
Treatment Barriers for Māori with Social Anxiety:

A Māori Perspective

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Abstract

Social anxiety is a common and debilitating mental health difficulty, however many individuals who suffer from it do not seek help. Research has found social anxiety to be prevalent among Māori and overall treatment rates disproportionately lower. This suggests that a large proportion of Māori with social anxiety in New Zealand are not seeking treatment, highlighting the need for research that explores a Māori perspective of social anxiety and its treatment barriers. In New Zealand there is limited literature pertaining to Māori experiences of treatment-seeking for social anxiety. Utilising a Māori-centred framework, this study aimed to address this through qualitative methods to describe how adult Māori with social anxiety understand their symptoms, treatment barriers, and how treatment barriers could be reduced. The study had the objective of giving validation to the unique perspective of Māori with social anxiety and contributing to the development of culturally appropriate mental health services in New Zealand. Eleven semi-structured interviews were carried out with adult Māori clients who had experienced social anxiety. A brief purpose-built questionnaire exploring six treatment barriers related to social anxiety identified in the literature was also utilised during the interviews. Participants' interview responses were analysed through thematic analysis to identify themes from the descriptions of their lived experience. Themes highlighted social anxiety as understood as complex and influenced by a number of factors. The questionnaire data supported the thematic analysis findings and together showed treatment barriers as relating to unrecognised social anxiety, social attitudes, psychological symptoms, and cultural disconnection. An increased awareness of social anxiety and its treatment barriers will likely benefit Māori clients and their whānau in managing social anxiety and accessing treatment. The implementation of group

programmes and additional information in the community will likely help to increase this awareness and help-seeking behaviours. The research makes a small but unique contribution to literature and clinical practice pertaining to Māori with social anxiety.

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Glossary of Māori Terms

Aotearoa	New Zealand, literal translation: land of the long white cloud
aroha	love
aroha ki te tangata	respect for people you are working with
awhi	to embrace, support
hā a koro mā, a kui mā	breath of life from forbearers
hapū	sub-tribe/s
iwi	tribe/s
iwi katoa	wider societal context
kanohi kitea	the seen face
karakia	prayer
kaua e takahia te mana o te tangata	do not trample on the mana of people
kaua e māhaki	do not flaunt your knowledge
Kaumātua	elder/s
kaupapa Māori	Māori approach
kawanatanga	government, governorship
kia tūpato	be cautious
koha	gift, offering, contribution
kōrero	speech, narrative, conversation, discussion
kuia	elderly woman, female elder
kupu	word

mana	power, authority, prestige
mana ake	unique identity
manaaki ki te tangata	be generous in sharing with and hosting people
Māori	Indigenous people of New Zealand
Māoritanga	Māori culture, Māori practices and beliefs, Māoriness
marae	gathering and meeting place
marae tikanga	marae custom
mauri	life force, life essence
nga hau e wha	four winds
Ngāi Tahu	Tribal group of much of the South Island of New Zealand
nga maramatanga	building insight
Ngāpuhi	Tribal group of much of the Northland region of New Zealand
nga roma moana	ocean currents
Ngāti Porou	Tribal group of East Coast area north of Gisborne to Tihirau in New Zealand
noa	free from the extensions of tapu, unrestricted
ora pai	good health
oritetanga	citizenship
Pākeha	of European descent
pepeha	tribal saying, saying of the ancestors

pōwhiri	welcome, rituals of encounter
pūtake o te tautoko	family support
rongoā	remedy, medicine
taha hinengaro	related to psychological and emotional wellbeing
taha tinana	related to physical wellbeing
taha wairua	related to spiritual wellbeing
taha whanau	related to family wellbeing
taiao	physical environment
Tāmaki Makaurau	Auckland region of New Zealand
	male, man
tangata whaiora/whaiora	participant, client, person seeking health
tangata whenua	people of the land
taonga tuku iho	Passed down cultural resources of communication and connection
tapu	sacred, restricted
tautoko	support
te ao Māori	the Māori world
te hiranga o te whānau	the importance of family
te reo Māori	the Māori language
Te Titiri o Waitangi	The Treaty of Waitangi
Te Whare Tapa Whā	model of Māori health by Sir Mason Durie, translated to: the four-sided house

Te Wheke	model of Māori health by Rangimārie Rose Pere, literally translated to: the octopus
tikanga	protocol, correct procedure, customs,
tino rangatiratanga	sovereignty
titiro, whakarongo, kōrero	look and listen first, speak later
tohunga	expert, healer
waiata	song
wairua	spirituality, spirit, soul
waka	canoe descended from
waka hourua	double-hulled canoe
whakamā	shy, embarrassed
whakapapa	genealogy
whakataukī	proverb, saying
whakatere	navigation
whakawhanaungatanga	process of establishing relationships
whānau	family, extended family
whanaungatanga	relationship, kinship, sense of family connection
whanonga pai	positive behaviour
whatumanawa	healthy expression of emotion

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INTRODUCTION

Kī mai ki ahau

‘He aha te mea nui i te ao?’

Māku e kī atu, ‘He tangata! He tangata! He tangata!’

If you ask me

‘What is the most important thing in the world?’

I will reply, ‘It is people! It is people! It is people!’

The above whakataukī¹ seemed appropriate to open this thesis as without the voices of the whaiora² involved in the study it would not have been possible. This thesis was born out of a desire to support our whaiora in clinical practice. It also stemmed from an honours project completed in 2013/2014 which explored treatment barriers for Social Anxiety Disorder from the perspective of New Zealand clinicians. From carrying out that piece of research it became clear that the voice of Māori³ affected by social anxiety was missing from the literature. Like many other indigenous cultures, differing worldviews and experiences affect treatment-seeking for Māori (Jansen, Bacal, & Crengle, 2008). Social anxiety presents its own unique barriers as the symptoms themselves can hinder treatment-seeking (Gross et al., 2005).

¹ Proverb, saying

² Participant, consumer, person seeking health

³ Indigenous people of New Zealand

In order to contribute to the gap in the literature and offer a space for the voices of whaiora with social anxiety to be heard, the current research explored a Māori perspective of social anxiety and its treatment barriers. Moreover, it explored what whaiora perceive can be done to reduce treatment barriers.

Positioning the Researcher

While I have Māori whakapapa, I acknowledge I am not an expert on all things Māori. I am aware of my position within the research that alongside my Māori heritage I am of European descent and acknowledge my own experiences of navigating the world as such are interwoven with who I am. The research, was driven by a desire to help our Māori whaiora. There was a feeling of responsibility to carry out the research and present participants experiences in a meaningful way. Therefore, I was careful throughout each stage of the study to acknowledge and reflect on how this informed the way meaning was made of the kōrero⁴ shared with participants. I acknowledge my developing experience as an Intern Psychologist and that the participants held the knowledge I was there to learn. They were the experts in their experiences and I was there to titiro, whakarongo, kōrero⁵.

Thesis Outline

A review of the literature is presented in Chapters 1 to 4. Chapter 1 of this thesis provides historical context to the current research through a brief discussion of Māori within the context of New Zealand history. Māori health in general is discussed followed by cultural identity and diversity among Māori. Chapter 2 focuses on Māori mental health and Māori health perspectives and models are discussed. An overview of mental health

⁴ Speech, narrative, conversation

⁵ Look and listen first, speak later

services in New Zealand is then provided. This is followed by prevalence rates of mental health difficulties and patterns of treatment-seeking and unmet need for care among Māori identified in the literature. Chapter 3 introduces the current literature on social anxiety, its prevalence, cultural expressions, and psychological treatment options. An overview of treatment barriers is the focus of Chapter 4 and the obstacles faced by ethnic minorities, Māori, and people with social anxiety are discussed. The current research is introduced in Chapter 5 which includes the rationale and aims of the study. The chosen methodology of the current research is outlined in Chapter 6. Chapter 7 presents the findings of the study through introducing the six themes from thematic analysis. The questionnaire findings are also presented. Finally, Chapter 8 presents a summary of the findings in the context of previous literature, in addition to possible implications of the findings and discussion of limitations of the current study alongside directions for future research. This chapter closes with researcher reflections and final conclusions.

CHAPTER 1: MĀORI AND THE NEW ZEALAND CONTEXT

Chapter Outline

The following chapter is descriptive and provides a brief historical context to the current research through describing the evolution of Māori as a people over time. The chapter begins with a brief introduction of Māori as Indigenous people of Aotearoa⁶ before the signing of Te Tiriti o Waitangi⁷ and some of the subsequent effects of colonisation. This will be followed by an overview of general Māori health and some of the psychosocial stressors faced by Māori today. Finally, Māori cultural identity and diversity will be discussed and how this may impact on health and wellbeing.

Te Tiriti o Waitangi: A Brief Overview

Māori are the Indigenous people of Aotearoa. The term tangata whenua⁸ is used to differentiate Māori from people of European nationalities who colonised Aotearoa from the late 1700s (Boulton, 2005). Māori as a collectivist culture were at this time largely living within their iwi⁹ and hapū¹⁰, with strong connections to their ancestral land and surrounding environment (Boulton, 2005).

The foundation for a bicultural relationship in Aotearoa was laid in 1840 with the signing of Te Tiriti o Waitangi, a documented agreement between Māori representatives and the British Crown. Te Tiriti set out the prospect of genuine recognition of peoples of two different cultures living together in equality and this prospect was specified through

⁶ New Zealand

⁷ The Treaty of Waitangi

⁸ People of the land

⁹ Tribe/s

¹⁰ Subtribe/s

three articles. Article I offered *kāwanatanga*¹¹ and good governance for residents of New Zealand; Article II offered *tino rangatiratanga*¹² for Māori; and Article III offered *oritetanga*¹³, ensuring fair and equal access of resources to Māori and non-Māori alike (Herbert, 2002). Kingi (2006) has described how Te Tiriti was poorly translated and explained between the Māori and English versions and how there is debate around the degree “to which Māori interests have been protected” (p.2).

The 1800s was characterised by a de-population of Māori due to a variety of complex reasons, including introduced disease and the Land Wars between Māori and European settlers (Kingi, 2006). This is a similar history to that of other Indigenous peoples who experienced colonisation, where their health status deteriorated as contact with European settlers increased (Durie, 2000). At a national census in 1896 the Māori population was approximately 42,000 (Von Dadelszen, 1987), a significant decrease from the reported estimated population of 150,000 in 1800 (Kingi, 2006). In 1856 a colonial politician in New Zealand, Dr Issac Featherston, suggested Māori were “dying out” and therefore the best Europeans could do was to “smooth down their dying pillow” (Te Rangi Hiroa, 1924, p. 363).

The 1900s showed the resilience of Māori and communities began to grow. Māori were involved in delivering and shaping health services, particularly at local levels (Durie, 1998). The passing of the Tohunga Suppression Act in 1907 communicated the governmental view that health care should be grounded within Western concepts. Essentially, this legislation outlawed the traditional healing practices of Māori *tohunga*¹⁴ and classified their approaches as misleading and superstitious (Durie, 1998).

¹¹ Government, governorship

¹² Sovereignty

¹³ Citizenship

¹⁴ Expert, healer

The Act has been discussed as a breach of Te Tiriti, given it challenged the legitimacy of Māori wisdom (Jones, 2007). Furthermore, the Act resulted in a loss of appreciation of rongoā¹⁵ for succeeding generations even after the Act's repeal in 1962 (Durie, 1998). Over time, many Māori have recorded breaches of Te Tiriti o Waitangi, including the misappropriation of land and a devaluation of te reo Māori¹⁶ (Hudson & Russell, 2008). The Treaty of Waitangi Act 1975, and the 1985 amendment were significant in New Zealand's history. Orange (2013) writes that these brought Te Tiriti to the front of political debate and served in "forcing governments to address long-deferred Māori claims and to set up appropriate structures for redress" (p. 230). By the 2000s the processes for settling claims was well established, however adequate funding for this is a key difficulty (Orange, 2013) and the importance of Te Tiriti remains a central issue in New Zealand.¹⁷

Māori Health in Aotearoa

Today, the Māori population is steadily growing. At the last national census in 2013, Māori made up approximately 18% of the New Zealand population of around four million (Statistics New Zealand, 2013). This represents growth of approximately 40% over the past 22 years (Statistics New Zealand, 2013) and projections suggest the Māori population will continue to grow at an increasing rate over the next 20 years (Macpherson, 2017).

Durie (2000) posits that like many other Indigenous cultures, Māori health status has suffered from the effects of colonisation. Since the arrival of European settlers through to contemporary times, Māori have had poorer average health outcomes and health

¹⁵ Remedy, medicine

¹⁶ The Māori language

¹⁷ Please see Claudia Orange's book titled 'The Treaty of Waitangi' (2013) for a more thorough discussion on the issues surrounding Te Tiriti.

characteristics than Europeans in New Zealand (Marriott & Sim, 2015). While the proportion of Māori gaining formal education qualifications and full-time employment is growing (Statistics New Zealand, 2013), the broad picture shows that a large number of Māori in New Zealand live below the poverty line (Rashbrooke, 2013). Māori adults are less likely indicate their health as good and have higher rates for most general health conditions in comparison to non-Māori (Ministry of Health, 2014a). Māori have lower average personal incomes, are less likely to hold formal qualifications, and experience higher unemployment rates (Ministry of Health, 2015). These psychosocial factors are purported to contribute to the health disparities that Māori experience in comparison to European New Zealanders (Marriott & Sim, 2015). This is further highlighted by Stevenson (2001) who has noted that individuals with lower income may lack the resources to afford sufficient health care, nutrition, or the financial capacity to support their children to engage in higher education.

Kukutai (2011) highlights how focusing on health disparities may implicitly imply that non-Māori and specifically Pākehā¹⁸ health status is an ideal to which Māori should aspire. She writes that this is problematic when statistical inequalities are taken as evidence of Māori deficits without consideration of the “ongoing impacts of inequalities in past and present institutional arrangements” (p. 49). In the context of Māori health, Te Tiriti is about equality: “an expectation by Māori of equal access to health services, appropriate outcomes, and in the design and delivery of health policies and services” (Kingi, 2006, p. 68). Taking this into account, Te Tiriti has great relevance to the status of contemporary Māori health as it recognises the rights of Māori to shape health services in a way that is beneficial for Māori and defined by Māori (Rochford, 2004).

¹⁸ Of European descent

Cultural Identity and Diversity

Cultural identity has been conceptualised in many different ways, particularly as the complex concept has been continuously evolving over the past century (Bennett, 2002) and is influenced by different processes including colonisation and urbanisation (Pere, 2006). Historically, a Māori person was defined as having at least 50% Māori blood (Pool, 1963). Then, in 1974 a descent method was implemented through the Māori Affairs Amendment Act which defined Māori as people who had descended from a Māori person, regardless of their level of Māori blood (Durie, 2001). This was further refined under the 1984 Electoral Act where self-identification of ethnicity was included (Tapsell & Mellsop, 2007).

Elements that can contribute to structuring a positive Māori identity include knowledge of whakapapa¹⁹, and te reo Māori (Te Huia, 2015). Māori world-views are unique and as tangata whenua, the construction of whānau²⁰, hapū, and iwi are also unique to Aotearoa (Te Pou o Te Whakaaro Nui, 2010). In Te Kupenga, Statistic New Zealand's first survey on Māori well-being, 70% of Māori adults reported being involved with Māori culture was at least somewhat important to them (Statistics New Zealand, 2014). Approximately 55% of Māori stated they could speak more than a few words or phrases of te reo Māori. Tribal connections remain important within Māori culture and when asked about tikanga,²¹ iwi affiliation was strong with 89% of Māori adults reporting that they knew their iwi and 55% of Māori knew their hapū. In the 2013 census, the largest iwi recorded for Māori in the North Island was Ngāpuhi²², followed by Ngāti Porou²³

¹⁹ Genealogy

²⁰ Family, extended family

²¹ Protocols, correct procedure, customs,

²² Tribal group of much of the Northland region of New Zealand

²³ Tribal group of East Coast area north of Gisborne to Tihirau in New Zealand

and in the South Island, Ngāi Tahu²⁴ was the largest iwi recorded (Statistics New Zealand, 2013). These results highlight that many Māori can identify their iwi; however, the significance of iwi relationships to their cultural identity is less clear (Te Huia, 2015).

Durie (1999) wrote about how Māori cultural identity is essential for Māori health and wellbeing. He states that this is beyond simple knowledge of whakapapa or iwi and requires access to aspects of te ao Māori²⁵ including land, language, and family networks. Therefore, for mental health services to be effective and strengthen cultural identity, they must align with the ‘diverse Māori realities’, a phrase coined by Durie (1995). The existence of diverse Māori realities in the context of cultural identity is further explained by Durie (1998):

Māori live in diverse cultural worlds. There is no one reality nor is there any longer a single definition which will encompass the range of Māori lifestyles . . . A Māori identity, even when vigorously defended, cannot be presumed to mean a conventional Māori lifestyle. Nor should it be forgotten that for many Māori, cultural identity is a sophistication; it is more than enough simply to get through the day.
(p. 215)

Diversity incorporates varying views and experiences of modern life and therefore a broad view of culture is needed in order to align with Māori mental health needs (Boulton, 2005). Wratten-Stone (2016) cautions “not to stereotype every Māori as having certain backgrounds or world views” (p. 13). Therefore, an awareness of Māori diversity is necessary for mental health providers to effectively engage and maintain

²⁴ Tribal group of much of the South Island of New Zealand

²⁵ The Māori world

therapeutic relationships when working alongside Māori in clinical practice (Te Pou o Te Whakaaro Nui, 2010).

Chapter Summary

This chapter focussed on providing a broad overview of the historical background of Māori in New Zealand. It began with a brief overview of Te Tiriti o Waitangi and discussed effects of colonisation including the depopulation of Māori and subsequent recovery over time. Colonisation has undoubtedly impacted on Māori health status, and in general Māori today face many psychosocial pressures that have bearing on health and wellbeing. Cultural identity has been noted in the literature to influence wellbeing and some markers of positive cultural identity have been discussed in this chapter. Alongside this, the diversity that exists among Māori today within ethnicity and ways of life was acknowledged. The discussions in this chapter highlight the importance of upholding the articles of Te Tiriti and retaining the right for Māori to define health and health services in ways that pertain to the advancement of Māori health. The following chapter expands on this with a specific focus on Māori mental health.

CHAPTER 2: MĀORI MENTAL HEALTH

Chapter Outline

This chapter begins with a discussion on Māori perspectives of mental health and wellbeing. Within this, models of Māori mental health are introduced, followed by an overview of mental health services in New Zealand. The prevalence of mental health difficulties among Māori is then discussed. Finally, patterns of treatment-seeking among Māori are discussed and an unmet need for care among Māori is highlighted from the literature.

Māori Perspectives on Mental Health and Wellbeing

King, Smith, and Gracey (2009), suggest that much of the research into Indigenous health has centred around non-Indigenous ideas of health such as disease and biological models of treatment. They write that this may be problematic given Indigenous peoples' definition of wellbeing is typically much broader than just physical health or the lack of disease. In New Zealand, Indigenous psychology has continuously played a role in how Māori approach wellbeing (Nikora, Levy, & Masters, 2004). The Māori view of mental health is centred around a holistic and collective perspective of well-being (Tassell, Flett, & Gavala, 2012). Nikora et al. (2004) suggest this is best defined by tikanga or the Māori customs, protocols, and values innate within Māori life. The Māori view of health contains a distinctive way of thinking, feeling, and behaving (Durie, 1998, 2001).

Given the diversity among Māori, it cannot be assumed all Māori will consider all traditional perspectives of Māori mental health as relevant. However, it is important to consider some of the general concepts in order to paint a picture of Māori mental health in New Zealand. This is highlighted by Durie (2004), who posited that when clinicians

ignore the health conceptualisations held by a population, misleading treatment choices and conclusions become possible.

Wairua²⁶ is generally acknowledged as central to Māori existence and ways of being; thus, fundamental to Māori mental health, identity, and reality (Valentine, Tassell-Mataamua, & Flett, 2017). While, wairua is difficult to define it refers to the spiritual dimension and is woven through all elements of wellbeing, inseparable from physical and mental health (Cherrington, 2009). Its importance and complexity have been described by many in the literature. Bidios (2006) has defined wairua as “that which is unique that is contained within” (p. 1). From a Māori perspective, all things have a spirit thus, Durie (2011) has highlighted the significance of wairua to the enduring connections between “people, ancestors, and the natural environment” (p. 30). Durie (1985) has also noted that spiritual awareness is essential for wellbeing, while (Henare, 2001) has asserted that “wairua is necessary for the existence of the body” (p. 209). Research carried out by Valentine (2009) has further highlighted the complexity of wairua, providing a detailed conceptualisation as:

an intuitive consciousness that exists within all Māori. It may also be the avenue through which Māori identity is expressed and maintained, relationships are forged, balance is maintained, restrictions and safety are adhered to, healing is transmitted, and the mechanism through which the tupuna (ancestors) and atua (Gods) remain connected to the living. (p.135)

The above descriptions highlight the importance of wairua to the lived experience of Māori. Research by Love (1999) suggests that wairua is significant in whaiora

²⁶ Spirituality, spirit, soul

presentations regardless of the degree to which a client or clinician acknowledges it. Thus, it is important to open discussion around wairua within clinical practice with Māori. Te Pou o Te Whakaaro Nui (2010) caution that when wairua is not assessed alongside other areas of health, mistreatment and misdiagnosis are possible.

Another important concept related to Māori mental health is whānau, which is much broader than how family is typically thought of in Western cultures (Durie & Hermansson, 1990). Whānau is considered a central cultural foundation that is fundamental to the mental health of Māori individually and collectively (The Families Commission, Te Kōmihana ā Whānau, 2012). Traditionally, whānau is conceptualised as whakapapa or ancestry based. Whakapapa whānau are bonded and drawn together through kinship and linked to the larger cultural and social whānau units of iwi, hapū, and waka²⁷ (Lawson-Te Aho, 2010).

Contemporary uses of the term whānau may include kaupapa whānau, which refers to people bonded by a shared purpose or goal. By describing a group as whānau, members indicate to themselves and others that they have modelled their group on whānau as extended family and adopted values that whānau ideally use to govern relationships (Metge, 1995). Given the intrinsic connection between an individual's mental health and their familial links it is often necessary to involve whānau in the process of therapeutic practice (Te Pou o Te Whakaaro Nui, 2010).

