

Social Anxiety and Social Anxiety Disorder Across Cultures

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As described throughout this book, social anxiety disorder (SAD) is characterized by marked fear of social situations in which the person may be exposed to possible scrutiny (e.g., DSM-5; [American Psychiatric Association, 2013](#)). Key characteristics of the disorder involve “clinically significant distress or impairment” and, importantly, the fear must be “out of proportion to the ... sociocultural context” (DSM-5; p. 203). At the same time social anxiety is experienced by most humans and, in its trait form, is normally distributed across populations ([Crozier & Alden, 2001](#)). Although the distinction between social anxiety and SAD has been a difficult issue to address, it is often argued that the difference lies in the distress and/or life interference associated with the mental disorder ([Beidel, Turner, & Dancu, 1985](#); [Rapee & Coplan, 2010](#); [Rapee & Spence, 2004](#)). [Rapee and Spence \(2004\)](#) have argued that it is this latter characteristic that is especially likely to be influenced by cultural factors.

Cognitive models of SAD ([Clark & Wells, 1995](#); [Rapee & Heimberg, 1997](#)) propose that the socially anxious individual holds negative self-beliefs, predicts negative outcomes, and uses avoidance and safety behaviors, which reinforce their fears. The reaction from the observer or audience is perceived as a threat by the socially anxious individual ([Rapee & Heimberg, 1997](#)). Considering that individuals are embedded in different cultures, influence and are influenced by their culture, and that socially anxious individuals rely on others’ expectations and standards, the experience and/or expression of social anxiety may differ according to factors shared within one’s culture. This chapter explores research based on the relationship between social anxiety, SAD, and culture (most commonly operationalized as country of influence).

PREVALENCE OF SOCIAL ANXIETY AND SAD ACROSS COUNTRIES

As noted earlier, an essential criterion for a diagnosis of SAD is that the anxiety must either interfere significantly with the individual's social, occupational or day-to-day functioning, or cause the individual marked distress ([American Psychiatric Association, 2013](#)). Trait social anxiety, in contrast, is a personality feature or temperament characterized by withdrawal, wariness and reticence in social situations that is normally distributed across populations ([Crozier & Alden, 2001](#)). Although the two constructs will be correlated, high social anxiety does not necessarily produce marked distress or impairment and therefore may not always equate to SAD. For this reason, the literature in each area will be reviewed separately.

Trait Social Anxiety

Several studies have compared trait social anxiety across countries. The most commonly used measure of social anxiety in these studies has been Social Interaction Anxiety Scale (SIAS; [Mattick & Clarke, 1998](#)). This 20-item self-report scale asks participants to rate their distress in situations that involve meeting and interacting with others, with a central theme of fear of negative evaluation. In one of the largest studies, [Heinrichs et al. \(2006\)](#) asked university students from eight countries (USA, Australia, Canada, Germany, Netherlands, Japan, Korea and Spain) to complete the SIAS. Participants in Japan, Korea and Spain reported significantly higher levels of social anxiety than those in the other countries. The study was replicated and extended by [Schreier et al. \(2010\)](#), who administered the SIAS to students in the same countries, except for Spain, and students in the Latin American countries of Costa Rica and Ecuador. Consistent with the findings of the Heinrichs study (2006), Schreier et al. found that students from the East Asian countries of Japan and Korea reported the most social anxiety. Additionally, they found that students in Latin America reported lower levels of social anxiety than the students in any of the other countries. The findings in these studies are consistent with earlier studies that also showed higher rates of self-reported social anxiety in East Asian than western countries ([Kleinknecht et al., 1997](#); [Norasakkunkit & Kalick, 2002](#)).

Prevalence of SAD

Epidemiological studies examining the prevalence of SAD have taken place in many countries, although these still represent only a fraction of the world's population. Unfortunately, studies have typically varied in terms of the instrument used to assess diagnoses, the classification system or edition used for criteria, and the timeframe over which prevalence data were aggregated. To allow the clearest comparison possible, only studies that have used a version of the most widely used instrument, the Composite International Diagnostic Interview

(CIDI) and reported 12-month prevalence using DSM-III-R or DSM-IV criteria, are described here.

The highest rates of SAD appear to be in the Americas, New Zealand and Australia. [McLean, Asnaani, Litz & Hofmann \(2011\)](#) combined the results from three major epidemiological studies in the USA to report that 4.8% of males and 6.5% of females had a diagnosis of SAD in the previous 12 months. This rate is somewhat lower than that reported in earlier studies such as that by [Kessler et al. \(1994\)](#) which reported rates of 6.6% for males and 9.1% for females in the USA. [McLean and colleagues \(2011\)](#) suggest that this difference may be due to the sample composition in their study, which was racially more diverse than those in earlier studies. Studies in Canada report similar rates of 5.4% for males and 7.9% for females using DSM-III-R criteria ([Offord et al., 1996](#)) and 7.2% overall using DSM-IV criteria ([Stein, Torgrud & Walker, 2000](#)). The 12-month prevalence of SAD in New Zealand appears to be slightly lower at 4.5% for males and 5.6% for females ([Wells et al., 2006](#)), and is similar to rates reported in Australia (3.8% males; 5.7% females; [Slade et al., 2009](#)).

In Brazil, [Vorcaro, Rocha, Uchoa, & Lima-Costa \(2004\)](#) reported one of the highest 12-month prevalence rates in the literature, with 7.6% of males and 10.2% of females reporting symptoms consistent with a diagnosis of SAD. It is noteworthy, however, that the population interviewed (using the computerized CIDI-Auto) in this study were exclusively from a small rural community characterized by high levels of poverty and low levels of education. A later study in São Paulo (a Brazilian “megacity” with approximately 20 million inhabitants), found markedly lower rates, with 2.8% of males and 4.9% of females meeting diagnostic criteria for SAD in the past year ([Andrade et al., 2012](#)). [Vicente et al. \(2006\)](#) reported slightly higher overall rates of SAD in Chile (2.5% for males and 9.7% for females) while reported rates of SAD in the Central American nation of Mexico in one study were surprisingly low, with a combined gender 12-month prevalence of 1.7% ([Medina-Mora et al., 2005](#)). Separate gender prevalence rates were not reported in this study, although it was noted that women in Mexico were more likely to meet criteria for an anxiety disorder than men.

