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Culturally Sensitive Adaptations to Evidence-Based Cognitive Behavioral Treatment for Social Anxiety Disorder: A Case Paper

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Cognitive Behavioral Group Therapy (CBGT), which involves restructuring maladaptive thoughts and exposures in social contexts in a group format, is an empirically supported treatment for social anxiety disorder (SAD). However, research on applying these skills to experiences of discrimination that may contribute to social anxiety in marginalized populations is limited. A case description is presented to demonstrate the ways in which culturally sensitive adaptations of CBGT were applied to treat social anxiety related to issues of discrimination. The case example includes outcome data from one individual diagnosed with SAD who experienced clinical improvement in symptoms of SAD after receiving CBGT as a part of a larger treatment trial for SAD. Specifically, this paper focuses on the way in which SAD manifested for a Latina woman based on a history, and current context of race-based and gender-based discrimination. We present strategies to address SAD related to experiences of discrimination within the context of CBGT as well as clinical implications related to the integration of multicultural principles and traditional cognitive behavioral therapies for SAD more generally.

Social anxiety disorder (SAD) is characterized by persistent fear and anxiety in 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 is a chronic disorder with a 12-month prevalence rate of 6.8% and a lifetime prevalence rate of 12.1% in the general population (Kessler et al., 2005). However, little research has specifically explored the nature and treatment of social anxiety related to issues of discrimination and marginalization in women and racial and ethnic minorities. In a national epidemiological study, Conway and colleagues (2006) found a lifetime prevalence rate of SAD to be 5.7% in women compared to 4.2% in men. Additionally, in a nationally representative sample, Breslau and colleagues (2006) found SAD to have a 10.8% lifetime prevalence rate in non-Hispanic Blacks and 8.8% in Hispanics. In an additional nationally representative cohort, Grant and colleagues (2005) found a lifetime prevalence rate of SAD to be 3.3% in individuals identifying as Asian, 3.2% in individuals identifying as Hispanic, and 8.6% in individuals identifying as Native American. Moreover, research suggests that anxiety, including SAD, is more persistent and chronic in racial and ethnic minority populations as compared to White populations (Breslau et al., 2006; Sibrava et al., 2013). Given the prevalence of SAD in women and racial and ethnic minorities as well as the limited research specifically exploring the nature of SAD in these populations, we present a case of a Latina female meeting full criteria for SAD. This case demonstrates the ways in which culturally sensitive adaptations of Cognitive Behavioral Group Therapy (CBGT; Heimberg and Barlow, 1991) were applied to the treatment of social anxiety related to issues of discrimination. (See Figure 1.)

One of the most frequently studied treatments for SAD is Heimberg's Cognitive Behavioral Group Treatment (CBGT; Heimberg and Barlow, 1991; Heimberg & Becker, 2002), which combines Beckian style cognitive restructuring with in-session and between-session exposures. CBGT has been shown to be more effective than wait-list control (Hope, Heimberg, & Bruch, 1995). In a placebo control study, 75% of CBGT participants showed clinically significant improvement compared to only 40% of the placebo control group (Heimberg et al., 1990). At a 5-year follow-up, clients who completed CBGT were more likely to have maintained or improved than were clients from the placebo control group (Heimberg, Salzman, Holt, & Blendell, 1993). CBGT has also been shown to be as equally effective as the monoamine oxidase inhibitor phenelzine (Heimberg et al., 1998). In this study, both

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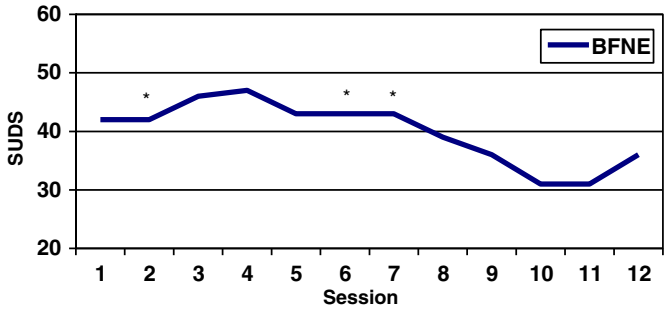

Figure 1. Session-by-Session Brief Fear of Negative Evaluation Scores (* represent sessions the client missed).