Whanaungatanga²⁸ is associated with the whānau value of aroha²⁹; however, it is typically considered a value in its own right (Metge, 1995). The word whanaunga translates as relative and whanaungatanga is kinship in its widest sense (Huriwai et al.,

²⁷ Canoe descended from

²⁸ Relationship, kinship, sense of family connection

²⁹ Love

2001). Whanaungatanga is “a relationship through shared experiences and working together which provides people with a sense of belonging. It develops as a result of kinship rights and obligations, which also serve to strengthen each member of the kin group” (Moorfield, 2017, paragraph 1). Thus, the value of whanaungatanga emphasises the linkage and commitment of members to one another and their responsibilities within relationships (Huriwai et al., 2001). Whakawhanaungatanga³⁰ is often carried out through sharing of whakapapa within clinical practice when working alongside Māori (Te Pou o Te Whakaaro Nui, 2010).

In a qualitative study looking into Māori experiences of health, participants saw whānau as a structure of support for Māori and thus central to Māori health and wellbeing (Cram et al., 2003). Participants in this study spoke of how unbalance within wairua of whānau may lead to a breakdown in the ability of this structure to support the wellbeing of individual members. Some participants spoke of whānau wairua breakdown needing to be traced to the colonisation processes of New Zealand. In addition, within the urban environments, whānau may experience stressors such as unemployment, poor living conditions, or low wages (Robson & Reid, 2007). Cram and colleagues (2003) highlight the ongoing need for health care professionals to consider how Māori individual and whānau health continue to be challenged, and thus what the key facilitators are in the health care delivery for Māori, as identified by Māori.

Another important concept related to Māori mental health is mauri³¹. Land and other environmental structures hold mauri and when people achieve balance in their lives their mauri is thought to be intact (Lawson-Te Aho, 2010). Durie and Hermansson (1990) write that “mauri implies thinking well of yourself, having high self-esteem, and

³⁰ Process of establishing relationships

³¹ Life force, life essence

accepting yourself for what you are, but, mostly, it involves experiencing things in spiritual terms” (p. 114). Within clinical practice, respect for a person’s mauri is crucial and, if displaced, helping them get back in touch with their mauri may involve encouraging exploration of cultural identity (Durie & Hermansson, 1990).

Also central to a traditional Māori worldview of mental health and illness are the concepts of tapu³² and noa³³. Tapu can refer to a person, object, or place and designated tapu requires respect and noa is the condition or state that balances tapu (Boulton, 2005). When these concepts are applied to health, becoming well involves balancing tapu and noa of the individual (bpac^{nz}, 2010). Given wellbeing is related to tapu, a person’s mana³⁴ can also be affected by tapu and therefore, providing ways to enhance mana may be an important part of mental health treatment for Māori (bpac^{nz}, 2010).

Māori Models of Health

A growing awareness of the need to provide health services that more closely align with Māori worldviews of health and wellbeing has resulted in the development of many Māori health models. Such models are holistic, underpinned by various Māori health perspectives and can be applied as cultural frameworks within psychological practice (Pitama et al., 2007). The implication of this is that the whole person is highlighted in comparison to treating individual difficulties (Ihimaera, 2004).

Te Whare Tapa Whā³⁵ is one Māori health model which has been widely embedded within the health sector and policy in Aotearoa. Te Whare Tapa Whā was developed by Sir Mason Durie (1985) and it is his sentiments that have informed the overview that

³² Sacred, restricted

³³ Free from the extensions of tapu, unrestricted

³⁴ Power, authority, prestige

³⁵ The four-sided house

follows. Defined by four dimensions (taha wairua³⁶, taha hinengaro³⁷, taha tinana³⁸, and taha whānau³⁹), the model represents basic systems of well-being that are each essential to maintaining balanced health. Taha wairua encompasses faith (not necessarily religious beliefs) and an ability to understand the significance of an individual's relationship with the physical environment. As discussed above, this is generally regarded as the most important aspect for good health. Land, lakes, mountains, and rivers hold spiritual significance for Māori and are fundamental to identity and whakapapa. Taha hinengaro relates to the expression of thoughts and feelings. Healthy thinking is considered integrative with the wider environment and explanations are often sought from outward rather than inward sources. Taha hinengaro also incorporates aspects of Māori communication, where unspoken signals are often emphasised (e.g., eye movement, facial expression). Taha tinana encompasses physical well-being through promoting the importance of bodily care and respect for body parts considered tapu, such as the head. Taha whānau acknowledges the fundamental importance of family to health and well-being and implies a collective worldview emphasising health as interdependence rather than independence.

Another model of Māori health widely implemented in Aotearoa is Te Wheke⁴⁰. Developed by Rangimārie Rose Pere, Te Wheke uses the metaphor of an octopus to demonstrate the intertwining relationship between individual and whānau. The four dimensions described within Te Whare Tapa Whā are represented in Te Wheke alongside the additional dimensions of mauri, mana ake⁴¹, whatumanawa⁴², and hā a

³⁶ Related to spiritual wellbeing

³⁷ Related to psychological and emotional wellbeing

³⁸ Related to physical wellbeing

³⁹ Related to family wellbeing

⁴⁰ Literal translation: the octopus

⁴¹ Unique identity

⁴² Healthy expression of emotion

koro mā a kui mā⁴³. The model is viewed as a holistic approach to health that is applicable across both individuals and groups (C. Love, 2004).

The Meihana Model is a comparatively recent framework of Māori mental health that emerged from the foundations of Te Whare Tapa Whā. First published in 2007, the Meihana Model aimed to provide guidelines that could be applied in clinical settings “to better serve Māori within mental health service delivery” (Pitama et al., 2007, p. 120). In its original form the model included the four dimensions of Te Whare Tapa Whā and the dimensions of taiao⁴⁴ and iwi katoa⁴⁵, all placed within the context of Māori beliefs, values, and experiences. More recently, the Meihana Model has been refined and further components have been included with the analogy of a waka hourua⁴⁶ utilised to illustrate how they interact. (Pitama, Huria, & Lacey, 2014). The additional components include nga hau e wha⁴⁷, nga roma moana⁴⁸, and whakaterere⁴⁹. Each of these components highlights specific aspects (e.g., colonisation, racism, tikanga) that may be needed for practitioners to more fully understand whaiora presentations in clinical settings (Pitama, Huria, & Lacey, 2014, p. 107).

Mental Health Services in Aotearoa

Mental health treatment in New Zealand is typically delivered through mainstream or culturally based services (Jeffery, 2005). District Health Boards (DHBs) provide the majority of mainstream mental health care (Ministry of Health, 2014b) and there are 20 DHBs in New Zealand with community based teams (secondary care) providing the majority of services for these (Ministry of Health, 2016). Community Mental Health

⁴³ Breath of life from forbearers

⁴⁴ Physical environment

⁴⁵ Wider societal context

⁴⁶ Double-hulled canoe

⁴⁷ Four winds

⁴⁸ Ocean currents

⁴⁹ Navigation

Centres (CMHCs) typically manage moderate to severe mental health presentations and involve multidisciplinary teams. Primary Health Organisations (PHOs) are increasing and their focus includes supporting people with mild to moderately severe mental health difficulties (Pavagada & Desouza, 2007). A growing proportion of mental health services in New Zealand are also provided through Non-Government Organisations (NGOs) (Brunton, 2011). NGO services include residential care, community and family supports, and employment services (Pavagada & Desouza, 2007). Often, the above services work within varying patterns of coordination (McMorland, Kukler, Murray, & Warriner, 2008).

The majority of services are delivered to Māori through mainstream providers (Peter Jansen & Smith, 2006). Currently, mainstream mental health services typically operate within a medical model paradigm which emulates Western cultural values on health (Wratten-Stone, 2016). Culturally appropriate services are essential for establishing trusting therapeutic relationships and respect for cultural preferences and worldviews (Wilson, 2008). It has been suggested that poor health outcomes for ethnically diverse populations are a consequence of an overt focus on Western models (Stewart, 2012).

New Zealand has Te Tiriti o Waitangi to provide guidance in addressing health inequalities and all health providers are required to engage with Te Tiriti and reflect on their practice to aid cultural safety (Came, McCreanor, Doole, & Simpson, 2016; Jeffery, 2005). The use of Māori health models when working with Māori is often included as part of this process. Improvements in the training of health professionals, including Clinical Psychologists, has also seen a greater emphasis on bicultural understanding and cultural competence (Herbert, 2002). However, many Māori prefer accessing services that are designed and delivered by Māori for Māori (Huriwai, Robertson, Armstrong, Kingi, & Huata, 2001).

Kaupapa Māori Mental Health Services

The option of accessing kaupapa Māori⁵⁰ services ensures Māori have the right to choose a service provider that best meets their mental health needs. Providers of kaupapa Māori services operate within DHBs, communities, or iwi and provide a treatment setting underpinned by Māori tikanga alongside mainstream medical treatments (bpac^{nz}, 2010). Kaupapa Māori services recognise that health and culture for Māori are intricately linked and utilise Māori models of health underpinned by concepts such as wairua, mana, tapu, and mauri. While there is no specific set of criteria, the cultural activities of te reo Māori, karakia⁵¹, counselling by kaumātua⁵², waiata⁵³, powhiri⁵⁴, and whānau participation also characterise kaupapa Māori services (Kingi, 2005). These processes are employed to aid treatment engagement and mental health outcomes through providing a cultural environment that fits for tangata whaiora (Kingi, 2005). This is likely to be important for many Māori in order to address mental health disparities (Newton-Howes, Lacey, & Banks, 2014). For example, using te reo Māori helps to keep the language alive, strengthens identity, and improves access to te ao Māori for tangata whaiora and whānau (Ihimaera, 2004). Similarly, waiata and karakia are considered taonga tuku iho⁵⁵ (Valentine, 2009). It is important to note that being flexible and taking into account an individual's level of cultural engagement is key when working alongside Māori to ensure responsiveness to individual needs.

Prevalence of Mental Health Difficulties Among Māori

In addition to general health concerns, many Māori carry a disproportionately large burden of psychological distress (Ministry of Health, 2014a). According to Durie

⁵⁰ Māori approach

⁵¹ Prayer

⁵² Elder

⁵³ Song

⁵⁴ Welcome, rituals of encounter

⁵⁵ Passed down cultural resources of communication and connection

(1999), the prevalence of mental health difficulties among Māori is increasing in comparison to non-Māori and these difficulties are among the most significant health problems Māori face today. This trend has continued over time and a large amount of literature and research suggests Māori have the greatest prevalence of difficulties relating to psychological health and wellbeing in New Zealand (Baxter, Kokaua, Wells, McGee, & Oakley Browne, 2006; Edmonds, Williams, & Walsh, 2000; Ministry of Health, 2013). While prevalence rates may be higher, there is no evidence that Māori are genetically predisposed to mental health difficulties and Māori experience the same range of disorders as other New Zealanders (bpac^{nz}, 2010).

The high prevalence of mental health difficulties among Māori is supported by results from The MaGPIE Research Group (2005), where anxiety, mood, and substance disorders were found to be more prevalent among Māori than non-Māori attending their General Practitioner. Researchers from this study concluded that higher prevalence rates among Māori could not be accounted for by social differences between ethnicities. The New Zealand Health Survey also identified that Māori have higher rates of psychological distress in comparison to non-Māori (Ministry of Health, 2013).

Another study that can provide some understanding of the mental health prevalence within the Māori population is Te Rau Hinengaro: The New Zealand Mental Health Survey (Oakley Browne & Wells, 2006). This epidemiological study is the largest known mental health survey undertaken in New Zealand and was based on the interview responses of 12,992 New Zealanders over the age of 16. One of its primary goals was to describe the one-month, 12-month, and lifetime prevalence rates of the following disorder categories: anxiety, mood, substance use, and eating. The study involved 2595 Māori participants and revealed that Māori are at a greater risk of developing a mental

health disorder than non-Māori in New Zealand (Baxter, Kokaua, et al., 2006). Even after adjustments were made for age, sex, education level, and household income, the 12-month prevalence of any mental health disorder was higher for Māori in comparison to non-Māori. Approximately half of the Māori participants had experienced one or more mental disorders in their lifetime and the most common lifetime disorders were anxiety followed by substance use and mood disorders (Baxter, Kingi, Tapsell, Durie, & McGee, 2006). In regards to age, mood and anxiety disorders were most prevalent among Māori aged between 25 and 44 years old (Oakley Browne, Wells, & Scott, 2006).

Higher rates of hospitalisation admissions for mental health disorders among Māori than non-Māori have been noted in the literature (Abas et al., 2003). In particular, higher hospital admission for serious disorders such as Schizophrenia have been reported in South Auckland Counties Manukau District Health Board profiles (Robson et al., 2015). This is supported by findings from Otago in the South Island where Māori were found to have higher rates of Schizophrenia diagnoses on discharge of first hospitalisation admission in comparison to non-Māori (Edmonds et al., 2000). While hospital admission data is helpful in reflecting trends over time, Durie (2001) cautions how such data may only reflect those accessing services and not necessarily the prevalence of general mental health status or mental ill health in the community. Factors contributing to higher hospital admissions among Māori could include urbanisation, greater deprivation, mismanagement of treatment, misdiagnosis, and different pathways to care (Durie, 2001). Hospitalisations generally represent a late form of intervention and therefore highlight a need for earlier service access and utilisation.

Treatment-Seeking and Unmet Need for Care Among Māori

While there has been an increase in Māori accessing mental health services (Ministry of Health, 2014b), for a number of Māori “initial contact with a mental health service is through the justice system, via the police or welfare services, and under compulsion” (Kingi, 2005, p. 1). Similar patterns of service utilisation has been found among other Indigenous populations (Eley et al., 2007). Partly due to such access pathways, Māori face difficulties that tend to be more serious and difficult to treat which consequently results in poorer health outcomes and higher rates of readmission (Durie & Kingi, 1997). Thus, Māori are not seeking treatment in proportion to their need.

Research suggests that despite higher needs for mental health care, initial mental health treatment-seeking rates have been reported to be comparatively lower for Māori than for Pākehā (Baxter, Kokaua, et al., 2006). A key issue identified in the literature is that for many Māori, treatment seeking occurs at a later stage and consequently Māori are more likely to have more severe symptoms on presentation (Eade, 2014). Te Rau Hinengaro findings showed many Māori who experience a mental health disorder do not seek contact with mental health services and that this has a relationship with disorder severity (Oakley Browne, Wells, & Scott, 2006). Findings from Te Rau Hinengaro reported 52.1% of Māori with a serious mental health disorder and 74.6% of Māori with a moderate mental health disorder had no contact within the health sector for their mental health. For Māori with a mild mental health disorder 84.3% had no contact for mental health concerns. Also in support of these findings, a study carried out by Simpson, Brindred, Fairley, Laidlaw, and Malcolm (2003) on psychiatric morbidity in New Zealand prisons, found Māori were less likely than Pākehā to access mental health services before and during incarceration.

The literature suggests that even when Māori access services at a similar rate to non-Māori there remains a gap in the care they receive (Elers, 2014; Jansen & Smith, 2006). The Ministry of Health (2013) reported Māori have a greater overall unmet need for health care than non-Māori and suggested Māori may be less likely to seek treatment for mental health concerns due to more barriers faced in accessing mental health treatment. The above findings are important as they highlight unmet need for care among Māori and suggest further investigation is needed into why Māori are not seeking earlier intervention and how to mitigate this.

Chapter Summary

This chapter has focussed on the literature in the area of Māori mental health. It began with an overview of some of the general concepts within Māori perspectives on mental health and discussed how the growing awareness of the need to incorporate these concepts when working with Māori has given rise to Māori models of health. Te Whare Tapa Whā is an example of a Māori model of health and the importance of considering each taha in the treatment of mental health difficulties for Māori was highlighted. Mainstream services provide the majority of mental health care to Māori in New Zealand and many of these services integrate culturally appropriate concepts within their service delivery. However, many Māori prefer kaupapa Māori services that align with their worldviews and incorporate Māori values throughout the entire service. The literature suggests a high prevalence of mental health difficulties among Māori, however focussing only on aspects such as hospitalisation rates comes with caution given this may represent different pathways to care or later stage intervention. Such pathways highlight an unmet need for care among Māori and the literature proposes that Māori are not seeking treatment in proportion to their need which is likely due to barriers accessing services.

CHAPTER 3: SOCIAL ANXIETY

Chapter Outline

The following chapter discusses social anxiety. It begins with defining social anxiety for the purpose of this thesis, followed by the diagnostic criteria of social anxiety. The prevalence of social anxiety in New Zealand and other parts of the world is then discussed. This is followed by a specific focus on the prevalence of social anxiety among Māori. Aetiology, common comorbidities, and cultural expressions of social anxiety are then commented on. Next, an overview of various psychological therapies for social anxiety are discussed. Finally, attention is drawn to the literature which suggests an unmet need for treatment of social anxiety.

Defining Social Anxiety

The term social anxiety typically refers to the clinically significant symptomology of Social Anxiety Disorder, as defined by the Diagnostic and Statistical Manual of Mental Disorders-5th Edition (DSM-5; American Psychiatric Association, 2013). However, due to the complex nature of mental health difficulties, it is increasingly recognised that individuals with difficulties that are subthreshold can still have a clinically relevant problem, despite not meeting the full criteria for a mental health disorder (Helmchen & Linden, 2000; Morgan, Chittleborough, & Jorm, 2016). Research suggests subthreshold forms of Social Anxiety Disorder are prevalent and can cause significant life interference (Davidson, Hughes, George, & Blazer, 1994; Fehm, Beesdo, Jacobi, & Fiedler, 2008; Wittchen, Fuetsch, Sonntag, Müller, & Liebowitz, 1999). These forms of social anxiety appear to be indicators of psychopathology and impairment, which suggests important clinical implications in regards to understanding, intervention, and prevention (Fehm et

al., 2008). Furthermore, strong collectivist cultures may report high levels of social anxiety but lower prevalence of it reaching diagnostic levels (American Psychiatric Association, 2013). This may be due to the likely influence of culture on the degree at which social anxiety is viewed as an impairment in one's life (Rapee & Spence, 2004). Taking the above into account, for the purpose of this thesis the term 'social anxiety' will refer to both diagnostically significant and life interfering forms of this mental health difficulty.

Diagnostic Criteria of Social Anxiety and Associated Features

The essential feature of Social Anxiety Disorder is a marked fear or anxiety of social situations where the individual may be evaluated negatively (American Psychiatric Association, 2013). Individuals with social anxiety fear scrutiny from others and are concerned they will act in some way that will cause them immense embarrassment or humiliation if they are exposed to a feared situation. For some individuals, this fear is related to only performance specific situations (e.g., public speaking) and the DSM-5 specifies this within the diagnostic criteria. For others, the feared situations are generalised to social situations which could involve their perceived inadequacies being appraised by others (e.g., socialising with peers, exposure to unfamiliar people).

Before a feared event, people with social anxiety typically focus on what they think will happen and this may include recalling previous experiences of rejection and failure (Clark, 2001). Excessive self-focus during social interactions and rumination of perceived inadequacy post interaction are also common (McGinn & Newman, 2013). This can lead to future situations being endured with intense anxiety or avoided for fear of judgments such as being anxious, stupid, or unlikeable. The avoidance of situations may be general (e.g., not attending social gatherings) or subtle (e.g., over preparing for

a presentation) (American Psychiatric Association, 2013). Common physical symptoms include blushing, sweating, and quickened heart rate (Stein & Stein, 2008). The symptoms themselves can be greatly distressing and cause significant impairment that interferes with routines including social activities, relationships, and occupational or academic functioning (American Psychiatric Association, 2013). For example, people with social anxiety may have difficulties with self-disclosure, assertiveness, and emotional expression, which can interfere in developing close relationships (Davidson, Wingate, Grant, Judah, & Mills, 2011). Given social relationships typically provide a level of social support the discomfort of engaging with others may be particularly difficult for those with social anxiety as socialisation cannot always be avoided (McNeil & Randall, 2014).

The symptoms of social anxiety are greater in intensity than those experienced in shyness as the course is typically more severe in social anxiety and the functional impairments more chronic (Turner, Beidel, & Townsley, 1990). For example, in a study conducted by Chavira, Stein, and Malcarne (2002), only half of the participants who self-rated high in shyness had Social Anxiety Disorder. In another study, Heiser, Turner, and Beidel (2003), found participants with social anxiety had more difficulties in the areas of symptomology and social skills than those who identified as shy. The literature has suggested that social anxiety may exist on a continuum, sitting between shyness and the extreme social withdrawal of Avoidant Personality Disorder (Rapee & Heimberg, 1997; Rapee & Spence, 2004).

Prevalence

Social anxiety is reported in the literature as a common mental health difficulty worldwide. In general, research findings have shown a higher rate of social anxiety

among women compared to men with odds ratios varying from 1.5 to 2.2 (Fehm, Pelissolo, Furmark, & Wittchen, 2005). From the literature, the course of social anxiety for male and females appears to be similar (Asher, Asnaani, & Aderka, 2017). However, it has been suggested that, from childhood, socially anxious behaviours in females may be more tolerated and therefore such behaviours in males may be associated with greater functional impairment (Rapee & Spence, 2004).

One large epidemiological study involving 17 countries (including New Zealand) has indicated Social Anxiety Disorder has an overall lifetime prevalence rate of 13% (Kessler et al., 2007). However, the prevalence of social anxiety has been reported to occur at different rates across different cultural groups. Findings have suggested Social Anxiety Disorder to be the second most common occurring anxiety disorder among New Zealanders after Specific Phobia, with a lifetime prevalence of 9.4% and a 12-month prevalence of 5.1% (Oakley Browne et al., 2006). For comparison, 12-month prevalence rates of Social Anxiety Disorder in other parts of the world have been estimated to be 0.8% in Japan (Kawakami et al., 2008), 1.3% in Australia (Andrews, Henderson, & Hall, 2001), 1.9% in South Africa (Williams et al., 2008), 2.1-3.4% in Europe (Wittchen & Jacobi, 2005), 8% in the United States (Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012), and 7% in Mexico (Medina-Mora et al., 2005). It is less clear to what extent these prevalence differences reflect genuine differences in psychopathology or reflect a need for further consideration of cultural aspects within the diagnostic criteria (Hofmann, Asnaani, & Hinton, 2010), given research on social anxiety has primarily involved Caucasians of European descent (Zerr, Holly, & Armando, 2002).