In Europe, the results have been somewhat mixed. In some studies, rates are comparable to those in the Americas. [Kringlen, Torgersen and Cramer \(2001\)](#) reported data from an epidemiological study of urban Norwegians, with 4.5% of males and 11.1% of females meeting criteria for SAD over the past year. In the Netherlands, the 12-month prevalence of SAD is reported to be 3.5% for males and 6.1% for females ([Bijl, Ravelli & van Zessen, 1998](#)). However, a large study of six European countries (Belgium, France, Germany, Italy, the Netherlands and Spain) reported by [Alonso et al. \(2004\)](#), suggests a much lower 12-month prevalence of SAD in Europe, with overall figures of 0.9% for males and 1.4% for females. This discrepancy may be due in part to the fact that the study by [Alonso et al. \(2004\)](#) used DSM-IV criteria, which are slightly different to the DSM-III-R criteria used in the earlier studies. Alternatively, it is possible that

the lower rates are due to cultural differences between different countries within Europe. An additional study in Germany, using DSM-IV criteria, also reported relatively low prevalence of SAD with 1.3% of males and 2.7% of females meeting criteria in the past 12 months (Jacobi et al., 2004, reported in Fehm, Pelissolo, Furmark & Wittchen, 2005).

In contrast to the rates reported in most Western countries, prevalence of SAD in several Asian countries has been remarkably low. In Korea, Cho et al. (2007) reported a 12-month prevalence of 0.1% for males and 0.2% for females. Similarly, Shen et al. (2006) reported an overall 12-month prevalence for SAD of 0.2% in China, and Kawakami et al. (2005) reported a slightly higher rate of 0.8% overall in Japan. While neither of these studies reported separate prevalence rates between the genders for SAD, both reported no difference between genders in the prevalence of anxiety disorders in general.

Finally, in studies from Africa, data have been slightly more inconsistent. In South Africa, the 12-month prevalence is relatively low, at 1.9% (Williams et al., 2008). While this rate is decidedly higher than the 0.3% one-year prevalence reported in a community study in Nigeria (Gureje, Lasebikan, Kola & Makanjuola, 2006), a study of Nigerian university students found markedly higher rates, with 8.4% and 8.7% of males and females respectively meeting criteria in the past year (Bella & Omigbodun, 2009). The authors of this study offered some possible explanations for the difference, including the fact that the general population study had an older sample who may have adapted to patterns of social avoidance, and that general community citizens were less likely to encounter public speaking demands than university students. Additionally, the authors pointed out that the CIDI interviews in the general study were conducted in the local language, Yoruba, whereas the university study interviews were conducted in English (the official language of instruction in Nigeria).

A different examination of the effects of culture on SAD would be to compare prevalence of specific cultural groups within the same country. This would reduce confounds associated with comparing different contexts, but would introduce additional confounds such as cultural acceptance and acculturation (Vijver & Leung, 1997). Unfortunately, there are few such studies. Asnaani, Richey, Dimaite, Hinton and Hofmann (2010) examined data from three nation-wide American surveys of mental health, all of which utilized the WHO-CIDI to diagnose mental disorders. White Americans were found to exhibit a significantly higher rate of SAD (12.6 %) than African Americans (8.6%), Hispanic Americans (8.2%) and Asian Americans (5.3%) who reported the lowest rates. This finding remained even when age, gender and socio-economic status were controlled, and is consistent with an earlier study that used a different diagnostic interview (Alcohol Use Disorder and Associated Disabilities Interview Schedule-IV; Grant et al., 2005). It is noteworthy that the study by Grant et al. (2005), identified Native Americans being more likely even than White Americans to have SAD, but the prevalence of SAD amongst Native Americans was not reported by Asnaani et al. (2010).

The prevalence figures outlined above indicate that SAD is more common among females than males in most countries. In clinical samples in the USA, females have also been found to report more intense fear of social situations (Turk et al., 1998). In contrast, males and females are reported to present for treatment in roughly equal proportions (Heimberg & Juster, 1995), although comparison of treatment-seeking samples across countries would be valuable.

In summary, research into levels of trait social anxiety and the prevalence of SAD point to some interesting culture-related differences. Although higher levels of trait social anxiety have been found in East Asian countries such as Korea and Japan than in Western countries, rates of SAD in these countries are markedly lower than those found in Western countries. This discrepancy between levels of trait social anxiety and rates of SAD across cultures has been the source of some discussion in the literature (e.g., Heinrichs et al., 2006; Rapee & Spence, 2004). One possible explanation is that the studies looking at trait social anxiety have primarily used university student samples, whereas those looking at diagnoses of SAD have used broader community samples. University students, being younger and under more performance pressures, may be more socially anxious than other members of the community (Bella & Omigbodun, 2009).

A more culturally-focused suggestion is that withdrawn, socially reticent behaviors may have different meaning and impact across cultures (e.g., Hofmann, Asnaani, & Hinton, 2010). It has been suggested that Western cultures place greater value on an extraverted and individualistic behavioral style (Marjoribanks, 1994), whereas East Asian cultures promote a behavioral style that is more self-effacing and quiet (King & Bond, 1985). Hence, it may follow that East Asian cultures would demonstrate higher levels of social anxiousness because the associated behaviors are more consistent with their cultural expectations and behaviors that deviate from cultural expectations would be more noticeable. In turn however, the behaviors associated with trait social anxiety may cause less life interference among those living in an East Asian society than those in a Western society since they are culturally consistent, thereby translating to lower levels of psychopathology (SAD) (Heinrichs et al., 2006; Hofmann et al., 2010; Rapee & Spence, 2004). In support of this suggestion, it has been shown that compared with people from Western countries (e.g., Australia, the Netherlands, USA), people from East Asian countries (Japan, Korea, China) reported less predicted negative impact from socially withdrawn behaviors on relationships, career prospects and social standing (Rapee et al., 2011). In addition, the relationship between quality of life and social anxiety was stronger for participants from the Western countries than those from the East Asian countries, suggesting that social anxiousness predicts poorer quality of life in Western countries than East Asian.

This hypothesis is consistent with earlier research regarding children. While shy children in Western countries have been shown to have worse psychological outcomes (Caspi, Elder & Bem, 1998; Coplan & Armer, 2005), this has

not been the case with shy Chinese children, (Chen, Chen, Li & Wang, 2009; Chen, Rubin & Li, 1995). Chen et al. (2009) found that greater withdrawal amongst Chinese preschoolers predicted more positive outcomes in school competence, social integration and peer liking five years later. This is consistent with a study directly comparing peer reactions, where shy and withdrawn behaviors were associated with positive reactions in China and negative reactions in Canada (Chen, DeSouza, Chen & Wang, 2006). In addition to differences in peer reactions, withdrawn behaviors in Chinese and Canadian children have also been found to elicit different reactions from their mothers, with Chinese mothers responding with more warmth and encouragement of these behaviors (Chen et al., 1998).

