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Cultural correlates of social anxiety disorder in the Iranian population: A qualitative study

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Abstract

Introduction: This study aimed to investigate the cultural aspects of social anxiety and its clinical features in an Iranian population.

Materials and Methods: The sample of this study consisted of the clients of Mashhad counseling centers. Twenty clients who had received the Social Anxiety Disorder diagnosis by a psychiatrist, were selected via a purposeful sampling to participate in the interview. The interviews were conducted using the semi-structured DSM-5 cultural formulation interviews. The transcripts of the interviews were analyzed by content analysis method using a seven-step Colaizzi technique and the concepts and categories were extracted.

Results: The content analysis of the interviews resulted in the identification and extraction of one hundred and fifty concepts that were classified into seventeen components: emotional feature, cognitive feature, behavioral feature, anxiety somatization, interaction and communication deficit, function reduction, the perceived social desirability of lack of self-assertiveness, the perceived religious desirability of behavioral and speech constraint, lack of perceiving and receiving family support, lack of perceiving and receiving relatives and friends' support, the impact of gender (being a girl) on the formation and continuation of anxiety, the causes of anxiety, applying ineffective coping strategies, ineffective encounter of family and friends with the treatment, ineffective individual encounter with the treatment, the influence of religious and spiritual resources, and the acceptance and the appropriate communication with the counselor and therapist.

Conclusion: Despite the similarity of the participants' social anxiety experiences with the theoretical models as well as the consistency of the syndromes with the DSM-5 criteria, the content differences were observed in the form of normative beliefs, supportive resources, coping strategies, and encounter with the therapeutic resources.

Keywords: Beliefs, Cultural feature, Interview, Social anxiety disorder

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Introduction

The prominent feature of social anxiety disorder (SAD) is the fear of being negatively evaluated by others (1). Social anxiety (charactrisized by the threat in social interactions) and is one of the most common forms of anxiety in the worldwide (2). People with SAD overestimate social criteria and social expectations and goals; as a result, they become anxious in social situations (3). Moreover, they overestimate the likelihood of potential social costs arising from dealing with social relationships (3). Thus, this disorder is directly related to social criteria and role expectations that are culturally dependent (1). Culture has a profound effect on how anxiety is formed, the experience of anxiety, the pattern of its syndromes, and its treatment (3,4). Accordingly, understanding the cultural context of the disease experience is essential for effective diagnostic evaluation and clinical management (5). Feelings of extreme anxiety are often associated with social interaction, which makes the appearance of social anxiety vary across cultures (6). Individuals use cultural issues to shape their identities and understand their experiences; therefore, it is vital to avoid the extreme generalization of cultural information in the form of established cultural traits (5). Unexamined cultural differences in how the disease and care are framed may distort the diagnosis and assessment of disease severity and create communication barriers; they may also unnecessarily prolong the extent of patients' involvement, their commitment and responsiveness, as well as their suffering (7,8). The therapist and patient's cultural differences in age, gender, socioeconomic status, race and ethnicity, religion, language, and nationality can influence all clinical interactions (9,10). Recently, numerous studies have been conducted to highlight the role of cultural factors in SAD (1,11-22). Cultural correlates and factors refer to the components such as individualism and collectivism, social norms and criteria, support networks, self-construal, gender role, shame, and religious beliefs (1).

Social anxieties and SAD exist internationally (23). Despite high similarities among groups, there are various aspects that go beyond the same presentation in the Diagnostic and Statistical Manual of Mental Disorders (the Fifth Edition) and the conceptualization of Western societies (24). Social anxiety occurs in a context that is personally meaningful. These contexts embody the shared social values and beliefs and expectations that shape one's perception of social success or failure (23). In recent years, new conceptual models, tools, and technologies, along with better data, have led to substantial changes in our understanding of the interactions of culture, social context, and neurobiology across development and over the course of illness, from the ecosocial view have supported mental disorders (19). In this view, culture emphasizes the way that cultural contexts influence developmental processes and exposure to social adversity to increase risk for specific types of psychopathology (19). The DSM-5 has made extensive efforts to modify the diagnostic criteria and to address potential cultural variables. It has replaced the prevalent belief of culture-bound syndromes with the three different types of cultural concepts related to discomfort and distress; each of which may be related to folk diagnostic categories: cultural syndromes (clusters of symptoms which may be related to but need not be 'bound' or limited to local cultures), causal explanations or attributions (e.g. 'fright illness' or 'susto'), and cultural idioms of distress (everyday ways of talking about distress that cut across syndromes (e.g. 'nerves'). These distinctions are based on the way individuals use indigenous and local concepts related to distress and discomfort and provide a useful set of conceptual tools to make sense of cultural variables affecting the disease experience (5,19).

A study on anxiety and its cultural complexity in the Iranian population identified eleven main theme categories related to emotional disorders in the Iranian ethnicities including: avoidance, dysfunction, arousality, disorganized personality, repetition, somatization, and problematic behavior, maladaptive cognition, awareness, positive and negative emotionality; in this study, the component of somatization was the most frequently reported symptom by the participants, and the main combination of symptomatology of depression and anxiety was the four main categories of somatization, negative emotion, repetition, and maladaptive cognition (25). In another study, Mohammadi et al. (26) examined the cultural aspects of SAD in the Iranian society. They explored the five distinct categories including; anxiety

experiences, core beliefs, reasons of being anxious, effects of SAD on life aspects; and coping strategies. The results indicated that the symptoms of SAD and its underlying beliefs, causes, effects, and coping strategies were almost similar to those presented in the DSM-5, and the only exception was the somatic symptoms are experienced by almost all participants (26).

In the present study, considering the impact of cultural aspects on SAD whether in the prevalence, appearance, syndromes, experience, or treatment of the disease, the theoretical and instrumental framework proposed in DSM-5 as the cultural formulation outline was employed. To this aim, a tool proposed by DSM-5 entitled the cultural formulation interview (27,28) was applied to study cultural factors and their influence on the appearance and manifestation of SAD.

