. The more long-term interventions such as psychotherapy or family therapy characteristic of the nationalized health care systems tend to treat symptoms as emotional in nature. Short-term interventions such as medication, characteristic of competitive health care systems, tend to stress the importance of controlling behavior defined as*

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3   Oliverio and Lauderdale's view of social control through medicine in the U. S. is supported by a number of writings. Sonnenstuhl (1983), for example, claims that the emergence of emotional health programs among 1970s American businesses led to a medicalization of performance problems. Indeed, it has been argued that the U. S. may have a "cultural condition" (such as the "protestant ethic") conducive to the medicalization of such problems (Merton, 1957, and Rotenberg, 1978, in Conrad and Schneider, 1980, 264). The value of individualism and trends to find individual and technological solutions to problems may further encourage a therapeutic style of social control (Conrad, 1992). Considering today's strong "pharmaceutical hegemony," even self-medication, such as the use of tranquilizers, could be viewed as a form of 'social control' (Radelet, 1979; Gabe and Lipshitz, 1984).

inappropriate in various social settings... (my emphasis, Oliverio and Lauderdale, 1996, page 359)

Although the authors are not entirely clear – and perhaps too simplistic – about the definition of health care systems and their link to therapeutic preferences, they do make important points by identifying potential cross-national differences in psychiatry, particularly by discussing connections between psychiatric research, therapeutic preferences and the way a disorder's symptoms may be viewed. Let me further elaborate on these points in the context of this article's proposed comparison between Swiss and American psychiatry.

2.3   Psychiatry in the United States and Switzerland

Switzerland may not represent a truly nationalized health care system (especially since new health care legislation was introduced in 1994), but its health sector has historically been subsidized by the government,[4] and, more importantly, Swiss psychiatry resembles that of Oliverio and Lauderdale's "nationalized health care" with respect to associated therapeutic interventions. Historically, Switzerland has never had a clear split between psychiatry and psychoanalysis, as has been the case in other countries such as neighboring Germany and Austria (Pöldinger, 1993, 371). In order to practice psychiatry in Switzerland, the title of "Psychiatrist and Psychotherapist FMH" has to be obtained, the prerequisite for which is a medical background. One of the main themes of psychiatric certification by the *Schweizerische Gesellschaft für Psychiatrie und Psychotherapie* is the integration of the psychiatric and psychotherapeutic, and, within those, the "psychological, social and biological dimensions of psychiatry and psychotherapy" (SGPP, 2000, 3). This includes training in traditional psychoanalysis.

In Switzerland, medical specialty board certification and medical licensure can be considered synonymous. In the United States, by contrast, psychiatrists are licensed by individual states, but certification by the American Board of Medical Specialties is not a prerequisite for psychiatric practice (ABMS, 2001). Psychiatric training, thus, may be affected to a greater degree by decentralized American educational institutions and their practices, including a strong research agenda. Psychiatric research, in turn, may lend itself to a positivist, natural science oriented and critical rationalist view (Pöldinger, 1993, 371–377). It has been argued that the changing face of American psychiatry over the past decades, including therapeutic trends toward pharmaceutical interventions, has produced a shift away from psychoanalysis and "socially sensitive" psychiatry in professional training (Weissman and Thurnblad, 1987; Glucksman, 1997; Moffic, Kendrick, Lomax and Reid, 1987). With the growing use of pharmaceutical therapies,

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4   For some insights into European health care systems see for example Moffitt et al. (2001); for a perspective on changes in the Swiss system see Zweifel (2000).

American psychiatric interns have come to identify more with the biological and medical view of mental illness than the psychodynamic or functional one (Glucksman, 1997).

2.4   Social Phobia and a "Behavioral/Emotional" Symptomatology

The second point brought up by Oliverio and Lauderdale (1996) relates to what they call "symptomatology". The authors argue that American psychiatrists tend to construe mental disorders as a behavioral problem, whereas some other psychiatric institutional contexts may view the same disorder as more emotional in nature. In the light of "anxiety disorders", a label which itself implies an "emotional" rather than a "conduct" disorder, the question arises whether the same emotional vs. behavioral difference in conceptualization might still be valid. Actually, U. S. and Swiss psychiatric contexts have the potential to reveal a *reversal* of these behavioral/emotional trends in symptomatology.

Theoretically speaking, medication use may be supported by ideologies that *individualize* emotions, such as a reductionist view of the symptoms of mental problems (Koumjian, 1981). If a biological/medical view, along with a tendency to use pharmaceutical interventions, is indeed more prominent in U. S. psychiatry, it would be no surprise to see a greater focus on "internal" manifestations of SP/SAD in the form of emotions. There appears to be some evidence for this in the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM),* which has recently adopted the label "social anxiety disorder" as a new term for "social phobia".[5] This new label is absent in the DSM's international counterpart, the *International Classification of Diseases* (ICD), which is more dominant in Swiss psychiatry.[6] The new label of "social anxiety disorder" may be indicative of a general American "toning down" of the disorder. From a semantic point of view, it is clear that "anxiety" does not have identical connotations as "phobia". "Anxiety" is simply an emotional state; "phobia" is a well-known psychiatric condition, indicating an irrational fear of an object that may be associated with avoidance behavior. This apparent "reduction" of the disorder to an emotional state seems to be further substantiated by the fact that the DSM-IV's diagnostic guidelines call for *either* symptoms of avoidance behavior *or* the endurance of social situa-

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5   According to Ballenger (1998) in Den Boer and Baldwin (1999, S14), "patient support groups and many medical professionals" and the International Consensus Group on Depression and Anxiety advocate the use of 'social anxiety disorder'.

