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CAN I TALK TO YOU? SOCIOPOLITICAL FACTORS AND THEIR RELATION TO SYMPTOMS AND TREATMENTS OF SOCIAL ANXIETY IN A SAMPLE OF AFRICAN AMERICANS WITH SOCIAL ANXIETY

by

MAYOWA OBASAJU

Under the Direction of Page Anderson, PhD

ABSTRACT

This study is exploratory in nature and focuses on the relation between the individual and macrosystems by investigating the link between African Americans' fear of confirming stereotypes and their experience with symptoms and treatments for social anxiety. This study hypothesizes that 1) among a sample of African Americans diagnosed with social anxiety, there will be a significant, positive relationship between African-Americans' self-reported concerns over confirming stereotypes relevant to both social anxiety and their own self-reported levels of social anxiety, 2) significantly more African Americans will drop-out of therapy than Caucasians, 3) amongst African Americans, significantly more will drop out of group therapy than individual therapy, 4) the racial composition of the group will matter, such that more African Americans will drop out of groups where they are the only African American participant, compared to if there are other African Americans in the group, and 5) the presence of

an African American co-therapist will impact attrition from group treatment, with higher attrition rates in groups without an African American co-therapist, compared to if there is one. Thirty-four participants, 23 females and 11 males, who self-identified as African Americans and forty-four participants, 23 females and 21 males, who self-identified as Caucasian took part in this study. Results did not show a relation between stereotype confirmation concern and social anxiety. Regarding attrition, results showed that significantly more African Americans dropped out of therapy than Caucasians. Additionally, more African Americans dropped out of group therapy than individual therapy. There was no impact of therapist ethnicity or the presence of other African Americans on attrition rates, though these tests were underpowered.

INDEX WORDS: African Americans, Social anxiety, Public speaking anxiety, Fear of confirming stereotypes, Attrition rates, Cognitive behavioral therapy

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MAYOWA OBASAJU

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Georgia State University

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August 2009

I would like to dedicate this dissertation to the Creator and Sustainer, who provided me with strength and support throughout graduate school as a whole, and the dissertation process in specific. Through whom all things are possible. I would also like to dedicate this work to my immediate family, Mom, Dad, Laju and Jr., my extended family, whose number is too great to list, and friends. Your belief in me and continued support helped carry me through.

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CHAPTER 1: LITERATURE REVIEW

The objective of this study is to examine the link between African Americans' fear of confirming stereotypes and their experience of social anxiety. This link is viewed in ecological terms whereby every individual is influenced by layers of social relationships (1979) which for many African Americans includes socio-cultural conditions of oppression (Kambon, 1998). The study is exploratory in nature and focuses on the relation between the individual and macrosystems by investigating the link between African Americans' fear of confirming stereotypes and their experience with social anxiety. As stated in the Supplement to the Surgeon General's Report on Mental Health, "Cultural and social influences are not the only influences on mental health and service delivery, but they have been historically underestimated – *and they do count"* (Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General, 2001). I hope that the study adds to the small body of literature examining the influences of sociopolitical, contextual variables to better inform treatment and research with African Americans.

First, it is important to discuss what is meant by the term "African American." African American has been used as a racial, ethnic, and cultural designation. According to the Supplement to the Surgeon General's Report on Mental Health (2001), the terms "race," "ethnicity," and "culture" are imprecise terms with no exact definition. The terms have many meanings that have changed and at times overlap. "Race" is often assumed to be a biological construct used to divide people into groups according to physical traits. However, race is not a biological construct, but a social construction with social meaning. It is a social categorization that groups people together based on socially significant physical characteristics and is often used to differentially allocate power and other resources. "Ethnicity" refers to a common heritage

shared by a group of people. Heritage encompasses factors such as history, language, rituals, music, and food. The terms race and ethnicity share some overlap, but have differing social meanings. For example, Caribbean Blacks have different ethnicities than others in their same racial group (e. g. African Americans). "Culture" denotes a shared, learned set of beliefs and meanings for a particular group. There a number of ways to define a cultural group (e.g., culture based on profession, social groups, or age), and many people subscribe to multiple cultural identities. People from the same racial or ethnic group may have very different cultural beliefs (Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General, 2001). As such, people who self-identified as Caribbean Black or from the Continent of Africa were not included in this study.

The term "African American" is used throughout this paper to as an ethnic group designation. It is used to refer to a diverse group of people who share a common heritage (i.e., language, history), and socioeconomic/sociocultural factors (Schraufnagel, Wagner, Miranda, & Roy-Byrne, 2006). The within-group diversity encapsulated by this term are highlighted at the onset as it groups people together from various socioeconomic backgrounds, geographic locations, religions, social classes, educational levels, and with differing environmental experiences (Schraufnagel, Wagner, Miranda, & Roy-Byrne, 2006).

Just as it is important to define the term "African American," it is important to understand the context within which this research developed. This research developed in the context of the Anxiety, Research, and Treatment (ART) Lab at Georgia State University. The ART lab began studying the interface between culture and anxiety with the Culture and Anxiety Study (CAS). In the CAS, undergraduates at Georgia State who identified as ethnic minority students, responded to a series of social anxiety measures. Those who scored high on social anxiety measures were

asked to participate in a qualitative interview assessing the impact of their ethnicity or culture on their experiences of anxiety. From results that indicated people perceived that their ethnicity and/or culture impacted their experience of anxiety, a thesis and dissertation were proposed. The dissertation was authored by a graduate student named Simon Kim. He examined whether Asian American and African American undergraduates who received feedback that was consistent with racially relevant stereotypes experienced decreases in their performance and increases in their public speaking anxiety levels. The study found a significant correlation between fear of confirming stereotypes and social anxiety measures for African Americans. The thesis, written by the author of this document, found that the more African American undergraduates reported that they were viewed negatively as a group, the higher their reported levels of social anxiety. This relation was mediated by concern over how behavior might negatively affect other African Americans.

The findings of these studies pointed to a significant role for contextual, group specific variables for African Americans in their experience of anxiety. As such, when the ART lab became involved in running a randomized clinical trial, Fear of Public Speaking-II (FOPS-II) to compare two treatments for social anxiety, group and virtual reality therapy, a decision was made to include a variable that might tap a group specific variable. It is hypothesized that this variable, fear of confirming stereotypes, might impact anxiety. The FOPS-II trial was relatively diverse compared to extant treatment outcome literature. Approximately one third of the participants were African American. Anecdotal evidence from the trial suggested a role for fear of confirming stereotypes. An African American participant in individual therapy reported that she feared talking to strangers at social events and work. She reported that she feared appearing “stupid” and “less intelligent” than other people at the events. She later discovered the previously

mentioned dissertation and thesis topics on a website of the ART Lab. She contacted the lab and asked for more information. She stated that she felt fear of confirming stereotypes was a salient aspect of her experience of social anxiety. It is this variable, understood as an ethnic group specific, sociopolitical variable that will be further discussed in this study in a clinical sample.

In the following sections, I will discuss a group specific, ecological approach to understanding African Americans' experience of social anxiety. Then I will address factors that may impede researchers' ability to identify sociopolitical contextual variables, concentrating on the lack of research with African Americans. Next, I will discuss the development and treatment for social anxiety and stereotypes and their effects on performance.

Ecological Approach

Many researchers have studied the detrimental mental health effects for African Americans in living in a social, political, economic, and cultural context that has been developed to benefit others, while subjugating African Americans (Akbar, 1996; Kambon, 1998) Yet, few clinical researchers have assessed the ways in which people of African descent experience and interact with systems in their environment, the world-views they develop, and how these world-views result in specific behaviors from the perspective of African Americans (R. T. Jones, Brown, Davis, Jeffries, & Shenoy, 1998). This continues though well-regarded models have highlighted the importance of understanding the systems in which all people operate. Bronfenbrenner's ecological model (1979) posits that people are impacted by the interconnections between their settings and the larger systems within which the settings are embedded. The ecological model is comprised of multi-leveled systems with each system nested inside the next. It begins with ontogenic development (individual's personal characteristics, e.g., temperament), moves outward to the microsystem (relation between person and immediate

setting, e.g., client and psychological service systems), then the mesosystem (interrelations between immediate settings, e.g. psychological service systems and school as it relates to receiving accommodations), the exosystem (formal and informal social structures that impact the person but do not directly contain the person, e.g., managed health care), and lastly, the macrosystem (societal/cultural context, e.g., stereotypes about ethnic groups). The framework is based on the premise that individual behavior can only be understood in the context of factors at the individual, interpersonal, social, and cultural levels. This model points to the need to understand the many contextual levels that impact people. Yet, many African American researchers have pointed out that prevailing psychological paradigms and models fail to take into account ethnic group-specific factors and systems that differentially affect African Americans (R. T. Jones, Brown, Davis, Jeffries, & Shenoy, 1998).

Researchers have called further attention to the need to research the effects of the macrosystem on individuals. African American researchers have posited that any theory used with African Americans must take into account the group status of African Americans in America and the unique stresses developed by trying to navigate American society (Anderson, 1989; Jones et al., 1998). Specifically, there is a need to research ethnic minority groups in terms of their group's shared experiences and norms (Ogbu, 1981), as these experiences and norms help form "blueprints" for individuals' behaviors. It has been suggested that we cannot only focus on individual behaviors in isolation, but also should understand individuals' behavior in the context of their ethnic group. For example, this would require that research intended to inform interventions with African Americans should be conducted with African Americans, taking into account their context. Instead of studying African Americans in terms of theories developed on European Americans, researchers should seek the input of the unique and shared

experiences of African Americans when developing theories for African Americans (Jones et al., 1998). This is critical as research with ethnic minority populations, from the perspective of the dominant culture, has contributed to the use of deficit models to describe behaviors of groups that are not part of the dominant group, European Americans (Cokley & Williams, 2005; Grills & Rowe, 1998; R. T. Jones, Brown, Davis, Jeffries, & Shenoy, 1998; Kambon, 1998). Using an ethnic group specific, ecological approach (Bronfenbrenner, 1979; R. T. Jones, Brown, Davis, Jeffries, & Shenoy, 1998; Ogbu, 1981) this study investigates the role of a macrosystem variable as it relates to the experiences of African Americans in the United States.

There is little psychological research that explores how sociopolitical, macrosystemic factors may impact the expression of psychological disorders in general, and social anxiety in particular, among African Americans. This is important because sociopolitical factors may impact people's experience of the course, intensity, and treatment of disorders. For example, Fanon highlighted the roles of macrosystem variables, colonization and oppression, as they concerned the mental health and psychology of Blacks across the globe (Fanon, 1967) while researchers such as Kambon (1998) focus on the mental health of Africans in America. This study explores the perspective of African Americans as it relates to their experiences of social anxiety, using their reports on a macrosystem related variable, the fear of confirming societal stereotypes.

Factors that Influence the Dearth of Research with African Americans

What is keeping researchers from exploring sociopolitical factors that may influence African Americans experience of anxiety? The finding of the Surgeon General's Report on Mental Health provides one answer. The report states that in comparison to European Americans, ethnic minorities in the United States are underrepresented in research. This

underrepresentation in research makes it less likely that researchers will capture African Americans' unique experiences in relation to ecological variables. What could contribute to this underrepresentation in mental health research? A primary path by which people participate in evidenced based and treatment outcome research is through professional diagnosis of a disorder and referrals for treatment. Research has documented a number of variables that impede the pursuit of mental health treatment by African Americans, thereby reducing the number who receive diagnoses and thus are able to participate in clinical outcome research. As elaborated below, factors such as pathologizing and misdiagnosing, mistrust of mental health research, and structural and psychological barriers to care have all been identified as impediments (Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General, 2001; Neal-Barnett & Smith, 1997; Paradis, Hatch, & Friedman, 1994; Schraufnagel, Wagner, Miranda, & Roy-Byrne, 2006).

