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Factors that hinder and facilitate help-seeking behaviors in individuals with social anxiety

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Factors that Hinder and Facilitate Help-Seeking Behaviors in Individuals with Social Anxiety

BY

Hyland L. Smith

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Factors that hinder and facilitate help-seeking behaviors in individuals with social anxiety.

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Abstract

This project focused on the development of a semi-structured interview for use in the exploration of factors that hinder or facilitate help-seeking behaviors of individuals with social anxiety. By participating in a qualitative semi-structured interview 10 participants identified factors that facilitated seeking professional help and barriers that prevented seeking professional help. Participants were grouped into two groups based on five stages of behavioral change proposed by Prochaska et al. (1983; 1991; 1992; 1999). The two groups were compared on the number of self-reported facilitator and barrier statements they made as well as their self-reported number of severity statements made. Participants in the preparation/contemplation/maintenance group reported significantly more facilitators to help-seeking behaviors than participants in the precontemplation/contemplation group. No significant differences were found between the groups for barriers to help-seeking behaviors or reported severity of social anxiety. However, since reliability for the coding categories derived from the semi-structured interview was found to be generally poor, the conclusions are tentative.

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Introduction

When examining the likelihood that individuals with social anxiety will seek out professional help, research indicates that they often do not seek treatment (Pollard, Henderson, Frank, & Margolis, 1989; Magee, Eaton, Wittchen, McGonagle, & Kessler, 1996). This poses important questions. What are the reasons that individuals with social anxiety do or do not seek out professional help? Are there any overarching beliefs or factors due to social anxiety that facilitate seeking out professional help? Are there specific types of beliefs or factors due to social anxiety that act as barriers to keep them from utilizing professional help? Do these facilitators or barriers change as the individuals' lives progress?

These questions have not been asked in past research. Therefore this study has attempted to begin to develop a model for researching these issues. The main goal of this study was to develop a reliable method for qualitative research on the beliefs and experiences of individuals who deal with social anxiety. This study has also attempted to explore the beliefs and experiences of individuals with social anxiety to help future research develop new questions and hypotheses. In examining the reported facilitators and barriers to seeking out professional help, this study seeks to bring into focus interior beliefs and life experiences that may be common among individuals with social anxiety.

Literature Review

There has been very little research on the help seeking behaviors of individuals with social anxiety other than studies indicating that they do not typically seek treatment (Pollard, Henderson, Frank, & Margolis, 1989; Magee, Eaton, Wittchen, McGonagle, &

Kessler, 1996). Pollard et al. (1989) gathered data from 1000 subjects in the St. Louis, Missouri area. By randomly generating area phone numbers by use of a computer, they contacted their subjects. Of those subjects, 142 were found to have agoraphobia, social phobia, or obsessive compulsive disorder. Pollard and his colleagues then obtained demographic information on those 142 subjects. Pollard found that of the 142 subjects, 113 suffered from social phobia. Only 10 of those 113 (8%) had received treatment for the disorder. Based on Pollard et al.'s interviews, they also found that for those who went to seek help, their first contact was usually with a physician. A few others first contacted a member of clergy, while the fewest number contacted mental health professionals first. Pollard et al. (1989) attributed this lack of help-seeking behavior to a "disabled but not presently distressed" theory. They suggested that many individuals suffering from anxiety disorders may not feel a high level of distress along with their impairment. Since the individuals do not experience acute distress, they feel no need to seek help for the problem.

Magee et al. (1996) examined phobias through data collected by the National Comorbidity Survey (NCS). The NCS obtained information from 8098 randomly selected individuals. The NCS determined that 13.3% of the individuals tested had a lifetime incidence of social phobia. They examined the prevalence of a variety of anxiety disorders and the number of those with those disorders who sought out professional help for their problems. When examining help-seeking behavior, they noted that of the social phobics in the study, 33.5% had some perceived role impairment due to the disorder, but only 19% had sought help for this problem. This study's findings may support Pollard et

al.'s assertion that of the many individuals who suffer from some sort of social anxiety, not all of them feel distressed enough by symptoms to acknowledge role impairment or to seek out professional help. While these data are helpful, it may have been more helpful if there had been an attempt to examine any potential differences between those who seek out help and those who do not seek out help.

Several researchers have noted that a significant number of individuals with social anxiety do not seek treatment (Pollard, Henderson, Frank, & Margolis, 1989; Prochaska, 1991; Magee et al, 1996; Olfson, Guardino, Struening, Schneier, Hellman, & Klein, 2000). One study (Olfson et al., 2000) in particular studied barriers that individuals face when seeking treatment for social anxiety. This study used data from the 1996 National Anxiety Disorders Screening Day and compared individuals that endorsed social anxiety symptoms with those that did not report symptoms of social anxiety. Individuals from two of the screening sites were then brought back and given the Structured Clinical Interview for DSM-IV. Factors identified that possibly contribute to the lack of treatment-seeking behavior were not knowing where to go for help, belief that the individual could handle their symptoms on their own, economic considerations (e.g. lack of insurance or inability to afford services), fear of what others may say or think, and inadequate recognition of social phobia by health care providers (Olfson et al., 2000). One identified limitation of this study was that due to the nature of the National Anxiety Disorders Screening Day, individuals were self-selected into the study, making generalization of results to other populations difficult (Olfson et al., 2000). Secondly, due to the low number of individuals who were found in the sub-study to met DSM-IV

criteria for social anxiety, the researchers recognized that the endorsement of items from the screening instrument did not necessarily correlate with high likelihood of DSM-IV criteria social phobia (Olfson et al., 2000). The final limitation identified by researchers was the difficulty in studying social anxiety while limiting the effects or occurrence of comorbid depression or anxiety, making the researchers question whether it is possible to study social anxiety while controlling for other disorders which may in fact be a part of the social anxiety symptom cluster (Olfson et al., 2000).

As individuals seek treatment or help for illnesses and disorders, it is helpful for clinicians to select a model of behavior change to provide a context from which to work. In turn, when examining the factors that facilitate or hinder an individual from seeking treatment, a useful tool to use is a theoretical model of behavioral change. Prochaska and DiClemente (1983) created a stage model of individual behavioral change. This model was developed during research on addictions, specifically nicotine, but has been applied to the area of anxiety disorders (Prochaska,1991). This model states that all people are in one of five stages with regard to changing a target problem behavior. These stages are precontemplation, contemplation, preparation, action, and maintenance (Prochaska & DiClemente, 1983; Prochaska, 1991; Prochaska, DiClemente, & Norcross, 1992; Prochaska & Prochaska, 1999).

The first of these stages, the precontemplation stage, is when the individual denies that they have a problem. They obviously can not initiate change. The second stage is the contemplation stage, in which the individual thinks that they may have a problem they want to change but is not sure. Contemplators don't want to change. The third stage is

the preparation stage where an individual is preparing to take action soon, and has unsuccessfully tried to change their behaviors on their own in the past. The fourth stage of behavior change is the action stage in which they are attempting change by utilizing professional help but have only been doing so for a short period of time. The final stage is the maintenance stage in which they have achieved some level of change and are attempting to maintain the new level of functioning. These stages are not a linear progression but a more like a spiral in which the individual moves back and forth through the stages and thus may repeat previous stages if they fall back into their problem behaviors.

Prochaska, DiClemente, & Norcross (1992) also discussed the thought processes or actions that individuals often go through in the various stages. Precontemplators often think less about their problems and have fewer negative emotional responses or report less distress due to their problems. Contemplators often raise their consciousness about their problems and reevaluate their lives and situations. They tend to think more about their distress and their anxiety, and then ask themselves if they need to do something to help with their problems. Those in the preparation stage often continue the work begun in the contemplation stage as well as beginning to make some small changes through their own individual efforts. Prochaska et al.(1992) noted that individuals in the action stage often move away from individual effort and begin to rely on support from Ahelping relationships@ due to the increased level of stress seen with this stage (p. 1109). Individuals in the action stage often demonstrate higher levels of willpower and endorse an internal locus of control. In the maintenance stage individuals are likely to constantly

reevaluate their situation in order to prevent a relapse of the problem, as well as continuing the work of the action phase.

When examining social phobia within Prochaska's stage model, only one article was found that examined phobias in relation to the stage of behavior change model. This article was written by Prochaska (1991) and focused on tailoring the treatment of phobic individuals in relation to the stage of behavior change that the client was in. For example, an individual who has come in for treatment in the precontemplation stage may need more help understanding that they have a problem, while an individual in the preparation or action stage understands that there is a problem and would be ready to begin working on it right away. This area has received little attention by researchers.

In order to understand why individuals with social anxiety do not seek treatment, it may be helpful to apply this model of behavior change. Specifically, it is worth examining whether or not the factors that facilitate or hinder behavior change vary across the five stages of behavior change. According to the model presented by Prochaska and Diclemente (1983), the factors that an individual is aware of, and thus would report, will vary across the five stages of behavior change. By exploring this concept it can be determined whether or not the factors that facilitate or hinder help seeking behaviors are constant across the five stages or if the factors vary. According to the model clients in the earlier stages of behavior change would have motivating factors that are external, coming from loved ones or authority figures, and would present more barriers to treatment. Meanwhile individuals in later stages of behavior change would have motivating factors that are more internal, moving themselves forward based on a desire to change and would

possibly show a decrease in hindering factors. It may be helpful to compare early stage individuals with late stage individuals to see if this holds true.

Another study of help-seeking behaviors was conducted by Cameron, Leventhal, & Leventhal (1993). This study focused on the cognitive schemas and motivational factors for help-seeking behaviors by individuals with a variety of medical illnesses. This study found that one important precipitator of help-seeking behaviors was symptom representation (Cameron et al., 1993). The more symptoms the subject had the more likely they were to seek help. Also the more serious the subject believed the symptoms to be the more they would seek out help. However, Cameron & colleagues noted that Athe mere presence of a symptom was not sufficient to motivate a decision for primary care, the care seekers gave their symptoms significantly higher seriousness ratings (p. 177). This suggests that individuals who subjectively interpret their symptoms as a serious problem or as a major impairment are more likely to seek help than individuals who judge their symptoms as less serious. This data also found that help-seekers were more likely to be actively coping with their symptoms than those who did not seek help. Another important finding was that help-seekers often discuss their problems with other individuals before seeking help. This results in a form of "direct advice or social permission to seek care" (Cameron et al., 1993, p.177). This points toward a possible barrier to treatment. Individuals may be less likely to seek help until a trusted individual (i.e. friend, family member, trained professional) gives the individual permission to do so.

When examining potential facilitating factors, very little research was found. Magee et al. noted that individuals who have comorbid psychological issues along with

their social anxiety, particularly agoraphobia, are more likely to seek out help than those with no comorbid symptoms (1996). They speculate that this may be due to the later onset of agoraphobic symptoms, which make it more likely that an individual will recognize it as a mental health issue (Magee et al., 1996).

In their study on the help-seeking behaviors of individuals seeking general medical help, Cameron, Leventhal, & Leventhal (1993) noted that "the seriousness *of the problem* [italics added] judged for the time of calling was the single most significant predictor" of help-seeking behavior (p.177). Other factors identified by Cameron et al.(1993) included duration of the problem and active coping behaviors. It was found that those actively coping with their problems were more likely to seek care, as were those who had suffered from the problem for a longer period of time (Cameron et al., 1993). It may be that the factors that they found to impact help-seeking behaviors with regard to physical symptomology may hold true for psychological symptomology.

By synthesizing some elements of both the Prochaska model and Cameron et al.'s (1993) work, we can get a glimpse of some possible factors that result in help-seeking behavior. First, Cameron et al (1993) found that help-seekers typically are "actively coping with their symptoms" (p. 177). This would place these help-seekers in the action phase of Prochaska's model due to the fact that they are actively seeking professional help. Also, Prochaska's model strongly supports the importance of social relationships in the help-seeking process. This relates to the concept of "social permission" discussed by Cameron et al. in which individuals are more reluctant to seek help until a trusted individual encourages them to do so(1993, p. 177). This reliance on social support

indicates placement in either the action stage or possibly the preparation stage of Prochaska's model. This suggests that individuals do not discuss their problems openly until they are already seeking help or on the verge of seeking it. This may be a part of the help-seeking process in which an individual asks trusted family or friends about their problems and the necessity for help, thereby allowing and encouraging the individual to seek out professional help more actively. Based on the information provided by Cameron et al (1993), it seems that the help-seekers in the study were all in the preparation or action stage of behavior change while those who did not seek help were in the precontemplation or possibly the contemplation stage.

The present study focuses on the help-seeking behaviors of individuals with social anxiety. First, by examining the types, if any, of help-seeking behaviors typically demonstrated by those with social anxiety, it may be possible to see what kinds of behaviors they use in order to elicit help from private (i.e. family, friends, minister, etc.) or professional (i.e. psychiatrists, psychologists, counselors, clinics, help-lines, etc.) sources. Second, this study hopes to shed some light on the perceptions individuals with social anxiety have of the severity of their problems during their decision to seek help. This study and similar studies may help us build treatment plans and outreach programs to help promote treatment with individuals with social anxiety.