6   From a social constructionist point of view, medical diagnostic manuals, such as the DSM, are an important tool of the medicalization process and psychiatric discourse, and have been a target of criticism (e. g. Gosden, 1997). Sands (1983) cites a study by Kendell et al. (1971) who found that "ambiguous symptoms" (i.e. symptoms which overlap across different diagnostic categories) of schizophrenia led to the application of differential labels in the U. S. in contrast to Britain. We can expect potential diagnostic ambiguities reflected in psychiatric manuals to be subject to biases induced by different institutional or professional contexts.

tions with great anxiety (417), while the ICD-10 states that avoidance behavior "must be a prominent feature" (137).

3   The Research Question

The codification and institutionalization of "disorders" in medical/psychiatric manuals like the DSM and ICD is an important (in some sense final, but certainly not uncontested) step in the medicalization process (Conrad and Schneider, 1980). In the following analysis, I will not concern myself with questions of why and how social phobia originally became medicalized, but discuss aspects of its ongoing medicalization from a cross-national perspective. This calls for a closer look at diagnostic manuals not only as sources of historical data, but professional tools that may directly influence psychiatric practice. Thus, individual psychiatrists' conceptions of social phobia (the dependent variable of this study) and the origins of possible Swiss-American differences will be explored in this light. More specifically, the goal is to test the hypothesis that there might be a greater "emotional" conception of SP/SAD in the U. S. and a more "behavioral" one in Switzerland. The study represents what we might call a "comparative sociology of knowledge" approach, based on a description of professional discourses, including changes in DSM and ICD classification and diagnostics, and an analysis of results from a small-n survey of psychiatrists in the U. S. and Switzerland.

4   "Social Phobia" and "Anxiety Disorders" in ICD and DSM Medical/ Psychiatric Manuals

4.1   DSM-II and ICD-9: Phobias as Neuroses

The American Psychiatric Association's DSM-II (1968) and the World Health Organization's ICD-9 (1974) include three main categories of mental disorders: neuroses[7], personality disorders and psychotic disorders. Phobic neuroses are characterized as an "intense dread of specific objects or situations that normally would not provoke such emotion" (ICD-8, 38). The DSM-II also mentions the physical symptoms of a phobic neurosis: "[this] apprehension may be experienced as faintness, fatigue, palpitations, perspiration, nausea, tremor, and even panic." At the same time, classic Freudian psychodynamic processes are included in the description of phobias: "Phobias are generally attributed to fears displaced to the phobic object or situation from some other object of which the patient is unaware" (40). At this point, 'social phobia' is not yet specified in either manual.

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7   Neuroses subtypes are anxiety, hysteria, phobias, obsessive compulsiveness and some forms of depression.

4.2   The ICD-9 and DSM-III: The Abandonment of 'Neuroses' in the DSM

The DSM-III and ICD-9 began to be used in clinical practice between 1978 and 1980. While the ICD-9 still serves mainly classification purposes, the DSM for the first time also includes diagnostic criteria. The term 'neuroses' is abandoned by the DSM-III, which represents a pivotal development in the conception of phobias:

> *Throughout the development of DSM-III the omission of the DSM-II diagnostic class of Neuroses has been a matter of great concern to many clinicians, and requires an explanation [...].*
>
> *Freud used the term [psychoneurosis] both descriptively (to indicate a painful symptom in an individual with intact reality testing) and to indicate the etiological process (unconscious conflict arousing anxiety and leading to the maladaptive use of defensive mechanisms that result in symptom formation).*
>
> *At the present time, however, [...] some clinicians limit the term to its descriptive meaning whereas others also include the concept of a specific etiological process. (DSM-III, 1980, page 9)*

According to the authors of the DSM, the term "neurosis" should be used as a descriptive (symptomatological rather than etiological) term, de-emphasizing emotions evident in psychodynamics while emphasizing those that are the effects of underlying processes (10). In lieu of the "neuroses", the DSM-III introduces the new category of *Anxiety Disorders,* with Phobic Disorders as a subtype. "The essential feature of [Phobic Disorders] is persistent and irrational fear of a specific object, activity, or situation that results in a compelling desire to avoid the [phobic stimulus]" (225). Social phobia, for the first time, becomes a distinct subcategory of phobias. In the ICD-9, however, social phobia is still termed a *neurotic* disorder.