CBGT and phenelzine were more efficacious than a pill placebo and an attention placebo.

However, there is little data referencing the efficacy of this treatment for individuals from traditionally marginalized backgrounds, specifically women and racial or ethnic minorities experiencing SAD related to issues of discrimination. The literature suggests that race-based and gender-based discrimination are experienced with frequency for individuals of color and women and that these experiences have a profoundly negative impact on mental health outcomes (Donovan et al., 2012; Kessler, Mickelson, & Williams, 1999; Landrine & Klonoff, 1996; Ming-Foynes et al., 2013; Pascoe & Smart, 2009; Pieterse et al., 2012). Gender-based discrimination has been negatively associated with depression and physical health outcomes (Landrine, Klonoff, Gibbs, Manning, & Lund, 1995). Additionally, race-based discrimination has been associated with symptoms of depression (Borrell, Kiefe, Williams, Diez-Roux, & Gordon-Larsen, 2006; Flores et al., 2008), anxiety (Donovan et al., 2012; Hunter & Schmidt, 2010; Soto et al., 2011), and posttraumatic stress (Flores, Tschann, Dimas, Bachen, Pasch & de Groat, 2010; Loo et al., 2001; Ming-Foynes et al., 2013; Williams et al., 2014). Other studies have also linked both macro- and micro-aggressive experiences of racial discrimination over the course of a lifetime, and specifically in relation to medical care, to a lack of treatment seeking and mental health disparities in care for racial and ethnic minorities (Freimuth et al., 2001; Snowden, 2003).

However, few studies to date have specifically explored the link between gender-based and/or race-based discrimination and SAD. In a case study exploring the treatment of SAD experienced by a 39-year-old African American female physician, Fink, Turner, and Beidel (1996) discussed a course of social effectiveness therapy (SET; Turner, Beidel, Cooley, Woody & Messer, 1994) and the ways in which the therapist included racially relevant cues in imaginal exposures as well as in vivo exposures to address the client's social anxiety related to working with White males in the hospital setting. Specifically, after little improvement over the course of three sessions, the therapist made a decision to reassess the client's core fears and found, through further assessment, that the client was frequently the only African American female resident in her work settings and experienced stereotype-related fears that students and faculty might view her as incompetent or insufficiently intelligent and that these fears were more intense when social encounters at work involved White males. These fears were based in a history of race-based discrimination experienced by the client. The client's exposures were then tailored to include racially salient cues. Specifically, the client was asked to invite a White male colleague and supervisor to lunch and to go to highly avoided areas in the hospital for specific periods of time. These culturally specific enhancements to the protocol led to clinically significant outcomes of less social anxiety for this client. In addition, through two case studies, Weiss, Singh, and Hope (2011) explored the effectiveness of a CBT for SAD for individuals who immigrated to the U.S. and for whom English was not their first language. These two individuals, one from China and one from Central America, evidenced significant improvement in symptoms with few adaptations of the traditional CBT protocol. In both cases, the therapist was able to tailor the protocol to the unique experiences of the client, including fear of judgment in social situations related to one of the client's accents and also fear of judgment related to making errors in writing or speaking English. Several other studies have highlighted the importance of culturally responsive adaptations to empirically supported cognitive behavioral treatments in the treatment of marginalized minority populations (Hwang, Wood, Lin, & Cheung, 2006; Sue & Sue, 2004).

This literature highlights the need for a focus on cultural sensitivity and responsiveness when using traditional cognitive behavioral approaches to treat SAD. Specifically, several studies have noted that racial and ethnic minorities consistently receive poorer quality mental health care (Harris, Edlund, & Larson, 2005;