

# Directions in Psychiatry

VOLUME 33 • 2013 • NUMBER 3

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The need to redesign health systems to integrate care for *mental health, neurological, and substance use* (MNS) disorders with other chronic disease care was identified as one of the *Grand Challenges in Global Mental Health*. The authors of this lesson consider the challenges to integrating mental health services into primary HIV care, and review the use of a life course approach and evidence-based interventions in this process to alleviate suffering.

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Clinicians will review relevant research on physical complications of alcohol use disorders. They will consider various adverse physical effects that occur secondary to the consumption of alcohol at more than recommended levels. This lesson will better enable clinicians to diagnose and manage those patients with alcohol-related problems.

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# Cognitive-Behavioral Treatment of Social Anxiety among Ethnic Minority Patients, Part 1: Understanding Differences

L. Kevin Chapman, PhD; Ryan CT DeLapp; and Monnica T. Williams, PhD

*The authors have declared that no competing interests exist.*

**KEY WORDS:** Social Anxiety Disorder • Culture • Ethnic Minorities • Cognitive-Behavioral Therapy

**LEARNING OBJECTIVES:** Upon the completion of the lesson, readers will (1) understand the symptomology of *Social Anxiety Disorder* (SAD) as it is defined in the DSM-5, and (2) become knowledgeable of the associated cultural variables that impact the expression of this disorder's symptoms among ethnic minority groups.

**LESSON ABSTRACT:** SAD is one of the most common anxiety disorders, and extant literature has demonstrated that differences in cultural background can moderate the expression of its symptomology. Inasmuch, it is important for mental health professionals to acknowledge the relevance of culture within the assessment and treatment of SAD. In this lesson, the authors seek to cogently describe how culture interacts with the expression of SAD symptoms in ethnic minorities, as well as provide practical suggestions for professionals to become more multiculturally competent when working with SAD patients of diverse ethnic backgrounds.

**COMPETENCY AREAS:** This lesson addresses the gap in learning regarding the use of multiculturally competent mental health practices by describing cultural variables that have been implicated in extant SAD literature and by providing detailed recommendations for how to incorporate knowledge of these variables in the treatment of SAD. If unaware of the importance of such cultural variables, clinicians risk overlooking culturally-specific environmental vulnerabilities and/or inaccurately pathologizing culturally normative life experiences that contribute to the expression of social anxiety in ethnic minorities. At the conclusion of reading this lesson, readers will have a better understanding of these cultural variables, as well as learn possible strategies to incorporate these variables in the CBT treatment of SAD.

## Introduction

*Social Anxiety Disorder* (SAD) is not only one of the most common types of anxiety disorders, but is overall one of the most common mental illnesses.<sup>1</sup> Given SAD's high prevalence, mental health professionals should be equipped to adequately assess and treat this disorder in patients of various ethnic backgrounds. However, if there is limited knowledge of cultural variables that impact the expression of social anxiety among diverse groups, then there is a high likelihood that mental health practices may be less effective in accurately conceptualizing and treating SAD symptoms. Prior to discussing how such cultural variables can be utilized to ameliorate debilitating social anxiety in diverse populations, the first part of this lesson assures that mental health professionals have a sound comprehension of the cognitions and behaviors that are typically associated with SAD and how the symptoms of this disorder can differ across cultures. Ultimately, the goal of the first part of this lesson is to begin bridging that gap between culturally-based findings regarding the expression of SAD in ethnic minorities and the use of empirically-supported treatment, Cognitive-Behavioral Therapy. Specifically, readers will obtain a clear understanding of SAD as defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5),<sup>2</sup> become aware of associated variables that impact the expression of this disorder's symptoms, and be introduced to evidence demonstrating the relevance of culture when working with ethnic minority patients.

