Eastern Illinois University
The Keep

Masters Theses | Student Theses & Publications

2004

An Examination of Explanatory Models, Coping Methods, and Help-Seeking Methods among Individuals with Social Phobia

Brooke Jasmine DiBello
Eastern Illinois University

This research is a product of the graduate program in Clinical Psychology at Eastern Illinois University. Find out more about the program.

Recommended Citation

DiBello, Brooke Jasmine, "An Examination of Explanatory Models, Coping Methods, and Help-Seeking Methods among Individuals with Social Phobia" (2004). *Masters Theses*. 1333.
https://thekeep.eiu.edu/theses/1333

This is brought to you for free and open access by the Student Theses & Publications at The Keep. It has been accepted for inclusion in Masters Theses by an authorized administrator of The Keep. For more information, please contact tabruns@eiu.edu.

THESIS/FIELD EXPERIENCE PAPER
REPRODUCTION CERTIFICATE

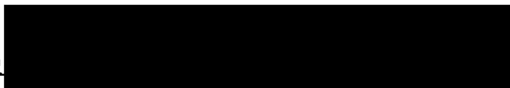
TO: Graduate Degree Candidates (who have written formal theses)

SUBJECT: Permission to Reproduce Theses

The University Library is receiving a number of request from other institutions asking permission to reproduce dissertations for inclusion in their library holdings. Although no copyright laws are involved, we feel that professional courtesy demands that permission be obtained from the author before we allow these to be copied.

PLEASE SIGN ONE OF THE FOLLOWING STATEMENTS:

Booth Library of Eastern Illinois University has my permission to lend my thesis to a reputable college or university for the purpose of copying it for inclusion in that institution's library or research holdings.



Author's Signature   4-28-04
                                                          Date

I respectfully request Booth Library of Eastern Illinois University **NOT** allow my thesis to be reproduced because:

____

____

____

Author's Signature   Date

thesis4.form

An Examination of Explanatory Models, Coping Methods, and Help-Seeking Methods Among Individuals with Social Phobia

(TITLE)

BY

Brooke Jasmine DiBello

THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

Master of Arts in Clinical Psychology

IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY
CHARLESTON, ILLINOIS

2004

YEAR

I HEREBY RECOMMEND THAT THIS THESIS BE ACCEPTED AS FULFILLING
THIS PART OF THE GRADUATE DEGREE CITED ABOVE

5/07/04

DATE

THESIS DIRECTOR

5/7/04

DATE

DEPARTMENT/SCHOOL HEAD

An Examination of Explanatory Models, Coping Methods, and Help Seeking Behaviors Among Individuals with Social Phobia

Brooke Jasmine DiBello

Eastern Illinois University

Acknowledgements

I would like to thank my thesis advisor, Dr. Keith Wilson, and the members of my committee, Dr. Ronan Bernas and Dr. Russell Gruber. I appreciate the time and effort put forth by Libby Keller and Kendra Holder in learning the coding manual and coding the transcripts. Thank you to Hyland Smith, who helped create the interview and coding manual. Most importantly, thanks to the participants in the study who allowed us to interview them. Lastly, thank you to my husband, Lou, for his patience and support.

Abstract

In this pilot study, explanatory models, coping methods, and help seeking behaviors among individuals with social phobia were explored using in-depth interviews. Participants were ten female college students with probable social phobia. Researchers created a coding manual to investigate the qualitative data by organizing it into categories. Coders were trained to utilize the coding manual, which explored several factors such as name for social anxiety, explanatory models, perceived level of severity, coping methods, and appraisals of coping methods. Contributions of this study are a semi-structured help-seeking interview, coding manual, and rich data. Although the results were inconclusive, this study provides a foundation for future research on help seeking behavior, coping strategies, and explanatory models among individuals with social phobia.

An Examination of Explanatory Models, Coping Methods,

and Help Seeking Behaviors Among Individuals with Social Phobia

INTRODUCTION

Social phobia is a devastating disorder with a lifetime prevalence rate according to the DSM-IV-TR of 3-13% (American Psychiatric Association, 2000). The reported lifetime prevalence of social phobia assessed in the National Comorbidity Survey was found to be 13.3% (Magee, Eaton, Wittchen, McGonagle, & Kessler, 1996). Stein, Torgrud, and Walker (2000) found incidence among a community sample to be 7%. Within the last decade, the prevalence of social phobia has been found to be very high within community and primary care settings.

Social phobia, also known as social anxiety disorder, is defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) as a "marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others (American Psychiatric Association, 2000). The feared social or performance situations are avoided or else endured with intense anxiety or distress. An individual may be diagnosed with nongeneralized social phobia or generalized social phobia, a specifier referring to fears of most social situations.

Individuals with social phobia have an increased public self-consciousness and sensitivity to being evaluated in social or performance situations. They fear others will perceive them as inadequate. It is thought that by paying extra attention to minor errors or negative feedback, the individual is provided with evidence confirming his or her expectations, creating a self-fulfilling prophecy. The individual learns that escaping or

avoiding the situation reduces anxiety, however the same avoidance while reducing anxiety also impairs social skills and quality of life (Radomsky, 2001).

Stein, Torgrud, and Walker (2000) examined the seriousness of social phobia as a public health problem by administering a survey to a random sample of participants from the community. Participants were interviewed over the telephone by professional interviewers. Each interview lasted approximately 30 minutes. Respondents rated how their social fears and/or avoidance had made an impact on specific functioning and if they had made accommodations. The researchers assigned participants with social fears into three groups based on the number of specific fears: 1-3, 4-6, and 7-12. The latter group consisted of those meeting DSM-IV criteria for generalized social phobia. One in five individuals with social phobia believed that their social fears had interfered significantly with their education, and almost one in two actually dropped a class because of these fears. One in five reported that social fears had hindered them considerably in getting or keeping a job. Approximately one third of individuals with social phobia in the community reported substantial interference with one or more areas of functioning attributed to their social anxiety and/or avoidance.

Pollard, Henderson, Frank, and Margolis (1989) found that only 8% of participants with social phobia reported seeking help for their disorder. One hundred forty two individuals were diagnosed according to DSM III criteria through a structured interview as having agoraphobia, social phobia, or obsessive-compulsive disorder. They were asked if and where they sought help and how they found or would find treatment. It was found that no demographic factors differentiated help seekers from non-help seekers other than those who sought help were more likely to live in a city. Almost half of help

seekers did not see mental health professionals, but rather clergy or family physicians. A limitation to this study is that the small number of help seekers limited their analyses of factors that might have been related to help seeking. Only 14% of the participants had ever received professional help. The researchers state that it may be easy for participants to cope with social phobia and other anxiety disorders by using avoidance techniques, therefore not necessitating professional help.

Zimmerman and Mattia (2000) examined whether individuals who utilize outpatient psychiatric services seek treatment for all the disorders or only for the principal disorder for which they are seeking help. Four hundred outpatients at a hospital affiliated, community based, psychiatric clinical practice were interviewed with the Structural Clinical Interview for DSM-IV (SCID). If a participant had more than one disorder, the diagnoses were assigned as principle or additional. This was determined by assessing if the disorder was the participant's stated primary reason for treatment or an additional disorder. For all disorders, participants were asked whether symptoms of each disorder were a reason for seeking treatment.

This study determined that most individuals with major depression wanted treatment for it and more than 85% of those with panic disorder, post-traumatic stress disorder, and generalized anxiety disorder reported symptoms of these disorders as reasons for seeking treatment. Only half to two thirds of individuals with social phobia, obsessive-compulsive disorder, intermittent explosive disorder, body dysformic disorder, or substance use disorders reported symptoms as reasons for seeking treatment. It was found that many individuals with social phobia seek treatment for symptoms of comorbid

conditions, such as depression. Only 53% of patients with social phobia reported that the symptoms of this disorder were their primary reason for seeking treatment. Zimmerman et al. state several possible reasons that patients might not seek treatment for all disorders, such as social phobia. One reason is that patients might have accepted it as part of their normal self. Another reason for not seeking treatment is lack of insight about the significance of symptoms. A limitation to this study is that its sample was drawn from an adult out-patient private practice setting, that did not accept Medicaid. The study did not have any lower-income participants due to this.

Many individuals develop comorbid disorders, with just one being the primary reason for attending treatment (Dingemans, van Vliet, Couvee, Westenberg, 2001). Although social phobia occurs frequently in the general population, it may be underreported due to masking by comorbid disorders. Dingemans et al. determined severity and disability of social phobia to depend on comorbidity with other disorders, such as depression, substance abuse, or affective disorders. This retrospective study was conducted in the Netherlands by evaluating sixty-four medical records from anxiety disorder clinics. The medical records used all contained a diagnosis of social phobia. Severity of social phobia was determined by examining symptoms of avoidance, behavior, anticipatory anxiety, and social impairment. Records were screened by a checklist screening for demographic data, symptoms, previous treatment, and present treatment.

Dingemans and colleagues (2001) found a 14-year delay between the onset of social phobia and treatment. Dingemans et al. report that, based on current research, many with social phobia believe they can handle their symptoms by themselves. They

also state that possibly the symptoms must become serious or disruptive enough to the individual's life to require treatment or these individuals may simply consider their disorder as a temporary problem. Another reason may be that as subsequent comorbid conditions worsen, the social phobia symptoms may become even more incapacitating. Many may be embarrassed to contact a mental health professional or fear psychiatric labeling. Some individuals may have come to accept social phobia as part of their personality and have learned to cope with it through avoidance, not knowing that it is a treatable disorder.

