How Utilizing an Online Holistic Social Media Group Impacts Symptoms and Quality of Life in

Individuals with Anxiety

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Abstract

The continuum between health and illness is a dynamic state influenced by stress. People are complex beings designed with interrelated parts composing a unique whole. Stress's disruption in the homeostatic balance can result in disease states in the body, mind, soul, and relationships. Panic disorder is one of these manifestations. This disorder causes physical and cognitive symptoms which impair quality of life. Although evidence-based treatments exist for panic disorder, barriers are evident for effective dissemination. This phenomenological study explored the experience of six individuals with anxiety disorder in a 30-day holistic, online social media group. Throughout the study, interviews and surveys will be conducted to assess symptom reduction and increased quality of life indicators. The group was conducted according to a BPSS model. Activities were derived from a mindfulness foundation and included exercise (walking), journaling (writing), spiritual mindfulness (worshipping) and relationship (witnessing) in online support of a group setting. It was expected that utilizing a holistic, online social media group would decrease anxiety disorder symptoms and increase the quality of life in these individuals.

Key Words: anxiety, treatment, holistic, online, biopsychosocial, stress

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CHAPTER ONE

Health is a state of vitality that is the quest of humanity, a force between life and death. Everyone lies on a continuum between these two states (Davidson & Strauss, 1995). It is a responsibility of man to have dominion over health states, whereas illness breeds a perception of lack of control. In the United States, the top 10 leading causes of death are all disease states except for unintentional injuries, with heart disease and cancer in the lead (Kochanek et al., 2017). In addition to the body, health also encompasses psychological and social states (Kristen, Ivarsson, Parker, & Ziegert, 2015).

Mental illness is prevalent in the United States. According to National Vital Statistics Reports, suicide accounted for 42,826 deaths, a 24% increase since 1999 (Center for Disease Control [CDC], 2018). Mental illness is a prominent risk factor for suicide (CDC). In addition, serious psychological distress is present in at least 3.3% (reported) of US adults, with a greater amount in the female population (CDC). Females also have the highest treatment for anxiety disorders (National Institute of Mental Health [NIMH], 2018).

In the middle of this continuum, a state of balance exists between health and illness with an interdependency between the two states (Kip & Hutschemaekers, 2018). Life maintains an innate sense of order. The methodical pattern of the night to the day, winter to spring, and summer to fall is evident. In the same way, a human body has an inherent balance and order within it. The body and mind conform to the patterns of the created universe regarding balance. The ebb and flow of physical and mental processes work synergistically for life sustainment and productivity. Problems occur when the homeostatic state is interrupted, resulting in an unbalanced state (Booij et al., 2018).

Since health relies heavily on maintaining homeostasis within the individual, any stressor in this state creates a conflict (Abelson et al., 2007). When this delicate balance is interrupted by internal or external stress, illness may result (Christopher, 2004). Health and illness are influenced by genetic, environmental, and personality factors that are usually not under the direct control of the individual. Stress is a powerful disruption of life balance that may not be controlled (Conway et al., 2016). People can improve their reaction to stress by strengthening their body, mind, soul, and relationships (Novack et al., 2007).

Empirical evidence demonstrated that mental illness was derived in part from acute and chronic stress (Mineka & Oehlberg, 2008). Anxiety was a by-product of the stress response. NIMH statistics relayed that 19.1 % of adults in the United States had some form of anxiety disorder, with females having almost twice the occurrence of males. Of this number, 56% of these individuals had moderate to severe impairment (NIMH, 2018). According to the DSM 5 (American Psychiatric Association, 2013), anxiety disorders included panic, social anxiety, generalized anxiety, unspecified anxiety, obsessive-compulsive disorder, and more. Anxiety manifested with chronic worry, panic attacks, physical symptoms, and feelings of dread and depersonalization. Several hypotheses existed regarding the etiology of anxiety disorders. These related to genetics, neurobiology, and genetic factors. Studies indicated that individuals with certain types of anxiety have a lower tolerance to stressful states (Conway et al., 2016).

Symptoms were particularly frightening with anxiety disorders. An array of bodily sensations, such as tachycardia, hyperventilation, tremulousness, and dizziness co-occurred with cognitive distortions such as catastrophic thinking, chronic worry, and hypochondriasis (Woud et al., 2013). Combining these created an inhibitory lifestyle resulting from a vicious cycle of fear. Patients exhibited anticipatory anxiety and maladaptive behavior changes (Perna & Caldirola,

2017). As a result, quality of life was diminished as occupational and relational infringements occurred (Carpenter et al., 2018). Evidence-based practice showed that cognitive-behavioral therapy and pharmacotherapy were excellent first-line treatment choices (Rufer et al., 2010). A large population of anxiety sufferers remained untreated or partially treated (Al-Asadi et al., 2014).

Despite several empirically based treatments for anxiety, a subset of individuals remained symptomatic with a decreased quality of life (Chen & Tsai, 2016). In addition, these treatments lacked a holistic foundation which left the individual in a subtherapeutic state (Elliott & Richardson, 2014). It was necessary to assimilate the lived experience of that disease state to understand the treatment needs (Elliott & Richardson, 2014).

A phenomenological approach (Moustakas, 1995) was used to explore participants' responses to a biopsychosociospiritual (BPSS) approach to treatment to comprehend the lived experience with anxiety. This qualitative study explored the lived experience of individuals with an anxiety disorder who have reported symptomatology and decreased quality of life. The perspective attained from these individuals offered an in-depth, preliminary understanding of participants' experiences. Study results demonstrated improvements in symptom reduction and increased quality of life through a comprehensive approach to an individual's biological, psychological, social, and spiritual (BPSS) spheres.

The first chapter presented the significance of the problem, inherent barriers, proposed solutions for lingering anxiety symptoms and decreased quality of life. A synopsis of the details of the study was presented. A brief literature review acknowledged discussed gaps, including the purpose statement, research questions and tactics, topic significance, limitations, and a conceptual framework. An introduction to the rest of the chapters was also given.

Summary of the Problem

  Anxiety disorders have required multi-faceted treatment, but modern practice maintained unipolar treatment (Schotte et al., 2006). Traditional biomedical approaches targeted only the body in treatment (Novack et al., 2007). Medication was primarily the focus to control symptoms. Unwanted side effects or fear of taking medicine caused some anxiety sufferers to forego this treatment (Blackwelder et al., 2018). Psychotherapy using cognitive-behavioral approaches had been highly effective in reducing symptoms and the number of anxiety attacks (Carpenter et al., 2018). One barrier with this approach was that many individuals do not seek care (Fleury et al., 2014).

Fragmented Care

  Numerous factors were indicated in producing barriers to the dissemination of effective treatment. Fragmented care inadequately addressed the treatment needs of the whole person (Suchman, 2005). It was the epitome of the traditional medical approach, whereas a biopsychsociospiritual (BPS) approach addresses the total health of an individual (Havelka et al., 2009). If individuals did not seek holistic care, they may not have received maximum treatment, which resulted in unremitted symptoms and a decreased quality of life (Cheetham et al., 2018).

Accessibility

  Another barrier to whole-person treatment was accessibility. Socioeconomic status was unequal, and many did not have adequate access to the simplest health services (Cheetham et al., 2018). Mental health caused an additional burden, with many adults not seeking care at all (Cadigan et al., 2018). A lack of knowledge of where to seek care was also evident (Goldstein et

al., 2006). Anxiety disorders created even more barriers to access to care (Christensen et al., 2014).

Socially, the symptoms affected relationships and lifestyles. Spouses may not have understood what was occurring with their loved ones. Occupations may have been interrupted by absenteeism from work for physical symptoms. An individual could also have suffered spiritually. Although the desire for spirituality to be addressed in therapy was increased, it still could be neglected in the secular world. Questions of one's faith and feelings of worthlessness accompanied this disorder (American Psychiatric Association, 2013).

Lack of Dissemination of Evidenced-Based Treatment

Another barrier to effective treatment is that evidence-based practice was not implemented for various reasons. Individuals with anxiety often sought care from places, such as emergency rooms, which were not designed for whole-person care (Abar et al., 2017). Since some physicians did not fully understand the manifestations of anxiety disorder and did not know how to treat it effectively, it was best to keep abreast of the best practices to utilize or refer for services such as pharmacotherapy or psychotherapy (Lee & Dade, 2003). Emergency room visits were limited to education and offer no follow-up to ensure proper care (Starcevic, 2008).

Cost

Mental illness came at a significant cost to society and individually. In 2014, mental health expenditures accounted for $186 billion, with inpatient and outpatient care leading costs (National Center for Health Statistics, 2016). The overuse of emergency rooms by patients with anxiety also increased healthcare costs (Abar et al., 2017). On an interpersonal level, loss of occupations, roles, and relationships were present in anxiety disorders (Perna & Caldirola, 2017).

Quality of Life

Another barrier was that quality of life may not be properly understood. All anxiety disorders showed substantial impairments in quality of life (Rapaport et al., 2005). Catastrophic misinterpretations and inadequate self-efficacy inherent in anxiety disorders contributed to prolonged symptoms and decreased quality of life (Chen & Tsai, 2016). Therefore, best practices for treating anxiety went beyond symptom reduction by addressing restoration of the quality of life (Rapaport et al., 2005).

Treatment Resistance

A frustrating factor for clients and providers alike was treatment resistance. Data demonstrated that patients became resistant to psychotherapy (Fischer & Cleare, 2017). Approximately one-third of anxiety patients became treatment-resistant (Chen & Tsai, 2016). Twenty to forty percent of patients failed to reach full remission of symptoms with drugs or therapy (Perna & Caldirola, 2017). Comorbidities and genetics contributed to this resistance (Chen & Tsai, 2016).

Relationship Between Anxiety and Stress

Acute and chronic stress created vulnerability to a wide array of emotional disorders (Conway et al., 2016). According to the stress-vulnerability theory, genetics and environment produced unique thresholds in which stress impaired the health balance of an individual (Zvolensky et al., 2005). It was thought that in anxiety and panic disorders, the hypothalamic-pituitary-adrenal (HPA) axis was stimulated so much by a chronic stress response that it failed to regulate at some point (Dirven et al., 2017). Ultimately, stress was why the normal flight or fight system was hyper-aroused in some anxiety disorder patients (Abelson et al., 2007; Wintermann et al., 2016).

Chronic stress resulted in an altered reactivity response (Wichmann et al., 2017). Somatization was where physical symptoms manifested in response to a psychosocial stressor (Bursch, 2016). Anxiety-prone patients' personalities were primarily reassurance-seeking, which contributed to a vulnerability to stress exposure (Conway et al., 2016). There demonstrated a direct correlation between chronicity, the severity of symptoms, and increased stress reactivity (Limmer et al., 2015).

Systems Theory and Panic

Another barrier to effective treatment of panic was a lack of attention to the effect of the parts of an individual to the whole. A bio-psycho-social-spiritual model addressed all parts. For example, if an individual received treatment for bodily symptoms, but the person's psychological, social, and spiritual/cultural aspects were left unaddressed, the individual remained unbalanced. Stressors continued to compound and defeat the natural defense structure. As cited by Karl and Holland (2015), General Systems Theory supported this in that in the same way cells and organs formed a more extensive system of a person, that individual also formed a larger network of family and community.

Hierarchy of Needs

Maslow's hierarchy of needs (Taormina & Gao, 2013) was applied to the health/illness continuum to support the significance of incomplete care for anxiety disorders. To review, at baseline for health, all humans first needed physiological needs, safety needs, belongingness and love, esteem, and finally, self-actualization. Illness skewed this ranked order. Safety needs created a barrier to physiological needs (Zheng et al., 2016). Since fear was a core issue in all anxiety disorders, safety needs had to be addressed before individuals meet their physiological needs for optimal health. This hierarchy was an important aspect to include as all needs

demonstrated a holistic aspect in that they were are all not purely biological (Silton et al., 2011).

Anxiety manifestations affected all parts of one's needs throughout the system.

Stress Reactivity

A stressor was defined as anything that disrupts homeostasis (Schneiderman et al.,

2005). Disruption occurred in the biological, psychological, social, or relational (BPS) realms.

The BPS model of challenge and threat assimilates that a physiological stress response elicited

an insufficient threat response (Rith-Najarian et al., 2014). Homeostasis was maintained by a

delicate balance between the body's regulatory nervous systems' functions. A stress response

induced a disruption in this stability (Kim et al., 2018). These researchers also contended that

shifts from internal regulation to an external focus resulted in dysregulation.

Normal functioning of this two-way system involved the sympathetic nervous system,

which controlled the flight or fight response and the parasympathetic system that inhibited this

process. In anxiety-prone individuals, the sympathetic system dominated a stress response

(Kotianova et al., 2018). When confronted with mental stress in individuals with anxiety, greater

reactivity was present than in healthy controls (Kotianova et al., 2018). Another component of

stress reactivity was cortisol response. Anxiety-prone patients had a hypoactive cortisol response

because of overuse (Wichmann et al., 2017). Since stress reactivity was increased, it was

expected that normal cortisol production would be skewed.

Worthiness of this Study

There were multiple reasons why this study was important. First, the study provided a

group setting that automatically established a support safety net (Holbrey & Coulson, 2013).

Many individuals with anxiety disorders isolated themselves for fear of experiencing more

attacks. In addition, group therapy proved effective in utilizing cognitive behavior formats with

anxiety (Rufer et al., 2010). Supporting systems theory, the parts of a group combined to form a stronger whole. The anticipated shift occurred when individuals of the group changed focus to becoming members, which brought an experiential level of awareness (Agazarian, 2012). The homogenous members strengthened each other and provided a social network of understanding unparalleled by outsiders. The group was viewed in part as a challenge against stagnation toward a state of well-being (Franks et al., 2015).

Another reason that this study proved worthy of symptom reduction and increased quality of life was because it utilized the modern platform of a social media group. The internet was an increasingly popular tool for expanding therapy in mental disorders. Anxiety disorders were specifically targeted in many studies with a successful treatment response rate (Al-Asadi et al., 2014; Carlbring et al., 2010). Social media provided anonymity, low cost, comfort, and accessibility. An internet group also enhanced motivation (Carlbring et al.). These all addressed the barriers to effective treatment in anxiety. Study participants easily accessed the group with instant social support and therapeutic activities from the comfort of their home or the ease of their cell phones.

Another primary concept that supported the vitality of this study was a holistic foundation. The study group consisted of planned activities addressing BPSS realms. It was expected that the synergistic effect of attention to all these areas would produce the maximal chance to achieve optimal health. The holistic emphasis was expected to strengthen homeostasis and produce a formidable opponent to stressors. The holistic foundation superseded most modern, unipolar treatment.

Purpose of the Study

The presented background information on anxiety disorders and barriers to effective symptom reduction and improved quality of life revealed gaps in the literature. Studies indicated that a need for multifactorial treatment is evident for all types of anxiety disorders, including a biopsychosocial approach (Novack et al., 2007). Barriers existed to implementing empirically based practices, including cost, availability of services, and wait times (Abar et al., 2017). Therefore, novel approaches to symptom amelioration and improved quality of life were needed. The internet enabled social support, personal challenge, and health growth (Barak & Grohol, 2011). The purpose of this phenomenological study was to explore the experience of a group of individuals with anxiety who are participating in a holistic, online social media group and how it affected symptoms and quality of life.

Research Questions

This study pursued the answer to a primary question:

RQ1

How does a group of individuals with anxiety describe the lived experience of using an online, holistic social media group?

RQ2

How does this group of individuals describe their experiences in symptom reduction?

RQ3

How does this group of individuals describe their experiences in improved quality of life?

RQ4

What would these individuals describe as the most impactful part of the group?

Methodology

This qualitative study was formatted according to a phenomenological approach (Moustakas, 1995). The broader concept of qualitative research supported a dynamic, inductive, and systematic approach (Ravitch & Carl, 2016). This type of research aimed to understand how individuals visualize and perceive experience in the world (Ravitch & Carl, 2016). Phenomenology exemplified a branch of qualitative research. According to Creswell (2013), a phenomenological study explored the common meaning of a group of individuals sharing a homogenous phenomenon.

For this phenomenological study, a group of six individuals experiencing anxiety were recruited from an ad placed on an online school email. Participants were invited to participate in a 30-day holistic, online social media group based on a BPSS model. Informed consent was obtained as well as medical clearance for exercise. Exclusions were some co-morbidities, exercise restriction, and current therapy. Interviews were conducted prior to the start of the group, at the 2-week mark, after the study.

The concept of mindfulness was the umbrella under which all the categorical activities were structured. Mindfulness had extensively been studied for mental health (Fjorback, 2012; Kim et al., 2013, 2016). This study targeted mindfulness specifically to a holistic approach to wellness, specifically a 4 Wellness Model (Appendix A). Within this holistic wellness group, four aspects were addressed. These included the concepts of walking, which treated the body; writing, which treated the mind; worshipping, which treated the soul; and witnessing, which built relationships. The specific activities focused on within this study group were mindful walking, mindful writing, mindful worshiping, and witnessing in a social group.

Exercise was one endeavor that was embarked upon within the group. The concept of mindfulness and exercise were combined into a mindful walking exercise which has been shown

to increase the quality of life in those with stress (Teut et al., 2013). Self-reflection about the day and the activities of the study were used as prompts for journaling. Socially, the group served as a source of support for the participants (Burns & Machin, 2013). Spiritually, mindful worship, in Christ-centered Present Moment Awareness, was used to connect with God. Personal development was the goal of all these activities and utilized to secure hope (Chang et al., 2016). Together, these activities addressed all states of man and were expected to reduce symptoms and increase the perception of quality of life.

Making the shift from reactive to proactive in stress response and health behaviors was vital to caring for the whole person. Since anxiety disorders fed on stress, it was necessary to break this cycle and retrain the brain to move to action rather than reaction. This modified stress response was proposed with a comprehensive program in a homogenous community within this study.

Activities were chosen for the group to address BPSS needs. These included a homogenous physical activity (mindful walking), spiritual mindfulness exercises, journaling, and group support. The group connected daily via a private Facebook group and consisted of brief check-ins of all members and daily activity. The rest of the activities were done in the participants' time frame.

It was expected that interviews would yield positive results at the end of the 30 days. Anxiety symptoms were expected to be reduced, and quality of life improved. These findings were further supported by improved occupational or educational endeavors, interpersonal relationships, and a subjective sense of improved well-being. Possible drawbacks included dropouts, access problems, or lack of commitment.

Significance of the Study

Application

Although this study addressed a small group of individuals with anxiety, it was expected to generalize to a larger subset of the population with anxiety disorders. Since treatment resistance was a known barrier to symptom reduction and quality of life with anxiety, introducing a multi-modal approach was expected to bring some benefit (Chen & Tsai, 2016; Jay et al., 2016). In addition, the use of the internet for therapy functions offered rapid dissemination of treatment (Helen et al., 2014). Since anxiety manifested on a personal level, the impact of a supportive community of individuals experiencing the same phenomenon could not be stressed enough. It was hoped that the results of this study would benefit the participants with reduced symptoms and increased quality of life.

Accessibility

As discussed previously, many barriers existed to the effective treatment of anxiety disorders. One of these issues was accessibility to services. A hallmark of this study was to use technology to the consumer's advantage. Internet options for treatment have been studied for anxiety with promising results (Andrews et al., 2018; Berger et al., 2018). Mental health apps for computers, tablets, or cellphones improved accessibility (Donker et al., 2013). Since the group in this study was in a closed social media group, the cell phone was a convenient way to access the application. Literature was limited on study information relevant to the use of cell phone applications with anxiety disorder treatment. It was also extremely limited regarding the use of social media groups for mental health treatment.

Accountability

One of the benefits of any group treatment was accountability. Relationships were integral to accountability and directly impacted it (Cheatham et al., 2017). Health processes viewed humans as vulnerable and interdependent (Herring, 2016). Technology changed the method of relating but did not remove the human factor (Whelton, 2016). Greater success in the treatment of mental health includds prevention modeled through accountability and technology (Wandersman & Florin, 2003).

Anonymity

One advantage of the design of this study was that web-based applications offer a degree of anonymity not always found in other treatments (Ashford et al., 2016). The internet offerred both autonomy and anonymity, which eased the burden of mental health stigma (Helen et al., 2014). Studies revealed positive feedback regarding phone and web applications if privacy was secured (Proudfoot et al., 2010). The homogenous group also helped destigmatize any preconceived notions of 'treatment for mental health.'

All-Inclusive

As previously discussed, one of the barriers to effective treatment was a lack of whole person care. This study was unique because it contributed to a wide gap in the literature regarding whole person care for mental health. Traditional medical models took a reductionistic approach to treating illness (Katerndahl & Oyiriaru, 2007). In contrast, a biopsychosocial approach addressed the client as a dynamic unit in which illness and health were influenced physiologically, psychologically, and socially (Fahlgren et al., 2015). A BPSS model, which this study was based upon, solidified a holistic stance with a spiritual dimension.

Allocation

It was hoped that this study would lay the groundwork for future research of BPSS models for anxiety and other mental health disorders. The quest for whole person treatment arose with added attention to spiritual issues (Fahlgren et al., 2015). The epidemic of anxiety disorders continued with at least 18.1% of the US population experiencing some form of anxiety unless proactive intervention was applied holistically (Trzcinski, 2018; World Health Organization [WHO], 2019). This concept was key to the unfolding of the framework for this study.

Assumptions and Limitations

Assumptions and limitations were a part of every study. Several assumptions were inherent in this study. Humanity was viewed as complex; therefore, holistic, multi-modal treatments were expected to treat disease states. Another assumption was that barriers were evident to successful treatment, symptom amelioration, and increased quality of life. A third assumption was related to humans choosing reactive or proactive responses to stress. Finally, the desired outcome was a homeostatic balance in body, mind, soul, and relationships.

Limitations were evident within this design. There was minimal literature support for this endeavor regarding the study group's model and design. Also, attrition was expected with the length of the study and necessary time commitment. It was also difficult to control other influences, such as additional therapies, medications, or undiagnosed comorbidities. It was desired that exploring the lived experiences of these individuals would overshadow any inherent weaknesses within the study design.

Conceptual Framework

The theoretical framework for this qualitative study lay in several conceptual genres of holistic treatment within a BPSS model. The idea of health and illness on a continuum in

dynamic states of flux was key to finding maximal treatment for any disorder (Trzcinski, 2018).

The powerful effect of stress on the homeostasis of this continuum was the driving force that was

addressed and thwarted (Mineka & Oehlberg, 2008). Once this delicate balance was interrupted

by acute or chronic stress, anxiety attacks ensued, which ultimately led to the development of

anxiety disorders.

Biopsychosociospiritual health was a conceptual ethic that laid the groundwork for this

study. It was based on the empirically supported biopsychosocial model (Katerndahl & Oyiriaru,

2007). BPSS defined what was essential to the core existence of humanity. Second, it educated a

person-centered approach to dealing with stress proactively (Fahlgren et al., 2015). Third, BPSS

gave back the dignity and worth that an individual with an anxiety disorder lost along the way to

recovery (Saraga et al., 2014).

To fully comprehend the impact of a BPSS model on anxiety disorders, it was necessary

to understand the concept of a biopsychosocial model. George Engel first introduced the model

when questions arose about the range of benefits of a traditional medical model (Engel, 1980).

The essence of the foundation of this study was that a medical model was not enough to meet the

needs of a whole person. Traditional medical model approaches looked solely at the human body

as a source of all illness (Engel). The focus was solely upon the practitioner for diagnosis and

treatment recommendations with little interaction with the client (Anderson, 1995). In contrast, a

biopsychosocial model was dubbed a multi-modal approach to disease management to prevent

inadvertently de-humanizing the patient (Saraga et al., 2014). Biopsychosocial implications

addressed quality of life issues such as lifestyle, roles, and identity (Cox et al., 2017).

This model addressed the whole-person's needs, including the body and psychosocial

aspects. Although all medicine had scientific underpinnings, humanness was not removed from

that equation (Karl & Holland, 2015). This signified the need for a more comprehensive approach than a traditional medical model. In addition, a biopsychosocial model integrated the biological aspects of disease states with psychological precepts and socio-cultural backgrounds (Brooks & McHenry, 2015). It also incorporated developmental and contextual factors (Becker et al., 2015).

Examples of utilizing a biopsychosocial model in biological medicine were evident. For example, in a study of patients with epilepsy, a biopsychosocial model application resulted in more significant gains in insight for quality of life issues than a traditional medical approach (Elliott & Richardson, 2014). Self-reflection is knowledge that significantly impacted a patient's life that may have been overlooked otherwise. Another study demonstrated the wide range of biopsychosocial needs apparent with a medical diagnosis when cancer patients were surveyed (Dawson et al., 2018). This showed the gaps in the traditional model in treating the whole person. Literature regarding BPSS models for psychological disorders was extremely limited. It was expected that this study would contribute to that gap.

The Integrated Model of Treatment for Holistic Health / 4 Wellness Model (Appendix B) encompassed the conceptualization of this study. The individual was in constant dynamic flux within a holistic state of body, mind, soul, and relationships. Stress was a constant influence on the hemodynamic state of balance with the human system. The direction of the continuum was heavily influenced by either a reactive choice or a proactive choice. Each aspect of the holistic social media group addressed the whole person's BPSS needs. It was expected to transition the individual from a reactive state (anxiety) to a proactive state of self-care toward the health continuum.

Summary

This introductory chapter presented a summary of the problem of anxiety disorders with residual symptoms and decreased quality of life. It presented barriers to achieving symptom remission. It also addressed the gaps in the literature for whole-person care for mental health but introduced a novel idea in the treatment of anxiety. A qualitative design with a phenomenological approach was chosen to best explore the data from this shared phenomenon as lived experiences. A nursing foundation and counseling background formed a major interest in the conceptual ethic of BPSS health. A BPSS holistic health model was presented within the methodological design to move the individual toward the health continuum. Research questions and study purposes were also addressed.

The remaining chapters discussed the following points. The second chapter detailed a literature review of the background problem, barriers, and proposed alternatives to whole-person care. Empirical data for BPS models was presented along with noted gaps in the literature for the BPSS models. The research design was the focus of the third chapter. Findings were processed in chapter four, with conclusions discussed in the final chapter.

CHAPTER TWO – LITERATURE REVIEW

It was necessary to complete a thorough review and analysis of the current and past literature regarding holistic treatment of anxiety disorders to broaden knowledge and provide value for this study. Due to the phenomenological nature of this study, this encompassed a substantial inquiry into the depth of literature relating to factors that the lived influence experience of individuals with anxiety. Synthesis of the literature regarding anxiety etiology and treatment, the context of the holistic concept of health, the role of stress, barriers to symptom resolution and quality of life, support for internet-based intervention, and support for qualitative, phenomenological methodology was conducted.

This literature review referenced the above topics regarding comparison and contrast between study findings. Essential concepts were defined with a literature synthesis, and inherent gaps were addressed. The rationale for the conceptual framework and potential themes from the literature were presented. In addition, support for the research methodologies was provided. Before beginning the synthesis of information, the search strategies for the literature were presented.

Verbiage from multiple sources was utilized to investigate the scope of data for individuals living with anxiety. Online databases were used, primarily EBSCO, Proquest, Google Scholar, and Web of Science. Boolean operators such as AND, OR, and BUT were used with keywords. For example, (Treatment) AND (anxiety), (Anxiety) AND (stress), (Anxiety) and (Treatment OR online), (Anxiety) and (Holistic); (Anxiety) and (Biopsychosocial). Although a plethora of data was obtained for most keywords, studies were narrowed to reflect the purpose of the study most closely.

It was noted throughout the search process that a BPSS model lacked in the treatment of anxiety disorders. Biopsychosocial models were apparent with primarily anxiety disorders. The spiritual component was often not integrated. In addition, although stress was accounted for in etiology, it was not considered in most treatments. The use of telehealth had much coverage in the literature, but the specific use of social media groups lacked. Individual case studies existed regarding specific treatments and nuances of panic disorder, but a phenomenological approach of a group of individuals with anxiety disorders in a social media group was not found. It was hoped that this study filled in these gaps.

Concept of Holistic Health

A delicate balance lay in the continuum between health and illness. Health maintained itself as a multi-dimensional state of being with a homeostatic state of all realms of existence. Body, mind, and spirit existed synergistically in a rhythm with the surrounding environment. Illness occurred when a stressor disrupted the homeostatic state. Stress was be physical, psychological, social, or spiritual. According to systems theory, what impacted one realm of an individual also impacted the others.

Health was a significant human need (Seyedfatemi et al., 2014). The literature presented dueling viewpoints regarding the concept of health as a dynamic force versus a static state. Several writers referred to the World Health Organization (WHO) definition of health as outdated – specifically about the use of "state" and "not merely the absence of disease" (Costello et al., 2009; Frenk & Gomez-Dantes, 2014; Hunter & Reddy, 2013). The argument was that "state" infers a static point that is a given and not changeable. The question arose if the preconceived notion of unchangeable circumstances contributed to this country's apathy and passiveness regarding health behaviors. A domino effect of this occurred in the individual. It

elicited a passive mentality that nothing can be done to change a set of health circumstances (Apostu, 2013; Donnelley, 2018).

Most of the literature supported the stance of this study that health was a dynamic entity (Apostu, 2013; Donnelley, 2018; Frenk & Gomez-Dantes, 2014; Hunter & Reddy, 2013; King et al., 2013). In addition, a theme of adaptability emerged from the data (Costello et al., 2009; Meier-Abt, 2014). Our bodies were inherently designed to withstand a lifetime of use in an ever-changing environment. The concept of adaptability within health gave hope to sufferers of biological, psychological, and spiritual disease states. If health was adaptable and a goal state to be achieved, it was necessary to understand health.

