

Sociocultural Interpretations of Social Phobia in a Non-Heterosexual Female

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ABSTRACT. Social Phobia is a prominent anxiety disorder that is not well understood, especially among socially marginalized, non-heterosexual individuals. A case description of Social Phobia symptoms in a female who is unsure of her sexual identity is presented and analyzed. The diagnostic assumptions of Social Phobia as applied to the case are critically examined. The goal is to highlight unanswered questions regarding social anxiety among non-heterosexuals and to open a discussion of cultural etiological theory. Implications for treating Social Phobia with a cultural component are discussed. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2005 by The Haworth Press, Inc. All rights reserved.]*

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“Normal” and “pathological” behavior is socially and culturally defined by the culture with the most power. Homosexuality was, at one time, considered a psychiatric disorder (Kitzinger, 2001; Stone, 2000). Accusations of outright cultural oppression resulted in challenges to the validity of the diagnosis. In the late 1970s, the diagnosis of homosexuality was removed from the American Psychiatric Association’s Diagnostic and Statistical Manual. Although it is impossible to fully separate value judgments from disorder conceptualization (Spitzer, 1981), it is useful to periodically re-examine existing psychiatric disorders as societal norms and values change.

The goal of this study is to explore the diagnosis of Social Phobia in non-heterosexuals. Currently, there is an absence of reliable data to determine the prevalence of Social Phobia in this group. The non-heterosexual population has been identified as an understudied minority group. Much of what we know about non-heterosexuals is based on small, convenience samples (Solarz, 1992). Difficulties with identifying sexual orientation of participants in larger psychological studies further adds to the measurement problem (Cochran, 2001).

Our review of the medical and psychological literature over the last twenty years yielded only one in-depth study specific to Social Phobia in a non-heterosexual individual (Safren & Rogers, 2001). This study is not discussed here because the diagnosis of Social Phobia was assumed valid without consideration of sexual orientation. It is questionable if all information obtained from studies on heterosexuals with Social Phobia can be generalized to the non-heterosexual population given the important role of social factors. There were no studies that explored whether social oppression of non-heterosexuals played a role in the display of Social Phobia symptomatology. A critical evaluation of Social Phobia symptoms among non-heterosexual individuals is needed in order to guide larger, prevalence-based studies and appropriate treatment.

AN OVERVIEW OF SOCIAL PHOBIA

According to the American Psychiatric Association (1994), Social Phobia (also called social anxiety disorder) involves an intense, irrational, and unremitting fear of social or performance circumstances where there is unnecessary worry about public humiliation or embarrassment. Affected individuals attempt to avoid any and all such situations, and as a result, everyday function is disrupted.

Symptoms of Social Phobia are believed to present most often in adolescence with a mean age range of onset to be 14 through 16 years. More women are represented by the diagnosis than men (Ballenger et al., 1998; Murray & Stein, 2001). While there is some disagreement (Chartier, Hazen, & Stein, 1998), the course of Social Phobia is generally considered to be unremitting across the adult lifespan (Ballenger et al., 1998; Murray & Stein, 2001).

The exact cause of Social Phobia has not been identified, although there is evidence to support roles for neurotransmitters (e.g., serotonin, dopamine), a genetic predisposition, a temperamental pre-disposition, and environmental influences, such as parenting (Chartier et al., 1998; den Boer, 2000; Gabbard, 1992). Culture has not been identified as an etiological factor.

Psychopharmacy is considered to be the treatment of choice for Social Phobia, especially anti-depressants (Schneier, 2001). A one year course of a selective serotonin re-uptake inhibitor is recommended for initial treatment (Ballenger et al., 1998; Schneier, 2001). Although available studies are inadequate to support polypharmacy as a standard of care, den Boer et al. (2000) indicate there may be a place for combined pharmaceutical agents. Cognitive-behavioral therapies are also identified as effective treatment agents (Ballenger et al., 1998; den Boer, 2000).