Dingemans et al. (2001) found that half of the clients used alcohol to self medicate. Half of the clients had a comorbid Axis I disorder, typically another anxiety disorder, an affective disorder, alcohol dependency, or a combination of these. Nine percent had an Axis II diagnosis in Cluster C, which consist of disorders where individuals often fear social relationships and feeling out of control. Those with a comorbid diagnosis reported more impairment in functioning.

After statistically analyzing demographic data, Dingemans and his colleagues concluded that men with a high educational level, a job, and a moderate form of social phobia tended to seek help more. Another group that tended to seek help consists of individuals with a severe form of social phobia who receive social security disability benefits. The reason for finding two groups of individuals who seek help may be because those who function at a higher educational and professional level have to face feared situations in a regular basis and have more exposure to fears, whereas those who are less educated are able to avoid fearful situations more. Limitations to this study are

that it is retrospective, based only on medical records, and was conducted in the Netherlands.

In summary, Pollard et al. (1989) found that only 8% of individuals with social phobia seek help. It appears that individuals with social phobia try to deal with their anxiety on their own until it causes sufficient distress, either by causing a comorbid condition or interfering significantly with the person's life (Dingemans et al., 2001). Often these individuals develop another disorder, such as depression or substance abuse, as a result of their anxiety and this prompts help seeking (Zimmerman et al, 2000). Those with social phobia may attempt to cope on their own, until their anxiety become too overwhelming.

The previous studies discussed, while offering valuable information, possess limitations that this study hopes to improve upon. Pollard et al.'s (1989) small number of help seekers limited their analyses of factors that might have been related to help seeking, whereas this study also has a small number of participants, but this is necessary in qualitative research. Zimmerman et al.'s (2000) study used a sample drawn from a single general out-patient private practice setting, therefore tended to have higher incomes. While the Dingemans et al. (2001) study is based only on medical records, the proposed study will interview participants in person and use additional psychometric measurement, thus resulting in greater reliability.

Even with several effective treatments available, many individuals with social phobia are especially unwilling to seek treatment. Social phobia is gradually becoming better known in the general community and accepted as a disorder, however it appears that many individuals are still not aware that it is a disorder. Despite the growing body of

research within the last decade, social phobia is a disorder in need of much more research. In particular, more knowledge on the process by which people come to seek help would be beneficial.

A longitudinal study by Cameron et al. (1993) examined how individuals seek medical care from the point of first noticing symptoms to deciding to call for help. Participants, drawn from a primary care roster of general and geriatric medicine clinics of a university hospital, were interviewed every three months, five times over approximately one and a half years. To assess change, participants were asked to evaluate symptoms from two time points: when they first noticed their symptoms and the present time. They also examined participants' symptoms representations. Symptoms representations consist of five components: the identity of the illness and the symptoms associated with it; the cause of the illness; the consequences of the illness; a time line for the illness; and the perception of the degree to which the illness is curable/controllable.

Cameron et al. (1993) found many differences between care seekers and non-care seekers. Participants who sought care rated their symptoms as higher on seriousness ratings (even if the symptoms were the same as non-help seekers) and were more likely to identify possible negative consequences of their symptoms. Help seekers were found to use more active coping skills, such as self-treatment attempts and seeking information about the health problem, while non-help seekers used more passive methods, such as distraction, attempts to ignore the problem, attempts to accept the problem, doing nothing, and attempts to redefine the symptoms as non threatening. Help seekers tended to use social communication more, as a means of telling others about their symptoms. The main reason for this appeared to be to simply talk to others about symptoms, not

necessarily to gain information. It was concluded that social communication helps people manage multiple stressors and minimize stress. Help seekers also had a name for their problem. A limitation to this study is its focus on general medical conditions, not mental disorders.

One way to learn more about how individuals with social phobia cope with their anxiety and why they choose to seek or not to seek help is to examine their explanatory models. Anthropologist Arthur Kleinman (1980) defines explanatory models (EM) as, "Notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process." Explanatory models help patients and practitioners decide among available treatments.

According to Kleinman (1980), explanatory models are better elicited in home settings, rather than clinical settings. However, it is possible to elicit explanatory models if mental health professionals are persistent, genuine, and non judgmental (Kleinman, 1980). It is necessary to let clients know their explanatory models are important. Individuals with social phobia may build upon their own explanatory model through communication with others about their symptoms. Explanatory models determine how individuals choose to cope with their problems, either passively or actively. Sharing EMs with others may influence an individual's likelihood to seek professional help.

Questions that help elicit explanatory models are (Kleinman, 1980, pp 106):

1. What do you call your problem? What name does it have?
2. What do you think has caused your problem?
3. Why do you think it started when it did?
4. What does your sickness do to you? How does it work?

5. How severe is it? Will it have a short or a long course?

6. What do you fear the most about your sickness?

7. What are the chief problems your sickness has caused for you?

8. What kind of treatment do you think you should receive? What are the most important results you hope to receive from treatment?

An element of explanatory models is explanatory or attributional style. According to Peterson and Seligman (1987), explanatory style (ES) is an individual difference that influences how people respond to bad events. A study was conducted on depressed college students and found that compared to nondepressed college students, they attributed bad outcomes to internal, stable, and global causes, as measured by an attributional style scale. The reformulated helplessness model of depression predicted this attributional style. Compared to nondepressed student, depressed college students attributed good outcomes to external, unstable causes (Seligman, Abramson, Semmel, & von Baeyer, 1979).

Kleinman (1980) and Seligman et al.'s (1979) research, although extremely important, have limitations in regards to social phobia. Kleinman's research on explanatory models involves medical illnesses, while Seligman et al. (1979) examined the explanatory styles among depressed individuals. This study will be focusing on explanatory models among individuals with social phobia and how they relate to help seeking. Cameron et al. (1993) focused on general medical conditions, whereas this proposed study utilizes a similar methodology to examine psychological disorders, specifically social phobia.

The following study borrows Seligman's categories of explanatory or attributional style. This study anticipates differences in explanatory styles among individuals with social phobia who seek help and those who do not. Specifically, it explores whether individuals with social phobia who seek help have external or internal explanatory styles.

Every individual has different way of interpreting and explaining events. The work of Seligman et al.'s (1979) has shown that depressed individuals have a different explanatory style than non-depressed individuals, where they tend to blame themselves and have a global and stable outlook on bad events. According to Kleinman, social communication with others is very important in eliciting and expanding upon one's explanatory model. Although explanatory models are often inconsistent, it is still imperative that mental health professionals elicit each individual's EM to provide the best treatment available. Similar to EMs, are Cameron's symptoms representations, which show how individuals perceive their symptoms. If an individual believes that her anxiety can be overcome, then she is more likely to utilize direct coping methods, such as seeking professional help, rather than passive methods. Cameron et al. (1993) found that help seekers tended to use more active coping methods, while non-help seeker utilized more passive methods. Many times individuals with social anxiety may talk about their symptoms with friends or family. Often it is someone close to the individual with social phobia who encourages that person to seek professional help (Cameron et al.).

The majority of research exploring social phobia and help seeking is quantitative research. The dominant research paradigm of quantitative research can be defined as "an approach in which one tries to devise investigations to rule out threats to validity, to test specific hypotheses, to identify the impact of variables on some outcome of interest, and

to analyze data statistically" (Kazdin, 1998). However, in order to explore internal states that are often subjective, qualitative research allows researchers to gain information that quantitative methods cannot. Qualitative research attempts to learn about individuals' opinions, experiences, and feelings. According to Kazdin, qualitative research is designed to provide a systematic approach to description and understanding and to provide replicable, reliable, and valid accounts.

The data for qualitative research can be obtained through direct observations, letters, journals, videotapes, or through interviews, as done in this study. In many qualitative studies, the data is coded into categories and analyzed statistically in order to examine the occurrence of themes and their interrelations. Due to the intensive and time-consuming nature of qualitative studies, small samples are often used. With qualitative data it is intended to have few participants, but obtain vast amounts of rich information from each one.

Exploratory research involving the thoughts and perceptions of young adults with social phobia has never been done. The following study utilized in-depth interviewing in order to learn more about how individuals with social phobia cope with it and how they perceive their anxiety, more specifically their explanatory models. As this is a pilot study, the main goals of this study are 1) to develop a reliable coding system, which allows coders to look for specific information and themes among large amounts of data and 2) develop a qualitative interview to explore help-seeking. Through the use of qualitative research, this study hopes to obtain information from individuals with social phobia regarding how they perceive their anxiety, and particularly how it affects help seeking and coping methods.

The proposed methodology could be used to examine how Cameron et al.'s (1993) medical study findings extend to social phobia. Medical help seekers had a name for their problem, therefore this study hypothesizes that those who have a name for their problem will be more likely to be seeking or have sought professional help. Also, those who had a name for their problem had engaged in a greater variety of active coping skills, which this study also hypothesizes. Dingemans et al. (2001) and Zimmerman and Mattia (2000) found that many with social phobia also have a comorbid disorder, therefore this study hypothesizes that those who have previously sought help will report other symptoms than social phobia. In Cameron et al.'s study help seekers also reported more symptoms. Dingemans et al. determined that more symptoms causes more distress, thus this study hypothesizes that individuals with social phobia who report more distress will also report more active coping skills, such as help seeking. Using Seligman et al.'s (1979) categories of explanatory style, it is anticipated that there will be differences between help seekers and non-help seekers. It is expected that those individuals with external ESs will be more likely to seek help.

This proposed methodology could conceivably be used to address the following hypotheses: First, participants who have a name for their problem are more likely to currently be seeking or have sought professional help. Second, those who have a name for their problem will have engaged in a greater variety of coping skills. Third, those who have previously sought help will report other symptoms than social phobia. Fourth, participants who report the most distress will report more active coping skills. Finally, help seekers will be more likely to have external explanatory models.