Although these results offer some insight as to why East Asian countries have lower rates of SAD despite higher levels of social anxiety, further research is required to better understand the interplay between social anxiety and cultural factors. Rapee et al. (2011) have noted that, although social anxiety appeared to have less impact in East Asian than Western countries, it was still associated with negative outcomes in both country groups. Participants from both East Asia and Western countries perceived the shy vignette characters as much less likeable and less likely to be successful in their careers, indicating that a shy behavioral style is perceived negatively across cultures, albeit to a lesser extent in East Asia.

CULTURAL DIMENSIONS THAT MAY IMPACT SOCIAL ANXIETY

In the context of cross-cultural research, researchers have the task of capturing individual nuances within their culture and comparing these to those in other cultures. Immersed in one's culture, one is influenced by cultural surroundings, beliefs and values, shaping and shaped by social context. In social anxiety, an individual's perception of social danger or threat evokes anxiety, and what constitutes threat has the potential to be culturally influenced. An individual's expression of social anxiety is likely to be impacted by factors shared within one's culture (Moscovitch, Hofmann, & Litz, 2005). Here, dimensions of culture, concepts of self-construal, social norms, and cultural bound syndromes are explored.

Individualism and Collectivism

Much of the literature regarding cultural expressions of social anxiety has explored differences between individualistic and collectivistic societies. While the classification of societies as either collectivistic or individualistic is not always clear, research has pointed to key differences in communication styles and social interactions (Oyserman, Coon, & Kemmelmeier, 2002). Specifically, individualistic societies encourage open interpersonal interaction and a straightforward

communication style, whereas collectivistic societies encourage interactions within “in-groups” (such as family, friendship groups) and face-saving. Whilst latent individualism and collectivism do not always underlie variability between cultures (Oyserman et al., 2002) they can impact some psychological processes relevant to social anxiety.

The perception of acceptable social interactions is likely to be defined by social norms, including expected behavior, values and goals. Such norms provide guidelines by which individuals appraise their own and others’ behaviors (Triandis, 1994). In a collectivist culture individuals are encouraged to work towards community goals, while in an individualistic culture individuals are encouraged to pursue their own individual goals. Because the self is conceptualized in relational terms in collectivist countries, perceived cultural norms have been found to be more predictive of life satisfaction in these countries compared to individualistic countries. By contrast, in individualistic countries where the self is conceptualized by internal attributes, life satisfaction is predicted by individuals’ emotions (Suh, Diener, Oishi, & Triandis, 1998).

Kim and colleagues (2008) investigated the motivation for and recurrence of social withdrawal in a cohort of Australian and Korean young adults during adolescence. The assessment of social withdrawal was carried out through retrospective questionnaires, and assessment of motivation for social withdrawal was carried out through questionnaires of perceived mood, shyness, isolation and lack of sociability. In both samples, results showed that recollection of social withdrawal was reported by participants with impaired self-concept and emotional well-being, the frequency of social withdrawal was negatively associated with perceived network support and perceived self-worth, and social withdrawal was found to predict social anxiety, depression and loneliness in early adulthood. The authors suggested that lack of social interaction (manifested in social withdrawal) may lead to social anxiety, as individuals miss out on possibilities to develop appropriate social skills and do not consolidate a positive self-image. Nonetheless, some interesting differences emerged between the Australian and Korean samples. Social withdrawal related to shyness and low sociability led to better social and emotional adjustment among Korean students than among Australians. In contrast, sad and isolated participants in Korea appeared to be more markedly impaired than those in Australia. These differences are consistent with suggestions that in collectivistic cultures reserved behaviors are more valued than outspoken behaviors, individuals encourage group harmony over individual goals, and individuals’ social lives are limited to and dependent on in-group friendships. In contrast, in individualist cultures, assertive communication is highly expected, and being ostracized by a group of friends is less influential, as moving to new situations and making friends seems to be easier.

Heinrichs and colleagues (2006), for example, compared individualistic (Australia, Canada, Germany, the Netherlands and the United States) and collectivistic (Japan, South Korea and Spain) countries in terms of individual and

cultural norms and their association with social anxiety and fears of blushing. Social vignettes were used to identify norms regarding acceptability of socially reticent behavior and withdrawal versus attention-seeking and outgoing behavior. Participants were asked to indicate the extent to which they, personally, would view the behavior as acceptable (personal norm) and the extent to which others within their culture would view the behavior as acceptable (cultural norm). Participants from collectivistic countries scored higher on measures of social anxiety than did participants from the individualistic countries. However, as a group, collectivistic cultures were found to be significantly more accepting of withdrawing and modesty in terms of their cultural norms, whereas individualistic countries were more accepting of attention-seeking behaviors. No differences were found between the groups of countries on personal norms regarding those behaviors. These results support the suggestion that culturally, collectivistic countries are more accepting of withdrawn and introverted behaviors, whereas the cultural norm in individualistic countries is more positively disposed toward extraverted and attention-seeking behaviors (Heinrichs et al., 2006). Although clearer rules for social behaviors seem to be present in collectivistic countries, individuals may be more attentive to norms for social behaviors and discrepancies may be more easily noticed by others (Hofmann, Anu Asnaani, & Hinton, 2010). As a result, these cultural norms may be more easily violated, leading to serious consequences such as social exclusion (Triandis, 2004).

Given that the results from the study by Heinrichs et al. (2006) included primarily Asian nations within their sample of collectivistic countries, Schreier et al. (2010) replicated the study including data from individualistic (Australia, Canada, Germany, Netherlands, and the United States) and Asian collectivistic (Japan, South Korea) countries and added countries from Latin America (Costa Rica and Ecuador), which are also considered to be largely collectivistic (Schreier et al., 2010). In addition to collectivism, Latin American countries also include a cultural script of *simpatía*, the social norm that supports sociability and gregariousness. Hence the design was able to indicate whether social anxiousness was generally associated with individualism/collectivism or more specifically with Asian cultural norms. As in Heinrichs et al.'s (2006) study, relatively high levels of social anxiety and support for socially reticent behaviors were found in the East Asian group. The Latin American sample, however, reported the lowest levels of social anxiety among the three groups, suggesting that collectivistic values alone do not explain differences in social anxiety across cultures. Interestingly, just like the East Asian groups, the Latin American countries were found to have higher support for socially reticent behaviors than the individualistic countries. Hence acceptance of socially reticent behaviors appears to be characteristic of collectivistic cultures but neither collectivism nor acceptance of socially reticent behaviors in and of themselves necessarily lead to higher social anxiety. The two types of collectivistic countries appear to have different ways of facilitating group harmony. East Asian

countries appear to maintain group harmony by promoting withdrawn submissive behaviors, whereas the embracing of *simpatía* in Latin American countries maintains social harmony through high sociability and gregariousness (Schreier et al., 2010). Thus both groups of collectivistic countries, East Asian and Latin American, may have lower levels of SAD (Furmark, 2002; Wittchen & Fehm, 2003), but through different mechanisms.