THE CURRENT STATUS OF SOCIAL PHOBIA

In general, Social Phobia is not well-understood (den Boer, 2000) and, as a result, it is often under-diagnosed (Pennington, 1997; Zerbe, 1994). If individuals with Social Phobia are able to discuss symptoms at all, the initial point of contact is the primary care provider, who may inadvertently focus upon somatic etiologies (den Boer, 2000). An additional complicating factor is the co-morbidity, as high as 70-80 percent, of other mental health disorders such as depression, substance use, and other anxiety disorders (Ballenger et al., 1998; den Boer, 2000; Magee et al., 1996). Often, the other disorders receive the focus of clinical attention while Social Phobia symptoms are ignored (Bisserbe, Weiller, Lepine, & Lecrubier, 1996; Lecrubier & Weiller, 1997; Schonfeld et al., 1997; Wittchen, 2000).

While Social Phobia may not win the focus of clinical attention, it has recently attracted the attention of researchers (Lang & Stein, 2001; Zerbe, 1994). It is estimated that Social Phobia has a lifetime prevalence

of 5-15 percent (Ballenger et al., 1998; Furmark et al., 1999; Magee et al., 1996; Olfson et al., 1997; Stein, Torgrud, & Walker, 2000; Weiller et al., 1996) with extraordinarily high psychosocial and economic costs (Ballenger et al., 1998; den Boer, 2000; Lipsitz & Schneier, 2000; Weiller et al., 1996; Wittchen, 2000). Schneier et al. (1994) found that 50 percent of individuals with Social Phobia had moderate to severe impairment in education, work, family, and social activities. A subset of the sample also reported problems in activities of daily living. It is further estimated that the costs associated with over utilization of medical services are profound (Rees, Richards, & Smith, 1998).

In summary, Social Phobia is a prominent anxiety disorder with significant direct and in-direct costs. The current state of the literature reflects a clear lack of understanding of the disorder, especially among non-heterosexuals. This is a critical knowledge gap as societal influences are key to conceptualizing the disorder. It is not discernible, based upon the lack of available data, if Social Phobia has the same prevalence and pathogenesis for heterosexuals and non-heterosexuals. This basic question exists, "is this the same disorder in both populations?" This is a crucial question that must be answered in order to guide treatment, but the question cannot be investigated without a theoretical guide. The goal of this article is to open a discussion of cultural etiological theory about Social Phobia in the non-heterosexual population. A case study is presented to critically examine the diagnostic assumptions of Social Phobia as applied to a socially marginalized group, non-heterosexuals.

THE CASE

Several weeks before Martha decided to seek therapy, she had an episode involving severe anxiety symptoms. She did not directly recognize the anxiety. She was convinced that she was having a heart attack. Martha self-presented at the hospital emergency room with complaints of racing heart, sweating, trembling, chest pain, and nausea. She was admitted to the hospital for 24-hour observation, which was uneventful. She was later informed that her symptoms represented a panic attack. Martha believed that her panic attack was strong evidence that her life was spinning out of control. After being discharged from the hospital, she presented her primary care physician with information about social anxiety obtained from a television commercial. Her physician diagnosed her with Social Phobia, prescribed 20 milligrams of Paxil once per day, and referred her for counseling.

Martha presented approximately one month later as a pleasant, well-organized, neat, and intelligent 41 year old, Caucasian female. She avoided eye contact, shifted in her seat, and displayed a slight tremble. At the time of initial evaluation, her symptoms included low energy, fatigue, initial and terminal insomnia, decreased concentration, and a moderate level of anxiety related exclusively to social contact. Martha was successfully employed in a high level position with a large organization, and she described an ability to do work-related presentations after years of practice. The domain of work somehow seemed different from other social contact. Martha was more confident about her work identity than her personal, social identity. It was as if she were able to play the role of professional more easily.

She denied any other psychological problems or medical disorders. She reported no nicotine, alcohol, or illicit drug intake. She had limited caffeine intake. Martha endorsed feeling sad about what she was missing in life, but she denied a clinically significant range of depressive symptoms. She reported hope for the future with good motivation to improve her function. Martha denied suicidal ideation, intention, plan, or past attempts.

