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# Adults' Reflections on Their Lived Experiences With Adolescent Social Anxiety Disorder

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Abstract

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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## Abstract

Anxiety disorders are the most prevalent mental health disorders for children and youths, and social anxiety disorder (SAD) is the third most common anxiety disorder. SAD can negatively impact school performance, mental health, and healthy social development. In comparison to other forms of anxiety, current treatments for SAD have not been as efficacious. The purpose of this qualitative phenomenological study was to explore other factors of adolescent SAD, such as the role of resilience. The two research questions addressed the lived experiences of adolescents with SAD and how they developed resilience in relation to their SAD. Bronfenbrenner's bioecological theory of development provided the framework for the study. Data collection involved semistructured interviews with 10 participants with SAD, ages 18–25. Data were analyzed using Moustakas's modification of the Van Kaam method. Participants identified several challenges associated with SAD, and each lived experience with SAD was unique. Participants developed resilience with SAD by accessing specific resources in their microsystems despite the fact that it was in these microsystems that participants encountered their challenges. For adolescents to develop resilience with SAD, they need to engage in their social environments. Recommended treatment for adolescent SAD begins with understanding the adolescent's unique challenges and existing areas of resilience. Through an individualized approach to treatment, the level of challenges that adolescents with SAD experience may be reduced. Facilitating healthy social development for adolescents with SAD is a valuable form of positive social change.

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It is with gratitude that I also acknowledge my participants, without whom I would not have been able to do this dissertation. Social anxiety disorder can impede individuals from engaging in social interaction, particularly when those interactions pose a risk of judgment. Despite having social anxiety disorder, 10 generous and courageous individuals agreed to be interviewed and share their lived experiences with me. I send my gratitude to each of you.

Table of Contents

List of Tables

List of Figures

# Chapter 1: Introduction to the Study

Social anxiety disorder (SAD) is a form of anxiety in which a persistent fear of being judged by others in social situations typically leads to avoidance of social situations (American Psychiatric Association, 2013) and negatively impacts healthy social and emotional development (Alfano & Beidel, 2011). SAD is the third most common anxiety disorder (Mathews, 2017) with an average age of onset at 13 years (Hill et al., 2016). SAD can negatively impact school performance, and can also lead to depression, suicidality, and substance abuse (Hill et al., 2016). In comparison to other forms of anxiety, current treatments for SAD were not as efficacious (Babinski & Nene, 2016), and more research was required to better understand and treat this mental health disorder. One area of adolescent SAD that had not been studied is resilience. Through a better understanding of resiliency factors of adolescents with SAD, professionals who provide treatment and support for these adolescents may make a more significant impact on their well-being. In this chapter, the background of the study is provided, followed by the problem statement, purpose of the study, research questions, theoretical framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, significance, and a summary.

## Background

Research of SAD in adolescence and its relationship with resilience was an unexplored area of research based on my review of the academic literature. The background literature for this study comprised studies in the areas of social anxiety,

adolescent anxiety or mental health, and adolescent resilience. There were many studies related to treatment for SAD, and these are explored in Chapter 2.

There were numerous studies pertaining to SAD, and some focused on childhood or adolescence as opposed to adulthood. Halldorsson and Creswell (2017) conducted a review of maintenance factors in childhood SAD and found that literature focused mostly on developmental and risk factors as opposed to maintenance factors, which is what is targeted in interventions. Halldorsson and Creswell recommended studies that would facilitate a better understanding of children's experience with SAD and how context (school and home) impacts experiences with SAD. Additionally, Pavlova and Kholmogorova (2017) investigated the psychological factors associated with SAD in a quantitative study. The psychological factors that they found were depression, perfectionism, emotion suppression, and suicidality. Their recommendations focused on how parents can model healthy behaviors for these adolescents. Finally, Di Blasi et al. (2015) conducted a quantitative study addressing the relationship between SAD and dimensions of self-image. Five dimensions of negative self-image were correlated with SAD: psychological health, mastery, family relationships (the more positive, the higher the SAD for females), academic goals (the higher the goals, the higher the SAD), and social attitude. Studies pertaining to adolescent SAD were limited, and therefore the background literature was extended to adolescent mental health studies in which SAD was an identified subarea of focus.

A number of studies into adolescent mental health involved multiple mental health disorders, and some provided useful information about anxiety disorders in general. Anttila et al. (2015) studied the hopes and concerns of adolescents with mental health disorders through a qualitative study. Hopes included social inclusion, social skills, cognitive clarity, independence, and close personal connections; main concerns were loneliness, self-confidence, stress management, delusions, independence, decision making, and insecurities. Also, de Lijster et al. (2018) completed a systematic review of academic and social difficulties for adolescents with anxiety disorders, and determined that it remains unknown which precedes the other, academic or social difficulties. It was their recommendation for professionals to assess and treat both dimensions. Although general in nature, the findings in these studies were relevant to the study of adolescent SAD.

In addition to literature in SAD and adolescent anxiety was research in adolescent resilience. Ungar and Hadfield (2019) examined the relationship between environment and well-being and determined that resilience is context specific. In particular, ecological factors impact youths differently depending on a youth's level of vulnerability. This study supported the notion that understanding the environment helps researchers understand resilience. This study and Ungar's (2011) work in ecological factors was aligned with numerous studies of adolescent resilience in specific populations such as immigrant youths (Motti-Stefanidi, 2019; Venta et al., 2019), pregnant teens (Solivan et al., 2015), adolescents in foster care (Shpiegel, 2016), mistreated youths (Oshri et al.,

2017), youths in the LGBTQ community (Asakura, 2019), and youths who have depression (Nishikawa et al., 2018). The focus on resilience and adolescent SAD had not been explored.

Key findings from each of these three areas of research were employed in the current study to address the gap in the literature regarding adolescent SAD and the role of resilience. This study was needed to provide a better understanding of how health professionals can promote higher well-being of adolescents with SAD. This gap in the literature was addressed in the problem statement for this study.

## Problem Statement

Anxiety disorders are the most prevalent mental health disorders for children and youths (Hill et al., 2016), and SAD is the third most common anxiety disorder, impacting 5.5% of children in the United States (Mathews, 2017). Left untreated, anxiety disorders in childhood and adolescence can negatively impact school performance and social development, and can also lead to depression, suicidality, and substance abuse (Hill et al., 2016). SAD can also hinder healthy social development during adolescence through social isolation, possible victimization, and peer rejection (Alfano & Beidel, 2011). In comparison to other forms of anxiety, current treatments for SAD had not been demonstrated as efficacious (Babinski & Nene, 2016); how best to treat it remained elusive. Based on their review of current literature of preadolescent SAD, Halldorsson and Creswell (2017) called for a qualitative approach in which research of SAD was exploratory and descriptive. Creswell and Creswell (2018) identified a number of criteria

for which qualitative research is appropriate, including when variables are not yet known. At the time of the current study, resiliency factors associated with SAD were unknown.

## Purpose

The purpose of this study was to explore the resilience and successes of adolescents with SAD from the retrospective lived experiences of young adults in Canada. Because current treatments for SAD had not been as effective as treatments for other forms of anxiety (Babinski & Nene, 2016), more understanding of this phenomenon was needed. I used a qualitative phenomenological approach with a focus of resilience, making this study a strength-based rather than a deficit-based study. Based on my literature review of adolescent SAD, this approach had not been applied to this area of study.

## Research Questions

1. From the perspectives of young Canadian adults, what was their lived experience of social anxiety during adolescence?
2. Did adolescents with SAD develop resilience in their social environment, and if so, how?

## Theoretical Framework

The theoretical framework in this study was Bronfenbrenner's (1979) bioecological model of development. In this theory, one assumption is that how a person perceives their environment impacts how they interact with it, and consequently how those in the environment reciprocate the interaction. This concept is relevant because

those with SAD struggle with fears of judgment and potential humiliation, resulting in avoidance of social situations (American Psychiatric Association, 2013). The underpinning of SAD involves how the individual experiences their social environment, which made the bioecological model of development applicable to the current study.

In this theory, there are reciprocal interactions between individuals and various systems in their social environment, and some systems may be more impactful on adolescent SAD than others. Bronfenbrenner (1979) identified five systems that compose the human ecological system. Microsystems are the most direct systems, such as home and school, with mesosystems acting as the interconnections between microsystems. These systems closest to the individual may have the most bearing on SAD. Exosystems are systems that indirectly impact the individual, such as a parent's workplace.

Expanding outwards, macrosystems exist on a cultural level, and the chronosystem is representative of time, such as generation or era. To be able to understand adolescent SAD, it is important to understand not only how individuals with SAD and their social environments reciprocally influence one another, but also which systems are the most impactful on the various aspects of SAD. The micro- and mesosystems were the primary social environments addressed in the current study.

## Nature of the Study

This was a qualitative study. Qualitative research is aligned with a constructivist worldview that values how individuals make sense of the world (Rubin & Rubin, 2012). Qualitative research comprises a number of components, including the researcher's

presence when gathering data, the use of description and analysis with data in an inductive process, and the researcher's reflective role in the data collection and meaning-making process (Ravitch & Carl, 2016). One of the characteristics of qualitative research is in the variety of ways in which to conduct a qualitative study. One qualitative approach to research is phenomenological.

The phenomenological approach to research is grounded in both psychology and philosophy connected to the people's lived experience with a particular phenomenon whereby the accumulation of participants' experiences are synthesized by the researcher to provide a more holistic understanding of the phenomenon (Creswell & Creswell, 2018). One key aspect of phenomenological research is capturing and articulating the participants' perceptions of the phenomenon (Ravitch & Carl, 2016). As Creswell and Creswell (2018) noted, in phenomenological studies, researchers start with the lived experiences of the participants to better understand the phenomenon. In the current study, the phenomenon was adolescent SAD. Experiences and perceptions with SAD were explored using a semistructured researcher-developed interview protocol allowing the participants to express their experiences in their words. This was the same approach used by Hjeltnes et al. (2016) in their study of why young adults seek support for their social anxiety, as well as in Akacan and Secim's (2015) study of social anxiety experiences of university students. The data in the current study were analyzed using Moustakas's modified Van Kaam data analysis approach.

## Definitions

There were five central concepts of this study that required definitions: SAD, adolescence, young adulthood, resilience, and well-being.

*Adolescence*: The period in human development ranging from ages 10 to 18 years; young adulthood spans 18–25 years of age (Arnett, 2013).

*Resilience*: From a developmental psychology perspective, the ability to successfully adapt to situations that may impede healthy functioning (Newman & Newman, 2016) by accessing environmental resources and using them in meaningful ways (Ungar, 2011).

*SAD*: A form of anxiety in which a persistent fear of being judged by others in social situations typically leads to avoidance of social situations (American Psychiatric Association, 2013) and negatively impacts healthy social and emotional development (Alfano & Beidel, 2011).

*Well-being*: From a developmental psychology lens, the healthy growth in response to changes within a person's lifespan (Newman & Newman, 2016) encompassing positive mental health in terms of experiencing wholeness, empowerment, and life satisfaction (Howell et al., 2016).

## Assumptions

Assumptions are aspects of the study that are believed to be true without evidence of being true. There were four assumptions in the current study. First, I assumed that participants would be honest with regard to having a diagnosis of SAD. Second, I

assumed that participants would consent to their interview being audio-recorded. Third, an assumption was made that participants would be able to identify and acknowledge their accomplishments and struggles in relation to their SAD. Lastly, because incentive to participate was minimal, I assumed that participants would recognize the value in participating by helping others and receiving a summary of the findings.

## Scope and Delimitations

Although SAD is impactful throughout most of the person's lifespan, I chose to focus on adolescence because that is the age of onset (Hill et al., 2016) and the provision of treatment in adolescence as opposed to adulthood has the potential to circumvent related issues of poor academic performance, substance abuse, and depression (Hill et al., 2016) in adolescence. Adolescent SAD negatively impacts social and emotional development at a stage when individuals are developing their sense of identity and preparing intimate relationships (Newman & Newman, 2016).

Recruiting young adult participants to share their lived experiences during adolescence instead of interviewing adolescents was based on ethical considerations. The Society for Adolescent Health Research (2003) maintained that inclusion of adolescents in research has benefits and risks, and these factors need to be considered when choosing research participants. Based on the Canadian Psychological Association's (CPA, 2017) definition of a vulnerable population, adolescents who have SAD meet the criteria of a vulnerable population due to probable limitations in cognitive and emotional functioning. In the Canadian Code of Ethics for Psychologists, researchers are encouraged to avoid

employing vulnerable populations for research if that research can be carried out as effectively with a less vulnerable population (CPA, 2017). In the current study, the risks would have outweighed the benefits if adolescents were interviewed about their SAD.

By recruiting young adults who experienced SAD during their adolescence, I not only presented less risk to the participants but also offered a deeper level of insight regarding how they overcame aspects of their SAD to experience successful life-course development. Young adulthood ranges from ages 18 to 25 based on Arnett's (2013) work on adolescence and emerging adulthood. According to Kitchener et al.'s (2006) reflective judgment model, young adults have typically achieved epistemic judgment whereby they can understand and evaluate information from a relativistic perspective instead of an absolutist perspective often associated with adolescent thinking. Additionally, young adults made better participants than older adults for the current study because autobiographical recall is more accurate in young adulthood than in older adulthood (see Meléndez et al., 2018). Young adults who are reflecting on their lived experiences during adolescence can do so with more cognitive maturity than their younger counterparts and more accuracy than their older ones.

One inclusion criterion was that participants are Canadian. The reason to exclude participants outside of Canada resided within the theoretical framework of this study. In this theory of human development, Bronfenbrenner (1979) recognized the impact of the macrosystem, which encompasses cultural values, economics, and politics. Even though Canada is closely connected to the United States geographically, the two countries differ

on a number of cultural aspects, including governance, education, and values of diversity and equality (Matthews, 2017). To address the impact of the macrosystem on adolescent SAD, participants were limited to the Canadian population.

## Limitations

There were three challenges in this study. One challenge was that adults who have lived with SAD in their adolescence may have been less inclined to meet face-to-face for an interview. Offering online interviewing was an alternative to face-to-face interviewing to address this challenge. A second challenge was possible recall difficulties. Adults may have had difficulty remembering adolescent experiences. For this reason, only participants in young adulthood (18–25 years) were recruited. A third challenge was ethical. As a university instructor in Calgary, I am aware of the ethical concerns of dual relationships with students who are also study participants. To avoid dual relationships, I recruited students outside of the departments in which I teach.

As a researcher in a qualitative study, I recognized my biases and addressed them so that they did not interfere with data collection and analysis. One of my biases was that I value face-to-face interviewing more than interviewing online. What is more pertinent, however, is the preference of my participants, and for that reason I offered both options. Researcher bias was addressed through reflexive practices such as a research journal.

In addition to these challenges, there was another noteworthy limitation to this study. Although the focus of this study was adolescent SAD, adolescents were not involved in the data collection. Although ethical and cognitive rationales for this decision

were provided, the exclusion of adolescents from this study also denied adolescents the opportunity for self-reflection and increased self-awareness that participation in such a study would have offered (Society for Adolescent Health Research, 2003).

## Significance

This qualitative, strength-based approach to exploring adolescent SAD offered significant implications. In this study, young adults reflected on their adolescent experiences of challenges and successes with SAD, providing insights about resilience and protective factors. Studying this phenomenon from a strength-based perspective addressed one of the gaps in the academic literature regarding adolescent SAD and may offer new insights that a deficit approach would not. Additionally, the qualitative nature of this research was intended to uncover unforeseen aspects of this phenomenon. New variables regarding resilience and success could have surfaced through the qualitative method and potentially be incorporated into future qualitative and quantitative studies. This data could then be implemented in existing interventions to provide more effective support for this population group as they transition into adulthood, thereby supporting professional practice. Together, these implications supported positive social change in that adolescents with SAD may benefit from more effective interventions that may lessen the challenges of SAD, including academic achievement, depression, suicidality, substance abuse (Hill et al., 2016), social isolation, possible victimization, and peer rejection (Alfano & Beidel, 2011). Implications for this study may impact researchers, mental health practitioners, and most importantly adolescents with SAD.

## Summary

This study was intended to explore the relationship between adolescent SAD and resilience using a qualitative phenomenological approach. The dual focus of adolescent SAD and resilience represented a gap in the literature, and the study had the potential to further academic understanding of the lived experiences of Canadian adolescents who have SAD and to offer new areas of focus in treatment and further research. This study was conducted using the theoretical framework of Bronfenbrenner's (1979) bioecological theory whereby the reciprocal interaction between the individual and the social environment is studied. A detailed review of the literature related to this study is provided in Chapter 2.

# Chapter 2: Literature Review

A significant number of children and youths throughout the world are living with one or more mental health disorders. In their meta-analysis of worldwide prevalence, Polanczyk et al. (2015) found that 13.4% of adolescents had a mental health diagnosis; anxiety disorders represented 6.5% of this population, depressive disorders accounted for 2.6%, attention-deficit disorders made up 3.4%, and 5.7% of adolescents had a disruptive disorder. Anxiety disorders, therefore, are the most prevalent mental health disorders for adolescents in the world.

The aim of this literature review was to provide an overview of the literature related to the current study, and to identify the gaps in the literature. In this qualitative study, young adults were interviewed regarding their experiences of challenges and successes with SAD during their adolescence. The purpose of the study was to obtain a more comprehensive understanding of these participants' lived experiences with the intent to better understand the role of resilience with adolescent SAD.

This literature review comprises four sections. In first section, there is an overview of the research strategy used in finding the studies relevant to adolescent SAD and the role of resilience. In the second section, Bronfenbrenner's bioecological theory is presented as the theoretical foundation of this study. This is followed by the third section in which literature concerning key concepts of this study is reviewed in four categories: definitions of constructs, SAD etiology, the treatment of SAD, and the role of resilience in the study of adolescent SAD. Summary and conclusions are presented in the fourth

section. Together, these four sections provide a review of the academic literature relevant for this study of adolescent SAD.

## Literature Search Strategy

The databases that I used were PsycInfo, PsychArticles, Science Direct, ERIC, and Psychology Database. All databases were accessed through the Walden University online library up to April 2020. Key search terms used for this proposed study were as follows: *social+anxiety*, *social+phobia*, *experience*, *qualitative*, *child(hood)*, *adolescent(ence)*, *resilience or resiliency or resilient*, *interview*, *self-report*, and *self-observation*. The search process began with *adolescence* and/or *childhood* and *social anxiety.* Most of the journal articles from this initial search were treatment studies using quantitative methodology. The search was expanded using terminology associated with qualitative studies, and a limited number of journal articles was found using adolescence, social anxiety, and qualitative search terms, so systematically one term was removed in the search, which opened up the search to include adults, other anxiety disorders, and mental health disorders in general. A parallel process occurred with adolescence and/or childhood, social anxiety, and resilience, whereby one of the three search terms was removed at a time to compensate for the limited journal articles found using all three terms in the search. This search process was followed with all five databases.

## Theoretical Foundation

Bronfenbrenner (1979) created the bioecological theory in which he proposed that the social environment is central to human development. Bronfenbrenner's bioecological

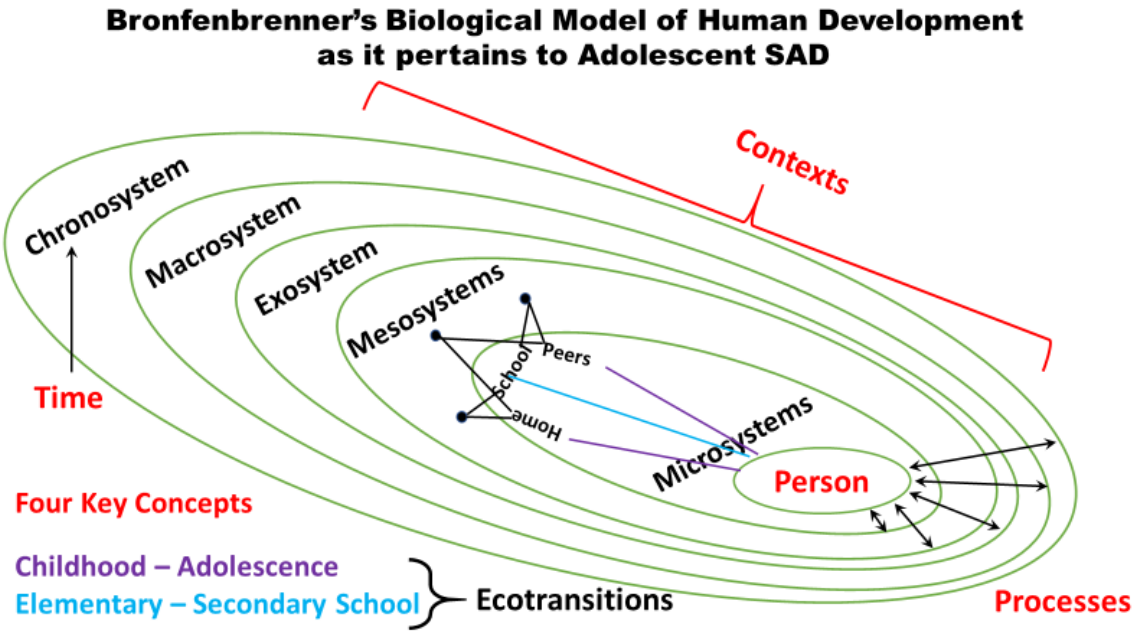
theory is a way in which to understand the reciprocal interaction between human development and a person's social environment. Bronfenbrenner identified levels of systems in which human development takes place. Most immediate are the microsystems, such as home and school, with mesosystems acting as the interconnections between microsystems. Exosystems are those that indirectly impact the individual, such as a parent's workplace. Macrosystems exist on a cultural level, and finally the chronosystem is representative of time, such as generation or era. It was possible that all levels of systems would be relevant in the current study, and it was likely that micro and mesosystems would be particularly significant. The systems and how the individual perceives and reciprocally interacts with the systems are a central part of this theory; there are other aspects of this theory that are less widely used that were also a part of the current study.

Ecological transitions are important in bioecological theory and had the potential to be significant to the current study (see Figure 1). Development occurs as a result of the individual's interaction with the demands of the environment, and as the individual grows and broadens their social context, the demands of their environment increase (Newman & Newman, 2016). Significant development occurs when individuals experience an ecological transition, whereby the individual's position in their environment has changed due to their role, surroundings, or possibly both (Bronfenbrenner, 1979). Examples of ecological transitions are a move to a new home, a change in family constellation, new peer groups, the transition from primary to secondary school, and the transition from

childhood to adolescence. These last two transitions may have been particularly germane to the current study of adolescent SAD and what challenges and successes adolescents with SAD experienced during these ecological transitions. Human development is conceptualized as the adaptation to ecological transitions in which the individual responds to and simultaneously influences their environment on various system levels.

**Figure 1**

*Bronfenbrenner's Bioecological Theory*




Bronfenbrenner continued to deepen and expand his theory from its inception in 1979 by adding precise terminology to elucidate the existing concepts. Bronfenbrenner (1979, as cited in Newman & Newman, 2016) added four key concepts of the theory: process, person, time, and contexts. Process represents the frequent and regular interactions between individual and environment that evolve as both the individual and

their environment change in relation to one another (Newman & Newman, 2016). For example, as individuals experience the ecological transition from childhood to adolescence, this growth impacts their reciprocal demands with the environment, and as a result, interactions with peers, family, and teachers change. Process is strongly impacted by the person, particularly what Bronfenbrenner identified as their demand features, and those relevant to the current study were SAD, resilience, and internal resources such as cognitive, psychological, and past experiences (see Newman & Newman, 2016). SAD has the potential to limit and perceptually skew interactions with the social environment (Alfano & Beidel, 2001), while resilience can positively impact process, which in turn can facilitate growth and capacity (Masten, 2009). Time refers not only to generation but also to concepts such as microtime, which represents how long an individual engages in an activity in a given microsystem (Newman & Newman, 2016). SAD is likely to limit time spent in social interaction, and consequently restrict social development. Finally, the context refers to the levels of systems in the social environment and includes both the setting as well as the typical activity related to that setting (Newman & Newman, 2016); for example, school is the setting, and learning is the activity. Those with SAD may have limited settings, or microsystems, in which to interact and this consequently will reduce the number and/or variety of processes that adolescents with SAD may experience.

These four concepts are interrelated, adding to the complexity of how individuals interact with their environments. For example, an adolescent with SAD will likely experience limitations in time, contexts, and processes due to the avoidant nature of SAD,

thereby perpetuating SAD. The level of resilience of an adolescent, however, may offset some of these limitations. Among these four additional theoretical concepts, only context was applied in the reviewed studies, representing one gap in the academic literature, especially given the interrelatedness of these four concepts.

## Related Theoretical Research

Research involving the bioecological theory in adolescent development was limited both in the scope of the theory and in the number of studies. Although bioecological theory had not been used to explore adolescent SAD specifically, researchers had applied this theory to research other phenomena related to human development, using school, home, and the mesosystem between these two microsystems. Bioecological theory was used as the theoretical framework in five studies published from 2012 to 2017. In two of these studies, the microsystem was the focus. In the remaining three studies, researchers concentrated on the interaction between school and its related mesosystems.

Research studies concerning academic development in mathematics and school belongingness highlighted the complexity of a microsystem. In the current study, it was likely that this same complexity would emerge between adolescents' microsystem(s) and their SAD. Martin et al. (2012) conducted a quantitative study to investigate how the study of mathematics is influenced by educational ecology; what these researchers found was that the home and school microsystems, as well as the student, were determining factors of learning mathematics. Furthermore, Martin et al.'s methodology had the

advantage of subcategorizing the microsystems into smaller units of study; this process may have been useful in the current study of adolescent SAD. Also focusing on the school microsystem was Allen et al.'s (2016) meta-analysis of school belongingness, in which the researchers emphasized the need to address school belongingness on the micro, meso-, and exosystem levels. Based on these two studies, it is clear that there are a number of factors within the school or home microsystem, the mesosystem of school and home, and the exosystem that can impact adolescent development, and by extension development during adolescence for those who have SAD.

Beyond the school microsystem, other studies addressed the mesosystem as a key factor in adolescent development, particularly in mental health, socioeconomic disadvantage, and academic achievement. Smokowski et al. (2016) conducted a 3-year quantitative study to investigate adolescent internalizing and externalizing behaviors, using home, school, and the community as the three microsystems. Smokowski et al. identified protective and risk factors from all three microsystems, further indicating the bidirectional impacts between microsystems, and thereby highlighting the role of the mesosystem. Additionally, Hacker and Hayes (2017) conducted a systematic review of how schools can support disadvantaged youths, and determined that intervention is most effective when it is delivered at both the school microsystem level as well as at the mesosystem level, whereby school and additional microsystems are incorporated into supports for youths. Finally, Hampden-Thompson and Galindob (2017) examined how the relationship between school and home relates to adolescent academic achievement in

their longitudinal quantitative study. Hampden-Thompson and Galindob found that there was a positive correlation between the school-home mesosystem and academic achievement; the determining factor was parent satisfaction with the school. In these three studies, these researchers identified different areas of focus, yet they all found that the mesosystems connecting school primarily to home and secondly to community were all impactful on adolescent development. Together, these conclusions highlighted the possibility that in the current study of adolescent SAD, the home-school mesosystem may have been equally important.

Researchers studying adolescent development through the theoretical lens of Bronfenbrenner's bioecological theory have made significant contributions to the academic literature of adolescent development. Researchers have used this theory to further understanding of academic, social, and psychological development in adolescence. These studies supported the notion that adolescents are impacted by their micro- and mesosystems and that specific aspects, and combinations thereof, may be uniquely pertinent to particular areas of development, such as belongingness, academic achievement, and level of (dis)advantage. It was possible that adolescent SAD and its relationship to resilience would be connected to its own combination aspects of micro- and mesosystems.

Bronfenbrenner's bioecological theory provided a valid theoretical approach to studying adolescent SAD. The way in which adolescents experience SAD is influenced not only by the context, but also by process, time, and personal demand features, such as

well-being, resilience, and SAD. According to the bioecological theory, the influence between an individual and their social environment is reciprocal, whereby adolescents' perception of their surroundings impacts how they behave in those environments. This is especially significant during ecological transitions. A foundational aspect of SAD is the individual's perception of social threat in their immediate surroundings (American Psychiatric Association, 2013), which is directly associated with their micro- and mesosystems. The macro- and chronosystems also factored into the exchange between individual and the environment, not to mention the underutilized components of process and time. By applying Bronfenbrenner's bioecological theory in a comprehensive manner, I sought to reveal not only the complexities of adolescent SAD, but also its relationship with resilience.