Materials and Methods

The current research is a qualitative study and its data were analyzed using phenomenological method and seven-stage Colaizzi technique. The sample consisted of all clients of Astan Mehr counseling centers, Ferdowsi University of Mashhad counseling center, and Soroush counseling center, who volunteered to participate in the study. Inclusion criteria were getting a diagnosis of SAD by a psychiatrist and not receiving medication. The participants were selected based on their willingness to participate in the research and the declaration of consent to participate in the interview.

The sample selection was purposive and the criterion for finishing sampling was to reach the information saturation. The participants were assured that the confidentiality would be observed. Based on the saturation criterion, after 20 interviews, the data collection process was completed. The interviews were semi-structured and after each interview session, which normally took an hour, the audio file was transcribed into text and uploaded to MAXQDA PRO 12.3. The interviews were reviewed several times and the concepts and components were extracted and classified into three categories.

Research instrument

The semi-structured cultural formulation interview was used to collect the data. This instrument is based on the Outline for Cultural Formulation (OCF) mentioned in the DSM-IV, a conceptual framework that helps therapists identify the effects of culture on illness and care during the clinical evaluation process (29,30). The CFI was developed by the American Psychiatric Association's DSM-5 Cross-Cultural Issues Subgroup with the aim of operationalizing OCF in the routine applications of the clinical evaluation of patients (30).

This semi-structured interview encompasses four main areas: (1) cultural definition of the problem, (2) cultural perceptions of cause, context, and support; (3) cultural factors affecting self coping and past help seeking; and (4) cultural factors affecting current help seeking (28). In the present study, the original version of the interview was used. Louise Fernandez, Roberto Agarwal, Neil Krishan et al. (27) examined the feasibility, acceptability, and clinical usefulness of this instrument in a comprehensive international study conducted in six countries. The results showed that the therapists and patients confirmed the feasibility, acceptability, and clinical usefulness of the tool.

Results

In total, twenty clients with diagnosed SAD were interviewed (seventeen women and three men). The patients' age ranged from eighteen to forty-five years old. The participants' educational background was undergraduate or above. As shown in Table 1, a total of one hundred and fifty concepts and seventeen components were extracted and classified into three categories. The First Theme – The Experience of Social Anxiety: This theme consists of five category as follows:

1. Emotional feature (situational and generalized): The diagnosis and classification of SAD has undergone a radical change over the past few decades, and there are controversies over the generalized and situational types and the specific subtypes (31). In the last edition of the DSM-5, the generalized specifier in the diagnosis of SAD was removed and only the performance specifier was added. This change was in line with the DSM-5 dimensional perspective, and anxiety situations were defined in three types:

(a) social interaction fears; (b) the fear of being observed; and (c) performance anxiety (5). Given the triple anxiety situations mentioned, the extracted anxiety types have situational diversity and overlap with the mentioned types of fears; however, some types include specific fears regarding doing certain activities. Accordingly, some participants experience anxiety only in specific situations such as experiencing anxiety in family gatherings and parties, experiencing anxiety in friends' gatherings, experiencing anxiety in front of strangers, experiencing anxiety in front of the opposite sex, experiencing anxiety in front of colleagues, experiencing anxiety in front of faculty professors, experiencing anxiety in large groups and gatherings, experiencing anxiety in new environments, and experiencing anxiety in the presence of older people, and do not have such experience in other situations.

One participant says, *"It hasn't been a long time that I have been suffering from anxiety since I didn't use to be anxious, and I didn't used to be too much shy except in gatherings that there were many strangers or, for example, I felt that they were much better than me. Among my classmates, I experience stress in front of those who are very smart, but I do not feel stressed in front of those who are just like me and I am comfortable with them."*

Another participant says, *"I don't have this problem with my classmates in college and class, but I have anxiety when I want to present the materials in front of the professor."*

While some participants experience anxiety in the specific situations, others reported experiencing anxiety in most social situations.

One participant says, *"I didn't talk at parties, even with my family, I would rather sit in the room and keep myself busy with the computer or mobile than, for example, talk. I mean I would prefer to be alone. Now, I also prefer and like loneliness more."*

Another participant says: *"I'm not that much interested in participating in gatherings and parties. Moreover, I'm not that much interested in attending conferences."*

2. Cognitive feature (repetitive negative thoughts including ruminations and worries): substantial and considerable evidence suggests that repetitive negative thoughts are a metadiagnostic risk factor; these studies suggest that mental occupation and worries predict the different levels of anxiety (32-34). After social interactions, people often make their mind busy with the quality of these events and how they behaved.

One participant says, *"When I know that I am supposed to talk to someone, that day my mind would be really busy, or, for example, today I am supposed to manage the sports exercise class, my mind will be completely busy."*

Another participant says, *"I always try to be excellent, and if something happens that I feel ashamed, my mind will be busy for several days."*

iThe other participant says, *"I would be influenced by my thoughts so much so that I feel anxious."*

3. Behavioral feature (avoidance and inhibition): avoidance and inhibition are among the psychological vulnerabilities observed in many psychiatric disorders and is particularly evident in SAD. The participants reported avoiding the social, communication, and performing situations in various forms.

A female participant says: *"For example, in the class when the professor was explaining the lesson and asking some questions, I knew the answers but I would never reply. Then, I would see someone else said something wrong, or some classmates said some nonsense things, but they replied; it was very hard for me."*

A male participant says: *"For example, when the guests come to our house, I quickly leave the house; or when we want to go to the party, I say I won't come. I attend parties less often and I don't stay home when the guests arrive. It was more like that."*

One participant puts it: *"I have gotten lazy in my daily affairs and make myself busy with the virtual space and social media like telegrams and things like that and this is really annoying; I'm usually passive and I am often kept to myself."*

4. Anxiety somatization: The physical symptoms of anxiety are very noticeable to the participants and cause their discomfort and annoyance.

The participants generally report the attention to and focus on these the symptoms in anxious situations and are concerned about others' attention to these symptoms; they perceive these symptoms to be due to their weakness and disability and attempt to use safe behavior to hide these symptoms and pay less attention to them.

