



STANDARD PAPER

# A Preliminary Examination of Treatment Barriers, Preferences, and Histories of Women with Symptoms of Social Anxiety Disorder

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## Abstract

Social anxiety disorder (SAD) is a common mental health condition that is characterised by a persistent fear of social or performance situations. Despite effective treatments being available, many individuals with SAD do not seek treatment or delay treatment seeking for many years. The aim of the present study was to examine treatment barriers, treatment histories, and cognitive behavioural therapy (CBT) delivery preferences in a sample of women with clinically relevant SAD symptoms. Ninety-nine women ( $M_{\text{age}} = 34.90$ ,  $SD = 11.28$ ) completed the online questionnaires and were included in the study. Participants were recruited from advertisements on community noticeboards and posts on social media. The results demonstrated that less than 5% of those who received psychological treatment in the past were likely to have received best-practice CBT. The most commonly cited barriers to accessing treatment for women with SAD related to direct costs (63%) and indirect costs (e.g., transport/childcare) (28%). The most preferred treatment delivery method overall was individual face-to-face treatment (70%). The study demonstrates a need to provide a variety of treatment options in order to enhance access to empirically supported treatment for women with SAD.

**Keywords:** social phobia; social anxiety disorder; treatment barriers; help-seeking

Social anxiety disorder (SAD) is characterised by persistent fear of social or performance situations (American Psychiatric Association, 2013). SAD is common with a 12-month prevalence rate of approximately 7% and a lifetime prevalence rate of 13% (Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012). SAD is associated with high levels of impairment and comorbidity (Ruscio et al., 2008), as well as increased levels of suicidal ideation (Olfson et al., 2000). While SAD is a common and impairing condition generally, the lifetime prevalence of SAD is significantly higher in women (14.2%) compared to men (11.8%) (Kessler et al., 2012), and women demonstrate higher levels of symptom severity when they present for treatment (Asher, Asnaani, & Aderka, 2017). For this reason, it is important to examine SAD specifically in women.

Despite the prevalence of SAD, as well as the pervasive negative consequences of the condition, individuals with SAD often do not seek help for their SAD symptoms (Ormel et al., 2008; Ruscio et al., 2008) or delay seeking treatment for many years after symptom onset (Grant et al., 2005; Thompson, Issakidis, & Hunt, 2008). Barriers identified for individuals with SAD include treatment costs, not knowing where to get help, and therapy wait times (Chartier-Otis, Perreault, & Bélanger, 2010). Additionally, there is some literature to suggest that those living in rural or remote areas have increased difficulty accessing mental health treatment or can have different barriers to accessing

care compared with those in urban settings (Logan, Stevenson, Evans, & Leukefeld, 2004; Smith, Paparo, & Wootton, 2021). For example, Logan *et al.* (2004) found that women in rural areas had more difficulty obtaining an appointment for mental health services than women in urban areas and had more concerns about confidentiality. There is also some research to suggest that barriers to treatment can differ across age groups, genders, and based on previous psychological treatment (McCausland, Paparo, & Wootton, 2021; Pepin, Segal, & Coolidge, 2009; Smith *et al.*, 2021). For example, Smith *et al.* (2021) found that young adults (18–25) with depressive symptoms endorsed barriers such as ‘*I don’t think that a therapist would be able to understand my problems*’ and ‘*I worry about the therapist keeping my problems confidential*’ significantly more than adults aged 25 and over. Similarly, McCausland *et al.* (2021) found that those who previously engaged with psychological treatment were significantly more likely to report no barriers to accessing treatment than individuals who had sought treatment in the past. Although mental health treatment barriers have been studied in the literature, to date no research has investigated the unique barriers that women with SAD may face.

There is now considerable evidence that SAD can be effectively treated with cognitive behavioral therapy (CBT) (Carpenter *et al.*, 2018; Mayo-Wilson *et al.*, 2014). Best-practice CBT for SAD generally involves weekly sessions, cognitive restructuring, graded exposure, and between-session homework tasks (Jørstad-Stein & Heimberg, 2009). Despite the research demonstrating the efficacy of CBT, less than 10% of individuals seeking help for their SAD symptoms receive notionally effective treatment, compared to approximately 60% for affective disorders (Andrews, Issakidis, Sanderson, Corry, & Lapsley, 2004). However, more recently, the focus on evidence-based practice has increased, and as such, the proportion of patients receiving evidence-based treatment may also have increased. Thus, it is important to investigate the treatment provided to individuals with SAD in a contemporary context. Such research may inform future policy and practice, for example, by ensuring that clinicians-in-training receive adequate education on the assessment, diagnosis, and delivery of evidence-based treatment for SAD.