This study will be qualitative in nature, focusing on obtaining a great deal of information from a few participants. This will allow an in-depth analysis of the help-seeking behaviors seen by individuals with social anxiety. The advantage to this method is that information is carefully obtained from the participants, and they are allowed to

expand upon information that they feel is relevant, unlike the standard questionnaire model of psychological research. While the more quantitative methods allow researchers to gather a large amount of data from a large number of participants, they are rigid and can overlook information that is not directly addressed in the questionnaires. This is one of the major weaknesses of previous studies on social anxiety and health-seeking behaviors. The previous studies discussed all used large numbers of participants with questionnaires or structured interviews (Pollard, Henderson, Frank, & Margolis, 1989; Prochaska, 1991; Magee et al, 1996; & Olfson, Guardino, Struening, Schneier, Hellman, & Klein, 2000). This study is also mostly exploratory in nature, due to the fact that very little previous research has been done in this area. Therefore one major goal of this study is to describe and identify factors that could be the focus of future research in this area. Another major goal of this study is to develop an interview and reliable coding procedures for that future research.

As this study is exploratory in nature one of the main purposes of this study is to develop a system to obtain reliable data about the ideas, attitudes, actions, and experiences of participants with social anxiety. Previously developed measures such as the Social Phobia and Anxiety Inventory (Turner, Beidel, Dancu, & Stanley, 1989), the Social Avoidance and Distress scale, and the Fear of Negative Evaluation scale (Watson & Friend, 1969) are useful tools in identifying individuals who may suffer from higher levels of social anxiety than most people. However, these instruments do not examine an individual's attitudes toward professional help or the actions that an individual has taken to help themselves deal with their social anxiety. They also do not examine the factors

which may facilitate or hinder an individual to seek out help for their social anxiety. In order to obtain more detailed, individual-specific information about their personal experiences with social anxiety and their thoughts and motivations regarding seeking out treatment, it is necessary to develop an interview and relevant scoring system for that interview.

Development of such a measure is, therefore, the main goal of this study. This semi-structured interview is intended to be robust and reliable, providing summaries of the participants' own words about their experiences. Based on research mentioned above, this interview will be designed to obtain information about an individual's own awareness of their problem, their personal perspective on the impact it has on their life, what measures they have taken to help themselves cope or learn to cope with their problem, what circumstances served as a barrier or acted as a facilitator to receiving said help in their life, and what they do to explain or understand the problem in their own thoughts or words. This detailed information can help us gain insight into a few individual's experiences and can be used to help stimulate future research questions and goals. This type of information cannot be adequately obtained from a quantitative measure; this necessitates the development of a semi-structured interview for the purpose of this study and studies like it.

Another goal of the current study is to examine three questions regarding social anxiety and help seeking behaviors. First, what factors facilitate or hinder individuals with social anxiety from seeking help? Second, are these factors different for individuals in various stages of behavior change? Third, do the individual's self-perceptions of the

severity of their problems differ between precontemplators and contemplators and preparers, action takers, and maintainers?

This study has four hypotheses. The first of these hypotheses is that anxiety about social interactions or fear of negative evaluation by an interviewer or health-care professional will be described as a hindering factor to treatment-seeking behaviors. This is supported by Olfson et al.'s (2000) research and makes logical sense due to the fact that anxiety about social interactions and a fear of negative evaluations are key diagnostic features of social phobia.

The second hypothesis is that peer, familial, or occupational support will be described as a major facilitative factor in seeking help. Support from family members, spouses, friends, employers, and other significant figures in a person's life may be a major facilitator in help seeking behaviors, especially considering the concept of social permission to seek out help discussed by above (Cameron et al., 1993).

The third hypothesis is that the number of self-identified facilitative and hindering factors for help seeking behaviors will differ between the early stages and later stages of behavior change. It is hypothesized that individuals who make more precontemplative and/or contemplative statements will have less facilitative and more hindering factors than those who make more statements that are categorized as referring to preparation, action, and/or maintenance stages of behavior change. Also it stands that the reverse would be true, those individuals who make more preparation, action, and/or maintenance statements will have more facilitative factors and fewer hindering factors than those who make more precontemplation and contemplation statements. This hypothesis is based on

the model developed by Prochaska and his colleagues (Prochaska and DiClemente, 1983; Prochaska, 1991; Prochaska, DiClemente, and Norcross, 1992; Prochaska and Prochaska, 1999).

The final hypothesis that this study will examine is that the participants' perceptions of the severity of their problems will differ depending on whether they are in earlier or later stages of behavior change. This hypothesis follows from the stage of behavior change model. This model suggests that precontemplators and contemplators are more unaware of or deny that they have any problem (Prochaska and Prochaska, 1999). Individuals in the other three stages of behavior change are more aware of the problem and are more willing to admit that it exists (Prochaska and Prochaska, 1999). This is supported by Cameron et al.'s finding that individuals subjective sense of the seriousness of their problem will act as a facilitator to seeking out professional help (1993). As individuals move through the stages of behavior change, they move toward treatment by professionals, thus those who are in later stages of change and are receiving professional help are more likely to rate their problems as more serious than those in the earlier stages of behavior change. According to this theory then, individuals with more precontemplative and contemplative statements should hold different perceptions of the severity (deny that anxiety is a problem) of their anxiety than individuals who make more preparation, action, or maintenance stage statements (acknowledge that their anxiety is a problem). These differences in perceptions may then directly influence the likelihood that a client will seek treatment for their anxiety.

Method

Participants

Two hundred ninety eight participants were screened during the first phase of the study using the Social Avoidance and Distress Scale (SAD) and the Fear of Negative Evaluation scale (FNE). Ten female undergraduate students from an introduction to psychology undergraduate research pool participated in the semi-structured interview developed for this study. Participants were 18 years of age or older. Participation was voluntary and all participants gave informed consent both at the screening phase and interview phase of the study. All subjects received class credit for participating and those who were interviewed received a ten dollar stipend for their assistance.

Materials

Six instruments were used in this study: the Fear of Negative Evaluation scale, the Social Avoidance and Distress scale, the Social Phobia and Anxiety Inventory, the Beck's Depression Inventory II, and the Michigan Alcohol Screening Test; and a semi-structured interview (see Appendix A). A coding manual for that interview (see Appendix B) and various training materials that were used to train coders (see Appendix C) were developed for this study.

The two measures used for initial screening were the Fear of Negative Evaluation (FNE) scale and the Social Avoidance and Distress (SAD) scale (Watson & Friend, 1969). The FNE and SAD scales are self-report measures with 30 and 28 items, respectively, to which the participant gives a true or false response. The FNE scale has been used to measure an individual's fear of negative evaluation by others in performance

situations (e.g., public speaking, interactions with superiors). Questions on the FNE include: "I am frequently afraid of other people noticing me shortcomings.", "If someone is evaluating me I tend to expect the worst.", and "I worry that others will not think I am worthwhile.". The SAD scale was developed in order to evaluate the amount of avoidance type behaviors that an individual engaged in (e.g., working alone, avoidance of social situations). Typical items on the SAD include: "I try to avoid talking to people unless I know them well.", "I would avoid walking up and joining a large group of people.", and "Being introduced to people makes me tense and nervous.". One month test-retest reliability was figured at .68 for the SAD and .78 for the FNE (Watson & Friend, 1969). Validity testing with the SAD demonstrated concurrent validity with the Manifest Anxiety scale (r = .54) and the Endler-Hunt S-R Inventory of Anxiousness (r = .45) while the FNE showed correlated with the above measures with scores of .60 and .47 respectively (Watson & Friend, 1969). Also it was found that individuals with high FNE scores were nervous in an evaluative situation while individuals with high SAD scores did indeed avoid social interactions and were nervous in interactions with other people (Watson & Friend, 1969). These two measures were used to screen subjects during the first phase of the study.

The participants selected to possibly participate in the interview portion of this study based on their SAD and FNE scores were given three additional inventories, the Social Phobia and Anxiety Inventory, and Beck's Depression Inventory II, and the Michigan Alcoholism Screening Test. The first measure used in during the interview portion was the Social Phobia and Anxiety Inventory (SPAI). The SPAI has been shown

to be a good measure of social phobia which can capture behaviors, cognitions, and physiological responses commonly associated with social phobia. Participants answer the items on a Likert scale ranging from 0 to 6 with 0 meaning "never" and 6 meaning "always". It has 45 items, of which 32 of them are used to measure social phobia while the remaining 13 are used to measure agoraphobia. While the social phobia scale attempts to capture relevant symptoms of social phobia, the agoraphobia scale helps to control for behaviors or thoughts that are similar to social phobia but are actually a result of agoraphobia. The difference of the scores on the two sets of items yields the instrument's final social phobia score. Difference scores of less than 34 indicate that social phobia is unlikely, scores of 34-59 indicate possible mild social phobia, scores of 60-79 indicate possible social phobia, while scores greater than 80 indicate probable social phobia. This larger inventory was developed by Turner, Beidel, Dancu, & Stanley (1989). Reliability figures for the SPAI show a two week test-retest score of .86 on the difference score and internal consistency scores of .96 for the social phobia subscale and .85 for the agoraphobia subscale (Turner, Biedel, & Dancu, 1996). Discriminant validity was demonstrated by comparing scores of socially anxious college students against a control of non-anxious students, with the anxious individuals scoring significantly higher (Turner, Biedel, & Dancu, 1996). Concurrent validity of the difference score with the Social Avoidance and Distress scale (r = .77), the Interactional Anxiety Scale (r = .75), the FQ Social Phobia Subscale (r = .64), and the Fear of Negative Evaluation scale (r = .54) was shown to indicate good to reasonable evidence of validity for the SPAI.

The Beck Depression Inventory II (BDI-II) is a 21 item inventory on which participants answer items on a 4 point Likert scale, with responses ranging from 0 - 3. Scores on the BDI-II can indicate possible faking health (0-4), no depression (5-9), possible mild to moderate depression (10- 18), possible moderate to severe depression (19-29), and possible severe depression (30-63). The BDI-II has demonstrated good test-retest reliability (r = .93) and strong coefficient alpha (.93) as well as convergent validity (r = .68 and r = .71) with the Beck Hopelessness Scale and the Revised Hamilton Psychiatric Rating Scale for Depression respectively (Arbisi, 2004; Farmer, 2004). It has been used in past research, and is often used by clinicians as a screening tool for depression (Cole, Grossman, Prillman, and Hunsaker, 2003; Dozois, Dobson, & Ahnberg, 1998; Steer & Clark, 1997).

The Michigan Alcoholism Screening Test (MAST) is a 24 item survey in which participants answer each item as true or false. Scores of 0 - 4 indicate no alcohol abuse, scores of 5 - 6 indicate possible alcohol abuse, while scores of 7 or greater indicate alcohol abuse. This measure has been shown to be reliable with internal consistency scores ranging from .83 to .95 and test-retest scores at one-day and 4.8 months of .97 and .84 respectively (Murdoch, 2004). Validity testing found that the MAST demonstrated reasonable concurrent validity, r = .83 and r = .31 to .46, with the General Alcoholism Factor of the Alcohol Use Inventory and the MacAndrew Alcoholism Scale respectively (Murdoch, 2004). It has been used in research in the past and has been proven to be useful in distinguishing those with diagnoses of alcoholism from those with out such a diagnosis (Ross, Gavin, & Skinner, 1990; Friedrich & Loftsgard, 1978).

Also, a semi-structured interview was used for this study. This interview elicited pertinent information on the factors that have facilitated or hindered help seeking behavior as well as obtained the subjects' perceptions of their anxiety and the causes of their anxiety. This interview focused on asking questions that relate to the reasons that subjects have or have not sought out treatment such as "Have you ever sought help for this problem?", "Where did you look for help from?", "In your opinion, what things helped you to seek help?", and "In your opinion, what things prevented you from seeking help or have led you to no seek help?". This interview also asked questions pertaining to the subjects' perceptions of their problems such as "How does this interfere with your life?", "How do you feel about what is happening at this time?", and "In your opinion, why do these things happen to you?". The main purpose of the interview was to gather information on the participants' personal experiences with and perceptions of their social anxiety. This interview was not a comprehensive mental health screening interview and was not developed in order to be used to diagnose social phobia in individuals. The complete interview can be found in Appendix A.

Procedure

Two hundred and ninety-eight participants were screened using the FNE and the SAD. Scores of 18 on the SAD and 23 on the FNE were set as the cut-off scores because those scores were one standard deviation above the mean on each respective measure, and the ten participants whose scores met or exceeded the cut-offs were contacted and an interview time of one hour was set up for each subject. Subjects were told that they had been selected randomly from all the participants who participated in the screening portion

of the study. Before the interview phase of the study each subject completed the SPAI, the BDI, and the MAST. Participants with a difference score of above 60 on the SPAI were included in the interview portion of the study, unless that participant obtained a score of more than 7 on the MAST indicating alcohol abuse or more than 30 on the BDI-II indicating severe depression. No participants met exclusion criteria. After completion of the interview, the subjects were paid ten dollars for their participation. After the interviews were completed they were transcribed for analysis. All the interviews were then coded according to the coding manual devised for use in this study (see Appendix B).

Coding

The categories coded for this study included barriers to help-seeking behavior, facilitators of help-seeking behavior, the participants' perceived severity of their social anxiety, and stage of change statements. Barriers to help-seeking behavior were defined as any thoughts, reasoning, actions, beliefs, events, etc. that prevented the participant from seeking help. Facilitators to help-seeking behaviors were defined as any thoughts, reasoning, actions, beliefs, feelings, events, etc. that encouraged the participant to seek out help. The perceived severity of the participants was defined as the participant's evaluation of the severity of their social anxiety or the level of impact it has on the participant's life. Stage of change statements were defined by stage. Precontemplation statements were defined as any statements indicating that the participant doesn't think anxiety is a problem and has not thought of seeking help. Contemplation statements were defined as any statements indicating that the participant thinks that their anxiety may be a

problem but is not thinking of seeking help. Preparation statements were defined as any statements indicating that the participant thinks that their anxiety is a problem and that they plan to seek professional help in the next 6 months. Action statements were defined as any statement indicating that the participant identifies anxiety as a problem and is currently seeking professional help for it. Maintenance statements were defined as any statements indicating that the participant used to identify anxiety as a problem, but is currently using coping strategies to help keep anxiety under control and reduce its impact on their life. The predictor variable, the category of stage of behavior change, was assessed by the percentage of stage of change statements in each category which were coded from the transcripts of the interviews. The predicted variables, facilitators, barriers, and severity of anxiety were coded from the transcripts of the interviews.