One female participant says: *"Most of the time when I get stressed, at first, my hands and*

feet start shivering. Then, it's a heartbeat that starts before I speak, and I have anxiety. However, it doesn't much affect my voice."

Another female participant says: *"Since, in the presentation, my voice and hands may tremble or I feel hot and I feel my face goes red (in these situations, I feel like this), in the whole course I had only one presentation."*

5. Interaction and communication deficit: Social skills are considered as the behaviors necessary for effective social communication and efficient social functioning (35). Experimental evidence suggests that the underlying deficiencies in social skills are a common manifestation of SAD (36,37).

One female participant who is an M.A. student says: *"I actually know myself as a really capable person, but because I can't communicate with my society, it means I am nothing, I have no ability, and I can't go into society and say my words. Now, at the university, I only have two very close friends and I'm very comfortable with them and I have nothing to do with the rest. I sit in front of the class and I don't see or look at the others."*

A male participant says: *"For example, if I want to go to the pool, if I want to go to the football game, if I want to go to the market, wherever I want to go, I can't go alone; there should be one or two close friends. If my friend brings his friend, I can't communicate with him."*

Parents can not only be the effective models of social behavior for children, but also have a unique opportunity to shape their children's behavior during the parent-child interaction period (24). Research has shown a high correlation between specific childhood events and the occurrence of social anxiety in later stages of life (38). The participants, in explaining their anxiety, referred to the impact of family and imposing constraint on the interactions and communication.

One participant says: *"When I think about this issue, the cause of anxiety is the family and that they didn't give me the opportunity to express myself... Another thing was that if there were any arguments or disputes in the family, they always told that I was wrong. Now that I have grown older and entered the university, I realize that sometimes they are wrong but they always tell me that I am wrong."*

Another participant says: *"The family was the reason that I wasn't seen when I was supposed to be seen, and it looks normal to me not to comment. Another thing was that I didn't try to attend conferences and things like that."*

6. Academic and occupational and financial function reduction: The fear of negative evaluation and distress are the predictors of academic adjustment problems; social anxiety has a negative impact on students' academic adjustment (39). These problems are manifested as avoiding class participation, commenting, and asking questions, avoiding seminars and lectures, postponing homework and teaching activities, losing job opportunities, rejecting challenging job responsibilities, and reducing income.

A participant says, *"Yeah, I was passive, I was telling myself why I had to study and I was disappointed."*

One of the female participants says: *"Yeah, it has an impact. Yes, when it affects the nervous system, it affects all my work."*

Another participant says, *"Yeah, it has had an impact. I was working in a pharmacy and my anxiety was causing me to forget the places of the medication and I had to work there just one month."*

The Second Theme - Cultural Manifestation of Social Anxiety: This theme consists of six components, as follows:

1. The causes of anxiety: Etiology studies point to the various factors associated with the causes of SAD; some of the research points to learning experiences, deficiencies in social skills, face sensitivity, cognitive bias, and biological and genetic factors (40). The factors stated by the participants are presented in Table 1.

One participant says, *"Maybe I got a lot of support from my family, and I entered the community late. That was probably the reason, because I even commute to my pre-university by the bus service and since I was in the second and third semesters of the university, I commute to the university alone. Maybe it was because I got a lot of support from my family since childhood and I was not present in the society very much."*

Another participant says, *"I think I escaped from it. For example, I gave the presentations to my friend to present; for example, once in the class, the professor blindsided me and asked me questions and I couldn't answer."*

The other female participant says: *"My self-confidence has decreased a lot. It used to be good, but it has decreased considerably and*

the experience of my former teacher caused me to lose my self-confidence. He didn't do it intentionally; his intention was to make student progress. However, his next student also had some problems with him."

2. The Perceived social desirability of lack of self-assertiveness: SAD can be defined as the growing fear of violating social norms. In societies where there is more regulations for social behaviors, people are more easily embarrassed because they are more concerned about their social behaviors and this is because it is easier to detect the violations of norms (1). One of the common normative beliefs that was evident among the participants was a tendency to lack self-assertiveness and the concern about being rejected by others because of the intolerance of their views and behaviors. The concepts stated by the participants are presented in Table 1.

A participant says: *"My mother always told me if you say something to the other person s/he might hate it; don't talk to anyone; this behavior is cheap; I knew it was not like what my mother was saying, but the psychological atmosphere of the family influenced me."*

A male participant says: *"I don't know why when I am alone with my dad and want to talk, I feel anxious in my mind, but I am not like that with my mother. My dad shouldn't even stretch his legs in front of his dad and my dad is the same, but softer. For example, while I am talking, I should not insult or stretch my legs, and I should not raise my voices, and my mother tells me don't tease your father. We also have religious recommendations that we should respect father.*

Another participant says, *"I'd like to say my words to the opposite side, but it's not possible. When I want to say my words, I think I am a bad person, I think others think about me as an impolite person. However, in the family, anyone says anything and I have to say ok, but I suffer a lot from this issue."*

A female participant says, *"No, this issue has recently become very prominent. Instead of shyly, people used to say how quiet and patient this person is. S/he has so much pain, but s/he doesn't say anything. But, now, I feel I am very quiet and can't say my words."*

Another participant says, *"Now, when I think, I see, I'm an M.A. student and it's too bad that I can't talk in front of few people."*

3. The perceived religious desirability of behavioral and speech constraint: In the Islam religion, abstinence refers to the moderating power of man's passions and instincts, and the serious attention of verses and the saints' narrations to this issue indicates its high importance (41). This process aims to enhance one's ability to control and modify one's self and it is necessary to have a correct understanding of the concept and not to have behavioral and speech avoidance and inhibition in all fields. Some participants have chosen specific understanding of the concept of abstinence that can create some limitations for the individual. The concepts stated by the participants are presented in Table 1.

