19 Cultural Considerations in Behavioral Health Service Delivery for Social Anxiety

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Social Anxiety Disorder: Prevalence and Correlates

Previously termed social phobia, social anxiety disorder (SAD) is the persistent fear and anxiety in one or more social or performance situations in which an individual may be exposed to scrutiny or negative evaluation by others (DSM 5, American Psychiatric Association, 2013). SAD has been associated with great impairment that reduces the quality of life (McEnery, Lim, Tremain, Knowles, & Alvarez-Jimenez, 2019). SAD is prevalent worldwide with Nigeria and China having the lowest prevalence rates of SAD and Australia, New Zealand, and the USA reporting the highest lifetime prevalence rates (Stein et al., 2017). Notably, countries with higher incomes are more likely to report higher prevalence rates of SAD than counties that have lower incomes (Stein et al., 2017). In the USA it is estimated that about 7% of adults aged 18 years or older had social anxiety in the past year (Harvard Medical School, 2007a), while about 13% of US adults had experienced SAD in their lifetime (Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012). In the USA, SAD was reported higher among females than males with 8% of females reporting SAD and 6% of males (Harvard Medical School, 2007b). Among various countries the onset of SAD occurs mid-late adolescent years and early 40s (Stein et al., 2017). Additionally, individuals with SAD were at higher risk for comorbidity of another mental illness (80%; Stein et al., 2017). Individuals with a psychotic disorder are at higher risk of experiencing SAD, with prevalence rates between 8% and 22% (McEnery et al., 2019). Worldwide only 38% of the population with SAD receive treatment for symptoms of SAD, which included medical, mental, and nontraditional healthcare (Stein et al., 2017).

Social Anxiety Among Latinxs

Anxiety disorders affect an estimated 21% of the Latinx population (Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2005). The exact number of Latinxs with SAD is not noted in the literature since all anxiety disorders are typically grouped under one term, anxiety disorders. A study by Bjornsson et al. (2014) examined the clinical characteristics and demographic variables of a sample of Latinxs with SAD, generalized anxiety disorder, or panic disorder with agoraphobia. The majority of Latinxs with SAD reported originating mostly from the USA, Puerto Rico, and the Dominican Republic. The mean onset of SAD was 13 years old with a duration rate of 21 years. Individuals with SAD had the mean age of

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35 years old, mostly single, female, had some college educations, were equally employed and unemployed, received income from their job, made less than $20,000 a year, and live alone. About 37% of participants with SAD reported a trauma history. Participants were also mostly likely to report a comorbidity with another psychological disorder. About 84% of participants reported a lifetime utilization of treatment with the majority utilizing individual therapy.

Social Anxiety Among African Americans

Anxiety disorders affect an estimated 25% of the African American population (Breslau et al., 2005). While the exact number of African Americans with SAD has not been documented in the empirical literature, cultural implications as they pertain to SAD among African Americans have been discussed. For example, Sibrava et al. (2013) examined the clinical characteristics and demographic variables of a sample of African Americans with SAD, generalized anxiety disorder, or panic disorder with agoraphobia. They found that the mean onset of SAD was 14 years old with a duration rate of 28 years. Individuals in their sample who had SAD had a mean age of 42 years old and were mostly single, female, had some college educations, were unemployed, received income from psychiatric disability, made less than $20,000 a year, and lived alone. Approximately 57% of participants with SAD reported a trauma history. Participants were also most likely to report a comorbidity with another psychological disorder. Approximately 95% of participants reported a lifetime utilization of treatment with the majority utilizing individuals' therapy.

When examining the factors that may influence the development of SAD among African Americans, Levine et al. (2014) indicated that everyday discrimination (but not major experiences of discrimination) are associated with SAD for African Americans, Caribbean blacks, and non-Latinx whites (NLW). Approximately 42% of Caribbean blacks and 43% African Americans were significantly more likely to report racial factors as the primary reason for major discrimination compared to non-Hispanic whites. Another study examined the relationship between stereotype confirmation concern among African Americans and NLWs with SAD (Johnson & Anderson, 2014). Stereotype confirmation concern has been defined as a "chronic experience of uncertainty and apprehension about appearing to confirm as self-characteristic a stereotype about one's group" (Contrada et al., 2001, p. 1775). The results indicated that fear of negative evaluation was positively correlated with stereotype confirmation concern (Johnson & Anderson, 2014). In summary results from empirical studies suggest individuals who are more racially diverse may experience more stereotype confirmation concern.

