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The Role of Gender and Culture in Treating Youth With Anxiety Disorders

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The purpose of this article is to discuss the complexities of working with anxious children and adolescents of diverse cultures within the context of cognitive-behavioral treatment. Our discussion will examine how culture, gender, and minority status affect anxious symptomatology in children and adolescents and how this may be addressed in treatment. The authors discuss the importance of considering the cultural variations in symptom expression, cultural norms and issues of acculturation, effects of discrimination, and finally the ways that gender can moderate symptom expression. Case examples are incorporated into each section. Recommendations include an emphasis on research on working with children of diverse cultures and the need for ongoing training that helps therapists to examine the impact of their own cultural beliefs on clinical care.

Keywords: anxiety; gender; culture; youth; children

Although research has demonstrated many similarities in the expression of anxiety among children, many differences also exist particularly with respect to how children of varying cultures report symptoms, respond to treatment and even respond to the therapist (Alfons, Achenbach, & Verhulst, 1997; Canino, 2004; Ginsburg & Silverman, 1996; Pina, Silverman, Fuentes, Kurtines, & Weems, 2003; Stewart et al., 2004; Yeh, Hough, McCabe, Lau, & Garland, 2004; Zane, Sue, Hu, & Kwon, 1991). Demonstrating sensitivity to observing these differences is critical for guiding our assessment and treatment strategies in order to optimize our work with children and families from diverse backgrounds. A concrete definition of culture is elusive. Culture can be loosely defined as a system of shared meanings, or more specifically "a common heritage or set of beliefs, norms and values" (U.S. Department of Health and Human Services,

1999). The emerging field of cultural competence speaks to the idea that these differences in beliefs and shared norms must be recognized and one must put forth effort to learn ways to not only "help" other cultures, but also seek to understand them (Stuart, 2004; Sue, 1998). There can be no blanket approach to working with individuals of diverse cultures, but instead a basic skill for a culturally competent therapist is to know "when to generalize and be inclusive and when to individualize and be exclusive" (Sue, 1998). This is not an innate skill, and requires an ability to be aware of and examine one's own assumptions and learn to apply this knowledge to treatment. It is a challenge to work with anxious children, and an additional challenge to work with anxious children of diverse cultures.

The 2001 supplement to the Surgeon General's Report on Mental Health found that "racial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their overall health and productivity" (U.S. Department of Health and Human Services, 2001). While the report touches only generally on the issues of culture and the mental health of minority children it is reasonable to conclude that the issues that affect adults likely impact their children as well. This article examines more closely the role of culture with respect to anxiety disorders in youth and provides suggestions for practitioners engaged in treating patients from many different cultures. We will discuss the ramifications of how various cultures define and express anxiety, how to engage families of anxious children in treatment, the effect of gender on symptom expression, assessing levels of acculturation and assimilation, and ideas for future research.

Cultural Differences in Symptom Expression

Cultural influences in treatment begin with the first point of contact. Culture may impact why and when a family seeks treatment for their child, and whom they trust to approach for treatment. Approaching the initial assessment with these factors in mind can lead to a stronger understanding of cultural issues and a stronger alliance between the family and therapist. It can be an easy mistake in a busy clinic to assume that each child who walks through the door with a diagnosis of anxiety will present with the same symptoms. Different cultures can focus on different aspects of anxiety, as the following two examples illustrate. John, a 17-year-old Asian American client, had been to multiple medical doctors throughout his life to obtain treatment for stomach cramping, nausea, and hot flashes in the morning before going to school. Blood tests and diagnostic exams had failed to identify any problem. Upon further questioning, one doctor identified that his symptoms occurred not only in the morning before school, but also upon any social interactions and referred him to the clinic. His psychiatric exam indicated that John met criteria for social phobia. In treatment, both he and his family felt it was most important to focus on his physical symptoms and thus tolerance of these physical symptoms became a vital part of his treatment plan. Okazaki (1997) found that "Asian Americans were more likely to be socially avoidant and distressed than White Americans" but questioned whether Western constructed measures of social anxiety adequately capture the distress experiences of Asian Americans.

