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Editor’s Introduction

An introduction to this issue, foreshadowing a special ‘issue’, advice for authors, and remembering James Liu.

Prelude to this issue: Volume 53, issue 1 presents six articles. We’ve ‘curated’ them into this issue as they are somewhat thematic. Specifically, they all have relevance to mental health. Further to that, three share a focus on men. Cooney and colleagues discuss DBT for men with anger problems; Watson and colleagues describe the role that meaning in life might play in the relationship between hopelessness and social connectedness, important pieces of one of the influential theories of suicide, and; Rudd and Treharne present qualitative analysis of interviews with young men about their mental health, and how masculinity and social relationships fit into that picture. The first two articles address a second sub-theme: psychologists’ experiences during the Covid-19 pandemic. Variava and colleagues dig into psychologists’ compassion and burnout in mid-to-late 2021. Readers may wish to consider this alongside Blayney and Kercher’s qualitative investigation of psychologist burnout, conducted around the same time, and published in the April 2023 issue of NZJP. Finally, Van Kessel and colleagues discuss psychologists’ experience of teletherapy during Covid.

Upcoming special ‘issue’ on Racism and Psychology: At the time of writing, the guest editors of this special issue are working with 15 manuscripts. Looks like it’s going to be a big one.

Advice to authors: Consistent with the imperative of the Journal, *any* submission must clearly articulate relevance in the context of Aotearoa New Zealand. The majority of desk rejections handled by NZJP are rejected for failing to make this case. Additionally, general attention to APA format is desirable – we’re happy to convert manuscripts into the NZJP format but it is easier to do so if it is already most of the way there! Additionally, we insist that authors provide de-identified manuscripts, consistent with our historical commitment to ‘blind’ review. I reserve the right to bounce manuscripts back if this has not been done, and that adds delays to what can be an already-lengthy process. I appreciate that sometime ‘blind’ review isn’t really blind, as in the case of studies that might explicitly draw from the NZAVS or Centre for Lifecourse Research – folks can guess who likely co-authors are, but I still appreciate authors attention to this requirement. Information about the Journal, and general author guidelines can be found here.

Additionally, the Covid-19 pandemic has dramatically affected the ways that academics work, and this can be seen in much greater difficulty securing reviews (for example, we have experienced significantly more declines of review invitations compared to pre-Covid times). Feel free to suggest reviewers with appropriate expertise (while being aware of conflicts of interest) and we will draw off that list when supplementing the invitations we extend.

Remembering Jim Liu: The publication of this issue follows close on the heels of the passing of Professor James Liu, most recently at Massey University since 2015, but prior to that at VUW, following his arrival in Aotearoa in the mid-1990s. Jim immersed himself in our culture, and his research and teaching were shaped heavily by his personal relationships with people representing the diversity of Aotearoa. He was instrumental in the establishment of the Asian Association of Social Psychology, the establishment of the Centre for Cross-Cultural Research at VUW, and a variety of other local and international initiatives. Jim was a charismatic classroom teacher (and presenter). I remember Taking for his second-year social psychology course and seeing him take his tape deck into classes to open lectures on social activism with the Indigo Girls, illustrate course material with his own personal experiences, and even sing the ‘Star Spangled Banner’ at a particularly memorable staff debate. He was also a prolific researcher, with publications in the most prestigious journals in social psychology, and cross-cultural psychology, in particular. And he also frequented the pages of NZJP, typically in collaboration with his postgraduate students. The eight papers co-authored in this manner have been collectively cited 417 times according to Google Scholar. Our thoughts are with Jim’s family, and the students he leaves behind.

Marc Wilson

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Volume 53, Number 1 (April), 2024

CONTENTS

Compassion and Burnout in Psychologists During the COVID-19 Pandemic in Aotearoa	*Rushaina Variava, Rosie Dobson, Meihana Douglas, and Lisa Reynolds*	4
Delivering Videocall Therapy During COVID-19: Counselling Psychologists' Experience	*Kirsten Van Kessel, Cherry Kura, Elizabeth du Preez, and Ties Coomber*	10
Dialectical Behaviour Therapy (DBT) skills for men with anger problems in Aotearoa	*Emily Cooney, Nick Mooney, and Paul Ryan*	21
Meaning in life moderates the relationship between social connectedness and hopelessness	*Lara J. Watson, Taylor-Jane Cox, Damian Scarf, and Seth C. Harty*	29
"Last year, I had an absolute mental breakdown […] and I only got better due to my family and friends": A qualitative study on the role of masculine norms and social relationships for young men's mental health	*Keita Rudd and Gareth Treharne*	39
Exploring the well-being of a Korean immigrant family caring for their elderly parent with an enduring mental illness	*Mina Aelyn Lee and Richard Fletcher*	49

SHORT REPORT:

Compassion and Burnout in Psychologists During the COVID-19 Pandemic in Aotearoa

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Stress is linked to negative outcomes in health professionals including burnout and reduced compassion. The COVID-19 pandemic and associated lockdowns impacted the delivery of psychological services in Aotearoa New Zealand. Thus, psychologists had to adapt to a rapidly changing context alongside increased demand for their services. This study aimed to bridge the gap in existing literature by exploring compassion for others and burnout amongst the psychologist workforce in Aotearoa during the pandemic. In total, 195 psychologists completed the online survey. Findings revealed that burnout was present in 14% of our sample and compassion for others was high. In conclusion, although the pandemic resulted in a stressful time for health professionals, psychologists reported high compassion for others and low rates of burnout compared to healthcare professionals in other countries.

Keywords: **Keywords:** *Psychologist, Compassion, Burnout, Covid-19, Aotearoa.*

INTRODUCTION

The COVID-19 pandemic and associated lockdowns significantly impacted the provision of healthcare services including psychological services (Hofmeyer et al, 2020). The first COVID-19 community case was reported in Aotearoa New Zealand on 28 February 2020. Subsequently, the government placed the country under a nationwide lockdown on 26 March 2020. From May 2020 until May 2022, various regions experienced different lockdown restrictions based on local levels of community transmissions (New Zealand Government, 2022). Nationwide COVID-19 restrictions were lifted in August 2023. Although the overall number of deaths and the impact on the health system ended up being proportionately lower than many countries overseas (Mathieu et al., 2020), healthcare workers in Aotearoa may have experienced similar challenges to international colleagues who reported high levels of burnout and impacts to levels of compassion (Trumello et. al, 2020).

During the pandemic and associated lockdowns, psychologists had to adapt to the rapidly changing context of psychological practice amongst increased demand for psychological services and limited resources (Simpson et al, 2021). There are many known negative impacts of stress on health professionals including emotional exhaustion (McManus, Winder, & Gordon 2002) and increased burnout (Visser, Smets, Oort, & de Haes 2003). Several studies have negatively linked the stress resulting from the pandemic to high rates of burnout and compassion fatigue in healthcare workers (Lluch-Sanz, Galiana, Doménech-Vañó, & Sansó, 2022), however, less is known about compassion itself during times of stress. This brief report presents the findings from a study exploring the levels of compassion and burnout in the psychologist workforce in Aotearoa during the pandemic in 2021.

Much has been written about the negative impact of COVID-19 on compassion fatigue in healthcare workers (Lluch-Sanz, Galiana, Doménech-Vañó, & Sansó, 2022), however, there has been almost no focus on compassion itself. Given that compassion has been described as a cornerstone of effective clinical practice in healthcare (Fernando & Consedine, 2014), the impacts of the COVID-19 pandemic on psychologists' compassion remains unexplored. Compassion refers to holding understanding and sensitivity towards others' suffering and having the motivation to alleviate that suffering (Sinclair et al, 2016). Fostering compassion in the therapeutic alliance is associated with enhanced therapist-client relationships and treatment outcomes (Kemp et al, 2021; Vivino et al, 2009). Psychologists in Aotearoa have an obligation under the Health Practitioners Competence Assurance Act (2003) to deliver safe, ethical, and compassionate healthcare, and psychologists are also mandated to conduct compassionate psychological practice, as highlighted within the Code of Ethics (New Zealand Psychologists Board, 2002).

While compassion to help others likely draws people to the practice of psychology, burnout can cause people to leave it. Burnout is classified as a syndrome of emotional exhaustion and depersonalisation (Lahana et al, 2017). Individuals who work in areas grounded in human suffering may experience burnout due to the demands of their roles (Kase et al, 2019; Perez-Chacon et al, 2021). Burnout is associated with poor quality of life, poor psychological wellbeing, negative attitudes regarding work and suboptimal performance (Rahdar et al, 2020). Thus, avoiding burnout within healthcare practice is essential. Prior evidence has illustrated a high prevalence of burnout and emotional exhaustion among psychologists (Delgadillo et al, 2018; O'Connor et al, 2018; McCormack et al, 2018). Factors associated with a higher risk of burnout within the psychologist workforce include lack of agency in the work setting, poor mental resilience, an external locus of control and a lack of acknowledgement and/or appropriate renumeration (Maslach & Leiter, 2017; Simpson et al, 2019; Yang & Hayes, 2020). During the pandemic, an increased prevalence of burnout was reported by psychologists globally (Serrão et al, 2022; Trombello et al, 2022). It is plausible that the stress associated with the COVID-19 pandemic may have also exacerbated the experience of burnout amongst psychologists in Aotearoa.

Despite previous studies noting the impacts of burnout and compassion on healthcare workers and psychologists overseas, there is a lack of literature examining whether the COVID-19 pandemic impacted the psychologist workforce in Aotearoa New Zealand. Thus, this paper aimed to bridge this gap and provide a snapshot of psychologists' experience of compassion for others and burnout during the pandemic in Aotearoa New Zealand.

METHOD

Design

The aim of this study was to explore the levels of compassion and burnout in the psychologist workforce in Aotearoa during the pandemic. A cross-sectional online survey of registered psychologists in Aotearoa was undertaken. Ethical approval for this study was obtained by the Auckland Health Research Ethics Committee on 09/03/2021 for three years (REF: #AH22139). Data were collected between 20/07/2021 and 12/11/2021 during which time the entire country was at various stages of lockdown with Auckland under the most stringent restrictions at Alert Level 3 and 4 (New Zealand Government, 2022). The 7-day rolling average of confirmed daily cases over this time increased rapidly from 2 at the start of data collection to approximately 177 by mid-November when data collection was completed (Mathieu et al., 2020).

Participants

In Aotearoa, psychologists can register under 'scopes of practice'. Scopes of practice include psychologist, clinical psychologist, counselling psychologist, educational psychologist, neuropsychologist, intern psychologist and trainee psychologist (New Zealand Psychologists Board, 2022). Each scope has detailed competencies and guidelines to inform the delivery of psychological practice. Therefore, the inclusion criteria for the study were developed to include psychologists who are registered under any scope of practice.

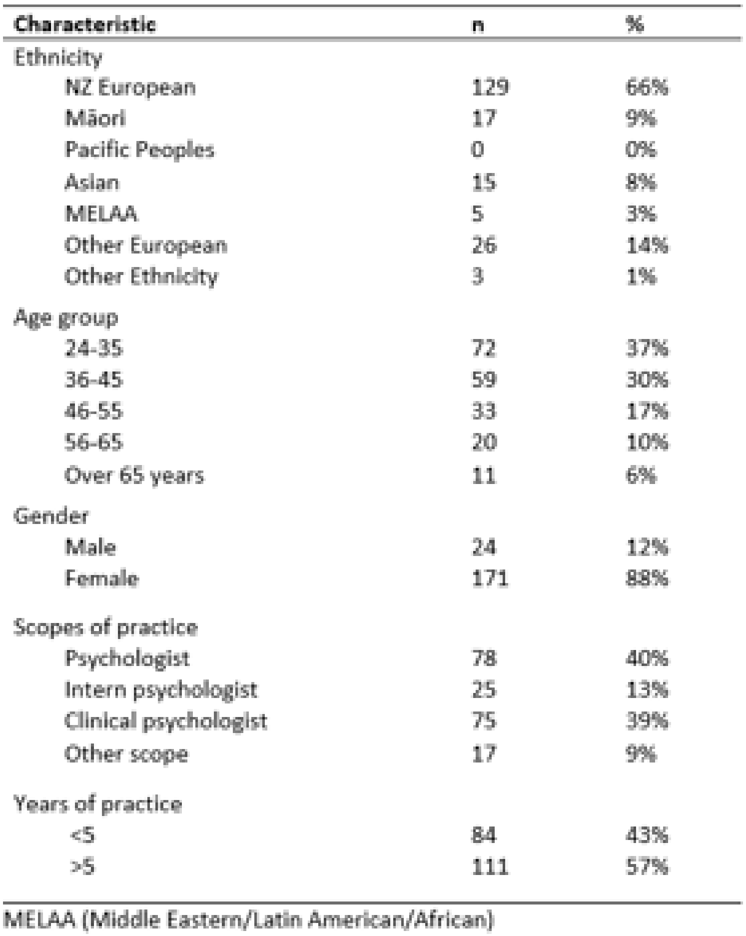
The inclusion criteria for the study were that participants needed to 1) be registered with the New Zealand Psychologists Board under any scope of practice (including 'intern psychologist'), 2) hold an annual practicing certificate, 3) work within any setting in Aotearoa and 4) speak English.

A total of 195 participants completed the study. A breakdown of demographic and professional characteristics is illustrated in Table 1. The sample were primarily New Zealand European (n = 129, 66%), female (n = 171, 88%) and registered under the 'psychologist' scope of practice (n = 78, 40%).

Measures

The adapted version (Baguley, 2020) of the 24-item Compassion Scale (Pommier, Neff & Tóth-Király, 2020) was used in this study to measure compassion for others. Baguley (2020) adapted the scale to measure compassion in healthcare workers by adding the item "I actively try to alleviate patients suffering or distress". For the current study, items encompassing the term 'patient' were replaced with 'people/person' as some psychologists may not encounter 'patients' in their practice.. This 25-item scale asked psychologists to rate themselves on a 7-point Likert scale from 1 'Not true of me' to 7 'Very true of me'. Example items included 'I realise when people are upset, even if they don't say anything', 'I like to be there for people in times of difficulty' and 'My heart goes out to people who are unhappy'. Negatively worded items were reverse scored and the mean score of the 25 items

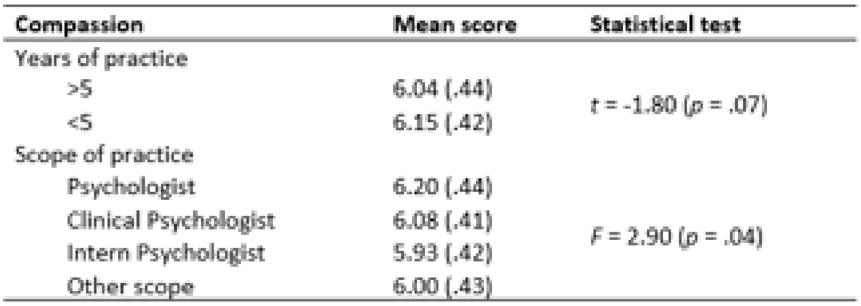
Table 1. *Demographic and professional characteristics of participants (N = 195).*



Characteristic	n	%
Ethnicity		
NZ European	129	66%
Māori	17	9%
Pacific Peoples	0	0%
Asian	15	8%
MELAA	5	3%
Other European	26	14%
Other Ethnicity	3	1%
Age group		
24-35	72	37%
36-45	59	30%
46-55	33	17%
56-65	20	10%
Over 65 years	11	6%
Gender		
Male	24	12%
Female	171	88%
Scopes of practice		
Psychologist	78	40%
Intern psychologist	25	13%
Clinical psychologist	75	39%
Other scope	17	9%
Years of practice		
<5	84	43%
>5	111	57%

MELAA (Middle Eastern/Latin American/African)

Table 2. *Differences in Compassion scores across years of practice and scopes.*



Compassion	Mean score	Statistical test
Years of practice		
>5	6.04 (.44)	*t* = -1.80 (*p* = .07)
<5	6.15 (.42)	
Scope of practice		
Psychologist	6.20 (.44)	*F* = 2.90 (*p* = .04)
Clinical Psychologist	6.08 (.41)	
Intern Psychologist	5.93 (.42)	
Other scope	6.00 (.43)	

provided a total compassion score between 1 and 7 where higher scores indicate greater compassion. The Compassion Scale has demonstrated construct, divergent, discriminant, and convergent validity (Baguley, 2020).

To minimise participant burden, burnout was assessed using thesingle item Maslach Burnout Inventory – Emotional Exhaustion (MBI-EE; Dolan et al., 2015) which has previously shown to have moderate convergent validity (r = 0.64) with emotional exhaustion (Dolan et al., 2015; Rohland et al., 2004). The single item has been successfully used in samples of medical students, general practice physicians, and practicing surgeons as a measure of physician burnout (West et al., 2009). Participants were asked to report the extent to which they feel the following statement reflects them in relation to their work: "I feel burned out from my work" answered on a 7-point scale from 0 ('Never') to 7 ('Everyday'). For the MBI-EE single item, higher scores represent greater burnout and scores of 4 ('Once a week') or more indicate "high levels of burnout" (Dolan et al., 2015).

Procedure

Convenience sampling techniques including professional mailing lists, snowballing sampling techniques, professional social media groups and word of mouth were employed to recruit participants. Online study advertising and emails about the study contained the survey link hosted by the online platform Qualtrics. When participants clicked on the survey link, they were redirected to the Participant Information Sheet which included study details and researcher contact information. Participation was voluntary and consent was assumed upon the submission of the anonymous survey. The survey questions covered the following: screening, demographics, psychological practice, compassion for others and burnout. The survey also included questions related to digital competence and use of digital technologies in practice which is published elsewhere (Dobson, Variava, Douglas & Reynolds, 2022). At the conclusion of the survey, participants could choose to be entered into the prize draw to win an iPad. The survey was estimated to take approximately 10 to 15 minutes to complete and was identical for all participants (no randomized items). Participants were able to review and alter their responses before submission.

Statistical Analysis

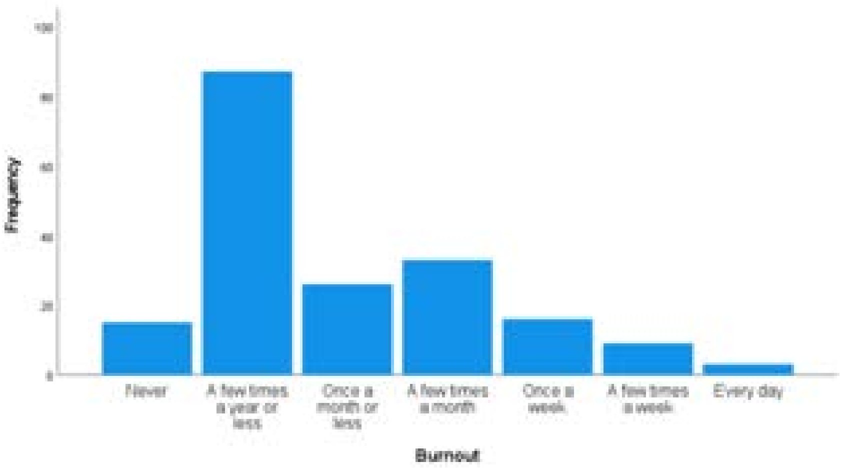
Statistical analyses were conducted using the Statistical Package for the Social Sciences (IBM SPSS Statistics V.28) software. Data collected from the survey was analysed and summarized using descriptive quantitative analyses. Means and standard deviations were calculated for items on the Compassion Scale, and the MBI-EE. To assess whether there were differences in compassion and burnout across scopes and years of practice, χ2 tests, ANOVA and t-tests were conducted. Ethnicity was coded as per the New Zealand Ministry of Health Protocol for Reporting of Ethnicity Data, with the 'prioritised ethnicity' output method used for reporting in this paper (Ministry of Health, 2017). No timeframe was imposed on participants to complete the questionnaire, cookies were not used to assign identifiers to each computer, and IP address information and view rates were not recorded. Adaptive questioning was not used within the survey. Multiple submissions were prevented on Qualtrics and further manual checks for multiple entries were also performed.

RESULTS

Compassion for others

The overall mean score on the Compassion Scale was 6.10 (*SD* = 0.43). Given the total possible mean was 7, this score suggests high self-reported compassion for others within this sample. Although there was no difference in compassion across years of practice, there was a difference in compassion across scopes (Table 2). Tukey HSD post-hoc tests revealed that the mean score for psychologist (mean = 6.20, *SD* = .44) was significantly higher than intern psychologist (mean = 5.93, *SD* =.42). No other differences across scopes were significant. Given the possibility that the difference in compassion

Figure 1. *Bar graph Illustrating the Frequency of Burnout (N = 189)*



between intern psychologists and psychologists might have been a factor of age, we ran an alternative model replacing scopes of practice with trichotomized age (24-35 years vs. 36-45 years vs. 46 years and older). The results of this model revealed no differences in compassion across age groups.

Burnout

A total of 189 participants completed the single-item MBI:EE measure (Figure 1), with 14.8% (n = 28) of participants reporting high levels of burnout according to the measure criterion (Dolan et al, 2015; West et al, 2012). The mean burnout score was 2.93 (*SD* = 1.41). There were no significant differences in frequency of burnout between scope or years of practice (Table 3). Contrary to expectations, burnout and compassion were not associated with each other (*r* = .09, *p* = .20).

DISCUSSION

Findings from the current study offer insights into the levels of compassion for others and burnout amongst psychologists during the COVID-19 pandemic. Although recent times have been stressful for the healthcare workforce, promisingly, psychologists reported high compassion for others. Based on these findings, it appears that psychologists are upholding their obligations to provide compassionate care to their clients (New Zealand Psychologists Board, 2002), amidst a challenging context of psychological practice.

However, it is noteworthy that there was a difference in compassion between intern psychologists and those registered under the general scope. Although relevant literature in this area is scarce, the finding does align with one study that showed differences between students and fully trained health professionals in reports of feeling caring and being willing to help across various hypothetical patient scenarios (Reynolds et al., 2019). Although our parallel analyses showed that neither clinical experience nor age explain the discrepancy between fully and partially trained psychologists, another possibility remains. Intern psychologists face a steep learning curve that can be challenging and stressful (Gilmore & Campbell, 2019) and it seems plausible that one of the costs of this period of rapid self-development, might be in the capacity to focus on others. This hypothesis requires further investigation. Another question worthy of further exploration is the extent to which training to become a psychologist via online channels, as was required by interns during lockdowns, might have impacted the development of compassion. It is also important to note that our survey was a single snapshot of time which inhibits our ability to determine whether our findings reflect the global pandemic context or whether interns might have consistently lower compassion during other time periods. Further investigation of these possibilities is warranted given the impact of such challenges not only to interns themselves but also to their clients.

We also found high levels of burnout in 14% of our sample. This finding is lower than expected given that burnout rates during COVID-19 of between 30-66% have been reported in healthcare workers in other countries (Dobson, et al., 2021; Melnyk et al., 2022). More specifically relevant to our study, 37% of a sample of Portuguese psychologists met the criteria for work-related burnout during the first wave of COVID-19 (Serrao et al., 2022) and 28% of Australian psychologists met the criteria for burnout prior to COVID-19 (McCade, Frewen & Fassnacht, 2021). Whilst our relatively lower rates of burnout might seem positive, especially given the impact of COVID-19, any risks to diminishing a workforce that is over-stretched and where there is a marked workforce shortage (RNZ, 2022) is concerning. Tracking rates of burnout over time to assess the well-being of this workforce seems a worthy area of investigation.

The findings from this study must be interpreted in light of its limitations. Firstly, this was a cross-sectional survey, precluding causal analyses. Secondly, the impact of the pandemic on participants was not assessed and nor were other factors related to burnout and compassion for others, limiting interpretation of these results. Next, the findings may not be generalisable to the broader psychologist population; the sample (N=195) was approximately only 6% of the total psychologist workforce with a current practicing certificate in Aotearoa (N= 3,199; New Zealand Psychologists Board, 2020). Finally, it is important to note that due to the study only including self-reported data, results may be limited by social desirability bias (Kuncel & Tellegen, 2009; Podsakoff et al., 2003; Podsakoff et al., 2012). As the Code of Ethics highlights psychologists' duty to provide ethical and safe practice, delivering compassionate care is an explicit expectation of psychological practice (New Zealand Psychologists Board, 2002). Thus, participating psychologists may have felt compelled to respond in a socially desirable manner e.g., reporting higher compassion for others and lower burnout. Lastly, it is important to note the timing of the current study. During recruitment, various regions in New Zealand were under different lockdown restrictions due to active community cases. These restrictions may have led to heightened workloads and increased pressure, which may have influenced findings. Due to these limitations, findings from the current study must be interpreted with caution.

Conclusion

The aim of the current study was to explore compassion for others and burnout amongst the psychologist workforce in Aotearoa during the COVID-19 pandemic. Our findings highlighted that although burnout was present in 14% of our sample, compassion for others remained high. Overall, although the pandemic was a stressful time for psychologists given increased demands amidst the changing landscape of psychological practice, it is reassuring that compassion for others remained high within this sample.

References

Baguley, S. (2020). *To Care and to Feel Cared for: A Study of Compassion in Patients and Their Doctors* [Master's thesis]. The University of Auckland Research Repositories, ResearchSpace. https://researchspace.auckland.ac.nz/handle/2292/56293

Delgadillo, J., Saxon, D., & Barkham, M. (2018). Associations between therapists' occupational burnout and their patients' depression and anxiety treatment outcomes. *Depression and Anxiety, 35(9), 844– 850.* https://doi.org/10.1002/da.22766

Dobson, H., Malpas, C. B., Burrell, A. J. C., Gurvich, C., Chen, L., Kulkarni, J., & Winton-Brown, T. (2021). Burnout and psychological distress amongst Australian healthcare workers during the COVID-19 pandemic. *Australasian Psychiatry*, *29*(1), 26–30. https://doi.org/10.1177/1039856220965045

Dobson, R., Variava, R., Douglas, M., & Reynolds, L. M. (2022). Digital competency of psychologists in Aotearoa New Zealand: A cross-sectional survey. *Frontiers in Digital Health.* https://doi.org/10.3389/fdgth.2022.951366

Dolan, E. D., Mohr, D., Lempa, M., Joos, S., Fihn, S. D., Nelson, K. M., & Helfrich, C. D. (2015). Using a single item to measure burnout in primary care staff: A psychometric evaluation. *Journal of General Internal Medicine*, *30*(5), 582–587. https://doi.org/10.1007/s11606-014-3112-6

Fernando III, A. T., & Consedine, N. S. (2014). Beyond compassion fatigue: The transactional model of physician compassion. *Journal of Pain and Symptom Management*, *48(2), 289-298.* http://dx.doi.org/10.1016/j.jpainsymman.2013.09.014

Gilmore, L., & Campbell, M. (2019). "It's a lot trickier than I expected": Assessment issues and dilemmas for Intern Psychologists. *Educational and Developmental Psychologist*, *36(1), 3–7.* https://doi.org/10.1017/edp.2019.3

Hofmeyer, A., Taylor, R., & Kennedy, K. (2020). Fostering compassion and reducing burnout: How can health system leaders respond in the Covid-19 pandemic and beyond? *Nurse Education Today*, *94*, 104502. http://dx.doi.org/10.1016/j.nedt.2020.104502

Kase, S. M., Waldman, E. D., & Weintraub, A. S. (2019). A cross-sectional pilot study of compassion fatigue, burnout, and compassion satisfaction in pediatric palliative care providers in the United States. *Palliative & Supportive Care*, *17*(3), 269-275. https://doi.org/10.1017/S1478951517001237

Kemp, E., Trigg, J., Beatty, L., Christensen, C., Dhillon, H. M., Maeder, A., Williams, P. A. H., & Koczwara, B. (2021). Health literacy, digital health literacy and the implementation of digital health technologies in cancer care: the need for a strategic approach. *Health Promotion Journal of Australia*, 32, 104-114.https://doi.org/10.1002/hpja.387

Kuncel, N. R., & Tellegen, A. (2009). A conceptual and empirical reexamination of the measurement of the social desirability of items: Implications for detecting desirable response style and scale development. *Personnel Psychology*, *62*(2), 201-228. https://doi.org/10.1111/j.1744-6570.2009.01136.x

Lahana, E., Papadopoulou, K., Roumeliotou, O., Tsounis, A., Sarafis, P., & Niakas, D. (2017). Burnout among nurses working in social welfare centers for the disabled. *BMC Nursing*, *16(*1), 15. https://doi-org.ezproxy.auckland.ac.nz/10.1186/s12912-017-0209-3

Lluch-Sanz, C., Galiana, L., Doménech-Vañó, P., & Sansó, N. (2022). The Impact of the COVID-19 Pandemic on burnout, compassion fatigue, and compassion satisfaction in healthcare personnel: A systematic review of the literature published during the first year of the pandemic. *Healthcare, 10(2),* 364. https://doi.org/10.3390/healthcare10020364

Maslach, C., & Leiter, M. P. (2017). Understanding burnout: New models. *The Handbook of Stress and Health: A Guide to Research and Practice, 36–56.* https://doi.org/10.1002/9781118993811.ch3

Mathieu, E., Ritchie, H., Rodes-Guirao, L., Appel, C., Hasell, J., Macdonald, B., Dattani, S., Beltekian, D., Ortiz-Ospina, E., & Roser, M. (2020). *Coronavirus Pandemic (COVID-19).* OurWorldInData.Org. https://ourworldindata.org/coronavirus#coronavirus-country-profiles

McCade, D., Frewen, A., & Fassnacht, D. B. (2021). Burnout and depression in Australian psychologists: The moderating role of self-compassion. *Australian Psychologist*, *56*(2), 111–122. https://doi.org/10.1080/00050067.2021.1890979

McCormack, H. M., MacIntyre, T. E., O'Shea, D., Herring, M. P., & Campbell, M. J. (2018). The prevalence and cause(s) of burnout among applied psychologists: A systematic review. *Frontiers in Psychology, 9,* 1897. https://doi.org/10.3389/fpsyg.2018.01897

McCormick, K. (2014). *Restoring and Strengthening Resilience in the Psychology Profession: The Rio Model of Resilience for Psychologists.* [University of Auckland]. https://researchspace.auckland.ac.nz/bitstream/handle/2292/23329/whole.pdf

McManus, I. C., Winder, B. C., & Gordon, D. (2002). The causal links between stress and burnout in a longitudinal study of UK doctors. *The Lancet, 359,* 2089–2090. https://doi.org/10.1016/S0140-6736(02)08915-8

Melnyk, B. M., Hsieh, A. P., Tan, A., Teall, A. M., Weberg, D., Jun, J., Gawlik, K., & Hoying, J. (2022). Associations among nurses' mental/physical health, lifestyle behaviors, shift length, and workplace wellness support during COVID-19: Important implications for health care systems. *Nursing Administration Quarterly*, *46*(1), 5–18. https://doi.org/10.1097/NAQ.0000000000000499

Ministry of Health. (2003). *Health Practitioners' Competence Assurance Act 2003*. http://www. legislation. govt. nz/act/public/2003/0048/latest/DLM203312.

Ministry of Health. (2017). *Ethnicity Data Protocols*. https://www.health.govt.nz/system/files/documents/publications/hiso_10001-2017_ethnicity_data_protocols_may-21.pdf

New Zealand Government. (2022). History of the COVID-19 Alert System. Unite against COVID-19. In *Covid19.Govt.Nz*. https://covid19.govt.nz/about-our-covid-19-response/history-of-the-covid-19-alert-system/

New Zealand Psychologists Board. (2002). *Code of Ethics.* https://www.psychology.org.nz/journal-archive/code-of-ethics.pdf

New Zealand Psychologists Board. (2020). *Annual Report 1 April 2019 – 31 March 2020.* https://psychologistsboard.org.nz/wp-content/uploads/2021/07/NZPB-Annual-Report-2020.-Final..pdf

O'Connor, K., Neff, D. M., & Pitman, S. (2018). Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants. *European*

Psychiatry, *53*, 74–99. https://doi.org/10.1016/j.eurpsy.2018.06.003

Perez-Chacon, M., Chacon, A., Borda-Mas, M., & Avargues-Navarro, M. L. (2021). Sensory processing sensitivity and compassion satisfaction as risk/protective factors from burnout and compassion fatigue in healthcare and education professionals. *International Journal of Environmental Research and Public Health*, *18*(2), 611. http://dx.doi.org/10.3390/ijerph18020611

Podsakoff, P. M., MacKenzie, S. B., Lee, J. Y., & Podsakoff, N. P. (2003). Common method biases in behavioral research: a critical review of the literature and recommended remedies. *Journal of Applied Psychology*, *88*(5), 879. http://dx.doi.org/10.1037/0021-9010.88.5.879

Podsakoff, P. M., Mackenzie, S. B., & Podsakoff, N. P. (2012). Sources of method bias in social science research and recommendations on how to control it. *Annual Review of Psychology*, *63*, 539-569. https://doi.org/10.1146/annurev-psych-120710-100452

Pommier, E., Neff, K. D., & Tóth-Király, I. (2020). The development and validation of the Compassion Scale. *Assessment*, *27*(1), 21-39. https://doi.org/10.1177/1073191119874108

Rahdar, S., Khajouei, R., & Mirzaee, M. (2020). Determining the effect of electronic health literacy on job burnout in the staff of health information management. *Journal of Advanced Pharmacy Education & Research*, *10*(S1), 93.