## Description of Social Anxiety Disorder

**Social Anxiety Disorder, also termed Social Phobia, is a pathological condition involving intense fear or anxiety of social situations, whereby an individual anticipates scrutiny by others.<sup>2</sup> This scrutiny may be the result of social interactions (e.g., having a conversation), being observed (e.g., eating or working), or performing in front of others (e.g., public speaking).**

For people with SAD, both specific and general social situations almost always provoke fear or anxiety, which includes somatic symptoms (e.g. trembling, sweating, blushing), cognitive symptoms (e.g. fear of

negative evaluation), and behavioral symptoms (e.g. avoidance of social situations),<sup>3</sup> although in children, the anxiety may be expressed by crying, freezing, clinging, or failing to speak. Due to the intensity of the fear, social situations are avoided or endured with distress. Although anxiety is normal in certain social situations, such as a job interview, people with SAD experience the anxiety out-of-proportion to the actual threat. Thus, symptoms often result in difficulties in social, occupational, and other important areas of functioning. Nonetheless, it is possible to have symptoms in just one area, such as public speaking.<sup>2</sup>

In order to meet criteria for a DSM-5 diagnosis of SAD, symptoms must be present for at least six months, not attributable to the direct effects of a drug or medical condition, and not better accounted for by another mental disorder.<sup>2</sup> **SAD should not be mistaken for conditions such as Panic Disorder (where individuals may avoid socializing due to fears of panic attacks), Separation Anxiety Disorder (where children may fear leaving their caregivers), Body Dysmorphic Disorder (where individuals may fear humiliation due to perceived physical flaws), or social communication difficulties (i.e., Autism Spectrum Disorders).**<sup>2</sup> SAD can be due to another condition (e.g., stuttering, Parkinson's disease, obesity, disfigurement) in which anxiety is unrelated or out-of-proportion to the medical condition itself.<sup>2</sup>

## Core Psychopathology in SAD

When engaging in or thinking about social encounters, people with SAD shift their attention inward, engage in detailed self-monitoring, and experience excessive, negative self-images. They underestimate their social abilities and retrospectively process social encounters in a manner that exaggerates shortcomings and minimizes accomplishments.<sup>4</sup>

It is important, however, to understand exactly what people with SAD fear. Negative evaluation, embarrassment, and loss of social status, may be feared outcomes, but are not the feared stimulus.<sup>4</sup> At the core level, SAD involves a distorted, negative view of the self and people with SAD believe they fall short of what others expect. This overlaps with the concept of shame, which implies a certain amount of uncontrollability over one's deficits. Thus, SAD may also be described as the fear of feeling

ashamed or being shamed by the negative evaluation of one's self.<sup>5</sup> Research indicates that people with SAD are more prone to experience shame than persons without it; analogous treatment of SAD with *cognitive-behavioral therapy* (CBT) results in the reduction of feelings of shame.<sup>6</sup>

**People with SAD believe they have deficits that fall within one or more of four broad categories: (1) inadequate social skills and behaviors; (2) an inability to hide visible signs of anxiety; (3) serious shortcomings in physical appearance; and (4) personality-related flaws.**<sup>4</sup> People with SAD feel powerless to correct these flaws; thus, they seek to conceal them through avoidance and the use of dysfunctional strategies (e.g., safety behaviors). Paradoxically, when individuals with SAD use safety behaviors, the likelihood that the feared outcomes will happen actually increases (rather than decreases), reinforcing the individual's negative beliefs about oneself and his/her inability to function in the social world.<sup>7</sup> Additionally, people with SAD generally rate themselves lower in their area of concern than others would rate them and overestimate the effects of their perceived deficits on others' evaluations of them.

In addition to the use of safety behaviors, SAD appears to be maintained by a failure to process potentially corrective information. People with SAD show an attentional bias towards threat (meaning that they pay too much attention to social cues that might indicate danger), and also experience deficits in processing positive information. Additionally, socially anxious individuals more quickly disengage from positive stimuli in comparison to controls.<sup>8</sup>

## Demographic Features of Social Anxiety Disorder

The experience of social anxiety is normal; therefore, SAD may be viewed as being on a spectrum where one end represents a total lack of social anxiety, followed by normal levels of social anxiety, followed by low-level shyness and milder social fears. Finally, at the other end of the spectrum are the more intense social fears, including non-generalized and generalized SAD, and ultimately Avoidant Personality Disorder.<sup>9</sup>