Surprisingly, the conceptualization of health was more elusive than thought, not only between patients but providers as well. Individuals thought of and talked of health in a broad sense but may not have fully understood the specific connotations of what that means. In a study by Hunter and Reddy (2013), extensive interviews were conducted with providers and patients to assess their health ideas. Most patients associated health with energy, vitality, and happiness; whereas, providers associated an absence of disease. Both referenced a holistic focus with a vague emphasis on spirituality. Although this aspect was essential to patients, they could not establish exactly how it fit into the picture of health. Finally, maintenance of health was advocated with a focus on resilience and coping. These findings simulated the craving for a holistic approach to health.

The strive for holism gradually evolved since the break from the traditional biological models of health by pioneers such as Engel, Dunn, and Hetler (Hunter & Reddy, 2013). Whole person care considered human nature's complexities, including biological and thought processes, spiritual awareness, and relationships. Health dimensions were integrated into a functional

whole, and maintenance of good health resulted from a balance between them (Apostu, 2013). Health care practitioners understood that individuals required more than just biological attention. The mental state was acknowledged to impact physical health and vice versa directly. In addition, the impacts of health in the social realm, such as occupational, interpersonal, and financial, also became more apparent. The piece lacking in most models of care in the literature was spirituality.

This theme throughout this literature review revealed a need for a complete treatment model. A BPSS model addressed all realms of an individual, potentially providing maximum support to an individual's health status. A plethora of literature proposed a BPS model for effective treatment (Buckner et al., 2013; Carlson & Tamm, 2000; Carpenter et al., 2018; Frankel et al., 2003; Hantsoo & Epperson, 2017; Krasen, 2018). If a BPS model provided adequate treatment of altered health states, then the proposed benefits of this study would be weakened. Myriads of individuals were not at maximum health. Instead, they were in another area on the health continuum: illness.

Concept of Illness

According to the WHO, health was "not merely the absence of disease" (Frenk & Gomez-Dantes, 2014, p. 1). Therefore, it was assumed that illness was the presence of disease. Conceptualization of illness was not as apparent in the literature as in health. A prevailing theme was the mainstream focus on chronic biological illness (Hendrix et al., 2015). The failure to recognize holistic connotations, such as mental, spiritual, and social aspects of illness, seemed to fall upon the provider's responsibility. Authors agreed that this was a prevalent issue, especially in primary care, which provides the majority of patient care treatment (Apostu, 2013; Garcia et al., 2014; Hendrix et al., 2015; Stuber et al., 2014).

If providers adhered to a holistic treatment model, their awareness of the far-reaching implications of chronic biological illness may have been recognized. BPSS literature agreed that illness could affect all domains (Donnelley, 2018; Fahlgren et al., 2015; Katerndahl & Oyiriaru, 2007; Rua et al., 2017). For example, several studies linked physical and mental health very closely (Garcia et al., 2014; Hendrix et al., 2015; Rua et al.; Stuber et al., 2014). Social function was also found impaired with a disease state. Zhang et al. (2018) conducted a concept analysis on the impact of family functioning concerning a chronic illness. Factors such as interpersonal relations, roles, coping, and adjusting ability were impaired with a member's illness. In the same way, spiritual health was impacted by illness. According to Khorashadizadeh (2016), one of the most important implications for spiritual health was the ability of the individual to define illness. If a provider never addressed this, the individual was unaware of proceeding.

Like various conceptions of illness, the cause of illness also had different theories. For this literature review, theories relative to the subject of mental illness were discussed. Three of the top theories in the literature were genetic/environmental, personal responsibility, and stress. Genetics and environment were inextricably linked in the literature for mental disorders (Goodyer, 2015; Ogorchukwu et al., 2016; Uher, 2009). Most of the studies presented used identical and fraternal twins to demonstrate genetic links (Goodyer, 2015; Jarnecke & South, 2014; Uher, 2009). In addition, environmental aspects were analyzed in accordance with parental relationships and developmental factors (Goodyer, 2015).

Studies also showed that paternal influences could influence genetic vulnerabilities more than maternal ones (Goodyer, 2015; Jarnecke & South, 2014). The diathesis-stress model was found throughout the literature o explain this connection more comprehensively. Diathesis stress models stated that gene variants possessed a latent vulnerability factor that reacted with

environmental stress, influencing negative outcomes for mental health (Goodyer; Jarnecke & South). This model was linked to mental disorders such as depression, schizophrenia, psychosis, and anxiety (Chang et al., 2016; Valli et al., 2021). A common theme throughout the literature regarding this model and its role in mental disorders was proactivity and reactivity in personal responsibility.

Heredity and certain environmental factors, such as childhood residence, the family of origin, and history, also were shown to interplay with health and illness. These factors provided the individual with limited control. Personal responsibility provided a locus of control for the individual along the health continuum. Personal responsibility related to positive health and hygiene practices included exercise, nutrition, and abstinence from tobacco and alcohol. These were proactive choices. When personal responsibility declined, resistance to outside stressors weakened (Adamo, 2017; Apostu, 2013; Hein et al., 2015; Hunter & Reddy, 2013). A reactive state occurred in that individual. Stress from the environment or lack of personal responsibility fueled this reactive state, cascading into negative effects throughout the body and mind (Booij et al., 2018). These negative effects translated to illness (Trzcinski, 2018).

As mentioned previously, homeostasis was adversely affected when a stressor affected the HPA axis (Abelson et al., 2007; Petrowski et al., 2010; Sartori et al., 2012). As the diathesis-stress model predicted vulnerability, a transactional stress model showed longitudinal effects of stress coupled with genetic/environmental vulnerability (Goodyer, 2015). This deregulatory process was suspect with certain anxiety disorders (Abelson et al., 2007; Petrowski et al., 2010). Anxiety patients demonstrated hypersensitivity to the effects of stress on the HPA axis (Petrowski et al., 2010). The desire for increased proactivity to stress response and decreased

reactivity to reach a better state of health occurred. A closer look was needed at the concept of stress itself to accomplish.

Concept of Stress

The focus of this proposed study included the effect of stress on mental health; therefore, a closer look into this perspective was necessary. The literature was consistent with the idea that continuous chronic stress was strongly linked to physical, emotional, and mental disorders (Conway et al., 2016; Esler, 2017; Fernandes & Osorio, 2015; James et al., 2017; Kim et al., 2018; Kotianova et al., 2018; Wichmann et al., 2017; Zorn et al., 2017). Physically, acute and chronic stress affects heart rate, blood pressure, cortisol, insulin, and weight (Abar et al., 2017; Li et al., 2016; Smith et al., 2015; Zorn et al., 2017). These physical attributes were inexplicably linked to mental and emotional states. For example, continuous high cortisol levels produced anxiety, and obesity contributed to depression (Chao et al., 2017).

An interesting theme noted in the literature regarding stress was the concept of benevolent chaos. A chaotic state ultimately produced an effect better than the original (Apostu, 2013; Laycraft, 2009; Lehrer & Eddie, 2013; Pascale et al., 1999). Khorashadizadeh (2016) wrote that one of the most essential functions of a human is to find meaning in life. If stress produced illness, and illness produced chaos, but chaos produced growth, what then was gained in that experience on the health continuum?

Mentally, stress neuroticized worry, anxiety, depression, and faulty thinking (Lenze et al., 2014). It triggered the stress response into flight or fight mode, which is necessary for real, inherent danger. The stress response was triggered for no apparent reason with no tangible threat, which created a chaotic state in the individual. This resulted in uncomfortable somatic

symptoms, sometimes to the point of feeling panic (Kotianova et al., 2018). Once these unprovoked attacks occur regularly, the foundation is laid for developing an anxiety disorder.

Anxiety

The literature review laid a foundation for the development of anxiety. Genetics, stress-related models and conditioned responses were the prevailing etiologies throughout the literature (Cameron et al., 2018; Gorman et al., 2000; Kotianova et al., 2018; Musazzi et al., 2018; O'Reilly, 2004). A combination of inherent factors with controllable features was the result. An individual may have been born with specific genetic traits but control diet, exercise, and stress were controlled. A strong neurobiological focus was also evident to explain the process (Al-Haddad et al., 2001; Furtado & Katzman, 2015; Gorman et al., 2000). The irony of the anxiety was that normal bodily reactions occurred but at the wrong time.

 According to Gorman et al. (2000), one of the most cited articles on anxiety, conditioned fear was the culprit for some types of anxiety. According to this theory, the body utilized an entire pathway for real or conditioned fear responses. For example, anxiety creating panic simply triggered this cascade effect at the wrong time for no apparent reason. The amygdala began the pathway by the receipt of a stimulus response which ultimately assisted with autonomic and behavioral responses. The amygdala was considered part of a primitive brain which triggered a purely emotional response. From the amygdala, autonomic processes were targeted, such as heart rate, respiration, blood pressure, and neurotransmitter release (Gorman et al., 2000). This theory also surmised that there might be a deficit in neurocognitive processing which misinterpreted bodily symptoms as catastrophic.

These theories accounted for most of the biological basis for anxiety as presented in the literature. Because anxiety presented as multi-faceted, it was necessary to look at the

psychological effects. Adrenalin was elevated during an anxiety attack, making thought

processes and concentration poor. Many individuals had an unrealistic fear of death or going

crazy as part of the sequelae of anxiety. After a course of prolonged anxiety, it was common for

depression or other co-morbidities to set in as well as spiritual apathy (Batinic et al., 2017;

Cavicchioli et al., 2018; Keating et al., 2013). Data also showed a strong correlation with rising

rates of panic disorder and suicide, with the most prevalent rates including an agoraphobia

component (de la Vega et al., 2018; Kanwar et al., 2013; Liaugaudaite et al., 2017; Nam et al.,

2016; Rapaport et al., 2005). These individuals proved the most difficult to treat since traditional

therapy is not an option due to fear of leaving home (Di Benedetto et al., 2014).

Stress

The literature showed a higher predominance of women with anxiety disorders (Kim et

al., 2018). It was discovered that there was a high correlation of studies that attribute hormonal

influences on anxiety and panic in women (Haigh et al., 2018; Li & Graham, 2017; Mattson &

Ekselius, 2002). Monthly hormonal changes contributed to more significant symptomatology in

women with anxiety and other stress-related disorders (Haigh et al., Li & Graham; Esmaeelzadeh

et al., 2018). Women expected hormonal fluctuations and had choice to exert some control if

they were cognitively aware of changes occurring (Jamieson et al., 2012). Recommendations in

the literature included education about the hormonal influence on symptoms (Jamieson et al.,

2012).

Modern expectations were noted for women to be multi-taskers while minimizing their

own needs. Women were also in the workplace and still expected to care for families (Duxbury

et al., 2018; West et al., 2014). The roles were flipped for men as well. Anxiety disrupted this

lifestyle and caused substantial loss of occupation, relationships, and self-esteem (Barbaglia et

al., 2015; Mehtap et al., 2015; Perrone et al., 2019). It was common for quality of life to decrease as symptoms went unabated (Altintaş & Taşkintuna, 2015; Di Giovanni et al., 2015). With targeted, multi-faceted treatment, symptom relief and improved quality of life were possible. The problem was that many individuals did not demonstrate help-seeking behaviors with anxiety disorders (Roness et al., 2004). Therefore, they remained undiagnosed with persevering symptoms resulting in a poorer quality of life.

Barriers to Treatment

The literature presented multiple barriers to the treatment of anxiety disorders in general. Common themes included accessibility of care, anonymity, lack of dissemination of evidence-based treatment, cost, quality of life, treatment resistance, and overall fragmented care. Mental health enveloped a stigma that permeated throughout an individual's entire concept of treatment (Borelius et al., 2014; Patterson & Van Ameringen, 2016). The imposed stigma affected the attainment of effective treatment in many aspects. In turn, this affected the individual biologically, psychologically, socially, and spiritually.

Physical Barriers

To further understand the interaction of stigma and barriers to treatment, findings from this review were discussed in terms of a physical sense. Regarding the accessibility of care, the literature demonstrated that a significant portion of individuals with anxiety disorders, particularly panic disorder with an agoraphobic component, had decreased accessibility to treatment (Titov et al., 2010). This implied simply geographic location or lack of resources for access to proper care in a physical sense. For example, several studies discussed the impact of rural areas with access (Nair et al., 2013; Weaver & Himle, 2017). Distance from treatment was indirectly impacted by lack of resources such as vehicle or gas money. The embarrassment of

requesting a friend or neighbor for transportation for a mental health appointment was also a real

problem.

Another tangible barrier was that of financial resources. Untreated or malingering anxiety

disorders proved very costly to taxpayers and the healthcare system (Andrade et al., 2014; Baxter

et al., 2014; Price et al., 2014). One of the common themes found in the literature was the use of

emergency rooms for care rather than primary care physicians (Murphy et al., 2016; Rodriguez-

Seijas et al., 2019). Higher charges and unpaid healthcare bills resulted.

Mental Barriers

In the same way, a person's mental state impeded accessibility. Individuals with anxiety

already had a heightened sense of pretense which escalated with merely a discussion of

symptoms with the provider (Patterson & Van Ameringen, 2016; Roemer et al., 2008; Waltz et

al., 2014;). Verbal completion of cognitive therapy was also more difficult for some anxiety

disorder patients (Morris, 2014). The acknowledgment of these difficulties prevented patients

from obtaining or maintaining effective treatment, which resulted in lingering symptoms and

poorer reported quality of life. These factors contributed to treatment resistance.

The literature was rich with studies that discussed treatment resistance with anxiety and

panic disorders. According to a recent meta-analysis, 40-60% of anxiety patients had residual

symptoms despite treatment (Patterson & Van Ameringen, 2016). Perhaps, a combination of all

the variables contributed to this resistance. The literature was vague about the etiology of the

resistance but offered hypotheses. One of these was the use of pharmacologic agents for anxiety.

Medications were often used to augment cognitive therapies. Patients usually stop taking them

due to untoward side effects and length of time for the treatment effect (Mogg & Bradley, 2016;

Patterson & Van Ameringen, 2016). Another theme noticed in the literature was unawareness of

an anxiety disorder by either the individual or clinician (Baldwin et al., 2014; Helen et al., 2014).

Finally, the data suggested that some anxiety patients required a different type of psychotherapy

other than empirically based cognitive-behavioral therapy (Campbell-Sills et al., 2016; Gloster et

al., 2017; Marker & Norton, 2018). A final common theme in treatment resistance of anxiety

disorders was fear (Rowa et al., 2014).

Social Barriers

Another treatment barrier the literature discussed involved the social spectrum. This

primarily focused on fragmented care and a lack of dissemination of evidence-based care.

Fragmented care resulted from a lack of continuity of care with primary care or psychiatric care

and increased, sporadic use of emergency rooms for treatment (Biringer et al., 2017; Hoertel et

al., 2013). Misdiagnosis was often a product of fragmented care (Metzler et al., 2016; Olariu et

al., 2015). Traditional medicine was used as a foundation with increased prescriptions and a lack

of psychotherapy (Benich et al., 2016; Muskens et al., 2013; Wong et al., 2017). Combined with

a lack of effective, evidence-based practice and maintenance care (emergency room), these

practices produced fragmented care, impeding effective treatment.

As mentioned previously, the stigma of mental illness prevented patients from involving

others in their care coordination (Hopkins & Shook, 2017; Ociskova et al., 2015, 2018). Most of

this literature implied an internalized stigma rather than an external one. Like Beck's cognitive

triad in depression (Wang et al., 2013), individuals with anxiety and panic created a self-

perception that was noticeably different from others (Livingston & Boyd, 2010; Ociskova et al.,

2018; Pedersen & Paves, 2014; Stanley et al., 2018). In essence, one of the keys to successful

treatment was removing this stigma. In addition to physical, mental, and social barriers to

accessibility, spirituality also influenced the stigma of mental illness.

Spiritual Barriers

Spirituality implied different meanings. Relative to this discussion, the literature on spirituality focused on hope and motivation and their influence on accessibility. Studies implied that decreased hope in individuals with anxiety disorders could impact attempts to access care (Ociskova et al., 2015; Thibodeau & Peterson, 2018). With depression being common comorbidity of anxiety, hopelessness was expected in these individuals, which indirectly affected accessibility to care. Motivation was another aspect that interacted with stigma and accessibility to care. Studies showed that decreased motivation and treatment drop out prevented individuals from performing health-seeking behaviors (Melville et al., 2010; Proudfoot et al., 2013).

Another core element of spirituality was quality of life. A plethora of studies was readily available in the literature regarding the concept of quality of life with anxiety and panic disorders (Carta et al., 2015; Hoffmann et al., 2014; IsHak et al., 2014; Kang et al., 2014; Oei & McAlinden, 2014; Primiano et al., 2014). Primary reasons for the poor quality of life discussed were extenuating symptoms, disrupted lifestyles, broken relationships, family turmoil, and comorbidities. Decreased quality of life was a barrier to treatment in that it embodied depression and hopelessness, which decreased motivation for treatment (Dickson et al., 2018; Servidio et al., 2018). To holistically impact these barriers to treatment, a comprehensive treatment approach needed to be utilized with anxiety and panic disorders.

Biopsychosocial Model (BPS Model)

One example of a more comprehensive approach to treatment found in the literature was the Biopsychosocial (BPS) model. This model developed primarily from the philosophy that the traditional medical model did not treat all patients sufficiently (Engel, 1980; Fava & Sonino, 2017; Plakun, 2018; Wade & Halligan, 2017). George Engel is deemed the founding father of the

BPS model, and it continued to evolve since (Henningsen, 2018; Searight, 2015). The primary catalyst which drove this model development was that medicine models could not effectively diagnose or thoroughly explain psychiatric disorders (Covan, 2018; Wade & Halligan, 2017). Several themes were found in the literature regarding this model; it was necessary first to discuss the traditional medical model.

A medical model denoted a traditional approach to treatment. Its primary, reductionist focus was treating the body with interventions targeted to the body, like medications (Fava & Sonino, 2017; Plakun, 2018). It was the most widely used treatment model in medicine (Plakun, 2018). Since the biological realm was the only aspect of an individual addressed, the psychological, social, and spiritual realms were left unattended. This resulted in incomplete and segregated care (Covan, 2018).

The literature discussed three main themes in the weakness of the traditional medical model. The first was that the traditional medical model failed to address emotional and relational issues. Again, these were essential aspects of an individual linked to various mental disease states; therefore, they needed to be adequately addressed. Most biological disease states were integrated with emotional and relational issues, so utilizing a more encompassing model was justified (Cicchetti & Cohen, 2006; Wade & Halligan, 2017). Another theme found in the literature was that other causes of illness were evident aside from pure genetics. This referred to the environment, personality features, and lifestyle (Rith-Najarian et al., 2014; Rodriguez et al., 2016; Smith et al., 2015; Sutton & Austin, 2015).

A third theme found was that medicine was not the only option for treatment. Many studies were evident for the use of biopsychosocial approaches in treatment. The concept of exercise to decrease the risk of physical disease and alleviate depression and anxiety was widely

circulated in the literature (Puterman et al., 2017; Sims-Gould et al., 2017; Yun et al., 2019). The use of tai chi and yoga for mental calming was also readily discussed (Bolton et al., 2018; Wang et al., 2013). Social aspects, such as mentorship and group support, demonstrated positive connections with health and wellness (Behenck et al., 2016). Spiritual practices, such as prayer and meditation, effectively targeted physical and mental disease processes (Gaiswinkler & Unterrainer, 2016; Masters & Spielmans, 2007; Victorson et al., 2014). The data demonstrated that an effective treatment model for all disease states was necessary to accommodate the totality and complexity of humanity.

One of the literature's predominant areas in using a BPS model was psychiatry (Gask, 2018; Plakun, 2018). This discipline was unique because disease states could not be readily explained by genetics or biological processes. Most mental illnesses had some component relative to early trauma, maladaptive relationships or coping, and individual personality or emotional traits (Goodyer, 2015; Uher, 2009). The BPS model encompassed the psychological and social aspects to compensate for other etiologies.

Another common element in the discussion was the resistance to using this model. Initially, the popularity of a novel treatment overtook the healthcare community. In recent decades, the use of the BPS model appeared to be declining (Plakun, 2018; Wade & Halligan, 2017). The literature suggested that possibly a biopsychosocial perspective was from the traditional medical school education (Shi et al., 2018; Wade & Halligan, 2017). The onslaught of nurse practitioners to the healthcare field produced practitioners with a more holistic mindset and approach to treatment (Eriksson et al., 2018; Theophilus et al., 2015). Despite resistance from some in the medical community, specific populations inherently benefitted from using a BPS model. Three primary focus areas for the BPS model were evident in the literature, including

biological and psychological disease states. These are issues with chronic illness, chronic pain, and co-morbidities. All these areas illuminated processes that occurred for a large portion of the life continuum, affected family and relational processes, and involved more than one aspect of the body or mind (Bolton et al., 2018; Bursch, 2016;).

As noted previously, some studies acknowledged spiritual practices that benefitted overall health. The BPS model failed to acknowledge a spiritual dimension. Biological, psychological, social, and spiritual aspects must all be addressed (Koenig, 2014). A BPSS model was needed for this purpose. The data overwhelmingly lacked support for a treatment model such as this, especially for medical conditions. If the interrelated body is truly capable of homeostatic regulation and healing (Fahlgren et al., 2015), then a search was necessary to find a model adequately equipped to combat stress and treat the whole person.

Bio-psycho-socio-spiritual Model (BPSS)

The bio-psycho-socio-spiritual model addressed an individual in his or her totality. It encompassed the physical, mental, and social aspects of the BPS Model but added the spiritual element. It operated along the line of thought of systems theory, in that all parts were interrelated and affected the whole. The issue with this model was the lack of literature support. Minimal studies were available which demonstrated the BPSS model in practice (Fahlgren et al., 2015; Katerndahl & Oyiriaru, 2007).

Several studies discussed a BPSS model about physical health. Fahlgren et al. (2015) discussed this from an osteopathic medicine view. This study looked at personality and temperament regarding health and illness. In lieu of passive healthcare, it suggested empowering the individual in a person-centered vs. patient-centered approach to allow for the spiritual aspects in treatment. This completed whole person care with the goal of this osteopathic model being to

reach a state of self-transcendence to achieve high levels of resilience (Fahlgren et al., 2015). Another study showed the positive effects of the BPSS model utilized in primary care (Katerndahl & Oyiriaru, 2007). The purpose of this study was to formulate a holistic assessment tool to help primary care providers visualize symptoms from all dimensions of an individual. This, in turn, provided complete treatment.

Results showed that all aspects of a person were affected when perceived health status was impaired Katerndahl and Oyiriaru (2007) took this a step further, as they implemented the assessment tool in primary care to analyze healthcare use and life satisfaction. One of the results was that high utilization of health services was combined with a poorer quality of life and signified spiritual issues. An individual sensed discord within their system but could not define it. The logical path was to see a primary care physician. This non-linear approach to address all symptoms and aspects of a person was recommended (Katerndahl & Oyiriaru, 2007). Beerbower et al. (2018) implemented one of several studies to address the use of a whole person approach with life-threatening illnesses. The end of life deserved an existential view; however, how essential was addressing these issues while the individual was in the prime of life?

Some studies discussed using a BPSS approach in assessment and treatment planning (Beerbower et al., 2018; Garland, 2018). Most literature support was recent within the last few years. The available literature demonstrated the need for a complete treatment model for physical health. Mental health was also in vital need of this. In contrast to the BPS model, much of BPSS literature support was equally related to physical health and mental health (Beerbower et al., 2018; Brooks & McHenry, 2015; Garland, 2018; Katerndahl & Oyiriaru, 2007). Some form of aerobic exercise was empirically proven to increase mental health and improve symptoms with anxiety disorders (Stathopoulou et al., 2006). Mindfulness was another tool that effectively kept panic

sufferers in the here and now to combat maladaptive thinking patterns (Cavanaugh et al., 2013;

Spijkerman et al., 2016).

Another theme revealed in the data regarding the relationship between physical and

mental health was using the whole person model for addiction treatment (Brooks & McHenry,

2015; Dermatis & Galanter, 2016; Garland, 2018; Tonigan et al., 2013; Wilcox et al., 2015).

Although not blatantly defined as BPSS, the addition of and focus on the spiritual realm of an

individual in the above studies was quite apparent. For example, most 12 Step Programs

emphasized a spiritual component (Brooks & McHenry, 2015; Tonigan et al., 2013; Wilcox et

al., 2015). Garland's study (2018) used a mindfulness approach to find meaning and fulfillment

without drugs. Again, the focus turned to the person instead of just the symptoms (Garland,

2018). This reiterated the essence of whole person care. The pattern of spirituality giving

meaning and purpose was evident in multiple studies (Balboni et al., 2014; Dermatis & Galanter,

2016; Garland, 2018; Tonigan et al., 2013). Also, spiritual growth was a mechanism of change

with increased abstinence and prolonged maintenance of recovery (Tonigan et al., 2013; Wilcox

et al., 2015). In substance abuse disorders with co-morbidity, spiritual practices, such as prayer

and meditation, improved mood and decreased depression (Wilcox et al., 2015).

If the implementation of spirituality in the treatment of physical illness and substance

abuse was demonstrated to have positive effects, then it made sense to utilize it in the treatment

of other mental disorders, such as anxiety. Even though the direct language of the BPSS model

was relatively void in the literature, there was much discussion about spiritual issues and illness

(Fombuena et al., 2016; Harris et al., 2015; Jones et al., 2018; Katerndahl & Oyiriaru, 2007;

Oxhandler et al., 2018). These studies ranged from youth to palliative care use, which

demonstrated the transcendental properties of a BPSS model. A revision of the BPS model was

necessary due to the impact of beliefs on health symptoms, coping, and resilience (Fahlgren et al., 2015; Katerndahl & Oyiriaru, 2007). Traditional medical views cued spirituality as a non-essential aspect of care. Health care professionals possessed a moral obligation to acknowledge spirituality and include it in treatment (Wilcox et al., 2015). One of the primary functions of spirituality found in the literature was coping (Bishop, 2009; Brown et al., 2013; Harris et al., 2015).

Positive emotions used in coping were linked to one's values and beliefs, and these beliefs were usually determined by spiritual beliefs (Harris et al., 2015). Bishop (2009) talked of essential aspects of spiritual beliefs to promote positive interpretations of negative medical situations. Individuals with higher reported levels of spiritual well-being were better equipped emotionally to handle anxiety-producing situations and had a lower amount of mental health concerns (Brown et al., 2013; Tonigan et al., 2013). The fact that there was much interest in the spiritual aspect of an individual foreshadowed the necessity of adding to the BPS model. It was the hope that this study would fill in a portion of the gap in the literature to complete a BPSS model, particularly for the treatment of anxiety disorders.

Use of Technology

This study proposed a unique platform to host a BPSS model to address the barriers to effective treatment. The literature defined telehealth as health care information delivered via media sources such as email, web, videoconference, or telephone (Durland et al., 2014). Healthcare users perused the internet to seek health information and find support (Durland et al., 2014; Firth et al., 2017; Kalckreuth et al., 2014). It was designed to counteract the barriers of accessibility, resistance, disease manifestations (avoidance of crowded places), anonymity, and affordability (Durland et al., 2014). Telehealth used psychoeducation, support, and therapy as

treatment modalities (Comer et al., 2014; Orman et al., 2014). Two modalities were used in

telehealth: stand-alone, which included material but no therapist interaction or technology-

assisted, which had some degree of interface with a therapist (Anton & Jones, 2017; Comer et

al., 2014; Orman et al., 2014). The presence of a therapist, to some degree, resulted in better

outcomes (Anton & Jones, 2017; Durland et al., 2014).

The literature supplied data that demonstrated the overwhelming use of the internet for

information-seeking of both physical and mental disorders (Borgueta et al., 2018; Firth et al.,

2017; Kalckreuth et al., 2014). In the same way, plentiful literature was available on the use of

telehealth. Most of the literature used to support this study were meta-analyses of those

numerous studies. Analyses showed that telehealth was more effective than waitlist or treatment

as usual and that it was as effective as face to face therapies for multiple mental disorders (Anton

& Jones, 2017; Borgueta et al., 2018; Comer et al., 2014; Durland et al., 2014; Orman et al.,

2014). A wide array of disorders was present in the literature, with anxiety as either an integral

component or comorbidity (Anderson et al., 2017; Charova et al., 2015; Comer et al., 2014). This

gave weight to this proposal as to the potential effectiveness of the intervention.

The use of an internet-based social media group supported a relational view of persons.

Man was created to be in union with others, demonstrating vulnerability, interdependence, and

compassion (Herring, 2016). The technology presented an ironic conundrum. It connected

individuals through unique bonding experiences yet challenged the notion of remembering that

humanity had intimacy needs (Whelton, 2016). Social support, increased motivation, personal

growth, and a common comradery were all benefits of utilizing a group format. The bonus of

utilizing an online format promoted accessibility, cost, and accountability (Rogers et al., 2017).

A larger systems format in which all members individually participated contributed to the whole

group's success. In addition, all domains of personhood were addressed, including biological, psychological, relational, and spiritual. It was desired that novel treatment and attention to whole-person care created an improved lifestyle for people living with panic disorder.

Specifically, quality of life and symptom improvement or abatement were primary effects of telehealth utilization (Anderson et al., 2017; Charova et al., 2015; Comer et al., 2014; Durland et al., 2014; Firth et al., 2017). A therapeutic alliance was preserved during telehealth (Durland et al., 2014). In most of the studies discussed in the meta-analyses, effect sizes were moderate to large (Anderson et al., 2017; Anton & Jones, 2017; Firth et al., 2017). The literature presented specific concerns with telehealth, including confidentiality, adherence, logistic issues, the technological experience of users, risks of patient distress, and third party reimbursement (Anton & Jones, 2017; Borgueta et al., 2018; Comer et al., 2014; Orman et al., 2014). Therefore, this study needed to look at the more specific use of telehealth.