Over the last decade, the use of technology to deliver CBT for mental health conditions has increased, and patients now have multiple options when accessing care. Treatments for SAD can be divided into those that are high intensity and those that are low intensity. High-intensity CBT treatments often require significant clinician time and patient resources. Common high-intensity treatments include traditional individual face-to-face treatment, group-based treatment, accelerated treatments, and internet videoconferencing. Each of these treatment modalities has been demonstrated to be efficacious for SAD in clinical trials (Mayo-Wilson *et al.*, 2014; Wootton *et al.*, 2018; Yuen *et al.*, 2013). Low-intensity treatments require much less clinician time and are a more efficient way of delivering treatment. Common low-intensity treatments include internet-delivered CBT (ICBT) and bibliotherapy-delivered CBT (BCBT). Low-intensity interventions have also been demonstrated to be efficacious in clinical trials for SAD (Andersson, Cuijpers, Carlbring, Riper, & Hedman, 2014; Furmark *et al.*, 2009).

Despite the availability of a variety of treatment approaches for SAD, there has been limited research examining the acceptability of these various approaches. In internet-treatment samples, the acceptability of ICBT is high (Titov *et al.*, 2010, 2009). However, in samples who are seeking treatment in a face-to-face clinic, patients prefer face-to-face treatment (Berle *et al.*, 2015). Several other studies have also found that low-intensity mental health treatment services were perceived as less acceptable than traditional face-to-face interventions (McCausland *et al.*, 2021; Robertson, Paparo, & Wootton, 2020; Smith *et al.*, 2021). Some researchers have also found differences in CBT treatment preferences based on age and geographical location (McCausland *et al.*, 2021; Smith *et al.*, 2021). For example, Smith *et al.* (2021) found that younger adults are significantly less likely to access internet videoconferencing-based CBT (VCBT) compared with adults aged 25 and above, and McCausland *et al.* (2021) found that individuals in rural locations were more likely to access internet videoconferencing-based CBT than individuals in urban locations. However, to date, the CBT treatment delivery preferences of those with SAD specifically have not been examined. It is possible that those with SAD may prefer non-face-to-face interventions, given the inherent avoidance associated

with the condition (American Psychiatric Association, 2013). An improved understanding of treatment delivery preferences in this population would enable the development and promotion of interventions that are most likely to attract and retain individuals with SAD symptoms in treatment.

Overall, the literature has identified clear barriers to evidence-based treatment for individuals with SAD, yet to date no studies have investigated the unique barriers that women face. Previous studies have demonstrated that less than one in 10 individuals with SAD receive best-practice treatment; however, these data are now outdated and may underestimate the proportion of individuals receiving evidence-based care. Furthermore, while evidence supports the efficacy of a variety of CBT approaches for SAD, little research has investigated treatment preferences for women with SAD. Given these limitations of the existing literature, the current study aims to examine: (1) reported barriers to treatment; (2) treatment histories; and (3) treatment preferences in a sample of women with clinically relevant SAD symptoms. The study was designed as exploratory with no *a priori* hypotheses. Given the literature highlighting potential differences in barriers based on age and geographical location (Logan et al., 2004; McCausland et al., 2021; Pepin et al., 2009; Smith et al., 2021), we examined group differences based on age, geographical location, and previous treatment experiences. Similarly, given the literature highlighting different levels of acceptability for the various CBT delivery methodologies (McCausland et al., 2021; Robertson et al., 2020; Smith et al., 2021), we wished to further examine whether there are any differences in acceptability based on age and geographical location.

## Method

### Participants

Ninety-nine women ( $M_{\text{age}} = 34.90$ ,  $SD = 11.28$ ) were included in the study. Participant characteristics are outlined in Table 1. To be included in the study, participants were required to (1) identify as female and be at least 18 years of age; (2) be located in Australia; (3) be able to read English; (4) score equal to or greater than seven on the short form of the Social Interaction Anxiety Scale (SIAS-6) (Peters, Sunderland, Andrews, Rapee, & Mattick, 2012) and equal to or greater than two on the short form of the Social Phobia Scale (SPS-6) (Peters et al., 2012); and (5) complete at least one of the study questionnaires in addition to the demographic information sheet. There were no other exclusion criteria and comorbidity data are not available.

### Measures

#### *Social Interaction Anxiety Scale and Social Phobia Scale – Short Form (SIAS-6 and SPS-6)*

The SIAS and SPS are a companion set of measures designed to assess two similar yet distinct aspects of SAD: scrutiny fears and more generalised social interaction anxieties (Mattick & Clarke, 1998; Peters et al., 2012). The short forms are self-report measures, each comprised of six items. The items are rated on a 5-point Likert scale ranging from 0 (*not at all characteristic or true of me*) to 4 (*completely characteristic or true of me*). The optimum cut-off scores for discriminating between those with and without a diagnosis of SAD are 7 or higher on the SIAS-6 and 2 or higher on the SPS-6 (Peters et al., 2012). The short forms have demonstrated sound psychometric properties displaying adequate to good internal consistency ( $\alpha = .75-.85$ ), convergent and discriminant validity, diagnostic discrimination, and treatment sensitivity in previous studies (Le Blanc et al., 2014; Peters et al., 2012).