Pathologizing and Misdiagnosing

Researchers have tended to pathologize the ethnic group-specific experiences of African Americans (McGoldrick, 1998) and have misused them in research (Freimuth, Quinn, & Thomas, 2001). Since the time of slavery, many African Americans have been misdiagnosed and pathologized by psychologists and psychiatrists (Baker, 2001; Garretson, 1993; Neal-Barnett & Smith, 1997). For example, Samuel Cartwright, a 19th century physician in the United States described two "mental disorders" common among slaves. One was *drapetomania*, a disorder wholly characterized by "the uncontrollable urge to escape slavery". The second disorder was *dyasthesia aethiopia*, which was comprised of many symptoms: "destroying property on the plantation, being disobedient, talking back, fighting with masters, and refusing to work" (McGoldrick, 1998). These diagnoses transformed a desire for freedom into a pathology that

only applied to African-American slaves. The field of psychology has long held a negative and damaging view of African Americans (R. T. Jones, Brown, Davis, Jeffries, & Shenoy, 1998) and examples of misdiagnosing and pathologizing African Americans can still be found in the present day. The Surgeon General's Supplement on Mental Health (2001) states that African Americans are more likely than European Americans to be misdiagnosed, especially as related to diagnoses of schizophrenia and anxiety disorders. A study by Paradis et al. (1992) found that anxiety disorders were significantly underdiagnosed for African Americans by staff in an outpatient psychiatric department in a municipal hospital. The research team interviewed patients at the hospital using the Anxiety Disorders Interview Scale-Revised (ADIS-R) and found discrepancies between diagnoses of research and hospital staff. Instead of an anxiety diagnosis, the hospital staff assigned diagnoses from the schizophrenia spectrum, which are considered more serious psychiatric illnesses.

Mistrust

Two studies have conducted focus groups with African Americans about their attitudes towards research. Their findings highlight African Americans' mistrust of research and mental health providers based on past misuse in research studies. The legacy of the Tuskegee Syphilis Study, in which African-American men were studied and not treated for their syphilis, even after penicillin had been found to be effective, continues to influence African-Americans' views of research. Freimuth, et al., (2001) conducted focus groups with 60 African Americans on this topic. They found that many participants believe the Tuskegee Syphilis Study continues to be typical of research studies, especially if African Americans are involved. Participants referred to HIV/AIDS as a laboratory-created experiment made to harm people of African descent. Freimuth et al. (2001) conclude that a number of factors contribute to mistrust of the mental health service

system and research, including unfair recruitment methods, the provision of misleading information about the nature of studies, and the lack of respect in the treatment of African American research participants.

Specific to mental health providers, Sanders-Thompson, Bazile, & Akbar (2004) conducted a focus group with 201 African Americans on their views of psychotherapy. They found that many cited mistrust as a reason for not seeking treatment. Respondents reported that many clinicians do not understand the struggle of African Americans and may believe stereotypes associated with African Americans. In addition, respondents were concerned that they would be misdiagnosed, labeled and brainwashed by clinicians. Instead of seeking care from clinicians, many African Americans prefer seeking help from clergy or family members (Neal-Barnett & Smith, 1997). Misuse by researchers and mistrust of mental health services and service providers has been used to explain why so few African Americans participate in research studies (Paradis, Hatch, & Friedman, 1994; Sanders-Thompson, Bazile, & Akbar, 2004).

Barriers to Receiving Care

Barriers to service delivery also impact participation in research as many research participants are recruited through healthcare delivery systems. Barriers for African Americans include psychological barriers such as stigma and discrepant attitudes and beliefs concerning mental illness from that of healthcare providers, as well as structural barriers such as transportation, insurance, and childcare (Schraufnagel, Wagner, Miranda, & Roy-Byrne, 2006). These barriers make it less likely that African Americans seek care, and thus have the opportunity to participate in outcome research (Regier et al., 1984). Additionally, African Americans may seek care but barriers may make it more likely they drop-out of treatment.

One prominent psychological barrier to seeking treatment is concern over the stigma associated with receiving a psychological disorder diagnoses. The fear of discrimination or rejection from both family members and wider social networks as a result of a diagnosis of mental illness is an impediment to accessing mental health services across ethnic groups (Gary, 2005). Studies have shown that after receiving a diagnosis of a mental illness, people experience decreased status and reputations in the community, feelings of alienation from family members, familial struggles with guilt, decreased self-esteem, lowered sense of self-efficacy, and the exhaustion of family resources (Gary, 2005; Hudson, 2005; Lefley, 1989; Link, Phelan, Bresnahan, Stueve, & Pescocsolido, 1999; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Pescosolido, Gardner, & Lubell, 1998). Furthermore, many African Americans may delay seeking treatment when they notice early symptoms to avoid the negative outcomes associated with a mental illness diagnosis. This avoidance may, in turn, lead to the development of stronger, more severe symptoms (Bolden & Wicks, 2005). The severity of the symptoms may lead to seeking care from primary care or emergency room settings. In these settings, African Americans are more likely to be misdiagnosed and less likely to be given evidence-based treatments or mental health referrals (Bolden & Wicks, 2005). If given more regularly, mental health referrals may have led to participation in outcome research studies.

The greater the discrepancy between a person's beliefs about the cause and treatment of psychological disorders from those held by the providers, the less likely the person is to access mental health care systems. Discrepant beliefs can be rooted in cultural differences in how mental illness is viewed, diagnosed, and treated across different ethnic groups (Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General, 2001). All societies transmit views concerning the nature and causes of mental illness.

The traditional view in American society is that of a biomedical model (Schraufnagel, Wagner, Miranda, & Roy-Byrne, 2006). The biomedical model contains three primary assumptions: illnesses have a single, underlying cause, a disease is the single cause, and removing the disease will result in better health (Wade & Halligan, 2004). These assumptions may not align themselves with the views of the person seeking treatment. For example, belief in folk, supernatural, spiritual, or mystical sources of illness have been documented in some ethnic minority populations (Alvidrez, 1999). Researchers have found that explanations for emotional distress amongst African Americans and others of African descent have included belief in changes in blood; whether it thickens or thins, heats or cools, or is out of balance or in balance (Snowden, 1999). In addition, the language used in some African American groups to explain emotional distress, (i.e., "nerves," "falling-out," and "high blood") may reflect a different belief regarding the causes of mental illness (Heurtin-Roberts, Snowden, & Miller, 1997). Discrepancies between the biomedical model and cultural explanations for distress may make it less likely that a person will seek treatment in a traditional biomedical setting (Schraufnagel, Wagner, Miranda, & Roy-Byrne, 2006).

In addition to psychological factors, there are a number of structural factors that serve as impediments to accessing mental health services. Lack of transportation, insurance, providers, and time, different styles of communication than those of health service providers, cost of treatment, need for assistance with childcare, and competing priorities have all been reported as structural barriers to accessing care among ethnic minorities (Alvidrez, 1999; Copeland, 2005; Schraufnagel, Wagner, Miranda, & Roy-Byrne, 2006). Research studies that address barriers to care, such as providing childcare and transportation, generally show that evidence-based

treatments are effective with African Americans. (Schraufnagel, Wagner, Miranda, & Roy-Byrne, 2006).

In summary, there are many factors that might explain the dearth of research with African Americans. African Americans' experiences with over-pathologizing and misuse in research have produced general feelings of mistrust of the mental health field and research (Freimuth, Quinn, & Thomas, 2001; McGoldrick, 1998; Neal & Turner, 1991). Moreover, African Americans also have been found to be less likely to seek treatment and hence, less likely to be referred for less treatment studies (Regier et al., 1984). Finally, African Americans face psychological and structural barriers to care (Copeland, 2005) which may prevent them from seeking treatment, and potentially learning about treatment studies.

What are the effects of the lack of research with African American populations? The lack of a strong body of empirical studies with African Americans may make it harder for researchers to identify and explore the role of group specific, sociopolitical factors in expression and treatment of psychopathology for African Americans. For example, most of the anxiety research with African Americans pertains to panic disorder. That research suggests there is a difference in the manner in which panic is described and possibly, the manner in which it is experienced for African-Americans. Studies have found that during panic attacks, African Americans report a significantly higher number of physical symptoms, such as numbing/tingling of the extremities (Smith, Friedman, & Nevid, 1999), hot and cold flashes (Horwath, Johnson, Hornig, & Weissman, 1993), and higher levels of isolated sleep paralysis (Friedman & Paradis, 2002; Paradis, Friedman, & Hatch, 1997) relative to European Americans. Differences in cognitive symptoms also have been documented, with African Americans reporting more intense fears of dying or "going crazy" than European American clients (Friedman & Paradis, 2002). In addition,

Smith et al. (1999) found that African Americans exhibited different coping strategies, such as counting one's blessings and religiosity. These studies of panic among African Americans highlight differences from European Americans. They do not describe why symptoms are different or how they could be related to African Americans' larger sociopolitical context and ethnic group-specific varibales. For social anxiety there is even less information for African Americans. There is some evidence for cross-cultural differences in the expression of social anxiety (e.g., taijin kyofusho), but to my knowledge no treatment studies have focused exclusively on African Americans. Because of its interpersonal, evaluative nature, social anxiety may be a particularly relevant disorder to study to investigate the role of sociopolitical factors. Thus, using an ecological perspective, what is needed to better understand social phobia among African Americans is not simply more research with them, but more research with African Americans that seeks to understand their experiences of social phobia within their sociopolitical context.

Social Anxiety, Stereotypes, and African Americans

The Executive Summary to the Surgeon General's Supplemental Report on Mental Health (2001) states that "Racial and ethnic minorities in the United States face a social and economic environment of inequality that includes greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health (p. 3)." African Americans in the United States have been subject to centuries of racial discrimination, forced acculturation, stereotyping and societal prejudice, all of which interact to affect mental health (Kambon, 1998). Whereas some African Americans have prospered socially, economically, and politically despite these challenges, African Americans as a group continue to occupy a disadvantaged social position in America (Copeland, 2005). As highlighted by Bronfenbrenner (1979) and Ogbu (1981), people

and their environments are in constant interactions, mutually influencing each other. African Americans are influenced by and influence factors in their social and political environment. As such, it is important to examine whether there are unique aspects to African-Americans' experiences with anxiety that are based on factors related to African Americans sociopolitical context.

Social Anxiety

Social anxiety is an extreme form of evaluative concern. It is defined by a "marked and persistent fear of social or performance situations in which embarrassment may occur" (DSM-IV, APA, 1994). The lifetime prevalence of social phobia has been estimated from anywhere between 3% and 13% (DSM-IV, APA, 1994) making it the third most prevalent psychiatric disorder (DSM-IV, APA, 1994). Social anxiety is consequential as well, as it is linked to an increased likelihood of being unemployed, lower income, reduced likelihood of attaining a post-secondary education, suicidal ideation, and alcohol abuse (Olfson et al., 2000; Stein, Walker, & Forde, 1994; Van Ameringen, Mancini, & Streiner, 1993).

Treatment for Social Anxiety

Behavioral, cognitive, and cognitive-behavioral therapies have all been demonstrated to be efficacious for the treatment of social anxiety, in comparison to wait list control (Heimberg, 2002). The focus of cognitive therapy is to help people change their thoughts and beliefs about social situations in an effort to decrease anxiety. The focus of behavioral therapy is having people expose themselves to feared social situations, in a therapeutic manner, in an effort to decrease anxiety through extinction of fear responses. Cognitive-behavioral therapy makes use of prolonged, therapeutic exposure and cognitive change techniques. Within cognitive-behavioral therapy, cognitive-behavioral group therapy is one of the most researched techniques. In

cognitive-behavioral group treatment, the group format provides opportunity for exposure, as the interpersonal contact with other group members is anxiety provoking. This format overcomes the disadvantages of individual treatment for social anxiety, in that it can be difficult to create realistic exposures in an individual therapy format. It has also been shown to be beneficial in randomized clinical trials and at long-term follow-up (Heimberg et al., 1990; Heimberg, Salzman, Holt, & Blendell, 1993). Individual based cognitive-behavioral therapies have also been shown to produce beneficial results (Wells & Papageorgiou, 2001) with recent literature on virtual reality based individual therapy showing promising results (Anderson, Zimand, & Hodges, 2005).