A female participant says, *"For example, we had a theology teacher who influenced me a lot. That is, the women should be more at home and enter the society less. That time, I was listening well and her speech was influencing me considerably. I read and acted based on my own understanding. I don't think I understood the religion well. I still haven't understood it because the religion says like this I should talk less."*

4. Lack of perceiving and receiving family support: Social networks are defined as all interpersonal relationships involved in one's life, and often play a key role in the onset, course and consequences of mental health; they include family, friends, and other social contacts (28). In SAD people, understanding one's role in the social network helps in the evaluation and treatment processes. The social network may have a facilitating or deterrent role in getting help (28). The participants put forward the concepts that illustrate the family's lack of understanding of the individual's anxiety problem and, consequently, lack of the needed support and help to deal with anxiety. The concepts stated by the participants are presented in Table 1.

One participant puts it: *"I guess my dad doesn't know at all. He knows I'm smart and I'm good but he feels I have nothing to offer; that is, the social sense of wanting to defend myself or the sense of responsibility that I should have in society."*

Another participant says: *"Not much, maybe I should say I'm a little bit reticent and I talk to my parents less, and maybe I talk to my friends more often. My parents know the condition and they know that I get stress; however, I don't explain them a lot."*

5. Lack of perceiving and receiving support from relatives and friends: The concepts stated

by the participants regarding the perceptions of the participants about the source of support from friends and other relatives are observed in Table 1.

"My parents don't know the details of my problem and my relatives doesn't know, too" says a female participant.

Another participant puts it: *"My relatives say I am very quiet. I don't like it myself and they look at this issue positively."*

6. The impact of gender (being a girl) on anxiety formation and continuation: The prevalence of SAD is approximately equal among men and women (40). Gender role and gender role identification (masculinity versus femininity) are constructs close to self-construal. Historically, femininity has been associated with shyness and social obedience, and masculinity has been associated with social dominance and aggression (1). The gender role of masculinity reduces the risk of social anxiety. Self-construal predicts the levels of social anxiety differently in men and women, so that in men the interdependence and independency are the predictors of social anxiety levels positively and negatively, respectively, whereas these dependency patterns were reversed in women (1). Gender in the CFI is considered as a subset of cultural background or cultural identity, and the attempt has been to focus more on the patient's self-descriptive identity rather than on the cultural identity attributed to the individual (28). The concepts stated by the participants are presented in Table 1.

One participant says, *"When I am in a gathering or with others, I smile a lot. This is out of my hands. Then, they tell me don't laugh too much. It is not good for a girl to laugh too much. Why do you laugh too much? Behave well. My mom says it's not good to laugh too much. Once, my grandmother also said the same thing."*

Another participant says, *"Yeah, I was more limited. In many places, I couldn't show myself very much because I was a girl."*

The Third Theme – The Therapeutic Considerations of Social Anxiety: This theme includes six components, as follows:

1. Applying ineffective coping strategies: Studies show that a key variable in the decision to seek help is the need perception (42-44). Many people who have health problems do not think that they need treatment because they believe the syndromes are temporary and not serious; moreover, they do not recognize their problem as a mental health problem and do not know that the right help is available. They believe that treatment does not aid them, and they are embarrassed to seek help and fear the label of the disease; in general, their perception of help is influenced by the social context and individuals' decision to respond to the syndromes (45). SAD sufferers generally choose ineffective coping strategies that do not have much effect on reducing their anxiety, and such actions are passive, temporary, and avoiding in nature and have not yet worked. The concepts stated by the participants are presented in Table 1.

One participant says: *"I just avoided it and didn't try to cure it. That I came here is the first step. In class, I didn't present as much as possible until I had to."*

Another participant says, *"I was self-suggesting that I didn't have any anxiety at all, and then when I was located in the situation, I could see that I really couldn't be relaxed, and I felt anxious. I told myself you had no problem but there seemed to be a problem."*

Another participant puts it: *"I told myself let's go and find the causes. First, I did some studies about anxiety and depression. Then, I found out that I had social anxiety. I read a book that explained the symptoms of social anxiety. I saw all symptoms were in line with my symptoms. I realized that, yes, I had social anxiety."*

Another participant says, *"Yes, I followed the psychology discussions about where the problems originate from and how they should be resolved."*

The other participant says, *"I didn't encounter such information by chance. I searched myself. For example, I did the tests at the University of Tehran's website and found out that yes, I have a problem. Or, if there is a psychology channel, I will join in to see what recommendations they suggest regarding my problem."*

Another participant says: *"It is always said that you should encounter yourself with the situation, but I can't handle the situation when I encounter with and I can't. I am always busy with the books and reading a lot of social anxiety books. But when it comes to action, I can't. This is out of my hands. I'm so scared that I think I have made no progress."*

2. Biased attitude and ineffective experience towards counseling and specialized help: In

mental health care, a positive relationship between patients and practitioners is of great value (45). Like other contexts of human interactions, patients and practitioners, in the process of receiving and providing mental health care, produce, reproduce, and transmit culture (28). In other words, the therapeutic knowledge is also cultural and the mental health care can be seen as a cultural product (47). The concepts stated by the participants about their relationship with the process of counseling and specialized help are presented in Table 1.

One participant says, *"There is a special view towards consultants there, and if you go for a consultation, they say s/he has gone for a consultation and they stick a label to that person. I'm sure if I were in my own village, I would never be able to come to counseling center, or because of the financial problems, I could not use counseling."*

Another participant says*: "When I was a teacher at school, I tried to talk to counselors a lot, but unfortunately I found out that they were not that much knowledgeable and expert. Some of them had just the titles of counselors. Then, during teacher training program at the university, I tried to talk to the person who was the professor of counseling and had M.A. in this field, and then I understood that he wasn't very proficient."*

3. Ineffective family encounter with treatment: According to many studies, the Iranian culture is a collectivist culture (48). Interpersonal cohesion and interdependence are highly valued and promoted in this type of culture. In the collectivist societies, the family follows the same principles of collectivism, and the cohesion between family members and supporting them is of high value.

