

2011

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Cognitive-Behavioral Therapy for Immigrants Presenting with Social Anxiety Disorder: Two Case Studies

Brandon J. Weiss*, J. Suzanne Singh[‡] and Debra A. Hope*

Abstract

Cognitive-behavioral therapy (CBT) for the treatment of social anxiety disorder (SAD) has demonstrated efficacy in numerous randomized trials. However, few studies specifically examine the applicability of such treatment for ethnic minority clients. Thus, the purpose of this article is to present two case studies examining the utility of individualized CBT for SAD with two clients who immigrated to the United States, one from Central America and one from China, for whom English was not the primary language. Both clients demonstrated improvement on a semistructured interview and self-report measures. Necessary adaptations were modest, suggesting that therapy could be conducted in a culturally sensitive manner without much deviation from the treatment protocol. Results are discussed in terms of adapting treatment to enhance acceptability for and better fitting the needs of ethnic minority clients and non-native speakers of English. Implications for treating ethnic minority clients, as well as the practice of culturally sensitive treatment, are discussed.

Keywords

Social anxiety disorder, Culturally sensitive treatment, Ethnic minority clients

1. Theoretical and Research Basis for Treatment

Social anxiety disorder (SAD) is characterized primarily by a marked or persistent fear of evaluation by others. It is the third most common psychiatric disorder (excluding specific phobia), with a lifetime prevalence of 12.1% (Kessler, Berglund, Demler, Jin, & Walters, 2005). Its chronic, unremitting course can lead to substantial interference, including impairment in romantic relationships and friendships (Whisman, Sheldon, & Goering, 2000) as well as poorer educational attainment and lower income (Magee, Eaton, Wittchen, McGonagle, & Kessler, 1996).

A number of randomized trials have demonstrated the efficacy of cognitive-behavioral therapy (CBT) for the treatment of SAD. CBT for SAD conducted in a group format has been shown to lead to superior outcomes compared with educational supportive group

Originally published online September 14, 2011; version of record, October 7, 2011.

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treatment (Heimberg et al., 1990, 1998) and pill placebo (Heimberg et al., 1998) as well as maintenance of treatment gains at a 5-year follow-up (Heimberg, Salzman, Holt, & Blendell, 1993) and considerably lower relapse rates than phenelzine (Liebowitz et al., 1999). An individualized version of the treatment (Hope, Heimberg, Juster, & Turk, 2000; see also Hope, Heimberg, & Turk, 2010) has also demonstrated efficacy compared with a wait-list control group (Ledley et al., 2009).

Although there is extensive evidence for the efficacy of CBT for SAD overall, less is known about the efficacy for underrepresented groups. Some single case descriptions have appeared in the literature. Walsh and Hope (2010) reported on the treatment for an individual whose recovery from SAD was complicated by his growing understanding of himself as gay. Fink, Turner, and Beidel (1996) illustrated the incorporation of cultural factors for an African American woman seeking treatment for SAD. Toyokawa and Nedate (1996) reported on CBT with a Japanese woman seeking treatment for anxiety in interpersonal situations. An interdisciplinary intervention for a woman with associated speech difficulties was described by Laguna, Healey, and Hope (1998). However, most major treatment samples have consisted primarily of European American individuals, who tend to be overrepresented in clinical research on CBT (Hays, 1995). Indeed, the treatment study with the most ethnically diverse sample (Ledley et al., 2009) included only 21.1% participants who were not European American.

There is a paucity of research on the efficacy of cognitive-behavioral interventions with ethnic minority clients (Horrell, 2008). However, a number of professional organizations have issued standards and guidelines to help improve delivery of treatment. One set of guidelines noted that clinicians must take into account a number of factors, including cultural norms, to effectively provide culturally sensitive treatment with ethnic minority clients (Council of National Psychological Associations for the Advancement of Ethnic Minority Issues, 2003). This is consistent with the American Psychological Association's Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (American Psychological Association, 1990). Indeed, the guidelines state that providers must "recognize ethnicity and culture as significant parameters in understanding psychological processes" (para. 10) and incorporate "an understanding of the client's ethnic and cultural background" (para. 10) throughout treatment. A careful understanding of such issues is critical to consider when delivering treatment. For example, interpersonal harmony is highly valued in Asian culture (Iwasama, 2003); thus, such clients might place great importance on the quality of their interpersonal interactions, which is quite relevant to take into account for Asian clients presenting with social concerns. In addition, ethnic minority clients' presentation of symptoms might initially focus on somatic distress (Iwasama, 2003) and may seek biological explanations for their difficulties and expect a corresponding pharmacological or nontraditional treatment. Also, many ethnic minority groups have experienced significant oppression and may initially have concerns with trusting their provider (e.g., Barcus, 2003). Thus, it is imperative when working with ethnic minority clients that therapists be aware of such cultural considerations that might impact treatment. However, it is not clear whether the core interventions in a comprehensive package require major modification to provide culturally sensitive treatment.

Thus, the purpose of this case study was to demonstrate culturally sensitive delivery of individualized treatment, with only modest adaptations needed, with two culturally diverse clients: Mr. M,¹ a client originally from Central America, and Ling, who recently immigrated to the United States from China.

2. Case Introduction and Presenting Complaints—Mr. M.

Mr. M. was a 57-year-old married man who contacted a speciality anxiety clinic in a university setting seeking social anxiety treatment. At the time of the intake, he reported that he experienced social anxiety in some situations such as talking in front of a group of people, writing in front of others, speaking with unfamiliar people, and asking others to change their behavior. In addition, he stated that he frequently avoided the aforementioned situations because of his social anxiety. The client reported that writing in front of others at his work caused the most interference in his daily life.

3. History

Mr. M. reported that he was born in Central America but that he immigrated to the United States as an adult more than 30 years prior to treatment. He stated that he had experienced problematic social anxiety since his childhood in Central America. As a child, he moved from his hometown, where the majority of people spoke an indigenous language, to a larger city where most people spoke Spanish. He described feeling worried that others might think poorly of him because he did not speak Spanish as well as they did.