Though treatments for social anxiety have been demonstrated to be effective, social anxiety has been found to have a low rate of recovery without psychological interventions (S. Taylor, 1996). A small number of people receive treatment for their social anxiety. Studies have reported that 72% to 95% of people with social anxiety report having never received anxiety treatment (Robins & Reiger, 1991; Schneier, Johnson, Hornig, Liebowitz, & Weissman, 1992). Studies also have reported that many people who begin treatment end up dropping out. Researchers have highlighted the importance of systematically reporting drop-outs or attrition rates when reporting the effectiveness of treatments. Non-reporting calls into question the validity of the study, as participants who drop out may be systematically different than those who participate. In response to calls for better tracking of attrition throughout the randomized trial process, a group of researchers developed the CONSORT (Consolidated Standards of Reporting Trials) diagram (Moher, Schultz, & Altman, 2001). This diagram reports the number of people assessed for eligibility, excluded during enrollment, randomized to condition, and people who completed each condition. Reporting the number of people who were assessed for eligibility

allows one assess the representativeness of participants in the trial, compared to those assessed for eligibility, which is relevant for external validity. Reporting the number of people who either did not receive the intervention or dropped out of the intervention allows one to assess the extent to which the efficacy of the treatment may have been underestimated, compared to ideal situations. This is relevant for internal validity. However, few clinical studies systematically examine attrition rates at each level of the process (Hofmann & Suvak, 2006).

One recent study examined points of attrition in a sample of people with social anxiety seeking treatment in an anxiety disorders specialty clinic. This study found that out of 395 initial phone screenings for social anxiety, only 60 people accepted and started treatment. The study found high attrition rates when they attempted to schedule an initial interview after the phone screen (19%), for attendance to the initial interview (48%), and for starting treatment after the initial interview (52%). This study found that African Americans were less likely to attend the assessment interviews than European Americans (Coles, Turk, Jindra, & Heimberg, 2004). Studies also have found that a high number of participants drop-out after the start of treatment. For example, clinical trials for cognitive-behavioral group therapy have reported 20-25% attrition rates (Davidon, Foa, & Huppert, 2004; Heimberg et al., 1990; Heimberg, Liebowitz, & Hope, 1998; Hofmann & Suvak, 2006). While the two studies on dropout analysis (Hofmann & Suvak, 2006; S. Taylor, 1996) did not report finding demographic differences in attrition, one, a meta-analysis, did not report on the racial or ethnic make-up of drop-outs (Taylor, 1996). The results of the other were based primarily on European-American participants, 89.5% (Hofmann & Suvak, 2006). Little is known about attrition rates amongst African Americans, which may be in part due to the small number of African Americans who participate in clinical research trials, as previously discussed. Yet, considering barriers to seeking care for African Americans, it is

likely that African Americans also face barriers in treatment that may lead to high attrition rates. In later sections I will discuss how attrition may relate to sociopolitical factors.

Another aspect of treatment outcome examined in the literature is therapist and client matching on race. This research has produced mixed findings. Atkinson (1983) found that African American clients reported a preference for African American counselors, more rapport with African Americans counselors, and more satisfaction with African American counselors, in comparison to European American counselors. Alternatively, Gottheil, Sterling, & Weinstein (1994), Sterling, Gottheil, Weinstein, & (1998) and Sue (1988) did not find consistent patterns of positive outcomes for client therapist matching on race. Sue (1988) posits the reason for these mixed findings. He states that ethnicity or race "tell us little about the attitudes, values, experiences, and behaviors of *individuals*, therapist or clients, who interact in a therapy session"(Sue, 1988, p. 306). Though there are a number of differences across groups, there are just as many differences within groups. Matching people who differ ethnically or racially may or may not work because both therapist and client may hold similar or dissimilar values, world-views, and experiences.

The potential relation between treatment for social anxiety and ethnic group-specific factors has been discussed, yet the question still remains, what does social anxiety look like? What factors might affect the experience of social anxiety for African Americans? In the following sections I will discuss a model of how social anxiety develops and factors that serve to maintain anxiety. Then, I will discuss the nature of stereotypes and their effect on behavior.

Model of the Development and Maintenance of Social Anxiety

What happens when a person with social phobia enters a performance situation? Recent models of social phobia have begun to place more emphasis on the person's interactions with

others during performance situations. Rapee & Heimberg (1997) developed a cognitive – behavioral model of social phobia that places more of an emphasis on the speaker's perceptions of the audience's evaluation of their performance (Figure 1).

The model begins with the socially anxious person's attention on the perceived audience, which is any person or group that has the chance to formulate a negative evaluation of the speaker. The next step leads the socially anxious person to form a mental representation of themselves as seen by the audience or others. The person forms this representation almost immediately after their discovery of who constitutes as their audience. For the person with social anxiety, the image they form of how they appear to others is more important than their own personal view of how they appear. This phenomenon occurs because people with social phobia find the thought of other people's evaluations more threatening than their own (Rapee & Heimberg, 1997; Rapee & Turk, 1995).

Following this thread, the third step is that of comparing the mental representation of the self as seen by others with an appraisal of expected standards of other people in the social situation. In this step, the person with social anxiety tends to project what they believe are the expected standards of their performance from the audience. They try and adapt their behavior to meet what they believe others expect from them, asking themselves questions such as, *"How good of a job are these people expecting from me?"*, *"How well do I have to speak for these people to remain engaged with what I am saying?"* People tend to compare the mental representation of themselves as seen by others with what is expected by others. Research has documented that socially anxious people believe that others hold expectations and standards that they will not be able to meet (Alden, Bieling, & Wallace, 1984).

The fourth step is the judgment of the probability and consequences of a negative evaluation from others in a performance situation. It has been documented that relative to people

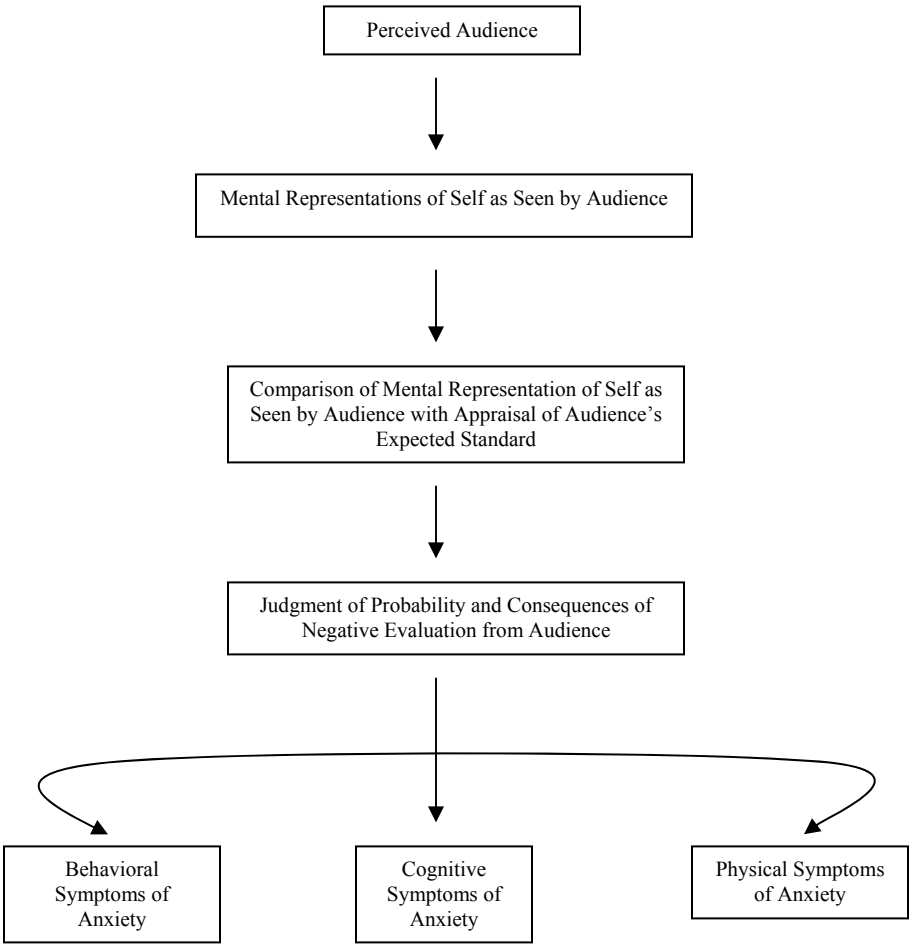

Figure 1: Rapee & Heimberg (1997) Model of Social Anxiety

without social anxiety, people with social anxiety tend to judge the likelihood and severity of a poor performance as high (Foa, Franklin, Perry, & Hebert, 1996; Lucock & Salkovskis, 1988; Poulton & Andrews, 1994).When one adds the burden of believing that they are not meeting the expectations of other people into equation, people with social phobia are more likely to believe that others are creating a negative evaluation of them and that the cost of that judgment will be high.

The fourth step of this path leads the person with social anxiety to more specific symptoms of anxiety, cognitive, behavioral, and physical. Many of the cognitive comments that are going through the person's head are negative in nature. *"I am messing up again," "They are all going to hate my talk,"* and so forth. In addition to their cognitions and behaviors, people who are socially anxious tend to have heightened autonomic arousal and their audience may witness the symptoms of that arousal.

When one combines an unfavorable mental representation of self, the belief that others have expectations that are out of reach, and a tendency to judge the likelihood of and cost associated with negative evaluations to be high, social situations become very threatening and anxiety producing, manifesting in cognitive, behavioral, and physical symptoms. In the end, a person with social anxiety has an extreme fear of being embarrassed or humiliated in front of others based on their performance in a social situation.

One can add yet another layer to the equation. Bronfenbrenner (1979) and Ogbu (1981) remind us that the individual is impacted by their ecological context, and for many groups, stereotypes are a part of that context. Stereotypes are societally held, social evaluations based on group membership with both social and political consequences (Sigelman & Tuch, 1997). What happens when a person with social phobia is a member of a group that has negative stereotypes associated with it and is devalued by society? How will knowledge of negative societal stereotypes of one's group impact an interpersonal, performance based interaction? In summary, how do societal views about African Americans as a group impact an individual African American's experience of anxiety? Any interpersonal interaction contains several levels of interactions. It is an interaction both between individuals and the social groups they represent. As such, any individual judgment contains a societal judgment. Research shows that stereotypes are

social evaluative judgments and have social and political consequences. Because of this, we should study the impact of stereotypes as they relate to African Americans.

Stereotypes and African Americans

Stereotypes can be understood as a macrosystem factor (Bronfenbrenner, 1979) that serve as a general societal "blueprint" for responding to one's environment. They are representations of social groups that serve to differentiate groups and contribute to individuals' social identity, and have real life consequences. Stereotypes are often negative and are motivated by a bias to enhance the group one belongs to and disparage out-group members. This disparaging of other groups increases in-group members' collective self-esteem and serves as a positive input to one's social identity (Klein & Azzi, 2001). Stereotypes are used as support for prejudice and discrimination against out-group members (Sigelman & Tuch, 1997). For example, compared to other European Americans, European Americans who hold negative stereotypes about African Americans as "lazy" and "dependent on welfare," are less likely to support government programs that help African Americans break out of poverty. As such, stereotypes have both social and political consequences (Sigelman & Tuch, 1997).

Devine & Elliot (1995) found that stereotypes about African Americans consistently have been negative over the last 70 years, though specific characteristics attributed to African Americans have changed. The impact of awareness of stereotypes has only recently been systematically explored (Contrada et al., 2001). The study of meta-stereotypes, individuals' beliefs about how they are viewed by other people, (Vorauer, Hunter, & Main, 2000) is an example of one such exploration. For African Americans, meta-stereotypes are defined as their beliefs about European-American's stereotypes of African Americans. Literature documents that many African Americans believe that members of the dominant culture hold negative views

about African Americans and their abilities (Harvey, 2001; Sigelman & Tuch, 1997). For example, Sigelmen and Tuch (1997) conducted research examining African-American's meta-stereotypes. The authors used data from a national Time/CNN survey. They found that two-thirds of the 504 respondents believed that European-Americans held negative beliefs about African-Americans. African-American respondents endorsed that they believed European-Americans viewed them as "less intelligent than whites," (76%), "always whining about racism" (74%), and "lazy," (69%). These beliefs can have a significant impact on the behavior of each group (Sigelman & Tuch, 1997). Some of these effects on African Americans have been documented by research on stereotype threat and fear of confirming stereotypes.