Social media used many platforms to launch information. These included websites, support groups, social pages (Facebook, Twitter), and chat rooms. As the topic narrowed, less information was readily available. For example, limited recent data was available for smartphones in healthcare treatment (Firth et al., 2017). Since many Americans use a smartphone, it made sense to incorporate this as a tool in telehealth (Firth et al., 2017; Ivanova et al., 2018). Large effect sizes were documented for the use of smartphone apps for anxiety and other mental health disorders (Firth et al., 2017).

Studies were virtually non-existent for the use of closed Facebook groups for healthcare support. One study was found for members of a Facebook group for bariatric surgery patients, which showed favorable recovery outcomes (Koball et al., 2017). Articles were available that investigated how the groups provoked anxiety but did not support anxiety (Campisi et al., 2017).

This indicated a gap in the literature. The literature discussed other forms of internet support

groups (Geramita et al., 2018; Griffiths et al., 2012; Martin et al., 2017). These proved successful

for both mental and physical conditions. It was hypothesized that internet group support could

also be successfully applied to anxiety treatment.

Support for Methodology

Studies of whole person care for mental health were minimal. Literature regarding the use

of various technologies for treating mental illness was evident. The specific use of social media

groups as a platform for this treatment method was essentially non-existent. Many of the

presented studies for the BPS/BPSS model employed quantitative studies or systematic reviews.

This study offered the advantages of utilizing a qualitative design to holistically fabricate a

meaningful strategy to treat a complex disorder. A qualitative platform allowed the expression of

meaning and lived experience which enriched the study's findings (Van Manen, 2017).

Phenomenological inquiry explicitly addressed the lived experience of a concept or

phenomenon (Creswell, 2013). It explored the relationship between an experience and the way

that experience was expressed (Van Manen, 2017). A key factor in phenomenological research

was using a shared, homogenous experience with a maximum group of 3-15 individuals

(Creswell, 2013; Ravitch & Carl, 2016). A shared experience helped provide rich, qualitative

data to the analysis. The beauty of a phenomenological approach was that it captured the essence

of the present moment and provided fresh perceptions instead of stale retrospection (Van Manen,

2017).

This study augmented quantitative studies available for the BPS/BPSS model. For

example, a study by Perna and Caldirola (2017) presented a heuristic proposal that impaired

bodily functioning and decreased level of fitness played a role in maintaining some types of

anxiety disorders. This study enriched those findings by the examination of the experience of improving physical fitness and other aspects of holistic health. Interviews and observations of the feelings and meanings perceived throughout the process perhaps gave light to the idea of treatment barriers for these individuals. In addition, this study added a constructive meaning to other studies which discuss only the lived experience of anxiety (Perrone et al., 2019). Although studies existed on the separate benefits of biological, psychological, spiritual, and social aspects of treatment for anxiety disorders, the combination of a holistic approach conducted in this study contributed to the literature.

Several phenomenological studies were found in the literature that used various inquiry methods. For example, one study on adolescent depression utilized only a literature review of 159 studies to produce five thematic categories. Another study used a meta-analysis of 17 critically appraised papers related to the qualitative analysis of the severely mentally ill. Several themes were categorized to incorporate into treatment ideals. Deeply analytic literature reviews such as these served several purposes. They identified key influences on the phenomenon being studied, gained innovative perspectives to guide further research, and learned specific concepts related to the phenomenon (Ravitch & Carl, 2016). Meta-analyses offered opportunities to synthesize essential data for a study (Pan et al., 2020).

The literature also presented an interesting pattern. Several qualitative, phenomenological studies were conducted regarding the lived experience of a medical issue and demonstrated the interconnectedness again between body, mind, soul, and relationships. For example, one phenomenological analysis explored the interaction between asthma and anxiety. Semi-structured interviews of individuals with both maladies were conducted, producing specific themes to improve treatment (Pateraki et al., 2018). Another study explored the lived experience

of a minor heart attack and cardiac rehab. This study utilized focus group interviews and individual interviews of 11 subjects. The most important facilitating factor in the path back to health was group support (Simony et al., 2017).

Another observation from the literature that supported this study's qualitative, phenomenological nature was that the goal was to improve care or outcomes for specific populations. For example, 12 participants were studied who transitioned from chronic pain medical management to only a chronic pain support group. With semi-structured interviews, an overriding theme emerged again the importance of social support for healing (Finlay & Elander, 2016). Hartley et al. (2016) acknowledged that the use of this type of research opened understanding and awareness to the deeply personal conditions of those suffering from chronic conditions. The authors of a study of the lived experience of ulcerative colitis emulated the importance of health professionals understanding the struggles of chronic disease to provide superior, therapeutic care (Sammut et al., 2015).

In viewing the examples from the literature, strong support was evident for using a phenomenological approach in this study. A concise group of individuals in a homogenous shared group were observed and interviewed. A lived experience of a chronic, debilitating phenomenon was explored. The data can improve the understanding, care, and treatment of these individuals and others with panic disorder. The foundation of social support was also strongly supported as a therapeutic path to healing and wholeness.

Support for Holistic Social Media Group

Since internet and phone apps function heavily saturated the literature to treat mental disorders, this study used a social media format as its treatment platform. Specifically, a closed Facebook wellness group entitled "A Fit Body, Mind, and Soul" was used for 30 days. This

holistic approach included activities that addressed individuals living with anxiety disorder symptoms with holistic effects. Each realm of focus was expected to synergistically contribute to a whole to bring the individual to an improved quality of life and reduced symptoms. The group was not intended as a formal treatment process but rather a supportive and augmented environment.

One aspect of support offered within this group was an exercise's biological component. Literature was plentiful regarding the positive influence of this entity on the physical realm. For example, aerobic exercise decreased anxiety and panic symptoms (LeBouthillier & Asmundson, 2017; Meng & D'Arcy, 2013). It also supplemented cognitive-behavioral therapy and pharmacological treatment (Garrett et al., 2019). The exercise served as a type of exposure therapy for some anxiety disorders as the somatic sensations during exercise can mimic a panic attack (Bischoff et al., 2019). The data supported the use of exercise to improve symptomatology of panic disorder. This was just one component of healing.

Another concept addressed in the group was the psychological constructs of panic. Psychoeducation was of paramount importance to decrease fear and stigma (Hidalgo-Mazzei et al., 2015; Shah et al., 2014;). The study participants were already aware of the nature of anxiety and what contributes to symptoms. In addition, relaxation techniques such as journaling and mindfulness were introduced to decrease anxiety and symptoms. The literature supported types of relaxation for anxiety disorders (Carver & O'Malley, 2015; Mrudula et al., 2018; Pangotra et al., 2018). It was anticipated that relaxation would help induce a calmer mental state so that spiritual enrichment through intentional mindfulness can occur.

Mindfulness was utilized in the existential process to augment therapeutic healing in the spiritual realm. Mindfulness techniques were used to elicit an improvement in symptoms. The

literature was saturated with studies of mindfulness for anxiety disorders (Chiesa & Serretti, 2009; Ghasemipour et al., 2013; Kim et al., 2016; Kraemer et al., 2015). Several of these studies presented data supporting the construct of mindfulness's effectiveness on neurocognitive aspects (Kim et al., 2016; Shipherd & Salters-Pedneault, 2017). Mindfulness increased self-awareness and promoted proactive health behaviors (Ghasemipour et al., 2013). One study demonstrated how mindfulness alleviated panic feelings in asthmatics (Kraemer et al., 2015). Since asthma attacks induced somatic symptoms like panic attacks, this study encouraged minimizing symptoms using mindfulness. Mindfulness was also appropriate for brief therapies, which the holistic support group mimicked (Chiesa & Serretti, 2009). Mindfulness was linked to the spiritual realm, particularly with spiritual connotations searching for wholeness and centeredness. (Garzon & Ford, 2016; Rosales & Tan, 2017).

Finally, a community of support enveloped the members of this study within the circle of the closed social media group. The literature supported group formats in treating anxiety disorders (Behenck et al., 2016; van Heyningen et al., 2017; Wang et al., 2013). The social group acted as a buffer, which created a resilience to mood disorders (Levy et al., 2018; Plaisier et al., 2007). Support was not differentiated to specific sectors such as family or friends; instead, it was a universal effect of having understanding and acceptance (Rapee et al., 2015). Despite the virtual setting, it was expected that this group connected members to others with similar struggles daily to lend support. Web support was shown to affect anxiety (Roy et al., 2017) positively.

Summary

This literature review illuminated the trail toward a holistic approach to the treatment of anxiety. It highlighted the gaps of a body, mind, soul, and relational approach to mental illness

treatment. Strong support for aspects of the group, such as exercise, mindfulness, journaling, and social support in a web-based setting, existed. The Fit Body Mind and Soul group foreshadowed a new era in creative treatment options for anxiety sufferers. The need to continue to develop resources and treatment protocols to alleviate symptoms and improve quality of life in anxiety was present. The next chapter introduced the research design for this study.

CHAPTER THREE: METHODS

The following chapter provided an in-depth outline of this qualitative study design. It was built upon the foundational elements of a phenomenological study. This chapter discussed subject recruitment methods, data collection, and experiential setting. In addition, this section restated the purpose statement and research questions with provided support. Ethical considerations ensued in a discussion.

The purpose of this study was to comprehend the lived experience of a group of individuals with anxiety symptoms who participated in a social media support group with holistic interventions. A qualitative, phenomenological study emulated this experience to demonstrate the positive effects of holistic interventions on mental health. A qualitative framework suited this study because it captured rich, subjective data from the participants. This study did not utilize an experimental approach; therefore, a quantitative design was not used. The problem statement of the need for a multifactorial treatment approach for a group of individuals with anxiety symptoms using a BPSS foundation manifested the need for a qualitative design.

The purpose of the study was to improve symptoms and quality of life. These are subjective issues by nature, so the goal of the study was to explore personal experiences of response to a holistic treatment approach. A research design that used observation and interview questions was the strongest approach to phenomenological feedback. Qualitative research allowed a subjective design in that it acknowledged that individual experience was embedded in the context of living and was experiential and influenceable to change (Ravitch & Carl, 2016). The design allowed for a social microcosm that incorporated a combination of evidence-based treatment modalities expected to improve the subjective experience of symptoms and quality of life with anxiety.

Justification for Phenomenological Design

A phenomenological design was used for this qualitative study as it described the lived experience of a group of individuals experiencing anxiety symptoms who were introduced to a BPSS approach to management. Phenomenological designs provided rich data which immersed the researcher into the world of the subject. A phenomenon was not bound by space or time and was related to a specific event (Ravitch & Carl, 2016). In the case of this study, this approach helped understand the struggles of living daily with anxiety. It demonstrated how immersing oneself in a homogenous social media group with targeted modalities for body, mind, and soul assisted in improving symptoms and overall quality of life.

Other qualitative approaches were not as appropriate for this study. For example, a grounded theory approach attempted to establish a new theory from a process or an action (Creswell, 2013). This study did not establish a new theory; instead, it sought to augment an empirically supported treatment model (BPS model) with an added spiritual element, which was already evident in the literature, although scarce. Themes were identified through interviews and observation not to form theory but for purely descriptive purposes. Also, a grounded theory approach required a larger sample size which would deter the intimacy and subjectivity of a phenomenological approach.

Another qualitative choice was that of a narrative approach. A narrative approach referred to an individualized story unrelated to any additional intervention or management strategy (Creswell, 2013). It relied on the written words and individual expressions of the individuals living within a specific context of interest (ATLAS ti, 2019). It was an approach that focused on the individual's life from their personal story. The interviews with a narrative approach spanned longer, which was inappropriate for this study. A narrative focus strung

together one or two individual stories to contribute to a cohesive story (Sauro, 2015). A narrative design would enable those with anxiety to express the lived experience of their disorder creatively, but it would slowly evolve, which was not the focus of this study.

Another style of qualitative design that was a choice was an Ethnography approach. This type of design immersed the individual in an environment to understand themes and culture but was not appropriate for this study for several reasons. First, it used a participant-observer approach in which the researcher was immersed in the daily culture of the participants (Creswell, 2013). The researcher was not part of the group in this study other than a leader/interviewer/observer. Finally, a case study approach was similar but only observed and studied an established case setting (i.e., a year in an individual's life with anxiety). A case study approach would not voice the subjective experience of a phenomenon (the holistic group).

Research Questions

Including essential research questions was vital to any study. In a qualitative study, the research questions reflected those involved in the social interaction (Agee, 2008). This study utilized the following five research questions aimed toward women with anxiety disorder.

1. How does a group of individuals with anxiety describe the lived experience of using an online, holistic social media group?

2. How does this group of individuals describe how they overcame barriers to holistic health?

3. How does this group of individuals describe their experiences in symptom reduction?

4. How does this group of individuals describe their experiences in improved quality of life?

5.   What would these individuals describe as the most impactful part of the group?

The use of this group of questions elicited a description of the lived experience of individuals with anxiety within this holistic treatment group who sought to improve their symptoms and quality of life. They were all descriptive to assess the holistic nature of the study. According to Agee (2008), the theory was inherently linked to research questions. Within these presented questions, a BPSS and systems theoretical approach was integrated.

Context of Study

The context of this study was vital to its success and generalizability. Accessibility, anonymity, and accountability were barriers to treatment and holistic care. Some of the issues with mental health treatment were discussed in Chapter One. With increased technology available, it made sense to utilize it to decrease or eliminate these barriers in the healthcare industry. Various methods focused on current studies in medical health and mental health. Current science dictates that clients seek the internet most of the time before seeking a health professional. Combining these approaches was a solution for treatment resistance.

Accessibility. Web-based resources showed increased engagement and accessibility for mental health disorders (Fletcher et al., 2018). A report from 2011 demonstrated that 75% of American households had at least one computer (US Census Bureau, 2013). It was assumed that the percentage is even higher almost a decade later. Computers gave rise to instant access to information, community, and pleasure. In addition to this, the increasing use of cell phones added to the convenience of thousands of applications at one's fingertips.

Multiple studies were done with phone applications and mental health self-help and treatment (Ainsworth et al., 2013; Ben-Zeev et al., 2013; Hidalgo-Mazzei et al., 2015; Naslund et

al., 2016; Proudfoot et al., 2013; Reid et al., 2011). They collectively demonstrated high usage among those with mental disorders, especially severe, chronic illnesses. Perhaps this was attributed to a lack of stigmatization from anonymity. In addition, individuals with mental illness sought social support and emotional stability from these accessible apps. The use of cell phone apps also enabled real-time self-monitoring and self-management (Proudfoot et al., 2013). Instant access was vital as it equipped the user to take responsibility for self-care and allowed mentoring others in the process, which are both key for growth. These applications were readily available and user-friendly (Hidalgo-Mazzei et al., 2015).

Anonymity

Computer-oriented applications eliminated the social bias and stigma from seeking mental illness treatment (Colder et al., 2018). Individuals had the convenience of getting treatment and social support from the comfort of their own home, in their car, or during their lunch hour. Accessibility and anonymity were provided and eliminated the barrier of not seeking treatment due to stigmatization. This anonymity provided a way for more honest self-disclosure than traditional therapy methods. Increased self-disclosure was shown to affect health (Rains, 2014) positively. As a result, a state of homeostatic balance of health was obtained.

Accountability

The use of cell-phone apps with social media increased emotional self-awareness (Reid et al., 2011), which contributed to healing and growth. Individuals gained relational support and emotional connections through multimedia tools (Colder et al., 2018). Human factors such as accountability and bonding enhanced e-learning environments for psychiatric populations (Mohr et al., 2011). The ease of access gave way to improved accountability. Shared rapport with a homogenous group also supported the concept of accountability.

Multimedia

Multimedia interventions illuminated engagement and learning processes and improvements in medical issues (Robbins et al., 2015). Multimedia made it possible to use counseling resources on audio, video, and live chat. An example of this was telehealth for appointments. Computers and cell phones provided instant access to information and support. This trend was evident in the realm of mental health also. Mobile phone software applications and ease of access were gradually introduced into care (Luxton et al., 2011). There were an estimated 325,000 applications for health-based applications on a cell phone (FDA, 2019). One concern with using media from phone applications was the validity of the information presented. One study presented demonstrated that evidence-based information was lacking from 25 of the top-rated mental health apps for anxiety (Bauer et al., 2020). Phone-based multimedia was a significant focus of this study.

Social Media

The premise of this study was based on the platform of social media. The use of social media in the education and treatment of mental health disorders is on the rise. Various venues included Facebook, Twitter, YouTube, Instagram, and countless other applications. These were on websites for educational purposes, groups for socialization, or podcasts for information. This environment created a safe place to be heard and mentor others (Radovic & Miller, 2019).

Facebook

The focus of this study was on utilizing a closed Facebook group. Using a social media group meant that participating individuals were invited to join the group, but it was closed off to the public. This reassured anonymity and helped create close group cohesion. Individuals with mental illness tended to use applications like Facebook more than the general population (Carras

et al., 2018). Very few studies on Facebook groups were used as a treatment modality for

anxiety/panic. Most of the literature discussed addiction with Facebook use. One study spoke of

the ease of Facebook use in individuals with anxiety (Indian & Grieve, 2014). After IRB

approval was received from Liberty University, participants' advertising and selection process

began. An integral part of this process was analyzing and discussing ethical issues for the study

and its participants.

Participants and Ethics

An important element in this study was addressing the concept of ethics. The participants

were human subjects that required a level of ethical protection. Different variables were

accounted for to protect the integrity of the information gleaned from the participants using

multimedia (Taylor & Pagliarli, 2018). Issues could be encountered during participant

acquisition and consent. Specific steps were taken to ensure this ethical safety for participants

(Bender et al., 2017).

Digital Ethics

The use of social media introduced a new array of ethical concerns. There could have

been tangential issues from basic ethical concepts of confidentiality and safety. Qualitative

research in the digital world posed "ethical reflexivity" because the cyber environment was

dynamic (Roth & von Unger, 2018). Continual reassessment of the environment for possible

threats to the ethical integrity of the research was conducted. Ethical concerns will not be solely

abolished by institutional approval; instead, they will need to be viewed as aspects of human life

and relations that evolve continuously (Roth & von Unger, 2018).

The internet also had millions of connected sources. The virality of a post or ad was

always a concern and threat to ethics. A researcher could post an ad for recruitment on a social

media site. It could go viral and be uploaded by other groups' sites on social media (Ellis-Barton, 2016). If that site were a closed group, access would not be available to see comments or requests to the ad. In addition, an interested party could have commented under the ad itself, making its name and information available to anyone. Private messaging was used to communicate with potential participants to avoid this.

Another issue with digital media research ethics' confidentiality was privacy. Even if the participant was at home using a personal laptop, it still joined that individual to a closed group of other individuals (Whiting & Pritchard, 2018). In the same sense, if a client visited a private therapy office and had information entered in an electronic health record, this still posed a risk to a breach of confidentiality. The use of digital research required ethical considerations in a bottom-up format since numerous other domains were linked to each other with their own governing rules for ethical boundaries (Ellis-Barton, 2016). For example, Facebook warned about the risk of dissemination of public/private posts in their legal statutes (Ellis-Barton, 2016).

Another issue of confidentiality that was addressed paralleled standard HIPAA guidelines. Members of the closed group were informed that they could not share information in private posts or conversations (Ellis-Barton, 2016). Other concerns in digital ethics also concerned participant safety. In a social media platform, user identity is not always guaranteed. Group participants were identified using Facebook profiles. Hackers or criminals could have designed these. Confidentiality and safety would also be at risk. Further rules to participant selection were considered, such as length of time as a Facebook member, to prevent this. Examination of this information helped distinguish if someone was a longstanding member or just made a quick profile to join the group.

Selection

      Participants' selection and ethical protection was an essential element of this study. A self-sponsored ad on the social media site Facebook was deployed to attract potential candidates for the study. This did not get much attention. The ad referred in general to the distress in living with anxiety. It mentioned that a research study would be conducted within a closed Facebook group that will include light exercise, spiritual mindfulness, journaling, and social group activities to help with anxiety in a closed group setting. It invited interested parties to private message this researcher for further information.

      Due to poor response on a Facebook ad, an email ad was used through a university department. The same criteria for participants and ad were utilized to recruit participants. The public expansion posed additional confidentiality threats for those that responded in that they may have known others in the study. The ad was designed to elicit responses from those suffering from symptoms of anxiety. It used a descriptive summation of key symptoms of anxiety and offered a holistic online 30-day challenge group that combined physical, cognitive, spiritual, and social elements.

      Once six responses to the ad were received, further screening ensued to rule out a few specific contraindications. Some exclusions included the use of concurrent therapies and physical limitations. The exclusions are applied to eliminate any potential bias or other threats to validity. The first six participants who met these qualifications were notified of their acceptance into the study. It was expected that more participants would be interested than could be accommodated at this time. Phone numbers for NAMI and Suicide Hotline were made available, and suggestions to go to local counselors or Emergency Room if warranted to protect the emotional safety of both

participants and wait-list individuals. It was stressed that the group was not considered therapy but a research study. There was not enough response to warrant a waitlist.

The use of a smaller group denoted a deeper depth of inquiry. The fewer participants allowed more time to inquire into the breadth of the lived experience of the disorder and the group. The frequency of data was not as important as individual meaning in qualitative research, and the lengthy interview process was less time-consuming with a smaller sample (Mason, 2010). This group also supported a therapeutic number suggested for group therapy work (Yalom, 2005).

Informed Consent

Informed consent was used to educate and ethically protect the participants prior to beginning the study. The consent was created to outline the study, offer the opportunity for withdrawal at any time, release liability, and ensure confidentiality outside of the closed group. The qualitative research process was briefly presented to the participants, acknowledging that it did not replace necessary medical or psychiatric treatment. The group was intended for individuals with bothersome yet manageable symptoms. These symptoms may have been present but did not cause major disruption of school or work.

Risks and Benefits

This study mandated a discussion of risks and benefits with the participants. For this study, various risks were present. Human subjects were always at potential risk for injury or illness during the study. The informed consent released liability for any harm during the study. An individual could become more mentally unstable during the study and require professional treatment. Also, individuals may have needed to drop out due to life circumstances, the need for medication or other professional treatment, or loss of interest. There was a risk of self-disclosure

and stigmatization within the small group. There was also the chance that the individual would not improve symptoms or quality of life.

Benefits were part of the proposed outcomes for this study. Participants had improved or decreased symptoms associated with anxiety/panic. Improvements in quality of life, defined by the participant, were reported. The 30 days of the group introduced holistic concepts of wellness regarding body, mind, soul, and relationships and established a habit of routine for the participants. The social microcosm of the homogeneous, closed group provided cohesion, support, and interpersonal relationships. One of the benefits of an online group was that it possibly increased adherence to the treatment protocol (Griffiths et al., 2012). Another study showed that social interaction and support were important to healing those with mental illness (Van Grieken et al., 2014). Participants in an online health support group also gained information and had improved preparation and acceptance (Huber et al., 2018). The group served as a reset button to guide the participants to a balanced lifestyle, which alleviated their symptomatology and decreased quality of life.

Role of the Researcher

As both a nurse and counselor, health and vitality were core functions in the care of persons. Treatment of the whole individual was critical for maximum health and growth. Anxiety touched all individuals to some degree; therefore, this study had significance for a broad part of the population. As a former sufferer of anxiety, I attested that a multi-modal approach was essential to symptom relief and increased quality of life. This study impacted individuals with anxiety or panic issues with provision of a program that touched all aspects of an individual.

Past/Current Professional Roles at Setting

I had experience running closed challenge groups as a health/fitness coach. The challenge groups consisted of physical exercise paired with a growth mindset. The study challenge group added the elements of cognitive and spiritual to the physical aspects of the challenge group. I am a seasoned nurse and psychiatric nurse practitioner with advanced knowledge of holistic health practices, function of the body and mind, and integration of the spirit into care.

Past/Current Professional Relationships with Participants / Data Collection

Although I did not have past relationships with the participants, I had personal experience of anxiety/panic symptoms. Familiarity and empathy with the symptoms and quality of life experienced by the participants were experienced by me in the past. I used similar methods to improve the experience of anxiety/panic successfully. A holistic mindset enabled an empathetic stance throughout the study during the data collection process. Since anxiety had been a personal experience, the impact of a supportive community of individuals experiencing the same phenomenon cannot be stressed enough.

Researcher/Participant Working Relationship

Establishing trust and rapport with the group and individual members was essential. This process started from the beginning screening process and carried through until the end of the group. Since the group was based within a social media context, there was no in-person interaction. Live group meetings substituted for this. MS Teams conferencing was used for interviews. In addition, daily posts to the site regarding tips suggested activities and motivational pieces were used. Researcher availability with MS Teams contact also was posted for any study-related questions.

Researchers Experiences/Biases

As stated previously, I utilized similar approaches in similar situations on myself. This created a favorable outlook on the research approach and interpretation of data. Qualitative research embraces the subjective, which could have potentiated bias on my part. The transparency used during the research process and the careful analysis of patterns that emerged from data were key concepts here (Galdas, 2017). Although passionate about holistic treatment approaches, I remained committed to conducting the study and interpreting data objectively.

Criteria for Participant Selection

Social Media Ads

The participants for this study were initially solicited through an ad on the social media site Facebook. The ad targeted individuals aged 25-55 with anxiety, panic, and mental health interests. When an individual purchased a Facebook advertisement, it automatically generated specific profiles linked to the categories of choice. For example, this ad populated on the news feed of Facebook users in that age group with those interests, making it a more efficient process. Once the user clicked on the ad, they were taken to the correct page, which told more about the study and link to an application. After six subjects (the first six qualify), the link would have been disabled, and the ad removed. Due to poor response and limited time, the ad was stopped and changed to an email ad through a department at a large university. The same ad language was used. At least five participants were required to give a depth of inquiry and enhance the quality of interaction within the group (Jacobs & Nakata, 2012).

Anxiety Criteria

Individuals prospected for this study must have had either a formal diagnosis or subjective symptoms of anxiety symptoms. The ad described anxiety symptoms to ensure

homogeneity of symptoms and disease process. Participants needed to be stable enough in their symptoms that they felt they could complete the study. The study appealed more to chronic sufferers rather than acute onsets of symptoms. The ad particularly sought those individuals who had tried multiple therapies or treatments and were still symptomatic.

Comorbidities

It was essential to exclude specific comorbidities to increase the generalizability of the study. Primarily, exclusions were made for diagnosed personality disorders, bipolar disorder, schizophrenia, and chronic illnesses. In addition to decreasing generalizability, these conditions also were associated with non-compliance and multiple medications. Depression was the sole comorbidity allowed in part due to its common coexistence with anxiety disorders.

Medications

Ideally, the participant was not on any medications. This exclusion proved a very difficult assumption in today's healthcare world. The first tier of medications of concern was psychotropics, including SSRIs and benzodiazepines. These medications were designed to decrease symptoms of anxiety. There also could be side effects that could impact physical or cognitive functioning. Some side effects of these drugs included mental fogginess, dizziness, fatigue, and stomach upset (Zoberi & Pollard, 2010). If a participant were on a medication, it could skew results from another participant who is not taking medication. It was assumed that a participant on medication could have fewer symptoms. If symptoms were truly being controlled, that individual likely would not have volunteered to participate.

It was expected that a population struggling with symptoms that interfere with the quality of life likely visited a physician for diagnosis and had been prescribed medication to manage symptoms. It was estimated that only one-third of treated patients have remission of symptoms,

and one out of five patients were left with a chronic, pervasive illness (Marchesi, 2008).

Therefore, both participants on and off medications could participate in the study, allowing for

some variance in results. It also made the study more generalizable to accommodate both

populations treated and untreated.

Interview

A short interview was needed with each potential participant to determine any exclusions.

Since the participants could be located anywhere in the country, a Microsoft Teams interview

was utilized. The interview was 15 minutes long and asked screening questions related to

previous or current treatments, medications, comorbidities, and the ability to participate in the

actual study exercises.

Data Collection Procedures

Data collection was completed according to the foundations of hermeneutical

phenomenology. This entailed capturing the spoken word, piecing together themes, and

illuminating patterns of experience within a lived experience (Sloan & Bowe, 2014). Narrative

interviews of the lived experience of anxiety/panic disorders were conducted. The interpretations

of these interviews justified the use of this hermeneutical approach. The researcher's job was to

hear both the joys and ills within this diathesis and unearth the meaning of the text itself

(Lindseth & Norberg, 2004).

Data Collection

An interview guide was used to structure the interview (Appendix B). Data collection

intervals were pre-study, two weeks, and four weeks. These blocks of time were chosen

strategically. Baseline data before the study begins was essential to providing foundational

markings for data development. Two-week intervals marked the mid-point and endpoint of the

study. Many of these activities within the group were healthy, holistic habits that hopefully were

incorporated into the participants' lifestyles. Data collection consisted of Microsoft Teams

interviews with a specific set of questions prior to starting and different sets of questions at the

remaining two checkpoints. Baseline questions included symptoms and quality of life issues,

alleviated symptoms, triggers, current fitness level, mental health knowledge/skills, and past

treatments.

I conducted the interviews, estimated to take approximately 20 minutes each. Interviews

were audio-recorded with the permission of participants. The interview was replayed and

allowed me to carefully assess the tapes for thematic patterns in greater detail. (Bailey, 2008).

Participant information was protected by using anonymity in the patient recordings. For example,

each subject was assigned a pseudonym to not identify by name (Stuckey, 2014). Coding directly

from tapes can bear more authenticity of voice and relay unique qualities that transcription

cannot (Tessier, 2012). The tapes were secured in a lockbox in my office.