Martha reported that she had been suffering from social anxiety all of her life. She referred to her problem as “shyness.” She worried uncontrollably about what other people would think of her. She worried that others would focus only on her faults. She then worried about becoming nauseous and vomiting in front of other people. She even worried about her worry, which she recognized as unreasonable. As a result, she avoided most social gatherings. Martha described mild symptom improvement with Paxil; however, she remained disengaged from meaningful social contact.

Developmental history was described to be unremarkable. Academic history revealed that grades were above average through all educational endeavors. Martha enjoyed and valued education. She had achieved advanced degrees in the public service field.

Martha’s parents divorced when she was an adult, and she has no contact with her father. She was the middle child with four siblings. She described good relationships with three of the siblings, but she was estranged from a brother. There was no report of physical, sexual, or emotional abuse. The family history was significant for bipolar disorder, depression, and substance abuse.

At the time of evaluation, Martha resided with her elderly mother, with whom she maintained a close relationship. She described her mother as devoutly religious, and she, too, was an active participant in

religion. Martha reported that she had four or five friends whom she trusted. She enjoyed reading, going to movies and concerts, and cleaning. She expressed interest in parties, social events, groups, and travel. Although Martha expressed an intense desire for intimacy, she had never experienced a romantic relationship.

At the end of the initial session, Martha set goals of reducing general anxiety and increasing social activity. She, then, peripherally mentioned that maybe she would like to explore her sexual identity. Throughout the interview, Martha had been shifting in her seat and avoiding eye contact. When she mentioned sexual identity, her reference was off-handed. She was looking away from the therapist as paperwork was being gathered in anticipation of the session's end. Martha was readying herself to leave. There was no time left in the session.

Over the next couple of sessions, Martha responded quickly to a cognitive-behavioral exploration of anxiety symptoms. She easily enacted anxiety management techniques including relaxation, exercise, deep breathing and visualization. It was clear that she preferred a cognitive approach to an affective one, and therefore, my stance became more humanistic-existential. A more emotion and process-focused therapy allowed Martha to become aware that she unconsciously avoided emotion and intimacy in anticipation of being hurt. This was incongruent with her expressed desire to become socially close with others. She discovered that she had great difficulty identifying and expressing her own feelings. In the therapeutic context of genuine acceptance and accurate empathy, Martha became more open to discussing her sexual orientation. While she initially described some attraction toward men but more attraction toward women, she later indicated that she was probably a lesbian. One of the main obstacles that prevented Martha from exploring her sexual orientation was a fear that she would hurt her elderly mother. Martha believed her mother would eventually be accepting but deeply pained.

Early in therapy, Martha was resistant to the question that her symptoms of Social Phobia may be related to her own fears of homosexuality, although she reported many negative "stereotypes." Over the course of therapy, however, she acknowledged how fears of being considered unacceptably different by family, religion, and society, in general, may have caused her to develop symptoms of Social Phobia. She began to grieve the loss of companionship experienced over the last 41 years.

What seemed to be a clear-cut case of Social Phobia eventually became a diagnostic dilemma. Although Martha technically met criteria for Social Phobia, the etiology seemed to be an arrest of psychosexual

development. Could this be a true case of Social Phobia? A review of the literature did not provide any answers to the question. While it may be impossible to make a firm statement about the etiology of Martha's anxiety, the role of sexual orientation appeared to be central. Should my conceptualization of this patient's diagnosis be altered by her struggle with sexual orientation? This was not merely an intellectual exercise. Understanding the etiology of Martha's Social Phobia symptoms was critical to developing an effective treatment plan.

SEXUAL ORIENTATION AND "COMING OUT"

Following almost 20 years of debate, the American Psychiatric Association rescinded homosexuality as an official mental disorder, but this question remained. Were non-heterosexual individuals at higher risk for the development of psychological disorders, such as Social Phobia, due to cultural oppression? The answer remains mixed.