Reliability

All interviews were taped and transcribed for analysis. The author and another advanced graduate student familiar with the stage of change theory and help-seeking behaviors precoded the transcripts (precoding 1) independently in order to identify areas of the transcripts where the independent coder would be coding information (e.g. barriers to help-seeking, facilitators to help-seeking, stage of change, and severity statements). Precoding was done by setting up two columns with the transcripts on the right side. When a statement was made the appropriate precoding category for that statement was placed across from that statement. Table 1 contains the percent agreement for the precoding done by the researchers for barriers to help seeking, facilitators to help-seeking, stage of change statements, and severity statements. Inter-observer agreement on the

precoding 1 was 83%, 55%, 75%, and 74%, respectively. An unacceptable overall reliability rating (69%) was found (see Table 1). The two precoders (the author and the advanced graduate student) then compared their precoding of the transcripts and produced the accepted standard for precoding of the transcripts.

Due to the poor precoding agreement for facilitator statements and marginal, but adequate agreement for barriers, stage of change, and severity statements this author and the advanced graduate student developed additional training tools (Appendix C, D, E, F, G, H, & I). Another independent observer (an undergraduate psychology student) who was unaware of the purpose of the study was then trained to precode the transcripts for comparison against the transcripts that were jointly precoded by the researcher and the graduate student who were aware of the purpose of the study (precoding 2). Reliability coefficients for the precoding 2 were found for the general categories of barriers to help seeking behaviors (70.4%), facilitators to help seeking behaviors (55.2%), stage of change statements (35.3%), and participants' perceived severity of their problem (45.5%). The overall reliability coefficient for precoding 2 was unacceptable (61.6%).

The same independent observer (undergraduate student) was then trained to code the transcripts that were precoded and considered the acceptable standard for precoding by the author and another graduate student. This coding was done by examining the precoded transcripts and the statements that were precoded for each particular category. The independent observer then coded the statements according to the coding procedures outlined in the coding manual (see Appendix B). The statements were also coded by the advanced graduate student in order to examine the reliability coefficients of the coding

system. The categories of participants' reported facilitators for help seeking behaviors (100%) and barriers to help seeking behaviors (100%) had acceptable reliability coefficients. Overall severity of anxiety (91.7%) was found to have an acceptable reliability coefficients with specific severity levels of low severity (100%), moderate severity (80.0%), and high severity (88.89%) all having acceptable reliability coefficients. The participants' reported stage of behavior change statements (76.6%) were found to have an acceptable overall reliability coefficient. Breaking behavior change statements down into individual subcategories revealed that contemplative statements (83.87%), action statements (83.33%), and maintenance statements (77.78%) had acceptable reliability. The reliability coefficients of precontemplation statements (50.0%) were found to be unacceptably low, however there were only 6 instances of precontemplation statements. No preparation statements were coded by the independent observer.

Results

A summary of the participants' SAD, FNE, SPAI, BDI, and MAST scores can be seen in Table 2. Participants' scores on the SAD ranged from 15 to 27 with a mean of 19.2 and a standard deviation of 4.3. FNE scores ranged from 18 to 30 with a mean of 26.6 and a standard deviation of 3.8. The participants' difference scores on the SPAI ranged from 70 to 134 with a mean of 103.5 and a standard deviation of 17.9. BDI-II scores ranged from a low of 4 to a high of 25 with a mean score of 13.0 and a standard deviation of 8.0. Participants' scores on the MAST varied from a low of zero to a high of 5 with a mean score of 1.9 and a standard deviation of 1.9.

A summary of the participants' individual frequency of coded responses to the interview can be seen on Table 3. Coded barriers to help-seeking ranged from one self-reported barriers to 6 self-reported barriers with a mean of 3.1 and a standard deviation of 1.79. Coded facilitators to help-seeking ranged from zero self-reported facilitators to 7 self-reported facilitators with a mean of 2.4 and a standard deviation of 2.80. Low severity statement frequency ranged from zero to 2, moderate severity statement frequency ranged from zero to 2, and high severity statement frequency ranged from zero to 4. The means (with standard deviation in parenthesis) of low moderate and high severity statements were 1.0 (0.8), 0.5 (0.7), and 1.0 (1.6), respectively.

Total stage of change statements ranged from zero to 9 with a mean of 4.9 statements coded with a standard deviation of 3.7. When examining each category of stage of change statements made; coded precontemplation statements ranged from zero to 2, coded contemplation statements ranged from zero to 8, no preparation statements were coded for any of the participants, coded action statements ranged from zero to 4, while coded maintenance statements ranged from zero to 7. The means (with standard deviation in parenthesis) of precontemplation, contemplation, action, and maintenance statements coded were 0.4 (0.7), 3.0 (2.9), 0.4 (1.3), and 1.1 (2.2), respectively.

In order to examine if there were any differences based on the participants' stages of change, it was necessary to categorize them into one of two groups due to the small number of participants and the low overall set of responses given in the interviews. The first group includes participants who made a majority of stage of change statements that were precontemplation and/or contemplation statements. The second group includes

participants who made a majority of stage of change statements that were preparation, action, and/or maintenance statements. In order to categorize each participant, the percentages of the stage of change statements in each category made by each participant were calculated. Participants were grouped by having a response percentage of 51% or higher in either the precontemplation/contemplation (P/C) group or the preparation/action/maintenance (P/A/M) group. Table 4 shows a summary of participants= responses categorized by group and percentages of their stage of change response rate for the two groups. Five participants' scores placed them in the P/C group, and the mean percentage of their total P/C statements was 100%. Four participants' scores placed them in the P/A/M group, and the mean percentage of their total P/A/M statements was 75%, while the mean percentage of their total P/C statements was 25%.

Another researcher was involved in a similar project and utilizing the same interviews. Her research examined whether or not the participants actually engaged in professional help services at some point (DiBello, 2004). This was coded as a direct coping method (see Appendix B). This information helps to shed better light on the examination of barriers and facilitators to professional help. Five participants had used professional help services at some time, four (participants 1, 2, 5, and 10) were in the P/A/M group and one was in the P/C group (participant 8). Precoding reliability reported for this data was 68.1% and coding reliability was 81.5% (DiBello, 2004).

Participant 1 received a score of 27 on the SAD and 23 on the FNE. During testing for the interview portion of the study she scored a 5 on the BDI indicating no comorbid depression. She also received a zero on the MAST indicating no alcohol abuse.

On the SPAI she received a 153 on the social phobia scale with a difference score of 111, indicating probable social phobia. From the interview participant 1 made no precontemplative statements, no contemplative statements, no preparation statements, no action statements, and one maintenance statement. This meant that her percentage of P/A/M statements was 100%. She made one barrier statement and 3 facilitator statements. With regard to her perceived level of severity of her anxiety she made 2 low severity statements, one moderate severity statement, and no high severity statements. She had sought professional help at some time.

Participant 2's screening scores on the SAD and FNE were 19 and 27 respectively. During testing for the interview portion of the study she scored a 20 on the BDI, indicating possible moderate depression. She also received a 3 on the MAST indicating no comorbid alcohol abuse. On the SPAI she received a score of 129 on the social phobia scale with a difference score of 114, indicating probable social phobia. From the interview participant 2 made no precontemplative statements, no contemplative statements, no preparation statements, no action statements, and one maintenance statement, therefore her percentage of P/A/M statements was 100%. She made 2 barrier statements and 6 facilitator statements, while she indicated only one low severity of symptoms statement and no moderate or high severity statements. She reported engaging professional help services.

Participant 3 scored a 17 on the SAD and a 25 on the FNE. After being called back for the interview portion of the study she received a 16 on the BDI indicating possible mild depression and a 4 on the MAST indicating no comorbid alcohol abuse.

On the SPAI she scored a 108 on the social phobia scale with a difference score of 70, indicating possible social phobia. During the interview participant 3 made one precontemplative statement, 3 contemplative statements, no preparation statements, no action statements, and no maintenance statements, yielding a percentage of P/C statements that was 100%. She made 2 barriers to help-seeking and no facilitators to help-seeking, and only made one low severity statement while indicating no moderate or high severity statements. She did not indicate that see had utilized professional help in the past.

During screening participant 4 received a score of 18 on the SAD and 30 on the FNE. While being tested for the interview portion of the study she received a score of 24 on the BDI indicating possible moderate to severe depression. Her score on the MAST was a 5 indicating possible alcohol abuse. On the SPAI her social phobia scale score was a 147 with a difference score of 103, indicating probable social phobia. During the interview participant 4 made one precontemplative statement, 7 contemplative statements and no preparation, action, or maintenance statements so her percentage of P/C statements was 100%. She made one barrier statement but no facilitator statements, and made no low severity statements, one moderate severity statement, and no high severity statements. She had not sought out professional help.

Participant 5 received a score of 18 on the SAD and 18 on the FNE during the screening. Although her score on the FNE was borderline, this author and the other researcher decided to recall this participant for inclusion in the interview portion of the study due to her elevated SAD score. During testing for the interview portion of the

study she received a 5 on the BDI, indicating no comorbid depression and a zero on the MAST indicating no alcohol abuse. On the SPAI she received a score of 112 on the social phobia scale with a difference score of 84, indicating probable social phobia. This supported the decision to include this participant in the study and lead the researchers to believe that she should be included in the study. From the interview participant 5 made no precontemplative statements, 2 contemplative statements, no preparation statements, zero action statements, and 7 maintenance statements resulting in her percentage of P/A/M statements being 77.8%. She made 6 barrier to help-seeking statements and 5 facilitator statements, and made one low severity statement, 2 moderate severity statement, and 3 high severity statements demonstrating her perceived distress due to her social anxiety. She had accessed professional help services in the past.

Participant 6 scored a 17 on the SAD and 26 on the FNE. After returning for the interview portion of the study she received a score of 4 on the BDI, indicating no comorbid depression and a score of zero on the MAST indicating no alcohol abuse. On the SPAI her social phobia scale score was a 134 with a difference score of 113, indicating probable social phobia. In the interview she made no precontemplative statements, 2 contemplative statements, and no preparation, action, or maintenance statements. This meant that her percentage of P/C statements was 100%. She made 3 barrier to help-seeking statements while making no facilitator statements, and reported her perceived level of severity as low 2 times, moderate one time, and did not report any high severity statements. She did not report using professional help.

During her participation in the screening session Participant 7 received a score of 27 on the SAD and 30 on the FNE. Her testing for the interview portion of the study yielded a score of 6 on the BDI indicating no comorbid depression and a 3 on the MAST indicating no alcohol abuse. On the SPAI her score of 157 on the social phobia scale with a difference score of 105 indicated probable social phobia. Participant 7 made no stage of change statements at any of the five levels nor did she make any severity statements. She did report 3 barrier to help-seeking statements but reported no facilitator statements. Due to the lack of any stage of change statements, participant 7 will be excluded from statistical analysis due to inability to place her in either of the groups for the independent variable (i.e. stage of behavior change). She made no indications of using professional help services.

Participant 8 received a score of 15 on the SAD and 29 on the FNE. She received a 12 on the BDI indicating possible mild depression and a 1 on the MAST indicating no alcohol abuse. Her score of 130 on the social phobia scale of the SPAI and her difference score of 110 indicated probable social phobia. Participant 7 made no precontemplative statements, 8 contemplative statements, no preparation statements, no action statements, and no maintenance statements during her interview so her percentage of P/C statements was 100%. She reported 6 barrier statements and 3 facilitator statements, while her severity statements were scored as low 2 times and high 4 times with no moderate severity statements coded. She reported some contact with professional help services.

While being screened participant 9 received a score of 18 on the SAD and 29 on the FNE. While participating in the interview portion of the study she scored a 13 on the

BDI indicating possible mild depression and a 3 on the MAST indicating no alcohol abuse. On the SPAI she received a 170 on the social phobia scale with a difference score of 134, indicating probable social phobia. During her interview she made 2 precontemplative statements and 5 contemplative statements, but no preparation, action, or maintenance statements making her percentage of P/C statements 100%. She made 4 barrier statements but no facilitator statements, and made no low or moderate severity statements but made 3 high severity statements. She did not state that she had accessed professional help.

Participant 10 received a score of 16 on the SAD and 29 on the FNE. While her SAD score was beneath the cut-offs set for inclusion in the study, her elevated FNE score caused her to be called back for possible inclusion in the study. During testing for the interview portion of the study she received a 25 on the BDI indicating possible moderate to severe depression and a zero on the MAST indicating no alcohol abuse. Her SPAI scores of 115 on the social phobia scale with a difference score of 91 indicated probable social phobia. This score confirmed that she met criteria for participation in the study. Her interview yielded no precontemplative statements, 3 contemplative statements, no preparation statements, 4 action statements, and 2 maintenance statements. Thus her percentage of P/A/M statements was 66.7%. She made 2 barrier statements and 7 facilitator statements, and reported one low severity statement, no moderate severity statements, and no high severity statements. She had accessed professional help.