Mr. M. reported that his social anxiety continued through his adulthood and that he used alcohol frequently to cope with his anxiety. He stated that he became sober and used a self-help book to address his social anxiety. However, he indicated that he needed therapy to truly overcome his anxiety.

4. Assessment

Diagnostic Evaluation

Mr. M. endorsed a number of symptoms consistent with SAD (nongeneralized type) on the Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV; Brown, DiNardo, & Barlow, 1994), with no secondary or additional diagnoses. The most problematic situations included writing in front of others, speaking in front of a group of people, and being the center of attention. An ADIS-IV Clinician's Severity Rating of 5 (out of 8) was assigned to this diagnosis, indicating that his symptoms were moderate to severe.

Mr. M. reported that his social anxiety caused him occupational and educational difficulties. The fear of writing in front of others was particularly problematic because his job required it. In addition, he stated that he had always restricted himself to occupations that involved little contact with others. Mr. M. also stated that he started a computer class but did not return due to the fear that he would have to speak in front of others during the class if called on or if he did not understand the material presented.

Questionnaire Assessment

Fear of Negative Evaluation–Brief Version (BFNE).

The BFNE (Leary, 1983) is a 12-item measure of the extent to which the respondent worries that others have an unfavorable view of themselves, which is thought to be a core feature of social anxiety. Respondents are asked to rate how characteristic of them each item is on a scale ranging from 1 (*not at all characteristic of me*) to 5 (*extremely characteristic of me*). The scale demonstrates good internal consistency and is correlated in expected ways with

measures of loneliness and depression (Duke, Krishnan, Faith, & Storch, 2006), although some analyses suggest that the reversed scored items are not as related to theoretically similar constructs as the nonreversed scored items (Rodebaugh et al., 2004). Mattick and colleagues (Mattick & Peters, 1988; Mattick, Peters, & Clarke, 1989) found that change in fear of negative evaluation was a good predictor of positive long-term outcome in CBT for SAD. The BFNE was administered during the first and last treatment sessions.

Social Interaction Anxiety Scale (SIAS).

The SIAS (Mattick & Clarke, 1998) is a 20-item self-report measure of social anxiety during social interactions. Participants rate how characteristic each item is of them on a scale from 0 (*not at all characteristic or true of me*) to 4 (*extremely characteristic or true of me*). Individuals diagnosed with social anxiety tend to score higher on the SIAS than individuals without that diagnosis (Brown et al., 1997), providing evidence of construct validity. In addition, the scale has acceptable internal consistency (Osman, Gutierrez, Barrios, Kopper, & Chiros, 1998). The SIAS was administered during the first and last treatment sessions.

Social Phobia Scale (SPS).

The SPS (Mattick & Clarke, 1998) is a 20-item self-report measure of anxiety when anticipating or actually being observed by others. Respondents rate how characteristic each item is of them on a scale that ranges from 0 (*not at all characteristic or true of me*) to 4 (*extremely characteristic of me*). Scores on the SPS range from 0 to 80, and a cutoff score of 24 has been suggested to be indicative of diagnostic status for SAD (Heimberg, Mueller, Holt, Hope, & Liebowitz, 1992). Psychometric studies (Heimberg et al., 1992; Mattick & Clarke, 1998) show that the SPS has demonstrated good internal consistency, test-retest reliability, convergent validity, divergent validity, and discriminant validity. The SPS was administered during the first and last treatment sessions.

Social Anxiety Session Change Index (SASCI).

The SASCI (Hayes, Miller, Hope, Heimberg, & Juster, 2008) is a four-item self-report measure that is typically administered weekly prior to the session. Respondents are asked to indicate how much they feel they have changed since the beginning of therapy in terms of anxiety during or in anticipation of social situations, avoidance of social/performance situations, concern regarding humiliation and embarrassment, and interference associated with social anxiety symptoms. Ratings are made on a 7-point Likert-type scale ranging from 1 (*much less*) to 4 (*not different*) to 7 (*much more*). The SASCI has demonstrated good internal consistency, discriminant validity, and sensitivity to change (Hayes et al., 2008). The SASCI was administered at each treatment session, except Session 4.

Fear and Avoidance Hierarchy.

As part of the treatment protocol (Hope et al., 2000), an individualized Fear and Avoidance Hierarchy was developed during the fourth session. After collaboratively constructing a list of feared situations, the client rated the level of anxiety that each situation evoked and how often he avoided the situation. Level of anxiety is rated via a subjective units of discomfort (SUDS; Wolpe & Lazarus, 1967) rating, which ranges from 0 (*no anxiety*) to 100 (*very severe anxiety, the worst ever encountered or can imagine experiencing*). Avoidance is rated on a similar scale that ranges from 0 (no avoidance) to 100 (complete avoidance). SUDS and avoidance ratings were obtained during the fourth and last treatment sessions.

Table 1. Sequence of Treatment for Mr. M. and Ling

	Mr. M.	Ling
Session 1	Psychoeducation on the nature of social anxiety	Psychoeducation on the nature of social anxiety
Session 2	Psychoeducation on the nature of social anxiety	Psychoeducation on the nature of social anxiety
Session 3	Psychoeducation on the nature of social anxiety	Discussion of the client's unrelated personal issue that needed attention in session
Session 4	Construction of a fear and avoidance hierarchy	Psychoeducation on the nature of social anxiety
Session 5	Cognitive restructuring	Construction of a fear and avoidance hierarchy
Session 6	Cognitive restructuring	Construction of a fear and avoidance hierarchy
Session 7	Exposure: Writing in front of others	Cognitive restructuring
Session 8	Exposure: Writing in front of others	Cognitive restructuring
Session 9	Cognitive restructuring	Cognitive restructuring
Session 10	Cognitive restructuring	Exposure: Initiating and maintaining a conversation with a coworker
Session 11	Exposure: Writing in front of others	Exposure: Asking a coworker to lunch
Session 12	Exposure: Writing in front of others	Exposure: Initiating and maintaining a conversation with a professor (authority figure) at her new job after relocating
Session 13	Advanced cognitive restructuring	Advanced cognitive restructuring
Session 14	Advanced cognitive restructuring	Advanced cognitive restructuring
Session 15	Exposure: Writing in front of others	Advanced cognitive restructuring
Session 16	Relapse prevention	Termination
Session 17	Termination	NA

Note: Cognitive restructuring sessions focused on identifying and challenging automatic thoughts. Advanced cognitive restructuring focused on challenging core beliefs. All exposure sessions were conducted as an in-session role-play and were assigned as homework for in vivo exposure.