Reynolds, L. M., Powell, P., Lin, Y. S., Ravi, K., Chung, C. K., & Consedine, N. S. (2019). Fighting the flinch : Experimentally induced compassion makes a difference in health care providers. *British Journal of Health Psychology*, 1–17. https://doi.org/10.1111/bjhp.12390

RNZ. (2022). Wellington at top of list for widespread shortage of psychologists. *RNZ News*. https://www.rnz.co.nz/news/national/464457/wellington-at-top-of-list-for-widespread-shortage-of-psychologists

Rohland, B. M., Kruse, G. R., & Rohrer, J. E. (2004). Validation of a single-item measure of burnout against the Maslach Burnout Inventory among physicians. *Stress and Health: Journal of the International Society for the Investigation of Stress*, *20*(2), 75-79. https://doi.org/10.1002/smi.1002

Serrão, C., Rodrigues, A. R., Teixeira, A., Castro, L., & Duarte, I. (2022). The impact of teleworking in psychologists during COVID-19: Burnout, depression, anxiety, and stress. *Frontiers in Public Health*, *10*, 984691. https://doi.org/10.3389/fpubh.2022.984691

Simpson, S., Richardson, L., Pietrabissa, G., Castelnuovo, G., & Reid, C. (2021). Videotherapy and therapeutic alliance in the age of COVID-19. *Clinical Psychology & Psychotherapy*, *28*(2), 409-421.https://doi.org/10.1002/cpp.2521

Simpson, S., Simionato, G., Smout, M., van Vreeswijk, M. F., Hayes, C., Sougleris, C., & Reid, C. (2019). Burnout amongst clinical and counselling psychologist: The role of early maladaptive schemas and coping modes as vulnerability factors. *Clinical Psychology & Psychotherapy*, *26(1)*, 35–46. https://doi.org/10.1002/cpp.2328

Sinclair, S., McClement, S., Raffin-Bouchal, S., Hack, T. F., Hagen, N. A., McConnell, S., & Chochinov, H. M. (2016). Compassion in health care: an empirical model. *Journal of Pain and Symptom Management*, *51(*2), 193-203. http://dx.doi.org/10.1016/j.jpainsymman.2015.10.009

Trombello, J. M., David, N. S., Robbins, M. A., & Ruchinskas, R. A. (2022). Burnout during the COVID-19 pandemic: Descriptive and predictive data from a survey of psychologists at a single academic medical center. *Academic Psychiatry*, *46*(6), 718–722. https://doi.org/10.1007/s40596-021-01562-4

Trumello, C., Bramanti, S. M., Ballarotto, G., Candelori, C., Cerniglia, L., Cimino, S., Crudele, M., Lombardi, L., Pignataro, S., Viceconti, M. L., & Babore, A. (2020). Psychological adjustment of healthcare workers in italy during the COVID-19 pandemic: Differences in stress, anxiety, depression, burnout, secondary trauma, and compassion satisfaction between frontline and non-frontline professionals. *International Journal of Environmental Research and Public Health*, *17*(22), 1–13. https://doi.org/10.3390/ijerph17228358

Visser, M. R. M., Smets, E. M. A., Oort, F. J., & de Haes, H. C. (2003). Stress, satisfaction and burnout among Dutch medical specialists. *Canadian Medical Association Journal*, *168*, 271–275

Vivino, B. L., Thompson, B. J., Hill, C. E., & Ladany, N. (2009). Compassion in psychotherapy: The perspective of therapists nominated as compassionate. *Psychotherapy Research*, *19*(2), *157-171*. http://dx.doi.org/10.1080/10503300802430681

West, C. P., Dyrbye, L. N., Satele, D. V., Sloan, J. A., & Shanafelt, T. D. (2012). Concurrent validity of single-item measures of emotional exhaustion and depersonalization in burnout assessment. *Journal of General Internal Medicine*, *27*(11), 1445-1452. http://dx.doi.org/10.1007/s11606-012-2015-7

West, C. P., Dyrbye, L. N., Sloan, J. A., & Shanafelt, T. D. (2009). Single item measures of emotional exhaustion and depersonalization are useful for assessing burnout in medical professionals. *Journal of General Internal Medicine*, *24*(12), 1318-1321. http://dx.doi.org/10.1007/s11606-009-1129-z

Yang, Y., & Hayes, J. A. (2020). Causes and consequences of burnout among mental health professionals: A practice-oriented review of recent empirical literature. *Psychotherapy, 57(3), 426.* https://doi.org/10.1037/pst0000317

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Delivering Videocall Therapy During COVID-19: Counselling Psychologists' Experience

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Video-call therapy has been a burgeoning area of research and practice in recent years. While many therapists were already adding online modes of therapy delivery to their toolkits, the COVID-19 pandemic prompted their necessary and rapid uptake, whatever the therapist's pre-pandemic preferences. The present study explored counselling psychologists' experience of adapting to and using online video-call platforms to deliver therapy during the COVID-19 pandemic in Aotearoa New Zealand. Eight registered counselling psychologists in Aotearoa New Zealand were interviewed. Thematic analysis revealed four themes: (i) pre-pandemic hesitancies towards video-call therapy, (ii) managing the rapid transition to video-call therapy, (iii) integrating the learnings from the transition to video-call therapy and (iv) contextual factors. Pre-pandemic hesitancies included concerns that video-call therapy hinders the therapeutic relationship and misses subtleties. The transition process highlighted considerations around transparency and flexibility, in addition to practical considerations and peer support. Post-transition learnings included a more nuanced understanding of the shift from sharing physical space with clients to practicing from home; the mixed blessing of technology; the balancing versus merging of work- and home-life; and the impact on client progress. The fourth theme of broader contextual factors included the counselling psychology perspective, lockdown parameters, and cultural factors. Findings from this study are consistent with the literature on therapists' experiences of video-call therapy in general and add a unique counselling psychology perspective from the context of Aotearoa New Zealand. Findings also highlight considerations for therapists who are transitioning to video-call therapy, whether by choice or necessity.

Key words: *Online therapy, Teletherapy, Videocall therapy, Transition, Covid-19 pandemic, Counselling psychologists*

INTRODUCTION

The utilisation and development of technology-delivered psychological interventions have flourished in recent years (Kraus, Stricker, & Speyer, 2010; Richards & Viganó, 2013). One aspect of technology-delivered interventions is online video-call therapy, which offers clients the benefits of continuing therapy remotely, saving time and money otherwise spent for travel, while allowing for synchronous interactions of speech and body movement in real time (Simpson, 2009). As opposed to in-person therapy, client and therapist use the Internet to communicate with each other in real time (Sucala, Schnur, Brackman, Constantino, & Montgomery, 2013). As therapy occurs in an online environment, video-call therapy is not defined as a form of therapy but rather as a means to deliver therapy (Sucala et al., 2013).

Prior to the COVID-19 pandemic, studies have indicated that technology-based therapeutic tools are effective in treating a variety of mental health presentations including: mood disorders, eating disorders, post-traumatic stress disorder, obsessive compulsive disorder and chronic pain (Beintner, Jacobi, & Taylor, 2012; Loucas et al., 2014; Pozza, Andersson, Antonelli, & Dèttore, 2014; Sloan, Gallagher, Feinstein, Lee, & Pruneau, 2011; Varker, Brand, Ward, Terhaag, & Phelps, 2019). The working alliance in video-call therapies has been shown to be high (Norwood, Moghaddam, Malins, & Sabin-Farrell, 2018) and comparable to the alliance in face-to-face therapies (Bouchard et al., 2004), especially when rated by clients (Ruwaard et al., 2009).

Despite this pre-pandemic empirical support for video-call therapy, other studies have documented therapists' concerns that video-call therapy may detract from the therapeutic relationship (Aafjes–van Doorn, Békés, Prout, & Hoffman, 2022; Alqahtani et al., 2021; Jerome & Zaylor, 2000; Rees & Stone, 2005; Reilly et al., 2022; Van Kessel, Parr, & Feather, 2022), and therapists reported a generally neutral, conservative, or negative view towards integrating video-call therapy into clinical practice (Geller, 2021). Pre-pandemic reluctance towards video-call therapy was linked to a lack of training and lack of empirical evidence on the effectiveness of video-call therapy, ethical risk management and confidentiality concerns (Carper, McHugh, & Barlow, 2013; Van Kessel et al., 2022). The potential for technological glitches and other unforeseen challenges have also been noted in pre-pandemic studies (Aafjes–van Doorn et al., 2022; Al-Mahrouqi et al., 2022; Carper et al., 2013; Sherrill, Wiese, Abdullah, & Arriaga, 2022), and a New Zealand study found that counselling psychologists pre-pandemic generally perceived telepsychology as having a good fit with counselling psychology paradigm, yet also reported the computer screen detracted from the therapeutic relationship, and could result in miscommunication and misinterpretation (Van Kessel et al., 2022). Amongst pre-pandemic research on videocall therapy, there is a noticeable underrepresentation of counselling psychology perspectives (Mallen & Vogel, 2005; Mallen, Vogel, & Rochlen, 2005), which is surprising given its strong emphasis on the therapeutic relationship (Manthei, Stanley, & Gibson, 2004).

Since the start of 2020, the COVID-19 pandemic accelerated the need for remote and flexible methods to deliver mental health care with large parts of the world in 'lockdown' conditions without access to face -to- face mental health care. Video-call therapy emerged as the primary tool for therapists to provide continuity of care, prompting the necessary and rapid uptake of video-call therapy, whatever the therapist's pre-pandemic preferences. Interestingly, there is a lack of general research exploring how psychologists experienced the necessary transition to video-call therapy during the pandemic, and more specifically within Aotearoa New Zealand.

The aims of this study were to explore and document the experiences of counselling psychologists delivering video-call therapy in Aotearoa New Zealand during COVID-19; develop an in-depth and context-based understanding and exploration of the complexities inherent to delivering video-call therapy within a COVID-19 context in Aotearoa New Zealand; and explore how video-call therapy could be integrated into the counselling psychology discipline.

METHOD

This study utilised a qualitative descriptive (QD) approach to understand counselling psychologists' experiences of delivering video-call therapy during COVID-19. As the primary focus of this study was to understand the unique experiences of counselling psychologists, a low-inference interpretation of data that is granted by QD methods was selected as an appropriate method. Although the description of data cannot be free of researcher interpretation, a QD approach encourages the researcher to stay closer to the data, words, and events described by participants compared to other ethnographic or narrative approaches (Sandelowski, 2000).

Participant Recruitment

Participants were recruited through professional network online forums and adverts as well as snowball sampling. Inclusion criteria required participants to be psychologists practicing within the counselling psychology scope and registered with the NZ Psych Board; reside in NZ; and have current or previous experience delivering online therapy during the emergence of the COVID-19 pandemic.

Eight counselling psychologists participated in this study: seven identified as female, and one identified as male. Five identified as New Zealand European, with the remaining three identifying as Tongan European, Māori, and Taiwanese, respectively. Their ages ranged from 26 to 56. Seven were registered counselling psychologists with the New Zealand Psychologists Board, and one was a registered counselling psychology intern. Their lengths of professional registration ranged from six months to eight years. Five worked for a not-for-profit trust, with the remaining three working in a government agency, a primary healthcare organisation, and private practice, respectively.

Data Collection

The method of data collection was through semi-structured interviews (SSI) conducted between 30th July 2021 and 21st September 2021. The SSIs were approximately an hour in length, which is the recommended length in order to minimise fatigue for both the interviewer and participant (Adams, 2015). A list of interview questions was developed prior to the interview process and were informed by current research and literature on video-call therapy, counselling psychology and the impacts of the COVID-19 pandemic. The primary investigator (CK) conducted all interviews using a videoconferencing platform to allow participants to save on travel time and cost of transport and parking, and CK then transcribed the digital audio recordings. Transcripts were checked multiple times to ensure accuracy, with each participant also being offered their transcript for them to review. CK undertook initial data coding and identified potential themes followed by a cross-checking process with two of the other researchers (KvK, EdP). CK developed initial themes' names and definitions and further feedback and clarifications from KvK and EdP were incorporated. Ethical approval for this study was granted by the Auckland University of Technology Ethical Committee (AUTEC) on the 26th of May 2021.

Data Analysis

Braun and Clarke's (2006) six-phase thematic analysis was employed to analyse the transcripts. Phase One (Immersion in the data) focused on becoming familiarised with the data through process of in-depth immersion in the data (Braun & Clarke, 2006). This included the primary investigator listening to the audio recordings of interviews and reading the transcripts of interviews to prompt the note-taking process. Notes were taken on potential themes which were based on emergence of participants' experiences, views, strategies, or approaches in relation to delivering video-call therapy.

Phase Two (Generating initial codes) represented the start of the systematic analysis of the data using a process of generating codes. Codes assist in identifying and providing a label for features in the data that are relevant to the research question (Braun & Clarke, 2006). The primary investigator generated codes by identifying interesting, relevant, and meaningful aspects of the data which were shared across participants (Braun & Clarke, 2006). A process of identifying similarities and differences between participants' experiences of delivering online also began, whereby corresponding codes were grouped together. Notes were also made in relation to the codes.

Phase Three (Generating themes) marked a shift from generating codes to generating themes. A theme refers to a label which captures important aspects of the data in relation to the research question and represents some level of shared responses or meanings within the interviews (Braun & Clarke, 2006). The codes from Phase Two were organised into potential themes. The themes were still developed in a descriptive manner to stay close to the meaning and content of the participants' descriptions. Themes also corresponded to words used by the participants, or meanings they had attributed to their experiences.

Phase Four (Reviewing potential themes) represented a form of quality checking to ensure the potential themes aligned closely with the content and meaning of the data set, remained relevant to the research question, and reflected wider discourse (Braun & Clarke, 2006). To uphold external heterogeneity and internal homogeneity, a process of altering, keeping and discarding themes was required (Patton, 1990). A theme was valid if it was distinctively varied from other themes, whilst also containing subthemes within the theme that were related to each other. This phase prompted an interactive and reflexive process, where data sets were reconsidered to prompt new insights or relevance to a theme. To add to the rigour of the data analysis process (Braun & Clarke, 2006), a cross checking consultation with the other authors was conducted to ensure accurate representation of the data. In this cross-checking process, all authors collaboratively ensured that the themes were relevant to the research question and had good face validity in relation to the codes that comprised them and the discourse in the literature. The primary investigator ensured that the final themes remained aligned with the content and overall meaning of the data set.

In Phase Five (Naming and determining themes), each theme and relevant data extracts were re-read alongside allocating relevant and concise titles to themes and sub-themes. Care was taken to ensure the naming of the themes was close to the participants' own words as possible. The selected themes were chosen to represent central concepts to the phenomenon of delivering video-call therapy in a COVID-19 and clinical context.

Phase Six (Producing the report) included analysing themes individually, with supplementary evidence from the data set through the forms of excerpts being used to clearly demonstrate the theme and its meaning in the participants own language. The findings were grounded in discussions related to the research question, reference to literature, cultural and ethical factors, and implications of this research.

ANALYSIS AND COMMENTARY

Thematic analysis of the eight transcripts revealed four major themes: Pre-pandemic Hesitancy; Managing the Transition; Integrating the Learnings; and Contextual Factors. These are presented and summarised in Figure 1.

Theme 1. Pre-Pandemic Hesitancy

The first theme reflects participants' pre-pandemic hesitancy towards video-call therapy. When participants were asked to reflect retrospectively on their pre-pandemic attitudes towards video-call therapy, seven of the eight participants saw it as an adequate backup in some exceptional circumstances but were hesitant to use it unless necessary. The exceptional circumstances related mainly to accessibility issues

> *"It was a second-best option that was useful when… someone had a problem, and they couldn't leave the house or they had trouble with I don't know getting childcare" (P5)*

The belief that video-call therapy is not conducive to the therapeutic relationship was one of the main reasons participants saw video-call therapy as 'second best'. This appeared to be a particularly important concern during long assessment interviews and before a therapeutic relationship has been established. Additional hesitancies reported were difficulty noticing subtle processes such as non-verbal communication and unforeseen failures and obstacles that may arise from video-call therapy technology. The prevailing pre-pandemic perspective on video-call therapy was that it was: suboptimal in its ability to maintain and particularly to establish a therapeutic relationship; suboptimal in its ability to notice and use subtle therapeutic processes; prone to technological mishaps; but nonetheless useful as a backup given its accessibility advantages.

> *"A lot of us have been hesitant to do two- or three-hour assessments on video… not just because of the length of time on screen… You have to think about other ways to build that relationship, especially if it's the first assessment session" (P7)*

Theme 2. Managing the Transition

The second theme reflects how participants managed the necessary transition to video-call therapy. Lockdown restrictions imposed a sudden requirement to either stop therapy or transition to online platforms. This necessitated therapists to immediately prepare themselves to deliver therapy online, not just practically, but also psychologically and emotionally, while continuing to uphold ethical and competent practice throughout a disruptive and uncertain time. Four common considerations were identified in how participants adapted to this forced transition: practical considerations; peer support; transparency; and flexibility.

Practical Considerations: – Physical, Technological, Educational

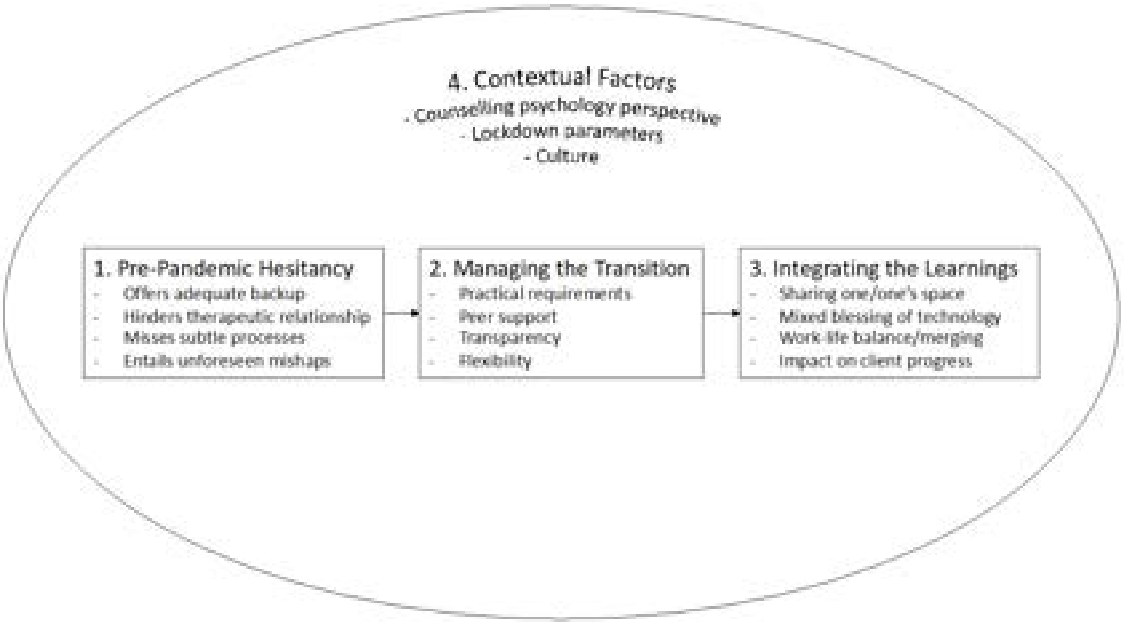
Participants viewed video-call therapy as having different physical, technological, and knowledge requirements than does in person therapy. Although the interaction occurs online, participants noted that the physical room in which the therapist sits is still important in its ability to convey meaning, create a desired atmosphere, and maintain privacy. Participants also noted the need to consider the technological requirements, such as adequate computer systems, internet connection, licenses for online platforms, even tripods and computer stands to enhance the online experience. Finally, participants reflected on their self-guided learning around how best to deliver video-call therapy. However, they also noted the need for more training resources and best-practice guidelines specific to video-call therapy.

> *"Maybe a bit more information and a bit more research… and just really accessible resources and information that is clear but not too lengthy" (P4)*

Peer Support – Connection, Solidarity, Learning

Participants reported the importance of peer support for their successful rapid adaptation to video-call therapy. Planning time to meet online with peers offered a sense of social connection, solidarity in the face of shared

Figure 1. *Major themes and main considerations*



challenges, and opportunities for informal learning from how others have navigated the new challenges. Five participants also reported the importance of solicited guidance from more experienced psychologists or supervisors, particularly in relation to maintaining ethical and culturally safe practice online.

> *"We've scheduled both formal and informal meetings. So formal meetings we talk about the client stuff and the informal meetings – it's Friday afternoon where we bring our snacks and drinks… and we just chat about life… or rant about work" (P7)*

Transparency – Keeping the Client in the Loop

Participants made sure to keep clients updated with what services they are offered during lockdown. Transparency also involved recognising that both the therapist and client were navigating an uncertain environment, both in terms of the pandemic response in general and the new way of doing therapy. Transparency in this context created an opportunity for collaboration and acceptance that some participants found useful.

> *"I think, overall, it became a positive experience because we made it that way… Between the client and I… we accepted 'okay this is the way it is, so how are we going to make the most of the situation?'" (P8)*

Flexibility – Overcoming New Challenges and Recognising New Advantages

The new challenges that therapists faced through their rapid imposed transition to video-call therapy were novel to the therapist and different for different clients, and required being open to creative solutions to each client's unique set of circumstances. Part of this entailed accepting that although everyone was going through the same pandemic, not everyone had the same experience or needs. Indeed, the transition required accepting that some clients chose to wait until face-to-face sessions resumed.

> *"[Therapists] are more mindful that maybe some clients don't want to show others their home, so [clients] just refuse video outright. So, I think from the therapist's side, you have to be willing to be more flexible" (P7)*

Flexibility not only describes the ability to manage oneself in a new set of constraints, but it also describes the ability to recognise new advantages within the new context. Exploring the affordances of online platforms allowed participants to change how they did therapy in ways that offered unique benefits.

Theme 3. Post-Transition Understandings – Uncovering Key Considerations for Effective Video-call Therapy.

The third theme reflects participants' understanding of video-call therapy following the transition phase. Through trial and error across repeated lockdowns, participants' pre-pandemic hesitancies towards video-call therapy transformed into a more nuanced understanding of advantages and challenges of video-call therapy and how to manage these in different contexts. Their reported experiences reflect that the characteristics of video-call therapy that are challenging in some respects are helpful in others. These trade-offs reveal that video-call therapy is not necessarily better or worse than in person therapy, but rather it is different. Four overarching trade-offs were identified within this theme.

From Sharing One Space to Sharing One's Space - Seeing Each Other in Our Home Environments

Transitioning from in-person to video-call therapy during lockdown entailed client and therapist no longer meeting in the same physical room, but rather meeting online from within their own personal living spaces. As noted, in Theme 1, participants expressed the pre-pandemic view that not sharing the same space will hinder the therapeutic relationship and the non-verbal cues that support it. While it was generally acknowledged that this did have some impact, three participants were surprised at the depth of the connection fostered online. Some hypothesised that their therapeutic relationships were less impacted than expected because key elements of developing and maintaining the relationships were still possible online. Interestingly, more than half of the participants reported a different kind of intimacy granted by seeing each other in their own home environments. This was seen as particularly valuable for those who work with family system approaches, as being virtually in the client's own living space afforded an increased opportunity to engage with their family.

> *"You lose the intimacy of being in a room with someone, but somehow now there's this other intimacy that's there, in that I'm talking to a person inside their own home and they're seeing me inside my own home" (P4)*

The shift away from sharing a physical therapy room meant the participants had less control over important aspects of the therapeutic environment, such as privacy and safety. Participants reported that some clients seemed more comfortable and open at home, particularly those for whom the closeness from sharing a room with a therapist may be uncomfortable. However, participants also recognised that these unique advantages applied only to the extent that the client experienced video-call therapy in their home environment as safe and confidential. Indeed, it was noted that some cases, such as those involving family violence, required serious ethical consideration around confidentiality and risk.

> *"I noticed in lockdown everybody's at home so my clients are having to talk really quietly or not being able to be totally authentic and honest because someone might hear. And just… I had a client in a domestic violence relationship… he was quite controlling of her [the client] so she wasn't able to go for a walk to chat with me" (P3)*

Given that participants no longer had control over the safety and privacy of the therapeutic environment, the impact of this transition partly depended on the safety and privacy of the client's home and the extent to which they presented with risk.

The Mixed Blessing of Technology

Participants reported they appreciated the increased accessibility, and also found technological mishaps challenging, particularly when dealing with risk or highly sensitive content. Some participants learned that the technological interface itself enhanced their connection with some clients, and hypothesised that the distance from interacting online may feel safer for some clients. However, some participants noted that interacting through a screen for long periods of time made them feel more tired, citing possible reasons such as exerting extra energy compensating for the lack of non-verbal communication that is afforded by face-to-face therapy. Some therefore chose to either shorten their sessions or reduce the number of clients per day. Four participants also noted the effects of seeing themselves on the screen. Two found it distracting or became hyperaware of themselves (this can also add to fatigue), while the others found it insightful to notice and reflect on how they use non-verbal communication.

> *"I learnt a lot about how I move my hands, my own body language, sort of how I position myself" (P2)*

The extent to which technology is a blessing, or the technological mishaps are a significant disruption, may be partly moderated by the therapist's and client's existing familiarity with using online communication tools. Some participants noted that this balance tended to be associated with age, with younger clients, such as university students, apparently having no issues with the technological side of video-call therapy.

Working from Home – Enabling Work-Life Balance and Blurring Work-Life Boundaries

Working from home was typically experienced as time-efficient, freeing up more time to engage in other meaningful activities. For some participants, this meant more time for other work-related tasks. For others it meant more time for self-care, contributing to a greater sense of work-life balance. The merging of therapist's personal and professional lives was sometimes reported as pleasant, such as feeling more comfortable doing therapy from home in comfortable clothes yet was also reported as challenging, such as when engaging in emotionally demanding work.

> *"The other challenge I guess is just personally like being in your home space and doing some quite heavy work… You're sort of sitting in people's trauma a lot and in your own home, in your own space. So I know I personally prefer to go to an office and then have this process of being able to leave that [work] in the office" (P5)*

Perceived Impact on Client Progress

Participants noted that the efficacy of video-call therapy for their clients depended partly on their clients' presenting problems. Six participants noted that clients presenting with higher risk, post-traumatic stress disorder, or borderline personality disorder appeared to make less progress online than in person. Three participants noted that clients with social anxiety tended to feel better, but they were not sure if this was due to progress during video-call therapy or the general removal of their anxiety-provoking situations from lockdowns. Conversely, one participant had a client who struggled with online technology and who made better progress through the increased exposure to using video-call therapy. Finally, participants noted that some clients opted to wait until in-person therapy was available again, halting progress altogether.

> *"There are a lot of people who felt their anxiety was dropping because they no longer had to expose themselves to certain situations…So I felt with some of my clients it was actually kind of hard to measure progress" (P1)*

Theme 4. Contextual Factors Influencing Experience of Video-call therapy

The fourth theme reflects participants' descriptions of broader contextual factors that influenced their experience of video-call therapy during the pandemic: the counselling psychology perspective, lockdown parameters themselves and cultural factors.

Counselling Psychology Perspective

Participants noted that their counselling psychology perspective influenced how they approached the transition to video-call therapy. While their emphasis on the therapeutic relationship underpinned some of their reservations around whether an effective relationship could be established and maintained online, it also underpinned their continual effort to do so. Similarly, counselling psychology's emphasis on the context in which the client is embedded primed participants to notice the ways that video-call therapy enhanced their contextual and phenomenological understanding. The act of offering video-call therapy itself was seen as consistent with counselling psychology's systemic emphasis.

> *"I think that when we consider context, that can mean working in ways that considers the systems people are in. In particular, when we are going through lockdowns… there is genuinely a direct barrier to face-to-face therapy. So, in some ways, I see video-call therapy as being a really ethical choice, particularly through a pandemic, because we are considering systems in which people are now shifting and living their lives and this is removing a barrier to accessing care" (P1)*

If the systems in which a client is embedded impact their ability to access in-person therapy (in this case, a public health system mandating the use of lockdowns), then offering video-call therapy was considered a flexible way of meeting the client where they are at.

Lockdown Parameters – Restrictions and Repetitions

At a basic level, lockdown restrictions created the sudden need to transition to video-call therapy and required participants to do this from their living space rather than from an external location. Interestingly, the fact that there were repeated lockdowns was noted by participants and provided opportunity to acclimatise to video-call therapy and refine their approach with each successive exposure.

> *"Each [lockdown] has kind of gotten a little bit better… as we're more, I guess used to it or prepared for it" (P5)*

Culture

Many participants noted that the client's cultural identity and the therapist's cultural competence could influence the extent to which transitioning to online methods impacted the therapeutic relationship. Some participants described giving extra attention to exploring how to create a culturally safe environment online (flexibility), including attending cultural supervision (peer support).

> *"So for me it was really difficult like 'right, how do I facilitate an environment [online] where [clients] could feel comfortable bringing that cultural element into the session" (P2)*

One participant noticed a disproportionate reduction in their Māori and Pasifika client numbers during lockdown, hypothesising that they may have wanted more privacy around their therapy than their home environment could offer. Another participant noticed a similar trend with younger clients – namely that they wanted to keep their therapy more private from their parents (sharing one's space) yet younger participants also tended to take to video-call therapy more readily than did older ones.

> *"I mean, for millennial clients and younger clients, technology is great for them because they're all over it" (P4)*

Participants hypothesised this openness to video-call therapy was due to their youth culture's familiarity with online platforms (the mixed blessing of technology).

CONCLUSIONS AND IMPLICATIONS

This research sought to understand how counselling psychologists in Aotearoa New Zealand experienced online video-call therapy and the rapid transition to it during the COVID-19 pandemic. The findings suggest that participants' pre-pandemic hesitancies towards online video-call therapy morphed into more nuanced understandings of its advantages and challenges. These nuanced understandings, and the factors that influenced the transition process, offer considerations for others who are introducing more video-call therapy in their work.

From Pre-Pandemic Hesitancies to Post-Transition Understandings

Participants in the current study expressed pre-pandemic hesitancies consistent with the literature. In particular, the perception that video-call therapy is less conducive to developing a therapeutic relationship and noticing subtleties, such as nonverbal cues and transference/countertransference (Aafjes–van Doorn et al., 2022; Alqahtani et al., 2021; Reilly et al., 2022; Wray & Rees, 2003). Unforeseen challenges, particularly technological ones (Carper et al., 2013), and the anxiety or doubt around whether one is competent to manage them is also commonly reported (Aafjes-van Doorn, Békés, & Prout, 2021; Aafjes–van Doorn et al., 2022; Al-Mahrouqi et al., 2022; Sherrill et al., 2022). These concerns contribute to the perception that video-call therapy is sub-optimal though useful in certain contexts, such as when accessibility is limited (Reilly et al., 2022).

Interestingly, after repeated pandemic lockdowns in which therapy either had to go online or stop, participants in the current study developed a more nuanced appreciation and optimism towards video-call therapy's potential utility and effectiveness – a general trend shared by many studies documenting therapists' experiences of OT during the pandemic (e.g., Aafjes-van Doorn, 2022; Aafjes–van Doorn et al., 2022; Ahlström, Von Below, Forsström, & Werbart, 2022; Dowling et al., 2022; Emran, Smith, & Iqbal, 2022; Kotera, Kaluzeviciute, Lloyd, Edwards, & Ozaki, 2021; Reilly et al., 2022; Sherrill et al., 2022; Shklarski, Abrams, & Bakst, 2021; Tomaino, Viganò, & Cipolletta, 2022).

One of the most salient differences between in-person and online video-call therapy is that the client and therapist no longer sit in the same room. Findings from the current study suggested that an effective relationship could still be maintained online even if it was different in some ways, consistent with other research (Aafjes-van Doorn et al., 2021; Aafjes–van Doorn et al., 2022; Banack, 2021; Fernández-Álvarez & Fernández-Álvarez, 2021; Gordon, Shi, Scharff, Fishkin, & Shelby, 2021; Reilly et al., 2022; Shklarski et al., 2021). Study participants' success in this domain may be partly attributable to the high importance counselling psychologists place on the therapeutic relationship (du Preez, Feather, & Farrell, 2016; Manthei et al., 2004; Stanley, 2013), combined with their attitude of openness and flexibility expressed towards working with the affordances of an online context.

It is noteworthy that participants in the current study did find online video-call therapy more tiring, which is consistent with other research (Aafjes-van Doorn, 2022; Aafjes–van Doorn et al., 2022; Ahlström et al., 2022; Békés, Aafjes–van Doorn, Prout, & Hoffman, 2020; Emran et al., 2022; Goldschmidt et al., 2021; Sampaio, Navarro Haro, De Sousa, Vieira Melo, & Hoffman, 2021; Shklarski et al., 2021). This fatigue may be partly explained by the extra effort spent on transferring relational skills to a two-dimensional screen, and by simultaneously managing the impact of the pandemic on oneself while supporting the client to do the same (Barry & Singer, 2022; Békés et al., 2020; Nuttman-Shwartz & Shaul, 2021). Research is emerging on how to foster and maintain therapeutic relationships online (Banack, 2021; Geller, 2021; Rodgers, Tudor, & Ashcroft, 2021). As these guidelines develop, and therapists become more familiar with online video-call therapy and managing its challenges, the perceived effort to establish and maintain relationships online may decrease. Indeed, research suggests that through exposure and experience, video-call therapy typically becomes less challenging over time (Sherrill et al., 2022).

The lockdown restrictions meant that client and therapist joined the online session from their own homes, entailing the sharing of their personal spaces with each other. Our participants noted that the privacy and safety of the therapeutic environment therefore depended on the privacy and safety of the client's home, which is a concern echoed in the literature (Al-Mahrouqi et al., 2022; Downing, Marriott, & Lupton, 2021; Emran et al., 2022; Goldschmidt et al., 2021; James, Schröder, & De Boos, 2022; Jurcik et al., 2021; Kotera et al., 2021; Reilly et al., 2022; Shklarski et al., 2021; Smith & Gillon, 2021; Tomaino et al., 2022). In cases where privacy is a concern, flexibility around timing (e.g., clients waiting for a private moment) and mode (e.g., texting or emailing for support rather than video calling) may be helpful.

Given the lack of therapist control over the safety of the client's home, some participants wondered if video-call therapy is not suited for higher risk cases, consistent with similar research (Appleton et al., 2021; Reilly et al., 2022; Smith & Gillon, 2021). In cases where the home environment is relatively safe, the glimpse into each other's private lives may actually improve some aspects of the relationship and offer a more direct understanding of the client's ways of relating to their environment, as found by many of our participants and other similar studies (Ahlström et al., 2022; Shklarski et al., 2021; Smith & Gillon, 2021; Tomaino et al., 2022). Participants in the current study noted that the ability to experience aspects of a client's context through online video-call therapy suited the counselling psychology approach, with its emphasis on understanding the systems of which the client is a part (du Preez & Goedeke, 2013).

Video-call therapy from home also entails a change in the boundaries between personal life and work life (Alqahtani et al., 2021; James et al., 2022; Reilly et al., 2022). The current participants appreciated the convenience of working from home because it freed up more time for other important aspects of their lives, such as self-care and personal or professional development, as found in other research (Al-Mahrouqi et al., 2022). At the same time participants noted that aspects of work could seep into their personal lives in undesirable ways, such as noticing residual uncomfortable feelings in their home after working with heavy content. Therapists transitioning to video-call therapy might wish to consider boundaries between their personal and professional lives. Although not an option during lockdowns, therapists working online at other times might wish to do so from their office, so that their usual rituals around putting on their professional persona and travelling to and from work remain intact. Alternatively, new rituals could be established to help enter in and out of work/therapy mode when working from home (Geller, 2021).

Participants in the current study felt that most clients who engaged in online video-call therapy during lockdown progressed well. However, they also noted that this mode of therapy suited some clients more than others. Conversely, participants expressed hesitation towards working online with clients at higher risk of self-harm or with higher severity disorders, which is a trend found in the literature (Aafjes-van Doorn, 2022; Appleton et al., 2021; Fernández-Álvarez & Fernández-Álvarez, 2021; Kotera et al., 2021; Melluish, Bhola, Gutierrez, Critchfield, & Atwood, 2022; Reilly et al., 2022; Smith & Gillon, 2021). Participants also wondered if online video-call therapy enabled the avoidance of social situations and therefore was less conducive to treating social anxiety symptoms, which is also echoed in the literature (Jurcik et al., 2021). Research is emerging on how to work with specific disorders online (e.g., Komariah et al., 2022; Stewart et al., 2021), and as this research grows, therapists may gain the confidence to work with presentations that have typically been considered challenging to work with online.