The study of Lesbian Gay Bisexual and Transgendered psychology developed from broad-based sociopolitical discrimination (Kitzinger, 2001). Researchers note that although society has become more accepting of non-heterosexual individuals, homophobia abounds in the form of hate crimes, harassment, and legal discrimination (Gilman et al., 2001; Kitzinger, 2001; Saari, 2001). Given these very real threats to psychological and physical well-being, many non-heterosexual individuals avoid issues of sexual orientation or choose to remain "in the closet."

Models have been developed to describe common experiences to non-heterosexual identity formation (Sophie, 1986). Although the stages in the models have different labels, the ideas or themes are similar. Stage One involves confusion about sexual identity. Individuals in Stage One question if they are non-heterosexual. They report feeling uncomfortable with a sense of being different, and they begin to educate themselves about non-heterosexual orientations. Individuals who progress to Stage Two seriously consider that they may be non-heterosexual. They may experiment with feelings of sexual attraction and/or share feelings with confidants. Stages One and Two generally include expected feelings of distress, confusion, and denial as developmentally appropriate milestones due to cultural oppression. Later stages in the non-heterosexual identity development models involve the process of publicly acknowledging to self and others that one is not heterosexual.

This process is called "coming out." It has not been well-studied, and researchers do not totally agree on what is involved (Saari, 2001). What is known, however, is that it is not a linear or single event (Saari, 2001). In fact, it occurs each time a person encounters a new social situation, and the person is potentially exposed to scorn and negative evaluations by others (Saari, 2001). It is not uncommon for individuals to avoid exposing themselves to such social scrutiny. The fear of persecution is valid (Anhalt & Morris, 1998; Saari, 2001). An individual may decide that it is easier to become socially isolated (Saari, 2001).

It has been suggested that the process of coming out may be different for men and women, as women may not be aware of same sex attractions until adulthood (Cohen & Savin-Williams, 1996; Saari, 2001). Nevertheless, these women may have had a long-term feeling of being different from others that could cause guilt and social isolation (Cohen & Savin-Williams, 1996). There is some evidence to suggest that women are more inclined than men to silence themselves to protect social affiliations (Gilligan, 1982). This would suggest an alternative explanation for the delay in "coming out."

If feelings of difference are present during adolescence (when Social Phobia is hypothesized to emerge), a culturally induced etiology for Social Phobia is plausible. Core identity features are developing, and to discover that one has feelings that are condemned by society may be personally devastating (Kitzinger, 2001). To suggest that an anxiety disorder could develop under these circumstances would be easily conceivable. The mere risk of violence has been associated with increased risk of mental disorders, including depression, anxiety, substance use, suicide attempts, and Social Phobia (Anhalt & Morris, 1998; Cochran & Mayes, 2000; Cochran & Mayes, 2000; Gilman et al., 2001; Gonsiorek, 1996; Kessler, Mickelson, & Williams, 1999; Otis & Skinner, 1996; Sandfort, de Graaf, Bijl, & Schnabel, 2001; Stone, 2000). Risk of victimization is just one threat facing non-heterosexual adolescents (Anhalt & Morris, 1998).

THEORETICAL LINKS BETWEEN SOCIAL PHOBIA AND SEXUAL ORIENTATION

In order to cope with unacceptable feelings, individuals may use repression, suppression, rationalization, compartmentalization, withdrawal, sublimation, reaction formation, and denial as defense mechanisms (Cohen & Savin-Williams, 1996). When the defenses aimed at warding off unac-

ceptable impulses break down, anxiety results (Gabbard, 1992). The anxiety is displaced onto a more safe, acceptable object or situation, such as social situations (Compton, 1992). This psychoanalytic conceptualization of anxiety provides a theoretical link between Social Phobia symptoms and sexual orientation.