Barriers to help-seeking behavior

The coded barrier to help-seeking statements made by the participants can be seen on Table 5. While all ten of the participants reported barriers to help-seeking behaviors, only three indicated that their social anxiety served as a barrier to help seeking behaviors. Six participants reported that they did not feel that their anxiety was a big enough problem to warrant treatment. Another barrier to help-seeking behavior that was reported by three participants was that they did not know where or how to receive help. Two participants indicated that the social stigma about receiving professional help for psychological issues was a barrier to help-seeking for them. One participant reported financial concerns were a barrier to continuing help-seeking. One participant stated that she simply did not want to receive help for her social anxiety. Other individually reported barriers included disbelief that professional help would be effective, lack of time, and being scared of counseling.

Facilitators to help-seeking behavior

Participants' coded facilitator to help-seeking statements can be see on Table 6. When examining facilitators to help seeking behaviors it is important to note that only five of the participants reported utilizing professional help at some time and none of the participants that had not used professional help reported any facilitators. Out of the five participants that reported facilitators to help-seeking behaviors four reported that parental support or demands served as a facilitator to their help-seeking behaviors. Also, four of the participants noted that the severity of their social anxiety symptoms moved them toward seeking out professional help. Two participants endorsed a personal realization of

their need for help as a facilitator. Individually reported facilitators included comfort level with health professional, realization of possible loss of support system, and personal belief in the effectiveness of treatment.

Barriers and facilitators in relation to stage of behavior change

A *t* test for independent means was used to compare the mean number of coded self-reported barriers made between the precontemplation/contemplation (P/C) group and the preparation/action/maintenance (P/A/M) group. There was no significant difference between the reported barriers of the P/C group ($M = 3.2$, $SD = 1.92$) and the P/A/M group ($M = 3.00$, $SD = 2.16$), $t(7) = 0.15$, $p = .89$.

A *t* test for independent means was used to compare the mean number of coded self-reported facilitators made between the P/C group and the P/A/M group. The P/A/M group ($M = 5.25$, $SD = 1.71$) reported significantly more facilitators to help-seeking than did the P/C group ($M = 0.60$, $SD = 1.34$), $t(7) = 4.46$, $p = .003$.

Reported severity of anxiety in relation to stage of behavior change

In order to compare the reported severity of social anxiety statements made by the participants, a mean severity score was computed for each participant. Low severity statements were given a value of 1, moderate severity statements were given a value of 2, and high severity statements were given a value of 3. For each participant their total score was added, then divided by the total number of severity statements they made. For example, participant 5 made 1 low severity statement, 2 moderate severity statements, and 3 high severity statements. Her total severity statements score was 14, which was

divided by her total number of severity statements made, which was 6. Her mean severity score was 2.33. The mean severity score for each participant can be seen in Table 3.

A *t* test for independent means was used to examine if there was a significant difference in the mean scores of the self-reported severity of social anxiety symptoms between the P/C group and the P/A/M group (see Table 7). There was no significant difference between the mean severity scores number of the P/C group ($M = 1.93$, $SD = 0.80$) and the P/A/M group ($M = 1.42$, $SD = 0.63$), $t(7) = 1.06$, $p = .33$.

Discussion

Due to the exploratory nature of this study, it is important to remember that the primary goal of this study was to develop an instrument for qualitative research to investigate questions about an individual=s experiences with social anxiety. A secondary goal of this study were to examine the help-seeking behaviors of individuals with social anxiety.

Interview

The primary goal of this study was to develop an instrument that could be used to reliably gather data regarding an individual's experiences with social anxiety. This instrument would yield data qualitative in nature and would attempt to uncover an individual=s thoughts, feelings, and actions regarding their social anxiety. Examining the precoding reliability data reveals that the procedures did not yield an acceptable amount of reliability across any of the areas examined. Precoding 1 reliability coefficients ranged from 55% to 83% with an overall of 69.0% for the author and the advanced graduate

student and the precoding 2 reliability coefficients fell to 35% to 70% with an overall of 61.6% for the precoded standard and the independent observer (See Table 1).

The nature of precoding the transcripts yielded by the interview may be one reason that precoding reliability was generally poor. The researchers and the independent observer attempted to classify statements into general categories (barriers, facilitators, stage of change, and severity). The sheer number of statements made by each subject made this task extremely difficult. Also given the fact that the researchers and the independent observer had to examine each statement within the entire transcript made this task all the more difficult.

One possible way to improve precoding reliability would be to have precoders examine each statement in the transcripts separately, outside of the entire transcript. Each statement could be examined individually and a decision made to precode it according to one of the categories or to not precode it. By separating every statement we could then evaluate each behavior (statement) in a more independent way. This may help decrease the chances that a statement would not be overlooked while surrounded by all the other statements. While this would increase the time and effort required for precoding and analyzing transcripts yielded by this measure it may help to increase its reliability.

A second possible obstacle regards the stage of behavior change statements specifically. The precoding reliability between the author and the advanced graduate student was 75% while the reliability between the accepted standard and the independent observer precoder (undergraduate student) was 35.3%. Since an individual can fluctuate back and forth through the different stages of the model it can be very difficult to

determine whether a particular statement made is referring to a past or present understanding of the nature of a problem.

Stage of change statement reliability is possibly the most problematic. It is the most abstract of the categories. It requires an adequate understanding of the stage of change model by the precoders and the coders. During the training the researchers felt that adequate attention was given to the model, but the data (35.3% reliability with independent observer) obtained suggests otherwise. Developing more in depth training procedures may increase the likelihood of accurately and reliably classifying these statements. Required reading detailing the development of the model as well as more training time spent with researchers discussing the stage of change model may be beneficial. Improved training materials might include exercises on identifying individual statements into one of the stage of change categories.

Precoding reliability coefficients for barriers ranged from 83% (precoding 1) to 70% (precoding 2) which was within acceptable limits. Facilitator reliability coefficients were poor at (55%) in both instances. Severity reliability coefficients were 74% during precoding 1 and 45.5% during precoding 2. Once again, it may be that attempting to precode statements while they are still in the complete transcript is to difficult a task. Examining each statement individually may help to increase precoding reliability for these categories.

The coding of the jointly precoded transcripts (accepted standard) for individual statements yielded much higher overall reliability coefficients. Facilitator and barrier statements were 100% reliable while overall severity statements reliability was 92%.

Overall stage of change reliability was at 77%. While at first glance this seems to be positive, the unreliable precoding of the transcripts casts doubt on the statement coding. It cannot be said that all statements were adequately and evenly evaluated for coding. It may be that several statements were either missed or falsely categorized by the precoding. The first and most important step in evaluating the efficacy of the interview should be to improve precoding to acceptable levels, perhaps by using the suggestions above, and then re-evaluate statement coding based on reliably precoded transcripts.

While seeing the extremely high facilitator and barrier coding reliability coefficients, it is tempting to point to them as an encouraging sign. However, the yes or no nature of coding for facilitators or barriers may have left no room for any error. Each statement was precoded as containing the appropriate type of statement. The independent observer may have simply assumed that the statement had to be coded and did so without evaluating each statement equally. One way to help control for this, and not get falsely high reliability coefficients would be to have facilitators and barriers precoded together instead of separately, forcing the independent observer to evaluate statements as a possible facilitator, barrier, or neither. Also, coding facilitators and barriers with regard to a specific type of facilitator (i.e. family support, severity of symptoms, etc.) or barrier (i.e. lack of money, social stigma, etc.) may also encourage a more thorough evaluation of the statements being coded.

The reliability coefficients for severity may be the most encouraging. These statements were precoded and then the independent observer had to decide between one of four possible choice for each statement, low, moderate, high or none. This may have

resulted in a better, and more reliable, evaluation of these statements. Of course, the low precoding reliability for the severity category casts doubt on all of these coded statements, but the method of statement coding and the data seen are encouraging.

When examining the interview on its own it becomes apparent that an important piece of information is not adequately collected by the interview; the time frame that a particular statement is referring to. We attempted to control for this by separating the conversation with the participant by talking about past experiences with social anxiety and then talking in a latter part of the interview about their present experiences.

Observed results seemed to indicate that this was not sufficient for several reasons. First, the participants, being unaware of the importance of distinguishing between past and present thoughts, feelings, and actions would jump ahead to reflections on their present circumstances or backtrack to how they dealt with their anxiety in the past. Second, the semi-structured nature of the interview was perhaps too lax in prohibiting interviewers from allowing the interviewee from these moments of reflection or introspection during the wrong parts of the interview. This made coding facilitators, barriers, severity statements and stage of change statements according to time impossible. The interviewers in this study were the author and another advanced graduate student, who were not blind to the purpose of the study, as stated earlier. It seems that in the interests of obtaining Ainteresting@ data they may have not been focused enough on keeping the discussion of the past focused on the past, and the discussion of the present focused there.

In order to address the confound that may have been introduced by the researchers there are two possible remedies. First, having independent interviewers who were blind to the purposes of the study may help keep the interview focused and prevent the jumping in chronological order sometimes seen in the transcripts. Of course, this requires a significant increase in the amount of resources needed to conduct research using this interview. Training procedures and practice interviews would need to be developed. The number of man-hours would increase significantly. The increase in needed resources may make this instrument almost prohibitively difficult to use except in funded research.

The importance of being able to classify the chronological place of a statement in the context of the participants life may not only help improve the data collected by the interview, but would allow the interview to be used in studying past and present thoughts, feelings and actions about social anxiety more effectively. This would open up the possibility of studying a participant's own perceived development of their social anxiety as well as examining the changes that may be seen due to treatment by professional services.

One method that may help improve the ability of the interview to place statements in their appropriate chronological place would be to add follow-up questions after every statement of thought, feeling, or action that would query the participant as to when this thought, feeling, or action applied. This would allow examination of coded statements to be appropriately categorized as past, present or both by examining the response to the associated follow-up question.

A second, less prohibitive alternative may be to change the nature of the interview from semi-structured to structured. This would inhibit the researchers from allowing the interview to go off topic at all. This would decrease the ability of the interview to gather information as it became apparent to interviewers, but it may help to increase the overall reliability of the instrument, especially with regard to placing statements made into their appropriate chronological places.

The interview could be further developed into a powerful tool in studying an individual or group of individuals' experiences with social anxiety. At this time it does not demonstrate adequate reliability in its present form and administration. However, changes to the measure, such as additional follow-up questions or making it a structured interview rather than a semi-structured interview as well as improving the precoding and coding procedures used to analyze the data gathered by the measure may help strengthen its currently weak psychometric properties.

Due to the overall poor reliability of the interview the exploratory data and hypotheses that were the secondary purpose of this study cannot be discussed with much confidence. Also the small number of participants decreases the statistical power available for analysis. As a result, this discussion is an exploration for possible trends or themes that could be used in future studies.

Barriers

Ten female students from an undergraduate research pool participated in this study as a result of the probability of their having social anxiety based on their responses to measures of social anxiety. All ten reported barriers to help-seeking. There seemed to

be some common themes across the participants. First, three of the participants indicated that their symptoms were a barrier to seeking out professional help. Second, six of the participants reported that a reason that they didn't seek out professional help was that they did not see their anxiety as a problem that warranted professional help. Third, three participants reported that not knowing where or how to receive help was a barrier to utilizing professional help. Fourth, two participants indicated that their concerns of what other people would think if it was found that they were seeing a counselor served as a barrier to seeking help. Lastly, two participants simply stated that their own wish not to get help acted as a barrier to help-seeking.

Three of the participants reported that their symptoms directly served as a barrier to them seeking out professional help. Participants 2, 5, and 7 reported this. Of those three, only participants 2 and 5 had seen a health professional in the past, and neither were currently utilizing professional help at the time of interview. Participant 2 stated that "What people might say." acted as a barrier to seeking help. This relates to one of the basic symptoms of social anxiety, that is, the fear of negative evaluation by others. Participant 5 made several statements indicating that her anxiety may have acted as a barrier to her seeking out professional help. She noted that she couldn't open up to her counselor because "It was a stranger. . . I don't know, I just couldn't for some reason." Also she stated that "I didn't want to let people know that maybe something is wrong with me, you know?" These indicate possible barriers due to the nature of social anxiety, specifically fear of talking to strangers and a fear of negative evaluation by others. Participant 7 simply stated:

> "I just don't like talking to people. Like I don't. I just keep everything to myself and just not share anything." and "I just keep everything to myself and just not share anything like little things I guess, but really anything . . .".

Only these three participants indicated that their symptoms directly acted as a barrier to seeking out professional help.

The first hypothesis of this study was that anxiety about social interactions or fear of negative evaluation by an interviewer or health-care professional would be described as a hindering factor or barrier to treatment-seeking behaviors. Of the ten participants in this study, three of them (participants 2, 5, and 7) reported that their anxiety acted as barriers to seeking out professional help. This seems to indicate that this hypothesis may have merit. It seems logical that the very nature of social anxiety would serve as a barrier to help-seeking. The nature of the disorder indicates a tendency to avoid anxiety producing situations, which often include meeting new individuals, fear of negative evaluation by others (especially authority figures), and presenting oneself to others in a less than positive light. All these can be seen in seeking out help from a trained help professional. Olfson et al. stated, "It is ironic that the very symptoms socially anxious individuals seek to relieve may interfere with their ability to seek treatment" (2000, p. 525). The fact that less than half of the participants indicated that their social anxiety served as a barrier to help-seeking behaviors may point to a lack of realization of the ways that their social anxiety impacts their lives. It may also indicate that they are in denial about their problem or that it quite possibly may not act as a barrier at all.