## Literature Review Related to Key Variables and Concepts

This section is divided into two subsections. The first subsection comprises the four key concepts related to the study: SAD, adolescence, resilience, and well-being. This is followed by the second subsection that consists of related research in the specific areas of SAD etiology, treatment for SAD, and the role of resilience with adolescent SAD. Together, these subsections provide an in-depth overview of the literature and concepts associated with this current study.

### Concepts

There were four key concepts related to this current study. These concepts are: SAD, adolescence, resilience, and well-being; all of which represent demand features of

the person. These four concepts are presented in an intentional order. SAD and adolescence are the first two terms and represent the two foundational components of the sample population for this current study. They are followed by resilience which is the concept that has been predominantly absent in research with adolescent SAD. Last is well-being, which is conceptually related to resilience and yet not a central focus of this current study.

### *Social Anxiety Disorder*

Anxiety is a complex phenomenon that is used as an umbrella term in some studies found in this literature review. As conceptualized by psychology pioneer Aaron Beck, anxiety is comprised of physiological arousal, a cognitive preoccupation towards potential danger, and a heightened emotional state; anxiety is perpetuated by continued cognitive distortions that signal the emotional and physiological responses associated with anxiety (Beck & Emery, 1985). The current conceptualization of anxiety remains somewhat consistent with Beck's earlier work. In the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), the American Psychiatric Association (2013) identified the components of anxiety as an emotional response of fear to a cognitively-perceived threat, the related autonomic physiological reaction, and the possible resulting avoidant behavior. Moreover, there are twelve categories of anxiety, according to the DSM-5 (American Psychiatric Association, 2013). The focus of this current study concerned one distinct anxiety disorder that is comparably complex which was SAD.

There has been an evolution of what is the current-day conceptualization of SAD and most studies in this literature referred to its definition from either the DSM-4 or DSM-5. References to shyness and phobias have been present since Hippocrates, however, the term social phobia only emerged in the early 1900s and social neurosis in the 1930s (Thomas, 2018). It was not until the 1960s that the term social phobia appeared in the DSM-2; and it was in 1980 that the American Psychiatric Association identified social phobia as a specific diagnosis in the DSM-3 (Thomas, 2018). The American Psychiatric Association changed the categorization of social phobia to social anxiety disorder in 1994 in the DSM-4, however, some current studies in this literature review referred to social phobia instead of social anxiety. In both the DSM-4 and the DSM-5, revisions of the diagnosis for SAD were made (Thomas, 2018) and it is possible that some recent studies may have used an earlier version of the SAD diagnosis in their research. What currently exists in the DSM-5 is the product of conceptual evolution. The definition of SAD, according to the DSM-5 (American Psychiatric Association, 2013), is as follows:

1. A 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. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be embarrassing and humiliating.

2. Exposure to the feared situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally pre-disposed Panic Attack.
3. The person recognizes that this fear is unreasonable or excessive.
4. The feared situations are avoided or else are endured with intense anxiety and distress.
5. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
6. The fear, anxiety, or avoidance is persistent, typically lasting 6 or more months.
7. The fear or avoidance is not due to direct physiological effects of a substance (e.g., drugs, medications) or a general medical condition not better accounted for by another mental disorder.

For the purposes of this study, SAD was defined based on the DSM-5 and all participants in this study met these criteria, with the acknowledgement that the research in the literature review may represent earlier conceptualizations of SAD.

Interestingly, the seven criteria for SAD named by the American Psychiatric Association (2013) span Bronfenbrenner's four components of his bioecological theory. The context is social and performance situations. Process includes the perception of

threat, distress, and consequent avoidance. Time is present in the criteria of the SAD lasting for at least 6 months. Finally, the demand feature of the person is the social anxiety. By considering SAD through the lens of bioecological theory, new insights about this phenomenon were attained.

The prevalence rate of SAD denotes its importance as a mental health disorder. SAD is the second most common anxiety disorder, impacting 5.5% of adolescents in the United States (Mathews, 2017). Specific phobia is the most common anxiety diagnosis for American adolescents at 15.1% and panic disorder and agoraphobia represent 2.3% and 2.4% respectively of American adolescents (Mathews, 2017). Comparative to other common anxiety disorders, SAD has a moderately high prevalence rate for adolescents. The average age of onset makes SAD particularly important in adolescent mental health. According to Hill et al.'s (2016) overview of anxiety disorders in childhood and adolescence, the average age of onset of SAD is 13 years, denoting the significance of the ecological transitions from childhood to adolescence and/or from primary to secondary school. Only one other anxiety disorder typically emerges earlier in childhood and that is separation anxiety (Hill et al., 2016). Other forms of anxiety, such as agoraphobia and panic disorder, tend to emerge in the early 20s, and generalized anxiety disorder in the early 30s (Hill et al., 2016). SAD is the only anxiety disorder that has an average age of onset during adolescence. Despite the important connection of SAD and adolescence, research in this area is not consistent in terms of how adolescence is defined.

### *Adolescence*

Adolescence has had its place in academic thought since ancient Greece when Plato and Aristotle considered adolescence as the third stage of life (Arnett, 2013). Adolescence became part of more contemporary academia when Stanley Hall established adolescence as a distinct area of study in the early 1900s and prominent in Erikson's stages of psychosocial development in the 1950s (Arnett, 2013). More recently in developmental psychology, adolescence is understood as the period between the onset of puberty and the life responsibilities of adulthood, signifying the biological and cultural factors that comprise adolescence, making the age range of adolescence from 10 to 18 years of age (Arnett, 2013).

It is important to establish how the developmental stage of adolescence was treated in this current study. Adolescence was defined as the time span between 10 and 18 years of age. It is important to note that there was inconsistent use of the adolescent period amongst the research cited in this study. For example, some researchers grouped children and adolescents together, ranging from 5-18 years (Maynard et al., 2018) or 6-18 years (Scaini et al., 2016). Other researchers identified their age range as adolescence, using the age ranges of 12-18 years (Meeus, 2016; Polanczyk et al., 2015; Smokowski et al., 2016), 12-16 years (Pavlova & Kholmogorova, 2017), 13-18 years (Moksnes et al., 2019), and 10-19 years (de Lijster et al., 2018). Moreover, other researchers identified their age range as youth, representing an 8-14 year span (Ost et al., 2015), despite the World Health Organization's (2019) definition of youth as ranging from 15-24 years; developmental psychology does not seem to have an established definition of youth as

terminology. It is important to note that the research upon which this current study was drawn comprises conflicting descriptions of adolescence, as it does with resilience.

### *Resilience*

The evolution of resilience dates as far back as post World War II (Masten, 2014) with a concentrated increase in interest for the past 50 years (Masten, 2009). The concept of resilience has recent origins in both the psychology of coping with adversity and the physiology of stress (Tusaie & Dyer, 2004) and its numerous times of increased attention are often the outcome of significant challenges in the world (Masten, 2014). Research in resilience has occurred in four waves (Masten, 2014). In the first wave, the focus was on describing resilience. The second wave involved understanding how resilience surfaced, focusing internal personal factors and external environmental factors; later on, internal factors became known as protective factors and environmental factors, as social support became more specified; risk factors came to exist in both domains (Tusaie & Dyer, 2004). The third wave saw researchers studying interventions as a means to encourage resilience. The fourth, and present wave of resilience research is centered on how the individual and the environment interact as a way of understanding resilience, making this wave highly aligned with Bronfenbrenner's bioecological theory. Currently, researchers recognize that there is a complex interplay between the protective factors, social support, and risk factors, which has led to the realization of the bi-directional, reciprocal relationship among these components of resilience (Tusaie & Dyer, 2004). Resilience continues to evolve, and consequently its definition is not fully established.

Resilience is a term that does not have one universal definition in the academic literature. From a developmental psychology perspective, resilience is the ability to successfully adapt to situations than impede healthy functioning (Newman & Newman, 2016) by accessing environmental resources and using them in meaningful ways (Ungar, 2011). Through the lens of bioecological theory, this involves the demand features of the person as well as process in particular contexts. The understanding of resilience involves considering how protective and risk factors are associated with an individual in a particular social context (Newman & Newman, 2016), and this may involve the person interacting with different levels of ecological systems, or contexts. Resilience can exist on an individual, systems, or societal level, and in this current study, the focus was solely on individual resilience. Given the numerous definitions of resilience that exist in the academic literature, Schultz-Lutter et al. (2016) pointed out the importance of providing a context in which resilience is used. For this study, I applied the developmental psychology definition of individual resilience.

### *Well-Being*

Well-being, from a developmental psychology perspective, reflects healthy growth in response to changes within a person's lifespan (Newman & Newman, 2016). Moreover, well-being represents positive mental health in terms of experiencing wholeness, empowerment, and life satisfaction (Howell et al., 2016). Seligman (2018) identified five building blocks to well-being that form the acronym PERMA: positive emotion, engagement, relationships, meaning, and accomplishment. In the American

Psychological Association's (2020a) dictionary of terms, two aspects of well-being are identified. They are affective well-being, comprising pleasant and unpleasant emotions, and cognitive well-being, which represents areas of life satisfaction. Well-being is therefore more than the absence of illness (Howell et al., 2016) and was treated in this paper as a separate construct from the absence of SAD. By incorporating the definitions of Seligman and the American Psychological Association, well-being encompasses positive mental health, social engagement in social environments, as well as developing healthy individual relationships.

Together, these key terms provide a landscape of interrelated concepts with which to understand adolescent SAD. SAD exists as interplay between the adolescent and the social environment in which SAD represents the negative circumstance and resilience as a personal factor that allows for adaptation in social contexts, particularly in periods of ecological transitions, resulting in well-being. The interconnectedness between adolescent SAD, resilience, and well-being can be understood within a theoretical context, like Bronfenbrenner's bioecological model, because this model conceptualizes development as the interaction between the individual and the environment.

**Related Research**

Research related to this current study was organized in three key categories. First is the etiology of SAD using a developmental psychopathology framework, in which the reciprocal relationship between the individual and the social environment is highlighted. Second is the review of research of SAD treatment interventions which underscores the

need for a different approach to conceptualizing and treating adolescent SAD. This leads to the third category of literature, and that is the role of resilience in adolescent SAD research and how Ungar's socioecological theory applies.

### *Etiology of Social Anxiety Disorder*

From a developmental psychopathology framework, the likely cause(s) of SAD exist in the interplay of numerous factors. According to the developmental psychopathology framework, development is a result of numerous external factors interacting with one another and with the individual, explaining how unique the development of psychopathology is from one person to the next. Predisposing, precipitating, and maintaining factors can all contribute to the etiology of SAD, or perhaps only one factor need be present within this framework (Higa-McMillan & Ebesutani, 2011). Predisposing factors include genetics and temperament, and these are what Bronfenbrenner would call demand features, while a third predisposing factor, parenting, represents the family microsystem (Higa-McMillan & Ebesutani, 2011). Precipitating factors, on the other hand, often closely precede the onset of SAD; examples are trauma, other negative life events, and modelled behavior of social anxiety (Higa-McMillan & Ebesutani, 2011). Finally, there are maintaining factors, which encompass examples from the first two factors as well as deficits in social skills and negative cognitive bias within ambiguous social situations (Higa-McMillan & Ebesutani, 2011). Although these factors may be a byproduct of maintaining factors, they fall into

the demand features category, illustrating how the demand features of the person can be impacted by predisposing factors and maintaining factors.

Elements of this developmental psychopathology framework are present in existing research about SAD. Researchers in four recent studies provided findings that add both clarity to the origins of adolescent SAD and support of the developmental psychopathology framework. Predisposing, precipitating, and maintenance factors become so intertwined that knowledge of the etiology does not necessarily shed light on effective treatment. Pavlova and Kholmogorova (2017) examined the psychological factors related to SAD with adolescents aged 12-16 years and identified positive correlations between SAD and depression, forms of perfectionism, emotion suppression, and suicidality. Unfortunately, it is unknown if Pavolova and Kholmogorova's four related psychological factors represented causes, results, or comorbid factors of SAD. Similarly, in Meeus' (2016) review of adolescent psychosocial development, this researcher identified eight patterns of adolescent development, four of which are particularly relevant to adolescent SAD. Meeus found that: (a) children are influenced by their parents' behaviors, (b) when adolescents experience psychopathology, their relationships are negatively impacted, (c) this psychopathology hinders independence from parents, and (d) when parents intervene in their adolescents' personal issues. This last stage leads back to the first, interconnecting the predisposing and maintenance factors of adolescent SAD and highlights the bi-directional relationships between the person and the context.

Additional research examples represent how predisposing factors can later become maintenance factors. Di Blasi et al. (2015) discovered five distinct aspects of negative self-image as factors of SAD: mastery, family relationships, academic goals, mental health social attitude, and emotional tone. Any of these forms of negative self-image has the potential to perpetuate social anxiety. Experiences of loneliness, vulnerability, and uncontrollable emotions, which were all experiences of the participants in Hjeltnes et al.'s (2016) study of social anxiety, can also be considered maintenance factors that may once have been predisposing factors. Finally, fears of humiliation and being looked at by everyone were situations identified by university students in Akacan et al.'s (2015) study of social anxiety, which can be labelled as predisposing factors that later may evolve into maintenance factors. These factors can begin as causes of SAD and may also be the reason why this anxiety disorder is perpetuated, creating a pathway of avoidance that then entrenches the anxieties (Akacan et al., 2015). These processes are more circular than they are linear, with the potential of compounding SAD for adolescents.

Bi-directionality of the causes of adolescent SAD were further highlighted in two additional studies. Ollendick and Grills (2016) carried out a qualitative review of seminal research conducted in 1998 by Chorpita, Brown, and Barlow, who attributed childhood anxiety to the level of parental control and the child's perceived external locus of control. Ollendick and Grills extended this original conceptualization to include the possibility that the child's anxious behavior may lead to overcontrolling behaviors in parents,

reinforcing the developmental psychopathology framework in that the parenting factor can be both a predisposing factor and maintaining factor. This conclusion was supported by what Borelli et al. (2015) found in their study of parental reactivity, that highly reactive or anxious parents can create anxiety in their children, and anxious children can lead parents to be reactive. In both of these studies, the bi-directionality occurs in the home microsystem, which is the first and most prominent microsystem for the adolescent (Bronfenbrenner, 1979). The family microsystem provides foundational opportunities for bi-directional process over a prolonged period of time for adolescents.

The developmental psychopathology framework and the contributions of Higa-McMillan and Ebesutani (2011) remain both relevant and valid in understanding the etiology of SAD. Recent research supports the impact of one of more forms of factors that are correlated to SAD. Moreover, recent research and the developmental psychopathology framework underscore a central piece of Bronfenbrenner's bioecological model; that is the impactful, bi-directional relationship between the individual and the home microsystem. The etiology of SAD is multi-dimensional and part of a larger developmental, socioecological system. This makes treating SAD a complex endeavor and suggests that treatment ought to reflect a holistic systems approach. This developmental psychopathology framework, however, is based on a deficit model and is likely to elicit research for treatment from a deficit perspective, which is predominant in the following review of treatment research.

### *Research on Treatment*

Research on the treatment of adolescent SAD is equally robust as the research on its etiology and yet it is not conclusive of how best to treat adolescent SAD. Treatment was one factor in how adolescents experience SAD. Researchers have focused studies on treatment interventions in both the clinical setting as well as in schools. Cognitive behavior therapy (CBT) has received the most attention in clinical research, although research does extend to alternative interventions as well. In the school setting, researchers have investigated the role of the teacher, student characteristics, academic achievement, and access to services as prominent factors related to supporting adolescents with SAD.

There is a great deal of literature and research involving CBT as a treatment for anxiety. In a CBT clinical intervention, the individual with SAD learns new ways of thinking about their social fears, which then impacts their level of anxiety and their behaviors in social situations. As Aaron Beck explained in his foundational theory, affect and behavior are greatly determined by a person's cognitive perceptions of a situation (Corey, 2005). The purpose of CBT is to help individuals change the way they think and perceive social situations. Although researchers have found CBT to be less effective in treating SAD than other forms of anxiety (Babinski & Nene, 2016), CBT is widely used in clinical settings and some school settings.

The essential components of a CBT program for adolescent SAD remain undetermined. Studies provided contradictory results regarding the need for parent training, whereby some studies indicated that parent training is not necessary (Ost et al., 2015; Scaini et al., 2016 ) and others do (Babinski & Nene, 2016). The best way to

deliver the CBT intervention is also uncertain, whether that be individualized (Babinski & Nene, 2016), or in a group setting (Donovan et al., 2015). Additionally, if SAD ought to be treated generically as an anxiety disorder (Spence et al., 2017), or if treatment specific to SAD is warranted (Hearn et al, 2018) has yet to be resolved. Additionally, if SAD ought to be treated specifically, it is unknown which particular SAD factors ought to be isolated: loneliness (Baytemir & Yildiz, 2017), hopes and concerns (Anttila et al., 2015), stereotypes (Fox et al., 2016), or negative self-image (Di Blasi et al., 2015). Based on this existing research, it is apparent that how best to treat adolescent SAD through CBT continues to evolve. On a broader level, delivery of interventions can also extend beyond the clinical environment to the school environment.

School is a significant microsystem in an adolescent's social environment and it is in this setting that adolescents may also receive interventions for SAD. In Scaini et al.'s (2016) meta-analysis of CBT interventions for childhood and adolescent SAD, these researchers identified school as a more effective setting for intervention than a clinical setting. Properly trained school counsellors can deliver a CBT program to students with SAD as well as psychologists in a clinical setting (Warner et al, 2016). Additionally, parents are in support of schools attending to students' mental health needs (Searcey van Vulpen et al., 2018), making school interventions for adolescents with SAD a potential form of treatment.

There are factors within the microsystem of a school, however, that need to be in place in order for this to be effective. These include positive student/teacher relationships

(Maynard et al., 2018), parental engagement, and school-level programs using a positive, as opposed to a deficit approach (Carroll & Hurry, 2018). Parental engagement with school treatment may, however, be impacted by stigma of mental health based on cultural values (Turner et al., 2015), general concern of societal stigma (Chaviraa et al., 2017), and parental perceptions of treatments (Roberts et al., 2016). In order for schools to properly provide treatment for adolescents with SAD, a number of factors would require investigation and pre-planning, including the preparation of teachers.

Teachers represent a central factor in the school setting and lack training in mental health. St. Onge and Lemyre (2017) identified knowledge of mental health disorders, perceptions of school accommodations, and confidence in supporting students to access support as three fundamental variables in a teacher's ability to support student mental health. Unfortunately, what Urhanhe and Zhu (2015) found in their study was that teachers are not competent in estimating student well-being in terms of mental health. This may help explain the low referral rates of teachers to mental health support as found in Hinchliffe and Campbell's (2016) research. The implications of these particular studies highlight the need for additional education for teachers regarding mental health (Urhanhe & Zhu, 2015), as well as training with a decision-making model with regards to making mental health referrals (Hinchliffe & Campbell, 2016).

A variety of interventions exist to treat adolescent SAD and research continues to ascertain the most effective way to use these interventions. There is potential to provide treatment in a school setting, however, there are particular factors that require attention in

order for this to be a viable option. Continued research in the area of adolescent SAD will provide further clarity about how best to support this population. Research involving resilience offers a different perspective on how to study and support adolescent SAD and represents a second gap in the literature.

### *Role of Resilience in Adolescent SAD*

The majority of the literature reviewed thus far has approached SAD within a deficit model and as such, the focus has been on reducing the negative impacts of SAD through various interventions. This deficit-approach has produced valuable insights into adolescent SAD, and yet treatment efficacy remains less than that of other anxiety disorders (Babinski & Nene, 2016). In this section, a different approach to conceptualizing adolescent SAD is explored; it is a strength-based approach with a focus on resilience. Employing a resilience-focused, strengths-based approach has the potential to improve and/or prevent hardships (Masten, 2009) and to offer a more balanced understanding of adolescent SAD. Resilience encompasses the protective factors and risk factors that originate in either the individual, the social environment, or both, and how they relate to one another (Ungar, 2011). Models of resilience provide the landscape onto which research studies that focus on well-being, positive psychology, and resilience are explored.

Some models of resilience are used to enhance understanding about personal aspects that act as protective factors with regards to resilience. Early work conducted by Masten identified the 10 protective factors contributing to adolescent resilience and they

are: intellect, self-regulation, self-efficacy, meaning, attachment to caregivers and to adults, friendships, and connections to school, community, and culture (Bosma et al., 2019, p. 737). A number of these factors may be limited for adolescents with SAD who avoid social situations and have limited social interactions. Later, models were developed that provided organization and structure to the numerous protective factors. Moore and Woodcock (2017) developed a factorial model of resilience in which the three categories of personal factors are mastery, relatedness, and emotional reactivity. Similar to the factorial model is Grych's resilience portfolio model, in which resilience was conceptualized into these three categories: self-regulation, interpersonal strengths, and meaning-making (Hamby et al., 2018). These three models all overlap in most of the personal factors associated with resilience, and yet they are limited to only one grouping of resilience, which is protective factors of the individual.

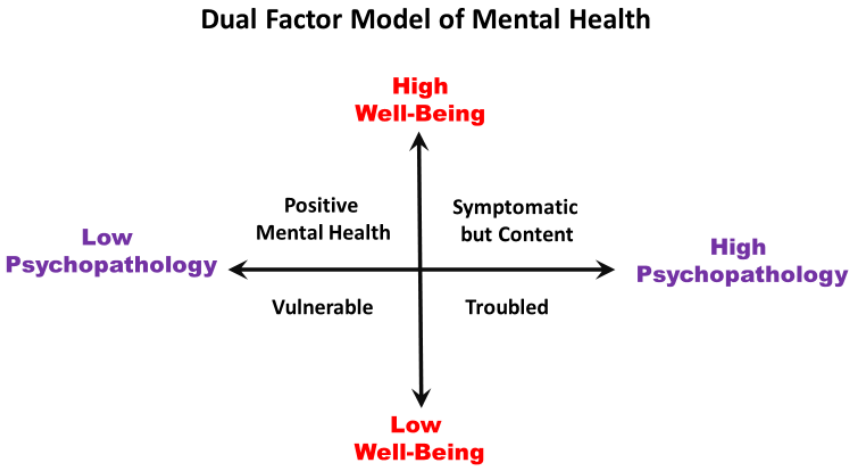
Michael Ungar (2011) developed a model of resilience that incorporates individual and social factors. This social ecological theory of resilience is based on four principles: resilience is about the interaction between the individual and the environment, the interplay is complex, what is maladaptive in one social context may be adaptive in another, and resilience is context-specific. This theory recognizes the personal aspects that act as protective factors as they interact with other factors in the social environment. This model is the most comprehensive and most aligned with Bronfenbrenner's bioecological theory of development. The social ecological theory of resilience was incorporated into this current study, and it revealed how processes and contexts can

reduce the precipitating and maintaining factors of psychopathology. In this way, social ecological theory was used alongside other theories in order to create a holistic view of how adolescents experience resilience and SAD.

The dual factor model of mental health is a holistic way to understand mental health and is an additional theory that can balance the deficit approach of the developmental psychopathology framework (see Figure 2). In this model, four categories exist to represent ways in which an individual can experience psychopathology, such as SAD, and well-being (Grych et al., 2020). These are: *positive mental health*, where well-being is high and psychopathology is low; *troubled* is represented by low well-being and high psychopathology; *vulnerable* exists where both areas are low; and *symptomatic but content* occurs with high well-being with symptoms of psychopathology. This last category was of particular interest in this study of adolescent SAD, as it suggested that SAD symptoms can exist alongside well-being for these adolescents. This dual model of mental health corroborates Howell et al.'s (2016) argument that well-being is distinct from illness. This model provides a different approach to treating approach SAD; instead of minimizing symptoms of SAD and focusing on the troubled and vulnerable quadrants, the goal is to strengthen well-being in the symptomatic but content quadrant.

**Figure 2**

*Dual Factor Model of Mental Health*




There are examples of recent research in which researchers have used a strength-based approach in mental health and psychological functioning, in which well-being and resilience have been at the forefront of understanding anxiety and adversity. Wu et al. (2018) found trait resilience as the moderating factor between bully victimization and social anxiety among 1903 children. In their cross-cultural study, Brailovskaia et al. (2018) concluded that resilience and social support both act as protective factors for adolescent anxiety. In a study of 1183 adolescents, Moksnes and Lazarewicz (2019) noted that resilience moderated how stress impacted emotional symptoms, while Min et al. (2015) found in their study of adults that resilience reduces the risk of suicidality of those with anxiety disorders. Prince-Embury (2015) noted the negative correlation between resilience and risky behaviors. Slaten et al. (2019) found that resilience promotion positively impacts self-efficacy and self-regulation. Lastly, in their systematic

review, Fritz et al. (2018) concluded that various resilience factors ought to be considered together to predict psychopathology resulting from adversity. These studies support the inclusion of resilience in research regarding adolescent mental health and promote understanding how some adolescents are in the symptomatic but content quadrant.

There are a number of additional arguments for the incorporation of resilience into research of adolescent mental health. Based on their study of SAD and post-traumatic stress disorder, Marx et al. (2017) concluded that addressing resilience as a target for intervention can be a way in which to promote life-long recovery. As Grych et al. (2020) noted in their application of the dual factor model of mental health, by recognizing well-being and resilience, researchers can learn more about protective factors that can be incorporated into interventions. Drvaric et al. (2015) came to a similar conclusion in their study of adolescents at risk for psychosis, in that these researchers promoted a strength-based approach of well-being and resilience as a viable treatment intervention.

Research involving resilience in areas outside of mental health all pointed to an important consideration. How to address resilience in research studies? These considerations can be conceptualized using Bronfenbrenner's four key concepts: person, context, process, and time (Newman & Newman, 2016).

The individual is a central factor in understanding the lived experience of adolescent SAD and the role of resilience. Masten's 10 protective factors, Grych's resilience portfolio model, and Moore and Woodcocks's factorial model of resilience all

highlight the protective factors that exist in a resilient individual. Common implications of research on resilience also support the need to individualize research, interventions, and conceptualizations of resilience to particular populations due to their unique qualities. Examples include Asakura's (2019) study of resilience with LGBTQ youth, Cunningham et al.'s (2018) research of resilience in African American adolescents, Shpiegel's (2016) study of resilient adolescents in foster care, Fayyad et al.'s (2017) resilience study of war-exposed youths, Solivan et al.'s (2015) study of resiliency with teen pregnancy, and Venta et al.'s (2019) research of resilience among immigrant youth. In each study, researchers found that factors of resilience were unique to the particular population, and this represents the role of the person's particular demand features in Bronfenbrenner's bioecological theory. In this current study, adolescents with SAD also represented a unique set of resilient factors.

Context signifies the social environment and its many levels of systems. Context is also an important consideration when studying resilience and its connection to adolescent SAD. A number of recent studies of resilience emphasized the need to consider social environment as a context. Included are social environments of discrimination and immigration present among Latino youth (Bosma et al., 2019), low socio-economic status among Turkish high school students (Bulut et al., 2019), adversity in the lives of Aboriginal youth (Hopkins et al., 2018), and adolescents impacted domestic violence (Kassis et al., 2018). Each of these studies supported Ungar and Hadfield's (2019) assertion that resilience is context-specific. These contexts represent

microsystems, exosystems, and macrosystems. By interviewing individuals about their experience with SAD during adolescence, more was learned about significant contexts beyond the immediate micro- and mesosystems found in existing research using bioecological theory of adolescent development.

According to bioecological theory, the interaction between social context and the individual is called process. In this current study, the process of interacting with the social environment, despite SAD, illustrated resilience. As Ungar (2011) explained, this interaction is complex because it involves a number of personal and environmental factors. Moreover, process involved multiple personal factors in conjunction with one another in response to high adversity; this is what Hamby et al. (2018) referred to as poly-strengths. An additional aspect of process is how the combination of environmental factors can be experienced by an individual, as Rowe et al. (2016) found in their study of how adolescents experience divorce and resilience. Participants in this current study described their unique lived experience with process, underscoring the complexity of process.