#### *Treatment Barriers Questionnaire*

The Treatment Barriers Questionnaire (TBQ) was used to assess barriers to treatment. The measure was developed for this study and was based on similar measures used in the literature (Langley, Wootton, & Grieve, 2018; McCausland et al., 2021; Robertson et al., 2020). Participants were asked to indicate factors likely to impede future psychological help-seeking by selecting applicable factors from a list of 22 response options, e.g., *'I think I can/should work out my own problems rather than talking to a psychologist'* and *'I would not be able to afford treatment'*.

**Table 1.** Demographic Characteristics and Outcome Measures (*N* = 99)

Category	<i>n</i>	%	<i>M</i>	<i>SD</i>
Age	–	–	34.90	11.28
<i>Young adult (aged 18–25)</i>	26	26.3	–	–
<i>Older adult (aged 26 and above)</i>	73	73.7	–	–
Location <sup>a</sup>				
<i>Major city/urban</i>	71	71.7	–	–
<i>Regional/remote</i>	28	28.3	–	–
State of residence				
<i>New South Wales</i>	41	41.4	–	–
<i>Queensland</i>	20	20.2	–	–
<i>Victoria</i>	16	16.2	–	–
<i>South Australia</i>	10	10.1	–	–
<i>Australian Capital Territory</i>	6	6.1	–	–
<i>Western Australia</i>	4	4.0	–	–
<i>Tasmania</i>	2	2.0	–	–
<i>Northern Territory</i>	0	0	–	–
Education				
<i>High school</i>	27	27.3	–	–
<i>Trade/diploma</i>	33	33.3	–	–
<i>University degree</i>	39	39.4	–	–
Language other than English (% yes)	9	9.1	–	–
Aboriginal and/or Torres Strait Islander (% yes)	1	1.0	–	–
SIAS-6	–	–	13.89	4.65
SPS-6	–	–	13.71	6.25
Duration of SAD symptoms (years) <sup>b</sup>	–	–	15.60	12.44
Average age of SAD symptom onset (years) <sup>c</sup>	–	–	19.45	10.92
Past psychological treatment (% yes)	66	66.7	–	–

Note. <sup>a</sup>Regional/remote status was calculated by postcode using The Accessibility/ Remoteness Index of Australia (ARIA).

<sup>b</sup>*n* = 87.

<sup>c</sup>*n* = 96.

### *Treatment History Questionnaire*

The Treatment History Questionnaire (THQ) is a 9-item scale developed specifically for this study to ascertain the past experience with various SAD treatments and was based on the previously published literature (McCausland *et al.*, 2021; Robertson *et al.*, 2020; Stobie, Taylor, Quigley, Ewing, & Salkovskis, 2007). Example items include ‘*Who did you first approach for professional help for your social anxiety symptoms?*’ and ‘*Which of the following types of professional help have you ever received for your social anxiety symptoms?*’ Only those who indicated previously engaging in psychological treatment for SAD completed the THQ.

### *Treatment Preferences Questionnaire*

The Treatment Preferences Questionnaire (TPQ) assessed CBT treatment delivery preferences. The TPQ has been used in previous similar research (McCausland *et al.*, 2021; Robertson *et al.*, 2020;

Smith et al., 2021). The 8-item questionnaire asked participants to firstly indicate their preference between various types of CBT treatment approaches for SAD including high-intensity (i.e., individual face-to-face, group-based treatment, accelerated treatment, and internet videoconferencing) and low-intensity options (i.e., ICBT and BCBT). Participants were also asked to indicate how likely they would be to use each of the treatment approaches on a scale of 0 (not at all likely) to 100 (extremely likely).

### Procedure

Ethical approval was provided by the University of Technology Sydney Human Research Ethics Committee. The measures were administered online using REDCap electronic data capture tools hosted at the University of Technology Sydney (Harris et al., 2019, 2009) and were accessible via a link provided in the hardcopy/online advertisements. Participants were recruited from advertisements on community noticeboards and posts on social media between March and August 2019.

### Data Analysis

Treatment barriers, histories, and preferences were analysed using descriptive statistics. Group differences were examined using Pearson's chi-square test of contingencies and independent samples *t*-tests. When examining group differences based on age, young adult participants were categorised as those aged 18–25 and adult participants were those aged 26 and above. For chi-square analyses, effect-size estimates were calculated using  $\phi$  where values of .1, .3, and .5 were interpreted as small, medium, and large, respectively (Cohen, 1992). When expected frequencies were below five, Fisher's exact test was interpreted. Effect sizes for independent samples *t*-tests were estimated using Cohen's *d* and values of .20, .50, and .80 were interpreted as small, medium, and large, respectively (Cohen, 1992). All data were analysed with IBM SPSS Statistics for Windows, Version 27.0.