Data Analysis

In phenomenology, the premise of the analytical process was for the description,

interpretation, and organization of the data of the lived experience of a phenomenon (Moser &

Korstjens, 2018). Special analytical software was unnecessary since a relatively small sample

size was used. Rather, this researcher looked for and identified patterns within the interview data.

Common themes in responses and the group process were noted. The data analysis process was

maintained according to foundations established by phenomenological leaders in the field. Data

must be organized specifically to begin the analysis process (Moser & Korstjens, 2018). The

steps of this analysis process were viewed in various ways amongst the first of the

phenomenologists.

Moustakas' (1995) approach to this analytical process involved looking at the experience of a phenomenon as a whole and within context. This research approach supported the philosophy that the whole was always greater than the sum of its parts – the lived experience as a solidified endeavor gave forth more data than individual components (Adams et al., 2007). Moustakas also described an epoché process to identify ideas on the topic at hand and lower the risk for researcher bias (Phillips-Pula et al., 2011; Yuksel & Yildirim, 2015). This type of approach lent an emphatic understanding to the effects of living with a mental illness (Sutton & Austin, 2015).

After data collection, Moustakas described a horizontalizing process that gleaned irrelevant data not part of the research element (Moustakas, 1995). Then, a reductive process that molds data into structural transcriptions with infused subjectivity was performed (Phillips-Pula et al., 2011). Thematic constructs were gathered from the data (Yuksel & Yildirim, 2015). This process was repeated until a level of saturation was reached (Phillips-Pula et al., 2011). No new information was available anymore, and maximum information was taken from the study (Moser & Korstjens, 2018).

Another phenomenologist, Colazzi, had four steps that he felt were integral to the analytical process. He believed in reading and rereading the data multiple times to gain a more personal kinship with the experience (Phillips-Pula et al., 2011). Next, the main statements that were indicative of the phenomenon were studied. Third, different meanings from the data were extrapolated. Finally, prominent themes were isolated (Phillips-Pula et al., 2011).

Trustworthiness

Although approaches to phenomenological data analysis varied, they shared similar goals overall. It was also important to develop rigorous standards to ensure that collected data was

reliable and valid. Trustworthiness needed to be established. Four criteria of trustworthiness in qualitative studies were credibility, transferability, dependability, and confirmability (Sutton & Austin, 2015). There were several ways to establish trustworthiness. In this study, the following procedures were used to establish rigor and trustworthiness: interviews, triangulation, member checks, debriefing, and retention tactics.

Interviews

Interviews were the gold standard for qualitative research. These interviews were semi-structured with a standardized set of questions for each interval of study and each participant. The sole researcher conducted the interviews. Interviews were done privately and not in the group setting to promote confidentiality and disclosure. Data was transcribed as interview verbatim.

Triangulation

Triangulation used more than one method to obtain data (Carter et al., 2014). In this study, observation and interviews were utilized. Observations, or field notes, were done during the study when an all-group meeting was held. Meetings served the purpose for the social aspect of the group and updates, shares, and encouragement. Focus groups consisted of all the participants at the end of the study to discuss what worked the best and what was least helpful. It gives a sense of partnership and enforces the relational aspect of the group. Focus groups were not utilized but may have proved beneficial.

Member Checks

Member checks were another method to establish trustworthiness in a qualitative study. Member checks have different methods. One of these was to email all participants copy of all three transcribed interviews. The participants would have gotten a chance to double-check or add

anything to the final transcripts, which infers higher accuracy of data. It also could promote

group adhesiveness as the participants will feel like integral team players and be considered co-

researchers in this process. The inclusion and value of participants demonstrated an aspect of the

horizontalization process described earlier (Yuksel & Yildirim, 2015). In addition, the primary

research-validated data depends on the co-researcher's final answers (Yuksel & Yildirim, 2015).

Member checks were not used but may have proved useful in validating data.

Debriefing

Debriefing was an important function for the researcher to prevent bias and dropout. It

helped deter any negative feelings or emotions the study may have imposed (Kazvin, 2002). It

was a time used for questions, concerns, or guidance. After the study, debriefing also was done

with some of the members to process thoughts and emotions linked to the intervention. Above

all, the researcher reassured against deception (Kazdin, 2002). Full disclosure of any part of the

study that may have been hidden would be completed after the study is finished. Debriefing

participants included the following: the purposes of the study, the observations, the reactions of

participants, and all aspects of the study that were considered (Kazdin, 2002). Debriefing was

done individually in the last interviews.

Retention Tactics

There were several tactics for retention that could have been utilized. One of these was

an incentive gift card, like Starbucks. Everyone who completed the study would have received

one. Incentives were not used but may have increased retention and participation. Another tactic

was to allow voluntary withdrawal if something happened during the study. This was enforced

and utilized in the study. Study reminders of group meetings or activities were also important for

retention. All participants had a reason for doing the study. Simple reminders at each weekly

session helped them continue forward. Also, the altruistic effect was that their results could help others struggling with the same issues. Kazdin (2002) recommended being proactive in looking at potential attrition reasons and trying to negate those from the beginning.

The primary goal of Chapter Three was to establish procedures for data collection and analysis for this qualitative study. Various elements about the foundation of the study, such as participants, selection, procedure, ethics, trustworthiness, and data collection and analysis, were discussed. According to the founders of this approach, a phenomenological approach to the data collection and analysis process was used. The primary goals for Chapter Four was to dissect the research findings further and demonstrate that all protocols were followed to protect the reliability and validity of the study.

CHAPTER FOUR: FINDINGS

This phenomenological study examined six individuals with anxiety who participated in a holistic social media group. This intervention was structured to integrate the physical, mental, spiritual, and relational aspects. Information from these participants was gleaned primarily through semi-structured interviews, individual and group, and the social media page observation. The interviews were both recorded and transcribed. Interviews were done by phone or audio/video on Microsoft Teams and were about 15 minutes in length. Participants chose if the camera was on or off depending on their comfort level. There was an initial interview, a two-week interview, and a final interview for everyone. In addition, weekly group interviews were arranged. Interview guides were utilized for each interview session to keep variability to a minimum. Anonymity was generated by using pseudonyms for each participant. Recordings were to a cassette tape and transcription. Cassette tape data and transcription printouts were scrutinized repeatedly to identify any pertinent data themes. In addition, this researcher utilized a notebook to handwrite patterns and emerging themes for each participant as the transcripts and audio tapings were further reviewed. Individual data were then grouped into respective categories of larger themes and subthemes. Chapter Three described the data collection and analysis process in detail.

As described in Chapter Three, Moustakas' (1995) method of data collection and analysis was used for each participant in the study (relative to data obtained). The information was laid out, and all generated data was viewed as a whole and then sifted through individually. Reduction and elimination procedures occurred according to the method by Moustakas. Each quotation was ensured that it validated the lived experience in one or both domains of symptoms and quality of life, and it could be reduced to a specific theme or subtheme. Next, this extracted

information was used to generate themes unique to each participant. Themes were formed against the data to ensure they validated the personal attributes of this individual's experience. Then, textual descriptors of this data were studied for each participant using quoted material. These were integrated to form a wholeness in themes and subthemes as a group overall.

The problem at hand and purpose of the research was that individuals with residual anxiety symptoms have not effectively received holistic treatment for all areas of self. The research questions were strategically designed to inquire into two specific areas affected by anxiety: symptoms and quality of life. The findings reflected each research question and were categorized into themes and subthemes. Table 1 depicts this data.

Before beginning, the general demographic data of participants will be discussed. A total of six participants were approved, consented, and enrolled in the study. All six participants were either counseling students or worked in the counseling profession or both. Five participants were female, and one was male. All ranged from young adulthood to middle-aged. All participants were married or separated, and all had children except for two individuals. Table 2 further illustrates these demographics.

Table 1

Participant Demographics

Participant	Employment	Marital Status	Children	Treatments	Completion of Group Activities
Sally	Yes Doctoral student	Single	Yes	No	2/4
Bill	Yes	Married	Yes	Medication	3/4

	Counseling Student				
Suzy	Yes Counseling student	Married	No	Therapy	3/4
Amy	Yes	Divorced	Yes	Therapy	2/4
Missy	Yes Counseling student	Yes	Yes	No	unknown
Anna	Counseling Student	No	No	No	2/4

Background Data of Participants

All the participants reported anxiety prior to the study and how it impacted their daily lives. All have presented vivid descriptions of physical, mental, spiritual, and relational symptoms related to anxiety that affect the overall quality of their lives. Despite all being related to the counseling profession, they were deficient in finding self-care practices to assuage their anxieties. The following data will take a deeper look into the lived experience of these participants dealing with chronic anxiety.

Physical

Physical symptoms were prevalent with anxiety (Woud et al., 2013). These symptoms ranged from mild to severe and produced a chronic sense of fear and dread, debilitating for

lifestyles and relationships. Symptoms varied with each individual but included increased heart rate, palpitations, shortness of breath, tremulousness, gastrointestinal effects, dizziness, and faintness. These symptoms mimicked heart problems and other medical disorders, further perpetuating anxiety. Symptoms began suddenly and lasted for several hours. The following verbatim will give a closer glimpse into the participants' lived experiences of physical effects with anxiety.

Most participants had physical effects from the daily anxiety they experienced. For example, Bill described that he "physically feels like someone is scraping nails down my back. I get kind of tensed up, my body clenches. Depending on how much my anxiety progresses, my chest feels like it is being squished." Amy described "difficulty sleeping, eating, poor hygiene, and picking at skin." Stress serves as an antagonist and triggers more physical symptoms. Suzy shared, "My health is just kind of all over the place. I have one or two panic attacks per year. I feel shortness of breath and electricity running through my body." Sally also explained how "stress makes me totally forget what I need to be doing." Anna described full-blown panic attacks – "My heart starts to race, I can't stop shaking, I can't go in stores."

Mental

The mental aspect of anxiety was just as frightening and inhibiting as the physical effects. Anxiety stirred up a primal sense of fear and dread in an individual. This fear froze attempts at living a productive and healthy life. Worry and panic ensued, creating a chaotic state of existence in one's mind. Most individuals refrained from sharing these experiences with others for fear of appearing crazy; therefore, they became silent sufferers. The domino effect of the mental state to potentiate isolation was observed.

Most participants described an internal mental process that also affected or was affected by anxiety. Suzy further described this feeling, explaining, "there is an anxiety that is overarching where no matter what really is going on, even if really nothing is going on. I can't feel like I'm settled." Bill stated, "I will start worrying about something that hasn't even happened yet. I will play out scenarios in my head." Anna explored another dimension there. She stated, "I feel like I lack confidence because of anxiety and negative self-talk." Her response begs the anxiety emanates from an internal source versus external sources. Is the stress occurring before or after the anxiety, or is it a vicious cycle?

Spiritual

The spiritual component of anxiety further exemplified how each dimension of a human was interrelated. Several participants noted a sense of discomfort or lack of peace in the spiritual realm. It was difficult to ascertain if this occurred directly or indirectly due to anxiety or if the spiritual riff had created anxiety. Spirituality defined by these participants evoked a relationship with a higher being. It also refers to an individual's sense of meaning and existence. Participants shared some surface-level discord about their spiritual state but did not disclose much of the intimacies involved. Spirituality was voiced as an area of struggle for several study members. There was a consensus of difficulty in this area before and within the group. Bill described a state of "spiritual limbo." Suzy stated that "her faith has been something that has been difficult for her," which impacted her completing the spiritual exercises.

Relational

In the same way that physical, mental, and spiritual components are affected by anxiety, relationships are another element that was significantly impacted by living with anxiety. All individuals were involved at some level with interpersonal relations with another. These

interactions were affected when one did not have personal needs met somehow. Relationships varied between family, friends, God, work, home, or school. Much data from participants indicated a struggle in this area.

All participants described relationships at home and/or at work. Most appeared only to have difficulty with relationships at home. Work appeared as a protected area where the guard was not let down. Bill stated that anxiety "obviously affects my family and kids. If something gets me the wrong way, I get snappy. Sometimes it hurts to be touched by others. When I am in a large crowd, I feel like someone's on my shoulder." Bill further explained, "one thing that can really affect me is if I'm starting to feel anxious, and we have an event coming up like we have to go somewhere, even to a cookout across the street. I will sometimes just not be able to deal with people." Suzy shared, "I'm married. I'm sure it is not fun for him to deal with. If he gets me at the wrong time, I think it sometimes can feel like it's getting under my skin a little bit." She also stated, "I would cancel plans, cancel appointments."

Anna shared, "I get irritated, get mad. I cry and say things I shouldn't." Amy described how her anxiety had kept her isolated at work. "I've hidden how much anxiety I have had; I became a master of disguise." Missy stated that her anxiety prevents her from going inside stores. Within the group, isolation was demonstrated as minimal interaction in the social group. Amy stated, "the social group ended up not really being. I felt a more structured approach would have helped. People that do struggle with anxiety almost need that structure." After the group, isolation did not improve much. Although some participants started to walk outside more, significant social interaction has not improved. These examples demonstrated how anxiety could be detrimental to self and others physically, mentally, spiritually, and relationally.

Barriers

In addition to these negative impacts on one's life, the participants voiced perceived barriers in overcoming these challenges to a balanced state of health. Barriers can be anything that stops an individual from progressing. These were personal, environmental, financial, physical, mental, spiritual, or relational. Most participants voiced at least one barrier in combatting anxiety symptoms and decreased quality of life.

All participants acknowledged a lack of time and busy schedules as a barrier to achieving a state of health and peace. Lack of time, a busy schedule, and distractions were all described as contributing forces that impeded study participants from achieving a state of holistic health. Some of these distractions included work, school, family, and stress. Participants also voiced discomfort as a barrier to reaching holistic health. Sometimes, the environment-induced enough discomfort to prevent holistic activities. Sally described, "Putting myself in a time crunch makes it set in my mind that I don't have time to do anything else." She also described how the hot temperature stops her from mindful walking. Bill described having to force himself through a social situation and would just rather stay home. Suzy stated she "hates journaling as it reminds her of school." Anxiety even created discomfort in one's own life. Amy stated, "I almost have to give myself permission to live." The spirituality element was another area that caused discomfort.

Participants also cited that they do things a certain way because of their personalities. Examples include trying new activities, like journaling or walking. Resistance was met on some levels because these were activities that individual participants did not enjoy. Their minds were closed to trying new things. For example, Bill referred to "personality traits," which cause him to want to isolate and "feel like a jerk" in social settings. He also stated, "I am not good at

journaling. My mind has more of a stream of consciousness pattern. When I feel like I'm forced, then it is not helpful to me." Suzy felt that "a few weeks is not enough to make changes" in her mindset. Missy relayed how early childhood abuse and trauma significantly impacted her worries about her current family. "I have a problem letting them grow up. Worrying that my husband will leave me also affects our relationship." All participants also shared that stress is a forerunner of anxiety and a byproduct. Stress was present whether within the group or outside the group. Participation in the group did not negate the existence of daily stress

Interpersonal Activities

Regarding interpersonal activities, most participants did an average of two activities daily, with one participant doing three activities and two members doing less than two. One participant stopped responding during the study. The remaining participants found activities that they liked or did not like. All but one participant stopped the activity that they disliked. One participant transitioned from dislike to that activity being the most impactful, mentioned by Amy above.

These descriptions emulated how anxiety created chaos holistically. Descriptions of physical symptoms included the following: stomach aches, insomnia, racing heart, shakiness, tight chest, picking at skin, and lethargy. Mentally, participants described a lack of focus, irritability, distraction, and a feeling of overwhelm. Spiritually, several participants battled a struggle with their faith systems. Relationally, isolation was a common finding. Barriers were intertwined with the maladies of anxiety: desired but unfulfilled potential further fueled erratic symptoms and reduced quality of life.

Findings

The findings integrated into the essence of the research questions and design. They emulated the spirit of the lived experience with anxiety and its relation to every area of being. The following section dissected each research question into various themes and subthemes. Introspection into the participant's hearts during the immersion in this group was discovered through shared quotes of their experiences. The research questions were as follows:

1. How does a group of individuals with anxiety describe the lived experience of using an online, holistic social media group?

2. How does this group of individuals describe how they overcame barriers to holistic health?

3. How does this group of individuals describe their experiences in symptom reduction?

4. How does this group of individuals describe their experiences in improved quality of life?

5. What would these individuals describe as the most impactful part of the group?

RQ1: How does a group of individuals with panic anxiety describe the lived experience of using an online, holistic social media group?

The participants in this study experienced an online, holistic group in the context of social media. All were included in a private Facebook group together. Each day of the study, participants were asked to perform self-care exercises designed to care for the body, mind, and spirit and weekly group relational interactions. Mindfulness was the basis of all the exercises. The participants experienced mindful walking, mindful, spiritual awareness, and reflective journaling. A social media group was designed for interaction between the members to provide

encouragement and support. The activities required changing their existing daily habits to restructure their time accordingly.

Regarding the primary research question, several themes and subthemes emerged. Most of the participants shared commonalities in these answers. The group served as a sort of microcosm to their actual daily lives. It reflected priorities, time management, relationships, and self-care. Three main themes evolved from the lived experience of a holistic, online social media group. These included Reflection, Isolation, and Stress. Each theme also segued into a subtheme(s). Reflection produced the sub-theme of Revelation; Isolation produced Disengagement, and Stress produced either Avoidance or Growth. Each of these themes and subthemes were further defined.

Reflection

The first theme encountered in response to this research question was Reflection. The act of looking inward further defined this concept. The Merriam-Webster dictionary (2021) gave several interpretations of the meaning of the word reflection. These included "an effect produced by an influence; a thought, idea, or opinion formed, or a remark made as a result of meditation; and consideration of some subject matter, idea, or purpose." Reflection allows an individual to appraise innate qualities or traits by personal evaluation and experience (Pool & Qualter, 2018). Reflection was usually not a quick process; rather, it evolved with intent and time. It was grounded in an individual's lived experience and negated any preconceived perceptions with the expanse of time (Pool & Qualter, 2018).

The participants' responses supported the theme of reflection. As demonstrated in the definitions above, an individual must take the necessary time for reflection. In the busyness of daily schedules, the participants discovered that a pause was necessary to seek answers or

tranquility. Pauses were created by the performance of each of the mindfulness exercises in the study. Amy said that "journaling helped slow my racing thoughts down." She also shared that "Doing the walking, I was trying to get to the bottom of like why this is so difficult for me to stop and pause." Suzy stated that "Shutting out the world for a little bit was very helpful for me." Bill explained why doing one of the activities helped bring a better perspective. He discussed "being able to take time on walking to focus on something positive and not always just like I'm rushing from point A to point B." He also described a mindful walking experience, "The roses were blooming, and I just got a giant whiff of roses, and it kind of made me stop for a second and just pay attention to what was going on around me."

Reflection was necessary for inner growth. It enabled the individual to introspect about life, purpose, and meaning. Reflection required intentionality. After initial reflection, another layer of self was discoverable. The revelation occurred after a period of reflection, which gave way to deeper growth and self-actualization.

Revelation

A subtheme that emerged from Reflection was Revelation. Revelation was defined as bringing awareness to the previously hidden or unknown (Merriam-Webster, 2021). Participants discovered that opportunities were created for deeper introspection in pausing the busyness. Bill stated, "I'm noticing moments where I can just stop, even if it is just for 30 seconds and be mindful, and it is helpful". Sometimes, these opportunities can bring groundbreaking truths to the surface. Amy explained:

> During the walking, a huge kind of groundbreaking thing happened in the last week. A
> lot of my anxiety is rooted in this idea from a very young age, but I feel like I live as if
> someone is watching me, not in a paranoid way. A lot of my anxiety is like I am almost

watching like I'm not in my life. I'm watching from above. I'm constantly trying to live up to whoever that is. I am constantly criticizing every single move, and so, of course, I'm not able to stop and breathe and be mindful.

Through reflection and revelation, several participants experienced a surge in personal growth. Through these deliberate pauses from the busyness of daily life, these individuals developed a new perspective on the deep origins of their anxiety. These breakthroughs demonstrate the effectiveness of the act of intentional mindfulness. Even though some participants experienced this type of growth, most participants remained stagnant in one area. This was dominant in the social realm and maintained isolation from others in the group and life.

Isolation

Surprisingly, isolation was a common theme as part of the lived experience of an online, holistic social media group. Isolation was defined with several terms, such as withdrawal, separation, seclusion, and partition. Merriam-Webster (2021) defined isolation as "without relation to other people or things." Isolation was noted both between members and me. Isolation involved lack of involvement in the social media exercise or response for study meetings. A subtheme of Disengagement emerged from this theme.

Group members focused their experience of isolation on the social media group. Across all participants, the group was the least engaged activity. Bill shared, "I was trying to be engaging. At times it just felt like discussion board homework. There's no real interaction." Several participants thought there would have been more participation if the group were bigger. This could have been that most were introverts and rely on others to engage while they stayed in the background. Some participants felt the group needed more structure, although the specific task of posting weekly and engaging support with other members was required. A key point of

the structure was to leave it unstructured for mutual support and sharing. Amy stated, "I just hide in my little shell."

Disengagement

Disengagement was defined as "emotional detachment; objectivity" (Merriam-Webster, 2021). Disengagement also referred to withdrawal concerning a stimulus perceived as threatening (Garner et al., 2011). The perceived environment promoted isolation. Disengagement can also be a passive attempt to withdrawal in relationships to avoid conflict (Backer-Fulghum et al., 2018). Isolative behavior was evidenced by several participants in home and work relationships and the study group. Throughout the study, several members became disengaged, stopped responding, and one member dropped out. Disengagement occurred not only relationally but also spiritually. Several participants shared a struggle spiritually, which proved enough discomfort to limit or stop the exercise. For example, Amy said, "the spiritual aspect of this is probably the most uncomfortable just because I don't feel completely settled." Anna dropped out of the study because the mindful, spiritual exercises caused her to become more anxious thinking about her father's death and her mortality. Bill eliminated the spiritual aspect from his meditation exercise as he described himself as "struggling spiritually."

Stress

A final theme that emerged in answer to this research question was that of Stress. Most participants led very busy lifestyles, so adding more tasks to their daily lists created some increased stress. Stress housed many definitions. The most pertinent one here is the effect of an internal or external force on one's well-being. It is an automatic state of environmental stimuli that produces mental and emotional tension (Vahedi & Saiphoo, 2018). As evidenced by their self-imposed time constraints, stress was created or imposed. The definition also correlated to

which domain of an individual is impacted (Vahedi & Saiphoo). For example, relationship issues created social stress, and mental health issues created psychological stress. The stress created a continuum of sorts. It paralyzed and sabotaged the individual from moving forward. If stress created a level of anxiety that was beyond an individual's coping capacity, mental health conditions deteriorated (Vahedi & Saiphoo). The theme of stress was divided into the subthemes of Avoidance and Growth to illustrate the dual nature of what participants expressed about their experience.

   Avoidance. Avoidance was an intentional refrainment from activities or persons. Discomfort promoted avoidance and fear as well. Avoidance was a protective factor, a way the mind, body, and soul shut down from potential harm. It was also a type of conditioned response from which the individual has adapted. Dictionary (2021) defined avoidance as "the action of keeping away from or not doing something." It was a deliberate action on behalf of the individual to prevent themselves from a particular experience.

   Sally shared that "everything fell out the window" when a stressful event occurred during the study. She referred to when she was trying to develop good habits in the group, but her hard drive crashed and lost lots of data. This stressor influenced her to stop all her healthy activities and propagated more anxiety. Another participant echoed this concept as well. For example, Bill shared, "More stress affected some of the things not helping at the moment." Bill also felt that doing the group activities "felt more reactive than proactive." He further explained that he had not yet developed the daily habits necessary to engrain the activities into his routine to be helpful to use when anxious. Rather, he only remembered to do them after the anxiety started to worsen. Sally defended not performing all wellness activities by stating, "I'm just so swamped with other stuff. I have not done the walking so much just because of the time needed to do it." Bill shared

the struggles of adding the activities to work and family. "I find myself at the end of the day that I still need to do this – that's my struggle, and that's more just because of everything going on with school, work, and family. I struggle to get up at 4:30 to journal because I'm up until 11 pm doing school and my second job." One participant felt that the structure of her packed schedule helped keep the anxiety at bay. Suzy explained that the study occurred after graduation from a rigorous master's program. She stated, "I wasn't stressed two weeks ago when my plate was full. Without schedule or rhythm in my days, my anxiety is higher."

Growth. Growth also occurred from stress. Growth was also an indirect result of voluntary action. Hazlett and Stevens defined personal growth as the intentional process of aligning personalized goals and values with veracity to strengthen an internalized view of self (as cited in Aafjes-van Doorn et al., 2020). Personal growth was a core, intrinsic need for every individual (van Woerkom & Meyers, 2019). Growth resulted from personal responsibility for self-directed activities combined with initial resistance to change (Martin-Wagar et al., 2021). An individual with a holistic mindset embodied increased self-awareness, evidence of growth (Bilohur, 2019). Some participants were compliant with the activities of the group. As a result, they experienced noticeable growth in one or more areas of their lives.

For example, Suzy discovered that the busyness kept the anxiety lower. "Without a schedule or rhythm to my days, my anxiety is higher." Amy felt the mindful walking helped get her out of the house again. "I was trying to just get myself outside for the sake of going outside. I know towards the beginning that was the hardest for me, but I think coming toward the end, it's probably what I got the most out of."

To summarize findings related to the primary research question, participants' data reflected the themes of Reflection, Isolation, and Stress. Subthemes that emerged were

Revelation, Disengagement, Avoidance, and Growth. The mindful activities created an opportunity for introspection about the present and past for these individuals. This focus on intentional presence appeared to have halted anxieties during those moments for most participants and led to personal discovery for some. One participant felt too overwhelmed by the intimacy of mindfulness and integrated past traumatic memories into the worry of her future. As a result, she felt the need to drop out of the study. When participants took the time to reflect, a positive or negative revelation occurred. The participants appeared to carry their introverted natures into the group microcosm. A few participants became disengaged during the study without meeting with the group, neglecting to post on the social media page, and stopping correspondence. The remaining members had limited engagement during the group meetings or social media pages. Adding the study tasks to the participants' daily lives also created additional stress. The participants believed that the stress resulted in either avoidance or growth. Group members who experienced additional stress during the study stopped the daily activities, and one dropped out altogether. Other members specifically eliminated one or two activities if they believed the activity caused discomfort in any way. A few members experienced personal growth once they persevered through the initial stages of a change in routine and discomfort.

RQ2: How does this group of individuals describe how they overcame barriers to holistic health?

The data generated from the next research question of this phenomenological process contains one theme and subtheme. The data revealed that several barriers exist in the approach to health taken in this study. Even when the path was suggested, individuals still found difficulty overcoming these barriers. This resistance was reflective of their personal lives in the study. Most barriers appeared to have been self-imposed or orchestrated around a lifestyle that the

individual has constructed. Most barriers were associated with a pre-determined mindset and pattern of behaviors. Participants noted this from personality traits that contributed to motivation to change when confronted with an obstacle. Some participants were successful in overcoming a barrier to completing holistic activities. Not one participant followed the program exactly as it was prescribed.

In the context of this study, barriers to holistic health referred to obstacles perceived by the individual that prevented full completion of the requirements of the study. These requirements included participation in four daily/weekly activities, attendance of weekly group meetings, and attendance in three individualized interviews. The four required activities were daily mindful walking, daily mindful spiritual exercise, daily journaling, and weekly posting on a social media page. One primary theme emerged in answering this research question with one subtheme: Intentionality and Planning. This theme and subtheme will be further explored with supporting data from the participants.

Intentionality

Intentionality was the sole theme that emerged to answer the research question about barriers to achieving holistic health within this study. Intentionality was a deliberate, purposeful act to accomplish something. It is a holistic concept which embraces the individual potential for a biopsychosocial awareness (Deary et al., 2011). A change was required to be made to add or remove behaviors to incorporate something new into one's life. Adaptation was heightened with intentionality (Hibbard & Pope, 1993). Intentionality was also linked to motivation to develop a new habit (Gardner & Lally, 2018). Intentionality forced the individual to be present and attend to the present moment. Strage and Merdinger described intentionality as one of the key factors for personal growth and renewal (as cited in Santovec, 2014). The following verbatim quotes

from participants demonstrated their perceived need for intentionality in overcoming barriers to successfully implement the study activities to achieve a holistic state of health.

One of the actual words repeated by most members was intentionality. Intention surmounted to be a powerful force in success or failure with the group activities. Bill explained that one of the most helpful pieces was "just being more intentionally aware of what's going on around me and also how that's affecting me and how I'm affecting that also." Suzy stated, "I had to schedule time." Amy explained how intentionality and structure bring her success. "My brain finds excuses not to slow down. Sometimes it takes checking the boxes to implement that. I had to make it in my brain like this was an assignment. Hopefully, moving forward won't frame it that way." This association with school and assignments also upheld the assumption that these participants with anxiety are very task oriented. This appeared to be the perception that cognition is programmed. Bill explained, "during mindful walking, I have to keep refocusing. I've been noticing when I walk around, the one thing that I'm guilty of is having my head stuck in my phone." Through being intentional, the participants discovered a vital component to the success of implementing new habits. The act of planning formed the subtheme of Consistency.

Consistency. Consistency was doing something repetitively and in a methodical manner. It contributed to habit-forming and resulted from intentionality. It was also be described as the quality of always behaving similarly (Dictionary, 2021). Consistency wove together the object of pursuit and integrated it into aspects of self to a thriving wholeness of being. Consistency contributed to habit formation by repetition of necessary behaviors to make continued, self-regulated changes (Gardner & Lally, 2018). This concept also referred to repeating the same behavior simultaneously to produce an effective change (Bond et al., 2019). Consistency helped

eliminate barriers to achieving holistic health within the context of the study group. Repetitive and scheduled actions promoted success in incorporating holistic health habits.