4.3   The Present: ICD-10 and DSM-IV

With the introduction of diagnostic criteria in the ICD, similarities in descriptions but also differences in labels and diagnostic features between the ICD and DSM have become detectable. The (1992) ICD-10 describes social phobia as a disorder that may be accompanied by physical symptoms and is often marked by avoidance behavior. Nevertheless, the ICD's diagnostic guidelines indicate that "*avoidance* of the phobic situations *must be* a prominent feature" (my emphasis, page 137).[8] Behavioral and physical symptoms are also mentioned in the DSM-IV, which introduces the new term '*Social* Anxiety Disorder". However, the

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8   The *German* translation of the ICD-10 states: "*If possible [wenn möglich]*, avoidance of the phobic situation." There might be some diagnostic difficulty and ambiguity with respect to the recognition of *sufficient* avoidance behavior.

DSM-IV appears to be less insistent on avoidance behavior, in prescribing that "the feared social or performance situations are avoided *or else* are endured with intense anxiety or distress" (my emphasis, page 417). Thus, there are subtle differences between the ICD and American DSM with respect to the behavioral conception of the disorder, although both may leave the behavioral diagnostic criteria to the psychiatrist's discretion to some extent.[9] In a later section analyzing survey results we shall see how diagnostic prescriptions and boundaries may play themselves out with respect to psychiatrists' 'behavioral' conception of social phobia.

5   "Social Phobia" and "Anxiety Disorders" in the American and Swiss Psychiatric Discourse

The prevalence of articles about social phobia in the official professional journals of the American and Swiss professional psychiatric associations may be indicative of varying degrees of importance allocated to the disorder. Between 1975 and 1999, the American Journal of Psychiatry (AJP) featured 26 articles about social phobia, the first of which appeared in 1979. Ten of those discuss the disorder in relation to pharmaceutical treatment or biochemistry. The Swiss Archive for Neurology and Psychiatry (SANP) – which consists of separate sections and editorial boards for each discipline – does not feature a single article on social phobia,[10] but published some on neuroses or anxiety disorders. Generally speaking, some differences consistent with the countries' professional contexts of psychiatry as well as dominant psychiatric manuals become evident in their respective professional discourse.

In 1986, an article by Cameron et al. was published in the AJP, which seeks to reaffirm the validity of the newly established diagnostic category of "anxiety disorders" by means of Anxiety Symptom Questionnaire scores and State-Trait Anxiety Inventories. Aside from psychological items, the researchers rely on biological/physical indicators of anxiety, such as "dry mouth," "fast heartbeat" or "blurred vision," but, perhaps not surprisingly, they do not discuss issues about patients' backgrounds or behaviors. Similarly, Papp et al. (1988) present a study relating physiological variables to subjective anxiety. In the same year, Reich and

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9   Both manuals also alert psychiatrists to diagnostic boundaries in cases of total avoidance behavior. In cases of complete isolation or "houseboundedness," diagnoses such as agoraphobia (ICD-10) or avoidant personality disorder (DSM-IV) should be considered.

10   The absence of articles does not necessarily mean that there is no interest for the disorder in Switzerland. Instead, it may be indicative of social, economic and institutional realities, which may focus on some disorders at the expense of others. We also have to keep in mind that Swiss psychiatrists probably read foreign (e. g. German or American) journals.

Yates (1988) first report the successful treatment of social phobia patients by means of medication. Throughout the 1990s, a therapeutic shift appears to have occurred toward administering anti-depressant medication to treat social phobia. In an article on the treatment of SP with *Fluvoxamine,* Stein et al. (1999) write:

> [P]sychological therapies [...] owing in part to the specialized training required by therapists and in part to inadequacies in access to care, are not widely available or accessible for most patients in many regions. Pharmacological treatments, which are generally more available, offer physicians the opportunity to provide relief to many patients with social phobia and improve the quality of their lives. (page 757)

The AJP's social phobia peak year of 1988 also represents a high water mark in SANP articles related to neurotic disorders. In discussing differential experiences of anxiety states, one such article uses a case report to illustrate problems in using the American DSM-III for diagnosing and classifying mental disorders. The author (Wacker, 1988) emphasizes the importance of a holistic view by considering hereditary, neurobiological and environmental factors in order to explain panic attacks. An 1989 paper by Francois Ferrero represents a critique of the DSM category "anxiety disorders", acknowledging how an increasingly biological experimental approach has induced changes in American psychiatric categories. In the process, according to the author, the DSM has come to consider "anxiety disorders" as psychiatric illnesses *in and of themselves,* neglecting individual personality, biography and psychodynamics. These changes in psychiatry lead José Guimón (1997) to ask the question *La névrose, est-elle morte?* and criticize the viability and reliability of biological data in the diagnosis of neuroses:[11]

