Treatment of Social Anxiety Disorder or Neuroenhancement of Socially Accepted Modesty? The Case of Ms. Suzuki

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26.1 Introduction

People see psychiatrists for various reasons, and their willingness to treat their disorders also varies. Negative or ambivalent attitudes toward psychiatric treatment are not uncommon among patients with psychotic disorders, which present moral dilemmas for mental health professionals. However, such situations are not restricted to psychotic disorders. There are cases where a person makes a psychiatric visit to have a psychiatrist arbitrate which party should yield when there is a gap between what she can do and what those who surround her expect her to do. The psychiatrist's role in such cases may be unproblematic if the diagnosis of mental disorder is obvious, but when the case lies on the border between normality and pathology, it is not clear how psychiatrists as mental health professionals should behave.

In this chapter, I will illustrate the issues arising in such cases with the story of Ms. Suzuki, a fictitious case narrative but one based on multiple cases I have experienced. As will be seen, it is natural that those concerned seek to resolve their difficulties by reference to factual norms of psychiatric diagnosis from which to draw an ethical guidance. But I will argue that this disguises value judgments for matters of fact, and I will illuminate how the patient's and the clinician's values impact on clinical decision making.

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26.2 Case Narrative

Ms. Suzuki was 43 years old when she first visited a psychiatrist. She was a small Japanese woman who lived in the urban district with her husband. When she first visited the clinic in Tokyo, she wore neat clothes and sat down in the chair softly looking at the psychiatrist with downcast eyes.

She had been experiencing nervousness in front of others since she was in the fifth grade. In elementary school, teachers sometimes selected pupils to read from the textbook. She disliked reading aloud in the class; her heart used to flutter with anxiety lest she be picked to read. This concern clouded her school life, but she stayed in school. As she got older, she became very considerate—sometimes too considerate—for others. For example, she always walked in the street so attentively as not to bother the other pedestrians. When she went to the supermarket, it was onerous for her to ask a salesclerk about the merchandise because she took a long time waiting for the best time to call a salesclerk so as not to impose on their time unnecessarily. Others who noticed her sensitivity sometimes appreciated her attentiveness. She was prone to gloominess, but she was generally emotionally stable and had never suffered from a prolonged depressive state.

She entered a middle-ranked university and majored in literature. After graduation, she started work as a clerk in the office of a company dealing in furniture. Making a phone call and picking up the phone made her nervous. Yet her careful way of doing her job and sensitivity in interpersonal relationship were positively evaluated by her boss and colleagues in most cases. She was rather inconspicuous in her workplace because she rarely expressed her own opinion. She had once made an appointment with a psychotherapist of a behavioral cognitive orientation and received psychotherapy for 6 months, which helped her to overcome her hardship in her mid-twenties. Her social anxiety, however, was not greatly ameliorated.

When she was 28 years of age, she received a proposal of marriage from a man she had known since she was a university student and they married. She and her husband tried to have a child until she was in her thirties, in the end without success. Her relationship with her husband was satisfactory. Because her husband also had a job, she lived in financial comfort. In Japan, women who marry tend to leave work after the first child is born. She kept working in the same company because she had not borne a child.

Her situation changed when, now aged 43, she received a promotion. The personnel department decided to promote her because, as is often the case in Japan, an employee of her age and with 20 years of service with the company was expected to undertake an administrative post. After her promotion, she managed three subordinates and had to make presentations to executives. When she made these presentations, she fretted over the trembling of her hands and stuttering of her voice, wondering if she looked strange to her colleagues. She frequently regretted that she behaved inappropriately after she had talked to others. One of her subordinates reported her problem to her supervisor. The supervisor recommended that she see a psychiatrist, whereupon she reluctantly made an appointment for a psychiatric visit.

Although her job performance seemed unsatisfactory, her capacity for clerical business was intact. She was doing well with her husband. She had no physical health issues. She never smoked or took alcohol. As for her family history, her mother went to a psychiatric clinic regularly and took minor tranquilizers.

She clearly had some of the symptoms of social anxiety disorder (SAD), but it was uncertain whether she met the diagnostic criteria. Her adaptation to social life had been good until she was 43 and her functional impairment was restricted to certain types of tasks that were associated with her promotion, rendering the satisfaction of the “clinically significant distress or impairment” clause questionable. Her attitude towards psychiatric treatment was ambivalent; while she did not want to visit the clinic regularly and receive treatment, she did want to improve her situation.