## Results

### Preliminary Analyses

Table 1 outlines the demographic information and outcomes of each of the measures. Participants were, on average, aged in their mid-30s ( $M = 34.90$ ;  $SD = 11.28$ ) and resided in a major city (71.7%). Participants were located across most of the Australian States/Territories and 1% of the sample identified as an Aboriginal and/or Torres Strait Islander. Participants had experienced social anxiety symptoms for an average of 15.60 years ( $SD = 12.44$ ). The average age of symptom onset was 19.45 years ( $SD = 10.92$ ).

### Treatment Barriers

The mean number of barriers was 3.78 ( $SD = 2.84$ ) and endorsed barriers are outlined in Table 2. Chi-square tests indicated that younger women were more likely (9/26; 34.6%) than older women (4/73; 5.5%) to endorse a fear of criticism [ $\chi^2(1, N = 99) = 14.27, p < .001; \phi = .38$ , medium effect]. Younger women were also more likely (9/26; 34.6%) than older women (10/73; 13.7%) to think that their symptoms were just part of who they were [ $\chi^2(1, N = 99) = 5.41, p = .02; \phi = .23$ , small effect].

Women living in regional/remote areas were more likely (7/28; 25%) than women in urban areas (5/71; 7.0%) to think that a therapist would not be able to understand their problems [ $\chi^2(1, N = 99) = 6.08, p = .01; \phi = .25$ , small effect]. Women living in regional/remote areas were also more likely (5/28; 17.9%) than women in urban areas (3/71; 4.2%) to report not having treatment options in their area [ $\chi^2(1, N = 99) = 5.02, p = .03; \phi = .23$ , small effect].

Women who had previously received psychological treatment were less likely (3/66; 4.4%) than women who were treatment-naïve (9/33; 27.3%) to endorse that their symptoms did not constitute

**Table 2.** Treatment Barriers ( $N = 99$ )

	<i>n</i>	%
I would not be able to afford treatment	63	63.6
I would not be able to afford the associated costs of treatment (e.g., transport, child care, etc.)	28	28.3
I think I can/should work out my own problems rather than talking to a psychologist	25	25.3
I have consulted a psychologist in the past and it wasn't helpful	25	25.3
A therapist might make me do things in therapy that I do not want to (such as confronting my fears)	23	23.2
I can't take time off work for treatment	23	23.2
I would not have time to see a psychologist for treatment	22	22.2
I feel too embarrassed or ashamed to seek treatment	20	20.2
I think my symptoms are just part of who I am rather than a mental health condition	19	19.2
I think therapy would be too confronting for me	15	15.2
I fear that I would be judged by my therapist	15	15.2
I fear that I would be criticised by others for seeking help from a psychologist	13	13.1
I don't think my symptoms constitute a mental health condition that requires treatment	12	12.1
I don't think that a therapist would be able to understand my problems	12	12.1
I do not think treatment with a psychologist would help me	12	12.1
If I see a professional, I might find out I am crazy	10	10.1
I am not comfortable discussing my problems or confiding in a stranger	10	10.1
I worry about the therapist keeping my problems confidential	8	8.1
There are no available treatment options or services in my local area	8	8.1
I prefer to seek help from family or friends rather than a psychologist	5	5.1
None of these	8	8.1
Other	6	6.1

a mental health condition requiring treatment [ $\chi^2(1, N = 99) = 10.67, p = .001; \phi = .33$ , medium effect]. Women who had previously received psychological treatment (21/66; 31.8%) were also more likely than women who were treatment-naïve (4/33; 12.1%) to endorse that past treatment had not been helpful [ $\chi^2(1, N = 99) = 4.52, p = .03; \phi = .21$ , small effect].

### Treatment History

Sixty-six participants (66/99; 66.7%) indicated that they had previously sought help from a health professional regarding their SAD symptoms and provided details. The professionals consulted are outlined in Table 3, and the types of treatments received are outlined in Table 4. Most participants (42/66; 63.6%) initially sought help from a general practitioner, followed by a counsellor (10/66; 15.2%) and a psychologist (10/66; 15.2%). Participants reported that on average, they had previously consulted 6.34 ( $SD = 6.47$ ) health professionals for their SAD symptoms. Medication was the most commonly reported type of help received when treatment was first sought (19/66; 28.8%), followed by supportive counselling (18/66; 27.3%) and CBT (13/66; 19.7%). Of those who stated they had ever received CBT ( $n = 46$ ), 28 (60.9%) reported focusing on the SAD symptoms for the majority of the session, 19 (41.3%) reported completing exposure tasks, 14 (30.4%) reported having at least weekly sessions, and 35 (76.1%) reported being given tasks to complete between sessions. Two of the 46 participants (4.3%) received all the above and thus likely received best-practice CBT.

**Table 3.** Professionals Accessed for Treatment ( $N = 66$ )

	First professional		Professionals ever seen	
	<i>n</i>	%	<i>n</i>	%
General practitioner	42	63.6	59	89.4
Counsellor	10	15.2	40	60.6
Psychologist	10	15.2	64	97
Psychiatrist	2	2.0	32	48.5
Other	2	2.0	10	15.2

Note. For professionals ever seen, respondents could select more than one option; therefore, percentages do not equal 100.