Stereotype Threat

Steele et al. (1995, 1997) developed the construct of stereotype threat to partially explain the impact of the awareness of stereotypes about one's group. Steele & Davies (2003) define stereotype threat as "the pressure that a person can feel when she is at risk of confirming, or being seen to confirm a negative stereotype about her group." Stereotype threat research documents that knowledge of societal stereotypes about different groups can influence the intellectual performance of group members (Steele, 1997; Steele & Aronson, 1995; Steele, Spencer, & Aronson, 2002). The effect of stereotype threat has been documented for women in relation to their mathematic ability (Spencer, Steele, & Quinn, 1999), for Latino students and their scholastic ability (Aronson & Salinas, 1997), and with the elderly and their cognitive functioning (Levy, 1996). Studies conducted with women, African-Americans, and Latinos found that reports of anxiety partially mediated the relationship between of stereotype threat and their test performance (Osborne, 2001; Spencer, Steele, & Quinn, 1999). The situations where the negative stereotypes exist can become self-threatening if the person identifies with the

situation or considers it relevant to their sense of self. This situation is viewed as self-threatening because the person fears that the stereotypes surrounding their group are not just stereotypes, but are in fact characteristic of themselves. This self-threatening situation can produce anxiety in an individual who fears confirming the negative stereotype about their group (Steele, 1997). For example, an African American who gives a speech in front of her college class may fear that a poor performance will confirm stereotypes concerning African Americans' intelligence, contributing to her feelings of anxiety.

Researchers hypothesize that anxiety is a mechanism by which stereotype threat impacts behavior (Cadinu, Maass, Frigerio, Impagliazzo, & Latinotti, 2003; Spencer, Steele, & Quinn, 1999). For example, Spencer et al. (1999) found that self-reports of anxiety partially mediated the connection between stereotype threat status and test performance on an intellectual task for women, African Americans, and Latinos.

Research using less obtrusive, non-verbal indicators of anxiety also supported anxiety as an underlying link explaining the impact of reminders of stereotypes on decreased performance. Using a rater who was blind to procedures and hypotheses to code participants' non-verbal anxiety while interacting with children, researchers found that non-verbal anxiety mediated the relation between stereotype status for gay men and their performance on an interpersonal task. This relation did not exist for non stereotype threatened gay men. Gay men who received reminders of their sexual orientation identity before interacting with preschool children displayed poorer childcare performance, relative to gay men who did not receive reminders of their identity (Bosson, Haymovitz, & Pinel, 2004). Anxiety may mediate the relation between fear of confirming stereotypes and decreased performance. The question then arises; can societal

stereotypes about groups influence another performance-based behavior, the expression of social anxiety amongst African Americans?

This question moves researchers beyond individually focused variables to the investigation of aspects of the sociopolitical environment that impact African Americans. Stereotype threat is based on concern over evaluative scrutiny. It is more than a fear of evaluation from other individuals; it rests on a fear of societal evaluations of one's group. It is a social-psychological threat which can develop when a person is in a situation where a negative stereotype of their group exists. People fear being reduced to the stereotype and then treated or judged in terms of the stereotype. Hence, the social environment which produces stereotypes about African Americans as a group has the possibility of affecting an individual African Americans' experience with social anxiety, a disorder which is based on concerns over receiving negative evaluations. Research has not explored the influence of this concept in African Americans with clinical levels of social anxiety.

Stereotype Confirmation Concern

Whereas stereotype threat may be conceptualized as an acute stressor, Contrada et al. (2001) have developed the notion of stereotype confirmation concern as a chronic stressor. Stereotype confirmation concern is viewed as a chronic concern of members of a stigmatized group who fear confirming stereotypes about their group. Contrada et al. (2001) suggest that the degree to which group members feel enduring or chronic concern over confirming a negative stereotype varies between two extremes. On one extreme, there are people who are constantly concerned with appearing to confirm a stereotype of their group, while on the other extreme there are people who are free from concern over confirming stereotypes. Research conducted on an ethnically diverse, college student sample found that stereotype confirmation concern was a

source of ethnicity-related stress and that individuals differed in their self-report of stereotype confirmation concern (Contrada et al., 2001). This form of concern over group related, negative evaluations may not only operate in specific situations (e.g., stereotype threat), but also serve as a chronic manifestation of concern in social situations.

Summary

People are impacted by their ethnic group membership and the larger systems within which they operate (Bronfenbrenner, 1979; Ogbu, 1981; Jones et al., 1998). The experience of psychopathology should be understood and explored within these broader contexts. Yet, there is a dearth of research taking into account the social and political realities that many African Americans function in as it relates to psychological disorders in general, and social anxiety in specific. A number of reasons have been proposed for this lack of research; experiences with pathologizing and misdiagnosing, mistrust of the research enterprise and clinicians, and barriers to participating in treatment and treatment research (Baker, 2001; McGolderick, 1998; Freimuth, Quinn, & Thomas, 2001; Neal-Barnett & Smith, 1997; Sanders-Thompson et al., 1994). The little research conducted with African Americans and anxiety has provided some evidence for differences in the manner which anxiety of described and experienced for African Americans (Smtih, freidmen & Nevid, 1999; Horwath et al., 1993; Friedmen & Paradis, 2002; Paradis et al., 1997). Social anxiety is an especially relevant anxiety disorder to explore by taking into account macrosystem variables as it rests on individual and social evaluative fears. African Americans with social anxiety many not only feel concern over being judged negatively as individuals, but based on the ubiquity and impact of stereotypes, they may also feel concern over being judged negatively based on their group membership. The rationale for the current study hypothesis will be explored in the next chapter.

CHAPTER 2: INTRODUCTION

The focus of much research on psychological disorders is on the impact of individual-focused variables. This study is exploratory in nature and seeks to understand the impact of larger systems, from an individuals' perspective, on the expression of social anxiety in African Americans. Specifically, the goal of this study is to investigate the impact of fear of confirming stereotypes in African Americans' experience of Social Anxiety.

Why study social anxiety? It is the third most common psychological diagnosis with studies finding 3-13% lifetime prevalence rate (DSM-IV, APA, 1994), though few people seek treatment for it (Robins & Reiger, 1991; Schneier et al., 1992). It is consequential and has been linked to decreased likelihood of employment or post secondary education and lower income (Olfson et al., 2000; Stein, Walker, & Forde, 1994; Van Ameringen, Mancini, & Streiner, 1993). It is based on a social evaluative concern, a marked and persistent fear of social or performance situations in which embarrassment may occur (DSM-IV, APA, 1994). As such, this disorder already points to understanding interactions with others in a social context. This study broadens the concept of looking at the influence of the social context from focusing on specific social situations, to taking into account the macrosystem within which the situations occur.

How can we understand the role of the macrosystem in the context of African Americans in America? This study explores the role of stereotypes as a sociopoltical, macrosystem variable. Any interpersonal interaction contains several layers of interactions, interactions between individuals and the social groups they represent and as such, any individual judgment can contain a societal one. Stereotypes are social evaluative judgments with social and political consequences (Sigelman & Tuch, 1997). There are a large number of negative stereotypes for African American related to social situations, i.e., less intelligent, and inarticulate when

speaking. Research on meta-stereotypes has shown African Americans are aware of negative stereotypes about their group (Vorauer, Hunter, & Main, 2000) and stereotype threat work has shown that awareness of stereotypes concerning one's group has the ability to impact an individual's behavior (Steele, 1997; Steele & Aronson, 1995; Steele, Spencer, & Aronson, 2002). Stereotype confirmation concern proposes that fear of confirming stereotypes is a chronic form of stress and is not based on an specific situations (Contrada et al., 2001). Yet the question remains, how does research on stereotypes, stereotype threat, and fear of confirming stereotypes relate to African Americans experience of social anxiety?

Elucidating the Relation between Stereotype Confirmation Concern and Social Anxiety for African Americans

How can fear of confirming stereotypes relate to social anxiety for African Americans? Rapee & Heimberg's (1997) model of social anxiety may be viewed through the lens of research on stereotypes, stereotype threat, and stereotype confirmation conern as shown in Figure 2. People with social anxiety develop mental representations of themselves as seen from an observer perspective (Rapee & Heimberg, 1997). African Americans' mental image of self as seen by the others may include stereotypes that they believe others hold of African Americans, e.g. meta-stereotypes. Additionally, socially anxious individuals compare their behavior to what they believe others expect of them (Rapee & Heimberg, 1997). Fear of confirming stereotypes may also influence African Americans' perceptions of what others expect of them in social situations, such as giving a speech. Research has shown that a majority of African-Americans are aware of negative meta-stereotypes concerning African-Americans' intelligence (Sigelman & Tuch, 1997). African Americans who believe that others view African Americans, as a group, negatively may believe that others have low expectations of their own individual speaking

abilities. This belief can serve to elicit fears about confirming stereotypes, which may contribute to the speakers' anxiety.

In addition, recall that people with social anxiety judge the probability and cost of a negative social behavior to be high (Foa, Franklin, Perry, & Hebert, 1996; Lucock & Salkovskis, 1988; Poulton & Andrews, 1994). The judgment of the probability of receiving a negative evaluation may be affected by stereotypes. Stereotypes of African Americans exist in the general public and African Americans themselves are aware of their existence (Devine & Elliott, 1995; Sigelman & Tuch, 1997). This awareness may increase an African American's belief that she/he will be judged in a negative manner.

As found in my thesis, the cost associated with receiving a negative evaluation from the audience may be viewed in terms of individual and societal concerns for an African-American speaker. The speaker not only views the cost of a negative evaluation as high and detrimental for themselves as an individual, but also as high and detrimental because it may impact other African Americans. The relation between stereotypes and social anxiety is complex and potentially quite strong, highlighting the importance of understanding behavior in its larger context (Bronfenbrenner, 1979; Ogbu, 1981). As argued above, stereotypes may be understood in the context of African Americans unique sociopolitical context in the United States.

Attrition and Therapist Matching as Part of the Sociopolitical Context

Attrition rates in therapy can be understood as another factor related to the socio-political, historical context of African Americans. Previous research has found that a large percent of people who inquire into treatment for social anxiety and up to a quarter of people who participate in treatment drop out (Davidon, Foa, & Huppert, 2004; Heimberg et al., 1990; Heimberg, Liebowitz, & Hope, 1998).

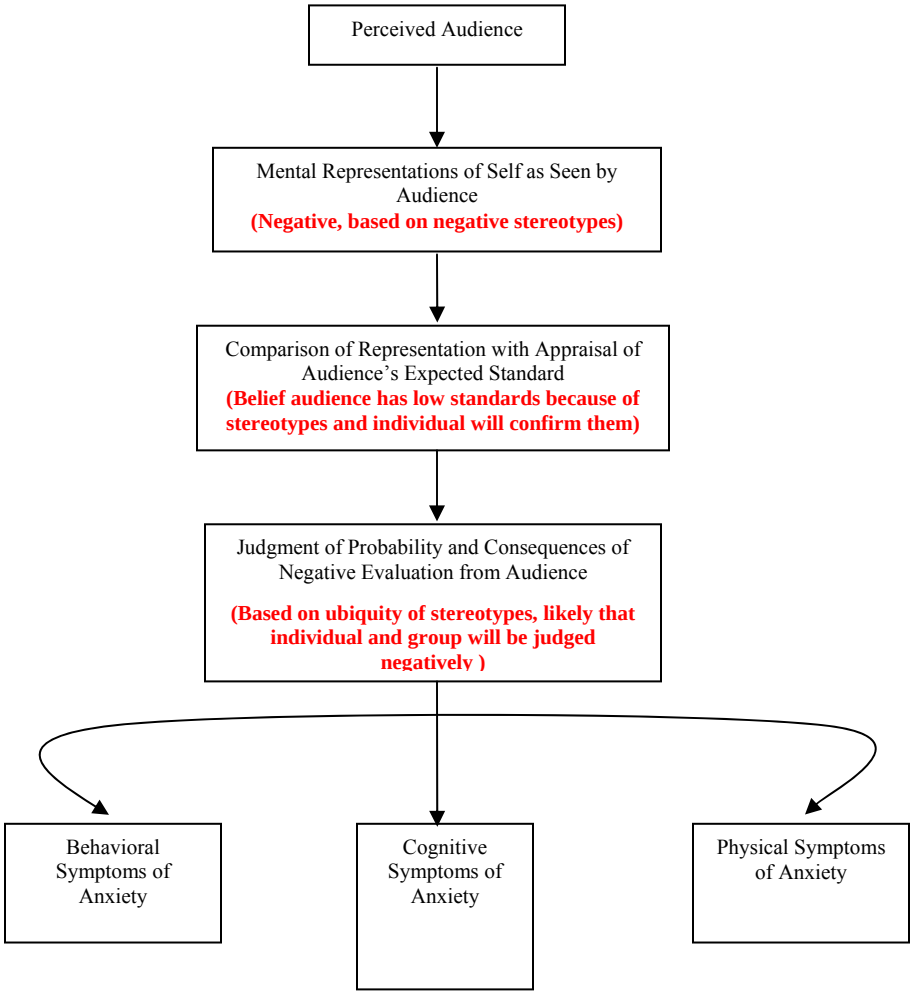

Figure 2: The Hypothesized Influence of Culture on the Rapee & Heimberg (1997) Model of Social Anxiety

Of the studies that have examined attrition rates in social anxiety research, results have not shown racial/ethnic differences in treatment attrition rates (Hofmann & Suvak, 2006; Taylor, 1996). However, the participants in one study were predominantly European American, 89.5%, (Hoffmann & Suvak, 2006). The second study, a meta-analysis, did not report on the racial or make-up of the studies surveyed (Taylor, 1996). Thus, almost nothing is known about the attrition rates among ethnic minorities participating in treatment outcome research, including

attrition rates for African Americans. There are two reasons to predict higher attrition rates among African Americans in this study, fear of confirming stereotypes and structural barriers to care.