Social Anxiety Among Māori

Besides prevalence rates, there is little existing literature on anxiety disorders within the adult Māori population and no known literature focusing solely on Māori experiences of

social anxiety and treatment-seeking. In regards to prevalence rates, the Te Rau Hinengaro study found anxiety disorders to be the most common mental health conditions among Māori in terms of one-month (13.4%), 12-month (19.4%), and lifetime (31.3%) prevalence (Baxter, Kingi, et al., 2006). In the same study, social anxiety was found to be the second most commonly occurring anxiety disorder among Māori with a lifetime prevalence of 11.4%. In addition, among Māori with 12-month prevalence anxiety disorders, the majority were considered to be serious (33.3%) or moderate (40.9%) suggesting that anxiety disorders such as social anxiety are not only common among Māori but may be experienced at high levels (Baxter, Kokaua, et al., 2006). Another study involving a systemic review and meta-analysis of the literature involving Māori and Indigenous people of Australia (i.e., Aboriginal and Torres Strait Islander) found that Māori did not significantly differ in the prevalence rates of anxiety disorders when compared to non-Māori; however, they suggested that overall, Indigenous people were more likely to receive a diagnosis of social anxiety than non-Indigenous people (Black, Kisely, Alichniewicz, & Toombs, 2017).

In another study which looked at the psychopathology of eating disorders and social anxiety in 52 New Zealand females, response differences between Pākehā, Māori, and mixed cultural groups were analysed across the self-report measures (McClintock & Evans, 2001). The primary finding from McClintock and Evans (2001) was that a lack of support, fear of criticism or rejection, and negative self-evaluation were important variables in the assessment of social anxiety, eating disorders, and body esteem. For social anxiety, a fear of negative evaluation was positively correlated with low social support. In addition, low self-acceptance was found to act as a mediator between social supports and social anxiety behaviours.

Aetiology

Similar to other mental health difficulties, there is no one certain cause of social anxiety. However, various factors have been associated with increased risk of developing social anxiety and these include biological, temperamental, and environmental elements. Generally, the symptoms of social anxiety develop in adolescence and increasing impairment develops if left untreated (Hidalgo, Barnett, & Davidson, 2001). In New Zealand, the median age of onset has been estimated to be 12 years of age (Oakley Browne et al., 2006). This is comparable to other countries, for example, Australia and the United States, where the median age of onset has been reported to be 13 years (Kessler, Berglund, Demler, Jin, & Walters, 2005; McEvoy, Grove, & Slade, 2011).

Research has suggested the development of social anxiety may follow negative life experiences (e.g., being bullied, isolation from peers) (Hudson & Rapee, 2000). However, social anxiety may also be insidious and develop slowly (American Psychiatric Association, 2013). The life stage of adolescence is often associated with increased independence, awareness of peer evaluation, and involves a number of biological changes (Spence & Rapee, 2016). The literature has suggested that the adapting to these novel changes could contribute to some individuals' sensitivity to such experiences and therefore increase their likelihood of developing social anxiety (Hidalgo et al., 2001).

The literature suggests a possible genetic component to social anxiety with higher rates of the difficulty found among adolescents whose parents have Social Anxiety Disorder (Stein & Merikangas, 2000). However, some studies suggest this familial association may reflect inheritance of a predisposition towards anxiousness in general, rather than social anxiety itself (Spence & Rapee, 2016). Literature suggests there may also be a

social learning component to the development of social anxiety as symptoms may develop in individuals via information learned through observation of their caregivers' behaviours and attitudes (Wong & Rapee, 2016). For example, through caregivers' modelling anxiety responses or expressing doubts about their own social competence.

Comorbidities

Social anxiety frequently occurs alongside other mental health difficulties and comorbidity is considered to be the rule rather than the exception (Lecrubier et al., 2000). Lifetime comorbidity rates have been recorded as high as 69% (Schneier, Johnson, Hornig, Liebowitz, & Weissman, 1992) and 92% (Faravelli et al., 2000). Research has suggested comorbidity is significant regardless of whether the symptoms of social anxiety reach diagnostic levels or are subthreshold (Fehm et al., 2008; Filho et al., 2010).

Other anxiety disorders, mood disorders, and substance use disorders are among the most commonly occurring comorbidities with social anxiety (Kessler, Stang, Wittchen, Stein, & Walters, 1999; Steinert, Hofmann, Leichsenring, & Kruse, 2013). The relatively early age of onset of social anxiety means it generally precedes other mental health difficulties. Therefore, the literature suggests social anxiety may function as a causal risk factor for a more severe course and the development of additional psychopathologies (Beesdo et al., 2007; Fehm et al., 2008). For example, in relation to alcohol use disorders, people with social anxiety may begin drinking alcohol socially as a form of self-medication to ease social fears, which in time can lead to unhealthy patterns of alcohol use (Lipsitz & Schneier, 2000). Further highlighting the need for early targeted treatment of social anxiety is the suggested increased risk of suicidal ideation with comorbid Social Anxiety Disorder and Major Depressive Disorder (Stein et al., 2001).

Social anxiety is commonly comorbid with psychosis (Gumley, O’Grady, Power, & Schwannauer, 2004) and has been estimated to occur in more than a third of individuals experiencing psychotic symptomology (Pallanti, Quercioli, & Hollander, 2004). Unfortunately, social anxiety may go unrecognised or deemed to be part of the psychotic symptomatology (Pallanti et al., 2004). For example, social withdrawal in psychosis may be attributed to negative symptoms that might better reflect a comorbid social anxiety difficulty (Castle, 2015). However, similar to the other comorbidities discussed above, social anxiety often develops prior to the onset of psychosis and may continue to persist even when psychosis is well managed (Halperin, Nathan, Drummond, & Castle, 2000). In addition, social anxiety has been found to be unrelated to psychotic symptoms (Pallanti et al., 2004) and the severity of social anxiety when co-morbid with psychosis has been found to be indistinguishable from non-psychosis social anxiety (Birchwood et al., 2007; Michail & Birchwood, 2009).

Cultural Expressions of Social Anxiety

Social anxiety occurs in individually meaningful contexts “including shared social values, beliefs and expectations that shape perceptions of social success or failure” (Hong & Woody, 2007, p. 1). While the underlying continuum of social anxiety is likely to be fairly constant across cultures (Rapee & Spence, 2004), research involving ethnic populations has suggested there may be cultural variation in how social anxiety is expressed and contextualised (Kleinknecht, Dinnel, Kleinknecht, Hiruma, & Harada, 1997). Strong collectivist cultures may view disruptions to the group as being a great threat, which could be manifested as fears of causing distress to others, in comparison to the self (Rapee & Spence, 2004). Therefore, an individual’s cultural context may influence not only how they define the self but also their perception of appropriate social behaviour and social consequences of inappropriate behaviour (Hong & Woody, 2007).

Although there is recognition that cultural variation impacts the expression of social anxiety, there is little research into the cultural influences of its understanding (Kleinknecht et al., 1997). Furthermore, the existing literature that details how culture may shape social anxiety has predominantly focused on East Asian cultures (e.g., Zhou et al., 2014).

Taijin Kyofusho

The Japanese syndrome of social anxiety – Taijin Kyofusho – is a fear of offending other people through behaviours including blushing and facial expressions considered improper by the individual (Kleinknecht et al., 1997). The fear leads to social avoidance, often of situations where familiarity is involved (e.g., speaking with work colleagues). The cultural foundation of the social avoidance is the fear that the behaviour of an in-group member will bring shame to other members of the group and the group as a whole (Kleinknecht et al., 1997). According to the DSM-5, taijin kyofusho may also be found in non-Asian settings.

Whakamā

While there is no culturally related expression of social anxiety relevant to Māori currently identified within the DSM-5, whakamā⁵⁶ may be one example of a uniquely Māori cultural concept that bears some similarities to the expression of social anxiety. Although whakamā has no literal English translation, its meaning can refer to feelings of shyness, modesty, shame, and embarrassment (Sachdev, 2009). Combined within whakamā may be feelings of anger that are directed inward or towards others (Ritchie, 1963). Metge (1986) writes how there are variations in expression, intensity and duration of whakamā and notes that these are closely linked to the cause of whakamā. She notes that whakamā may be more intensely experienced in the presence of others, especially

⁵⁶ Shy, embarrassed

unfamiliar people, and that criticisms, fear of failure, fear of appearing as a ‘show-off’ and standing up in front of an audience can contribute to feelings of whakamā. Presentations of whakamā can include becoming silent in social interactions, withdrawal, and avoidance which often occur within the interpersonal context of an individual evaluating themselves as at a disadvantage and a possible loss of mana within the wider group (Perminder S. Sachdev, 2009). Whakamā can vary in duration and group whakamā (e.g., whānau, iwi) can also occur (Metge, 1986).

Psychological Treatment of Social Anxiety

Social anxiety responds well to treatment (Rodebaugh, Holaway, & Heimberg, 2004) and individuals who receive treatment to the point of recovery have been found to stay well in comparison to individuals with other anxiety disorders (Bruce et al., 2005). Treatment for social anxiety typically involves psychological intervention. Three key psychological treatment modalities supported in the literature are Cognitive Behaviour Therapy (CBT), Acceptance and Commitment Therapy (ACT), and Interpersonal Psychotherapy (IPT). These are discussed below.

Cognitive Behaviour Therapy

CBT is a structured, collaborative, short-term, and problem-focused approach and is one of the most widely empirically supported psychological interventions (Feldman, 2007). As an intervention for social anxiety, CBT targets maladaptive thinking and behaviours with the objective of reducing social fears through techniques including cognitive restructuring and exposure, and homework (Hope, Burns, Hayes, Herbert, & Warner, 2007). Homework might include completing a CBT five-part model involving recording thoughts, behaviours, emotions, and physical sensations within a given situation or a thought record which involves recording, rating, and balancing distressing thoughts. Under the guidance of a clinician, the individual learns to restructure their thought

patterns that may be making them vulnerable to cognitive distress (Hofmann, 2007). Clark (2001) recommends exposure through video feedback to treat social anxiety, enabling individuals to observe their behaviour from an outsider's point of view. Video feedback can help clients to learn they present more positively than they assume and thus, that their impression of themselves is inaccurate (Clark, 2001). CBT can be administered in traditional client therapist sessions as well as in group settings, both of which have been found to be effective in reducing symptoms of social anxiety (Morgan & Raffle, 1999).

Adapting CBT when Working with Māori

Applying a culturally appropriate assessment framework has been identified as important when working with Māori (bpacnz, 2006). However, care should be taken to ensure cultural concepts are not introduced based purely on ethnicity and research on integrating concepts of whānau and whanaungatanga when working with Māori with alcohol and drug use difficulties illustrates this. In their research, Huriwai, Robertson, Armstrong, Kingi, and Huata (2001) cautioned how stereotypical assumptions that all Māori share the same values and attitudes may place unrealistic expectations on clients to attain them. Thus, Māori clients' individual needs and uniqueness should be taken into account.

In parts of the world such as North America, literature on adapting CBT for ethnically diverse groups is more abundant (e.g., Kelly, 2006). Despite the large amount of research supporting the effectiveness of CBT, there is little literature about its use in New Zealand when working with Māori (Te Pou o Te Whakaaro Nui, 2010). There is also no known research involving adapted CBT for Māori with social anxiety.

As discussed in Chapter Two, cultural and spiritual factors are generally important within the Māori view of health and these components are not traditionally incorporated

within CBT. Research by Bennett, Flett, and Babbage (2014, 2016) has made progress in closing this gap through including non-traditional CBT strategies to reflect Māori values and worldviews within CBT treatment for Māori with depression. Their research involved five phases of treatment: whakawhanaungatanga, nga maramatanga⁵⁷, whanonga pai⁵⁸, whakaaro pai, and ora pai⁵⁹. Within these phases, adaptations such as the use of te reo Māori, Te Whare Tapa Whā, karakia, and whakataukī were employed if participants nominated them as culturally relevant to better reflect their views of health as Māori. Participants in this study reported high satisfaction with the adapted therapy and experienced significant improvements in their symptoms of depression upon completion of the intervention. Thus, the findings provide a significant contribution to the literature and understanding regarding best practice when working alongside depressed Māori whaiora.

Acceptance and Commitment Therapy

A part of the third wave of CBT, ACT integrates mindfulness and acceptance techniques into CBT practice (Prochaska & Norcross, 2010). One of the primary messages of ACT is “accept what is out of your personal control and commit to taking action that enriches your life” (Harris, 2009, p. 2). Therefore, symptom reduction is not the central goal of ACT (Dalrymple & Herbert, 2007), rather it is about creating a valued and meaningful life alongside accepting the painful parts of life (Russ Harris, 2009). Mindfulness techniques involving encouraging awareness of the present moment can help individuals to evaluate anxious thoughts without judgement while distancing from internal experiences (Jørstad-Stein & Heimberg, 2009). One core component of ACT is values clarification to create more meaning and direction in individuals’ lives through creating

⁵⁷ Building insight

⁵⁸ Positive behaviour

⁵⁹ Good health

behavioural change through setting behavioural goals that align with their values (Russ Harris, 2009).

ACT has shown to be effective in treating social anxiety (Brady & Whitman, 2012; Dalrymple & Herbert, 2007). ACT can be used in group settings and a Canadian study involving group based ACT with mindfulness was found to be comparatively effective as group based CBT in the treatment of Social Anxiety Disorder (Kocovski, Fleming, Hawley, Huta, & Antony, 2013). More recently, research has suggested the values clarification component of ACT combined with CBT may be effective in the treatment of Social Anxiety Disorder (Grumet & Fitzpatrick, 2016).

Interpersonal Psychotherapy

IPT centres on the assumption that psychological difficulties occur within an interpersonal context. It is a time limited therapy that focuses on stressors within relationships and strategies to aid engagement with social supports to improve quality of relationships (Weissman, Markowitz, & Klerman, 2007). IPT was originally developed for the treatment of depression; however, over the past two decades overseas research has emerged on its application for social anxiety, helping individuals to use social performance skills to improve symptoms (Borge et al., 2008; Cuijpers, Donker, Weissman, Ravitz, & Cristea, 2016; Lipsitz, Markowitz, Cherry, & Fyer, 1999; Stangier, Schramm, Heidenreich, Berger, & Clark, 2011).

In one of the earlier studies on anxiety disorders, IPT was modified specifically for the treatment of Social Anxiety Disorder (Lipsitz et al., 1999). The focus of this treatment was identifying and treating interpersonal difficulties through techniques including encouraging affective expression, exploring related thoughts and feelings, and role-playing. Individuals showed improvements in symptoms, indicating support for the treatment model of IPT for social anxiety. More recent support for the efficacy of IPT

as a treatment for social anxiety was demonstrated by Borge et al. (2008), who found participants' improvements were maintained at a 1-year follow-up.

Unmet Need for Treatment of Social Anxiety

While the literature suggests social anxiety responds well to treatment, many individuals suffering from social anxiety may not seek help (Coles, Turk, Jindra, & Heimberg, 2004). Research in the United States by Wang and colleagues (2005) found treatment-seeking for social anxiety took a median of 16 years from the initial onset of symptoms. In New Zealand, the median duration of delay in treatment-seeking for social anxiety has been estimated to be 28 years, with only 4.9% of people making contact for treatment when symptoms first arise (Oakley Browne & Wells, 2006).

An early step in the process of successful treatment is making initial contact with a mental health provider (Wang et al., 2005). Individuals with social anxiety have been found to be less likely to make this initial contact than individuals with anxiety or mood disorders (Issakidis, Sanderson, Corry, Andrews, & Lapsley, 2004; Katzelnick et al., 2001; Patel, Knapp, Henderson, & Baldwin, 2002). In addition, social anxiety has been found to be poorly recognised and undertreated (Wittchen, Fuetsch, Sonntag, Müller, & Liebowitz, 1999). This is supported by the majority of the research carried out in this area which has suggested individuals with social anxiety have a substantial unmet need for treatment (Chartier-Otis, Perreault, & Bélanger, 2010; Oakley Browne, Wells, & McGee, 2006; Olfson et al., 2000; Wang et al., 2005). In addition, many people with mental health difficulties do not seek help because they underestimate symptom severity, do not recognise their symptoms as psychological, or do not know that help is available (Mojtabai et al., 2002). Research by Olfson et al., (2000) has suggested that raising public awareness of service for social anxiety is needed.

It is recognised that high rates of comorbidity for social anxiety can make it difficult when considering treatment seeking patterns (Lipsitz & Schneier, 2000). Socially anxious people rarely report their symptoms or seek help unless their symptoms are comorbid with another disorder (Stein & Kean, 2000; Weiller, Bisslerbe, Boyer, Lepine, & Lecrubier, 1996) and research has suggested that only approximately 5% of individuals experiencing non-comorbid social anxiety seek treatment (Schneier et al., 1992). In addition, subthreshold social anxiety complicates the picture of treatment-seeking. Overseas research found that individuals with subthreshold social anxiety have a higher uptake of mental health services than those with Social Anxiety Disorder, who may be more inhibited in seeking treatment (Acarturk, Smit, Graaf, & Straten, 2009). This highlights a need for early identification and treatment of social anxiety before the manifestation of more chronic symptoms of avoidance. Furthermore, effective early intervention may have positive effects on the occurrence of later comorbid difficulties (Weiller et al., 1996).

A study by Gross et al. (2005), carried out in the United States reported fewer visits to primary care by individuals with Social Anxiety Disorder than individuals with other psychological difficulties. These results could not be explained by comorbidity with major depression or subjective distress. Furthermore, less than half of the individuals with Social Anxiety Disorder had received mental health treatment in the previous year, suggesting that there might be social anxiety-specific barriers to treatment. Considering the information discussed in the preceding chapters, it seems likely the majority of Māori living in New Zealand and experiencing social anxiety are not seeking treatment. Understanding delays to seeking treatment is likely to be of importance in helping to encourage treatment-seeking for Māori with social anxiety at both subthreshold and clinically significant levels.

Chapter Summary

This chapter has concentrated on providing an overview of what social anxiety is and highlighting the impact it can have on peoples' lives. Social anxiety is a commonly occurring mental health difficulty and often co-occurs with other mental health difficulties, which has been found to impact on treatment-seeking. Social anxiety may be experienced in different ways across cultures, however at present the DSM-5 recognises only Taijin Kyofusho as a culture bound disorder. There are various 'Western' psychological approaches to treatment of social anxiety and when working with Māori it is important to consider each whaiora's individual needs when applying culturally based concepts. The literature suggests people with social anxiety delay treatment-seeking for a variety of reasons and often for a number of years. This suggests there is an unmet need for treatment of social anxiety; however, it provides limited insight into what obstacles interfere with the process of treatment-seeking. This will be addressed in the next chapter.

CHAPTER 4: TREATMENT BARRIERS

Chapter Outline

Making an initial appointment with a healthcare provider is difficult for many people (bpac^{nz}, 2008). This chapter explores some of the treatment barriers that individuals face when seeking treatment. It begins with an overview of obstacles faced by people of ethnic diversity when engaging with treatment, followed by a focus on common treatment barriers experienced by Māori within the New Zealand health system. Finally, barriers to treatment that have been identified as *social anxiety specific* and utilised within the questionnaire of the current study are discussed.

Treatment Barriers for Ethnically Diverse Populations

There is little known documented research on treatment barriers for people of ethnic diversity with social anxiety; however, ethnic minorities have been consistently found to be less likely to seek treatment for mental health concerns in proportion to their needs (Dobalian & Rivers, 2008; Westerman, 2004). This suggests there may be barriers that contribute to the low treatment rates for people of ethnic minorities.

Many people living under socio-economic stress report financial factors as barriers to treatment (Zambas & Wright, 2016). Research has suggested lower income minorities (Hispanics and Black Americans) were less likely than lower income majorities (White Americans) to seek help from a mental health practitioner, possibly due to working in roles that make it more difficult to get time off to attend appointments (Dobalian & Rivers, 2008).

One study carried out with Indigenous Aboriginal and Torres Strait Island people suggested that themes including shame and respect and reciprocity represented barriers of cultural differences. The themes identified in the study were compared with non-Indigenous health practitioners' views and it was found that some health practitioners expressed views indicative of *difference blindness* or treating all clients the same, regardless of age, gender, or culture (McBain-Rigg & Veitch, 2011). Such views may highlight perceived attitudes of hostility or indifference by health practitioners which in turn could contribute to barriers faced by Aboriginal and Torres Strait Islanders when seeking treatment. Consistent with these findings, limited availability of culturally responsive services has been noted to be a barrier for Aboriginal Torres Strait people accessing community care (Maar et al., 2009). Similarly, limited cultural services, lack of cultural competence by clinicians, language differences, prejudice, and discrimination have consistently been identified by the literature as barriers to mental health care for ethnic minorities in North America (Corrigan, Pickett, Batia, & Michaels, 2014; Gary, 2005; Lantz et al., 2003; Padela, Gunter, Killawi, & Heisler, 2012).

In other international research, 'prioritising the needs of others' has been found to be a barrier to healthcare for Native American people (Lantz et al., 2003). This barrier has been discussed in the literature as consistent with Native American and Indigenous collective cultural perspectives, where individual standing often relates to the degree to which one fulfils their responsibilities to other group members (Waller, Okamoto, Miles, & Hurdle, 2003). In another study, Native American peoples reported communication and trust barriers when seeking treatment for mental health difficulties (Oetzel et al., 2006). These barriers were found to decrease with more instrumental social supports, however, individuals with anxiety disorders were more likely to report trust and

communication obstacles to treatment (Duran et al., 2005). This is in line with the symptomology of social anxiety which includes fear of negative evaluation.

One study found Chinese immigrants living in North America were less likely to seek treatment for social anxiety than people of European heritage (Hsu & Alden, 2008). The researchers concluded that this treatment-seeking delay was not due to Chinese immigrants perceiving the symptoms of social anxiety as less disabling, rather, that unfamiliarity with services and language differences acted as treatment barriers. This research further highlights the need for a deeper understanding of treatment barriers for social anxiety among the ethnically diverse.

Treatment Barriers for Māori in Aotearoa

While research has not specifically explored treatment barriers for Māori with social anxiety, there is a growing body of literature on barriers to healthcare *in general* among Māori (Jansen, Bacal, & Crengle, 2008). There is also a growing body of literature pertaining to the process of culturally appropriate engagement with Māori that is aimed at mental health practitioners (e.g., bpac^{nz}, 2010; Te Pou, 2010), which also highlights possible treatment barriers. The diverse nature of the Māori population suggests that not all treatment barriers reported in the literature will apply to all Māori. However, some of the general treatment barriers for Māori noted in the literature include cost and access, communication, stigma and discrimination, and cultural differences and these are discussed below.