> *In the DSM-III classification (which pretends to be "atheoretical," although it has been based on a biological model), the concept of "neurosis" has disappeared because this term had too many narrative connotations and the concept was a psychoanalytical one [... The new concept of "anxiety disorder"] is confusing, because the term "anxiety" has itself been used to describe a mental state [...] a situational response and a psychiatric disorder [... By contrast, neurotic disorders can be defined as] "states in which the manifestations of alteration are mainly psychological, but include behavioral problems, somatic manifestations, accompanied by subjective emotions, a deteroration of social functioning or voluntary behavior". (page 20)*

Guimón's points about the concept of anxiety and its relationship to issues of voluntary behavior and social functioning are important, since we are investigating the possibility that the American move toward "anxiety disorders" may be

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11   Translation from the original French by the author.

symptomatic of a more reductionist and "emotional" view of social phobia, while
the Swiss view is hypothesized to accentuate "behavior". As the social scientist/
psychiatrist Asmus Finzen reminds Swiss psychiatrists in a 1987 issue of the
SANP, "psychiatric illnesses are always [also] behavioral disorders, regardless how
[they are] otherwise characterized." Perhaps inspired by Guimón (1997), a theoretical
SANP article by Michel Lansel (1998) discusses the semantic and psychotherapeutic
implications of the "anxiety" concept. According to the author, anxiety can be
defined as an "emotional state" with cognitive correlates and physical/biological
(somatic) symptoms (240). It is American research reported in the AJP, however,
which has demonstrated this empirically by establishing links between physiological
and subjective emotional symptoms as well as changes induced by pharmaceutical
treatment. In remaining sections we will see whether this perspective may have an
effect on individual psychiatrists' conception of social phobia.

6   Survey Results

In order to study psychiatric attitudes, beliefs and conceptions about social phobia,
psychiatrists in the United States (n = 29) and Switzerland (n = 34) were recruited
to complete an online survey.[12] (Since I will statistically analyze a notably small
sample in this section while including references to significance levels, it would be
prudent to treat findings as simply an exploration of what we might expect to find
in the population of psychiatrists). The survey contained a variety of 7-point
scale items, an open-ended question asking psychiatrists to describe the nature of
social phobia or social anxiety disorder, as well as some questions pertaining to
respondents' professional practices and background. The questionnaire sent to
Swiss psychiatrists was translated into German[13]. Two types of questionnaires
entitled "Social Phobia Survey" and "Social Anxiety Disorder Survey" were randomly
assigned to potential respondents. Unlike the SP survey, the cover letter
accompanying the SAD survey and the introductory paragraph on the survey
itself parenthesized the alternative term "social phobia" to remind respondents
that the two labels should be understood as the same disorder. Individual ques-
tions on this survey, however, were limited to the consistent use of the term

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12   Both recruiting and the completion of surveys occurred through the Internet. Potential
      respondents were psychiatrists whose email address was published on several major medical/
      psychiatric Web directories in Switzerland and the U. S. In addition to increased efficiency, I
      believe that the Internet provided the benefit of anonymity. It is possible, however, that the
      chosen medium influenced the sample, especially with respect to respondents' age distribution.
      The survey was conducted in March/April 2001.

13   Although Swiss-German psychiatrists are not fully representative of Swiss psychiatry, surveys
      in French and Italian would have complicated this study by introducing another cultural (i.e.
      linguistic) variable.

"social anxiety disorder".[14] The survey version (i. e. "label used") represented an important control variable since it was hypothesized that the label "social anxiety disorder" may itself be an indicator of a more "emotional" view of SP/SAD.

6.1   Psychiatric Practices, Ideologies and Therapeutic Preferences

As expected, there is virtually no variation in the use of diagnostic manuals among psychiatrists of a given country: more than 90% of American and Swiss psychiatrists claim to primarily use the DSM or ICD, respectively.[15] Survey results indicate that respondents' professional experience with SP/SAD is roughly equal for American and Swiss psychiatrists (7,6% vs. 7,1% of all patients, respectively). However, the *perceived prevalence* of the disorder is higher among American than Swiss psychiatrists,[16] while American psychiatrists also more strongly agree that the treatment of SP/SAD is important in order to help patients have a more fulfilling and productive career (means were 2,2 for the U. S., 1,5 for Switzerland). By the same token, U. S. psychiatrists indicate a greater willingness to administer antidepressant medication for the treatment of job-related "performance problems" (means of 0,21 U. S. and -0,50 Switzerland).[17] Generally speaking, however, American respondents favor medication over other forms of therapy for SP/SAD only slightly more than the Swiss (means are 2,1 and 1,7 respectively). Finally, there are remarkable differences across national samples in the way ideological items are *interrelated*. Among Swiss respondents, the perceived importance of SP/SAD as a psychiatric "discovery" is significantly related to attitudes about social costs and beliefs about the prevalence of the disorder. In the U. S. sample, neither one of these variables are associated.

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14   A lower response rate obtained for 'social anxiety disorder' (*soziale Angststörungen*) than 'social phobia' (*soziale Phobie*) surveys in Switzerland (SP=24, SAD=10 vs. U.S.: SP=15, SAD=14) is probably indicative of the fact that the label is less established there than in the U. S. This is consistent with den Boer and Dunner's (1999) findings that European psychiatrists have a lower rate of awareness about this label than their American counterparts.

