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Cognitive-Behavioral Treatment of Social Anxiety among Ethnic Minority Patients, Part 2: Bridging the Gap in Treatment

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LEARNING OBJECTIVES: Upon the completion of the lesson, readers will (1) become knowledgeable of important cultural factors that influence the expression of SAD in ethnic minorities and (2) consider strategies to incorporate these factors within a culturally-sensitive *Cognitive-Behavioral Therapeutic* (CBT) approach.

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 one of the most common types of anxiety disorders, and in fact one of the most common mental illnesses overall, with a lifetime prevalence as high as 12.1% in the United States (Ruscio et al, 2008). Individuals with SAD experience intense fear or anxiety of social situations, when anticipating scrutiny by others. This scrutiny may be the result of social interactions, being observed, or performing in front of others. The experience and prevalence of SAD differs cross-culturally, and clinicians must be cognizant of these differences when treating diverse populations. As such, the relevance of culture in the treatment of SAD is bolstered by discrepancies in prevalence rates cross-culturally and the existence of alternative cultural presentations of social anxiety, such as *Taijin Kyofusho* (TKS) and symptoms of social anxiety within the ultra-Orthodox Jewish community. Furthermore, extant literature has also identified several culturally-influenced variables that interact with the expression of social anxiety, which should be considered when working with ethnic minority clients. Ultimately, in light of the possible interplay of culture and SAD within ethnic minority patients, the goal of this lesson is to bridge the gap between culturally-based findings regarding the expression of SAD in ethnic minorities and the use of an empirically-supported treatment, *Cognitive-Behavioral Therapy* (CBT), to treat SAD. Specifically, readers will acquire an understanding of what cultural variables have been identified in extant SAD literature and be provided with detailed suggestions on how to integrate knowledge of these variables within specific areas of the CBT protocol (i.e., psychoeducation, cognitive restructuring, and exposure).

Cultural Factors Influencing the Expression of Social Anxiety

There are several cultural factors that have been identified in extant literature that may guide a mental health professional's assessment and subsequent treatment of debilitating social anxiety in ethnic minorities. First, evidence suggests that an individual's cultural orientation (i.e., collectivism and individualism) can moderate the expression of social anxiety.[1] Collectivism "describes the relationship between members of social organizations that emphasize the interdependence of its members," which ultimately places social harmony and acceptance as defining characteristics of one's being.[1] In more collectivistic cultures, there are stricter social rules defining appropriate behaviors for different situations and settings, which creates more pressure to abide by social rules in order to maintain harmony (and avoid social blunders). Contrarily, individualism is described as the prioritizing of personal achievement and success as the optimal reward and the primary source of social admiration. **Given such distinctions in culturally sanctioned social behaviors, many researchers have proposed that the more stringent social regulations defining socially appropriate behaviors in collectivistic societies account for the increased likelihood of Eastern cultures to endorse significantly higher social anxiety compared to Western cultures.**[2,3,4] **Interestingly, such findings appear to contradict the lower prevalence rates often found in East Asian cultures relative to Western cultures (as described earlier).** However, it is important to remember that an individual must demonstrate considerable impairment as evidenced by situational avoidance, marked distress upon exposure to feared social stimuli, and reduced functioning in at least one life domain, in addition to the expression of social anxiety when diagnosing SAD.[5] Given that impairment can be heavily influenced by culturally defined social norms, socially withdrawn, reticent, and/or shy individuals who endorse greater social anxiety may be interpreted differently across collectivistic and individualistic societies.[2,4] In other words, socially anxious individuals may experience greater impairment in cultures in which personal gain, assertiveness, and individuality are prioritized in relation to cultures in which fitting in and social harmony are emphasized.