Familial context for African Americans may also be associated with SAD among this group. Levine, Taylor, Nguyen, Chatters, and Himle (2015) found that among African Americans and Black Caribbeans who have close supportive ties with family and friends may be protected against developing SAD. However, if individuals had negative interactions with family (e.g., conflicts), they are at an increased risk for meeting criteria for SAD (Levine et al., 2015). African Americans who are not close to their family and experience negative interactions with their family are at an increased risk of developing SAD (Levine et al., 2015). For Caribbean Blacks, the odds of meeting criteria for SAD were higher among Black Caribbeans who had high negative interaction with family as well as low levels of friendship closeness (Levine et al., 2015).

Summary

An extensive review of the literature revealed that research on SAD among certain cultural groups (i.e., Asians, Native Americans) is minimal. There is some literature on Asians and SAD; however, it discusses the cultural differences in SAD between Eastern (especially Japanese,

Korean, and Chinese) and Western (US American and European) samples (Choy, Schneier, Heimberg, Oh, & Liebowitz, 2008; Hofmann, Asnaani, & Hinton, 2010). For example, Japanese and Koreans use the term taijin kyofusho (TKS) to describe culturally specific SAD (Choy et al., 2008). More specifically TKS is focused on an individual doing something that will embarrass the other person, which in contrast to SAD focuses on embarrassing oneself (Choy et al., 2008). While there is some research on the Latinx population, the research is limited although it is clear that Latinxs are affected by SAD. As summarized above, across the major ethnic minority groups in the USA, the bulk of the research has been conducted with African Americans. Further research is needed to understand the prevalence rates of SAD among diverse groups in the USA so as to establish risk and protective factors in the development and maintenance of SAD. As noted with the studies on African Americans, discrimination or marginalization impacts SAD, but little is known about the impact of discrimination or marginalization among other diverse groups with SAD. There are various treatments that can be used with individuals with SAD, but CBT is usually the first line of treatment, and CBT has been adapted to be used with individuals who are culturally diverse.

Treatment Options for SAD: Cognitive Behavioral Therapy (CBT)

Cognitive behavior therapy is effective for reducing psychological distress among a range of populations with various disorders including social anxiety disorder (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). CBT for social anxiety involves restructuring negative thoughts and having the client experience exposures in social contexts (Graham-LoPresti, Gautier, Sorenson, & Hayes-Skelton, 2017). More specifically, CBT techniques focus on modifying the catastrophic thinking patterns and beliefs that social failure and rejection are likely (Forman & Kaye, 2016). CBT exposure therapies are designed to gradually encourage the individual to enter feared social situations and try to remain in those situations (Forman & Kaye, 2016). Individual therapy is most frequently used but cognitive behavioral therapy has been effective among diverse groups such as Latinos with anxiety disorders (Chavira et al., 2014). Additionally, CBT in group format (CBGT) has also been effective among diverse populations (Graham-LoPresti et al., 2017; Leichsenring & Leweke, 2017). The standard group protocol is 12–16 sessions, with each group session lasting 2.5 h (Hoffman & Otto, 2017). According to Hoffman and Otto (2017), the sessions are formatted in the following way:

- Session 1: Establish rapport, make group members comfortable with a socially challenging situation, and provide treatment rationale, with attention to the structure of exposure practice. A fear and avoidance hierarchy is created with the most feared and avoided social situations. Clients are assigned homework where they are to perform behaviors or place themselves in situations that were previously avoided or tolerated only with excessive anxiety.
- Session 2: Briefly review past weeks' topic. Review of home practice from the past week by identifying anxiety-provoking aspects of the situations. Examine perceptions of control over anxiety, and examine self-focus and self-perception. Identify safety behaviors and other avoidance strategies. Explore post-event rumination. Clients will conduct in-session exposures, by conducting a speech performance. Clients will be assigned home practice.
- Sessions 3–6: Clients continue to do numerous trials of speech exposures. The topics should be adapted to each client. The clients continue to be given home practice assignments, for example, speaking in front of a mirror about a random topic and to audiotape one of the speeches.
- Session 7 till the last session: In vivo exposure situations are assigned for outside of the group. Each situation should be individually

tailored to the client and should be based on the fear and avoidance hierarchy. A relapse prevention segment should be included in the final session. Summary of progress of each group member should be conducted. Booster sessions can be offered if needed.