The psychodynamic understanding of Social Phobia focuses upon the role of shame in the development and maintenance of Social Phobia (Zerbe, 1994). Feelings of shame leave individuals vulnerable to perceived scorn and rejection by others (Jones, 2001). These individuals view themselves as inherently flawed, and they believe that others will see their true selves. Shame is common to individuals with Social Phobia (Gabbard, 1992) and non-heterosexual individuals (Jones, 2001). Jones (2001) describes shame as a multi-faceted emotion in which the superego functions as a restraint to the desires of the id by producing painful emotions. If the superego is splintered and then internalized, self-resentment may result. Individuals with Social Phobia have internalized object representations (introjects) of important others who may shame, criticize, or embarrass them (Gabbard, 1992).

Sexual orientation is perceived to be the most salient aspect of individuality because society has strongly pathologized (shamed) non-heterosexual individuals (Davison, 2001). As a result, non-heterosexuals may avoid social situations as a method of self-protection. It is the sense of shame that interferes with interpersonal connections lest the individual be vulnerable to rejection (Zerbe, 1994). This is ironic given that social support has been identified as a key buffer from the development of psychological disorders (Gabbard, 1992; Gonsiorek, 1996).

Smith (1988) emphasizes the importance of understanding how societal homophobia contributes to psychological difficulties among non-heterosexual individuals. The negative attitudes of society are ingrained at a very early age, prior to sexual exploration. When individuals internalize the message that non-heterosexual orientations are pathological and later contemplate being non-heterosexual, they may direct pathological ideas at themselves.

Safren and Rogers (2001) caution against attributing too much power to the role of sexual orientation in regard to psychological disorders. If clinicians attribute psychopathology to cultural factors, actual disorders are missed (Davison, 2000). Smith (1988) argues that if the presenting symptoms are anxiety-related, the focus of therapy should be upon the anxiety rather than sexual orientation (Smith, 1988). Furthermore, Davison (2001) and Kitzinger (1997) oppose the idea that non-heterosexual individuals internalize negative feelings or ideas about homo-

sexuality (internalized homophobia). Kitzinger believes that internalized homophobia implies that non-heterosexual individuals impose self-harm because society's negative standards about sexuality have been internalized, which further blames the victim. In general, there is the suggestion that if clinicians focus too much upon sexual orientation in relation to maladjustment, sexual orientation becomes re-pathologized.

How can psychology acknowledge the potential relationship between sexual orientation and psychological problems without pathologizing sexual orientation? Hancock (2000) maintains that it is essential for mental health providers to understand how prejudice and discrimination play roles in psychopathological presentation. What seems pathological may, in fact, be adaptive. That is, denial of a non-heterosexual orientation and subsequent development of anxiety may be a means of survival. Could this be the basis of Social Phobia among some non-heterosexual individuals?

There appear to be dangers associated with an approach that either focuses too little or too much upon the relationship of sexual orientation and anxiety. Although study of mental health disorders among non-heterosexuals are fraught with measurement problems, Cochran (2001) acknowledges that non-heterosexual individuals may be at increased risk for the development of psychological disorders. She suggests that to ignore this reality would be "unconscionable" (p. 941).

DIAGNOSIS AND TREATMENT

Based on the presenting symptoms and available literature, the Diagnostic and Statistical Manual Fourth Edition (1994) offers a couple of options. Martha's symptoms are consistent with the technical definition of Social Phobia, but is it proper to diagnose Social Phobia for what could be construed as an adaptive response to cultural repression or the internalization of shame invoked by a society that does not fully accept non-heterosexual orientations? Does this re-victimize Martha? Would it lead us toward or away from a helpful treatment plan? How does sexual orientation fit into existing etiological possibilities?

An alternative diagnostic option to Social Phobia is the diagnosis of Sexual Disorder, NOS. This diagnosis is assigned for a sexual problem that is not specific to another sexual disorder. Little description is available, although it is noted to be appropriate for individuals who have unremitting distress about sexual orientation. There is no mention of

distress etiology, and the etiology of Martha's distress was key to developing an effective treatment plan. The source of her distress had both external factors (cultural oppression of non-heterosexuals) and internal factors (internalized homophobia). The rather loose definition of Sexual Disorder, NOS, seems both non-descript and pejorative. One could argue that this diagnostic label implies the disorder is a sexual problem with no societal component. Mental health professionals who use Sexual Disorder, NOS, in the current, non-descript form may ignore the practical, social stressors faced by patients like Martha.