SAD typically has its onset during adolescence, with those who have more fears exhibiting an earlier age of

onset.<sup>10,11</sup> In the *National Comorbidity Survey Replication* (NCS-R), the estimated lifetime and 12-month prevalence of SAD was 12.1% and 7.1% respectively; the most common social fears were public speaking or performance (89%), speaking in a meeting or class (85%), and meeting new people (81%).<sup>11</sup> Those with SAD were six times more likely to have another comorbid disorder compared to those without SAD (odds ratio [OR] 6.1), and the most common comorbidities were Agoraphobia, Dysthymia, and Specific Phobia.<sup>11</sup> In the NCS-R, among adolescents (ages 13-18), approximately 9% met the criteria for lifetime Social Phobia. Of these, 56% had the generalized subtype, while 44.2% had non-generalized social phobia, based on the DSM-IV criteria.<sup>12</sup>

It is not uncommon for those with SAD to use alcohol to help cope with social distress, which puts such individuals at an increased risk for alcohol use disorders. Thus, people with SAD have increased rates of alcohol dependence (OR 2.8) and alcohol abuse (OR 1.2); SAD occurred prior to alcohol dependence in 79.7% of comorbid cases.<sup>13</sup> Also, there is evidence of a subtype of SAD that may involve more risk-prone behaviors. Analysis of NCS-R data supported two classes of SAD: (1) the typical pattern of behavioral inhibition and risk aversion, and (2) an atypical pattern of high anger and aggression, sexual impulsivity, and substance abuse problems, which was evident in 21% of those with SAD. Those with risk-prone SAD were younger, had less education, and greater functional impairment and psychiatric comorbidities, such as impulse control and bipolar disorder.<sup>10</sup>

In terms of gender differences, a large epidemiological study (National Epidemiologic Survey on Alcohol and Related Conditions) found that women reported more lifetime social fears and internalizing disorders, and were also more likely to have received pharmacological treatment for SAD, whereas men were more likely to experience fears about dating, externalize disorders, and use substances to manage social anxiety.<sup>14</sup>

## Etiology of SAD

Multiple factors appear to increase the risk of developing SAD, including both biological and psychological vulnerabilities (detailed below). Studies of twins have consistently shown the heritability of traits, such as

behavioral inhibition, shyness, and a fear of negative evaluation, which are believed to contribute to the development of SAD.<sup>15</sup> Most of the genetic variance is linked to a general risk for emotional disorders; however, a smaller proportion of the variance seems specific to social concerns.<sup>9</sup> Studies to date have indicated that early attachment is also related to the development of social anxiety. Retrospective studies indicate that parents of socially anxious individuals tend to underemphasize sociability, overemphasize the opinions of others, and isolate their children.<sup>15</sup>

Individuals with any of the predisposing factors described previously could develop SAD without exposure to a precipitating factor, but individuals may also encounter an event that leads to the development of SAD. The two main contributors are early childhood stressors (i.e. sexual abuse, severe illness, separation from parents, family conflict, parental psychopathology, etc.), and conditioning experiences.<sup>15</sup> Conditioning experiences involve exposure to an unpleasant social event, such as making a mistake in a social situation, being bullied at school, or being the target of racism at a party. A previously neutral social event then becomes a conditioned stimulus for a set of socially phobic conditioned responses because the event is paired with the experience of social defeat, danger, or humiliation.<sup>15</sup> Vicarious conditioning can also occur, in which social fears are acquired through observing another's fearful behavior, for example, a child who witnesses a parent frightened by another person. Therefore, emotional conditioning may occur through vicarious conditioning experiences.

## Social Anxiety and Culture

Culture influences the expression of social anxiety by affecting one's perception of perceived social threats, sense of social self, and expectations of socially appropriate and successful behavior.<sup>16,17</sup> One form of evidence supporting the relevance of culture when treating SAD comes from studies examining the prevalence rate of the disorder across ethnicities. The existence of cultural variation between Eastern (e.g., Japanese, Korean, and Chinese) and Western (e.g., United States and Canada) samples demonstrates that a fear of negative evaluation is unequally expressed across nationalities. **In a recent review of literature, Hoffman, Asnaani, and Hinton**

**(2010) summarized the 12-month prevalence rates of SAD found in extant literature and reported that the United States and South America yielded the highest prevalence rates (e.g., 7.1-9.1%), whereas China, Taiwan, Korea, and Nigeria had the lowest rates (e.g., 0.2-0.4%), which suggest cultural disparities may moderate the presentation of social anxiety.**<sup>18</sup>