Method

Participants

Participants were ten female college students from an introductory psychology subject pool at a small midwestern university. They were selected from an initial screening of two hundred ninety eight students. Participants received course credit and ten dollars for their participation.

Materials

Instruments used were the Fear of Negative Evaluation Scale (FNE), Social Avoidance and Distress Scale (SAD), the Social Phobia and Anxiety Inventory (SPAI), Michigan Alcohol Screening Test (MAST), and the Beck Depression Inventory (BDI). A semi-structured interview (see Appendix A), coding manual (see Appendix B), and various training materials (see Appendix C) were also utilized.

The Fear of Negative Evaluation Scale (FNE) and the Social Avoidance and Distress Scale (SAD) are self-inventories for assessing social phobia. The SAD includes 28 items, such as "I feel relaxed even in unfamiliar social situations" and "I usually feel uncomfortable when I am in a group of people I don't know." The FNE contains 30 items, which are rated as true or false, such as "I rarely worry about seeming foolish to others" and "I am usually worried about what kind of impression I make." These scales were used to screen participants who may possess social anxiety. It is not conclusive if these scales alone are appropriate for the assessment of social phobia, but they do assess social anxiety (Watson and Friend, 1969). Therefore, these instruments were only used for the initial screening. Participants who met the cutoffs of greater or equal to 18 and 23 (one standard deviation above the mean) were then given the Social Phobia and Anxiety Inventory (SPAI) before they were interviewed.

The SPAI (Clark, Turner, Beidel, Donovan, Kirisci, & Jacob, 1994) is a 45-item self-report measure of social anxiety and agoraphobia developed for adults to specifically address various components of social phobia, including overt behaviors, cognitions, and physiological response. The SPAI contains two scales, a 32-item Social Phobia subscale and a 13-item Agoraphobia subscale. The Agoraphobia subscale differentiates individuals with social phobia from those with panic disorder and agoraphobia. The difference score is computed by subtracting the Agoraphobia score from the Social Anxiety score. A score below 34 indicates social phobia is unlikely, scores between 34 and 59 indicate possible mild social phobia, scores between 60 and 79 indicate possible social phobia, and scores over 80 indicate probable social phobia.

The Michigan Alcohol Screening Test (MAST) is the most frequently administered and researched alcoholism screening instrument (Conoley, 2001). The MAST is a self-assessment of the perceived control of drinking behavior and alcohol-related personal and interpersonal problems (Thurber, Lewis, & Hodgson, 2001). It is a 24-item, true-false questionnaire that works best with individuals who identify themselves as alcoholics (Friedrich & Loftsgard, 1978). A score of four or less signifies non substance abuse, a score of five-six as a possible substance abuse, and a score of seven or more as substance abuse (Conoley, 2001).

The Beck Depression Inventory (BDI) is a self-administered 21 item self-report inventory measuring characteristic attitudes and symptoms of depression (Beck, Ward, Mendelson, Mock & Erbaugh, 1961). A score below 4 may indicate faking, while a score between 5-9 indicates an individual with normal ups and downs, 10-18 indicates mild to moderate depression, 19-29 indicates moderate to severe depression, 30-63

indicates severe depression (Beck et al., 1961).

Procedure

The Fear of Negative Evaluation Scale (FNE) and the Social Avoidance and Distress Scale (SAD) inventories were administered to all participants, in order to screen for potential social phobia. Ten individuals who met the pre-designated criteria scores of greater than or equal to 18 and 23 (one standard deviation above the mean), respectively, were called back and asked to participate further in the study. All who were called agreed to participate. They completed the Social Phobia and Anxiety Inventory (SPAI), the Beck Depression Inventory (BDI), and the Michigan Alcohol Screening Test (MAST). Participants with MAST or BDI scores above 7 and 30, respectively, would be excluded. A score on the MAST of seven points or more indicates substance abuse, however no participants scored in this range. Additionally, no participants had to be excluded due to results indicating severe depression. The ten participants were Caucasian females, ages 18-20.

Participants with results on the SPAI indicating probable or possible social phobia (according to the SPAI, a difference score of 60 or higher) were given a semi-structured interview (see Appendix A) as a means to present subject areas for discussion without overly structuring participants' responses. The interviews took approximately one hour each and the interviewers were advanced master's level students. Participants were paid $10 at the completion of the interview. Another researcher used the interviews to obtain information regarding barriers and facilitators to professional help seeking (Smith, 2004).

Responses that were coded were name (yes/no), coping behaviors (direct or passive-avoidant or passive-ruminative), appraisal of coping behaviors (had effect, had

no effect, or had aggravated effect), explanatory style (internal/external, stable/unstable, global/specific), comorbidity (yes/no), help-seeking (yes/no), and self-reported severity of social anxiety (high, moderate, or low - see coding manual in Appendix B). Coding for name refers to a passage in which a participant is asked if she has a name her problem and whether she provides a name or does not have a name. Coping refers to a passage in which a participant describes a particular coping behavior. Appraisal of coping behaviors refers to a passage where the participant is asked whether the coping method was effective or not. Explanatory style refers to a passage in which a participant describes her social anxiety as internal/external, stable/unstable, or global/specific. Comorbidity refers to a passage in which a participant describes having symptoms of a comorbid disorder or having been treated for a comorbid disorder. Help seeking refers to a passage in which a participant says she has sought professional help. Severity refers to a passage in which a participant is asked whether she sees her anxiety as a problem, somewhat of a problem, or not a problem.

Coders were given specific instructions for each category (see coding manual in Appendix B). A transcript could only be coded for having a name if the participant spontaneously gave a name immediately after being asked, otherwise it would be coded as no name. The self-reported severity of social anxiety category was usually coded as high if the participant stated her social anxiety was a problem. It was coded as moderate if the participant stated it was somewhat of a problem and was coded as low if the participant stated that her social anxiety was not a problem.

Coping behaviors were defined as behaviors taken by a participant that are intended to help the participant deal with anxiety or the consequences of the anxiety.

Direct coping consisted of behaviors that are active or goal-oriented ways to help deal with or resolve anxiety, such as social contact, seeking professional help, or self help techniques, such as deep breathing or exercising. When a participant sought professional help, coders reported it to researchers for hypothesis one. Passive coping consisted of behaviors engaged in that are not active, goal-oriented ways to deal with anxiety. This category was broken down into avoidant and ruminative. Avoidant coping involves retreating from the situation or attempting to ignore the problem. This could be done by "normalizing" the problem or using distraction. Ruminative coping is defined as internal thoughts that do not bolster the participants drive to change and are often repetitive and negative. Examples may be, "Everyone will laugh at me when I give my speech," or "They're all thinking about how pathetic I am with my hands shaking."

The effectiveness of coping skills was defined as having an effect, whether positive or negative; no effect; or an aggravated effect, where the effect is both positive and negative.

Explanatory styles (ES) were defined relying primarily on the subjective interpretations and meaning that individuals assign to symptoms and illnesses. Internal ESs refer to the cause or reason for the problem being within the participant's personality or physiological make-up. External ESs refer to the cause or the reason for the problem being outside of the participant. This could be by blaming others for the problem or believing that others' views or the environment are the root of the problem. Stable ESs refer to the participant perceiving social anxiety as unchangeable; may state having always been or always being socially anxious, whereas a person with an unstable ES perceives social anxiety as having the potential to be overcome (e.g., does not believe

will always be socially anxious.) Global ESs refer to a participant who believes their anxiety is present in most social situations, while specific ESs refer to a participant who believe their anxiety is present only in certain social situations.

The author and another investigator (the reliability coders) pre-coded the transcripts independently using categories from the coding manual. This was accomplished by creating two columns, where the transcript was placed on the right side (e.g. see Appendix D). When locating a sentence in which a participant discussed either having a name for her social phobia, ES, severity of her social phobia, coping methods, or appraisals of the coping strategies, the reliability coder would type the category on the left side. An agreement for precoding was defined as both reliability coders identifying the same passage. The reliability coders then met and resolved any differences and produced the "gold standard". These pre-coded interviews served as the basis for all coding. An undergraduate research assistant (primary observer #1) who was not told the purpose of the study, then independently coded the revised pre-coded transcripts. This was done by locating the specific codes in the areas indicated by the researchers and highlighting the appropriate phrase or sentence (eg. the participant discusses seeing a counselor for her social anxiety. On the left, the reliability coders will have marked "coping". Primary observer #1 would then specify "direct coping" because the participant was discussing direct coping by seeing a professional counselor.) The primary observer #1 received approximately four hours of training on how to use the coding manual to assess several factors such as coping styles (direct, passive/avoidant, passive/ruminative); appraisals of each coping style (had an effect, did not have effect, had aggravated effect); reported severity of social phobia (high, moderate, low); name for

anxiety (yes, no); and explanatory models (stable or unstable, global or specific, internal or external). She was provided a manual and researchers reviewed it with her. Primary observer #1 was also given sample two transcripts, in which she had to achieve 90% reliability before receiving the actual transcripts. Reliability was achieved by comparing the coding of primary observer #1 with the coding of the two reliability coders. Reliability was obtained by dividing the number of agreements by the total number of agreements plus disagreements. An agreement for coding was defined as both primary observer #1 and reliability coders highlighting the same sentence.

Due to inadequate reliability, another primary observer (primary observer #2) was recruited. This student was a first year clinical psychology graduate student who received approximately eight hours of training. Training was much more in-depth and consisted of a thorough review of the coding manual. Sample transcripts focusing on each code were provided to the coder, coded and reviewed. After completely these, she was then given two full sample transcripts, on which she achieved 90% reliability, which was determined by comparing the coding of primary observer #2 with the reliability coders. Primary observer #2 pre-coded and coded the interviews based on the gold standard provided by the reliability coders. Primary observer #2 also coded for two additional codes, comorbidity and help-seeking.