Self-construal

Self-construal, a term coined by Markus and Kitayama (1991), refers to how individuals perceive themselves in relation to others, particularly the level of connectedness with and separateness from others, based upon culturally shared assumptions. Markus and Kitayama (1991, 2010) explained social relations in terms of differing modalities of sense of self, called independent and interdependent construal. The primary attribute of the independent construal refers to the development of the individual as an autonomous person, in which the individual's behavior is organized in relation to one's range of thoughts, feelings and actions. In a social situation, the focus of the independent construal is to express internal attributes and to reinforce inner self, promoting development of one's desires, goals and abilities. In this form of construal one can move easily between in-groups to out-groups. In contrast, interdependent construal refers to one's connectedness to each other; one's agency is guided in terms of the perceptual relationship to others' feelings, thoughts and actions. In social interaction, the interdependent construal places self-assertion and autonomy as secondary. The ability to self-regulate is seen as a central task, a sign of maturity; the self-representation is then fluid, in accordance with significant others and contingencies. Although dependent and interdependent construal seem to be similar to individualism and collectivism, the latter refers to cultural norms that influence the individual's tendency to socialize, whereas self-construal refers to how cultural norms are internalized. Studies have found that self-construal mediates the impact of collectivism and individualism on communication methods (Gudykunst et al., 1996) and conversational restrictions (Kim et al., 1996).

Several studies have examined the relationship between social anxiety and self-construal and have found that social anxiety is negatively associated with independent self and positively associated with interdependent self (Dinnel, Kleinknecht, & Tanaka-Matsumi, 2002; Hong & Woody, 2007; Levinson, Langer, & Rodebaugh, 2011; Moscovitch et al., 2005; Norasakkunkit & Kalick, 2009; Okazaki, 1997, 2000). Park and colleagues (2011) found that both types of self-construal had a significant indirect effect on social anxiety through emotion suppression. In particular, interdependent self was positively correlated with more emotional suppression and with higher levels of social anxiety, suggesting that interdependent selves are more prone to look for social cues, and are more sensitive to evaluation from others (Park et al., 2011).

CULTURAL VARIATIONS OF SOCIAL ANXIETY

Perhaps the most widely described cultural variation of social anxiety is taijin kyofusho (TKS) (Kirmayer, 1991). The meaning of the expression is as follows: Kyofusho means symptoms (sho) of fear (kyofu), and taijin means face-to-face contact (Kirmayer, 1991). TKS has been recognized in Japan as a distinct diagnostic category since the 1930s (Stein, 2009), and it is included in the DSM-5 as a cultural variation, although a broader disorder than SAD.

The disorder has two subtypes—the neurotic and the offensive types (Iwase et al., 2000). The neurotic subtype is characterized by fears of interpersonal interactions and negative evaluation and therefore is essentially similar to Western descriptions of SAD. In contrast, the offensive subtype of TKS features negative beliefs about the self being flawed, offensive, or inappropriate, and thus the individual has fears of offending others. The offensive subtype focuses mainly on the thoughts and feelings of others, distinguishing it from the neurotic subtype that focuses on one's own thoughts and feelings (Lewis-Fernandez et al., 2010; Russell, 1989). In the offensive subtype, common fears include fears of making eye contact, fears of body odors or intestinal gas, fears of having a deformed body, or fears of blushing, and it can reach delusional proportions (Choy, Schneier, Heimberg, Oh, & Liebowitz, 2008).

TKS has been found mostly in East Asian cultures such as Japan and South Korea (Dinnel et al., 2002; Essau, Sasagawa, Chen, & Sakano, 2012; Kleinknecht, Dinnel, Kleinknecht, Hiruma, & Harada, 1997). The fear of offending others or conveying shame to others leads to avoidance behavior, as one's behaviors cause shame to oneself, and one's family and social group, which in turn interferes with group connectedness. This characteristic is mostly found in collectivistic cultures rather than individualistic cultures. Nonetheless, some features of TKS have been found also in individualistic cultures, such as the USA and Canada (Choy et al., 2008). In this study, 75% of the participants endorsed moderate to severe fears of symptoms of the offensive subtype, and up to 39% endorsed moderate to severe fears of offending others. Although features of TKS subtypes were endorsed in this study, the presence of the full syndrome was not assessed.

The obvious similarities between TKS and social anxiety, especially with the non-offensive subtype of TKS, have been supported empirically. For example, Kim and colleagues (2008) found that social fears correlated more strongly with symptoms of the TKS general type than the TKS offensive type among both the general population in Australia as well as a sample with SAD (Kim, Rapee, & Gaston, 2008). However, among the sample with SAD, none of the sample met full diagnostic criteria for TKS, indicating at least some distinction between the two clinical disorders.

Despite the fact that TKS and social anxiety share considerable similarities, they constitute distinct constructs representing specific symptoms and cognitions; that is, social phobics are fearful of embarrassing themselves while

TKS sufferers are fearful of offending or embarrassing others (Kleinknecht et al., 1997). This differentiation provides an indication of how culture may affect one's self-construal in different generations. For example, a study designed to compare the frequency and correlates of TKS between two generations of the same family in Japan, found that TKS was significantly associated with anxiety symptoms in each generation, however the association between TKS and self-construal differed between the generations. In adolescents, independent self-construal was related to lower TKS, while in parents interdependent self-construal related to lower TKS. The authors suggest that the negative relationship between TKS and interdependent self-construal found among parents may indicate a greater sense of community belonging, providing them with a sense of security which subsequently decreased TKS levels (Essau, Sasagawa, Ishikawa, et al., 2012). Overall, Essau et al. attributed these findings to significant social changes in Japan, impacting on family environment and peer support, and consequently one's self-construal.

CHALLENGES OF CROSS-CULTURAL ASSESSMENT

Although the increasing use of standardized diagnostic interviews, such as the CIDI, has no doubt improved the reliability of assessment across cultures, significant issues still remain in the way social anxiety is identified and measured. One obvious issue regards language. As many of the measures of social anxiety were developed in English-speaking countries, these measures must first be translated before they can be used in nations where English is not the primary language. This creates opportunity for subtle changes in meaning and may reduce the reliability of the measure. Along similar lines, it is possible that similar symptoms or behaviors may manifest slightly differently between cultures. Thus even an accurate translation might not capture the same meaning across different cultures. A less obvious, but arguably more significant assessment issue regards the diagnostic category of SAD itself. Kleinman (1977) has pointed to the fact that diagnostic categories (such as those in the DSM-5) are embedded in Euro-American psychiatric conceptualization and practice. Culturally distinctive factors may have been completely overlooked in the current diagnostic system (Canino, Lewis-Fernandez & Bravo, 1997). Henrich, Heine & Norenzayan (2010) have discussed the way psychological research published in high ranking journals is based largely on samples from WEIRD (western, educated, industrialized, rich and democratic) societies, and caution against making generalizations across populations from this unusual sub-population.