5. Case Conceptualization

Mr. M. reported experiencing excessive social anxiety since childhood. He indicated that being observed in social situations (e.g., writing in front of others, talking in front of a group of people) was particularly problematic. Mr. M.'s beliefs about the visibility of his anxiety symptoms and the disastrous consequences of being seen as anxious appeared to be distorted. The subsequent avoidance of a number of social situations in which Mr. M would be the center of attention likely served to maintain his symptoms of SAD because he never learned that the feared outcomes were unlikely.

6. Course of Treatment and Assessment of Progress

The therapist was a European American woman in a doctoral program in clinical psychology. A European American woman who was a licensed psychologist with extensive experience in the treatment of anxiety disorders supervised the therapist. Treatment consisted of 17 sessions and focused on psychoeducation, cognitive restructuring, and exposure using Hope and colleagues' (2000) *Managing Social Anxiety: A Cognitive-Behavioral Approach* manual. Sequence of treatment is described in Table 1. Sessions were 50 min weekly. See Figure 1 for SASCI scores corresponding to treatment sessions.

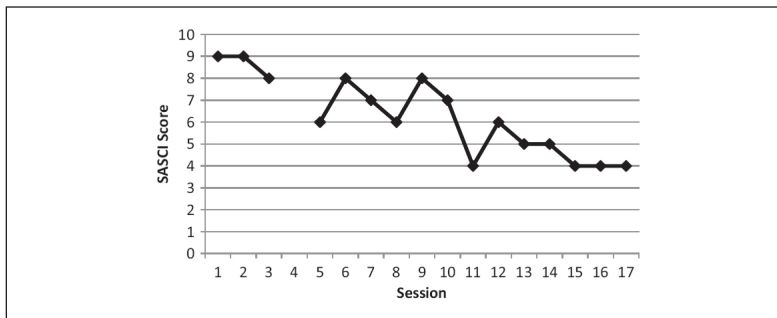


Figure 1. Social Anxiety Session Change Index Scores by session for Mr. M.

Note: SASCI = Social Anxiety Session Change Index.

Sessions 1 through 3 focused on psychoeducation about the nature of social anxiety and its treatment. Readings from the client workbook supplemented information presented in treatment sessions. The therapist made an effort to be more interactive in presenting the material, placing emphasis on the application of the material to Mr. M.'s social anxiety.

Topics in Session 1 included an overview of the diagnosis, the difference between normal and excessive social anxiety, the components of the treatment program and its effectiveness, and expectations of the client in treatment (e.g., an active role, homework completion). Mr. M. and the therapist agreed that Mr. M.'s social anxiety was excessive, and Mr. M. expressed enthusiasm about actively taking steps to reduce his social anxiety. Mr. M.'s SASCI score of 9, rated prior to this session, indicated that his symptoms of social anxiety had improved somewhat between the intake and first session. This is consistent with Mr. M.'s expressed enthusiasm for treatment and should be taken into account when interpreting his subsequent SASCI scores.

Session 2 focused on the cognitive, behavioral, and physiological components of social anxiety. Mr. M. reported having the following automatic thoughts in a specific anxiety-provoking situation: "I get very nervous," "It is hard for me to relax," and "I cannot concentrate." The following physiological symptoms were prominent: heart palpitations, shakiness, ringing in the ears, and tingling in the extremities. The therapist explained that the three components of social anxiety could interact with each other to intensify the anxiety and that cognitions play a very important role in the initiation and intensification of anxiety. The therapist discussed with Mr. M. the short- and long-term consequences of behavioral avoidance as well as the anxiety reduction that occurs in the absence of avoidance, thus providing some information about the function of exposures. The client appeared to understand and accept this treatment rationale.

During Session 3, the therapist and Mr. M. discussed a biopsychosocial model of the etiology of social anxiety in relation to Mr. M.'s experiences. The model presented highlighted the influence of genetics, experiences with the family of origin, and important experiences as contributors to social anxiety. Mr. M. recalled that having an accent in Spanish that significantly differed from the accent of his classmates in the city in which Spanish was the primary language was an important childhood experience that might have contributed to the development of his social anxiety. Also, Mr. M. reported that when he wet the bed as a child, his grandfather would hang the wet bed sheets outside of the house to dry. Mr. M. recalled that these incidents were very embarrassing for him and likely contributed to his social anxiety. Finally, the therapist reviewed the rationale for the treatment.

Table 2. Mr. M.'s Fear and Avoidance Hierarchy

Situation	Anxiety		Avoidance	
	Pretreatment	Posttreatment	Pretreatment	Posttreatment
Speaking up in class	90	0	50	0
Writing while others watch	75	15	0	0
Public speaking (familiar topic)	60	15	25	0
Speaking at a conference	50	25	50	0
Talking to a "not nice" person	50	25	0	0
Talking to a police officer	40	0	0	0
Talking in a work meeting	40	0	0	0
Making a mistake	25	25	0	0
Being the center of attention	25	15	75	0

Note: Ratings are 0 to 100 with higher numbers indicating greater anxiety or avoidance behavior.