Cost and Access

As discussed in Chapter Two, there are many factors that influence the health status of Māori. Baxter (2008) writes that the socioeconomic positioning of many Māori has implications for Māori mental health needs as it adds to increased risk for mental health

difficulties and treatment barriers (e.g., cost as a barrier to accessing counselling and psychological services). For many Māori this may have a compounding effect, given mental health difficulties may also contribute to secondary socioeconomic disadvantage (Baxter, 2008).

The New Zealand Health survey reported cost and availability of appointments as the two main reasons for overall unmet need for primary care identified by Māori (Ministry of Health, 2013). Similarly, research carried out by Jansen, Bacal, and Crengle (2008) involving whaiora has suggested that cost and access were among the greatest barriers for Māori seeking healthcare. Cost barriers included direct costs (e.g., cost of appointment) and indirect costs (e.g., loss of wages, childcare costs). Information from the National Primary Medical Care Survey reported that a slightly larger proportion of Māori access after-hours emergency services for ‘mental visits’ in comparison to non-Māori (Crengle, Lay-Yee, Davis, & Pearson, 2005). This suggests that Māori are accessing these services outside typical working hours although the reason for this is unclear.

Access barriers in the study by Jansen et al. (2008) included distance of travel to healthcare, availability of appointments and waiting times. Barriers related to accessibility of services may compound barriers of cost as evidenced in a study involving sole Māori mothers where not owning a car, limited support from friends and family to help with transport, and difficulties with public transport were reported as access barriers to primary care services.

Communication

Effective communication skills foster better relationships between clients and their health care providers, which in turn impacts on client understanding (Jansen & Smith, 2006). Given the majority of healthcare providers in New Zealand are non-Māori there

is an increased risk of cross-cultural miscommunication in healthcare settings (Metge & Laing, 1984). Communication style, body language, and competence in Te Reo have all been identified as potential barriers to effective communication with Māori (Mauri Ora Associates, 2006). Therefore, clinicians not being able to effectively communicate with whaiora due to a lack of understanding of Māori culture and norms may contribute to less engagement with healthcare services among Māori (Eade, 2014). In addition, communication may also act as a treatment barrier for Māori when language used by mental health providers is overly technical (Jansen, 2009; Mauri Ora Associates, 2006; Pomare, 2015). In one New Zealand study, whaiora reported better relationship building with health and disability services when they experienced good communication alongside good provision of healthcare (Jansen et al., 2008), highlighting the value that many Māori place on whakawhanaungatanga.

Stigma and Discrimination

Many people with mental health difficulties experience stigma resulting from the discriminatory behaviours and attitudes of others which is a significant barrier to recovery (Ministry of Health, 2009). Experiences of stigma and discrimination impact on many life factors including participation in social activities and treatment seeking (Ministry of Health, 2009). Research on the stigmatisation of social anxiety disorder has suggested that people report more desire to distance themselves socially from individuals with social anxiety when they were perceived as dangerous or embarrassed by their difficulties (Anderson, Jeon, Blenner, Wiener, & Hope, 2015).

Stigma and discrimination have been reported in the literature to be significant barriers contributing to delayed treatment-seeking among Māori (Te Pou o Te Whakaaro Nui, 2010). For example, one qualitative study reported that participants identified experiencing stigma and discrimination barriers in relation to taking antipsychotic

medications and some participants reported that such barriers existed within the wider community as well as their whānau (Yesterday Today & Tomorrow Ltd, 2006). In another New Zealand study, fear of discrimination against mental illness (typically based on past experience) was found to be equally debilitating as discrimination itself and prevented social interaction (Peterson, Pere, Sheehan, & Surgenor, 2004). Within this study, Māori reported discrimination due to mental illness and ethnicity from a number of avenues including people in the community and health providers that impacted them in ways including limiting social contact. In addition, a number of Māori involved in the study indicated receiving ‘tough love’ and a lack of understanding from whānau about their mental illness. However, it was found that understanding and acceptance grew as whānau became more informed with the difficulties faced by the individual.

Other studies highlight stigma and discrimination from mental health professionals. A study by Johnstone and Read (1999) involving 247 psychiatrists found that approximately one in five male psychiatrists held unfounded beliefs that Māori were more genetically predisposed than others to mental illness. Such beliefs could mean less consideration of the continued psychosocial and cultural stressors that affect Māori which may result in misdiagnosis, over prescription of medication, and ultimately a negative experience of the healthcare system by whaiora. Taking this into account it is not surprising that negative attitudes towards Māori within health care services create treatment-seeking barriers (Jansen, 2009) and contribute to poorer health outcomes for Māori (Harris et al., 2005). Te Pou (2010) highlight the importance of mental health clinicians having an awareness of such potential treatment barriers when engaging with Māori in order to foster an environment where whaiora feel safe to talk about anxiety and other difficulties.

Cultural Fit

The literature suggests another barrier to Māori accessing treatment is a lack of understanding of Māori values within the health system (Te Pou o Te Whakaaro Nui, 2010). Caccioppoli and Cullen (2005) argue that approaching treatment within a Western model of health does little to support health gains among Māori as many may have difficulty relating to them. Furthermore, cultural differences in the perceptions of illness can act as a treatment barrier. Durie (2001), writes that many Māori may avoid seeking help particularly if the difficulty is perceived as resulting from cultural infringement (e.g., infringement of tapu). For these reasons, many Māori may prefer seeking treatment from Māori who may be more likely to understand their cultural worldviews. However, research by Jansen et al. (2008), identified that this preference often goes unfulfilled. This is supported by research by Cram (2014), who also found a lack of Māori staff as a barrier to accessing healthcare among Māori.

A qualitative study that explored how Māori living in urban Auckland conceptualise health suggested whakamā may also act as a potential treatment barrier (Cram, Smith, & Johnstone, 2003). In this study, participants talked about whakamā as a barrier to seeking treatment, discussing health concerns with healthcare providers, and building rapport. Participants also emphasised the importance of having personal support (e.g., whānau member to speak on their behalf) when engaging in treatment services. Other research carried out by Matoe-Bendixen (2008) identified whakamā as a barrier of cultural pride to accessing primary mental health service for the Māori participants. Matoe-Bendixen (2008) found Māori health professionals reported that whaiora experienced barriers to accessing mental health services when acculturated stress meant less support from their extended whānau, hapū, and marae⁶⁰. Jansen (2009) further

⁶⁰ Gathering and meeting place

highlights the importance many Māori place on having whānau support during the process of treatment and that this may be a barrier to care in clinic settings where whānau support is not offered or acknowledged.

Treatment Barriers for Social Anxiety

Treatment barriers have been investigated across a range of psychological difficulties; however, research on treatment barriers for anxiety disorders are less extensively covered and the literature on this topic for social anxiety is limited. Research conducted in the United States by Craske et al., (2005) investigated treatment barrier for Panic Disorder and through factor analysis identified five factors that act as treatment barriers: cost, loss of pay, access, services, and social attitudes. Through adaptations of this research, Chartier-Otis et al. (2010) found these barriers may also apply to individuals with social anxiety and/ or panic living in Canada. Another study has suggested the psychological symptoms of social anxiety may also hinder treatment-seeking (Olfson et al., 2000). The barriers identified from these studies are discussed below.

Cost

Past research has suggested the factor of cost as a treatment barrier to include the cost of getting help and health insurance concerns (Chartier-Otis et al., 2010; Craske et al., 2005). Chartier-Otis et al. (2010) found cost of getting help to be the most highly endorsed treatment barrier with over half (63.9%) of the participants citing it as an obstacle. In addition, over half (52.4%) of participants endorsed health insurance as a barrier to treatment-seeking. Similarly research in the United States by Olfson and colleagues (2000) found 24.5% of participants with symptoms of social anxiety endorsed cost and 16.6% endorsed insurance worries as barriers to treatment.

Loss of pay

Loss of pay as a treatment barrier has been investigated in the literature through questioning whether foregoing paid employment hours to attend a therapy appointment interfered with treatment-seeking. Moderate endorsement of this barrier has been reported in the literature, for example, Chartier-Otis et al. (2010) found 20.1% of participants endorsed it.

Access

Access barriers have been previously investigated through barriers of inability to get to a provider's office during opening hours, the length of time taken to get there being too great, and a lack of knowledge of where to go to get help (Chartier-Otis et al., 2010; Craske et al., 2005). In the study by Chartier-Otis et al. (2010) the time related barriers of access (i.e., opening hours and distance) did not significantly affect treatment-seeking. However, lack of knowledge of where to go to get help was highly endorsed (61.3%). This is consistent with research by Olfson et al. (2000), where not knowing where to go to get help was found to be the most frequently identified barrier among participants with social anxiety.

Services

The factor of services has been explored in previous research through questions relating to the following treatment barriers: inability to reach the mental health provider on the telephone, appointment waiting time being too great, and finding suitable childcare (Chartier-Otis et al., 2010; Craske et al., 2005). Waiting time for an appointment was found to be a notable treatment barrier with 52.1% of participants endorsing it in the study by Chartier-Otis et al. (2010). In this study, the barriers of not being able to get through on the telephone and inability to find childcare were found to be less significant obstacles to treatment-seeking.

Social Attitudes

Social attitude obstacles to treatment-seeking for social anxiety have been explored through barriers related to beliefs that the individual cannot be helped, embarrassment to discuss difficulties, and worry about others would think about treatment-seeking (Chartier-Otis et al., 2010; Craske et al., 2005). The study by Chartier-Otis (2010) found these barriers were frequently endorsed at 49.5%, 43%, 41.8% respectively. Similarly, Olfson (2000) found being afraid of what other people might think to be endorsed by 19.4% of participants. This barrier reflects concern of social stigma which may be of importance to individuals with social anxiety given they fear negative evaluation.

Psychological Symptoms

Socially anxious people are often embarrassed by their symptoms and this can hinder them discussing their difficulties with healthcare professionals (Olfson et al., 2000). Therapy itself is a social interaction and seeking treatment may involve situations that are feared by individuals with social anxiety, for example, passing through a busy reception area and interacting with unfamiliar people (Gross et al., 2005). Research carried out with Clinical Psychologists in New Zealand found participants most agreed with psychological symptom treatment barriers (i.e., worry that symptoms would cause embarrassment, concern they would be too anxious to attend an appointment, fear of how the clinician would perceive them) as help-seeking obstacles for clients with Social Anxiety Disorder (Armstrong-Barrington, unpublished).

Chapter Summary

This chapter focussed on discussing barriers to treatment-seeking. It began with reviewing the literature on treatment barriers for ethnically diverse populations and then focussed specifically on treatment barriers faced by Māori. Due to the lack of literature around treatment barriers for social anxiety, a focus on overview of general healthcare

barriers was presented. This highlighted how Māori may face additional barriers to accessing services than European New Zealanders and it is likely of importance for clinicians to be aware of these barriers to be faced and overcome when working with whaiora. Of particular concern, is the literature pertaining to the presence of stigma and discrimination within healthcare services. This chapter finished with an overview of treatment barriers identified in the literature as being specific to social anxiety. Alongside commonly occurring barriers is the additional barrier of the symptomology of social anxiety which interferes with treatment-seeking, further highlighting a need for the area of treatment barriers for social anxiety to be addressed.

CHAPTER 5: THE CURRENT RESEARCH

Chapter Outline

This chapter provides a brief overview of the current research. It will present the rationale for focussing on the particular area of treatment barriers for Māori with social anxiety. In addition, it will highlight the aims and of the current study as well as the research questions it set out to address.

Rationale for the Current Research

As discussed in the preceding chapters, social anxiety can have debilitating effects on peoples' lives yet research indicates many people experiencing social anxiety typically delay treatment-seeking for a range of postulated reasons. The literature clearly highlights social anxiety as a significant health concern among Māori; however, aside from prevalence rates, a deeper exploration of how social anxiety is understood among Māori has not been undertaken. Finally, the literature suggests an unmet need among Māori seeking help for mental health difficulties. There is an apparent gap in the literature on what treatment barriers might exist for Māori with social anxiety and how these may be overcome from a Māori whaiora perspective. The importance of such knowledge is highlighted by Baxter (2008): "To achieve good health outcomes for Māori there is a need for much more information about both the nature and impact of barriers to access of services ..." (p.91).

Together, the identified gaps in the literature provide strong rationale for the relevance of the current research. It is clear there is a need to address these issues in order to facilitate improved access to services for Māori with social anxiety. Furthermore, it is

argued that in order for positive change to occur, a Māori perspective of social anxiety and its treatment barriers is required.

Research Aims and Questions

The purpose of the current research is to explore how Māori with social anxiety understand the treatment barriers they have encountered in order to identify obstacles that need to be addressed to encourage treatment-seeking. The research will also explore how Māori understand social anxiety from their lived experience. It is hoped this research will benefit Māori through providing a space for Māori participants to share their experiences of social anxiety and its treatment barriers. It is also hoped that through contributing to the literature and sharing the findings with clinicians working in mental health an improved understanding of the process of engaging Māori with social anxiety in treatment will be gained.

The current research aims to address the following questions:

1. How do Māori experiencing symptoms of social anxiety understand their symptoms?
2. How do Māori with social anxiety understand treatment barriers that they have experienced or anticipate experiencing?
3. How do Māori with social anxiety think treatment barriers could be reduced?

In order to achieve the above aims and address the research questions semi-structured interviews were carried out with whaiora currently within secondary mental services, who provided their insider knowledge of their experiences of social anxiety and its treatment barriers. A questionnaire outlining the common barriers of social anxiety identified in the literature was also used with participants in order to provide a

comparison with the existing literature. The research took a Māori-centred approach where each stage of the research process was considered within the context of Māori development.

Chapter Summary

This chapter has briefly outlined the current study, first by providing the rationale, followed by the research aims and questions. In summary, this research will explore whaiora experience of social anxiety and its treatment barriers through a Māori-centred approach, in the hope that this will advance understanding in this under researched area. The methodology and methods used to collect the data will be discussed in more detail in the following chapter and subsequent chapters present the findings and conclusions.

CHAPTER 6: METHODOLOGY

Chapter Outline

The following chapter will discuss the methods used in the current research. It begins with an overview of Māori-centred research and provides rationale for this as the chosen approach. The specific methods used in recruiting and interviewing participants will be presented followed by ethical considerations made during the research process. Finally, the methods used during the analysis stage of the current study will be discussed.

A Māori-Centred Approach

Milne (2005) has written that it “has long been noted that there are fundamental differences between Māori and Western methodologies of enquiry in the pursuit of knowledge” (p. 8). Māori knowledge is linked with Māori culture and personal identity and in the past, Western methodologies have been used to explore Māori lifestyles from the perspective of European values and norms (Forster, 2003). Such approaches positioned the researchers as the ‘experts’ and thus undervalued the legitimacy of Māori knowledge (Bishop & Glynn, 1999). In response to this, Māori methodologies have emerged which more closely align with Māori cultural preferences and aspirations.

The Health Research Council of New Zealand (HRC) provide guidelines that support various approaches when conducting research with Māori (Health Research Council of New Zealand, 2010). This includes distinctions made between kaupapa Māori and Māori-centred research methodologies. According to the HRC, kaupapa Māori research typically involves all Māori members of the research team and the controls remain within Māori institutions. In comparison, Māori-centred research does not necessarily

involve all Māori team members and the controls remain within mainstream institutions (e.g., universities). The HRC (2010) highlights cultural consultation as a vital step within any chosen methodology. Herbert (2001) suggests there may not be one set definition of research with Māori, although however research is defined it should be considered in the context of Māori development.

A Māori-centred approach was considered appropriate for this research given the controls remain within a university and not exclusively with Māori. In addition, my supervisors were mainly of European descent. A Māori-centred framework is considered compatible with the equity claims of Article III of Te Tiriti (Herbert, 2001). This approach acknowledges the importance of Māori culture and knowledge and offers a space for traditional principles to be applied to contemporary concerns (Forster, 2003). In addition, it has been suggested a Māori-centred approach can help facilitate Māori to be involved in mainstream research, thus contributing to the aims of Māori development and the preservation of traditional practices and knowledge (Forster, 2003).

While operating within a Māori-centred framework, the current research interweaved principles of kaupapa Māori research to ensure the study was carried out in a culturally safe and ethical manner. The following principles were outlined by Mead (1996) and have been discussed in the literature by a number of researchers, including those who have incorporated them within a Māori-centred approach (e.g., Boulton, 2005; Moyle, 2014; Poananga, 2011). Moyle (2014) describes the principles as aroha ki te tangata⁶¹, kanohi kitea⁶², titiro, whakarongo, kōrero, manaaki ki te tangata⁶³, kaula e takahia te

⁶¹ Respect for people you are working with

⁶² The seen face

⁶³ Be generous in sharing with and hosting people

mana o te tangata⁶⁴, kia tūpato⁶⁵, and kua e māhaki⁶⁶. These principles were considered throughout the research process. For example, the principles of kia tūpato was considered in designing the current research. In terms of ethical considerations this means the study aimed to take care in accessing and providing information to participants, ensuring safety, and ensuring ethical obligations were carried out (Moyle, 2014). The research as a qualitative study involved the use of kanohi ki te kanohi interactions with participants, those involved in recruitment, and those who provided support throughout the research process, ensuring the principle of kanohi kitea.

Method

The following is an overview of the methods used in the current research. Qualitative interviews were utilised, which fits in line within the principles of Māori-centred research. A brief questionnaire was used, with discussion around responses. It was intended these approaches would help enable a Māori-perspective and the uniqueness of participants' experiences to be heard.

Participants

Individuals who identified as Māori, were 18 years of age or older, and had experienced symptoms of social anxiety as one of their primary presenting difficulties currently or previously were eligible to participate in the study. Due to the pervasive nature of personality disorders, individuals presenting with a diagnosis of a personality disorder were part of the exclusion criteria. Initially, individuals who had experienced psychosis were also part of the exclusion criteria. However, during the early stages of recruitment it quickly became clear this would not capture the experiences of many individuals who

⁶⁴ Do not trample on the mana of people

⁶⁵ Be cautious

⁶⁶ Do not flaunt your knowledge

experience social anxiety and their patterns of treatment seeking. This was of importance given the literature suggesting social anxiety often develops before psychotic symptomology and can continue after psychosis is managed (Halperin et al., 2000). Therefore, an amendment was sought and approved through the appropriate ethical pathways to include individuals who may have experienced psychosis in the past but were not currently experiencing active psychosis, as deemed by their mental health provider.

Although some demographic information was collected through the interviews and questionnaire, to protect the participants' identities, minimal demographic information is presented. Five females and six males participated in the study aged 22 to 63. Five participants fell within the age range of 35 to 45 and the mean age was 40. Together, the participants represented a number of different iwi and hapū and some participants shared iwi affiliations. Two participants did not know their iwi or hapū and three participants knew their iwi but not their hapū. The participants had a broad range of education backgrounds and current employment.

Recruitment

Participants were recruited through three CMHCs in the Counties Manukau district of Tāmaki Makaurau⁶⁷: Te Puna Waiora, The Cottage, and Manukau. Awhinatia CMHC in Counties Manukau was also involved in recruitment, however no participants were recruited through this service. Te Puna Waiora was the only kaupapa Māori CMHC within this group and the early stages of recruitment involved recruiting participants solely through this service. However, it became apparent that this approach could mean not capturing the experiences of Māori who may not seek treatment through a kaupapa

⁶⁷ Auckland region of New Zealand

Māori service or live near one. Therefore, an amendment was sought and approved through the appropriate ethical pathways to include the three additional CMHCs in the recruitment process.

The study used purposive sampling methods to select participants. Individuals were identified as eligible to participate by their supporting mental health professionals. Potential participants were provided with a brochure (Appendix A) and an information sheet (Appendix B) outlining the study and inviting them to participate by their mental health provider. In line with Māori-centred research, participants were provided with the option of attending the interview with a support person. One participant opted to attend with support. Potential participants were invited to contact the researcher or to arrange for the researcher to contact them via their mental health provider. This allowed further explanation of the study, opportunity to answer any questions, and to arrange a date for the interview. Some participants opted to organise an interview time through their mental health provider.

The principle of *aroha ki te tangata* (respect for the people you are working with) was adhered to through participants being clearly and carefully informed of the process that was to be used to keep their information private (Moyle, 2014). The names of participants in the study were kept confidential and all audio and written information collected was labelled with a code based on the chronological order of the interviews (i.e., P1 to P11). All computer files were password protected.

Interviews

The principle of *kaua e takahia te mana o te tangata* was carried out through taking care to inform the participants of the research process (Moyle, 2014). Participation in the current research was entirely voluntary and this was made explicit to participants through the information sheet and prior to the commencement of the interview.

Interviews were carried out at the offices of the participants' mental health providers to ensure they were conducted in a familiar space for participants. Karakia and sharing of whakapapa were offered before the start of the interviews. Some participants preferred to carry out karakia and share their pepeha⁶⁸ or a statement about themselves and their whānau, others preferred that I initiate karakia, and others preferred to carry out the interviews without this. Regardless, in line with the principle of manaaki ki te tangata, each interview began with some form of whakawhanaungatanga, acknowledgement of participants' involvement in the study, and offer of refreshments.

Prior to the commencement of the interviews, the nature and purpose of the research was explained and participants were given the opportunity to ask questions. Participants were provided with another copy of the information sheet and this was discussed. The consent form (Appendix C) was then explained and discussed before the participants signed it. The interviews varied in time from approximately 30 minutes to 1 hour. Audio recordings were made of each interview to allow for accurate transcription of the data. The interviews were guided by topics (Appendix D) that aimed to address the research questions and this was flexible depending at what point during the interview participants discussed their experiences relating to the topics. The majority of participants were asked if they thought there was a Māori kupu⁶⁹ that better represented the term social anxiety. Participants were offered the opportunity to receive a summary of the data collected on completion of the research. In line with Māori-centred research, participants were offered a koha⁷⁰ of a \$20 grocery voucher to show acknowledgment and appreciation of their willingness to participate in the study. Towards the end of each interview, participants were asked to fill in a brief questionnaire and discussion around

⁶⁸ Tribal saying, saying of the ancestors

⁶⁹ Word

⁷⁰ Gift, offering, contribution

their responses was encouraged (Appendix E). The design of the questionnaire is discussed below.

Questionnaire Design

Participants completed a questionnaire based on existing literature and originally designed and used in my Honours project which investigated treatment barriers for social anxiety from clinicians' viewpoints. The intention of the questionnaire was to provide a starting point for exploration of the barriers identified in the overseas literature and a practical element for discussion should participants' anxiety inhibit their interview responses. The questions were guided by literature that had investigated barriers to treatment of anxiety disorders (e.g., Chartier-Otis et al., 2010; Craske et al., 2005).