### Treatment Delivery Preference

Treatment delivery preferences are outlined in Table 5. The most preferred treatment delivery method overall was individual face-to-face treatment (67/96; 69.8%). The most commonly endorsed remote treatment was low-intensity treatment options, such as ICBT or BCBT (12/96; 12.5%), rather than high-intensity remote treatment, such as VCBT (4/99; 4.2%). Those who had previously received psychological treatment from a mental health professional reported a preference for individual face-to-face treatment ( $M = 76.69$ ,  $SD = 19.05$ ) more often than those who had not ( $M = 62.47$ ,  $SD = 22.79$ ) [ $t_{(94)} = -3.25$ ,  $p < .01$ ,  $d = .72$ , medium effect]. There were no significant differences in treatment delivery preferences according to age or geographical location.

### Discussion

The aim of the current study was to examine barriers to treatment, treatment histories, and treatment preferences in a sample of women with clinically relevant SAD symptoms. Consistent with existing research on SAD (Chartier-Otis et al., 2010), as well as other mental health conditions (Langley et al., 2018; McCausland et al., 2021; Smith et al., 2021; Spence et al., 2011), the most frequently endorsed barrier to treatment was cost: *'I would not be able to afford treatment'*, with more than half the sample endorsing this barrier. Thus, despite the widespread availability of effective treatments, many women with SAD symptoms are not able to afford treatment.

We identified some group differences in treatment barriers which were of moderate size. Firstly, the results indicated that younger adults (aged 18–25) were more likely than older adults (aged over 25) to endorse fear of criticism as a barrier to accessing treatment. This finding is consistent with the existing

**Table 4.** Type of Treatment Received ( $N = 66$ )

	Treatment first received		Ever received	
	<i>n</i>	%	<i>n</i>	%
Medication	19	28.8	53	80.3
Supportive counselling	18	27.3	51	77.3
Cognitive behaviour therapy	13	19.7	46	69.7
Relaxation	5	7.6	51	77.3
Mindfulness	2	3.0	41	62.1
Not sure	4	6.1	1	1.5
Other	5	7.6	8	12.1



**Table 5.** Treatment Preferences ( $N=96$ )

	Preference		<i>M</i> likelihood	<i>SD</i>
	<i>n</i>	%		
Standard treatments				
<i>Individual treatment</i>	67	69.8	71.95	20.67
<i>Group treatment</i>	5	5.2	29.40	28.51
<i>Accelerated treatment</i>	8	8.3	39.73	28.28
Remote treatments				
<i>Low-intensity remote (i.e., ICBT or BCBT)</i>	12	12.5	48.54	29.14
<i>High-intensity remote (i.e., internet videoconferencing)</i>	4	4.2	39.30	28.44

literature (Mackenzie, Gekoski, & Knox, 2006; Mackenzie, Heath, Vogel, & Chekay, 2019), and highlights the importance of intervention services specifically for adolescents and young adults, which may assist in helping young women to access treatment, as such speciality services may make young women feel more at ease when access treatment. Secondly, we found that women who had previously received psychological treatment were less likely to endorse that their symptoms did not constitute a mental health condition requiring treatment. This finding may indicate that the treatment that participants received helped to normalise symptoms and improve mental health literacy. While other group differences emerged, the effects were small in size and require replication.

Despite CBT being an effective treatment for SAD (Carpenter *et al.*, 2018; Mayo-Wilson *et al.*, 2014), that is recommended as a first-line intervention (National Institute for Health and Care Excellence, 2013), our results found that only 4% of our sample received a likely best-practice intervention when they sought help from a health practitioner. This finding is consistent with the findings of earlier research (Andrews *et al.*, 2004; Chapdelaine, Carrier, Fournier, Duhoux, & Roberge, 2018) that demonstrates many patients with SAD do not receive adequate treatment and highlights the potential of therapist drift (Waller, 2009; Waller & Turner, 2016) as being a major issue in the community. Much research demonstrates that exposure-based interventions are generally under-utilized in the treatment of anxiety disorders (Hipol & Deacon, 2013), and it is important that clinical psychologists are adequately trained and supervised in the delivery of evidence-based interventions for SAD in the future.

Despite the efficacy (Andersson *et al.*, 2014; Furmark *et al.*, 2009) and widespread availability of remote treatment for SAD (Titov *et al.*, 2015, 2017), the majority of women in the current sample indicated that traditional face-to-face treatment was their preferred method of treatment delivery. This finding is consistent with previous studies that have highlighted that patients prefer face-to-face treatment over remotely delivered treatments (Berle *et al.*, 2015; McCausland *et al.*, 2021; Robertson *et al.*, 2020; Smith *et al.*, 2021). Furthermore, our analysis of group differences in treatment preferences indicated that those participants who had previously received psychological treatment from a mental health professional preferred individual face-to-face treatment more often than those who had not. While this is not surprising, given the participant was familiar with that treatment methodology, it is possible that consumers lack awareness of the availability and efficacy of remote treatments. Thus, enhancing knowledge of these low-intensity treatment options, possibly as part of stepped-care approaches, is an important area for future research.