Contextual Considerations

Participants noted that the more nuanced understandings gained from video-call therapy experience intersected with cultural variation. Their observation that millennials and high school or university students seemed more comfortable communicating online, has been supported by other research (Dowling et al., 2022). In addition to age, political-economic considerations around inequity in the access to fast internet and laptops/smartphones may also influence the accessibility of video-call therapy for clients (Dowling et al., 2022; Goldschmidt et al., 2021; Melluish et al., 2022). Video-call therapy is generally viewed as more accessible, yet this may only apply to cultural and sociodemographic groups who hold adequate access to technology, internet, and private spaces to attend video-call therapy sessions. Māori participants in a recent New Zealand study reported many benefits to telehealth consultations yet also mentioned barriers to digital access, which have the potential to widen disparities (Wikaire et al., 2022). Future research could explore factors which may restrict access to care/video-call therapy for certain cultural and socio-economic groups. The challenges in nurturing vā with Pasifika communities in online spaces during COVID-19 is not widely researched in the Aotearoa New Zealand psychology context, though this is a noticeable concern cited among related research (Faleolo, 2021; Matapo, 2021; Refiti et al., 2021).

The lockdown restrictions themselves were a shared context, for both the participants and their clients, that simultaneously provided the challenge and the opportunity to become more familiar with online video-call therapy and its affordances. As already outlined, a resounding pattern within the literature on therapist experiences of video-call therapy during the COVID-19 pandemic is one in which video-call therapy is "better than expected" (Dowling et al., 2022, p. 1). Sherrill et al. (2022) conceptualised this in terms of exposure for technophobia. The nature of recurring lockdowns in Aotearoa New Zealand created repeated exposure opportunities of video-call therapy, allowing participants to practice and consolidate their experiences and learnings of this means of delivering therapy.

Managing the Transition

The finding that participants felt the need to self-educate given the lack of explicit guidelines and training for how to do effective therapy online is also echoed in the literature (e.g., Aafjes–van Doorn et al., 2022; Ahlström et al., 2022; Al-Mahrouqi et al., 2022; Goldschmidt et al., 2021; Kotera et al., 2021; Reilly et al., 2022; Tomaino et al., 2022). This educational gap has started to be addressed, with recent research towards developing guidelines and training programs emerging for video-call therapy in general and in relation to specific modes of therapy and client presentations (e.g., Cavanagh, Gerson, Gleason, Mackey, & Ciulla, 2022; Dolev-Amit, Leibovich, & Zilcha-Mano, 2021; Foroughe, Soliman, Bean, Thambipillai, & Benyamin, 2022).

Transparency with clients was also found to help with the transition to video-call therapy. Given that both therapist and client were affected by the pandemic, some level of transparency from the therapist about how they were experiencing the pandemic may have helped to strengthen the relationship and normalise some of the client's own struggles (e.g., Shklarski et al., 2021). Participants in the current student described their ability to be flexible. Given the uncertainty around how the pandemic would unfold, the requirement to transition to online video-call therapy, and the pre-pandemic hesitancies towards video-call therapy, having an open and flexible attitude may have facilitated exploration of what online video-call therapy had to offer, increasing the potential for learning.

The propensity of our participants to embody a flexible and collaborative attitude is consistent with counselling psychology. Counselling psychology distinctively embraces contextual factors in a person's life, including those that constrain them beyond their control, while working towards empowerment within those constraints. In other words, it is often about helping people to do what is important to them using what is available to them. Therapists were similarly required to do what they could within the constraints of the pandemic. Continuing to be present, empathetic, relationship-centric therapists in clients' lives, given the markedly changed set of available means through which to do so, required precisely the kind of flexibility that counselling psychologists help clients to adopt in the face of their own challenges. Modelling this flexibility therefore became an opportunity for congruence between what therapists practice and what they preach.

Conclusion

As we live in a world that is increasingly characterised by online interactions, it is useful for counselling psychologists to competently meet clients in that space. The pandemic conferred a fast-tracked exposure to video-call therapy and stimulated rapid adaptations to it. As a profession, counselling psychologists can now take stock of what was learned and build on their understanding of how to be an effective online therapist and provide effective video-call therapy. An optimistic general message can be taken from his qualitative study with counselling psychologists in Aotearoa New Zealand during the COVID-19 pandemic. That is, online video-call therapy is not necessarily better or worse, but it can be used effectively, particularly when the therapist is flexible and open towards learning new ways of building relationships online, is willing to adjust workload depending on the fatigue they feel, can relinquish some of the influence over the physical environment for a given client, and is comfortable with exploring how to navigate a new set of boundaries between therapy and daily life. The pursuit of becoming competent with online video-call therapy is an extension of the same process that therapists are already embedded in. That is, continuing education so that psychologists may competently meet clients where they are at. This study has provided a practice-oriented understanding into counselling psychologists' experiences of video-call therapy and how the discipline impacts their delivery, views, and ideas about the ongoing integration of video-call therapy as part of their clinical practice.

References

Aafjes-van Doorn, K. (2022). The complexity of teletherapy: Not better or worse, but different.

Aafjes-van Doorn, K., Békés, V., & Prout, T. A. (2021). Grappling with our therapeutic relationship and professional self-doubt during COVID-19: will we use video therapy again? *Counselling Psychology Quarterly, 34*(3-4), 473-484.

Aafjes–van Doorn, K., Békés, V., Prout, T. A., & Hoffman, L. (2022). Practicing Online During COVID-19: Psychodynamic and Psychoanalytic Therapists' Experiences. *Journal of the American Psychoanalytic Association, 70*(4), 665-694.

Adams, W. C. (2015). Conducting semi-structured interviews. *Handbook of practical program evaluation*, 492-505.

Ahlström, K., Von Below, C., Forsström, D., & Werbart, A. (2022). Therapeutic encounters at the onset of the COVID-19 pandemic: psychodynamic therapists' experiences of transition to remote psychotherapy. *Psychoanalytic Psychotherapy*, 1-19.

Al-Mahrouqi, T., Al-Alawi, K., Al-Alawi, M., Al Balushi, N., Al Ghailani, A., Al Sabti, H., & Al Sinawi, H. (2022). A promising future for tele-mental health in Oman: A qualitative exploration of clients and therapists' experiences. *SAGE Open Medicine, 10*, 20503121221086372.

Alqahtani, M., Alkhamees, H., Alkhalaf, A., Alarjan, S., Alzahrani, H., AlSaad, G., . . . Alqahtani, K. (2021). Toward establishing telepsychology guideline. Turning the challenges of COVID-19 into opportunity. *Ethics, Medicine and Public Health, 16*, 100612.

Appleton, R., Williams, J., San Juan, N. V., Needle, J. J., Schlief, M., Jordan, H., . . . Roxburgh, E. (2021). Implementation, adoption, and perceptions of telemental health during the COVID-19 pandemic: systematic review. *Journal of Medical Internet Research, 23*(12), e31746.

Banack, K. D. (2021). Adapting emotion-focused therapy for teletherapy. *Person-Centered & Experiential Psychotherapies, 20*(4), 303-311.

Barry, J. E., & Singer, J. B. (2022). Finding Our Way Together: Relational Therapy during a Global Pandemic. In *Shared Mass Trauma in Social Work* (pp. 131-153): Routledge.

Beintner, I., Jacobi, C., & Taylor, C. B. (2012). Effects of an Internet-based prevention programme for eating disorders in the USA and Germany—A meta-analytic review. *European Eating Disorders Review, 20*(1), 1-8.

Békés, V., Aafjes–van Doorn, K., Prout, T. A., & Hoffman, L. (2020). Stretching the analytic frame: Analytic therapists' experiences with remote therapy during COVID-19. *Journal of the American Psychoanalytic Association, 68*(3), 437-446.

Bouchard, S., Paquin, B., Payeur, R., Allard, M., Rivard, V., Fournier, T., . . . Lapierre, J. (2004). Delivering cognitive-behavior therapy for panic disorder with agoraphobia in videoconference. *Telemedicine Journal and E-health, 10*(1), 13-25.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Carper, M. M., McHugh, R. K., & Barlow, D. H. (2013). The dissemination of computer-based psychological treatment: a preliminary analysis of patient and clinician perceptions. *Administration and Policy in Mental Health and Mental Health Services Research, 40*, 87-95.

Cavanagh, R., Gerson, S. M., Gleason, A., Mackey, R., & Ciulla, R. (2022). Competencies Needed for Behavioral Health Professionals to Integrate Digital Health Technologies into Clinical Care: a Rapid Review. *Journal of Technology in Behavioral Science*, 1-14.

Dolev-Amit, T., Leibovich, L., & Zilcha-Mano, S. (2021). Repairing alliance ruptures using supportive techniques in telepsychotherapy during the COVID-19 pandemic. *Counselling Psychology Quarterly, 34*(3-4), 485-498.

Dowling, D., Martland, N., King, S., Nguyen, J., Neely, E., Ball, J., . . . McNulty, N. (2022). Better than expected: client and clinician experiences of videoconferencing therapy (VT) during the COVID-19 pandemic. *The Cognitive Behaviour Therapist, 15*.

Downing, L., Marriott, H., & Lupton, D. (2021). "'Ninja'levels of focus": Therapeutic holding environments and the affective atmospheres of telepsychology during the COVID-19 pandemic. *Emotion, Space and Society, 40*, 100824.

du Preez, E., Feather, J., & Farrell, B. (2016). Counselling psychology in New Zealand. *Counselling Psychology Quarterly, 29*(2), 163-170.

du Preez, E., & Goedeke, S. (2013). Second order ethical decision-making in counselling psychology: Theory, practice and process. *New Zealand Journal of Psychology, 42*(3), 44-49.

Emran, A., Smith, J. A., & Iqbal, N. (2022). Psychotherapists' experience of the transition to telepsychotherapy amidst COVID-19 in India. *Counselling Psychology Quarterly*, 1-24.

Enari, D. &Matapo, J. (2021). Negotiating the relational vā in the University: A transnational Pasifika standpoint during the Covid-19 pandemic. *Journal of Global Indigineity, 5*.

Faleolo, R. (2021). Talanoa moe vā: Pacific knowledge-sharing and changing sociocultural spaces during COVID-19. *Waikato Journal of Education, 26*, 125-134.

Fernández-Álvarez, J., & Fernández-Álvarez, H. (2021). Videoconferencing psychotherapy during the pandemic: exceptional times with enduring effects? *Frontiers in Psychology, 12*, 589536.

Foroughe, M., Soliman, J., Bean, B., Thambipillai, P., & Benyamin, V. (2022). Therapist adaptations for online caregiver emotion-focused family therapy during the COVID-19 pandemic. *Person-Centered & Experiential Psychotherapies, 21*(1), 1-15.

Geller, S. (2021). Cultivating online therapeutic presence: strengthening therapeutic relationships in teletherapy sessions. *Counselling Psychology Quarterly, 34*(3-4), 687-703.

Goldschmidt, L., Langa, M., Masilela, B., Ndhlovu, L. M., Mncina, B., Maubane, B., & Bujela, K. (2021). Telepsychology and the COVID-19 pandemic: the experiences of psychologists in South Africa. *South African Journal of Psychology, 51*(2), 314-324.

Gordon, R. M., Shi, Z., Scharff, D. E., Fishkin, R. E., & Shelby, R. D. (2021). International Survey of Negative and Positive Reactions to Psychoanalytic Distance Treatment at the Beginning of the Pandemic1. *Int J Psychological Psychoanalysis, 7*, 053.

James, G., Schröder, T., & De Boos, D. (2022). Changing to remote psychological therapy during COVID-19: Psychological therapists' experience of the working alliance, therapeutic boundaries and work involvement.

Psychology and Psychotherapy: Theory, Research and Practice, 95, 970-989.

Jerome, L. W., & Zaylor, C. (2000). Cyberspace: Creating a therapeutic environment for telehealth applications. *Professional Psychology: Research and Practice, 31*(5), 478.

Jurcik, T., Jarvis, G. E., Zeleskov Doric, J., Krasavtseva, Y., Yaltonskaya, A., Ogiwara, K., . . . Grigoryan, K. (2021). Adapting mental health services to the COVID-19 pandemic: reflections from professionals in four countries. *Counselling Psychology Quarterly, 34*(3-4), 649-675.

Komariah, M., Amirah, S., Faisal, E. G., Prayogo, S. A., Maulana, S., Platini, H., . . . Arifin, H. (2022). *Efficacy of Internet-Based Cognitive Behavioral Therapy for Depression and Anxiety among Global Population during the COVID-19 Pandemic: A Systematic Review and Meta-Analysis of a Randomized Controlled Trial Study.* Paper presented at the Healthcare.

Kotera, Y., Kaluzeviciute, G., Lloyd, C., Edwards, A.-M., & Ozaki, A. (2021). Qualitative Investigation into Therapists' Experiences of Online Therapy: Implications for Working Clients. *International Journal of Environmental Research and Public Health, 18*(19), 10295.

Kraus, R., Stricker, G., & Speyer, C. (2010). *Online counseling: A handbook for mental health professionals*: Academic Press.

Loucas, C. E., Fairburn, C. G., Whittington, C., Pennant, M. E., Stockton, S., & Kendall, T. (2014). E-therapy in the treatment and prevention of eating disorders: a systematic review and meta-analysis. *Behaviour Research and Therapy, 63,* 122-131.

Mallen, M. J., & Vogel, D. L. (2005). Introduction to the major contribution: Counseling psychology and online counseling. *The counseling psychologist, 33*(6), 761-775.

Mallen, M. J., Vogel, D. L., & Rochlen, A. B. (2005). The practical aspects of online counseling: Ethics, training, technology, and competency. *The Counseling Psychologist, 33*(6), 776-818.

Manthei, R., Stanley, P., & Gibson, K. (2004). Counselling and Counselling Psychology in New Zealand: Similarities and Differences. *New Zealand Journal of Counselling, 25*(1).

Melluish, S., Bhola, P., Gutierrez, M. C., Critchfield, K., & Atwood, K. (2022). Psychological impact and clinical psychology responses to COVID-19: Comparative case studies from Cuba, Ethiopia, India, the United Kingdom, and the United States. *International Perspectives in Psychology: Research, Practice, Consultation, 11*(2), 98.

Norwood, C., Moghaddam, N. G., Malins, S., & Sabin-Farrell, R. (2018). Working alliance and outcome effectiveness in videoconferencing psychotherapy: A systematic review and noninferiority meta-analysis. *Clinical Psychology & Psychotherapy, 25*(6), 797-808.

Nuttman-Shwartz, O., & Shaul, K. (2021). Online therapy in a shared reality: The novel coronavirus as a test case. *Traumatology, 27,* 365-374.

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.): SAGE Publications, inc.

Pozza, A., Andersson, G., Antonelli, P., & Dèttore, D. (2014). Computer-delivered cognitive-behavioural treatments for obsessive compulsive disorder: preliminary meta-analysis of randomized and non-randomized effectiveness trials. *The Cognitive Behaviour Therapist, 7,* e16.

Rees, C. S., & Stone, S. (2005). Therapeutic alliance in face-to-face versus videoconferenced psychotherapy. *Professional Psychology: Research and Practice, 36*(6), 649-653.

Refiti, L. i. A., Engels-Schwarzpaul, A.-C. T., Lopesi, L., Lythberg, B., Waerea, L., & Smith, V. (2021). Vā at the time of Covid-19: When an aspect of research unexpectedly turns into lived experience and practice. *Journal of New Zealand & Pacific Studies, 9*(1), 77-85.

Reilly, K., Maher, M., Smith, E., Coyne, E., Murphy, S., & Wilson, C. (2022). A qualitative exploration of psychologists' experiences of teletherapy within the Irish Public Mental Health System. *Counselling and Psychotherapy Research, 22,* 644-657.

Richards, D., & Viganó, N. (2013). Online counseling: A narrative and critical review of the literature. *Journal of clinical psychology, 69*(9), 994-1011.

Rodgers, B., Tudor, K., & Ashcroft, A. (2021). Online video conferencing therapy and the person-centered approach in the context of a global pandemic. *Person-Centered & Experiential Psychotherapies, 20*(4), 286-302.

Ruwaard, J., Schrieken, B., Schrijver, M., Broeksteeg, J., Dekker, J., Vermeulen, H., & Lange, A. (2009). Standardized web-based cognitive behavioural therapy of mild to moderate depression: a randomized controlled trial with a long-term follow-up. *Cognitive behaviour therapy, 38*(4), 206-221.

Sampaio, M., Navarro Haro, M. V., De Sousa, B., Vieira Melo, W., & Hoffman, H. G. (2021). Therapists make the switch to telepsychology to safely continue treating their patients during the COVID-19 pandemic. Virtual reality telepsychology may be next. *Frontiers in Virtual Reality, 1,* 576421.

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health, 23*(4), 334-340.

Sherrill, A. M., Wiese, C. W., Abdullah, S., & Arriaga, R. I. (2022). Overcoming Clinician Technophobia: What We Learned from Our Mass Exposure to Telehealth During the COVID-19 Pandemic. *Journal of Technology in Behavioral Science, 7*(4), 547-553.

Shklarski, L., Abrams, A., & Bakst, E. (2021). Navigating changes in the physical and psychological spaces of psychotherapists during Covid-19: When home becomes the office. *Practice Innovations, 6*(1), 55.

Simpson, S. (2009). Psychotherapy via videoconferencing: A review. *British Journal of Guidance & Counselling, 37*(3), 271-286.

Sloan, D. M., Gallagher, M. W., Feinstein, B. A., Lee, D. J., & Pruneau, G. M. (2011). Efficacy of telehealth treatments for posttraumatic stress-related symptoms: a meta-analysis. *Cognitive Behaviour Therapy, 40*(2), 111-125.

Smith, J., & Gillon, E. (2021). Therapists' experiences of providing online counselling: A qualitative study. *Counselling and Psychotherapy Research, 21*(3), 545-554.

Stanley, P. (2013). Defining counselling psychology: what do all the words mean? *New Zealand Journal of Psychology (Online), 42*(3), 27-34.

Stewart, C., Konstantellou, A., Kassamali, F., McLaughlin, N., Cutinha, D., Bryant-Waugh, R., . . . Baudinet, J. (2021). Is this the 'new normal'? A mixed method investigation of young person, parent and clinician experience of online eating disorder treatment during the

COVID-19 pandemic. *Journal of Eating Disorders, 9*(1), 1-11.

Sucala, M., Schnur, J. B., Brackman, E. H., Constantino, M. J., & Montgomery, G. H. (2013). Clinicians' attitudes toward therapeutic alliance in E-therapy. *The Journal of General Psychology, 140*(4), 282-293.

Tomaino, S. C. M., Viganò, G., & Cipolletta, S. (2022). The COVID-19 Crisis as an Evolutionary Catalyst of Online Psychological Interventions. A Systematic Review and Qualitative Synthesis. *International Journal of Human–Computer Interaction*, 1-13.

Van Kessel, K., Parr, C., & Feather, J. S. (2022). New Zealand Counselling Psychologists' Views and Experiences of Using Telepsychology in Clinical Practice. *New Zealand Journal of Psychology, 51*(1), 28-35.

Varker, T., Brand, R. M., Ward, J., Terhaag, S., & Phelps, A. (2019). Efficacy of synchronous telepsychology interventions for people with anxiety, depression, posttraumatic stress disorder, and adjustment disorder: A rapid evidence assessment. *Psychological Services, 16*(4), 621-635.

Wikaire, E., Harwood, M., Wikaire-Mackey, K., Crengle, S., Brown, R., Anderson, A., . . . Keenan, R. (2022). Reducing healthcare inequities for Māori using telehealth during COVID-19. *The New Zealand Medical Journal (Online), 135*(1552), 112-117.

Wray, B., & Rees, C. (2003). *Is there a role for videoconferencing in cognitive–behavioural therapy.* Paper presented at the 11th Australian Association for Cognitive and Behaviour Therapy State Conference, Perth, Western Australia, Australia.

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Dialectical Behaviour Therapy (DBT) skills for men with anger problems in Aotearoa

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Eleven men of Māori, Indian, Fijian, Samoan, South African and Pākehā descent (37% Pākehā or European) participated in a 6-month DBT skills group focused on reducing anger and emotion dysregulation. Two men withdrew early, and two additional men joined for the last 8 weeks. Adjusting for multiple comparisons, scores showed significant decreases on the Total Trait Anger domain of the Spielberger State-Trait Anger Inventory-2 between pre and post-treatment. Feedback from a post-treatment focus group indicated participants found the DBT skills group acceptable and useful, with skills from the distress tolerance and mindfulness modules used most often. Recommendations for improvement included reducing the time for homework review and increasing it for teaching. This paper offers considerations for responding to aggression in research contexts, and adds to growing evidence for DBT skills as a promising intervention for problems related to anger for men.

Key words: *Dialectical behaviour therapy, men, anger*

INTRODUCTION

Dialectical Behaviour Therapy (DBT) is an intensive outpatient treatment with multiple components. These include weekly individual therapy, weekly skills training (usually in groups of up to 8-12 participants), and telephone coaching for clients. DBT also includes weekly consultation meetings for therapists, focused on increasing practitioners' capacity and motivation to provide the treatment. Multiple research trials have demonstrated its efficacy for reducing suicidal and self-injurious behaviour in individuals with borderline personality disorder (Linehan et al., 2006; Swales, 2018). Most trials have involved 12 months of DBT, however a recent non-inferiority trial suggests that 6 months of DBT may be just as effective, and potentially offer faster improvements (McMain et al., 2022).

Initial trials of DBT involved samples comprised of North American women with borderline personality disorder (BPD), chronic suicidal behaviour and self-injury. Since then, people have applied DBT to a range of problems in which emotion dysregulation seems to be a key factor, including substance use disorders (Axelrod, 2018), eating disorders (Ben-Porath et al., 2020), and aggression (Frazier & Vela, 2014). DBT reduces anger (Ciesinski, Sorgi-Wilson et al. 2022) and has been associated with improvements in irritability and violent behaviour in females with borderline personality disorder (Linehan et al., 2008), and in men with BPD and antisocial behaviour (Wetterborg et al., 2020). DBT has also been adapted for use with suicidal and emotionally dysregulated individuals suffering from PTSD (Harned & Schmidt, 2019), particularly complex PTSD related to childhood abuse (Bohus et al., 2020). Emerging evidence suggests that DBT may have application for both victim-survivors and those who have engaged in family violence (Fruzzetti & Levensky, 2000). Evidence also shows it is effective for suicidal adolescents (McCauley et al., 2018; Mehlum et al., 2014), and is associated with improvements in aggressive behaviour for incarcerated youth offenders (Shelton et al., 2011; Trupin et al., 2002). Efforts to adapt DBT to cultures beyond WEIRD[1] populations (Clancy & Davis, 2019; Henrich et al., 2010) have included adaptations for native American youth diagnosed with substance use disorders (Beckstead et al., 2015), and Nepali women who have experienced domestic violence (Ramaiya et al., 2017).

Skills training is a major element of DBT. Component analysis and mechanisms research suggests that learning and using skills may be critical ingredients in the treatment's efficacy (Edwards et al., 2021; Linehan et al., 2015a; Neacsiu et al., 2010). Acquisition of DBT skills have been shown to mediate improvements in emotion regulation, anger control, and suicidal behaviour for adult women with BPD (Neacsiu et al., 2010). Moreover, positive changes in emotion regulation have been shown to predict improvements in symptom distress, behavioural control, and assertiveness for individuals with BPD receiving DBT. DBT skills training alone or with standard elements of usual mental health care (e.g. case management) has benefited suicidal women with BPD (Linehan et al., 2015b), adult women with eating disorders (Safer & Jo, 2010), emotionally-dysregulated adults

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[1] Western, Educated, Industrialised, Rich, Democratic societies

(Neacsiu et al., 2014), adults with attention-deficit hyperactivity disorder, and adults with BPD (Soler et al., 2009). Most evaluations of DBT skills training as a stand-alone treatment have involved shorter durations, ranging between 9 and 32 weeks (Valentine et al., 2015). Accordingly, DBT skills training groups offer a treatment option that is relatively scalable and cost-effective, thereby enhancing access for those that could benefit from this approach.

The majority of DBT trials have been conducted with adult women with borderline personality disorder; men are under-represented in evaluations of this treatment. This gender difference is echoed in prevalence estimates of BPD in clinical vs non-clinical samples. Among treatment-seeking samples, estimates of the proportion of males with borderline personality have hovered around 25% (Johnson et al., 2003; Skodol & Bender, 2003). However, among community and incarcerated samples, estimates of the proportion of males meeting criteria for BPD is closer to 50% (Grant et al., 2008; Tomko et al., 2014; Trestman et al., 2007). Furthermore, males with BPD report receiving less psychotherapy and medication than their female counterparts (Goodman et al., 2010). There are a number of potential reasons for this discrepancy between the male prevalence of BPD in clinical samples versus those in the community who meet criteria for BPD. It may reflect gender biases in treatment referral and acceptance rates, gender differences in treatment engagement, or gender differences in the behavioural expression of emotion dysregulation. It may also reflect gender differences in how societies respond to men with emotion dysregulation; the pipeline from emotion dysregulation to prison may be wider for males than it is for females (Sansone & Sansone, 2011).

Because many randomised controlled trials of DBT have included female-only samples, we know less about the efficacy and the acceptability of DBT for men with problems with anger and aggression. However, a number of pre-post trials have indicated improvements in aggression for adult men in forensic inpatient settings (Tomlinson, 2018; Tomlinson & Hoaken, 2017), aggressive incarcerated male adolescents (Shelton et al., 2011), and within male-majority mixed samples of adults with intellectual disabilities and histories of aggression (Brown et al., 2013; Sakdalan & Collier, 2012; Sakdalan et al., 2010).

To our knowledge, as yet there have been no published studies specifically evaluating the acceptability of standard outpatient DBT skills training for men in Aotearoa New Zealand with problems with anger, or examining outcomes for these participants. The majority of large-scale treatment programmes for aggression in Aotearoa New Zealand are typically conducted in a group format (Arias et al., 2013; Babcock et al., 2004). Given that aggression and violent behaviour continue to be major social problems in our country, particularly within the home (Family Violence Death Review Committee, 2020; Lambie, 2018), we were interested in assessing whether this approach showed promise for treating such problems. In particular, the objective of this study was to assess the acceptability of both this intervention and the research methods to men in Aotearoa New Zealand.

Treatment acceptability is a multi-faceted concept, encompassing emotional, behavioural, and cognitive responses indicative of the extent to which a health service user likes the treatment they receive, and perceives it as appropriate (Sekhon et al., 2017). Treatment acceptability is an early focus of treatment outcome research design. In the current study we expanded this focus to consider the acceptability of the research framework designed to evaluate the treatment, particularly the outcome measures and strategies used to recruit and retain participants in the research. Our primary indices of acceptability focused on recruitment treatment engagement and non-engagement (i.e. treatment dropout), study engagement, and qualitative feedback on the treatment, and on research design. As the primary target of the intervention was problematic anger, the inclusion of a measure examining the subjective experience of anger was an important outcome variable. Because emotion regulation appears to be a key mediator of outcome in DBT (Lynch et al., 2006; Mehlum et al., 2014) and because depression in men has been implicated in aggressive behaviour in general (Krakowski & Nolan, 2017), and intimate partner violence in particular (Graham et al., 2012; Shorey et al., 2012), we also examined changes in emotion regulation, and depressive symptoms associated with DBT skills participation. Finally, we wanted to examine the acceptability of Hua Oranga, as a more holistic measure of wellbeing developed specifically for Māori tāngata whaiora, for Māori men taking part in this study. A key focus of qualitative feedback was the acceptability of DBT for cultural minority group members, given DBT's origins as a highly westernised and relatively monocultural treatment developed far from Aotearoa. As such, we were particularly keen to elicit participants' opinions on the acceptability of the intervention, including how and by whom it was delivered.

1. The aims of the research were to answer two main questions:
2. Is 6 months of weekly DBT skills acceptable to men in Aotearoa New Zealand who are experiencing anger-related problems?

Is participation in DBT skills training associated with improvements in psychological wellbeing for men experiencing anger-related problems, as measured by responses on self-report questionnaires assessing problems related to anger, emotion dysregulation and depression?

Accordingly, we recruited adult men who reported experiencing problem with anger for a DBT skills training group to be run weekly across 6 months. This duration was chosen because it allowed the opportunity to teach the full standard 26-week DBT skills curriculum, and assess without assumption which skills participants would find most relevant and useful.

METHOD

Participants

Adult men aged 18 years and over were recruited via research brochures sent to non-governmental community health and social services, governmental mental health and addiction treatment providers, and primary care services in the Auckland area. As such, individuals could be informed of the research opportunity by health providers, or through brochures in waiting areas. Interested men or their whānau then got in touch directly with the researchers.

Prior to group sessions, potential participants met with one of the researchers for screening, orientation to the study and consent. Typically, this meeting ended with the man being provided with written information about the study, the consent form, and the assessment questionnaires, with the agreement that they would decide whether to take part, and an appointment set for 1-2 further meetings to complete the consent form and assessment, and to receive their skills workbook.

Inclusion criteria were identifying as male, proficiency in spoken English, and self-reported problems with anger and emotion dysregulation. Initial exclusion criteria were active psychosis, and intellectual impairment that precluded the individual from providing informed consent. Initially we required literacy, however relaxed this for one group member who struggled to read and write. These criteria were subsequently expanded following an incident during screening in which a potential group member touched the torso of one of the clinicians while demonstrating a stabbing. After extensive consultation, this led to the pragmatic development of a further exclusion criterion; touching a screening clinician in a threatening manner during pre-treatment assessment.

Fifteen men expressed interest in the group, 4 of whom did not take part. One did not proceed with screening because of concerns regarding the age range of the group (18 years and over), another didn't like the 6-month commitment and the third didn't think he was experiencing the problems the group intervention treated. The fourth was discontinued following the aforementioned threatening behaviour during screening.

Men were aged 23-70 years with a mean age of 44 years. Participants were of Māori, Indian, Fijian, Samoan, South African and NZ European descent. The majority (4/11) were Caucasian. Six reported a history of violence towards a family member, and 5 reported seeking help for significant physical violence.

Intervention

The intervention was comprised of 26 weeks of weekly 2-hour DBT skills training groups covering (in the following order) mindfulness, distress tolerance, emotion regulation, and interpersonal skills using an early version of the 2nd edition of the DBT skills training manual (Linehan, 2014). The first session focused on orientation to group guidelines, and identification of personal goals for the group. Group sessions took place on an evening during the week. The first hour was dedicated to a brief mindfulness practice followed by review of homework from the week prior. Following a 15-minute break, the second hour focused on skills instruction. Food was served for the 15 minutes before group and during the group break. When group members didn't show, they were text messaged and called by group leaders from the first author's phone. To aid retention in both the research study (Teague et al., 2018) and the group, group members received birthday and end of year greeting cards from the group leaders. Mindfulness skills were taught in 2-week blocks 3 times during the 6-month cycle, per the standard DBT curriculum.

Adaptations to the skills curriculum were minimal, but facilitators intentionally chose examples and stories that group members were likely to relate to. Discussions often focused on the relevance or appropriateness of a skill for the lives of men in Aotearoa. At group members' request, emotion regulation skills also included some information on chain analysis when describing the model of emotions, and content on validation and dialectics during the Interpersonal Effectiveness module.

All three authors were involved in the delivery of skills group sessions, with the 2nd and 3rd authors acting as co-leader for 3 months each, and the first author leading facilitation for the full 6 months of the skills group (i.e. group sessions were led by 2 facilitators at a time). Two of the facilitators were clinical psychologists, and one was a clinical psychology intern at the time of the study. All were trained in DBT. Two of the authors attended weekly DBT consultation team meetings with other members of a DBT adolescent and family programme. The focus of these meetings was on increasing practitioners' motivation and skills in delivering the therapy. All facilitators identified as Pākehā/NZE.

The final session involved food and a graduation ceremony followed by feedback on the group, which was gathered by the group leaders. All graduating group members ended skills training group on the same date; i.e. the intervention was established as a closed group. In the feedback session, group participants were asked what they liked and disliked about group, the skills they used most often, their recommendations for change, and their recommendations regarding matching the ethnicity of group leaders for participants.

This study received ethics approval from the Northern X Regional Health & Disability Ethics Committee (NTX/08/04/038), and was retrospectively registered with the Australia New Zealand Clinical Trial Registry (#ACTRN12621000921886). This study was unfunded.

Measures

Assessments were administered prior to and at the conclusion of group skills training, and at 6 months follow-up. Self-report questionnaires included the following:

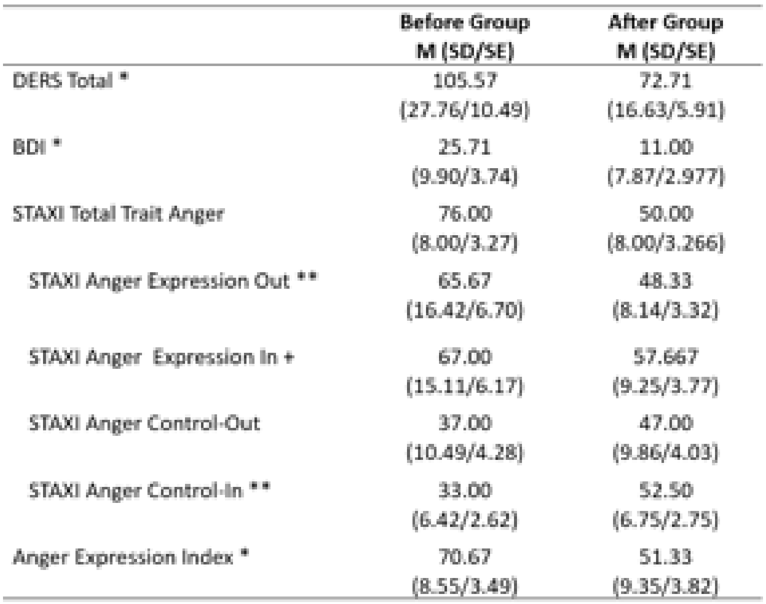
Depression was assessed using the second edition of the Beck Depression Inventory (BDI-II: Beck, 1991). The BDI-II is a 21-question multiple-choice self-report inventory designed to examine the scope and severity of depressive symptoms, with higher scores indicating greater distress (*Cronbach's* $\alpha = .90$ for the overall score; Scale min/max=0 to 63). Participants responded to each item on an escalating scale of depressive symptomatology from a 0 (e.g. "I do not feel sad") to 3 (e.g. "I am so sad or unhappy that I can't stand it").

Emotion dysregulation was assessed using the Difficulty with Emotion Regulation Scale (DERS: Gratz & Roemer, 2004) is a 36-item self-report questionnaire designed to assess clinically-relevant problems in regulating emotions, with higher scores indicating greater difficulties (*Cronbach's* $\alpha = .93$ for the overall score; Scale min/max=36 to 180). Participants responded to each item on a 1 (“almost always”) to 5 (“almost always”) with 11 items reverse-scored.