Moreover, epidemiological studies examining SAD's prevalence within the ethnically diverse United States bolster the relevance of culture in SAD. In particular, Breslau, Aguilar-Gaxiola, Kendler, Su, Williams, and Kessler (2006) examined 5,424 non-Hispanic Black, Hispanic, and non-Hispanic White respondents from the *National Comorbidity Survey-Replication* (NCS-R) study and found that non-Hispanic Black (10.8%) and Hispanic (8.8%) individuals had a significantly lower lifetime prevalence rate for SAD compared to non-Hispanic Whites (12.6%).<sup>19</sup> Furthermore, Himle, Baser, Taylor, Campbell, and Jackson (2009) also found a higher prevalence rate (i.e., 12-month prevalence) for SAD in non-Hispanic Whites, utilizing data from the *National Survey of American Life* (NSAL) and the NCS-R, but also found that the African-American and Caribbean Black samples experienced significantly more severe social anxiety.<sup>20</sup> Collectively, these findings clearly represent differences in the prevalence of the disorder across diverse nationalities and intra-national cultural groups; however, the NSAL findings demonstrate that SAD's lower base rate in a given ethnic group is not particularly synonymous with a lower severity of the disorder, which is an important consideration when treating ethnically-diverse SAD clients. However, more nascent work has indicated an opposite trend; African Americans who have received culturally sensitive anxiety assessments have been shown to endorse more social anxiety disorders and specific phobias than other anxiety disorders.<sup>21,22,23</sup> In summary, an awareness of cultural factors (described later in the lesson) impacting social anxiety undoubtedly plays an integral role in the assessment.

Further evidence that supports the relevance of culture in the expression of social anxiety is the existence of culturally influenced presentations of a fear of negative evaluation. **Most notably, *Taijin Kyofusho* (TKS) has been implicated as a disorder in which**

**the individual is not concerned with embarrassing or humiliating oneself, but with offending or making others uncomfortable. To account for the broad spectrum of TKS symptom presentations, researchers have divided TKS into two subtypes: General and Offensive, where the former is more consistent with SAD, given that these individuals possess a fear of being negatively evaluated as a result of a physical characteristic, which leads to avoidance of certain social situations.**<sup>24</sup> Contrarily, the Offensive subtype is better characterized by a delusion that one's physical characteristics are defective and therefore offensive to others.<sup>18,24</sup> The symptom presentation of TKS has also been divided into four different categories in the Japanese diagnostic system: fear of blushing (*sekimen-kyofu*), fear of eye glance (*shubo-kyofu*), fear of physical deformity (*jikohisen-kyofu*), and fear of foul odor (*jikoshu-kyofu*). Common factors that influence the expression of each category include a feeling of shame, being unaccepted, and becoming avoidant of others as a result of displaying one of these self-perceived physical abnormalities.<sup>18</sup> Moreover, individuals with TKS tend to only exhibit one circumscribed fear at a time (e.g., only *sekimen-kyofu*) and their fear is usually most severe around familiar people.<sup>24</sup>

Despite culturally-specific implications for the expression of the symptomology of TKS, Hoffman et al. (2010) proposes that TKS should not be considered a purely culturally-bound disorder, i.e. "recurrent, locality-specific patterns of aberrant behavior and troubling experience" as it is described in the DSM-IV.<sup>25</sup> In particular, individuals who experience a fear of blushing (*Sekimen-kyofu*) would also meet the criteria for SAD, given that the fear is related to feelings of embarrassment and results in avoidance of social encounters.<sup>18,24,26-27</sup> Additionally, a fear of physical deformity (*Shubo-kyofu*) can be captured by the criteria that defines Body Dysmorphic Disorder, which is categorized in the DSM-5 as an Obsessive-Compulsive Spectrum Disorder, in which an individual's belief of having one or more physical defects is accompanied by repetitive actions (e.g., excessive grooming) or thoughts (e.g., comparing one's appearance to others).<sup>2</sup> **Together, the overlap of these TKS categories with DSM-5 disorders supports the**