Considering social anxiety specifically, it is likely that social and/or performance situations commonly encountered in one culture do not occur, or occur with a different social meaning, in another. Measures of social anxiety are therefore at risk of including irrelevant situations, or omitting relevant ones when they are used in a different culture from that in which they were designed (Caballo, Salazar, Irturia, Arias, & Hofmann, 2012). It is noteworthy,

for instance, that in the previously cited Chinese epidemiological study (Shen et al., 2006), nearly 60% of the DSM-IV anxiety disorders identified fell into the Not Otherwise Specified category. Prior to publication of the DSM-5, some authors recommended broadening the first criterion of social anxiety disorder to include allocentric (focusing on others) fear, such as that seen in *taijin kyofusho*, and specifying that the individual must recognize that their fear is excessive or unreasonable *in the social reference group they identify with* (Lewis-Fernandez et al., 2010). Unfortunately, this more inclusive cultural suggestion does not seem to have been picked up by the DSM committees. Although the DSM-5 does now include brief mention that social fears must be out of proportion to the sociocultural context (criterion E), this point refers to the degree of fear and avoidance and not to its form.

It should also be noted that the culture of the diagnostician or interviewer may impact the way relevant information is elicited and interpreted. A study by Tseng, Asaim, Kitanishi, McLaughlin, and Kyomen (1992) presented Japanese and American psychiatrists with written case histories and videotaped interviews of Japanese patients from Tokyo and Japanese-American patients from Hawaii. All patients had been previously diagnosed with SAD, but the Japanese and American psychiatrists differed in the diagnoses they gave. The Japanese psychiatrists tended to diagnose SAD in the Japanese but not the Japanese-American patients. The American psychiatrists tended to diagnose SAD in all patients, in addition to a range of other diagnoses such as generalized anxiety disorder and avoidant personality disorder. These findings parallel much earlier work by Cooper et al. (1972), which showed that British and American psychiatrists also gave different diagnoses when viewing videotapes of patients, particularly when the cases were not straightforward, but rather included mixed symptom profiles. Similar results were reported in a study based on case-study vignettes of people with a variety of social fears in which diagnostic agreement according to DSM-IV criteria between raters from a variety of countries was modest (Kinoshita et al., 2008).

A further challenge faced by those developing culturally sensitive measures of social anxiety is the rapid societal change occurring in many cultures. Draguns and Tanaka-Matsumi (2003) point out that the impact of globalization and other social transformation may quickly render particular research findings obsolete. They recommend that culturally-oriented researchers follow and document the impact of social changes on distress and disability. These authors also warn that researchers must note the overlaps between cultures and resist turning cultural characteristics into stereotypes.

PSYCHOLOGICAL TREATMENT OF SAD ACROSS CULTURES

There is scant literature on cross-cultural response to psychological treatment for SAD. While there is strong evidence for the use of cognitive behavior therapy (CBT) in treating this disorder, the majority of studies have taken

place in Western countries, such as the USA and United Kingdom (Hofmann & Smits, 2008). There is some indication that CBT for SAD has been effective with Japanese and Hispanic-Latino patients (Chen et al., 2007; Pina et al., 2003), however this is limited to studies with small numbers of participants. A review of treatment outcomes for ethnic minority adults with anxiety disorders in the USA (Carter, Mitchell & Sbrocco, 2012), reported virtually no studies examining the effect of treatment for African American, Asian American or Native American adults with SAD. The only SAD research cited in this review was a single case study in which an African American woman was successfully treated with an exposure-based treatment (Fink, 1996).

Despite the lack of evidence regarding differences in treatment response across cultures, it does appear that there may be cultural differences in treatment-seeking behaviors (Hofmann, Asnaani & Hinton, 2010). For example, students of first-generation Chinese heritage have been shown to be significantly less willing to seek help for moderate levels of social anxiety than students of European heritage (Hsu & Alden, 2008). This is consistent with broader findings that Asians in North America wait longer before seeking mental health treatment (LeMeyer, Zane, Cho & Takeuchi, 2009). It is also consistent with the previously described findings that social anxiety may impact less on quality of life among people of Asian background (Rapee et al., 2011).

Social anxiety has reportedly been successfully treated with Morita therapy, both in Japan and in the West (Ishiyama, 1986; Ishiyama, 1987, Maeda & Nathan, 1999), although the authors of this chapter are not aware of any published randomized controlled studies. Morita therapy, a psychotherapy developed by Japanese psychiatrist, Dr. Shoma Morita, is based on Eastern philosophy (Chen, 2010). It originally comprised four stages which included inpatient isolation, but is now commonly conducted in outpatient groups (Stein, 2009). Morita therapy has been compared to CBT in its encouragement of exposure to social interaction despite discomfort (Stein, 2009), and Acceptance and Commitment Therapy in terms of its emphasis on non-judgmental awareness and acceptance (Chen, 2010; Hofmann, 2008).

CONCLUSION

Despite the clear challenges of cross-cultural research, recent years have seen an increase in our understanding of the expression and experience of social anxiety and social anxiety disorder across cultures, particularly in East Asian and Western countries. Cultural theories, involving collectivism/individualism, social norms and self-construal, increase our understanding of why an individual may be more or less likely to develop a distressing or debilitating level of social anxiety within a particular cultural context, and emphasize the importance of considering a person's cultural background when appraising their social beliefs and behaviors. Further research is needed to understand the development, presentation and treatment of social anxiety across a broader

range of cultures. In particular, researchers may wish to further investigate the impact of culture on individuals' responses to psychological treatments for social anxiety.