State/trait anger was assessed using the State-Trait Anger Expression Inventory-2 (STAXI-2: Spielberger, 1999; *Cronbach’s α’s* = .84-.87 for the overall trait score; total Scale min/max=57 to 228) is a 57-item self-report questionnaire designed to measure multiple dimesions of the experience of anger, with higher T-scores indicating greater problems related to angry affect. Participants responded to each item on a 1 (“almost never”) to 4 (“almost always”),

Finally, we used an early version of the Hua Oranga (Kingi & Durie, 2000) - a suite of 4-item questionnaires designed to assess the 4 dimensions of wellbeing identified by the whare tapa whā model of health (Durie, 1994). Positive scores indicate improvements in wellbeing due to an intervention and negative scores indicate declines in wellbeing due to an intervention. It has 3 forms or perspectives: one is completed by the individual, another is completed by whānau, and another form is completed by a clinician working with the individual (*Cronbach’s α* = .87 for the overall self-report score: Chalmers & Williams, 2018; Scale min/max=-32 to +32). Participants responded to each item on a -2 (“Much Less”) to +2 (“Much More”). Group members identifying as Māori completed the Tangata Whaiora/client version of the Hua Oranga.

Table 1. *Before-to-after group Means (SD/SE) of scale variables*



	Before Group M (SD/SE)	After Group M (SD/SE)
DERS Total *	105.57 (27.76/10.49)	72.71 (16.63/5.91)
BDI *	25.71 (9.90/3.74)	11.00 (7.87/2.977)
STAXI Total Trait Anger	76.00 (8.00/3.27)	50.00 (8.00/3.266)
STAXI Anger Expression Out **	65.67 (16.42/6.70)	48.33 (8.14/3.32)
STAXI Anger Expression In +	67.00 (15.11/6.17)	57.667 (9.25/3.77)
STAXI Anger Control-Out	37.00 (10.49/4.28)	47.00 (9.86/4.03)
STAXI Anger Control-In **	33.00 (6.42/2.62)	52.50 (6.75/2.75)
Anger Expression Index *	70.67 (8.55/3.49)	51.33 (9.35/3.82)

*Note: + p < .10; * p < .05; ** p < .01*

Analysis

Paired *t*-tests were calculated for pre and post scores on the 3 outcome measures, and then corrected for multiple comparisons using the Bonferroni method. We have also presented the unadjusted comparisons to allow readers to interpret the results dependent on their view of the need for adjustment, as for this stage of study (i.e. an uncontrolled pre-post study, with a small sample size) it may be more effective and in keeping with the exploratory nature of the research not to adjust for multiple comparisons.

RESULTS

Two participants dropped out within the first 4 weeks citing work commitments, and a clash with another course that had already been paid for. In the last module (i.e. 2 months before the conclusion of skills training), we received a request from another man to join the group. Subsequently, he and another male relative participated in the remaining 8 sessions.

Table 1 shows scores on the outcome measures before and after skills training. Using *t*-tests, comparisons of scores on outcome measures before and after group showed significant decreases in scores on the DERS (p = 0.047), BDI (p = 0.018), STAXI Total Trait Anger (p = .001), and STAXI Anger Expression Index p = .028), and a significant increase in STAXI Anger Control-In scores (p = .009).

The adjusted threshold for statistical significance from the Bonferroni correction is 0.05 / 8 = 0.00625. Following Bonferroni corrections for multiple comparisons, the decrease in STAXI Total Trait Anger remained significant.

Themes from qualitative feedback from group members included liking mindfulness activities, the use of text messaging and phone calls to ‘chase [them] up’, the provision of food, and the orientation to group guidelines. They disliked discussions going off on tangents, especially during homework review, and ‘being counselled’ by other group members. The skills they reported using most often were from the crisis-survival section of the distress tolerance module (TIP, Pros & Cons, ACCEPTS, and Self-soothe), and from the mindfulness module (Observe, Describe, Participate and Wise Mind). Their recommendations for improvement included the provision of skills instruction recordings for self-review, having weekly mini-reviews of mindfulness and crisis-survival skills, including more space for taking notes in the workbooks, reducing the time for homework review and increasing the time for skills instruction (i.e. 40 and 80 minutes rather than apportioning an hour to each). Two group members wanted to make group longer (i.e. 3 hours) however others didn’t agree with this. Most group members reported that the ethnicity of facilitators didn’t matter. The group members who disagreed reported that they didn’t think they would attend if the facilitators’ ethnicity matched their own, owing to concerns about confidentiality as their communities were small and close-knit.

DISCUSSION

The current study found that participation in a 6-month DBT skills group was associated with significant improvements in anger, emotion regulation and depressive symptomatology for a small group of men in Aotearoa New Zealand. Completers were uniformly positive about the impact of learning and using DBT skills on their lives and relationships, reporting that they found both the skills and the method of delivery acceptable and useful for them. The men provided robust feedback regarding their likes, dislikes and areas for improvement. Accordingly, the two primary aims of the study were met. Six months of DBT skills training appears to be acceptable to men in Aotearoa who endorse problems with anger, and participation in this intervention was associated with positive change in self-reported difficulties in emotion regulation, anger, and depressive symptoms.

The strengths of the study include the focus on providing DBT skills training to fidelity, the inclusion of NZ men, the focus on engagement, and the relatively low dropout rate (Dixon & Linardon, 2020). The duration of sessions mirrored those provided within the treatment developer's clinic where the first author was trained. Two of the three facilitators attended a DBT consultation team, and the entire standard adult skills core curriculum was included, allowing the participants to comment on the acceptability of all core skills. Although the group sessions weren't coded for adherence, the lead facilitator has extensive experience with this modality, having provided adherent DBT group sessions on two trials (Cooney et al., 2010; Linehan et al., 2006).

The authors engaged in a range of strategies both to retain participants in group, and also to retain them in the study. Unfortunately we were not able to obtain 6-month data for the two participants who dropped out of group skills training. However, based on the low drop-out rate and feedback from participants, group members may have felt cared for, attached, and more likely to remain in group as a result. The strategies (termed 'attachment strategies' in DBT, and particularly used to engage individuals with addictive disorders in DBT for substance use) included the provision of food, the inclusion of goal-setting at the outset of group, calling group members during group sessions and breaks if they no-showed, sending cards and other messages inviting them to return if they had missed 3 sessions in a row, obtaining detailed information at the outset from group members about ways of getting in contact with them, and getting permission to contact other people in their lives to track them down if we were having trouble reaching them (Dimeff & Linehan, 2008; Salsman, 2022).

This study has a number of limitations which signal important considerations for the design of a full-scale trial evaluating DBT for violent behaviour. The criterion excluding individuals who engaged in highly intimidating behaviour during the screening and pre-treatment assessment process significantly limits the validity of our findings. This criterion was driven by pragmatic concerns, as working with the individual whose behaviour led to this criterion crossed the limits of some research staff after the screening interaction, owing to potential risks to the safety of the leaders and the other group members. Given the timeframe and an absence of alternative providers, we opted to exclude this individual from the trial. For future research, it will be important to have processes and contingency plans to protect the safety of assessors, therapy staff and participants during the trial, that are acceptable to all members of the research team.

The pre-post study design makes it impossible to determine whether the improvements in participants' scores on research measures were due to the intervention, or other unmeasured factors, such as additional unassessed problems experienced by participants. The absence of a control group, and random assignment to either intervention or control means it's entirely possible that improvements in outcome measure scores were due to the passage of time, or other uncontrolled and unmeasured variables. Furthermore, the researchers included additional participants in the second half of the intervention, in a way that was unplanned, in response to requests. This limits the generalisability of the acceptability findings, in particular. These participants received a smaller dose of the intervention and therefore had less time to tire or become dysregulated by the process and withdraw prematurely. It's also possible there may have been material in the first half that they disliked and may have led to dropout if they were present for it.

The sample itself was very small, and then made smaller by the dropout by two members, who didn't complete outcome measures at 6 months. These pose further threats to the validity of the quantitative findings. Finally, the fact that the focus group was run by the group leaders limits the validity of the qualitative feedback. In other treatment feasibility research conducted by our team, post-intervention focus groups have been facilitated by interviewers who are independent from the therapy team. The interviews are typically individuals with lived experience of mental distress, and the feedback is anonymous to the group leaders. We are strong proponents of service user-led research, and independence of intervention provision and evaluation, and are committed to this going forward.

Despite these limitations, this study garnered useful information for the provision of DBT skills groups for adult men in Aotearoa New Zealand, in that it provided quantified data on changes in symptoms, recruitment, and dropout rate, as well as rich qualitative information gathered both from the participants' feedback, and also their behaviour. In addition to the findings reported above, we noted a phenomenon that we have repeatedly experienced in Aotearoa, in comparison with our experiences delivering DBT skills training in the US and the UK. There were three instances during the course of this intervention when individuals brought members of their family along to group. This pattern occurred for a number of ethnic identities. One instance involved a request to do so ahead of time, which led to the standard informed consent and orientation process before the family member joined. The other two instances involved family members unexpectedly showing up despite a careful informed consent and orientation process that preceded group members' joining group. Anecdotally, the authors have experienced this previously with other Aotearoa New Zealand DBT groups comprised of both adolescents and their families, as well as adults, with multiple settings and ethnicities. Group members have brought partners, siblings, in laws, and adult children along to group sessions whom they believed could benefit from learning DBT skills. Often, this has occurred with no notice, and with the expectation that the person could join group on the day. Personal communication with DBT providers and researchers in other countries suggests that this pattern is specific to Aotearoa New Zealand. During this study, on the occasions that this occurred without warning, group leaders were highly conflicted about turning guests away, feeling that it violated important values of hospitality and manaakitanga. We believe that this transaction (both the expectation that the uninvited guests would be included as a matter of course, and the strong urge to include them experienced by group leaders) may reflect something about a collective social tenet in Aotearoa New Zealand of welcoming people, especially those seeking support. It may also indicate a lean towards a collective rather than individual identity in NZ society. Accordingly, we recommend routinely including in the DBT group guidelines for NZ tāngata whaiora an explicit statement of the DBT team's position on the inclusion of friends and family members in group, and consideration of how whānau may be involved in learning skills.

The other significant lessons in this research related to the event that prompted the additional exclusion criterion. This underscored two things. First, there is a need for all individuals involved in skills training with this population to be very clear from the outset with themselves and with participants about personal and organisational limits regarding threats or acts of violence. One of the principles of DBT is not to exclude people from treatment for engaging in behaviour that the intervention is designed to treat. At the same time, DBT's original focus was on the treatment of borderline personality disorder, with suicide attempts and non-suicidal injury targeted as behavioural markers of BPD, rather than aggression towards others. This creates challenges when the target behaviour involves harm towards treatment providers or other group members. The act by the individual being screened was highly threatening to both assessors, and involved direct physical contact. Broad consultation with multiple forensic, ministry of justice, and DBT specialists occurred regarding how to respond. All non-DBT specialists were based in Aotearoa New Zealand. They unanimously surmised that the individual appeared to be highly dangerous, and strongly advised that the individual be declined for the skills group, and referred elsewhere. In contrast, one forensic DBT specialist based in North America voiced mixed feelings about having this individual in group, noting that the combination of aggression and emotion dysregulation was common in forensic settings (McCann, personal communication, October 2008). She also noted that there was far more control over the environment in secure units, where aggressive behaviour can be more contained and therefore safety is easier to establish and maintain. Furthermore, the specialist observed that more homogeneity in the risk profiles of group members in such settings meant that group members were able to 'keep each other in line'. In many respects this individual's profile was highly consistent with the problems the skills group sought to treat. However the severity of these problems far exceeded those of the majority of group members, none of whom engaged in such behaviour during assessment or group sessions. The research team had a clear safety protocol relating to skills group delivery, however screening and assessment safety measures involved simply ensuring that individuals were either seen within a service during working hours, or if outside of working hours, were not seen individually. This was insufficient. Furthermore, the team's limits regarding threatening behaviour were not clear. We learned from this that it is important that all parties involved in violence prevention research are in clear agreement about exclusion criteria, and the research team's policy regarding response to threats by group members. Similarly, the research team needs to have a clear policy regarding assault by group members and to communicate this to everyone involved. In addition, the setting, timing, and environment of the group needs to be set up in a way that minimises the risk for all parties.

Second, in addition to having an agreement about exclusion criteria, and refining details of the safety protocol for researchers, further concerns related to participant safety and informed consent. Over and above retaining a valued member of the research team, the self-report and behaviour of this individual indicated a level of violence that was more pervasive and extreme than that of other participants. This underscores the need for participant information to be clear about the personal risk of assault related to taking part in group interventions for violence, and the reality that if group leaders witness or are victims of violence by group members, they will report it to police. In addition, group guidelines need to specify expectations regarding how group members interact with each other, in terms of communication, unwanted touch and non-verbal intimidation.

Several weeks after the decision to exclude the individual from the study, the first author was able to consult with the treatment developer of DBT. Linehan was strongly against the exclusion, stating (1) researchers on interventions for violent behaviour needed to be willing and able to work with individuals at risk of engaging in violence, (2) that simply being afraid of someone was not a reason not to work with them, and (3) that there was no evidence that taking part in DBT skills training had made people's behaviour worse (Linehan, personal communication, January 2009). Integrating her position with that of forensic practitioners who hold extensive knowledge and experience in working with violent offenders may pose a dialectical opportunity for future thought and research. There is a difference between declining to work with an individual simply because their presentation is frightening, as opposed to a situation where the treatment setting and context offers insufficient protection given a violent history coupled with a presentation that includes physical threats.

This study indicates that DBT skills may be a promising intervention for men struggling with problems related to anger in Aotearoa New Zealand. However it is a leap to conclude that the next step would be a randomised controlled trial for dysregulated men engaging in violent behaviour, particularly if the focus was on family violence. Future research on DBT skills as an intervention for family violence needs to examine in more detail issues related to trial design, and to explore in more depth the cultural acceptability of DBT skills training as an intervention for Indigenous men who have engaged in family violence. Issues relating to design include how to engage and retain men and their families in research of this nature, the feasibility of gathering collateral information on primary outcomes (i.e. violence to family members) without jeopardising the safety of informants, and how to raise the chances of accurate self-report from participants while also meeting duties of care regarding harm to minors if participants disclose family violence to research assessors. Most countries mandate reporting of child abuse, regardless of whether the information is obtained via research activity. Certificates of confidentiality for research in the US, for example, do not exempt researchers from their obligation to report child protection concerns. Research on family violence in other countries has circumvented this by ensuring anonymity of research assessments. Assessments occur online or via anonymous phone lines, and participants only disclose which treatment they're receiving and broad demographic details rather than their identity. However, an ethics submission by our team for a study interviewing individuals with lived experience of family violence and offering participant anonymity was declined on the basis that the researchers had "an ethical and legal obligation to contact relevant authorities if they discover a person in the community who is at risk of violence or harm from another, and not recording identities goes against this" (March, 2021). Clearly this is an issue that is fraught with important and conflicting principles. Further research, including consultation with whānau most affected by such safety concerns, is sorely needed.

The current study provided support for the acceptability of DBT skills for men experiencing anger-related problems in Aotearoa New Zealand, and the feasibility of conducting pre-post outcome evaluation with this population. Results indicated that this intervention is acceptable and holds promise of benefit for men with anger problems in Aotearoa New Zealand. Further research is needed on these issues, in order to evaluate the efficacy of this treatment for a significant and tragic problem affecting Aotearoa New Zealand.

References

Arias, E., Arce, R., & Vilariño, M. (2013). Batterer intervention programmes: A meta-analytic review of effectiveness. *Psychosocial intervention, 22*(2), 153-160.

Axelrod, S. R. (2018). Dialectical behaviour therapy for substance use disorders. In *The Oxford Handbook of Dialectical Behaviour Therapy* (pp. 595–614). United Kingdom: Oxford University Press.

Babcock, J. C., Green, C. E., & Robie, C. (2004). Does batterers' treatment work? A meta-analytic review of domestic violence treatment. *Clinical Psychology Review, 23*(8), 1023-1053.

Beckstead, D. J., Lambert, M. J., DuBose, A. P., & Linehan, M. (2015). Dialectical behavior therapy with American Indian/Alaska Native adolescents diagnosed with substance use disorders: Combining an evidence based treatment with cultural, traditional, and spiritual beliefs. *Addictive Behaviors, 51*, 84-87.

Ben-Porath, D., Duthu, F., Luo, T., Gonidakis, F., Compte, E. J., & Wisniewski, L. (2020). Dialectical behavioral therapy: an update and review of the existing treatment models adapted for adults with eating disorders. *Eating Disorders, 28*(2), 101-121.

Bohus, M., Kleindienst, N., Hahn, C., Müller-Engelmann, M., Ludäscher, P., Steil, R., . . . Stiglmayr, C. (2020). Dialectical Behavior Therapy for Posttraumatic Stress Disorder (DBT-PTSD) Compared With Cognitive Processing Therapy (CPT) in Complex Presentations of PTSD in Women Survivors of Childhood Abuse: A Randomized Clinical Trial. *JAMA Psychiatry, 77*(12), 1235-1245.

Brown, J. F., Brown, M. Z., & Dibiasio, P. (2013). Treating individuals with intellectual disabilities and challenging behaviors with adapted dialectical behavior therapy. *Journal of Mental Health Research in Intellectual Disabilities, 6*(4), 280-303.

Ciesinski, N. K., et al. (2022). The effect of dialectical behavior therapy on anger and aggressive behavior: A systematic review with meta-analysis. *Behaviour Research and Therapy, 154*, 104122.

Clancy, K. B., & Davis, J. L. (2019). Soylent is people, and WEIRD is white: Biological anthropology, whiteness, and the limits of the WEIRD. *Annual Review of Anthropology, 48*, 169-186.

Dixon, L. J., & Linardon, J. (2020). A systematic review and meta-analysis of dropout rates from dialectical behaviour therapy in randomized controlled trials. *Cognitive Behaviour Therapy, 49*(3), 181-196.

Edwards, E. R., Kober, H., Rinne, G. R., Griffin, S. A., Axelrod, S., & Cooney, E. B. (2021). Skills-homework completion and phone coaching as predictors of therapeutic change and outcomes in completers of a DBT intensive outpatient programme. *Psychology and Psychotherapy: Theory, Research and Practice*.

Family Violence Death Review Committee. (2020). *Sixth report | Te Pūrongo tuaono: Men who use violence | Ngā tāne ka whakamahi i te whakarekereke*. Wellington Retrieved from https://www.hqsc.govt.nz/assets/FVDRC/Publications/FVDRC6thReport_FINAL.pdf

Frazier, S. N., & Vela, J. (2014). Dialectical behavior therapy for the treatment of anger and aggressive behavior: A review. *Aggression and Violent Behavior, 19*(2), 156-163.

Fruzzetti, A. E., & Levensky, E. R. (2000). Dialectical behavior therapy for domestic violence: Rationale and procedures. *Cognitive and Behavioral Practice, 7*(4), 435-447.

Goodman, M., Patil, U., Steffel, L., Avedon, J., Sasso, S., Triebwasser, J., & Stanley, B. (2010). Treatment utilization by gender in patients with borderline personality disorder. *Journal of Psychiatric Practice®, 16*(3), 155-163.

Grant, B., Chou, S., Goldstein, R., Huang, B., Stinson, F., Saha, T., . . . Pickering, R. (2008). Prevalence, correlates, disability, and comorbidity of DSM-IV BPD: results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry, 69*, 533-545.

Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of psychopathology and Behavioral Assessment, 26*(1), 41-54.

Harned, M. S., & Schmidt, S. C. (2019). Integrating post-traumatic stress disorder treatment into dialectical behaviour therapy: Clinical application and implementation of the DBT prolonged exposure protocol.

Henrich, J., Heine, S. J., & Norenzayan, A. (2010). Beyond WEIRD: Towards a broad-based behavioral science. *Behavioral and Brain Sciences, 33*(2-3), 111.

Iverson, K. M., Shenk, C., & Fruzzetti, A. E. (2009). Dialectical behavior therapy for women victims of domestic abuse: A pilot study. *Professional Psychology: Research and Practice, 40*(3), 242-248.

Johnson, D. M., Shea, M. T., Yen, S., Battle, C. L., Zlotnick, C., Sanislow, C. A., . . . McGlashan, T. H. (2003). Gender differences in borderline personality disorder: Findings from the Collaborative Longitudinal Personality Disorders Study. *Comprehensive Psychiatry, 44*(4), 284-292.

Kingi, T. K., & Durie, M. (2000). *Hua Oranga: A Māori measure of mental health outcome.* Paper presented at the Proceedings of the conference, Mental Health Outcomes Research in Aotearoa, Health Research Council Auckland.

Lambie, I. (2018). Every 4 minutes: A discussion paper on preventing family violence in New Zealand.

Linehan, M. M. (2014). *DBT Skills training manual*: Guilford Publications.

Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., . . . Lindenboim, N. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry, 63*(7), 757-766.

Linehan, M. M., Korslund, K. E., Harned, M. S., Gallop, R. J., Lungu, A., Neacsiu, A. D., . . . Murray-Gregory, A. M. (2015). Dialectical behavior therapy for high suicide risk in individuals with borderline personality disorder: a randomized clinical trial and component analysis. *JAMA Psychiatry, 72*(5), 475-482.

Linehan, M. M., McDavid, J. D., Brown, M. Z., Sayrs, J. H., & Gallop, R. J. (2008). Olanzapine plus dialectical behavior therapy for women with high irritability who meet criteria for borderline personality disorder: a double-blind, placebo-controlled pilot study. *The Journal of Clinical Psychiatry, 69*(6), 999-1005.

McCauley, E., Berk, M. S., Asarnow, J. R., Adrian, M., Cohen, J., Korslund, K., . . . Gallop, R. (2018). Efficacy of dialectical behavior therapy for adolescents at high risk for suicide: A randomized clinical trial. *JAMA Psychiatry, 75*(8), 777-785.

Mehlum, L., Tørmoen, A. J., Ramberg, M., Haga, E., Diep, L. M., Laberg, S., . . . Sund, A. M. (2014). Dialectical behavior therapy for adolescents with repeated suicidal and self-harming behavior: a randomized trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 53*(10), 1082-1091.

Neacsiu, A. D., Rizvi, S. L., Vitaliano, P. P., Lynch, T. R., & Linehan, M. M. (2010). The dialectical behavior therapy ways of coping checklist: development and psychometric properties. *Journal of Clinical Psychology, 66*(6), 563-582.

Ramaiya, M. K., Fiorillo, D., Regmi, U., Robins, C. J., & Kohrt, B. A. (2017). A cultural adaptation of dialectical behavior therapy in Nepal. *Cognitive and Behavioral Practice, 24*(4), 428-444.

Sakdalan, J. A., & Collier, V. (2012). Piloting an evidence-based group treatment programme for high risk sex offenders with intellectual disability in the New Zealand setting. *New Zealand Journal of Psychology, 41*(3), 6-12.

Sakdalan, J. A., Shaw, J., & Collier, V. (2010). Staying in the here-and-now: A pilot study on the use of dialectical behaviour therapy group skills training for forensic clients with intellectual disability. *Journal of Intellectual Disability Research, 54*(6), 568-572.

Sansone, R. A., & Sansone, L. A. (2011). Gender patterns in borderline personality disorder. *Innovations in Clinical Neuroscience, 8*(5), 16-20.

Shelton, D., Kesten, K., Zhang, W., & Trestman, R. (2011). Impact of a dialectic behavior therapy—Corrections Modified (DBT-CM) upon behaviorally challenged incarcerated male adolescents. *Journal of Child and Adolescent Psychiatric Nursing, 24*(2), 105-113.

Skodol, A. E., & Bender, D. S. (2003). Why are women diagnosed borderline more than men? *Psychiatric Quarterly, 74*(4), 349-360.

Spielberger, C. (1999). State-trait anger expression inventory-2: Professional manual. Psychological Assessments Resources. In: Inc.

Swales, M. A. (2018). *The Oxford Handbook of Dialectical Behaviour Therapy*: Oxford University Press.

Tomko, R. L., Trull, T. J., Wood, P. K., & Sher, K. J. (2014). Characteristics of borderline personality disorder in a community sample: comorbidity, treatment utilization, and general functioning. *Journal of Personality Disorders, 28*(5), 734-750.

Tomlinson, M. F. (2018). A theoretical and empirical review of dialectical behavior therapy within forensic psychiatric and correctional settings worldwide. *International Journal of Forensic Mental Health, 17*(1), 72-95.

Tomlinson, M. F., & Hoaken, P. N. (2017). The potential for a skills-based dialectical behavior therapy program to reduce aggression, anger, and hostility in a canadian forensic psychiatric sample: a pilot study. *International journal of Forensic Mental Health, 16*(3), 215-226.

Trestman, R. L., Ford, J., Zhang, W., & Wiesbrock, V. (2007). Current and lifetime psychiatric illness among inmates not identified as acutely mentally ill at intake in Connecticut's jails. *Journal of the American Academy of Psychiatry and the Law Online, 35*(4), 490-500.

Trupin, E. W., Stewart, D. G., Beach, B., & Boesky, L. (2002). Effectiveness of a dialectical behaviour therapy program for incarcerated female juvenile offenders. *Child and Adolescent Mental Health, 7*(3), 121-127.

Wetterborg, D., Dehlbom, P., Långström, N., Andersson, G., Fruzzetti, A. E., & Enebrink, P. (2020). Dialectical behavior therapy for men with borderline personality disorder and antisocial behavior: A clinical trial. *Journal of Personality Disorders, 34*(1), 22-39.

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Meaning in life moderates the relationship between social connectedness and hopelessness

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Suicide is one of the leading causes of death worldwide. Men are significantly more likely to commit suicide yet are an understudied population in suicide research. Hopelessness has repeatedly been shown to be one of the strongest predictors of suicide ideation, attempt, and completion. Meaning in life and social connectedness have been shown to be inverse associates of hopelessness. In a sample of n = 398 males living in Aotearoa, New Zealand between the ages of 18-30, this study examined the relationship between social connectedness, meaning in life, and hopelessness. Meaning in life and social connectedness were hypothesized to be negatively associated with hopelessness and that the relationship between social connectedness and hopelessness would vary across different levels of meaning in life. Results revealed that meaning in life and social connectedness were negatively associated with hopelessness. Meaning in life moderated the relationship between social connectedness and hopelessness such that the effect meaning in life exerted on hopelessness was strongest when social connectedness was low.

Key words: *Suicide, Hopelessness, Meaning in life, Social connection, Young males*

INTRODUCTION

Globally, each year over 700,000 individuals die by suicide (World Health Organisation, 2019). Despite a small reduction in the global suicide rate across the 21st century, suicide remains a leading cause of preventable death (United Nations, 2019; World Health Organisation, 2014). In Aotearoa, New Zealand the suicide rate has increased by 6% in the past decade and the number of deaths caused by suicide has risen by 21% (Office of the Chief Coroner of New Zealand, 2020). Effective responses to this crisis require the identification of both risk and protective factors for suicide and an understanding of how these factors can be targeted to promote better outcomes (World Health Organisation, 2014). Past research has identified a number of psychological, neurobiological, psychosocial, social, and demographic risk factors for suicidal behaviour including major depression, impulsivity, dysregulated serotonin systems, historical abuse and unemployment (for reviews see O'Connor et al., 2023; Turecki et al., 2019).

Hopelessness has been repeatedly shown to be a robust predictor of suicidal behaviour, which consists of suicidal ideation, intent, attempt and completion (Beck et al., 1990; Ribeiro et al, 2018; Weishaar & Beck, 1992; Wetzel et al., 1980). A recent meta-analysis of 365 studies occurring over the last 50 years found that hopelessness was the second leading predictor of suicidal ideation (Franklin et al., 2017). Hopelessness has been shown to be both a proximal and distal predictor of suicidal behaviour (Beck et al., 1990; Ribeiro et al., 2018; Rudd et al., 2006) and the association between hopelessness and suicidal behaviour has been observed in children, adolescents, and adults and in both clinical and non-clinical populations (Beck et al., 1985; Nock & Kazdin, 2002; Sueki, 2020; Thompson et al., 2005). Given congruent empirical evidence, hopelessness has been included in several causal models of suicide including the Interpersonal Theory of Suicide (Van Orden et al., 2010), the Hopelessness Theory of Suicidality (Abramson et al., 2002), the Cognitive Model of Suicidal Behaviour (Wenzel & Beck, 2008), and the Three-Step Theory of suicide (Klonsky & May, 2015).

Hopelessness can be defined as a cognitive orientation characterized by the presence of negative expectancies and the absence of positive expectancies regarding the self, the future, and the world (Beck et al., 1974, Becker-Weidman et al., 2009). Hopelessness develops when individuals experience negative events which influence the formation of cognitive expectancies (Morselli, 2016). Hopelessness is reinforced as further negative events occur which support hopelessness related cognitions, resulting in perceptions of negative events as unrelenting and uncontrollable (Morselli, 2016). These processes are associated with increasing feelings of helplessness and thoughts of giving up on goals and hopes for the future (Marchetti, 2018; Marchetti et al., 2019).

Predictors of hopelessness include negative internal attributional style, a strong desire to be liked by others, social problem-solving orientation, emotional abuse in childhood and decreased future orientation (Becker-Weidman et al., 2009; Gibb et al., 2001; Mac Giollabhui et al., 2018; Marchetti et al., 2019). Contextual factors such as socioeconomic conditions and emotional contexts are also an important component in predicting hopelessness (Morselli, 2016). Further, relationship status and employment have been tied to hopelessness, with an increased risk of stable hopelessness being found in unemployed, unmarried men (Haatainen et al., 2003).

The Expanded Hopelessness Theory of Depression posits that loneliness and reduced social support increase the likelihood of negative social events which lead to hopelessness (Panzarella et al., 2006). Relatedly, supportive social factors such as relationships and community contexts buffer against the adverse impact of known risk factors (Beautrais et al., 2005). In addition, several known protective factors for hopelessness operate on an individuals' social context. For example, O'Connor and Pirkis (2016) report that relationship status and employment are protective against hopelessness through fostering social connection and belonging.

Social Connectedness

Social connectedness can be understood as the degree of closeness an individual perceives between themselves and their social world (Lee & Robbins, 2000). Social connectedness is considered a core facet of belonging, and the terms belonging and social connectedness are often used interchangeably (Bel et al., 2009).

Social connectedness (SC) has been shown to be negatively correlated with suicidal ideation (Arango et al., 2018; Reyes et al., 2020). The role of social connectedness in hopelessness has been explored empirically, though mostly through the lens of risk related to low connectedness. For example, Eraslan-Capan (2016) found that university students with low levels of social connectedness were more likely to be hopeless, which resulted in low flourishing. Similarly, social connectedness has been found to be an inverse determinant of hopelessness (Bolland, 2005; Choudhary et al., 2021). Relatedly, McCay et al. (2011) reported that a relationship-based intervention for homeless adolescents and young-adults significantly increased social connectedness with relative reductions in reported hopelessness.

Meaning in Life

Meaning in life (MIL) is the extent to which an individual perceives their existence makes sense, has purpose, and holds significance (George & Park, 2016; Martela & Steger, 2016). Individuals have been shown to create meaning through various processes such as social connection and involvement, religion, and personal performance (Zhang et al., 2018).

Meaning in life is associated with physical and psychological wellbeing, perceived freedom, optimism regarding oneself and future goals, coping, self-realization, life satisfaction, and autonomy (García-Alandete et al., 2014; Lambert et al., 2013). Individuals with high MIL are equipped to successfully navigate negative events, which may buffer against the formation of negative cognitions that lead to hopelessness (García-Alandete, 2014). Conversely, low MIL has been associated with adverse outcomes such as psychopathology and reduced psychosocial functioning (Dezutter et al., 2014; Kleftaras & Psarra, 2012). Suicidal ideation and suicide have also been associated with low MIL (Costanza et al., 2019). There is a growing literature on the relationship between MIL and hopelessness. Meaning in life was found to be a significant, negative predictor of hopelessness in individuals diagnosed with Borderline Personality Disorder (García-Alandete et al., 2014; Marco et al., 2016) and has been prospectively associated with decreased hopelessness in depressed US veterans (Braden, 2017). Further, among individuals diagnosed with a depressive disorder, meaning in life was found to mediate the relationship between hopelessness and depression (Sun et al., 2016). As such, more research is needed to understand the role of meaning in life in buffering against hopelessness in both clinical and non-clinical populations.

Social Connectedness and Meaning in Life

Not surprisingly, social connectedness and meaning in life are related to one another (Stavrova & Luhmann, 2015). Empirical work suggests that a sense of belonging predicts meaning in life (Lambert, 2013). Additionally, when individuals are asked to consider what constitutes meaning in life, most refer to social relationships (Stillman & Lambert, 2013).

Relatively recent studies have demonstrated that the relationship between social connectedness and meaning in life is bidirectional (Stavrova and Luhmann, 2015). Across three studies comprised of young adults, Zhang et al (2018) found that the degree of social connectedness was related to the likelihood of using social connectedness as a primary source of meaning (Zhang et al., 2018). As individuals perceive the most accessible and affirming sources as the most important to them, those that are socially connected are more likely to base their sense of meaning on social connection. Further, Zhang and colleagues (2018) found social exclusion decreased both meaning in life and the importance individuals ascribed to social connectedness as a source of meaning. These findings suggest a compensatory process may be at work. Specifically, Zhang et al. (2018) demonstrated that socially excluded participants shifted from utilizing social connectedness to affirm meaning to using sense of autonomy. While there is no work to date that examines how social connectedness and meaning in life interact in relation to hopelessness, the work reviewed above suggests that meaning might moderate the relationship between social connectedness and hopelessness.

The present study

Worldwide, suicide is the second-leading cause of mortality for individuals aged 15 to 29 (World Health Organisation, 2019). Research indicates that young adults between 18-30 years old are particularly vulnerable to life stressors, and a critical period in which to study hopelessness (Medley, 2019).

The male-female ratio for suicide deaths is disproportionate, with up to three times as many males completing suicide relative to females globally (World Health Organisation, 2019). In 2019, 69% of individuals who died by suicide worldwide were men, with 15% of all suicides being men aged between 15 and 29 years old (Global Burden of Disease Collaborative Network, 2020). In Aotearoa, 72% of deaths by suicide in in 2019-2020 were males, and 21% were males under the age 30 (Office of the Chief Coroner of New Zealand, 2020).

Despite being over-represented in these statistics, young adult males are often 'invisible' when it comes to their mental health, due in part to men's mental health having been under-researched, particularly when it comes to the way men approach interpersonal connection (McKenzie et al., 2018). While evidence is mixed, of the extant literature, several studies have found that, relative to females, males are more likely to experience hopelessness (Girgin, 2009; Bolland, 2005; Özmen, 2009), with one study finding that daily stress is a particularly salient predictor of hopelessness in young men (Rodríguez-Naranjo & Caño, 2016).