The questionnaire involved rating 15 treatment barriers on a purpose-built Likert scale from 1 (*little barrier*) to 5 (*big barrier*). Twelve of the barriers were taken from the factor analysis by Craske and colleagues (2005) and related to dimensions of cost, loss of pay, access, services, and social attitudes, as discussed above. Guided by the literature (Mojtabai et al., 2002; Olfson et al., 2000), three additional barriers were designed to include the potential sixth dimension of psychological symptoms. These were worry that symptoms would cause embarrassment, concern you would be too anxious to attend, and fear of how the clinician would perceive you. Participants were given the opportunity to report any unlisted barriers through an option of 'other' barriers at the end of the questionnaire. General demographic information was collected through the questionnaire (e.g., age, gender, hapū, iwi).

Ethical Considerations

The current research provides insight into the participants' unique experiences of social anxiety and treatment barriers. Ethical approval for the current research was granted by the Health and Disability Ethics Committee. Massey University reviewed and provided

sponsorship of the study. Approval was also granted by the Counties Manukau Health Research Office (CMH Research Office). The amendments described above and a time extension were made through HDEC and the CMH Research Office. In addition, the study was approved by the Counties Manukau Maaori Research Review Committee (MRRC). On recommendation of the MRRC, the Tainui spelling convention of te reo Māori of using double vowels instead of macrons was included on the participant information sheet and consent form (e.g., Maaori in place of Māori).

To help ensure the research would be of benefit to Māori, the initial formation of the research process involved cultural consultation. This included kōrero⁷¹ with kaumātua, Pā Nephi Skipwith, on awareness for the process of engagement with participants and maintaining the tapu of the data collected. Early in the research process I regularly attended fortnightly wananga with Pā Nephi, where Māori knowledge was discussed and how this applied to the current research. I engaged in kōrero with staff from Ōrākei Marae, which included discussion on how best to approach further meetings with tangata whenua, how Māori might perceive the research, and how to ensure that cultural factors were incorporated within the research (e.g., cultural expressions of social anxiety). In addition, the cultural consultation process also involved discussions with the cultural supervisor, Dr Simon Bennett, throughout the research process. Supervision with my additional supervisors' Dr Angela McNaught and Associate Professor Ross Flett was also sought throughout the study. As part of my clinical training I completed a clinical placement at Te Puna Waiora, where supervision with Dr Willem Louw and engagement with other team members included furthering my knowledge of tikanga Māori.

⁷¹ Speech, narrative, conversation, discussion

Thematic Analysis

Audio recordings of each interview were transcribed verbatim to convey as fully as possible participants' kōrero. Thematic analysis was used to analyse the data and generate overarching themes and subthemes. Thematic analysis is widely used as a method of data analysis to identify and explain patterns across a data-set. Thematic analysis can be used to address a number of research questions including those concerning individual's experiences and how they make sense of them. Furthermore, through theoretical freedom, thematic analysis has the advantage of flexibility which can allow for a full and intricate account of a data set (Braun & Clark, 2006). The guidelines of thematic analysis outlined Braun and Clarke (2006) were followed using an inductive approach. Therefore, the process was data-driven; however, it is acknowledged that researchers carry their own experiences with them into the coding and that this played a role in the process.

Responses were analysed from a critical realist perspective. First, the data was read to help the familiarisation with the text and to identify relevant meaningful patterns. Next, initial data driven codes were generated that reflected the relevant semantic content of the data set. This involved assigning one or more codes to sections of each transcript using the comments tool in Microsoft Word. This resulted in an initial 83 coding categories that were reviewed to collate the relevant coded data into broad themes. Next, subthemes were identified within the broader themes and thematic maps were generated to help determine relationships between them. Definitions of each theme and subtheme were generated. A review of the data was then carried out to ensure that appropriate names, definitions, and accompanying data to support each theme were described. During the entire process of analysis, supervision was regularly sought to ensure validity. This included discussion, feedback, and revision of the codes, themes and

subthemes. On completion of this process, the themes were shared and discussed with kaumatua, Pā Nephi Skipwith.

Questionnaire Analysis

In line with previous literature, the Likert data collected was considered to be interval (Norman, 2010). Responses from the 15 barriers were grouped into the dimensions indicated in past research: cost, loss of pay, access, services, social attitudes, and psychological symptoms to allow for descriptive analysis. The means and standard deviations of the responses were calculated and are reported in the following chapter. Discussion carried out around the barriers was included within the thematic analysis, also reported in the following chapter.

Chapter Summary

This chapter outlined the methodology of the current research. The research was presented within a Māori-centred framework with principles of kaupapa Māori research considered and woven throughout. As the researcher, I acknowledged my position within the research and identified the participants as the experts of their knowledge and experiences. Ethical considerations during the study were also presented in this chapter. The current study involved eleven kanohi ki te kanohi interviews with whaiora who had experienced symptoms of social anxiety. Participants were asked about their experiences of social anxiety, treatment barriers, and suggestions of ways to reduce treatment barriers. Towards the end of each interview a purpose-built questionnaire was administered and responses discussed. Thematic analysis was carried out on the transcripts and descriptive statistics were calculated for the questionnaire. The following chapter presents these findings.

CHAPTER 7: FINDINGS

Chapter Outline

Presented in this chapter are the unique perspectives of the participants in the current study. It begins with an overview of the six themes and their subthemes identified from thematic analysis of the participant transcripts. Each theme and subtheme are then presented. The findings from the questionnaire are then reported.

Thematic Analysis

The current study sought to explore three components of social anxiety and treatment-seeking: understanding of symptoms, treatment barriers, and how treatment barriers could be reduced. The identified themes and subthemes are presented in Table 1.

Table 1

Themes and Subthemes

Theme	Subthemes
1. Te hiranga o te whānau	Pūtake o te tautoko Obstacles to treatment-seeking
2. The experience of social anxiety	Social engagement difficulties Te taha tinana
3. Unrecognised social anxiety and treatment-seeking	
4. Past experiences as barriers	Social attitudes The importance of connection
5. Cultural disconnection and engagement	Disconnection Māoritanga
6. Increasing awareness of social anxiety to reduce barriers	Reach out for help, you are not alone Additional support is needed

Theme 1: Te Hiranga o te Whānau

Participants discussed te hiranga o te whānau⁷² across many of the interview topics. The theme of te hiranga o te whānau was defined as how whānau may have helped or hindered participants during their experiences of social anxiety, treatment-seeking, and on-going treatment. Within this theme two subthemes were identified: pūtaka o te tautoko⁷³ and obstacles to treatment-seeking. These are discussed in more detail below.

Pūtaka o te Tautoko

This subtheme concerns how whānau provided a valued source of support during their experiences of social anxiety and treatment-seeking. The tautoko⁷⁴ that whānau provided came in many different forms. Some participants spoke of how whānau offer practical support in their daily lives: “By contacting me through texts and that, or ring me and come and visit” (P8) and “Having my Nana to help” [with childcare] (P4). Other participants indicated that whānau support was offered during the initial treatment-seeking stage through offering guidance on who to see and accompanying them to initial engagements. One participant discussed how her sister supported her through organising a meeting with a kuia⁷⁵ in the community: “I told my sister ... a while back, a few years, that I was sort of feeling out of all sorts and she took me to speak to one of the elders” (P8).

Practical support from people outside of whakapapa whānau at the initial treatment-seeking stage was also mentioned. One participant said: “I had a good friend and he helped me ... Took me to the appointments and stayed with me” (P4). For another

⁷² The importance of family

⁷³ Source of support

⁷⁴ Support

⁷⁵ Elderly woman, female elder

participant, this type of practical support continued into treatment. For example, “I use my neighbour’s landline a lot and he doesn’t mind at all” (P1).

Many participants indicated that having the support of whānau around them assisted in managing symptoms of social anxiety. For one participant, the general aroha shown by whānau aided in combating symptoms of social withdrawal:

It’s good to have a supportive family yeah, it’s really important. Yeah if I didn’t, [I’d be] more likely to close off ... Just like showing me that they care and that they love and that they’re always there for me no matter what I’m going through (P11).

For other participants, whānau’s direct experience of their social anxiety acted as a means to foster whānau understanding and thus perceived support. They spoke about how over time, their whānau came to recognise the signs and symptoms of social anxiety and were then able to offer their support to help participants cope. One participant spoke of how understanding was strengthened through residing with whānau: “but I think now that, you know, they’ve moved in, and it’s only been a month now ... I think she [Mum] can understand me now a bit more” (P3).

Other participants echoed these statements of whānau offering support to them with their social anxiety. One participant spoke about how whānau’s direct experience of their social anxiety over time contributed to their ability to recognise when support is needed:

They’re getting an idea of how to deal with it, kinda how to prevent it beforehand. When they notice that I’m starting to kind of curl back a little bit, not being so open and stuff like that (P5).

Another participant spoke of their appreciation of a whānau member showing their support by gaining a deeper understanding of social anxiety through the media. They described how this assisted in their mother's understanding of the difficulties they cope with and an acknowledgement that this process takes time:

She [Mum] watched a programme on attitude. It was about people with anxiety. So, she watched it and she said 'oh wow, I understood more about you now'. I was like, 'oh thank you!' ... Yeah and she's slowly getting there, not quite one hundred percent (P7).

For many of the participants, whānau support was shown through kōrero. For some, kōrero had particular value in fostering more positive coping skills (e.g., communication) and for providing a means for whānau understanding of how they can begin to help to manage symptoms. One participant said their mother would kōrero with them to alleviate their anxiety: "when I'm getting nervous ... Mum will talk to me and I'm able to sort of slowly let the anxiety come out" (P3). Some participants discussed a level of difficulty talking about social anxiety in the past and how they have become more comfortable with this. For example, as one participant said: "I can talk about it at any time. With especially my family now because they're all aware about it" (P5). Another participant discussed the benefit of talking through their difficulties with whānau and with health professionals in treatment:

Coz I know that they won't be able to help me properly if I don't tell them what's truly going on. So, I thought bugger it. Coz I used to be a shy guy and I'd never open-up to no one. Not even my own family. But this is the way to feel better about myself (P1).

Another participant spoke about how wider whānau support was offered through whānau stepping back from direct kōrero about social anxiety, instead letting them talk about it in their own time:

You know whānau, family, or the hapū of our tribe we get together on the marae, they never bring it up ... I tell them ... they're all supportive of me. So, I try my best to go home and see them all as much as I can (P2).

Obstacles to Treatment-Seeking

This subtheme concerns participants' descriptions of barriers to seeking treatment that stemmed from within the whānau. Some participants expressed less whānau support in their experiences of social anxiety and treatment-seeking. Those with less of a whānau support system around them described obstacles to treatment-seeking. For example: "because I had no one ... I sort of had to do my own thing in my own way" (P3). Some participants indicated how less whānau support contributed to a sense of not feeling heard. As one participant described: "Coz it's really hard to explain to people and they just go 'yeah, yeah, yeah', but really they're not even taking it in ..." (P7). Another participant described how the whānau they initially opened-up to did not respond as they expected and this hindered their desire to reveal more to other whānau: "Yeah, they don't say much, in fact they said nothing. So, they were the last family I told. Didn't tell anyone else after that. It wasn't worth it" (P6).

Some participants described whānau taking a "harden up" attitude when participants approached them regarding difficulties they were facing. These participants expressed a feeling of not being understood and this made treatment-seeking more difficult. Two participant descriptions are below:

It's just really pride with my family ... When I first told my mother she told me I don't need to [receive treatment] – 'you're alright, you can handle it', you know, or 'harden up' basically ... It was quite, I felt like nobody understood me, yeah (P7).

Mum would text me or whatever when they were in their place and 'oh so and so's birthday' or 'oh we've got a barbeque here and there' and I was like 'nah I'm not going'. And you know, I would explain to her why but it was like 'oh you gotta get over it'. And the more she said that, the harder it got (P3).

Accumulated stressors within the whānau were discussed by some participants as contributing to treatment-seeking barriers. One participant expressed how their whānau did not want them to reach out for help for difficulties unrelated to social anxiety, which meant social anxiety went unrecognised: "It was my family ... they stopped me from reaching out" (P9). Another participant described how personal difficulties faced by individual members staying with them intermittently got in the way of seeking treatment for social anxiety. They described this as a barrier to treatment-seeking: "Stuff at home, really. Like family coming through and bringing their problems with them ... Yeah. Family stressors can all build up and just lose the plot" (P6). This participant also described feeling that it was hard for whānau to converse with them at social gatherings. They expressed their experience of this and their coping strategy of alcohol consumption:

And they kind of don't talk to you either. Or they talk to you for a little bit but then, yeah, they move on. That's the trouble I had ... That's

probably why I talk to the bottle. Just to help me through those moments with whānau (P6).

One participant explained how they had expected whānau to take more of an active role in the kōrero around their difficulties and their whakapapa. For them, this was related to a desire to gain a deeper understanding of their cultural heritage and they described this as a cultural treatment barrier:

So, the more I keep searching and searching and trying to get to my roots and all that ... it just left me a dead end. So that's why I don't really open-up much to family because ... I don't know, I don't who to trust or who should be the one giving me the advice or the information that I'm after. It's pretty much how it is now. Come to (Psychologist's name) and offload everything that I'm thinking, feeling, saying. Where I thought, you know, my parents should be the ones, or family members (P3).

Summary

Te hiranga o te whānau was expressed by participants in a variety of ways. For some, whānau took a supportive role through offering practical assistance in getting to appointments and showing their aroha by phoning or offering childcare. The tautoko from whānau was expressed as a willingness to increase their understanding of social anxiety and for some this resulted in a sense that whānau were then able to better support them in managing the symptoms. Engaging through kōrero whether direct or indirect was also highlighted by participants as a source of support. Some participants described how less whānau support presented obstacles to treatment-seeking. Some participants described experiences of not feeling heard and perceiving a reluctance from their whānau to engage with them in general and sometimes pertaining to matters of

whakapapa and identity. Therefore, whether supportive or detrimental it was evident that whānau played a significant role in participants experiences of social anxiety and treatment-seeking. Moreover, from the perspective of the whaiora, whānau support either was or would have been valued in the context of their experience of social anxiety.

Theme 2: The Experience of Social Anxiety

The theme of the experience of social anxiety focuses on how participants described their understanding of their symptoms of social anxiety through their lived experience. The theme concerns participants descriptions of different areas that social anxiety impacts. Two subthemes were identified: social engagement difficulties and te taha tinana. When asked about te reo Māori alternatives for the term social anxiety, none of the participants responded that they did not know any, and expressed their understanding through their symptomatic experience.

Social Engagement Difficulties

This subtheme concerns the obstacles that social engagement presented for many of the participants, a number of whom articulated their experience of social anxiety symptoms as difficulty with engagement during social interactions. Some participants described this as “embarrassing”. Many expressed their understanding of social anxiety as difficulties initiating or carrying out conversations. For example: “Talking to someone” [is hard] (P4), “yeah that one’s a big one for me, feeling embarrassed to talk to someone” (P1), and “it’s affected me bad ... I couldn’t talk to people. I couldn’t talk to a normal conversation” (P9). Some of the participants expressed feeling inferior to others and this impeded social interactions. As highlighted by the following comment: “like I might say the wrong thing or like I think it’s like feelings of inferiority” (P11).

A number of the participants described utilising strategies to help them cope and avoid engaging during social interactions. For example: “Yeah, I get it heavy, not talking to people but I just put my headphones on” (P1), “usually I don’t say much” (P7), and “yeah socialising, that’s a hard one. I actually keep to myself” (P2). One participant described previous substance use coping strategies and their now most effective strategy of actively engaging in communication:

With help from family support and social workers like (mental health clinician’s name) I have found a coping mechanism to cope with what’s going on. So, I used to indulge in things so I could try and stay well. I went from marijuana, alcohol, cigarettes. But I don’t do all that anymore. So just the anxieties. Communication is the one that’s working for me now (P2).

Some participants indicated a tendency to avoid engaging in kōrero had created challenges in attracting and maintaining meaningful relationships. One participant expressed how their desire to make friends was overshadowed by uncertainty of how to approach someone unless they deemed it a reciprocal interaction. As they described below:

Like I only engage with them if they show interest in me. So, if they don’t show any interest in me I won’t and that’s what makes it hard ...
It’s like I don’t know what to say or how to say it. Even if I am wanting to be friends with them (P11).

Another participant described how not speaking to people in public presented an obstacle to making friends:

If I'd opened-up then I would have made a hell of a lot of friends but I never. I just held it in there and just didn't say nothing. So yeah, that's another one of social anxiety is not talking to people ... in public, I don't normally talk to anyone in public (P1).

Some of the participants expressed difficulties engaging when treatment-seeking and during therapy (e.g., talking to a clinician). One participant described how they would "hold back" due to feelings of "shyness". They expressed being able to openly kōrero with some people but found kōrero with other people more difficult: "here [CMHC office] I can and certain people I can [talk to], but not everyone. I just go mute and that's it" (P3). Another participant described how anticipating the social interaction of a therapy appointment caused anxiety: "sometimes I'd ring in say I'm sick, only coz my anxiety was too bad. Knowing I've got an appointment freaks me out" (P6).

Te Taha Tinana

The subtheme of te taha tinana concerns participants understanding of the symptoms of social anxiety as in part relating to physical sensations. A number of participants described their experience of social anxiety as linked to physical sensations that occurred in anticipation and during social interactions. Physical sensations such as increased heart rate are common symptoms of social anxiety and participants' descriptions echoed this. For example: "... my heart starts racing" (P2). Some participants described coping strategies to help them manage physical symptoms of social anxiety. For example: "I just can't stop fidgeting. I kind of like, wherever I am I'll withdraw, like immediately" (P5). Another participant expressed how their coping strategy created the feeling of safety:

Nervousness, that kicks in and then once I'm hot, flustered, nervous, I sit in a position and don't move until it's passed ... Yeah, I just, I don't

know maybe that's my comfort zone or my safety zone of just sitting the way I sit, to let that feeling go (P3).

Some participants expressed how the physical experiences of social anxiety affected their social activities. One participant described how the physical symptoms of social anxiety would build up and eventuate in them not attending social functions: "I get all hot and flustered and then, yeah I've just built myself up that much that 'oh I'm not going to go anymore'" (P3). Another participant described their experience of social anxiety as being predominantly linked to physical sensations that occur in everyday social interactions, as described below:

Mainly physical. Breathless, irrational heartbeat, and sometimes stutter, I stutter when I speak ... Sometimes when, in the supermarket and I have to approach the checkout person and when people talk to me, that's when the physical [symptoms start] ... sometimes when I have to go to a family gathering it happens as well (P7).

The same participant elaborated on what this was like for them: "oh, it's horrible coz people think you're stupid and you're dumb and yeah. You know, I'm not stupid or dumb but it just comes out the wrong way what I say and yeah" (P7). A number of the participants indicated they became better able to manage their physical symptoms through treatment. For example, one participant described how this was aided by putting into practice the techniques discussed in session:

When I first started the treatment, I was just trying to keep it together. My heart was racing, flustered, sweating, I wouldn't really talk. But after talking to (psychologist's name) for a while, yeah slowly I opened-up and then started putting everything she said into place (P6).

Some of the participants indicated experiencing physical sensations of social anxiety occurred alongside thoughts associated with what people might think of them. For some, this meant hypervigilance in social situations. As one participant described: “you’re always looking around wondering what people are thinking ... I know they’re probably not thinking that but your thoughts and body takes over and controls your whole thinking” (P7). Another participant described concern over how their social anxiety would affect them during an upcoming social interaction: “am I gonna get nervous? Am I gonna get scared? How am I gonna talk?” (P3). Some participants described embarrassment or worry about what a clinician would think of them. For example, “just like ‘oh I hope she don’t think, like I wonder if thinks I’m like really messed up” (P11) and “sometimes I just come out with you know, wrong, if someone asks me a question sometimes it’s wrong what I answer back. Coz my brain just goes overload” (P7).

Summary

Participants expressed their understanding of the symptoms of social anxiety through their experiences. Many described difficulties engaging during social interactions and this caused some embarrassment. For some, this led to the adaptation of strategies to avoid any social interaction and others described how difficulties with engagement had impaired establishing valued relationships. The process of engaging in therapy was also highlighted as difficult within participants’ experience of social anxiety. Many of the participants emphasised their experience of social anxiety as a physical one. They articulated a range of bodily sensations and described that the intensity of these could present as hurdles to engaging with others. Some participants indicated thoughts related to being judged occurred alongside the physical sensations. The reduction of physical sensations associated with social anxiety through treatment was also highlighted within this theme.

Theme 3: Unrecognised Social Anxiety and Treatment-Seeking

Encompassed within this theme are participants' experiences of social anxiety as an unrecognised difficulty and the barriers this posed to treatment-seeking. One participant described the 'hidden' nature of social anxiety: "you wouldn't be able to tell the difference between someone that goes through it and someone who doesn't" (P5). Akin to the existing literature (e.g., Stein & Kean, 2000), a number of participants highlighted they did not initially seek treatment for social anxiety, rather a comorbid difficulty. For example, one participant explained how symptoms of panic caused them to seek help which led to social anxiety being recognised by their health provider:

"coz I started having panic attacks ... and I was trying to figure out why, what it was, and why it happened. I saw my doctor and he kind of asked me a few questions and kind of put two and two together."
(P5).

Some participants described how comorbid difficulties contributed to initial treatment barriers but once treatment was sought they saw improvements. One participant described this below:

"I didn't want to talk about my past ... that's when I came to my senses and said oh yes I am unwell so I need help so that's why I came out with the past with the psychologists and it ... slowly got better"
(P9).

For many, treatment-seeking was further complicated by limited understanding of social anxiety prior to accessing treatment. As one participant explained: "I didn't know how to feel at first because I still didn't know what it was exactly. Like what part of me qualified for that kind of diagnosis" (P5). Another participant described how not

knowing they had social anxiety was coupled with not knowing treatment for social anxiety was an option: “yeah, I just thought I was like awkward or I didn’t realise it was that and I didn’t realise that there was help for that” (P11). This participant also elaborated on not knowing what social anxiety was until they were receiving treatment for another difficulty, a common factor among a number of participants: “Well I never really knew that it was social anxiety until I talked to my psychologist because I just thought that I was shy” (P11). Another participant described their experience below:

It was the psychiatrist that told I had anxieties. I was none the wiser. Now that I’m six, seven months down the track I understand it because I know now that I am on that trail, was on that trail of anxieties, it’s what I never knew then. They diagnosed it and they found it and at the end of the day it worked out for me because it benefitted my inner self, my self-being. I could feel the improvement (P2).