The current study was conducted as part of a NIMH funded, randomized clinical trial comparing virtual reality therapy, group therapy, and waitlist control. For group therapy, participants met once a week for two and a half hours with two therapists. In the first session, participants were educated about the treatment model. In session two through six, participants were asked to give a speech on a pre-determined topic for three minutes as an exposure exercise. Each speech was videotaped. After giving the speech, other group members and therapists provided feedback. Following the feedback, participants watched their performance on tape and were asked to comment on their performance. Session seven comprised of an exposure outside of the group setting and the last session was focused on summarizing and highlighting improvements.

Individual therapy consisted of one therapist and one participant. Eight sessions were scheduled for 75 minutes, once a week, on specific day. The first four sessions were focused on the cognitive aspects of social anxiety. Participants videotaped themselves giving talks how they thought they came across in a pre-treatment speech. Then they watched the actual speech and compared how they thought they came across to how they actually performed. The last four sessions employed virtual reality for exposure therapy. Participants used a head mount display to give talks in front of a virtual audience. Participants did not receive videotape feedback during the last four sessions. In group therapy participants were asked to talk and give speeches in front of the therapist and other group members. In individual therapy, participants were asked to give talks in front of the therapist and virtual audiences.

African Americans have reported that they believe therapists may hold negative stereotypes of their group (Neal-Barnett & Smith, 1997). Performing poorly in a speech, a task that can be seen as an indicator of intelligence of which many negative stereotypes exist about African Americans, can be seen a stressor. This stressor, in conjunction with the stress of treatment itself, may lead to high attrition rates with African Americans. Group therapy, which is completed in front of therapists and other individuals with social anxiety, may produce even more stress. An African American participant may not only fear confirming negative stereotypes of therapists, but also of other group members. This fear may impact African Americans' anxiety to the point that treatment may become to stressful, leading to higher attrition rates. Additionally, participants in individual treatment were able to reschedule their sessions multiple times, while those in group were able to reschedule once. This represents a structural barrier to care that may lead to higher attrition rates for group therapy.

Conclusion

In summary, many African Americans are aware of the negative stereotypes that exist concerning their group (Sigelman & Tuch, 1997) and feel concern when placed in situations where they can confirm the negative stereotypes concerning their group (Steele & Davies, 2003; Steele, Spencer, & Aronson, 2002). Fear of confirming stereotypes is both a source of situational stress (e.g., stereotype threat) and chronic stress (e.g., stereotype confirmation concern). The proposed study will examine fear of confirming stereotypes as a chronic form of stress. This chronic form of stress may be understood as a group specific aspect of social anxiety which is related to African Americans' unique history and experiences in the United States which may influence the experience of social anxiety and treatment for it.

Hypotheses

Combining the empirical literature on stereotype threat and stereotype confirmation concern with theoretical models of social anxiety, this study hypothesizes that 1) among a sample of African Americans diagnosed with social anxiety, there will be a significant, positive relationship between African-Americans' self-reported concerns over confirming stereotypes relevant to both social anxiety and their own self-reported levels of social anxiety.

Combining literature on fear of confirming stereotypes, treatment for social anxiety and barriers to receiving care for African Americans, this study hypothesizes that 2) significantly more African Americans will drop-out of therapy than Caucasians, 3) amongst African Americans, significantly more will drop out of group therapy than individual therapy, 4) the racial composition of the group will matter, such that more African Americans will drop out of groups where they are the only African American participant, compared to if there are other African Americans in the group, and 5) the presence of an African American co-therapist will impact attrition from group treatment, with higher attrition rates in groups without an African American co-therapist, compared to if there is one.

CHAPTER 3: METHOD

Participants

The focus of the study is African Americans' experiences with social anxiety understood in an ecological context. Thus, the primary focus is on participants who were African American women and men who participating in a larger study for social anxiety. Inclusion criteria for the larger treatment study include a principal diagnosis of Social Anxiety with prominent fear of public speaking, English speaking, and ages 18-65. Exclusion criteria are suicidal ideation,

seizures, haven taken medication for a psychological condition for less than three months, current substance abuse or dependence, past mania or psychosis, and current treatment for social anxiety.

Thirty-four participants, 23 females and 11 males, who self-identified as African Americans took part in this study. A summary of the demographic characteristics of the sample is found in Table 1. The total sample ranged in age from 19 to 69, with a mean age of 40. Half of the participants were diagnosed with Social Phobia, non-generalized type while the other half was diagnosed with Social Phobia, generalized type. The majority of the participants were single (52.9%), had attended some college or completed college (70.6%), and made between $10,000 and 50, 000 (64.7%).

As a hypothesis of the study compares attrition between African American and Caucasian participants, forty-four participants, 23 females and 21 males, who self-identified as Caucasian also took part in this study. A summary of the demographic characteristics of the sample is found in Table 2.

The total sample ranged in age from 21 to 62, with a mean age of 38. More than half of the sample was diagnosed with Social Phobia, non-generalized type (59%), while the rest were diagnosed with Social Phobia, generalized type (41%). The majority of the participants were married (61%), had attended some college or completed college (59%), and made more than $50,000 (61%).

Table 1

Demographic Characteristics of African American Participants

Demographic	Range	N	%
Age	19-69	34	100

Mean	40.00		
SD	13		
Gender	Female	23	68
	Male	11	32
Education Level	Some H.S	1	3
	Completed H.S	3	9
	Some college 1-2yrs	8	24
	Some college 3+ yrs	5	15
	Completed college	11	32
	Some graduate school	4	12
	Completed graduate school	2	6
Income	less than 5,000	4	12
	5-10,000	1	3
	10-20,000	7	21
	20-30,000	7	21
	30-50,000	8	24
	> 50,000	7	21
Marital Status	Single	18	53
	Married	6	18
	Separated	1	3
	Divorced	7	21
	Widowed	2	6

Table 2

Demographic Characteristics of Caucasian Participants

Demographic	Range	N	%
Age	21-62		
Mean	38		
SD	11		
Gender	Female	23	52
	Male	21	48
Education Level	Some H.S	0	0

	Completed H.S	0	0
	Some college 1-2yrs	7	16
	Some college 3+ yrs	2	5
	Completed college	17	39
	Some graduate school	9	21
	Completed graduate school	9	21
Income	less than 5,000	0	0
	5-10,000	0	0
	10-20,000	4	9
	20-30,000	6	14
	30-50,000	7	16
	> 50,000	27	61
Marital Status	Single	12	27
	Married	27	61
	Separated	0	0
	Divorced	1	2
	Widowed	0	0
	Living with someone	4	9

Recruitment

Participants were recruited for a larger study entitled "Virtual reality exposure therapy and exposure group therapy for fear of public speaking." The study was funded by the National Institutes of Mental Health (NIMH).

The purpose of the larger study was to compare two treatments for social anxiety, group therapy and virtual reality therapy. Participants were recruited through newspaper advertisements, public service announcements, magazine articles, and fliers placed in Georgia State University (GSU) and community locations. Participants who completed the study and follow-up assessments at 3 and 12 months received a hundred dollars over the span of a year.

Procedures

Interested people phoned the Anxiety Research and Treatment Lab and left their contact information on an answering machine. They were then contacted by an assessor who conducted an initial 30 minute to one hour phone screen as part of a two- part assessment process to determine eligibility for the study and begin the process of informed consent.

If identified as potentially eligible for the study, participants were asked to come to GSU for a face-to-face interview. During the face-to-face interview, participants were given a clinician-administered interview, the Structured Clinical Interview for the DSM-IV (SCID-IV) (First, Spitzer, Gibon, & Williams, 2002) to assess if individuals met DSM-IV criteria for Social Phobia. Additionally, participants completed self-report measures, including the measures used in this study, Stereotype Confirmation Concern Scale (SCCS) and Personal Report of Confidence as a Speaker (PRCS). At the end of the interview, respondents participated in a standardized behavioral assessment task (Beidel, Turner, Jacob, & Cooley, 1989) which required them to give a speech in front of a camera for a maximum of ten minutes. Participants were subsequently randomly assigned to Virtual Reality exposure therapy, Enhanced cognitive behavioral group exposure therapy, or to a waitlist control group. Attrition at each stage of the randomized clinical trial is documented in Figure 3.

Consent Procedures

The phone screen consent form was read over the phone to participants during the phone screen. Callers were given the opportunity to ask any questions. If callers were willing to volunteer for the research study they gave verbal consent to the assessor. The assessor then signed the consent form. Participants meeting the initial phone screening criteria were scheduled for a face-to-face interviews and were asked to sign a research participation consent form at the

onset of the interview. Participants were given the opportunity to ask any questions. The GSU Institutional Review Board (IRB) monitored this research.

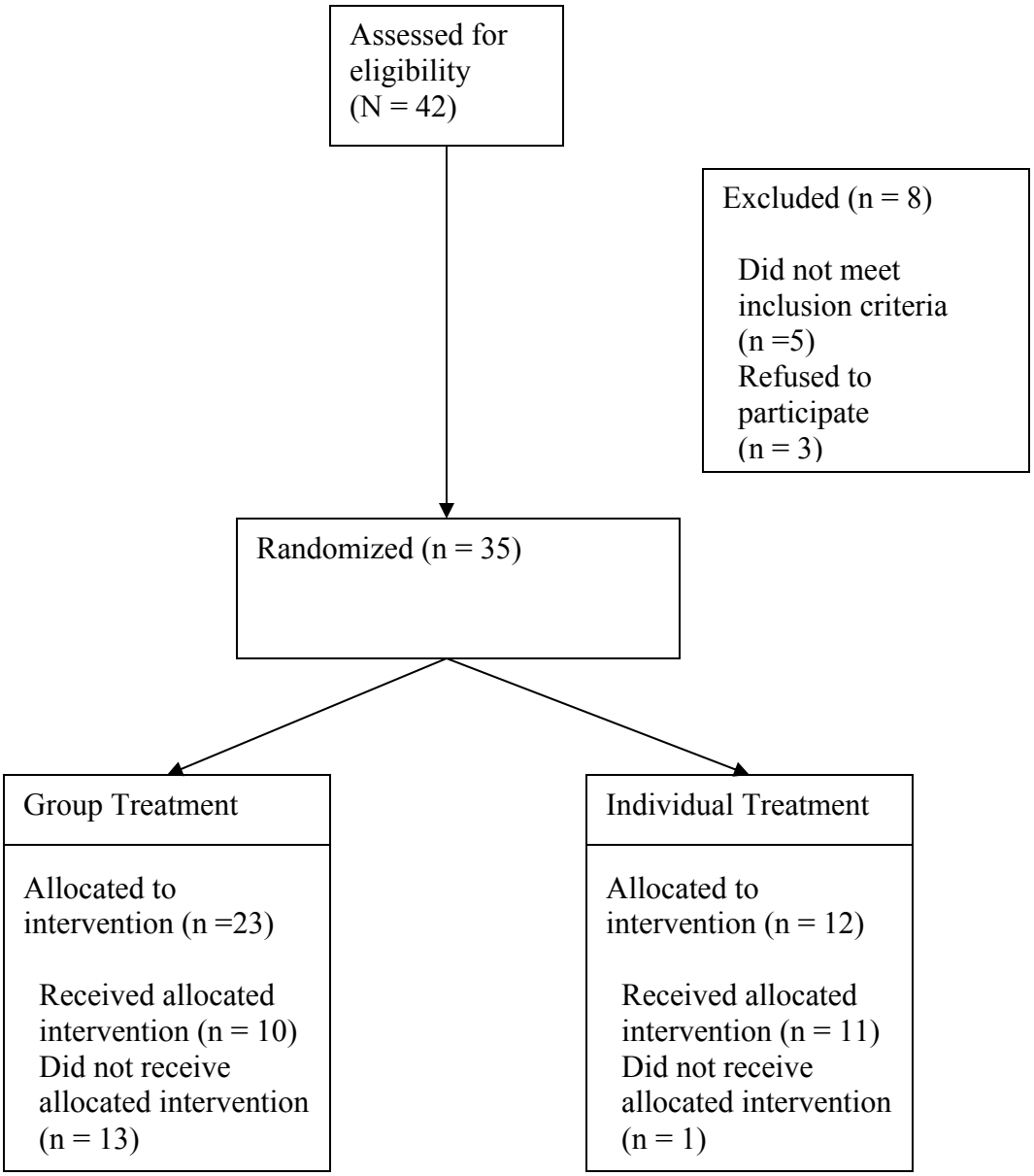

Figure 3: Flow of African American Participants through Stages of a Randomized Trial

Note.
After being randomized to condition, one of the participants was deleted from the analyses as an outlier

Measures

All measurements that will be used in subsequent analysis are shown in the Appendices.