15   Due to a virtually constant pattern of manual use and the small sample size, 'manual use' will not be introduced as a control variable.

16   This is based on an item measuring the relative agreement with a question asking whether a 10% social phobia rate in a given country should be considered an overstatement (means were -.6 for the U.S., .35 for Switzerland).

17   The precise wording of this item was: "Hypothetical scenario: A patient is up for a promotion at his/her job. The patient is qualified but says that s/he will not accept the promotion due to a fear of the public speaking (i.e. presentations) that would be associated with the new job.

In my view, the best form of therapy in this case is a fast and effective treatment by means of anti-depressants."

6.2 Determinants of the Conception of Social Phobia as an Emotional/Behavioral Problem

In order to investigate psychiatrists' conception of SP/SAD as a "behavioral" vs. "emotional problem", a quantitative measure of a behavioral-emotional continuum (qualitative measures will be discussed later) was constructed. The variable is based on two scaled questions asking respondents whether SP/SAD should be considered primarily an emotional problem (due to the negative emotions individuals experience in social situations) or behavioral problem (due to avoidance behavior by individuals).[18] A "behavioral-emotional problem" score was computed by subtracting the "emotional" question score from that obtained by the "behavioral" question, producing a scale ranging from negative (relatively more emotional) to positive (relatively more behavioral) values.

Differences in the 'behavioral-emotional' quantitative scores between the United States and Switzerland (means of -1,0 and -1,1 respectively; see also Table 1) are virtually zero. Considered separately, neither the "emotional" nor the "behavioral" scores are significantly different, although the mean "emotional"

Table 1:   Standardized Coefficients for Regression of "Behavioral-Emotional Scale" on "Country" and "Cohort"

Independent Variable	Model 1	Model 2	Model 3
Country (0 = Switz., 1 = U. S.)	0.021[†] (0.164)	0.036[†] (0.288)	0.057[†] (0.448)
Cohort (0 = less than 20 yrs.)		-0.293* (-2.347)	-0.268* (-2.111)
Control Variable			
Survey (0 = SP, 1 = SAD)			-0.126[†] (-0.976)
Number of cases	63	63	63
R-Square	0	0.086	0.101

Note

Numbers in parentheses are t-statistics.

[†]$p > 0.05$ *$p < 0.05$

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18   Agreement/disagreement with the following statements represented the 'emotional' and 'behavioral' variables:

1) "I believe that social phobia should be considered primarily an emotional problem, because the most central point of its diagnosis are the negative emotions that people with the illness have to endure in social situations."

2) "I believe that social phobia should primarily be considered a behavioral problem, because individuals with the illness avoid social situations."

score is somewhat higher for Swiss respondents. This finding does not support the hypothesis that Swiss psychiatrists view SP/SAD as more of a behavioral problem than their American colleagues nor that the latter group holds a more emotional view. The "emotional/behavioral" variable also does not appear to be correlated with therapeutic preferences (use of pharmaceuticals), failing to lend support to the perspective that therapeutic styles are related to conceptions of psychiatric illnesses or "symptomatologies".

Instead, the survey data suggest differences in the conception of SP/SAD on the basis of psychiatric cohorts (Table 1). Among *American* respondents, psychiatrists with 20 or more years of practice tend to view SP/SAD as more emotional than the younger generation (Table 2, Model 1). This is an interesting relationship if we recall that around 20 years ago, in 1980, the American DSM-III abandoned the ("psychoanalytic") category of "neurosis" in favor of the new "anxiety disorders". In any event, the relationship in question does not appear to be due to a greater "behavioral" view of the younger generation, but an older generation of psychiatrists, which seem to have retained a more "emotional" view of social phobia.[19] No such cohort effect is evident among Swiss respondents (Model 1, Table 2). Instead, two ideological variables suggest to be useful predictors. The first is a "social cost" variable indicating an attitude about the importance of

Table 2: Standardized Coefficients for Regression of "Behavioral-Emotional Scale" on Selected Independent Variables

Independent Variable	United States Model 1	Switzerland Model 1	United States Model 2	Switzerland Model 2
Cohort (0 = less than 20 yrs.)	-0.403*	-0.154[†]	-0.412*	0.018[†]
	(-2.279)	(-0.860)	(-2.332)	(0.109)
"Social Cost" Attitude			-0.241[†]	0.522**
			(-1.413)	(3.198)
"Social Functionality" Attitude			-0.080[†]	0.425**
			(-0.466)	(2.814)
Control Variable				
Survey (0 = SP, 1 = SAD)	-0.246[†]	-0.008[†]	-0.260[†]	-0.072[†]
	(-1.389)	(-0.044)	(-1.455)	(-0.475)
Number of cases	29	34	29	34
R-Square	0.279	0.024	0.347	0.377

Note
Numbers in parentheses are t-statistics.
*p < 0.05 **p < 0.01 [†]p >0 .05

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19   This is confirmed by separate regressions examining the cohort effect on the "behavioral" and "emotional" scales.

treating SP/SAD due to *social costs* incurred by the disorder.[20] The second variable could be called a "social functionality" variable, representing psychiatrists' belief whether individuals who endure anxiety in social situations, yet are *socially functional*, should not be considered as suffering from SP/SAD.[21] The two variables are themselves not related, making it unnecessary to consider an interaction effect between the two in computing a regression.