Reliability

Primary observer #1 did not pre-code the transcripts, therefore the only pre-coding reliability figures are from the primary observer #2. The pre-coding figures were 61.60% overall (name: 63.60%, explanatory style: 47.70%, self-reported severity: 45.50%, comorbidity: 100.00%, coping: 68.10%, and appraisal of coping: 44.90%).

Table 1 presents the reliability figures for coding. The reliability figures for primary observer #1 were: 50.54% overall [name: 88.90%, coping: 76.90% (direct coping: 70.60%, passive coping: 60.20%, ruminative coping: 60.70%), appraisal: 73.80%, and self-reported severity: 90.00%, explanatory style: 57.80% (internal ES: 58.50%, external ES: 29.00%, global ES: 9.50%, specific ES: 28.10%, stable ES: 28.10%, unstable ES: 9.10%)]. Comorbidity was not yet part of the coding manual during the first coding. Primary observer #1 did not code for help seeking.

Coding reliability figures from primary observer #2 were: 80.17% overall [name/yes: 100.00%, name/no: 100.00%, comorbidity/yes: 100%, help seeking/yes: 100%, explanatory style: 50.33% (internal ES: 74.40%, external ES: 50.00%, global ES: 44.40%, specific ES: 52.60%, stable ES: 47.30%, unstable ES: 33.30%), self-reported severity: 74.87% (high severity: 85.70%, moderate severity: 57.10%, low severity: 81.8%), coping: 76.90% (direct coping: 81.50%, passive/ruminative: 61.50%, passive/avoidant: 73.70%), and appraisal of coping: 59.10% (effect: 83.50%, no effect: 54.50%, aggravated effect: 39.29%)].

Results

Given the general improvement in coding with primary observer #2, her results will be reviewed. However, the results should be interpreted with caution. Table 2 presents a summary of the response frequencies for the interviews. Response frequencies are a tally of the number of times a category is coded for each participant. Table 3 presents the FNE, SAD, BDI, MAST, and SPAI scores for each participant. The SPAI scores of all participants support a diagnosis of possible or probable social phobia.

Table 4 presents a summary of the descriptive statistics for coping, appraisal of coping, and self-reported severity. The mean number of overall coping strategies was 22.60. Participants reported more active coping than passive or ruminative coping, (13.30 and 1.70) respectively. More participants reported their coping methods having an effect than having no effect and having an aggravated effect (7.00, 2.10, and 1.40, respectively). The mean for low reported level of severity was 1.00, while the mean for moderate and high reported level of severity was 0.40 and 0.80, respectively.

The percentages of explanatory styles were computed for each participant by dividing the response frequencies of each ES by that number plus the response frequencies for the corresponding group (e.g., percentage of internal statements is equal to the number of internal statements divided by the sum of number of internal and external statements). The groups are specific/global, internal/external, and stable/unstable. The mean percentage for each explanatory style was computed by adding each participant's percentage and dividing the sum by the number of participants. Participants who did not endorse an ES for a particular group were excluded (e.g., no statements for either internal or external). The mean percentage for specific explanatory style was 68.57% and global explanatory style was 31.43%. The mean percentage for internal explanatory style was 85.00% and the external explanatory style was 15.00%. The mean percentage for stable explanatory style was 78.57% and unstable explanatory style was 21.43%. Participants tended to report specific, internal, and stable illness attributions. Table 5 presents a summary of the explanatory style percentages.

Participant 1 scored 0 on the MAST indicating non-substance abuse. She scored 5 on the BDI, which indicates normal ups and downs. Her social phobia score on the

SPAI was 133 and her difference score was 111. This SPAI score indicates probable social phobia. Participant 1 endorsed having a name for her social anxiety, which was "nervous". She endorsed six external ESs, six specific ESs, low self-reported severity twice, and moderate severity once. Participant 1 endorsed more direct coping than passive/avoidant and passive/ruminative coping (33, 3, and 2, respectively). She endorsed coping as having an effect two times and coping as having an aggravated effect once. Participant 1 reported having symptoms of depression and having sought professional help.

Participant 2 scored 3 on the MAST, indicating non-substance abuse. She scored 20 on the BDI, which falls in the moderate depression range. Her social phobia score on the SPAI was 129 and her difference score was 114. This SPAI score indicates probable social phobia. Participant 2 endorsed having no name for her social phobia, endorsed one internal ES, and endorsed low self-reported severity. She endorsed direct coping more than passive/avoidant and passive/ruminative coping (9, 3, and 1, respectively). She endorsed coping as having an effect five times and coping as having no effect two times. Participant 2 reported having symptoms of depression and had sought professional help.

Participant 3 scored 4 on the MAST, indicating non-substance abuse. She scored 16 on the BDI, suggesting possible mild depression. Her social phobia score on the SPAI was 108 and her difference score was 70. This SPAI score indicates possible social phobia. Participant 3 endorsed having no name for her social anxiety, endorsed four stable ESs, three internal ESs, and low self-reported severity once. She endorsed direct coping more than passive/avoidant and passive/ruminative coping (4, 1, and 2, respectively). She endorsed coping as having an effect once and coping as having an

aggravated effect twice. Participant 3 did not report any comorbid symptoms, such as depression, and had not sought professional help.

Participant 4 scored 5 on the MAST, indicating a possible substance use problem. She scored 24 on the BDI, which falls in the moderate depression range. Her social phobia score on the SPAI was 147 and her difference score was 103. This SPAI score indicates probable social phobia. Participant 4 endorsed having a name for her social anxiety, which was "nervousness". She endorsed one unstable ES, three internal ESs, one specific ES, and one global ES. She endorsed direct coping three times, passive/avoidant coping four times, passive/ruminative coping once, and endorsed coping as having an effect once. Participant 4 reported no comorbid symptoms and had never sought professional help.

Participant 5 scored 0 on the MAST, indicating non-substance abuse. She scored 5 on the BDI, which falls in the normal range. Her social phobia score on the SPAI was 112 and her difference score was 84. This SPAI score indicates probable social phobia. Participant 5 endorsed having a name for her social phobia, which was "anxiety or nervousness". She endorsed two stable ESs, two unstable ESs, twelve internal ESs, four external ESs, and one specific ES. She endorsed low self-reported severity once, moderate severity once, and high severity twice. Participant 5 endorsed direct coping more than passive/avoidant coping (13 and 3, respectively). She endorsed coping as having an effect once and coping not having an effect twice. Participant 5 reported having symptoms of depression and had sought professional help.

Participant 6 scored 0 on the MAST, indicating non-substance abuse. She scored 4 on the BDI. Her social phobia score on the SPAI was 134 and her difference score was

113. This SPAI score indicates probable social phobia. Participant 6 endorsed having no name for her social anxiety, one stable ES, one internal ES, one specific ES, one global ES, endorsed low self-reported severity twice, moderate self-reported severity once, endorsed direct coping 22 times, passive/avoidant coping three times, passive/ruminative coping two times, endorsed coping as having an effect nine times, coping as having an aggravated effect three times, and coping as having no effect one time. Participant 6 did not report any comorbid symptoms and had not sought professional help.

Participant 7 scored 3 on the MAST, indicating non-substance abuse. She scored 6 on the BDI, which falls in the normal range. Her social phobia score on the SPAI was 157 and her difference score was 105. This SPAI score indicates probable social phobia. Participant 7 endorsed having a name for her social phobia, which was "nervous". She endorsed two stable ESs and three internal ESs. She endorsed direct coping more than passive/avoidant and passive/ruminative coping (26, 14, and 3, respectively). She endorsed coping as having an effect four times, coping as having an aggravated effect twice, and coping as having no effect three times. Participant 7 reported no comorbid symptoms and had never sought professional help.

Participant 8 scored 1 on the MAST, indicating non-substance abuse. She scored 12 on the BDI, which falls in the possibly mild depression range. Her social phobia score on the SPAI was 130 and her difference score was 110. This SPAI score indicates probable social phobia. Participant 8 endorsed having a name for her social anxiety, which was "anxiety". She endorsed two stable ESs, three internal ESs, one external ES, three specific ESs, endorsed low self-reported severity twice, and high self-reported severity four times. She endorsed direct coping twenty-one times, passive/avoidant

coping twenty times, and passive/ruminative coping four times. She endorsed coping as having an effect twelve times and coping having no effect four times. Participant 8 did not report any comorbid symptoms, but had sought professional help from her school guidance counselor for anxiety.

Participant 9 scored 3 on the MAST, indicating non-substance abuse. She scored 13 on the BDI, which falls in the possible mild depression range. Her social phobia score on the SPAI was 170 and her difference score was 134. This high SPAI score indicates probable social phobia. Participant 9 endorsed having a name for her social anxiety, which was "shyness". She endorsed three stable ESs, five internal ESs, four specific ESs, one global ES, and two endorsements of high self-reported severity. She endorsed direct coping fifteen times, passive/avoidant coping twenty times, and passive/ruminative coping twice. She endorsed coping having an effect more than coping not having an effect and having an aggravated effect (11, 2, and 3, respectively). Participant 9 reported symptoms of depression, but had never sought professional help.

Participant 10 scored 0 on the MAST, indicating non-substance abuse. She scored 25 on the BDI, which was the highest score of all participants. This score suggests moderate depression. Her social phobia score on the SPAI was 115 and her difference score was 91. This SPAI score indicates probable social phobia. Participant 10 endorsed having a name for her social anxiety, which was "anxiety". She endorsed three internal ESs, one global ES, one endorsement of low self-reported severity, four endorsements of direct coping, and five endorsements of passive/avoidant coping. She endorsed coping having an effect more than coping having no effect and having an

aggravated effect (9, 2, and 3, respectively). Participant 10 reported being under the care of a therapist for an eating disorder.