Sarah, a 13-year-old African American female, was referred to our clinic for heart palpitations and excessively sweaty hands after a transfer from a small school to a larger public school. She had not previously endorsed any somatic complaints and said that while she liked her new school it was a difficult adjustment. Like John, she did not apply the term "anxious" or "worried" to her experience. Upon psychiatric interview, however, she also met criteria for social phobia. Like Okazaki, Carter, Miller, Sbrocco, Suchday, and Lewis (1999) found that traditionally validated scales for White Americans do not adequately capture the anxious (and depressive) experience for African Americans. Neal and Turner (1991) asserted that anxiety symptoms may present in unique ways in the African American population. In both examples a therapist who approached the evaluation and discussion with the family with a rigid set of norms and symptom classification may have missed a key understanding of the clients and their cultural understanding of symptom

expression. In John's case, he and his family had understood his problem as physical, and spent many years going from doctor to doctor looking for a treatment. In Sarah's case, her symptoms became most evident during a transition into a new school but manifested in a somatic form. She did not have the vocabulary to discuss or identify anxious feelings. Each family's cultural understanding of their child's problems influenced where and when they sought treatment. By taking a wider approach with questioning and by allowing the patient to create a personal and cultural context of his/her symptoms, the diagnosis became clear.

Culture, the Perception of Etiology and Treatment Compliance

Culture may affect the beliefs that a family holds regarding the etiology and origin of anxiety. Yeh et al. (2004) found that "discrepancies between a parent and service providers' beliefs about a problem etiology may affect service compliance and treatment outcomes." If a therapist insists on a specific interpretation of a child's needs that is at odds with the family's belief system, it is unlikely that the family will comply with treatment recommendations. While some cultures may focus on physical origins (i.e., Hispanic culture; Canino, 2004), other cultures may look to social problems (i.e., the Japanese American culture; Narikiyo & Kameoka, 1992) as the explanation for anxiety. Still other cultures such as South American or American Indian may look to spiritual sources such as unhappy or unsettled ancestors, lack of appropriate religious piety, internal disharmony, and "magical" influences as an explanation for a child's anxious symptoms. Some cultures may attribute anxiety symptoms such as physical ailments, "odd" or avoidant behavior, and unexplained fear responses as the effects of a curse. These beliefs are not necessarily incongruent with cognitive-behavioral treatment, but must also be taken into account when formulating treatment plans and goals. In some cases, what are thought to be very different views on the origins of anxiety may blend together to create a perplexing problem for the therapist to address.

In the case examples mentioned in the previous section, each family held different beliefs about the origins of their child's problem. John's family maintained that he had an undiagnosed medical illness, but due to the chronicity of his symptoms and the lack of success with other treatments they were willing to try a course of cognitive-behavioral therapy (CBT). Sarah's mother felt that her symptoms were largely a manifestation of a sudden physical problem, but when discussing Sarah's history, she realized that Sarah's shyness and avoidance had been present since a very young age. Thus, it is important to craft a plan for treatment that respects the family's belief about the context in which the symptoms occur.

The Effects of Prejudice and Discrimination

Another cultural issue to consider is how beliefs about prejudice and discrimination are integrally related to psychiatric symptomatology and treatment seeking (Cross, 2003; Gone, 2004). Yeh et al. (2004) found that "African Americans and Asian Pacific Islanders reported the experience of prejudice as a cause (of child problems) more often than non-Hispanic whites." Perceptions of prejudice or discrimination are important to consider, as they may impact the trusting relationship between the therapist and client almost immediately. While discrimination exists on many levels, it may also exist as an unspoken question in the session, dictating for the family what and how much to disclose to the therapist. Often children coming into treatment are just developing their sense of self in relation to others, and may be cognizant of possible prejudice even before they are able to explain it.

Sarah (mentioned above) became quiet and withdrawn after several sessions. She became evasive about scheduling and seemed uncomfortable speaking about trying exposures outside of sessions. Almost accidentally, a discussion about a recent anxiety-provoking event sparked another

discussion about her family's feeling about treatment. While her mother was very supportive of her treatment, she revealed that her father was suspicious and distrustful of the mental health system. Sarah felt this disruption and was keenly aware of its impact on the family. Further, the extended family was also suspicious of treatment and gave little support to her mother.