As Model 2 for Switzerland in Table 2 indicates, the attitude that socially functional individuals should not be considered cases of SP/SAD appears to be related to a more behavioral / less emotional view of SP/SAD, while the same positive association holds between the dependent variable and the "social cost" attitude about SP/SAD treatment. I do not wish to make strong causal claims about the direction of this relationship.[22] Moreover, it is difficult to pinpoint the source of cross-national variation in the predictive utility of these attitudes in relationship to the dependent variable. However, the data may reflect a pattern of Swiss psychiatrists' greater "social-contextual" or "socially sensitive" thinking, while American respondents' ideas about the role of psychiatry in society may be more "random," perhaps in part due to both a different and less standardized socialization of U. S. psychiatrists.

6.3   A Possible "Labelling Effect"?

As indicated, the "survey" (whether questions used the term "social phobia" or "social anxiety disorder") does not have an effect on the "emotional/behavioral" scale when used as a control variable (Tables 1 and 2). Used by itself, however, it

Table 3:   Crosstabulation of "emotional problem" variable on "survey" variable for the United States

	"Social Phobia" Survey	"Social Anxiety Disorder" Survey	Total
Disagree (−)	8 (57.1%)	2 (16.7%)	10 (38.5%)
Agree (+)	6 (42.9%)	10 (83.3%)	16 (61.5%)
Total	14 (100%)	12 (100%)	26 (100%)

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20   "The treatment of social phobia is important, because people suffering from the illness tend not to live up to their full capacity, which leads to great indirect costs for society."

21   "In my view, an individual who is socially functional but endures anxiety in social situations should not be diagnosed as someone with social phobia."

22   If we consider the attitudes in question as part of a larger "social contextual thinking," entailing an ideology about psychiatric disorders in relation to a social context, a treatment of these variables as independent may be warranted.

may reveal the extent of a lurking "labeling effect." Indeed, a comparison of means shows that "social anxiety disorder" surveys have a mean score on the "behavioral-emotional problem" scale that is more "emotional" (negative) than scores from the "social phobia" survey (-1,5 and -0,82 respectively). Considered on a country-by-country basis, this difference in scores appears to be significant only in the case of the U. S. (-1,71 and -0,40 respectively). If the "emotional" variable is examined separately, agreement with the question whether SP/SAD should be considered an emotional problem increases if the label "social anxiety disorder" is used (Table 3[23]).[24] The finding that labels might make a difference is important, suggesting possible variations in meaning of "anxiety disorder" as opposed to "phobia".

6.4 Conceptions of "Social Phobia" or "Social Anxiety Disorder": Psychiatrist Descriptions

In order to further illuminate the meaning of "emotional" and "behavioral" aspects of SP/SAD, respondents were asked to describe the nature of the psychiatric disorder in terms understandable to a non-psychiatrist, based on which a content analysis was performed. In the responses, it is common for both Swiss and American psychiatrists to mention elements of a severe, excessive or "irrational" fear and the disabling character of the disorder. Consider the following descriptions given by a Swiss[25] and American psychiatrist, respectively:

> [Swiss:] A person suffering from social phobia is afraid of contacts with other people, especially with strangers. To give a presentation, a date or a party lead to a marked anxiety in this person or he avoids these situations altogether. If he tries anyway, he retrospectively finds to have done everything wrong.
> [American:] Social phobia is when a person consistently experiences severe anxiety in social situations. The nervousness is so distressing that it causes the sufferer to avoid social situation or else endure them with great difficulty. A person with social phobia has an unrealistic sense of being carefully scrutinized by other people.

Whether respondents were asked to describe the nature of "social phobia" or "social anxiety disorder" does not appear to have significantly influenced the content of their answer. The following are two American descriptions of SAD

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23   The "cohort" control variable has shown no significant effect on this association and has been omitted in this table.

24   An obverse (and thus consistent) effect is suggested by the use of the "behavioral" variable, although it is not statistically significant.