Again, although the coding reliabilities were low the hypotheses bear examination as an exploratory exercise. The first hypothesis stated that individuals with social phobia who had a name for their anxiety will be more likely to be seeking or have sought professional help. Four participants who had a name also had sought professional help. Three participants who had a name had not sought professional help. One participant did not have a name for her anxiety, but had sought professional help. Two participants did not have a name for their anxiety and had not sought professional help. Fisher's Exact Test was conducted and results were not significant, χ^2 (1, $\underline{N}$ = 10) = 1.00, $p > .05$. Table 6 presents the results.

The second hypothesis stated that individuals with social phobia who had a name for their anxiety would have engaged in a greater variety of number of coping skills. Results show a mean number of coping skills of 25.57 (SD = 14.93) for those with a name and a mean of 15.67 (SD = 10.26) for those without a name. Due to the small sample size and poor reliability, no inferential statistics were computed.

The third hypothesis stated that participants who have previously sought help will report other symptoms than social phobia. Five participants reported seeking professional help and four of those five indicated another disorder, such as depression and eating disorders. One participant did not seek professional help, but did report symptoms of depression. Fisher's Exact Test was conducted and results were not significant, χ^2 (1, $\underline{N}$ = 10) = .21, $p > .05$. Table 7 presents a summary of the results.

The next hypothesis stated that participants who report the most distress would report more active coping skills. Three participants reported their severity as high, one reported severity as moderate, five participants reported their severity as low, and one participant did not endorse a level of severity. Participants' endorsements were not consistent and several reported more than one level of severity. Therefore, results are based on the level endorsed most frequently by each participant. Results show that the mean number of coping skills for high severity was 16.33 (SD = 4.16), the mean number of coping skills for moderate level of severity was 3 (SD = 0), and the mean number of coping skills for low severity was 14.40 (SD = 12.74). Table 8 presents a summary of the results.

The last hypothesis stated that compared to non help-seekers, help-seekers will have more extensive external EMs. Results show an average percentage of external statements endorsed by help-seekers to be 50%, while the percentage for non help-seekers was 0%. Again, due to the poor reliability of the data, no statistical analyses were conducted.

Discussion

This study was conducted, first and foremost, as a pilot study with two primary goals. The first goal was to create a semi-structured interview yielding qualitative information for examining help seeking behaviors among individuals with social phobia. The second goal was to develop a reliable coding system to explore the relationship between help seeking behaviors, coping methods, and explanatory models. The research achieved mixed success with respect to these two goals.

If this study is to be replicated or researched further, much emphasis should be placed on training coders more extensively on the coding manual. A limitation was the inadequate inter rater agreement, as the reliability for the pre-coding was poor and the coding was overall, inadequate. In retrospect, this study was extremely ambitious in its range of independent and dependent variables, therefore the coding manual and interview may have contained too much information for a coder to learn to use efficiently. It would be beneficial to simplify it, perhaps by having coders concentrate on only a few variables, such as only coping methods or explanatory styles.

Pre-coding and coding was a continually changing process, as the reliability coders improved the manual and methods of training coders. After primary observer #1 had completed coding and her scores were compared with the reliability coders' gold standard various ways of improving coding were noted. However, there was insufficient time and resources to have the reliability coders again pre-code or code the data or recruit a new reliability coder, so no changes were made to the gold standard pre-coded interviews or the coded interviews before training primary observer #2. Changes were made only in the training procedures. It should be noted that had the reliability coders been availed of the extensive training given to primary observer #2 and pre-coded again, reliability would possibly have been much higher. The same would possibly have been the case for the coding. For example, it was unclear at the time of the initial coding if primary observer #1 should code for "name" each time an interviewer asked. Later, it was decided that "name" should only be coded for the first time an interviewer asked a participant what she called her anxiety. If the participant was probed and mimicked the interviewer, this was counted as "no name".

For primary observer #2, the manual and training were improved, for instance, to clarify definitions and add examples. Training was much more thorough and the second coder was given a test over the coding manual and several example interviews to code reliably before she coded the actual interviews. Reliability was slightly improved with primary observer #2 with overall reliability increasing.

Due to the improvement and clarification of several aspects of coding, there was no longer agreement with how the interviews had initially been coded. However, re-coding the interviews was not possible, therefore the initial coding was compared with the second coder. Additionally, reliability may have improved if more observers had been recruited and the best of these recruits selected.

The interview could be also be improved for future studies. There was some variability with researchers straying from the format of the interview at times. This was in part due to the desire of achieving a free flowing interview and making the participants feel comfortable. A more simplified and structured interview might be easier to follow and there would be less room to go astray from the format. However, the researchers had initially been interested in gaining information and allowing the interview to be less structured. It would be helpful to perhaps only focus on coping behaviors or explanatory styles. Because of the subjectivity of thoughts and feelings, it would be important to ask participants to use a ratings scale of 1-10 to clarify certain feelings. An example is when participants were asked about the severity of their social phobia. The participants in this study answered that their anxiety was a problem, was somewhat of a problem, or was not a problem. A ratings scale would have been much more informative and more easily coded and interpreted.

Due to the low reliability, the following hypotheses are tentative. It was hypothesized, as with Leventhal's study, that participants who had a label for their problem will have engaged in more active coping methods. Our results were inconclusive, but this hypothesis should be researched in future studies. In addition, it would be interesting to see if those without a name for their anxiety will tend to use more passive methods. The reasoning behind these hypotheses is that those who have a label or name for their problem will be more likely to be informed about the problem and will be trying to cope more actively than those who are not aware that their anxiety has a name.

The hypothesis that participants who have previously sought help will report other symptoms than social phobia should be researched further, based on current research. Four out of five participants who were currently seeking or had previously sought professional help (e.g. psychologists, psychiatrists, youth pastor) were found to have coexisting comorbid disorders, such as depression and eating disorders. These participants sought help for the comorbid conditions, usually due to the advice of others:

> Participant #9: Yeah, last year a girl always told me she thought I need to go to Buzzard and see a counselor. And I was like, "Yeah." She thought I was depressed or something like that cause both second semesters that I've been here, I've had my own room and I use it to my advantage and I sit there by myself and whatever, and she told me that she thought I should see somebody, that I had a problem (laughs).

Another participant's parents took her to a psychologist for depressive symptoms:

Participant # 5: Um, not really, like I didn't really, um, like I don't know, I just like, like I said to myself you know, you have to like make more effort and try to, you know, talk to people more and stuff like that, but I don't think I really did anything because I don't know, it was just too hard for me and I couldn't take that step, you know? But, um, 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 a while, but I wasn't really like, you know, getting anything out. So, he couldn't help me. So then I didn't really do that for long. But my parents noticed this and they wanted to help me, you know.

Four participants reported the psychological and psychiatric help was unhelpful, while one reported it was helpful. The following participant went to a doctor due to her parent's concern about her depressive symptoms, but did not want to deal with the side effects of medication:

Participant #1: Umm…I think, I don't know, it kind of had something to do with it, but I can't remember if it was my junior or senior year, that I started feeling really tired all the time and just kind of wound down from having so many things to do. Like with my regular classes and then with all my speeches….I think it was senior year, so, um, I went to see a doctor and he, like, prescribed me something and then it had like a huge list of, like, all these side effects and I just didn't take it and so I kind of told myself, "Well, I'm going to be fine."

One participant, whose therapy was unhelpful, reported discussing her anxiety with her youth pastor was helpful. It appears that those who reported the mental health

sessions as unhelpful never addressed their social anxiety with the therapist, ironically because they would not open up:

> Participant #5: No. No. Right. Um, I don't know. Not for long. Maybe like three months, I don't know. Probably somewhere around there.
>
> R: And you just didn't want to open up to him?
>
> P: Yeah. Right. Because, I don't know. It was a stranger. You know? I don't know. I just didn't feel like telling my business or personal feelings or whatever. I don't know. I just couldn't for some reason.

Several participants stated that although they went to a mental health professional, they never discussed their social phobia, so we do not know if these participants would perceive their experiences differently had they opened up more. From the transcripts, it appears these participants did see their social anxiety as a problem:

> Participant # 5: Well, it just like, it just holds me back from meeting new people, so I would have less friends. I would like not, um, have like the, I don't know what you would call it, to join clubs or whatever because there would be new people there, you know? Or, um, and then it would just like hold me back from like you know...

Although these participants reported being bothered by their anxiety, they typically sought professional help for their symptoms of depression. Dingemans et al. (2001) found that the symptoms must eventually cause sufficient distress, either by causing a comorbid condition or interfering significantly with the person's life before seeking help. Those with social phobia often develop another disorder, such as

depression or substance abuse, as a result of their anxiety and this encourages help seeking (Zimmerman et al, 2000).

The same participant describes how her social anxiety was related to her depression:

> Participant #5: Yeah. Like, I would probably say I was depressed. Yeah, because I would of course, you know, be sad or whatever for you know, people not, like, coming up. 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.

Future studies should explore a hypothesis that participants find talking to others, not only mental health professionals, about their anxiety as helpful:

> Researcher: I think it's interesting that you went to see the counselor and you found your mother to be more helpful.
>
> Participant #2: It was just that I could open up more with my mom than a stranger.
>
> R: Yeah, that makes sense. So how did you feel about asking your mom for help when that point came? Or, I mean, it sounds like you talk with her pretty often.
>
> P: Mmmm. At first maybe it was a little bit hard, but not really, just cause I knew that she would be there for me and she wouldn't make fun of me for whatever my problem was.