Demographic Questions

A series of questions were developed to assess demographic information (see Appendix A).

Screening Measure

Telephone Screening. The telephone screen is a set of questions developed to determine participant's eligibility for participation in this study.

Diagnostic Measure

Structured Clinical Interview for DSM-IV-TR Axis I Disorders (SCID). The SCID-IV (First, Spitzer, Gibon, & Williams, 2002) is a standardized structured interview used to diagnose disorders found in the Diagnostic and Statistical Manual for Mental Disorders-Fourth Edition-Text Revision.

Stereotype Confirmation Concern Scale (SCCS). The SCCS (Contrada et al., 2001) is a self-report scale that measures people's concern over confirming stereotypes. The questions reflect a broad range of social and behavioral domains. Respondents are asked to rate how often over the past three months they have been "concerned that by ___ [they] might appear to be confirming a stereotype about [their] ethnic groups." The SCCS includes 11 items which are rated using a 7-point Likert type scale ranging from 1 ("never") to 7 ("always"). Scores range from 11 to 77, with higher scores reflecting greater concern over confirming stereotypes. In this study, four items were used, concern over "Talking in a certain way," "Attending or participating in certain social activities," "Dressing a certain way," and "The way you look (your physical appearance)." These items were chosen a priori because they seemed most relevant to social anxiety. Reliability was tested using Cronbach's measure of internal consistency. Resulting

coefficient for the SCCS across all ethnic groups assessed is α = .91(Contrada et al., 2001). To determine whether the four items from the SCCS showed internal consistency with one another in this sample, Cronbach's α was computed for the sub-scale. The internal consistency of this sub scale = .89, indicating adequate internal consistency (Field, 2005). (see Appendix B)

Personal Report of Confidence as a Speaker. The PRCS (Paul, 1966) is a self-report measure that assesses public speaking fears. Respondents are asked to base their responses on their most recent public speaking experience. It contains 30 items; for example, "I am terrified at the thought of speaking before a group of people." Items are rated using a True/False format. Scores range from 0 (no fear, all responses "false") to 30 (extreme fear, all responses "true"), with higher scores reflecting extreme fear in public speaking situations. Reliability has been reported at α = .91 (Paul, 1966). In the CAS study, reliability was reported at α = .84. To my knowledge, this is the only social anxiety measure with information on psychometrics for African Americans (see Appendix C).

CHAPTER 4: RESULTS

One participant was deleted from the sample, as they did not complete one of the variables of interest. Preliminary analyses were performed on the variables of interest to screen for violations of normality. To detect outliers, boxplots and histograms were graphed, using the criterion of greater than or equal to 3 standard deviations above or below the mean of the distribution. One outlier was detected for the PRCS and was removed. For skew the data was visually inspected and the skew statistic was divided by the standard error of the skew. Any value +/- 1.96 standard deviations above or below the mean was considered skewed. The PRCS was skewed and transformed using a square root transformation, which did not improve the

skew. Because the PRCS is categorical with only two categories, the data do not have to be normally distributed (Field, 2005).

Assumptions for the chi square analyses were tested. The first assumption for chi square analyses, each person contributing only one cell in the contingency table, was met in this sample. The second assumption for chi square analyses, expected frequencies greater than 5, was met for hypotheses 2, but not for hypotheses 3-5. This resulted in a loss of statistical power for hypotheses 3 through 5, allowing for the possibility of a type II error, failing to detect a genuine effect (Field, 2005).

Potential Confounds

African American participant's age, gender, education level, marital status, income and treatment condition were examined in a correlation matrix to assess if any of these demographic variables were highly correlated with variables of interest, serving as potential confounds. As shown in Table 3, none of the variables were significantly related to the PRCS and SCCS.

Analyses

Hypothesis 1: Among a sample of African Americans diagnosed with social anxiety, there will be a significant, positive relationship between African Americans' self-reported concerns over confirming stereotypes relevant to both social anxiety and their own self-reported levels of social anxiety.

The relation between participants' concerns over confirming negative stereotypes and the PRCS was examined using Pearson's product moment correlation coefficient. The SCCS was not significantly related to the PRCS, $r = -.09$, p (one-tailed) $>.05$.

Hypothesis 2: Significantly more African Americans will drop out of therapy than European Americans.

Table 3

Pearson and Point Biserial Correlation Coefficients among Variables

Variable	a	b	c	d	e	f	g	h
(a) Treatment Condition	1.00	-.38*	-.44**	.09	-.62**	.04	-.16	.12
(b) Gender		1.00	.01	.23	.12	-.09	.10	-.25
(c) Age			1.00	-.23	.65**	-.08	-.01	-.03
(d) Education Level				1.00	-.13	.37*	-.02	.09
(e) Marital Status					1.00	.04	.16	-.05
(f) Income						1.00	.04	-.03
(g) PRCS							1.00	-.16
(h) SCCS								1.00

Note.
* Correlations are significant at the α =. 05 level (1-tailed)
** Correlations are significant at the α = .01 level (1-tailed)

Chi-square analyses indicated that African Americans were more likely to drop out of therapy than Caucasians (χ^2 (1, N = 78) = 6.63, $p < .05$). The odds ratio indicates that African Americans were 3.62 times more likely to drop out of therapy than Caucasians.

Hypothesis 3: Among African Americans, significantly more will drop out of group therapy than individual therapy.

Chi square analyses indicated that African Americans were more likely to drop out of group than individual therapy (χ^2 (1, N = 31) = 4.64, $p < .05$). The odds ratio indicated that African Americans were 9.29 times more likely to drop out of group than individual therapy. As shown in Table 4, 13 of the 14 African American drop-outs from therapy conditions were from group, in comparison to individual treatment.

Hypothesis 4: The racial composition of the group will matter, such that more African Americans will drop out of groups where they are the only African American participant, compared to if there are other African Americans in the group.

Chi square analyses indicated that there was not a significant difference between the numbers of drop outs for African Americans in a group therapy condition where they were the only African American in the group versus if there were other African Americans in the group, (χ^2 (1, N = 19)= .28, $p > .05$). As shown in Table 5 there were 5 groups in which there was only 1 African American participant and 4 groups in which there were greater than 1 African American group members. There were a total of 8 drop- outs from groups in which there were greater than one African Americans, one drop-out

Table 4

Attrition Rates for African American Participants for Individual and Group Therapy (N = 34)

	Dropped out after pre-treatment meeting	Dropped out from Group Therapy	Dropped out from Individual Therapy
Participants	3/34	13/23	1/11
(%)	9%	57%	9%

Table 5

Attrition and Number of African Americans in Group

Group	More than one African American in group?	AA Drop Outs
1	No	0
2	No	0
3	Yes	1
4	NA	NA
5	NA	NA
6	Yes	2
7	No	1
8	Yes	1
9	Yes	1
10	Yes	3
11	No	0

Note. 4 participants were assigned to group but never showed up for any group sessions, As such, they were not included in this analysis
NA refers to the fact that there were no African Americans in that group.

from groups in which a participant was the only African American, and no drop-outs from three of the groups in which a participant was the only African American.

Hypothesis 5: The presence of an African American co-therapist will impact attrition from group treatment, with higher attrition rates in groups without an African American co-therapist, compared to if there is one.

Chi square analyses indicated that there was not a significant difference between the numbers of drop outs for African Americans in groups where there was an African American co-therapist versus if they were in groups where there was not an African American co-therapist, (χ^2 (1, N = 19)= .54, p > .05). As shown in Tables 6 and 7, there were 4 groups in which there was an African American co-therapist and three participants dropped-out from those groups. There were 7 groups in which there was not an African American co-therapist and 6 participants dropped-out from those groups.

CHAPTER 5: DISCUSSION

Two primary questions were asked: is fear of confirming stereotypes related to African Americans' reports of social anxiety and what variables are related to attrition rates among African Americans? These questions were asked within a framework seeking to understand ethnic group-specific sociopolitical influences on the experience of social anxiety and participation in a research based treatment study. This study was undertaken to add to the small body of literature examining sociopolitical factors in African Americans' experience with anxiety.

In the following discussion, I will summarize the findings of the study, describe implications of the findings, discuss the strengths and limitations of the study, and conclude with future directions for research.

Table 6

Ethnicity of Therapists and of Group Members

Group	African American	Caucasian	Hispanic	Other	Multiracial/ Biracial	Therapist	Drop outs
1	1	2	1 0			1 AA, 1EA	0
2	1	3				1 AA, 1 EA	0
3	4					2 EA	1
4	0	1		1 Chinese		2 EA	NA
5	0	2		1 African	1	2 EA	NA
6	3	1				1 AA, 1 EA	2
7	1	2		1		2 EA	1
8	1	2				2 EA	1
9	3					1 AA, 1 EA	1
10	3	2				2 EA	3
11	1	1		1		2 EA	0

Note: AA = African American, EA = European American

Table 7

Therapist-client Partial Match on Ethnicity

Group	Therapist-Client Match on Ethnicity?	Partial	Drop Outs
1	Yes		0
2	Yes		0
3	No		1
4	No		NA
5	No		NA
6	Yes		2
7	No		1
8	No		1
9	Yes		1
10	No		3
11	No		0

Note. If answer is yes, there was 1 African American therapist and 1 European American therapist. If answer is no, there were 2 European American therapists.
4 participants were assigned to group but never showed up for any group sessions, as such they were not included in this analysis
NA refers to the fact that there were no African Americans in that group.

In summary, results did not show a relation between stereotype confirmation concern and social anxiety. Regarding attrition, results showed that significantly more African Americans dropped out of therapy than Caucasians. Additionally, more African Americans dropped out of group therapy than individual therapy. There was no impact of therapist ethnicity or the presence of other African Americans on attrition rates, though these tests were underpowered.

Explaining Findings

Fear of Confirming Stereotypes and Social Anxiety

There are a number of factors to consider in placing the null finding in context. One potential explanation for the lack of a significant relation between fear of confirming stereotypes and communication anxiety is that no relation exists. Concern over confirming stereotypes may not be a salient aspect of African Americans' experiences with social anxiety.

There are alternate explanations. One pertains to the measurement of this construct. The Stereotype Confirmation Concern Scale (SCCS), the measure used to assess fear of confirming stereotypes in this study, assesses personal concern over confirming stereotypes. This measure was not designed for any particular ethnic group and items on this measure may not adequately tap into stereotypes that African Americans fear confirming. The measure also asks respondents to answer question regarding their concern over confirming stereotypes over the last three months. Many people who are socially anxious avoid social situations and may not have experienced events that would elicit this concern in the last three months. In addition, participants were not explicitly asked to consider their fear of confirming stereotypes in a situation that produced social anxiety symptoms. Participants may have had non-socially anxious situations that were not relevant to their social anxiety in mind when answering these questions.