In such societies, the family presents itself as an excellent source of care for mental illness (49). Given the important and influential role of the family, the participants did not receive the family support to deal with their anxiety. This has been occurred because of some obstacles, such as the financial and economic problems, the internal family conflicts, and lack of understanding among family members. Given the existing obstacles, it seems that the family does not play an effective supportive role in resolving the individual's anxiety problem. The concepts stated by the participants are presented in Table 1.

One participant says, *"Some people consider it very bad as well as the people in the place where I live, if I say I'm going to a counselor, they say I have a mental problem and think badly of it."*

Another participant says: *"My brother gets angry fast; this has a huge impact on me and he brings tension into the family. We also have a financial problem and my parents are suffering from it and I am saddened by their suffering again. My other siblings are not like that, but I am. I become unhappy by their sadness and I cannot see their sadness."*

Another participant says: *"One thing is that my mom and dad think very differently. My mom says you need to talk to a psychologist to solve your problem."*

4. Ineffective individual encounter with treatment: Many people with SAD, before entering a social event, often experience a period of antecedent anxiety during which they are reminded of past negative experiences, and the expectations of failure and the images of poor performance are called for, which can lead to complete avoidance of the situation or entry into a state of self-focus and a diminished capacity to pay attention to others' positive reactions (40).

This avoidance is also observed in seeking help and receiving treatment. The concepts stated by the participants are presented in Table 1.

One participant says, *"The first time I wanted to come here I was scared that my friends would see me. I came late. I wanted to come in the sixth semester and I didn't come until the eighth semester. The first sessions that I was coming one of my friends came, and I was upset that he was coming and seeing me."*

Another participant says: *"Regarding my problem, one belief that did not let me be treated is that I am not optimistic about the treatment. I feel I'm an introvert and I try very hard; I can cure it 10% and then that's it."*

5. The influence of religious and spiritual resources: Paying attention to a patient's relationship to the spirituality, religion, and moral traditions is important to assess mental health.

This relationship often encompasses the meaning and purpose of life and can be an essential component of one's personal identity. Religion can play an important role in the transmission of cultural values, social behavior, and even meaning in the stages of

psychological development. The concepts stated by the participants are presented in Table 1.

One participant says: *"It's soothing because I always think I have a supporter."*

Another participant says, *"It has been very effective, like this prayer, 'O Lord, open my chest', that I say before speaking. This prayer helps very well and it's soothing."*

A participant says about the status of religious practices and behavior in his life: *"It has a high status in my life and I have really gotten the result."*

Another participant says*: "It is more likely that I read a verse, such as Ayatolkorsi, or I do a vow. I accept these more."*

Regarding the role of religion and spirituality in daily life, another participant says, *"It gives me peace and a sense of satisfaction."*

Another participant says, *"In the case of anxiety, what helped me was my connection with God. My religious beliefs helped me."*

Another participant says, *"No, it didn't help me. I grew up with the belief that everything is done with the trust in God and you should vow. When I was at high school, I vowed for three days that I would no longer have stress on the board. No changes were made to me."*

7. Acceptance and proper relationship with counselor and therapist: Humanitarianism in medicine is characterized by the establishment of a consensual and respectful relationship between physicians and patients (50). Without a trusting relationship, the patient will not be open and honest about his or her thoughts, feelings, and behaviors, and the accuracy of psychiatric diagnosis will be reduced. In addition, patients may not follow therapist's recommendations, change their behavior, adhere to the therapy, and engage in psychotherapy (28). Regarding the relationship with the therapist and counselor, the participants of the current study had a positive and pleasant feeling, and they accepted the relationship. Even though they previously had unpleasant counseling experiences, they reported feeling safe and comfortable with the counselor in the current situation. The concepts stated by the participants are presented in Table 1.

A participant says, *"I don't have any problem with this issue. From the first semester that I entered the university as an M.A. student I wanted to come for counseling. The pressure of the lessons and maybe a little avoidance did not let me come, but now in the sixth semester I came."*

Another participant says, *"No, I wasn't worried and I could say my words well."*

Table 1. Extracted concepts, components and themes

CFI Axis and question	Extracted concept	Extracted category (Subcategory)	Theme (Class)
Axis 1 Cultural definition of the problem (Explanatory model: general understanding of the problem) related questions (1,2,3)	The experience of anxiety in familiar and family gatherings and parties The experience of anxiety in friends' gatherings The experience of anxiety in front of strangers The experience of anxiety in front of the opposite sex The experience of anxiety in front of colleagues The experience of anxiety in front of professors The experience of anxiety in large crowds The experience of anxiety in new environments The experience of anxiety in critical situations The experience of anxiety in all social situations	Emotional feature (Situational and generalized)	The experience of social anxiety
Axis 1 The cultural definition of the problem (Explanatory model: general understanding of the problem) related questions (1,2,3)	Mental occupation after shaming experience Worry before entering an anxiety situation Mental occupation with avoidance behaviors Sensitivity to the behavior and speech of others Mental occupation with changing the way others think about oneself Worry about destroying family's reputation because of anxiety Worry about transforming anxiety into one's constant attribute Mental occupation with shame and embarrassment in the presence of others Worry about the appearance of physical symptoms of anxiety	Cognitive feature (Mental occupations and worries)	