A second, yet related, factor implicated in previous research is the incorporation of collectivistic versus individualistic values in the definition of one's self, or a *self-construal*. In particular, it is important not only to understand the cultural orientation one was raised in, but also to what degree he embodies the social norms and values endemic to a collectivistic versus individualistic culture. Inasmuch, an endorsement of separateness, individuality, and personal achievement is

evidence of an independent self-construal,[6] and these individuals are theorized to aspire to distinctive, yet positive, personal attributes that transcend across environments.[2] Contrarily, individuals who define the self by the maintenance of social harmony and conformity to social obligations typify an interdependent self-construal.[2,6] Because individuals with an interdependent self-construal identify more strongly with their families or cultural groups, they tend to be more likely to feel shame, in addition to social anxiety when their behaviors fall outside of social norms. Extant literature has identified the independent self-construal as highly indicative of social anxiety across samples of Western and Eastern nations. Specifically, Kleinknecht et al. (1997) found that the independent self-construal was inversely related to SAD and TKS symptoms in United States (US) and Japanese samples, as well as a significant predictor of TKS symptoms in a Japanese sample, which suggests that endorsing an independent self-construal may be a protective factor when faced with social stress. Additionally, Hong and Woody (2007) found that the independent self-construal mediated the relationship between ethnicity (Korean versus Euro-Canadian) and social anxiety, despite Korean individuals endorsing more interdependent self-construals relative to the Euro-Canadian sample. Aside from measurement error in validly assessing self-construals, Hong and Woody (2007) proposed that differing thresholds and culturally normative standards defining debilitating social anxiety, may account for the greater relevance of independent self-construals.

In addition to the influence of one's cultural orientation, the expression of social anxiety in ethnic minorities may also be impacted by their *ethnic identity* or a sense of belonging to a chosen ethnic heritage, as well as their *acculturation* or how well they manage conflicting dominant and ethnic cultural streams of influence (e.g., values, language, national identities).[7] Specifically, existing theoretical models collectively explain that one's ethnic identity can shift from ethnic uncertainty (minimal interest or perceived relevance of one's ethnic background), ethnic curiosity (heightened interest in one's cultural heritage potentially accompanied by a devaluing of other ethnic groups), and multicultural appreciation (combining of one's devotion to his ethnic background with an acceptance of other ethnic groups).[8] Despite an absence of evidence specifically examining ethnic identity's influence on social anxiety, extant literature has shown that one's sense of belonging to a cultural group moderates the expression of depression and anxiety symptoms in ethnic minorities[9,10] and suggests that the stage of ethnic identity development, age, and level of perceived stress can reduce the protective nature of high ethnic identity.[11]

Moreover, though originally defined as the degree to which ethnic minorities adopt the values and engage in traditional practices of the dominant culture, nascent conceptualizations of acculturation describe how individuals balance conflicting cultural streams across various areas of their lives. In particular, ethnic minorities are often faced with reconciling discrepancies in their identities (ethnic versus national identity), value systems (individual versus collectivism), language proficiencies (ethnic versus national language fluency), cultural knowledge, and cultural practices.[12,13,14] Consequently, ethnic minorities may encounter acculturative stress (or experience difficulty integrating disparities in their ethnic and mainstream cultural identities), which has been associated with psychopathology in these individuals (e.g., more eating disorder symptoms;[15] greater levels of depression.[12,16] Regarding the impact of acculturative stress on the expression of social anxiety, Hsu and colleagues (2012) examined the social anxiety of bicultural (residing in a foreign country) and unicultural (residing in native country) college students of *East Asian-heritage* (EAH) and Western-heritage.[17] Notably, researchers found that bicultural EAH college students reported the highest social anxiety and depression, which highlights the distress experienced by ethnic minorities who face dual cultural influences as a result of considerable exposure to two different cultures. Overall, based upon the aforementioned findings describing the relevance of acculturation and ethnic identity in the expression of social anxiety, we recommend that mental health professionals specifically consider the impact of these variables when treating social anxiety in ethnic minorities.