These issues were addressed by a series of family meetings consisting of educational discussions about treatment and making the therapy process as transparent to the family as possible. The therapist emphasized the need for the input of the family for successful treatment and made sure to keep them updated and involved. The therapist also gave her mother psychoeducational materials to share with the extended family, and role-played several situations with the mother to help her communicate with the family about her daughter's anxiety symptoms and the role of treatment. It is critical for the therapist to empathize with the family and express a willingness to discuss issues of possible prejudice, as well as to use the familial networks to facilitate treatment.

Cultural Differences in Family Practices

Culture may also effect how the family is organized, and this will be an important construct to consider when developing a treatment plan. Is there a strong patriarchal or matriarchal orientation? If so, it is important to involve the symbolic and literal head of the family in treatment planning. Are decisions made within the context of the immediate family, or does the larger family consult amongst themselves? These are not characteristics that would be immediately apparent within the first few sessions, but appear important to assess over time and can affect treatment tremendously. The impact can be seen in session attendance, homework completion, cooperation and continuation with exposures outside of sessions. It is important to make sure that all family members who are closely involved in a child's life understand the treatment process, agree with the goals and feel acknowledged as an important part of the treatment process. John's treatment for social phobia progressed well and he was able to understand the concepts of cognitive restructuring. He began the exposure phase of treatment and suddenly began to miss sessions due to "transportation problems." Although John was worried about completing the exposures, it became evident that John's mother was uncomfortable with his newly found confidence and independence. Outside of sessions he began to request to have more time to talk with peers, and even to meet a friend at the mall. John's mother had trouble becoming accustomed to American society, and held to traditional Chinese values. She felt very threatened when she believed John was choosing time with his friends over his obligations with the family. Due to linguistic barriers, his mother was not able to talk about this in sessions, and so the therapist and John spent time discussing the balance between his emerging social desires and the cultural obligation he felt for his family. Through problem solving, and encouraging John to voice his love of his family to his mother, they were eventually able to come to an agreement about how he would spend his time. Culture can also influence the way that the family will react to an anxious child. They might be ashamed, or fear that the family will be viewed negatively if he or she is given a psychiatric diagnosis. They might also fear that the treatment would somehow dilute or change the culture within. Gone (2004) found that many Native Americans perceive psychotherapy as an attempt to further acculturate and dilute the traditional culture. The treatment of the child's anxiety might be an open topic of discussion, or might never be mentioned. Sarah's mother took an enormous risk by bringing her to treatment, and it became important to recognize this as well and talk with her about her support systems. Still other families might be able to normalize the anxiety, and not experience shame in seeking treatment. Living with an anxious child can be stressful, and this may stress the typical cultural practices and coping methods.

The nature of the cultural beliefs of the family is usually deep-rooted and very sensitive to intrusion. Many families are rightly suspicious of any outsider's attempt to alter their beliefs and can perceive many suggestions as critical and change as threatening or insulting. It is far

more productive to look at children within the context of their family and the resulting strengths afforded to them. An open discussion with the family about the goals and specific interventions intended can begin a dialogue to help dispel possible misconceptions.

Culture and Religion

Culture is not necessarily an indicator of religion, but along with a careful assessment of culture, the religious orientation of the family will also have an impact on treatment. Religious views might prohibit some forms of independence for teenagers, or might place limitations on females from interacting with males. Religious beliefs might also have strict dictates about acceptable behaviors and goals. Westernized ideals of independence, self-reliance and encouragement of questions might put a child directly at odds with his parents and his community and become countertherapeutic. Conversely, a culture that encourages its children to voice opinions might put them at odds with religious leaders. It is possible to use the religious beliefs as a therapeutic tool, and combine beliefs seamlessly with therapeutic interventions. Religious beliefs can also be used for coping thoughts (e.g., a favorite prayer, reliance on a higher power), and can even be used in exposures activities (e.g., reading aloud at church, speaking at temple) as well as developing a strong alliance to help the family. In his work with Native Americans, Gone (2004) feels that it is essential to work in consultation with clergy, healers, and other figureheads in the community to ascertain the validity and effectiveness of any intervention.