The current study endeavoured to better understand the relationship between meaning in life, social connectedness and hopelessness in a sample of young-adult males living in Aotearoa, New Zealand. Based on the above evidence, we hypothesized that meaning and social connectedness would be significant, negative predictors of hopelessness (Hypothesis 1). We also expected that the relationship between social connectedness and hopelessness would be moderated by meaning in life (Hypothesis 2). Specifically, we expected that meaning in life would be most effective in reducing hopelessness in individuals with low social connectedness. At high levels of connectedness, meaning may not contribute a notable additive effect given that social connectedness would likely be a primary source of meaning in life. However, at low levels of social connectedness, alternate sources of meaning may be utilized by individuals to reaffirm meaning in life, facilitating its buffering effect on hopelessness.

METHOD

Participants

This study is part of a larger cross-sectional study measuring risk and protective factors associated with wellbeing in young adult males living in Aotearoa, New Zealand. Recruitment took place between December 2019 and April 2020. Participants were 440 individuals who self-identified as male, aged between 18-30 years old. The mean age was 23 *(M*= 22.74, *SD* = 3.46). Of the 440 participants, 398 completed all measures of interest for the current study.

Measures

The Beck Hopelessness Scale is considered a gold standard in suicide research (Kliem et al., 2018). This measure includes 20 true-false items (e.g. "*my future seems dark to me*") which assess hopelessness through self-report of negative feelings about the future, loss of motivation and negative future expectations (Beck et al., 1974). The total hopelessness score is represented by the sum of scores across items, ranging from 0 to 20, where higher scores reflect greater hopelessness (Beck et al., 1974). Widely accepted norms for this measure suggest that scores between 0 and 3 signify a normal level of hopelessness, scores between 4 and 8 signify mild hopelessness, scores from 9 to 14 signify moderate hopelessness and scores over 14 signify severe hopelessness (Beck & Robert, 1993).

Meaning in life was measured using the Meaning in Life Questionnaire (MLQ), which measures the perceived presence of and search for meaning in life (Steger et al., 2006). Individuals were responded to 10 items (e.g. *"I understand my life's meaning")* on a 7-point Likert Scale from 1 (absolutely untrue) to 7 (absolutely true) (Steger et al., 2006). Higher scores indicated stronger MIL.

Social Connectedness was measured using the Social Connectedness Scale (SCS). Developed by Lee and Robbins (1995), the SCS assesses the extent to which the individual perceives interpersonal, emotional distance between themselves and their social world and difficulty in maintaining a sense of closeness (Lee & Robbins, 1995, 2000). The scale is comprised of eight items (e.g. *"I feel so distant from people")* measured on a 6-point Likert-type scale from (1 = strongly agree to 6= strongly disagree) so that higher scores signify a stronger sense of belonging (Lee & Robbins, 1995).

Procedure

The questionnaire was hosted on Qualtrics, with participants from across Aotearoa, New Zealand accessing the questionnaire via a secure online link or QR code provided on advertisements. Before engaging in the questionnaire, participants read information about the study and electronically signed a consent form. Participants were provided with the opportunity to opt-in to a draw to win one of eight gift vouchers to be randomly selected at the conclusion of the study. Once the individual consented to participate, they were taken to a separate webpage to complete the questionnaire. The questionnaire took approximately 20 minutes to complete. A resource sheet was provided at the end of the questionnaire which outlined national helplines and resources.

Descriptive statistics were computed on relevant demographic and study variables. A Pearson product-moment correlation was constructed as an initial examination of the relationships between variables. A hierarchical linear regression, regressing hopelessness on social connectedness and then meaning in life was conducted, testing the hypothesis that both factors predicted BHS scores. An interaction term was created (SCSxMLQ) to examine meaning as a potential moderator of the relationship between connectedness and hopelessness. Age was included as a covariate and all predictor variables were mean-centred. Data were analysed using IBM SPSS Statistics version 25.0. ModGraph-I (Jose, 2013) was used to illustrate the results of the moderation analysis and perform calculations of simple slopes. Simple slopes analyses followed the process outlined by Aiken et al. (1991).

The current study was reviewed and approved by the Human Ethics Committee at the University of Canterbury (HEC 2019/69).

RESULTS

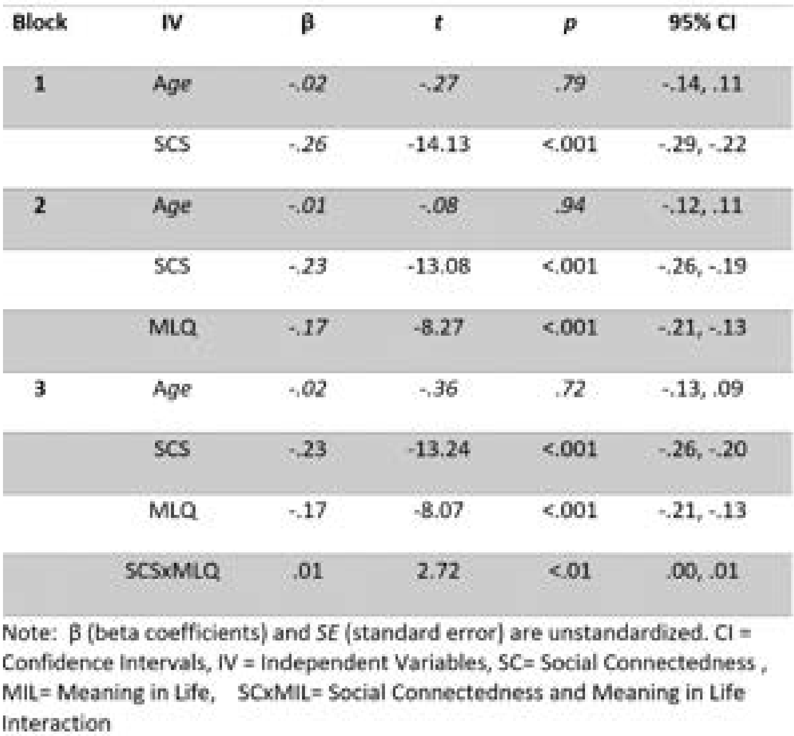
Descriptive statistics

Frequency analyses revealed that participants were normally distributed across the 18-30 age range. The majority of participants identified as urban (n = 333, 76%), single (n = 250, 57%), NZ European (88%; 9% Maori) with at least some tertiary credit (n = 243, 55%) and employed at least part time (93%).

In this sample of young adult males, 69% (n = 303) reported never having received a mental health diagnosis. The average hopelessness score was 5.90 (*SD* = 5.17) which falls within the mild category according to BHS normative data. Frequency analysis revealed that approximately three-quarters (74%) of the sample reported normal to mild levels of hopelessness < 8), while the remaining 26% displayed moderate to severe hopelessness ($\geq$ 9).

Results of the bivariate correlation revealed that social connectedness (*r* = -.58) and meaning in life (*r* = -.43)

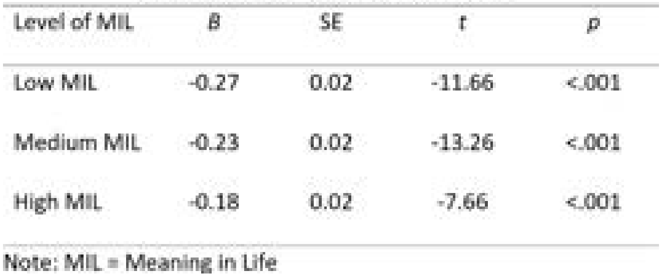
Table 1. *Hierarchical Linear Regression Coefficients*



Block	IV	β	t	p	95% CI
1	*Age*	*-.02*	*-.27*	*.79*	-.14, .11
	SCS	-.*26*	-14.13	<.001	-.29, -.22
2	*Age*	*-.01*	*-.08*	*.94*	-.12, .11
	SCS	-.*23*	-13.08	<.001	-.26, -.19
	MLQ	-.*17*	-8.27	<.001	-.21, -.13
3	*Age*	*-.02*	*-.36*	*.72*	-.13, .09
	SCS	-.23	-13.24	<.001	-.26, -.20
	MLQ	-.17	-8.07	<.001	-.21, -.13
	SCSxMLQ	.01	2.72	<.01	.00, .01

Note: β (beta coefficients) and *SE* (standard error) are unstandardized. CI = Confidence Intervals, IV = Independent Variables, SC= Social Connectedness , MIL= Meaning in Life, SCxMIL= Social Connectedness and Meaning in Life Interaction

Table 2. *Simple slopes for Meaning in Life (MIL) as a Moderator of the Relationship Between Social Connectedness and Hopelessness*



Level of MIL	*B*	SE	*t*	*p*
Low MIL	-0.27	0.02	-11.66	<.001
Medium MIL	-0.23	0.02	-13.26	<.001
High MIL	-0.18	0.02	-7.66	<.001

Note: MIL = Meaning in Life

were significantly associated with hopelessness with Pearson coefficients indicating moderate inverse relationships. A small significant association was seen between SCS and MLQ scores ($r = .22$).

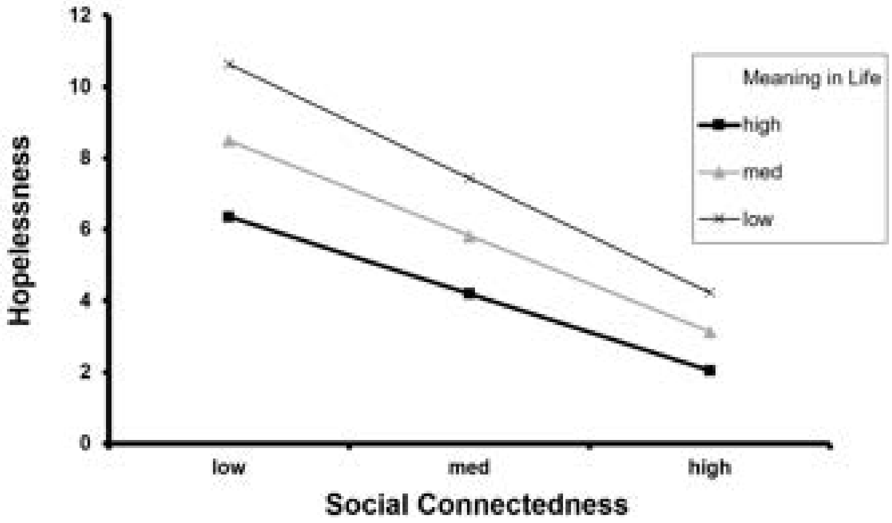
Regression analysis

A hierarchical linear regression was conducted to further examine the relationship between social connectedness, meaning in life, and hopelessness. Results revealed that Block 1 was significant and explained 34% of variance in hopelessness, $R^2 = .34$, $F(2, 395) = 100.09$, $p < .001$. As shown in Table 1, social connectedness, but not age, was a significant, inverse predictor of hopelessness within this model. Block 2 was also significant and explained 44% of variance in hopelessness, $R^2 = .44$, $F(3, 394) = 100.94$, $p < .001$. Further, the increase in explained variance was found to be significant, $\Delta R^2 = .10$, $F(1, 395) = 68.72$, $p < .001$, such that MIL accounted for variance in hopelessness over and above social connectedness (See Table 1).

The MLQ x SCS interaction term was included in Block 3 to examine the relationship between meaning in life and social connectedness as related to hopelessness. This block explained 45% of variance in hopelessness, $R^2 = .45$, $F(4, 394) = 78.84$, $p < .001$. Further, Block 3 was significantly more predictive than Block 2, $\Delta R^2 = .01$, $F(1, 394) = 7.41$, $p = .007$, indicating that the moderation effect was significant after controlling for SCS and MLQ as significant, independent predictors.

Figure 1 illustrates the moderation of meaning in life on the effect of social connectedness on hopelessness. Analysis of simple slopes revealed a significant negative relationship between connectedness and hopelessness across levels of meaning in life, as each slope was found to be significantly different from zero. Examination of standardized beta weights seen in Table 2 and consideration of relative slope differences seen in Figure 1, indicate revealed that the inverse association between social connectedness and hopelessness were most apparent when meaning in life was low. Further, when social connectedness was low, high meaning in life was associated with lower levels of hopelessness.

Figure 1. *Moderation of the Effect of Social Connectedness on Hopelessness by Meaning in Life*



DISCUSSION

The current study examined the relationship between meaning in life and social connectedness and their association with hopelessness in young-adult males. The primary aim of this research was to examine these relations given the robust association between hopelessness and suicidal behaviour. Additionally, young adult men are a cohort both understudied and at heightened risk of suicide. Based on the current literature, we expected that meaning in life and social connectedness would have significant, inverse associations with hopelessness, and that meaning in life would moderate this relationship. Results supported these hypotheses and simple slopes analysis indicated that the association between connectedness and hopelessness was significant across all levels of meaning in life.

The average level of hopelessness in this study (mild hopelessness) is in line with previous literature on non-clinical populations (Chioqueta & Stiles, 2007; Kocalevent et al., 2017). However, it is notable that moderate-to-severe ratings were approximately twice as high as rates seen in previous studies with Spanish university student and American adult samples (Mair, 2012; Viñas, 2004). Such elevated rates of clinically significant hopelessness among this at-risk sample is a concern and may reflect the current difficulties in mental health shown to exist in Aotearoa, New Zealand (Every-Palmer et al., 2022; Mulder et al., 2022).

To our knowledge, there is no work to date examining both social connectedness and meaning in life in relation to hopelessness. Regression analyses revealed that the hypothesized inverse relationship between social connectedness and hopelessness remained significant when meaning in life was introduced to the model. As shown in the previous literature and reflected in the change in the SC beta with the introduction of MIL, there is some shared variance between these factors. However, in the current study, and supported by the small association seen in the correlation analysis, SC and MIL are independent factors, both inversely related with hopelessness.

This study also sought to examine meaning in life as a moderator of the relation between connectedness and hopelessness. Inclusion of the interaction term in the third block of the model resulted in significant associations for all included variables. Not surprisingly, analysis of simple slopes revealed that that hopelessness was lowest when both meaning in life and social connectedness were high and highest when both factors were low. Examination of simple slopes further revealed that meaning in life differences were most apparent when connectedness was low. Notably, when social connectedness was low, high meaning in life was associated with low levels of hopelessness (See Figure 1). In the instance of low connectedness, meaning is likely sourced from other domains (e.g. faith or work performance) as posited by Zhang et al (2018).

Our findings have broad implications for positive psychology, the study of hopelessness and suicidology, and for literature focused on young-adult males. This study has highlighted the importance of both social connectedness and meaning in life in relation to hopelessness and adds distinct value to the emerging resiliency literature in the study of hopelessness. This work is the first known study that has examined the interaction between established factors associated with hopelessness, providing a more nuanced understanding of the construct. For the field of suicidology, results demonstrate the value in contextualizing key predictors of suicide, with the overarching aim of being able to intervene to prevent suicide and at an earlier stage, where interventions may be better able to target hopelessness.

Real-world Applications

The Government Inquiry into Mental Health and Addiction, (2018) has recommended a 20% reduction in suicide rates by 2030. Similarly, the United Nations have called for a worldwide reduction of non-communicable diseases (including suicide) of one-third by 2030 (United Nations, 2015). Reaching these goals necessitates the application of novel evidence-based intervention that target suicide antecedents. While there are a number of evidence-based cognitive and behavioural interventions designed to address moderate and severe depression, targeting hopelessness in interventions has largely been unsystematic (for review, see Marchetti, 2023).

The practice of suicide prevention may benefit from deeper consideration of interventions that build resiliency against key predictors of suicidal ideation, attempt and completion, such as hopelessness. Work in this area is growing and shows promise. For example, increasing social connectedness among older individuals has been shown to reduce hopelessness (Choudhary et al., 2021) and McCay et al. (2011) found that a relationship-based group intervention improved social connectedness and reduced hopelessness among a group of homeless late adolescents/young adults. Therapeutic interventions have been shown to raise meaning in life and reduce hopelessness. For example, Brietbart and Heller (2003) developed a meaning-centred psychotherapy to reduce feelings of hopelessness and increase meaning among terminally ill patients and recently, Sun et al. (2022) found that logotherapy helped reduce feelings of hopelessness and increase a sense of meaning among individuals with depression. Currently, there are no interventions specifically targeting meaning in life to reduce hopelessness. However, a recent meta-analysis reported overall moderate effects across a variety of interventions targeting increased meaning (Manco et al., 2021) and Luz et al. (2017) found that a six-week intervention targeting meaning in life resulted in increased positive affect and decreased negative affect. As such, future research examining how these factors may be increased to reduce hopelessness may provide a foundation for the development of interventions targeting a salient predictor of suicidal behaviour.

Beyond interventions by mental health practitioners, business, social groups and individuals can promote the emerging idea of “the social cure”, which emphasizes that identity and behaviour is influenced deeply by group membership and social connectedness which are vital to general wellbeing (Jetten et al., 2017). Groups that are free of stigma, promote healthy norms and provide social support can increase social connectedness, meaning in life and myriad other positive outcomes (Jetten et al., 2017). Initiatives like ‘Surfing for Farmers’ (Star News, 2020), Menz Sheds New Zealand (Holden, 2020) and the weekly “yarnologist/peer support appointments” at Benny’s Barber Shop (Northcott 2019) are several examples of social groups that engage young-adult men in Aotearoa in activities and conversations about mental wellbeing, and foster meaning in life through social connection.

This study is not without limitations and caution should be taken when interpreting findings. Given that this was a sample recruited from the community, a large proportion of individuals reported normal to minimal hopelessness. Also, while Māori make up 16.5% of Aotearoa and 19% of males between 15 and 29 years-old, 9% of participants in this study identified as Māori. Further work in this area would benefit from increased ethnic representativeness. Lastly, the cross-sectional nature of this study limits the ability to assess directionality of findings. Examination of the relationships between hopelessness, meaning in life and social connectedness with longitudinal methods would be beneficial in corroborating these findings.

The current study provides a springboard for future research across several domains. This study was conducted with young adult males. Future work may seek to replicate these findings across gender identities. Given that meaning in life stems from multiple avenues, research may wish to explore the extent with which meaning in life moderates the relationship between hopelessness and social and vocational outcomes such as work satisfaction, educational achievement, and sense of faith. An emerging body of research such as the qualitative work with New Zealand men aged 20-40 year-old by from McKenzie et al. (2018) shows that young-adult males value different forms of social connection compared to females, and have diverse patterns of connection. Lee and Robbins (2000) also found that social connectedness for men was based in differentiation of the self from connected individuals and groups, a unique source compared with women who prefer physical closeness and opportunity for nurturance. Future work could explore whether different types of social connection and support are predictive of hopelessness in this cohort and if the moderation effect remains. With increased ethnic representativeness, further work should also consider how Māori conceptualizations of meaning and connectedness affect hopelessness. Meaning in life and social connectedness could be examined as moderators between known risk factors and hopelessness, extending knowledge of resilience regarding hopelessness. Future research should also seek to consider how this knowledge can be applied to interventions for suicide prevention and in working with individuals who experience feeling suicidal.

In summary, the current study sought to address a critical gap in literature by exploring social connectedness and meaning in life as psychological buffers of hopelessness. Results indicated that these factors were independently associated with hopelessness. Further, meaning in life was found to moderate the relationship between social connectedness and hopelessness, indicating that high meaning in life was associated with reduced hopelessness when social connectedness was low. To our knowledge, this is the first study that has looked at these relationships and done so in a sample of individuals at risk for suicidal thoughts and behaviours. These findings have broad implications for future exploratory work on psychological buffers of hopelessness, as well as practical applicability to suicide prevention.

References

Abramson, L.Y, Alloy, L.B, Hogan, M.E, Whitehouse, W.G, Gibb, B.E, Hankin, B.L, Cornette, M.M (2002). The Hopelessness Theory of Suicidality. In Joiner, T., & Rudd, M (Eds.), Suicide Science: Expanding the Boundaries. (pp. 17-32). Kluwer Academic Publishers

Aiken, L. S., West, S. G., & Reno, R. R. (1991). Multiple regression: testing and interpreting interactions. Sage Publications.

Arahanga-Doyle, H., Moradi, S., Brown, K., Neha, T., Hunter, J. A., & Scarf, D. (2019). Positive youth development in Māori and New Zealand European adolescents through an adventure education programme. *Kōtuitui: New Zealand Journal of Social Sciences Online*, 14(1), 38-51. https://doi.org/10.1080/1177083X.2018.1508479

Arango, A., Cole-Lewis, Y., Lindsay, R., Yeguez, C. E., Clark, M., & King, C. (2018). The protective role of connectedness on depression and suicidal ideation among bully victimized youth. J*ournal of Clinical Child & Adolescent Psychology*. http://dx.doi.org/10.1080/15374416.2018.1443456

Baumeister, R. F. (1991). *Meanings of life*. Guilford Press.

Baumeister, R. F., & Leary, M. R. (1995). The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological bulletin, 117*(3), 497-529. https://doi.org/10.1037/0033-2909.117.3.497

Beck, A. T., Brown, G., Berchick, R. J., Stewart, B. L., & Steer, R. A. (1990). Relationship between hopelessness and ultimate suicide: A replication with psychiatric outpatients. *Am J Psychiatry, 147*(2), 190-195. https://doi.org/10.1176/ajp.147.2.190

Beck, A. T., Steer, R. A., Kovacs, M., & Garrison, B. (1985). Hopelessness and eventual suicide: A 10-year prospective study of patients hospitalized with suicidal ideation. *Am J Psychiatry, 142*(5), 559-563. https://doi.org/10.1176/ajp.142.5.559

Beck, A. T., Weissman, A., Lester, D., & Trexler, L. (1974). The measurement of pessimism: The Hopelessness Scale. *Journal of Consulting and Clinical Psychology, 42*(6), 861-865. https://doi.org/10.1037/h0037562

Beck, A. T., Robert. A. (1993). *BHS, Beck hopelessness scale: manual*. Psychological Corp.

Becker-Weidman, E. G., Reinecke, M. A., Jacobs, R. H., Martinovich, Z., Silva, S. G., & March, J. S. (2009). Predictors of hopelessness among clinically depressed youth. *Behavioural and cognitive psychotherapy, 37*(3), 267-291. https://doi.org/10.1017/S1352465809005207

Bel, D., Smolders, K., IJsselsteijn, W., & Kort, Y. D. (2009). Social connectedness: concept and measurement. *International Conference on Intelligent Environments, 4*, 933-940. https://doi.org/10.13189/ujer.2016.040501

Bolland, J. M., Lian, B. E., & Formichella, C. M. (2005). The origins of hopelessness among inner-city African-American adolescents. *American Journal of Community Psychology, 36*(3-4), 293-305. https://doi.org/10.1007/s10464-005-8627-x

Braden, A., Overholser, J., Fisher, L., Ridely J. (2017) Life meaning is predictive of improved hopelessness and depression recovery in depressed veterans. *Journal of Social and Clinical Psychologym 36* (8), 629-650. https://doi.org/10.1521/jscp.2017.36.8.629

Breitbart, W., & Heller, K. S. (2003). Reframing hope: Meaning-centered care for patients near the end of life. *Journal of Palliative Medicine*, *6*(6), 979-988. http://dx.doi.org/10.1089/109662103322654901

Chioqueta, A. P., & Stiles, T. C. (2007). The relationship between psychological buffers, hopelessness, and suicidal ideation: Identification of protective factors. *Crisis, 28*(2), 67-73. https://doi.org/10.1027/0227-5910.28.2.67

Choudhary, P., Devi, R., Naz, S., & Rai, K. (2021). Social connectedness, spirituality, quality of life, and hopelessness among older adults. *Annals of the Romanian Society for Cell Biology*, *25*(6), 12241-12253.

Costanza, A., Prelati, M., & Pompili, M. (2019). The meaning in life in suicidal patients: The presence and the search for constructs. A systematic review. *Medicina*, *55*(8), 465.

Dezutter, J., Waterman, A. S., Schwartz, S. J., Luyckx, K., Beyers, W., Meca, A., ... & Caraway, S. J. (2014). Meaning in life in emerging adulthood: A person-oriented approach. *Journal of Personality*, *82*(1), 57-68. http://dx.doi.org/10.1111/jopy.12033

Elledge, D., Zullo, L., Kennard, B., Diederich, A., Emslie, G., & Stewart, S. (2019). Refinement of the role of hopelessness in the Interpersonal Theory of Suicide: An exploration in an inpatient adolescent sample. *Archives of Suicide Research*, 1-15. https://doi.org/10.1080/13811118.2019.1661896

Eraslan-Capan, B. (2016). Social connectedness and flourishing: The mediating role of hopelessness. *Universal Journal of Educational Research*, *4*, 933-940. https://doi.org/10.13189/ujer.2016.040501

Every-Palmer, S., Grant, M. L., & Thabrew, H. (2022). Young people don’t tend to ask for help more than once: Child and adolescent psychiatrists’ views on ailing mental health services for young New Zealanders. *Australasian Psychiatry*, 30(6), 684-688. http://dx.doi.org/10.1177/10398562221115624

Franklin, J. C., Ribeiro, J. D., Fox, K. R., Bentley, K. H., Kleiman, E. M., Huang, X., Musacchio, K. M., Jaroszewski, A. C., Chang, B. P., & Nock, M. K. (2017). Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. *Psychological bulletin, 143*(2), 187-232. https://doi.org/10.1037/bul0000084

García-Alandete, J., Marco, J. H., & Pérez, S. (2014). Predicting role of the meaning in life on depression, hopelessness, and suicide risk among borderline personality disorder patients. *Universitas Psychologica, 13*(4), 1545-1555. https://doi.org/10.11144/Javeriana.UPSY13-4.prmi

George, L. S., & Park, C. L. (2016). Meaning in life as comprehension, purpose, and mattering: Toward integration and new research questions. *Review of General Psychology, 20*(3), 205-220. https://doi.org/10.1037/gpr0000077

Gibb, B. E., Alloy, L. B., Abramson, L. Y., Rose, D. T., Whitehouse, W. G., Donovan, P., Hogan, M. E., Cronholm, J., & Tierney, S. (2001). History of childhood maltreatment, negative cognitive styles, and episodes of depression in adulthood. *Cognitive Therapy and Research, 25*(4), 425-446. https://doi.org/10.1023/A:1005586519986

Girgin, G. (2009). Evaluation of the factors affecting loneliness and hopelessness among university students in Turkey. *Social Behavior and Personality: An International Iournal, 37*(6), 811-817. https://doi.org/10.2224/sbp.2009.37.6.811

Global Burden of Disease Collaborative Network (2020). *Global Burden of Disease Study 2019 (GBD 2019) Disease and Injury Burden 1990-2019* [Data set]. Institute for Health Metrics and Evaluation (IHME) https://doi.org/10.6069/P5WM-5A36

Gvion, Y., & Levi-Belz, Y. (2018). Serious suicide attempts: systematic review of psychological risk factors. *Frontiers in psychiatry*, *9*, 343506. http://dx.doi.org/10.3389/fpsyt.2018.00056

Haatainen, K. M., Tanskanen, A., Kylmä, J., Honkalampi, K., Koivumaa-Honkanen, H., Hintikka, J., Antikainen, R., & Viinamäki, H. (2003). Stable hopelessness and its predictors in a general population: A 2-year follow-up study. *Suicide and Life-Threatening Behavior, 33*(4), 373-380. https://doi.org/10.1521/suli.33.4.373.25237

Holden, J. (2020) *Timaru Menz Shed turns attention to expanding after making room.*

Retrieved 2020 from https://www.stuff.co.nz/timaru-herald/news/122609514/timaru-menz-shed-turns-attention-to-expanding-after-making-room

Horwitz, A. G., Berona, J., Czyz, E. K., Yeguez, C. E., & King, C. A. (2017). Positive and Negative Expectations of Hopelessness as Longitudinal Predictors of Depression, Suicidal Ideation, and Suicidal Behavior in High-Risk

Adolescents. *Suicide and Life-Threatening Behavior, 47*(2), 168-176. https://doi.org/10.1111/sltb.12273

Jetten, J., Haslam, S. A., Cruwys, T., Greenaway, K. H., Haslam, C., & Steffens, N. K. (2017). Advancing the social identity approach to health and well-being: Progressing the social cure research agenda. *European Journal of Social Psychology, 47*(7), 789-802. https://doi.org/10.1002/ejsp.2333

Joiner, T. E. (2005). *Why people die by suicide*. Harvard University Press. http://dx.doi.org/10.2307/j.ctvjghv2f

Jose, P. E. (2013, October, 03). *ModGraph-I: A programme to compute cell means for the graphical display of moderational analyses: The internet version, Version 3.0.* Victoria University of Wellington. https://psychology.victoria.ac.nz/modgraph/

Kocalevent, R. D., Finck, C., Pérez-Trujillo, M., Sautier, L., Zill, J., & Hinz, A. (2017). Standardization of the Beck Hopelessness Scale in the general population. *Journal of mental health, 26*(6), 516-522. http://dx.doi.org/10.1080/09638237.2016.1244717

Kleiman, E. M., Adams, L. M., Kashdan, T. B., & Riskind, J. H. (2013). Grateful individuals are not suicidal: Buffering risks associated with hopelessness and depressive symptoms. *Personality and Individual Differences, 55*(5), 595-599. https://doi.org/10.1016/j.paid.2013.05.002

Kleftaras, G., & Psarra, E. (2012). Meaning in life, psychological well-being and depressive symptomatology: A comparative study. *Psychology, 3*(04), 337. http://dx.doi.org/10.4236/psych.2012.34048

Kliem, S., Lohmann, A., Mößle, T., & Brähler, E. (2018). Psychometric properties and measurement invariance of the Beck Hopelessness Scale (BHS): Results from a German representative population sample. *BMC Psychiatry, 18*(1), 110. https://doi.org/10.1186/s12888-018-1646-6

Klonsky, D., E., & May, A. M. (2015). The three-step theory (3ST): A new theory of suicide rooted in the "ideation-to-action" framework. *International Journal of Cognitive Therapy*, *8*(2), 114-129. https://doi.org/10.1521/ijct.2015.8.2.114

Koni, E., Moradi, S., Arahanga-Doyle, H., Neha, T., Hayhurst, J., Boyes, M., Cruwys, T., Hunter, J., & Scarf, D. (2019). Promoting resilience in adolescents: A new social identity benefits those who need it most. *PLoS ONE*, 14(1), e0210521. https://doi.org/10.1371/journal.pone.0210521

Lambert, N. M., Stillman, T. F., Hicks, J. A., Kamble, S., Baumeister, R. F., & Fincham, F. D. (2013). To belong is to matter: Sense of belonging enhances meaning in life. *Personality and Social Psychology Bulletin, 39*(11), 1418-1427. https://doi.org/10.1177/0146167213499186

Lee, R. M., & Robbins, S. B. (1995). Measuring belongingness: The Social Connectedness and the Social Assurance Scales. *Journal of Counseling Psychology, 42*(2), 232-241. https://doi.org/10.1037/0022-0167.42.2.232

Lee, R. M., & Robbins, S. B. (2000). Understanding social connectedness in college women and men. *Journal of Counseling and Development, 78*(4), 484-491. https://doi.org/10.1002/j.1556-6676.2000.tb01932.x

Luz, J. M. O. D., Murta, S. G., & Aquino, T. A. A. D. (2017). Intervention for promoting meaning in life in adolescents: Evaluation of the process and results. *Trends in Psychology*, 25, 1795-1811. https://doi.org/10.9788/TP2017.4-14Pt

Mac Giollabhui, N., Nielsen, J., Seidman, S., Olino, T. M., Abramson, L. Y., & Alloy, L. B. (2018). The development of future orientation is associated with faster decline in hopelessness during adolescence. *Journal of Youth and Adolescence*, *47*(10), 2129-2142. https://doi.org/10.1007/s10964-017-0803-4

Manco, N., & Hamby, S. (2021). A meta-analytic review of interventions that promote meaning in life. *American Journal of Health Promotion*, *35*(6), 866-873. http://dx.doi.org/10.1177/0890117121995736

Marchetti, I., Alloy, L. B., & Koster, E. H. (2023). Breaking the vise of hopelessness: Targeting its components, antecedents, and context. *International journal of cognitive therapy*, *16*(3), 285-319. https://doi.org/10.31219/osf.io/ryvwu

Marco, J. H., Guillén, V., & Botella, C. (2016). The buffer role of meaning in life in hopelessness in women with borderline personality disorders. *Psychiatry Research, 247*, 120-124. https://doi.org/10.1016/j.psychres.2016.11.011

Martela, F., & Steger, M. F. (2016). The three meanings of meaning in life: Distinguishing coherence, purpose, and significance. *The Journal of Positive Psychology, 11*(5), 531-545. https://doi.org/10.1080/17439760.2015.1137623

McCay, E., Quesnel, S., Langley, J., Beanlands, H., Cooper, L., Blidner, R., Aiello, A., Mudachi, N., Howes, C., & Bach, K. (2011). A relationship-based intervention to improve social connectedness in street-involved youth: A pilot study. *J Child Adolesc Psychiatr Nurs, 24*(4), 208-215. https://doi.org/10.1111/j.1744-6171.2011.00301.x

McKenzie, S. K., Collings, S., Jenkin, G., & River, J. (2018). Masculinity, social connectedness, and mental health: Men’s diverse patterns of practice. *American Journal of Men's Health, 12*(5), 1247-1261. https://doi.org/10.1177/1557988318772732

Medley, K. (2019). *Factors predicting sadness and hopelessness among young adults* [Thesis, Southern Connecticut State University]. ProQuest Dissertations & Theses http://search.proquest.com.ezproxy.canterbury.ac.nz/docview/2299815847?accountid=14499

Morselli, D. (2016). Contextual determinants of hopelessness: Investigating socioeconomic factors and emotional climates. *Social Indicators Research, 133*(1), 373-393. https://doi.org/10.1007/s11205-016-1346-x

Mulder, R. T., Bastiampillai, T., Jorm, A., & Allison, S. (2022). New Zealand's mental health crisis, He Ara Oranga and the future. *The New Zealand Medical Journal (Online)*, 135(1548), 89-95.

National Institute for Health and Care Excellence (Great Britain). (2022). *Depression in adults: treatment and management*. National Institute for Health and Care Excellence (NICE).

Nock, M. K., & Kazdin, A. E. (2002). Examination of affective, cognitive, and behavioral factors and suicide-related outcomes in children and young adolescents. *Journal of Clinical Child and Adolescent Psychology, 31*(1), 48-58. https://doi.org/10.1207/S15374424JCCP3101_07.