Finally, the expression of social anxiety in ethnic minorities also may be influenced by exposure to *ethnic/race-based stressors*. Particularly relevant to the expression of social anxiety in ethnic minorities is perceived *ethnic/racial discrimination*, which describes

the sense that "dominant members' actions have a different and negative effect on subordinate racial/ethnic groups."[18] An abundance of past literature has established that high levels of various forms of perceived discrimination contribute to negative health outcomes. Specifically, Pascoe and Richman (2009) conducted a meta-analysis examining the health risks associated with perceived discrimination and found that greater discrimination was significantly related to severe mental health outcomes (e.g., depression, anxiety, psychiatric, general well-being) and was comparatively harmful across both genders and diverse ethnic groups (i.e., Asian American, African American, Hispanic, Native American, and non-Hispanic White American).[19] Moreover, Pascoe and Richman reported that more recent encounters compared to lifetime and chronic exposure to discrimination were more significantly related to negative mental health outcomes, which highlights the temporality of the discriminatory act as a possible moderator in the expression of psychological symptoms. Though not yet empirically studied in ethnic minority populations, perceived discrimination has been identified by extant literature as the most salient minority stress factor in predicting social anxiety among homosexual men.[20] Interestingly, the attribution of discriminatory acts as "costly" with "widespread implications" was related to more severe social anxiety within this specific minority sample.[20] Regarding social anxiety among ethnic minorities, socially anxious individuals who employ a similar attribution style when encountering ethnic/race-related discrimination (e.g., believing that you were denied a promotion because of your ethnicity/race; feeling that people are laughing at you during a presentation because of your ethnicity/race) could conceptually trigger the development of conditioned fear responses across situations involving similar cues (e.g., potential job promotion, being a minority amongst a majority, public speaking). Though this assertion requires more empirical support, we suggest that mental health professionals inquire about potentially harmful instances of discrimination in order to determine if such an experience has become generally applied across social situations and encounters.

Furthermore, extant literature has also identified another ethnic/race-based stressor that may impact the expression of social anxiety in ethnic minorities. **Specifically, *stereotype threat*, or the conscious or subconscious awareness of an identity (e.g., ethnicity, gender) that is negatively stereotyped to perform inferiorly, may contribute to performance anxiety commonly experienced in socially anxious individuals.** Steele (1997) described that in order for stereotype threat to impact performance, the individual must find the negatively stereotyped group to be "self-relevant," meaning that he/she must strongly identify with the group and the individual must perceive the situation as "self-threatening," meaning he/she is concerned that his/her performance may confirm the negative stereotype.[21] An illustration of the harmful effects of this is best shown in the seminal study conducted by Steele and Aronson (1995) in which they found that making African American students aware of a racial stereotype (i.e., African Americans perform poorly on standardized tests) prior to taking an exam, led them to perform poorly in comparison to other African-American students whose awareness was not primed in such a way.[22] Additionally, stereotype threat has shown to influence performance across various domains, including ethnicity, gender, and socioeconomic status,[23] which highlights the cross-cultural applicability of this construct. Despite such findings, researchers assert that stereotype threat may only apply to a subset of negatively stereotyped individuals,[21,24] suggesting that solely being a member of a stereotyped group does not automatically yield poor performance. Socially anxious individuals who strongly identify with a negatively stereotyped group (e.g., ethnic minorities who are high in ethnic identity) may potentially represent a subset of individuals who are considerably susceptible to the harmful effects of stereotype threat. In theory, this assertion could contribute to the conceptualization of culturally specific SAD symptomology, as ethnic minorities may experience anticipatory anxiety and/or avoidance of social situations or interactions when their performances on a given social task (e.g., speaking in front of predominantly non-Hispanic White colleagues) conflict with the awareness of a negative stereotype about their performances or abilities within the given task (e.g., African Americans are less intelligent than non-Hispanic Whites). Once again, though limited by an absence of empirical data supporting this specific conceptualization, we believe that

stereotype threat may represent another relevant culturally specific variable that can uniquely explain variability in SAD among ethnic minorities.

In conclusion, though many of the aforementioned findings were derived from non-clinical and/or college-age populations, and therefore lack replication in clinically diagnosed samples, we strongly recommend that mental health professionals inquire about the influence of such factors and include this in the conceptualization of social anxiety in ethnic minority clients. Additionally, the impact of culture on social anxiety is cogently defined in extant literature; therefore, we strongly recommend that professionals allow these factors to inform their application of the impairment criterion required by the DSM. In other words, by overlooking or ignoring the influence of cultural orientation, self-construals, ethnic identity, acculturation, and ethnicity/race-based stressors, there is an increased likelihood for cultural or environmental normative social anxiety to be misinterpreted. In the following sections, we will provide detailed instructions for how to integrate knowledge of these cultural variables within the conceptualization and treatment of SAD in ethnic minorities.