Time is the fourth element of bioecological theory and researchers have noted this aspect of the theory in recent research of resilience. In their study of negative life events and adolescent depression, Nishikawa et al. (2018) noted that the timing of a negative life event has an impact on how individuals experience resilience. Masten (2009) also explained how there are opportune stages in which resilience can be fostered, such as the transitions into school and from adolescence to adulthood. Additionally, van Harmelen et

al. (2017) found that protective factors depend on the stage of development, whereby enhancing family connection to build resilience is more impactful during childhood, and that in adolescence, friendship acts as a more significant protective factor. Timing is a determining factor for when to provide particular interventions and support to build resilience and also for understanding how much resilience is warranted. Participants in this current study shared their experiences during the time period of adolescence, which is a significant stage of development with its own unique factors.

In order to study the lived experience of adolescent SAD and the role of resilience, a number of key concepts and theories were relevant. Prominent were theories that identify personal protective factors, Ungar's model of resilience, and the dual model of mental health. These all represent a strength-based approach and align well with Bronfenbrenner's bioecological theory.

## Summary and Conclusions

The intent of this literature review was to present an overview of the academic literature relevant to adolescent SAD and resilience in order to represent the current status of this topic, as well as to identify the gaps in the literature. The gaps in the literature are the limited use of Bronfenbrenner's bioecological model in adolescent development research and the absence of a strength-based approach to researching adolescent SAD. A recurring theme in this literature review was the interrelated dynamic that exists between the individual and the social environment, present in Bronfenbrenner's bioecological model of development, the developmental

psychopathology framework of SAD, Ungar's social ecological theory of resilience, and the dual factor model of mental health.

These four components were assembled in such a way as to better conceptualize adolescent SAD. It began with the broad perspective of Bronfenbrenner and acknowledging the bi-directional interactions between person, process, context, and time. With the presence of adolescent SAD, the focus is to reduce the negative impacts of the precipitating and maintaining factors; this is based on the developmental psychopathology framework. At the same time, an additional focus was to foster protective factors and resources, as indicated in a strength-based, resilience model. The theoretical result was to bolster well-being and facilitate the adolescent's place in the symptomatic but content quadrant of the dual factor of mental health model.

This literature review provides both direction and validation for this current study. The aim of this study was to explore the resilience and successes of adolescent SAD, using a strength-based approach. By applying the whole context of Bronfenbrenner's bioecological model of development as the theoretical umbrella under which aspects of additional theories and models can address the complexities and interrelatedness of adolescent SAD, this current study provided an alternate, more comprehensive approach to treating this phenomenon.

In order to address these gaps in the literature, I conducted a qualitative study in which I interviewed adults about their lived experiences with SAD during their

adolescence. Chapter 3 will further expand on the methodology associated with this current study.

# Chapter 3: Methodology

The purpose of this study was to explore the resilience and successes of adolescent SAD from the retrospective lived experiences of young adults in Canada. In this chapter, information pertaining to various aspects of this study's methodology is provided. This chapter begins with an overview of the research design and rationale and is followed by an explanation of the role of the researcher. Next, the following areas of methodology are addressed: participant selection logic, instrumentation, procedures for recruitment, participation, data collection, and data analysis plan. Subsequent to the methodology are issues of trustworthiness, ethical procedures, and this chapter's conclusion.

## Research Design and Rationale

The foundation of the research design is in the research question(s), the central concepts of the study, the research approach, and the research tradition (Creswell & Creswell, 2018). In this section, each level of the research design is explained and rationalized, including the two research questions, the four central concepts, the qualitative approach, and the constructivist research tradition. Both the qualitative approach and Moustakas's modified Van Kaam approach to data analysis are justified. The research questions guiding this study were as follows:

1. From the perspectives of young Canadian adults, what was their lived experience of social anxiety disorder during adolescence?

2. Did adolescents with SAD develop resilience in their social environment, and if so, how?

The central concepts, all directly connected to these research questions, were adolescence, SAD, resilience, and well-being. Adolescence is the developmental period between childhood and adulthood, spanning 10 to 18 years of age (Arnett, 2013). SAD is an anxiety disorder diagnosis that features a fear of judgment in social situations, often leading to avoidance of those social situations (American Psychiatric Association, 2013). The hallmark of resilience is the ability to overcome adversity by adapting (Newman & Newman) and by accessing external resources (Ungar, 2011). Lastly, well-being embodies healthy growth and development (Newman & Newman) and is more than the absence of illness (Schultz-Lutter et al., 2016). These four central concepts were integral in exploring the answers to the research questions because they each had direct relevance to the question.

There were three main reasons why a qualitative approach was chosen for the current study. As Creswell and Creswell (2018) explained, factors such as the research problem, the research methods of data collection, and the researcher's philosophical assumptions inform the decision of what research approach to use. All of these factors led to my decision to use a qualitative approach in this study. The research problem was that current treatments for adolescent SAD are not as effective as treatments for other anxiety disorders, yet adolescent SAD impacts 5.5% of U.S. adolescents (Mathews, 2017). An exploratory qualitative approach to this research problem provided an opportunity to

identify new factors of this phenomenon by learning more about people's lived experiences with SAD; this opportunity would not have been possible in a quantitative study in which I would have needed to identify the factors in advance. Additionally, the data collection and analysis were aligned with a qualitative approach. Data were collected through semistructured interviews and were analyzed using Moustakas's (1994) modification of the Van Kaam method of analysis. This phenomenological method was chosen specifically for its concentration on the individual as opposed to the group, as well as its distinction between textural and structural descriptions (Moustakas, 1994); these factors made this data analysis approach the best choice over other phenomenological approaches. The third factor was my philosophical assumptions found in the research tradition. Pursuing this research problem qualitatively made it possible for the findings in this study to be translated into other contexts and be applied in quantitative research.

Within the realm of qualitative methodology is the phenomenological approach to research. Other qualitative approaches include case studies, ethnographic studies, and narrative research (Creswell & Creswell, 2018). Phenomenology, however, was the best approach for this study. The focus of the study was the phenomenon of adolescent SAD, as opposed to how one individual lives with SAD in a case study, the ethnography of adolescence as a culture, or the narrative of adolescents' lives. Through a focus on adolescent SAD, the phenomenological approach offered a way to gather firsthand lived

experiences of this mental health disorder to better understand its relationship with resilience.

The research tradition found in the outermost system of influence was constructivism. Constructivism is one of four philosophical world views; the other three are postpositivism, transformative, and pragmatism (Creswell & Creswell, 2018). Constructivism is aligned with qualitative research because it recognizes that multiple truths can exist, as each individual constructs their subjective meaning from their experiences (Creswell & Creswell, 2018).

Moreover, there are three fundamental assumptions in constructivism: People construct meaning from their experiences, each person's social context impacts how they make meaning, and meaning making is a product of social interaction (Crotty, 1998). A constructivist approach was used in the current study because of the central role of perspective in both constructivism and adolescent SAD. SAD is highly dependent on adolescents' perception of social threat, and approaching this phenomenon from a constructivist lens offered alignment between the phenomenon and the research tradition.

## Role of the Researcher

### Role

My role in this qualitative study was that of a consistently present instrument influencing each stage of the research from research question development to data analysis (see Ravitch & Carl, 2016). I was an observer of the phenomenon through the interview process, and I was the one who decided who would participate and how, what

questions to ask, and how to organize the data. My role as the researcher was both complex and central to the study.

Part of the complexity of my researcher role was positionality. Positionality refers to the relationships between the researcher and the research (Ravitch & Carl, 2016). My positionality with adolescent SAD was quite involved. As a former secondary school teacher, I encountered a number of students who struggled socially and were disengaged from school. While working as a high school counselor, I conducted research with emotional intelligence and at-risk youths. As a counseling psychologist, I treat adolescent clients whose SAD is a factor that impedes leaving the home. I teach educational psychology at undergraduate universities and explore adolescent SAD with university students. My professional experiences impacted how I understood this phenomenon; specifically, I had witnessed adolescent SAD as an obstacle to healthy social development.

My beliefs impacted my role as the researcher. It was my conviction that adolescent SAD is a relevant issue in adolescent development and one that may worsen as technology and social norms make it increasingly acceptable to lead socially isolated lifestyles. I valued face-to-face social interaction more than digital interaction. I had a bias that the former has more value than the latter.

My bias was likely founded in my identity. I am a middle-age, heterosexual White female from a middle-class socioeconomic status. I have not personally experienced any clinical forms of anxiety, and the minimal discrimination that I have personally

experienced was based on gender; neither prejudice nor discrimination has restricted any aspirations in my life. I only knew secondhand how an issue like adolescent SAD can impact a person's development and life trajectory.

**Bias Management**

There were a number of specific, concrete ways in which I managed my biases, and they all revolved around the core concept of reflexivity. Reflexivity involves ways in which the researcher recognizes and remains accountable for the subjective presence that they bring into the research process, which increases validity (Creswell & Creswell, 2018). My biases were managed using two reflexivity strategies: thick description and a research journal. I had intended to use a third strategy of member checks; however, one of the partner universities in which I recruited participants suggested that I not use this technique in their ethics review feedback. They stated that this technique added an unnecessary burden to the participants. Thick description entails the researcher describing the context in which the data were collected (Ravitch & Carl, 2016) as well as the words used by the participants. In the current study, thick description included transcripts to capture the participants' words and my observations of social context, tone, and affect. Reflective journaling is considered good practice in qualitative research (Ravitch & Carl, 2016). I used this strategy after each interview and daily when I conducted analysis to record insights, pose questions, and challenge biases. These reflexive practices enhanced the rigor of the research and provided an established forum to address my biases.

## Relevant Relationships

My social location as an instructor at two local universities impacted potential participant relationships because my primary form of recruitment was from postsecondary institutions in my area. In universities in which I was an instructor, I recruited only students who were studying in departments outside of the ones in which I taught, and by doing so I avoided the ethical issue of having a dual relationship with students and research participants.

## Ethical Issues

I developed a plan to avoid the ethical issue surrounding dual relationships with students/participants. Originally, I had hoped to meet with participants on their campus in a neutral and private space, such as a library conference area, rather than in my office, which may have created a perception of a power differential during the interview. Due to the COVID pandemic, I was limited to meeting participants online.

In terms of incentives, I offered each participant access to a summary of my findings with the hope that this information may be used as a resource or form of validation of their resilience. I also offered each participant a $10 gift card. The $10 amount was chosen because it was enough money to represent a token of appreciation but not so much that it would influence participation. These forms of incentive did not create any ethical issues.

# Methodology

## Participant Selection Logic

The sample population in this study was young Canadian adults age 18–25 years who were diagnosed with SAD before adulthood. In a qualitative study such as this, purposeful sampling was used to gather information, whereby participants were chosen based on their personal experience with adolescent SAD. There are over 30 purposeful sampling strategies (Ravitch & Carl, 2016) used in qualitative research, and of those 30, I employed the one that was most congruent with the phenomenological approach. The sampling strategy was group characteristic sampling, whereby participants were chosen based on the group characteristic of a SAD clinical diagnosis before adulthood. This group characteristic sampling strategy represented one of three key inclusion criteria. The three inclusion criteria were the SAD diagnosis, the young adulthood age range, and the geographical location.

Participants needed to have been diagnosed with SAD before adulthood. Participants self-reported their diagnosis, which was based on the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) from a qualified health professional. Nonclinical SAD exists in which individuals experience symptoms of SAD but with no formal diagnosis; these individuals did not meet the inclusion criteria. The reason why the diagnosis needed to have occurred before adulthood was to exclude anyone who began to experience SAD in adulthood and therefore could not speak to their lived

experience with SAD during adolescence. The diagnosis was not limited to adolescent onset to include individuals who were diagnosed with SAD during childhood.

Participants needed to be young adults ranging in age from 18 to 25 years. The rationale for this criterion was based on ethical and cognitive considerations. According to the Society for Adolescent Health Research (2003), inclusion of adolescents in research has benefits and risks, and these factors need to be considered when choosing research participants. Based on the CPA's (2017) definition of a vulnerable population, adolescents who have SAD meet the criteria of a vulnerable population due to probable limitations in cognitive and emotional functioning. In the Canadian Code of Ethics for Psychologists, researchers are encouraged to avoid employing vulnerable populations for research if that research can be carried out as effectively with a less vulnerable population (CPA, 2017). In the current study, young adults were recruited to participate instead of adolescents. By recruiting young adults who experienced SAD during their adolescence, I not only presented less risk to the participants but also may have offered a deeper level of insight regarding how they overcame aspects of their SAD. According to Kitchener et al.'s (2006) reflective judgment model, young adults have typically achieved epistemic judgment, whereby they can understand and evaluate information from a relativistic perspective instead of an absolutist perspective often associated with adolescent thinking. Additionally, young adults made better participants than older adults for the current study because autobiographical recall is more accurate in young adulthood than in older adulthood (see Meléndez et al., 2018). Young adults who are reflecting on their lived

experiences during adolescence can do so with more cognitive maturity than their younger counterparts, more accuracy than their older ones, and with less ethical concerns than with adolescents.

Because of the method of recruitment from local universities, these participants were all residents of Alberta, Canada. The reason to exclude participants outside of Canada resided within the theoretical framework of this study. In the theory of human development, Bronfenbrenner (1979) recognized the impact of the macrosystem, which encompasses cultural values, economics, and politics. Even though Canada is closely connected to the United States geographically, the two countries differ on a number of cultural aspects, including governance, education, and values of diversity and equality (Matthews, 2017). To reflect the impact of the macrosystem on adolescent SAD, participants were limited to the Canadian population.

The number of participants in this study was based on methodology as well as the concept of saturation, with the caveat that there is no overall consensus with regards to the right number of participants (Mason, 2010). In this study, I employed a phenomenological approach, using group characteristic sampling, a type of purposive sampling strategy. In terms of methodology, Creswell and Creswell (2018) identified a range of participants for a phenomenological study as 3-10, whereas Mason (2010) cited Morse's (1994) guidelines for a phenomenological study as a minimum of six. The concept of saturation, on the other hand, is based on the point at which no new information is emerging from additional participants (Guest et al., 2006). What Guest et

al. found in their review of qualitative research using purposive samples was that saturation occurred between the sixth and twelfth sample. Considering the rigor that is expected in a PhD dissertation (Mason, 2010), and with the assumption that it was better to err on the side of caution than to miss new themes by assuming saturation prematurely, I was conservative and originally aimed for 12 as the number of participants for this study; due to saturation, however, this study comprised 10 participants.

The following was how the identification, contact, and recruitment of the 10 participants occurred. Identification of participants was based on the inclusion and exclusion criteria identified above and these criteria were provided in the recruitment poster (see Appendix A). When participants responded to the recruitment posters, I reviewed the inclusion and exclusion criteria to ensure that they met the requirements for the study. I had an initial data collection plan as well as a secondary plan if the initial plan did not yield enough participants. My initial plan for data collection was face-to-face interviews and the rationale for this choice is due to a number of advantages of this approach identified by Opdenakker (2006), including: the presence of participant social cues, the continuity and pace of the interview, and the option to amalgamate the audio-recording and researcher notes. My secondary plan via online interviews afforded a wider participant base and more privacy to the participant (Opdenakker, 2006) at the expense of the first option's advantages. I used my secondary plan out of necessity due to the COVID pandemic restrictions. Regardless of how I had intended to collect my data, my form of recruitment involved inviting those interested in participating to contact me.

I chose postsecondary institutions in Calgary, Alberta as the primary location for recruitment for two main reasons. First, I had access to these locations geographically, and second, young adult students at undergraduate universities and colleges make up from 20- 80% of the student population (The Hamilton Project, 2016), making these institutions viable areas for recruitment. I contacted the communication offices of Mount Royal University, University of Calgary, Bow Valley College, St. Mary's University, and the Southern Alberta Institute of Technology (SAIT) to post recruitment posters on their online platforms. Bow Valley College and SAIT did not reply to my requests and the timeline of the University of Calgary's Institutional Review Board (IRB) process was a significant obstacle. For this reason, I did not pursue recruitment at the University of Calgary. I attained permission for recruitment from Mount Royal University and St. Mary's University through an IRB from each university.

Originally, I planned to place my posters in public notice boards on campus where communications are permitted. On the poster, there was going to be a quick response (QR) code generator that potential participants could read with their mobile phone that would provide them with my contact information. Instead, I shared my recruitment posters with department leaders who then either shared it with their teaching staff to post in their courses, or the department leaders gave me permission to send emails to teaching staff members with my request to post my recruitment information. Several department leaders and teaching staff members shared my recruitment information with their students. As I had intended, I also discussed my research study with campus counsellors,

who were in a position to promote my study to students; enlisting the aid of established and trusted members of post-secondary institutions is a recommended way to increase recruitment (Namageyo-Funa et al., 2014). These contacts with university counselors did not lead to any recruitment.

I also employed a small portion of my secondary plan for recruitment. This plan involved posting recruitment invitations online in six possible online forums: social anxiety supports groups in Facebook, the Social Anxiety Support (SAS) Forum, the Social Anxiety Institute Forum, The Social Anxiety Forum at Mental Health Forums, the Social Phobia at Psych Forums, and *LinkedIn.* I initiated my secondary plan by first contacting colleagues through *LinkedIn* and I asked colleagues to pass the invitation along to their clients. This is how I found my tenth participant. I did not use any of the other online forums.

Each intended method of recruitment had advantages and disadvantages. Had I been able to interview participants in person at their universities, perhaps I would have been able to provide thicker description of the interview process. Connecting with participants online, however, may have felt more comfortable for the participants and it may have afforded them more privacy than meeting on campus.

**Instrumentation**

There was one instrument for data collection and it was a researcher-developed interview protocol. The interview questions were researcher-developed, following Castillo-Montoya's (2016) *Interview Protocol Refinement Framework* (IPR). This

framework follows four phases in interview protocol development: (a) aligning of interview questions with research questions, (b) facilitating inquiry-based conversation, (c) obtaining feedback on the interview protocol, and (d) using a small sample to pilot the interview protocol (Castillo-Montoya, 2016). In phase 1, the researcher creates a matrix to identify how each interview question aligns with the research question(s) to ensure that interview questions coincide with the research questions and to remove any questions that are not relevant to the research questions (Castillo-Montoya, 2016). The focus of phase 2 is to create a format for an inquiry-based conversation, and this is accomplished by making certain that the language used in the interview questions is conversational rather than academic, and also by ordering the questions to follow an introduction, a transition leading to the central questions, and closure with an opportunity for the participant to reflect and add more information (Castillo-Montoya, 2016). In phase 3, the researcher receives feedback about the interview protocol from volunteers and colleagues; Castillo-Montoya recommended using three volunteers to be the participant while providing think-aloud feedback of how they respond to each question. The researcher asks an additional three colleagues with experience in qualitative research to review the interview protocol using a checklist (see Appendix D). Finally, in phase 4 the researcher pilots the interview protocol with participants who meet the requirements of the study in order to refine the questions even further. These four phases of the Interview Protocol Framework provided a means to increase the trustworthiness of the interview protocol and were followed in this study.

The interview protocol was field tested, following Castillo-Montoya's (2016) IPR Framework. In phase 1, I created a matrix of alignment between interview and research questions (see Appendix E). In phase 2, I addressed wording in the protocol to ensure a conversational tone. In the third phase, field testing occurred in three distinct stages. First, three professional colleagues engaged in a think-aloud in the role of participant where they provided their thoughts about the interview questions as I read them aloud. This provided me with feedback about the wording, order, and other objective insights about the questions. Second, three colleagues with experience in qualitative research at the doctoral level reviewed my interview protocol and offered feedback using a checklist (see Appendix D). Third, an acquaintance with anxiety took the role of the participant and answered the questions as I interviewed them. This gave me practice at interviewing and using the protocol.

In addition to using the IPR framework, the interview protocol is also grounded in the literature. The interview protocol was influenced by questions used in similar studies using semistructured interviews. The following two studies provided useful exemplars of interview questions that are open-ended and judgment-free.

In Bosma et al.'s (2019) study of resilience of Latino youths, the researchers avoided asking *why* by asking "*what are the reasons…*" (p. 741) and doing so avoided the perception of judgment. In addition, there was an implicit acknowledgment that there will be successes and challenges in goal attainment in Bosma et al.'s (2019) questions and this normalized these experiences. Another noteworthy aspect of these questions was

their order, beginning with the strength-based question and balancing it with its opposite; Bosma et al.'s first asked about what makes it easier for youth to reach their goals and followed this question with one asking about what makes it harder to reach their goals. In contrast to Bosma et al.'s study, the interview protocol for this study lead with the deficit question of challenges connected with SAD followed by strength-based questions. I made this change based on the feedback from volunteers and colleagues during the IPR process.

In another study, Asakura's (2019) research of resilience and adversity among LGBTQ youth modeled two useful components of an interview protocol. First, Asakura embedded a concise definition of resilience, followed by a resilience question; this made the question more understandable to the participant, and as a result, more useful to the study. Second, there were key questions starting with *what* that were followed by a *how* question, allowing the answers to begin broad and become more specific. An example of this pairing was as follows. "Thinking about yourself and your LGBTQ peers, what do you think are challenges or difficulties LGBTQ youth are experiencing? Can you tell me how you and/or your peers have experienced these challenges?" (Asakura, p. 273). Asakura's study provided useful interview strategies that I incorporated into this study's interview questions.

In sum, these two studies highlighted important features of a semistructured interview protocol: avoidance of *why* questions, normalization of experiences, definition

use, and creating questions that can expand from the broad to the specific. I applied these aspects to the interview protocol for this current study.

In addition to the interview protocol, I also used specific devices in the data collection process. I used the voice recorder function of a password protected Samsung mobile phone as a secondary recording device; this was meant to be my primary recording device for face-to-face interviews. As the interviews were over the internet, I used a Hewlett Packard laptop with a built-in camera and microphone and Zoom was the video conferencing tool. Through Zoom I made my primary audio recording of the interview.

**Procedures for Recruitment, Participation, and Data Collection**

There were two research questions for which to collect data. I followed six steps in collecting the data. They were: IRB approval, permission to contact university staff members to distribute my recruitment posters, recruitment poster distribution, preliminary contact with participants, the interviews, and activation of the secondary recruitment plan. Each step is further explained.

This first step involved IRB approval. I obtained conditional IRB approval for this current study at Walden University, followed by IRB approval from the two partner universities. Then Walden University provided full IRB approval based on IRB approval from the two partner universities.

In the second step, I requested permission from the local postsecondary institutions to use their online platforms (see Appendix F). I did this by reaching out to

department leaders, teaching staff members, and counselors at the postsecondary institutions to explain my research and ask for them to share my recruitment posters with any students who would fit the criteria.

I then moved on to step three in which I distributed my recruitment posters to those who were willing to post them in their classrooms. Many department leaders and teaching staff members offered to post my recruitment information. Some of these people requested more information about the study and/or asked to see my IRB approval. These contacts yielded nine participants.

This led to step four of preliminary contact with participants. As participants contacted me, I ensured they met the inclusion criteria and we scheduled the interview. I emailed the informed consent in advance so that participants had the option of reading it in beforehand.

The interview was the fifth step. When I met each participant for the interview over Zoom, I followed the interview protocol, starting with the informed consent process, I audio-recorded the interviews, and I wrote notes throughout the interview. The duration of each interview was less than 60 minutes. At the end of the interview, I continued to follow the interview protocol to debrief with participants how they experienced the interview process. I offered to send them an executive summary of the research results and all 10 participants requested a copy.

My primary form of recruitment only yielded nine participants, and I was not certain that I had reached saturation. I used my alternate form of recruitment via *LinkedIn* in step six in which I connected with colleagues to ask for their assistance in circulating my recruitment posters.

**Data Analysis Plan**

According to Patton (2015), there are ten ways in which to analyze qualitative data. The process of analysis began with the full transcription of each interview. I used verbatim transcription and did so in a researcher-developed table format in *Microsoft Word* with five columns: time, transcription, code, theme, and my impressions. In order to become as familiar with the data as possible, I did not use any voice-to-text software for transcription. I transcribed the interviews by listening to the interviews and typing out the text.

In this phenomenological study, I analyzed the data using Clark Moustakas's (1994) modification of the Van Kaam method of analysis of phenomenological data. There are nine steps involved in this process. The first six steps are completed on individual transcripts: horizonalization from the transcription, reduction and elimination, thematization into constituents, a theme check, individual textural descriptions, and individual structural descriptions. Once all of the interviews are complete, the next three steps are: composite textural descriptions, composite structural descriptions, and a synthesis of the data.

The first two steps are horizonalization, followed by reduction and elimination. In horizonalization, every relevant expression is listed and treated as equally valuable (Moustakas, 1994). In reduction and elimination, each expression is eliminated if it cannot meet two criteria: that the expression is necessary and adequate in understanding the phenomenon, and that the expression can be labeled; vague or repetitive expressions are also eliminated (Moustakas, 1994). The next steps are thematization and theme-checking.

Thematization and theme checking were achieved as an iterative process. Thematization involves a number of considerations. A theme represents explanations of what is happening in the interview and/or how concepts are related (Rubin & Rubin, 2012). Some of the themes related specifically to the interview questions, such as challenges or successes, whereas others emerged from the sorting of codes. Moreover, some themes represented what was already present in the literature, such as symptoms of SAD. Then I checked the themes against the transcripts and determined that the themes did indeed represent the data from the interview transcripts.

Individual textural descriptions was the next step of data analysis. Based on each participant's transcript, I wrote a summary of the key statements that each participant made. These summaries were written on large post-it notes and served as an overall synopsis of the content of each participant's interview.

The individual structural descriptions served a different purpose than the individual textural descriptions. In this step, I wrote a summary of each participant's

emotional, cultural, and social context. This included level of engagement, level of anxiety, and any cultural factors that I either observed or that the participant shared with me.

Up until this point, data analysis was conducted on each interview separately. The last three steps involved analysis of the data as a whole. These last three steps were composite textural descriptions, composite structural descriptions, and finally the synthesis.

The composite textural descriptions involved bringing together all of the content from the interviews in a way that portrayed how the data fit together. All of the themes identified in an earlier step were arranged in a table and also written on post-it notes and arranged on poster boards. This process involved determining how the pieces of data within a theme came together. For example, I placed *Challenges in the Microsystems* with Research Question #1 because the data fit as an extension of how participants described their lived experiences with SAD as challenging. By finding relationships between the themes identified in the coding process, I attained new understandings about the connection between resilience and adolescent SAD.

In the eighth step of data analysis, a composite of structural descriptions was developed. Aspects of this composite were age, ethnicity, socio-economic status, gender, geographic location, and engagement during the interview. None of these aspects of structural description stood out as determining factors of resilience with SAD during adolescence.

The synthesis of this data, in the last step of data analysis, yielded additional findings. Conclusions drawn from the composite steps of analysis provided few generalizable results. This led to additional focus on the results from the individual descriptive steps of data analysis. These findings are explored in Chapter 4.

## Issues of Trustworthiness

Trustworthiness represents how validity is treated in qualitative research, corresponding to the extent to which a study is rigorous and an accurate representation of what the participants have shared (Ravitch & Carl, 2016). Credibility, transferability, dependability, and confirmability are all distinct aspects of the trustworthiness in a qualitative research design (Shento, 2004). Each is addressed separately in this section.

Credibility refers to how the researcher accommodates for the level of complexity in the data, both through choices in research design and in the instruments used to collect the data (Ravitch & Carl, 2016). This research involved semistructured interviews in which a small number of open-ended questions were prepared in advance with the potential for follow-up questions, hence tailoring the interview to the individual participant (Ravitch & Carl, 2016). This format allowed for the complexity in each participant's answers to be expressed. Credibility was further enhanced through the use of a research journal. For example, I noted in my research journal that I was grouping my themes according to interview questions rather than compiling data from all questions into broader themes. This insight allowed me to reorganize the data. Challenging my

biases, choices, and assumptions in my research journal during thematic coding was very helpful.