Using the Personal Report of Confidence as a Speaker (PRCS) may have been problematic as well. This measure was chosen because it was tested with an African American sample. However, the PRCS asks respondents to report on their most recent public speaking experience and does not capture the range of social anxiety situations. A measure questioning a longer period of time may have been more relevant. Also, this measure does not include any contextual information, for example, who comprised the audience, how many people were in the audience, or what the reason was for the situation.

Finally, in line with African centered scholars' views, the use of theories from Western worldviews and tested on predominantly European-American samples may not be appropriate for understanding African Americans' experiences of psychological disorders. It is possible, as argued by Kambon (1998), that the study of maladaptive behaviors in African Americans needs a "…much broader paradigm of African mental health analysis than that offered by conventional models of 'abnormal behavior' or maladaptive and dysfunctional behaviors that derive from Eurocentric psychology" (Kambon, 1998, p. 34). Researchers have asserted that work with African Americans should take into account ethnic group specific factors in the development of theories. Failure to do so may lead to theories and paradigms that at best are incomplete, and at worst harmful (R. T. Jones, Brown, Davis, Jeffries, & Shenoy, 1998).

The purpose of this section is to offer some of the critiques and conceptualizations from African centered researchers in the context of the null finding. How would one proceed to develop a conceptual framework of social anxiety that took into account ethnic group-specific variables and is grounded in the experiences of African Americans? First, researchers would need to understand how a concern of one's behaviors in social situations relates to the worldview and experiences of African Americans from a normative perspective, while acknowledging the

factors that can transform a normative experience to a maladaptive one. As stated by Cokley & Williams (2005), "The ability to assess ways in which African people experience the world can inform more appropriate theory and practice for this population" (Cokley & Williams, 2005, p. 828).

When considering a conceptual framework within which to understand African Americans' experiences with social anxiety, Steele's work on stereotype threat (1997, 1998) provides us with some direction. Stereotype threat has been linked to anxiety for African Americans (Osborne, 2001), women (Osborne, 2001; Spencer, Steele, & Quinn, 1999), and gay and bisexual males (Bosson, Haymovitz, & Pinel, 2004). To further illustrate the theory of stereotype threat, Steele (1997) tells us a story; when an observer looks into a classroom with a white and black student, the situation for both students seems virtually the same. Teachers, materials, peers, are all the same. Yet, the two children may experience the classroom environment as completely different due to the effects of stereotype threat, the knowledge of negative stereotypes concerning one's group. In the stereotype threat literature, specific variables need to be present for the threat to affect performance. First, a person must care about the situation they are placed in or have a stake in the outcome. In addition, they must personally identify with the situation or domain. Finally, one must be aware of the societal messages about one's group and recognize these messages may be applied to the person in a particular situation. These variables come together to negatively impact a person's behavior. This difference in experience between the black and white students may be so strong that it can affect the performance and achievement of the students. I propose a similar difference in the experience of social anxiety. An African American, European American, Latino, or person of another ethnic

group, with clinical levels of anxiety may be in the same social situation, yet have different experiences of social anxiety based on ethnic group-specific factors.

Although the idea of comparing oneself to other's expected standards is grounded in European American theory of social anxiety, African centered scholars have described similar processes. An understanding of their work may yield a more appropriate frame of reference for understanding social anxiety among African Americans. The importance of seeing oneself through others eyes is especially salient for African Americans in America, as captured by DuBois. W. E. B. DuBois (1903) discussed potential consequences of the mental conflict for African Americans living in a European American dominated and controlled society through a concept he referred to as double consciousness. Double consciousness is "the sense of always looking at one's self through the eyes of others, of measuring one's soul by the tape of a world that looks on in amused contempt and pity. One ever feels his two-ness – an American, a Negro, two souls two thoughts, two unreconciled strivings, two warring ideals in one dark body, whose dogged strength alone keeps it from being torn asunder…The history of the American Negro is the history of this strife, - this longing…to merge his double self in to a better and truer self (DuBois, 1903, pp. 16-17)." In the DuBois (1903) analysis, race is the salient aspect of self-identity through which people develop a mental representation of self and use to measure their interactions with others.

Yet, based on models of social anxiety and experiences of African Americans as discussed by Steele (1995, 1997) and DuBois (1903), the question of whose eyes African Americans were seeing themselves through in social situations appears to be a significant aspect of a conceptual framework for anxiety. Unfortunately, the nature of the observer was not asked in the current study, and is a limitation of the study and leaves many unanswered questions.

What aspect of themselves was most salient for participants in this study when developing a mental representation of self? What reference group were African Americans using when developing an appraisal of the observer's expected standards? Next, I offer ideas for future directions for research by considering African centered perspectives if race is a salient aspect of social identity. I offer two perspectives for racial saliency: when European Americans serve as the reference group or "other" and when African Americans serve as the reference group or "other."

Kambon (1996) points out that the American social/cultural reality is based on a Eurocentric worldview. This worldview places a primacy on the history, philosophy, and culture of European peoples. As a whole, European American communities control much of United States society, and as such, the Eurocentric worldview is superimposed on non-European communities. Jones (1996) points out that when one group or culture is embedded in another, the superculture often controls resources and opportunities. In order to access benefits, people often must function within the rules and structures of the superculture and not those of their own worldview. This can produce a psychological strain. Kambon (1996) states for African Americans, functioning in this superimposed worldview, results in cultural and psychological oppression which Kambon labels as psychological misorientation. Cornell West (1999) appears to refer to this misorientaion when he writes about African Americans having to function within a "White normative gaze." West (1999) discusses how this gaze is a reflection of an overarching white-supremacist assault on the intelligence and ability of Black people. It is an overarching gaze from people who not only pass judgment on Black people's humanity but impact their access to resources. It is a gaze that some Black people are preoccupied with and they "search for validation and recognition" within it. This fruitless search and preoccupation with a normative

gaze impacts peoples' ability to fully act themselves, instead they act in response to the white normative gaze. Research on social anxiety highlights the detrimental side to adjusting one's behaviors to other's perceived expectations. This is especially the case when others have negative expectations and beliefs regarding your performance or behaviors. Arguably, the more one is aware of and adjusts one's behaviors in response to this white normative gaze, the more psychological misorientation one can experience. If an African American person uses a European American reference group, or normative gaze, when developing an appraisal of the observer's expected standards, then negative societal messages about African Americans may influence their judgment that they will fail to live up to the observer's standards. This psychological misorientation may be a part of some African Americans' experience of social anxiety. It can be psychologically harmful to view oneself through the eyes of another group, especially a group who has devalued one's own group. The experience of social anxiety may contain a psychological conflict between one's own culture, worldview, and values, and the worldview, culture, and values of a superculture.

What would the experience of social anxiety look like for African Americans if race is a salient aspect of African Americans mental representation of self and the reference group is African Americans? Arguably, from an African centered perspective this would produce a healthier psychological mindset and possibly serve as a buffer for anxiety. But what happens if an African American believes that others view them as someone who violates African American ethnic group norms? Research shows that views on ethnic or social group norms influence individual behavior (Bradley, Curry, & McGraw, 2004; Hanson, 1996) For example, researchers have found that subjective group norms influence smoking behaviors (Hanson, 1996) and use of long-term care for health problems among African Americans (Bradley, Curry, & McGraw,

2004). Knight, Bernal, Gaza, & Cota (1993) posit that one aspect of ethnic group identity development is developing an understanding of ethnic role behaviors. Ethnic role behaviors refer to "knowing the various ways in which members of one's ethnic group act that reflect the ethnic cultural values, styles, customs, traditions, and languages (Jones, 1996, p. 292)." One's understanding of ethnic role behaviors may form a "Black normative gaze." Jones (1996) reports that African Americans may elicit negative reactions from other African Americans when they violate ethnic group norms by taking on customs of the superculture. For example, some researchers have argued that underachievement in African American high school students may be partly attributed to students not wanting to violate what they view as an ethnic group norm and align themselves with the oppressor (Fordham & Ogbu, 1986). Concern with violating ethnic group norms may exist even if one does not fear aligning with the oppressor. For example, homosexuality is still frowned upon in many African Americans high in religiosity (Schulte & Battle, 2004). Being gay or lesbian, and feeling as if you have to hide this aspect of your identity in a social situation (i.e. conversations at church) where you believe people have negative judgments concerning gay or lesbian people can produce a psychological strain. An African American person can feel they violate ethnic group norms in a variety of other ways, i.e. language, occupation, dress, and more. Arguably, if an African American person uses a African American reference group when developing an appraisal of the observer's expected standards, and feels that she somehow violates African American group norms, this fear may influence the judgment that she will fail to live up to the observer's standards. This concern over violating group norms may be a part of some African Americans' experience of social anxiety. It can be psychologically harmful to view oneself through the eyes of your own group and judge yourself

as violating group norms. The experience of social anxiety may contain a psychological conflict between salient aspects of one's identity and one's perceptions of ethnic group norms.

In the previous section, race was considered the salient aspect of identity. Yet, race or ethnicity may not be the most salient aspect of identity for African Americans. For example, Phinney & Alipuria (1990) explored the importance of ethnicity as an identity issue. They asked participants to rate the importance of five domains of their identity. They were asked to rank occupation, politics, religion, sex role, and ethnicity on a four-point Likert-type scale from *not important* to *important*. Results from the study indicated that African American participants ranked occupational identity as most important, then sex role identity, next a tie between religious identity and ethnic identity, and lastly political orientation. As such, when an African American views themselves through the eyes of others, this view may contain other salient aspect of their identity besides race or ethnicity. Thus, mental representation may be focused on identity aspects, such as gender and the reference group one's judges one's performance against may be gender based. Additionally, if both ethnicity and gender are important, there may be an interaction between race, gender, and the experience of anxiety.

It has been said that to best understand the psychological health of African-Americans, knowledge of ethnic group context is a necessity (McCombs, 1985). However, many mainstream clinical theories do not explicitly acknowledge African Americans' social, political, historical, or economic context in the United States nor do they explore the possible psychological consequences associated with that history (Allen & Bagozzi, 2001). For African Americans with social anxiety, the role of the observer may be an important issue to consider in the context of African Americans experiences in America. Social anxiety researchers discuss how developing a mental representation of self as seen by others can lead to symptoms of social anxiety (Rapee &

Heimberg, 1997). DuBois (1903) and Steele et al. (1995, 1997) discuss the power of the "other" on the mental health of African Americans in terms of "double consciousness" or looking at one's self through the eyes of others. DuBois' and Steele's (1995, 19967) argument is based on the social, political, historical, and economic context of African Americans. DuBois, Steele, and social anxiety researchers highlight the premise that it can be psychologically maladaptive to measure oneself through the eyes of others (Moore, 2005). This may be true for African Americans, whether the normatize gaze one is measuring oneself through is "Black", "White", another ethnic group, or another aspect of identity that is salient and one judges oneself lacking in. Exploring the influence of the observer or "other" in social situations will enable researchers to develop a conceptual framework within which to understand the role of ethnic group specific factors in African Americans' experiences of social anxiety while taking into account African Americans history in the United States.

Explaining Findings on Attrition Rates

This study found that significantly more African Americans dropped out of therapy than European Americans. Additionally, more African Americans dropped out of cognitive behavioral group therapy than individual therapy.

Revisiting each type of treatment is necessary to explore these findings. Group therapy took place over the course of eight weeks. Participants took part in one session a week, for two and a half hours, at a specific time and day of the week, with no option for re-scheduling past the first session. Groups were led by two therapists and the number of group members ranged from three to five. The first session focused on the rationale for treatment. Sessions two through six followed a similar format. Participants were asked to give a speech on a pre-determined topic for three minutes as an exposure exercise. Before giving the speech, participants stood in front of the

group and stated their personal goals and gave their anxiety ratings. Each speech was videotaped. After giving the speech, other group members and therapists provided feedback. Following the feedback, participants watched their performance on tape and were asked to comment on their performance. In between each session, homework was assigned. Session seven comprised of an exposure outside of the group setting. Participants engaged in tasks from striking up conversation with strangers to giving a speech in the middle of a crowded hallway on a college campus. The last session was focused on summarizing and highlighting improvements.