Six of the participants reported that a barrier to seeking out professional help was their personal belief that their anxiety or problems were not big enough or did not see a reason to seek out professional help. This was the most commonly reported barrier to help-seeking given by the participants in this study. Participants 1, 3, 4, 6, 9, and 10 noted this as a barrier to seeking out professional help. Of those participants, only two (1 and 10) had utilized professional help in the past and participant 10 was currently utilizing professional help. Most participants that felt their anxiety was not a problem reported that they felt no need to seek out help. Participant 1 noted that the reason she did not seek help was:

> "Just kind of how much a big deal it is. Like if it's something I think I can handle, a little speech like two minutes long, I'm kind of anxious about it but I don't care, it's two minutes."

Participant 3 noted, "I guess I never really saw it as a problem . . . So I didn't see the reason to have help." Participant 4 stated that it was, "'Cause I didn't think it was a big problem." Also participant 6 indicated that she did not see her anxiety as a problem. In response to the interviewer question to why she never talked with anyone about her anxiety she responded, "Just 'cause I'm usually not or it goes away once I'm there you know?" Another example comes from Participant 9 who stated:

> "So I mean, I've never thought about it but I didn't ever like think it was really that big of a deal that I needed to go talk to somebody about it."

A final statement was given by participant 10, ". . . I felt like my problem wasn't big enough to go get help. . ." This trend indicates that many of the participants did not feel that their problem was severe enough to warrant professional help.

This reflects Cameron et al.'s (1993) findings that the perceived severity of the problem was the most significant predictor of help-seeking behavior. As these individuals did not perceive the severity of their problem to warrant attention, they allowed themselves to not seek out help. Olfson et al. (2000) reported that one barrier to help-seeking was that individuals with social anxiety believed they could handle their symptoms on their own. If the problem "isn't big enough" they don't see a reason to seek help. Past research (Pollard et al.,1989) noticed that individuals suffering from social anxiety may not suffer from heightened distress even though the anxiety results in impairment. This is similar to the results found in the current study. The participants may have not noticed severe enough impairment from their anxiety. Also, the participants may be in denial about their problem as denying their problem also allows them to avoid seeking help. Pollard et al. notes that this may be due to the fact that individuals with social anxiety may have "clinical levels of distress even though they are disabled by avoidance" due to the nature of the disorder (1989, p. 136). This may lead to those individuals from not experiencing distress because they avoid the situations which would cause the distress. Many individuals may then feel or think ". . . I never really saw it as a problem . . . So I didn't see the reason to have help.".

Three of the participants (6, 8, and 9) claimed a barrier to seeking out professional help was the fact that they didn't know where or how to receive professional help. None

of these three participants were utilizing any form of professional help at the time of interview. Participant 6 stated:

> "I wish there was a way I wouldn't be quite as nervous about doing, getting up in front of people and meeting different people. But, I don't really know what you could do for it so."

Participant 8 had utilized professional help in the past in the form of a high school guidance counselor, but on three separate instances during the interview she stated, "I really have no idea who to go to." Participant 9 stated:

> "I know that I probably should do something because I don't know, maybe something would help. But I don't really know how . . . (trails off)"

These comments indicate a possible lack of knowledge of the public in the services that professional help can provide for anxiety. Olfson et al. (2000) also reported that not knowing where to go for help was a barrier to help-seeking behaviors. They reported it as their most commonly found barrier. This may indicate that a general lack of information in the public about social anxiety and the treatment of it may exist. Spending time developing outreach programs and public awareness campaigns may help to educate the public as to professional health services available to them.

Two of the participants (2 and 5) reported that the stigma attached to seeing a health professional was a barrier to seeking out professional help. Both participants had seen a health professional in the past as a result of their perceived symptoms. Neither participant was currently utilizing professional help. Participant 2 answered that the main thing that prevented her from seeking help earlier was, "What people might say." As

noted above, Participant 5 stated that "I didn't want to let people know that maybe something is wrong with me, you know?"

Past research has also found that social stigma serves as a barrier to help-seeking behavior (Olfson et. al, 2000). As well as being indicative of the symptoms of anxiety serving as a barrier to help-seeking, this also speaks to a fear of the social stigma attached to professional help. This social barrier to treatment is problematic for people with all forms of emotional or behavioral disorders, and it may be especially problematic for individuals with social anxiety due to the fact that their symptoms play right into this widely held notion.

Finally, two participants (5 and 10) reported that they simply did not want to get professional help. Participant 5 stated, "I didn't want to like see anybody to, you know, to get better." Participant 10 reported that, "I pretty much didn't want it." Both participants had used professional help services and one (10) was currently seeing a counselor. This barrier to help-seeking behaviors may be more of a summary statement, rather than a unique type of barrier. However, personal choice to want or not want professional help may have an impact on whether or not an individual seeks-out professional help. No research in the past identified this as a barrier to help-seeking behaviors.

Other observed barriers to help-seeking behaviors were reported by participants. Participant 2 cited lack of money as a barrier to help-seeking. She reported that "we had to quit because we couldn't afford her". Olfson et al. also reported that economic considerations served as barriers to help-seeking behaviors (2000). Participant 5 reported

she felt like her problem was something she should keep to herself. She said, "Maybe I just thought like it was something that I was going through so I should just keep it to myself." No previous research reported this barrier. Participant 6 indicated that one barrier to help-seeking was that it had never occurred to her, "Um, well, I just never really thought about going to get help for it so." No previous research indicated a similar type of barrier. Participant 7 noted that they did not believe that professional help would be effective. She responded:

> "I don't know if talking to them would really change what goes through my head and really make a difference when it actually comes to going in to a situation."

Previous research did not report this as a barrier to help-seeking behaviors. Participant 8 claimed that lack of time to utilize professional help served as a barrier for them. She stated simply, "Didn't have time to." She also stated:

> ". . . we had guidance counselors there, sometimes I'd just go in there and just talk to her, but not very often, because they switched in between like, my junior (year) I got a new one, and I just didn't go in there very much." (added for clarity)

This was not demonstrated in other studies of barriers to help-seeking behaviors in individuals with social anxiety. A barrier reported by participant 8 was she was avoiding the problem and hoping it would go away on its own. She stated, "Um, probably because I just figure that it won't go away and I'm avoiding it but I know that it won't." No previous research discussed this barrier. Participant 10 openly admitted to being scared of counseling before they started seeing a counselor on a regular basis. "I was kind of scared to speak up about it", she said. This was not reported by previous research.

A number of themes found among the ten interviews were identified. The participants reported that their social anxiety, their disbelief that their anxiety was a problem, lack of knowledge about the types and availability of services, and social stigma all served as barriers to help-seeking behaviors for these ten participants. Conclusions from the observed barriers should be done cautiously. This project was largely exploratory in nature and was not intended to make definitive statements regarding its findings. It is presumably safe to admit that the symptoms of social anxiety do indeed serve as barriers to help-seeking behaviors in some individuals. The extant to which this occurs is a question that could be addressed in future research projects.

Facilitators

In this study's examination of facilitators to help-seeking behaviors we found that, of the ten participants, only 5 (participants 1, 2, 5, 8, and 10) had utilized some form of professional help in the past and only one (participant 10) was utilizing professional help at the time of the interview. In examining the reported facilitators to seeking out professional help, three common themes became apparent. First, five of the participants reported that the severity of their symptoms served as a facilitator to seeking out professional help. Second, four participants also noted that their parents demands or encouragement served as a facilitator to seeking out help. Third, two of the participants expressed that their own desire for help served as a facilitator to seeking out help.

The first common facilitator to seeking out professional help reported was the participants' own perception of the severity of their symptoms. Participants 1, 2, 5, 8, and 10 reported symptoms as a facilitator to professional help-seeking. Participant 1

noted "that I started feeling really tired all the time and just kind of wound down from having so many things to do". Participant 2 also noted that perceived symptoms helped lead to her seeking out help. She noted:

> "Um, um, I used to hang out with my friends a lot more and I just kind of stopped doing that and I just stopped enjoying what I used to do and I would just be more irritable and then what put it over the edge was that fight with my youth pastor." and "I was just having troubles with my friends or something and it was just bother me so much and I would think about it constantly and so I guess that." (sic)

She also stated that, "It was just all get built up and so I just decided that I better talk to somebody before I blow up." Participant 5 said:

> "My parents noticed you know that I was more you know, I don't know they thought maybe I had depression or something" and "also like my parents said I slept a lot more".

Participant 8 said that "Just because the way I feel, so uncomfortable." was a facilitator to seeking out professional help. Participant 10 explained that as a result of losing a lot of weight "I just got, started getting really sick and so . . ." it resulted in her seeing a professional. All of these participants had utilized professional help in the past.

It is interesting to note that none of the above participants indicated that their anxiety symptoms per se caused them to seek out professional help. In fact, it seems that the symptoms that lead them to seek out help are more often associated with depression. The above reported symptoms of feeling tired or run down, withdrawing from previously enjoyed activities, increased sleep and feelings of being tired, and weight loss are all

symptoms of possible depression. This may be indicative of the comorbid relationship that depression and social anxiety often have. When examining these participants' scores on the BDI we can see that participants 1, 2, 5 and 10 scored a 5, 20, 5, and 25 respectively. There is evidence of possible depression in the scores of participants 2 and 10, while the scores of participants 1 and 5 seem to indicate no comorbid depression. Since these participants reported that depressive symptoms facilitated help-seeking it may indicate that the while the symptoms of social anxiety may serve as barriers to help-seeking as discussed above, the comorbid symptoms of depression may serve as facilitators to help seeking behaviors. This relates to Magee et al.'s (1996) findings that the symptoms of comorbid psychological disorders may serve as facilitators to help-seeking more so than the symptoms of social anxiety would. The perceived impairment of the comorbid disorder is more obvious than the lack of perceived impairment of social anxiety discussed above. This may be due to a perceived difference in the perceived severity or impairment of depressive and social anxiety symptoms.

The second common facilitator reported by the participants was familial support or pressure. This came from the participants' parents. Again participants 1, 2, 5, and 10 all reported parental encouragement or demands as facilitators to help-seeking behavior. As stated before, all of these participants had utilized professional help in the past, but only participant 10 was still actively seeing a health professional for her anxiety. In the interview with participant 1 we see:

Researcher: "Was it - did your mom kind of influence you to . . . see somebody?"

> Participant 1: "Umm, a little bit because I had been tired and she thought, umm, she has like Bipolar disorder and then my dad, like has, umm just diabetes, like really bad, so the being really tired, she just wanted to see if it was a cause (sic) from either of those maybe effecting me . ."

From the interview with participant 2, it is stated:

> Researcher: "Well what kinds of things were going on at that point where you decided to go see a counselor?"
>
> Participant 2: "Well actually my mom decided for me . . ."

Also later in the interview she repeated, "It was my mom's idea for me to go." As stated above participant 5 revealed that:

> "My parents noticed you know that I was more you know, I don't know they thought maybe I had depression or something," she continued to say "so they, umm, took me to, you know, like a psychologist or something or whatever for awhile . . . my parents noticed this and they wanted to help me."

She also stated, "It was more my parents just like, you know, making me go because they wanted me to get better or whatever." Also participant 10 noted that, "My mom found out and kind of made me start going so, that's kind of how I started."

This reveals a trend in the help-seeking behaviors of the participants. Of the five that had sought out professional help, all but one reported that their parents encouraged or forced them to do so. It is also interesting to note that these same four participants are the same participants who indicated that their depressive symptoms had acted as facilitators to help-seeking behavior. It is possible that parents and family members may be more

familiar with depressive symptoms that with the symptoms of social anxiety. Thus the familial support and pressure may be seen more with individuals with the easily recognizable and more widely known symptoms of depression. Family, friends, and coworkers of individuals with social anxiety may be just as uninformed about the symptoms and the impact of social anxiety as those who suffer from it. This relationship between the severity of depressive symptoms and recognition of a need for treatment reflects the findings of Cameron et al. (1993). The increased perception of severity results in an increase in help-seeking behaviors. It is interesting to note that the depressive symptoms may have been deemed more severe and thus prompted a heightened response by participants' family. This also relates to the social permission concept discussed by Cameron et al. (1993). These participants may have felt that accessing help services was more acceptable as their families had encouraged them. No participants explicitly stated this, but the fact that familial support was one of the most reported facilitators in this study, it quite possibly played some role.

The second hypothesis of this study was that peer, familial, or occupational pressure will be described as a major facilitative factor in seeking help. While examining the results found by the interview we saw that of the five participants who had used professional help services, four participants (1, 2, 5, and 10) reported that familial pressure served as a facilitator to help seeking behaviors. Familial support or pressure seems to be a strong facilitator to help-seeking behavior. Due to the small number of individuals participating in this study, caution should be used when interpreting what this may mean. Also, the above noted influence of depressive symptoms cannot be forgotten.

The suggestion made by the findings indicate familial support or pressure is indeed a facilitator to help-seeking behaviors, but is this due to the nature of trust built into the parent-child relationship or is it due to parental fear regarding the frightening depressive symptoms the participants reported. How much encouragement did the parents offer? How strenuously did they insist on treatment? These are all questions not examined by this study. There is no way of qualifying the motives of the participants or their parents or the level of support or pressure that was present. These are all factors that would have played into the decision to seek help. For now, it can only be said that there is tentative evidence supporting the role of family in facilitating help-seeking behaviors for young adults, and more research is needed to examine this question more thoroughly.