In contrast to the internal focus of credibility, transferability embodies the applicability of the study to other external contexts (Ravitch & Carl, 2016). Typically, transferability is not a central goal in qualitative research (Ravitch & Carl, 2016) and yet an area of transferability was somewhat present in this study; it was the role of social context in resilience. The relevance of social context on resilience is an area of transferability in related studies of resilience (Asakura, 2019; Bosma et al., 2019; Bulut et al., 2019; & Hamby et al., 2018). This current study of adolescent SAD and resilience also highlighted the central function of social context when understanding resilience. Transferability can also be enhanced through thick description (Ravitch & Carl, 2016). Thick description was provided by creating transcripts of the interviews that included participant tone and affect, researcher impressions, and a description of the context of the interview, such as participant eye contact during an online interview. One significant contextual factor in this study was the potential impact of the participant's SAD and their resulting comfort level with the interview process. Rich description of the interview process strengthened the transferability in this study.

Dependability is a third aspect of trustworthiness and delineates how the methodology allows for the researcher to answer the research question by employing an audit trail (Ravitch & Carl, 2016). Analysis was based on Moustakas's modification of the Van Kaam method of phenomenological data analysis. This process of data analysis

was tailored for phenomenological research and Moustakas (1994), a pioneer in phenomenology, endorsed this form of data analysis. This research design reinforced the dependability of this study. By identifying and explaining research design, methodology, data collection, and how reflexivity was employed in the study, future researchers are able to repeat this study, hence strengthening its dependability (Shento, 2004).

Confirmability is distinct from these other aspects of trustworthiness; it represents the way in which researcher bias is managed (Ravitch & Carl, 2016). I did not have any agenda in terms of what I hoped to find from this research. I did, however, have biases. Ways in which I attended to my biases were through the reflexive practices of using a research journal and providing rich description in my interviews. For example, I became aware that my preference for face-to-face interviewing and my bias against online interviewing was unfounded; rich dialogue occurred in this current study with online interviews. Reflexivity was the primary way in which I strengthened the confirmability of this study.

## Ethical Procedures

This research was affiliated with an American university and was conducted in Canada. For this reason, both the American Psychological Association (APA) and the CPA's codes of ethics were referenced in this section. First, a review of *Section 8, Research and Publication*, of the APA's code of ethics will be addressed. Following will be connections made from *Section 8* and the four principles in the *Canadian Code of*

*Ethics for Psychologists* as they pertain to research. Both codes of ethics are aligned and complement one another through different code formats.

In *Section 8, Research and Publication*, the APA (2020b) identified 15 standards. In accordance with standard 8.01, I obtained institutional approval before conducting this study. Informed consent, standard 8.02, is comprehensive and lists eight points that are required in the informed consent process. All of these were included in the informed consent (see Appendix B). Standard 8.03 was also relevant in that consent to be recorded is included in the informed consent (see Appendix B). Standard 8.04 was not relevant as I did not recruit participants who were clients, students, or subordinates, nor is Standard 8.05 as I did not dispense with informed consent. With regards to inducements for participation, I offered participants access to a summary of the findings in my study and a $10 gift card for participating; these inducements were neither excessive nor inappropriate, as noted in Standard 8.06. No deception or use of animals was used in this study, and so Standards 8.07 and 8.09 were not relevant. In terms of debriefing (Standard 8.08) I offered debriefing after the interview. I was aware to report only accurate data and not to plagiarize another's work, as indicated in Standards 8.10 and 8.11. Standards 8.12 and 8.13 address ethical publication, and I will be principle author on this research and this data will be published as original data only once. Lastly, in accordance with Standard 8.14, I will share my data with colleagues in my field upon request should others wish to substantiate my data. Meeting these standards coincided with meeting Canadian standards as well.

The Canadian Code of Ethics is organized in four aspirational principles (CPA, 2017), and each is pertinent to research. The first principle is *Respect for the Dignity of Persons* and identifies standards for informed consent, in which consent needs to be written, that consent is a process of discussion and not just a written form, and informed consent address the same points highlighted in the APA Code of Ethics (see Appendix B). Additionally in this first principle is freedom of consent, one aspect of which is being responsive to a participant's non-verbal indications to end the interaction and I was vigilant of any indications that a participant wished to discontinue the interview. Privacy and confidentiality were also addressed in the informed consent. According to *Section 4: Privacy and Confidentiality* (APA, 2020) and the Canadian Code of Ethics, psychologists protect confidential information through proper storage and inform participants of limits to confidentiality. The interview recording and transcript were stored on a password-protected external drive in one secure location and the corresponding names of participants were stored in a separate secure location. Participants' names did not appear on the transcripts. The second principle is *Responsible Caring* and includes maximizing benefits and minimizing harm; this principle was addressed in the decision to utilize young adults rather than adolescents with SAD, who met the criteria for a vulnerable population (CPA, 2017). *Integrity in Relationships* is the third principle and echoes a number of standards in the American Code of ethics, such as accuracy and disclosure. Avoidance of conflict of interest is also found in this principle and was addressed by excluding any participants with whom I had a prior relationship. Fourth and final

principle is *Responsibility to Society* and calls upon researchers to be sensitive and knowledgeable about the communities involved in research and I did so by being vigilant of any indication of participant distress. When I inquired, participants disclosed minimal distress during the interview.

Using two codes of ethics provided the benefits of both formats and approaches to ethical research practices. The American Code of Ethics is broad and comprehensive in its standards to research and publication. The Canadian Code of Ethics overlaps significantly with the American code and offers additional guidance that both reinforces and bolsters these standards. By employing both codes of ethics in my research, I enriched my level of ethical practice with this current study.

## Summary

The purpose of this study was to explore the resilience and successes of adolescent SAD from the retrospective lived experiences of young adults in Canada. Exploratory in nature, this study was best aligned with a qualitative approach. It was a phenomenological study and adolescent SAD was the principle phenomenon. The constructivist philosophy was present in this study, as it was the meaning that individuals made of their experiences that was explored through the interview process. In data collection, I interviewed young adults about their lived experiences of SAD during their adolescence. This involved a semistructured interview that was researcher-developed using the Interview Protocol Refinement Framework. Data was analyzed using Moustakas's (1994) modification of the Van Kaam method of analysis of

phenomenological data. As the researcher, I was aware of my biases and I remained reflective of my impacts on every stage of the research process, including issues of trustworthiness and ethical procedures. It was essential that every aspect of the methodology was addressed before conducting the research so that I could fulfill the purpose of this study.

# Chapter 4: Results

The purpose of this qualitative study was to explore the resilience and successes of adolescent SAD from the retrospective lived experiences of young adults in Canada. Because current treatments for SAD had not been as effective as treatments for other forms of anxiety (Babinski & Nene, 2016), more understanding about this phenomenon was needed. In this study, a phenomenological approach was used with an additional focus of resilience, making this study a strength-based rather than a deficit-based study. This study was guided by two research questions:

1. From the perspectives of young Canadian adults, what was their lived experience of social anxiety during adolescence?
2. Did adolescents with SAD develop resilience in their social environment, and if so, how?

In this chapter, the results of this research are presented. The chapter is organized in seven sections. First is the setting in which conditions of data collection are described. The second section provides demographic information of the participants. Data collection is the third section and comprises information about participants, setting, how the data were recorded, any changes from the original data collection plan, and unusual circumstances in data collection. Data collection is followed by data analysis in the fourth section and includes how analysis transitioned from initial coding to categories and then to themes, a description of the categories and themes, and a description of how incongruent data were incorporated into the analysis. In the fifth section, evidence of

trustworthiness is presented by addressing credibility, transferability, dependability, and confirmability. The results are found in the sixth section and are organized by research question. In the seventh section, the answers to the research questions are summarized.

## Setting

This section provides an overview of any conditions that may have impacted participants or data collection. Due to the global COVID-19 pandemic, interviews were virtual, and participants were all interviewed from their homes. The COVID-19 pandemic may have been influential to participants during their interviews. These interviews were conducted at a time when Alberta was experiencing fluctuating closures, openings, and restrictions of restaurants, travel, and social gatherings. The pandemic may have impacted participants in a number of ways, including limited social interaction, increased time spent in front of a computer, intermittent self-isolation, attending courses online, and various impacts on employment conditions.

## Demographics

There were 10 participants in this study. Participants ranged in age from 18 to 23 years, with a mean and median of 20 years; the mode was 19 years. Among the participants, eight identified as female, one specifically as cisgender female; one identified as nonbinary; and one identified as male. Nine of the 10 participants were undergraduate students. All participants spent their adolescence in Alberta, three in rural areas and seven in urban areas. All participants had a diagnosis of SAD before adulthood. With regard to the age at diagnosis, the mean was 14.5 years, the median was 15 years, and the mode was 16 years (see Table 1). Each participant had a pseudonym; seven participants chose their pseudonym, and three wanted their pseudonym chosen by me.

**Table 1**

*Participant Demographics*

| Participant | Pseudonym | Age at interview | Age at diagnosis | Gender | Location during adolescence |
|---|---|---|---|---|---|
| P1 | Velma | 22 | 11 | Female | Urban |
| P2 | Abby | 18 | 14 | Cisgender | Rural |
| P3 | Jigger | 18 | 15 | Female | Urban |
| P4 | Lily | 20 | 15 | Male | Urban |
| P5 | Karen | 19 | 16 | Female | Rural |
| P6 | Erin | 23 | 12 | Female | Urban |
| P7 | Bridget | 20 | 16 | Nonbinary | Urban |
| P8 | Rose | 19 | 16 | Female | Urban |
| P9 | Tanya | 21 | 18 | Female | Urban |
| P10 | Jennifer | 19 | 13 | Female | Rural |

## Data Collection

On November 12, 2020, I received IRB approval #11-12-20-0670293 from Walden University to conduct this study. This approval was conditional on IRB approvals from the five postsecondary institutions in which I intended to recruit participants. With Walden University's conditional IRB approval, I formally requested approval from the five postsecondary institutions to recruit their students, some of which required a separate IRB application. Two postsecondary institutions did not reply to my request to recruit their students, and in the reply from the fifth postsecondary institution, it was made clear that the process to obtain IRB approval to recruit on their campus was problematic due to a lack of affiliation. As a result, I submitted a request to change my recruitment plan. On January 19, 2020, I received approval from Walden IRB to do so, and I moved forward using two postsecondary institutions. One of the postsecondary

institutions required that I use their template for consent, and so most of the participants provided their consent on two separate forms; one form was approved by Walden and the other from the local postsecondary institution. The process for IRB applications with the two partner postsecondary institutions took place from mid-November 2020 to late January 2021. Once these approvals were in place, I submitted them to Walden's IRB for final approval.

The next step was to reach out to departments in the two universities to ask permission to post my recruitment poster in their classes. In some departments, the chair of the department offered to share my recruitment poster with faculty members, and in other departments I was given permission to reach out to faculty members individually with my request to share my recruitment poster. From one postsecondary institution, I did not receive any emails from interested participants. From the other, 13 individuals responded to my recruitment, and from that group nine met the inclusion criteria. I applied for one additional change to my recruitment and received approval on March 5, 2021; this request was to share my recruitment poster with mental health professionals. This is how I found my tenth participant.

Data collection was completed in 42 days. The average duration of the interviews was 24 minutes, the mode and median were 25 minutes, and the range of interview duration was between 16 and 46 minutes. This was shorter than I had anticipated. Two possible explanations are that many participants prepared their responses in advance and that many responses were so comprehensive that some interview questions were not

needed. The first interview was on February 12, 2021; the date of the last interview was March 25, 2021. Data were recorded using two methods: The interview was recorded on Zoom from which an audio file was saved, and the interview was audio recorded on a Smartphone. Additionally, I wrote notes during the interviews.

Data collection followed the same process for each participant. The participants responded to my recruitment posters via email, and I replied by asking for confirmation that they were between 18 and 25 years of age and had a diagnosis of SAD before adulthood. Once these criteria were confirmed, I emailed the consent forms to the participants and invited them to ask any questions about consent. Once the participant signed and returned the consent forms, I suggested a few possible dates and times for the interview, and the participant chose when to meet online for the interview. Part of the interview protocol involved reviewing the consent forms. At this time, two participants asked how the results would be used. Following the review of consent, I began the semistructured interview. There were 17 possible questions in the interview (see Appendix C).

During the interviews, there were no occasions in which the participant asked to stop or to take a break. Each interview was audio-recorded, I took notes during the interview. Afterward, I transcribed the interviews verbatim.

There were six variations in data collection from what was originally indicated in Chapter 3. Four variations were related to the COVID-19 pandemic. One variation in

recruitment was made out of need for more participants. Another variation occurred late in the data collection process regarding the number of participants and saturation.

The COVID-19 pandemic had significant impacts on data collection in this study. First, the original intention was to post recruitment posters in physical spaces on campuses, but this was not an option because postsecondary institutions in Alberta were strictly online at the time of data collection. As a result, recruitment posters were posted on department and course online platforms, and I included instructors and department chairs in the recruitment process. Second, data collection was intended to be face-to-face interviews with online interviews as a secondary option; however, online interviews became the only viable option. Third, the interviews were to be recorded using the Smartphone audio application only; however, with the use of Zoom and its recording function, it made sense to use both forms of audio recording, with one as the backup. Fourth, the hope was to use library spaces for the interviews; however, due to restricted access to public spaces and safety precautions, participants and I engaged in the interview process from home instead.

A fifth adaptation in the recruiting process was made in response to needing more participants. Only nine participants who met the inclusion criteria responded from recruitment in postsecondary institutions. Consequently, an additional form of recruitment was used; I reached out to professional colleagues in the counseling psychology discipline to share the recruitment posters with clients. This was done with IRB approval.

The last variation to the methodology from Chapter 3 involved the number of participants and saturation. Saturation occurs when there is no longer any new information coming out of the data (Creswell & Creswell, 2018). Originally, there were to be 12 participants in this study; this was the high end of the range of saturation for phenomenological research (see Guest et al., 2006). However, saturation was reached after eight participants. Ten interviews were conducted to determine whether any new data would emerge from these interviews; no new data were generated after the seventh interview. This was consistent with saturation in a phenomenological study occurring with between three and 10 samples/participants (see Creswell & Creswell, 2018) and Morse's (2000, as cited by Mason, 2010) guidelines for saturation in a phenomenological study of at least six samples/participants.

In this current study Saturation was determined using an approach developed by Guest et al. (2020), which involved three factors. First, the base size was the total of unique themes in the first four interviews that became the denominator (see Table 2).

**Table 2**

*Determination of Saturation: Base Size*

| Interview number | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| New themes per interview | 8 | 3 | 1 | 1 |
| Number of base themes | | | | 13 |

In this study, the denominator was 13. Second is the run length, which in this case was two additional interviews (see Table 3).

**Table 3**

*Determination of Saturation: First Run Length*

| Interview number | 5 | 6 |
|---|---|---|
| New themes per interview | 1 | 0 |
| New themes in a run | | 1/13 = 8% |

Two run lengths were required because the first run length equaled 8% with two new themes (1/12), and Guest et al. (2020) recommend that saturation is achieved when the new themes equal less than 5%. Saturation was reached in the second run length (see Table 4) when the new themes equaled 0% (0/13).

**Table 4**

*Determination of Saturation: Second Run Length*

| Interview number | 7 | 8 |
|---|---|---|
| New themes per interview | 0 | 0 |
| New themes in a run | | 0/13 = 0% |

Although saturation was reached at eight interviews, I chose to complete two additional interviews to be secure in the saturation of information; no new themes emerged from the last two interviews.

Two unusual situations occurred while collecting data. In one instance, the participant was not able to use their camera, and so I was unable to see the participant. In the second instance, the internet connection was unstable and as a result, the interview was moved from Zoom to Google Meets, where the connection seemed to be better but not ideal. As a result of the second unusual situation, there were many times in which the

participant or I needed to repeat ourselves, and approximately 5 minutes was spent moving from one platform to another.

## Data Analysis

Data analysis involved an inductive process, using Clark Moustakas's (1994) modification of the Van Kaam method of analysis of phenomenological data. The purpose of this approach was two-fold: to collect individuals' descriptions of their lived experience the phenomenon of SAD, and to create more general understandings and meanings of the experience (Moustakas, 1994). This method moves from individual to composite descriptions and comprises nine steps: horizonalization, reduction and elimination, identification of themes, theme check, individual textural descriptions, individual structural descriptions, composite textural descriptions, composite structural descriptions, and synthesis (Moustakas, 1994). The first six steps are completed with each new interview and once all of the interviews have been analyzed with steps 1-6, then the final three steps are performed. Each step will be described below. This section concludes with discrepant cases in the data.

In this first stage of data analysis, horizonalization refers to the identification and collection of each quote, referred to as a constituent, from the data that is relevant to the study and all constituents are treated as equally valuable in this stage (Moustakas, 1994). The data in this study were organized in a five column table. In this step of horizonalization, data from the transcriptions were separated into individual constituents; constituents are pieces of information based on meaning, and therefore the length of

constituents varied from a short phrase to paragraph in length. Each constituent was individually placed into the horizonalization column. These individual constituents were ready for the next step.

In the second step, each constituent is evaluated based on two criteria: its importance to understanding the phenomenon and if its meaning can be identified (Moustakas, 1994). Both criteria must be met, otherwise the constituent is eliminated. Examples of data eliminated in this study included greetings, discussions regarding consent, pleasantries at the end of the interview, and in a few cases, participant statements that were unrelated to the interview questions. The majority of eliminated constituents were either at the beginning or the end of the interview transcripts. The remaining constituents were used in the following step of theme identification.

In this third step, each constituent is connected to a theme or themes. The intent is to associate the constituent with a shorter phrase or more abstract concept (Pietkiewicz & Smith, 2012) that may evolve into a theme. In this study**,** analyses of interviews were performed within no more than four days of each interview, and so with each analysis, themes became increasingly easy to identify.

The fourth step in the data analysis is to check the themes against the data. Using the thematic outline (see Tables 7 and 8), I reviewed the transcripts to ensure that each participant's narrative was represented in the themes. Up until this point, the data from each participant was analyzed in order to identify themes. In this fifth step of individual textural descriptions, each participant's data was analyzed for their textural content.

In step 6, it is through the structural descriptions of each interview that the participants' words are connected to their overall experiences, be it socially, emotionally, and/or culturally (Moustakas, 1994). Reading between the lines of each participant's interview provided a more interpretive layer to the participants' words in the transcripts. One significant aspect of the structural descriptions was the extent to which the participants presented as anxious in interview.

The seventh step of data analysis is composite textural descriptions. The participants and themes are organized in a table, indicating the associations between participants and themes. This process draws attention to the most frequently recurring themes, how they are distributed among the participants, and how to interpret the totals (Moustakas, 1994). In this current study, there were a number of recurring themes, however, how participants experienced these themes differed from one lived experience to another.

The composite structural description is the eighth step in data analysis. This involves identifying the common aspects of the individual structural descriptions (Moustakas, 1994) from step six. In this study, participants' positive social-emotional skills were significant in the composite structural description.

The synthesis is the ninth and final step of data analysis. It is here that the composite textural description and the composite structural descriptions from steps seven and eight are brought together (Moustakas, 1994). In this study, the individual textural and structural descriptions were prominent in synthesizing the data.

Each step in data analysis will be explored individually in the *Results* section of this chapter. Prior to an examination of the results, discrepant cases and evidence of trustworthiness will be discussed.

## Discrepant Cases

Each participant's interview provided a unique perspective of adolescent SAD. There were not any interviews, however, that represented discrepancies in their lived experiences with the phenomenon. All participants identified challenges associated with SAD as well as areas of success despite having this mental health disorder. In each participant's lived experience with adolescent SAD, resilience was present.

## Evidence of Trustworthiness

Trustworthiness corresponds to how the data in qualitative research accurately represents what the participants have shared during data collection (Ravitch & Carl, 2016). The four aspects of trustworthiness are credibility, transferability, dependability, and confirmability (Shento, 2004). Each is addressed in this section.

### Credibility

Credibility refers to how the researcher accommodates for the level of complexity in the data, both through choices in research design and in the instruments used to collect the data (Ravitch & Carl, 2016). Originally, the interview protocol comprised a small number of open-ended questions with the possibility of follow-up questions in a researcher-made semistructured interview; this format was meant to tailor the interview to the participant, and hence allowing for the complexity of the participants' answers.

One adjustment was made to the interview protocol. Instead of having a small number of questions with possible follow-up questions on hand, the interview protocol included 17 questions that included specific follow-up questions if needed. The participants viewed the interview questions in advance, allowing them to read how I planned to follow-up on certain interview questions. Not all 17 questions were used in each interview, as some participants' answers were comprehensive and addressed more than one question with their answer.

Another aspect of credibility that I considered in the methodology of this study was to give participants the opportunity to review their own transcript. These member checks (Shento, 2004) allow for participants to verify the transcript for accuracy as well as providing input regarding the thematic coding. In the IRB process, the IRB reviewer suggested that the member checks be removed for three reasons: it is an extra burden to the participants, participants rarely remember exactly what they said, and member checks are not necessary unless the researcher needs to provide the opportunity for a participant to retract statements around sensitive topics. Member checks were therefore removed as a method of enhancing credibility.

As originally planned, I used a research journal as a way to strengthen credibility of the study. I wrote in this journal after each interview, noting any assumptions that I made either during the interview or while transcribing. After each work period of coding the data, I also wrote in the journal, identifying any biases that I was aware of. The research journal was a helpful tool throughout the data collection and analysis processes.

It became a way in which to write down fleeting thoughts and questions about how I was organizing the data.

**Transferability**

In contrast to the internal focus of trustworthiness, transferability embodies the applicability of the study to other external contexts (Ravitch & Carl, 2016). Transferability was not the aim of this study of adolescent SAD. However, the role of resilience in this phenomenon had the potential to be transferable to the growing body of knowledge of resilience. Interestingly, related studies of resilience (Asakura, 2019; Bosma et al., 2019; Bulut et al., 2019; & Hamby et al., 2018) underscored the relevance of social context on the study of resilience. This current study added to the transferability of studies of resilience with by supporting the idea that particular social contexts impact resilience. To that end, transferability was also enhanced through thick description. Thick description (Ravitch & Carl, 2016) was accomplished through the use of verbatim transcripts of the interviews that included participant tone and affect, a description of the context of the interview, and researcher impressions. One significant contextual factor in this study was the participants' comfort levels with the interview process, given their diagnosis of SAD.

**Dependability**

Dependability is a third aspect of trustworthiness and delineates how the methodology allows for the researcher to answer the research question (Ravitch & Carl, 2016). Analysis was based on Moustakas's modification of the Van Kaam method of

phenomenological data analysis. This process of data analysis is tailored for phenomenological research and Moustakas (1994), a pioneer in phenomenology, endorsed this form of data analysis. This research design reinforces the dependability of this study, whereby any researcher can follow the nine steps of data analysis in this method, allowing future researchers to duplicate the process. Each step in the research design, methodology, data collection, and data analysis was employed in the study. Future researchers are therefore able to repeat this study, hence strengthening its dependability (Shento, 2004).

### Confirmability

Confirmability is distinct from these other aspects of trustworthiness; it represents the way in which researcher bias is managed (Ravitch & Carl, 2016). I did not have an agenda in terms of what I hoped to find from this current study. Because I did recognize that I had biases, I addressed these through reflexive practices of using a research journal regularly, and providing rich description in my interviews. Reflexivity was my primary method to address the confirmability of this study.

## Results

Results of the data analysis are presented by following the steps of Moustakas's modified Van Kaam analytical approach, beginning with step three. The first two steps, horizonalization and reduction and elimination, set the foundation for the results, but do not need to be expanded upon in this section. In steps three to nine, data was analyzed using tables, figures, and quotes from interview transcripts.

**Step 3: Identification of Themes**

Each research question was analyzed separately for themes. In research question #1, regarding the lived experiences of SAD during adolescence, eight themes were identified. For research question #2 about resilience and SAD, there were six themes. For each research question, the themes are presented in a separate table and further illustrated with participant examples.

***Research Question 1: Lived Experience With SAD***

Research question #1 was: From the perspectives of young Canadian adults, what was their lived experience of social anxiety during adolescence. The participants' lived experiences SAD came primarily from interview questions #6 and #7 (see Appendix C), whereby participants were asked what it was like living with SAD and what challenges they experienced with SAD; in some interviews, I prompted the participants to speak more about challenges in a particular domain, such as school, home, and/or with friends. Interview question #6 was intentionally open-ended, allowing participants to describe their lived experience without any specific direction. All 10participants began their response to interview question # 6 by either specifically stating that living with SAD was challenging, difficult, or stressful, or by describing how they experienced challenges. Because the aspect of SAD being challenging was so prominent in how participants answered this interview question, interview question #7 regarding challenges was included with the lived experience of SAD during adolescence. There were eight themes that emerged from interview questions # 6 and # 7 (see Table 5). These themes are: fear,

hypervigilance, lack of knowledge, emotional toll of SAD, automatic reactions, missed opportunities, challenges in the microsystems, and challenges in the macrosystem.

**Table 5**

*Lived Experience With SAD During Adolescence: Themes*

| Theme | Theme cluster | Participant identifier |
|---|---|---|
| Fear | Fear of judgment, of being noticed, making a mistake. Embarrassment, failing, or disappointing | P1, P2, P5, P6, P10 |
| Hypervigilance | Heightened awareness, analyzing past, what others are thinking, over-preparation | P4, P7, P8, P9, P10 |
| Lack of knowledge | Not knowing what SAD is, what is normal, or what is real | P1, P3, P4, P5, P7 |
| Emotional toll of SAD | Exhaustion, frustration, stress, misery, negative self-concept, over-sensitivity | P1, P2, P4, P5, P6, P9, P10 |
| Automatic reactions | Body sensations, brain not able to let go, inability to relax | P2, P3, P4, P5, P9 |
| Missed opportunities | School clubs, speaking in class, speaking in public, having conversations | P3, P4, P6, P8, P10 |
| Challenges in the microsystems | Presentations, group projects, making friends, conversations | P2, P3, P4, P5, P7, P8, P9, P10 |
| Challenges in the macrosystem | Socio-economic status, ethnicity, stigma | P1, P6 |

**Fear.** Fears posed a substantial obstacle for adolescents with SAD, often on a daily basis. These fears existed in social contexts where there are other people. Jennifer mentioned, “I was terrified of that. And like, just not be normal, basically.” Jennifer also explained how she experienced fear specifically in school:

> And, like, you’re just scared to do normal activities like asking to go to the bathroom and sharpening pencils. And, like, you’re just scared to do normal activities like asking to go to the bathroom and sharpening pencils. And like, if you drop your book on the ground, it’s literally like, the end of the world because everyone looks at you. So there’s a lot of fear with everything.

In fact, Karen shared that fear persisted throughout most of her time in school, so much so that the first time she raised her hand to go to the bathroom was in Grade 12; she was too afraid to raise her hand in class. Fear of judgment was identified by Velma and Abby. For Abby, this was connected to fear of competition and being judged for not succeeding. For Velma, judgment was associated with a constant fear of embarrassment, but also part of a bigger fear:

> I just felt like the constant fear of mostly like, of being places where other people have the capacity to think thoughts about me. So it could be thoughts of like, judgment and negativity. They were the main ones but like, just the fact that they can think thoughts about me. It could even be good thoughts, but I, because I don’t know what they are. It was scary and quite daunting.

As Karen explained, the fear developed into a general state of not feeling safe. In Abby's experience, however, her relationship with fear has a more positive outlook, as she noted "fear is the worst part and once you do it, it's not that bad." In the meantime, this fear can lead to hypervigilance.

**Hypervigilance.** Many of the participants described their experiences with SAD as increased alertness and overthinking. Bridget described her experience:

> Yeah, it's, it's just I would say like a heightened awareness. When you're in some sort of social situation, you get really nervous or like anxious about things. I would spend a lot of time if I thought I said something like wrong or something like that. I would just spend a lot of time focusing on that or like, yet just like fixated on that or worried about something in the future. And so I would just say like, is something where you spend a lot of time analyzing your actions or like being nervous about something that's going to happen.

Jennifer's experience with hypervigilance is connected to fear of judgment, as she explained "It's basically like, feeling like everyone's watching you all the time. And mostly worrying, like, what they're thinking about you and how they're judging you." This experience of hypervigilance was further described by Lily as she demonstrates the interconnectedness between fear of judgment and how that translates into overthinking:

> Just like, it's a lot in my head of like, am I going to say something wrong? Am I going to do something wrong? How are people going to react when or if I do

> something wrong? And like, what are others thinking about me right now? And just a lot of those thought processes.