The previous statement shows a participant reporting professional help to be less effective, however she was able to open up to her mother and a youth pastor about her anxiety.

Kleinman believes patients and physicians have differing interpretations or explanatory models of disorders. Therefore, one can imagine the difficulty in treating clients who are socially anxious. An example situation would be a client who perceives herself as "shy" and has never heard of social anxiety disorder or social phobia. Her social anxiety contributes to her comorbid depression, which alarms her mother who encourages her daughter to seek professional help. The daughter, however, may not see the shyness as a big problem or something that can be treated. It is dependent upon the mental health professional to discover the underlying social phobia. Unfortunately, we have discovered at times that the mental health professionals tended to be unsuccessful in detecting the client's social anxiety:

> Researcher: So when you went to see the counselor did you address a lot of that stuff and..?
>
> Participant #2: Not really.
>
> R: How long did you meet with her?
>
> P: Um, well, I didn't really talk to her because I didn't know her. So I just, um, like at first it was just an hour at a time and since I didn't talk much, she made it to 40 minutes and then she made it to less, so....
>
> R: Mmm hmmm... and how long did you see her, like during the school year or a couple months?
>
> P: It was just a couple months. Well, I just, I didn't know her, so I didn't really open up and like, tell her how I was feeling and stuff, so...

Although this participant made it clear in the transcript that her shyness was a problem for her, it was unclear if she actually related this to her therapist. It appears that her symptoms of depression were what prompted the therapy sessions:

> Researcher: So, was the main reason that your mom thought you needed to see her, that was, can you kind of clarify that more?
>
> Participant #2: Oh, sorry. Um, well, like I…
>
> R: Because of the shyness or?
>
> P: Um, um, I used to hang out with my friends a lot more and I just kind of stopped doing that and I just kind of stopped enjoying like 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, so. . .

Kleinman explains that lay explanatory models may be complex, illogical, and inconsistent, as this study has found. This is evident in several interviews when many participants describe the extent of the symptoms and then report the severity as low. A participant reports that her social anxiety is not a problem, although her SPAI difference score indicates possible social phobia (70):

> Researcher: Okay, umm. In your opinion, what are the reasons you haven't talked with your friends or your mom or anyone about this. Why haven't you sought help for it? It is just because….?
>
> Participant # 3: Ummm…I guess I never really saw it as like a huge problem. I mean it's been recently that I saw that it's having an impact on my life…but then I didn't see it as like a problem. So I didn't see the reason to have help.

Another participant denies her social anxiety interfering with her life and rationalizes the fact that she seldom goes out alone, however she has an SPAI difference score of 113 indicating probable social phobia:

> Researcher: Um, okay, how do you think it affects your life now or does it interfere with your life, does it not interfere with your life?
>
> Participant # 6: I would say for the most part it doesn't. I mean I don't really go that many places by myself, but I mean that's just kind of safety thing anyway. You know?
>
> R: Right, right.
>
> P: So, um, other than that, I guess it doesn't really affect too bad.

Based on the interviews conducted and contradictory to our hypothesis regarding help seekers and external ESs, future studies may consider researching an hypothesis that participants who engaged in more direct or active coping methods would perceive their anxiety as internal. They seem have more accurate perceptions of their social anxiety and tended to take responsibility for their anxiety, i.e., used active coping. One participant who has an internal ES because she sees herself as shy, describes how she has begun coping more actively:

> Participant #7: Well, when I was younger, I would usually just not talk, but I'm taking baby steps and slowly talking more and starting conversations, so. . . that's I guess what I'm doing now.
>
> R: Was there a specific, you know, time when you just said, I'm going to start doing this?
>
> P: No, because I've always said I was going to do it, it's just I've actually started

doing it, I guess.

R: Ok, do you have any ideas why you've actually started doing it?

P: Because I don't like being shy.

Similarly, a new hypothesis that individuals with social phobia who rely on passive coping methods would perceive their anxiety as external should be researched based on the transcripts. These individuals appear to make external statements blaming others or environmental factors to minimize the effect that their social anxiety has on them. The following participant continues to make external statements throughout the transcript as she blames her teacher for her social anxiety with speeches:

> Participant #1: Well, like the very first time I had to give a big speech, it was a psychology class in high school. And that was a 40-minute speech we had to give. And it was like at the end, the very end of our semester, like right before Christmas, so that gave us the whole semester because we started research at the very beginning and then our class, I mean I knew most of the people there, but I was still kind of worrying about it so much because she (teacher) made such a big deal out of it and the speeches after that kind of made me nervous, I think.

This same participant utilizes a variety of passive coping methods, primarily rumination and creative ways of avoidance:

> Participant #1: Umm..I don't know...the sociology class, umm, that one's a lot easier cause it's comforting to know that there's so many people, what's the odds he's going to pick me out of all these people and be like, "Come up here," and I don't know, "We're going to use to as the whole experiment" or something. She actually, in the psychology class I had, she actually did that but she asked for

volunteers, so it's easier, it's kind of a hazard sitting in the front row cause we're right there and they see you and you think, "Well, should I sit here or not sit here?" So, yeah, in small classes it's harder because they pick you out. Both of the lecture classes, the way they're set up kind of like little stair steps, so he's kind of like more on an eye level with the second or third level, so I don't worry about it.

This study had several limitations, one being its relatively small number of participants, as only ten interviews were conducted and all ten were female. Even though male participants were involved in the initial screening, females outnumbered them. No males from the screening met the pre-designated criteria scores. Another limitation is that this study only used college students. Ideally a community sample would be used to provide a more representative sample. College students were used in this study; however many individuals with severe social phobia are unable to attend college.

The participants in this study reported having faced a large social fear, in that they have endured facing the transition from high school to college.

Researcher: Did, when you first started and you were still feeling nervous and everything adjusting, do you think it interfered with your life at that time?

Participant # 2: Um, maybe, cause instead of like, going and meeting people in the dorm, I would just kind of stay in my room and I had my door open so people could come, but…

Another participant describes her transition from high school to college:

Researcher: How did you feel about what was happening and things like that? How do you feel about it now?

Participant # 3: I'm kind of used to it now. Like, I didn't think I would adjust as well. I think I did pretty good. Umm..It was kind of overwhelming at first. Like, orientation just about killed me. I thought I was going to die.

The fact that these participants were able to make the transition from high school to college may imply that they are less impaired or have less severe social phobia than a community sample.

Other limitations are with the coding definitions. One example concerns the code "coping". Researchers used frequency counts to analyze the codes, however some participants would discuss the same coping strategy throughout the interview and would be coded each time it was discussed. However, other participants would discuss several ways they coped with their social anxiety. This particular code could have been improved by examining each coping strategy, instead of coding them only as direct or passive or researchers could have coded the coping strategy only the first time it was mentioned. It would be helpful also to have a checklist of coping strategies to ask each participant during the interview.

If this study was to be replicated, researchers anticipate much higher reliability, due to the improvement on the coding manual and training procedures. It is highly recommended that the interview and manual be simplified. Contributions from this study include a first step toward a good qualitative interview resulting in rich data and a reliable coding system, which will be extremely helpful to other researchers studying social phobia.

References

Beck, A.T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry 4*, 561-571.

Beidel, D. C., & Turner, S. M. (1998). Assessment. *Shy children, phobic adults: Nature and treatment of social phobia* (pp. 91-109). Washington, DC: American Psychological Association.

Cameron, L, Leventhal, E. A., & Leventhal, H. (1993). Symptom representations and affect as determinants of care seeking in a community-dwelling, adult sample population. *Health Psychology, 12*(3), 171-179.

Conoley, J. C. (2001). In B. S. Plake, & J. C. Impara (Eds.), *The fourteenth mental measurements yearbook* (pp. 751-753). Lincoln, NE: The Buros Institute of Mental Measurements.

Dingemans, A. E., van Vliet, I. M., Couvee, J., & Westenberg, H. G. (2001). Characteristics of patients with social phobia and their treatment in specialized clinics for anxiety disorders in the Netherlands. *Journal of Affective Disorders, 65*(2), 123-129.

Friedrich, W. N., & Loftsgard, S. O. (1978). A comparison of the Mac Andrew alcoholism scale and the Michigan alcoholism screening test in a sample of problem drinkers. *Journal of Studies on Alcohol,* 39, 1940-1944.

Jacobson, N.S., Follette, W.C., & Revenstorf, D. (1984). Psychotherapy outcome research: Methods for reporting variability and evaluating clinical significance. *Behavior Therapy, 16,* 249-262.

Jacobson, N.S., & Truax, P. (1991). Clinical significance: A statistical approach to

defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59,* 12-19.

Kazdin, A. E. (1998). Qualitative Research Methods. *Research Design in Clinical Psychology* (3rd ed., pp. 245-262). Boston: Allyn and Bacan.

Kleinman, A. (1980). *Patients and Healers in the Context of Culture: An Exploration of the Borderline between Anthropology, Medicine, and Psychiatry* (pp. 104-118). Berkeley, CA: University of California Press.

Magee, W. J., Eaton, W. W., Wittchen, H., McGonagle, K. A., & Kessler, R. C. (1996). Agoraphobia, simple phobia, and social phobia in the national comorbidity survey. *Archives of General Psychiatry, 53,* 159-168.

Pollard, C. A., Henderson, J. G., Frank, M., & Margolis, R. B. (1989). Help-seeking patterns of anxiety-disordered individuals in the general population. *Journal of Anxiety Disorders, 3*(3), 131-138.