26.3 The Values Arising in this Story

The psychiatrist was faced with the dilemma of what to do. On the one hand, Ms. Suzuki had sought help for a potentially remediable condition. However, this was at her boss’s instigation, and Ms. Suzuki did not satisfy widely accepted norms for the relevant diagnostic category (SAD). So, what should the psychiatrist do? To refuse to help might put her work situation and hence other aspects of her personal well-being at risk, but treatment in this situation might amount to an abusive use of psychiatry, since it seems to serve social rather than medical ends.

The number of prescriptions of antidepressants and psychostimulants has been increasing in recent years [1]. The expansion of pharmacotherapy is occurring where the borderline between normality and pathology is ambiguous, such as neurodevelopmental disorders, mood disorders, and anxiety disorders. To elucidate the problems associated with the expansion of pharmacotherapy for these disorders, it is helpful to refer to the ethical debates on what has come to be called “neuroenhancement”—applying biomedical technologies to improve cognitive or emotional capacities beyond therapeutic purposes—because neuroenhancement is continuous with the treatment of these disorders.

Discussions of the use of psychotropic agents for nontreatment purposes make explicit hitherto unnoticed values in psychiatric practice. The ethical concerns associated with neuroenhancement are as follows [2, 3].

- *Safety/efficacy*: The safety and efficacy of psychotropic agents for the healthy should be all the better and more securely established than for patients with mental disorders because healthy people do not have urgent reasons to take them.
- *Coercion*: Coercion is a situation where individuals unwillingly take neuroenhancing medication in response to direct or indirect pressure from the people around them, even if they use this type of drugs formally of their own free will. Those who belong to an organization are especially vulnerable to coercion from their colleagues. Coercion to use enhancing drugs is not uncommon among professional athletes.

- *Complicity*: What kind of change is recognized as enhancing human capacity depends on the culture and the period in which one is embedded and is relative to the values of the people surrounding them. Therefore, neuroenhancement has the possibility of entrenching the dominant values of the time that are arbitrary and sometimes unjust. For example, a cosmetic surgeon's performing skin whitening for black people in a region with discrimination against blacks reinforces the racist idea that white skin is more valuable than black skin [4].
- *Authenticity*: Authenticity is "being true to oneself." The use of psychotropic drugs is often considered as threatening one's true self. In the world of professional sports, a performance achieved with the aid of a drug is considered counterfeit. In addition, a person's decisions made under the influence a drug are often questioned as being truly hers. Quite a few people fear taking psychotropic drugs because their personality might change.

Ms. Suzuki was ambivalent toward pharmacotherapy because she held mutually competing values. She was proud that she had carried out her responsibility in her workplace and her home, which made her hesitant to rely on medications. Although she had been impeded by her social anxiety, her interpersonal subtlety and social anxiety were two sides of the same coin. The former sometimes made a positive contribution to her relationship with others and was part of her identity. Therefore, she was not sure whether getting rid of it would spoil her "true" self or instead help her to become her true self, as described by "Tess" in Kramer's *Listening to Prozac* [5]. Her attitude toward her promotion was also equivocal. She thought that she did not need the promotion because it entailed tasks she was not good at (i.e., more assertiveness and leadership). At the same time, she wanted to meet the expectations of the company she had belonged to for so many years.

From the viewpoint of the psychiatrist, it was perplexing whether to treat her case as a psychiatric disorder because he also had values pulling him for opposing directions. Most psychiatrists have will to help anyone in psychological difficulty. At the same time, they often observe the policy that a physician should devote herself to the treatment of "true" illnesses and refrain from engaging in the "enhancement" of those who are troubled but healthy. The latter intention is especially strong when they attend patients under the coverage of national health insurance, for it in principle presupposes that an individual has been diagnosed with a particular disorder before receiving treatment. Daniels distinguished these two values or ethos as among physicians and called the "expansive" and "hard-line" views of medicine [6].

In addition, in the case of Ms. Suzuki, the psychiatrist was anxious about violating her autonomy by diagnosing her as suffering from SAD and treating her because she had been prompted to see a psychiatrist. Treating a person who is not fully willing to receive treatment but has been urged to see a psychiatrist by those around her or who cannot refuse to accept medication because of the situation in which she is embedded is a milder form of coercion.

If the status of her disorder had been unquestionable, the psychiatrist would have straightforwardly recommended treatment for her without much deliberation based on the general idea that "a disorder should be treated." In borderline cases like Ms.