Rebekah, a 15-year-old female from an Orthodox Jewish family, was referred to our clinic due to constant worries and difficulties separating from her mother to attend school. School officials felt that her absences were impeding her schoolwork and instructed the family to obtain treatment. Her family was extremely reluctant, and missed many sessions. After many attempts to engage the family, the therapist obtained permission to speak with Rebekah's rabbi. After consulting the rabbi about the treatment issues, and his resulting conversation with the family encouraging them to participate in treatment, Rebekah began to attend sessions regularly. The therapist was careful to maintain contact with her rabbi, to make sure that the treatment would not put her at odds with the family's beliefs. By developing a firm alliance with the rabbi, the family felt that the therapy was sanctioned by their religious leader and felt more comfortable attending. Although some of her needs fell well out of the range of CBT, the therapist was able to work with the rabbi to develop a plan that felt acceptable for the family, while also respectful of religious treatment (see Plante, 1999, for further discussion of collaboration with clergy). Effective treatment with this population, and others like it, will have to address the confluence of philosophies that these beliefs present as well as a spiritual and physical understanding of the child's illness.

Acculturation

While considering the culture of the family, it is important to consider the level of acculturation of both the child and the family. Acculturation is a dynamic and fluctuating process and can be different for each generation. Differences in levels of acculturation may play an integral role in anxious symptomatology as well as in the process of implementing CBT for anxious children and adolescents. A thoughtful assessment of acculturative level of the child and his or her family will serve an important role in case conceptualization and treatment planning. It is important to gather information not only regarding ethnic background, but also about generational status of the child, reasons for immigration, and degree of acculturation for both the child and his or her support system.

Ethnic minorities may find themselves having to make regular transitions between alternating sets of expectations, values, and social roles (Harrison, Wilson, Pine, Chan, & Bureil,

1990) that may unnaturally force the pace of acculturation. The discrepancy between cultural expectations and traditions in a child or adolescent's family and those at school and in social relationships in a larger context may produce several challenges affecting anxiety (Varela et al., 2004). For example, Norman, a Korean American middle school student with social phobia who attended school and socialized in a primarily mainstream context found himself struggling with his own ethnic identity. Norman would avoid being seen in public with his parents, and he would walk ahead of them so it did not look as if they were together. Norman limited his parents' interactions with peers and tried to sidetrack school meetings. However, when he and his family were visiting extended family from primarily Korean American neighborhoods, he felt more comfortable about being seen with his family.

Although some degree of embarrassment about one's parents is developmentally normal, Norman's feelings were exacerbated by both acculturative issues and social anxiety. Further, in immigrant families there may be added issues of language that affect both symptomatology and treatment. To address this clinically, it was helpful to ask direct questions about Norman's feelings toward his family, and provide an environment that was open, accepting, and non-judgmental for him to further explore his expectation and anxiety. Questions were phrased several different ways, and the service of an interpreter was offered to the family.

Information regarding acculturation level may also be important in terms of assessing anxious symptomatology itself. It is important to ascertain which symptoms of anxiety are actually interfering with the child's functioning and which the child and/or family find distressing. During this process, it is crucial that the therapist refrain from making his or her own ethnocentric judgments about what constitutes "healthy" behaviors. Acculturative level and cultural background play an important role in interpreting the symptomatology data gathered. For example, in some Latino families it may be perfectly normal for children to sleep in their parents' bed and may not necessarily lead to distress or interference in functioning. Complications may occur when the child socializes with non-Latino peers, and this may lead to an exacerbation of anxiety symptoms. Likewise, it may be socially appropriate for a child or adolescent from one of the Asian cultures in which children are socialized to strive to achieve harmony in groups and be attentive to other's emotional states to be worried when someone is angry or upset (Gee, 2004). If the therapist approaches these as "problem behaviors," instead of looking at them in context, the family will likely become dissatisfied with treatment. An open conversation with the family regarding their cultural beliefs and how they might conflict with cultural beliefs around them may allow them to make a clearer decision about treatment. If the therapist can help them to see the conflict as a cultural difference, rather than a "right or wrong way" they can partner to develop a plan that satisfies the needs of the child and the culture of the family.