Culturally-Sensitive Treatment of Social Anxiety: Current Conceptualization

Although beyond the scope of this lesson, the generally accepted conceptualization of social anxiety disorder[1] deserves additional attention here due to the importance of integrating the aforementioned cultural variables into the treatment context. One currently accepted and empirically supported conceptualization for the development of SAD requires the presence of both a generalized psychological (e.g., parents modeling anxious behavior, tendency to view events as proceeding in an uncontrollable, unpredictable fashion) and biological (e.g., behavioral inhibition, familial anxiety, tendency to experience negative affect) vulnerabilities. However, the environment plays an integral role in the further development of the syndrome known as social anxiety disorder. In this conceptualization,[25] direct experience is extremely important. In Barlow's (2002) conceptualization, stress in the context of the aforementioned vulnerabilities led to a series of "alarm" reactions (e.g., panic/fear-based response). "False alarms" are considered panic-like reactions in which there is no obvious identifiable stressor. On the other hand, "true alarms" represent panic-like reactions in the context of realistically "dangerous" situations; in the case of social situations, "danger" would not be considered life-threatening, but represent social situations in which scrutiny or negative social evaluation has occurred (e.g., being scrutinized, ridiculed, or embarrassed in some way). Regardless of the alarm pathway, the fear-based symptoms become closely associated with the social context (a learned alarm) and the subsequent anxiety associated with future encounters; attentional biases that are largely self-focused (e.g., thinking errors, attention to potential threatening facets of social context, etc.) become specific psychological vulnerabilities (e.g., belief that social contexts are dangerous), leading to the development of social anxiety disorder. **Of particular note for practitioners is the plethora of cultural factors (e.g., ethnic/race stressors) that influence the "true alarm" reactions that are currently not accounted for by current models.** Below, we have delineated the empirically supported treatment for SAD, while considering the aforementioned cultural factors that are important considerations when considering the treatment of SAD.

Treatment of Social Anxiety Disorder

Although a number of pharmacological regimes (SSRIs and MAOIs, particularly *phenelizine* [Nardil]) have proven to be efficient treatments of SAD, roughly 50% of individuals on these medications relapse when their medications are discontinued.[26] As such, an equally effective treatment approach in which individuals do not tend to relapse is *cognitive-behavioral therapy* (CBT). Although there are a number of empirically supported, manualized CBT packages, the majority of the treatments consist of similar elements. Below, we will discuss each element and the importance of incorporating the aforementioned cultural variables into the treatment. In our view, the four most common elements of social anxiety treatment with CBT are psychoeducation (about social anxiety and CBT components), cognitive restructuring, systematic graded exposure, and homework

assignments. It should be noted that considerable attention has been given to systematic graded exposure and cognitive restructuring, since the authors believe these two treatment components contain the most important cultural considerations when engaging in CBT for social anxiety with ethnic minority patients. Furthermore, it should be noted that cultural competence and sensitivity are both necessary and important when engaging in psychoeducation and assigning homework throughout the course of treatment. As such, homework assignments should be guided by the facet of social anxiety that is discussed during each session and carefully implemented.