Northcott (2019) Popular Christchurch barber offering 'yarnologists' to talk mental health, Stuff New Zealand. Retrieved 202 from https://www.stuff.co.nz/business/110961072/ popular-christchurch-barber-offering-yarnologists-to-talk-mental-health

O'Connor, R., & Pirkis, J. (2016). *The international handbook of suicide prevention* (2nd ed.).Wiley

O'Connor, R. C., Fraser, L., Whyte, M.C., MacHale, S., & Masterton, G. (2008). A comparison of specific positive future expectancies and global hopelessness as predictors of suicidal ideation in a prospective study of repeat self-harmers. *Journal of Affective Disorders, 110*(3), 207-214. https://doi.org/10.1016/j.jad.2008.01.008

O'Connor, R. C., Worthman, C. M., Abanga, M., Athanassopoulou, N., Boyce, N., Chan, L. F., ... & Yip, P. S. (2023). Gone Too Soon: priorities for action to prevent premature mortality associated with mental illness and mental distress. *The Lancet Psychiatry*, *10*(6), 452-464. http://dx.doi.org/10.1016/S2215-0366(23)00058-5

Office of the Chief Coroner of New Zealand. (2020). Annual provisional suicide statistics for deaths reported to the Coroner between 1 July 2007 and 30 June 2020 https://coronialservices.justice.govt.nz/assets/Documents/Publications/2020-Annual-Provisional-Suicide-Statistics.pdf

Ozmen, E., Ozmen, D., Cetinkaya, A. C., Taskin, E. O., & Dundar, P. E. (2009). The relationship between gender and depression, self-esteem, hopelessness, submissive acts, guilt, shame and anger in adolescents. EP Lamont. *Social Psychology: New Research. New York: Nova Science Publishers*, 135-146.

Panzarella, C., Alloy, L., & Whitehouse, W. (2006). Expanded Hopelessness Theory of Depression: On the mechanisms by which social support protects against depression. *Cognitive therapy and research, 30*, 307-333. https://doi.org/10.1007/s10608-006-9048-3

Pharris, M. D., Resnick, M. D., & Blum, R. W. (1997). Protecting against hopelessness and suicidality in sexually abused American Indian adolescents. *Journal of Adolescent Health, 21*(6), 400-406. https://doi.org/10.1016/S1054-139X(97)00166-3

Rew, L., Taylor-Seehafer, M., Thomas, N. Y., & Yockey, R. D. (2001). Correlates of resilience in homeless adolescents. *Journal of Nursing Scholarship, 33*(1), 33-40. https://doi.org/10.1111/j.1547-5069.2001.00033.x

Reyes, M. E. S., Davis, R. D., Chua, C. A. P. Q., Olaveria, G. L., Pamintuan, L. J. E., Serrano, M. K. B., & Tan, J. L. E. C. (2020). Relative Importance of Social Support and Social Connectedness as Protective Factors of Suicidal Ideation Among Selected Filipino Late Adolescents. *Suicidology Online*, *11*(1).

Ribeiro, J. D., Huang, X., Fox, K. R., & Franklin, J. C. (2018). Depression and hopelessness as risk factors for suicide ideation, attempts and death: Meta-analysis of longitudinal studies. *British Journal of Psychiatry, 212*(5), 279-286. https://doi.org/10.1192/bjp.2018.27

Rodríguez-Naranjo, C., & Caño, A. (2016). Daily stress and coping styles in adolescent hopelessness depression: Moderating effects of gender. *Personality and Individual Differences*, *97*, 109-114. http://dx.doi.org/10.1016/j.paid.2016.03.027

Rudd, M. D., Berman, A. L., Joiner, T. E., Nock, M. K., Silverman, M. M., Mandrusiak, M., Van Orden, K., & Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behavior*, *36*(3), 255-262. https://doi.org/10.1521/suli.2006.36.3.255

Scarf, D., Moradi, S., McGaw, K., Hewitt, J., Hayhurst, J. G., Boyes, M., Ruffman, T., & Hunter, J. A. (2016). Somewhere I belong: Long-term increases in adolescents' resilience are predicted by perceived belonging to the in-group. *British Journal of Social Psychology*, 55(3), 588-599. https://doi.org/10.1111/bjso.12151

Star News (2020). Surfing for farmers begins at Gore Bay, Retrieved 2020, from https://www.odt.co.nz/star-news/star-districts/star-north-canterbury/surfing-farmers-begins-gore-bay.

Stavrova, O., & Luhmann, M. (2015). Social connectedness as a source and consequence of meaning in life. *The Journal of Positive Psychology*, *11*(5), 470-479. https://doi.org/10.1080/17439760.2015.1117127

Steger, M. F., Frazier, P., Oishi, S., & Kaler, M. (2006). The Meaning in Life Questionnaire: Assessing the presence of and search for meaning in life. *Journal of Counselling Psychology*, *53*(1), 80-93. https://doi.org/10.1037/0022-0167.53.1.80

Stillman, T. F., & Lambert, N. M. (2013). The bidirectional relationship of meaning and belonging. In Hicks, J., Routledge, C. (Eds) The Experience of Meaning in Life (pp. 305-315.) Springer

Sueki, H. (2020). Relationship between Beck Hopelessness Scale and suicidal ideation: A short-term longitudinal study. *Death studies*, 1-6. https://doi.org/10.1080/07481187.2020.1740833

Sun, F. K., Wu, M. K., Yao, Y., Chiang, C. Y., & Lu, C. Y. (2022). Meaning in life as a mediator of the associations among depression, hopelessness and suicidal ideation: A path analysis. *Journal of psychiatric and mental health nursing*, *29*(1), 57-66. http://dx.doi.org/10.1111/jpm.12739

Sun, F. K., Chiu, N. M., Yao, Y., Wu, M. K., Hung, C. F., Chen, C. C., ... & Chiang, C. Y. (2022). The effects of logotherapy on meaning in life, depression, hopelessness, and suicidal ideation, in patients with depression: An intervention study. *Perspectives in psychiatric care*, *58*(4), 1891-1899. http://dx.doi.org/10.1111/ppc.13003

Thompson, E. A., Mazza, J. J., Herting, J. R., Randell, B. P., & Eggert, L. L. (2005). The mediating roles of anxiety, depression, and hopelessness on adolescent suicidal behaviors. *Suicide & Life-Threatening Behavior*, *35*(1), 14-34. https://doi.org/10.1521/suli.35.1.14.59266

Turecki, G., Brent, D. A., Gunnell, D., O'Connor, R. C., Oquendo, M. A., Pirkis, J., & Stanley, B. H. (2019). Suicide and suicide risk. *Nature reviews Disease primers*, 5(1), 74. http://dx.doi.org/10.1038/s41572-019-0121-0

United Nations. (2019). *Report of the Secretary-General on SDG progress 2019: Special edition*. Retrieved from: https://sustainabledevelopment.un.org/content/documents/24978Report_of_the_SG_on_SDG_Progress_2019.pdf

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner, T. E., Jr. (2010). The Interpersonal Theory of Suicide. *Psychological Review*, *117*(2), 575-600. https://doi.org/10.1037/a0018697

Weishaar, M. E., & Beck, A. T. (1992). Hopelessness and suicide. *International Review of Psychiatry, 4*(2), 177-184. https://doi.org/10.3109/09540269209066315

Wenzel, A., & Beck, A. (2008). A cognitive model of suicidal behavior: Theory and treatment. *Applied & Preventive Psychology. 12*, 189-201. https://doi.org/10.1016/j.appsy.2008.05.001

Wetzel, R. D., Margulies, T., Davis, R., & Karam, E. (1980). Hopelessness, depression, and suicide intent. *The Journal of Clinical Psychiatry*, *41*(5), 159-160. https://doi.org/ 10.1001/archpsyc.1976.01770090059005

World Health Organisation. (2014). *Preventing suicide: A global imperative*. Retrieved from https://www.who.int/publications/i/item/9789241564779

Zhang, H., Sang, Z., Chan, D. K. S., & Schlegel, R. (2018). Threats to belongingness and meaning in life: A test of the compensation among sources of meaning. *Motivation and Emotion*, *43*(2), 242-254. https://doi.org/10.1007/s11031-018-9737-8

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“Last year, I had an absolute mental breakdown […] and I only got better due to my family and friends”: A qualitative study on the role of masculine norms and social relationships for young men’s mental health

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Past research shows that men experience difficulties seeking help for their mental health, and further research is needed to understand how masculine norms can be a barrier. The aim of the current study was to explore young men’s perspectives on social relationships, masculine norms, and help-seeking. Inductive thematic analysis was conducted on interviews with four men aged 19–24 years. The young men specified how masculine norms are all encompassing and act as a barrier to help-seeking that can prolong the pain. Social networks composed of receptive people were perceived to be beneficial but require the ‘right’ people to be helpful for men experiencing mental health difficulties. The young men also posed ways of breaking free from ‘stereotypical’ masculinity. Overall, the findings inform how education about men’s mental health could encourage the formation of social networks and ways of redefining masculinity that promote help-seeking.

Key words: *Masculinity, Men, Mental Health, Relationships, Help-Seeking*

INTRODUCTION

It is well established that men struggle more to ask for help when experiencing mental health difficulties. For example, a systematic review by Seidler et al. (2016) revealed that rather than seeking help for their mental health, men tend to fall into social withdrawal as a way of coping. The difficulties that men have in expressing feelings such as depression are linked to the prevalence of male suicide (Clare, 2001). In 2019, global suicide rates were twice as high in men compared to women (World Health Organization, 2022). Men’s difficulties in opening-up to others about their mental health contributes to the high rates of suicide (Bilsker & White, 2011). It is particularly important to consider the mental wellbeing of young men as half of all mental health diagnoses appear during the teenage years, and by the mid-twenties this increases to three-quarters (Kessler et al., 2007).

Help-seeking in relation to mental health issues can be done formally via health services or informally through talking to people such as family, friends, teachers, chaplains, or coaches (Rickwood & Thomas, 2012). Regardless of who is sought out, seeking help involves the interconnectedness between people – a social relationship. Based on the understanding that men are generally hesitant to communicate their feelings to others (Bilsker & White, 2011; Clare, 2001; Seidler et al., 2016), it is necessary to explore communication, connection, and social relationships. The simplest form of social connection is a social dyad – a group of two people (Smith & Christakis, 2008). Examples of relationships that can impact people’s health include friendships, familial relations, marriages, and membership of religious groups (Umberson & Montez, 2010).

Research also suggests that adverse social relationships can have a negative impact on long-term mental health (Angelakis & Gooding, 2021). There are also other negative aspects of social relationships including being pressured by others to drink alcohol and unsupportive peers thwarting healthy routines (Umberson & Montez, 2010). Notwithstanding the complexities of social relationships and health, there is still a large body of evidence that points towards the benefits of social relationships. Specifically, the psychosocial explanation as to how social relationships benefit health argues that support benefits mental health via lessening stress and developing a sense of purpose and meaning (Umberson & Montez, 2010).

The past research reviewed above demonstrates how social relationships are important for mental health. In addition, the dynamic between social relationships and mental health is influenced by gender, and the role of masculine norms is particularly relevant. Gender norms are based on societal expectations of women and men (Courtenay, 2000). Men are expected to conform to masculine norms, which commonly include being stoic, refraining from emotional expression, and showing independence (Mansfield et al., 2003). Such societal beliefs about how men should behave has been coined ‘The Man Box’ (The Men’s Project & Flood, 2020). This metaphorical box contains several key pressures that men face, including but not limited to: being physically and mentally tough; refraining from help-seeking; and conforming to strict masculine gender roles. The influence of masculinity is relevant to young men, where masculine norms are widely subscribed to in adolescence (Kågesten et al., 2016). Furthermore, these norms are promoted mainly by those in an individual’s interpersonal sphere, such as family and friends (Kågesten et al., 2016). The dysfunction strain paradigm proposes that men can experience strain due to masculine norms being unrealistic (Pleck, 1995). Such expectations can ultimately be dysfunctional as they can lead to negative consequences (e.g., exacerbated depression due to feeling the need to be entirely self-reliant). Further, the theory of gender norm conformity (Mahalik et al., 2003) ties masculine norms specifically to mental health, arguing that these norms can lead men to think, feel, and act in a way that can worsen mental health outcomes (such as the hiding of one's emotions exacerbating depression). It is important to consider how masculine norms such as independence, being emotionless, and stoicism relate to the forming of social relationships.

Compared to women, men have fewer 'close' social relationships and fewer instances of social support (Fuhrer & Stansfield, 2002; Liebler & Sandefur, 2002). Men who have more negative views towards asking for professional help with psychological issues have higher scores with respect to alexithymia (difficulties expressing emotions), masculine ideology, and fear of intimacy (Sullivan et al., 2015). Further, the norm of self-reliance is positively correlated to depressive symptoms in male university students in the US and is explained by lower willingness to open-up to others about negative feelings (Iwamoto et al., 2018). Focus groups with British young men have shown that help-seeking was seen as a last resort by the young men (Richardson & Rabiee, 2001). Specifically, it was discussed how part of being a man meant help-seeking was not required unless the situation was particularly severe. This desire of men to fulfil the masculine norms of society was again shown by Davies et al. (2000), who found that the greatest barrier for male university students seeking help is the desire to hide vulnerability and appear independent. Participants expressed in focus groups how help-seeking would seem weak and was a last resort. Societal pressures of masculinity were a key barrier to men reaching out for help.

Help-seeking can be hindered because of what men perceive they are supposed to be, and this viewpoint is particularly potent in younger men (O'Brien et al., 2005). Participants in O'Brien et al.'s (2005) study made the point that asking for help for 'minor' problems was unnecessary, and that it was better to cope with such problems alone. Across the findings of Richardson and Rabiee (2001), Davies et al. (2000), and O'Brien et al. (2005), the consistent theme is that men deem help-seeking as a last resort. It seems that societal pressures of having to be independent, self-reliant, and stoic have convinced men that trying to deal with problems on one's own is what a man must do.

Internalisation of masculine norms such as being independent and self-sufficient can be associated with worrying consequences, including suicidal ideation. Cleary (2012) conducted interviews with young men who had attempted suicide. A theme in the interviews was that the strain of dealing with and hiding one's feelings led to a sense of being trapped, where suicide was seen as a way out of this situation. These men attempted suicide rather than disclose their negative emotions to other people, as this was consistent with societal masculine norms. Further interview-based research has indicated the role of masculinity and the related stoic perspectives (e.g., isolation from others when feeling upset) as a risk factor for male suicidality (Player et al., 2015). Interviews with the family and friends of men who have taken their own life showed that one of the key themes was the deceased had hidden their feelings of suicidality and need of mental support (Oliffe et al., 2020). This further emphasises the barrier that men have regarding reaching out for help, even from their friends and family. However, Seidler et al. (2021) found that some men have sudden positive realisations that they cannot solve their problems alone. Initially, men tended to use tactics such as social isolation and distress concealment rather than reaching out for help. However, it was after a long period of exhausting self-sufficiency that men realised the necessity to look past their stoicism and communicate their feelings to others. Because Seidler et al.'s (2021) study considered men of all ages, this raises the question about the perspectives of young men specifically regarding overcoming normative masculine barriers to help-seeking when experiencing mental health difficulties.

The current study aimed to integrate ideas across the literature reviewed above. While much of the existing research focuses on masculine norms and mental health, there is little explicit discussion of the role that social relationships have within this pairing. Indeed, such relationships are likely to encompass the aspects of help-seeking and communication of emotion, yet there is a dearth of research that prioritises the role of social relationships in this equation. The study was undertaken in Aotearoa New Zealand – a point of difference to most other research. Based on data from 41 developed countries, Aotearoa New Zealand has the second worst youth suicide rate (UNICEF, 2020). Additionally, as of 2015, the suicide rate for 15-24-year-old men from Aotearoa New Zealand was 20.3 per 100,000, while for women of the same age range this was 13.2 (Phillips, 2019). In tandem, the saliency of masculinity in Aotearoa New Zealand is exemplified through the term 'Kiwi bloke' – a representation of a rugged, hard-working man who keeps to himself (Bannister, 2005; Joseph & Falcous, 2017; Phillips, 1987). While the research on men's mental health, masculinity, and help-seeking is limited in Aotearoa New Zealand, a recent study by Gallagher et al. (2022) considered young men's perspectives towards mental health services such as therapy and social support. Conducted just prior to the Covid-19 pandemic, one of the main themes reflected the idea of how men feel the need to try to be independent rather than seek help, as well as have control over their lives. Furthermore, participants identified the importance of social support in coping with and overcoming mental health struggles. Such support was seen as something that was offered through a variety of avenues, such as family or professional services. These findings indicate the relevance of masculinity in Aotearoa New Zealand, as well as the need for more research to better understand what young men see as the important aspects of social relationships.

The current study aimed to explore how young men in Aotearoa New Zealand perceive masculinity and social relationships with regard to help-seeking for mental health difficulties. The two connected research question being investigated were: 1) How do masculine norms effect help-seeking for mental health difficulties among young men? 2) What connections do young men draw between mental health help-seeking and the nature of their social relationships?

METHOD

Design

Using a qualitative methodology, the current study employed semi-structured, one-on-one interviews to collect data. The data was coded using an inductive, semantic, and essentialist/realist approach (Braun & Clarke, 2006; 2022). Inductive analyses are centred on the idea that themes are extracted from the data gathered, rather than attempting to use any particular theory to code the data and identify themes (Braun & Clarke, 2006; 2022). Identifying themes at a semantic level involves carefully considering the surface expressions of participants; the focus is on explicit meanings expressed by participants. Additionally, an essentialist/realist approach looks to conceptualise meaning and experiences from the data at face-value (Braun & Clarke, 2006, 2022).

Participants and Procedure

Participants were recruited using a purposive approach seeking young men. Physical posters, digital posts, and word of mouth. The physical posters were displayed around the University of Otago campus. A digital post was made on the Facebook page Otago Flatting Goods, where this page often has a range of advertisements posted beyond topics tied to flatting.

The resulting sample consisted of four participants who were students at the University of Otago. All participants were young men aged 19–24 years old. Their ethnicities were: New Zealand European/Pākehā; Māori/Samoan; South-East Asian; and South Asian.

The project was reviewed and approved by the University of Otago Human Ethics Committee (Reference: 22/150). Participants were provided with an information sheet about the study and had the opportunity to ask any questions before providing consent prior to their interview. All interviews took place in a private room on the University of Otago campus. For the sake of consistency, each participant was interviewed by me as the primary researcher. Participants were informed that the interview would last approximately 60 minutes, and interview length ranged from 34 minutes to 56 minutes, with a mean interview time of 44 minutes.

The questions asked in the interviews were primarily open-ended. The use of open-ended questions in interviews allows for a more detailed understanding of personal perspectives (DiCicco-Bloom & Crabtree, 2006). These questions looked to uncover the thoughts and/or personal experiences of the participants regarding the role of masculine norms on mental health, specifically in relation to forming social relationships. A consequence of using open-ended questions is that participants are allowed greater freedom to respond in ways which are complex and unique, or they may simply discuss ideas that were not anticipated by the researcher (Albudaiwi, 2017).

Due to the possibility of the discussion being mildly distressing, the contact details of relevant support services were provided at the conclusion of the interview. Each participant was reimbursed for expense with a supermarket voucher.

Data Analysis

Interviews were recorded and then transcribed using Otter.ai software and checked for accuracy. The general conventions used when going over the transcripts included replacing identifiers with square brackets (e.g., [name of school]), deleting any superfluous transcribed sounds (e.g., ‘um’), and including commas or full stops to signify when the participant was thinking or had finished a thought. The participants’ real names were replaced with pseudonyms, and other names that were mentioned were masked.

The subsequent analysis followed the six-phase approach to reflexive thematic analysis outlined by Braun and Clarke (2006, 2022). The first author was the primary researcher of this project and was a young male postgraduate student studying psychology with an older male supervisor experienced in supporting qualitative research. Reflective discussions were held between the authors throughout the study. As noted by Braun and Clarke (2022), this subjectivity is a useful component to thematic analysis, where the researchers themselves are tools that contributes to the analysis.

In phase one of the data analysis, the primary researcher familiarised himself with the data by reading over the transcripts. Preliminary notes were taken based on the research aim outlined in the introduction. In phase two, codes were generated based on the commonalties that were identified between interviews. Quotes related to codes were identified throughout each interview by repeatedly re-reading the transcripts.

Phase three of the analysis focused on compiling preliminary themes. The codes were brought together in different groups to form broader themes. During this phase, virtual sticky notes were utilised to organise the codes into different themes. Phase four involved reviewing these themes. This meant that each theme was checked to make sure it reflected one coherent overall idea that was distinct from the other themes, as well as ensuring that the theme related to the overall research questions, as well as the participants’ discussion.

For phase five, themes were labelled with names that reflected the main idea of what was conveyed by the participants. Moreover, a short definition was crafted to accompany each theme. Phase six involved producing the report, where quotations were chosen from the transcript that clearly represented each theme. These quotations are presented in the following results section alongside the related theme and its definition.

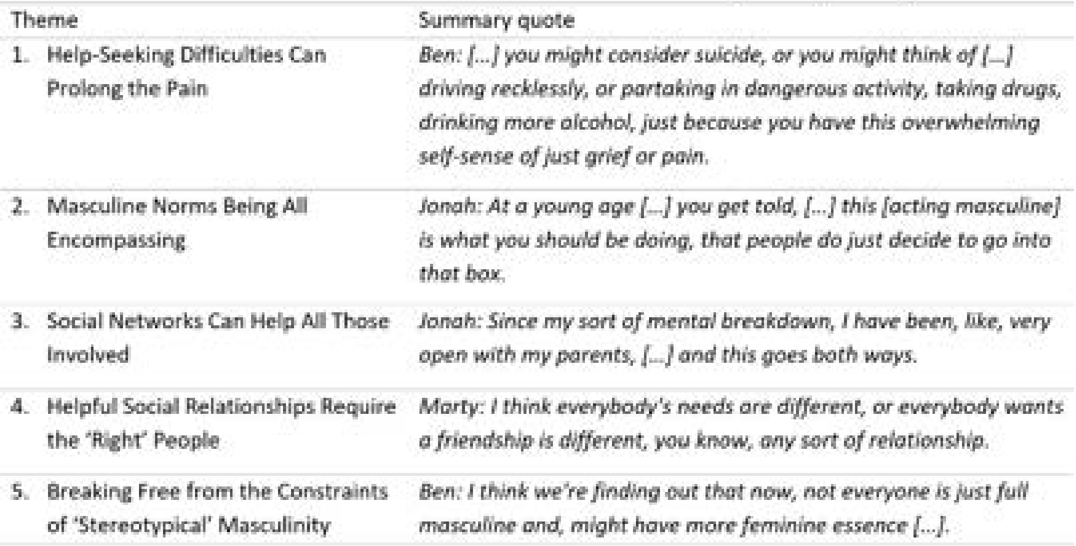
ANALYSIS AND COMMENTARY

Five themes were identified from the thematic analysis, as outlined in Table 1 along with a key supporting quote for each theme.

Theme 1:
Help-Seeking Difficulties Can Prolong the Pain

The first theme encompasses why young men find it difficult to seek help for difficult times in their lives. The young men described wanting to get help but feeling like they could not for the fear of appearing weak. This was tied to how men can struggle to utilise social relationships to overcome their mental health struggles. The consequence of being reluctant to help-seek was the build-

Table 1. *The five themes related to the role of masculinity in help-seeking*



Theme	Summary quote
1. Help-Seeking Difficulties Can Prolong the Pain	*Ben: [...] you might consider suicide, or you might think of [...] driving recklessly, or partaking in dangerous activity, taking drugs, drinking more alcohol, just because you have this overwhelming self-sense of just grief or pain.*
2. Masculine Norms Being All Encompassing	*Jonah: At a young age [...] you get told, [...] this [acting masculine] is what you should be doing, that people do just decide to go into that box.*
3. Social Networks Can Help All Those Involved	*Jonah: Since my sort of mental breakdown, I have been, like, very open with my parents, [...] and this goes both ways.*
4. Helpful Social Relationships Require the 'Right' People	*Marty: I think everybody's needs are different, or everybody wants a friendship is different, you know, any sort of relationship.*
5. Breaking Free from the Constraints of 'Stereotypical' Masculinity	*Ben: I think we're finding out that now, not everyone is just full masculine and, might have more feminine essence [...].*

up of pressure and prolonging of pain from mental health difficulties or other challenges in life.

With regards to what being masculine typically entails, participants referred to ideas of confidence and not wanting to appear weak:

> *Marty: I can see how if you would want to like sort of uplift this masculine image, […] the idea of seeking help […] would be seen as sort of weak, you know, and that's not what you want to do. You know you don't want to show that you don't know something or that you're confused about something, or you want to have make it seem like that you are confident and that you are sort of assertive and assured in who you are.*

Evidently, even in the most difficult of times, young men prolong the pain by being reluctant to help-seek. In a pertinent example, Jonah talked about having a mental breakdown following the end of a relationship, and that he tried to deal with the pain himself for as long as he could before he sought help:

> *Jonah: Last year, I had an absolute mental breakdown [laughs]. […] And it was due to holding on to a certain amount of pressure for a certain amount of time and not being able to hold that anymore. And I only got better due to my family and friends.*

Wyatt also talked about how a friend went through an extremely tough time and yet felt he had to uphold masculine norms and hold onto the pain himself:

> *Wyatt: And I know it, just kind of hurtful moment for him. But he don't want to share. [He] said 'I'm fine. I am I'm good'. But I can see in his eyes that how difficult he has to go through.*

Wyatt noted his friend still might seek help from others, however, was not entirely convinced that such help-seeking would occur.

Theme 2:
Masculine Norms Being All Encompassing

The second theme considers the way in which masculine norms can become instilled in men. Such norms were discussed as being promoted through societal pressures, friends, and 'influencers' on social media. The young men's discussion of how masculinity is promoted highlights how masculine norms can be pervasive.

It was discussed how societal pressure to be masculine begins early in life and how men just assume that they need to conform to these expectations, with Jonah saying:

> *Jonah: […] because at a young age you get, you're like, you get told, […] this is what you should be doing, that people do just decide to go into that box, and don't actually go, 'oh, I'm allowed outside of this box, I don't actually need to conform to that.' Yeah. 'That I don't need to conform to that societal, you know, standard, that pressure.'*

Friends and peers were seen as a big influence on engaging in masculine norms, making it easier to behave in a masculine way if people around you are doing so:

> *Ben: It very much depends on other friends around you too, because they could obviously be of good or bad influence. If their also, of have like, similar masculine essence, you know, like, it could, well, I guess it's more easier for you to feel that way.*

Technology was identified as another perpetrator of masculine norms, further highlighting how difficult it is to avoid the pressures to be masculine. Jonah said:

> *Jonah: Technology has created that sort of societal pressure via like social media and stuff like that. And I guess the most recent example, […] Andrew Tate [an 'influencer'] has been a massive swing for, for our generation, because we've become so impressionable through technology. […] [Andrew Tate] was talking about that women do not like when men show emotion. That whole cool, calm, collected, but also sort of being an arsehole is better than potentially being your true self.*

Ben also discussed how social media 'influencers' like Andrew Tate who promote a normative or idealised form of masculinity, where they suggest that such behaviour is what women are expecting from, and are attracted to, in men. Can negatively impact young men's mental health, reiterating how such people can have bad advice regarding men's mental health. Ultimately, Ben described being worried about how these negative influences will impact young men in the generations to come, saying: *"It's not good to see where it will take them into the future, it might bring up a whole bad generation of people with bad mentalities."*

Theme 3:
Social Networks Can Help All Those Involved

The third theme highlights how social relationships are useful in times of need, where talking to others allows for the release of negative feelings. Participants discussed how having a network of different social relationships was especially important to create a diverse support system, as well as how forming these diverse networks offered benefits to everyone involved, not just the help-seeker.

Jonah discussed the back and forth sharing of feelings, ideas, and problems with a network of people (whakawhanaungatanga):

> *Jonah: I mean, because there's like the idea of like, whakawhanaungatanga, sort of like coming together, looking after each other. Sort of that, like, which is probably why I am doing as good as I am. Because even though I mentioned in this that my mum helped me, also my aunties and uncles, were there as well. [...] I think I wouldn't be as far as I am being happy, if it, if I was just talking to my mum.*

Jonah believed that sharing problems with different people was seen a matter of getting various opinions and advice, which was more helpful than getting only one person's perspective. Wyatt also expressed how having various people to open-up to is important, where different people have different functions:

> *Wyatt: I guess it kind of depends on the people I want to share the information, because different people I will share different piece of information. It's like I have kind of big problem, but I just share that piece of information to them... So different people have different piece of information I'm going to share.*

Going beyond the idea that social relationships just benefit the help-seeker, participants discussed how seeking help can be beneficial to the person who is reached out to. The young men reflected on a variety of people that can reap the rewards of a positive social relationship, and Marty described social relationships as a way to create a sense of fulfilment between an individual and their family and friends:

> *Marty: Friends are going to maybe feel that they have more of a purpose. Like that they mean something to you, if they can feel that they can be of use to you. Same with parents and that sort of thing, who were there to support you and who have supported you.*

Furthermore, Ben explained how social relationships can create environments beneficial to all of those involved:

> *Ben: And that's when it can have a, like, create a positive environment to talk about things that's been on your mind, and, how you've been struggling or how they've been struggling. So it goes like two ways. It's not just you talk to someone, and they listen all the time, but you can also listen to them.*

Theme 4:
Helpful Social Relationships Require the 'Right' People

The fourth theme highlights how having social relationships alone is not sufficient to benefit mental health. Overall, participants explained that the quality of relationships are important, but that what is seen as a helpful relationship will differ from person to person.

The young men made it clear that getting help from others was not as easy as making friends with anyone and everyone. It was highlighted that the 'right' people need to be found for beneficial social relationships:

> *Ben: [...] it's also about being around the right people to support you during this time, who see that you want to get better. And that can be so helpful, because if you're around people that you can't really talk to about this with, it won't be that supportive for you, and it won't be encouraging for you to get help, seek better, get better, and just feel better, feel more positive about life.*

The young men found that when they shared their problems with the 'wrong' people, this can exacerbate the problems. For example, Wyatt is straight but discussed how a friend of his had opened-up with his sister that he is gay, and how the sister did not respond in a positive way:

> *Wyatt: She was mad at him, she's not happy, because you are gay. [...] But I said to him, like you just share the wrong information to wrong people. [...] Only the people who was in sort of circumstances can understand what you need to do.*

This idea of forming relationships with people who understand your situation was also emphasised by Marty:

> *Marty: Maybe the fear that they might not understand. Or they might not really empathise with what I'm saying. [...] I've had other friends who've had similar issues where they've tried to talk to their male friends about things and it's sort of been unsatisfactory [...].*

The participants also emphasised that the type of person that made for a supportive social relationship for one person, would not necessarily be the case for someone else, and that there were individual differences in how relationships could help:

> *Ben: It's just not one person fits all. That's also very, not a very good thing, [...] you actually need a whole variety of people, [...] because there's no one size fits all, there's a lots of different sizes and they help fill a lot of gaps. And that's a much better way of looking at it.*

Theme 5:
Breaking Free from the Constraints of 'Stereotypical' Masculinity

The fifth theme explores the idea of overcoming 'stereotypical' masculine norms. Whilst participants were aware that "*the stereotypes of masculinity*" persist (Marty), they noted that masculine norms are gradually changing making it more acceptable to deviate from norms like stoicism to become more vulnerable and seek help for their problems.

The idea that men are slowly breaking free of "*stereotypes*" associated with masculine norms is exemplified by the experiences of Jonah, who reflected on his road to being more open and vulnerable as "*a learning curve*" and noted this has led him to "*actually asking for help*". Marty also highlighted that while the stigma of men seeking help has not completely disappeared, men are slowly becoming able to talk about their mental health problems more:

> *Marty: Well I think like, in the past sort of maybe 5-10 years, it's sort of been a slightly more of a push for, you know, men to be more vulnerable, and to talk about different issues more.*

Such deviation from the masculine norms may be due to greater awareness about men's mental health:

> *Ben: That's coming from my experience too because there's been more advice offered, more information and, it can help me out and, and also those around me, to see how I can get other people to talk to and, what can I do to make others feel better and help with their mental health.*

Participants referred to the idea of redefining masculinity as well as escaping from the confines that are created by "*stereotypical*" norms. This discussion aligned with the idea that society creates a metaphorical 'box' that men should fit in to, but that men can exist outside of these masculine confines:

> *Wyatt: Being masculine is not just showing the public that you are man. It's that, the feel like from inner yourself, so the masculine come from inner self. Don't be ashamed who you are. Just embrace any moment in the life, because you only live once. So, masculinity, just the word. Masculinity, just the word. The masculine come from you. So you define own oneself.*

DISCUSSION

In this study, the aim was to explore how young men in Aotearoa New Zealand perceive masculinity and social relationships with regard to help-seeking for mental health difficulties. The findings of this thematic analysis contribute a specific focus on the role of social relationships within the field of masculinity and men's mental health. Past research has lacked detailed consideration of social relationships in the context of masculinity as a barrier to men's help-seeking. In addressing this gap, the findings reflect some nuanced ideas about social relationships in the context of help-seeking. The young men emphasised the importance of having a social network of people to reach out to, where such networks could benefit both the help-seeker *and* the people reached out to. Moreover, the participants discussed how merely the existence of a social relationship was inadequate – the 'right' person was required. The findings suggest masculine norms may still be a barrier for help-seeking in young men in Aotearoa New Zealand. However, there seems to be a gradual shift in the expectations of men away from 'stereotypical' masculine norms.

The present findings are largely consistent with past research, albeit there are differences to note. As highlighted in the theme *Help-Seeking Difficulties Can Prolong the Pain*, the young men reflected on the difficulties in seeking help for their problems, where wanting to avoid seeming weak meant their mental struggles were unresolved. This idea coincides with masculine norms such as stoicism and refraining from emotional expression (Kågesten et al., 2016; Mansfield et al., 2003). Relatedly, the influence and pervasiveness of masculine norms were evident in the theme *Masculine Norms Being All Encompassing*. Together, these themes highlight both the centrality of masculine norms in the lives of young men, as well as the problematic outcomes of conforming to such norms. Interestingly, the idea of independence was not as commonly discussed by the young men in this study, which differs from findings across men of all ages summarised by Mansfield et al. (2003). It may be that being stoic and emotionless was more relevant to the young men in the current study due to their age, their role as students, or aspects of the Covid-19 pandemic such as reduced social interaction with peers due to online learning.

The findings here indicated the saliency of masculinity in Aotearoa New Zealand, where the young men appear to fit the description of a Kiwi bloke in terms of wanting to keep to oneself, at least initially (Bannister 2005; Joseph & Falcous, 2017; Phillips, 1987). Moreover, the wide-reaching nature of these norms were evident. Similar to the findings of Kågesten et al. (2016), masculine norms were discussed by participants as being promoted by those in a young man's interpersonal sphere – namely family members and peers. A point of difference was that whilst Kågesten et al. (2016) found a lack of evidence on the influence of broader factors such as media, the current study identified technology and social media 'influencers' (e.g., Andrew Tate) as a central proponent of unhealthy masculine norms. As pointed out by Gavey et al. (2021), there are varying articulations of masculinity. Specifically, in the current study such 'influencers' seemed to promote a normative or idealistic form of masculinity, referring to what women find attractive as an incentive to following masculine norms. The current study provides evidence supporting the idea that masculine norms could be promoted by *both* interpersonal influences and broader societal influences.