Tanya used a metaphor is explaining how she experienced hypervigilance:

> If you could imagine somebody, you know, being in the corner, holding a clipboard, and just kind of writing everything you do down and, and it was always something negative. So if I did something or said something, and then I go back, and kind of like through my head, replay it, and it would just be like, Oh, you shouldn't have done this, maybe you should have, you should have done it this way. Or like, you should have said this, and not that or something like that. So it was always, Yeah, it was always basically like a mental critique of everything that I did or didn't do, say or didn't say.

Hypervigilance is often connected to fear of judgment, and was experienced by these participants before, during, and after a social experience.

**Automatic Reactions.** Many of the participants talked about how their bodies reacted physiologically to SAD as well as how their brains reacted cognitively. Lily described her physiological experience with SAD:

> It's, it's really bizarre. For me, it's like, it's like, I get like bodily sensations, I noticed that I'm like, really, I get really warm. And like I get all the cliches of like sweaty palms, butterflies, my cheeks will start to go red. I think they're doing that right now, as I'm thinking more about it. All those cliches of like anxiety and just being in social situations and stuff.

Jigger also described his physiological reaction to SAD and how one sensation triggers another:

> The physical things that come along with anxiety like, I don't know if this is with other people, but like with me, and I didn't even notice most of this myself, but other people have seen it. But like, when I'm anxious, people can just tell because my entire body will start shaking. ... It depends really on how how bad it is. Like, because also, I feel like a, like, I guess have pain in my chest at the same time. And then, like, if it's just a shaking, then it's not that big of a deal. But like, as it um, the more I shake, and the more the pain is in my chest.

Abby also explained how her brain reacts automatically with SAD even when faced with rational thinking:

> I feel like, I hear what you're saying. I understand that. That's totally reasonable. But my brain can't grasp that. Like, I still need to, like worry about this. It's almost like it's like, probably like defense mechanism of some kind. But like, it's like, I need to worry about this, I need to prepare myself to this. So that like, if does go bad then like, I expected it. I anticipated it like I know what to do kind of thing.

Abby's experience with how her brain reacts automatically highlights the presence of hypervigilance and sets the stage for the emotional toll that automatic reactions, fear, and hypervigilance can cause.

**Emotional Toll of SAD.** On an emotional level, SAD can be exhausting, frustrating, and can cause heightened sensitivity. Lily explained her exhaustion with SAD:

> It's exhausting. I'm just, I know anytime I hang out with my friends even now I'm like, done for the day, if, like after I'm done talking to them, because I'm just like, so drained from all the thinking I've done. And like just having that all that energy buildup before going to meet them, and then just feeling deflated afterwards. It's very tiring to like, try to work and do things socially with this anxiety thing. Yeah.

With this type of emotional toll, it makes sense that Lily also described SAD as "never getting out of the tunnel. ... It's all misery." Erin, on the other hand, spoke about the frustration that she had with SAD, particularly with her experience with others' expectations:

> Um, it was, like, really challenging and very frustrating, because like, growing up, you're kind of expected to, you know, be like participating in classes and like, there's group assignments. So like, when you have something that kind of blocks you from wanting to go out and meet people that kind of prevents your ability to have a good time in school. So it was like, it's been very challenging.

Overall, "people with social anxiety tend to be really hard on themselves," as Jennifer pointed out. Understandably, the emotional toll of living with SAD can trigger emotion and this was evident at the onset of Velma's interview, when she shared this:

> Um, I think it was challenging. That was one way to put it. And I just want to give a little disclaimer, if I do get emotional ... So it's like, emotions are heightened. I just wanna give this as a disclaimer.

Evidently, the emotional toll of SAD continues long after a challenging social experience and may trigger hypervigilance for present activities, or as Velma called it, being "super sensitive."

**Lack of Knowledge.** Along with the presence of specific personal factors of SAD, the absence of knowledge was also prominent in the challenges that SAD created for these participants. Velma was especially articulate when discussing how not knowing what SAD was or how it related to other mental health issues impacted her. She used a metaphor:

> And so in my experience, I feel like social anxiety was kind of one piece of the pie, if that makes sense. ... Because, one I didn't know umm what the, this pie was made out of. I didn't really know why it was that I was going through, I just know that it was happening. So it was challenging, because I think I was trying to figure out how much flour there was how much like jam there was, you know? So, um, yeah. And that kind of made it difficult to kind of like, what do I do with this pie? Do I eat it?

Velma was not the only participant who was negatively impacted by confusion regarding SAD. When Rose considered what would have made a difference for her and her SAD, she also spoke about the impact of not knowing about SAD sooner:

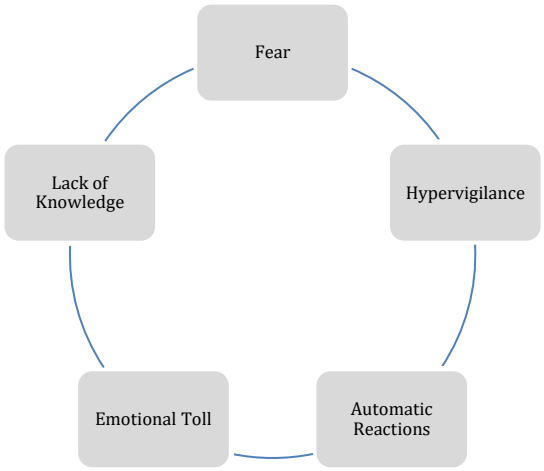
> I think having more awareness that it [SAD] exists. That no, I'm not just a very nervous person, that it's something that actually exists. And that can be helped. That would help because then no, okay, maybe I'm not crazy and excessively paranoid or something, to know that it exists.

As Rose pointed out, without knowing that SAD existed, she found other ways to explain her behavior that, in turn likely negatively impacted her self-concept. In Velma's lived experience with SAD, she explained that the knowledge and awareness about SAD was the first step, and that this preceded seeking strategies to deal with SAD. What I extrapolate from this is that the longer an individual goes without knowing about their mental health disorder, the longer they remained confused, negatively impacted, and without the tools that they need.

Together, these five personal factors that represent participants' lived experiences with SAD are inter-related (see Figure 3). The longer an adolescent lives with SAD without knowing about SAD, the more vulnerable they are to the fear, hypervigilance, automatic reactions, and resulting emotional toll of SAD.

**Figure 3**

*Inter-Relatedness of Personal Factors of SAD*




These personal factors also impact how the participants interacted with their social environments, leading to the remaining three themes to research question #1.

**Missed Opportunities.** Many participants described their experience with SAD in terms of what they were not able to do. For Jennifer, part of having SAD was not having any friends. In Lily's experience, it meant many days when she was unable to leave the house. For Erin, SAD and the related fear got in the way of a number of things:

> I mean, like, I guess, like, there was always the fear of like failing. So that kind of prevented me from trying either, like going and joining like, like extracurriculars in school or like speaking up in class, like, I've never done that through my entire, like, grades, you know, zero through 12.

Similarly, Rose explained how SAD was an obstacle to what she would have liked to do "I think without it [SAD] I might have liked to be involved in like different clubs at

school. ... So it's basically just like missing opportunities or getting really scared for certain things. ..." Not only did participants experience SAD as missed opportunities, but the interactions they did have in their social environments required extra care to navigate.

**Challenges in the Microsystems.** A variety of social interactions were challenging for the participants during adolescence, particularly school projects and conversations. Group projects and class presentations were common challenges in most participants' interviews. Group projects meant talking to classmates, while managing fear and automatic reactions, and class presentations amplified hypervigilance. For Abby, this led to an additional challenging situation in which she would need to inform the teacher that she did not have a group. A second common challenge amongst the participants was connecting with other people. For example, Jigger described his experience:

> Um, I guess it's mostly just like a, like having trouble talking to people that I don't know. Like, and like engaging with, like people that I don't know. ... And, like, I talk to them a lot, right? But then if I meet someone new, I have trouble like, I'm starting, like conversations. And, like, I guess making relationships with people.

For Karen, this challenge impeded her from getting support, as she explained "Um, like, it was very hard for me to connect with other people, because I was so anxious. And it was also hard for me to, like, seek out help sometimes." Moreover, Tanya was able to explain what it was about conversations that she struggled with:

> So it was kind of starting conversations. And then even once I was in the conversation, it was always hard to keep it going as well, it would be because somebody is talking. And we're all talking about a topic. And then I have something to say, but I'll think like, once or twice or three times about whether I should put my input in or not. And, and by the time, you know, I realized, okay, maybe let's let me just say it, people have moved on. And so you're kind of still behind on that. And you're like, Oh, you should have said something when you have a chance.

**Challenges in the Macrosystem.** The last theme related to how participants experienced SAD during adolescence emerged from two participants' interviews. These challenging experiences are associated with society in general, hence aligning with the participants' macrosystems. Specifically aspects of socio-economic status (SES), ethnicity and the impact of stigma were key factors in these two participants' lived experiences.

Velma discussed her experience with SAD as it related to diversity and SES, explaining that a significant challenge she faced with her SAD being diagnosed was the fact that her behavior was perhaps assumed to be more associated with being a visible minority from a low SES. She explained how here SES may have impacted her:

> So I think it's important to note where [ I grew up ]. I grew up in the northeast. So that's a little different than the south. And I think I should note that because there's a higher population of people of color and lower income. And so it was a

> cultural struggle, I want to say, so I feel like because there was this disadvantage to a large portion of people, that affected my school life and the people I was surrounded by. ... But it wasn't the, it's not the fault of that diversity. But I, it stems from a bigger systemic issue.

Velma went on to explain that her SAD symptoms may have been identified earlier, had she been in a school with more resources and that teachers would not have presumed that her behavior was a result of being in a high needs school or that it was culturally-based.

Erin spoke about the stigmatization of SAD and how the lack of knowledge and conversation about this disorder presented a challenge for her:

> So it's like, I think just like taking away that stigma to be like, this is something that maybe everybody has, it's kind of common, but it's not really talked about because people just think you're being ridiculous, or you're being like when people say that was like a snowflake, but it's like, you know, it is a really challenging thing to deal with.

Erin highlights to potential for judgment from society regarding symptoms of SAD, and it is these judgments that those with SAD fear.

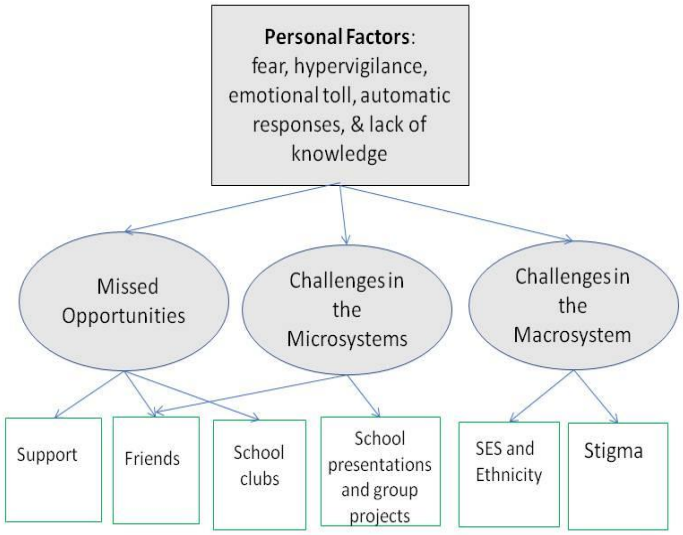
What Velma and Erin shared supports the idea that educating society about SAD is one way in which these challenges at the macrosystem can be addressed. Perhaps community education would not only remove stigma and lessen the chances of community members not recognizing SAD, but it would also address the challenge of

lack of knowledge that some of the participants identified as part of their lived experience with SAD.

From the perspectives of young Canadian adults, what was their lived experience of social anxiety during adolescence? Based on the eight themes associated with this research question, participants' lived experience with SAD was challenging. The participants experiences fear, hypervigilance, an emotional toll, automatic reactions, and a lack of knowledge about SAD. These personal factors led to missed opportunities and challenges on the microsystem and macrosystem levels of their social environments (see Figure 4).

**Figure 4**

*Lived Experience With SAD*




These challenges, however, do not represent the whole experience with SAD during adolescence. Despite these challenges, participants did engage with their social environments and experience successes. This presence of resilience is the focus in the second research question.

### *Research Question 2: Resilience*

The second research question was: Did adolescents with SAD develop resilience in their social environment, and if so, how. The data related to resilience came from interview questions #8-14 (see Appendix C) and included questions about: external resources, internal resources and how they believed that they developed these, their

experience with treatment, what the participants were able to do despite having SAD, and their explanation for this success. Resilience, from a developmental psychology perspective, is the ability to successfully adapt to situations that may impede healthy functioning (Newman & Newman, 2016) by accessing environmental resources and using them in meaningful ways (Ungar, 2011). The environmental resources were categorized into six microsystems. Four were typical microsystems: family, friends, school, and home. Internet and health services may not always be considered microsystems in Bronfenbrenner's model, but are presented as such in this study because of the participants' direct involvement with either one. Each participant accessed more than one environmental resource and some participants engaged with one environmental resource multiple times, illustrating the diversity with which participants access environmental resources (see Table 6).

**Table 6**

*Access to Environmental Resources Represented by Microsystems*

| Environmental Resource | P1 | P2 | P3 | P4 | P5 | P6 | P7 | P8 | P9 | P10 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| School | III | | | I | I | | | | | | 5 |
| Friends | | I | I | | II | I | I | I | I | | 8 |
| Community | | III | | | I | II | | | | I | 7 |
| Family | | I | I | I | I | | I | I | | I | 7 |
| Health services | | | | II | I | | | | III | IIII | 10 |
| Internet | | | | | | I | | I | | | 2 |

These microsystems were then grouped according to how they contributed to resilience. Six themes were drawn from the data regarding how these participants developed resilience in their social environments (see Table 7). These themes are: safety and support, opportunities for belonging, self-awareness and knowledge, skill development, attitude, and successes. Five themes represent factors of resilience and safety represents the result of these factors.

**Table 7**

*Development of Resilience: Themes*

| Theme | Theme clusters | Participant identifier |
|---|---|---|
| Safety and Support | Source: Family<br>Source: Friends<br>Source: Health services<br>Out of comfort zone | P2, P3, P4, P5, P6, P7, P8, P9, P10 |
| Opportunities for belonging | Source: School<br>Source: Community<br>Team sports | P1,P2, P4, P5, P6 |
| Self-awareness & knowledge | Source: Internet<br>Source: Health services | P5, P8, P9, P10 |
| Skill development | Source: Health services<br>Source: Experiences<br>Cognitive<br>Behavioral | P1,P2, P3, P4, P7, P8, P9, P10 |
| Attitude | Source: Family<br>Source: Experiences<br>Determined attitude<br>Open-mindedness<br>Positive | P1,P2, P3, P5, P6, P8, P10 |
| Successes | School<br>Community<br>Friends | P1,P2, P3, P4, P5, P6, P7, P8, P9, P10 |

**Safety and Support.** Safety and support was a central theme in understanding resilience and SAD. According to Maslow's hierarchy of needs (Woolfolk et al., 2016), safety and support is the second level of human needs, second only by physiological needs; safety and security needs must be met in order for individuals to properly focus on

higher needs, such as love and belonging, esteem, and self-actualization. Participants found safety and support primarily from two microsystems: family and friends.

Family was a source of support and security, as well as an impetus for new experiences. For example, when asked how she was able to participate in horseback riding, Jennifer explained:

> And my mom was always there. And my mom was kind of my security blanket for a lot of my childhood. So yeah. And she has anxiety too. So that helps like to get a good understanding. So she kind of knew, like, when it was too much for me, so she kind of like, put me out of there or whatever. So it was good.

Part of the safety that Jennifer's mother provided was her own personal experience with anxiety, allowing her to better understand Jennifer's experience. Abby's parents provided a different form of safety, as Abby described being pushed out of her comfort zone when she went to camp for the first time:

> And then honestly, there were a couple times where my parents kind of like, I don't want to say forced, but like, kind of forced me into situations. So like, I feel pivotal moment, kind of for like anxiety or whatever. ... And then my parents were like, Hey, you should do this. ... So then it's like, but yeah, it's like three weeks with people I've never met. So it's like, I didn't really want to go like, I was like, super melting down for probably like the month before, like, trying like everything to get out of it. ... I eventually realized, like, I'm not getting out of it, like, they're gonna make me go regardless. And the fear and my parents even

> said, like, go for the first week. And if you don't like it, you'll come back and bring you back. And then I did end up going and it was really good. Like, I felt it was like super positive. And like, that helped with a lot of things.

By offering a way to come home after the first week, Abby's parents provided a more manageable goal for Abby to undertake, and a safe place to land if she was not successful. Basically, Jennifer and Abby's experiences provided opportunities for them to step outside of the family microsystem and into the community microsystem while still benefitting from the safety of their family.

Similar to family, friends provided support and safety, but in slightly different ways than with family. When asked how friends made a difference for Abby, she explained:

> I'm thinking I think definitely, just because of them, like that's like, almost, like, encouraged me kind of, like motivation to like, get better with things and like, being in that comfortable space, like, between camp and people like, being comfortable with that, it's like, allowed me to like, step out of my comfort zone a bit.

In Abby's experience, moving out of her comfort zone was sequential; it began with her parents leading her to go to camp, where she then experienced a second stage of leaving her comfort zone with the support of friends. For Jigger, friends were a way to do more things and be outgoing. Jigger discussed how childhood friends provided support for him:

> Because like, when I'm with, because, like, a lot of my close friends, I've known since, like, the first day, I started school in kindergarten. And then so I'm like, we've just been friends since then. And then so with them, like, I'm pretty outgoing.

It was from Jigger's core group of long-term friends, which served as a microsystem, that Jigger was able to develop resilience. In Karen's case, existing friends served as a way to make new friends and she attributed much of her ability to socialize to her friends:

> Um, I was, but it was extremely difficult. Like in, in the way I mean, my friends, it wasn't like me, like seeking it out. It was more like I already, like I had a friend, and they would introduce me to somebody else in a small setting, so I wasn't able to , like go out and actually talk to people, it would l kind of have to be like, brought to me.

Essentially, Karen was able to develop a friend microsystem based on a few friends, which in turn offered Karen a source of resilience.

In terms of safety and support, the family and friend microsystems served particular functions for resilience. They provided the social environment in which the participants could safely leave their comfort zones, develop friendships, and have social experiences. According to Maslow's hierarchy of needs (Woolfolk et al., 2016) once safety needs are met, the individual can then embrace their need for love and belonging.

**Opportunities for Belonging.** Participants accessed opportunities for belonging from two principle microsystems: school and community. In relation to school, two

participants talked about their opportunities to belong through teachers and school programs. In the community, sports programs and camps had an impact on three participants.

Individual teachers impacted two participants' experiences with SAD. Velma discussed a teacher who made a difference in her journey of understanding SAD:

> Um, so one was, was an English teacher, she was also a teacher at my same junior high, so she kind of followed me through these, like few years of life, ... so she knew me quite well. And she was the one actually who kind of helped me identify that there was anxiety there. And it made me feel kind of like heard.

For Velma, because she had built such a strong relationship with this teacher, she was able to access two valuable resources: information and connection. Additionally, Velma's relationship with a school coach led to a valuable experience of belonging through opportunity:

> Another one would, probably would be a coach for when I was a basketball trainer. I didn't play basketball, but I was on the sports med, I was a sports and a trainer. So I was, I felt very part of the team, which is really nice. ... I think it was, that was a quality of these teachers that they made it feel very safe, like they put a touch of compassion and humanity into their work. So that definitely resonates with someone who deals with anxiety, social anxiety.

For Karen, it was a dance teacher; she stated "I had this, this dance teacher, and like, he really like pushed me and he just like, really, like, helped me to, like, gain more

confidence in myself." Obviously, this theme of being pushed out of one's comfort zone appears in the school microsystem as well.

On an institutional level, access to school programs also acted as environmental resources. What made a difference for Lily was access to quiet rooms so that she could self-regulate:

> My high school was incredibly supportive, like, so. Like, they were able to help me so so much. They had this other separate quiet space that anybody could access. So I would be in and out of that quiet space, most days, just spending my time there talking to the teachers, or just, just chilling out, grounding, just being in those spaces.

These participants highlight the fact that by accessing school resources, whether they are people or programs, they were strengthening their resilience with SAD.

Opportunities for belonging were also found outside of school and in the community. This was revealed in both Erin's and Abby's interviews. A significant source of resilience for Erin was in team sports. Team sports gave Erin the opportunity to be part of a team, as she explained:

> Um, I think with sports, like I've been doing it since I was little, so it was kind of like, I could focus on the fact that I knew what I was doing. And I was comfortable being like, I'm just here to play a sport.... But it was still like, I could be part of a team because the focus wasn't on me. So that really helped my anxiety to be like, it's about the group, not just like me. ... Um, I think it just goes

> back to like, you know, knowing you're not alone, like, we're all here for the same purpose, we all want the same things. It's kind of like, everyone's just here to have fun.

Not only did team sports provide connection, it also gave Erin the opportunity to normalize social anxiety, as she stated "At the end of the day, like, it's, you know, it kind of just normalizes that everyone's got a different experience, but who really cares when you we all come together for a common purpose kind of thing?" Going to a camp allowed Abby to develop skills to connect with others in a small social; she was then able to transfer these skills outside of camp. Abby explained:

> I'm thinking I think definitely, just because of them, like that's like, almost, like, encouraged me kind of, like motivation to like, get better with things and like, being in that comfortable space, like, between camp and people like, being comfortable with that, it's like, allowed me to like, step out of my comfort zone a bit.

What is evident in each example of community engagement is that connecting with a small community, be it a team or camp, provided a positive, connecting experience of belonging, and this in turn created more possibility of future opportunities for belonging.

**Self-Awareness and Knowledge.** The two main microsystems from which participants developed self-awareness and knowledge in relation to SAD are health services and the internet. The health services microsystem comprises professionals, treatment interventions, and medication. Google was the main search engine identified by

participants who used the internet as a resource. This factor of resilience is noteworthy, because it specifically addresses the challenge of lack of knowledge mentioned earlier.

Two participants explained how online resources made a difference for them with their SAD. Erin used websites to better understand SAD and found this helpful. Erin stated "like just being able to look that up online and really understand, you know, what anxiety means and what it looks like really helped." Similarly, Rose used *Google* to learn how to do things, such as do a presentation in front of a group. She explained:

> I guess just going on Google and being like, how to do a group presentation well, and just using those tips. So if I didn't know to look for social anxiety things, I didn't realize that I would have it. ... And then once I was 16, I was able to, like, look up more about social anxiety.

Rose inadvertently learned about SAD when trying to find information about confronting one of the challenges of SAD: group presentations. In both cases, the internet provided valuable information to Erin and Rose, which then led to a source of resilience.

All but one participant received some form of treatment for SAD, in the form(s) of medication, counseling, or both from health services. This may be because of the SAD diagnosis inclusion criteria of this study. Five participants named treatment from a health service provider as an external resource. Therapy received mixed reviews from participants. On the positive end of the spectrum, are Jennifer, Tanya, and Karen. Jennifer recounted "I went to therapy for, like, probably five years or so. And so I did a lot of work there, which was really, really helpful." Karen spoke of her therapy "my old

therapist, like one of my first therapists, um, she's now retired, but like, she really helped me, I think, just, like, understand more about myself and what I am capable of." In Tanya's experience, therapy opened her mind to hope, as she explained:

> It was kind of hard for me to, I remember, like, I was very close minded to the idea that ... I just kind of always had this thought in the back of my mind that this is something that I will always have to live with all throughout, for well, as long as I live.

Then Tanya started CBT, and she noticed:

> That slowly after I did, you know, do the little breathing things, or, sorry, the breathing exercises, or the journal prompts or whatever, I did notice myself becoming more open to the idea that the social anxiety can lessen.

While Abby, in the middle of the spectrum, stated:

> And then counseling, I've kind of been on and off again. And I feel like it does help but like, definitely, like, haven't found the right person yet for it to be especially helpful. But like, there's definitely things from previous counseling sessions that I've like, taken with me to like, help. ... kind of different perceptions of myself and ... just kind of like a better outlook on life.

Conversely, Velma had a negative experience with CBT:

> Because of the method of cognitive behavioral therapy, which is meant to put you kind of in an uncomfortable situation. So I kind of had resentful feelings at the time. So now older there, I see how there were times where that helped realize

> things because like, he would go from question to, well, the chain of reaction of social anxiety and do situation. And that was, like, very, I felt like almost it felt harmful. Like, it felt like there was like making me more anxious. And I think I read that that was like the point, but I didn't like it.

Retrospectively, Velma noted some possible advantages and she also highlighted the level of discomfort that CBT created for her.

Counseling was accessed by half of the participants, with CBT as a predominant form of intervention. The majority of participants found this helpful and a source of resilience, and many spoke of the CBT skills that they learned as a result of counseling.

**Skill Development.** Skill development can be traced to health services and to life experiences. Through health services, a few participants learned cognitive behavior (CBT) skills. Tanya described "my counselor, she taught me some like breathing exercises, some journaling prompts as well. So those two things definitely got me. Well, I wouldn't say got me through anxiety, but it helped me better manage the social anxiety." Additionally, Jennifer mentioned how the breathing exercises "that kind of just help chill your body out." In their interviews, these participants identified the CBT skill learned through health services as useful for SAD. A number of other participants described other cognitive and behavior skills that they learned through life experiences.

Cognitive skills refer to how individuals can regulate how they think. Self-talk, for example was used generally by Bridget as a way to calm down. She explained "I found little ways, I would just like, talk to myself, talk myself through things like, people

are thinking about themselves, like, it's that people aren't thinking about you to just like, talking to myself to calm myself down." Bridget learned this from her parents and teachers who taught her metacognitive skills. Jigger, on the other hand, used specific, humorous phrases to motivate himself to do something; he asked himself why he could not, for example, ask for extra whipped cream on his drink, when he thinks about superheroes who can accomplish amazing things. He attributed this skill to pop culture and how these characters modeled behavior. What is more, Lily learned how to mentally "flip a switch" and decide to do something; as she described:

> And I'm not sure what it is, but it does happen quite frequently when I'm, especially with social situations. It's like, I'm too scared. I'm too scared. I'm too scared. No, I can't go and then all of a sudden be like, I'm gonna go.

Lily shared that she developed this skill from having a near-death experience with an appendix rupture. Cognitive skills, therefore, can come from a variety of environmental resources and then be internalized as personal resources for resilience.

Behavioral skills, on the other hand, refer to what an individual is able to do. Bridget noted her ability to always find a bathroom when in need of escape "Sometimes I found the bathroom was like, there's a bathroom everywhere. So you can always go to the bathroom. And like, just take a minute by yourself." Rose also knew how to find a way out of situations that felt too much to handle, as she noted "school dances, I hated them, but we had to go. So I would sneak out to the washroom and then like run away to another part of the school." From experience, Abby learned the value of making plans

closer to the time of event as a way to limit time with anxiety, and Bridget could over-prepare for challenging tasks, such as pre-reading books for class. All of these behavioral skills, although avoidant in nature, have served these individuals well, and were learned through life experiences. Skill development, therefore, requires other people's influence and engagement in life experiences; both of which originate from the social environment.

**Attitude.** For the purpose of this data analysis, attitude represents how people think about and approach a task. When asked about their internal resources, six participants stated that they were determined/hard-working/perseverant. They all attributed this attitude to their family microsystems. For example, Velma explained:

> I have a very, my family has influenced a very determined driven nature. Because they, both my parents are immigrants, and they're very hard workers. So I think that instilled resourcefulness helped me kind of do what I can to, like, figure out how to help myself, like very kinda survival.

For Rose, aspiring to be like her sister instilled determination; she explained "It was basically ingrained in me by my family, and specifically my sister, because she's always been very determined. And I always wanted to be just like her. So I would just copy her." Similarly, when asked how she developed determination, Jennifer answered "Probably through my family, we're all pretty competitive. So we all get very, like, motivated off of each other kind of, and part of it was probably because I want to one up my brother." This attitude of determination was shared in more than half of the interviews, implying a particular importance to this resilience factor.

Apart from a determined attitude, a number of other traits emerged from this data. Abby, in particular, identified three of her personality traits that act as internal resources: independence, empathy, and introversion. Abby explained that these traits helped her to manage SAD during adolescence, and that they were likely present before her SAD. Humor is a trait that Erin named as a useful resource for resilience, as she recounted:

> I guess like being able to, you know, joke around with myself or other people and not take things too seriously and be like, yeah, like, I can't order more ketchup for myself friends, sorry. Like, it just kind of didn't allow me to take myself too seriously.