Psychoeducation:

Generally, there are a number of empirically supported CBT protocols that share similar elements in common for ameliorating symptoms endemic to social anxiety disorder.[26] Therefore, it is essential that the structure and ingredients of effective CBT remain intact while integrating cultural variables into the intervention. Furthermore, although empirically supported "culturally sensitive therapies" have yet to be evaluated consistently with RCT criteria,[27] practitioners are encouraged to utilize the salient, cultural factors that have been empirically evaluated as integral to understanding ethnic minority individuals. As such, we have utilized the manualized CBT approach employed by Hope and colleagues (2010) to describe the treatment of social anxiety, while simultaneously considering cultural factors. Although psychoeducation is a common feature throughout the duration of treatment, psychoeducation in the technical sense takes roughly 2-3 sessions in the current approach. Psychoeducation about the nature of social anxiety disorder (e.g., statistics, effectiveness of the protocol, common symptoms, etc.), and case vignettes normalize the experience of the patient, while providing feedback about his or her experience. Additionally, the three components of social anxiety (cognitive, physiological, and behavioral) are discussed, and the objective monitoring of experiences is encouraged. Moreover, motivational interviewing is utilized in the first two sessions to determine if the patient perceives the benefits of working on social anxiety as more important than the relative costs. Ultimately, the four main ingredients of treatment (psychoeducation, cognitive restructuring, systematic graded exposure, and homework) are discussed with the patient and examples of these activities are provided.

The validity of the psychoeducation portion of treatment appears to be particularly attractive given that the predominant emphasis at this stage of treatment is to acclimate the patient to the experience of social anxiety and how CBT is effective in ameliorating symptoms. However, it is also critically important at this stage to recognize the heterogeneity of patient experiences and how cultural factors play an integral role in the experience of social anxiety. When engaging in psychoeducation, it is paramount for practitioners to assess for "true alarm" experiences that are either overlooked or minimized in the treatment of ethnic minority patients. As previously indicated, assessing the relevance of cultural background (e.g., cultural orientation), experiences with discrimination, and acculturative stress are critically important, since these experiences could undoubtedly heighten the fear of scrutiny in social situations regardless of experiences with social anxiety. Additionally, stereotype threat (fear of confirming negative stereotypes, particularly in situations involving non-Hispanic White individuals)[22] is an additional consideration that clinicians, particularly non-Hispanic White clinicians, need to consider when working with ethnic minority patients with SAD. Since ethnic minorities in the US are susceptible to a number of negative stereotypes regardless of socioeconomic status, clinicians must be mindful of not viewing these experiences as examples of the pathology that is often characteristic of social anxiety disorder. As such, we must be cautious when explaining the thinking skills endemic to CBT, since suggesting that a patient identify thinking errors associated with these culturally-specific "true alarms," could further traumatize patients of color by discounting realistic experiences with discrimination and racism. Accurate cultural empathy and effective problem-solving techniques to utilize patient strengths at this stage (such as kin support, spirituality, and individual interests) may be more effective interventions than identifying thinking errors related to social situations. Therefore, clinicians have to be particularly cognizant of one's own cultural worldview while being mindful of the three integral components of social anxiety (cognitive, physiological, and behavioral). Therefore, psychoeducation follows a logical, structured sequence

that includes normalizing patient experiences with social anxiety, while carefully considering sociocultural factors that may exacerbate these experiences.

Cognitive Restructuring:

Although psychoeducation occurs throughout the duration of CBT for social anxiety disorder, the majority of psychoeducation as it pertains to cognitive restructuring occurs during the first few sessions and extends beyond the end of treatment, given that it forms the basis for systematic graded exposure (e.g., approximately session 3 through 16).[26] As such, the recording of cognitions in relation to social anxiety, specifically negative automatic thoughts, is paramount prior to exposure, and it is here where practitioners need to be increasingly cognizant of not discrediting the unique experiences of ethnic minority patients, which may lead to offending patients of color.[28] Therefore, clinicians should explicitly discuss matters of discrimination and acculturative stress with ethnic minority clients and clearly delineate social situations that elicit cognitions, and physiological or behavioral symptoms that are endemic to social anxiety. Additionally, explicitly discussing matters of discrimination and acculturative stress may further serve to bolster the therapeutic alliance, while objectively recording symptoms of social anxiety that lead to therapeutic change. Therefore, thinking skills need to be taught as they relate to clear instances in which social anxiety is present (e.g., "typical" social situations), rather than situations that may be anxiety-provoking due to realistic occurrences of discrimination, racism, and oppression; for instance, encouraging a client to evaluate thinking errors inherent in the cognition, "I know that my boss will respond negatively," when there is no evidence supporting this notion, is functionally different than, "my boss thinks that I will confirm a stereotype because I have heard him make racial comments before." Therefore, thinking skills need to be encouraged as part of the CBT protocol with realistic instances of discrimination, racism, and micro-aggressions. Along these lines, Hope and colleagues (2010) suggest utilizing disputing questions, which are all-purpose questions that allow one to consider evidence objectively as it relates to negative, unrealistic thoughts. When challenging automatic thoughts with disputing questions, (e.g., "are you 100% sure that your boss will think critically of you?"), key points are taken from this dialogue and a rationale response is developed and subsequently implemented during social anxiety-provoking situations (e.g., "I am prepared for this speech."). Given that our literacy is culturally based,[29] practitioners are also encouraged to use language that the client is comfortable with when creating and utilizing rationale responses to combat thinking errors. As such, it is best that the practitioner allows the patient to develop the rationale response that is based upon his or her worldview, rather than what the practitioner believes is a "better" rationale response.