Suzuki's, however, one can infer nothing from such a general idea. In such cases, clinicians actually consider whether the patient should be treated in the first place. They then add a factual judgment of whether or not she has a mental disorder in accordance with the primary value judgment, as if the former is inferable from the latter. Synofzik indicates that the diagnosis in such cases is a "cryptonormative rhetoric move" that disguises a value judgment for a judgment of fact [7]. As discussed further in Chap. 27, even the DSM's "criteria of clinical significance," although assumed by many to be descriptive (being part of a descriptive classification), require making a number of value judgments when applying them in a given clinical situation. Trying to reduce the problem to a matter of proper diagnosis thus disguises a value judgment as a judgment of fact and neglects the complicated entanglement of values of those involved. In other words, in cases such as Ms. Suzuki's, we should not evade wrestling with the conflict of values when deciding whether to treat the individual in front of us.

26.4 The Influences of Culture on this Story

The consideration of values in this case is complicated by the culture of the company to which Ms. Suzuki belonged and the culture of Japan of which she is a member. In regard to her company, this had adopted a wage system based on seniority, which is common in Japan. Therefore, as their employees get older, they are assigned heavier duties and are expected to do more supervisory and administrative jobs. That Ms. Suzuki had begun to suffer hard times in her forties was at least partly due to the expectations of her company.

In regard to her country, on the other hand, Japanese culture has been called "a culture of shame," and shyness, reserve, and nonassertiveness are accepted as the norm. Nonassertiveness has been thought of as a virtue of women in the past, and these cultural values have survived until today. As such, they are considered by many to be part of a continuing Japanese culture of oppression of women. For instance, the proportion of women in management positions in Japan is about 12%, the lowest among developed countries [8]. This might be related to the epidemiological finding that the prevalence rate of SAD is *lower* in Japan than in the United States [9, 10]. Because it is unlikely that Americans are more socially anxious than the Japanese, a possible explanation of this difference is that social anxiety with a severity that is pathologized in the US is normalized in Japan, where women's exclusion from management positions in the workplace is a norm rather than an exception. This is the context where Kramer's suggestion that SSRIs are "feminist drugs" is understandable, for they liberate and empower women [5].

From the viewpoint of psychiatry's complicity with culture, we can observe a tug-of-war between the values of the mesosocial culture—her company—and the values of the macrosocial culture, namely, those of Japan. On the one hand, diagnosing Ms. Suzuki with social anxiety disorder and treating her accordingly seems to endorse the culture of her company, which practices a seniority system that disregards individual differences in aptitudes for posts. On the other hand, denying her

disorder status and refraining from treating her would indirectly affirm Japanese culture's oppressiveness to women, hindering the advancement of woman's social status.

Finally, cultural differences have an influence not only on value judgments but also on the interpretation of the most factual part of psychiatry, namely, the scientific evidence of pharmacotherapy for SAD. The evidence of the efficacy of SSRIs for the treatment of SAD is abundant, whereas that for neuroenhancement is scarce. However, Japanese psychiatrists should consider the fact that SAD diagnoses are less frequent in Japan than in western countries, where most of the randomized controlled trials have been performed. This allows us to interpret the "neuroenhancement" of socially accepted modesty in Japan as pharmacologically equivalent to the "treatment" of SAD in western cultures, for which we have abundant evidence for the efficacy of SSRIs.

26.5 Conclusions

In this chapter, we have explored the influence of values in psychiatric practice through the fictitious case narrative of Ms. Suzuki, a Japanese woman with substantial anxiety in interpersonal situations, but whose diagnosis of SAD is questionable. The Two-Foot Principle of Values-Based Practice indicates that both values and facts are essential for clinical decision-making. In terms of the dichotomy of facts and values, it is usually thought that a diagnosis may be categorized as a matter of fact. However, the case presented in this chapter illustrates that the principle is applicable not only to treatment choice but also to the diagnosis of a mental disorder itself. A diagnosis of mental disorder has a value component that is sometimes influenced by the surrounding culture. This implies that the Two-Foot Principle cannot be fully materialized by grafting the discussion of values related to treatment options onto the psychiatrist's diagnosis, the latter of which is considered a purely factual judgment. To make better clinical decisions on diagnosis and treatment, we should explicitly state the conflicting values of those involved and the cultural influences on them.

Acknowledgements This study was supported by the Uehiro Foundation on Ethics and Education (<http://www.rinri.or.jp>). The foundation had no role in the design of the study. I also thank Bill Fulford for insightful comments and advice for completing the chapter.

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