Session 4 consisted of a review of Mr. M.'s reactions to starting treatment on a modification of Borkovec and Nau's (1972) measure of treatment credibility, and the construction of a Fear and Avoidance Hierarchy. A review of Mr. M.'s thoughts about starting treatment on a 1- to-10 scale revealed his belief that the treatment seemed logical (rating of 8), he was confident that this treatment would be successful in eliminating his fear (rating of 8), and he expected his symptoms of social anxiety to decrease during treatment (ratings of 2 and 1 for immediately and 1 year following treatment, respectively). Also, he believed that the treatment would be helpful to other people with excessive social anxiety (rating of 8). Table 2 contains Mr. M.'s Fear and Avoidance Hierarchy with the corresponding anxiety and avoidance ratings.

Session 5 focused on the identification of automatic thoughts (per Beck, Rush, Shaw, & Emery, 1979) and how automatic thoughts influence emotions. Perfectionistic thinking characterized many of his automatic thoughts in social situations (e.g., "[A task at work] has to be perfect"). His automatic thoughts suggested that others would be upset with him if he made any mistakes, especially at work. His score of 6 on the SASCI, rated prior to the session, indicated that he was experiencing significantly less social anxiety than at the start of treatment.

Session 6 involved the identification of logical errors in Mr. M.'s automatic thoughts and the development of disputing questions and rational responses. Mr. M. discussed his concerns about reading in front of a group of people and identified the following automatic thoughts: "They will laugh," "I will be nervous," "My heart will beat faster," and "I will look stupid, everybody will notice." Mr. M. identified logical errors associated with his automatic thoughts and that anxiety, nervousness, and embarrassment were products of his automatic thoughts. Mr. M. engaged in an exercise in which he verbalized a debate between the "anxious self" and the "coping self" to challenge his automatic thoughts and was able to generate an appropriate rational response.

Sessions 7 and 8 involved in-session exposures of writing in front of the therapist. During the first in-session exposure, the therapist asked Mr. M. to write names of U.S. states in front of the therapist on a dry erase board, a task he agreed would trigger his fears of performing well, but he believed he could name the states. His primary automatic thought was that his hand would shake. Mr. M. used disputing questions to arrive at a rational response to use during the exposure ("My hand might shake, but I'll do it"). The therapist

asked Mr. M. to report SUDS ratings and to repeat his rational response every minute. His SUDS was initially 50 and subsequently dropped to 25 until he was unable to remember any more states, at which point his SUDS ratings returned to a 40. He considered the exposure a success as he met his behavioral goal of writing until the therapist asked him to stop. To his surprise, his hand did not shake.

During Session 8, Mr. M. and the therapist reviewed his in vivo exposure that he completed for homework. Typically, homework would follow the in-session exposure, but no opportunity for writing was available. The client agreed that speaking up in front of a group would be similar. Mr. M. reported that he spoke in front of a group of people. He identified automatic thoughts concerning the ability of others to understand him, the shakiness of his voice, and his certainty that he will be anxious. He engaged in cognitive restructuring on his own. He reported that he learned that he could speak in front of others with less anxiety than he had expected.

The in-session exposure during Session 8 was similar to his first exposure except that he recorded country names on the dry erase board. His automatic thoughts were similar to the first exposure. His anxiety remained low throughout the exposure and he indicated that he had learned that his hand does not always shake when he writes.

Mr. M.'s score of 8 on the SASCI, rated prior to Session 9, indicated an increase of two points from the previous session, which was inconsistent with his reported success in homework that week. His homework for in vivo exposure involved writing in front of others. The client reported a significant drop in anxiety related to writing in front of others at work, so the focus of the session shifted to his desire to return to more in-depth cognitive restructuring to address his automatic thoughts.

Session 10 included a review of Mr. M.'s in vivo exposure and cognitive restructuring practice. He reported some anxiety surrounding the automatic thought that his hand would shake when writing in front of others at work during his in vivo exposure. He was able to identify logical errors in his automatic thoughts and use disputing questions to develop a rational response ("Even if my hand shakes, I am still going to [complete the task]"). He achieved his goal of completing the task and reported that his rational response worked well. In addition to the aforementioned in vivo exposure, Mr. M. attended church and a computer class prior to the session. He reported that he did not experience as much anxiety at church or at class as he had anticipated and that he would like to return to both of these settings.

By Session 11 it became apparent that his writing fears were not continuing to decrease with regular in vivo practice as expected, so in-session exposures again focused on writing. During Session 11, Mr. M. reported that he completed an in vivo exposure of writing in front of others at work. His automatic thoughts were again related to making a mistake and shaking. With cognitive restructuring, he developed a rational response ("I won't worry about mistakes because I can redo it and that won't be bad"). He achieved his goal of completing the task and reported that the rational response was helpful.

The in-session exposure completed in Session 11 and a similar exposure in Session 12 simulated Mr. M.'s task at work in which he had to write in front of others. He continued to expect that his hand would shake and that he would make a mistake during the task. Anxiety decreased during both exposures. During Session 12, a safety behavior of writing slowly to avoid mistakes was identified. His anxiety decreased throughout the exposure despite his refraining from the safety behavior. He stated that his rational responses were useful during the exposures and that he learned that he was more anxious than he needed to be when writing in front of others.

Sessions 13 and 14 focused on advanced cognitive restructuring, which involved the identification and challenging of core beliefs. Core beliefs were examined through the "peeling the onion" technique during which pervasive beliefs held by the individual are discovered through the downward arrow strategy (Beck, 1995). Mr. M. completed a "peeling the onion" worksheet in Spanish at home, and then some in-session "peeling the onion" work was done in English. Although the technique was used with a variety of initial automatic thoughts, one problematic core belief was revealed multiple times: "I will be lonely." Mr. M. was tearful in session when discussing the idea that he will be lonely in the future following rejection by others due to their perceptions of him when he was less than perfect because his hand shook or he made one error when speaking or writing in English. Throughout treatment, it was noted that other situations that related to a lack of connection with people (e.g., the death of his aunt and his inability to be with his Central American family around Christmas time) were also associated with heightened anxiety and made his social anxiety worse. Challenges to his core beliefs were discussed in Sessions 13 and 14. Challenges included gathering evidence against the idea that he will be lonely such as the fact that he has a wife, a child, and many grandchildren who live near him and spend time with him.