Amy felt that "the most helpful part of the study attempted at consistency by establishing routines." In the same way, Bill believed "that I need to practice every day to help it become more of a steady habit to do. I like having that in my back pocket." Doing a task over and over created healthy habits. Amy explained further. "I've been into more stressful circumstances recently, but I feel like my anxiety levels have been a lot lower because I've had something I had to schedule."

The participants demonstrated how intentionality developed into a consistency that helped incorporate change and healthy habits despite acknowledged barriers. Intentionality helped eliminate these barriers by small, deliberate steps in the direction of choice. Consistency in actions continued this process in overcoming barriers for the participants. Group members who did not implement intentionality and consistency completed less activities. As a result, not much changed within their systems of health. The number of activities completed is directly related to the amount of symptom reduction.

RQ 3: How does this group of individuals describe their experiences in symptom reduction?

With anxiety, a myriad of physical, mental, spiritual, and relational symptoms was present, as demonstrated in the background data from participants. It was essential to determine if implementing the study's daily and weekly mindfulness activities made a difference in reducing symptoms. Three pertinent themes were found to answer the research question: Decreased, Increased, or No Change. Participants who were most compliant with the study requirements showed at least one area of symptom reduction. The individuals who completed the

least activities did not specify much change in symptoms. One participant experienced an increase in symptoms and withdrew from the study.

Decreased

For this study, decreased was defined as less physical or mental anxiety symptoms. This referred to symptoms such as racing heart, hyperventilation, nausea, tremulousness, racing thoughts, and worry. Within the group, anxiety symptoms decreased slightly for a few participants. The physical and mental symptoms still waxed and waned for some. Sally stated, "Meditation was the most helpful with the physical symptoms." Chaos in thought patterns showed some improvement with implementing the holistic strategies. Amy stated, "I feel like my brain is a bunch of scrambled eggs. Journaling helped slow my racing thoughts down." Bill felt that improvement came "with just being more intentionally aware of what's going on around me and also how that's affecting me and how I'm affecting that also." Suzy stated that she felt "kind of a natural instinct for me to be mindful when I walk." She also moved from "what if" thinking which paralyzed her, to more freedom with mindfulness strategies. "I liked that actually that kind of helped me refocus a little bit, kind of like self-care." Amy felt the mindful walking helped get her out of the house again. "I was trying to just get myself outside for the sake of going outside. I know towards the beginning that was the hardest for me, but I think coming toward the end, it's probably what I got the most out of." Overall, four participants demonstrated a decrease in anxiety-related symptoms.

Increased

For the purposes of this study, increased symptoms referred to any physical or mental symptoms related to anxiety that is perceived to be worse than prior to the start of the study. Again, these symptoms included but not be limited to fast heart rate, hyperventilation, nausea,

tremulousness, racing thoughts, and worry. For example, one participant dropped out due to the experience of increased anxiety during mindfulness exercises. The type of anxiety that increased for this participant encompassed physical, mental, and emotional distress. Missy described that the spiritual mindfulness "brought back thoughts of her father's illness and death and makes me worry about her own demise." She stated she needed to stop the study activities and seek additional assistance from a mental health professional. She explained that taking time to allow her mind to relax and just be present opened some repressed memories and wounds. In summary, prior to study completion, one individual reported worsening symptoms that were severe enough for her to necessitate dropping out from the study.

No Change

The concept of no change described participants who did not perceive any significant difference in any physical, mental, spiritual, or relational symptoms. Stagnation was also evident in some of the members. No members completed all the holistic activities for the duration of the group. Most participants did an average of two activities daily, one participant completed three activities, and two members did less than two. One participant stopped responding during the study. The remaining participants found activities that they liked or did not like. All but one participant stopped the activity that they disliked. One participant transitioned from dislike to that activity being the most impactful, mentioned by Amy above. After the group, isolation lacked improvement. Although some participants increased the amount of outdoor walking, significant social interaction was not improved.

Overall, the members who contributed the most to the study activities reported the most improvement in symptoms— the acts of slowing down and focusing positively impacted several participants' symptom reductions. One participant experienced worsening symptoms when she

relaxed and focused during a meditation exercise. She did not properly follow the exercise to be in the moment; rather, she allowed her mind to wander to past events, which affected her anxiety in the present moment. Some members showed no changes, most notably in the form of isolation. Introverted behavior can also be linked to personality traits that are not likely to change. The personality trait may have increased the chances of allowing anxiety to affect interpersonal relationships. Anxiety was used as a type of scapegoat in this sense.

RQ 4: How does this group of individuals describe their experiences in improved quality of life?

Quality of life was described as good physical and mental health, stable or thriving interpersonal relationships, a grounded faith system, a sense of purpose, and hope for the future. Quality of life was not just the lack of mental illness; rather, it referred to elements that formulated a sense of fulfillment and worthiness (Keyes as cited in Assaf, 2020). Peace of mind, relationships, and health promoted an increased quality of life. The participants in this study spoke to impacts of quality of life on multiple levels. This data was previously discussed in the background of the participants. Physical symptoms were uncomfortable and prevented individuals from completing daily activities, such as going to the store, socializing with family and friends, and cultivating deeper relationships.

Additionally, anxiety affected the quality of life due to mental fogginess and racing thoughts which created issues with concentration and sleep. Spiritually, several participants vocalized having some difficulty in this realm. It was unclear if anxiety was impacting spirituality or vice versa. Relationally, all participants had struggles with spouses, family members, or work relationships, which often resulted in solitude. The emerged themes were organized according to Improved, Decreased, and No Change.

Improved

Ideally, for the purposes of this study, participants who expressed an increased quality of life described more peace, better relationships, improved mental state, and hope or purpose. A recent study demonstrated a direct link between subjective health anxiety and quality of life (Eriksson et al., 2018). It was assumed that fewer physical symptoms contributed to a better quality of life in that an individual may feel stronger or better health to pursue activities that led to an improved state of health. Several participants experienced personal growth, promoting a better quality of life. An enhanced quality of life enabled an individual to progress to the highest tier on Maslow's hierarchy of needs, which was self-actualization (Maslow, 1943). Maslow described self-actualization as an individual's desire for self-fulfillment and desire to grow to his or her peak potential (as cited in Taormina & Gao, 2013). The following quotes from the data supported the finding that some participants in this study experienced an improved quality of life after completing the study activities.

Although there was no reported improved quality of life with relationships, work, or school, participants demonstrated moments of increased introspection and clarity which resulted in personal growth or achievement. Bill stated that in the beginning stages of the study, "mindfulness is not proactive but reactive." He also had a revelation about his constant phone use. "I wonder how much being so connected to technology might impact those feelings of anxiety too." Suzy noted that finding some quiet time was most helpful by stating, "Mindfulness was most helpful in forcing me to set quiet for a little bit." Amy explained how the study encompassed her growth mindset. "Going through my education to be a therapist has been interesting in itself, so I think I'm just always wanting to learn, you know, new ways that can help me be healthier for myself, family, and clients." Missy also observed that she lacked

confidence due to anxiety. She dropped out, so she could not gauge if this improved with holistic interventions. Bill had much anxiety in his workplace and found that "doing mindfulness at work was better than doing nothing." Amy experienced a surge in personal growth toward the end of the study and compared how she was prior to the study. She stated, "I was constantly criticizing every single move, and so of course I'm not able to stop and breathe and be mindful. The last few days, it feels I have been stepping into my life." Suzy connected that mindfulness helped her self-care. Between the first and last interviews, her appearance and hygiene had improved. Overall, participants demonstrated various degrees of improvement in one or more facets of quality of life.

Decreased / No Change

For this study, a decreased quality of life resulted in poorer function in some aspects as compared to the beginning of the study. For example, if a participant experienced increased anxiety, his or her function at work or interaction with interpersonal relationships was negatively affected. Only one member reported worsening of symptoms during the study. The increased symptoms could have been speculated to have decreased her quality of life. The interaction was limited and stopped after her assessment of safety and cessation from the study. In addition, Anna reflected that her anxiety comes from trauma and abuse as a child, which negatively impacted her relationships with others. This participant stopped responding throughout the study, making it difficult to determine if she experienced any improvements. Her past trauma was not disclosed prior to the study.

Overall, most active participants noted some improvement that directly or indirectly impacted their quality of life for the better. Most participants found a practice that helped ground them in a more peaceful state. It was hypothesized that a more peaceful state contributes to

growth that gently guides an individual to an improved state of being When personal needs were met at this level, quality of life was expected to be better reflective of how individuals interacted with their environment. Two participants, Anna and Missy, were unable to be reassessed to see any other improvements in their quality of life. One of these individuals concluded that she needed to seek professional help. Although no immediate gains were evident in the quality of life for Missy, this sole act could have led her to a more improved quality of life as she took steps to deal with past trauma.

RQ 5: What would these individuals describe as the most impactful part of the group?

The description of the participants' most impactful part of the study group was subjective on several accounts. Whatever a participant found to be most distressing at onset and most relieved at the end was likely related to the most impactful activity. These activities consisted of different activities from what the participants were doing prior to the study. Each activity was connected to the larger concept of mindfulness; therefore, it is not surprising to reveal the answer to this research question. A profound theme emerged in response to the most impactful part of the group. It was ironic that all these participants were counseling students or in the counseling profession and were familiar with this concept. It was not until mindfulness exercises were intentionally utilized in their daily lives that full benefits were reaped. The theme that emerged in answer to this question was Mindfulness.

Mindfulness

This study involved dividing the broad concept of mindfulness into more specific categories linked with holistic activities. The use of specific mindfulness activities created a powerful, synergistic effect. The entire premise of mindfulness rested upon being present now

with deliberate focus. All participants who responded felt that some aspect of mindfulness positively affected them. Mindfulness created an opportunity for personal awareness and insight.

Awareness. Awareness emerged as a subtheme. Sally described mindful journaling and Christ-Centered Present Moment Awareness as the most frequently implemented activities and most impactful in her life. She stated, "The spiritual awareness was most impactful. The writing kind of helped me focus– - like, instead of focusing on all the negative, it was like, ok, yes, there are positive things going on too." Bill discussed that the most impactful piece for him was "the mindful walking and taking time to do breathing exercises." He felt that the element of mindfulness that was most helpful was "being able to use it anytime." Suzy relayed that mindfulness "helped me refocus a little bit, kind of like self-care." Amy demonstrated how using mindful walking proved most impactful for her. She stated, "I know towards the beginning that was the hardest for me, but I think that coming toward the end, it's probably what I got the most out of." Amy stated that "walking was a huge revelation in getting back in touch with nature." She also stated that "breathing kind of helped center that inaccurate view of God." Bill stated that "the mindfulness was definitely helpful because, it kind of allowed me time to sit and separate myself from minor details around me and put problems in perspective."

Overall, the participants who stayed with the study showed some impact from a mindful activity. All these activities contributed to the growth of at least one aspect of the individual. Physical, mental, and spiritual improvements were all noted within the group. Some improvements also took time. Several participants moved out of their comfort zones to complete the activities of the study. This was considered baby steps to a larger goal of improving relationships with families and friends.

Evidence of Quality

Several aspects of this study demonstrated evidence of quality and thus accuracy of the data. Trustworthiness was a core element established at first contact with the participants by discussing confidentiality, informed consent, personal safety, and options for dropping out of the study if needed. Safety and assurance of confidentiality were important aspects of trustworthiness. Trustworthiness was found in the interview process, debriefing, and attempts at triangulation regarding evidence of quality\y. Member checks were not used in the study as originally planned due to poor response.

The interview process was designed to eliminate bias and variation. One researcher performed the interviews with standardized questions for all participants at each interview phase. Debriefing of the study occurred in the final interview for participants who chose to complete the study. Triangulation was planned with observation, interviews, and focus groups. The observations were done at the weekly group meetings; some chose to have their cameras on while others just used their voice. A glimpse into their home environments and interpersonal mannerisms was detected through this process. Interviews were conducted individually and a group at designated periods during the study. One of the main issues with the participants was a lack of communication and follow-through. The lack of commitment impacted the completion of the focus group with all the members. Overall, this study supported sound rigor through a combination of the establishment of trustworthiness, the use of triangulation, and debriefing.

Chapter Summary

This chapter presented some background data of the participants. Some findings revealed busy lifestyles with little time for self-care. Most participants shared isolated backgrounds devoid of interpersonal relationships outside of required work or family obligations. Despite participants being schooled in counseling tools, none of them had successfully implemented any

mindfulness-based activities prior to the study. In addition, spiritual health was poor, with several participants voicing a disturbing sense of peace in this area.

Overall, participants who were most active in the study exercises reported more improvements in symptoms and quality of life in relation to anxiety. Major themes and subthemes emerged from the data. In answer to the primary research question concerning the lived experience of a holistic, online social media group, the themes of Reflection, Isolation, and Stress, along with subthemes of Revelation, Disengagement, Avoidance, and Growth, emerged. Reflection served as a pivotal process to awaken the senses to a more enriching existence for some participants. Through reflection, some participants grew to a deeper understanding of themselves and developed a realization of how the installation of a few self-care principles could empower them through personal revelation. In addition, despite being in a homogenous group, most members remained isolated, with the social media aspect of the group for the most part neglected. Interaction among members was minimal, and a lack of encouragement or support was provided. This behavior supported disengagement as a subtheme both in and outside the group. Finally, stress was a theme as the study activities initially appeared as a barrier to effective daily schedules.

The next research question sought to answer how participants overcame barriers to achieving holistic health. One theme and subtheme emerged from the finding: the theme of Intentionality with a subtheme of Consistency. Group members found that the act of being intentional was the single factor that dominated success if integrating healthy habits. The effect was the same if it was a physical, mental, spiritual, or relational activity. Planning and scheduling were vital for the participants to incorporate these new activities into their lives. Like

developing any new habit, the participants also found that consistency with the activity was the key ingredient for helping them implement and maintain holistic health behaviors.

The participants gave data with similar themes to answer the research questions about describing the holistic, online social media group's impact on symptom reduction and quality of life. Both answers concluded with themes of Improved, Decreased, or No Changes. Milestones in recovery were not expected due to the study timeframe only being four weeks in length. Several participants noted the establishment of holistic health practices and increments in feeling better. As stated previously, one or two participants felt worse or reported no changes during the study. Again, this seemed to directly correlate with input, effort, and following the directions for the activities.

Finally, the answer to the research question of the most impactful element of the study proved to be mindfulness. Mindfulness encapsulated most themes and subthemes and packaged them into an attainable holistic practice to produce peace of mind. Ironically, mindfulness was a concept that all participants were familiar with but neglected to incorporate routinely into their own lives. The mindful nature of all the group activities opened the door to possibilities for the epitome of self-actualization. At least one member was euphoric when describing her achievement reached this state. All members remarked on the reaped benefit of implementing the mindful activities.

Table 2 summarized the various themes and subthemes that emerged from the data in response to the research questions. Patterns were observed in the participant responses that molded these themes and subthemes. The final chapter provided further discussion of the findings of this study, including a more in-depth look at the themes and subthemes. An overview of the study with a summary of the findings was provided. Then, interpretation of the findings

was performed. This segued into any implications for social change from the outcomes. Finally,

recommendations for action and further study were presented. A reflection on the researcher's

experience throughout the research process and any resulting bias was also discussed.

Table 2

Research Questions and Themes

Research Questions	Themes	Subthemes
How does a group of individuals with anxiety describe the lived experience of using an online, holistic social media group?	Reflection Isolation Stress	Revelation Disengagement Avoidance or Growth
How does this group of individuals describe how they overcame barriers to holistic health?	Intentionality	Planning Consistency
How does this group of individuals describe their experiences in symptom reduction?	Decreased No Change Increased	
How does this group of individuals describe their experiences in improved quality of life?	Improved Decreased No Change	
What would each of these individuals describe as the most impactful part of the group?	Mindfulness	Awareness

Chapter Five: Discussion

This final chapter of the dissertation study restated the research problems, methodology, and findings and integrated these with current literature. Results and findings were discussed, and recommendations for future implications and research were suggested. Also, findings were dissected to analyze the reflection of the compounding literature from Chapter Two to support the hypotheses. Implications for social change, recommendations for actions and further study, and personal experience concluded this chapter.

Brief Overview of Study

This study was construed as a potential solution to the malady of persistent anxiety. The current medical model for treating physical and mental diseases was not holistic. It only served to treat a portion of the illness with the individual. For example, a person may have developed anxiety from chronic back pain, which prevented the individual from attending work and church. If the individual obtained medication to treat the pain, depression, spiritual apathy, and isolation might continue untreated. This left the individual closer to illness on the dichromatic scale of the health and illness spectrum. In addition, when stress ensued, the remaining symptoms likely increased and worsened.

This qualitative, phenomenological study was performed with six individuals with chronic anxiety. The study used interviews and observation to obtain participant data. All elected participants engaged in a 30-day study with daily and weekly activities that stemmed from a foundation of mindfulness. Activities included daily walking, daily spiritual mindfulness, daily journaling, and weekly check-ins with other members in a social media group. In addition, each participant had three individual meetings and weekly group meetings. The groups' premise was that it was based on an application of social media readily available to the participants. It

involved holistic activities targeting each realm of an individual: mental, physical, spiritual, and relational.

The primary research questions were as follows:

1. How does a group of individuals with anxiety describe the lived experience of using an online, holistic social media group?

2. How does this group of individuals describe how they overcame barriers to holistic health?

3. How does this group of individuals describe their experiences in symptom reduction?

4. How does this group of individuals describe their experiences in improved quality of life?

5. What would each of these individuals describe as the most impactful part of the group?

The findings of the study revealed several themes and subthemes. Research question number one themes included Reflection, Isolation, and Stress and the subthemes Revelation, Disengagement, and Avoidance or Growth. Findings related to the second research question included Intentionality as a major theme and Planning and Consistency subthemes. For research questions three and four, the themes were similar. In response to symptom reduction, the themes were Increased, Decreased, or No Change. For the quality of life, themes were Improved or Decreased / No Change. Finally, the data revealed that participants' most impactful part of the study was Mindfulness with a subtheme of Awareness.

Anxiety was debilitating for the participants, and they were drawn to the study to seek relief. Almost all participants had tried other remedies, including medication and therapy, prior

to the study. Prior to this study, I reviewed the literature extensively for etiology and treatment of anxiety, the concept of holistic health, the role of stress, barriers to symptom resolution and quality of life, and support for internet-based intervention. Surprisingly, few studies incorporated a BPSS model and even fewer studies that utilized a social media application for anxiety disorders. No studies were evident that utilized a Facebook group with holistic interventions.

Interpretation of Findings

To fully discuss the findings and their implications, it was necessary to analyze each research question independently and provide the answers from the study. The first question was, "How does a group of individuals with anxiety describe the lived experience of using an online, holistic social media group?" Responses varied, but some homogeneity was reflected in the themes and subthemes. There were both positive and negative connotations within the answers to this question. The one purpose that this study, and this question, essentially declared was that of an intentional pause in the normal rhythm of the participants' lives. They participated in something out of the ordinary to target their anxiety had some impact.

To further explain the findings, the responses to this question, in the format of themes and subthemes, were compared and integrated with the literature results and hypotheses. Before this was done, it was essential to revisit the premises of this study to fully understand the foundation as to why it was constructed in the manner it was. Simply put, the main hypothesis was that whole-person care was more beneficial for mental health in general than fragmented care. The literature reflected that this concept of wholeness was important for treatment and was a basic human need (Seyedfatemi et al., 2014). Although health existed as a dynamic state of being, most individuals maintained a passive mindset that their position on the health/illness continuum could not be changed (Apostu, 2013; Donnelley, 2018). This study embarked upon a

process to change this mentality for the participants. Since most had tried medications and therapy and were educated about anxiety, there was a gap in who they were and whom they desired to be. The chasm between these two states was defined as how illness (anxiety) impacted their position on this axis.

According to the literature, illness as a whole person concept was not fully reflected (Hendrix et al., 2015). Current medical models created a barrier to effective treatment. Lack of complete care exemplified why these participants, who had traditional treatment for anxiety such as medications and therapies, were left with increased symptoms and decreased quality of life. In addition, the literature strongly supported the coexistence of physical, mental, social, and spiritual states in the concept of illness (Donnelley, 2018; Fahlgren et al., 2015; Garcia et al., 2014; Hendrix et al., 2015; Katerndahl & Oyiriaru, 2007; Khorashadizadeh, 2016; Stuber et al., 2014). This phenomenological study incorporated positive health behaviors using mindfulness-based, structured, holistic activities. Each aspect of the study activities was compared with current literature to support this arrangement further.

The concept of mindfulness was the central construct weaved throughout each aspect of the study. The literature was robust in studies supporting the benefit of mindful activities for anxiety (Fjorback, 2012; Kim et al., 2013, 2016). For example, the study participants daily used mindful walking. The group responses to this first research question elicited three primary themes: Reflection, Isolation, and Stress. Furthermore, subthemes emerged and included the concepts of Revelation, Disengagement, and Avoidance or Growth.

In keeping with these themes, the literature produced generalized supporting data. The study group gave participants a chance for reflection and revelation. When one quieted the mind, the individual was enabled to have clarity in thought and direction. It was in this space that true

revelation could occur. The power of mindfulness activity was demonstrated in the response of at least one participant who experienced a major mental and spiritual breakthrough during the study. A state of self-transcendence promoted resiliency in a whole person care model (Fahlgren et al., 2015). The act of reflection was a gateway to this self-transcendent state for some participants. This finding corroborated with the existing literature on reaching a state of self-actualization through mindfulness.

It was also noted in both participant responses and observation of participation that there was a self-imposed barrier to completing some activities. This isolative behavior was described in the literature as common for individuals with anxiety. Internalized stigma (shame) created a sense of self markedly different from others (Ociskova et al., 2018; Pedersen & Paves, 2014; Stanley et al., 2018). Subsequently, the self-imposed stigma led to the isolation that kept others involved in their care (Ociskova et al., 2018; Quinn et al., 2015). The introverted tendencies explained the lack of participation with others in the social media group and lack of involvement and followed through with the daily and weekly activities. This disengagement was surprising in that others were experiencing the same battles with anxiety. Some participants continued resistance to treatment help even though they volunteered for it.

Similarly, the concept of stress was fully supported in the literature and its impact on health-promoting behaviors. The literature was rich with the support that implicated stress in poor physical or mental health primarily due to the chronic release of cortisol in the body (Conway et al., 2016; James et al., 2017; Petrowski et al., 2010; Sartori et al., 2012). The stress created a chaotic mind-state that replaced the desired homeostatic balance and perpetuated anxiety (Abelson et al., 2007). The participants voiced stress in fitting in the activities for the study amidst their already busy lives. The purpose of the study that some of them missed was to

incorporate these activities easily into the flow of their days. Participants that were successful in this demonstrated the most benefit from the study. The perception of stress produced either growth or avoidance in the study. Avoidance was reflected in a lack of participation and response. A few participants avoided the entire study or parts of it. Others used the stress for growth. The literature supported this in the idea of benevolent chaos, where stress propagated an improved effect from the original state (Apostu, 2013; Laycraft, 2009; Pascale et al., 1999). A decrease in personal responsibility is directly correlated with a weakened personal resistance to stress (Adamo, 2017; Apostu, 2013; Hein et al., 2015). The findings on stress further expanded the current literature on this subject.

The next analyzed research question was "How does this group of individuals describe how they overcame barriers to holistic health?" This study considered barriers in four categories presented in the literature: physical, mental, spiritual, and social. Physical barriers referred to barriers to access to care. The beauty of this study was that this barrier was eliminated for the participants using a phone and social media. Mental barriers were fear, unawareness of anxiety, and improper medication or therapy (Baldwin et al., 2014; Gloster et al., 2017; Patterson & Van Ameringen, 2016; Rowa et al., 2014). None of these emanated from the study participants. They were aware of their diagnosis, fear was not expressed in general, and most had already tried therapy and medication.

The literature described the social barrier as stigma and fragmented care (Biringer et al., 2017; Hoertel et al., 2013; Hopkins & Shook, 2017; Quinn et al., 2015). The participants did not verbally report stigma. Perhaps subconsciously, this was an attribute since all participants were in the counseling profession to some degree. A study by Green and Thorogood (2018) demonstrated increased stigma among medical professionals, preventing them from seeking

treatment. Also, all participants enforced aspects of fragmented care in their histories. Stigma influenced this as well as a host of other factors. All described components of present or past medications and/or therapies, as all were either students or professionals in the counseling field. All were aware of holistic therapies for anxiety, such as relaxation, mindfulness, deep breathing, but none practiced these. The literature supported group treatment formats for anxiety (Rosales & Tan, 2017). The social milieu could have been used to support and buffer mutually encountered symptoms to promote resilience in the study participants (Levy et al., 2018; Plaisier et al., 2007). Data from this study concurred with literature findings on this topic.

The final barrier, spiritual, seemed to echo most profoundly for this study group—spiritual barriers related to an individual's faith system, hope, meaning, and motivation. Spirituality supported the main theme and subthemes that emerged for this question: Intentionality, Planning, and Consistency. Although resistance and difficulty with the spiritual exercises related to faith were evident in several members, the overarching barrier appeared to lie within one's motivation. The literature explained that decreased hope is found in individuals with anxiety, impacting their access to care (Thibodeau & Peterson, 2018). The negativity and perception of busyness set these individuals up for failure. Part of the struggle was placing the importance of personal health as a top priority. The chronicity of anxiety and decreased quality of life also produced hopelessness which impacted motivation (Servidio et al., 2018). Spiritual apathy also played a role as a barrier. The data unearthed through this study upheld the literature by supporting the concept that struggles with one's faith can impose restrictions on the quality of life.

The participants felt that intentionality was the largest factor in overcoming barriers to holistic health. As part of this, planning and consistency were crucial to successfully

implementing the daily strategies to combat anxiety. Several participants realized that the only way to counteract holistic health activities with their busy schedules was to schedule them intentionally. For example, Bill relayed that increased awareness of his surroundings helped him realize his effect on the environment and others. Suzy said she had to schedule time for her study activities purposefully. Amy added that the act of being intentional through mindfulness helped her to slow down and be organized. She also stated that consistency helped her establish routines. Intentionality creates the pause that propagates reflection, revelation, and awareness. The findings from this research extended the literature by emphasizing that mindfulness practices are not easily attained. Planning and consistency of habits helped insert healthy activities into daily life. This was exemplified by the fact that these participants were all aware of and trained in mindfulness strategies.

The next two research questions were combined as outcomes, and data was similar: "How does this group of individuals describe their experience in symptom reduction and quality of life?" Themes for both were either increased, decreased, or no change. Summing up the previous information on barriers, it made sense that those who had more gains did more work in the study. The participants who did not experience much change became non-respondent, dropped out, showed increased or no change in symptoms, and decreased or no change in the quality of life. Specifically, the literature focused on positive effects on symptoms and quality of life through telehealth applications, which this study could qualify as (Anderson et al., 2017; Durland et al., 2014; Firth et al., 2017). A participant needed to perform the necessary activities prescribed to see results. One of the most effective factors in any treatment was the therapeutic relationship (Durland et al., 2014). Due to the brevity of this study, time was limited to orchestrate an alliance between the participants and me. The disconnect was responsible for the

lack of motivation to complete the activities. Also, a passive mentality was evident in several participants, which indicated stagnant health circumstances (Apostu, 2013; Donnelley, 2018). This observation corroborated with literature and common sense that increased motivation and participation results in more progress than lack of effort.

The final research question was, "What would each of these individuals describe as the most impactful part of the study?" Overall, the most popular answer among participants was mindfulness with a subtheme of awareness. Their descriptions aligned with a wealth of support for using mindfulness therapies and techniques in treating anxiety (Kim et al., 2016; Kraemer et al., 2015). Mindfulness was easy to do whether the participants were at home, work, or outside walking. It enabled a sense of control over the given moment and allowed time for reflection. Increased awareness produced pro-active health behaviors and growth (Ghasemipour et al., 2013). The mindfulness activity allowed the participant to pause to focus on the present moment in their daily activities. This function served to dissipate worries of tomorrow or regrets of the past. It permitted the participants to focus on themselves for a small time. Some part of the self must have been touched for healing to occur. This data further enriched the existing literature on mindfulness as a powerful antidote to anxiety disorders.

This study introduced several practical applications. One idea was adding more incentive to holistic-based practices to support further a BPSS model of care for anxiety disorders and other mental health disorders. Also, the idea of whole person care was applied to self-care, especially to that of counselors and other caregivers. Helping professions such as pastors, psychiatrists, nurses, and therapists also could benefit. This study highlighted a hidden gem that sometimes maladies can have their worst effects on those trained to treat them. Also, the lack of participation in some activities suggested treatment can be compared to an ill individual who

does not take the medication prescribed properly. They would not have full effect from the medication; in essence, the participants did not get the full effect of the study since they did not utilize the whole portion prescribed. Finally, the concept of mindfulness was again supported as a prime factor in resonating against treatment resistance with anxiety disorders.

Implications for Counselors and Counselor Educators

This study sparked positive implications for social change in both individuals and organizations. On an individual level, the concept of self-care was vital for the counselor as a caregiver. It was not planned for all participants to be in the counseling field. It was vastly important for those providing treatment for anxiety to embody holistic treatment successfully. It was dangerous for a caregiver not to give proper self-care and be expected to care for others (Mills & Chapman, 2016). One of the reasons that individuals in the counseling field seemed more susceptible to treatment resistance was their drive for perfection (Holden et al., 2019). This personality type created a barrier to self-care because the individual continually strived for perfection in all areas of life, but his or her health left a void in the process.