Gender and Symptom Expression in Anxious Children

Still another consideration when assessing and treating a child for anxiety is the influence of gender on symptom expression. Several studies have found that, compared to boys, girls experience a greater number of fears, anxiety symptoms, and anxiety disorders (for reviews, see Costello, Egger, & Angold, 2004; Craske, 1997; Ollendick, King, & Muris, 2002). Two recent studies have focused on adolescents and minority samples. Palapattu, Kingery, and Ginsburg (2004) examined the relation between gender, gender role orientation (i.e., masculinity and femininity), self-esteem and symptoms of anxiety in a community sample of African American adolescents. Based on African American experiences with slavery and discrimination in the United States, traditional gender roles, especially for women, are believed to be more fluid and flexible (Dade & Sloan, 2000; Konrad & Harris, 2002). Consistent with this notion, there were no differences in levels of masculinity between males and females. However, masculinity was negatively associated with anxiety symptoms. In contrast, femininity was positively associated

with anxiety symptoms. Although few empirical studies have examined the reasons for these differences, two broad theoretical frameworks, biological and psychosocial, have been suggested. Biological explanations propose that females are at a greater risk for anxiety due to sex-linked genetic and/or biological factors (e.g., hormonal changes, effects of androgens on the brain) (Earls, 1987; Hines, 2003; Mitchell, Baker, & Jacklin, 1989). Psychosocial explanations suggest that our culture's socialization practices of youth into masculine and feminine gender roles account for the gender differences (Block, 1983). More specifically, the gender role or socialization perspective postulates that expressing fear and anxiety is consistent with the feminine gender role and that avoidance in particular, which is thought to maintain anxiety, may be more accepted and even encouraged among girls (Bem, 1981). Conversely, expression of these negative emotions is considered to be inconsistent with the masculine gender role.

Ginsburg and Silverman (2000) examined the relationship between gender role orientation and intensity of fears in clinically anxious children from diverse backgrounds. Results indicated that masculinity was negatively related to overall levels of fearfulness as well as specific fears of failure and criticism, medical fears and fears of the unknown. In this study, no relation was found between femininity and fearfulness. However, Brody, Hay, and Vandewater (1990) found that youth who endorsed higher feminine gender role traits tended to report higher levels of fears toward peers and that gender role accounted for more of the variance in predicting fears than biological gender in a community sample of 120 children.

It may be important for the therapists to become sensitized to the gender role stereotypes within diverse cultures and how they may constrict or encourage symptom expression. Studies of other cultures may show greater or lesser variability in the divergence of symptom expression between girls and boys. It is easy to draw conclusions based on presentation; however, without a larger understanding of how a child is socialized to express fears and worries, a therapist might miss important cues. A basic discussion of how the child *might* express himself if he were worried could yield insight into the amount of filtering of his emotions. The following example speaks to the importance of the therapist being flexible when labeling emotions, and carefully considering the larger environment in treatment.

Thomas, a teenage male from Honduras, was brought to the clinic by his father after failing several classes, refusing to raise his hand in class, and having no involvement in school or peer activities. His father was extremely frustrated with him, and felt he was being oppositional and "lazy." Thomas was extremely uncomfortable coming to the clinic and remained largely silent in the assessment. After several sessions with a female therapist, he was able to say that he would not speak in school because he felt "stupid all of the time." He was unable to define more about what "stupid" felt like, but also endorsed somatic problems including upset stomach and sweating. When the therapist began to talk about possible "worries," Thomas emphatically replied that he never worries. The therapist then changed her terminology to address "stupid" feelings, and they began to work together on a plan for what to do when feeling stupid in school. As therapy progressed, Thomas began to endorse having some type of emotional reaction to time with peers (never specifically calling them worries) but would always be very concerned that his father would find out what he had said in session. The therapist found that Thomas believed that his father would think that worries and fears would be a sign of weakness and was afraid to share any feelings with him.

Engaging and Responding to Multicultural Needs

It should always be remembered that it is an initial act of trust for a family to walk into the therapist's office and be willing to discuss a problem. Regardless of cultural background, by the time they enter treatment, parents are possibly frightened, concerned, frustrated, and exasperated. Also, regardless of culture, children do not know what to expect, or what will be asked of them when they come to the clinic. Add possible misunderstandings, and preconceptions of

disparate cultures of the therapist and family into the mix, and the outcome can be frustrating and alienating for the family. Among other tasks, the therapist must be careful to note any possible areas in which culture might affect the alliance, and to be willing to question with sensitivity and a true desire for understanding. It would be easy to assume that a patient does not show up for an exposure activity due to avoidance or fear. But, as in John's case, with a family from a traditional Chinese culture it might be wise to take the time to ask and to more thoroughly explore the dynamics of why he did not come.