Similarly, some participants spoke about normalising or over-pathologising their experience of social anxiety before receiving treatment and learning more about it. One participant summarised this and how learning they had social anxiety made sense to them:

I didn’t know I had it so I thought I was just weird basically. I thought I was just weird and that it was normal. But I had to struggle with it most of my life and it was quite draining ... It made sense when they diagnosed it coz I thought I was a paranoid or something like that (P7).

For many people, social anxiety goes unrecognised and untreated (Wittchen et al., 1999) and some of the participants discussed this. One participant expressed how social anxiety

may be masked by other difficulties and therefore not recognised by themselves or their healthcare providers:

Some will never get diagnosed with it yet they'll have it. You gotta know, you gotta know what you're looking for when you have anxiety. Cos, it could be a combination of many things and you can't even see it (P2).

Other participants had sought and received treatment for comorbid difficulties before social anxiety was recognised by their clinicians. One participant summarised their experience of this process below:

Well even the doctors themselves were trying to figure it out. The medication wasn't working. Plus, I had a hard time taking the meds coz they always made me drowsy. And then it wasn't until my keyworker, he picked it up that I had social anxieties, yeah, severe (P6).

Summary

In summary, social anxiety was described by a number of participants as being unrecognised for some time. Their accounts suggested that many initially sought treatment for a comorbid difficulty and through treatment their social anxiety was identified and addressed. Some participants expressed a limited understanding of what social anxiety was prior to treatment and thus a tendency to normalise or attribute their experienced symptoms to another difficulty. Overall, it appears participants' experiences of unrecognised social anxiety presented a barrier to treatment-seeking.

Theme 4: Past Experiences as Barriers

Incorporated within this theme are participants' prior experiences of treatment-seeking within the mental health sector. In particular, it concerns how these experiences with people in general and in services contributed toward barriers to future help seeking for social anxiety. Two subthemes were identified and are discussed below: social attitudes and the importance of connection.

Social Attitudes

A number of participants described how discriminatory social attitudes had been embedded in their experience of social anxiety and treatment-seeking. This subtheme presents their experiences. Some of the participants described stigma around mental illness as contributing to their experience of social anxiety and desire to withdraw from social interactions. As one participant said: "everyone might kind of look at me and think I'm weird and there's a whole kinda stigma about being mentally ill and stuff" (P5). Some participants expressed how stigma surrounding mental health added to treatment barriers of embarrassment about reaching out for help. As one participant described: "being too embarrassed to talk to someone. Yeah, coz probably mainly because having a stigma on depression and anxiety" (P8).

Some participants expressed a sense of discrimination against Māori and mental illness that contributed to cultural treatment barriers. For example: "there's a big discrimination out there against Māori and other mental patients" (P10). Another participant described an attitude of thinking treatment would not work as a barrier. They expressed this as a hesitancy to seek help and suggested other Māori might also experience this: "probably what most Māoris' think, 'it won't work, why should I go? I'm not listening to someone else, you know, tell me what to do'" (P7).

Some of the participants expressed feeling judged by others because they were Māori. As one participant described, this had a negative impact on their sense of self, which in turn, decreased desire to seek help: “being Māori I just felt useless. Which made it worse for my self-esteem. I always thought people were thinking oh look at that Māori, ugh” (P6). Another participant described their experience of feeling judged within their experience of social anxiety and treatment-seeking because they were Māori:

I’m not too sure with the cultural thing but being a Māori, it makes it harder because I guess you get judged anyway sometimes in being a Māori. And when you have social anxiety you can act a bit strange and people think you take drugs. But I don’t take drugs (P7).

Some participants reported pride as a barrier to initially reaching out to support services. One participant described pride as less of a cultural barrier and more in line with Māori not wanting to be ‘put down’. They expressed doubt that treatment-seeking will ever be an easy process for Māori:

Break the ice, yeah. But a lot of Māoris won’t do that ... I dunno, it’s just pride I guess. It’s not cultural thing ... Yeah and a lot of Māoris don’t like people talking about them and get put down ... I don’t think it will ever be easier for Māori to be honest, yeah. Coz unless, I dunno, just do it for themselves and don’t worry about everybody else (P7).

Having gone through the treatment process, another participant encouraged others’ who encounter pride as a barrier to reach out to a support service for help. They expressed the following:

Some people just gotta learn to swallow their pride. They just have this brick wall. So, in those terms, in those cases I just say let it out. Cos,

you can get help at the Citizens Advice Bureau for counselling so there's a lot of places to get help. And people just think nah they don't need that crap or some people think they're too good, too cool, to do it. So, in that case I just say swallow your pride a bit (P1).

The Importance of Connection

This subtheme concerns the importance of connection during the process of seeking a service team that provides a supportive therapeutic relationship. Many of the participants spoke about barriers they had previously occurred within the therapeutic relationship once contact with a service had been made, for example: "like having a psychologist you don't feel comfortable with" (P7). Some participants indicated how after having made initial contact with a team, not knowing anyone within the service contributed to anxiety and a feeling that they could not be helped. One participant expressed the following: "made me feel anxious ... Because I didn't know anyone" (P4). Conversely, another participant shared how their anxiety eased after approaching a service and being greeted by someone they were familiar with:

Yeah, I was a bit anxious at first and I was sort of working myself up but then when I got there and I saw the lady, I had a lady there that already knew me so I felt safe (P8).

Some participants spoke about how they had started to receive treatment but felt that the clinicians they were working with at the time were not the right fit for them due to their approach to the initial sessions. Two participants' descriptions of this are below:

It was at this other place, I started doing psychology and like, I met with the psychologist a couple of times. It was okay but the stuff that

we were talking about was quite deep and I didn't feel comfortable sharing those things with her at the time so I stopped (P11).

... I had a few psychiatrists before I came here that like, I felt like I was, I was being laughed at ... and it felt to me like I was, he was telling me like I should just get over it kind of thing (P5).

Many of the participants highlighted the importance of having the right people involved in their care. They expressed qualities such as “supportive”, “not pushy”, and highlighted engagement through kōrero as a valued in their health care providers. One participant expressed how when a doctor they had worked with in the past was less forthcoming with engaging them in conversation, their anxiety increased and contributed alcohol consumption:

My first doctor, he was cool. He you know, talked all the time actually. But my last one, he didn't really talk, so he kind of made me anxious. I would talk to him when he just asked the questions. And at the end of it, what was the point? ... ‘Oh you're doing good’ – none of that. Just turns to the keyworker and says ‘what's this guy still doing here’? That made me relapse, ended up drinking hard that day (P6).

For some participants, finding a service team that was the right fit for them took some time. As one participant explained, they had seen other mental health clinicians in the past and found that repeatedly sharing their history to different people halted a desire to converse:

Well, my support worker, I had so many before him. Explaining the same story over and over. In the end I just kind of closed up. But my

current one, oh yeah, he's good. And my peer worker came along, he was really good too, coz you know he's been through it (P6).

Many of the participants echoed the above statement of satisfaction with their current CMHC mental health clinicians and described how supported they felt within their current team. Their comments indicated therapeutic relationships of connection and support, for example: "I always feel that these guys are there for me" (P1) and "I love it, yeah, it's so supportive. I've actually got a really good team and I'm grateful for being here actually, yeah" (P7). Some participants described finding a service that felt right for them had a positive impact on overcoming social anxiety and other difficulties. As one participant described: "this place has been really awesome and I've come a long way from when I started" (P8). Another participant reported an appreciation for the mental health system in general in regards to their social anxiety: "I like the system for my social anxiety. I got no problems with that" (P9).

Summary

Participants descriptions suggest that previous experiences both in and outside of treatment contributed to treatment barriers. Some described social attitudes of discrimination towards Māori and mental health consumers which contributed to an initial reluctance to seek help. For some, pride contributed to a hesitancy to seek help within the mental health system and, as articulated by one participant, in line with Māori not wanting to be put down. The importance of connection within the therapeutic relationship was highlighted by participants' descriptions of their past experiences as whaiora. Some expressed previously having seen a clinician they did not feel was the right fit for reasons including lack of engagement. Conversely, many of the participants highlighted the importance of connection through the supportive nature of their current CMHC and described this having a positive impact on their treatment for social anxiety.

Theme 5: Cultural Disconnection and Engagement

Incorporated within this theme are participants' descriptions of how cultural disconnection contributed to treatment barriers and cultural engagement helped to reduce social anxiety and aid treatment engagement. Two subthemes were identified: disconnection and Māoritanga⁷⁶. These are discussed below.

Disconnection

This subtheme concerns some of the participants reported disconnection from Māori culture when asked about cultural barriers to treatment-seeking. As one participant expressed, cultural treatment-seeking barriers occurred from a loss of cultural identity: "Only because I had lost my identity as a Māori woman" (P3). Some participants described how a disconnection from their Māori identity was in part due to being less familiar with aspects of te ao Māori. As two participants described: "I don't really go on my Māori side coz I don't know much about it" (P7) and "I don't know Māori ... coz Dad and them didn't speak Māori, they spoke English and they didn't teach us Māori" (P9). Another participant described their experience below:

I suppose being a Māori woman now, I still don't know how to be Māori ... And the beliefs and stuff like that wasn't, I don't know how to explain it. But I'm still learning it ... (P3).

One participant expressed a dislike for marae tikanga⁷⁷: "going through all the protocol, kind of freaked me out ... I just don't like the protocols ... The marae stuff and that" (P6). Another participant expressed treatment barriers as less related to culture, rather, related to childhood experiences and environment: "More like home upbringing more than cultural. The environment that you live in at home when you're a child ...

⁷⁶ Māori culture, Māori practices and beliefs, Māoriness

⁷⁷ Marae custom

Sometimes it's a lot of bad ways and abuse and things like that, neglection" (P7). Another participant expressed having knowledge that kaupapa Māori services were available. However, due to a disconnection with their taha Māori they reported a hesitancy to further describe potential cultural barriers they were less familiar with. They described this below:

But I have seen that there are, specifically for Māori they've got like kind of wellness, wellness groups and stuff like that and it's kind of Māori, Māori themed and, and takes in some of that spiritually stuff, which I've seen. And I quite admire, like that's cool. I'm not really kind of in touch with my Māori side. That's probably as far as I kind of can go when I think about that (P5).

Māoritanga

For many of the participants connecting to their Māori identity was beneficial to their experiences of social anxiety and treatment and this subtheme concerns their descriptions around this. Some participants indicated that the atmosphere of Māori services helped their recovery and barriers of treatment engagement. One participant described enjoying the whānau environment of a kaupapa Māori service and how Māori services explore aspects of te ao Māori that may not be addressed elsewhere:

It's a cultural base thing. At the same time ... It's got a whānau feeling, the cultural base. At the same time, they look at areas in the mental health system that Pākehā's would never even look at or go there. You know ... Whanaungatanga (P2).

Another participant reported that having a background in te ao Māori provided a supportive foundation for them when engaging with non-Māori services. They described

the following: “It’s different coming from a Māori view to a non-Māori thing. It’s a big difference. Like you have your spiritual sort of thing going on” (P8). Another participant described how being around Māori elders within their CMHC made them feel more comfortable in relation to social anxiety communication barriers:

So, in those terms with me meeting older people round here and that, the slang of talking to each other was alright. So that social anxiety with these people here disappeared more or less. It’s still there but nothing like before (P1).

For many of the participants, connecting with their culture resulted in a strengthening of identity and pride in being Māori. One participant described how engaging in Māori services helped to build their confidence to situate themselves within te ao Māori:

And I think helping, coming here and Māori services it’s helped me be more familiar with my culture and say ‘well yes, I am Māori’ and yeah, helps give me strength I guess ... yeah it gives you confidence and like confidence in who you are ... Just including myself as one in a bigger picture. Yeah, like so I’m not just me by myself. I have a family, I have, connects me to my, I have friends, I have a hapū, iwi, yeah (P11).

Some participants spoke about how engaging in activities such as karakia and waiata strengthened their cultural identity and pride. As one participant summarised: “it made me proud of my heritage ... And I’m proud that I’m a Māori” (P9). Some participants expressed how connecting with culture through waiata helped them to overcome symptoms of social anxiety and reduce treatment barriers. One participant summarised how attending waiata classes helped them to feel more relaxed: “It makes me forget

about things and I just zone in on listening to everybody. Coz we're a pretty good group. I dunno, there's something about it that just makes me relaxed" (P8). They also described how attending waiata classes helped them to feel more comfortable and facilitate social connections:

How I actually got over a lot of anxieties was coming to the waiata ... because I didn't want to go anywhere but when I used to come to waiata classes I started getting a bit more at ease around people ... Coz I love music and I've made some good friends over it (P8).

Another participant described how waiata and karakia through group programmes run through support services or churches have helped them to overcome social anxiety and encouraged a desire to connect with others. They described the following:

Well it makes me, for one thing it makes me have a good personality and another thing it helps me with my tinana, my body reactions, and not violent anymore. It's made me reach out to people and to want to help people like me. I want to, now that I'm well (P9).

One participant described how music in general has been helpful for them:

Music's very helpful and I guess how do you say it relaxes your mind and takes away. I can't explain it, it's so hard to explain all the physical emotion, yeah so that helps before you go somewhere or have to go somewhere. Or it helps for me anyway (P7).

A number of the participants expressed how attending church had been helpful for them in increasing their sociability and overcoming treatment barriers. For example, "just going to church and finding my faith in God" (P11) and "well it makes me have good

feelings about myself and it makes me want to associate with people more” (P9).

Another participant expressed a desire to join a church to help them overcome social anxiety and feel more comfortable around others. They described the following:

I need to join a church ... So, I really want to change the people that I'm mingling with. Yeah positive, just to get round that environment and that should help to get me more comfortable. Hopefully it will (P1).

Based on their experiences, one participant expressed a recommendation for Māori with social anxiety to attend church and explore their connection with te ao Māori. They expressed the following when asked about what Māori with social anxiety could do to reduce treatment barriers: “Probably, their like belief systems, their belief systems and their connection with their culture. Just like finding the strength” (P11).

Summary

Cultural disconnection and being less familiar with aspects of te ao Māori was expressed by some participants as a cultural barrier to treatment. For some, this contributed to a sense of a loss of cultural identity. Many of the participants described how engaging in Māori services or cultural activities facilitated a strengthening of their understanding of te ao Māori and cultural identity. Some expressed how cultural activities such as waiata also served to improve symptoms of social anxiety. Spirituality was also emphasised as a means to strengthen identity and improve social anxiety.

Theme 6: Increasing Awareness of Social Anxiety to Reduce Barriers

This theme concerns recognition of social anxiety to support treatment-seeking. It incorporates participants' comments around a need for more information and acknowledgement of social anxiety to allow individuals to recognise the symptoms and

increase treatment-seeking. Two subthemes were identified: reach out for help, you are not alone and additional support in the community.

Reach Out for Help, You Are Not Alone

Part of the initial treatment-seeking process involves the individual acknowledging that help is needed and reaching out for support. This subtheme concerns taking this initial step through increasing recognition and understanding that support is available. A number of the participants reported that their reasons for taking part in the research was to awhi⁷⁸ other Māori with social anxiety who may be at an earlier stage of the treatment-seeking process. As one participant expressed: “so that it can get around ... and that’s why I’m here. Maybe it will benefit a thousand people” (P2). Some of the participants spoke about advice they would give to Māori with social anxiety thinking about treatment is to acknowledge when help is needed. As one participant described: “... the biggest thing is can you acknowledge that you can see the problem” (P2). Some participants empathised that seeking help can be a difficult process, for example: “It’s just hard. To ask for help, to get the help, to want to get the help.” (P6). However, a common factor among participants was that treatment was helpful after the initial treatment-seeking process. Two participants expressed how important it is to reach out for help and talk to someone:

“Therapy helps ... Only thing is to talk about it. No one’s gonna help you if you don’t talk about it. It’s basically to talk about it and reach out to places like the clinics ... don’t’ worry about what everyone else is saying about you coz it really does work if you get help” (P7).

⁷⁸ to embrace, support

I know it, it's harder than it sounds but like you have to tell someone.

You have to tell someone. I don't think I can explain how, how tough it is to actually do that but I just know in the, in the long run its worth it (P5).

Some participants indicated how finding out that other people suffered from social anxiety was helpful in their treatment journey. One participant described how finding out that other people had similar difficulties had reduced an 'outsider' feeling. They described the following: "because there was other people like me. I didn't know there was other people like me and I found out that I'm not the only one" (P9). Some participants provided suggestions for those seeking treatment. As one participant recommended: "number one is stick to all, you know, all the help you're given and all the programmes. Yeah that's the main point I guess, is to stick to it and help yourself as well" (P7). A number of the participants spoke about a desire to support others in the initial treatment-seeking phase by letting them know they are not alone in experiencing social anxiety. As one participant summarised below:

I'd just like people to know that, that like you're not the only one kind of thing. Like I've got a story to tell now so, you know I'm happy to share, to share with people who are going through the same thing. And there's other people like that who have a story to tell and that like you're never alone, kind of thing (P5).

Additional Support is Needed

This subtheme focuses on participants' call for greater support options for social anxiety. While a number of the participants described receiving treatment and support for social anxiety within their CMHC, many of the participants expressed a desire for additional support to be available in the wider community. Some participants emphasised how

having more information in the community about social anxiety would make understanding symptoms and the treatment-seeking process easier. As one participant said: “I reckon that kind of having some kind of education in this kind of field beforehand would, would be able to kind of help, I think” (P5). They elaborated on how this might benefit those with social anxiety and their whānau below:

It would just be nice to know that like say if there was another, another person with their family who doesn't quite know what to do that they already knew what to do beforehand coz they had already learnt about it (P5).

Some of the participants had ideas about how information about social anxiety could be disseminated within the community. One participant suggested advertising through newspapers: “because I look in the newspaper and you know I look at what's available out in the community, whether there is anything there for me” (P3). Another participant suggested online avenues for publicising social anxiety and treatment paths: “... advertising would be great ... [on] social media ... Maybe a website and then number to call” (P11). This participant elaborated on how information about social anxiety disseminated at an earlier age through the high school system would have benefitted them and could benefit others in the future:

I reckon just information at the schools and coz I don't think, like I didn't know that I had social anxiety so I think a lot of people might not know that - social anxiety. Maybe if they taught about it at school, like coz they have health and yeah, maybe they need to learn things at school (P11).

Some of the participants described how programmes or group support for social anxiety would be beneficial for them: “Programmes. If we had programmes that could help us in that area like how to deal with social anxiety, life would be more easier” (P10).

Another participant elaborated on the idea of group support below:

If I was in, if there was a group thing that was going for people that has social anxieties I'd like to go that class or group. So, I can have someone for myself or a group of people that understand where I'm coming from and where they're coming from. So, we can get skills together to manage that (P3).

Summary

Participants expressed a need for greater recognition of social anxiety among individuals suffering from it and within information available in the community. Some expressed this through encouraging others experiencing social anxiety to know that support is available and emphasis was placed on how treatment can help. A number of participants made suggestions about how information on social anxiety could be distributed within the community including group programmes, online, and newspapers. Overall, a sense of awahi was communicated by a number of the participants through their reasons for taking part and desire to let other Māori with social anxiety know they are not alone.

Questionnaire Findings

The questionnaire administered was based on existing literature and discussion around the barriers were encouraged. The 15 barriers were grouped into the dimensions established from the literature. The means and standard deviations were calculated for each barrier as well as each barrier dimension. As reported in Table 2, participants rated the highest level of agreement with the barrier dimensions of psychological symptoms

(M= 3.67, SD= 1.36) and social attitudes (M= 3.52, SD= 1.75), and the least level of agreement with the services dimension (M= 2.03, SD= 2.03). The highest level of agreement for an individual barrier was around worry about what people would think (M= 4.45, SD= 1.29) within the dimension of social attitudes. When asked about further about this, a number of the participants replied that this applied to “everyone” (i.e., whānau, friends, clinicians). The individual barrier of not being able to get through on the telephone within the dimension of services was least agreed with in the ratings by participants (M= 1.73, SD= 1.01). Six participants indicated additional barriers to those listed in the questionnaire. These were mingling, prefer Māori clinician, shyness/talking, transport, [concern that] treatment wouldn’t work, and crowds.

Table 2

Descriptive Statistics for the Eleven Participants' Questionnaire Ratings

Barriers to treatment	<i>M</i>	<i>SD</i>
Cost	2.64	1.50
Concern about the cost of getting help	2.56	1.13
Health insurance won't cover cost	2.73	1.85
Loss of pay	3.00	1.84
Worry about losing pay	3.00	1.84
Access	2.58	1.54
Not knowing where to go to get help	2.91	1.81
Unable to go to appointments during office hours	2.45	1.57
Time taken to get to clinician's office too great	2.36	1.29
Services	2.03	1.49
Waiting time for an appointment too long	2.27	1.56
Not being able to get through on the telephone	1.73	1.01
Unable to get childcare	2.09	1.87
Social attitudes	3.52	1.75
Thinking you can't be helped	2.64	1.75
Worry about what other people would think	4.45	1.29
Being too embarrassed to talk to someone	3.45	1.81
Psychological symptoms	3.67	1.36
Worry that symptoms would cause embarrassment	3.64	1.50
Concern you would be too anxious to attend	4.00	1.83
Fear of how the clinician would perceive you	3.36	1.43

Chapter Summary

This chapter presented the findings of the current research. Six themes were identified through thematic analysis: *te hiranga o te whānau*, the experience of social anxiety, unrecognised social anxiety and treatment-seeking, past experiences as barriers, cultural disconnection and engagement, and increasing awareness of social anxiety to reduce barriers. Overall, participants unique experiences of social anxiety and treatment-seeking highlighted their understanding of social anxiety and its treatment barriers. Furthermore, the participants suggested a number of practical ways to reduce treatment

barriers and improve access for Māori seeking care. The questionnaire findings showed that social attitudes and psychological symptoms of social anxiety were the highest endorsed treatment barriers. The findings and their implications will be discussed in more detail in the following chapter.

CHAPTER 8: DISCUSSION

Chapter Outline

This chapter presents the key findings of the current research which explored Māori experiences of social anxiety and treatment barriers. A summary of the key findings will be discussed across the three research questions and links to the literature will be made. The clinical implications of the current research for Māori development will be discussed. Limitations of the current study will be identified as a basis for recommendations of future research directions and researcher. Following this, researcher reflections are made and final conclusions are discussed.