While the current study provides a preliminary understanding of treatment barriers, treatment preferences, and treatment histories of women with SAD symptoms, it is important to highlight some limitations of the present study. Firstly, the use of a cross-sectional design only offered information at a single time point. Future studies may wish to utilise a longitudinal, prospective design in order



to allow inferences to be generated. Secondly, the study comprised self-report measures only, which can be susceptible to bias. Future research may wish to replicate the findings using a sample of individuals who have been assigned a diagnosis of SAD based on a diagnostic interview and may also wish to interview participants about their treatment histories and preferences in order to ensure that participants fully considered the questions being asked of them and were able to ask clarification questions as needed. Thirdly, while all participants demonstrated clinically relevant symptoms of SAD, it is unknown if SAD was the primary mental health disorder for each participant and future research may wish to replicate the study in a sample of participants with SAD as their primary mental health condition. Fourthly, it is unknown if participants were currently in treatment or wanting treatment for their SAD symptoms. Future research may examine and control for concurrent treatment. Finally, limited demographic information was elicited from participants, and other demographic details such as employment status, ethnicity, and relationship status may influence the results of this study if they were controlled for.

### **Implications for Practice and/or Policy**

The results of the present study have a number of important considerations for practice and policy. Firstly, the results of the study demonstrate that many women with SAD symptoms are unable to access effective treatment because of cost. Thus, it is important for governments to provide low-cost treatment options for women suffering from anxiety disorders, including SAD. Such options may include low-intensity services such as ICBT or BCBT, especially for women who are treatment-naïve. Secondly, many women are not being provided with evidence-based treatment when they do access care. As such it may be important for regulatory bodies to routinely assess their members' understanding of, and commitment to, evidence-based practice when working with common mental health conditions.

### **Conclusions**

The current study demonstrates that women experience a number of barriers to accessing treatment for SAD symptoms. Additionally, the study demonstrates that when women do seek treatment, they are often provided with pharmacological interventions or non-evidenced-based psychological treatments. Participants in this study highlighted a preference for face-to-face treatment, although indicated they would likely try a low-intensity intervention such as ICBT. Given SAD is a common and disabling mental health condition, it is important that (1) future government policy addresses barriers to care; (2) measures are put in place to ensure that clinicians-in-training are trained in best-practice assessment and treatment of SAD symptoms; and (3) that a number of efficient and effective treatment options are available to women with SAD symptoms.

### **Availability of Data and Material**

De-identified data will be made available to other researchers upon reasonable request pending ethical approval.

### **Authors' Contributions**

B.W. developed the research idea. Material preparation and data collection and analysis were performed by B.W., J.B., and J.P. The first draft of the manuscript was written by J.B. and B.W., and J.P. commented on previous versions of the manuscript. All authors read and approved the final manuscript.

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**Ethics Approval.** The methodology for this study was approved by the University of Technology Sydney Human Research Ethics Committee (Ethics approval number: ETH18-2759).