REFERENCES

- Alonso, J., Angermeyer, M. C., Bernert, S., et al. (2004). 12-Month comorbidity patterns and associated factors in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. *Acta Psychiatrica Scandinavica*, *109*, 28–37.
- American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th Edition). Arlington, Virginia: American Psychiatric Association.
- Andrade, L. H., Wang, Y. P., Andreoni, S., Silveira, C. M., Alexandrino-Silva, C., Siu, E. R., et al. (2012). Mental disorders in megacities: findings from the Sao Paulo megacity mental health survey. *Brazil. PLoS one*, *7*, e31879.
- Asnaani, A., Richey, J. A., Dimaite, R., Hinton, D. E., & Hofmann, S. G. (2010). A cross-ethnic comparison of lifetime prevalence rates of anxiety disorders. *The Journal of Nervous and Mental Disease*, *198*, 551–555.
- Beidel, D. C., Turner, S. M., & Dancu, C. V. (1985). Physiological, cognitive and behavioral aspects of social anxiety. *Behaviour Research and Therapy*, *23*(2), 109–117.
- Bella, T. T., & Omigbodun, O. O. (2009). Social phobia in Nigerian university students: prevalence, correlates and co-morbidity. *Social Psychiatry and Psychiatric Epidemiology*, *44*, 458–463.
- Bijl, R. V., Ravelli, A., & van Zessen, G. (1998). Prevalence of psychiatric disorder in the general population: results of the Netherlands Mental Health Survey and Incidence Study (NEMESIS). *Social psychiatry and psychiatric epidemiology*, *33*(12), 587–595.
- Caballo, V. E., Salazar, I. C., Irturia, M. J., Arias, B., & Hofmann, S. G. (2012). The Multidimensional Nature and Multicultural Validity of a New Measure of Social Anxiety: The Social Anxiety Questionnaire for Adults. *Behavior therapy*, *43*(2), 313–328.
- Canino, G., Lewis-Fernandez, R., & Bravo, M. (1997). Methodological challenges in cross-cultural mental health research. *Transcultural Psychiatry*, *34*(2), 163–184.
- Carter, M. M., Mitchell, F. E., & Sbrocco, T. (2012). Treating ethnic minority adults with anxiety disorders: Current status and future recommendations. *Journal of Anxiety Disorders*, *26*(4), 488–501.
- Chen, C. P. (2010). Morita therapy and its counseling implications for social anxiety. *Counselling Psychology Quarterly*, *23*, 67–82.
- Chen, J., Nakano, Y., Ietzugu, T., Ogawa, S., et al. (2007). Group cognitive behavior therapy for Japanese patients with social anxiety disorder: preliminary outcomes and their predictors. *BMC Psychiatry*, *7*(1), 69.
- Cho, M. J., Kim, J. K., Jeon, H. J., et al. (2007). Lifetime and 12-month prevalence of DSM-IV psychiatric disorders among Korean adults. *The Journal of Nervous and Mental Disease*, *195*, 203–210.
- Choy, Y., Schneier, F. R., Heimberg, R. G., Oh, K. S., & Liebowitz, M. R. (2008). Features of the offensive subtype of Taijin-Kyofu-Sho in US and Korean patients with DSM-IV social anxiety disorder. *Depression and Anxiety*, *25*(3), 230–240. doi:10.1002/da.20295.
- Clark, D. M., & Wells, A. (1995). A cognitive model of social phobia (R. G. Heimberg, Trans.). In R.G.H., e., al.], (Ed.), *Social phobia: diagnosis, assessment, and treatment* (pp. 435). New York: Guilford Press.

- Cooper, J. E., Kendell, R. E., Gurland, B. J., Sharpe, L., Copeland, J. R. M., & Simon, R. (1972). *Psychiatric Diagnosis in New York and London*. London: Oxford University Press.
- Crozier, W., & Alden, L. E. (Eds.). (2001). *International handbook of social anxiety: Concepts, research and interventions relating to the self and shyness*. New York: John Wiley & Sons.
- Dinnel, D. L., Kleinknecht, R. A., & Tanaka-Matsumi, J. (2002). A cross-cultural comparison of social phobia symptoms. *Journal of Psychopathology and Behavioral Assessment*, 24(2), 75–84. doi:10.1023/a:1015316223631.
- Draguns, J. G., & Tanaka-Matsumi, J. (2003). Assessment of psychopathology across and within cultures: issues and findings. *Behaviour Research and Therapy*, 41(7), 755–776.
- Essau, C. A., Sasagawa, S., Chen, J., & Sakano, Y. (2012a). Tajjin kyofusho and social phobia symptoms in young adults in England and in Japan. *Journal of Cross-Cultural Psychology*, 43(2), 219–232. doi:10.1177/0022022110386372.
- Essau, C. A., Sasagawa, S., Ishikawa, S. I., Okajima, I., O’Callaghan, J., & Bray, D. (2012b). A Japanese form of social anxiety (tajjin kyofusho): Frequency and correlates in two generations of the same family. *International Journal of Social Psychiatry*, 58(6), 635–642.
- Fehm, L., Pelissolo, A., Furmark, T., & Wittchen, H. U. (2005). Size and burden of social phobia in Europe. *European Neuropsychopharmacology*, 15(4), 453–462.
- Fink, C. M., Turner, S. M., & Beidel, D. C. (1996). Culturally relevant factors in the behavioral treatment of social phobia: A case study. *Journal of Anxiety Disorders*, 10(3), 201–209.
- Furmark, T. (2002). Social phobia: Overview of community surveys. *Acta Psychiatrica Scandinavica*, 105(2), 84–93.
- Grant, B. F., Hasin, D. S., Blanco, C., Stinson, F. S., Chou, S. P., Goldstein, R. B., Dawson, D. A., Smith, S., Saha, T. D., & Huang, B. (2005). The epidemiology of social anxiety disorder in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry*, 66, 1351–1361.
- Gudykunst, W. B., Matsumoto, Y., Ting-Toomey, S., Nishida, T., Kim, K. S., & Heyman, S. (1996). The influence of cultural individualism-collectivism, self construals, and individual values on communication styles across cultures. *Human Communication Research*, 22, 510–543.
- Gureje, O., Lasebikan, V. O., Kola, L., & Makanjuola, V. A. (2006). Lifetime and 12-month prevalence of mental disorders in the Nigerian Survey of Mental Health and Well-Being. *The British Journal of Psychiatry*, 188, 465–471.
- Heimberg, R. G., & Juster, H. R. (1995). Cognitive-behavioral treatments: Literature review. In R. G. Heimberg, M. R. Liebowitz, D. A. Hope, & F. R. Schneier (Eds.), *Social phobia: Diagnosis, assessment, and treatment* (pp. 261–309). New York: Guilford Press.
- Heinrichs, N., Rapee, R. M., Alden, L. A., Bögels, S., Hofmann, S. G., Ja Oh, K., & Sakano, Y. (2006). Cultural differences in perceived social norms and social anxiety. *Behaviour Research and Therapy*, 44(8), 1187–1197.
- Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world. *Behavioral and Brain Sciences*, 33(2–3), 61–83.
- Hofmann, S. G. (2008). Acceptance and Commitment Therapy: New wave or Morita Therapy? *Clinical Psychology: Science and Practice*, 15, 280–285.
- Hofmann, S. G., Asnaani, A., & Hinton, D. E. (2010). Cultural aspects in social anxiety and social anxiety disorder. *Depression and Anxiety*, 27(12), 1117–1127.
- Hofmann, S. G., & Smits, J. A. (2008). Cognitive-behavioral therapy for adult anxiety disorders: a meta-analysis of randomized placebo-controlled trials. *The Journal of Clinical Psychiatry*, 69(4), 621.
- Hong, J. J., & Woody, S. R. (2007). Cultural mediators of self-reported social anxiety. *Behaviour Research and Therapy*, 45(8), 1779–1789.