During Session 14, Mr. M. reflected on how much he had changed since the start of treatment. For example, he stated that he used to feel that he was not as smart as most other people but that he no longer believed that he was inferior. Mr. M. discussed with the therapist an in vivo exposure involving asking questions to an intimidating coworker. He stated that his anxiety was manageable and that he learned that "there is nothing wrong with asking questions" to coworkers.

Session 15 involved the discussion of an in vivo exposure and another in-session exposure revolving around writing in front of others. Mr. M. completed an in vivo exposure during which he read out loud in front of a coworker. His automatic thought was "I will get nervous." He identified logical errors in the thought and used disputing questions to develop the rational response of "Even if I get anxious, I will read." Mr. M. reported that this was a successful exposure as his anxiety decreased throughout the task.

Mr. M. completed the cognitive restructuring work for the in-session exposure prior to session in Spanish and translated it for the therapist. He identified his automatic thought as "I will be nervous" (translation). He identified logical errors in his thought and used disputing questions to develop the rational response of "Even if I get nervous, I will do it" (translation). Although the translations of the automatic thoughts that he had in Spanish were similar to the automatic thoughts reported in prior sessions in English, the client reported that the challenge of his thoughts in Spanish felt more effective. Also, he appeared to be more engaged than usual when cognitive restructuring was reviewed. The client reported his SUDS and rational response each minute during the exposure. The drop in SUDS from the start until the end of the exposure was more dramatic than in previously completed in-session exposures.

Session 16 focused on relapse prevention. The therapist and Mr. M. discussed ways to continue to make progress toward reducing social anxiety such as engaging in more exposures, using cognitive restructuring skills, and continuing to attend social meetings such as Bible study.

Session 17 was the termination session. Mr. M.'s score on the SASCI of 4, rated prior to session, had remained stable for the past three sessions. Mr. M. completed the anxiety and avoidance ratings on his Fear and Avoidance Hierarchy (see Table 2) without reference to pretreatment ratings. Dramatic improvements were evident, especially on the avoidance

ratings. Mr. M. stated that he felt as though he had a more positive view of his life at the end of treatment than he had at the start of treatment. In addition, he felt as though he experienced significantly less social anxiety and avoidance of social situations. The client set a goal of attending more social events over the next month.

7. Follow-Up

During telephone contact one month after the final session, Mr. M. reported that he was doing well and continued to attend social events. Approximately 8 months later, the therapist called the client to seek permission to use his case in this article. He informed the therapist that he felt as though he had maintained treatment gains in terms of a reduction in anxiety and avoidance. No formal assessment was done.

Based on a review of the record, an ADIS-IV Clinician's Severity Rating of 1 (0-8 scale) was assigned to the clinical severity of Mr. M.'s social anxiety, which is a decrease of 4 points from his initial ADIS-IV Clinician's Severity Rating of 5.

Figure 1 contains Mr. M.'s scores on the SASCI by session. As can be seen in Figure 1, Mr. M.'s final score on the SASCI indicated that he felt as though his social anxiety was much less than when he started treatment, even though his initial scores were very low.

Mr. M.'s scores on general measures of social anxiety decreased over the course of treatment as well. Mr. M.'s scores prior to treatment of 38 on the BFNE, 43 on the SIAS, and 26 on the SPS at the start of treatment suggested high levels of social anxiety. At posttreatment, his scores were in the average-to-low range (BFNE = 23, SIAS = 11, and SPS = 3), compared with community normative values (Heimberg et al., 1992; Weeks et al., 2005). These changes are consistent with the improvement seen on the Fear and Avoidance Hierarchy.

8. Complicating Factors, Treatment Implications of the Case, and Recommendations to Clinicians and Students

Mr. M.'s cultural background influenced his treatment in a number of ways. First, it affected the approach taken to cognitive restructuring. The first step in cognitive restructuring is reporting of automatic thoughts. Typically, the therapist asks the client to identify the automatic thoughts that are anxiety provoking as a first step to the modification of the thoughts. For clients whose primary language is not the same as the language in which therapy is being conducted, the essence of the client's thoughts can be lost in translation, making cognitive work less beneficial.

Mr. M. reported that he learned Spanish as a child, interacted with family and friends primarily in Spanish, and thought in Spanish, so early in therapy the therapist recommended that the client complete his cognitive homework in Spanish (Note: Mr. M. reported that his first language does not have a written form). The client stated that he feared that the therapist thought that he was not able to complete his homework in English because he was not fluent in English, a likely manifestation of his social anxiety. Treatment progressed in English only until rapport was greater between the therapist and the client and the therapist reintroduced the idea. The client appeared enthusiastic and completed the remainder of his homework in Spanish. The client reported that he found it helpful and appeared to be better able to dispute his automatic thoughts in Spanish and the thoughts appeared to be more emotionally laden. His SUDS ratings appeared to decrease more quickly with the use of a Spanish rational response.

Second, his perceived inability to speak the language of the dominant culture well was discussed occasionally in session. Although some accent was noticeable, Mr. M.'s spoken English was very clear. Mr. M. reported that some of his social anxiety symptoms were related to this distorted perception of his English proficiency and that he felt "dumb."² Cognitive restructuring and exposures were useful in combating these thoughts. He came to understand how his avoidance behavior prevented him from gathering evidence of his competence, which became apparent in exposure.

