Introduction to the Special Issue: Anxiety Disorders in Cross-Cultural Perspective

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This special issue explores the cross-cultural variation in the presentation and generation of anxiety disorders. As a background review, in this Introduction, we illustrate how the cognitive theory of the generation of anxiety disorders explains how such cross-cultural variation occurs. We first show how the “catastrophic cognitions” theory applies to panic disorder and then suggest how the “catastrophic cognitions” theory applies to all anxiety disorders—and so explains the existence of profound cultural influence on the presentation and generation of the anxiety disorders.

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Do anxiety disorders vary across cultures? If so, why, and in what ways? Cognitive theories of the generation of anxiety disorders would suggest that “culture”—here meant in the sense of local ideas about psychology, physiology, and types of illnesses—will profoundly influence the presentation and generation of anxiety disorders. As a theoretical introduction to the special issue, we will illustrate how the cognitive theory of panic applies to panic disorder and how the “catastrophic cognitions” theory would indicate that there should be profound cross-cultural variation in all the anxiety disorders. We conclude with a brief summary of the articles in the current special issue.

According to the cognitive theory of panic disorder, catastrophic cognitions about somatic and psychological symptoms play a key role in the generation of the disorder [1,2]: they produce panic attacks. The initial somatic or psychological symptoms about which the person catastrophically cognizes may be triggered in many ways: by an emotion, such as anger, excitement, or anxiety (the emotion may give rise to arousal-type somatic symptoms and arousal-type psychological symptoms [e.g., racing thoughts and a sense of imminent loss of control]); by standing up from the sitting position (dizziness); by

exercise (breathlessness or palpitations); by drinking coffee (palpitations); by temperature and humidity changes (excessive heat and shortness of breath); and by hyperventilation (blurry vision, chest tightness, hand numbness, and derealization). Once the symptom occurs, the person catastrophically cognizes about it and this leads to a surge of fear; that surge of fear worsens the very feared symptom, leading to an escalating spiral of panic.

According to the catastrophic cognitions theory of panic disorder, the catastrophic cognitions that give rise to panic will vary depending on local ideas about the psychological and physiological significance of arousal symptoms, such as the illness syndromes that the arousal symptoms are feared to indicate (for a review, see Ref. [2]). Such cross-cultural variation in catastrophic cognitions has been amply demonstrated [2], and has important theoretical implications with respect to the generation, phenomenology, and treatment of patients in other cultural contexts:

- Panic disorder patients in different cultures may vary in the degree of fear of certain anxiety symptoms (of dizziness, shortness of breath, tinnitus, palpitations, and so on), owing to difference in the

conceptualization of how those symptoms are generated, of the dangerousness of the symptom-producing physiology, and of the dangerousness of the “cultural syndromes” the symptoms are thought to indicate. Consequently, certain cultures may have greater fear of anxiety symptoms and hence higher rates of panic disorder.

- Even if panic disorder patients from different cultures have the same degree of fear about a certain somatic symptom, for example, dizziness, the reason for fearing that symptom may greatly vary, depending on the physiology and cultural syndromes the symptom is attributed to. For instance, dizziness may cause a Westerner to fear stroke and a Cambodian refugee to fear a surge of a wind-like substance called *khyâl* into the cranium. Such knowledge is vital, as it facilitates the modification of catastrophic cognitions to enhance the treatment of individuals from other cultural contexts.

This same type of cognitive argument can be made for all the anxiety disorders. For each of the disorders, there will be a culturally specific manner of interpreting its symptoms (such as the symptoms indicated in the disorder’s diagnostic criteria) and that interpretation will determine the physiological processes and syndromes that these symptoms are attributed to and the perceived dangerousness of those symptoms. The person will hypervigantly survey the body for the presence of symptoms that his or her culture indicates to be produced by a dangerous disturbance of physiology or by a dangerous illness syndrome; if the symptom is perceived, the person will have great fear, with that very fear inducing and worsening anxiety-type symptoms—including the symptom that was first observed and caused fear. In this way, a vicious circle ensues so that the cultural interpretation of the symptom worsens and shapes the anxiety disorder.

Moreover, if some symptoms of a DSM (Diagnostic and Statistical Manual of Mental Disorders) diagnostic disorder are attributed to a certain cultural syndrome or cultural specific ethnophysiology (ethnophysiology meaning the physiology of the body as conceived by that group), this will profoundly influence the understanding of a disorder, the experience of it, and treatment seeking: among Puerto Rican patients, anxiety symptoms such as trembling may be attributed not to a “panic attack” but rather to an “*ataque de nervios*,” a syndrome thought to possibly result in a loss of control, particularly throwing things and other acting-out behaviors, and even in insanity. Among Cambodian patients, posttraumatic stress disorder (PTSD) symptoms such as hypervigilance and start-

le may be attributed to a “weak heart” and the cause of this heart weakness may be thought to be poor sleep and appetite. “Weak heart” concerns will lead to great fears of cardiac arrest and to the person seeking ways to redress the dangerous cardiac weakness—for example, strengthening the body (to strengthen the heart) by taking medicinal tonics that improve appetite and sleep. A psychiatrist treating this Cambodian patient would ideally emphasize the ability of medications to improve sleep and appetite.

Many of the articles in this collection show cross-cultural variation in the anxiety disorders and several specifically discuss cognitive theories for this variation. Some of the articles examine the symptoms of panic disorder and obsessive compulsive disorder to see whether they vary across cultures and others investigate certain symptoms that are much more prominent in anxiety disorders in other cultural contexts: orthostatic panic among Cambodian refugees and sleep paralysis in African-American populations. One of the studies investigates what is the most important cultural syndrome associated with anxiety disorders in Caribbean-Latino patients, namely, *ataque de nervios*. Another study investigates a fear that is unique to certain cultural contexts, but that impacts on anxiety disorder severity, namely, fears of cultural extinction (common among many groups, e.g., Holocaust survivors, American-Indian groups, and almost all refugee groups), and explores the interrelationship of this variable to PTSD, depression, life stress, and trauma. One article in this collection gives a biological rather than a psychological explanation for cross-cultural differences in the anxiety disorders: it reviews potential genetic differences across ethnic groups that may influence anxiety presentations and how those anxiety presentations respond to pharmacological treatment. And one article examines gender and anxiety disorders in cross-cultural perspective. We hope that this volume provides some indication of the richness of the cross-cultural perspective in understanding the breadth of manifestations of anxiety across people from different backgrounds and experience.

Conflict of Interest

Mark Pollack has been on advisory boards and has done consultation for AstraZeneca, Brain Cells Inc, Bristol Myers Squibb, Cephalon, Dov Pharmaceuticals, Forest Laboratories, GlaxoSmithKline, Janssen, Jazz Pharmaceuticals, Labopharm, Eli Lilly & Co, Medavante, Neurocrine, Neurogen, Novartis, Otsuka Pharmaceuticals, Pfizer, Predix, Roche, Laboratories, Sanofi, Sepracor,

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