This study also developed important implications for the counselor as an educator. The role of the educator was not taken frivolously. A counselor educator has an added responsibility for other educators as they understand the workings of the mind and how it relates to all areas of an individual. An instructor must be a model for the students (Sangganjanavanich & Balking, 2013). As a counselor educator, one must have a grounded teaching philosophy that incorporates whole person care to deliver effective learning. Just as a counselor caregiver benefits from holistic health, a student would also be expected to benefit from a framework of teaching in an environment that addresses the body, mind, spirit, and relationships. An element of responsibility for student well-being exists within the role of counselor educator (Sangganjanavanich &

Balking, 2013). To truly nurture a student's potential, both the educator and the student must be living in a productive state of health.

Due to the speed and busyness of today's society, an application that can be portable and accessible anywhere was needed (Rathbone & Prescott, 2013). This study demonstrated that cell phones or computers could use a social media application and ease of use for health and social connections. Internet and telehealth have skyrocketed over the years, supporting this treatment venue. The main tenets of this study included mindful walking, mindful journaling, mindful spirituality, and social connection. These all reinforced integrating one of the most empirically studied treatments for anxiety with other proven solutions. The combination of each one, just like the sum of the parts to make a whole, encompassed a whole person approach to anxiety treatment. The foundation of mindfulness added a necessary pause in the lives of individuals to focus on themselves in the present moment to decrease stress, thereby improving symptoms and quality of life.

Recommendations for Counselors and Counselor Educators

This study outlined some of the necessary changes needed on an individual and organizational level to combat treatment resistance in mental illness. The recent pandemic mandated that everyone seek to be as healthy as possible. This era has also ushered in need for physical distancing and virtual appointments. Telehealth and web applications have never been more popular. Individuals, especially those responsible for others' health, must take responsibility to care for themselves effectively. Organizations need to provide proactive health solutions for their employees, such as gym memberships, refresher breaks during the workday, and support services as needed. The concept that health is a dynamic state impetrates the need to support proactive ways to maintain it.

Counselor educators have embraced this using virtual classrooms and meetings (Chen et al., 2020). The impact of the pandemic on the counseling profession has caused increased burdens in the provider roles (Harrichand et al., 2021). Counselor educators must continually reassess the learning environment and individual students for stressful cues (Cicco, 2014). Students must be taught that steps must be taken to protect their health as caregivers and patients in this demanding field (Harrichand et al., 2021). If counselors apply the foundations of this study to their student population, it can possibly mitigate the effects of the profession's demands. The use of virtual classrooms also parallels the study in that educators can use the same-type applications to impact students. Virtual meetings can be used between faculty and students or just students for support, extra discussions on self-care, or to teach some brief mindfulness activities to use on themselves and clients.

Results can be disseminated in several ways. Social media was a part of the study and can be a vehicle to advertise and formulate more groups. Facebook advertises many health and wellness groups. There are not any holistic type groups. This is important to introduce this concept to the health and wellness communities. Other social media applications like Twitter and Instagram can also model holistic wellness and promote groups. Counselors and practitioners can prescribe holistic prescriptions, including medication and exercise, spirituality, journaling, and mindfulness activities. The momentum must be started with one patient, who can help a family member, who can start a support group, which expands to social media, and reaches hundreds. This mirrors a well-known poem by an unknown author.

> Once there was a man who wanted to change the world. He was unsure how to, so he tried to change his country. That did not work, so he tried to change his state. That did

not work, so he tried to change his family. Finally, he realized he needed to change

himself. He could change his family, state, and country if he changed himself.

Author Unknown

Limitations and Recommendations for Further Study

This study provoked ideas for other similar topics for research. For example, more

studies are needed to demonstrate how a BPSS model can be effectively used with mental health

disorders. Whole person care, especially with anxiety disorders, can affect treatment resistance

and decrease healthcare costs. The number of studies in the literature relating a BPSS model to

mental health disorders such as anxiety was severely lacking. In addition, the use of social media

groups, specifically Facebook, with mental health was also absent from the literature. It would be

helpful to conduct more studies to show the necessity of a more in-depth model of treatment that

includes essential spirituality in the mix. Overall, a larger study with more participants was

needed to obtain results with more generalizability. A large-scale study on counselors' self-care

for anxiety would potentially reveal more answers as well.

Qualitative study options abound, such as looking at the lived experience of more specific

anxiety disorders. These could include panic disorder, social anxiety disorders, phobias, and

obsessive-compulsive disorders. Quantitative studies may reveal a bit deeper into the

effectiveness of each treatment. For example, a control group with one specific intervention

could yield more distinct results. More studies focusing on the BPSS model with mental health,

especially anxiety disorders, are needed as the literature is lacking.

Some limitations of this study became apparent. Due to drop out and lack of

participation, incentives will be offered in the next study to help retain participants. More

background history on the participants would have been helpful to enrich the data further. The

limitation of lack of activity would be addressed with stringent rules for participation. Also, a longer course for the study will prove beneficial as more time will be allotted for participation, therapeutic relationship, and observation.

Reflection on Researcher's Experience

The study was a positive experience but propagated ideas for improvements for the next studies. First, my dislike of conflict perhaps created an environment where ground rules were lax. I found that passivity can breed disengagement. I celebrated even the growth of one individual. It was enriching to see the positive feedback from the participants that certain aspects of the study helped them in that moment of life. I am hopeful that the study reflects the core of who they are, the importance of their role, and why self-care of the whole person is so important.

Comprehensive Summary

The following will be a summary of each chapter of this dissertation study. To begin, Chapter One presented the foundation for the study by providing the background information congruent to the purpose of the study. In addition, the conceptual framework of holistic health was introduced. Research questions and assumptions were also discussed. Chapter Two provided an extensive literature review. Anxiety disorders, in general, were searched about symptoms and quality of life. Concepts such as health, wellness, illness, and stress were unearthed. Finally, studies that included mental health with either a BPS or BPSS model were searched.

Chapter Three linked the study's methodology and research design. The phenomenological approach was explained in deeper detail, with significance placed on the specificities of this study. Participants, methods, exclusions, informed consent, and other issues were addressed for this study. Chapter Four presented the findings from the 30-day study. Themes and subthemes were formulated and discussed. Actual verbiage from the participants

was also included to create the lived experience fully. Finally, Chapter Five segued into a discussion of the findings, suggestions for future research, and applications to the field of counselor education.

Conclusion

Since up to 60% of anxiety sufferers remain treatment-resistant (Patterson & Van Ameringen, 2016), another means of symptom relief and quality of life reduction was needed. The traditional medical model did not encompass mental health, and the BPS model lacked the vital spiritual component. Therefore, the BPSS model must be strengthened for holistic use with mental health disorders, especially anxiety. There was rich data that mindfulness was strongly effective in managing anxiety. Incorporating this concept as the foundation for holistic activities was the essence of this study. Helping individuals, especially health professionals, take important steps toward their whole person care was vital for growing and preventing additional co-morbidities. The possibility of personal growth was paramount.

The primary takeaway from this study is to intentionally pause time to be in the present moment and focus on wholeness. Worries or fear cannot preside when one is in the present moment. Anxiety disorders were shown to be especially responsive to mindful activities. Incorporation of these activities required intentionality to bear to action. Awareness of what needs to be done and motivation to do what needs to be done are important factors. Since the balance of health lies in a balanced, flux state, illness can be decreased, and health increased if everyone maintains holistic intentions. Finally, one must take care of the body, mind, soul, and relationships to fully develop the healthiest self to care for others. Self-care is especially true for us as counselor educators. We must embody a biospychosociospiritual foundation to deliver that care model effectively to our students and clients.

References

Aafjes-van Doorn, K., Békés, V., Prout, T. A., & Hoffman, L. (2020). Psychotherapists'

vicarious traumatization during the COVID-19 pandemic. *Psychological Trauma:*

Theory, Research, Practice, and Policy, *12*(S1), S148.

Abar, B., Holub, A., Lee, J., DeRienzo, V., & Nobay, F. (2017). Depression and anxiety among

emergency department patients: utilization and barriers to care. *Academy of Emergency*

Medicine, 24(10), 1286-1289, https:// doi: 10.1111/acem.13261

Abelson, J., Khan, S., Liberzon, I., & Young, E. (2007). Hpa axis activity in patients with panic

disorder: review and synthesis of four studies. *Depression and Anxiety,* 24, 66-76.

Adamo, S. A. (2017). The stress response and immune system share, borrow, and reconfigure

their physiological network elements: Evidence from the insects. *Hormones and*

Behavior, *88*, 25-30.

Adams, T. B., Moore, M. T., & Dye, J. (2007). The relationship between physical activity and

mental health in a national sample of college females. *Women & Health*, *45*(1), 69-85.

Agazarian, Y. M. (2012). Systems-Centered? Group Psychotherapy: Putting Theory into

Practice. *International Journal of Group Psychotherapy, 62*(2), 171-95.

http://dx.doi.org.ezproxy.liberty.edu/10.1521/ijgp.2012.62.2.171

Agee, J. (2008). Developing qualitative research questions: a reflective process. *International*

Journal of Qualitative Studies in Education, 22, 431-447, https://doi-

org.ezproxy.liberty.edu/10.1080/09518390902736512

Ainsworth, J., Palmier-Claus, J., Machin, M., Barrowclough, C., Dunn, G., Rogers, A., Buchan,

I., Barkus, E., Kapur, S., Wykes, T., Hopkins, R., & Lewis, S. (2013). A comparison of

two delivery modalities of a mobile phone-based assessment for serious mental illness:

native smartphone application vs text-messaging only implementations. *Journal of Medical Internet Research,* 15(4), 60-67.

Al-Asadi, A., Klein, B., & Myer, D. (2014). Pretreatment attrition and formal withdrawal during treatment and their predictors: an *exploratory* study of the anxiety online data. *Journal of Medical Internet Research,* 16(6). doi: 10.2196/jmir.2989.

Al-Haddad, M. K., Sequeira, R. P., & Nayar, U. (2001). Neurobiological correlates of panic disorder and agoraphobia. *Journal of postgraduate Pedicine*, *47*(1), 55.

Altintaş, E., & Taşkintuna, N. (2015). Factors associated with depression in obsessive-compulsive disorder: a cross-sectional study. *Nöro Psikiyatri Arşivi*, *52*(4), 346.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). American Psychiatric Publishing, Arlington: VA.

Anderson, J. K., Howarth, E., Vainre, M., Jones, P., & Humphrey, A. (2017). A scoping literature review of service-level barriers for access and engagement with mental health services for children and young people.

Anderson, R. (1995). Patient empowerment and the traditional medical model: A case of irreconcilable differences? *Diabetes Care,* 18(3), 412-415.

Andrade, L. H., Alonso, J., Mneimneh, Z., Wells, J. E., Al-Hamzawi, A., Borges, G., Bromet, E., Bruffaerts, R., De Girolamo, G., De Graaf, R., Florescu, S., & Kessler, R. C. (2014). Barriers to mental health treatment: results from the WHO World Mental Health surveys. *Psychological medicine*, *44*(6), 1303-1317.

Andrews, G., Basu, A., Cuijpers, P., Craske, M., McEvoy, P., English, C., & Newby, J. (2018). Computer therapy for the anxiety and depression disorders is effective, acceptable and

practical health care: An updated meta-analysis. *Journal of Anxiety Disorders,* 55, 70-78. https:// doi: 10.1016/j.janxdis.2018.01.001.

Anton, M. T., & Jones, D. J. (2017). Adoption of technology-enhanced treatments: Conceptual and practical considerations. *Clinical Psychology: Science and Practice*, *24*(3), 223.

Apostu, M. (2013). New points of view on concept of health and lifestyle. *Procedia-Social and Behavioral Sciences*, *92*, 50-54.

Ashford, M., Olander, E., & Ayres, M. (2016). Finding web-based anxiety interventions on the world wide web: A scoping review. *JMIR Mental Health,* 3(2)

DOI: 10.2196/mental.5349

Assaf, E. A. (2020). *Hidden Power: Journalistic representations of mental health labels* (Doctoral dissertation, Chapman University).

ATLAS ti. (2019). Narrative research What is narrative research. Retrieved from https://atlasti.com/narrative-research/ .

Backer-Fulghum, L. M., Anders, C., & Sanford, K. (2018). Assessing Context-Specific Attributions During Couples' Conflict Interactions. *Assessment*, *25*(6), 801-812.

Bailey, J. (2008). First steps in qualitative data analysis: transcribing. *Family Practice,* 25(2), 127-131, https://doi.org/10.1093/fampra/cmn003.

Balboni, M. J., Puchalski, C. M., & Peteet, J. R. (2014). The relationship between medicine, spirituality and religion: Three models for integration. *Journal of Religion and Health*, *53*(5), 1586-1598.

Baldwin, D. S., Anderson, I. M., Nutt, D. J., Allgulander, C., Bandelow, B., den Boer, J. A., Christmas, D. M., Davies, S., Fineberg, N., Lidbetter, N., Malizia, A., & Wittchen, H. U. (2014). Evidence-based pharmacological treatment of anxiety disorders, post-traumatic

stress disorder and obsessive-compulsive disorder: a revision of the 2005 guidelines from the British Association for Psychopharmacology. *Journal of Psychopharmacology*, *28*(5), 403-439.

Barak, A., & Grohol, J. (2011). Current and future trends in internet-supported mental health interventions. *Journal of Technology in Human Services,* 29, 155-196.

Barbaglia, M. G., ten Have, M., Dorsselaer, S., Alonso, J., & de Graaf, R. (2015). Negative socioeconomic changes and mental disorders: a longitudinal study. *J Epidemiol Community Health*, *69*(1), 55-62.

Batinic, B., Opacic, G., Ignjatov, T., & S Baldwin, D. (2017). Comorbidity and suicidality in patients diagnosed with panic disorder/agoraphobia and major depression. *Psychiatria Danubina*, *29*(2), 186-194.

Bauer, M., Glenn, T., Geddes, J., Gitlin, M., Grof, P., Kessing, L. V., Monteith, S., Faurholt-Jepsen, M., Severus, E., & Whybrow, P. C. (2020). Smartphones in mental health: a critical review of background issues, status and future concerns. *International journal of bipolar disorders*, *8*(1), 2. https://doi.org/10.1186/s40345-019-0164-x

Baxter, A. J., Vos, T., Scott, K. M., Ferrari, A. J., & Whiteford, H. A. (2014). The global burden of anxiety disorders in 2010. *Psychological Medicine*, *44*(11), 2363-2374.

Becker, S., Langberg, J., & Byars, K. (2015). Advancing a biopsychosocial and contextual model of sleep in adolescence: A review and introduction to the special issue. *Journal of Youth and Adolescence,* 44(2), 239-270.

Beerbower, E., Winters, D., & Kondrat, D. (2018). Bio-psycho-social-spiritual needs of adolescents and young adults with life-threatening illnesses: Implications for social work practice. *Social Work in Health Care*, *57*(4), 250-266.

Behenck, A. S., Gomes, J. B., & Heldt, E. (2016). Patient rating of therapeutic factors and response to cognitive-behavioral group therapy in patients with obsessive-compulsive disorder. *Issues in Mental Health Nursing*, *37*(6), 392-399.

Bender, J., Cyr, A., Arbuckle, L., & Ferris, L. (2017). Ethics and Privacy Implications of Using the Internet and Social Media to Recruit Participants for Health Research: A Privacy-by-Design Framework for Online Recruitment. *Journal of medical Internet research*, 19 (4), pp.104.

Benich, J. J., Bragg, S. W., & Freedy, J. R. (2016). Psychopharmacology in primary care settings. *Primary Care: Clinics in Office Practice*, *43*(2), 327-340.

Ben-Zeev, D., Kaiser, S., Brenner, C., Begale, M., Duffecy, J., & Mohr, D. (2013). Development and usability testing of FOCUS: a smartphone system for self-management of schizophrenia. *Psychiatric Rehabilitation Journal,* 36(4), 289-296. https://doi:10.1037/prj0000019.

Berger, T., Boettcher, J., & Caspar, F. (2018). Internet-based guided self-help for several anxiety disorders: a randomized controlled trial comparing a tailored with a standardized disorder-specific approach. *Psychotherapy,* 51(2), 207-219. https://doi:10.1037/a0032527

Bilohur, V. (2019). Formation of the concept of innovative sports management in Ukraine. *Humanities Studies*, (1), 27-38.

Biringer, E., Hartveit, M., Sundfør, B., Ruud, T., & Borg, M. (2017). Continuity of care as experienced by mental health service users-a qualitative study. *BMC Health Services Research*, *17*(1), 1-15.

Bischoff, L. L., Otto, A. K., Hold, C., & Wollesen, B. (2019). The effect of physical activity interventions on occupational stress for health personnel: A systematic review. *International Journal of Nursing Studies*, *97*, 94-104.

Bishop, J. P. (2009). Biopsychosociospiritual medicine and other political schemes. *Christian Bioethics*, *15*(3), 254-276.

Blackwelder, R. S., Hortman, M., Leberknight, D., & Bragg, S. (2018). Creating a Geriatrics Curriculum in a Continuing Care Retirement Community. *PRiMER: Peer-Review Reports in Medical Education Research*, *2*.

Bolton, R. N., McColl-Kennedy, J. R., Cheung, L., Gallan, A., Orsingher, C., Witell, L., & Zaki, M. (2018). Customer experience challenges: bringing together digital, physical and social realms. *Journal of Service Management*.

Bond, G. R., Drake, R. E., & Pogue, J. A. (2019). Expanding individual placement and support to populations with conditions and disorders other than serious mental illness. *Psychiatric services*, *70*(6), 488-498.

Booij, S., Snippe, E., Jeronimus, B., Wichers, M., & Wigman, J. (2018). Affective reactivity to daily life stress: Relationship to positive psychotic and depressive symptoms in a general population sample. *Journal of Affective Disorders,* 225(1), 474-481. https://doi.org/10.1016/j.jad.2017.08.051.

Borelius, M., Lindhardt, A., & Schalling, M. (2014). Help break the stigma against mental illness!. *Nordic journal of psychiatry*, *68*(4), 225-226.

Borgueta, A. M., Purvis, C. K., & Newman, M. G. (2018). Navigating the ethics of internet-guided self-help interventions. *Clinical Psychology: Science and Practice*, *25*(2), e12235.

Brooks, F., & McHenry, B. (2015). *A contemporary approach to substance use disorders and addiction counseling: a counselor's guide to application and understanding*. Retrieved from https://ebookcentral-proquest-com.ezproxy.liberty.edu.

Brown, D. R., Carney, J. S., Parrish, M. S., & Klem, J. L. (2013). Assessing spirituality: The relationship between spirituality and mental health. *Journal of Spirituality In Mental Health*, *15*(2), 107-122.

Buckner, L., Croucher, K., Fry, G., & Jasinska, M. (2013). The impact of demographic change on the infrastructure for housing, health and social care in the North of England. *Applied Spatial Analysis and Policy*, *6*(2), 123-142.

Burns, R., & Machin, M. (2013). Psychological wellbeing and the diathesis-stress hypothesis model: The role of psychological functioning and quality of relations in promoting subjective well-being in a life events study. *Personality and Individual Difference,* 54, 321-326.

Bursch, B. (2016). Pain and the biopsychosocial model. *Journal of the American Academy of Child and Adolescent Psychiatry,* 55(10), 34, https://doi.org/10.1016/j.jaac.2016.07.565

Cadigan, J., Lee, C., & Larimer, M. (2018). Young adult mental health: prospective examination of service utilization, perceived unmet service needs, attitudes, and barriers to service use. *Prevention Science,* 1-11, ttps://doi.org/10.1007/s11121-018-0875-8

Cameron, J., Hart, A., Brooker, S., Neale, P., & Reardon, M. (2018). Collaboration in the design and delivery of a mental health recovery college course: experiences of students and tutors. *Journal of Mental Health*, *27*(4), 374-381.

Campbell-Sills, L., Roy-Byrne, P. P., Craske, M. G., Bystritsky, A., Sullivan, G., & Stein, M. B. (2016). Improving outcomes for patients with medication-resistant anxiety: Effects of

collaborative care with cognitive behavioral therapy. *Depression and anxiety*, *33*(12), 1099-1106.

Campisi, J., May, J., Burch, K., Larson, K., Doscher, J., Doherty, S., Isaacson, K., Sebring, K., & Gahan, A. (2017). Anxiety-inducing Facebook behavior is associated with higher rates of upper respiratory infection in college-aged users. *Computers in Human Behavior*, *76*, 211-217.

Carlbring, P., Maurin, L., Törngren, C., Linna, E., Eriksson, T., Sparthan, E., Strååt, M., Marquez, C., Bergman-Nordgren, L., & Andersson, G. (2010). Individually-tailored, internet-based treatment for anxiety disorders: a randomized controlled trial. *Behaviour Research and Therapy,* 49, 18-24.

Carlson, C. L., & Tamm, L. (2000). Responsiveness of children with attention deficit–hyperactivity disorder to reward and response cost: Differential impact on performance and motivation. *Journal of consulting and clinical psychology*, *68*(1), 73.

Carpenter, J. K., Andrews, L. A., Witcraft, S. M., Powers, M. B., Smits, J. A., & Hofmann, S. G. (2018). Cognitive behavioral therapy for anxiety and related disorders: A meta-analysis of randomized placebo-controlled trials. *Depression and Anxiety*, *35*(6), 502-514. https://doi.org/10.1002/da.22728.

Carras, M. C., Mojtabai, R., & Cullen, B. (2018). Beyond social media: A cross-sectional survey of other internet and mobile phone applications in a community psychiatry population. *Journal of Psychiatric Practice*, *24*(2), 127.

Carta, M. G., Di Fiandra, T., Rampazzo, L., Contu, P., & Preti, A. (2015). An overview of international literature on school interventions to promote mental health and well-being

in children and adolescents. *Clinical Practice and Epidemiology In Mental Health: CP & EMH*, *11*(Suppl 1 M1), 16.

Carter, N. R. N., Bryant-Lukosius, D., Alba, R. N., Blythe, J., & Neville, A. J. (2014). The Use of Triangulation in Qualitative Research. *Oncology Nursing Forum, 41*(5), 545-7.http://ezproxy.liberty.edu/login?qurl=https%3A%2F%2Fwww.proquest.com%2Fdocview%2F1559261620%3Faccountid%3D12085

Carver, M. L., & O'Malley, M. (2015). Progressive muscle relaxation to decrease anxiety in clinical simulations. *Teaching and Learning in Nursing*, *10*(2), 57-62.

Cavanaugh, K., Strauss, C., Cicconi, F., Griffiths, N., Wyper, A., & Jones, F. (2013). A randomised controlled trial of a brief online mindfulness-based intervention. *Behaviour Research and Therapy,* 51, 573-578.

Cavicchioli, M., Movalli, M., & Maffei, C. (2018). The clinical efficacy of mindfulness-based treatments for alcohol and drugs use disorders: a meta-analytic review of randomized and nonrandomized controlled trials. *European Addiction Research*, *24*, 137-162.

Center for Disease Control. (2018). Data & statistics. Retrieved from http://www.cdc.gov/

Chang, E., Yu, T., Chang, O., & Hirsch, J. (2016). Hope and trauma: Examining a diathesis-stress model in predicting depressive and anxious symptoms in college students. *Personality and Individual Differences,* 96, 52-54.

Chao, A. M., White, M. A., Grilo, C. M., & Sinha, R. (2017). Examining the effects of cigarette smoking on food cravings and intake, depressive symptoms, and stress. *Eating Behaviors*, *24*, 61-65.

Charova, E., Dorstyn, D., Tully, P., & Mittag, O. (2015). Web-based interventions for comorbid depression and chronic illness: a systematic review. *Journal of Telemedicine and Telecare*, *21*(4), 189-201.

Cheatham, J., Holttum, S., Springham, N., & Butt, K. (2017). 'I can see it and I can feel it, but I can't put my finger on it': A Foucauldian discourse analysis of experiences of relating on psychiatric inpatient units. *Psychology and Psychotherapy,* https://doi:1111/papt.12162.

Cheetham, M., Van der Graaf, P., Khazaeli, B., Gibson, E., Wiseman, A., & Rushmer, R. (2018). "It was the whole picture" a mixed methods study of successful components in an integrated wellness service in Northeast England. *BMC Health Services Research*, *18*, 200. http://doi.org/10.1186/s12913-018-3007-z

Chen, M., & Tsai, S. (2016). Treatment-resistant panic disorder: clinical significance, concept and management. *Progress in Neuro-Psychopharmacology and Biological Psychiatry,* 70(3), 219-226. https://doi.org/10.1016/j.pnpbp.2016.02.001.

Chen, S., Wathen, C., & Speciale, M. (2020). Online clinical training in the virtual remote environment: Challenges, opportunities, and solutions. *The Professional Counselor,* 10(1), 78-91.

Chiesa, A., & Serretti, A. (2009). Mindfulness-based stress reduction for stress management in healthy people: a review and meta-analysis. *The journal of Alternative and Complementary Medicine*, *15*(5), 593-600.

Christensen, H., Batterham, P., & Calear, A. (2014). Online interventions for anxiety disorders. *Current Opinions in Psychiatry,* 1, 7-13. https:// doi: 10.1097/YCO.0000000000000019

Christopher, M. (2004). A broader view of trauma: A biopsychosocial-evolutionary view of the

    role of the traumatic stress response in the emergence of pathology and/or growth.

    Clinical Psychology Review, 24, 75-98.

Cicchetti, D., & Cohen, D. J. (Eds.). (2006). *Developmental psychopathology, volume 1: Theory*

    and method (Vol. 1). John Wiley & Sons.

Cicco, G. (2014). Building effective supervisory relationships in the online counseling course:

    faculty and student responsibilities. *I*-Manager's *Journal on School Educational*

    Technology, (10)2, 1-8.

Colder, M., Mojtabai, R., & Cullen, B. (2018). Beyond social media: A cross-sectional survey of

    other internet and mobile phone applications in a community psychiatry population.

    Journal of Psychiatric Practice, 24(2), 127-135.

Comer, J. S., Elkins, R. M., Chan, P. T., & Jones, D. J. (2014). New methods of service delivery

    for children's mental health care.

Conway, C., Rutter, L., & Brown, T. (2016). Chronic environmental stress and the temporal

    Course of depression and panic disorder: A trait-state modeling approach. *Journal of*

    Abnormal Psychology, 125 (1), 53-63.

Costello, A., Abbas, M., Allen, A., Ball, S., Bell, S., Bellamy, R., Friel, S., Groce, N., Johnson,

    A., Kett, M., Lee, M., & Patterson, C. (2009). Managing the health effects of climate

    change: lancet and University College London Institute for Global Health

    Commission. *The lancet*, *373*(9676), 1693-1733.

Covan, K. E. (2018). Learning from mental health research. *Health Care For Women*

    International, *39*(7), 717-718.

Cox, R. S., Irwin, P., Scannell, L., Ungar, M., & Bennett, T. D. (2017). Children and youth's biopsychosocial wellbeing in the context of energy resource activities. *Environmental Research*, *158*, 499-507.

Creswell, J. (2013). *Qualitative Inquiry & Research Design.* Los Angeles: Sage Publishers.

Davidson, L., & Strauss, J. (1995). Beyond the Biopsychosocial Model: Integrating Disorder, Health, and Recovery. *Psychiatry,* 58(1), 44-55.

Dawson, E., Clark, K., Obenchain, R., Loscalzo, M., & Folbrecht, J. (2018). Biopsychosocial distress in young adult oncology patients: Examining sex differences in sources of high distress and requests for assistance. *Journal of Young Adult and Adolsecent Oncology*, doi: 10.1089/jayao.2017.0081.

Deary, I. J., Liewald, D., & Nissan, J. (2011). A free, easy-to-use, computer-based simple and four-choice reaction time programme: the Deary-Liewald reaction time task. *Behavior Research Methods*, *43*(1), 258-268.

de la Vega, M. R., Chapman, E., & Zhang, D. D. (2018). NRF2 and the hallmarks of cancer. *Cancer Cell*, *34*(1), 21-43.

Dermatis, H., & Galanter, M. (2016). The role of twelve-step-related spirituality in addiction recovery. *Journal of Religion and Health*, *55*(2), 510-521.

Di Benedetto, M., Lindner, H., Aucote, H., Churcher, J., McKenzie, S., Croning, N., & Jenkins, E. (2014). Co-morbid depression and chronic illness related to coping and physical and mental health status. *Psychology, health & medicine*, *19*(3), 253-262.

Dickson, K., Richardson, M., Kwan, I., MacDowall, W., Burchett, H., Stansfield, C., Brunton, G., Sutcliffe, K., & Thomas, J. (2018). Screen-based activities and children and young people's mental health and psychosocial wellbeing: A systematic map of reviews.

Dictionary, C. (2021). Participation. *Retrieved from Cambridge Dictionary: https://dictionary. cambridge. org/dictionary/english/participation*.

Di Giovanni, J., Levchenko, A. A., & Ortega, F. (2015). A global view of cross-border migration. *Journal of the European Economic Association*, *13*(1), 168-202.

Dirven, B., Homeberg, J., Kozicz, T., & Henckens, M. (2017). Epigenetic programming of the neuroendocrine stress response by adult life stress. *Journal of Molecular Endocrinology,* 59(1), DOI: 10.1530/JME-17-0019.

Donker, T., Petrie, K., Proudfoot, J., Clarke, J., Birch, M., & Christensen, H. (2013). Smartphones for smarter delivery of mental health programs: a systematic review. *Journal of Medical Internet Research,* 15(11). https://doi:10.2196/jmir.2791

Donnelley, M. (2018). Health stewardship: a concept for best health outcomes. *Nursing Standard*, *32*(21).