It is critically important to know how to look at the individual with the context of culture and not define the individual by his or her culture. Obviously this is easier said than done. This concept can be put into practice by cultivating a willingness to question, examine one's own behavior and ask for feedback. It is impossible to be an expert on every culture with which one comes in contact, but it is very possible to be willing to learn. Some families will be able to address the cultural divide directly; others may not realize the influence of their beliefs. Some children may be able to "voice" the differences in their families from others, others may simply give you the needed information within a narrative about his or her week, or a recent anxiety-provoking event. In some cases, the therapist might choose to include the family in sessions, or to make a special effort to talk with the "leader" of the family to make sure that planned interventions do not clash with cultural expectations or norms. If this direct conversation is not possible then a careful discussion with the parents regarding expectations for treatment, pictured outcomes and target behaviors can begin to create an outline for the therapist to follow. Questioning about the nature of the illness, and the hopes for change, will be an effective tool to aid in developing a better understanding. Working closely with the child can also yield needed information. For example, asking the child about the behavior of other family members (what does your cousin do when he is worried?) or asking about the possible reactions of family members (what would your dad say if you asked to sleep at a friend's house for the first time?) allows the child to illustrate his or her world for the therapist.

Recommendations for Further Consideration

More research is needed to further develop and refine interventions for minority cultures and children. It should be expected that structured protocols be empirically validated with minority populations. Recruitment strategies should contain a plan to reach and include diverse cultures and examine closely the barriers that arise. Whether there are cultural, financial, or linguistic barriers, research should be structured to not only take this into account, but also strategize to overcome these barriers as best as possible. Feedback from families and leaders within the community should be solicited and carefully considered and implemented in study design.

Given the complexities of working with diverse cultures, and the variability within each culture, it is difficult to recommend a specific set of changes or augmentations to clinical practice or research. Perhaps the clearest recommendation is a change in mindset. Instead of attempting to "add" cultural competence and issues related to culture and gender into practice, it should be an ongoing topic of discussion with clients, or in supervision. Graduate training should integrate multicultural competency into most classes and practica. Perhaps the assumption should be that each therapist will be in contact with clients of many cultures and should therefore be expected to show competence with all clients. As stated earlier, one cannot expect to be an expert in every cultural nuance, but perhaps the willingness to question cultural assumptions, see how they apply in the therapeutic relationship, and learn to adapt to the needs of clients would be a reasonable expectation. This can be reflected in treatment plans as well as direct interactions with the client.

Stuart (2004) suggests a 12-step approach that can be used as a guideline. His proposal includes recommendations for evaluating personal bias and theoretical bias and seeing the individual within the context of his or her culture. Continuing education seminars on multicultural

competence can be required, but instead of emphasizing one particular culture or doctrine, it should cover the process of questioning and challenging one's beliefs and examine their influence in session. Large agencies should develop curricula that are tailored to the needs of each department, as the knowledge of how to address culture does not lend itself to a one-size-fits-all approach.

Conclusions

This article has attempted to begin a discussion about the considerations of working with anxious children of different cultures. Successful treatment includes consideration of gender and its interaction with symptom presentation, and the subtle ways culture and level of acculturation can impact the way an anxious child will present symptoms, and the ongoing concerns that culture may present in the therapeutic relationship.

This is by far not an exhaustive set of considerations, and the authors are cognizant that we have presented challenging issues related to culture. However, therapists and researchers have a unique opportunity to reach more people than ever before and find new ways of helping and learning from those around us. The key is realizing that successful treatment is not forcing our clients or the environment around them to change, it is helping them to successfully adapt to the cultures, environments, personalities, and challenges in their lives. Partnering with families on this goal, and cultivating their strengths and knowledge to help their children, can prove to be the most challenging and rewarding aspect of working with individuals of varying cultures.

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