25   All statements translated from the original German by the author.

and SP, respectively, both of which emphasize the physical symptoms of the disorder:

> *[Social anxiety disorder] is a condition wherein people get feelings of nervousness, manifested by physical symptoms of tremor, fear, frequent urination, and/or stomach jitters, wherein they have a feeling of withdrawing from the situation that causes them stress.*
> *[Social phobia] is an anxiety disorder than enhances the person's sensitivity to social situations, particularly new ones, and unfamiliar individuals. Produces intense fear of scrutiny, performance anxiety, nervousness. Also increases arousal and causes palpitations, restlessness, sweating, muscle tension. Often pressures the individual to escape or avoid social situations.*

In quantitative terms, American psychiatrists' inclusion of physical symptoms is significantly more likely than among their Swiss colleagues in my sample. Surveyed Americans also more often mention *performance contexts*, such as public speaking, as a characteristic of the disorder:

> *[Social phobia is a] fear that one will not perform appropriately in public; a fear that one will make a fool of oneself publicly; being terrified of speaking publicly.*

Swiss respondents, by contrast, are more likely to emphasize the behavioral consequences of SP/SAD. Their mention of avoidance behavior occurs somewhat more often compared to U. S. psychiatrists. More importantly, they more frequently describe the disorder's consequences with respect to *relationships,* as opposed to just contexts of social contact. The following are two examples:

> *[Social phobia:] Difficulties in getting in contact with other people, to maintain relationships. Lives very isolated.*
> *[Social anxiety disorder:] Inhibitions [...] and fear of starting social relationships, appearing in public and meeting new people. Avoidance of all opportunities that lead to contact with other people.*

Some of the surveyed Swiss psychiatrists go even further by mentioning social withdrawal and social isolation, a feature virtually absent among American descriptions:

> *[Social phobia:] Partially inexplicable but strong fears, in relationship with other people, which become so strong that one does not dare to leave the house anymore, even if one would like to do so.*
> *[Social phobia is] a fear [anxiety] which occurs during contacts with other people, leading to the patient's withdrawal and increasing social isolation.*

Cross-national differences in SP/SAD descriptions (see Table 4 for a summary) suggest a more "reductionist" tendency among American psychiatrists, especially evident in the inclusion of physical symptoms of anxiety. The Swiss psychiatrists surveyed are more likely to mention avoidance behavior and significantly more often include "social-behavioral" consequences, such as effects on social relationships or complete social withdrawal and isolation. By virtue of the question asked, these differences between the two samples are probably of a more symptomatological than etiological nature – they are associated with observable symptoms or consequences rather than psychological causes of the disorder. It is perhaps this finding that best explains why my data produces no significant relationship between psychiatrist conceptions of SP/SAD as evident in these descriptions and their conception as measured by the *quantitative* "behavioral-emotional problem" scale. Although the questions making up the scale *referred to* emotional/behavioral *symptoms* ("enduring negative emotions" in social situations; "avoiding social situations"), their associated problematic could have been interpreted either as "problem as a cause" or "problem as an effect" by respondents. In other words, calling social phobia an "emotional problem" may imply either emotional roots

Table 4:   Mentions (counts/percentages) of SP/SAD features: United States vs. Switzerland

Feature	Absent/Present	United States		Switzerland	
Disabling nature	Absent	22	(78.6%)	24	(72.7%)
	Present	6	(21.4)	9	(27.3%)
Avoidance of social situations	Absent	17	(60.7%)	14	(42.4%)
	Present	11	(39.3%)	19	(57.6%)
*Occurs in performance situations (e. g. public speaking)**	Absent	17	(60.7%)	27	(81.8%)
	Present	11	(39.3%)	6	(18.2%)
Affects social relationships*	Absent	28	(100%)	29	(87.9%)
	Present	0	(0%)	4	(12.1%)
Social withdrawal/ isolation***	Absent	26	(92.9%)	21	(63.6%)
	Present	2	(7.1%)	12	(36.4%)
Physical/somatic symptoms**	Absent	18	(64.3%)	30	(90.9%)
	Present	10	(35.7%)	3	(9.1%)

Note

Significance levels are based on Chi-Square statistics

* p > 0.10;   ** p < 0.05;   *** p < 0.01

(childhood experiences, for example) or emotional symptoms (emotions endured in a social setting etc.). Thus, while the *behavioral* aspect of a disorder could mostly be regarded as an *effect* or symptom of underlying cognitive, emotional or biological processes, *emotions* are probably more ambiguous in the sense that they can have both etiological and symptomatological implications (see section 4.2). As we have already seen, the sample of American psychiatrists who have been practicing for 20 or more years hold a more "emotional" view than their younger colleagues, possibly because the "age of the anxiety disorders" has brought about an abandonment of the psychodynamic and emotional etiological view captured by the concept of "neurosis".

7   Discussion

This article illustrated how the national contexts of the psychiatric professions in the United States and Switzerland may have produced variations in the conception of SAD/SP as well as different relationships between this variable and psychiatric cohorts or ideologies. I attempted to show that the historical and institutional context of the American psychiatric profession has increasingly favored a positivist, medical view of social phobia, exemplified by the introduction of the classification of "anxiety disorders" in place of the traditionally psychoanalytic "neurosis". A shift from an etiological to a symptomatological perspective on *emotions* thereby occurred. Swiss psychiatry, which has traditionally been more psychoanalytic and social psychiatric, appears to have reacted critically to American trends toward a biologically informed, positivist psychiatry.