In line with the dysfunction strain paradigm (Pleck, 1995), the young men who participated in our study felt the need to fulfil societal expectations of masculinity. The conformity to masculine norms described by young men in our study puts a strain on the mental health on young men, where the sense of feeling unable to reach out for help was dysfunctional as it prolonged the pain that was being experienced. This finding also aligns with findings of research by The Men's Project and Flood (2020) who posed the concept of 'The Man Box' as the repository of masculine norms. The way young men in our study described societal pressures to uphold masculine ideals provides further support for calls to 'unpack' the Man Box (The Men's Project & Flood, 2020). Moreover, consistent with the theory of gender norm conformity (Mahalik et al., 2003), young men in the present study reflected on how conforming to these masculine norms, discussing was seen as a weakness to seek help, leaving unresolved negative feelings, ultimately leading to the reluctance to utilise social relationships. Help-seeking was seen as a last resort in the current study, which is consistent with previous research (Davies et al., 2000; O'Brien et al., 2005; Richardson & Rabiee, 2001). Young men want to appear confident, assured, and stoic, which is consistent with the limited research conducted in Aotearoa New Zealand (Gallagher et al., 2022).

While the young men who participated in this study did express difficulties in help-seeking, they also explained how help was sometimes sought once a breaking point was reached. This is different to previous research indicating that suicide is often seen as the only alternative instead of help-seeking (Cleary, 2012; Oliffe et al., 2020; Player et al., 2015). At the same time, our findings coincide with Seidler et al.'s (2021) findings that men will look past their stoicism and seek help only after exhausting themselves through self-sufficiency. This may reflect how masculine norms are gradually changing, illustrated through the novel theme *Breaking Free from the Constraints of 'Stereotypical' Masculinity.* Young men talked about how greater awareness about men's mental health can help reduce the stigma associated with help-seeking, encouraging men to be vulnerable and redefine masculinity in a healthier way. Gavey et al.'s (2021) gender and masculinity workshops with young men emphasises how awareness of gender stereotypes can be the catalyst for positive change away from harmful norms. The current study's theme of redefining masculinity is consistent with the findings of Gallagher et al. (2022), where the young men recognised how social support was an important factor in overcoming mental health issues, indicating that men may be adhering less rigidly than in the past to masculine norms such as stoicism and avoidance of emotion.

In terms of overcoming the difficulties tied to help-seeking and utilising social relationships, participants in the current study echoed the benefits of relationships in the theme *Social Networks Can Help All Those Involved*. Connecting with a variety of different people as well as getting a diverse range of advice was seen to be an important aspect of the effectiveness of social relationships. Relationships were seen to be mutually beneficial for all parties, not just the help-seeker, where the person providing the support gains a sense of purpose. Furthermore, the nuances tied to these relationships was highlighted in the theme *Helpful Social Relationships Require the 'Right' People*, where the young men recognised individual differences in terms of what is needed from a social relationship. For example, some young men emphasised the preference for reaching out to women for advice because they are seen to be more knowledgeable about mental health. Others talked about seeking help from people who were simply receptive and available to the needs of the help-seeker.

These findings align with the psychosocial explanation of why social relationships are beneficial for mental health (Umberson & Montez, 2010). Participants in the current study described how family and friends were caring, and that this created a positive environment that helped alleviate some of their pain. A possible interpretation of this is that by people taking the time to offer advice, or even simply listen, this helped give the young men more purpose and meaning. Furthermore, the current study adds to the psychosocial explanation by highlighting how experiencing purpose and meaning is not exclusive to the help-seeker, and that these feelings can be experienced by the person who is reached out to as well. The findings also align with the stress-buffering model of social support (Cohen & Wills, 1985). Participants' discussion in the current study reflects the idea that in times of stress, supportive, receptive social networks allowed for stress to be shared and alleviated.

It is important to note that not all social relationships buffered the young men's stress levels. In some cases, family and friends were seen to be unhelpful due to not understanding the difficulties that the young men were experiencing. Hence, it is not as straightforward as saying social relationships universally alleviate stress; it appears that people who understand what men are experiencing are better at assisting in men's mental health struggles. The importance of a social *network* rather than just a social dyad ties to the variety of people that can be reached out to (Rickwood & Thomas, 2012). In addition, the concept of needing the 'right' people in relationships as alluded to by the young men in the current study supports how some social relationships can have negative impacts on the individual (Angelakis & Gooding, 2021; Umberson & Montez, 2010). There may be cases where family or peers may promote unhelpful masculine norms or may be unreceptive to help-seeking. These are the nuances to be aware of when considering the benefits of social relationships.

Strengths, Limitations, and Future Research

This research has several strengths and limitations. Using a methodology of semi-structured, one-on-one interviews was a strength because it allowed participants the opportunity to engage in thoughtful and reflective discussion with minimised social pressures. Another strength of the current study was that having four participants was within the suggested number of participants when focusing on personal experiences (Smith et al., 2009) and allowed an appropriate depth of analysis of each participant. The sample was diverse in terms of ethnicity but not sexuality. One of the participants identified as Māori and Samoan, meaning that some aspects of Māori and Pasifika worldviews were incorporated but, there was limited discussion specifically referencing Māori cultural views on masculinity. Based on past research, some Māori believed that masculine and feminine norms could both be expressed by men, whilst others believed it was not tika, or correct, to do so (Daniell & McConnell, 2021). King and Robertson's (2017) research on Māori conceptualisations of masculinity found that some Māori men see colonisation as having contributed to the narrative that they are aggressive and violent. Yet the men in this study looked to challenge this view and highlight the intimate positive relationships they have as part of their manhood. Moreover, Aspin and Hutchings' (2010) work on Māori queering of masculinity suggests Māori were traditionally supportive of sexual diversity prior to colonisation by the West. Through a takatāpui (a term that centres on the fluidity of one's sexual identity) lens, these authors outline how Māori today are looking for inspiration from the past regarding sexuality, and that the Indigenous view of sexual identity recognises how one's sexuality can evolve and change. Therefore, in terms of transferability of the current findings, a greater consideration of the Māori worldview is necessary in future research to better account for the Indigenous perspectives associated with masculinity. Using a Kaupapa Māori approach (Smith, 2021), future research could explore Māori perspectives on masculinity and how this relates to social relationships to better understand the state of men's mental health in Aotearoa New Zealand.

Although not necessarily a limitation, it is important to note the reflexivity tied to the interviews being conducted by a young, male researcher. As noted by Braun and Clarke (2022), the subjectivity brought to the research by researchers can be used as a tool that contributes to the analysis. Efforts were made to connect with the young men who participated by being empathetic and receptive to the points raised. In addition, the rigour associated with the process of reflexive thematic analysis helped ensure that positionality was a tool in understanding the findings, and this was supported by regular meetings between both authors to ensure reflection during each stage of the process.

A potential limitation is that all participants had engaged in some form of help-seeking. This suggests the likelihood of self-selection bias. It might be that the young men were aware of the issues related to masculine norms and had experienced the benefits of social relationships in dealing with mental health struggles, and so were more willing to participate. Thus, it is possible that the participants reflected on the more negative aspects of masculinity, as well as how helpful social relationships can be. This is not to take away from the authenticity of what the young men said. However, the participants in this study may have been more likely to discuss the issues of masculinity and benefits of social relationships based on their past experiences. Future research could employ stratification to also explore the perspectives of young men who have not engaged in help-seeking before.

Implications and Applications

There are several implications and applications of the current findings. First, if having a social network of supportive and receptive people promotes help-seeking in men and gives purpose to those reached out to, then it is worthwhile to consider how such networks can be created. At the core of this point is mental health literacy. Schools could consider incorporating coverage of men's mental health needs. Being more aware of issues like the barriers that masculinity poses to help-seeking could create a cultural shift where society is more informed as to the help-seeking needs of men (Lynch et al., 2018). Those who are reached out to are in a position to make themselves available to men experiencing mental health difficulties and be receptive to the struggles that men express. By having greater literacy on men's mental health, this may foster more social networks comprised of the 'right' people that men are able to utilise in times of need.

Second, it can be tentatively suggested that the next generation of young men could experience masculine pressures unlike what has been experienced in the past. With the rise of social media video platforms like TikTok, excessive watching of such videos can have a negative impact on individual wellbeing (Wu et al., 2021). 'Influencers' like Andrew Tate provide for highly accessible content promoting the idea that men should be emotionless and that being vulnerable in social relationships is a sign of weakness. Therefore, it is a matter of being wary that going forward, social media may have far-reaching influences on masculine norms for young men, making them more salient than ever before. It is unlikely that social media can be regulated in such a way as to prevent the likes of Andrew Tate from expressing their views. This prospect emphasises the need for more interventions to combat the rise of unhelpful masculine norms.

Third, from the young men's discussion comes speculative ideas for what interventions can do to aid in the redefining of masculine norms, promoting the formation of supportive social networks. Redefining masculine norms in a positive manner is an effective way to promote help-seeking in young men (Sagar-Ouriaghli et al., 2019). For example, the norm of being strong could be framed in a way which suggests that a strong man is someone who has the courage to seek help for their struggles. This redefining process could take place in a semiformal setting through group discussion support services (Lynch et al., 2018). As already highlighted by the workshops held in the study by Gavey et al. (2021), young men are receptive to being informed about the harms that can come from conforming too rigidly with gender norms. Elements from these workshops that were noted to be effective in promoting change included having a balance between providing knowledge to the young men, as well as allowing constructive debate and discussion. Furthermore, the act of providing food created a more relaxed atmosphere, which in turn facilitated more engagement in the personal discussions. These are ideas that should be considered in future interventions with young men. If there is a gradual change of masculine norms towards men being more vulnerable and utilising social relationships, then such interventions may encourage further societal shifts in a positive direction.

In conclusion, the current study suggests that masculine norms remain a powerful barrier to help-seeking among young men experiencing mental health difficulties in Aotearoa New Zealand. The young men who participated in this study discussed the benefits of having a network of social relationships in dealing with mental health struggles, as well as the importance of such networks being comprised of supportive, receptive relationships. While it was acknowledged that the problematic norms associated with masculinity seem to gradually be changing, this is not to say that the harms associated with masculinity are resolved. If supportive social networks are central to improving men's mental health, then fostering such relationships should be prioritised to help men in Aotearoa New Zealand and beyond.

References

Albudaiwi, D. (2017). Survey: Open-ended questions. In M. Allen (Ed.), *The SAGE Encyclopedia of Communication Research Methods* (pp. 1716–1717). SAGE Publications. https://doi.org/10.4135/9781483381411.n608

Angelakis, I., & Gooding, P. (2021). Adverse social relationships in childhood: Are there links with depression, obsessive-compulsive disorder and suicidality in adulthood? *Child Psychiatry & Human Development*, *52*(5), 945–956. https://doi.org/10.1007/s10578-020-01077-3

Aspin, C., & Hutchings, J. (2007). Reclaiming the past to inform the future: Contemporary views of Maori sexuality. *Culture, Health & Sexuality, 9*(4), 415–427. https://doi.org/10.1080/13691050701195119

Bannister, M. (2005). Kiwi blokes: Recontextualising white New Zealand masculinities in a global setting. *Genders: Presenting Innovative Work in the Arts, Humanities and Social Theories*, *42*, 1–25.

Bilsker, D., & White, J. (2011). The silent epidemic of male suicide. *British Columbia Medical Journal, 53*(10), 529–534.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. SAGE Publications.

Clare, A. (2001). *On men: Masculinity in crisis*. Arrow Books.

Cleary, A. (2012). Suicidal action, emotional expression, and the performance of masculinities. *Social Science & Medicine*, *74*(4), 498–505. https://doi.org/10.1016/j.socscimed.2011.08.002

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin*, *98*(2), 310–357. https://doi.org/10.1037/0033-2909.98.2.310

Daniell, J., & McConnell, G. (Hosts) (2021, January). Tama tū, tama ora (No. 5) [Audio podcast episode]. In *He'll be right.* Stuff.

Davies, J., McCrae, B. P., Frank, J., Dochnahl, A., Pickering, T., Harrison, B., Zakrzewski, M., & Wilson, K. (2000). Identifying male college students' perceived health needs, barriers to seeking help, and recommendations to help men adopt healthier lifestyles. *Journal of American College Health*, *48*(6), 259–267. https://doi.org/10.1080/07448480009596267

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education, 40*(4), 314–321. https://doi.org/10.1111/j.1365-2929.2006.02418.x

Fuhrer, R., & Stansfeld, S. (2002). How gender affects patterns of social relations and their impact on health: a comparison of one or multiple sources of support from "close persons." *Social Science & Medicine*, *54*(5), 811–825. https://doi.org/10.1016/s0277-9536(01)00111-3

Gallagher, J. M., Tuffin, K., & Van Ommen, C. (2022). "Do they chain their hands up?": An exploration of young men's beliefs about mental health services. *New Zealand Journal of Psychology, 51*(2), 4–14.

Gavey, N., Calder-Dawe, O., Taylor, K., Le Grice, J., Thorburn, B., Manuela, S., Dudley, M., Panditharatne, S., Ross, R., & Carr, A. (2021). *Shifting the Line: Boys talk on gender, sexism and online ethics.* Tāmaki Makaurau Auckland: Te Kura Mātai Hinengaro | School of Psychology, Te Whare Wānanga o Tāmaki Makaurau | The University of Auckland. https://www.shiftingtheline.ac.nz/report/

Iwamoto, D. K., Brady, J., Kaya, A., & Park, A. (2018). Masculinity and depression: A longitudinal investigation of multidimensional masculine norms among college men. *American Journal of Men's Health, 12*(6), 1873–1881. https://doi.org/10.1177/1557988318785549

Joseph, J., & Falcous, M. (2017). Negotiating the 'Kiwi bloke': Accessing mosaic masculinities through Afro-Brazilian sport in New Zealand/Aotearoa. *Qualitative Research in Sport, Exercise and Health*, *11*(2), 258–273. https://doi.org/10.1080/2159676x.2017.1380694

Kågesten, A., Gibbs, S., Blum, R. W., Moreau, C., Chandra-Mouli, V., Herbert, A., & Amin, A. (2016). Understanding factors that shape gender attitudes in early adolescence globally: A Mixed-Methods systematic review. *PLOS ONE, 11*(6), e0157805. https://doi.org/10.1371/journal.pone.0157805

Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Ustun, T. B. (2007). Age of onset of mental disorders: A review of recent literature. *Current Opinion in Psychiatry*, *20*(4), 359–364. https://doi.org/10.1097/yco.0b013e32816ebc8c

King, P. K., & Robertson, N. R. (2017). Māori men, relationships, and everyday practices: Towards broadening domestic violence research. *AlterNative: An International Journal of Indigenous Peoples, 13*(4), 210–217. https://doi.org/10.1177/1177180117729850

Liebler, C. A., & Sandefur, G. D. (2002). Gender differences in the exchange of social support with friends, neighbors, and co-workers at midlife. *Social Science Research, 31*(3), 364–391. https://doi.org/10.1016/s0049-089x(02)00006-6

Lynch, L., Long, M., & Moorhead, A. (2018). Young men, help-seeking, and mental health services: Exploring barriers and solutions. *American Journal of Men's Health, 12*(1), 138–149. https://doi.org/10.1177/1557988315619469

Mahalik, J. R., Locke, B. D., Ludlow, L. H., Diemer, M. A., Scott, R. P. J., Gottfried, M., & Freitas, G. (2003). Development of the conformity to masculine norms inventory. *Psychology of Men & Masculinity*, *4*(1), 3–25. https://doi.org/10.1037/1524-9220.4.1.3

Mansfield, A., Addis, M., & Mahalik, J. (2003). "Why won't he go to the doctor?": The psychology of men's help seeking. *International Journal of Men's Health*, *2*(2), 93–109. https://doi.org/10.3149/jmh.0202.93

O'Brien, R., Hunt, K., & Hart, G. (2005). 'It's caveman stuff, but that is to a certain extent how guys still operate': Men's accounts of masculinity and help seeking. *Social Science & Medicine*, *61*(3), 503–516. https://doi.org/10.1016/j.socscimed.2004.12.008

Oliffe, J. L., Broom, A., Rossnagel, E., Kelly, M. T., Affleck, W., & Rice, S. M. (2020). Help-seeking prior to male suicide: Bereaved men perspectives. *Social Science & Medicine*, *261*, 1–9. https://doi.org/10.1016/j.socscimed.2020.113173

Phillips, J. (1987). *A man's country?: The image of the pakeha male-a history.* Penguin Books.

Phillips, J. (2019, July 16). *Suicide*. Te Ara - the Encyclopedia of New Zealand. Retrieved August 8, 2022, from https://teara.govt.nz/en/suicide/print

Player, M. J., Proudfoot, J., Fogarty, A., Whittle, E., Spurrier, M., Shand, F., Christensen, H., Hadzi-Pavlovic, D., & Wilhelm, K. (2015). What interrupts suicide attempts in men: A qualitative study. *PLOS ONE*, *10*(6), 1–13. https://doi.org/10.1371/journal.pone.0128180

Pleck, J. H. (1995). The gender role strain paradigm: An update. In R. F. Levant & W. S. Pollack (Eds.), *A new psychology of men* (pp. 11–32). Basic Books.

Richardson, C. A., & Rabiee, F. (2001). A question of access: An exploration of the factors that influence the health of young males aged 15 to 19 living in Corby and their use of health care services. *Health Education Journal*, *60*(1), 3–16. https://doi.org/10.1177/001789690106000102

Rickwood, D., & Thomas, K. (2012). Conceptual measurement framework for help-seeking for mental health problems. *Psychology Research and Behavior Management*, 173–183. https://doi.org/10.2147/prbm.s38707

Sagar-Ouriaghli, I., Godfrey, E., Bridge, L., Meade, L., & Brown, J. S. L. (2019). Improving mental health service utilization among men: A systematic review and synthesis of behavior change techniques within interventions targeting help-seeking. *American Journal of Men's Health*, *13*(3), 1–18. https://doi.org/10.1177/1557988319857009

Seidler, Z. E., Dawes, A. J., Rice, S. M., Oliffe, J. L., & Dhillon, H. M. (2016). The role of masculinity in men's help-seeking for depression: A systematic review. *Clinical Psychology Review*, *49*, 106–118. https://doi.org/10.1016/j.cpr.2016.09.002

Seidler, Z. E., Wilson, M. J., Oliffe, J. L., Kealy, D., Toogood, N., Ogrodniczuk, J. S., & Rice, S. M. (2021). "Eventually, I admitted, 'I cannot do this alone'": Exploring experiences of suicidality and help-seeking drivers among Australian men. *Frontiers in Sociology*, *6*, 1–12. https://doi.org/10.3389/fsoc.2021.727069

Smith, L. T. (2021). *Decolonizing methodologies: Research and indigenous peoples* (3rd ed.). Bloomsbury Academic & Professional.

Smith, K. P., & Christakis, N. A. (2008). Social networks and health. *Annual Review of Sociology*, *34*(1), 405–429. https://doi.org/10.1146/annurev.soc.34.040507.134601

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. SAGE.

Sullivan, L., Camic, P. M., & Brown, J. S. L. (2015). Masculinity, alexithymia, and fear of intimacy as predictors of UK men's attitudes towards seeking professional psychological help. *British Journal of Health Psychology*, *20*(1), 194–211. https://doi.org/10.1111/bjhp.12089

The Men's Project & Flood, M. (2020). *Unpacking the Man Box: What is the impact of the Man Box attitudes on young Australian men's behaviours and wellbeing?* Jesuit Social Services. https://jss.org.au/programs/research/unpacking-the-man-box-report/

Umberson, D., & Montez, J. K. (2010). Social relationships and health: A flashpoint for health policy. *Journal of Health and Social Behavior*, *51*(S), S54–S66. https://doi.org/10.1177/0022146510383501

UNICEF. (2020, September 3). *New report card shows that New Zealand is failing its children*. Retrieved August 1, 2022, from https://www.unicef.org.nz/stories/new-report-card-shows-that-new-zealand-is-failing-its-children

World Health Organization (Ed.). (2022, May). *World health statistics 2022*. https://www.who.int/publications/i/item/9789240051157

Wu, Y., Wang, X., Hong, S., Hong, M., Pei, M., & Su, Y. (2021). The relationship between social short-form videos and youth's well-being: It depends on usage types and content categories. *Psychology of Popular Media*, *10*(4), 467–477. https://doi.org/10.1037/ppm0000292

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Exploring the well-being of a Korean immigrant family caring for their elderly parent with an enduring mental illness

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The purpose of this study was to explore the well-being of an informal carers; a Korean immigrant family caring for an elderly parent with an enduring mental illness in Aotearoa New Zealand. This research utilised a qualitative approach using a life history method to explore the well-being of one Korean immigrant family caring for their elderly parent in Aotearoa New Zealand. Four major themes were discerned. The first major theme was the acceptance of the role as a caregiver. The second major theme was the participant's perceived challenges as a caregiver. The third major theme was the support received from the community. The final theme was the participant's revelation of greater independence, self-reliance and integrity. Although their roles in caring for their elderly parent proved to be challenging, life as a carer in New Zealand was reported to increase their overall life satisfaction.

Keywords: *Korean immigrant families, caregivers, life history, well-being, culture, New Zealand.*

INTRODUCTION

Globally, carers make an enormous contribution to their homes, family, to the community, and society at large. They contribute to making a difference in the lives of others in need, which forms from a labour of love that continues even when love wanes. Generally, there are two types of carers; informal and formal carers. Informal carers are defined as unpaid carers who are usually a family member or friend, providing support and care for people with disabilities, illness, or frailty, that require assistance for managing everyday living (Jorgensen, Parsons, Jacobs, & Arksey, 2010). Formal carers provide the majority of paid care to people requiring long-term care needs and assist with activities of daily living (Ravenswood, Douglas, & Teo, 2015). For example, this includes, but are not limited to tasks such as; bathing and dressing, housekeeping, laundry and cooking, assistance with shopping, and exercise (Ravenswood et al., 2015). Nevertheless, the essential aspect of their role is to care for another person, and for many, caring is the crucial element that makes their jobs worthwhile (Ravenswood et al., 2015).

Little attention has been paid in the psychological literature to the overall quality of life of Korean immigrant carers in the unique New Zealand context. The voices of ethnic minorities, such as Korean migrants are seldomly heard, thus the researcher wanted to fill in the gap in the psychological literature created by the lack of research and representation in the New Zealand context.

It is often assumed that family carers have an emotionally and physically demanding job to take care of vulnerable family member's. Thus, the current aim of this paper is to explore the unique and rich idiosyncratic experiences by a life history approach to gain a comprehensive understanding of the general well-being of a Korean immigrant family caring for their elderly parent with an enduring mental illness in the context of Aotearoa New Zealand and whether specific life domains of their lives might actually be flourishing.

Caregiving in Migrant Korean families

Caring for an elderly parent with mental health concerns can be particularly challenging for immigrant families. Migrants are often faced with acculturation difficulties settling into the host society and have been associated with higher levels of psychological distress (Kuo, 2014). For example, migrants experience encounters with cultural differences, language barriers, and resettlement processes (Choi, Park, & O'Brien, 2017). Moreover, gaining access to healthcare services can be an additional obstacle for migrants seeking help and support. Studies reveal that ethnic minorities caring for children with disabilities are more likely to face immediate barriers in accessing healthcare services in regards to equality of treatment and equality of opportunity compared to families of the host society (Choi et al., 2017). On this basis, immigrant carers experience significant levels of stress that affect their overall quality of life (Shah, Wadoo, & Latoo, 2010).

In conjunction with these general considerations, understanding culturally unique family caregiving in Korean families may be necessary because of their prominence of collectivist values and hands-on care for their elderly parent. Studies reveal that there is a strong consistency of informal care amongst Asian American families looking after a family member with a mental illness in their homes, providing intensive care, compared to their White counterparts (Park M, 2012). This is supported by Park (2012) who found in one study that 95% of Korean Americans with schizophrenia live with their families compared to 9.5% of their White counterparts. Thus, it can be argued that ethnic differences in general caregiving characteristics is culturally grounded and culturally prescribed.

There are several explanations as to why Korean families are pervasive on providing hands-on family care. A large body of literature suggests that East Asian cultures, including South Korea, score highly on Collectivism (Ahn, 2011). Whereas Individualism promotes autonomy, Collectivism promotes interdependence. Collectivist values amongst South Koreans are deemed essential to ensure continued harmonious relationships with families and others, as they are willing to put aside their own personal needs for the good of one's social group (Cho, Mallinckrodt, & Yune, 2010). This suggests that Korean families may feel cultural pressures to ensure the welfare of one's family.

Multiple socio-cultural factors influence the cultural context of caregiving in Korean families; Confucianism clearly being the most dominant belief system (Chung, 2015). It is believed that Confucian influence is still strong in modern Korean families and prevails to govern various aspects of the individual and family life, as well as shaping the behavioural pattern and structure of families and communities (Park & Cho, 1995). The Confucianism literature emphasises the principles of filial piety and familism (Kim, 2001). Filial piety (Hyo, or Hyodo) is an important socio-cultural value and reverential virtue that children are obliged to in terms of being respectful, loyal, obedient, and compliant towards their parents (Chung, 2015). The central familial relationship within the traditional Confucius system is between the parent and child, especially between father and son; not husband and wife (Park & Cho, 1995). Thus, the relationship between family members is not based on mutual love and quality, but filial piety, benevolence, and authority (Park & Cho, 1995). The authority within one's family rests with the male, and differences in status exist amongst other family members (Park & Cho, 1995). For example, differences in filial responsibility are found amongst the hierarchy of birth order and sex, with the eldest son having the highest filial responsibility than the rest (Cho & Shin, 1996).On this basis, taking care of elderly parents mainly rests on the eldest son, and his responsibility also extends to his wife, due to the roles of gender in Korea (Kim, 2001). Under these traditional social values, taking care of family members, especially older persons, shape the moral basis for family-centred caregiving in Korean families, with the highest filial piety resulting in a higher level of quality in care (Cho & Shin, 1996). A study outlined by Choi (1996) suggested that there are changes in traditional family obligations under the influence of modernisation. This is supported by Stowell (2003) who found that younger generations in South Korea, especially under the age of 30, deviate from traditional Confucius values, as well as showing less respect for traditions. Moreover, changes from the traditional stem family to a nuclear family, from large to small families, as well as greater female participation in the workforce have strongly weakened the traditional socio- cultural values within Korean families (Park & Cho, 1995). As a result of these social changes in familial factors, the ability to provide care for adult children's elderly parents have been limited in Korean families.

Despite current changes, Confucianism is still deeply rooted in Korean society, as they feel a strong sense of filial piety and obligation toward their elderly parents, as well as combined cultural pressures and social norms of family-centred caregiving (Kim, 2001). The dynamic of family caregiving in Korean families demonstrate that traditional social values are an essential factor in ensuring high quality of care for older people.

The impact of caring and carer's well-being

The concept of a 'carer' is a socially constructed term that encapsulates people's experiences of caring when it is provided by family and friends (Henderson, 2010) and is formed by intimate one to one relationship (Gill, 2004). Thus, caring for an elderly parent with enduring mental health concerns arises from a voluntary service by members of the family to assist in their everyday lives. There has been a gradual shift in the provision of care from hospitals and aged-care institutions to care in their own family homes (Jorgensen et al., 2010). In Aotearoa New Zealand, a large proportion of informal care that is provided mainly by the family is estimated to be at 10% of the population at 420,000 (Jorgensen et al., 2010).

Literature findings indicate that gender differences in caring also need to be taken into consideration (Sachez-Tereul, Robles-Bello, Sarhani-Robles, & Sarhani-Robles, 2022). Women are more likely to become carers than men, as the bulk of caring responsibilities and domestic tasks are traditionally expected of women (Gill, 2014, Sanchez-Tereul et al.,2022). However, research findings also suggests that for both men and women who have become carers, they are more likely to have similar experiences of caring, and gender concerns were less important compared to issues of capability and commitment; that is people who did not have any other caring commitments tended to provide more care (Gill, 2014, Pusey-Murray & Miller, 2013, Shah, Wadoo, & Latoo, 2010). Nonetheless, caring spans across all social classes, involving a range of people, that also varies in the degree of assistance provided to those in need.

There is no doubt that family members play a vital role in supporting their family members with enduring mental health concerns. However, a large body of literature that have investigated the lived experiences of carers looking after their relative with mental illness suggests that caregiving burden is a universal phenomenon (Chadda, 2014, Shah, Wadoo, & Latoo, 2010, Pusey-Murray & Miller, 2013, Chang & Horrocks, 2006).

According to a scoping review of the impact of caring for family members with a mental illness for the caregiver, suggests negative consequences on carer well-being (Phillips, Durkin, Engward, Cable, & Iancu, 2022). Specifically, caring for people with schizophrenia has been reported to be overwhelming for carers who indicated to have feelings of resentment, anger, helplessness, fear, guilt and loss (Shah, Wadoo, & Latoo, 2010). Family carers face challenges in terms of adjustment or socioeconomic difficulties that may cause psychological and physical health problems (Phillips et al., 2022). In particular, Korean immigrant carers may experience more challenges, because of stressful acculturation processes, different thought processes and values, and concerns regarding English proficiency (Choi, Park, & O'Brien, 2017). This is likely to occur when caregivers' workload with the addition of other commitments exceeds the resources the carer has available to respond effectively to caregiving roles (Knight et al., 1998). As a result, carers' health can be adversely affected by psychological distress and tension, anxiety, depression, as well as physical health problems, including back injury and hypertension (Chadda, 2014). This is supported by findings from Carers UK (2002), in which carers frequently reported feelings of being mentally, physically, and emotionally drained, anger, sadness for care recipients, loneliness, guilt, and disturbed sleep,

Nevertheless, carers have reported to feel their roles to be rewarding as well because it helps to foster personal growth, meaning, and a sense of fulfilment (Pusey-Murray & Miller, 2013). For instance, a study conducted with family caregivers of people with Dementia found that family caregiving has been associated with altruistic and spiritual benefits, as well as positive emotions such as feelings of satisfaction, sense of meaning, and the pleasure of having been of service (Sanchez et al., 2022).

Theoretical explanations for a possible link between caregiving and well-being typically focuses on the role of caring (Bell & Richard, 2000). According to Bell and Richard (2000) caregivers develop a sense of attachment to care recipients which stems from an autonomous motivation of care that is oriented towards the care recipient's needs; rather than from the pleasure of the caregiver. As a result, by providing social support, and fulfilling the need for social relationships, may contribute to carers well-being (Ryan & Deci, 2001)

Coping resources and resilience

Many previous studies have shown that social support is a significant factor in reducing psychological distress (Pinquart & Sorensen, 2005; Satorius et al., 2005). Satorius et al. (2005) found that carers of people with Dementia who had close social networks and family ties had lower levels of depressive symptoms and higher rates of life satisfaction. Moreover, empirical evidence has strongly supported the conclusion that people can experience positive emotions in the most un-dire circumstances (Folkman & Moskowitz, 2000). For example, positive reappraisal, problem-focused coping, and the creation of positive events were the three identified coping mechanisms that helped individuals appraise a stressful event as a challenge rather than as a threat which has a positive effect on well-being (Folkman & Moskowitz, 2000). Amongst Korean caregivers, filial piety acted as a strong coping skill and developed strong resilience to take care of their family member (Kim, De Bellis, & Xiao, 2018). Recent studies outlined by Kim et al. (2018) found that the obligation of filial piety amongst Korean family carers was accompanied by reciprocity so that adult children looking after their elderly parent was a form of repayment. This promotes the idea that people with high filial responsibility have lower caregiving burden and stress, and that the strength of each persons' filial piety acted as a coping mechanism, resilience and motivation to fulfil caregiving roles (Kim et al., 2018).

Nonetheless, to further assist the issues raised regarding ethnic minority families caring for their elderly parent, there is a lack of studies undertaken in Aotearoa New Zealand. Currently, Koreans are the largest Asian groups living in New Zealand (Statistics New Zealand, 2013), and little is known about their lives. Based on the preceding review of the literature, the purpose of this study was to explore a relatively under-researched topic using a life history approach to obtain a better understanding of the well-being of Korean immigrant family caring for their elderly parent in the New Zealand context.

METHODOLOGY AND METHODS

The purpose of this study was to explore a relatively under-researched topic to gain a deeper understanding of their experiences and perceptions through a Life History (Atkinson, 2001). This qualitative approach not only looks at the narratives of the family members but to explore their life as a whole.

A life history is distinguished from life stories as it is based on the accounts of an individual's lived experience that is set within a broader context, and how these individual's make meanings of their lives (Dhunpath & Samuel, 2009). Essentially, as Hatch and Wisniewski note, "...an analysis of the social, historical, political and economic contexts of a life story by the researcher is what turns a life story into a life history" (1995, p.125). Integral to the research design, the life history method is a collaborative process between the researcher, who does the contextualisation of data collected, and the participants who are also involved in interpretation and contextualisation themselves, through their telling (Sikes & Everington, 2001). On this basis, the life history method adopted for this study provides a method to show how people interpret and make sense of their social world by exploring the events that have happened to them throughout their lives (Sikes & Everington, 2009).

This small-scale exploratory study was conducted by the author, a Korean student who made it possible to establish rapport and a trusting relationship with participants. Within this position, and a member of the migrant community, it made it possible for the participants to be more willing to participate and to tell their stories openly. The rapport established between the researcher and the participants ensured that the credibility of the data was enhanced.

All procedures were disclosed to and approved by the Massey University Human Ethics Committee (MUHEC) 4000020526.

Sampling

The three Korean participants in this study were recruited within a metropolitan area of New Zealand. As a method of identifying the potential participants, the researcher placed advertisements in places that are frequented by Korean families such as restaurants and Korean grocery stores. Using the social media platform Facebook, the researcher put a notice on the Korean community Facebook page 'New Zealand Stories/ 뉴질렌드 이야기" advertising the study and requesting participation. The above process included information regarding the study, including the purpose of the research and contact details of the researcher. One family was recruited from this process of advertising as they were the only family who met the inclusion criteria. A written informed consent by all the participants was also collected.

The inclusion criteria required families to (a) be born in the Republic of Korea, (b) currently live in New Zealand, (c) currently caring for a family member with an enduring mental illness in New Zealand (d) be willing to participate. Families who were now no longer caring for a family member were excluded. Thus, this study solemnly focused on current caregiving. Participants years of residence in New Zealand was approximately 26 years, the mother and father ages ranged from their late 60's, and the son's age was early 40's.