Durland, L., Interian, A., Pretzer-Aboff, I., & Dobkin, R. D. (2014). Effect of telehealth-to-home interventions on quality of life for individuals with depressive and anxiety disorders. *Smart Homecare Technology and TeleHealth*, *2*, 105-119.

Duxbury, L., Stevenson, M., & Higgins, C. (2018). Too much to do, too little time: Role overload and stress in a multi-role environment. *International Journal of Stress Management*, *25*(3), 250.

Elliott, J., & Richardson, V. (2014). The biopsychosocial model and quality of life in persons with active epilepsy. *Epilepsy Behavior,* 41, 55-65, https://doi:10.1016/j.yebeh.2014.09.035.

Ellis-Barton, C. (2016). Ethical Considerations in Research Participation Virality. *Journal of Empirical Research on Human Ethics,* 11(3), 281–285. https://doi.org/10.1177/1556264616661632

Engel, G. (1980). The clinical application of the biopsychosocial model. *American Journal of Psychiatry,* 137(3), 535-545.

Eriksson, M., Ghazinour, M., & Hammarström, A. (2018). Different uses of Bronfenbrenner's ecological theory in public mental health research: what is their value for guiding public mental health policy and practice?. *Social Theory & Health*, *16*(4), 414-433.

Esler, M. (2017). Mental stress and human cardiovascular disease. *Neuroscience & Biobehavioral Reviews*, *74*, 269-276.

Esmaeelzadeh, S., Moraros, J., Thorpe, L., & Bird, Y. (2018). Examining the association and directionality between mental health disorders and substance use among adolescents and young adults in the US and Canada—a systematic review and meta-analysis. *Journal of Clinical Medicine*, *7*(12), 543.

Fahlgren, E., Nima, A., Archer, T., & Garcia, D. (2015). Person-centered osteopathic practice: patients' personality (body, mind, and soul) and health (ill-being and well-being). *Peerj,* 27(3). doi: 10.7717/peerj.1349

Fava, G. A., & Sonino, N. (2017). From the Lesson of George Engel to Current Knowledge. *Psychotherapy and Psychosomatics*, *86*(5), 257-259.

Fernandes, V., & Osorio, F. L. (2015). Are there associations between early emotional trauma and anxiety disorders? Evidence from a systematic literature review and meta-analysis. *European Psychiatry*, *30*(6), 756-764.

Finlay, K. A., & Elander, J. (2016). Reflecting the transition from pain management services to chronic pain support group attendance: An interpretative phenomenological analysis. *British Journal of Health Psychology*, *21*(3), 660-676.

Firth, J., Torous, J., Nicholas, J., Carney, R., Pratap, A., Rosenbaum, S., & Sarris, J. (2017). The efficacy of smartphone-based mental health interventions for depressive symptoms: a meta-analysis of randomized controlled trials. *World Psychiatry*, *16*(3), 287-298.

Fischer, S., & Cleare, A. (2017). Cortisol as a predictor of psychological therapy response in anxiety disorders – systematic review and meta-analysis. *Journal of Anxiety Disorders,* 47, 60-68. Doi 10.1016/j.janxdis.2017.02.007.

Fjorback, L. O. (2012). Mindfulness and bodily distress. *Danish Journal of Medicine*, 59(11): B4547.

Fletcher, K., Foley, F., & Murray, G. (2018). Web-based self-management programs for bipolar disorder: insights from the online, recovery-oriented, bipolar individualized tool project. *Journal of Medical Internet Research,* 20(10), e11160. https://doirg.ezproxy.liberty.edu/10.2196/11160.

Fleury, V. P., Hedges, S., Hume, K., Browder, D. M., Thompson, J. L., Fallin, K., El Zein, F., Reutebuch, C. K., & Vaughn, S. (2014). Addressing the academic needs of adolescents with autism spectrum disorder in secondary education. *Remedial and Special Education*, *35*(2), 68-79.

Fombuena, M., Galiana, L., Barreto, P., Oliver, A., Pascual, A., & Soto-Rubio, A. (2016). Spirituality in patients with advanced illness: The role of symptom control, resilience and social network. *Journal of Health Psychology*, *21*(12), 2765-2774.

Food and Drug Administration. (2019, November 5). *Device Software Functions Including Mobile Medical Applications*. https://www.fda.gov/medical-devices/digital-health-center-excellence/device-software-functions-including-mobile-medical-applications

Frankel, A., Gandhi, T. K., & Bates, D. W. (2003). Improving patient safety across a large integrated health care delivery system. *International Journal for Quality in Health Care*, *15*(suppl_1), i31-i40.

Franks, B., Chen, C., Manley, K., & Higgins, T. (2015). Effective challenge regulation coincides with promotion focus-related success and emotional well-being. *Journal of Happiness Studies,* 17, 981-994.

Frenk, J., & Gomez-Dantes, O. (2014). Designing a framework for the concept of health. *Journal of Public Health Policy*, *35*(3), 401-406.

Furtado, M., & Katzman, M. A. (2015). Examining the role of neuroinflammation in major depression. *Psychiatry research*, *229*(1-2), 27-36.

Gaiswinkler, L., & Unterrainer, H. F. (2016). The relationship between yoga involvement, mindfulness and psychological well-being. *Complementary Therapies in Medicine*, *26*, 123-127.

Galdas, P. (2017). Revisiting bias in qualitative research: reflections on its relationship with funding and impact. *International Journal of Qualitative Methods,* 16, 1-2, https://doi.org/10.1177/1609406917748992.

Garcia, H. A., McGeary, C. A., McGeary, D. D., Finley, E. P., & Peterson, A. L. (2014). Burnout in Veterans Health Administration mental health providers in posttraumatic stress clinics. *Psychological Services*, *11*(1), 50.

Gardner, B., & Lally, P. (2018). Modelling habit formation and its determinants. *The psychology of habit*, 207-229.

Garland, C. (2018). *Understanding trauma: A psychoanalytical approach*. Routledge.

Garner, M., Clarke, G., Graystone, H., & Baldwin, D. S. (2011). Defensive startle response to emotional social cues in social anxiety. *Psychiatry Research*, *186*(1), 150-152.

Garrett, J. K., Clitherow, T. J., White, M. P., Wheeler, B. W., & Fleming, L. E. (2019). Coastal proximity and mental health among urban adults in England: The moderating effect of household income. *Health & Place*, *59*, 102200.

Garzon, F., & Ford, K. (2016). Adapting mindfulness for conservative Christians. *Journal of Psychology and Christianity*, *35*(3), 263.

Gask, L. (2018). In defense of the biopsychosocial model. *The Lancet Psychiatry*, *5*(7), 548-549.

Geramita, E. M., Belnap, B. H., Abebe, K. Z., Rothenberger, S. D., Rotondi, A. J., & Rollman, B. L. (2018). The association between increased levels of patient engagement with an internet support group and improved mental health outcomes at 6-month follow-up: post-hoc analyses from a randomized controlled trial. *Journal of Medical Internet Research*, *20*(7), e10402.

Ghasemipour, Y., Robinson, J. A., & Ghorbani, N. (2013). Mindfulness and integrative self-knowledge: Relationships with health-related variables. *International Journal of Psychology*, *48*(6), 1030-1037.

Gloster, A. T., Meyer, A. H., & Lieb, R. (2017). Psychological flexibility as a malleable public health target: Evidence from a representative sample. *Journal of Contextual Behavioral Science*, *6*(2), 166-171.

Goldstein, R. B., Olfson, M., Martens, E. G., & Wolk, S. I. (2006). Subjective unmet need for mental health services in depressed children grown up. *Administration and Policy in Mental Health and Mental Health Services Research*, *33*(6), 666-673.

Goodyer, I. M. (2015). Genes, environments and depressions in young people. *Archives of Disease in Childhood*, *100*(11), 1064-1069.

Gorman, J. M., Kent, J. M., Sullivan, G. M., & Coplan, J. D. (2000). Neuroanatomical hypothesis of panic disorder, revised. *American Journal of Psychiatry*, *157*(4), 493-505.

Green, J., & Thorogood, N. (2018). *Qualitative methods for health research*. sage.

Griffiths, K., Mackinnn, A., Crisp, D., Christensen, H., & Bennett, K. (2012). The Effectiveness of an Online Support Group for Members of the Community with Depression: A Randomised Controlled Trial. *Plos One,* 7(12), 1-10, https://doi:10.1371/journal.pone.0053244

Haigh, E. A., Bogucki, O. E., Sigmon, S. T., & Blazer, D. G. (2018). Depression among older adults: a 20-year update on five common myths and misconceptions. *The American Journal of Geriatric Psychiatry*, *26*(1), 107-122.

Hantsoo, L., & Epperson, C. N. (2017). Anxiety disorders among women: a female lifespan approach. *Focus*, *15*(2), 162-172.

Harrichand, J., Litam, S., & Ausloos, C. (2021). Infusing self-care and wellness into CACREP curricula: Pedagogical recommendations for counselor educators and counselors during Covid-19. *International Journal for Advancement of Counseling,* 43, 372-385.

Harris, M. G., Diminic, S., Reavley, N., Baxter, A., Pirkis, J., & Whiteford, H. A. (2015). Males' mental health disadvantage: An estimation of gender-specific changes in service

utilisation for mental and substance use disorders in Australia. *Australian & New Zealand Journal of Psychiatry*, *49*(9), 821-832.

Hartley, S., Johnco, C., Hofmeyr, M., & Berry, A. (2016). The nature of posttraumatic growth in adult survivors of child sexual abuse. *Journal of Child Sexual Abuse*, *25*(2), 201-220.

Havelka, M., Lucanin, J., & Lucanin, D. (2009). Biopsychosocial model--the integrated approach to health and disease. *Collegium Antropologicum,* 33(1), 303-310.

Hein, T. W., Rosa, R. H., Ren, Y., Xu, W., & Kuo, L. (2015). VEGF receptor-2–linked PI3K/calpain/SIRT1 activation mediates retinal arteriolar dilations to VEGF and shear stress. *Investigative ophthalmology & visual science*, *56*(9), 5381-5389.

Helen, C., Philip, B., & Alison, C. (2014). Online interventions for anxiety disorders. *Current Opinion in Psychiatry,* 27(1), 7-13. https://doi:10.1097/YCO.0000000000000019

Hendrix, C. C., Pereira, K., Bowers, M., Brown, J., Eisbach, S., Briggs, M. E., Fitzgerald, K., Matters, L., Luddy, C., & Braxton, L. (2015). Integrating Mental Health Concepts in the Care of Adults With Chronic Illnesses: A Curricular Enhancement. *Journal of Nursing Education*, *54*(11), 645-649.

Henningsen, P. (2018). Management of somatic symptom disorder. *Dialogues in clinical neuroscience*, *20*(1), 23.

Herring, J. (2016). Health as Vulnerability; Interdependence and Relationality. *The New Bioethics,* 22(1), 18-32. doi: 10.1080/20502877

Hibbard, J. H., & Pope, C. R. (1993). The quality of social roles as predictors of morbidity and mortality. *Social Science & Medicine*, *36*(3), 217-225.

Hidalgo-Mazzei, D., Mateu, A., Reinares, M., Undurraga, J., del Mar Bonnín, C., Sánchez-Moreno, J., Vieta, E., & Colom, F. (2015). Self-monitoring and psychoeducation in

bipolar patients with a smart-phone application (SIMPLE) project: design, development and studies protocols. *BMC Psychiatry*, *15*(1), 1-9.

Hoertel, N., Le Strat, Y., Angst, J., & Dubertret, C. (2013). Subthreshold bipolar disorder in a US national representative sample: prevalence, correlates and perspectives for psychiatric nosography. *Journal of Affective Disorders*, *146*(3), 338-347.

Hoffmann, H., Jäckel, D., Glauser, S., Mueser, K. T., & Kupper, Z. (2014). Long-term effectiveness of supported employment: 5-year follow-up of a randomized controlled trial. *American Journal of Psychiatry*, *171*(11), 1183-1190.

Holbrey, S., & Coulson, N. (2013). A qualitative investigation of the impact of peer to peer online support for women living with Polycystic Ovary Syndrome. *BMC Womens Health,* 13(51), 1-9.

Holden, K. G., Reding, D. M., Ford, N. B., & Bronikowski, A. M. (2019). Effects of early nutritional stress on physiology, life histories and their trade-offs in a model ectothermic vertebrate. *Journal of Experimental Biology*, *222*(11), jeb200220.

Hopkins, P. D., & Shook, N. J. (2017). A review of sociocultural factors that may underlie differences in African American and European American anxiety. *Journal of Anxiety Disorders*, *49*, 104-113.

Huber, J., Muck, T., Maatz, P., Keck, B., Enders, P., Maatouk, I., & Ihrig, A. (2018). Face-to-face vs. online peer support groups for prostate cancer: A cross-sectional comparison study. *Journal of Cancer Survivorship,* 12, 1-9, https://doi-org.ezproxy.liberty.edu/10.1007/s11764-0170633-0

Hunter, D. J., & Reddy, K. S. (2013). Noncommunicable diseases. *New England Journal of Medicine*, *369*(14), 1336-1343.

Indian, M., & Grieve, R. (2014). When Facebook is easier than face-to-face: Social support

    derived from Facebook in socially anxious individuals. *Personality and Individual*

    Differences, 59, 102-106.

IsHak, W. W., Mirocha, J., Pi, S., Tobia, G., Becker, B., Peselow, E. D., & Cohen, R. M. (2014).

    Patient-reported outcomes before and after treatment of major depressive

    disorder. *Dialogues in Clinical Neuroscience*, *16*(2), 171.

Ivanova, I., Wauters, M., Vander Stichele, R., Christiaens, T., De Wolf, J., Dilles, T., &

    Elseviers, M. (2018). Medication use in a cohort of newly admitted nursing home

    residents (Ageing@ NH) in relation to evolving physical and mental health. *Archives of*

    gerontology and geriatrics, *75*, 202-208.

Jacobs, A., & Nakata, K. (2012). Organisational semiotics methods to assess organisational

    readiness for internal use of social media.

James, M. H., Campbell, E. J., & Dayas, C. V. (2017). Role of the orexin/hypocretin system in

    stress-related psychiatric disorders. *Behavioral Neuroscience of Orexin/Hypocretin*, 197-

    219.

Jamieson, J. P., Nock, M. K., & Mendes, W. B. (2012). Mind over matter: reappraising arousal

    improves cardiovascular and cognitive responses to stress. *Journal of Experimental*

    Psychology: General, *141*(3), 417.

Jarnecke, A. M., & South, S. C. (2014). Genetic and environmental influences on alcohol use

    problems: Moderation by romantic partner support, but not family or friend

    support. *Alcoholism: Clinical and Experimental Research*, *38*(2), 367-375.

Jay, K., Brandt, M., Jakobsen, M. D., Sundstrup, E., & Berthelsen, K. G. (2016). Ten weeks of

    physical-cognitive-mindfulness training reduces fear-avoidance beliefs about work-

related activity: Randomized controlled trial. *Medicine*, *95*(34).

https://doi:10.1097/MD.0000000000003945.

Jones, T. M., Nurius, P., Song, C., & Fleming, C. M. (2018). Modeling life course pathways

from adverse childhood experiences to adult mental health. *Child Abuse & Neglect*, *80*,

32-40.

Kalckreuth, S., Trefflich, F., & Rummel-Kluge, C. (2014). Mental health related Internet use

among psychiatric patients: a cross-sectional analysis. *BMC Psychiatry*, *14*(1), 1-11.

Kang, H. T., Shim, J. Y., Lee, H. R., Park, B. J., Linton, J. A., & Lee, Y. J. (2014). Trends in

prevalence of overweight and obesity in Korean adults, 1998–2009: the Korean National

Health and Nutrition Examination Survey. *Journal of Epidemiology*, JE20130017.

Kanwar, A., Malik, S., Prokop, L. J., Sim, L. A., Feldstein, D., Wang, Z., & Murad, M. H.

(2013). The association between anxiety disorders and suicidal behaviors: A systematic

review and meta-analysis. *Depression and anxiety*, *30*(10), 917-929.

Karl, S., & Holland, J. (2015). The roots of psychosomatic medicine II: George L. Engel.

Psychosomatics, 56(6), 630-633.

Katerndahl, D., & Oyiriaru, D. (2007). Assessing the biopsychosociospiritual model in primary

care: development of the biopsychosociospiritual inventory (BioPSSI). *International

Journal of Psychiatry in Medicine,* 37(4), 393-414.

Kazdin, A. E. (2002). The state of child and adolescent psychotherapy research. *Child and

Adolescent Mental Health*, *7*(2), 53-59.

Keating, B., Campbell, J., & Radoll, P. (2013). Evaluating a new pattern development process

for interface design: Application to mental health services. In *Proceedings of the 34th*

International Conference on Information Systems (ICIS 2013) (pp. 1-10). Association for Information Systems (AIS).

Khorashadizadeh, F. (2016). Creation of illness meaning: A central concept of spiritual health. *Evidence Based Care*, *6*(2), 75-76.

Kim, B., Cho, S. J., Lee, K. S., Lee, J. Y., Choe, A. Y., Lee, J. E., Choi, T. K., & Lee, S. H. (2013). Factors associated with treatment outcomes in mindfulness-based cognitive therapy for panic disorder. *Yonsei Medical Journal,* 54(6), 1454–1462. https://doi.org/10.3349/ymj.2013.54.6.1454

Kim, H. G., Cheon, E. J., Bai, D. S., Lee, Y. H., & Koo, B. H. (2018). Stress and heart rate variability: A meta-analysis and review of the literature. *Psychiatry Investigation,* 15(3), 235-245.

Kim, M. K., Lee, K. S., Kim, B., Choi, T. K., & Lee, S. H. (2016). Impact of Mindfulness-Based Cognitive Therapy on Intolerance of Uncertainty in Patients with Panic Disorder. *Psychiatry Investigation*, 13(2), 196–202. https://doi.org/10.4306/pi.2016.13.2.196

King, C. R., Collins, S., Fuller, D., Wang, P. C., Kupelian, P., Steinberg, M., & Katz, A. (2013). Health-related quality of life after stereotactic body radiation therapy for localized prostate cancer: results from a multi-institutional consortium of prospective trials. *International Journal of Radiation Oncology* Biology* Physics*, *87*(5), 939-945.

Kip, R., & Hutschemaekers, G. (2018). Health, well-being, and psychopathology in a clinical population: Structure and discriminant validity of Mental Health Continuum Short Form (MHC-SF). *Journal of Clinical Psychology,*

Klein, B., Richards, J., & Austin, D. (2004). Efficacy of internet therapy for panic disorder. *Journal of Behavior Therapy and Experimental Psychiatry,* 37, 213-238.

Koball, A. M., Jester, D. J., Domoff, S. E., Kallies, K. J., Grothe, K. B., & Kothari, S. N. (2017). Examination of bariatric surgery Facebook support groups: a content analysis. *Surgery for Obesity and Related Diseases*, *13*(8), 1369-1375.Kochanek, K., Murphy, S., Xu, J., & Arias, E. (2017). Mortality in the Unites States, 2016. *NCHS Data Brief,* 293. www.cdc.gov.

Koenig, H. G. (2014). The Spiritual Care Team: Enabling the Practice of Whole Person Medicine. *Religions, 5*(4), 1161-1174. http://dx.doi.org.ezproxy.liberty.edu/10.3390/rel5041161

Kotianova, A., Kotian, M., Slepecky, M., Chupakova, M., Prasko, J., & Tonhazjerova, L. (2018). The differences between patients with panic disorder and healthy controls in psychophysiological stress profile. *Neuropsychiatric Disease and Treatment,* 14, 435-441.

Kraemer, M. U., Sinka, M. E., Duda, K. A., Mylne, A. Q., Shearer, F. M., Barker, C. M., Moore, C. G., Carvalho, R. G., Coelho, G. E., Van Bortel, W., Hendrickx, G., & Hay, S. I. (2015). The global distribution of the arbovirus vectors Aedes aegypti and Ae. albopictus. *Elife*, *4*, e08347.

Krasen, C. E. (2018). Biopsychosocial factors: Antecedent and consequential to women's health issues. *Health care for women international*, *39*(3), 261-262.

Kristen, L., Ivarsson, L., Parker, J., & Ziegert, K. (2015). Future challenges for intervention research in health and lifestyle research*A systematic meta-literature review. *International Journal of Qualitative Studies on Health and Well-being,* 10.

Laycraft, K. (2009). Positive maladjustment as a transition from chaos to order. *Roeper Review*, *31*(2), 113-122.

LeBouthillier, D. M., & Asmundson, G. J. (2017). The efficacy of aerobic exercise and

    resistance training as transdiagnostic interventions for anxiety-related disorders and

    constructs: A randomized controlled trial. *Journal of Anxiety Disorders*, *52*, 43-52.

Lee, J., & Dade, L. A. (2003). The buck stops where? What is the role of the emergency

    physician in managing panic disorder in chest pain patients? *CJEM : Journal of the*

    Canadian Association of Emergency Physicians, 5(4), 237-8.

    http://ezproxy.liberty.edu/login?qurl=https%3A%2F%2Fwww.proquest.com%2Fdocview

    %2F195786010%3Faccountid%3D12085

Lehrer, P., & Eddie, D. (2013). Dynamic processes in regulation and some implications for

    biofeedback and biobehavioral interventions. *Applied psychophysiology and*

    Biofeedback, *38*(2), 143-155.

Lenze, E. J., Hickman, S., Hershey, T., Wendleton, L., Ly, K., Dixon, D., Doré, P., & Wetherell,

    J. L. (2014). Mindfulness-based stress reduction for older adults with worry symptoms

    and co-occurring cognitive dysfunction. *International Journal of Geriatric*

    Psychiatry, *29*(10), 991-1000.

Levy, C. E., Spooner, H., Lee, J. B., Sonke, J., Myers, K., & Snow, E. (2018). Telehealth-based

    creative arts therapy: Transforming mental health and rehabilitation care for rural

    veterans. *The Arts in Psychotherapy*, *57*, 20-26.

Li, S. H., & Graham, B. M. (2017). Why are women so vulnerable to anxiety, trauma-related and

    stress-related disorders? The potential role of sex hormones. *The Lancet Psychiatry*, *4*(1),

    73-82.

Li, S. S., Liddell, B. J., & Nickerson, A. (2016). The relationship between post-migration stress and psychological disorders in refugees and asylum seekers. *Current psychiatry reports*, *18*(9), 1-9.

Liaugaudaite, V., Podlipskyte, A., & Mickuviene, N. (2017, October). Comorbidity of depression and panic disorder affects suicide attempts in patients with mood disorders. In *European Neuropsychopharmacology* (Vol. 27, pp. S872-S873). PO BOX 211, 1000 AE AMSTERDAM, NETHERLANDS: ELSEVIER SCIENCE BV.

Limmer, J., Kornhuber, J., & Martin, A. (2015). Panic and comorbid depression and them associations with stress reactivity, interoceptive awareness and interoceptive accuracy of various bioparameters. *Journal of Affective Disorders,* 185, 170-179.

Lindseth, A., & Norberg, A. (2004). A phenomenological hermeneutical method for researching lived experience. *Scandinavian Journal of Caring Sciences,* 18, 145-153.

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine*, *71*(12), 2150-2161.

Luxton, D. D., McCann, R. A., Bush, N. E., Mishkind, M. C., & Reger, G. M. (2011). mHealth for mental health: Integrating smartphone technology in behavioral healthcare. *Professional Psychology: Research and Practice, 42*(6), 505–512. https://doi.org/10.1037/a0024485

Marchesi, C. (2008). Pharmacological management of panic disorder. *Neuropsychiatric Disease and Treatment*, *4*(1), 93–106. https://doi.org/10.2147/ndt.s1557

Marker, I., & Norton, P. J. (2018). The efficacy of incorporating motivational interviewing to cognitive behavior therapy for anxiety disorders: A review and meta-analysis. *Clinical Psychology Review*, *62*, 1-10.

Martin, R. M., Ridley, S. C., & Gillieatt, S. J. (2017). Family inclusion in mental health services: Reality or rhetoric?. *International Journal of Social Psychiatry*, *63*(6), 480-487.

Martin-Wagar, C. A., Boswell, R. G., Bennett, B. L., Perelman, H., & Forrest, L. N. (2021). Psychological and eating disorder symptoms as predictors of starting eating disorder treatment. *International Journal of Eating Disorders*.

Maslow, A. (1943). "A Theory of Human Motivation". *In Psychological Review*, 50 (4), 430-437.

Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Forum: Qualitative Social Research,* 11(3), Art 8.

Masters, K. S., & Spielmans, G. I. (2007). Prayer and health: Review, meta-analysis, and research agenda. *Journal of behavioral medicine*, *30*(4), 329-338.

Mattson, P., & Ekselius, L. (2002). Migraine, major depression, panic disorder, and personality traits in women aged 40-74 years: a population-based study. *Cephalalgia*, *22*(7), 543-551.

Mehtap, B., Tasgin, E., Lok, N., & Lok, S. (2015). Review of physical activity levels of elderly people living in nursing home. *Science, Movement and Health*, *15*(2), 15.

Meier-Abt, P. J. (2014). The Meikirch Model of Health fits well into the concept of 'personalized health.' *Journal of public health policy*, *35*(3), 420-421.

Melville, K. M., Casey, L. M., & Kavanagh, D. J. (2010). Dropout from Internet-based treatment for psychological disorders. *British Journal of Clinical Psychology*, *49*(4), 455-471.

Meng, X., & D'Arcy, C. (2013). The projected effect of increasing physical activity on reducing the prevalence of common mental disorders among Canadian men and women: a national population-based community study. *Preventive medicine*, *56*(1), 59-63.

Merriam-Webster, I. (2021). Credibility| Definition of Credibility by Merriam-Webster.

Metzler, D. H., Mahoney, D., & Freedy, J. R. (2016). Anxiety disorders in primary care. *Primary Care: Clinics in Office Practice*, *43*(2), 245-261.

Mills, J., & Chapman, M. (2016). Compassion and self-compassion in medicine: Self-care for the caregiver. *The Australasian Medical Journal*, *9*(5), 87-91.

Mineka, S., & Oehlberg, K. (2008). The relevance of recent developments in classical conditioning to understanding the etiology and maintenance of anxiety disorders. *Acta Psychologica,* 127, 567-580.

Mogg, K., & Bradley, B. P. (2016). Anxiety and attention to threat: Cognitive mechanisms and treatment with attention bias modification. *Behaviour Research and Therapy*, *87*, 76-108.

Mohr, D., Cuijpers, P., & Lehman, K. (2011). Supportive accountability: a model for providing human support to enhance adherence to eHealth interventions. *Journal of Medical Internet Research,* 13(1), e30. https://doi-org.ezproxy.liberty.edu/10.2196/jmir.1602.

Morris, L. A. (2014). The impact of work on the mental health of parents of children with disabilities. *Family Relations*, *63*(1), 101-121.

Moser, A., & Korstjens, I. (2018). Series: Practical guidance to qualitative research. Part 3: Sampling, data collection and analysis. *European Journal of General Practice*, *24*(1), 9-18.

Moustakas, C. (1995). *Phenomenological research methods*. Sage.

Mrudula, G. B., Haritha, H., Kumar, C. S., Kumar, A. A., & Gopinath, S. (2018, December). Feature normalization for improving the performance of sleep apnea detection system. In *2018 15th IEEE India Council International Conference (INDICON)* (pp. 1-5). IEEE.

Murphy, D., Palmer, E., & Busuttil, W. (2016). Mental health difficulties and help-seeking beliefs within a sample of female partners of UK Veterans diagnosed with Post-traumatic stress disorder. *Journal of Clinical Medicine*, *5*(8), 68.

Musazzi, L., Tornese, P., Sala, N., & Popoli, M. (2018). What acute stress protocols can tell us about PTSD and stress-related neuropsychiatric disorders. *Frontiers In Pharmacology*, *9*, 758.

Muskens, E., Eveleigh, R., Lucassen, P., van Weel, C., Spijker, J., Verhaak, P., Speckens, A., & Voshaar, R. O. (2013). Prescribing AntiDepressants Appropriately (PANDA): a cluster randomized controlled trial in primary care. *BMC Family Practice*, *14*(1), 1-8.

Nair, R. L., White, R. M., Roosa, M. W., & Zeiders, K. H. (2013). Cultural stressors and mental health symptoms among Mexican Americans: A prospective study examining the impact of the family and neighborhood context. *Journal of Youth and Adolescence*, *42*(10), 1611-1623.

Nam, S., Hu, K. H., Butte, M. J., & Chaudhuri, O. (2016). Strain-enhanced stress relaxation impacts nonlinear elasticity in collagen gels. *Proceedings of the National Academy of Sciences*, *113*(20), 5492-5497.

Naslund, J., Aschbrenner, K., Marsch, L., & Bartels, S. (2016). The future of mental health care: peer to peer support and social media. *Epidemiology and Psychiatric Sciences,* 25(2), 113-122. DOI:10.1017/S2045796015001067.

National Center for Health Statistics. (2016). Mental health and substance use disorder

expenditures. *Health, United States.* Retrieved from https://www.cdc.gov.

National Institute of Mental Health. (2018). Health topics. Retrieved from

http://www.nimh.nih.gov/

Novack, D., Oliver, C., Epel, E., Ader, R., Waldstein, S., Antoni, M., & Wainer, A. (2007).

Psychosomatic Medicine: The Scientific Foundation of the Biopsychosocial Model.

Academic Psychiatry, 31(5), 388-401.

Ociskova, M., Prasko, J., Kamaradova, D., Grambal, A., & Sigmundova, Z. (2015). Individual

correlates of self-stigma in patients with anxiety disorders with and without

comorbidities. *Neuropsychiatric Disease and Treatment*, *11*, 1767.