Third, Mr. M.'s physical separation from his family in Central America might have contributed to his social anxiety symptoms. Family is thought to play an important role in the lives of many Hispanic individuals (*familismo*; Marin & Marin, 1991), and the importance of family was discussed frequently with Mr. M. Due to financial and time constraints, he was not able to visit family in Central America as frequently as he would have liked. During treatment, it became apparent that some of Mr. M.'s anxiety-provoking automatic thoughts were related to Mr. M.'s core belief that he would be alone eventually with no one to care for him. For example, he indicated that he feared that if he made a mistake while writing in front of others they would be mad at him and, therefore, he would be alone. He was able to identify logical errors associated with these thoughts (e.g., catastrophizing) and develop more rational responses (e.g., "If I make a mistake, I can usually fix it"). Without the physical separation from his family in Central America, it is possible that Mr. M.'s social anxiety would have been less severe as he might not have been so concerned with making mistakes that would lead him to be alone.

Fourth, the therapist adhered to many of the guidelines set forth by Organista and Muñoz (1996) for working clinically with a Latino population. For example, Organista and Muñoz stress the importance of showing respect (*respecto*) for others based on age and gender (as well as other variables) when working with a Latino client. For example, the therapist, a woman younger than Mr. M., always addressed him formally and never referred to him by his first name.

9. Treatment Summary

Overall, it appears as though cognitive-behavioral treatment for Mr. M.'s social anxiety was successful. He was able to benefit from the core components of treatment with only a few adaptations. Encouraging the client to complete cognitive restructuring activities in Spanish, addressing his perceived difficulties with English and his physical separation from his family, and following Organista and Muñoz's (1996) guidelines appear to have had a beneficial effect on treatment. It is notable that the necessary adaptations to perform culturally sensitive treatment were modest and did not require substantial deviation from the treatment protocol. A number of self-report measures of social anxiety indicate that his social anxiety decreased throughout the course of treatment. In addition, he reported that treatment helped him think in a more adaptive way and allowed him to engage comfortably in activities that he used to avoid or that used to cause him considerable anxiety such as attending classes and church.

10. Case Introduction – Ling

Ling was a 32-year-old female who emigrated from China to the United States approximately three years prior to the diagnostic evaluation. She had obtained a doctorate in the natural sciences before moving for work. She was single at the time of the diagnostic evaluation but married during treatment.

11. Presenting Complaints and History

Ling contacted a specialty anxiety clinic in a university setting due to problems related to self-reported social anxiety and depression. She reported that she had experienced at least some social anxiety since she was a child growing up in China. She described being reserved in school and not having close social contacts. However, she believed that her social anxiety became much more severe when she moved to the United States from China. She indicated that she had not anticipated that a strong interpersonal component would be important for her career, and her distress regarding social anxiety became elevated once this became apparent to her. She also reported that she had been experiencing intermittent feelings of depression since moving from China.

12. Assessment

Diagnostic Evaluation

Ling endorsed a number of symptoms consistent with SAD (generalized type) on the ADIS-IV. She indicated that she experienced anxiety in a number of social situations, including dating situations, talking to persons in authority, initiating and maintaining conversations, and being assertive, such as when asking others to change their behavior or refusing unreasonable requests. She reported that she felt foolish in these situations and was afraid others will think badly of and dislike her. She also indicated a strong desire to please others. An ADIS-IV Clinician's Severity Rating of 6 (out of 8) was assigned for this diagnosis.

Ling also endorsed a number of symptoms consistent with major depressive disorder (MDD), recurrent. She indicated that she had experienced feelings of depression and loss of interest in usual activities nearly every day during the past 2 weeks. In addition, she endorsed experiencing loss of energy, feelings of guilt, impaired concentration, and indecisiveness nearly every day during the past 2 weeks. An ADIS-IV Clinician's Severity Rating of 5 was assigned for this diagnosis.

Ling indicated that her symptoms of social anxiety and depression caused her occupational problems. Specifically, with regard to social anxiety, she constantly worried that her boss did not like her and that he thought that she was performing poorly at work. Also, she avoided social interactions at work as she believed that her coworkers did not like her. In addition, she reported turning down a job offer that would have advanced her career because she worried that she would not do well in a more stressful position. Finally, she felt as though her lack of interpersonal skills had caused her to be less productive at work as she avoided collaborating with colleagues. She indicated that she sometimes felt like giving up her career and that she felt inadequate.

Questionnaire Assessment

The BFNE (Leary, 1983) was administered pre- and posttreatment. The Beck Depression Inventory– II (BDI-II; Beck, Steer, & Brown, 1996), a widely used 21-item self-report measure of depressive symptomatology, was administered each session due to the additional diagnosis of MDD. No other assessment was conducted due to the abbreviated time frame of treatment.

Table 3. Ling's Fear and Avoidance Hierarchy

Situation	Anxiety		Avoidance	
	Pretreatment	Posttreatment	Pretreatment	Posttreatment
Speaking in front of a group	100	40	50	40
Job interview	100	70	0	30
Speaking with professors	75	50	75	60
Speaking with boss (older, authority figure)	50	40	25	40
Being the center of attention	75	70	90	70
Asking coworkers to join lunch	75	70	100	70
Saying no (being assertive)	75	70	85	70
Inviting people to social event	75	60	75	70
Asking for help (coworkers/friends)	75	70	75	70
Talking with husband's family	75	50	50	60
Initiating small talk with coworkers	75	50	25	50
Maintaining conversations with coworkers	50	70	50	70

Note: Ratings are 0 to 100 with higher numbers indicating greater anxiety or avoidance behavior.

13. Case Conceptualization

Ling's symptoms of social anxiety primarily entailed irrational beliefs about her inadequacy in interpersonal situations as well as overt and subtle behavioral avoidance of anxiety-provoking situations. It is likely that her symptoms of social anxiety were exacerbated when moving to the United States as she perceived that the interpersonal demands were greater than they had been in China, particularly at her place of employment.

14. Course of Treatment and Assessment of Progress

Treatment was conducted over 16 sessions using the same treatment protocol as that of Mr. M. Sessions were conducted twice a week due to the client's impending relocation for a new job. The therapist was a European American man in a doctoral program in clinical psychology. See Table 1 for the sequence of treatment.