- Hsu, L., & Alden, L. E. (2008). Cultural influences on willingness to seek treatment for social anxiety in Chinese- and European-heritage students. *Cultural Diversity and Ethnic Minority Psychology, 14*(3), 215–223.
- Ishiyama, F. I. (1987). Use of Morita Therapy in Shyness Counseling in the West: Promoting Clients' Self Acceptance and Action Taking. *Journal of Counseling & Development, 65*(10), 547–551.
- Ishiyama, F. I. (1986). Brief Morita Therapy for Social Anxiety: A Single Case Study of Therapeutic Changes. *Canadian Journal of Counselling and Psychotherapy/Revue canadienne de counseling et de psychothérapie, 20*, 56–65.
- Iwase, M., Nakao, K., Takaishi, J., Yorifuji, K., Ikezawa, K., & Takeda, M. (2000). An empirical classification of social anxiety: Performance, interpersonal and offensive. *Psychiatry and Clinical Neurosciences, 54*(1), 67–75. doi:10.1046/j.1440-1819.2000.00639.x.
- Jacobi, F., Wittchen, H. -U., Höltling, C., Höfler, M., Pfister, H., Müller, N., & Lieb, R. (2004). Prevalence, comorbidity and correlates of mental disorders in the general population: results from the German health interview and examination survey (GHS). *Psychological Medicine, 34*, 593–611.
- Kawakami, N., Takeshima, T., Ono, Y., Uda, H., et al. (2005). Twelve-month prevalence, severity, and treatment of common mental disorders in communities in Japan: preliminary finding from the World Mental Health Japan Survey 2002-2003. *Psychiatry and Clinical Neurosciences, 59*, 441–452.
- Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., et al. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: results from the National Comorbidity Survey. *Archives of General Psychiatry, 51*, 8–19.
- Kim, J., Rapee, R. M., & Gaston, J. E. (2008). Symptoms of offensive type Taijin-Kyofusho among Australian social phobics. *Depression and Anxiety, 25*(7), 601–608. doi:10.1002/da.20345.
- Kim, J., Rapee, R. M., Ja Oh, K., & Moon, H. S. (2008). Retrospective report of social withdrawal during adolescence and current maladjustment in young adulthood: Cross-cultural comparisons between Australian and South Korean students. *Journal of Adolescence, 31*(5), 543–563. doi:10.1016/j.adolescence.2007.10.011.
- King, A. Y. C., & Bond, M. H. (1985). The Confucian paradigm of man: A sociological view. In W. S. Teng, & D. Y. H. Wu (Eds.), *Chinese culture and mental health*. New York: Academic Press.
- Kinoshita, Y., Chen, J., Rapee, R. M., Bogels, S., Schneier, F. R., Choy, Y., et al. (2008). Cross-cultural study of conviction subtype Taijin Kyofu: Proposal and reliability of Nagoya-Osaka diagnostic criteria for social anxiety disorder. *The Journal of Nervous and Mental Disease, 196*(4), 307–313.
- Kirmayer, L. J. (1991). The place of culture in psychiatric nosology: Taijin Kyofusho and DSM-III-R. *Journal of Nervous and Mental Disease, 179*(1), 19–28.
- Kleinknecht, R. A., Dinnel, D. L., Kleinknecht, E. E., Hiruma, N., & Harada, N. (1997). Cultural factors in social anxiety: A comparison of social phobia symptoms and Taijin Kyofusho. *Journal of Anxiety Disorders, 11*(2), 157–177. doi:10.1016/s0887-6185(97)00004-2.
- Kleinman, A. (1977). Depression, somatization, and the 'New Cross-Cultural Psychiatry'. *Social Science and Medicine, 11*, 3–9.
- Kringlen, E., Torgersen, S., & Cramer, V. (2001). A Norwegian psychiatric epidemiological study. *American Journal of Psychiatry, 158*(7), 1091–1098.
- Le Meyer, O., Zane, N., Cho, Y. I., & Takeuchi, D. T. (2009). Use of specialty mental health services by Asian Americans with psychiatric disorders. *Journal of Consulting and Clinical Psychology, 77*(5), 1000–1005.