Ociskova, M., Prasko, J., Vrbova, K., Kasalova, P., Holubova, M., Grambal, A., & Machu, K.

(2018). Self-stigma and treatment effectiveness in patients with anxiety disorders—A

mediation analysis. *Neuropsychiatric Disease and Treatment*.

Oei, T. P., & McAlinden, N. M. (2014). Changes in quality of life following group CBT for

anxiety and depression in a psychiatric outpatient clinic. *Psychiatry Research*, *220*(3),

1012-1018.

Ogorchukwu, J. M., Sekaran, V. C., Nair, S., & Ashok, L. (2016). Mental health literacy among

late adolescents in South India: What they know and what attitudes drive them. *Indian

journal of Psychological Medicine*, *38*(3), 234-241.

Olariu, E., Forero, C. G., Castro-Rodriguez, J. I., Rodrigo-Calvo, M. T., Álvarez, P., Martín-

López, L. M., Sánchez-Toto, A., Adroher, N. D., Blasco-Cubedo, M. J., Vilagut, G.,

Fullana, M. A., & Alonso, J. (2015). Detection of anxiety disorders in primary care: A

meta-analysis of assisted and unassisted diagnoses. *Depression and Anxiety*, *32*(7), 471-

484.

O'Reilly, M. L. (2004). Spirituality and mental health clients. *Journal of Psychosocial Nursing and Mental Health Services*, *42*(7), 44-53.

Orman, J., O'Dea, B., Shand, F., Berk, M., Proudfoot, J., & Christensen, H. (2014). Patients and technology: E-Mental health for mood and anxiety disorders in general practice. *Australian Family Physician*, *43*(12), 832-837.

Oxhandler, H. K., Ellor, J. W., & Stanford, M. S. (2018). Client attitudes toward integrating religion and spirituality in mental health treatment: Scale development and client responses. *Social Work*, *63*(4), 337-346.

Pan, S., de Haro, J., Yang, W., & Amorós, J. (2020). Understanding the phenomenology of interacting dark energy scenarios and their theoretical bounds. *Physical Review D*, *101*(12), 123506.

Pangotra, A., Singh, T. K., & Sidana, A. (2018). Effectiveness of progressive muscle relaxation, biofeedback and L-theanine in patients suffering from anxiety disorder. *Journal of Psychosocial Research*, *13*(1), 219-228.

Pascale, R. T., Milleman, M., & Gioja, L. (1999). Surfing the edge of chaos. *Creative Management and Development*, *3*.

Pateraki, E., Vance, Y., & Morris, P. G. (2018). The interaction between asthma and anxiety: an interpretative phenomenological analysis of young people's experiences. *Journal of Clinical Psychology In Medical Settings*, *25*(1), 20-31.

Patterson, B., & Van Ameringen, M. (2016). Augmentation strategies for treatment-resistant anxiety disorders: A systematic review and meta-analysis. *Depression and Anxiety*, *33*(8), 728-736.

Pedersen, E. R., & Paves, A. P. (2014). Comparing perceived public stigma and personal stigma of mental health treatment seeking in a young adult sample. *Psychiatry Research*, *219*(1), 143-150.

Perna, G., & Caldirola, D. (2017). Management of treatment-resistant panic disorder. *Current Treatment Options in Psychiatry,* 4(4), 371-386.

Perrone, S., Laschi, E., & Buonocore, G. (2019). Biomarkers of oxidative stress in the fetus and in the newborn. *Free Radical Biology and Medicine*, *142*, 23-31.

Petrowski, K., Herold, U., Joraschky, P., Wittchen, H. U., & Kirschbaum, C. (2010). A striking pattern of cortisol non-responsiveness to psychosocial stress in patients with panic disorder with concurrent normal cortisol awakening responses. *Psychoneuroendocrinology*, *35*(3), 414-421.

Phillips-Pula, L., Strunk, J., & Pickler, R. H. (2011). Understanding phenomenological approaches to data analysis. *Journal of Pediatric Health Care*, *25*(1), 67-71.

Plaisier, I., de Bruijn, J. G., de Graaf, R., ten Have, M., Beekman, A. T., & Penninx, B. W. (2007). The contribution of working conditions and social support to the onset of depressive and anxiety disorders among male and female employees. *Social Science & Medicine*, *64*(2), 401-410.

Plakun, E. M. (2018). Psychodynamic psychiatry, the biopsychosocial model, and the difficult patient. *Psychiatric Clinics*, *41*(2), 237-248.

Pool, L. D., & Qualter, P. (Eds.). (2018). *An introduction to emotional intelligence*. John Wiley & Sons.

Price, M., Yuen, E. K., Goetter, E. M., Herbert, J. D., Forman, E. M., Acierno, R., & Ruggiero, K. J. (2014). mHealth: a mechanism to deliver more accessible, more effective mental health care. *Clinical Psychology & Psychotherapy*, *21*(5), 427-436.

Primiano, S., Marchand, A., Gosselin, P., Langlois, F., Bouchard, S., Bélanger, C., Labrecque, J., Dugas, M., & Dupuis, G. (2014). The effect of a combined versus a conventional cognitive-behavioral therapy on quality of life for comorbid panic disorder with agoraphobia and generalized anxiety disorder: preliminary results. *Behavior Modification*, *38*(1), 3-24.

Proudfoot, J., Clarke, J., Birch, M., Whitton, A., Parker, G., Manicavasagar, V., Harrison, V., Christensen, H., & Hadzi-Pavlovic, D. (2013). Impact of a mobile phone and web program on symptom and functional outcomes for people with mild-to-moderate depression, anxiety and stress: a randomised controlled trial. *BMC Psychiatry,* 1-12, https://doi.org/10.1186/1471-244X-13-312.

Proudfoot, J., Parker, G., Hadzi, D., Manicavasagar, V., Adler, E., & Whitton, A. (2010). Community attitudes to the appropriation of mobile phones for monitoring and managing depression, anxiety, and stress. *Journal of Medical Internet Research,* 12(5). Doi: 10.2196/jmir.1475.

Puterman, E., Weiss, J., Beauchamp, M. R., Mogle, J., & Almeida, D. M. (2017). Physical activity and negative affective reactivity in daily life. *Health Psychology*, *36*(12), 1186.

Quinn, L. D., Straker, K. C., Guo, J., Kim, S., Thapa, S., Kling, G., Lee, D. K., & Voigt, T. B. (2015). Stress-tolerant feedstocks for sustainable bioenergy production on marginal land. *BioEnergy Research*, *8*(3), 1081-1100.

Radovic, A., & Miller, E. (2019). Experience of peer bloggers using a social media website for adolescents with depression or anxiety, giving back in a safe place. *Journal of Adolescent Health,* 64(25).

Rains, S. (2014). The implications of stigma and anonymity for self-disclosure in health blogs. *Health Communication,* 29(1), 23-31, DOI: 10.1080/10410236.2012.714861.

Rapaport, M., Clary, C., Fayyad, R., & Endicott, J. (2005). Quality-of-Life impairment in depressive and anxiety disorders. *American Journal of Psychiatry,* 162 (6), 1171-1178.

Rapee, R. M., Peters, L., Carpenter, L., & Gaston, J. E. (2015). The Yin and Yang of support from significant others: Influence of general social support and partner support of avoidance in the context of treatment for social anxiety disorder. *Behaviour Research and Therapy*, *69*, 40-47.

Rathbone, J., & Prescott, A. (2013). The use of mobile apps and SMS messaging as physical and mental health interventions: systematic review. *Journal of Medical Internet Research,* 19(8).

Ravitch, S., & Carl, N. (2016). *Qualitative Research.* Los Angeles: Sage Publishers.

Reid, S., Kauer, S., Hearps, S., Crooke, A., Khor, A., Sanci, L., & Patton, G. (2011). A mobile phone application for the assessment and management of youth mental health problems in primary care: a randomised controlled trial. *BMC Family Practice,* 12(131).

Rith-Najarian, L., McLaughlin, K., Sheridan, M., & Nock, M. (2014). The biopsychosocial model of stress in adolescence: self-awareness of performance versus stress reactivity. *Stress,* 17(2), 193-203.

Robbins, R., Mellins, C., Leu, C., Rowe, J., Warne, P., Abrams, E., Witte, S., Stein, D., & Reiman, R. (2015). Enhancing lay counselor capacity to enhance patient outcomes with multimedia technology. *Aids and Behavior,* 19(2), 163-176.

Rodriguez, C. M., Tucker, M. C., & Palmer, K. (2016). Emotion regulation in relation to emerging adults' mental health and delinquency: A multi-informant approach. *Journal of Child and Family Studies*, *25*(6), 1916-1925.

Rodriguez-Seijas, C., Eaton, N. R., & Pachankis, J. E. (2019). Prevalence of psychiatric disorders at the intersection of race and sexual orientation: Results from the National Epidemiologic Survey of Alcohol and Related Conditions-III. *Journal of Consulting and Clinical Psychology*, *87*(4), 321.

Roemer, L., Orsillo, S. M., & Salters-Pedneault, K. (2008). Efficacy of an acceptance-based behavior therapy for generalized anxiety disorder: evaluation in a randomized controlled trial. *Journal of Consulting And Clinical Psychology*, *76*(6), 1083.

Rogers, M., Lemmen, K., Kramer, R., Mann, J., & Chopra, V. (2017). Internet-delivered health interventions that work: Systematic review of meta-analyses and evaluation of website availability. *Journal of Medical Internet Research,* 19(3), https:// doi: *10.2196/jmir.7111*.

Roness, A., Mykletun, A., & Dahl, A. (2004). Help-seeking behaviour in patients with anxiety disorder and depression. *Acta Psychiatrica Scandinavia*, 111(1), pgs 51-58. https://doi-org.ezproxy.liberty.edu/10.1111/j.1600-0447.2004.00433.x

Rosales, A., & Tan, S. Y. (2017). Mindfulness-based cognitive therapy (MBCT): Empirical evidence and clinical applications from a Christian perspective. *Journal of Psychology and Christianity*, *36*(1), 76.

Roth, W., & von Unger, H. (2018). Current Perspectives on Research Ethics in Qualitative

Research. *Qualitative Social Research,* 19(3),

Art.33.http://dx.doi.org.ezproxy.liberty.edu/10.17169/fqs-19.3.3155.

Rowa, K., Gifford, S., McCabe, R., Milosevic, I., Antony, M. M., & Purdon, C. (2014).

Treatment fears in anxiety disorders: Development and validation of the Treatment

Ambivalence Questionnaire. *Journal of Clinical Psychology*, *70*(10), 979-993.

Roy, M. J., Baker, R., & Kerr, S. (2017). Conceptualising the public health role of actors

operating outside of formal health systems: The case of social enterprise. *Social Science*

& Medicine, *172*, 144-152.

Rua, M., Hodgetts, D., & Stolte, O. E. E. (2017). Māori men: An indigenous psychological

perspective on the interconnected self.

Rufer, M., Albrecht, R., Schmidt, O., Zaum, J., Schnyder, U., Hand, I., & Mueller-Pfeiffer, C.

(2010). Changes in quality of life following cognitive-behavioral group therapy for panic

disorder. *European Psychiatry*, *25*(1), 8-14.

Sammut, G. E., Andreouli, E. E., Gaskell, G. E., & Valsiner, J. E. (2015). *The Cambridge*

handbook of social representations. Cambridge University Press.

Sangganjanavanich, V., & Balking, R. (2013). Burnout and job satisfaction among counselor

educators. *The Journal of Humanistic Counseling,* 52(1), 62-79.

Santovec, M. L. (2014). Klawe Determined to Boost Women in Computer Science. *Women in*

Higher Education, *23*(12), 6-7.

Saraga, M., Fuks, A., & Boudreau, J. D. (2014). GEORGE ENGEL'S EPISTEMOLOGY OF

CLINICAL PRACTICE. *Perspectives in Biology and Medicine, 57*(4), 482-494.

Retrieved from http://ezproxy.liberty.edu/login?url=https://search-proquest-

com.ezproxy.liberty.edu/docview/1728137634?accountid=12085

Sartori, A. C., Vance, D. E., Slater, L. Z., & Crowe, M. (2012). The impact of inflammation on cognitive function in older adults: implications for health care practice and research. *The Journal of Neuroscience Nursing*, *44*(4), 206.

Sauro, J. (2015). 5 types of qualitative methods. *Measuring U,* measuringu.com. Retrieved 12/7/19.

Schneiderman, N., Ironson, G., & Siegel, S. D. (2005). Stress and health: psychological, behavioral, and biological determinants. *Annu. Rev. Clin. Psychol.*, *1*, 607-628.

Schotte, C., Van Den Bossche, B., De Doncker, D., Claes, S., & Cosyns, P. (2006). A biopsychosocial model as a guide for psychoeducation and treatment of depression. *Depression and Anxiety,* 23, 312-324.

Searight, H. R. (2015). Culture, Colonization, and the Development of Psychiatry in Nigeria.

Servidio, R., Gentile, A., & Boca, S. (2018). The mediational role of coping strategies in the relationship between self-esteem and risk of Internet addiction. *Europe's Journal of Psychology*, *14*(1), 176.

Seyedfatemi, N., Rafii, F., Rezaei, M., & Kolcaba, K. (2014). Comfort and hope in the preanesthesia stage in patients undergoing surgery. *Journal of PeriAnesthesia Nursing*, *29*(3), 213-220.

Shah, S., Van den Bergh, R., Van Bellinghen, B., Severy, N., Sadiq, S., Afridi, S. A., Akhtar, A., Maïkére, J., Van Overloop, C., Khilji, T. B. U. D., van Griensven, J., & Zachariah, R. (2014). Offering mental health services in a conflict affected region of Pakistan: who comes, and why?. *PLoS One*, *9*(6), e97939.

Shi, C. R., Tung, J. K., & Nambudiri, V. E. (2018). Demographic, academic, and publication factors associated with academic dermatology career selection. *JAMA Dermatology*, *154*(7), 844-846.

Shipherd, J. C., & Salters-Pedneault, K. (2017). Psychological Trauma: Theory, Research, Practice, and Policy.

Silton, N. R., Flannelly, K. J., Milstein, G., & Vaaler, M. L. (2011). Stigma in America: has anything changed?: Impact of perceptions of mental illness and dangerousness on the desire for social distance: 1996 and 2006. *The Journal of Nervous and Mental Disease*, *199*(6), 361-366.

Simony, C. P., Dreyer, P., Pedersen, B. D., & Birkelund, R. (2017). It is not just a minor thing–A phenomenological-hermeneutic study of patients' experiences when afflicted by a minor heart attack and participating in cardiac rehabilitation. *Scandinavian Journal of Caring Sciences*, *31*(2), 232-240.

Sims-Gould, J., Vazirian, S., Li, N., Remick, R., & Khan, K. (2017). Jump step-a community based participatory approach to physical activity & mental wellness. *BMC Psychiatry*, *17*(1), 1-8.

Sloan, A., & Bowe, B. (2014). Phenomenology and Hermeneutic Phenomenology: the Philosophy, the Methodologies and Using Hermeneutic Philosophy, the Methodologies and Using Hermeneutic Phenomenology to Investigated Lecturers' Experiences of Phenomenology to Investigate Lecturers' Experiences of Curriculum Design Curriculum Design. *Quality and Quantity,* 48(3), 1291-1303. doi:10.1007/s11135-013-9835-3

Smith, M. W., Stocks, C., & Santora, P. B. (2015). Hospital readmission rates and emergency department visits for mental health and substance abuse conditions. *Community Mental Health Journal*, *51*(2), 190-197.

Spijkerman, M. P. J., Pots, W. T. M., & Bohlmeijer, E. T. (2016). Effectiveness of online mindfulness-based interventions in improving mental health: A review and meta-analysis of randomised controlled trials. *Clinical Psychology Review*, *45*, 102-114.

Stanley, I. H., Hom, M. A., & Joiner, T. E. (2018). Modifying mental health help-seeking stigma among undergraduates with untreated psychiatric disorders: A pilot randomized trial of a novel cognitive bias modification intervention. *Behaviour Research and Therapy*, *103*, 33-42.

Starcevic, V. (2008). Treatment of panic disorder: recent developments and current status. *Expert Review of Neurotherapeutics, 8*(8), 1219-32.

http://dx.doi.org.ezproxy.liberty.edu/10.1586/14737175.8.8.1219

Stathopoulou, G., Powers, M., Berry, A., & Smits, J. (2006). Exercise Interventions for Mental Health: A Quantitative and Qualitative Review. *Clinical Psychology: Science and Practice, 13*(2), 179-193.

Stuber, J. P., Rocha, A., Christian, A., & Link, B. G. (2014). Conceptions of mental illness: Attitudes of mental health professionals and the general public. *Psychiatric Services*, *65*(4), 490-497.

Stuckey, H. (2014). The first step in Data Analysis: Transcribing and managing qualitative research data. *Methodological Issues in Social Health and Diabetes Research,* 2(1), 1-3.

Suchman, A. (2005). The current state of the biopsychosocial approach. *Families, Systems, and Health,* 23(4), 450-452.

Sutton, J., & Austin, Z. (2015). Qualitative research: Data collection, analysis, and

    management. *The Canadian Journal of Hospital Pharmacy*, *68*(3), 226.

Taormina, R., & Gao, J. (2013). Maslow and the Motivation Hierarchy: Measuring Satisfaction

    of the Needs. *The American Journal of Psychology, 126*(2), 155-177.

    https://doi:10.5406/amerjpsyc.126.2.0155

Taylor, J., & Pagliarli, C. (2018). Mining social media data: How are research sponsors and

    researchers addressing the ethical challenges? *Research Ethics Review*, 14(2), pgs 1-39.

    https://doi.org/10.1177/1747016117738559

Tessier, S. (2012). From Field Notes, to Transcripts, to Tape Recordings: Evolution or

    Combination. *International Journal of Qualitative Methods,* 11(4), 446-460.

Teut, M., Roesner, E. J., Ortiz, M., Reese, F., Binting, S., Roll, S., Fischer, H. F., Michalsen, A.,

    Willich, S. N., & Brinkhaus, B. (2013). Mindful walking in psychologically distressed

    individuals: a randomized controlled trial. Evidence-based complementary and

    alternative medicine: eCAM, 2013, 489856. https://doi.org/10.1155/2013/489856

Theophilus, P. A. S., Victoria, M. J., Socarras, K. M., Filush, K. R., Gupta, K., Luecke, D. F., &

    Sapi, E. (2015). Effectiveness of Stevia rebaudiana whole leaf extract against the various

    morphological forms of Borrelia burgdorferi in vitro. *European Journal of Microbiology*

    and Immunology, *5*(4), 268-280.

Thibodeau, R., & Peterson, K. M. (2018). On continuum beliefs and psychiatric stigma:

    Similarity to a person with schizophrenia can feel too close for comfort. *Psychiatry*

    Research, *270*, 731-737.

Titov, N., Andrews, G., Kemp, A., & Robinson, E. (2010). Characteristics of adults with anxiety or depression treated at an internet clinic: comparison with a national survey and an outpatient clinic. *PloS one*, *5*(5), e10885.

Tonigan, J. S., Rynes, K. N., & McCrady, B. S. (2013). Spirituality as a change mechanism in 12-step programs: A replication, extension, and refinement. *Substance Use & Misuse*, *48*(12), 1161-1173.

Trzcinski, A. P. (2018). *Advanced biological, physical, and chemical treatment of waste activated sludge*. CRC Press.

Uher, R. (2009). The role of genetic variation in the causation of mental illness: an evolution-informed framework. *Molecular Psychiatry*, *14*(12), 1072-1082.

US Census Bureau. (2013). Computer and internet use in the United States. Retrieved from www.infrastructureusa.org.

Vahedi, Z., & Saiphoo, A. (2018). The association between smartphone use, stress, and anxiety: A meta-analytic review. *Stress and Health*, *34*(3), 347-358.

Valli, M., Cho, S. S., Masellis, M., Chen, R., Koshimori, Y., Diez-Cirarda, M., Mihaescu, A., Christopher, L., & Strafella, A. P. (2021). Extra-striatal dopamine in Parkinson's disease with rapid eye movement sleep behavior disorder. *Journal of Neuroscience Research*, *99*(4), 1177-1187.

Van Grieken, R., Kirkenier, A., Koeter, M., & Schene, A. (2014). Helpful self-management strategies to cope with enduring depression from the patients' point of view: a concept map study. *BMC Psychiatry,* 14, https://doi.org/10.1186/s12888-014-0331-7

van Heyningen, T., Honikman, S., Myer, L., Onah, M. N., Field, S., & Tomlinson, M. (2017). Prevalence and predictors of anxiety disorders amongst low-income pregnant women in

urban South Africa: a cross-sectional study. *Archives of Women's Mental Health*, *20*(6), 765-775.

Van Manen, M. (2017). But is it phenomenology?. *Qualitative Health Research*, *27*(6), 775-779.

van Woerkom, M., & Meyers, M. C. (2019). Strengthening personal growth: The effects of a strengths intervention on personal growth initiative. *Journal of Occupational and Organizational Psychology*, *92*(1), 98-121.

Victorson, D., Banas, J., Smith, J., Languido, L., Shen, E., Gutierrez, S., Cordero, E., & Flores, L. (2014). eSalud: designing and implementing culturally competent ehealth research with latino patient populations. *American Journal of Public Health*, *104*(12), 2259-2265.

Wade, D. T., & Halligan, P. W. (2017). The biopsychosocial model of illness: a model whose time has come. *Clinical Rehabilitation*, *31*(8), 995-1004.

Waltz, T. J., Powell, B. J., Chinman, M. J., Smith, J. L., Matthieu, M. M., Proctor, E. K., Vega-Potler, N., Langer, N., Alexander, A., Kovacs, M., Litke, S., & Kirchner, J. E. (2014). Expert recommendations for implementing change (ERIC): protocol for a mixed methods study. *Implementation Science*, *9*(1), 1-12.

Wandersman, A., & Florin, P. (2003). Community interventions and effective prevention. *The American Psychologist,* 58(6-7), 441-48.

Wang, L., Liu, L., Shi, S., Gao, J., Liu, Y., Li, Y., Zhang, Z., Wang, G., Zhang, K., Tao, M., Gao, C., Li, K., Wang, X., Lv, L., Jiang, G., Jia, H., Zhang, J., Lu, C., ... & Kendler, K. S. (2013). Cognitive trio: relationship with major depression and clinical predictors in Han Chinese women. *Psychological Medicine, 43*(11), 2265-75. http://dx.doi.org.ezproxy.liberty.edu/10.1017/S0033291713000160

Weaver, A., & Himle, J. A. (2017). Cognitive–behavioral therapy for depression and anxiety disorders in rural settings: A review of the literature. *Journal of Rural Mental Health*, *41*(3), 189.

West, D. L., Peck, C. M., Reitzug, U. C., & Crane, E. A. (2014). Accountability, autonomy and stress: Principal responses to superintendent change in a large US urban school district. *School Leadership & Management*, *34*(4), 372-391.

Whelton, B. (2016). Being human in a global age of technology. *Nursing Philosophy,* 17(1), 28-35. doi: 10.1111/nup.12109

Whiting, R., & Pritchard, K. (2018). Digital Ethics. In C. Cassle, A. Cunliffe, & Grandy, G. (Eds). *The SAGE Handbook of Qualitative Business and Management Research Methods: History and Traditions.* https://dx-doi-org.ezproxy.liberty.edu/10.4135/9781526430212

Wichmann, S., Kirschbaum, C., Bohme, C., & Petrowski, K. (2017). Cortisol stress response in post-traumatic stress disorder, panic disorder, and major depressive disorder patients. *Psychoneuroendocrinology,* 83, 135-141. https://doi.org/10.1016/j.psyneuen.2017.06.005.

Wilcox, C., Van Sebille, E., & Hardesty, B. D. (2015). Threat of plastic pollution to seabirds is global, pervasive, and increasing. *Proceedings of The National Academy of Sciences*, *112*(38), 11899-11904.

Wintermann, G., Kirschbaum, C., & Petrowski, K. (2016). Predisposition or side effect of the duration: the reactivity of the HPA-axis under psychosocial stress in panic disorder. *International Journal of Psychophysiology,* 107, 9-15.

Wong, Y. J., Ho, M. H. R., Wang, S. Y., & Miller, I. S. (2017). Meta-analyses of the relationship between conformity to masculine norms and mental health-related outcomes. *Journal of Counseling Psychology*, *64*(1), 80.

World Health Organization. (2019). *Meeting report: WHO technical consultation: nutrition-related health products and the World Health Organization model list of essential medicines–practical considerations and feasibility: Geneva, Switzerland, 20–21 September 2018* (No. WHO/NMH/NHD/19.1). World Health Organization.

Woud, M., Zhang, X., Becker, E., McNally, R., & Margraf, J. (2013). Don't panic: Interpretation bias is predictive of new onsets of panic disorder. *Journal of Anxiety Disorders,* 28, 83-87.

Yalom, I. (2005). *The practice and theory of group psychotherapy*. Basic Books: New York.

Yuksel, P., & Yildirim, S. (2015). Theoretical frameworks, methods, and procedures for conducting phenomenological studies in educational settings. *Turkish Online Journal of Qualitative Inquiry*, *6*(1), 1-20.

Yun, J. Y., Shim, G., & Jeong, B. (2019). Verbal abuse related to self-esteem damage and unjust blame harms mental health and social interaction in college population. *Scientific Reports*, *9*(1), 1-13.

Zhang, Y., Zheng, D., & Deng, R. H. (2018). Security and privacy in smart health: Efficient policy-hiding attribute-based access control. *IEEE Internet of Things Journal*, *5*(3), 2130-2145.

Zheng, Z., Gu, S., Lei, Y., Lu, S., Wang, W., Li, Y., & Wang, F. (2016). Safety needs mediate stressful events induced mental disorders. *Neural Plasticity*, *2016*.

Zoberi, K., & Pollard, C. (2010). Treating anxiety without SSRIs. *The Journal of Family Practice,* 59(3), 148-154.

Zorn, J. V., Schür, R. R., Boks, M. P., Kahn, R. S., Joëls, M., & Vinkers, C. H. (2017). Cortisol stress reactivity across psychiatric disorders: A systematic review and meta-analysis. *Psychoneuroendocrinology*, *77*, 25-36.

Zvolensky, M., Kotov, R., Antipova, A., & Scmidt, N. (2005). Diathesis stress model for panic-related distress: a test in a Russian epidemiological sample. *Behavior Research and Therapy,* 43, 521-532.

Appendices

Appendix A

Screening Questions

1. Have you been diagnosed with an anxiety or panic disorder?

2. What treatment have you had?

3. Are you currently on any medications to treat this disorder?

4. Do you have any health conditions to prevent you from exercise?

5. Do you have any other psychiatric disorders?

Appendix B

Interview Guide

Pre Study

1. What are your current symptoms?

2. How bothersome are they to your daily life (scale 1-10)?

3. What triggers these symptoms? What alleviates these symptoms?

4. How would you describe your current quality of life and why?

5. What contributes to and takes away from your quality of life?

6. What is your current fitness level?

7. What are some past treatments you have tried for anxiety?

8. What is your level of knowledge about your disorder?

9. Why are you participating in this study?

2 and 4 week intervals

1. Have you been compliant with practices of group daily?

2. What are your current symptoms?

3. How bothersome are they to your daily life (scale 1 – 10)?

4. How would you describe your current quality of life and why?

5. What aspect(s) of the group do you feel is / are helping you the most right now?

6. What are some challenges or barriers that you are experiencing?

Appendix C

CONSENT FORM FOR QUALITATIVE STUDY

Consent to take part in research

•I..voluntarily agree to participate in this

research study.

•I understand that even if I agree to participate now, I can withdraw at any time or refuse to

answer any question without any consequences of any kind

.•I understand that I can withdraw permission to use data from my interview within two weeks

after the interview, in which case the material will be deleted.

•I have had the purpose and nature of the study explained to me in writing and I have had the

opportunity to ask questions about the study.

•I understand that participation involves participation in a weekly online support group,

including mindfulness activities of daily walking / exercise, writing / journaling, worshipping /

Christ -centered present moment awareness, and witnessing / relationship in support group.

•I understand that I will not benefit directly from participating in this research.

•I agree to my interview being audio-recorded.

•I understand that all information I provide for this study will be treated confidentially.

•I understand that in any report on the results of this research my identity will remain anonymous. This will be done by changing my name and disguising any details of my interview which may reveal my identity or the identity of people I speak about.

•I understand that disguised extracts from my interview may be quoted in a dissertation.

•I understand that if I inform the researcher that myself or someone else is at risk of harm, they may have to report this to the relevant authorities -they will discuss this with me first but may be required to report with or without my permission.

 •I understand that signed consent forms and original audio recordings will be retained in a lockbox with primary researcher until end of study

•I understand that a transcript of my interview in which all identifying information has been removed will be retained for 2 months.

•I understand that under freedom of information legislation I am entitled to access the information I have provided at any time while it is in storage as specified above.

•I understand that I am free to contact any of the people involved in the research to seek further clarification and information. Names, degrees, affiliations and contact details of researchers (and academic supervisors when relevant).

Signature of research participant--

Date

Signature of researcher

(this form was taken and modified from

https://www.tcd.ie/swsp/assets/pdf/Participant%20consent%20form%20template.pdf)

Appendix D

INTEGRATED MODEL OF TREATMENT FOR HOLISTIC HEALTH

4 WELLNESS MODEL

- WALKING
- WRITING

BODY | MIND

SOCIAL | SOUL

- WITNESSING
- WORSHIPPING

STRESS

ILLNESS ← REACTIVE | PROACTIVE → HEALTH