Open-mindedness and a positive disposition were also named as valuable internal resources. Karen linked her positive disposition and perseverence to her mother's modelling:

> Um, I think mostly for my mother, because she's such a hard worker. And she always told me like, just to, like, stay positive. And just like told me like you can accomplish, like, whatever you want to do. And you just have to, like, put the work in and believe in yourself. So I think that was where I developed them.

These examples support Erin's belief that personality traits like resilience are, in part, results of lived experiences. Erin shared this thought:

> Um, I guess it's just like, having harder experiences you're put through and, you know, you still come out on the other side, and you're still okay, you're still like, you know, surviving or you're still thriving, and it's just kind of like, oh, like, if I

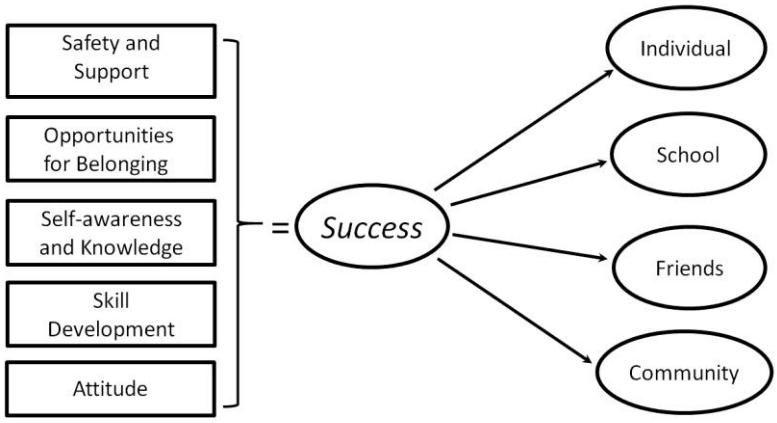
> can get through that then, you know, it just continues to build your resilience, like, okay, like I'm strong enough to handle this same situation, or maybe a variation. So I think just like, it builds as you, you know, go through things.

In essence, Erin is highlighting the value of engaging with the social environment as a means to build resilience, hence supporting Bronfenbrenner's argument of human development as a product of the reciprocal interaction with the environment that lead to developmental successes.

**Successes.** Participants identified a number of successes when asked what they were able to do even though they had SAD. It was intentional that the interview question #8 did not include the term, 'success,' in case the participants did not make the association between what they were able to do and it be considered a success. Their responses were evenly representative of four categories of success: individual, school, friends, and community. Each participant was able to name at least one thing that they were able to do despite having SAD. See Figure 5 for an overview of resilience, incorporating how participants were able to succeed and in what areas of life they experienced successes.

**Figure 5**

*Overview of Resilience*




Individual successes ranged from general to specific accomplishments. Three participants shared that they were able to try new experiences. Abby, for example shared "It's like, ordering food or like, trying new social experiences," and in Erin's experience, she described success as "Um, I did keep, like positive relationships with my friends." These examples indicate that important successes may come in the form of common-place accomplishments. More specific successes included Tanya's experience with public transit:

> Same with public transportation. I really didn't like crowds. But, you know, to get to school or to get to somewhere I needed to be, obviously, I would have to take it. But I did always try to plan either getting there ahead of time or taking a bus that was less crowded. So I you know, I'm able to take public transportation, but obviously, it wasn't without its difficulties.

Jigger's experience with getting a job is another example of a specific accomplishment. He shared this incident of success:

> Um, I think a big one for me was getting my first job. Because I, during the interview, I really thought that I was gonna mess up a billion times. And I was second guessing every single thing that I was saying, but then I ended up getting the job.

There was a similar range of responses associated with successes at school. On a more general level, participants like Lily named attending school daily and graduating as successes. Lily talked about what she was able to do despite having SAD "Well, one, I graduated high school, I'm so like, that's an achievement. That's like, I actually did this. So graduating high school was difficult, but I managed to get to classes every day." More specifically, there were successes that reflected the challenges previously mentioned, including class presentations and participating in group projects. Some successes extended beyond typical school expectations. Lily, for example, won a citizenship award at school and Velma participated in student council. All participants noted at least one school-related success.

Where there is a range of diversity in individual and school successes, successes with friends seem to range in perceived level of difficulty. On one side of the spectrum, some participants' successes were talking to people, as Jigger mentioned:

> Well, um, I still, like can talk to people. Like, I still, like, for example, even I'm, like, I don't know you, but I'm still like, telling you about it. Like my experiences

> and stuff. So I'm basically like, even though I have a lot of trouble doing it, I still try and push myself to talk to people and like, like, engage with others.

In Jigger's interview, it seemed as though he was acknowledging his ability to talk to people and that this was a small accomplishment, perhaps compared to his other accomplishment of getting a job.

In the middle, other participants noted that they were able to maintain relationships. As Tanya shared "So, I mean, I've been able to maintain friendships and stuff. So like that, obviously, one on one, it's a lot easier for me to talk to my friends. In groups, it's a little bit harder." In this example, Tanya recognized the degree of difficulty of this accomplishment.

On the far end of this spectrum, two participants had significant social success. Velma stated "I was, the funny thing about my social anxiety is, I was still quite a social butterfly." Additionally, Bridget, stated that SAD did not hold her back from going to parties or hanging out with friends. She stated:

> Yeah, I feel like it [SAD] didn't hold me back in the sense that there wasn't like nothing that I could do. I felt like everything, I would still go hang out with friends, go to parties, play all my sports, and really, there wasn't much that I felt that I couldn't do. I just would be really stressed about it. So even though I did everything, it was just really, really stressful for me. And I think that took a pretty big toll on me.

In Bridget's example, the presence of resilience is clear; she did not let SAD hold her back and she dealt with the resulting stress of her actions.

Successes within the community revolved around sports, clubs, and in one case, a community festival. Three participants identified their ability to play in team sports as a success. For example, Erin shared how she was able to play sports "Um, I think with sports, like I've been doing it since I was little, so it was kind of like, I could focus on the fact that I knew what I was doing." Two more named their connection to performing arts. Karen, for example, said "And I was also able to do some activities I really enjoyed. Like, during that time I started dancing." Participating in a youth group was another example of success, as was Lily's experience helping to create a display for a local festival, as she noted "I've done a few things with some, like family friends doing some and worked on a project that got on a Beakerhead runway fashion thing. So I've done a few things that were, that were pretty big." What all of these successes have in common is their opportunity for connection and belonging to further build resilience.

It is noteworthy that participants' experiences with success represented three key microsystems: home, school, and community. Equally interesting is how the participants accounted for these successes.

Participants' explanations for their successes was revealing in a few ways. With interview question #8, participants were asked how they explained what they were able to do from interview question #7 (see Table 2). For many participants, there was a pause before answering, suggesting that this question was not as easy to answer as other

interview questions. Two participants began their answer by saying that they did not know. Lily's began her response with "Honestly, some days? I don't know." Each participant's explanation also indicated if they attributed their success to personal factors, environmental factors, or a combination of the two.

Five participants accredited their successes wholly to environmental resources. Most participants in this category identified particular individuals as being responsible for their successes. Jigger acknowledged his cousin as the reason why he got his first job. Velma noted encouraging individuals who saw her potential. Moreover, when friends and family were identified as the environmental factor, the tone in which participants referred to them has valuable implications. For example, Karen shared that friends and family pushed her in a supportive way, whereas Jennifer explained that she was able to go to show choir because her family dragged her there. This distinction highlights the variability in how participants experienced how others brought them out of their comfort zones.

On the other end of the spectrum was a participant who attributed her successes all to her own personal factors. Tanya explained that she was able to use public transportation by taking an earlier, less crowded bus. Additionally, Tanya was able to do group projects because going to school was her job and she had an interest in school. Tanya used self-talk often in order to meet challenging school expectations. Tanya seems to be the exception in this group of participants who attributed her successes to herself.

The remaining four participants represented a middle-ground by attributing their successes to both personal and environmental factors. Erin, for instance, discussed that she was able to play sports because she could focus on the team goals (personal), and she was able to make friends by modelling other friends' behaviors (environmental). Similarly, Bridget was able to go to social events because she could use self-talk to calm herself down, find a bathroom to regroup (personal) and she had one good friend with her for support (environmental). Erin used a distinct attribution for each success, whereas Bridget attributed one success to both personal and environmental factors, highlighting the diversity of success attribution with SAD.

Based on these ten participants' explanations for success and their related success attribution, three conclusions can be made. First, there is a higher rate of success attribution to environmental factors than to personal factors among these participants. Second, personal and environmental attributions are diverse within this group of participants. Third, it would be an incorrect assumption to presume that individuals with SAD are associated with one type of success attribution.

Resilience, from a developmental psychology perspective, is the ability to successfully adapt to situations that may impede healthy functioning (Newman & Newman, 2016) by accessing environmental resources and using them in meaningful ways (Ungar, 2011). These participants showed resilience as they adapted to social situations in a variety of ways, the majority of which accessed environmental resources to do so. As Velma pointed out in her interview, however, knowing about SAD precedes the

development of coping strategies and not knowing that one has SAD is a significant obstacle to getting help. Resilience, therefore, may begin with identifying what SAD is, possibly through the environmental resources like the internet or health services, so that the individual can discern between normal and abnormal social anxiety. Most youth would not know that they have SAD without someone else in a social environment like school to point it out. What led to success for these participants were safety and support, self-awareness and knowledge, skill development, and attitude. All of these were accessed from the social environment, specifically through six microsystems: home, school, friends, community, internet, and health services. Based on Bronfenbrenner's bioecological theory (Bronfenbrenner, 1979), there is a reciprocal, bi-directional interaction between the individual and their social environment, meaning that each time any of these participants interacted with a microsystem, both they and their microsystem were impacted, further impacting their continued interaction.

**Step 4: Theme Check**

Each participant's data can be categorized into the existing themes (see Tables 7 & 9). Additionally, I noted that each participant was not represented in each thematic category, and this demonstrates the diversity of lived experiences of adolescent SAD amongst the participants. With regards to the eight themes associated with research question #1, two to eight participants were represented in each theme. The theme represented by the most participants was *Challenges in the Microsystems.* This makes sense because so many participants spoke about their challenges when explaining what

their lived experience with SAD was during adolescence. For the second research question about resilience and its related six themes, there was a range of four to ten participants associated with each theme. The one theme that involved all ten participants was *Successes*, highlighting the level of resilience within this group of participants.

**Step 5: Individual Textural Descriptions**

Here, data is presented in relation to each participant. I chose to include two to three quotes from each participant that represented something unique and/or central to their lived experience. Each participant is identified with a pseudonym and will be presented in the order in which they were interviewed.

***Velma (P1)***

Velma's experience with SAD in adolescence was influenced by her barriers to service and her lack of information. First Velma described what it felt like to not have this information, and later in the interview she talked about possible reasons why she did not have the information she needed about SAD.

Velma used a metaphor to express her experience about not knowing what SAD was and this metaphor evolved during the interview:

> I think it's [social anxiety] a stem from other mental illnesses such as ADHD. And I found that out later that lots of that is interconnected. And so in my experience, I feel like social anxiety was kind of one piece of the pie, if that makes sense…. Because, one I didn't know what the, this pie was made out of. I didn't really know why that was what I was going through, I just know that it was

> happening. So it was challenging, because I think I was trying to figure out how much flour there was how much like jam there was, you know? So, um, yeah. And that kind of made it difficult to kind of like, what do I do with this pie?

This lack of knowledge was integral in her inability to get help with her SAD, as were other related barriers.

Additional inter-related barriers to service were identified by Velma: being a visible minority, living in a low SES community, and having some teachers who did not initiate intervention. Velma stated:

> And I think I should note that because there's a higher population of people of color and lower income. And so it was a cultural struggle, I want to say, so I feel like because there was this disadvantage to a large portion of people that affected my school life and the people I was surrounded by. …. I feel like being of color kind of affected how I was, like the treatment and the approach to social anxiety, if that makes sense. So if I was a white woman [living] in _____, I feel like it would have been taken more seriously earlier on.

Velma clearly made connections to systemic barriers that impacted her, as well as the role some teachers played in her experience. It is important to note that Velma identified a few teachers who made a very positive impact on her in school and she revisited the lack of accountability of other teachers three times in the interview, at one point stating:

> And it's like a human choice, right? Like, there are, there were definitely teachers who probably saw my anxiety but chose not to provide compassion because they just didn't have that agency and they saw the signs but they chose not to.

As Velma explained, her experience with SAD would likely have been different had she been white, in a higher SES neighborhood, with more teachers like the few who did take an interest in her and help address her SAD in school.

***Abby (P2)***

One predominant aspect of Abby's experience with SAD was the associated fears and how she overcame some of them. A pivotal point in Abby's SAD during adolescence was going to camp. This experience highlighted the potential benefits of being pushed out of one's comfort zone as well as the value of exposure to anxiety-producing social experiences. As Abby explained, anticipating camp was fraught with anxiety:

> And then honestly, there were a couple times where my parents kind of like, I don't want to say forced, but like, kind of forced me into situations. … I eventually realized, like, I'm not getting out of it, like, they're gonna make me go regardless. And the fear and my parents even said, like, go for the first week. And if you don't like it, we'll come back and bring you back. But at that point, it was like, I felt the anxiety, like, the fear of being in prison, … I didn't really want to go, I was like, super melting down for probably like the month before, like, trying like everything to get out of it.

This anxiety was followed by the positive impacts of exposure, as Abby explained:

> And then I did end up going and it was really good. Like, I felt it was like super positive. And like, that helped with a lot of things. So like, I kept going back and gone back, like the last three years and like, I've made a lot of friends there. And I feel like the camp itself has like definitely helped me like grow and like overcoming it a bit like public speaking even it's like a huge trigger kind of thing. And like through camp, I've been able to like, work on that a bit more and do that a bit more.

Abby's lived experience with SAD highlights the level of turmoil involved in engaging with new life experiences, with both the emotional cost and the potential reward in both personal and social development.

***Jigger (P3)***

What is noticeable Jigger's transcript was the frequency with which he referred to his strategies to cope with SAD as an adolescent. Without naming them as such, Jigger found success when he engaged in particular cognitive behavioral strategies. He shared two examples of self-talk, and one of self-reinforcement.

Both forms of self-talk act as motivators for Jigger. In the first example, Jigger explained how this strategy leads to resilience:

> This might sound a little vulgar, but this is what I do for most things. I just told myself, like, I just keep saying, in my mind, stop being a bitch about. Until I do it. Like, any time I'm, like, resilient to do something. In my mind, I just keep saying that over and over, and then eventually, I'll just do it.

A second form of self-talk, as Jigger noted, was influenced by popular culture and provides a unique perspective:

> If I'm really into a show … I'll adopt characters, like, there's been so many shows that have literally influenced, like, me. And then … it sounds kind of corny, but like, it's honestly true, really. Um, like, for example, in like a superhero show or something like that, like, that guys fight. This is really stupid for an 18 year old to say. Like, if he's fighting a bunch of people, they have guns pointed at him and stuff like that. And he's still doing it. Why can't I ask for the Tim Horton's lady to add extra whipped cream to my ice cap or something like that?

Both of these forms of self-talk are ways in which Jigger has developed an inner monologue to address and resist the avoidance associated with SAD.

Additionally, Jigger explains the value of moving past his avoidance as a form of self-reinforcement and managing his SAD:

> Um, I guess in a way, it's kind of reinforcement. Okay, because, um, because I'm basically like, if I, if I end up doing this thing, then I'm essentially proving myself wrong. And saying, like, like, I can do it. I'm not being a bitch about it, versus if I don't do it, then I am. And like, maybe, maybe it's just like, some wiring in my brain or something like that. That makes me act like that. But it's like, if I can prove myself to myself that I can do it, then I can basically do anything.

Essentially, Jigger's success with self-talk and reinforcement illustrates the process of a cognitive behavioral approach, wherein the negative cognition is identified and then

refuted through behavioral evidence. What is particularly striking is Jigger's ability to do this independently.

***Lily (P4)***

Lily's experience with SAD embodies significant obstacles and equally significant successes. Much of Lily's experience with SAD was intertwined with health services. Lily's experience with mental health exceeded the diagnosis of SAD, and Lily spent time in both an inpatient and later an outpatient program. She also benefitted from family therapy.

Lily was able to identify qualities of her experience with hospitalization that helped her overcome aspects of her mental health:

> I liked the structure. I liked the routine. I also liked that it was just a tiny community … that felt very safe. I was able to be safe in that small, little bubble. And that was so nice to just have not be so big and overwhelming. … So, a little bubble. … My hospitalization was kind of weird. They didn't give me a counselor, so wasn't particularly helpful. But it was a nice pause in my day-to-day of going to be anxious. So it's just like a big stop. To decide, no, this is the path.

When asked about any other forms of treatment that Lily underwent as an adolescent, she spoke about family therapy:

> Um, family counseling, … and that has been extremely helpful for like, not just my mental health, but I know my parents and my brothers as well. We all work together as a unit more cohesively and our, it's just been so helpful to like if I'm

> having an episode, knowing what to say to my family, and then if my, my family has been able to support me when I'm having an episode. So it's been that has just been so helpful.

Lily went on to make connections between her treatments and her successes at graduating high school and her family's ability to work as a team. Lily's lived experience with SAD, however, is not remembered through rose-colored glasses, as she emphasized in one of her concluding remarks "it gets easier and it always feels like dog shit." Lily overcame severe levels of poor mental health and developed both a hopeful, yet realistic perspective of SAD.

***Karen (P5)***

The principle essence of Karen's interview was how she experienced SAD before her diagnosis, compared to afterwards. Pre-diagnosis, Karen's experiences were expressed as what she could not do:

> And like, for example, like, I've like, the first time I ever, like raised my hand in school was like, my senior year of high school. So like, just stuff like that, or like, I'd be too scared. Like, if I needed to go to the bathroom, I wouldn't go to the bathroom. There's just stuff like that, like, I'd be too scared to do anything.

This was juxtaposed with what she could do after her diagnosis:

> Um, I think a big part of it was finally just, like being diagnosed and starting to get some help with that, like, I like seeing my therapist, especially. And just my family, like, now they understand they were supporting me through everything.

> And also, some of my closest friends were like, there along the way to like, kind of what pushed me ahead and stuff like that. So it's kind of like the community, like, around me that, like, understood and was trying to help me, I think.

Based on Karen's narrative, the diagnosis alone was not the cause of change, but rather was the impetus for progress that may have assisted friends and family to better support her, as she explained this impact "… that I don't have to go through it alone is like, the biggest part for me."

***Erin (P6)***

Erin spoke, not only about individual experiences and impacts of SAD, but also on the stigma associated with SAD. This supports what Erin shared repeatedly during the interview, about togetherness, whether it be about a building a friendship or being on a team. When discussing an important friendship, Erin stated:

> Um, I think just like a lot of commonalities, like we both come from rather like broken families, and we can relate on some, like mental health issues as well. So when we started having those conversations, it was like, oh, like, I'm not alone.

Erin's experiences on sports teams provided a similar result:

> Um, I think it just goes back to like, you know, knowing that you're not alone, like, we're all here for the same purpose, we all want the same things. It's kind of like, everyone's just here to have fun.

The stigma, on the other hand, may impede this experience of connectedness that Erin spoke about. Erin explained:

> Um, I think like, the stigmatization of anxiety is kind of what like, hinders, you know, getting past or like the acceptance of it. So like, I think, people need to accept it, that it is something that, you know, can affect some people … So it's like, I think just like taking away that stigma to be like, this is something that maybe everybody has, it's kind of common, but it's not really talked about because people just think you're being ridiculous, … But I think, you know, once we remove that stigma, when we're able to talk about it more than people can say, oh, like, this is more common than I think it is. And so maybe I should not be as judgmental, that people aren't like me kind of thing.

From Erin's perspective, removing the stigma may open the doors the more understanding, and perhaps more connection. Erin explains that if people were aware that anxiety is not about being difficult, ridiculous, or overly sensitive; that it is real and difficult to live with. This removal of the stigma may lessen the judgment that exists in society. Erin noted:

> It's that, you know, this is a very, like, serious disorder that really prevents me from doing like, you know, quote, unquote, normal people are able to do so easily. ... And I don't really think a lot of people give it that credit that it does effect, just like your mental health, but your physical health like it. It's really hard to get past and I think people look at it as like, you know, it's a choice. But I think, you know, once we remove that stigma, when we're able to talk about it more than people can say, oh, like, this is more common than I think it is.

***Bridget (P7)***

A key theme in Bridget's interview is the development of self-efficacy through life experiences. As Bridget stated "I feel like it [SAD] didn't hold me back in the sense that there wasn't, like nothing that I couldn't do." When exploring how Bridget was able to do so much, she used self-talk and behavioral strategies. Bridget gave examples of her self-talk "… I would just like talk to myself through things like, people are thinking about themselves …" as well as an often-used strategy:

> I would go to the bathroom. Sometimes I found the bathroom was like, there's a bathroom everywhere. So you can always go to the bathroom. And like, just take a minute by yourself. Kind of like, remove yourself from the situation.

It seems that because Bridget was able to experience success in going to social events, she gave herself opportunities to build her strategies, which in turn strengthened her sense of self-efficacy to engage socially, hence explaining why Bridget was not held back by her SAD. This is further exemplified in her advice to other youth with SAD:

> Engage in social activities as much as you can. Because the more you're, like introduced to it, or the more you're in them, I think the better you get at it at handling it, … Yeah, and, and also, like, remind yourself like, that people are very worried about themselves, so they're not always thinking about you.

Bridget's lived experience with SAD differs from the majority of the participants, as her adolescence was not as encumbered by SAD; instead, she founds ways to manage it.

***Rose (P8)***

In Rose's experience with SAD, there was a repeated presence of comparison. In some cases, this comparison may have impeded Rose from seeking help, as she explained "because I didn't want to be seen as different at all. … But that prevented me from like, maybe learning what it [SAD] was sooner." Rose made comparisons between her SAD in adolescence to adult stress:

> It [SAD] basically just felt like a lot more stress than other people, … And I guess that's how I related it to normal people. Because how I acted normally was how they acted when they were very stressed. Yeah, I'm like, as a teenager, when you're getting more used to sickness and like, adult stress, that's kind of what the anxiety felt like, at least from what I know about normal people's stress.

Rose also drew comparisons with her sister that highlighted the positive effect of comparison as she explained how she developed determination:

> It was basically ingrained in me by my family, and specifically my sister, because she's always been very determined. And I always wanted to be just like her. So I would just copy her. And like, she was so determined. So I was like, okay, I need to be determined as well.

Rose's lived experience with SAD underscores the impacts of upward and downward comparisons as well as the complex influence of the social environment on human development.

***Tanya (P9)***

Tanya spoke about the individual impacts on her self-concept, interpersonal skills, and her beliefs about how others consequently perceived her. Tanya's transcript stresses the relationship between thoughts and perceptions, which is one of the hallmarks of SAD (American Psychiatric Association, 2013). Tanya articulated her experience with SAD through metaphor:

> If you could imagine somebody, you know, being in the corner, holding a clipboard, and just kind of writing everything you do down and it was always something negative. So if I did something or said something, and then I go back, and kind of like through my head, replay it, and it would just be like, Oh, you shouldn't have done this, maybe you should have, you should have done it this way.

This, in turn, would impact how Tanya would experience interactions with others and her perceptions of how others experienced her:

> And then even once I was in the conversation, it was always hard to keep it going as well, … And then I have something to say, but I'll think like, once or twice or three times about whether I should put my input in or not. And, and by the time, you know, I realized, okay, maybe let's let me just say it, people have moved on. … You're like, Oh, this is how they want me to act, because this is how they see me. And so it was just kind of hard to be, like 100% myself. … And so it kind of made me look a little bit distant, distant or uninterested.

This self-perpetuating cycle of over-thinking and perceptions of others' thoughts, which then led back to more over-thinking, is an articulate example of how SAD exists on a cognitive level.

***Jennifer (P10)***

The idea of normal resonated with Jennifer throughout her interview. The fear of not being normal encumbered Jennifer's daily life at school, as she described:

> And mostly worrying, like, what they're thinking about you and how they're judging you. And, like, you're just scared to do normal activities like asking to go to the bathroom and sharpening pencils, like getting in class to sharpen pencils. … Um, I was scared to just like, say the wrong things and like, get in trouble. I was terrified of that. And like, just not be normal, basically.

Once Jennifer established what was normal, she strived for normal in her life. Jennifer connected her determination to how she perceived normal stating, "so once I was like, okay, well, this isn't what a normal person feels like every day. Then I was like, okay, well, I want to get to normal kind of like." Even when sharing her competitiveness with her brother, Jennifer worded it as "it was probably because I want to one up my brother. But yeah, so just that like competitive nature kind of is like, okay, let's just get this done, get to normal and be able to function." Jennifer mentioned that what would have made a difference for her would have been friendships at a young age so that she would have had a clearer context to recognize what was normal. She said "and just like realizing that not everyone worries all the time. Like me like, just realizing that I actually was different

than what's normal kind of." Apparently, knowledge about normalcy was both elusive and a guiding factor in how Jennifer experienced SAD during adolescence.

In each interview, the participants described their lived experiences with SAD during their adolescence. Their words reflect central perceptions and significant events and each participant's story is unique in some way (see Table 8). The above quotations capture some of that uniqueness.

**Table 8**

*Overview of Each Participant's Textural Themes*

| Participant | Central point of the lived experience with SAD |
|---|---|
| Velma | Ethnicity and SES as barriers to service and diagnosis |
| | Negative impact of lack of knowledge |
| Abby | How she overcame fears through exposure |
| | Transitional experience of going to camp |
| Jigger | Use of CBT strategies like self-talk and self-reward |
| Lily | Experience with health services |
| | Overcoming significant obstacles in mental health |
| Karen | Transition point of a diagnosis of SAD |
| | How a diagnosis positively impacted Karen and others |
| Erin | Stigma of SAD |
| | Not being alone and the value of belonging |
| Bridget | Self-efficacy through mastery experiences |
| | Ways to manage SAD so that it did not get in the way |
| Rose | Comparison as an obstacle to seek help |
| | Comparison as a positive motivator |
| Tanya | Cycle of over-thinking |
| | Thoughts and perceptions |
| Jennifer | Fear of not being normal |
| | Knowledge of normal as a turning point |

Equally valuable in this data analysis is the information that exists between the lines and behind the words.

**Step 6: Individual Structural Descriptions**

To begin, there are some general statements that reflect the cultural contexts of the participants. Overall, nine of the ten participants were university students in undergraduate programs. They all seemed proficient in English, although, for some, this may have been a second language. All participants ranged in age from 18-25 years and represented a number of ethnicities. Seven participants grew up in urban areas and three others were in more rural communities. Most notably, when considering the social context of these interviews, all participants had SAD, which often precludes individuals with this mental health disorder from engaging in social interactions where they risk judgment from others (American Psychiatric Association, 2013), such as being interviewed. With each participant, I will provide an overview of their structural description, supported by observations noted during the interview under the heading of *My Impressions* (see Table 8) and/or quotations from the transcripts.

***Velma (P1)***

Culturally, Velma shared that her parents immigrated from a poor country, that she grew up in a low SES community, and she identified as a woman of color. Velma was 22 years old.

Velma demonstrated enthusiasm, confidence, self-awareness, and caring as a participant. Velma was the first to reply to my recruitment and she expressed enthusiasm to participate. Communication to establish consent and schedule a time for the interview was swift. Velma expressed both enthusiasm and self-confidence at the beginning of the

interview when she took some control over the process and put me at ease when she stated:

> I'll be happy to clarify anything as well. So if you do ever want to ask something again, or to like just for me that I, like, kind of digress a little more, I'll be happy to do that as well.

This self-confidence appeared again when Velma shared an online resource with me part way through the interview. Velma's level of self-awareness was apparent when she shared "And I just want to give a little disclaimer, if I do get emotional ..." Velma confidently advocated for cultural equality and for accountability of teachers as she shared her lived experience of SAD. As the interview was at its conclusion, Velma showed her caring both towards me and the general public once more when she expressed:

> You know, I think we covered a lot of ground. Your questions are very thorough, and I'm glad that I was kind of worried that I, because I really was eager to help this study. And I found that very painful to me. So I'm like, I hope I can give a lot of helpful points, but I felt like your questions made sure that I was able to give as much insight as I could.