	Mental occupation with the manner of speaking and dialect Worry about others' negative response Concern over proposing discussion and conversation Worry about the mind being emptied and forgetfulness Worry about teaching Worry about job interview Worry about improvement and sudden socialization		
Axis 1 The cultural definition of the problem (Explanatory model: general understanding of the problem) related questions (1,2,3)	Avoiding class presentation before university and in university Not asking questions in groups and gatherings Not answering class questions despite knowing the answer Postponing the courses with presentations to the last semester Avoiding the real world and turning to the virtual world Avoiding voluntary and unpredictable activities Avoiding phone calls Avoiding participating in student or non-student groups or organizations Avoiding being exposed to others Taking excessive care of behaving abnormally and wrongly Taking excessive care of expressing abnormal and mistaken speech Not starting talking in familiar and unfamiliar gatherings Being silent in gatherings and parties Not expressing one's opinion because of not disturbing the other side	Behavioral feature (Avoidance and inhibition)	
Axis 1 The cultural definition of the problem (Explanatory model: general understanding of the problem) related questions (1,2,3)	The shivering of hands, feet, and body The shake of the sound Tick The redness of face and ears and hands and feet Feeling hot and hot flashes The increase of heart rate The shortness of breath Blurred vision Explaining the physical symptoms of anxiety to family	Anxiety somatization	
Axis 1 The cultural definition of the problem (Explanatory model: general understanding of the problem) related questions (1,2,3)	Lack of communication skills from childhood and adolescence Limited communication and interactions in childhood and adolescence Lack of anxiety and emotion control skills Having no friends or having limited friends since childhood Difficulty in making friends Lack of self-expression at school The existence of shyness behavior in childhood and adolescence Isolation and seclusion in childhood and adolescence Interest in being alone from childhood Having passive behaviors from childhood	Interaction and communication failure	
Axis 1 The cultural definition of the problem (Explanatory model: general understanding of the problem) related questions (1,2,3)	Job performance decline Quitting the job Academic performance decline Bad performance in the interview	Functional reduction (Academic, career and financial)	
Axis 2 The cultural perceptions of cause, context, and support (Explanatory model, Social networking, older adults) related questions (4,5)	The influence of family upbringing on anxiety formation and creation Having perfectionist beliefs Lack of self-confidence Caring about the opinions, judgments, and evaluations of others The existence of physical abnormalities Continuous behavioral and speech inhibition Inheritance and genetics factors Delay in entering the community	The causes of anxiety	The cultural manifestation of social anxiety

Axis 2 The cultural perceptions of cause, context, and support (Explanatory model, Social networking, older adults) related questions (4,5)	The notion of being impolite in case of one's expressing his views The negative impressions of self-expression in front of parents and elders Self-sacrifice to prevent the discomfort and judgment of others The social perception of being reticent and lacking self-assertiveness as being patient Being a good student means having no anxiety The unpleasantness of one's lack of ability to speak in public or in a group The desirability of the feature of shyness The positive attitude of family members towards being quiet	The perceived social desirability of lack of self-assertiveness and being quiet	
Axis 2 The cultural perceptions of cause, context, and support (Explanatory model, Social networking, older adults) related questions (4,5)	The perception of religion as the more presence of women at home The religious belief that boys should not talk to girls The religious belief that women should stay more at home One's perception of a religious person as a person who is quiet	The perceived religious desirability of behavioral and speech constraint	
Axis 2 The cultural perceptions of cause, context, and support (Explanatory model, Social networking, older adults) related questions (5,6)	Lack of parents' awareness of one's anxiety Lack of spouse's awareness of one's anxiety Non-acceptance of one's anxiety by family Family distress from one's anxiety Family's complain about the way of one's talking in gatherings The awareness of parents and spouse of one's anxiety	Lack of understanding and support from family	
Axis 2 The cultural perceptions of cause, context, and support (Explanatory model, Social networking, older adults) related questions (5,6)	Not expressing anxiety problem to family and friends Pretending to have no anxiety in the presence of the family stand on ceremony with family members Misunderstanding of one's anxiety by those around the one Not being treated warmly by the people around due to the one's anxiety Being ridiculed by relatives The reaction of those around in the form of compassion The reduction of family communication and interactions Expressing the anxiety problem to friends	Lack of understanding and support from relatives and friends	
Axis 2 The cultural perceptions of cause, context, and support (The role of cultural identity) related questions (8,9,10)	The existence of limitation in society and in the family for the self-expression and presence of girls More anxiety of girls due to more expectation of the community and family of them The existence of more anxiety in girls than boys Lack of gender effects on anxiety		
Axis 3 Cultural factors affecting self-coping and past help seeking related questions (11,12)	Searching the internet and reading articles or watching a clip Visiting websites and completing various questionnaires Listening to the radio and watching TV Studying to find the coping strategy Saying positive motivational words to oneself Setting an appointment for counseling and postponing it repeatedly Attending an oratory class Avoiding counseling because of destroying one's reputation due to the one's lack of ability to communicate and being exposed to be seen The selection of counseling major in M.A. The use of medication to overcome anxiety The use of traditional and herbal medicines The use of energy therapy Doing physical exercises (deep breathing) Pre-planning for everything Fail to gradually encounter	Applying ineffective coping strategies	Therapeutic considerations of social anxiety

	Offering solutions by people around (parents and friends) Making friends with all students to overcome anxiety Rehearsing many times for presentation and dealing with anxiety Avoiding situations Putting oneself against the act done Not receiving help from a specific person so far Not dealing with anxiety so far because of considering it as something natural Not taking any specific action to combat anxiety so far Not searching the internet and reading an article or watching a clip		
Axis 4 Cultural factors affecting current help seeking (social network, caregivers, older adults) related questions (14,15)	Lack of support, coordination, and serious companionship of parents, spouse, family, and friends Lack of the family awareness of effective treatments Inappropriate quality of one's relationship with parent or spouse Spouse unemployment and financial problems Disagreement with parents and lack of sympathy and consultation The existence of conflict between parents The rejection of counseling by relatives and ridiculing it The existence of bias and negative attitudes towards counseling in the place of living	Ineffective encounter of family and friends with treatment	
Axis 4 Cultural factors affecting current help seeking (social networking, caregivers, older adults, clinician - patient relationship) related questions (14,15, 16)	Fear of attending for counseling Worry about being seen by friends during counseling The experience of ineffective consulting and the inefficiency of consultants An individual effort to solve the problem Not expecting help from another person Positive look and the acceptance of consulting from clients	Ineffective encounter of individuals with treatment	
Axis 4 Cultural factors affecting current help seeking (religion and spirituality) related questions (14,15)	Belief in the effect of religion and religious and spiritual resources on reducing anxiety Using religious and spiritual resources to reduce anxiety (religious practices and behaviors, reading the Quran and prayers) Using the help of religious advisers and clergies to overcome anxiety Using religious books and lectures believing in the effect of religion and religious and spiritual resources on reducing anxiety Not using religious resources to deal with anxiety	The influence of religious and spiritual resources	
Axis 4 Cultural factors affecting current help seeking (clinician - patient relationship) related question (16)	Not having worry about being in touch with the counselor and the physician and being comfortable with them The positive opinion of the client towards counseling sessions The positive opinion of the client towards the effectiveness of counseling and treatment The client's good communication with and acceptance of specialized help and counseling The acceptance of counseling by the client himself as opposed to the opinions of people around him	The acceptance and having appropriate communication with counselor and therapist	