Session content was very similar to that described for the previous case except for specific in-session and in vivo exposures. Ling's responses to a modification of Borkovec and Nau's (1972) measure of treatment credibility revealed that she believed that the treatment seemed logical (rating of 8 on a 1-10 scale), she was confident that this treatment would be successful in eliminating her fear (rating of 7), and she expected her symptoms of social anxiety to decrease during treatment (ratings of 4 and 5 for immediately and 1 year following treatment, respectively). Also, she believed that the treatment would be helpful to other people with excessive social anxiety (rating of 7). A Fear and Avoidance Hierarchy was developed in Sessions 5 and 6. See Table 3 for the specific situations and ratings.

As with the previous case, cognitive restructuring was originally performed in English so that the therapist could gauge the client's understanding of and proficiency with the procedure. Beginning with Session 9, the client was encouraged to complete the cognitive restructuring in Chinese, which was her first language. The client reported that she found the cognitive restructuring far more effective when completing it in Chinese given that it is the language in which she experienced thoughts.

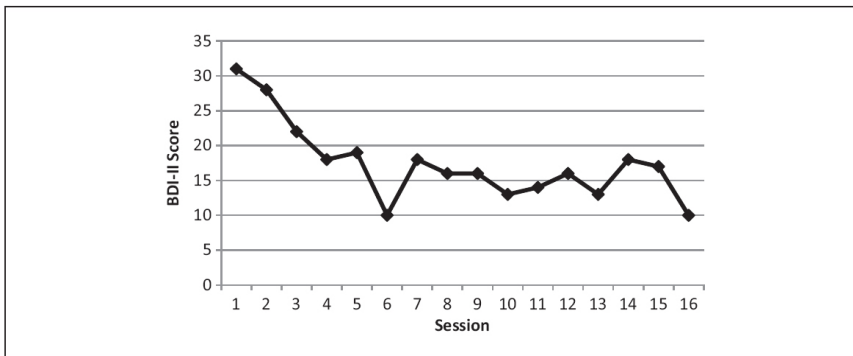


Figure 2. Session-by-session Beck Depression Inventory–II scores for Ling
 Note: BDI-II = Beck Depression Inventory–II.

We were able to complete only three in-session exposures. The initiation of in-session exposure was delayed in this case due to spending a session discussing the client's unrelated personal issue that needed attention in session, spending two sessions constructing a Fear and Avoidance Hierarchy, and spending three sessions on cognitive restructuring so that Ling could demonstrate proficiency in the skill and then complete it in Chinese. Session 10 consisted of completing an exposure focusing on initiating and maintaining a conversation with a coworker, and Session 11 consisted of an exposure focusing on asking a coworker to lunch. The client's automatic thought preceding each exposure was similar: "I will come across as weird" and "[My coworker] will think I'm annoying." These automatic thoughts were challenged by assessing the likelihood that such thoughts were true and imagining the worst possible outcome if such thoughts were true. Ling successfully completed both exposures in session and homework outside of session.

Sessions 12 through 15 focused on preparing the client for her impending relocation for her new job. Session 12 consisted of an exposure focusing on initiating and maintaining a conversation with a professor (an authority figure) at her new job. Sessions 13 through 15 focused on identifying and challenging core beliefs. Ling reported that her most troublesome core belief was "I am a loser." To challenge this core belief, she was encouraged to operationally define what a "loser" is using the downward arrow technique and then identify evidence for and against this belief. Ling was able to provide more than twice as much evidence that she was not "a loser" than evidence that she was "a loser." Ling reported that learning to challenge her core beliefs was one of the most beneficial aspects of treatment and that she looked forward to further challenging this belief after starting her new job.

Session 16 focused on discussing termination and relapse prevention. Ling reported during this session that she felt less anxious in social situations and had reduced her avoidance of such situations, particularly with regard to assertiveness. However, she was able to identify a number of covert avoidance behaviors (e.g., talking less than she wanted to when engaged in conversation with a group of coworkers) that she felt still interfered with her life. She expressed confidence that she would be able to continue reducing her avoidance in the future as she had learned skills to manage her anxiety. She stated that she would continue to use these skills in the future and would seek additional help after moving if needed. A referral was provided for her new city.

15. Follow-Up

Based on a review of the record, an ADIS-IV Clinician's Severity Rating of 4 (0-8 scale) was assigned to the clinical severity of Ling's social anxiety, which is a decrease of 2 points from her initial ADIS-IV Clinician's Severity Rating of 6. This indicates that her symptoms of social anxiety were still clinically severe but had decreased over the course of treatment.

Ling's posttreatment ratings for her Fear and Avoidance Hierarchy are presented in Table 3. For the majority of situations, her anxiety and avoidance decreased somewhat. However, it is interesting that her avoidance increased for both initiating small talk and maintaining conversations with coworkers. This is consistent with her report during the termination session that she continued to engage in covert avoidance behavior for these two domains. Also, it is unclear why Ling rated that her anxiety increased at posttreatment for initiating small talk with coworkers, which is inconsistent with her self-report during session and on homework assignments.

Ling's pretreatment score on the BFNE was 53, which is clinically significant and suggests high levels of social anxiety. Her score on the BFNE at posttreatment was 48, which is also clinically significant and indicative of high levels of social anxiety. Her scores on the BDI-II decreased dramatically over the course of treatment. Her score prior to the first treatment session (31) indicates that she was experiencing severe depressive symptoms prior to treatment, whereas her posttreatment score (10) indicates that she was experiencing only mild depressive symptoms at the end of treatment. See Figure 2 for a graphical representation of BDI-II scores.

At posttreatment, Ling was still experiencing SAD, though there is some evidence of reduction in severity compared with prior to beginning treatment. Also, she no longer met diagnostic criteria for MDD.