Velma demonstrated a keen desire to help in the area of adolescent SAD, despite this interview's impact on her, and in participating in this interview, Velma demonstrated that an individual can have SAD and be self-confident in how they express themselves and advocate for others.

***Abby (P2)***

Abby was an 18 year old Caucasian female and from a cultural perspective, seemed knowledgeable about the diversity that exists around gender identity. I draw this conclusion from the fact that when asked about her gender, Abby replied "Cisgender female." Abby spent her adolescence in a rural, agricultural community.

One of the central themes of Abby's interview was personal empowerment and overcoming obstacles. The same can be said for the feeling of the interview. There were some time delays in the online interview, and so that may have been the reason for the presence of some awkwardness in the interview; another factor may have been that Abby experienced some awkwardness while speaking about SAD. I noted that Abby often spoke quickly when sharing her experiences and smiled infrequently. Despite this possible awkwardness, Abby provided long and articulate answers without the need for much prompting on my part. As the interview was coming to a close, I asked Abby how she was feeling about the interview because it seemed as though her voice was cracking and she was speeding up her words even more near the end. Abby responded "I'm pretty good." I interpreted this to mean that this interview was difficult and that she was able to manage her level of discomfort, showcasing her personal empowerment and ability to overcome obstacles.

***Jigger (P3)***

Jigger was the only male participant in this study and he identified with his Punjabi heritage. Jigger was 18 years old, a visible minority, and lived in an urban center.

Jigger came across as an unassuming, humble, self-aware, and authentic individual. He displayed his unassuming nature at the onset of the interview by asking "I was, I was just a little curious. You don't have to answer this if it if you can't, but I was just curious, like, what you were gonna do with the results?" as well as repeatedly finishing his answers with " ... if that makes sense." Jigger demonstrated his sense of humility when he explained how his teachers often assumed that he was not intelligent:

> I'm not, I'm not trying to brag when I say this. But like, I think I'm a pretty smart person. But I'm not one of one of those people that like, and many teachers over the years have told me this. Like, they didn't realize that I was a smart kid until they saw my test results.

Jigger was aware of how he may sound both when he explained his use of superheroes as role models:

> I'll adopt characters ... it sounds kind of corny, but like, it's honestly true, really. .... For example, in like a superhero show or something like that, like, that guys fight. This is really stupid for an 18 year old to say.

As well as when he was explaining his use of self-talk, explaining that "this might sound a little vulgar, but this is what I do for most things. ... I just keep saying, in my mind, stop being a bitch about it." Lastly, Jigger's sense of authenticity and self-identity was revealed at the end of the interview when asked to choose his pseudonym for this study. He chose the name, 'Jigger' because it is the Punjabi word for friend and he wanted a name that reflected his parents' language. The qualities that Jigger displayed during the

interview speak to his level of personal awareness and ability to express himself authentically, the second of which is not often associated with SAD.

***Lily (P4)***

Lily was born and raised it the same urban city, and was a 20 year old Caucasian female. Nothing else about Lily's cultural background emerged in the interview.

Lily brought an animated, open, and prepared presence to the interview. It is noteworthy that when given some choice for the date of the interview, Lily chose the first available date, even though it was on a weekend. She began by sharing why she chose to participate "yeah, a little bit of exposure. And I think it's a thing. It's kind of fun to do, sort of jump in to do like ... things I haven't done before." Lily was open in sharing at the beginning "yeah, I think I'm good. A little nervous, but, yeah, okay." Several times during the interview, Lily referred to the notes that she had written in preparation for the interview. Lily shared a lot of information about her experience being hospitalized for mental health as well as her experiences in an outpatient program. At the end of the interview, Lily asked about how one develops SAD. In my opinion, Lily volunteered to be interviewed not only for the exposure of a new experience but also to learn more about SAD, illustrating how SAD can be an impetus for personal growth.

***Karen (P5)***

Apart from Karen mentioning that she lived in a moderately affluent neighborhood in a semi-urban community, and that she was a 19 year old female, little

was known about her cultural context. One reason for this was that I was unable to see Karen during the interview.

There were two limitations present in Karen's interview. First, it was one of the shortest interviews in the study, lasting only 20 minutes. Second, I did not have access to any of Karen's non-verbal cues because I was not able to see her during the interview. It is possible that Karen chose not to be seen during the interview, as she inquired about whether or not cameras were involved in the interview a week prior to the interview date, and it is also possible that her camera was not working. The fact that Karen had concerns about being in front of a camera and that she still participated in this study speaks to her perseverance and courage. Her willingness to participate in this study is congruent with how Karen's self-perception. As she explained "I think I'm a person that like, doesn't give up easily and always perseveres ... So, learning what I needed to do to better myself, I would always try everything and try to do it to work forward." What was also apparent during the interview was Karen's confident tone, clarity in her words, and her ability to quickly name her positive attributes. The possible contradiction in Karen's discomfort in being seen and willingness to be heard is a further illustration of the complexity of social interaction for an individual with SAD.

***Erin (P6)***

Culturally, Erin lived in an urban center, was a 23 year old Caucasian, and represented a non-dominant group gender-wise, identifying as non-binary.

Erin brought openness, a level of investment, and confidence to the interview. Erin rescheduled the interview from the original date to accommodate their schedule and seemed to be comfortable in doing so. This suggests that Erin is able to advocate for themself and their needs. This is aligned with a value statement that Erin made midway through the interview, when they said "So I think, you know, not really being taken as like, the expert of yourself when you're younger, versus when you're older people start to like, believe you more." In this interview, Erin came across as the expert of themself.

At the beginning of the interview, Erin asked "... when, like, would I expect, like the results to be published? Like, I would like to follow up?" Erin seemed both interested and invested in this study. This level of investment in learning more about SAD was further demonstrated at the end of the interview when Erin asked "I guess how many students struggle like on average with social anxiety?" The whole interview had a natural and easy flow between questions and answers, and one reason for this easy flow may have been that Erin reviewed the questions in advance and referred to their notes a few times during the interview. Erin's easiness during the interview continued on to the very end in how they graciously said goodbye, "I really appreciate it, letting me be a participant. You to stay safe and get outside; it's a nice day." Erin was very easy to talk to and she seemed self-assured throughout the interview.

***Bridget (P7)***

Bridget was a 20 year old Caucasian female whose family was in the mid- to upper- SES. Erin was living in an urban center and she mentioned Catholic school, indicating her religious affiliation.

Similar to Erin, Bridget's presence was confident, encouraging, and articulate. Bridget needed minimal prompts, as she provided detailed answers. Additionally, there are far less 'ums' and 'likes' in Bridget's transcript than there are in the other participants'. When I began the interview by thanking her for her participation, she responded "Yeah, totally. It's, it's really awesome. I think it's a great thing to study. So I wanted to help you out." And when asked if she had any questions before we began the interview, Bridget said:

> I don't think so. It, you sent me the list of the questions I believe you are going to ask, which just like kind of off topic, but I love that because it allows me to prepare. So, as somebody with social anxiety, like being able to prepare for a situation is really helpful. So I just wanted to commend you on that, because I found that was very helpful.

From both of these initial statements, it felt like Bridget was encouraging and supporting me. Near the end of the interview, I asked Bridget interview question #16, inquiring if there is anything else that the participant would like to share that was not directly asked, and her response was "Hmm, um, I don't think there is really anything unless there's something that you are still looking for?" Bridget continued to be aware of my experience during the interview. Although this may suggest hypervigilance on Bridget's part, her

tone, coupled with her words, was likely an indication of well-developed emotional intelligence (Goleman, 2005), whereby the individual is both aware and can respond appropriately to others during an interaction.

***Rose (P8)***

Rose was a 19 year old Caucasian female from an urban center. Rose was both a problem-solver and thoughtful respondent during the interview. The interview began with technical difficulties and it was Rose's idea to switch online platforms for better internet connection. This action is congruent with Rose's representation of a combined locus of control, wherein she attributed her successes both to her own abilities and factors external to her. Rose's voice was soft and low and she seemed to pause before answering a number of questions. Rose seemed to judge, or accept judgment of some of her responses, such as when explaining how she managed to go to school dances and then escape:

> But like, a really simple example, school dances, I hated them, but we had to go. So I would sneak out to the washroom and then like run away to another part of the school. ... I had to know, okay, I can handle that. And then I would find ways out of it, which doesn't sound good. ... Then I would make a way out of it, where hopefully no one would even notice.

A few of Rose's responses were followed by the question, "did I answer the question?" This could suggest a number of things: a level of tentativeness on Rose's part, that Rose was questioning herself, or that she was over-thinking during the interview. What was

interesting about Rose's individual structural description was the potential contradiction of her self-confidence; Rose was able to initiate and resolve a technical issue, and she was apparently less confident in expressing herself with the interview questions.

***Tanya (P9)***

Culturally, Tanya represented a visible minority group and was 21 years old. Tanya was a strong and articulate communicator during the interview. Unlike Velma's interview, ethnicity and culture in general did not factor into Tanya's responses. Tanya was often precise in her language as she expressed her lived experience with SAD. For example, when asked about the impacts of her external resources, Tanya explained "Well, I wouldn't say it got me through anxiety, but it helped me better manage the social anxiety." What stood out about Tanya's responses to the interview questions was twofold: the responses were longer than average amongst the transcript for this study, and Tanya's demeanor throughout the interview was calm. Interestingly, during adolescence, Tanya had difficulty keeping a conversation going and, as she noted:

> And we're all talking about a topic. And then I have something to say, but I'll think like, once or twice or three times about whether I should put my input in or not. And, and by the time, you know, I realized, okay, maybe let's let me just say it, people have moved on.

Overall, Tanya had a calming presence over the interview as she shared her experiences with SAD and this was not at all representative of how Tanya described her experiences of conversations during adolescence.

***Jennifer (P10)***

In terms of cultural background, Jennifer was a 19 year old Caucasian female from a semi- rural community. She is the one participant who is not a university student.

Jennifer's interview was one of shorter interviews, lasting less than 20 minutes. Her tone was agreeable, casual, and matter-of-fact. She seemed prepared with her answers and comfortable sharing her experience. When I expressed appreciation for her participation at the beginning of the interview, Jennifer responded "No worries." Soon after when I asked if she had any questions before we begin the interview questions, her answer was "I don't think so. I think we're good." From there the interview had a smooth and moderately quick rhythm. At one point in the interview, it sounded like there was a catch in Jennifer's voice, and when I asked how she was doing with these questions, she told me "I'm okay." At the conclusion of the interview, I again expressed my appreciation, to which she responded "You're welcome. Thank you for doing this. It's cool for the future."

It is noteworthy to compare Jennifer's demeanor in the interview with how she managed SAD during adolescence. As Jennifer explained, one of her main strategies was to minimize human interaction, whether that was by taking an earlier train or becoming involved in horseback riding. For someone who used to seek out activities for their minimal human interaction, Jennifer seemed very comfortable in this interview.

Reading between the lines of each participant's interview, through the individual structural descriptions, provides a more interpretive layer to the participants' words in the

transcripts. This layer of analysis highlighted a number of important aspects of the data. How participants managed the interview often spoke to their levels of social skills and emotional intelligence. There were noteworthy congruencies between some participants' words and behaviors, as well as incongruencies that may highlight individual progress from adolescence to early adulthood. More will be explored in an upcoming section of composite structural descriptions.

**Step 7: Composite Textural Descriptions**

In order to provide a composite textural description, the 10 participants and the 14 themes are organized in a table, indicating the associations between participants and themes. This process draws attention to the most frequently recurring themes (Moustakas, 1994), how they are distributed among the participants, and how to interpret the totals. Table 9 provides information regarding number of occurrences and number of participants represented with each theme.

**Table 9**

*Composite Textural Descriptions: Totals*

| | Total number of occurrences | Number of participants represented |
|---|---|---|
| RQ1 | | |
| Lived experience with SAD | | |
| Fear | 11 | 5 |
| Hypervigilance | 9 | 5 |
| Lack of knowledge | 4 | 5 |
| Emotional toll | 7 | 7 |
| Automatic reactions | 6 | 5 |
| Missed opportunities | 5 | 5 |
| Challenges in the microsystems | 17 | 8 |
| Challenges in the macrosystem | 3 | 2 |
| RQ2 | | |
| Resilience | | |
| Safety and support | 12 | 9 |
| Opportunities for belonging | 11 | 5 |
| Self-awareness and knowledge | 12 | 4 |
| Skill development | 21 | 8 |
| Attitude | 17 | 7 |
| Successes | 31 | 10 |

For the first research question, the themes that emerged the most often were *challenges in the microsystems*, *fear*, and *hypervigilance*. Five participants identified *Fear*, and five identified *hypervigilance*. This means that five participants spoke about these themes more than once in their interviews. *Challenges in the microsystems* occurred the most often and from eight of the 10 participants; the other two participants spoke about their challenges on a macrosystem level. These themes were primarily drawn from two interview questions.

Interestingly, the second research question about resilience emanated from seven interview questions, which may explain their higher rates of occurrence. The theme of *successes* was present in each participant's interview and was attributed to the following factors: *safety and support, opportunities for belonging, self-awareness and knowledge, skill development,* and *attitude.* Among the first three factors, *safety and support* was identified by the most (nine) participants, although these three factors were comparable in terms of number of occurrences overall. *Skill development* and *attitude* occurred with higher frequency than the first three factors, and were identified by eight and seven participants, respectively.

What conclusions can be drawn from the composite textural descriptions? When considering the five personal factors that led to missed opportunities and challenges in the microsystems and macrosystem, fear and hypervigilance are the most prominent. Additionally, successes in home, school, community and on an individual basis are the result of five resilience factors, possible with attitude and skill development as the most influential factors.

**Step 8: Composite Structural Descriptions**

As a whole, this group of participants had both commonalities and differences, from social, emotional, and cultural perspectives. The commonalities all originate from the inclusion criteria of this study, and to some extent, the recruitment process.

The 10 participants shared some similarities, all of which made them eligible for this study. Culturally, they ranged in age from 18-25 years old, they were all Canadian,

specifically from the province of Alberta. Socially, each participant had a diagnosis of SAD during adolescence which predisposed them to have developed avoidant behaviors regarding social situations. Nine of the 10 participants were undergraduate university students, which also was an indication of these participants' ability to manage the social interactions associated with postsecondary education.

Emotionally, all 10 participants agreed to be interviewed about their SAD, despite the inherent aspects of being interviewed that are particularly challenging for those with SAD, including fear of judgment, discomfort with speaking to strangers, being the center of attention, and engaging in a social interaction that may be embarrassing. Each participant has found a way to manage their SAD in such a way that they volunteered to be interviewed. Based on individual structural descriptions from the interviews, these participants presented as having positive social-emotional skills that were not influenced by any cultural differences (see Table 10).

**Table 10**

*Social-Emotional Presentation During the Interview and Cultural Differences*

| Participant | Gender | SES | Dominant/Non-dominant population | Geographical location | Social-emotional presentation |
|---|---|---|---|---|---|
| Velma | Female | Low | N-dom | Urban | Enthusiastic<br>Confident<br>Self-aware |
| Abby | Cisgender Female | Unknown | Dom | Rural | Empowered<br>Awkward<br>Resilient |
| Jigger | Male | Unknown | N-dom | Urban | Unassuming<br>Humble<br>Self-aware |
| Lily | Female | Unknown | Dom | Urban | Animated<br>Open<br>Prepared |
| Karen | Female | Middle | Unknown | Rural | Perseverant<br>Courageous |
| Erin | Non-binary | Unknown | Dom | Urban | Open<br>Confident<br>Self-assured |
| Bridget | Female | High | Dom | Urban | Confident<br>Encouraging<br>Articulate |
| Rose | Female | Unknown | Dom | Urban | Problem-solver<br>Thoughtful<br>Tentative |
| Tanya | Female | Unknown | N-dom | Urban | Articulate<br>Calm |
| Jennifer | Female | Unknown | Dom | Rural | Agreeable<br>Casual |

There were also a number of differences among these participants, yet these differences were not significant in terms of the high level of social-emotional presentation during the interview. Differences included: whether they were part of the dominant (Caucasian) or non-dominant population, SES, gender, and geographical location. All participants were able to describe their lived experiences with SAD, identify how they overcame challenges associated with SAD, and name successes despite having SAD as an adolescent. In this small sample size, social factors such as ethnicity, SES, gender, and geography did not have any apparent impact on participants' ability to discuss SAD, level of resilience, or general social-emotional presentation.

**Step 9: Synthesis**

By combining the two composite descriptions from Steps 7 and 8, a more holistic view of the qualitative data from this study emerged. Synthesizing the composite data, however, may obscure the most pertinent data instead of providing clarity.
Contrary to what a person might expect from composite analyses, synthesizing the data from steps 7 and 8 created more generalities than clear comprehension of adolescent SAD. Based on the composite data from structural and textural descriptions, I determined the following: each participant represented a unique disbursement of themes that are not indicative of their social factors; some themes were more predominant because they were named more frequently and by more participants. The overall absence of patterns in the composite data supported the argument that adolescent SAD is an individually experienced phenomenon, from lived experiences to experiences with resilience, and that

in order to support adolescents with SAD, and individualized approach to treatment is warranted. In other words, the individual textural and structural descriptions in this study were more instructive in understanding the lived experiences of SAD and how adolescents with SAD develop resilience in their social environments.

## Summary

Based on the above data analysis, the results will be presented as the answers to the two research questions that guided the study. The first research question was about lived experiences with adolescent SAD. This was a general question that then set the foundation for the second research question about developing resilience with SAD.

The first research question was: From the perspectives of young Canadian adults, what was their lived experience of social anxiety during adolescence? In answer to this question, related data was named *Lived Experience with SAD During Adolescence*. These participants experienced fear, hypervigilance, automatic reactions, an emotional toll and a lack knowledge about SAD during adolescence. These personal factors resulted in missed opportunities and challenges in the microsystems and in the macrosystem. Based on the data analysis applied in this study, the lived experience with SAD during adolescence is a challenging experience, unique to the individual. These lived experiences are aligned with how social anxiety disorder is defined in the DSM-V (American Psychiatric Association, 2013). This conceptualization translates into the specific challenges that adolescent SAD produces, particularly in the principal microsystems of school, friends, and home, and also on individual and societal levels. Common challenges that

participants identified were: school presentations, group assignments, making friends, talking to people, parents not understanding SAD, and overthinking social situations. Despite the commonalities of some answers, each participant expressed their own, individual lived experience with SAD, in which their own lived experiences, paired with unique social experiences with various microsystems, developed into a distinct lived experience. As each participant brings their own individual characteristics into their social environment, a unique sequence of social interactions between individual and environment occur, some of which expose how adolescents with SAD develop resilience in their social environment.

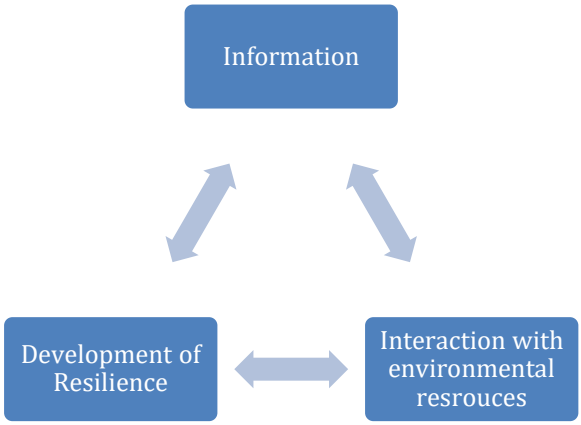
The second research question was: Did adolescents with SAD develop resilience in their social environment, and if so, how? Data about resilience was derived from questions about internal and external resources, successes and participants' explanations of their successes. Essentially, these participants developed resilience by engaging with their microsystems as environmental resources, while simultaneously strengthening their resilience, which consequently allowed them more successes in their social environment. Participants found environmental resources in six microsystems: school, friends, community, family, health services, and the internet. Often, these resources provided specific support for the participants: friends and family provided support and safety; school and community allowed for a sense of belonging and personal development; health services and the internet offered coping strategies and information. When asked what else would have made a difference with their SAD, six of the 10

participants stated that they wished they had known about SAD sooner so that they could have gotten help earlier. As Velma pointed out in her interview, knowing about SAD precedes the development of coping skills.

Resilience, therefore, may begin by addressing one of the personal factors associated with SAD; this is lack of knowledge. This is possible through accessing the environmental resources, such as internet or health services, and ideally through more principal microsystems, such as home and school. This is followed by the reciprocal interaction between the individual, and their resilience, with their microsystems that act as environmental resources. Within these interactions, individuals with SAD have the opportunity to connect with those people and opportunities that further enhanced individual resilience, leading to more successful social experiences (see Figure 6). Information is intentionally located at the top, indicating that it needs to be present for the other two to develop.

**Figure 6**

*Development of Resilience*




It is the reciprocal nature of this diagram, indicative of Bronfenbrenner's bioecological model of development, that supplies a continual opportunity to develop resilience. This is particularly important in resilience with SAD, because many of the microsystems that present challenges with SAD, such as school, friends, and home, also act as the environmental resources that support resilience. Information and level of resilience may be the determining factors in whether or not adolescents with SAD continue to engage with their microsystems in their journey to stronger resilience, or if they develop avoidant behaviors, limiting their opportunities to benefit from these microsystems as environmental resources.

# Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to explore the resilience and successes of adolescent SAD from the retrospective lived experiences of young adults in Canada. Because current treatments for SAD had not been as effective as treatments for other forms of anxiety (Babinski & Nene, 2016), more understanding about this phenomenon was needed. In this study, a qualitative phenomenological approach was used with an additional focus on resilience, making this a strength-based rather than a deficit-based study. Having analyzed the lived experiences of the 10 participants in this study, I identified eight themes connected to participants' lived experiences with SAD during adolescence and six themes related to resilience with SAD. With regard to lived experiences with SAD during adolescence, the eight themes were fear, hypervigilance, lack of knowledge, emotional toll, automatic reactions, missed opportunities, challenges in the microsystems, and challenges in the macrosystem. In terms of resilience with SAD, the six themes were safety and support, opportunities for belonging, self-awareness and knowledge, skill development, attitude, and successes.

## Interpretation of Findings

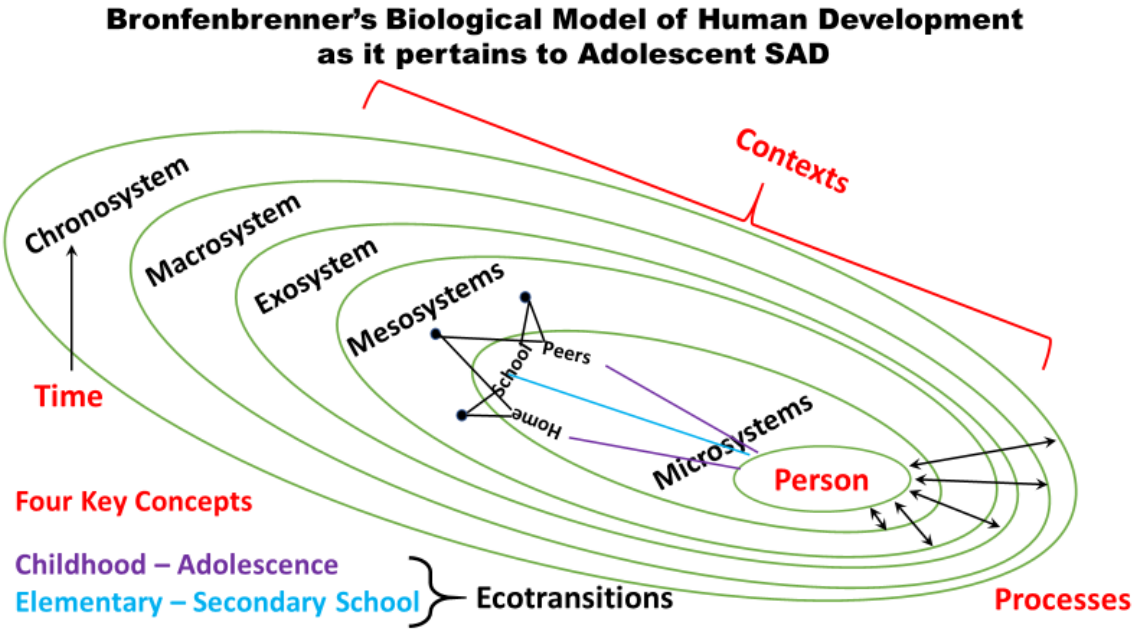
Themes associated with each research question are interpreted in two ways. First, I interpret the data through the theoretical framework of Bronfenbrenner's bioecological theory. Second, I compare the data and examine how they substantiated, refuted, or added to the existing academic literature related to SAD.

## Findings of the Study Compared to the Theoretical Framework

My findings in this study provided strong but incomplete support for Bronfenbrenner's bioecological theory of human development (see Figure 7).

**Figure 7**

*Bronfenbrenner's Bioecological Model*




More specifically, key concepts of context, process, person, time, and ecological transitions were compared in the data. These concepts were explored in relation to both research questions because the lived experience with SAD and the role of resilience were intertwined in the individual's bidirectional relationship with their social environment. Equally intertwined are the key concepts from Bronfenbrenner's theory.

### *Context*

Context refers to the levels of systems in a person's social environment (Newman & Newman, 2016). The two levels of systems that were relevant in the current study were microsystems and the macrosystem. Family, school, friends, community, health services, and the internet were key microsystems in the development of resilience. Interestingly, many of these same microsystems (school, friends, family, and community) were also the social contexts in which participants experienced challenges with SAD. The macrosystem also represented challenges with SAD during adolescence, with regard to ethnicity, socioeconomic status, and stigma. One interesting finding was that mesosystems were not relevant in lived experiences of SAD or resilience. The overlap of contexts that provided both challenges and resilience can be further understood through the lens of process.

***Process***

Process represents the frequent and regular interactions between an individual and their social environment that evolve as the individual and their environment change in relation to one another (Newman & Newman, 2016). In the current study, participants experienced challenges with SAD in many of their microsystems, yet also derived resilience from them, indicating that these participants continued to interact with these microsystems. SAD compels individuals to avoid social environments that elicit anxiety (American Psychiatric Association, 2013), yet current participants maintained engagement with these microsystems and benefited by developing resilience. Factors that enabled participants to remain engaged included safety and support, opportunities for belonging, self-awareness and knowledge, skills development, and attitude. These factors

were all accessed from participants' four key microsystems: family, friends, school, and community. How these factors of resilience were accessed depended on the individual.

### *Person*

Process is strongly impacted by the person, particularly what Bronfenbrenner (1979) identified as their demand features. Participants in the current study portrayed conflicting demand features. First, when describing their lived experiences with SAD, participants identified fear, hypervigilance, automatic reactions, an emotional toll, and a lack of knowledge. Later, when discussing their successes despite having SAD, participants revealed additional demand features: cognitive and behavioral skills, determination, independence, open-mindedness, and resilience. Moreover, based on structural descriptions from Step 6 of the data analysis, these participants presented in the interviews as confident, courageous, articulate, encouraging, and self-aware. Microtime was helpful in understanding how these contradictory demand features were explained.

### *Time*

Time refers to generation, but also the concept of microtime, which represents how long an individual engages in an activity in a given microsystem (Newman & Newman, 2016). The length of time in which current participants persevered in their social environments may account for the evolution of their demand features, evolving from fear based and hypervigilance to determination and resilience. Increasingly sustained exposure to the social environment, likely rooted in safety and support, allowed for opportunities for belonging and skill development; at the same time, missed

opportunities and challenges at the macro- and microsystem levels were reduced. Ecological transitions are not likely the answer to explain where these pockets of increased microtime originate and how they be facilitated.