The third and final common theme reported by participants was the participants' own realization that they wanted or needed professional help to relieve the distress that resulted from their symptoms. Participants 8 and 10 reported this as a facilitator to seeking out professional help. Both had seen a health professional in the past about their anxiety, but only participant 10 was still using professional help regularly at the time of the interview. Participant 8 noted that:

> Participant 8: "To make myself feel better about it really. Just to, cause if I don't talk to anybody about it, then it's not gonna help me out any, cause I need to talk to somebody to make myself feel better."

This helped lead participant 8 to also seek out help from her school's guidance counselor. When asked why participant 10 continues to seek out treatment for her problems she stated "I know that if I want to feel better then I got to go." and "Cause I want it. I want to

feel better." She also commented, "I know if I go I'll feel better." The commonality of these two participants having internal motivations for seeking out professional help is encouraging. It is important to remember that a strong internal motivation toward health may act as a facilitator to seeking out or maintaining professional help, despite reported barriers that pull individuals away from it. It is necessary to note that participant 10 did not start out with this internal motivation, but that she developed it after continued help from her counselor. It was her family's decision that she should go that started her treatment, which then evolved into her personal desire for health. No previous research listed this as a facilitator to help-seeking behaviors.

Other facilitators were reported by participants. Participant 2 noted that there was a precipitating event that served as a facilitator. She said ". . . and then he started yelling at me as if I hadn't done anything all day so I started yelling back at him." Participant 5 indicated that interactions with others indicated to her that she may need help. She stated:

> "Like it was weird like I was mad at people because they didn't come up to me but I also thought I could have come up to them too, so it was kind of my fault also." and "so I was mad at her but then that when like I noticed that, wow, other people are noticing that I have a problem, so that maybe I do."

Participant 8 noted that the fact that they understood that family support was not always available served as a facilitator. She stated, "Um, mostly because I knew my mom couldn't always talk to me." Participant 10 reported that the belief that professional help worked and made them feel better was a facilitator to using professional help. She noted "I guess just . . . feeling better and happier in general I feel like I can do it now." and "I

guess finally figuring out that I did have a problem and that it was important enough and that I . . . knowing that there was something that could be done about it." None of the participant reported peer pressure as a facilitator to help-seeking. Likewise none of the participants reported occupational or school pressure as a facilitator to help-seeking. Participants 3, 4, 6, 7, and 9 reported no facilitators to help-seeking behaviors.

Stage of change and barriers and facilitators to help-seeking behaviors

The third hypothesis was that the number of self-identified facilitative and hindering factors for help seeking behaviors will differ between early stages of behavior change and later stages of behaviors change. While no significant differences in self-reported barriers were found between the P/C group and the P/A/M group, the P/A/M group did report significantly more facilitators to help-seeking than did the P/C group. This difference makes sense in that, those who have sought help or are planning to seek out help (P/A/M group) would have internal or external reasons for seeking out that help. On the other hand, those who have never sought out help or thought of seeking out help (P/C group) would not necessarily have identified internal or external reasons for doing so. Since the P/A/M group has access to their past and present barriers as well as their facilitators to help-seeking, it stands to reason that they would be able to report as many barriers to seeking help as those who have never sought out help. An effective method in obtaining more sensitive data for this hypothesis may be to include a way to differentiate between past and present barriers to help-seeking behaviors, thereby allowing a comparison of current barriers to help-seeking between both groups. This would allow for a way to exclude past barriers that may no longer hinder help-seeking behavior.

Another possible direction future research could take would be to categorize facilitators and barriers into separate categories. This would allow us to examine different types of facilitators and barriers and how they may vary depending on where an individual is in the stage of change process. P/A/M group individuals may report different types of facilitators than P/C group individuals. For example, P/A/M group individuals may report that their personal awareness of their need for help was a facilitator while P/C group individuals report that the severity of their symptoms served as a facilitator for them seeking help. The same may hold true for barriers, P/C group individuals may report different types of barriers than P/A/M group individuals. P/C group individuals may report that their anxiety wasn't a big enough problem to warrant seeking help while P/A/M group individuals may report that their discomfort with their professional help provider acted as a barrier to seeking (or continuing) help.

Stage of change and perceived severity of symptoms

The fourth and final hypothesis was that precontemplators and contemplators will report the severity of their problems with anxiety as less severe than individuals who are in the preparation, action or maintenance stages of behavior change. There was no significant difference in the reported severity of the participants' social anxiety between the P/C group and the P/A/M group. The small number of participants in this study does not give sufficient statistical power to make a comparison of the groups' means.

In looking at the mean score of reported severity statements per group (Table 7), the mean score of the P/C group was slightly higher than the mean score of the P/A/M group. While this difference is not significant, it may indicate that the reverse of this

hypothesis is true. It is possible that those who have at some point received some form of professional help have learned to better cope with their anxiety and thus report less severe symptoms than those who have not received therapy. According to the stage of change model it was predicted that the P/C group would deny or not realize the severity of their problems. The current evidence may indicate that they are aware of the severity of their anxiety yet have not given thought to professional help.

Re-examining this question may be of value. An examination of the awareness of severity may be less important than an examination of coping strategies used in dealing with the perceived severe symptoms of social anxiety. A fellow researcher was examining this issue and combining the results found here as well as her results may be useful for formulating future avenues of research. If individuals in the P/A/M group did indeed use strategies learned from professional help services it may explain why the results of this study did not support the hypothesis.

The method used to evaluate the participants' perceived severity of symptoms allowed us to obtain their perceptions of the impact of the symptoms in their daily lives. This allowed us to examine severity based not on external measures of severity, but on the participants own awareness of the severity of their symptoms, be they symptoms of social anxiety or otherwise. This, in theory, coordinates well with the stage of behavioral change model used in the interview and study. Unfortunately, the poor reliability coefficients for precoding of severity statements makes the veracity of any conclusions to be drawn from the research doubtful. By restructuring the interview and the precoding

and coding methods (as described above) it may be possible to re-examine this question in a more confident way.

Another possible examination of the severity of symptoms of social anxiety for future research may be to compare (reliable) self-perceptions of severity and compare the data to the amount of severity indicated by external sources or other instruments. The use of observed severity data gathered from friends, roommates, family members, or professional services as well as measures such as the SPAI would allow for examining the potential difference in the participants' own perceptions of the severity of their symptoms against observed severity from outside sources. This would help to determine, for instance, whether P/C participants are minimalizing the severity of their symptoms or if the symptoms are simply not that severe.

Conclusion

The major goal of this study was to open the door to qualitative research in this area by developing an interview to gather data regarding socially anxious individual's feelings about their anxiety and their experiences with it. Specifically, this interview would help researchers to gather information from socially anxious individuals about their attempts to cope with their anxiety, their explanations about their anxiety, their stage of behavior change, and the things that have helped them to seek out help or that have hindered them from seeking help. Development of this interview continued over several months and was focused on having content validity and reliability in each of the areas that it examined. Upon examination of the reliability coefficients it was found that overall, the interview did not have acceptable reliability. Specifically the precoding of the

transcripts demonstrated poor reliability across all categories. Further development and testing of this interview would be helpful in refining training procedures and application of the interview to increase reliability across all categories. This measure's inability to reliably capture information thus far throws many of this study's conclusions into doubt.

The importance of this area of research has been stated before, and further exploration of these questions would be valuable to clinicians working with socially anxious individuals. Reexamining barriers while controlling for P/A/M awareness of their past barriers to help-seeking behaviors may help further differentiate between precontemplators and contemplators and preparers, action takers, and maintainers.

Another important question is what effect, if any, an individual's personal perception of the nature of their problem may have on the types or numbers of facilitators and barriers, or even their perceived level of severity they report. Individuals who view their social anxiety as shyness or as a neurological issue may have very different ideas about the need for professional help. Moreover, individuals that consider their social anxiety as a stable or fundamental part of their personality (i.e. shyness) may not consider it something that can be changed or as deserving receiving professional help for.

Also, an examination of specific barriers and facilitators, categorized into distinct categories is necessary for any serious research in this area. The failure of this study to attempt to categorize and code for different types or themes of facilitators and barriers in any way is a serious weakness of the current work. Research in this area is dependent upon finding or developing a psychometrically sound instrument to examine the facilitators and barriers to help-seeking experienced by individuals.

Another weakness of this study was obvious and known from the start. The limited number of participants in the interview portion of the study makes statistical analysis speculative at best. Opening up the scope and number of this study's participants could help to find more patterns and would increase the ability and power of statistical analysis. Using participants from an in-patient or out-patient treatment center who have been diagnosed with social anxiety may help increase the number of participants. A longitudinal study focusing on individuals' barriers and facilitators and their stages of behavioral change throughout the duration of their treatment would prove invaluable in a serious evaluation of barriers and facilitators in relation to stage of behavioral change.

Finally, one obstacle faced by the current study was the problem of attempting to examine the symptoms of social anxiety and their effect on help-seeking behaviors when several participants indicated symptoms of depression as well as social anxiety. This was especially apparent in discussing symptoms acting as barriers or facilitators to help-seeking. It often seemed that participants attributed depressive type symptoms as facilitators while noting that anxiety symptoms acted as barriers. The major problem was the fact that participants were not capable or did not see these different symptom clusters as separate problems. Participants discussed their "problems" and they saw them as a single set of problems. While this may reflect the comorbid nature of social anxiety and depression, it makes analysis of the effect of symptoms as barriers or facilitators difficult.

One possible control for this confound would be to remove any participants with comorbid depressive symptoms from the study. While this would indeed control for the influence of depressive symptoms on help-seeking behaviors, it may also make obtaining

participants even more difficult than it already is. A more inclusive way of controlling for depressive symptomology would be to code for depressive and anxiety symptoms separately, and to be sure in the interview to obtain information on how each separate symptom influenced help-seeking behavior. This would allow for the inclusion of participants with comorbid depression, which would help strengthen future research's ability to generalize to the general population, which often demonstrates comorbid depression and social anxiety.

This study's attempt to develop an interview to examine facilitators and barriers to help-seeking behaviors in individuals with social anxiety yielded data that proved to be generally unreliable. The value of this type of instrument is high enough to warrant continued effort on developing the interview and coding procedures for use in future research. The examination of barriers to help-seeking behaviors indicated some possible types of barriers for further study including that social anxiety symptoms, an individual's belief in the unimportance or seeking help for their anxiety, not knowing where to access help, and the social stigma attached to psychological services. Possible types of facilitators to help-seeking behaviors indicated include severity of symptoms (albeit maybe not anxiety symptoms), familial support or demands, and an individual's personal desire to become healthier. While no difference was found between the precontemplation/contemplation (P/C) group and the preparation/action/maintenance (P/A/M) group when examining the number of barriers reported or the reported severity of social anxiety symptoms, the P/A/M group did report significantly more facilitators to help-seeking than the P/C group. Reexamining these hypotheses when more reliable data

can be collected from the interview would help to support the current study's tentative findings.

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Table 1

Summary of interobserver percent agreement for precoding

	Precoding 1	Precoding 2
Barriers to help seeking	83	70
Facilitators to help seeking	55	55
Stage of change statements	75	35
Severity	74	46
Overall	69	62

Table 2

Summary of Participant Scores on SAD, FNE, SPAI, BDI, and MAST (N = 10)

	1	2	3	4	5	6	7	8	9	10
SAD	27	19	17	18	18	17	27	15	18	16
FNE	23	27	25	30	18	26	30	29	29	29
SPAI	111	114	70	103	84	113	105	110	134	91
BDI	5	20	16	24	5	4	6	12	13	25
MAST	0	3	4	5	0	0	3	1	3	0

Note. SPAI score: >80 probable social phobia; 60-70 possible social phobia; 34-59 possible mild social phobia; <34 social phobia unlikely

Table 3

Summary of Individual Coded Response Frequency (N = 10)

	1	2	3	4	5	6	7	8	9	10
Barriers	1	2	2	1	6	3	3	6	4	2
Facilitators	3	6	0	0	5	0	0	3	0	7
Stage of Change										
Prec.	0	0	1	1	0	0	0	0	2	0
Cont.	0	0	3	7	2	2	0	8	5	3
Prep.	0	0	0	0	0	0	0	0	0	0
Act.	0	0	0	0	0	0	0	0	0	4
Main.	1	1	0	0	7	0	0	0	0	2
Severity										
Low	2	1	1	0	1	2	0	2	0	1
Mod.	1	0	0	1	2	1	0	0	0	0
High	0	0	0	0	3	0	0	4	3	0
Mean score of coded severity statements	1.33	1.00	1.00	2.00	2.33	1.33	0.00	2.33	3.00	1.00
Professional Help Used	yes	yes	no	no	yes	no	no	yes	no	yes

Table 4

Summary of Stage of Change Statements with Response Percentages (N = 10)

	1	2	3	4	5	6	7	8	9	10
Number of Precontemplation/ Contemplation Statements	0	0	4	8	2	2	0	8	7	3
Number of Preparation/ Action/ Maintenance Statements	1	1	0	0	7	0	0	0	0	6
Percentage of Precontemplation/ Contemplation Statements	0	0	100	100	22.2	100	0	100	100	33.3
Percentage of Preparation/ Action/ Maintenance Statements	100	100	0	0	77.8	0	0	0	0	66.7

Note. Percentages over 51% place participant into either the precontemplation/contemplation or the preparation/action/maintenance group.