Discussion

The present study, aiming at understanding the experience of clients with SAD, is the first conducted study in Iran, using the cultural aspects of DSM-5 cultural formulation interview. This tool was designed to facilitate identifying the effects of culture on illness and care period (27) and includes four axes: (1) cultural definition of the problem, (2) cultural perceptions of cause, context, and support; (3) cultural factors affecting self-coping and past help seeking; and (4) cultural factors affecting current help seeking. The findings of this study presented in the form of one hundred and fifty concepts, seventeen components, and three theme. These categories were: (a) the experience of social anxiety; (b) the cultural manifestation of social anxiety; and (iii) therapeutic considerations of social anxiety. In the first category (the experience of social anxiety), the five components extracted are: emotional feature (situational and

generalized), cognitive feature (mental occupations and worries), behavioral feature (avoidance and inhibition), anxiety somatization, interaction and communication deficit, and function reduction (academic, career, and financial). Considering the concepts and components identified in the first category, no significant difference observed between the pattern of social anxiety experience among the participants in the present study and the common models explaining social anxiety in other cultures, especially the Western culture. The syndromes reported by the participants in this study are similar to the SAD criteria in the DSM-5; however, they are not consistent with the culture-dependent type of SAD reported in the East Asian countries as Taijin Kyofusho. It is important to note that in countries where interpersonal dependency is of high cultural value, such as in East Asian countries versus the countries where individual independence is highly valued, such as Western countries, the SAD syndromes are closer to the Taijin Kyofusho type. However, these syndromes were not observed in the Iranian culture, and this occurred despite the dominant collectivism in this culture. Given that SAD should be defined in relation to a particular reference group, certain social behavior can be perceived quite differently within certain socio-cultural subgroups (1). In spite of the similarity between the observed pattern of anxiety experience and the pattern prevalent in the Western cultures, the content differences are observed in the participants' repetitive beliefs such as the concern about destroying family's reputation that, in the Iranian culture, the preservation of family status and its social value is of particular importance. Also, having a mental preoccupation with how to speak and having a specific local accent in the presence of non-native people has caused the participants' mental occupation. Another concern that has been addressed in SAD explanatory patterns but is particularly relevant to the Iranian culture is the importance of others' thoughts and opinions about the individual. This concern was specifically reported by the participants. Another point to note is that all participants reported physical symptoms of anxiety, and these symptoms were an important part of their annoying and unpleasant anxiety experience, and focus on themselves and these symptoms were common. Focusing on symptoms and somatization of anxiety, as other studies have shown, indicate a tendency among the non-Western or Eastern countries, including Iran, to somaticize anxiety and distress with respect to the cultural beliefs or receiving more attention (26,51,52). The physical manifestations of anxiety are common symptoms of anxiety in all cultures, but this distinction and saliency in the Iranian culture appear to be due to not accepting the cognitive and behavioral symptoms of anxiety in the cultural context and one's effort to achieve a secondary benefit such as more support and acceptance from one's people around and social network.

In the second theme (the cultural feature of social anxiety), the six category extracted are: (a) The causes of anxiety; (b) The perceived social desirability of lack of self-assertiveness; (c) The perceived religious desirability of behavioral and speech constraint; (d) lack of understanding and receiving support from family; (e) lack of understanding and receiving support from relatives and friends; and (f) the impact of gender (being a girl) on the formation and continuation of anxiety.

One of the most important normative beliefs in the formation and continuation of SAD is people's perception of social desirability of lack of self-expression in front of people and in different situations and that, behavioral and speech inhibition is considered as a manifestation of politeness and respect. Moreover, reticence and shyness are considered desirable and have value. This belief that has emerged and appeared in the different cultural and social layers can, at the individual and group level, create some expectations for the individual and groups of their members and shape their behavior. Whether or not this belief is true or false, the participants have emphasized its effect on their behavioral inhibition.

Another normative belief is the perceived religious desirability of behavioral and speech constraint. The perception of the participants is that women should limit and minimize the level of their interactions, both in person and verbally with others, especially with men. There is also the perception that a religious person should be reticent and should not have much conversation with others. This belief stems from the religious beliefs of individuals, and given the high level of religiosity in the

Iranian society, it has a profound effect on the behavioral regulation of the believers.

One's social network plays an important role in the onset and continuation of one's anxiety and can have a considerable influence on facilitating or inhibiting the disease and treatment process. The participants of this study lack the perception of support from family, friends, and people around so that most of them did not report their social anxiety to their family members including parents, spouse, and siblings, and they stated that there was no need to inform them. In some cases, the family reaction not only has not been supportive, but has had a negative impact, and the individual prefers not to inform them. Similarly, this pattern of behavior was also perceived by the participants from the relatives and friends. Due to the reasons such as the family's mockery, misunderstanding of those around, the compassion of people around, or having rudarbayesti (a kind of behavioral and speech inhibition due to some important considerations for the individual and society) against them, the participants pretended to have no anxiety, preferred not to talk about it to them, or reduced the level of their interaction with them.

Another component that the female participants referred to and perceived is the impact of gender (being female) on the formation and continuation of anxiety. This stems from the parents' beliefs in their parenting process and their parenting style, and the specific reaction and interaction they have with their daughters. According to this belief, it is necessary to impose some restrictions on social interactions with girls. This attitude applies to the different parts of society directly and indirectly and affects girls' social behavior and their possible inhibition.