Systematic Graded Exposure:

Similar to other CBT protocols for anxiety and related disorders, social anxiety disorder requires the creation of an exposure hierarchy with the most anxiety-provoking situation placed at the top of the hierarchy (e.g., rated as "100"). Although the exposure hierarchy for social anxiety is typically created in approximately session three,[26] the practice of situations in the hierarchy is usually not conducted until approximately session seven, when thinking skills have been sufficiently practiced. As such, when collaboratively creating the exposure hierarchy with the patient, anchor points are typically created as an objective basis for assessing general distress. Anchor points are typically created for non-social anxiety- provoking situations so that the patient can objectively evaluate his or her distress in social anxiety-provoking situations. These ratings are typically assessed with a *Subjective Unit of Discomfort/Distress Scale*, otherwise known as a "SUDS" rating, with a range of 0 (no distress) to 100 (extreme distress). Anchor points are typically created at 25, 50, 75, and 100.[26] Once anchor points are established, SUDS ratings are assigned to each social situation in a hierarchical fashion and are revisited for therapeutic exposure (practice with the practitioner) in approximately session seven. When creating anchor points and assigning SUDS ratings, it is here that practitioners are further encouraged to engage in accurate cultural empathy and sensitivity. It is here that the practitioner may obtain anchor points that are directly related to patient experiences and may include discriminatory experiences or instances of racism. Furthermore, a patient could realistically report an anchor point of "75" when he or she believes that he/she was verbally mistreated by a taxi driver or when going through

airport security, or encountered a condescending tone by an advisor. The extent to which practitioners can engage in accurate cultural empathy with patients of color could significantly enhance the therapeutic alliance by not pathologizing realistic instances of discrimination, while clearly underscoring settings in which social anxieties occur. It should further be noted that discrimination, racism, and micro-aggressions can be manifested by symptoms of anxiety. However, it is underscored that these instances need to be assessed rather than relegated to an exposure hierarchy in need of CBT interventions. The latter point may further alienate patients of color and potentially increase stigmas associated with mental health. Therefore, the exposure hierarchy should include approximately 8 to 10 situations[26] that the clinician and patient agree upon, all of which to be practiced in the therapeutic context prior to the patient engaging in self-guided exposure outside of the therapeutic context. Moreover, patients who complete the exposure hierarchy (approximately 16 sessions) are encouraged to engage in further CBT interventions aimed at discovering core beliefs associated with social anxiety that serve as the driving force for the social anxiety on a more observable level.

Summary

This lesson has provided a detailed description of cultural variables that can influence the symptom presentations of Social Anxiety Disorder among ethnic minorities, as well as recommendations for how to integrate an understanding of these variables within the treatment of SAD. Though the authors' recommendations are believed to yield more culturally-sensitive mental health practices, it is worth noting that there remains a dearth of empirically supported treatments that have investigated the efficacy of incorporating the aforementioned cultural variables in CBT treatment of SAD. Despite such limitations, we encourage mental health professionals to use the information provided in this lesson to inform their conceptualization and treatment of SAD in ethnic minority patients.

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