Table 5

Barrier statements made by individual participants

Participant	Barrier Statements
1	P: "Just kind of how much a big deal it is. Like if it's something I think I can handle, a little speech like two minutes long, I'm kind of anxious about it but I don't care, it's two minutes."
2	P: "But we had to quit because we couldn't afford her anymore and we felt like I was okay, so . . ." P: "What the people might say."
3	P: "I guess I never really saw it as like a huge problem." P: "I didn't see the reason to have help."
4	P: "'Cause I didn't think it was a big problem."
5	P: ". . . but I wasn't really like you know saying anything, you know, getting anything out." P: "It was a stranger." P: "I don't know, I just couldn't for some reason." P: "Maybe I just thought like it was just something that I was going through so I should just keep it to myself." P: "I didn't want to let people know that maybe something is wrong with me, you know?"

Participant	Barrier Statements
5	P: "It was weird. I didn't want to like see anybody to you know, to get better."
6	P: "I wish there was a way I wouldn't be quite as nervous about doing, getting up in front of people and meeting different people. But I don't really know what you could do for it so." P: "Just cause I'm usually not or it goes away once I'm there, you know?" P: "Um, well, I just never really thought about going to get help for it so."
7	P: "I just don't like talking to people." P: "I just keep everything to myself and just not share anything like little things I guess but really anything like . ." P: "I don't know because I don't know if talking to them would really make a difference when it actually comes to going into a situation."

Participant	Barrier Statements
8	P: ". . . we had guidance counselors there, sometimes I'd just go in there and just talk to her, but not very often, because they switched in between like, my junior (year) I got a new one, and I just didn't go in there very much."
	P: "Didn't have time to"
	P: "I don't really know where to go."
	P: "Um, probably because I just figure that it won't go away and I'm avoiding it but I know that it won't."
	P: "I really have no idea who to go to."
	P: "I'm like I don't know who to go to. I have no idea."
9	P: "I just never really thought about it and like I just never really. I don't think I've ever really thought about it."
	P: "I've never really thought about it, anything more than just shyness or anything."
	P: "So I mean. I've thought about it but I didn't ever like think it was really that big a deal that I needed to go talk to somebody about it."
	P: "I don't really know how."

Participant	Barrier Statements
10	P: "I pretty much just didn't want it." P: "I was kind of scared to speak up about it like I felt like my problem wasn't big enough to go and get help so I should just kind of shut up about it and it'll eventually be okay."

Table 6

Facilitator statements made by individual participants

Participant	Facilitator Statements
1	P: " I think . . It had something to do with it, . . . that I started feeling really tired all the time and just kind of wound down from having so many things to do." P: ". . . Umm, a little bit because I had been tired and she thought, umm, she has like Bipolar disorder and then my dad, like has, umm just diabetes, like really bad, so the being really tired, she wanted to see if it was a cause (sic) from either of those effecting me of if it was just cause of stress and everything." R: "It sounds like if you got to the point where you know things are going really hard, you would go and seek help for it?" P: "Uh, huh."
2	P: "Well, actually my mom decided for me." P: ". . . and then he started yelling at me as if I hadn't done anything all day so I started yelling back at him." P: "It was my mom's idea to go."

Participant	Facilitator Statements
2	P: "I used to hang out with my friends a lot more and I just kind of stopped enjoying what I used to do and I would just be more irritable and then what put it over the edge was that fight with my youth pastor." P: "It was just all get built up and so I just decided that I better talk to somebody before I blow up." P: "I was just having troubles with my friends or something and it was just bother me so much and I would think about it constantly and so I guess that."
3	No facilitator statements coded.
4	No facilitator statements coded.
5	P: "But my parents noticed you know that I was more you know, I don't know, they thought maybe I had depression or something, so they um, took me to, you know, like a psychologist or whatever for awhile." P: "It was more my parents just like, you know, making me go because they wanted me to get better or whatever." P: "Like it was weird like I was mad at people because they didn't come up to me but I also thought I could have come up to them too, so it was kind of my fault also."

Participant	Facilitator Statements
5	P: "But also like my parents said I slept a lot more. . ."
	P: "And so I was kind of mad at her but then that when like I noticed that, wow, other people are noticing that I have a problem, so that maybe I do."
6	No facilitator statements coded.
7	No facilitator statements coded.
8	P: "Just to, 'cause if I don't talk to anybody about it, then it's not gonna help me out any, 'cause I need to talk to somebody to make myself feel better."
	P: "Um, mostly because I knew my mom couldn't always talk to me."
	P: "Just because the way I feel, so uncomfortable."
9	No facilitator statements coded.
10	P: "I just started getting really sick so . . ."
	P: "Mm, hmm. Like my mom found out and kind of made me start going so, that's kind of how I started."
	P: "I guess just . . . feeling better and happier in general I feel like I can do it now."
	P: "I know if I go I'll feel better."
	P: "I know that if I want to feel better then I got to go."

Participant	Facilitator Statements
10	P: "'Cause I want it. I just want to feel better." P: "I guess finally figuring out that I did have a problem and that it was important enough and that I . . . knowing that there was something that could be done about it."

Table 7

Mean number of coded barrier and facilitator statements and mean severity score by stage of change group (N = 9)

	Barriers	Facilitators	Mean Severity Score
Precontemplation/ Contemplation stages	3.20	0.60	1.93
Preparation/ Action/ Maintenance stages	3.00	5.25*	1.42

* $p = .005$

Appendix A
Social Anxiety Help-Seeking Interview

Goal of Interview

To define factors that facilitated and hindered help-seeking behavior from the beginning when the participant first realized the problem to the present date. If participant had not sought treatment, the goal is to identify factors that has kept the participant from seeking treatment and their ideas and beliefs about the nature of their problem.

General Form of Interview

Ask client to define the social anxiety problem as indicated by surveys. Then, ask them to recall their first experiences with it (first problematic experience) followed by subsequent (problematic) experiences to the present. At each experience, assess how the thought about it, how they felt about it, how they acted (or didn't) in response to it, and why they did what they did in their opinion. Use expressions like, *"Can you tell me more bout that?"* or *"Can you help me understand that better?"* to prompt elaboration by the participant at each point in the interview.

Start of Interview

Introduction

First review SPAI with the participant.

Many people struggle with social situations. By your responses on the surveys I asked you to fill out, it seems that you may have some problems of your own when you are in social situations. What I'm interested in learning from you is if you have ever thought this as a problem, and if so, what you have done in the past or are currently doing to help yourself cope with this problem. Psychologists know relatively little about how people try to cope with this problem on their own. Since you have gone through this and know more about it than I do, I just want to ask you a few questions and ask that you give me your best impressions about what you've gone through. Is that okay with you?

If they agree.....*Okay, let's start with this question...*

Definition of Anxiety

In our own words, how do you describe what social situations are like for you? How do they affect you or interfere with your life? What do you think about this problem? Why? How do you feel about it? Why?

First Memories of Anxiety

Please tell me as best as you can about the first time you realized that this might be a problem for you?

What did you think it was?
How was it interfering with your life?
How did you fell about what was happening?
What actions did you take at that time to cope with this?
Why do you think you took these actions at that time?
When you first noticed this, what short or long term effects did you notice if any?

Present Experiences with Anxiety

Okay, let's move along from then and please tell me about your current problems in social situations?

What do you think it is?
How does it interfere with your life?
How do you feel about what is happening at this time?
What actions do you take now to cope with these problems?
Why do you think you take these actions?
In your opinion, why do these things happen to you?

Help-Seeking Behaviors

From your description of this, it seems like this is something that (choose appropriate term.. *Don't see as a problem, Think may be a small problem for you, See as a major problem for you). Have you ever sought help for this problem? Where did you look for help from? Let's summarize all the things you've done to help you cope with this?*

1. Ask and list all the ways that the participant sought help, from the first to the current instances (Include any information seeking actions, friends, family, prayer etc., self-help, professional help). You can ask about specific ways if needed.

For each different place they sought help from ask the following...

Why did you seek help from (insert place or person)?
How did you feel about asking them for help?
What did you think about asking them for help?
Did you feel that you received help from them?

At the end of the interview, ask the following questions:

1. *In your opinion, what things prevented from seeking help or have led you to not seeking help?*
Try to have the participant verbalize all the reasons that they can think of. Have them rank order them from most influential to least influential.

2. *In your opinion, what things helped you to seek help?*
Try to have the participant verbalize all the reasons that they can think of. Have them rank order them from most influential to least influential.

3. *In your opinion, what is/are the most important thing(s) that made you seek help? That prevented you from seeking help earlier?*

4. *Do you feel you have resolved this?*
If YES ask, "Did you resolve this more than six months ago?"

If NO ask?, "Have you taken action to resolve this within the last six months?"
If NO ask, "Are you intending to take action in the next month?"
If NO ask, "Are you intending to take action in the next six months?"

During the last question, if the participant asks the interviewer whether or not they think the participant should seek help, the interviewer should reinforce the idea that these types of problems are normal and that the way that people deal with them differs from person to person. Reemphasize the fact that we are merely collecting data on the social interactions of college students, their perceptions of them, and their methods of dealing with them.

Appendix B

CODING MANUAL

Introduction

The purpose of this study is to collect data on the social interactions of socially anxious individuals. While mental health professionals know a great deal about these types of anxieties, there is a surprising lack of literature examining those behaviors that socially anxious individuals engage in to help themselves. The importance of studies such as this one are evident when one realizes just how little we actually know about individuals efforts to cope with these problems or difficulties outside of the realm of counseling or psychotherapy.

Your role in this study is to code transcripts taken from interviews with individuals who struggle in social situations. You will code for the presence of several variables such as the participants' explanatory models of their problems, actions they have taken to help themselves cope with these situations, and barriers and facilitators that may have influenced their decisions on whether or not to seek out professional help.

One of the most important aspects of psychological research is confidentiality. Whenever psychology students or professionals run research projects, they are collecting personal information about their participants. Just as in a therapy setting, keeping that information confidential is absolutely necessary to protect the participants and researchers from negative consequences. As coders in this study, you will be privy to information about individuals that is personal and could be upsetting or damaging to the participants should that information be treated unprofessionally. It is your responsibility to ensure

that all the information you work with is kept safe. Anyone who works on a project such as this must understand and agree to respect the information they work with. This means that no information that you see or hear during work on the project is to be discussed with anyone outside the project or in an environment that is not private. All information that you see during your work on this project is to be kept absolutely private and treated with utmost respect. The consequences of violating confidentiality on this project include removal from the project team and other possible disciplinary actions.

Thank you for your assistance with this study and we hope that you enjoy working on this project.

Stages of change

Prochaska and DiClemente (1983) created a stage model of an individual behavioral change. This model was developed during research on addictions, specifically nicotine, but has been applied to the area of anxiety disorders (Prochaska,1991). This model states that all people are in one of five stages with regard to changing a target problem behavior or theme of problem behaviors. These stages are precontemplation, contemplation, preparation, action, and maintenance (Prochaska & DiClemente, 1983; Prochaska, 1991; Prochaska, DiClemente, & Norcross, 1992; Prochaska & Prochaska, 1999).

The first of these stages, the precontemplation stage, is when the individual denies that they have a problem. They obviously cannot change. The second stage is the contemplation stage, in which the individual thinks that they may want to change but is not sure. They realize that there may be a problem and are considering what they should

do about it. The third stage is the preparation stage where an individual is preparing to take action soon, and has unsuccessfully tried to take action in the past. The fourth stage of behavior change is the action stage in which they are attempting change but have only been doing so for a short period of time. The final stage is the maintenance stage in which they have achieved some level of change and are attempting to maintain the new level of functioning. These stages are not a linear progression but a more like a spiral in which the individual moves through the stages and will repeat previous stages when they fall back into their problem behaviors.

Help (Health) seeking behaviors

Definition- Behaviors taken by a participant that are intended to help the participant deal with their anxiety or the consequences of their anxiety. These behaviors can be active (problem specific strategies, talking about their anxiety with someone, relaxation techniques, etc.) or passive(avoidant behaviors, or internal processing with no real change intended).

1. Five stages of behavioral change

    i. Precontemplation-Doesn't think anxiety is a problem and has not thought of seeking help.

        Examples: "I don't really think of it as a problem."

        "It doesn't really bother me."

        "I don't think that I really need any help with it."

    ii. Contemplation-Thinks anxiety may be a problem but not thinking of seeking help from professionals.

Examples: "It seems like it holds me back some."

"I wonder if I should try and do something about it."

"I have thought that it might be a problem, but I don't know what to do about it."

iii. Preparation- Thinks anxiety is a problem and will be seeking professional help in next 6 months.

Examples: "Yeah it keeps me from doing stuff."

"I think that it is a real problem for me, but haven't done anything yet."

"I have thought about getting some help for it."

iv. Action- Identifies anxiety as a problem and is currently seeking professional help.

Examples: "I realized that it was a problem, and I am seeing a counselor about it."

"I started seeing a counselor because my parents made me, but I keep going because it is helping me."

"I have been seeing a psychiatrist, and I talk to my pastor about it."

v. Maintenance- Identified anxiety as something that used to be a problem, but is using coping strategies to help keep the anxiety under control and reduce its impact on their life.

Examples: "I used to see a counselor, and I learned ways that I can cope with it."

"I have figured out ways to deal with it and it no longer is as big a problem as it was."

"I keep working to keep my anxiety under control."

2. Name

Name for social anxiety. (Participant must spontaneously give name after being initially asked.)

"Nerves"

"Shyness"

"Butterflies"

No name for social anxiety. (Participant does not give a name spontaneously and gives nothing or mimics a word given by the interviewer.)