**Code Availability.** Code will be made available to other researchers upon reasonable request.

## References

- American Psychiatric Association** (2013). *Diagnostic and statistical manual of mental disorders* (5th ed. Arlington, VA: American Psychiatric Association).
- Andersson G, Cuijpers P, Carlbring P, Riper H and Hedman E** (2014). Guided internet-based vs. Face-to-face cognitive behavior therapy for psychiatric and somatic disorders: A systematic review and meta-analysis. *World Psychiatry*, **13**, 288–295. doi:10.1002/wps.20151.
- Andrews G, Issakidis C, Sanderson K, Corry J and Lapsley H** (2004). Utilising survey data to inform public policy: Comparison of the cost-effectiveness of treatment of ten mental disorders. *British Journal of Psychiatry*, **184**, 526–533. doi:10.1192/bjp.184.6.526.
- Asher M, Asnaani A and Aderka IM** (2017). Gender differences in social anxiety disorder: A review. *Clinical Psychology Review*, **56**, 1–12. doi:10.1016/j.cpr.2017.05.004.
- Berle D, Starcevic V, Milicevic D, Hannan A, Dale E, Brakoulias V and Viswasam K** (2015). Do patients prefer face-to-face or internet-based therapy? *Psychotherapy and Psychosomatics*, **84**, 61–62. doi:10.1159/000367944.
- Carpenter JK, Andrews LA, Witcraft SM, Powers MB, Smits JAJ and Hofmann SG** (2018). Cognitive behavioral therapy for anxiety and related disorders: A meta-analysis of randomized placebo-controlled trials. *Depression and Anxiety*. doi:10.1002/da.22728.
- Chapdelaine A, Carrier JD, Fournier L, Duhoux A and Roberge P** (2018). Treatment adequacy for social anxiety disorder in primary care patients. *PLoS One*, **13**, e0206357. doi:10.1371/journal.pone.0206357.
- Chartier-Otis M, Perreault M and Bélanger C** (2010). Determinants of barriers to treatment for anxiety disorders. *Psychiatric Quarterly*, **81**, 127–138. doi:10.1007/s11126-010-9123-5.
- Cohen J** (1992). A power primer. *Psychological Bulletin*, **112**, 155–159. doi:10.1037/0033-2909.112.1.155.
- Furmark T, Carlbring P, Hedman E, Sonnenstein A, Clevberger P, Bohman B, ..., Andersson G** (2009). Guided and unguided self-help for social anxiety disorder: Randomised controlled trial. *British Journal of Psychiatry*, **195**, 440–447.
- Grant BF, Hasin DS, Blanco C, Stinson FS, Chou SP, Goldstein RB, ..., Huang B** (2005). The epidemiology of social anxiety disorder in the United States: Results from the National Epidemiologic Survey on alcohol and related conditions. *Journal of Clinical Psychiatry*, **66**, 1351–1361.
- Harris PA, Taylor R, Minor BL, Elliott V, Fernandez M, O’Neal L, ..., Duda SN** (2019). The REDCap consortium: Building an international community of software platform partners. *Journal of Biomedical Informatics*, **95**, 103208. doi:10.1016/j.jbi.2019.103208.
- Harris PA, Taylor R, Thielke R, Payne J, Gonzalez N and Conde JG** (2009). Research electronic data capture (REDCap): A metadata-driven methodology and workflow process for providing translational research informatics support. *Journal of Biomedical Informatics*, **42**, 377–381. doi:10.1016/j.jbi.2008.08.010.
- Hipol LJ and Deacon BJ** (2013). Dissemination of evidence-based practices for anxiety disorders in Wyoming: A survey of practicing psychotherapists. *Behavior Modification*, **37**, 170–188. doi:10.1177/0145445512458794.
- Jorstad-Stein EC and Heimberg RG** (2009). Social phobia: An update on treatment. *Psychiatric Clinics of North America*, **32**, 641–663. doi:10.1016/j.psc.2009.05.003.
- Kessler RC, Petukhova M, Sampson NA, Zaslavsky AM and Wittchen HU** (2012). Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States. *International Journal of Methods in Psychiatric Research*, **21**, 169–184. doi:10.1002/mpr.1359.
- Langley EL, Wootton BM and Grieve R** (2018). The utility of the health belief model variables in predicting help-seeking intention for anxiety disorders. *Australian Psychologist*, **53**, 291–301. doi:10.1111/ap.12334.
- Le Blanc AL, Bruce LC, Heimberg RG, Hope DA, Blanco C, Schneier FR and Liebowitz MR** (2014). Evaluation of the psychometric properties of two short forms of the Social Interaction Anxiety Scale and the Social Phobia Scale. *Assessment*, **21**, 312–323. doi:10.1177/1073191114521279.
- Logan TK, Stevenson E, Evans L and Leukefeld C** (2004). Rural and urban women’s perceptions of barriers to health, mental health, and criminal justice services: Implications for victim services. *Violence and Victims*, **19**, 37–62. doi:10.1891/vivi.19.1.37.33234.
- Mackenzie CS, Gekoski WL and Knox VJ** (2006). Age, gender, and the underutilization of mental health services: The influence of help-seeking attitudes. *Aging and Mental Health*, **10**, 574–582. doi:10.1080/13607860600641200.
- Mackenzie CS, Heath PJ, Vogel DL and Chekay R** (2019). Age differences in public stigma, self-stigma, and attitudes toward seeking help: A moderated mediation model. *Journal of Clinical Psychology*, **75**, 2259–2272. doi:10.1002/jclp.22845.
- Mattick RP and Clarke JC** (1998). Development and validation of measures of social phobia scrutiny fear and social interaction anxiety. *Behaviour Research and Therapy*, **36**, 455–470. doi:10.1016/S0005-7967(97)10031-6.