Segee, P. F., Maguire, L., Ross, J., Malik, M. L., Colket, J., & Davidson, J. R. T. (1999). Demographics, treatment seeking, and diagnoses of anxiety support group participants. *Journal of Anxiety Disorders, 13*(3), 315-334.

Seligman, M. E. P., Abramson, L. Y., Semmel, A., and von Baeyer, C. (1979). Depressive attributional style. *Journal of Abnormal Psychology, 88,* 242-247.

Stein, M. B., Torgrud, L. J., & Walker, J. R. (2000). Social phobia symptoms, subtypes, and severity: Findings from a community survey. *Archives of General Psychiatry, 57,* 10-46.

Thurber, M. S., Lewis, D., & Hodgson, J. M. (2001). Item characteristics of the Michigan alcoholism screening test. *Journal of Clinical Psychology, 57,*

139-144.

Watson, D., & Friend, R. (1969). Measurement of social-evaluative anxiety. *Journal of Clinical Consulting Psychology, 33,* 448-457.

Zimmerman, M., & Mattia, J. I. (2000). Principal and additional DSM-IV disorders for which outpatients seek treatment. *Psychiatric Services, 51,* 1299-1304.

Table 1

Comparison of Primary Observer Reliabilities

	Primary Observer #1	Primary Observer #2
Name	88.90	100.00
Coping	63.83	76.90
Active	70.60	81.50
Avoidant	60.20	73.70
Ruminative	60.70	61.50
Appraisal	73.80	59.10
Effect	-----	83.50
No effect	-----	54.50
Aggravated	-----	39.20
Severity	90.00	74.87
Low	-----	81.80
Moderate	-----	57.10
High	-----	85.70
ES	27.05	50.33
Internal	-----	74.40
External	-----	50.00
Specific	-----	52.60
Global	-----	44.40
Stable	-----	47.30
Unstable	-----	33.30

Table 2

Summary of Codes and Code Frequency (N = 10)

	Participants									
	1	2	3	4	5	6	7	8	9	10
Name(Y/N)	Y	N	N	Y	Y	N	Y	Y	Y	Y
Coping	38	13	7	8	16	27	26	45	37	9
Direct	33	9	4	3	13	22	9	21	15	4
Avoidant	3	3	1	4	3	3	14	20	20	5
Ruminative	2	1	2	1	0	2	3	4	2	0
Effect	20	5	1	2	1	9	4	8	11	9
Aggravated	1	0	2	0	0	3	2	0	3	3
No Effect	2	2	0	0	5	1	3	4	2	2
ES-Specific	6	0	0	1	1	1	0	3	4	0
ES-Global	0	0	0	1	0	1	0	0	1	1
ES-Internal	0	1	3	3	12	1	3	3	5	3
ES-External	6	0	0	0	4	0	0	1	0	0
ES-Stable	0	0	4	0	2	1	2	2	3	0
ES-Unstable	0	0	0	1	2	0	0	0	0	0
Comorbidity	Y	Y	N	N	Y	N	N	N	Y	Y
Low	2	1	1	0	1	2	0	2	0	1
Moderate	1	0	0	1	1	1	0	0	0	0
High	0	0	0	0	2	0	0	4	2	0
Sought Help	Y	Y	N	N	Y	N	N	Y	N	Y

Table 3

Summary of Social Phobia Scores (N = 10)

	Participants									
	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	3	4	6	12	13	25
MAST	0	3	4	5	0	0	3	1	3	0

Note. SPAI score:

>80	*probable social phobia*
60-79	*possible social phobia*
34-59	*possible mild social phobia*
<34	*social phobia unlikely*

Table 4

Descriptive Statistics for Coping, Appraisal of Coping, and Self-Reported Severity

	Mean	Median	Mode	Range	Standard Deviation
Coping	22.60	20	0	38	13.96
Direct	13.30	11	4	30	9.67
Avoidant	7.60	3.5	3	19	7.43
Ruminative	1.70	2	2	3	1.25
Appraisal					
Effect	7.00	6.5	1	19	5.81
Aggravated	1.40	1.5	0	3	1.35
No Effect	2.10	2	2	5	1.60
Severity					
Low	1.00	1	1	2	0.82
Moderate	0.40	0	0	1	0.51
High	0.80	0	0	4	1.40

Table 5

Percentages for Endorsements of Explanatory Styles (N) = 10

	Participants									
	1	2	3	4	5	6	7	8	9	10
Specific	100	0	0	50	100	50	0	100	80	0
Global	0	0	0	50	0	50	0	0	20	100
Internal	0	100	100	100	75	100	100	75	100	100
External	100	0	0	0	25	0	0	25	0	0
Stable	0	0	100	0	50	100	100	100	100	0
Unstable	0	0	0	100	50	0	0	0	0	0

Table 6

Number of Help-Seekers by Name for Social Anxiety (N = 10)

		Name	
		Yes	No
Help-Seeking	Yes	4	1
	No	3	2

Table 7

Number of Help-Seekers by Comorbidity (N = 10)

		Comorbidity	
		Yes	No
Help-Seeking	Yes	4	1
	No	1	4

Table 8

Mean of Direct Coping Statements and Self-Reported Symptoms Severity

	Mean	Standard Deviation
High	16.33	4.16
Moderate	3.00	0.00
Low	14.40	12.74

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 have kept the participant from seeking treatment and their ideas and beliefs about the nature of their problem.

General Form of Interview

Review the SPAI with the participant and ask if they have a name for their problem. Ask participant 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 about 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

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 difficulties of your own when you are in certain 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. Psychologists know relatively little about how people try to cope with this on their own. Since you have gone through this and know more about it than we do, your participation is very valuable to us. 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...*

Review SPAI with the participant. Then ask the participant, *"Is there a name that you would give for this? If so, what is it?"*

Definition of Anxiety

In your own words, how do you describe what (NAME) are like for you? How does it 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?
How effective were all of these coping strategies?
When you first noticed(NAME), how did it impact you? Did it have any lasting effects?

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?

Coping 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). Let's summarize all the things you've done to help you cope? Have you ever talked to anyone about this? Have you ever sought help for this problem? Where did you look for help from?*

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 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. *Thinking back to when you first noticed this, has your view of the problem changed?* If YES ask, *"How has it changed?" Has it changed in a way that has caused you to seek help for it?*

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
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).

Explanatory models (EM)
Explanatory models rely primarily on the subjective interpretations and meaning that individuals assign to symptoms and illnesses. 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? Explanatory styles are a component of EMs. ESs can be either internal/external, global/specific, or stable/unstable.

1. Five stages of behavioral change

A. 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."

B. 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."

C. 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."

D. 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.

E. 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 it's 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

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

"Nerves"

"Shyness"

"Butterflies"

B. 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.

Examples 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.
Examples 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
Definition- 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.)

Examples 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 (this may consist of self help books or tapes or utilizing relaxation techniques, such as deep breathing, imagery, 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'.

Over-preparing/being very familiar with topic

"I practiced my speech over and over."

Shortening length of anticipation

"I always volunteer to go first. It's easier."

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."

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."

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.

A. The behavior had an effect.

"It really made me feel better."

B. The behavior had no effect.

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

"It held me back from meeting people."

C. 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 Styles

7. Internal/External

Internal (Def.-Internal explanatory styles 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 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."

8. Stable/Unstable

Stable (Def.- The participant 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."

Unstable (Def.- The participant 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."

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.)

"I just don't like being around people."

Specific (Def.- The participant notices the anxiety only in specific social situations or around certain people. 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.)

"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."

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

"My anxiety holds me back. It is a problem."

Moderate

"It only bothers me sometime. It is somewhat of a problem."

Low

"My anxiety is no big deal. 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:**

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.

Appendix D

Coping/Appraisal Training Coding Key

1.

coping: passive-avoidant	"What do you do to help deal with your nervousness at school?" "I just don't go to a lot of classes. I probably miss three classes a week."

2.

coping: direct appraisal: effect	"What actions do you take at parties to feel more comfortable?" "I drink a lot and it also helps to smoke weed. This calms me down somewhat. Sometimes I'll try to hook up with a guy, which is slutty, but makes me feel more confident."

3.

coping: direct appraisal: effect	"I try to join clubs that interest me. If it something I like and know a lot about, I feel more comfortable. It is still kinda hard to talk and participate, but it's ok."

4.

coping: direct appraisal: effect	"I just go to school and work. I don't have any friends. It is just easier to not have to deal with people and be so nervous all the time."

5.

coping: passive/avoidant	"I do not use public restrooms because I get embarrassed. I will

appraisal: effect coping: passive/avoidant	just wait until I get home." "What do you think about this?" "I know it's silly, but I've managed so far. I don't have a problem with it. Many people don't like using public restrooms."

6.

coping	"At my dorm I wait for the dinner rush to get over with before I go down to the cafeteria. This way I can eat by myself without feeling like everyone is staring at me, wondering why I'm such a loser." "Does this work for you?"
appraisal: aggravated	"Yes. Ideally, it would be nice to eat with friends, but I don't have any. That's also what's so embarrassing. People probably sit and talk about me. I don't get so nervous when the cafeteria is not full."

7.

coping: passive/avoidant appraisal: effect	"I like to walk around the neighborhood, but I get embarrassed and feel like everyone is staring. So I like to walk my roommate's dog. This way the attention is not on me. Also, I think it's good for the dog to get exercise because my roommate never walks him."

8.

coping: direct appraisal: effect	"Before I have to give a speech, I run five miles on trails. It's nice and relaxes me. It seems to help me get through it. Don't get me wrong, I still get really nervous, but not as bad as before."

9.