Although the survey data has to be interpreted with caution due to the small sample size, and perhaps should be considered exploratory rather than explanatory, I believe it is useful when considered in juxtaposition with the qualitative data of this research. In any event, the survey results only partially supported my hypothesis, which held that social phobia as a neurotic disorder may be conceived of as a more "emotional" than "behavioral' problem in American as opposed to Swiss psychiatry – the opposite of the tendency implied by Oliverio and Lauderdale (1996). As measured by a quantitative "emotional/behavior problem" continuum, no significant differences became apparent between U. S. and Swiss psychiatrists in the conception of SP/SAD. Nevertheless, *cohort* differences in the U. S. sample suggested a shift away from an "emotional problem" view of the disorder that occurred about 20 years ago. Among Swiss respondents, where a psychotherapeutic view consistent with the ICD concept of "neurosis" may have prevailed to a greater degree, "social contextual" ideologies ("social cost" and "social functionality" thinking) about SP/SAD were instead good predictors of variations in emotional/behavioral conceptions. Other survey results lent some support to a key premise of my

hypothesis. In a separate analysis, surveys which employed the term "social anxiety disorder" produced somewhat greater agreement with a view of SP/SAD as an "emotional problem". However, this was only the case among American respondents and did not make the *overall* American degree of this emotional conception greater than that of the Swiss.[26]

The qualitative data obtained from American respondents indicated a greater emphasis on the physiological aspects of SP/SAD than their behavioral consequences. While those psychiatrists tended to describe the nature of SP/SAD by pointing out the *physical symptoms* of anxiety and performance *contexts*, Swiss psychiatrists were far more likely to describe larger social consequences, such as effects on social *relationships* or outright *isolation*. Consistent with differing (but nonetheless somewhat ambiguous) diagnostic guidelines about avoidance behavior in the DSM and ICD, Swiss psychiatrists' descriptions of SP/SAD suggest a more behavioral view, which also could be influenced by a more "social problem" oriented profession. Given also the somewhat lower perception of the disorder's prevalence in the Swiss sample (see section 6.1), it may be reasonable to expect that conceptual differences could result in a higher threshold for the diagnostic inclusion of a patient as "social phobic" in Switzerland.

If we acknowledge that the American sample's "reductionist" view of SP/SAD entailing somatic/physical symptoms is about biological aspects of *emotions,* while the Swiss "social" view is about the consequences of (often extreme) avoidance *behavior,* the qualitative data does lend support to the hypothesis of this study. However, since these views were themselves not related to the quantitative variable measuring "emotional/behavioral" beliefs about the SP/SAD problematic, we should perhaps conceptualize two independent "emotional/behavioral" axes. The first axis is about SP/SAD as a (possibly etiological) emotional or behavioral problem. The second axis, by contrast, is of a more diagnostic/symptomatological nature. Emotions, in this dimension, are merely an aspect of a more reductionist-biological as opposed to a social-behavioral view of symptoms. Consequently, if there is indeed an American tendency to emphasize "behavioral problems" or consequences of disorders, as argued by Oliverio and Lauderdale (1996), it may apply to conduct disorders, such as ADHD, but not necessarily also to neurotic or

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26   There may be two reasons for the finding that the labeling effect was not significant in Switzerland. First, and most important, the concept "social anxiety disorder" originated in the U. S. and may be more established/recognized there than it is in Europe (see Den Boer and Dunner, 1999). Second, it could be due to a different semantic meaning of the German (psychiatric) word for anxiety, *Angst,* which probably has fewer physical/somatic connotations. *Angst* is usually translated into English as "fear". It can be argued that, semantically, "fear" (or *Angst*) comes closer to "phobia" than "anxiety", because the latter has more physiological/ biological connotations. This would make sense if a biological/reductionist and positivist view of SP indeed influenced the creation of the category of "anxiety disorder".

"emotional" disorders, which tend not to be strongly associated with norm-violating behavior.[27]

Finally, despite conceptual (and consequently possible diagnostic) differences, which reinforce a social constructionist view of psychiatric designations, the data in this study did not suggest dramatic variations in *therapeutic* (e. g. pharmaceutical) *preferences* among psychiatrists of those countries. At the same time, there was no detectable link between such preferences and the conception of the disorder across *individual* respondents, as implicit in Oliverio and Lauderdale's (1996) theory. In future research it would be interesting to more specifically investigate the influence of the pharmaceutical industry on the conception and diagnosis of social phobia in different national contexts. This may also include a closer look at cultural and economic factors that were beyond the scope of this study.

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27   I believe that Oliverio and Lauderdale's (1996) argument suffers from a too liberally applied meaning of "symptomatology" in the first place.   In generalizing that different health care systems favor different symptomatologies via therapeutic preferences and research agendas, the authors did not sufficiently account for the etiological aspects of psychiatric disorders and their categorization.   It appears that they compare a view of behavioral symptoms with the etiology of emotions under the same heading of "symptomatology."

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