**assertion that these syndromes are not limited to East Asian individuals.**

Contrarily, researchers assert that the fear of eye glance (*Jikohisen-kyou*) and fear of emitting a foul odor (*Jikoshu-kyofu*) are not as easily captured by the DSM-IV-TR<sup>18,25</sup> or DSM-5<sup>2</sup> criteria. In particular, Iwata et al. (2010) utilizes several case studies to differentiate the fear of eye glance, the TKS subtype, from the fear of eye-to-eye contact, a potential SAD symptom presentation. Specifically, each case narrative describes individuals who are primarily concerned that their eye glances are unique, harmful, and uncontrollably directed towards others, rather than fearing eye-to-eye contact due to anticipated personal embarrassment or humiliation.<sup>27</sup> Notably, one example described a young East Asian female who, in adolescence, was concerned that she "worried" others and made them feel uncomfortable with her glance. The authors explained that such a fear resulted in clinically significant impairment as evidenced by her dropping out of high school, and frequently looking down and closing her eyes to avoid eye contact with others.<sup>27</sup> Regarding *Jikoshu-kyofu*, or the fear of emitting a foul odor, researchers explained that this category is most synonymous with the Western physical condition (not included in the DSM-IV or DSM-5) termed *Olfactory Reference Syndrome* (ORC), in which the individual is concerned that his/her personal body odor is offensive to others.<sup>24</sup> Commonly, individuals who suffer from such concerns engage in frequent hygiene practices, such as taking showers, brushing teeth, or changing clothes to alleviate their distress.<sup>24</sup> Though the categories that describe fear of eye glance (*Jikohisen-kyofu*) and emitting a foul odor (*Jikoshu-kyofu*) arguably fall outside the criteria for SAD delineated within the DSM-IV and DSM-5, cross-cultural comparisons (e.g., Western culture - United States/Canada versus Eastern culture - Japan/Korea) have supported the overlap in the expression of TKS symptoms across cultures; this is shown by endorsements of TKS and SAD symptoms in Japanese and American college students,<sup>16</sup> as well as clinically significant cases in other Americans.<sup>26</sup> As a result of such findings, the DSM-5 no longer classifies mental illnesses like TKS as "cultural-bound syndromes," and more accurately acknowledges that psychological symptoms are rarely specific to a geographic location, but

reflect culturally-influenced concepts of distress.<sup>2</sup> Given that extant literature has provided evidence that TKS symptomology is not locality-specific, mental health professionals should not overlook evidence of these symptoms in non-Asian heritage clients.<sup>2</sup>

Aside from TKS, another culturally specific variation of social anxiety has been identified in the ultra-Orthodox Jewish community. This community illustrates the unique interplay of strict social and religious norms that govern interactions within its society. Specifically, Greenberg, Stravynski, and Bilu (2004) note that within Jewish law, social conversation is discouraged between men and women as a means to reduce the temptation of sexually immoral behavior and to increase attention to religious study. Also, researchers reference religious texts that encourage silence “unless to say matters of wisdom or matters to do with physical needs.”<sup>28</sup> Given the religious and social context at the foundation of this community, men are socialized early on in adolescence to become more socially withdrawn and avoidant of interpersonal contact than men are in more secular communities. Furthermore, though authors describe that a zaddik (religious leader) is often lauded by his community as a “righteous person” for remaining socially withdrawn in order to become immersed in religious study, the immense pressure to uphold such a morally upright lifestyle and devout religious practice can lead some men to develop symptoms of social anxiety. In utilizing several case examples to illustrate the expression of SAD within the religious and social context of this

community, Greenberg and colleagues (2004) describe men who experience debilitating performance anxiety during public prayers and scripture readings.

Overall, the cultural pressures that underlie these presentations (TKS and in the ultra-Orthodox Jewish community) of social anxiety serve as evidence that the Western-defined criteria for SAD may not fully encapsulate the expression of social anxiety cross-culturally. Though there are clearly overlapping symptomologies, mental health professionals must interpret the clients’ cognitions and behaviors within the context of their cultural backgrounds.

## Summary

This lesson has provided a detailed overview of the core symptoms of *Social Anxiety Disorder* (SAD) as defined by the DSM-5 as well as described associated variables that influence the expression of these symptoms (e.g., demographics features, etiological factors). Additionally, a discussion of cross-cultural discrepancies in the prevalence of SAD and examples of culturally-influenced social anxiety (e.g., Taijin Kyofusho) were utilized to convey the importance of culture when conceptualizing and treating diverse populations. In the second part of this lesson, the authors present cultural variables that have been shown to interact with symptom presentations of SAD as well as provide detailed recommendations for how to integrate knowledge of these variables within Cognitive Behavioral Therapy for ethnic minority patients with SAD. ■

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