- Mayo-Wilson E, Dias S, Mavranzeouli I, Kew K, Clark DM, Ades AE and Pilling S (2014). Psychological and pharmacological interventions for social anxiety disorder in adults: A systematic review and network meta-analysis. *The Lancet Psychiatry*, **1**, 368–376. doi:10.1016/S2215-0366(14)70329-3.
- McCausland J, Paparo J and Wootton BM (2021). Treatment barriers, preferences and histories of individuals with symptoms of body dysmorphic disorder. *Behavioural and Cognitive Psychotherapy* **49**, 582–595. doi:10.1017/S1352465820000843.
- National Institute for Health and Care Excellence (2013). *Social anxiety disorder: Recognition, assessment and treatment*. London: National Institute for Health and Care Excellence, CG159.
- Olfson M, Guardino M, Struening E, Schneier FR, Hellman F and Klein DF (2000). Barriers to the treatment of social anxiety. *American Journal of Psychiatry*, **157**, 521–527. doi:10.1176/appi.ajp.157.4.521.
- Ormel J, Petukhova M, Chatterji S, Aguilar-Gaxiola S, Alonso J, Angermeyer MC, ..., Kessler RC (2008). Disability and treatment of specific mental and physical disorders across the world. *British Journal of Psychiatry*, **192**, 368–375. doi:10.1192/bjp.bp.107.039107.
- Pepin R, Segal DL and Coolidge FL (2009). Intrinsic and extrinsic barriers to mental health care among community-dwelling younger and older adults. *Aging and Mental Health*, **13**, 769–777. doi:10.1080/13607860902918231.
- Peters L, Sunderland M, Andrews G, Rapee RM and Mattick RP (2012). Development of a short form Social Interaction Anxiety (SIAS) and Social Phobia Scale (SPS) using nonparametric item response theory: The SIAS-6 and the SPS-6. *Psychological Assessment*, **24**, 66–76. doi:10.1037/a0024544.
- Robertson L, Paparo J and Wootton BM (2020). Understanding barriers to treatment and treatment delivery preferences for individuals with symptoms of hoarding disorder: A preliminary study. *Journal of Obsessive-Compulsive and Related Disorders*, **26**, 100560. doi:10.1016/j.jocrd.2020.100560.
- Ruscio AM, Brown TA, Chiu WT, Sareen J, Stein MB and Kessler RC (2008). Social fears and social phobia in the USA: Results from the National Comorbidity Survey Replication. *Psychological Medicine*, **38**, 15–28. doi:10.1017/S0033291707001699.
- Smith S, Paparo J and Wootton BM (2021). Understanding psychological treatment barriers, preferences and histories of individuals with clinically significant depressive symptoms in Australia: A preliminary study. *Clinical Psychologist*. doi:10.1080/13284207.2021.1892453.
- Spence J, Titov N, Solley K, Dear BF, Johnston L, Wootton B, ..., Choi I (2011). Characteristics and treatment preferences of people with symptoms of posttraumatic stress disorder: An internet survey. *PLoS One*, **6**, 7. doi:10.1371/journal.pone.0021864.
- Stobie B, Taylor T, Quigley A, Ewing S and Salkovskis PM (2007). Contents may vary: A pilot study of treatment histories of OCD patients. *Behavioural and Cognitive Psychotherapy*, **35**, 273–282. doi:10.1017/S135246580700358X.
- Thompson A, Issakidis C and Hunt C (2008). Delay to seek treatment for anxiety and mood disorders in an Australian clinical sample. *Behaviour Change*, **25**, 71–84. doi:10.1375/bech.25.2.71.
- Titov N, Andrews G, Schwencke G, Solley K, Johnston L and Robinson E (2009). An RCT comparing effect of two types of support on severity of symptoms for people completing internet-based cognitive behaviour therapy for social phobia. *Australian and New Zealand Journal of Psychiatry*, **43**, 920–926. doi:10.1080/00048670903179228.
- Titov N, Andrews G, Schwencke G, Robinson E, Peters L and Spence J (2010). Randomized controlled trial of internet cognitive behavioural treatment for social phobia with and without motivational enhancement strategies. *Australian and New Zealand Journal of Psychiatry*, **44**, 938–945. doi:10.3109/00048674.2010.493859.
- Titov N, Dear BF, Staples LG, Bennett-Levy J, Klein B, Rapee RM, ..., Nielssen OB (2015). Mindspot clinic: An accessible, efficient, and effective online treatment service for anxiety and depression. *Psychiatric Services*, **66**, 1043–1050. doi:10.1176/appi.ps.201400477.
- Titov N, Dear BF, Staples LG, Bennett-Levy J, Klein B, Rapee RM, ..., Nielssen OB (2017). The first 30 months of the MindSpot Clinic: Evaluation of a national e-mental health service against project objectives. *Australian & New Zealand Journal of Psychiatry*, **51**, 1227–1239. doi:10.1177/0004867416671598.
- Waller G (2009). Evidence-based treatment and therapist drift. *Behaviour Research and Therapy*, **47**, 119–127. doi:10.1016/j.brat.2008.10.018.
- Waller G and Turner H (2016). Therapist drift redux: Why well-meaning clinicians fail to deliver evidence-based therapy, and how to get back on track. *Behaviour Research and Therapy*, **77**, 129–137. doi:10.1016/j.brat.2015.12.005.
- Wootton BM, Hunn A, Moody A, Lusk BR, Ranson VA and Felmingham KL (2018). Accelerated outpatient individual cognitive behavioural therapy for social anxiety disorder: A preliminary pilot study. *Behavioural and Cognitive Psychotherapy*, 1–16. doi:10.1017/S1352465818000267.
- Yuen EK, Herbert JD, Forman EM, Goetter EM, Juarascio AS, Rabin S, ..., Bouchard S (2013). Acceptance based behavior therapy for social anxiety disorder through videoconferencing. *Journal of Anxiety Disorders*, **27**, 389–397. doi:10.1016/j.janxdis.2013.03.002.

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