	So your job doesn't leave a lot of time for friends? How does this affect your anxiety?"
coping: passive/avoidant	"No. My anxiety is no big deal. My job is just very important to me. I don't really need friends."

10.

coping: passive/ruminative coping: passive/avoidant coping: direct	"The weeks and days before speeches and presentations, I worry all day long. It's all I can think about. I try to keep busy cleaning and stuff, but it's frustrating. At night, I can't sleep. I 'm constantly worrying about what will go wrong with my speech. Sometimes I'll take NyQuil or something to help me sleep."
	"That sounds like it must be very annoying for you. Is this an effective way to deal with your anxiety?"
appraisal: aggravated	"I guess so. I don't know what else to do. I hate it. The NyQuil does help, but I wish I didn't have to take something to help me sleep. I don't like having to live this way."

Appendix E

Severity Training Coding Key

	#1 R: So how much do you feel that your anxiety affects your life?
Severity-low	P: [It doesn't really affect my life.] R: Not at all? P: No, not really.
	#2 R: You were talking about your discomfort in social situations before, how big a problem is that for you?
Severity-moderate	P: Well, it depends. [If I'm just with family or friends, you know, people I know, well then it's not a problem at all. But if I'm with people I don't know, then it is a problem.] R: How so?
Severity-No	P: Well, I can't talk or anything. I'm very self-conscious. But only around strangers or people I don't know very well.
	#3 R: So in what way does your nerves affect you?
Severity-high	P: [I'm always dealing with them.] It becomes tiring actually. R: What do you mean?

	P: It's just always there you know. I always have these feelings. R: Okay.
	#4 R: So what is it like to have these kinds of problems? P: It sucks. I mean, there's not a lot you can do about it. R: And how does it affect you?
Severity-moderate	P: [Just like I said before, I get nervous some of the time.] R: How often would you say you get nervous? P: oh I don't know. Not to often.
	#5: R: What did you mean by that?
Severity-low	P: [Well, it's just that it really isn't that big a deal.] I make due you know. R: So it doesn't bother you? P: No not really. R: Okay.
Severity-moderate	P: [Well, I guess sometimes, but just sometimes.]
	#6:

	R: Could you tell me more about that?
	P: Well I was just trying to have a good time with my friends and all of a sudden I felt horrible. I just wanted to leave you know. Just get out as fast as possible. It was like everything was closing in on me.
	R: Does this happen to you a lot?
	P: Sometimes it does, but not all the time. I mean, I was having such a good time and then it all came to a screeching halt. I couldn't understand it at all.
	R: That must have been difficult.
Severity-high	P: [Yeah it was, it really was.]
	#7 R: Is this a constant thing that you deal with?
Severity-high	P: [Yeah, it is pretty much all of the time.] It's like always there in the back of my mind.
	R: I see.
	P: It's actually a lot better now that I have started talking to people about it. I mean, I can definitely see that it's not as bad as it used to be.
	R: But it's still pretty bad?
Severity-high	P: [Yeah.]

Appendix F

Explanatory Styles Training Coding Key

	Do you feel nervous a lot in social situations?
ES-specific, stable	Well, it's mainly when I'm around people I don't know, especially guys. I've always felt this way so it's kind of normal for me.
	When did you first realize this might be a problem for you?
ES-external	Probably when all of my friends started dating and I realized I couldn't talk to guys. If we were around a group of guys, they would just ignore me like I wasn't there.
	Is it any easier to talk to guys now?
ES-external	Well, I guess. I used to get really mad because I know I'm just as pretty as all of my friends, but no guys would ever ask me out. I didn't know why. Sometimes now I try to talk and it's not so bad. I just realized that I couldn't wait for them to talk to me.
	Why do you think you experience such anxiety giving speeches?
ES-internal	I don't know. My mom works in marketing and has to deal with people all of the time and she's real outgoing. My brother and sisters act like speeches are no big deal. So, I guess it's just that I'm weird.
	Do you get nervous talking in front of large groups only?
	No, I don't like talking in front of anyone. I really hate the beginning of school when

ES-global	you have to introduce yourself. I get so nervous. How does this interfere with your life?
ES-external	I don't have any friends. I don't see why no one will even talk to me. If someone would approach me first, I'd be fine. They don't give me a chance. Have you ever had any friends?
ES-internal	I used to be friends with some girls who were really outgoing and they approached me first. I think they got bored with me though, because I'm so shy. I can't help it. I've always been this way. I wish I had a different life. How does this interfere with your life? It is just really hard for me to do new things. Things that everybody else does and are no big deal. I make myself go to class and talk if I'm called on and I give my speeches, but I get so nervous every single time. I hope that if I force myself to talk in front of people it'll get better, but it hasn't yet. That seems like a good way to deal with it. Do you think that it will get better?
ES-unstable, internal	Entering college made me realize that almost all professions I want to go into, you have to deal with people and talking. I'm going to have to get used to talking to people. It's just part of life. It just wish it wasn't so hard for me, but I'm working on it.

Appendix G

Training Interview

	R: Do you have a name for this feeling?
name-no	P: No, not really.
	R: Many people struggle with being around large groups of people. How do you describe what social situations are like for you?
	P: I'm afraid people will judge me and think I'm stupid.
	R: How does that interfere with your life?
	P: I don't like to speak out in front of people. I usually just go with the flow. I don't talk in class. I don't volunteer information.
	R: So it sounds like it interferes quite a bit.
severity-hi ES-specific	P: Yeah, I really don't talk in front of crowds. I wish I wasn't like that.
	R: Are you OK with speaking in front of smaller groups?
ES-specific	P: Not really. If it's more than just me and one other person I usually just stay quiet.
	R: How do you feel about it?
	P: I wish I could be more outgoing.
	R: Ok, you wish you could be more outgoing, but how do you feel about it?
	P: It makes me kind of sad sometimes because I don't have very many friends.
	R: That must be hard. How do you deal with this?

coping-passive/avoidant, direct	P: I try to tell myself that I don't need friends. I study a lot. I have a roommate who sometimes will ask me to hang out with her.
	R: When was the first time you realized that this might be a problem for you?
ES-internal	P: My whole life. Ever since I was little, I knew I was different. I used to play by myself a lot. I never really had a lot of playmates.
	R: What did you think it was?
ES-internal, external	P: I just thought I was weird. I couldn't understand why nobody would play with me.
	R: How did it interfere with your life?
	P: I never got invited to birthday parties. All the other girls would go roller skating on the weekends, but never asked me. I spent all my time at home by myself.
	R: What actions did you take to cope?
coping-passive/avoidant	P: Nothing really. I was just sad a lot. I played with my dolls a lot and would pretend that I had friends. I used to draw and write stories too.
	R: So you were involved in many solitary activities.
	P: Yeah.
	R: Why do you think you took those actions?
	P: I just wanted to forget that I didn't have any friends.
	R: Ok, let's move along from then and tell

	me about current problems in social situations.
ES-unstable	P: Well, things are better now.
	R: How are they better?
coping-direct	P: I have a few good friends now that I met in band in my high school . Also, I have met a few people in my dorm that my roommate introduced me to.
	R: Ok. So your main difficulty now is speaking in front of others?
ES-specific	P: Yep. I hate talking in class. I'm always the quiet one when hanging out with friends. They tease me about it.
	R: How does it interfere with your life?
	P: Mmm… It's hard to meet to guys. I'm really shy around guys. I've never even had a boyfriend. Sometimes I get worse grades than I should because I won't do presentations.
	R: So this is really difficult for you?
	P: Yeah.
	R: How do you feel about what is happening at this time?
ES-internal, unstable	P: I've kind of accepted that this is who I am. At least I'm not as shy as I was growing up. It still makes me sad when I think about it, though.
	R: How do you cope with this?
coping-direct (friends and counselor) stage of change-action facilitator-yes	P: I talk to my two closest friends. They're the only ones I can confide in. Actually, that's not right because they encouraged me to see a counselor here on campus a couple of months ago because

	they were worried about me. R: Does it seem like that helps? P: Yeah, because I can tell her more things than I tell even my friends. But I still have a long way to go. R: It sounds like this is something that you see as a pretty big problem. To summarize some of the things you've done to cope with this were avoiding giving presentations, talking to your friends, and talking to a counselor. P: Yeah. R: Is there anything else you've done to help yourself cope with this? P: No. R: Why did you start talking to your friends? P: They accept me for who I am. We have a lot of stuff in common and it's easier for me to talk to them. I don't feel like they judge me. R: I thought you said they teased you. P: No, it's really the people I've met in my dorm. But, they don't do it in a mean way. R: How do you feel about talking to your friends? P: It feels good to be able to open up to people after all these years. I never could talk to my parents cause they seemed so busy. R: Do you think talking to your friends have helped you?

	P: Yeah. I now know that I'm not completely weird because they even say they get nervous sometimes talking in class.
	R: What things have prevented you from seeking help?
barrier-yes ES-stable (past)	P: I didn't think anything would help me. I thought I would just have to be this way forever.
	R: Do you still think that?
	P: I know that I'm always going to be shy, but it doesn't have to keep me from doing the things I want to do.
	R: You go, girlfriend! What has helped you to seek help?
ES-internal, unstable facilitator-yes coping-direct	P: Meeting my friends and learning that everybody gets nervous sometimes. I just do more.
	R: Has your view of this problem changed?
ES-unstable, external (past), internal (present)	P: Yes, I see it as something I have some control over. I used to think that people should be talking to me, but now I know I need to be approaching other people.
	R: Do you feel you have resolved this?
stage of change-action	P: No! Far from it! But I know that it will take time.
	R: Have you taken action to resolve this within the last six months?
stage of change-action	P: Yes. I started seeing my counselor three months ago and will keep seeing her.