16. Treatment Summary

Overall, results indicate that Ling had begun to respond to treatment but would benefit from additional sessions focusing on social anxiety. Her depressive symptoms dramatically decreased. Treatment had to be terminated prior to fully remitting the client's symptoms of social anxiety due to her relocation for a new job. Such an abbreviated time frame for treatment might partially account for the modest change in BFNE scores compared with the ADIS-IV Clinician's Severity Rating. The limited change on the BFNE is particularly concerning given that changes in fear of negative evaluation have been shown to be the strongest predictor of long-term functioning (Mattick & Peters, 1988). Treatment progress was mixed on the Fear and Avoidance Hierarchy, and the elevated avoidance ratings did not bode well for long-term improvement without additional treatment. Nevertheless, the overall data suggest that treatment did result in significant gains for Ling, and she repeatedly expressed this to her therapist toward the end of treatment. The best evidence was for an improvement in her depressive symptoms.

17. Treatment Implications of the Case and Complicating Factors

Norms regarding appropriate social behavior may arise during treatment, particularly with immigrant clients. For example, Ling reported that her social anxiety became more severe after moving to the United States. She expressed difficulty in adapting to the perceived importance of socializing at work, whereas she had felt more comfortable with her

colleagues in China who acted in a more reserved manner and did not consider socializing at work an important aspect of one's career. Thus, it was important to be mindful of cultural norms regarding social behavior. Ling did express a desire to change her behavior in social situations and noted that her anxiety in such situations superseded the cultural aspect.

As discussed with the previous case, ethnic minority clients may experience automatic thoughts and core beliefs in their native language, which may lose meaning in translation. Unlike Mr. M, Ling was open to doing the cognitive work in her native language from the beginning. Given that her proficiency in English was lower than that of Mr. M, working in her native language was even more important for her. However, it was initially useful for the therapist to observe her proficiency with the skill, although it appeared that the cognitive skills were only marginally effective for her when conducted in English, as she reported that some of her thoughts and dialogue while using disputing questions did not translate effectively. The client was subsequently encouraged to complete the homework exercises, particularly pre- and post-cognitive restructuring of in vivo exposures, in Chinese and found this more helpful. Also, she stated that it was easier for her to notice themes in her automatic thoughts when such thoughts were recorded in Chinese. Thus, for Ling, completing the cognitive restructuring exercises in her primary language led to a much deeper identification and activation of her core beliefs, which facilitated the process of effectively challenging those beliefs. There were no difficulties translating for the therapist when discussing homework.

As noted above, treatment progressed more slowly than usual. This was not only due, in part, to the language difference but also due to other events in Ling's life that were sometimes discussed in session. Thus, one additional cultural adaptation was slowing down the pace of the protocol.

As with Mr. M., it is worth noting that it was possible to implement culturally sensitive treatment with minimal necessary modifications to the treatment protocol. Adaptations to the protocol were modest yet still served to increase acceptability and effectiveness of treatment, as demonstrated by Ling's self-report. However, given that Ling's symptoms of social anxiety did not fully remit by the end of, albeit abbreviated, treatment, it is possible that further cultural adaptations might have been beneficial.

18. Recommendations to Clinicians and Students

It is important to actively assess the client's understanding of session material, particularly if the client's native language is different from that in which the treatment is being conducted. According to Iwasama, Hsia, and Hinton (2006), cultural norms might explain why Asian immigrant clients tend to ask fewer questions, interact less with the therapist, and agree with therapist's statements even if they disagree, which may impede understanding of session material. Furthermore, it is likely that an individual from an Asian culture with SAD would exhibit exaggerated tendencies toward these behaviors. Indeed, Ling experienced difficulty completing the SASCI but did not seek assistance. SASCI scores are not reported for Ling because it was clear that she had not understood the instructions. The visual format of the SASCI has since been redesigned (Hope et al., 2010) to make the measure more accessible for a wide range of clients. Thus, it is important to continually monitor the client's understanding of session material, assessment instruments, and their feelings toward the therapeutic interaction.

Asian clients typically only seek treatment once the problem has resulted in significant interference and distress, for which they desire relatively quick symptom reduction (Toyoka-

wa & Nedate, 1996). Thus, CBT may be particularly useful for Asian clients, given the short-term, problem-focused nature of the treatment modality, in addition to its focus on contextual factors (Iwasama et al., 2006).

19. General Summary

These two cases illustrate the efficacy of CBT for SAD in two ethnic minority clients of different backgrounds, differing time in the United States, and differing proficiency with English. The goal was to illustrate cultural adaptations of the treatment, especially related to language, when the therapist and the client do not share the same primary language. It is particularly notable that few modifications to the protocol were necessary, while still increasing acceptability and effectiveness of treatment procedures. Certainly, an important future direction would be to examine this treatment with various cultural groups when the therapist and client are from the same culture and language group. An additional future direction would be to examine cultural adaptations of the new edition of the treatment protocol (Hope et al., 2010). Given that both iterations of the treatment focus on the same therapeutic components (e.g., exposure and cognitive restructuring), it is likely that results from these two cases will generalize when using the new edition; however, this is worth explicitly examining.

Interpersonal relationships are strongly influenced by culture, making discussion of cultural norms especially important when treating social anxiety. The language demands of cognitive restructuring indicated that important work needed to be done in a primary language. As demonstrated here, the therapist need not share that language for successful outcomes.

Authors' Note

The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institute of Mental Health or the National Institutes of Health. Portions of this work were presented at the 2009 convention for the Anxiety Disorders Association of America, Santa Ana Pueblo, New Mexico.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The project described was supported by Grant Number F31MH091882 from the National Institute of Mental Health awarded to the first author.

Notes

¹Identifying details, including names, have been modified to protect anonymity of the clients. Both clients provided written consent for inclusion of their de-identified information in this article.

²Social rejection or discrimination may occur based on the perception that the individual is a non-native English speaker or an immigrant. In such cases, fear of rejection would not be considered irrational and should not be treated as such. For Mr. M, it was apparent to his therapist, and quickly to him, that his perception was distorted and decreasing avoidance gave him naturalistic feedback to disconfirm his automatic thought.

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