Graham-LoPresti et al. (2017) adapted the CBGT protocol to be culturally sensitive. The authors assessed outcomes from the adapted CBGT using a case study. In addition to the 12 sessions of the group therapy, the authors added a therapist engagement session. The purpose of this session was to obtain a better understating of the client's race, ethnicity, gender, sexuality, disability, and class (Graham-LoPresti et al., 2017). In the study during the engagement session, therapists were trained to ask clients about their experiences of marginalization and/or discrimination in their life context and the ways that these experiences have (or have not) contributed to their experience of SAD. Previous research has shown marginalized groups can experience separation or exclusion from mainstream society, poor treatment, poor access to resources, and overall social devaluation which can contribute to the development and maintenance of SAD (Graham-LoPresti et al., 2017; Sue, 2010). Using cognitive restructuring marginalized groups can focus on restructuring internalized experiences, such as discrimination (Graham-LoPresti et al., 2017). During the in-session exposure segment of the adapted CBGT, the clients' exposures included exercises that addressed anxiety due to marginalization experiences. For the in-between session, the clients' assignment encouraged them to interact with groups they felt marginalized by. The culturally adapted treatment focused on marginalization and discrimination positively impacted other members in the group. Using examples of discrimination allowed group members of color to note if they too experienced such issues and the examples were also a teachable moment for White identified group members to learn about the impact of experiences of discrimination and prejudice on anxiety for individuals of color. The results from the case study indicated that the individuals scores decreased significantly and no longer met criteria for SAD posttreatment and during the follow-up. Additionally, the participant reported having positive experiences, especially with the integration of marginalization (Graham-LoPresti et al., 2017). Exploring treatments that aim at targeting marginalization or stereotype confirmation concern in addition to other social experiences may be beneficial for individuals who have SAD. All goals could be met with a culturally adapted cognitive behavioral therapy.

Stereotype confirmation concerns have also been noted to be related to treatment. Johnson, Price, Mehta, and Anderson (2014) found that stereotype confirmation concerns were associated with higher dropout rates of treatment. African Americans were more likely to drop out of treatment compared to NLWs, specifically if they were in the cognitive behavioral therapy exposure group versus the virtual reality group (Johnson et al., 2014). The authors suggest that individuals who are African American may fear endorsing negative stereotypes of their group (Johnson et al., 2014). Being in a group setting may increase stereotype confirmation concerns specifically if group members are not African American.

Recommendations for Working with Clients with Social Anxiety Disorder

There are no clear clinical practice guidelines developed for working with people with SAD, especially for individuals from diverse backgrounds. The National Institute for Health and Care Excellence (2013) developed recommendations for working with clients with SAD. There are 18 recommendations and below are a few of them (full list can be found at https://www.nice.org.uk/guidance/cg159):

- Be aware that people with social anxiety disorder may:
  - not know that social anxiety disorder is a recognized condition and can be effectively treated
  - perceive their social anxiety as a personal flaw or failing
  - be vulnerable to stigma and embarrassment
  - avoid contact with and find it difficult or distressing to interact with healthcare professionals, staff, and other service users
  - avoid disclosing information, asking and answering questions, and making complaints
  - have difficulty concentrating when information is explained to them.
- Consider arranging services flexibly to promote access and avoid exacerbating social anxiety disorder symptoms by offering:
  - appointments at times when the service is least crowded or busy
  - appointments before or after normal hours, or at home initially
  - self check-in and other ways to reduce distress on arrival
  - opportunities to complete forms or paperwork before or after an appointment in a private space support with concerns related to social anxiety (for example, using public transport)
  - a choice of professional if possible.
- When assessing a person with social anxiety disorder:
  - suggest that they communicate with you in the manner they find most comfortable, including writing (for example, in a letter or questionnaire)
  - offer to communicate with them by phone call, text, and email
  - make sure they have opportunities to ask any questions and encourage them to do so
  - provide opportunities for them to make and change appointments by various means, including text, email, or phone.
- When assessing an adult with possible social anxiety disorder:
  - conduct an assessment that considers fear, avoidance, distress, and functional impairment
  - be aware of comorbid disorders, including avoidant personality disorder, alcohol and substance misuse, mood disorders, other anxiety disorders, psychosis, and autism.

Summary

There are not many clear guidelines and principles in working with diverse clients who have SAD. If a therapist, psychologist, or researcher is interested in working with the individuals with SAD, knowledge of the diverse social stressors being faced by those individuals is important. The therapist needs to be aware of their limitations and own biases. Seeking additional resources from the community and other therapists is always recommended by the general psychological guidelines and principles. Since the USA continues to grow in diversity, therapists working with individuals with SAD should become more familiar with social stressors such as experiences with discrimination or marginalization.

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