3. Endorsed barriers to seeking professional help

Definition- Any thoughts, reasoning, actions, beliefs, feelings, events, etc. that prevented the participant from seeking help.

Types of Barriers:

Didn't think treatment was necessary

"I just figured it wasn't something I needed."

Didn't think treatment would help

"I didn't talk to anyone about it cause it didn't seem like it would help."

"It didn't seem like something that would help me."

"I just never thought it would do me any good."

Didn't know where to go

"I have thought it was a problem, but I don't know where to get help for it anyway."

"I wouldn't know who to talk to."

Didn't know help was available

"There isn't anywhere to get help for it."

"I don't think that there s anything that can help me with it."

To embarrassed to seek out help

"It was like, I can't see someone about this, I would just die."

"I wouldn't talk to them anyway, it was to embarrassing."

Not financially able

"I can't afford to see a therapist about it."

"My insurance wouldn't cover it."

Social stigma

"Normal people don't go to therapists."

4. Endorsed facilitators to seeking professional help

Definition- Any thoughts, reasoning, actions, beliefs, feelings, events, etc. that encouraged the participant to seek out help.

Types of facilitators:

Family recommended

"My mom told me she was really worried and asked me to go talk to someone about this."

Family forced

"My parents made me go see a counselor and a psychiatrist."

Friends recommended

"My friends told me that I should go see someone because they were worried about me."

Self-recommended

"I just decided that it was something I needed if I was going to get better."

Positive reports from trusted others about effectiveness of treatment

"My friend told me that seeing a counselor really helped them."

Referred by physician

"My family doctor told me to go see this counselor."

Increased symptoms

"It seemed like it was getting worse."

"I noticed that it seemed like it was becoming a bigger problem."

Comorbidity (The presence of possible other mood disorders)

"I was depressed."

"I slept all day."

"I cried a lot."

5. Coping Behaviors

Defintion- Behaviors taken by a participant that are intended to help the participant deal with their anxiety or the consequences of their anxiety.

A. Direct coping (Def.- Behaviors that the participant has engaged in that are active or goal orientated ways to help them deal with or resolve their anxiety.)

Types of Direct Coping

Social Contact

Parents/family

"I talked to my mom about it."

"My dad and I talked about it quite a bit"

"I'm really close with my sister and she talks with me a lot about this."

"My brother goes with me to a lot of places I wouldn't go to by myself."

Friends

"I talked to my friends about my problems."

"I tell my friends some of it, but not all."

"I go places with my friends to help myself feel more comfortable."

"I usually meet new people through my friends."

Professional Help

Mental health professionals (psychologists, psychiatrists, therapists)

"I talked to a counselor about this."

"My mom made me go to a therapist."

"A psychiatrist (or doctor) prescribed me some medicine for it."

Religious figures (priests, ministers, etc)

"I have talked to my pastor about this quite a bit."

"I talked with my minister about it once."

Psychotropic medications (antidepressants, anti-anxiety, Must be prescribed by a doctor)

"I tried taking medication that my doctor prescribed for awhile."

"I take some drugs my doctor prescribed."

Self-medication (use of alcohol or drugs)

"I started smoking a lot of pot."

"I drink quite a bit to help take my mind of it."

"When I drink or get high I don't notice it at all."

Self help (books, tapes, etc)

"My mom gave me some books to read about it."

"I read about it on the internet."

Forcing self to endure anxiety-provoking situations

"I made myself go to the party even though I didn't want to."

"I thought about skipping class that day, but I went anyway."

Using positive self-talk

"I just kept telling myself, 'I can do this'."

"I kept telling myself to calm down."

"I just kept thinking over and over again, 'It will be fine'."

B. Passive Coping (Def.- Behaviors that the participant has engaged in that are not active, goal orientated ways to deal with their anxiety.)

Types of Passive Coping

i. Avoidant (retreating from the situation or attempting to ignore the problem)

Normalize or attempt to redefine the situation as nonthreatening

"Everybody gets nervous giving speeches, don't they?"

Distraction

"I tried to concentrate on my job."

Attempts to accept the problem

"This is who I am, so I have to live with it."

Attempts to ignore the problem

"It's no big deal."

Doing nothing

"I decided not to go to the party."

"I was too nervous to meet her friends, so I told her I was sick."

"I didn't want to join the club because I didn't know anyone."

Attempts to manipulate the environment

"I sit in the back of the class so I won't get called on."

"I like to eat at the table in the corner of the room so no one sees me."

ii. Ruminative coping (Internal thoughts that do not bolster the participants drive to change and are often repetitive and negative.)

"I wish I was more outgoing."

"All I did during school was worry about the speech."

6. Appraisals of Coping

Definition- The participants own opinion on what effect the behaviors taken had.

i. The behavior had an effect.

"It really made me feel better."

ii. The behavior had no effect.

"I didn't feel like I could open up to a stranger."

"It held me back from meeting people."

iii. Aggravated effect.

"It had both negative and positive consequences."

"Well, I didn't have to give the presentation, but now I have to take the course over because I dropped it."

Explanatory models: Includes etiology, time and mode of symptom onset, pathophysiology, course of disorder, and treatment.

7. Internal/External

Internal (Def.-Internal explanatory models refer to the cause or reason for the problem being within the participants personality or physiological make-up.)

Physiological/biological (Includes any physiological or genetic explanations for the cause of the problem such as inheritance, genes, brain chemistry, brain physiology, etc.)

"My mom is shy, so I think I inherited it from her."

Personality (Includes any personality traits or personality make-ups that are identified by the participant to be the cause or root of the problem such as personality traits, personal preference, etc.)

"It's the kind of person I am."

"It's a part of who I am."

"I'm just a shy person."

External (Def.-External explanatory models refer to the cause or the reason for the problem being outside of the participant. This refers to blaming others for the problem or believing that others views or the environment are the root of the problem.)

"It's them."

"They acted like it was a big deal!"

"No one asked me to the dance."

8. Stable/Unstable

Stable (Def.- The participant perceives social anxiety as unchangeable.)

"It's always going to be there."

"There's nothing I can do to change."

Unstable (Def.- The participant perceives social anxiety as having the potential to be overcome.)

"I can change."

"I probably won't be like this when I'm older."

9. Global/Specific

Global (Def.- The participant notices the anxiety in all social situations regardless of the type of situation. Important note: This refers to a participant stating that anxiety is noticed during all social events regardless or their nature or the circumstances around the situation. For example, a participant states that they become nervous whenever

they are in a social situation, regardless of the circumstances. This is considered to be global.)

"It affects everything."

Specific (Def.- The participant notices the anxiety in specific social situations but not all. Important note: This refers to a participant stating that anxiety is noticed during social events of a specific nature or under specific circumstances. For example, a participant states that they become nervous whenever they give speeches, but not when hanging out at a party. This is considered to be specific.)

"It affects only this."

"Only speeches."

"Only around authority figures."

10. Severity of social anxiety: (Def.- The participant's evaluation of the severity of their social anxiety or the level of impact it has on the participants life.)

High

"It is a problem."

Moderate

"It is somewhat of a problem."

Low

"It is not much of a problem."

11. Comorbidity: (Def.- The participant reports having symptoms of another disorder or being diagnosed with another disorder other than social phobia.)

Yes

"I felt tired all the time and cried for no reason."

"My friends thought maybe I was depressed."

No Code

Participant does not report any other symptoms.

Appendix C

Coding Manual Quiz Key

1. Briefly describe the stages of change according to Prochaska:
Precontemplation: Individual is not aware of problem or minimizes impact of problem.
Contemplation: Individual is aware of problem and acknowledges impact of problem.
Preparation: Individual is aware of problem and is or has attempted to improve their life without use of professional help. May be planning to seek out professional health or has given serious thought to seeking out professional help.
Action: Individual is aware of problem and is actively using professional help for problem.
Maintenance: Individual is aware of past problem. Problem has been minimized or resolved after using professional help.

2. Define help (health) seeking behaviors:

Behaviors that allow individual to deal with anxiety or consequences of anxiety. They may be direct or passive.

3. Define explanatory models (EM):

EMs rely primarily on the subjective interpretations and meaning that individuals assign to symptoms and illnesses.

4. What are two questions EMs ask?

EMs ask these questions: What do you call the problem; what do you think the illness is; what do you think the natural course of the illness is; what do you fear; why do you think this illness or problem has occurred; how do you think the illness should be treated; how do you want us to help you; who do you turn to for help; and who should be involved in decision making?

5. What are the five stages of behavioral change? Give an example statement of each one.

Precontemplation-Example: "I don't really think of it as a problem."
Contemplation-Example: "It seems like it holds me back some."
Preparation- Example: "Yeah, it keeps me from doing stuff."
Action- Example: "I realized that it was a problem, and I am seeing a counselor about it."

Maintenance-Example: "I used to see a counselor, and I learned ways that I can cope with it."

6. When must you code yes for name?

Participant must spontaneously give name after being initially asked.

7. Define barriers as they apply to professional help seeking:

Any thoughts, reasoning, actions, beliefs, feelings, events, etc. that prevent individual from seeking help.

8. Give two example of barriers:

Didn't think treatment was necessary
"I just figured it wasn't something I needed."
Didn't think treatment would help
"I didn't talk to anyone about it cause it didn't seem like it would help."
"It didn't seem like something that would help me."
"I just never thought it would do me any good."
Didn't know where to go
"I have thought it was a problem, but I don't know where to get help for it anyway."
"I wouldn't know who to talk to."
Didn't know help was available
"There isn't anywhere to get help for it."
"I don't think that there s anything that can help me with it."
To embarrassed to seek out help
"It was like, I can't see someone about this, I would just die."
"I wouldn't talk to them anyway, it was to embarrassing."
Not financially able
"I can't afford to see a therapist about it."
"My insurance wouldn't cover it."
Social stigma
"Normal people don't go to therapists."

9. Define facilitators as they apply to professional help seeking:

Any thoughts, reasoning, actions, beliefs, feelings, events, etc. that encourage individual to seek out help.

10. Give two examples of facilitators to seeking professional help:

Family recommended
"My mom told me she was really worried and asked me to go talk to someone about this."
Family forced
"My parents made me go see a counselor and a psychiatrist."
Friends recommended
"My friends told me that I should go see someone because they were worried about me."
Self-recommended
"I just decided that it was something I needed if I was going to get better."
Positive reports from trusted others about effectiveness of treatment
"My friend told me that seeing a counselor really helped them."
Referred by physician
"My family doctor told me to go see this counselor."
Increased symptoms
"It seemed like it was getting worse."
"I noticed that it seemed like it was becoming a bigger problem."
Comorbidity (The presence of possible other mood disorders)
"I was depressed."
"I slept all day."
"I cried a lot."

11. Define coping behaviors:

Behaviors taken by an individual that are intended to help deal with anxiety or the consequences of anxiety.

12. Name and define the two main kinds of coping:

Direct- Behaviors an individual has engaged in that are active or goal orientated ways to help them deal with or resolve anxiety.
Passive- Behaviors an individual has engaged in that are not active, goal orientated ways to deal with anxiety.

13. Give three examples of avoidant coping:

Normalize or attempt to redefine the situation as nonthreatening
"Everybody gets nervous giving speeches, don't they?"
Distraction
"I tried to concentrate on my job."
Attempts to accept the problem

"This is who I am, so I have to live with it."

Attempts to ignore the problem

"It's no big deal."

Doing nothing

"I decided not to go to the party."

"I was too nervous to meet her friends, so I told her I was sick."

"I didn't want to join the club because I didn't know anyone."

Rationalizing

Attempts to manipulate the environment

"I sit in the back of the class so I won't get called on."

"I like to eat at the table in the corner of the room so no one sees me."

"I held a poster to hide behind."

14. Give one example of ruminative coping:

"I wish I was more outgoing."
"All I did during school was worry about the speech."

15. Define appraisal of coping:

The participant's own opinion on the effect of the coping strategy.

16. Name the three appraisals that may be coded:

The behavior had an effect.
The behavior had no effect.
Aggravated effect.

17. Define internal ES and give an example:

Internal explanatory styles refer to the cause or reason for the problem being within the participant's personality or physiological make-up.
"My mom is shy, so I think I inherited it from her."
"It's the kind of person I am."
"It's a part of who I am."
"I'm just a shy person."

18. Define external ES and give an example:

External explanatory styles refer to the cause or the reason for the problem being outside of the participant. This refers to blaming others for the problem or believing that others views or the environment are the root of the problem.

"If he would have said that, I wouldn't have been nervous."
"They acted like it was a big deal!"
"No one asked me to the dance."

19. Define stable ES and give an example:

Individual perceives social anxiety as unchangeable; may state having always been or always will be socially anxious.
"I'm always going to be shy no matter what."
"There's nothing anyone can do to help me change."

20. Define unstable ES and give an example:

Individual perceives social anxiety as having the potential to be overcome; does not believe will always be socially anxious.
"I have to change in order to do well at school."
"I probably won't be like this when I'm older."

21. Define global ES and give an example:

Individual notices the anxiety in all social situations regardless of the type of situation. Important note: This refers to a participant stating that anxiety is noticed during all social events regardless or their nature or the circumstances around the situation.
"I just don't like being around people."

22. Define specific ES and give an example:

Individual notices the anxiety only in specific social situations or around certain people.
"I only get nervous around authority figures."
"I don't like eating in front of people, but I'm OK in other social situations."
"I can talk in front of class, but I cannot play my flute during recitals because I get too scared."

23. What are the three levels of severity that may be coded?

High, moderate, low.