Final diagnostic considerations include Identity Problem, Phase of Life Problem, or Acculturation Problem. All seem relevant, although not widely used. In addition, the suggestion that the symptoms are not clinically significant did not fit for Martha. Her symptoms were debilitating. In the end, no available diagnosis seemed to accurately reflect the range and severity of her symptoms. The diagnosis of Social Phobia was reluctantly maintained.

The manner in which clinicians conceptualize symptoms of Social Phobia is a critical guide to treatment. Based upon the paucity of literature, definite etiological answers to conceptual questions are not empirically available. Additional research is clearly needed. Clinical knowledge, based upon developmental understandings of non-heterosexual identity development, suggests that Sexual Disorder, NOS, is in no way appropriate and may, in fact, be harmful. Furthermore, the manner in which it is currently described is woefully lacking such that it may easily be misapplied and misunderstood. Such misunderstanding then has the potential to misguide treatment. For example, would the goal of therapy be to eliminate distress about sexual orientation by encouraging heterosexual contact or changing sexual orientation? Likewise, would treatment include a sedative medication to mask the distress? It is the opinion of the authors that both answers should be "no."

In some ways, however, treatment for Social Phobia and sexual orientation anxiety is similar. It is the role of therapists to provide a corrective emotional experience for individuals seeking help (Gabbard, 1992; Reynolds & Hanjorgiris, 2000). Psychoanalytic therapists suggest that individuals with Social Phobia will present as fearful of rejection by the therapist. The therapist should provide a safe, non-humiliating environment where the client can modify shaming and criticizing introject(s).

Empirically validated treatment recommendations are not available for Social Phobia symptoms among non-heterosexuals. Our experience suggests that when anxiety is present in non-heterosexual individuals,

clinicians must commit to providing a safe, accepting environment to explore the potential roles of sexual orientation, internalized shame, and culturally induced repression in symptom development and maintenance. Special attention must be given to the spiritual and religious concerns of clients that may be deeply tied to feelings of shame and self-rejection. Clinicians should use sexual identity development models to conceptualize symptoms of Social Phobia among non-heterosexual individuals. The models may be used in therapy to validate the experiences of clients and to more appropriately define what is normal or expected. Identity development models do not provide a complete explanation of Social Phobia symptoms, but they do provide a premise for a different understanding of symptom etiology and suggest clinical approaches that will enhance self-acceptance and social engagement (Hanley-Hackenbruck, 1988).

CONCLUSION

After a few counseling sessions, Martha placed herself between Stages One and Two in non-heterosexual identity formation. She was confused, distressed, and in denial of her sexual orientation. As therapy progressed, she began to move into stage three, acknowledging her sexual orientation and beginning the process of self-validation and tolerance. Acceptance of her sexual orientation meant coming to grips with appreciable losses. Martha had to face the reality of societal injustices and the possibility of rejection by loved ones. At the same time, acceptance of her sexual orientation opened the door to a future that allowed for intimacy and a life with a loving partner.

Martha continues to explore Stage Three sexual identity developmental issues and has experienced significant reductions in "Social Phobia" symptoms. Martha will need assistance reaching out to the gay community that will allow her to move beyond tolerance and towards pride.

In the case of Martha, a traditional, simple conceptualization of Social Phobia, while technically correct, would have led to incomplete treatment. Psychopharmacy and cognitive-behavioral therapy were not curative for Martha. Individuals, such as Martha, benefit more from engaging in the process of self-discovery within the micro-contexts of family, friends, and spiritual beliefs and the macro-context of societal discrimination. Learning about gay culture and the accomplishments of the gay community can transform self-consciousness into pride. With

an appreciation of the non-heterosexual patient's cultural context, including ethnic, individual, family, spiritual, and social influences, clinicians will be in a much more solid position to make an accurate differential diagnosis. Part of having an open mind is considering how clinicians may use the standards of the powerful heterosexual society to unwittingly practice cultural oppression (Green, 2000).

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