Individual therapy consisted of one therapist and one participant. Eight sessions were scheduled for 75 minutes, once a week, on specific day. If participants needed to reschedule, they were given that option. The first four sessions were focused on the cognitive aspects of social anxiety. Participants learned about the connection between thoughts, feelings and behaviors. They videotaped themselves acting out how they thought they came across in public speaking situations. They then watched the videotape of how they actually came across in public speaking situations and compared it to the videotape of them acting out how they thought they came across. The last four sessions employed virtual reality for exposure therapy. Participants used a head mount display to give talks in front of a virtual audience. The audiences were a small conference room of five people, a classroom of approximately thirty people, and an auditorium of approximately hundred of people. Participants did not receive videotape feedback during the last four sessions.

Considering the specifics of the treatment in the context of factors proposed to impact the attrition of African American participants is illustrative. The finding that more African Americans dropped out of group therapy is consistent with the literature on structural barriers to care. Group therapy was held on a specific day of the week, at a specific time each week. If

competing issues, such as childcare or work issues arose, participants were unable to make up sessions. If participants were unable to attend sessions on a consistent basis, many may have chosen to drop-out of treatment.

Attributions of normative gaze, whether it is Black, White, Female or Male, may have been influential in the findings of higher attrition rates for group therapy, as opposed to individual therapy. If one is seeing oneself through the eyes of a reference group, one is more likely to encounter people from that reference group in group therapy, versus individual therapy. Study therapists consisted of one African American, female therapist and three European American female therapists, who conducted individual therapy. Comparatively, there was one African American, female therapist, three European American, female therapists and one European American male therapist conducting the group therapy sessions. In individual therapy, the participants only interacted with one other person who may not have been matched to race. In group therapy, typically participants encountered multi-ethnic group members as well as two therapists (see Table 6). Additionally, all the African American participants were confronted with both male and female members of multiple ethnic groups. This was not the case in individual therapy. This confrontation with a reference group, through whose eyes you potentially develop a mental representation of self, compare your representation to their expected standards, and judge yourself as unable to meet those standards, may impact your experience of anxiety such that you are more likely to drop-out of group therapy sessions.

Findings indicated no significant effect for the presence of other African Americans in group therapy or for the presence of an African American therapist. However, the sample size to explore these relations was small, and the test was underpowered. As such, this study cannot

speak to the effect of therapist matching or the presence of people from the same ethnic group, and can only encourage further research in this area.

Though based in the literature, these explanations for attrition rates observed in the present study are speculative. It is unclear as to why the drop-out numbers are higher for African Americans and why it is higher for those in group therapy. More research is needed to explore reasons for higher numbers of drop-outs in general, and for group therapy in specific. The high number of drop-outs from group is especially concerning as group therapy is considered the "gold standard" of treatment for social anxiety. The field of psychology has called for more Evidence-Based Practices in Psychology (EBPP), defined by the APA Presidential Task Force on Evidence Based Practice (2006) as " the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences"(APA, 2006, p. 273). It is possible that group therapy may have the most empirical support, but may not be in line with African Americans preferences and as such would not be evidence-based practice. More research should be conducted on African Americans' characteristics, i.e., culture, ethnicity, race, and their preferences for treatment. Assessing whose eyes African Americans see themselves through may aid in the development of anxiety producing, exposure situations. Additionally, researchers should ground their work in the historical, political, social and economic realities of African Americans in an effort to develop relevant and efficacious forms of treatment.

Strengths and Limitations

There are strengths of this study that should be identified. For one, participants self-identified as African-American, reducing researcher bias as to who is considered African-American. Participants were all diagnosed with clinical levels of social anxiety. In addition, there was a large sample size of people with clinical levels of social anxiety, allowing for adequate power to

detect significant relationships between stereotypes confirmation concern and social anxiety, as well as to examine attrition rates between African American and European Americans. The study was too small to adequately test attrition rates amongst African Americans as they related to individual versus group treatment, the presence of other African Americans, and the presence of an African American therapist in group treatment.

Future Directions

In general, there is a need for more research with African-Americans with clinical levels of anxiety. In the future, researchers should develop more nuanced conceptualizations and theories to determine the impact of ethnic-group specific, sociopolitical variables on African Americans' experience of social anxiety. Continued research will help to rule out factors that are not relevant to African Americans' experience of anxiety, while acknowledging the impact of those factors that are relevant. Research should assess the impact of the observer or audience on people's experiences. Additionally, the salience of social identities in social situations should be explored.

There is room for continued quantitative research in the exploration of the relation between ethnic group-specific measures and social anxiety. Fear of confirming stereotypes could be explored from an ethnic group-specific approach. Future studies could develop a fear of confirming stereotype scale that is specific to stereotypes related to African Americans. There are different ways that fear of confirming stereotypes may impact African Americans' experiences of social anxiety. African Americans may need to believe in and subsequently internalize stereotypes about their group for stereotypes to significantly impact behavior. For example, the Nadanolitization Scale taps into such a concern. The Nadanolization scale "estimates the extent to which African Americans identify with White stereotypes about African

Americans" (J. Taylor & Grundy, 1996, p. 220). Researchers found that African Americans who reported higher internalized racialism also reported higher scores of depression as assessed by the Beck Depression Inventory. Further research could assess whether this measure is also related to social anxiety for African Americans.

Alternatively, a salient factor may be a more racialized belief that your group is held in low regard. African Americans may not need to internalize stereotypes, but instead believe that their group has low social status in society and that status affects others views and behaviors towards them. In this line, the public regard aspect of the Multidimensional Inventory of Black Identity (MIBI) (Sellers, Rowley, Chavous, Shelton, & Smith, 1997) which measures "the extent to which individuals feel that others view African Americans positively or negatively"(Sellers, Rowley, Chavous, Shelton, & Smith, 1997, p. 807), may be a relevant sub-scale to measure with social anxiety. African-Americans who feel that others they interact with view African-Americans as a group negatively may believe the same others they interact with will view them, as an individual, negatively, and feel increased anxiety in social situations.

One can also take into account African Americans beliefs concerning other in- group members, as opposed to their beliefs over how "other" non-group members view them. Fordham & Ogbu (1986) discussed how African American students accuse other African American students of "acting white" as a way to establish their direct opposition to an unjust educational system established and controlled by European Americans. Contrada et al. (2001) hypothesized that this phenomena reflected a broader form of pressure that many ethnic groups feel, the pressure that one's behavior may violate one's own ethnic group norms about how to dress, behave, talk, etc. This form of own-group conformity pressure may impact one's experience of social anxiety. For example, what if an African American is in a social situation that triggers

their anxiety, such as an African American book club meeting where they are asked to give their opinion on books. What if they hold a position that is in direct conflict with what "African Americans are supposed to believe"? They may feel constrained by the expectations of other group members and feel increased anxiety over the potential of violating a normative belief. The Own-Group Conformity Pressure Scale (OGCPS) by Contrada et al. (2001) is one measure that can be used to explore this potential relation.

Moreover, there is room for qualitative work to discuss with African-Americans the specifics of the underlying mechanisms that may best explain the interface between ethnic group-specific variables and anxiety. Qualitative work would present African-Americans with the opportunity to discuss relations they view as relevant. This could be especially relevant when exploring the role of contextual factors in the experience of social anxiety, such as reference group and salience of social identities. Does the racial or ethnic make-up of the people in the social context make a difference? People with social anxiety are concerned with embarrassing themselves in someone's eyes and the question remains, whose eyes are most relevant? When thinking about the influence of ethnic group-specific factors, is the reference point for participants other African Americans? European Americans? Both? Or another group entirely? Is the answer to this question based on the specific social situation? Does the gender make up of the situation have a role? What about the nature of the situation? For example, will a high stakes situation, i.e., a speech in front of your work colleagues where your performance will be evaluated by your boss, be experienced differently than a relatively low stake situation, i.e., a book club discussion with people who are not your friends? In line with the call of many researchers, theories and paradigms should be developed based on the experiences and worldviews of African Americans.

Conclusion

This study focused on the influence of fear of confirming stereotypes on African Americans' experience of social anxiety. Results showed no relation between fear of confirming stereotypes and social anxiety. Results also revealed that more African Americans dropped out of treatment than European Americans. Additionally, more African Americans dropped out of group therapy than individual treatment. These findings highlight the need for more research with African-Americans with clinical levels of anxiety. This research should be conducted with the participation of African Americans who are experiencing this disorder. "To understand the complicated and intricate psychology of African people, theory must be created, research must be conducted, and practice must be applied that are developed out of the experience and worldview of African people throughout the Diaspora" (Cokley & Williams, 2005, p. 828).

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Appendix A: Demographic Information

Participant Number: _____

Date: _____

Gender: **M** O
F O

Age: _____

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
O	O	O	O	O	O	O	O	O	O
O	O	O	O	O	O	O	O	O	O

Date of Birth: _____

Racial/Ethnic Origin:

O African American
O Caucasian
O Hispanic
O Asian American
O Biracial/Multiracial
O Native Hawaiian or other Pacific Islander
O American Indian/Alaska Native

O Other (please specify) _____

Highest level of Education Completed:

O Some high school
O Completed high school
O Some college (1-2 years)
O Some college (3+ years)

- O Completed college degree
- O Some graduate school
- O Completed graduate degree

Current Marital Status:

- O Single
- O Married
- O Separated
- O Divorced
- O Living with someone
- O Widowed

Current Total Annual Household Income:

- O Less than $ 5,000
- O $ 5,000 - $ 10,000
- O $ 10,000 - $ 20,000
- O $ 20,000 - $ 30,000
- O $ 30,000 - $ 50,000
- O More than $ 50,000

Appendix B: Stereotype Confirmation Concern Scale

Please indicate how often over the past 3 months you have been concerned that by _____ you might appear to be confirming a stereotype about African-Americans

1	2	3	4	5	6	7
Never						Always

1. Owning certain things
2. Attending or participating in certain social activities
3. The way you look (your physical appearance)
4. Shopping in certain stores or eating in at certain restaurants
5. Eating certain foods
6. Doing certain households tasks
7. Dressing a certain way
8. Playing certain sports
9. Taking your studies too seriously
10. Talking in a certain way
11. Revealing your socioeconomic status

Appendix C: Personal Report of Confidence as a Speaker

This instrument is composed of 30 items regarding your feelings of confidence as a speaker. After each question there is a "true" and a "false." Try to decide whether "true" or "false" most represents your feelings associated with your most recent speech, then fill in the bubble to indicate "T" or "F." Work quickly and don't spend much time on any one question. We want your first impression on this questionnaire.

1. I look forward to an opportunity to speak in public.
2. My hands tremble when I try to handle objects on the platform.
3. I am in constant fear of forgetting my speech.
4. Audiences seem friendly when I address them.
5. While preparing a speech I am in a constant state of anxiety.
6. At the conclusion of a speech I feel that I have had a pleasant experience.
7. I dislike to use my body and voice expressively.
8. My thoughts become confused and jumbled when I speak before an audience.
9. I have no fear of facing an audience.
10. Although I am nervous just before getting up I soon forget my fears and enjoy the experience.
11. I face the prospect of making a speech with complete confidence.
12. I feel that I am in complete possession of myself while speaking.
13. I prefer to have notes on the platform in case I forget my speech.
14. I like to observe the reactions of my audience to my speech.
15. Although I talk fluently with friends I am at a loss for words on the platform.

16. I feel relaxed and comfortable while speaking.

17. Although I do not enjoy speaking in public I don't particularly dread it.

18. I always avoid speaking in public if possible.

19. The faces of my audience are blurred when I look at them.

20. I feel disgusted with myself after trying to address a group of people.

21. I enjoy preparing a talk.

22. My mind is clear when I face an audience

23. I am fairly fluent.

24. I perspire and tremble just before getting up to speak.

25. My posture feels strained and unnatural.

26. I am fearful and tense all the while I am speaking before a group of people.

27. I find the prospect of speaking mildly unpleasant.

28. It is difficult for me to calmly search my mind for the right words to express my thoughts.

29. I am terrified at the thought of speaking before a group of people.

30. I have a feeling of alertness in facing an audience.