### *Ecological Transitions*

According to Bronfenbrenner's theory, ecological transitions are periods of time when the demands of the environment increase and subsequently impact the individual's role within that context (Newman & Newman, 2016). Basic ecological transitions, such as progressing from elementary to junior high school or from childhood to adolescence, were not significant to current participants' lived experiences with SAD or with their development of resilience. Although Abby noted the value of being pushed out of her comfort zone when she went to camp, there were few examples in the data of participants rising to the increased demands of their social environments. It is possible that ecological transitions were present for these participants and were smaller in scope, such as the first time they presented in front of the class or when they tried to initiate a conversation independently. Regardless, ecological transitions did not seem to be integral to understanding how adolescents with SAD develop resilience. What appears to have made a difference for these participants was increased capacity in the forms of safety and support, as well as opportunities for belonging, knowledge, self-awareness, attitude, and skill development. This increased capacity assisted participants in further engaging with their social environments, thereby developing resilience. For individuals with SAD,

personal factors that increase capacity may allow these individuals to meet increasing demands in their environments on a subtle, recurring level.

Bronfenbrenner's bioecological theory provided a strong theoretical framework in which to understand adolescent SAD and the role of resilience. Many aspects of this theory were applicable to adolescent SAD, including process, context, time, and person. The concept of ecological transitions, however, did not seem to apply. What was apparent from this study was that adolescents with SAD could build resilience by sustaining connection to their social contexts so that they could develop resiliency. In doing so, these adolescents would be better equipped to meet increasing demands from their social environment. Resilience with adolescent SAD, therefore, did not develop through discontinuous, significant ecological transitions, but instead through small, continuous bidirectional interactions between the individual and their social environment.

## Findings of the Study Compared to the Literature

Two principal concepts were explored in the literature review: SAD and resilience. Each concept was associated with one research question. SAD was explored with Research Question 1: From the perspectives of young Canadian adults, what was their lived experience of social anxiety during adolescence? Resilience was explored with Research Question 2: Did adolescents with SAD develop resilience in their social environment, and if so, how? Answers to these research questions are compared to the academic literature on well-being and SAD treatment.

### *SAD*

Participants' lived experience of SAD during adolescence both supported and expanded on existing literature of SAD. Comparisons are made between the current study findings and the literature from the DSM-V, the developmental psychopathology framework, and related studies focusing on adolescent SAD. Most research on adolescent SAD focused on etiology and treatment efficacy as opposed to lived experience. According to the results of the current study, the lived experience of SAD during adolescence primarily involved fear, hypervigilance, lack of knowledge, an emotional toll, missed opportunities, automatic reactions, and challenges in the macro- and microsystems.

**DSM-V**. Current study themes of fear, hypervigilance, automatic reactions, and missed opportunities were congruent with the DSM-V definition of SAD, as were particular challenges with performing in front of people and having conversations (American Psychiatric Association, 2013). Beyond this preexisting definition of SAD, this research added to the understanding of SAD by highlighting the emotional toll of this disorder, the impact of not knowing what SAD is, and additional challenges associated with SAD at the macrosystem level, such as stigma, socioeconomic status, and ethnicity.

**Developmental Psychopathology Framework.** According to the developmental psychopathology framework, individuals have unique experiences with their environments, leading to unique developmental pathways with psychopathologies (Higa-McMillan & Ebesutani, 2011), such as SAD. This framework highlights the interplay of how predisposing, precipitating, and maintaining factors lead to the unique development

of a mental health disorder like SAD (Higa-McMillan & Ebesutani, 2011). Although the focus of the current study was not to explore how SAD develops, the findings from this study supported the developmental psychopathology framework in that this research underscored the unique lived experience of each participant with SAD, arguably resulting from unique pathways of development.

**Related Research.** This research confirmed some conclusions found in related research regarding how SAD and treatments for SAD are experienced by adolescents. Participants in this study shared experiences of negative self-image, as Di Blasi et al. (2015) found in their study. Additionally, participants talked about fears of humiliation and being scrutinized by others, which is similar to what Akacan et al. (2015) found in their study. Any participant who received counseling treatment underwent CBT, as many studies established (Babinski & Nene, 2016; Di Blasi et al., 2015; Hearn et al., 2018; Ollendick et al., 2019), and the mixed reviews of the CBT experience echoed findings from Babinski and Nene (2016) who concluded that CBT for adolescent SAD lacks the same level of efficacy that is present in CBT treatment for other anxiety disorders.

Some findings of the current study, however, were incongruent with related research. Pavlov and Kholmogorova (2017), for example, found correlations between SAD and depression, suicidality, perfectionism, and emotion suppression. Amongst the 10 current participants, only one discussed hospitalization and none mentioned depression or suicidality. Meeus (2016) noted how patterns of adolescent development were impacted by psychopathology, including the increased level of parental control

resulting from adolescent psychopathology. Although some current participants named their family microsystem as a source of challenges with SAD, these experiences were mostly regarding extended family gatherings and parents not understanding; no participants identified parental control as a particular challenge. Another inconsistency between this study and prior research concerned locus of control. Although Ollendick and Grills (2016) identified perceived external locus of control as a contributing factor to adolescent SAD, this finding was not indicated in the current study; five participants attributed their successes to external factors, one to internal factors, and four to a combination of internal and external factors. This study offered more disconfirming than confirming data with regard to related research. One reason for this may be due to differences in research purposes. The purposes of related studies were associated with SAD etiology and treatment efficacy, whereas the current study's purpose was to explore lived experience with SAD and resilience.

### *Resilience*

Developmentally, resilience is the ability to successfully adapt to situations that may impede healthy functioning (Newman & Newman, 2016) by accessing environmental resources and using them in meaningful ways (Ungar, 2011). In the current study, participants accessed environmental resources through their microsystems. This study confirmed most of the academic literature on adolescent resilience, specifically Masten's 10 protective factors, Ungar's social ecological theory of resilience, the dual factor model of mental health, and related research.

**Masten's 10 Protective Factors.** Masten (2001, 2009), as cited in Bosma et al., 2019) identified the 10 protective factors contributing to overall adolescent resilience: intellect, self-regulation, self-efficacy, meaning, attachment to caregivers, attachment to adults, friendships, connections to school, connections to community, and connections to culture. The factors of resilience for the current study were aligned with Masten's protective factors (see Table 11).

**Table 11**

*Alignment Between Masten's Protective Factors and Factors of Resilience*

| Resilience factors in adolescent SAD that lead to success | Masten's protective factors |
|---|---|
| Safety and support | Attachment to caregivers and to adults<br>Friendships |
| Opportunities for belonging | Connections to school, community, and culture<br>Self-efficacy |
| Self-awareness & knowledge | Intellect |
| Skill development | Self-regulation |
| Attitude | Meaning |

What Masten (2014) referred to as protective factors were treated as internal and external resources in the interview questions, and were later identified as personal factors and environmental resources in the data analysis. Regardless of the terminology, the current study supported Masten's research in protective factors for adolescent resilience.

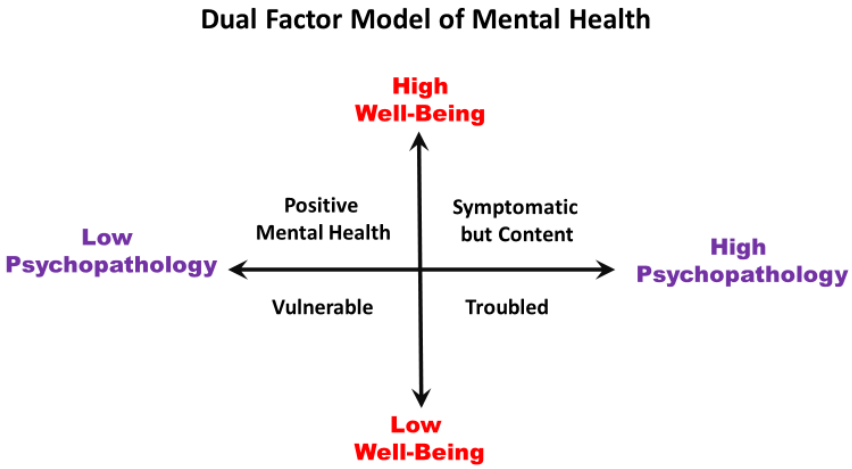
**Social Ecological Theory.** Ungar's (2011) social ecological theory of resilience is based on four principles: resilience is about the interaction between the individual and the environment, the interplay is complex, what is maladaptive in one social context may

be adaptive in another, and resilience is context-specific. This current study supported all four principles of the social ecological theory of resilience. Participants' experiences with resilience and SAD were a consequence of interacting with six microsystems: family, friends, community, school, health services, and the internet. The complexity of these interactions was shown in how each participant's experience with resilience was unique. The idea of maladaptive behaviors was present in participants' avoidant behavior skills that that actually served as forms of resilience. Lastly, resilience was context-specific in this currentstudy, as demonstrated *Table 7: Development of Resilience: Themes,* where each factor of resilience was associated with specific microsystems.

**Dual Factor Model of Mental Health.** There are four ways within the dual factor model of mental health that an individual can experience psychopathology and well-being (Grych et al., 2020). These are: *Positive Mental Health*, where well-being is high and psychopathology is low; *Troubled* is represented by low well-being and high psychopathology; *Vulnerable* exists where both areas are low; and *Symptomatic but Content* occurs with high well-being with symptoms of psychopathology (see Figure 8).

**Figure 8**

*Dual Factor Model of Mental Health*




The *Symptomatic but Content* quadrant is representative of when resilience and SAD co-exist. This is when participants experienced the fear, hypervigilance, lack of knowledge, emotional toll, automatic reactions, missed opportunities, and challenges in the macro- and microsystems, while also enjoying successes in their microsystems due to resilience factors: safety and support, opportunities for belonging, self-awareness and knowledge, skill development, and a determined attitude. The possibility of high well-being despite high psychopathology is suggested in this study in that each participant was able to name at least one success during adolescence despite having SAD. Although participants did not indicate that they were content as adolescents dealing with SAD, they did demonstrate a level of well-being through their successes. This model suggests a distinct division between the two quadrants, and the data from this study implies more fluidity between *Troubled* and *Symptomatic but Content*. This fluidity was indicated in

how participants shared concurrent challenges and successes with SAD in their lived experiences. Data from this currentstudy, therefore, supportedthis model's identification of different levels of well-being with SAD, but the model does not showcase the level of fluctuation between high and low well-being with this mental health disorder that participants expressed in their interviews.

**Related Research.** This study supported a common theme among many studies of resilience, which is the need to individualize research, interventions, and conceptualizations of resilience with particular populations due to their unique qualities. The results of this current study suggested that adolescents with SAD are a distinct population who experience resilience differently than would other sub-populations of adolescents. Successes for participants in this study included making friends, going to school, talking to people, taking public transit, and ordering food. Moreover, factors of resilience were identified as safety and belonging, opportunities for belonging, self-awareness and knowledge, skill development, and attitude. This study was aligned with many others in which researchers noted that factors of resilience were unique to a particular population. For example, Cunningham et al. (2018) found that a factor of resilience for African American adolescents was racial identity; factors of resilience in adolescents in foster care included level of education, and avoidance in pregnancy, substance use, and homelessness (Shpiegel, 2015); and factors that contributed to resiliency among pregnant adolescents were self-efficacy, self-acceptance, and external

supports (Solivan et al., 2015). This study provided additional confirmation that resilience is specific to the population.

**Summary of Interpretation**

The two central concepts explored in this study were SAD and resilience. Theoretically, both of these concepts, and how they related to one another, fit well into Bronfenbrenner's bioecological theory. Context, process, person, and time all helped illustrate how SAD and resilience exist for adolescents in their social environments. Ecological transitions, however, did not align with the results of this study, as the adaptation that adolescents with SAD experience is more subtle and continuous than typical ecological transitions identified in this theory.

This current study confirmed and extended current understanding of SAD provided by the DSM-V. The study also supported the Developmental Psychopathology Framework, in that each adolescent's journey with SAD is distinct and composed of a unique combination of factors. There was a mixture of confirming and disconfirming results when this study was compared with other studies about adolescent SAD. One possible explanation for the high level of disconfirming results was the difference in the purpose of this current study compared to existing literature about SAD.

The results regarding SAD from this current study were predominantly aligned with existing literature about resilience. The study was congruent with Masten's 10 protective factors and Ungar's social ecology theory, and the theme in related research regarding unique populations needing their own research and interventions for resilience.

In terms of the Dual Factor Model of Mental Health, there was agreement between this study and the model's depiction of different levels of well-being, and this model would better represent adolescent SAD if there were more fluidity between *Troubled* and *Symptomatic but Content*.

## Limitations of the Study

Three foreseeable challenges were identified at the inception of this study. The first was the possibility that young adults with SAD would be unwilling to meet face-to-face for an interview. The alternative, which became the only option due to the COVID-19 Pandemic, was to conduct the interview virtually. Being interviewed in any way may have dissuaded some potential participants from this study, suggesting that those who did participate may be managing their SAD more effectively than others who chose not to participate. The second challenge was potential recall difficulties of participants. The only interview question that participants seemed to struggle with was when I asked them how they explained their accomplishments; this was not a recall question, and therefore recall did not appear to be a limitation of this study. Lastly, I recognized a possible ethical challenge with dual relationships and recruiting from the university in which I taught. I did not recruit from my department and I did recruit from over 10 other departments, and so this posed neither a challenge nor a significant limitation for this study.

I also had an initial concern related to trustworthiness; I wanted to ensure that I recognized and addressed my bias for face-to-face interviews. This was not an issue, as

all interviews were virtual due to the COVID-19 Pandemic and by the time of the interviews, I already had extensive experience in working virtually. The COVID-19 Pandemic afforded me the opportunity to move past this bias of face-to-face being superior to virtual interaction.

Beyond the limitations that I identified before data collection, an additional limitation of this study was in the participant pool. Nine of the 10 participants were undergraduate students and as such, may not have fully represented a full picture of lived experiences of adolescent SAD. These nine participants managed their SAD well enough to be able to attend university and did not necessarily represent those whose SAD management was not as effective.

## Recommendations

The following recommendations for future research were based on the strengths and limitations of this current study and the existing literature related to adolescent SAD and resilience. As I indicated in the literature review, more research about adolescent SAD from a strength-based approach would provide some balance with the existing deficit-model studies. Because of the level of disconfirmation between this study and other studies of adolescent SAD, I recommend more research to further explore the factors of adolescent SAD identified in this study, primarily the emotional toll and lack of knowledge which were additive to the existing literature. Due to the unique nature of adolescent SAD, I also recommend more qualitative research, ideally with participants outside of the university context, so that a broader understanding of lived experience with

SAD can be explored. It would be interesting to replicate this study with young adults who do not attend university, in order to compare lived experience and resilience. Lastly, I recommend expanding this research to include adolescents, both as a way to compare results and to connect with a younger generational cohort whose SAD and resilience developed in a distinct chronosystem.

## Implications

There were three levels of implications of this study. First were implications for positive social change. Second were methodological and theoretical implications. Finally, there were implications for practice.

This current study had clear implications for social change, particularly for adolescents with SAD. Adolescents with SAD are at risk for limited social and emotional development at a stage in their lives, due to the avoidant tendencies associated with SAD (American Psychiatric Association, 2013), when identity development is paramount (Broderick & Blewitt, 2010) If adolescents living with SAD had access to more effective treatment, they could be less impacted by SAD and experience a healthier trajectory of social and emotional development.

Based on this current study, two methodological implications were noteworthy. Qualitative methodology was beneficial to this topic because of the unique way in which adolescents experience SAD; in the data analysis the composite descriptions added less value than did the individual descriptions and this highlighted the importance of individual data. A qualitative approach has the potential to further expand on distinct

lived experiences of this phenomenon, perhaps with different sample populations. Additionally, the results of this current study could be further analyzed using a quantitative approach, perhaps to refine and identify the extent to which factors of resilience impact well-being.

In terms of theory, two implications were important to consider. The main theoretical framework in this study was Bonfenbrenner's bioecological theory. The area of ecological transitions was not congruent with this study, however, the possibility of continuous and subtle transitions that facilitate resilience warrants further reflection as an alternative component of this theory. In this study, I also employed other theories on a smaller scale of application. One of which provides a new implication. In the dual factor model of mental health, there existed movement between *Troubled* and *Symptomatic but Content* and it would be beneficial to better understand the factors involved that regulate this movement.

This study provided a number of implications for practice for mental health practitioners, teachers, parents, and adolescents with SAD. Mental health practitioners would benefit from beginning treatment by asking their young clients how they experience SAD so that treatment can directly target their areas of challenge. Also, by exploring their successes, treatment can be strength-based and empowering as well as address the deficits associated with SAD. If practitioners ask about the emotional toll of SAD, they would be gathering a more holistic picture of their clients' experience and identifying additional areas of intervention, as opposed to focusing only on the primary

issue of SAD. If a practitioner is using CBT, it would be valuable to check in regularly with their clients to ascertain how they are experiencing this approach. In their role, practitioners provide opportunities for self-awareness, knowledge, and skill development as forms of resilience, and ought to be intentional with these opportunities. Lastly, part of any treatment ought to be consistent encouragement to stay engaged in various microsystems as best they can, as they provide worthwhile opportunities to build resiliency.

The implications for teachers cannot be understated. Teachers provide ways for their students to experience belonging and they are in an important position to educate students about SAD. Lack of knowledge was a prominent factor in how participants experienced SAD, as was knowledge a factor in resilience. Many participants noted that they wished that they had known about SAD sooner and within the social context of a classroom, teachers may notice indications of SAD before others in these adolescents' lives. This implication suggests that teachers would benefit from training and professional development related to identifying signs of mental health issues like SAD.

The implications for parents are straightforward. Within the family microsystem, it is often the parents providing safety and support as a factor for resilience. With a foundation of safety and support, adolescents are better equipped to engage more fully in other microsystems. The more parents are informed about mental health disorders like SAD, the better they are able to support their children. This education can come from

schools, community programs, or public health programs; the implication is that these programs are valuable and needed.

The implications for adolescents with SAD came from interview question # 17 in which I asked participants what advice they would give a teenager with SAD. This is how they replied:

- Surround yourself with people you are comfortable with. If you can push yourself with them, you can do it on your own too.
- Remind yourself that most people are worried about themselves, not you. So engage in social activities as much as you can.
- It's going to get better.
- If you can go out, build your confidence by yourself. If you can do that, then you can do other things. And go easy on yourself. You will make it through and you will be stronger than other people who haven't gone through it.
- You meet your real friends after high school. Also, when people offer to hang out with you, take that chance. Taking the chance can make a world of difference.
- Find skills and techniques that help calm you. Reaching out for help can be the hardest part.
- You are not alone. Other teenagers have been through it and they came out on the other side.
- Talk about it. Tell your friends so they can include you.

- Be patient with yourself. Be kind to yourself.
- You are not alone. When you talk about it, people can understand you better.

One way to aid adolescents in their knowledge about SAD is to circulate a list like this that they can use as a resource.

## Conclusion

SAD is an anxiety disorder characterized by a persistent fear of being judged by others in social situations that typically results in hypervigilance and avoidance of social situations (American Psychiatric Association, 2013). SAD negatively impacts healthy social and emotional development (Alfano & Beidel, 2011). Despite SAD being the third most common anxiety disorder (Mathews, 2017), current treatments for SAD are not yet effectively addressing this disorder (Babinski & Nene, 2016). The purpose of this study was to explore resilience and successes with adolescent SAD as a means of developing more efficacious treatment. Adolescents with SAD experience this mental health disorder differently, depending on their unique circumstances. SAD needs to be treated as a unique experience and not in a generalized manner. Resilience for adolescent SAD can be found is six microsystems, indicating that engagement with these social contexts is vital for these adolescents. From these microsystems, these adolescents benefit from safety and support, opportunities for belonging, self-awareness and knowledge, skill development, a determined attitude, and successes in their environments, which inspire further social engagement. Each microsystem has a role to play, and the more these adolescents stay engaged in these social environments, the less they are negatively

impacted by the challenges associated with SAD and the healthier their social and emotional development will be.

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# Appendix A: Recruiting Materials

## Invitation to Participate Recruiting Poster

The invitation to participate instrument is based on a template provided by Walden University in the *RSCH 8310: Qualitative Reasoning and Analysis* course and adapted for this study.

To be posted in physical and virtual spaces in post-secondary institutions and possibly online in social anxiety supports groups in Facebook, the Social Anxiety Support (SAS) Forum, the Social Anxiety Institute Forum, The Social Anxiety Forum at Mental Health Forums, and the Social Phobia at Psych Forums:

This is an invitation to participate in research regarding adolescent social anxiety disorder. My name is Shelley Skelton. I am a registered psychologist and a PhD student at Walden University. I am conducting a research study for my doctoral dissertation and I am looking for young adults (ages 18-25) who have been diagnosed with social anxiety disorder either during childhood or adolescence. The purpose of this study is to explore the successes and challenges of adolescents while experiencing social anxiety disorder so that helping professionals can provide more effective support for youth who continue to experience social anxiety disorder.

Would you be interested in participating? Participation would include:

- completing an Informed Consent statement that I would provide for you
- providing me with your contact information so that we can set up an interview
- meeting with me face-to-face, or virtually through Zoom, for a 60-90 minute interview
- deciding if you wish to continue in the study by reviewing your interview transcript and providing feedback about how the cumulative interview data is coded

Please let me know if you would like to participate. You can contact me by phone [403-701-8837], e-mail [Shelley.skelton@waldenu.edu] or use the QR code provided if you have any questions.

# Appendix B: Interview Protocol

This protocol is based on the *Interview Guide Worksheet* provided by Walden University, articles used in the *Advanced Qualitative Reasoning and Analysis RSCH 8360* course (Jacob & Furgeson, 2012; Turner, 2010).
Thank you very much for agreeing to join me today and participating in this interview. This interview is about your experience with social anxiety disorder as a teenager and how you experienced challenges and successes. I work as both a counseling psychologist and an educator, and I am doing this research in the hopes of finding new or better ways for health professionals to support youth who live with social anxiety.

Before we begin, I would like to review the informed consent with you.
What other questions do you have about this process?
Is there anything that I can do to make you more comfortable before we begin?

Please know that I am audio-recording this interview on my mobile phone with an attached microphone. I will also be taking notes throughout the interview. I have 17 interview questions; I may not need all of them if you have already answered a question in a different answer. Please know that you can give as little or as much information as you like for each question.
Interview questions:
I am going to start with some basic demographic questions that will help me organize my data.

1. When you were a teenager, in what city or town(s) did you live?
   (*If I am not familiar with the city/town, I ask question 2*)
2. Would you consider that urban or rural?
3. How old are you?
4. How old were you when you were formally diagnosed with social anxiety?
5. If you are comfortable sharing, what gender do you identify with?
   *Now I am going to move into some broader questions and they are all about when you were a teenager from approximately 13-18 years old*.
6. In your own words, what was it like having social anxiety as a teenager?
   (*Depending on how much information was provided with this answer, I will fill in the gaps with the following questions*)
7. What challenges did you experience with social anxiety?
   (*Possible prompts include: in school, at home, with friends …)*
8. Tell me about times when social anxiety didn't get in the way for you.
9. How do you explain that you were able to _____?
   *The next two questions include a short definition*.
10. External resources can be people, organizations, places, websites, and so on. What external resources made a difference for you and your social anxiety?
11. How did these external resources make a difference?

12. Internal resources are things like skills, talents, attitude, and other personality characteristics. What internal resources made a difference for you when dealing with your social anxiety?
13. How did you develop these internal resources?
14. I am aware that treatment for social anxiety often includes counseling and medication. Did you receive any treatment? If so, what was your experience?
15. Looking back, what else may have made a difference for you with your experience with social anxiety?
16. What else would you like to tell me about your experience with social anxiety that I did not ask?
17. What advice would you give a teenager who was living with social anxiety?

We have reached the end of my questions.

Additional probing questions that may be used include:

Can you tell me more about that?

Can you give me a specific example of that?

Debrief:

Thank you for answering my questions and sharing your experiences with me. As you know, I have taken notes during this interview and have made an audio-recording. My next step is to transcribe this interview, consult my notes, and create a printed version of this interview. When I collect all of the data from all of my interviews, I code the information, looking for themes to use as categories. When I reach that stage, are you interested in receiving an executive summary of my results?

*If no,*

Thank you again for your time. Should you have any additional questions or thoughts about this process, my contact information is on the consent form.

*If yes,*

Certainly, I will send you a copy of the summary using the email address that you have shared with me.

## Appendix C: Activity Checklist for Close Reading of Interview Protocol

Read questions aloud and mark yes or no for each item depending on whether you see that item present in the interview protocol. Provide feedback in the last column for items that can be improved.

| Aspects of an Interview Protocol | Yes | No | Feedback for Improvement |
|---|---|---|---|
| Interview Protocol Structure | | | |
| Beginning questions are factual in nature | | | |
| Key questions are majority of the questions and are placed between beginning and ending questions | | | |
| Questions at the end of interview protocol are reflective and provide participant an opportunity to share closing comments | | | |
| A brief script throughout the interview protocol provides smooth transitions between topic areas | | | |
| Interviewer closes with expressed gratitude and any intents to stay connected or follow up | | | |
| Overall, interview is organized to promote conversational flow | | | |
| Writing of Interview Questions & Statements | | | |
| Questions/statements are free from spelling errors | | | |
| Only one question is asked at a time | | | |
| Most questions ask participants to describe experiences and feelings | | | |
| Questions are mostly open-ended | | | |
| Questions are written in non-judgmental manner | | | |
| Length of Interview Protocol | | | |
| All questions are needed | | | |
| Questions/statements are concise | | | |
| Comprehension | | | |
| Questions/statements are devoid of academic language | | | |
| Questions/statements are easy to understand | | | |

Note. This checklist was reprinted from: Castillo-Montoya, M. (2016). Preparing for interview research: The interview protocol refinement framework. *The Qualitative Report*, *21*(5), p. 825.

# Appendix D: Alignment of Research and Interview Questions Matrix

| Interview Questions | | RQ1 | RQ2 |
|---|---|---|---|
| | Demographic Questions | From the perspectives of young Canadian adults, what was their lived experience of social anxiety disorder during adolescence? | How do adolescents with SAD develop resilience in their social environment? |
| Where did you live as a teenager? | x | | |
| Would you consider that urban or rural? | x | | |
| How old are you? | x | | |
| How old were you when you were diagnosed with social anxiety disorder? | x | | |
| What gender do you identify with? | x | | |
| In your own words, can you tell me what it was like having social anxiety disorder as a teenager? | | x | |
| What particular successes did you experience? | | x | |
| How do you explain your success? | | | x |
| What particular challenges did you experience? | | x | |
| External resources can be people, organizations, places, websites, etc. What external resources made a difference for you and your social anxiety disorder when you were a teenager? | | x | |
| How did they make a difference? | | | x |
| Internal resources are things like attitude, self-concept, personality characteristics, etc. What internal resources made a difference for you and your social anxiety disorder when you were a teenager? | | | x |
| How did you acquire these resources? | | | x |
| Treatments for social anxiety disorder include counseling and medication. Did you receive any treatment for social anxiety disorder? | | x | |
| Looking back, what else may have made a difference for you as a teenager with your social anxiety disorder? | | | x |
| What else would you like to tell me about your experience with social anxiety disorder as a teenager that I did not ask? | | x | |

Appendix E: Letter of Request to Postsecondary Institutions

date

To: Campus Administration

Name of Post-Secondary Institution

I am writing this letter to request your authorization to recruit participants from your student body for my doctoral research study beginning in September 2020. I am making this request to four post-secondary institutes in Calgary.

My name is Shelley Skelton and I am a PhD student in Developmental Psychology at Walden University. I am also a sessional instructor at Mount Royal University and St. Mary's University.

I am conducting a qualitative study regarding adolescent social anxiety disorder and the role of resilience and am seeking 12 young adults (18-25years) who were diagnosed with social anxiety disorder before adulthood so that I can interview them about their successes and challenges with this form of anxiety. I am happy to provide a copy of my prospectus upon request.

I request your authorization for the following:

- Post my recruitment poster in your institute's online communication platform,
- If students have returned to campus and COVID-19 restrictions have been lifted
- Publicize my recruitment poster in your physical student common areas
- Reserve private spaces in your institute's library facility to conduct 60-90 minute interviews

I invite you to connect with my doctoral supervisor: Dr. Sandra Street at 708-320-8503 or sandra.street@mail.waldenu.edu if you have any questions.
I can be reached at 403-701-8837 or at Shelley.skelton@waldenu.edu.

Thank you very much for your consideration and I look forward to hearing from you,

Respectfully,

Shelley Skelton, *R. Psych, PhD Student*