- Levinson, C. A., Langer, J. K., & Rodebaugh, T. L. (2011). Self-construal and social anxiety: Considering personality. *Personality and Individual Differences, 51*(3), 355–359.
- Lewis-Fernandez, R., Hinton, D. E., Laria, A. J., Patterson, E. H., Hofmann, S. G., Craske, M. G., & Liao, B. (2010). Culture and the anxiety disorders: Recommendations for DSM-V. *Depression and Anxiety, 27*(2), 212–229. doi:10.1002/da.20647.
- Maeda, F., & Nathan, J. H. (1999). Understanding taijin kyofusho through its treatment, Morita therapy. *Journal of Psychosomatic Research, 46*, 525–530.
- Marjoribanks, K. (1994). Cross-cultural comparisons of family environments of Anglo-, Greek-, and Italian-Australians. *Psychological Reports, 74*, 49–50.
- Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review, 98*(2), 224–253.
- Markus, H. R., & Kitayama, S. (2010). Cultures and selves: A cycle of mutual constitution. *Perspectives on Psychological Science, 5*(4), 420–430. doi:10.1177/1745691610375557.
- Mattick, R. P., & Clarke, J. C. (1998). Development and validation of measures of social phobia scrutiny fear and social interaction anxiety. *Behaviour Research and Therapy, 36*, 455–470.
- McLean, C. P., Asnaani, A., Litz, B. T., & Hofmann, S. G. (2011). Gender differences in anxiety disorders: prevalence, course of illness, comorbidity and burden of illness. *Journal of Psychiatric Research, 45*, 1027–1035.
- Medina-Mora, M. E., Borges, G., Lara, C., Benjet, C., Blanco, J., Fleiz, C., et al. (2005). Prevalence, service use, and demographic correlates of 12-month DSM-IV psychiatric disorders in Mexico: results from the Mexican National Comorbidity Survey. *Psychological Medicine, 35*, 1773–1783.
- Moscovitch, D. A., Hofmann, S. G., & Litz, B. T. (2005). The impact of self-construals on social anxiety: A gender-specific interaction. *Personality and Individual Differences, 38*(3), 659–672.
- Norasakkunkit, V., & Kalick, S. M. (2009). Experimentally detecting how cultural differences on social anxiety measures misrepresent cultural differences in emotional well-being. *Journal of Happiness Studies, 10*(3), 313–327.
- Offord, D. R., Boyle, M. H., Campbell, D., Goering, P., Lin, E., Wong, M., & Racine, Y. A. (1996). One-year prevalence of psychiatric disorder in Ontarians 15 to 64 years of age. *Canadian journal of psychiatry. Revue canadienne de psychiatrie, 41*(9), 559–563.
- Okazaki, S. (2000). Asian American and White American differences on affective distress symptoms: Do symptom reports differ across reporting methods? *Journal of Cross-Cultural Psychology, 31*(5), 603–625.
- Okazaki, S. (1997). Sources of ethnic differences between Asian American and White American college students on measures of depression and social anxiety. *Journal of Abnormal Psychology, 106*(1), 52–60.
- Oyserman, D., Coon, H. M., & Kemmelmeier, M. (2002). Rethinking individualism and collectivism: Evaluation of theoretical assumptions and meta-analyses. *Psychological Bulletin, 128*(1), 3–52.
- Park, I. J. K., Sulaiman, C., Schwartz, S. J., Kim, S. Y., Ham, L. S., & Zamboanga, B. L. (2011). Self-construals and social anxiety among Asian American college students: Testing emotion suppression as a mediator. *Asian American Journal of Psychology, 2*(1), 39–50.
- Pina, A. A., Silverman, W. K., Fuentes, R. M., Kurtines, W. M., & Weems, C. F. (2003). Exposure-based cognitive-behavioral treatment for phobic and anxiety disorders: Treatment effects and maintenance for Hispanic/Latino relative to European-American youths. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(10), 1179–1187.
- Rapee, R. M., & Coplan, R. J. (2010). Conceptual relations between anxiety disorder and fearful temperament. *New directions for child and adolescent development, 2010*(127), 17–31.
- Rapee, R. M., & Heimberg, R. G. (1997). A cognitive-behavioral model of anxiety in social phobia. *Behaviour Research and Therapy, 35*(8), 741–756.

- Rapee, R. M., Kim, J., Wang, J., Liu, X., Hofmann, S. G., Chen, J., & Alden, L. E. (2011). Perceived impact of socially anxious behaviors on individuals' lives in Western and East Asian countries. *Behavior Therapy, 42*(3), 485–492. doi:10.1016/j.beth.2010.11.004.
- Rapee, R. M., & Spence, S. H. (2004). The etiology of social phobia: Empirical evidence and an initial model. *Clinical Psychology Review, 24*(7), 737–767.
- Russell, J. G. (1989). Anxiety disorders in Japan: A Review of The Japanese literature on Shinkeishitsu and taijinkyōfushī. *Culture, Medicine and Psychiatry, 13*(4), 391–403. doi:10.1007/bf00052047.
- Schreier, S. -S., Heinrichs, N., Alden, L., Rapee, R. M., Hofmann, S. G., Chen, J., & Bogels, S. (2010). Social anxiety and social norms in individualistic and collectivistic countries. *Depression and Anxiety, 27*(12), 1128–1134. doi:http://dx.doi.org/10.1002/da.20746.
- Shen, Y. C., Zhang, M. Y., Huang, Y. Q., et al. (2006). Twelve-month prevalence, severity, and unmet need for treatment of mental disorders in metropolitan China. *Psychological Medicine, 36*, 257–268.
- Slade, T., Johnston, A., Teesson, M., Whiteford, H., Burgess, P., Pirkis, J., & Saw, S. (2009). *The mental health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing*. Canberra: Department of Health and Ageing.
- Stein, D. J. (2009). Social anxiety disorder in the West and in the East. *Ann Clin Psychiatry, 21*, 109–117.
- Stein, M. B., Torgrud, L. J., & Walker, J. R. (2000). Social phobia symptoms, subtypes, and severity: findings from a community survey. *Archives of General Psychiatry, 57*(11), 1046–1052.
- Suh, E., Diener, E., Oishi, S., & Triandis, H. C. (1998). The Shifting Basis of Life Satisfaction Judgments Across Cultures: Emotions Versus Norms. *Journal of Personality and Social Psychology, 74*(2), 482–493.
- Triandis, H. C. (1994). *Culture and Social Behavior*. McGraw-Hill.
- Tseng, W. S., Asaim, M., Kitanishi, K., McLaughlin, D. G., & Kyomen, H. (1992). Diagnostic patterns of social phobia: comparison in Tokyo and Hawaii. *The Journal of Nervous and Mental Disease, 180*(6), 380–385.
- Turk, C. L., Heimberg, R. G., Orsillo, S. M., et al. (1998). An investigation of gender differences in social phobia. *Journal of Anxiety Disorders, 12*, 209–223.
- Vicente, B., Kohn, R., Rioseco, P., Saldivia, S., Levav, I., & Torres, S. (2006). Lifetime and 12-month prevalence of DSM-III-R disorders in the Chile psychiatric prevalence study. *American Journal of Psychiatry, 163*(8), 1362–1370.
- Vijver, F., & van de Leung, K. (1997). Methods and Design. In F. van de Vijver, & K. Leung (Eds.), *Methods and data analysis for cross-cultural research* (pp. 27–58). Thousand Oaks, California: Sage.
- Vorcaro, C. M. R., Rocha, F. L., Uchoa, E., & Lima-Costa, M. F. (2004). The burden of social phobia in a Brazilian community and its relationship with socioeconomic circumstances, health status and use of health services: the Bambui study. *International Journal of Social Psychiatry, 50*(3), 216–226.
- Wells, J. E., Browne, M. A. O., Scott, K. M., McGee, M. A., Baxter, J., & Kokaua, J. (2006). Prevalence, interference with life and severity of 12 month DSM IV disorders in Te Rau Hinengaro: The New Zealand Mental Health Survey. *Australian and New Zealand Journal of Psychiatry, 40*, 845–854.
- Williams, D. R., Herman, A., Stein, D. J., Heeringa, S. G., Jackson, P. B., Moomal, H., & Kessler, R. C. (2008). Twelve-month mental disorders in South Africa: prevalence, service use and demographic correlates in the population-based South African Stress and Health Study. *Psychological Medicine, 38*, 211–220.
- Wittchen, H. U., & Fehm, L. (2003). Epidemiology and natural course of social fears and social phobia. *Acta Psychiatrica Scandinavica, Supplement, 108*(417), 4–18.