Summary of Key Findings

The broader aim of the research was to explore how Māori with social anxiety understand treatment barriers in order to identify approaches to help whaiora overcome obstacles and encourage treatment-seeking. The research also explored how Māori understand social anxiety from their lived experience. Eleven semi-structured interviews were carried out with whaiora who had experienced social anxiety. Participants were asked about their experiences of social anxiety, treatment barriers, and their recommendations for how treatment barriers could be reduced. A questionnaire rating scale was used with common barriers identified in the literature and participant responses were discussed during the interviews. Thematic analysis of the interview transcripts was carried out. Participants understanding of social anxiety and its treatment barriers were captured across a range of the themes and the questionnaire.

Social anxiety presents with a number of significant difficulties and treatment barriers for those who experience it. While social anxiety has been found to be one of the more prevalent anxiety difficulties among Māori there is no known literature that explores Māori experiences of social anxiety and treatment-seeking. Thus, the exploratory nature of the current research is important to note. Through the experiences of the whaiora involved in this study, the findings highlighted their understanding of social anxiety and treatment barriers. While findings cannot be generalised beyond the participants' unique experiences, the findings from the current study provide insight into Māori perspectives of social anxiety and treatment-seeking. In line with the research questions, participants' understanding of social anxiety symptoms, treatment barriers, and their recommendations for reducing treatment barriers are discussed in turn below.

How do Māori Experiencing Symptoms of Social Anxiety Understand their Symptoms?

Participants understood their social anxiety symptoms as complex and relating to numerous factors. Social anxiety was experienced as multidimensional, affecting participants socially, physically, psychologically, and culturally. Participants conceptualised social engagement difficulties associated with social anxiety as trouble initiating and carrying out conversations. For some, this prompted avoidance and impacted on their ability to develop meaningful relationships. This is in line with the literature on the associated social engagement difficulties of social anxiety (McNeil & Randall, 2014). Participants' descriptions of physical symptoms and co-occurring cognitions associated with fear of evaluation were also in line with the current literature on social anxiety (Stein & Stein, 2008) and highlight the link between te taha hinengaro and te taha tinana.

Interwoven within their experiences of social anxiety and social avoidance, some participants described experiencing stigma and discrimination which was not only perceived in relation to mental illness but also in relation to their Māori identity. Social avoidance associated with social anxiety was understood in part as being linked to multi-level experiences of discrimination. This corroborates previous research that has highlighted discrimination and its impact on social interaction for Māori suffering from mental illness (Peterson et al., 2004).

Many of the participants were not aware what social anxiety was prior to receiving treatment. Some described previously understanding their symptoms as “just shy” or “weird” and through intervention their understanding grew to how they conceptualise social anxiety today. This is consistent with past research that has suggested clients may not recognise their problems as psychological (Mojtabai, Olfson, & Mechanic, 2002). Comorbid difficulties ‘masking’ the symptoms prior to intervention could have contributed to this finding. Nevertheless, learning about social anxiety through intervention validated their experiences and aided the treatment process for a number of the participants.

Whanaungatanga, or whānau working to support each other, is an important element that can contribute to whānau wellbeing (Lawson-Te Aho, 2003). Whānau contact is a social interaction in itself and whānau support was understood by some of the participants as assisting in the management of social anxiety symptoms. Some described how whānau understanding of social anxiety symptoms grew through exposure and information about how best to support them. This highlights the collective nature of whānau, with each member central to wellbeing and is similar to past research by Peterson et al. (2004), where whānau understanding of individual mental illness also increased through exposure and information.

Consistent with a Māori perspective of health, strengthening spiritual and cultural engagement was understood by participants, in part, as a pathway to improving social anxiety symptoms. Some indicated engagement with Māori services facilitated by karakia and waiata assisted in facilitating social connections, reducing physical symptoms, and improving communication skills. Some highlighted extending their spiritual connection through participating in church to increase their desire to interact with others. Participants understood tikanga as pathways to heal and express their sense of connection within the often isolating experience of social anxiety.

How do Māori with Social Anxiety Understand Treatment Barriers that they have Experienced or Anticipate Experiencing?

Participants encountered various psychosocial and cultural obstacles that interfered with seeking treatment. Treatment barriers included unrecognised social anxiety, social attitudes, previous therapeutic relationship disruptions, cultural disconnection, and limited whānau support. Findings from the questionnaire further highlighted social attitudes in addition to psychological symptoms as prominent treatment barriers. Overall, the majority of participants reported more than one treatment barrier, highlighting the complexity of the treatment-seeking process for whaiora.

As described above, a number of participants did not know what social anxiety was prior to intervention. This lack of knowledge contributed to delays in treatment-seeking as participants did not recognise symptoms as psychological or know that treatment was available for social anxiety. This finding aligns with literature suggesting that perceived need plays a role in the treatment-seeking process (Mojtabai et al., 2002). Also in line with the literature (Stein & Kean, 2000), many participants initially sought treatment for a comorbid difficulty. More concerning is the finding that some of the participants experienced social anxiety that at some point had gone unrecognised by the clinicians

they had been working with. This is consistent with literature where social anxiety has been noted as an undertreated and unrecognised difficulty (Pallanti et al., 2004; Wittchen et al., 1999).

Stigma and discrimination can be significant treatment-seeking barriers for Māori (Te Pou o Te Whakaaro Nui, 2010). Key findings from the current study indicate participants experienced such social attitudes as contributing to a reluctance to seek help and described concern about what whānau, friends, and clinicians would think. A number of participants also described barriers arising from past therapeutic relationships in which they felt unheard and uncomfortable. This highlights the enduring nature of treatment barriers for our whaiora and the importance of whanaungatanga in all stages of the treatment process.

Some participants discussed pride as a barrier to treatment-seeking. In general, participants described this as less in line with 'cultural barriers' and more in line not wanting to be viewed stereotypically. This is partially supported by previous research where whakamā was found to contribute to cultural pride as a treatment barrier; however, given none of the participants explicitly discussed whakamā, its connection to pride for whaiora in the current study is less clear. Some participants expressed disconnect from their cultural identity as contributing to treatment-seeking barriers through being less familiar with te ao Māori. This finding suggests the whaiora placed importance on having a secure cultural identity as a foundation to support treatment processes. Some participants expressed hesitancy in describing cultural barriers when they were less familiar with te ao Māori.

A number of participants felt unheard by their whānau when describing their social anxiety or treatment-seeking desires and a stoic 'harden up' approach was described by

some as an obstacle to treatment-seeking. These findings highlight the important role that whānau play in Māori health and wellbeing while emphasising the complexity of whānau relationships. Accumulated stressors were noted by some participants as contributing factors of receiving less whānau support in their experiences of social anxiety and treatment-seeking. Many whānau within the urban environment are under stress due to factors such as poor living conditions, lower incomes, and unemployment (Robson & Reid, 2007) and this may mean that day-to-day survival surpasses health concerns (Cram, Smith, & Johnstone, 1999). Therefore, whānau may not have the capacity to offer support that individuals may desire. Furthermore, for a number of the participants, whānau understanding of how best to support the individual grew through their indirect experience of social anxiety, suggesting their willingness to offer support over time.

From the questionnaire it was found that symptoms associated with social anxiety were also perceived as treatment barriers by a number of participants. Overall this barrier dimension was the most highly endorsed by participants and is consistent with the literature that has suggested the symptoms of social anxiety interfere with treatment-seeking (Gross et al., 2005). This finding alongside the above findings of unrecognised social anxiety suggest that while participants may not have attributed their symptoms to social anxiety their symptoms still impacted negatively on treatment-seeking. Social attitudes as treatment barriers was also highly endorsed by participants. This is in line with other findings on social attitudes discussed above and previous literature on treatment barriers for social anxiety (e.g., Chartier-Otis et al., 2010).

The questionnaire barriers related loss of pay, access, and services were found to be moderately endorsed by participants. These findings are consistent with the literature by Chartier-Otis et al. (2010). The barriers related to cost were only moderately agreed upon

by participants, a finding which is inconsistent with past research (Chartier-Otis et al., 2010; Craske et al., 2005). However, these barriers may not have been highly rated due to participants attending funded CMHC services. Overall, the relatively moderate endorsement of these barriers could suggest that these more practical obstacles were easier to address prior to treatment than the those related to social attitudes or psychological symptoms. In addition, a number of participants described receiving practical support from whānau (e.g., transport) in the initial treatment-seeking process and early stages of treatment which could also have contributed to these findings.

How do Māori with Social Anxiety Think Treatment Barriers Could be Reduced?

Participants recommendations for the reduction of treatment barriers highlighted a desire for increased awareness of treatment barriers faced by whaiora with social anxiety. The findings included increasing understanding among whaiora that the experience of social anxiety need not be one of isolation and improving recognition and understanding of social anxiety within the wider community. The importance of connection within the therapeutic relationship, cultural and spiritual engagement, and whānau support were also noted in some way as contributing to a reduction in treatment barriers. These findings are discussed below.

The participants were very open about their experiences of social anxiety and treatment-seeking. Given the interview was a social interaction with an unfamiliar person this was particularly notable. Many participants described their involvement in the research as an overarching desire to awhi those who may follow; to inform Māori who may be experiencing social anxiety that they are not alone, nor should they be. Thus, participants recognised that other whaiora may experience similar treatment barriers and sought to communicate the importance of seeking support for social anxiety. They empathised that this can be a difficult process through reflecting on their own journey, emphasising the

positive impact that support had or additional information on social anxiety would have had on their experience.

A number of participants called for more group services to specifically address social anxiety and suggested a desire to connect and share their experiences. Some participants expressed how it would be beneficial to incorporate additional approaches (e.g., advertising) specifically about social anxiety in the wider community, to improve recognition of social anxiety, understanding of treatment options, and treatment-seeking. This is similar to previous research where raising awareness of social anxiety has been suggested as a means to help improve treatment-seeking (Olfson, 2000). Findings from the current study suggest this would not only benefit whaiora but also their whānau in furthering understanding of social anxiety.

Participants highlighted the importance of connection and whanaungatanga within the therapeutic relationship. Talking to someone about social anxiety was highlighted as an important part of the therapeutic journey. Many described valuing the support they received within their current service and for some it took time to find such a 'fit'. These findings indicate that participants placed importance on connection and whanaungatanga within the therapeutic relationship.

Māori are as diverse as any culture and this was reflected through their kōrero. Some participants expressed stronger cultural identity and some were navigating their way to feel more comfortable within te ao Māori. For many, connecting with Māoritanga contributed to a more secure identity and this helped to address social anxiety and support treatment engagement. Specifically, for some, waiata and karakia were central to helping manage symptoms and increase social engagement, indicating they were successful treatment components for social anxiety.

Highlighting the collective nature of Māori within both whakapapa and kaupapa whānau; tautoko from whānau was valued by a number of participants, particularly in terms of practical support (e.g., transport, childcare) during treatment-seeking and the initial stages of treatment. Supported by findings from the questionnaire, suggest this level of support helped to reduce a number of initial treatment barriers for the participants.

Implications of Findings

The current research findings have implications for those working alongside whaiora with social anxiety in clinical practice. The current study is the first to explore social anxiety and its treatment barriers among Māori. This study was important to give voice to an otherwise unexplored area of Māori mental health and build a clearer understanding of Māori perspectives of social anxiety, treatment barriers, and how to improve treatment-seeking. We know that Māori mental health continues to present challenges for Māori and the current study provides only a small insight into some of the challenges that whaiora face each day. Overall, the findings suggest there is a need to consider how best we can support our Māori experiencing social anxiety to access services that best meet their individual and whānau needs.

There is a need to empower Māori with social anxiety to seek help when it is needed. However, treatment is unlikely to be sought if social anxiety is not understood as a difficulty for which support exists. Implications for the mental health sector focus on the need for improved dissemination of information on social anxiety for whaiora and their whānau. The responsibility of education about social anxiety should not fall on the shoulders of the individual or whānau alone. Findings suggest if there was more information about social anxiety readily available in the media it would improve

understanding and treatment engagement. Furthermore, increasing the amount of information on social anxiety available to the general public may help to normalise social fears and reduce stigma around seeking treatment for mental illness. It may also encourage self-directed help-seeking behaviours.

Findings suggest the implementation of group therapy programmes for social anxiety is needed and wanted by whaiora. This suggests that despite difficulties with social engagement, participants held a desire to share their experiences and learn from others who might be facing similar challenges. A desire for ‘togetherness’ in this way, suggests a desire for kaupapa whanau to promote healing, highlighting the link within Māori model of health between whānau connection and wellbeing. In addition, findings on how social anxiety was understood by participants aligns with Māori models of health, further highlighting the value of cultural conceptualisations of health in the treatment of Māori with social anxiety.

Barriers of social attitudes and psychological symptoms are likely to be the most difficult to address at the initial point of contact. Care taken in building the therapeutic relationship is likely to be crucial in response to these treatment barriers. Participants expressed the importance of connection and when this was not perceived as important to the clinician, treatment engagement suffered. Furthermore, these past experiences affected future treatment-seeking. Thus, there is a need for clinicians to consider and advance their own cultural competency. To take time for whanaungatanga within the collaborative therapeutic relationship. Sharing of whakapapa or genealogy is one approach to establishing this therapeutic connection. Addressing treatment-seeking barriers is not the only task. It is the first step. Providing a space where Māori feel supported and encouraged is essential to holding engagement and thus treatment gains that meet individual needs. Thus, time needs to be taken to discuss what is important to

whaiora on their journey to wellbeing. Finding out what uplifts and centres individual whaiora works towards the goal of reconnecting to their sense of wairua (Cherrington, 2009). Given the intertwining of wairua within all aspects of Māori wellbeing, this goal is significant in holistically addressing areas of social anxiety relating to physical, cognitive, and social difficulties.

The inclusion of tools such as karakia and waiata would be of value for whaiora with social anxiety to assist in engagement. Linked to concepts of wairua, these tools open a pathway to securing identity, social connection, and recovery in a way that legitimises Māori knowledge and practices (Valentine, 2009). Checking with whaiora before using these tools communicates consideration for diverse Māori realities as it cannot be assumed that all Māori share the same worldviews. However, it is crucial that individual Māori worldviews are explored in clinical practice to ensure gains for Māori health. Given diversity among Māori and the complexity of being Māori, it is up to the clinician to ask how being Māori fits within the individual and whānau experience of social anxiety, treatment barriers, and what this means to the individual whaiora.

Limitations and Directions for Future Research

When considering the implications of the above findings, it is important to acknowledge the limitations of the current research and recommend how future studies can improve on the design. This research represents only a small group of whaiora and the findings cannot be generalised to the wider population of Māori with social anxiety. Furthermore, the whaiora involved in the study had already accessed treatment. Future studies could involve whaiora in the initial treatment-seeking stage to more fully capture the breadth of their experiences and understanding of treatment barriers as they are facing them. Future studies could also involve those working alongside whaiora with social anxiety

to gain their understanding and knowledge of how treatment barriers could be addressed in service.

While none of the participants conceptualised social anxiety as relating to whakamā, the link between social difficulties and stigma and discrimination they discussed does reflect to some extent how whakamā has been described in the literature (e.g., Sachdev, 1990). To what degree if at all, whakamā interacts with social anxiety is suggested as an avenue of exploration for future research. This could potentially provide a deeper understanding of how social anxiety is expressed among Māori to help our whaiora and those working alongside them to in the assessment and treatment.

The questionnaire design could have been improved through including more of the treatment barriers faced by Māori identified in the literature. This would allow for better reflection of treatment barriers experienced by Māori such as cultural fit, rather than the sole focus on social anxiety treatment barriers identified in the literature. Questions such as ‘worry about what people would think’ could have included further questions around whakapapa and kaupapa whānau to more clearly determine who participants were referring to. Future studies could address these limitations through refinement of the questionnaire. In addition, within the scope and size of the current research the questionnaire findings had limited usefulness as a quantitative measure. Future studies could address this through a larger sample size which would allow for deeper exploration of the questionnaire barriers.

The limitations of thematic analysis should also be acknowledged. For example, as is the case with qualitative research, the findings can be influenced by the researcher’s interpretation of the data. However, efforts were made to adhere to clear and concise

guidelines of thematic analysis to manage potential researcher bias (Braun & Clark, 2006).

Researcher Reflections

This thesis was born out of an honours project which explored treatment barriers for social anxiety from the perspective of New Zealand psychologists. What stood out for me while completing the honours project was the literature on the high rates of social anxiety among Māori combined with low treatment seeking rates for individuals with social anxiety. However, there appeared to be a gap in the literature on social anxiety and treatment seeking from a Māori perspective. Thus, I set out to explore this.

The thesis from its conception to completion has taken approximately four years. It was important to me to carry out a piece of work that could benefit Māori and thus important to take time to allow for reflection as I navigated the various stages. The recruitment process was at times slow. However, I see this was likely always going to be the case given I was exploring social anxiety. I found being *kanohi kitea* within the CMHCs I was recruiting through as crucial to maintaining the recruitment momentum. For participants, the interview was a social interaction with an unfamiliar person. I was aware of this as I moved through the interview process and took care to help ensure I created a space where participants were the expert. What struck me was the overwhelming sense of *awhi* from the participants. They weren't there for themselves, they had already faced the treatment barriers. They were there to support Māori. To better the pathway for Māori with social anxiety.

Many of our *whaiora* face challenges in accessing services and social anxiety can further complicate this through the symptoms themselves. This research has emphasised the importance of working within a *tikanga* based approach to help our *whaiora* overcome

social anxiety. I see the value in working to better understand how Māori experience social anxiety and its treatment barriers to not only address the barriers prior to care but enrich the experience of care once it is accessed in a manner that is culturally relevant for individual whaiora.

For me, this research has in part represented a personal journey. I wanted to support our whaiora and along the way it inspired a deeper desire to further my own understanding and identity as Māori. Experiences with the many people I encountered during the process of this thesis deepened my own understanding of Māori tikanga. I treasure these experiences and humbly acknowledge that I am still learning and growing.

Final Conclusions

The current research makes a unique contribution to the area of Māori mental health, specifically the literature pertaining to the advancement of culturally appropriate treatment engagement for Māori with social anxiety. The over-arching goal of this study was to capture the voices and experiences of a significantly marginalised group. People experiencing social anxiety may be marginalised as a result of their psychological symptoms alone but many participants in this study have also experienced marginalisation as a result of their Māori identity. It is hoped that by capturing the rich narratives of these eleven whaiora, those responsible for writing policy and allocating resources in the mental health sector will be better informed to facilitate clinical and cultural engagement with Māori experiencing social anxiety. In addition, the research has provided strong endorsement for an approach guided by Māori tikanga. Last but by no means least, it is hoped that capturing these voices validates, acknowledges, and ultimately benefits the 31.3% of Māori (Baxter, Kingi, et al., 2006) who experience the debilitating effects of anxiety at some stage in their lives. In

Aotearoa we are still some way from an equitable health system that embodies the understood intent of Articles II and III of Te Tiriti o Waitangi guaranteeing Māori at least equivalent health status. Understanding Māori perspectives of mental health is key to progression toward this goal.

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Appendices

Appendix A: Participant Information Sheet



Maaori Understandings of Social Anxiety and Treatment-Seeking

Participant Information Sheet

Teena koe,

You are invited to participate in my study on the treatment barriers for Maaori with social anxiety.

My name is Pixie Armstrong-Barrington and I am a Clinical Psychology Trainee at Massey University. I am carrying out this research as part of my doctoral studies. I am of Maaori descent with iwi links to Whakatoheea and Ngaati Porou. My supervisors for this study are Dr Angela McNaught (Senior Lecturer, Massey University), Dr Ross Flett (Associate Professor, Massey University), and Dr Simon Bennett (Senior Maaori Lecturer, Massey University).

This Participant Information Sheet will help you to decide if you would like to take part in this study. If you would like, I can answer any questions you may have. Before you decide, you may want to talk about the study with other people, such as whaanau, or healthcare providers. Please feel free to do this.

If you agree to take part in this study, you will be invited to sign a Consent Form before the research takes place. You will be given a copy of both the Participant Information Sheet and the Consent Form to keep. This document is three pages long. Please make sure you have read and understood all the pages.

What is the study about?

The aim of the study is to look at what barriers Maaori with social anxiety face when seeking treatment. The study aims to look at what Maaori think can be done to reduce these treatment barriers and how social anxiety is understood. The findings are likely to contribute to encouraging culturally appropriate treatment for Maaori.

What are my rights?

You are free to decline participation in this study and this will have no effect on your current or future healthcare. Participation is voluntary. Whether or not you take part is your choice. You do not have to answer any questions you do not want to. You can withdraw from the study at any time up to the completion of the interview. You have the right to access information collected about you as part of the study. You can ask questions about the project at any time.

Am I eligible to participate?

If you identify as Maaori, are 18 years of age or over and have been feeling anxious in social situations you are eligible to participate in this study.

What would happen if I agreed to participate in this study?

If you agree to participate, we can arrange a time that suits you to meet with me for an interview. The interview will take approximately 45 minutes. The interview will be held at your health provider's office. You will be provided with a koha in the form of a \$20 food voucher to acknowledge your contribution to the research.

What does the interview involve?

The interview will involve sitting down with me and talking about your experiences of social anxiety and seeking treatment. It also involves a brief 15 item questionnaire. The interview will be audio-recorded to allow me to transcribe your spoken word. If you would like to conduct the interview in Te Reo Maaori, you can ask to have an interpreter before the interview takes place. You will be provided with refreshments during the interview.

Can my whaanau attend my interview?

You are welcome to bring whaanau support people to your interview with you. These can either be members of your family, friends, or other health professionals involved in your care. Your support person will not be asked to answer any questions for the study.

How will my information be used?

The results of this study may be published in a summarised form that makes sure you remain anonymous. You can request a copy of a summary of the results from the study, which will be given to you when the study is finished in 2016.

How will my confidentiality be protected?

My supervisors and I are responsible for storing the information you provide. Your name will be kept private in the study and you will be given a code name. Computer files will have a password. After the interview, the audio recordings and transcripts will be kept for 10 years in a locked cabinet at the School of Psychology, Massey University. At the end of this period, these will be destroyed by staff at Massey University.

Who do I contact if I have concerns about this research project?

If you have any concerns about your rights as a participant in this study, you may want to contact a Health and Disability Advocate. Contact details are below:

Phone: 0800 555 050

Fax : 0800 2 SUPPORT (0800 2787 7678)

Email: advocacy@hdc.org.nz

If you require Maaori cultural support, talk to your whaanau first. Alternatively, you can contact: [Contact details were included for cultural support relevant to CMHC location].