In explaining the cause of social anxiety, apart from the existing theoretical models used and conceptualized by therapists as the therapeutic protocols, the CFI seeks to identify the terminology and expressions of patients, their family, and their relatives about the causes of the problem and the process of its formation with the aim of illuminating and culturally understanding the disease and the meanings exchanged within the social group (28). Some of the reasons stated by the participants are consistent with the causal explanations of existing theoretical models of social anxiety, including individual factors such as perfectionist thoughts and lack of self-confidence, family factors such as family upbringing, social factors such as unpleasant social experiences, as well as the impact of inheritance and physical abnormalities noted by the participants. However, other influencing factors mentioned by the participants are the common normative beliefs within the Iranian culture, which are culturally dependent and specific to the Iranian culture, and they were mentioned earlier. In general, in order to explain the causal pattern of social anxiety, while adhering to the evidence-based theoretical models, it is necessary to pay attention to the common normative beliefs influencing the cultural layers of the Iranian society.

In the third theme (the therapeutic considerations of social anxiety), the five extracted categories' are: (a) applying ineffective coping strategies, (b) ineffective encounter of family and friends with treatment, (c) ineffective individual encounter with treatment, (d) the influence of religious and spiritual resources, and (e) acceptance and proper communication with the counselor and therapist. The CFI considers the history of seeking help extensively to identify the aids and interventions within and outside health systems as well as the potential barriers to assess how effective these actions have been. This information helps the clinician to develop a treatment plan according to the patient's condition (28). As stated earlier, many people do not recognize their problem as a mental health problem and do not know that appropriate help is available; they believe that treatment does not help them and are ashamed to seek help. Moreover, they are afraid of the disease label. Overall, their perception of help is influenced by the social context and the decision of the individual to respond to the syndromes (45). The participants of this study had applied a wide range of coping methods and actions over the different periods of time that had not been helpful to their own acknowledgment. Ultimately, given to the distress and discomfort caused by the progressive anxiety, they decided to go to the official health sources such as the counseling centers. Some of the employed methods of encounter are passive in nature, such as searching in the internet, watching video clips and TV shows, reading books and articles, repeating motivational words, planning ahead

for all tasks, and so on. Some other methods have ineffective therapeutic nature, such as energy therapy, traditional and herbal medicine use, arbitrary use of medication, repeated postponement of consultation time, the implementation of strategies provided by those around them, and unsuccessful encounter. Finally, some participants did not take any actions. Given the variety of actions and strategies employed by the participants, that have generally been ineffective, there is a tendency to seek out informal therapists, and this is influenced by the cultural context of the Iranian society, and some Asian countries have also reported this tendency (52).

Examining the problems and barriers to treatment is one of the goals of the CFI and it intends to address patients' concerns and ultimately to try to resolve them (28). One of the barriers and problems reported by the participants is the lack of support from the family and the individual around them in the process of effective with the anxiety problem. This lack of understanding and support caused the participants not to make family and those around aware of the problem and to act individually to address the problem, or to expect no help from them.

Furthermore, the participants found the family and parent's conflict, the disagreement with parents, the poor quality of within family relationships, the economic problems and negative attitudes toward prior counseling, the rejection, bias, and negative attitudes of those around toward counseling, as other barriers to receiving help . It should be noted that, in spite of the perceived obstacles and difficulties in receiving treatment, most participants were positive about receiving the specialized services such as counseling and psychotherapy, group therapy, and drug therapy.

There is a growing interest in examining the effects of religion and spirituality on mental and physical health in the research background.

Accordingly, many studies suggest that religious practices and behavior are associated with better physical and mental health, and that being religious or spiritual is recognized as an important protective factor (53). Most of the participants in this study stated that religion and spirituality play an important role in their lives; however, there have been some controversies regarding the use of this capacity to cope with their anxiety. Some participants used religious sources such as holy words (azkar), prayers, and reading the Qur'an to reduce their anxiety; additionally, in some cases, they asked the religious counselors and clergies to help them and suggest them some coping strategies to overcome their anxiety. In contrast, the other group did not believe in the influence of religion and did not use it.

The findings of this study indicate the similarities and differences between the model of SAD in the Iranian culture and those of other cultures. In the experience of social anxiety, there was no significant difference between this model and the common theoretical models; nonetheless, the important point was the existence of the differences in the content of common beliefs and the somatization of anxiety among the participants. In the particular cultural manifestations of social anxiety, we can refer to some beliefs.

A fundamental and influential belief in the formation and continuation of social anxiety is the belief in the desirability of lack of self-assertiveness and behavioral and speech inhibition, both socially and religiously. This belief was widespread among the participants and played a significant role in regulating their behavior. Another belief which was expressed indirectly was the necessity to limit the social interactions of girls. The perception of this belief was evident from the female participants. The participants also perceived that they would not receive any support from the social networks such as family, friend, people around, and relatives. These beliefs and perceptions, along with the causal factors raised by the theoretical models, are involved in understanding and explaining the causal factors influencing the creation and formation of social anxiety.

Concerning the coping strategies and treatment, the participants have employed a variety of ineffective and passive coping strategies, and a tendency to informal treatment and even a tendency to refrain from any treatment in the patients with social anxiety could be observed due to their avoidance tendencies.

The participants had a positive view towards receiving the specialized help from the health care providers, but they reported the perceived lack of support and cooperation from the family and relatives, as well as the biased and

negative attitudes toward receiving specialized help from them. Concerning the use of religious and spiritual resources to cope with the anxiety, the participants' encountered it in the two different ways: the religious group used the religious and spiritual strategies and reported moderate effectiveness for them, and the group that did not believe in these strategies did not use them.

Conclusion

Despite the similarity of the participants' social anxiety experiences with the theoretical models as well as the consistency of the syndromes with the DSM-5 criteria, the content differences were observed in the form of normative beliefs, supportive resources, coping strategies, and encounter with the therapeutic resources.

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