Who do I contact if I want to participate in this study?

If you would like to be involved in this study, or if you have any questions, please feel free to contact me. My contact details are below. If you would prefer, I can contact you through your health provider. Just let them know.

Pixie Armstrong-Barrington

School of Psychology
Massey University
Private Bag 102-904
North Shore
Auckland 0745

Email: XXX
Phone: XXX

If you would like, you may also contact my supervisors if you have any questions about the study:

Dr Angela McNaught

School of Psychology
Massey University
Private Bag 102-904
North Shore
Auckland 0745

Email:XXX
Phone: XXX

Dr Ross Flett

School of Psychology
Massey University
Private Bag 11-222
Palmerston North 4442

Email:XXX
Phone: XXX


Dr Simon Bennett

School of Psychology
Massey University
P.O. Box 756
Wellington 6140

Email:XXX
Phone: XXX

This project has been reviewed and approved by the Northern A Regional Ethics Committee, Application 14/NTA/194

Appendix B: Participant Brochure



The cover of the participant brochure features a blue background with green wavy borders at the top and bottom. On the left side, there is a grey vertical band containing the Massey University logo and name. The right side contains the Massey University logo and name at the top, followed by the title "SOCIAL ANXIETY FROM A MAAORI POINT OF VIEW" in bold, black, uppercase letters.

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

SOCIAL ANXIETY

**FROM A MAAORI POINT
OF VIEW**



The content page of the brochure is divided into several sections. On the left, there is a "Kia ora" (Hello) greeting in a yellow circle, followed by a photo of Pixie Armstrong-Barrington. Below the photo is a paragraph in Māori and English. The middle section contains three questions: "Do you ...", "Have you ...", and "Would you ...". The right section is titled "Your participation could help the understanding of ..." and lists three bullet points. At the bottom right, there is a box with contact information for Pixie Armstrong-Barrington.

Kia ora
Hello



Do you ...
Feel uncomfortable in social situations?

Have you ...
Experienced any difficulties seeking treatment, or think that you might?

Would you ...
Like to talk about these experiences with me?

Your participation could help the understanding of ...

- What difficulties Māori face when wanting treatment for social anxiety
- What can be done to reduce these difficulties
- How Māori view social anxiety

For more information ...

For an information sheet please ask your health provider

OR

If you have any questions or are keen to participate please contact me. I can give you more information on the study:

Pixie Armstrong-Barrington

Email:
XXX
Phone:
XXX

Appendix C: Consent Form



Maaori Understandings of Social Anxiety and Treatment-Seeking

Consent Form

I have read and understood the Participant Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction and I understand that I may ask further questions at any time.

I understand that taking part in this study is voluntary (my choice) and that I do not have to answer any questions I do not want to.

I agree to have my interview audio-recorded. I understand that the audio-recordings and transcripts will be kept at Massey University and destroyed after 10 years.

I have been informed that the information I provide for the study will remain confidential and that all information will be stored under a code name.

I know how to contact the researcher if I have any queries.

I agree to participate in this study under the conditions set out in the Participant Information Sheet.

Full Name: _____

Signature: _____ Date: _____

If you would like to receive a summary of the findings when the study is finished, please provide your email or postal address below:

Email address	
Postal address	

Appendix D: Interview Topics

- Opening karakia
- Sharing of whakapapa – whakawhanaungatanga
- Understanding of the symptoms of social anxiety
 - What is social anxiety like for you?
 - How do you experience social anxiety?
 - How do you make sense of social anxiety?
- Experience of seeking treatment for social anxiety
 - What was it like for you when you were first thinking about getting treatment for social anxiety?
 - What was your main reason for looking for treatment?
- Experience of any treatment barriers faced/anticipated
 - When you were first looking for treatment for social anxiety did you experience any obstacles that made getting treatment for social anxiety difficult?
 - How did that affect you looking for treatment?
- Experience of any cultural treatment barriers faced/anticipated
 - When you were looking for treatment for social anxiety did you experience any cultural obstacles that made getting treatment difficult?
 - How did that affect you looking for treatment?
- Ideas for what can be done to reduce the barriers
 - What do you think needs to happen to make getting treatment for social anxiety easier?
 - How do you think this could be done?
 - Who do you think this would help? How?
- Questionnaire
 - Demographic information
 - Barriers suggested in the literature – rating scale
- Closing karakia

Appendix E: Questionnaire

Participant code #:

Iwi:

Hapū:

Age:

Gender:

Employment:

Highest Education:

Please rate your level of agreement with the following statements about treatment barriers:

	Little Barrier			Big Barrier	
Concern about the cost of getting help	1	2	3	4	5
Health insurance won't cover the cost	1	2	3	4	5
Worry about losing pay from work	1	2	3	4	5
Not knowing where to go to get help	1	2	3	4	5
Unable to go to during open hours	1	2	3	4	5
The time taken to get to there is too great	1	2	3	4	5
Waiting time for an appointment is too long	1	2	3	4	5
Not being able to get through on the telephone	1	2	3	4	5
Unable to get childcare	1	2	3	4	5
Thinking you can't be helped	1	2	3	4	5
Worry what other people will think	1	2	3	4	5
Being too embarrassed to talk to someone	1	2	3	4	5
Worry that symptoms would be embarrassing	1	2	3	4	5
Concern you would be too anxious to attend	1	2	3	4	5
Fear of how the clinician would perceive you	1	2	3	4	5
Other	1	2	3	4	5

Appendix F: Case Study

The following is a case study in the form of a research article on preliminary findings of the current research. This was completed and reviewed during the internship period as partial fulfilment of the requirements for the degree of Doctor of Clinical Psychology. Massey University requirements state that it is to be included in the back of the current thesis.

Māori and Social Anxiety: Emerging Ideas about Whānau

Abstract

This article reports on one emerging idea of whānau within the preliminary findings of an ongoing qualitative study. The study is investigating Māori understandings of social anxiety, treatment barriers, and ideas of how treatment barriers could be reduced. The overriding objective of the study is to understand what obstacles need to be addressed to encourage treatment-seeking for Māori with social anxiety. Six participants were recruited through Counties Manukau Community Mental Health Centres and interviews were carried out these services. A Māori-centred approach shapes the research. Thematic analysis is being used in the ongoing study to examine participants' understandings, experiences, and ideas. Trends from the six participants' descriptions suggest whānau as a developing idea within the larger study. The descriptions suggest that whānau can be a source of support and communication for Māori experiencing social anxiety. They also suggest that more information may need to be available in the

community in order to assist whānau in understanding how best to support members with social anxiety.

Introduction

Social anxiety is a serious mental health condition that international research has suggested occurs at an overall higher frequency than other anxiety disorders (Hofmann & Bogels, 2006). Social anxiety is related to feelings of extreme distress when an individual interacts with others or anticipates a threat of negative evaluation (American Psychiatric Association, 2013). Individuals with social anxiety fear the scrutiny of others and are concerned they will act in a way that will cause them embarrassment (Stein & Stein, 2008). In addition, individuals with social anxiety typically experience both behavioural and emotional symptoms such as avoidance and anxious anticipation (Gross et al., 2005). This can result in avoidance of situations such as public speaking, or meeting unfamiliar people for fear of being disliked or being evaluated negatively (Stein & Stein, 2008).

Treatment Barriers for Social Anxiety

While the literature suggests that evidence based treatment are effective interventions for social anxiety, many individuals suffering from it do not seek help (Coles, Turk, Jindra, & Heimberg, 2004). Overseas research by Wang et al. (2005) has suggested seeking treatment took a median of 16 years from the initial onset of social anxiety. In New Zealand, the median treatment-seeking delay for social anxiety is approximately 28 years (Oakley-Browne & Wells, 2006).

Understanding the delays to seeking treatment is likely to be of importance in helping to increase treatment rates for individuals with social anxiety. It appears that the literature in this area of treatment barriers is limited to a handful of studies (e.g.,

Chartier-Otis et al., 2010; Mojtabai, Olfson, & Mechanic, 2002; Olfson et al., 2000). One study (adapted from Craske et al., 2005) suggested that there are five factors that act as treatment barriers for individuals experiencing symptoms of social anxiety and/or Panic Disorder with Agoraphobia: cost, loss of pay, access, services, and social attitudes (Chartier-Otis et al., 2010). Results from this study found cost (i.e., monetary cost of appointment) and access (i.e., not knowing where to go to get help) to be the most frequent barriers to treatment. Another study has suggested that the psychological symptoms of social anxiety may also predict unmet need for care (Olfson et al., 2000). Similarly, Chartier-Otis et al. (2010) found avoidance to be a predictor of unmet need for care for social anxiety. In addition, research carried out with Clinical Psychologists in New Zealand found that participants most agreed with psychological symptoms as a treatment barrier for clients with Social Anxiety Disorder (Armstrong-Barrington, 2014).

Māori Health

Māori are the indigenous people of Aotearoa New Zealand. In 1840, an agreement between indigenous Māori and British representatives called the Treaty of Waitangi was signed. It is unique in that it set out the prospect of the genuine recognition of two distinct peoples of different cultures living together in equality, specified through three articles (Rochford, 2004). Article I offered kawanatanga (governance) for residents of New Zealand; Article II offered tino rangatiratanga (absolute sovereignty) for Māori over all things Māori; and Article III offered oritētanga (citizenship) to all, ensuring fair and equal access to resources (Herbert, 2004). However, the Treaty was poorly translated and explained between the Māori and British versions and there have been breaches to its conditions which have led to Māori losing land, elements of their culture, and also

to develop a sense of powerlessness (Kingi, 2006). Today, Māori make up approximately 18% of the New Zealand population (Statistics NZ, 2013). The effects of colonisation have impacted the status of Māori health and these effects still resonate through Māori. Therefore, the Treaty of Waitangi has significant relevance to the status of Māori health today as it asserts Māori as having the right to define the delivery of health services in a way that benefits Māori (Rochford, 2004).

Māori and Health Treatment Engagement

Although rates of health difficulties have been found to be higher among Māori, overall treatment rates are disproportionately lower for Māori than non-Māori (Jansen & Smith, 2006). According to findings in the New Zealand Health Survey, two in five Māori adults in the past 12 months reported an unmet need for primary health care and overall the unmet need was 1.5 times greater for Māori than non-Māori (Ministry of Health, 2013). Almost half of Māori women in the survey had unmet need for primary health care in the previous 12-month period. The two main reasons for overall unmet need for primary care treatment that Māori identified were related to cost (23%) and availability of appointments (20%).

Māori Mental Health

Mental health difficulties have been said to be one of the most significant health problems that Māori face today. According to Durie (1999), the prevalence of mental health difficulties among Māori is increasing in comparison to non-Māori, particularly amongst the young adult population. This is supported by findings from a study by The MaGPIE Research Group (2005) where anxiety, mood, and substance disorders were more prevalent among Māori than non-Māori.

Another study that can provide some understanding of the mental health prevalence within the Māori population is Te Rau Hinengaro: The New Zealand Mental Health

Survey (Oakley-Browne, Wells, & McGee, 2006). The study involved 2595 Māori participants and results suggested that Māori are at a greater risk of developing a mental health disorder (i.e., anxiety, mood, substance use, eating) than non-Māori (Baxter, Kokaua, Wells, McGee, & Oakley-Browne, 2006a). The 12-month prevalence of any mental health disorder was higher for Māori in comparison to non-Māori and approximately half of the Māori participants had experienced one or more mental disorders in their lifetime (Baxter, Kingi, Tapsell, Durie, & McGee, 2006b).

Māori and Social Anxiety

The prevalence of social anxiety has been reported to occur at different rates across different cultural groups (Rapee & Spence, 2004). Anxiety disorders have been found to be the most common mental health conditions among Māori in terms of one-month (13.4%), 12-month (19.4%), and lifetime (31.3%) prevalence. Social anxiety has been found to be the second most commonly occurring anxiety disorder among Māori with a lifetime prevalence of 11.4%. In addition, among Māori with 12-month prevalence anxiety disorders, the majority were considered to be serious (33.3%) or moderate (40.9%) (Baxter et al., 2006b). These findings indicate an elevated need for mental health treatment among Māori, perhaps particularly for anxiety-related concerns. However, besides prevalence rates, there is very little existing literature on specific anxiety disorders within the adult Māori population, particularly social anxiety. The existing literature that details how culture may shape social has predominantly focused on East Asian cultures (e.g., Zhou et al., 2014). For example, the Japanese conceptualisation of social anxiety – *Taijin Kyofusho* (TKS) – a fear of offending other people through behaviours including blushing and facial expressions considered improper by the individual (Kleinknecht et al., 1997).

Whānau and Whanaungatanga

The word whānau is commonly used to refer to immediate family, extended family group, or as a “familiar term of address to a number of people” (Moorfield, 2017, paragraph 2). Traditionally, whānau is conceptualised as whakapapa or ancestry based. Whakapapa whānau are bonded and drawn together through kinship. linked to the larger cultural and social whānau units of iwi (tribe descended from), hapū (subtribe descended from), and waka (canoe descended from) (Lawson-Te Aho, 2010). Today, Māori use the word whānau to describe an increasingly wide range of groups. Contemporary uses of the term whānau may include kaupapa whānau, which refers to people bonded by a shared purpose or goal. The social constructs of whakapapa and kaupapa whānau can be viewed along a continuum and it is whānau who define the boundaries in different situations (Lawson-Te Aho, 2010). While there may not be one generic definition of whānau, it is considered a central cultural foundation for Māori that is fundamental to the wellbeing of Māori individually and collectively (The Families Commission, Te Kōmihana ā Whānau, 2012). By describing a group as whānau, members indicate that they have modelled their group on whānau as extended family and adopted values (e.g., whanaungatanga/kinship) that whānau ideally use to govern relationships (Metge, 1995). Whanaungatanga is associated with the whānau value of aroha (love) (Metge, 1995). Therefore, the value of whanaungatanga highlights the linkage and commitment of whānau to one another and responsibilities within whānau relationships (Huriwai et al., 2001).

Whānau Health

Māori views of health are holistic. There is a focus on whānau health and wellbeing in comparison to simply the health of the individual (Cram, Smith, & Johnstone, 2003). As such, there are a number of models of health and wellbeing situated within a Māori

cultural framework that incorporate whānau as a central element. For example, the well-known model of Te Whare Tapa Whā includes the component taha whānau, which acknowledges the fundamental importance of whānau to health and well-being. It implies a collective worldview and emphasises health as interdependence rather than independence, reinforcing whānau as a core institution of Māori culture and health (Durie, 1988). Te Whare Tapa Whā also includes the components of taha wairua (to do with the spirit), taha tinana (to do with the body), and taha hinengaro (to do with emotions and the mind). Together, these four components represent the basic systems for maintaining wellbeing, balance, and waiora (health).

Huriwai and colleagues (2001) suggest that health professionals should be guided by how whānau is perceived by clients. In a qualitative study looking into Māori experiences of health, participants saw whānau as a structure of support for Māori that was central to Māori health and wellbeing (Cram et al., 2003). Participants in this study spoke of how unbalance within the wairua (spirit, soul) of whānau may reduce the ability of this structure to support individual members. Within the urban environments, whānau may experience this due to a dislocation from marae or hapū or stressors such as poverty. Some participants spoke of a whānau wairua breakdown needing to be traced to colonisation. This highlights the need for health care professionals to consider how Māori health continues to be challenged, and what the key facilitators are in the delivery of health care for Māori (Cram et al., 2003).

Method

The current study aims to explore social anxiety and its possible treatment barriers experienced by adult Māori to understand what obstacles need to be addressed to encourage treatment-seeking. Another aim of the current study is to provide a space for

Māori to contribute in a research area that is lacking in the literature. The outcomes of the research could contribute to guiding best practice in encouraging treatment engagement for Māori with social anxiety. Providers of mental health care are likely to have a particular interest in identifying the types of approaches that could minimise treatment barriers for social anxiety and contribute to improved mental health outcomes among Māori. In this regard, the findings are likely to make a useful and practically relevant contribution to the literature pertaining to the advancement of culturally relevant mental health treatment for Māori with social anxiety.

The current study uses a predominantly qualitative design within a Māori-Centred research approach. Data collection is on-going. Whaiora (service users) who identify as Māori, are 18 years of age or older, and currently or previously experienced symptoms of SA as one of their primary presenting issues (excluding personality disorders) were eligible to participate. Four Counties Manukau Community Mental Health Centres (CMHC's) have been involved in participant recruitment: Te Puna Waiora CMHC, The Cottage CMHC, Manukau CMHC, and Awhinatia CMHC. Eligible participants were identified by the mental health professionals they were working alongside. These mental health professionals provided participants with the information sheet and study brochure which outlined the study and invite participation. Given the current research is a single locality study, Tainui spelling of Māori words (e.g., Maaori, whaanau) were used on the study brochure and information sheet. This was at the suggestion of the Counties Manukau Maaori Research Review Committee (MRRC), who reviewed the study prior to recruitment. Through an open-ended interview format, participants were encouraged to talk on a number of topics including their experience of social anxiety, treatment barriers and recommendations for reducing barriers.

Thematic analysis is being used to analyse the data and generate overarching themes and subthemes. The overall research findings remain in their preliminary stages and therefore this report presents the emerging idea of whānau from six of the semi-structured participant interviews. To protect their anonymity, participants were given codes (e.g., P1). Interviews were audio-recorded and transcribed verbatim. Participants also filled in a brief questionnaire on treatment barriers which was designed for the purpose of this study and based on existing literature. Results from the questionnaire are yet to be analysed in their entirety and therefore are not included in this article.

Ethics and Cultural Consultation

Ethical approval was sought and gained from the Health and Disability Ethics Committee, Counties Manukau Maaori Research Review Committee, and the Counties Manukau Health Research Office. Consultation for the current study has included discussions with kaumatua and ongoing consultation is being sought through cultural and general supervision.

Results and Discussion

A preliminary analysis of the six participant interviews suggests an emerging idea of whānau within the current study. Participants spoke about whānau in relation to their experiences of social anxiety and its symptoms, treatment seeking, and treatment barriers in a number of different ways. Some of these are discussed below.

When speaking about their experiences of social anxiety, whānau support was mentioned frequently. Some participants' talked about the difficulties of opening up to other people including whānau when beginning to think about seeking treatment for social anxiety. They spoke about how with whānau support and the support of healthcare

providers they were guided on their path to wellness. This is demonstrated by the two quotes below:

Cos I know that they won't be able to help me properly if I don't tell them what's truly going on. So I thought bugger it. Cos I used to be a shy guy and I'd never open up to no one. Not even my own family. But this is the way to feel better about myself. (P1)

With help from family support and social workers ... I have found a coping mechanism to cope with what's going on. So I used to indulge in things so I could try and stay well. I went from marijuana, alcohol, cigarettes ... But I don't do all that anymore ... Communication is the one that's working for me now. (P2)

Other participants' echoed these statements of whānau offering support to them with their social anxiety. One participant spoke about how wider whānau support was offered through whānau stepping back from directly asking about their social anxiety, instead letting them talk about it in their own time:

You know whānau, family, or the hapu of our tribe we get together on the marae. They never bring it up ... they never hurt me and bring it up. I tell them. (P2)

Whānau direct experience of participants' social anxiety was also mentioned as a means to foster understanding of how social anxiety is experienced. One participant spoke about how their whānau supported them when their symptoms of social anxiety arose:

I can talk about it at any time. With especially my family now. Because they're all aware about it. And they've seen me kinda at my worst. They're getting an idea of how to deal with it, kinda how to prevent it beforehand.

When they notice that I'm starting to kind of curl back a little bit, not being so open and stuff like that. (P5)

Participants' discussions around whanaungatanga suggest that whānau support is valued in the context of Māori experiencing social anxiety. From the quotes above, it seems this may be of particular value for fostering more positive coping skills and for providing a means for whānau understanding of how they can begin to help to manage symptoms.

Other participants spoke about perceiving less whānau support when experiencing symptoms of social anxiety and treatment seeking. Their social anxiety contributed to a sense that it was harder for whānau to converse with them at social gatherings. One participant described their experience of this and their coping strategy of alcohol use:

And they kind of don't talk to you either. Or they talk to you for a little bit but then, yeah, they move on. That's the trouble I had ... That's probably why I talk to the bottle. Just to help me through those moments with whānau. (P6)

One barrier to treatment was articulated as being related to accumulated stress within the whānau. One participant spoke about how personal difficulties faced by individual members staying with them intermittently got in the way of them seeking treatment for social anxiety:

Stuff at home really. Like family coming through and bringing their problems with them ... Family stressors can all build up ... (P6)

In the urban environment many whānau are under stress due to factors such as poverty and unemployment. This may mean that day-to-day survival supersedes health concerns (Cram, Smith, & Johnstone, 1999). This suggests that for some individuals with social anxiety, whānau may not have the ability to support them to the extent that they

desire. Furthermore, many may not know what social anxiety is or how best to offer support to whānau experiencing it, particularly given as it is not as universally recognised or publicised in the media as other disorders, such as depression.

More education about social anxiety and its signs could help better enable understanding of social anxiety. However, the responsibility of educating whānau about social anxiety should not fall solely on the shoulders of the individual or whānau alone. One participant called for more information on social anxiety to be accessible in the community. They suggested that such information could be helpful to break down barriers to treatment seeking for Māori experiencing social anxiety and their whānau. These ideas are described within the quote below:

It would just be nice to know that like, say if there was another person with their family who doesn't quite know what to do that they already knew what to do beforehand cos they had already learnt about it. (P5)

Conclusion

It must be noted that the results presented is a summary of one emerging idea within the preliminary findings from a study still in progress. The findings do however provide a starting point for further exploration and suggest the need for further analysis of the idea of whānau as a theme or subtheme within the current study as it progresses.

Social anxiety is a commonly occurring difficulty experienced by Māori, yet there is a lack of literature on the Māori experience of social anxiety and treatment barriers. Whānau is widely viewed as a fundamental ingredient for Māori to move towards waiora (Durie, 1998). The participant quotes in this article suggest that whānau may play a role in participants' experiences of social anxiety and treatment seeking. Some participants'

spoke of great whānau support and understanding. Others' spoke of less whānau support and how difficulties faced by individual members within the wider whānau delayed their own treatment seeking. However, further analysis of the transcripts in their entirety may produce different or contradictory ideas about whānau than those presented in this article. The scarcity of research around Māori experiences of social anxiety and treatment seeking barriers further highlights the need for the idea of whānau to be explored within this context in future research.

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