Data Collection

Data were collected through semi-structured individual interviews to explore the experiences, thoughts, and feelings of being a Korean immigrant carer in New Zealand. Interviews were designed to be guided by several guiding questions centred on the topics of their motives, barriers and supporting factors of being a carer so that in-depth responses and discussions could be elicited. Over three months, ten visits were made at the interviewee's home as they preferred to be interviewed at home, and asked that the interview be conducted in the participant's native language, Korean. The researcher audio-recorded the interviewee's responses with verbal permission and these were translated from Korean into English and transcribed verbatim by the researcher. On average, each participants were interviewed face-to-face for 10 sessions over the course of three months lasting on average 60 minutes per session, totalling 600 minutes. The results were written in a narrative form for participants to read to see if they agreed with the findings. Participants contacted the researcher to make minor changes, and soon after they agreed with the interpretation of the final results.

Analysis

The current study employed a paradigmatic analysis of narratives as a procedure to configure storied accounts or data into a coherent whole (Polkinghorne, 2016). The paradigmatic analysis of data allowed the researcher to understand participants narratives by categorisation, themes, and coding that gave an in-depth insight into their experiences and intimate lives. Throughout the research process, it was important for the researcher as a Korean to personally interact with the Korean family following Confucius values to show upmost respect and appreciation for their valuable insight into their intimate lives. The researcher has immersed in the participant's narratives and is always revising and reflecting on the meanings generated in their stories. Furthermore, the researcher and participants are inexorably intertwined in the generation of data and the analysis of findings which allowed for a richer understanding of the participant's world being particularised (Clandinin & Connelly, 2000).

The analysis is presented in two parts: A case description which beings with a detailed history of the context of the Jeong family (Clandinin & Connelly, 2000). Following this are the analysis of major themes which emerges throughout the interview transcripts. To ensure the credibility of the data, participants were provided with a written account of the findings to review and confirm the researcher's interpretation of their narratives (Choi, Park, & O'Brien, 2017). Moreover, the time invested in building a trusting relationship with participants allowed the opportunity to check the findings on multiple occasions which strengthened the authenticity of the research (Clandinin & Connelly, 2000).

Based on multiple readings of the transcripts and mutual agreement with the participants, four major themes were developed and identified with related sub-themes that emerged: 1) Acceptance of the role as a caregiver, 2) Perceived challenges as a caregiver, 3) Support received and 4) Greater independence, self-reliance, and integrity.

ANALYSIS AND COMMENTARY

The study focused on three members of the family who are currently caregiving their elderly family member: Chulsoo, Younghee, and Woori (pseudonyms). Having three participants, allowed the reader to gain a deeper understanding of how the Jeong's family experiences caregiving as an immigrant living in Aotearoa New Zealand and how this shaped the development, experiences, and their well-being as a caregiver. Based on the findings, the life history account illustrates an intimate insight into the Jeong's family, adding vivid recollections from the past and present of their caregiving experience and well-being.

The Jeong Family

Chulsoo (68) immigrated to New Zealand in 1992 with his wife Younghee (68), two sons Woori (41), Doori (40), and his elderly mother Sunny (88). Prior to their settlement in New

Zealand, Chulsoo's mother Sunny was diagnosed with schizophrenia in South Korea during her mid-40s. Chulsoo recalls the past with anguish as he witnessed his mother endure intense hardship before her diagnosis.

Sunny grew up during a turbulent time in the history of political turmoil in Korea- the forced Japanese occupation in Korea, as well as the Korean War that began in 1950. Younghee also vividly recalls the accounts told by her parents about how they hastily escaped North Korea to flee to the South, leaving behind their home, belongings, and their relatives. Until this day, Younghee longs to meet her uncle, aunties and cousin's that were left behind in the North, and lives with the fact that she will never see them again until there is reunification between the two Korea's.

According to both Chulsoo and Younghee, life for everyone back then was extremely difficult, and everyone lived in poverty and fear. Amongst this hardship, Chulsoo recalls the time when his father had abandoned his own family because he had found another woman:

> *"My father went to have an affair with another woman and had a family with her. My mother got thrown away like an old shoe from her husband and in-laws...she was not welcomed. So she felt extremely betrayed. Because of this, she held on to her children very dearly because they were her everything. She had no financial support and was jobless. No one was there to look after her so she had to fend for herself and make sure she could feed her children".*

Further adding to Sunny's life, she had lost two of her young children due to poverty, and with that shadowed intense sorrow and grief. Longing for relief and salvation, Sunny began attending churches and became heavily involved in religion. Chulsoo noticed how his mother began to change after her involvement with the church, thus marking the onset of her psychosis.

> *"My mother attended a notorious church called 'Seung Bok Eum'. That church quickly gained and expanded their popularity because the priest excites*

> *and stimulates everyone. She was extremely desperate; and relied heavily on the church. She would pray all together in huge numbers and go into really remote areas far away to pray. Even praying they do not do it quietly...they just cry and scream so loudly. Since her involvement with the church she started to have bizarre behaviours...then suddenly went berserk".*

Sunny's involvement with the church reached a point where she could no longer differentiate the real world from the unimagined world of God. She was formally diagnosed with Schiophrenia and was hospitalised for a month. Upon her discharge, Chulsoo and Youngehee with her new-born sons began their caregiving life for Sunny. Both Chulsoo and Younghee recall how disheartened they initially were to see Sunny deteriorate mentally and physically. Sunny was unable to recognise Chulsoo and Younghee and frequently referred to them as 'the devil'.

Several years of intense caregiving duties proceeded during their time in Korea. For example, changes to the carer's thought and behaviour patterns, as well as changes to their lifestyle to ensure proper and safe care for the care recipient. Often at times, Sunny would be uncooperative, and would frequently verbally and physically abuse Chulsoo and Younghee. Despite Sunny's aggression, both Chulsoo and Younghee put in their best efforts forward to take care of Sunny as well as their two young children. For the following 20 years in South Korea with frequent hospitalisations and interventions, Sunny's symptoms became more manageable. Chulsoo put forth the decision for the Jeong family to migrate to New Zealand because he wanted his children to have a better education and to 'start a new life'. Currently, without any formal treatment intervention, Sunny resides at home with both Chulsoo and Youngee both being retirees.

Thematic findings

Acceptance of the role as a caregiver

Family caregivers play a vital role in providing care for their loved ones (Cunningham, Cunningham, & Robertson, 2018). Throughout the interview, Chulsoo and Younghee mentioned that their lives and the dynamics of the family structure had dramatically changed since Sunny's illness. They were often challenged by the demands of fulfilling parental roles to their children as well as bearing the responsibility to care for Sunny. However, both Chulsoo and Younghee mentioned that accepting the role as a caregiver allowed them to structure their life appropriately.

Fate.

All the participants mentioned that their unexpected given role as a caregiver as fate. The family had not anticipated how challenging the expected duties would be and how much it would affect their lives. They described the daily routines as exhausting and a very lonely journey. Accepting their role to look after Sunny was about being taking it as their family's destiny so that they could make the necessary changes to fulfil their duties.

Younghee captures this notion well when she reflects upon her life throughout the years:

> *"I have to think that this is my fate, and there is no one else to blame. If I start to grumble and blame everyone, it would be endless."*
> *For Chulsoo, he further adds:*
> *"I am the eldest son, and she is my mother. Although I have much weight on my shoulders, I cannot abandon her, nor can I escape. This is my destiny, and I will continue to care for my mother until her last breath."*

The above notions suggests that family connection is strong and that the responsibility and duty to care for their elderly parent demonstrate their long tradition of Confucianism carried over into a foreign land.

Filial piety.

Confuciansim has played a central role in influencing each family member to an assigned role. Tradtionally in the patriarchal ideology of Confuciansim, it becomes the responsibility of the eldest son to take care of their elderly parents. Filial piety or Hyo is the value that children are obliged to be respectful and loyal towards their parents (Chung, 2015). Although it is Chulsoo's responsibility as the eldest son to look after his mother, much of the caregiving role was fulfilled by Younghee as the daughter in law. Aforementioned, the assigned roles also meant that the roles between male and female were hierarchically segregated. The role of the father's functions to financially support the family, whereas mothers were responsible for domestic domains, such as raising children, cooking, and cleaning (Cha & Kim, 2013). Younghee noted:

> *"It is my duty to protect and lead my family. And that is life. If I cannot look after my mother in law, then who will?? If I had chosen to abandon my mother in law and my husband, of course, it would be an end to this problem. Nevertheless, I question whether this is the right thing to do and whether I would be happy, it would be so hard if my family became broken. So I just thought if I just sacrificed myself, I can maintain this harmony within my family and because I am married, she is my mother in law; she is my family."*

For Chulsoo and Younghee taking care of Sunny as well as fulfilling parental roles to their children was a difficult task within their new lives as an immigrant. Participants had worked extremely long hours running a family-owned business in New Zealand and struggled to make constant efforts to care for Sunny as well as their two sons. Amongst their struggle, both Chulsoo and Younghee believed it was still best to take care of Sunny as the adult children because it was seen as a culturally expected and desirable behaviour. This suggests that filial piety still exists, and that long family traditions of collectivism remains strong in the context of migrant families. Chulsoo mentioned:

> *"I have seen my mother suffer extremely hard throughout the years. It would be cruel to not care for my elderly mother. Since moving to New Zealand, I have worked tirelessly in this foreign land, knowing very basic English, and realised that Auckland is such a small community, especially amongst Koreans. I do not want my family and especially me and my wife to be branded as the family who abandoned their mentally ill mother to some psychiatric ward. So, it is*

> *something I must do to keep my family together as the eldest son to my mother, a husband to my wife, and father to my sons."*

Contrary to the findings supported by Stowell (2003) that more modern Korean families deviate from the traditional Confucius values, within the Jeong Family, filial piety remains strong. The values of filial piety remains ingrained for Woori despite the shifting dynamics of modern families and generational gap and he views this gesture as a form of reciprocation towards his parents. As Woori mentioned:

> *"Koreans look after their parents. My parents especially put much effort in...I don't know if this kind of things (Confucian influence) happen anymore in modern families. However, I think I would look after my parents when they too get sick and old, just the same things as my parents are doing for my grandmother."*

This suggests that the Jeong family are rooted strong in their heritage of Confucianism of looking after their parents in terms of filial piety, reciprocity, and duty.

Perceived challenges as a caregiver

Providing care

All participants perceived various challenges within the family when dealing with caregiving. One of these was providing everyday care for Sunny, which included a wide range of activities such as assistance with daily hygiene, house chores, meal preparation, administering medications, and regular physical activity. In particular, Younghee and Chulsoo mentioned that preparing meals was a constant daily struggle because she would refuse to eat on several occasions due to suspicion of the Jeong family poisoning her. On other occasions, she would demand particular dishes she would like to be served. Chulsoo noted:

> *"Even just giving her a meal was a battle because she would be suspicious of the food, I have brought to her. She would say things like: You put poison in this food, right?! Even though she hardly ate on some days, her energy levels were so high she would be so vocally and physically strong when we tried to force her to eat."*

Younghee also mentioned that on the few occasions where Sunny would have the appetite to eat, she would demand several dishes to be prepared. Younghee would often send her son Woori to go to the Korean supermarket to buy the specific ingredients needed, and then she would spend several hours preparing the food. Woori noted:

> *"I always saw my mum putting in so many efforts ...which she still does today for my grandmother such as cooking and cleaning and looking after my brother and me. My mum lost so much weight she weighed less than 45 kilograms. I try to help out where I can but when I was a teenager, it was so annoying running errands because of my grandmother."*

Caregiving is not just about feeding, cleaning, and clothing. The Jeong's family demonstrate that caring is about understanding how to navigate a complicated relationship between those who give care and those who require it. The experience of providing care for Sunny by the Jeong family reveals that it was challenging to keep up with Sunny's demands because she was unable to do many things for herself. The time and effort put towards the daily routine care had shown to be physically and psychologically demanding for everyone involved. The fundamentals of caregiving are to provide care but not too much because carer's needs are equal to the needs of the care recipients as well.

Support received

Culturally tailored services

At first, the Jeong family resided in New Zealand and received their residency while Sunny was being taken care of by another family member in Korea. In 1992, Chulsoo brought his mother to New Zealand without a valid visa because they wanted to be together as a family. The Jeong family planned to keep Sunny hidden in the house as an illegal immigrant because they believed she could lead a normal life without getting caught by immigration, as long as she took her medication. However, after some time, Sunny's condition deteriorated, and she had to be hospitalised. The Jeong family panicked at the thought of Sunny being deported, as well as the outstanding hospital fees. Chulsoo noted:

> *"I just wanted her to recover quickly so I could bring her back home...I was so afraid of the hospital fee piling up to hundred thousands of dollars!! However, later the doctors told me that because mental illness is very dangerous, especially amongst people in the community and because it is a social problem, the New Zealand government will cover the cost...".*

After numerous efforts to obtain Sunny's permanent residency, she was finally able to reside with the Jeong family. Irrespective of the Jeong's family perceived low English proficiency, communication with formal health services in New Zealand was not an issue. Although they were initially ambivalent about the use of Western services, all participants reported high satisfiation regarding support recieved and education from New Zealand healthcare and legal services. Chulsoo and Younghee both expressed their gratitude towards the New Zealand doctors and lawyers who provided the knowledge and culturally sensitive assistance towards Sunny's care.

Younghee recalled the time when they found a lawyer that was willing to fight for Sunny's case to reside in New Zealand as a permanent resident:

> *"It was tough to get her residency because she did not fit any criteria to be a resident here in New Zealand. So, we went to several lawyers to find a solution, and we found this one outstanding Kiwi lawyer. She agreed to help under the Humanitarian category and although the chances were very slim to win the case, she wanted to fight for us".*

Chulsoo further commented on the legal court case:

> *"We lost so many battles and got rejected numerous times. But this lawyer urged on and fought for us continuously. According to the lawyer, she said: 'although we are getting rejected, your mother will still be in the hospital, then she can continue to receive the treatment she needs'. So the lawyer continued to fight for us. And finally, in the end, we got my mother her permanent residency".*

While Sunny was hospitalised during the court case, Chulsoo and Younghee recall the time the doctors and nurses wrote a letter to help obtain Sunny's residency. In the letter, Chulsoo and Younghee were moved by the doctors and nurses' sincere efforts to help by referencing the traditional Confucian values that influence Korean families. Younghee mentioned"

> *"The letter was very detailed. The doctor and nurses would explain that in the Korean traditional family culture, the eldest son must look after their elderly parents, and the elderly parent wishes to live with their eldest son. Even the nurses wrote this in their letters as well! They did this every single day for us...(wipes down tears)".*

The Jeong family expressed how grateful they were to see the sincere efforts put forth by New Zealand formal service providers because they would take the time out for Sunny's case. This suggests the difference in care between the mainstream healthcare systems in Korea compared to New Zealand. Both Chulsoo and Younghee mentioned that if the above same situation happened in Korea, the doctors would not have put in the same effort and care because they would expect gifts or incentives in return for the services provided. Thus, they experienced a more fair and equitable treatment amongst mental health patients in New Zealand despite having not to bribe doctors and nurses to provide attention and genuine care for their family member. Younghee mentioned:

> *"We were so thankful to the doctors and nurses, so we purchased a few gift cards from Smith and Caughey's. For the doctors we got about ten gift vouchers costing $200 and the nurses about 30 $50 vouchers for them and we gave them the vouchers and told them that it is a sign of appreciation for all the help they have done. But they concluded that they could not accept it as it was nott the right thing to do. They said that they already receive a salary and that they did what had to be done which was to help my mother in law...".*
>
> Chulsoo further added:
>
> *"If this were in Korea, it would be a no-brainer. They would take the gift vouchers without even saying thank you. If this was in Korea and you visit a patient, it is a protocol to buy something for the nurse at the front desk like something to eat. Sometimes if you put in some cash into the doctor's gown to look good in their eyes, they can look after the patient even better, but here the doctors are different in New Zealand. It was just so touching and very emotional for me...they genuinely cared for the patients from their hearts".*

Community.

Furthermore, other Korean immigrant families that knew about the Jeong's family situation would often provide emotional support as well as providing Korean meals for the family. The Jeong family noted that the Korean community in Auckland is very small, therefore 'everybody knew everybody'. The participants pointed out that this supportive environment helped them get through the difficulties they were facing in their everyday lives, and further appreciated their new lives in New Zealand. On this basis, collectivism remains strong amongst Korean migrants, and because of their solid cultural roots, they are able to maintain very close supportive networks amongst their communities. Younghee noted:

> *"We would often attend the church every Sunday, and after some time of meeting new people, everyone knew everyone. So because this space was so open, everyone at the Korean catholic church knew everything that was going on in my family, and I would know everything going on for them...we knew everything about each other. So often, at times, I would talk to them about what I am going through, and they would tell me how incredible we are for looking after my mother in law...they say things like 'oh you deserve an award!'. I guess this is how we would feel better about ourselves".*

Chulsoo further agreed that the Korean people, wherever they are in the world, always have compassion and attachment with each other and is something that is an integral part of their culture. He noted:

> *"Korean people have strong affection with each other, and will not ignore one and another, especially in a foreign land. Our Korean people here in New Zealand gave us so much support..and I cannot be more thankful enough. They will always try to help out when they can...it helped me a lot, and I always felt that because of others support, my life is not bad after all".*

The support received from the church community further extended to the support received from Woori's friend's parents. Woori would befriend other Korean friends from his school, and his parent's friends would come to know of his parent's caregiving duties and would further add encouragement and support. Woori noted:

> *"I would often go over to my Korean friend's house, and their parents would get to know my parents...and this spread out through to other Korean parents. They would sometimes send me home with Korean snacks and food and sometimes visit my mum to see how she is doing. Yeah...they were pretty kind like this...".*

Greater independence, self-reliance and integrity

The Jeong family all agreed how much their lives had changed dramatically since becoming caregivers for Sunny. Despite their difficulties and hardship, living in New Zealand allowed all the participants to become more independent to take better care of themselves, resilient, and a person with integrity. They learned how to effectively care for and live with persons with schizophrenia when no information was available, how to multi-task at the same time whilst dealing with the changing family dynamics, and the importance of having integrity as a caregiver.

Younghee noted how living in New Zealand has helped her ease off the caregiving burden and stress:

> *"I feel less stressed here in New Zealand because I am free from all the hustle and bustle of the city that never sleeps. You see, life in Korea is so complicated and stressful because there is no support from the Korean government to help the carers. No such things exist. But here in New Zealand...I remember when my mother in law was hospitalised the nurses told me to*

> *have a break and told me to take care of myself...but the most touching thing was that she told me that they would find a Korean chef to prepare Korean meals for my mother in law. If this were in Korea, the nurses would not give a damn about the patient unless you put extra money in their pockets! I feel so grateful to be here in New Zealand. If I were in Korea...things would have been very difficult for me to care for my mother in law...So I am very happy to be here".*

Younghee also noted how living in New Zealand has helped her move forward and become a better daughter in law for Sunny despite the overwhelming challenges. She learnt to build her own coping mechanisms to provide on-going care for her mother in-law, whilst also being a parent and wife. Her perseverance to cope with the hardship has built her to be a strong women that works to keep her family in harmony.

> *"I have learnt to cope better as a caregiver for my mother in law. I learnt to be independent and stronger than ever before. In life, there can be tough times, and we have to move on and live on...and even if you try to avoid such obstacles, those obstacles cannot even be avoided. Anyway, there will be another hardship, even if you tried to avoid the first obstacle".*

Chulsoo further commented on how he experienced more responsibilities as a caregiver and how much this has changed him as a whole:

> *"At first, we did not know anything about this disease and did not know anyone who had it. We always had to learn by ourselves and from the doctors spending a lot of time and money. Schizophrenia is an evil disease, and it made my family have a difficult time. Also, migrating to New Zealand and starting from scratch, I had to do everything by myself, dealing with housing, education for my sons, treatment for my mother, the court case. However, I am very proud of what we all have achieved.. I do the best to my ability to protect my family, and I think this is very important in life. Just because I want to be comfortable for myself, I should not do anything that I would regret later in life...I would never do something that I would be embarrassed and ashamed of".*

Woori also mentioned his experience of growing up with his grandmother and how this has shaped him to who he is today and also his view on his parents always making an effort to hold the family together:

> *"I always hated my grandmother from a young age because I would see my parents having such a hard time looking after her. I hated it. Our life was very restricted, and because of that, we have never been on a family holiday together because of my grandmother. But now, I feel sorry for my grandmother. I guess, you learn from a very young age about being independent and learning to cope with the everyday stresses in life, and you learn how to handle things better. You become a strong person with a very thick face. Because nothing is harder than looking after someone with a mental illness...at least if she were physically ill, she would consciously know that we all are trying hard to care for her...but my grandmother never knew or felt thankful for our contributions!".*

DISCUSSION

The purpose of this qualitative study was to explore the well-being of one Korean immigrant family caring for their elderly parent in the New Zealand context. The life history interviews have revealed an intimate experience and understanding of lived experiences of immigrant carers in a chronological pattern, which could not be made evident by quantitative inquiry.

In general, our results indicate that Korean immigrant carers viewed their caregiving journey as fate. Given their unexpected role as carers, participants reported the challenges and responsibilities associated with caregiving duties. As a result, coping strategies such as positive reappraisal were used by participants to manage a range of stressful events which helped them to appraise their role as "fate" rather than as a threat (Folkman & Moskowitz, 2000).Allowing this acceptance of the caregiver role as 'fate' gave the participants a sense of purpose to provide on-going care for their family member, and to make necessary changes to structure their lives. However, all the participants reported a decrease in their well-being as their caregiving duties proved to be challenging and stressful at certain time points, especially for Chulsoo and Younghee who also had to fulfil parental roles for their children. These findings are consistent with the larger body of literature on the effects of caregiver burden and stress (Knight et al., 1998). Knight et al.,(1998), in their investigation of caregiving and well-being, when the workload of carers such as fulfilling role expectations as a carer, spouse, or parental roles go beyond their maximum available resources, caregiving can result in strain on carers and cause deleterious effects between the carer's relationship with the care recipient. Cormac & Tihanyi (2006), also found that carers physical and mental health were adversely affected by their caring role, with the most frequently experienced mental health problems being stress and tension, followed by physical health problems such as back injury and hypertension.

Although much of these discussions dealt with the adverse effects of caregiving, the results of the current study also revealed a more neutral experience. Rather, Korean immigrant carers viewed their caregiving role as filial responsibility to look after their elderly parent. For example, Chulsoo sought to fulfil his filial duties for his mother as the eldest son to uphold the Confucius values of the traditional Korean culture such as benevolence, loyalty, and respect towards parents (Chung, 2015). Much research has explored the role of Confucian beliefs in collectivist cultures in South East Countries such as Korea (Ahn, 2001; Chung, 2015; Park & Cho, 1995). In particular, Korean caregiving families emphasise filial piety or, Hyo-do in Korean terms, when it comes to looking after their parents; thus ensuring a continuous harmonious relationship between family members (Cho, Mallinckrodt, & Yune, 2010). Other authors have argued that the traditional Confucian values and belief systems are less prevalent in modern families, suggesting that more families tend to deviate from looking after their elderly parent and choose to place them in suitable institutions (Stowell, 2003; Park & Cho, 1995).

The participants also addressed feeling culturally pressured to look after an elderly parent, more so because the Korean community in New Zealand is small and interconnected, the family feared of being labelled as a 'bad family'. This is consistent with findings outlined by Park (2012), who found that Korean American caregivers were more likely than White American caregivers to provide hands-on, informal home care because of the negative stigma and shame associated with mental illness, and placing an ill member of the family in institutions may lead to negative connotations from outsiders for making such a decision.

Consistent with findings from broader research, the demanding duties to provide care has shown to have detrimental effects on carer's health and well-being (Cormac & Tihanyi, 2006; O'Connell, Bailey, & Walker, 2003). The most troubling themes found were those related to the participant's perceived challenges in providing care. Family members felt that it was challenging to keep up with daily routines of care, as well as trying to keep up with abrasive demands commanded by the care recipient. Family members also reported feelings of exhaustion, frustration and annoyance when their elderly parent did not appreciate, nor co- operate with them. Woori also noted his mother being severely underweight during one time due to excessive caregiving duties. It has been reported that challenging behaviours from care recipients put tremendous strain on carers which adversely impacts their overall health and well-being (O'Connell, Bailey, & Walker, 2003). In the O'Connell, Bailey & Walker (2003) longitudinal study of 1000 cares in Australia, carers reported having lower health ratings, less life satisfaction, less positive affect, and more negative affect compared to non-carers. These findings support the participant's stressful experiences acquired by caregiving.

While participants experienced moments of tribulation, there were some moments where they also experienced positive moments as a carer. Participants reported receiving helpful and culturally tailored services in New Zealand regarding legal and medical assistance, which ensured the family to feel reassured and supported. Family members discussed how service providers and professionals went the extra mile to help the Jeong family by catering through their understanding of Collectivist values such as filial piety in Korean cultures. These findings were contrary to Choi's (2017) study of the experiences of Korean migrant carers with professionals in New Zealand. In Choi's (2017) investigation, Korean parents caring for their child with disabilities experienced poor services with professionals due to language barrier, lack of a therapeutic alliance, and limited understanding of Korean cultural values. However, our findings suggest that although participants reported feeling anxious and ambivalent of receiving help from professionals due to their lack of English proficiency, this was not an issue because they were given an abundant amount of resources and guidance to support the family. The participants reported feeling overwhelmingly grateful and appreciative, particularly when Sunny was allowed into New Zealand given she never originally had a valid visa, which helped them to lower their tensions and stress.

Furthermore, participants shared their feelings of unity with the Korean community in New Zealand, as they provided emotional support and assistance in caregiving duties. Taking advantage of social support can be seen as an effective coping stratgy to enhance people’s sense of belonging which can lead to positive feelings (Folkman & Moskowitz, 2000). In collectivist cultures such as Korea, interdependence amongst its group members are highly promoted (Cho, Mallinckrodt, & Yune, 2010). Thus, to ensure a harmonious relationship amongst group members, collectivist cultures are willing to support the good for one's social group by putting aside their personal needs (Cho, Mallinckrodt, & Yune, 2010). Previous literature has documented the importance of support for carers in reducing psychological distress and prevention of carer burnouts (Pinquart & Sorensen, 2005; Satorius et al., 2005; Folkman & Moskowitz, 2000). In Satoruis et al., (2005) study of carers of people with Dementia, close social support has been linked to increase positive emotions for carers in unformidable situations and decrease depressive symptoms. These findings suggest the importance of seeking social support because of the potential benefits it can have on carers well-being. However, findings reported by Choi (2017) suggests that often Korean migrant carers in New Zealand are reluctant in seeking social support or forming close relationships with other fellow Korean migrants due to social stigma. However, Choi's (2017) discussion only dealt with Korean carers experience with a lack of confidence to reach out for outside support, and perceived mistrust amongst non-carers who did not share the same values.

Unique to this current study was how the participants re-negotiated their caregiving roles to develop greater independence, self-reliance and integrity within themselves. Often family members were overwhelmed and challenged by the demands of caregiving duties, particularly for Chulsoo and Younghee who also had to fulfil parental roles for their children. However, one novel finding was that the somewhat forced and sudden role to become a carer in a foreign land allowed participants to cope better in their position and an ability to survive the direst circumstances. For example, navigating the healthcare systems and legal systems with low English proficiency, dealing with the changing dynamics in the family, daily caregiving duties and achieving overall life satisfaction. This finding is not surprising given that coping mechanisms such as positive reappraisal, problem-focused coping and the creation of positive events helped carers to appraise their hardships as a challenge rather than as a threatening event (Folkman & Moskowitz, 2000). The caregiving experience, therefore, led to participants personal growth in maturity, integrity, and boosted their self-confidence. Furthermore, our participants noted that filial piety was their primary source of motivation to ensure more exceptional care for their elderly parent with integrity. These findings are consistent with previous studies which found that Korean caregivers with the highest filial piety reported having lower caregiver burden and stress because they perceived their roles to look after their elderly parents as a form of repayment (Kim, De Bellis, & Xiao, 2018; Kim et al., 2018).

The study was explorative in nature and depended on past memories of caregiving as well as current experiences of caregiving. Furthermore, this study involved the use of the participants native language, Korean. To overcome language barriers, the translation, transcription and interpretation were done by the researcher who is also a Korean. The quality of translation and transcription were very much dependant on the researcher, therefore the quality of transcription may have been compromised. Employing professional translators and transcribers to validate the quality of interpretation may have enhanced the study. However, constraints on time and resources did not allow the researcher to employ the use of independent and qualified translators.

Conclusion

In conclusion, this paper aimed to explore the unique experiences of the general well-being of a Korean immigrant family caring for their elderly parent with an enduring mental illness in New Zealand. More research is needed to understand the well-being of Korean immigrant carers in New Zealand and how they experience their roles as a migrant. Although their roles in caring for their elderly parent proved to be challenging, life as a carer in New Zealand was reported to increase their overall life satisfaction. Professionals and the community gave a tremendous amount of support, despite language barriers and cultural differences.

Furthermore, the participants long and winding journey as a carer allowed the opportunity to evaluate their current selves more positively and to create more emotional bonds with their elderly parent. As part of the traditional Korean culture, filial piety ensured adult children cared for their elderly parent, whether in sickness or in health, as a form of reciprocity. No doubt, caregiving is a difficult job, and carers may find themselves lost, frustrated and confused. Thus, for carers to continue their caregiving duties for their loved ones, they must take care of themselves first in order to take care of another.

References

Ahn, D. D. (2011). Individualism and Collectivism in a Korean Population. *107*. Scripps Senior Theses. Retrieved from https://scholarship.claremont.edu/scripps_theses/107/

Bell, D. C., & Richard, A. J. (2000). Caregiving: The Forgotten Element in Attachment. *Psychological Inquiry, 11*(2), 69-83. doi:https://doi.org/10.1207/S15327965PLI1102_01

Chadda, R. K. (2014). Caring for the family caregivers of persons with mental illness. *Indian Journal of Psychiatry, 3*(56), 221-227.

Chan, B. (2010). Negative caregiving experience: A predictor of high expressed emotion among caregivers of relatives with schizophrenia. *Social Work in Mental Health, 8*(4), 375-397. doi:10.1080/15332980903539971

Chang, K., & Horrocks, S. (2006). Lived experiences of family caregivers of mentally ill relatives. *Journal of Advanced Nursing, 4*(53), 435-443.

Cho, B., & Shin, H. (1996). State of Family Research and Theory in Korea. *Marriage & Family Review, 22*(12), 101-135. doi:10.1300/J002v22n01_05

Cho, Y., Mallinckrodt, B., & Yune, S.-K. (2010). Collectivism and Individualism as Bicultural Values: South Korean Undergraduates Adjustment to College. *Asian Journal of Counselling, 17*(1-2), 81-104. Retrieved from https://www.researchgate.net/publication/265077955_Collectivism_and_Individualism_as_Bicultural_Values_South_Korean_Undergraduates'_Adjustment_to_College

Choi, C., Park, H.-J., & O'Brien, M. (2017). Caring for children with disabilities in a foreign land: Experiences and perceptions of a group of Korean immigrant parents and professionals. *Aotearoa New Zealand Social Work, 29*(4), 61-73. doi:https://doi.org/10.11157/anzswj-vol29iss4id398

Choi, S. (1996). The Family and Ageing in Korea: A New Concern and Challenge. *Ageing and Society, 16*(1), 1-25. doi:https://doi.org/10.1017/S0144686X00003111

Chung, E. Y. (2015). *Korean Confucianism: Tradition and Modernity.* Korea: The Academy of Korean Studies Press.

Clandinin, J. D., & Connelly, M. F. (2000). *Narrative Inquiry: Experience and Story in Qualitative Research.* Walnut Creek, California: Left Coast Press, Inc.

Cooke, P. J., Melchert, T. P., & Connor, C. (2016). Measuring Well-Being: A Review of Instruments. *The Counselling Psychologist, 44*(5), 730-757. doi:https://doi.org/10.1177/0011000016633507

Cunningham, N. A., Cunningham, T. R., & Robertson, J. M. (2018). Understanding and Measuring the Wellbeing of Carers of People With Dementia. *The Gerontologist, 59*(5). doi:https://doi.org/10.1093/geront/gny018

Denzin, N. (1994). Romancing the Text: The Qualitative Researcher-Writer-as-Bricoleur. *Bulletin of the Council for Research in Music Education,*(122), 15-30. Retrieved from http://www.jstor.org/stable/40318652

Denzin, N. K., & Lincoln, Y. S. (1999). *The Sage Handbook of Qualitative Research (3rd ed.).* Sage: Thousand Oaks.

Folkman, S., & Moskowitz, J. T. (2000). Stress, Positive Emotion, and Coping. *American Psychological Society, 9*(4), 115-118. doi:https://doi.org/10.1111/1467-8721.00073

Gill, C. (2014). *Carers' Stories: Walking Alongside a Person with Dementia.* Newcastle: Cambridge Scholars Publishing.

Hedley-Penna, S., Paylor, I., & Soothhill, K. (1995). *Job satisfaction and dissatisfaction amongst residential care workers findings.* London: Joseph Rowntree Foundation.

Henderson, J. (2010). '*He's not my Carer- He's my husband': Personal and policy constructions of care in mental health. Journal of Social Work Practice, 15*(2), 149-159. doi: https://doi.org/10.1080/02650530120090601

Jorgensen, D., Parsons, M., Jacobs, S., & Arksey, H. (2010). The New Zealand informal caregivers and their unmet needs. *The New Zealand Medical Journal, 123*(1317), 9-16. Retrieved from http://www.nzma.org.nz/journal/123-1317/4181/

Kim, J., De Bellis, A. M., & Xiao, D. (2018). The Experience of Paid Family-Care Workers of People with Dementia in South Korea. *Asian Nursing Research, 12*(1), 34-41. doi:10.1016/j.anr.2018.01.002.

Kim, J.-S. (2001). Daughters-in-law in Korean caregiving families. *Issues and Innovations in Nursing Practice, 36*(3), 399-408. doi:10.1046/j.1365-2648.2001.01987.x.

Kincheloe, J. (2001). Describing the Bricolage: Conceptualizing a new Rigor in Qualitative Research. *Qualitative Inquiry, 7*(6), 679-692. doi:https://doi.org/10.1177/107780040100700601

Knight, R. G., Williams, S., McGee, R., & Olaman, S. (1998). Caregiving and well-being in a sample of women in midlife. *Australian and New Zealand Journal of Public Health, 22*(5), 616-620. doi:https://doi.org/10.1111/j.1467-842X.1998.tb01448.x

Kuo, B. C. (2014). Coping, acculturation, and psychological adaptation among migrants: a theoretical and empirical review and synthesis of the literature. *Health Psychology and Behavioral Medicine, 2*(1), 16-33. doi:10.1080/21642850.2013.843459

NZ, S. (2015, June 30). *Stats NZ.* Retrieved from http://archive.stats.govt.nz/Census/2013- census/profile-and-summary-reports/quickstats-65-plus/population-overview.aspx

Park, I. H., & Cho, L.-J. (1995). Confucianism and the Korean Family. *Journal of Comparative Family Studies, 26*(1), 117-134. doi:http://www.jstor.org/stable/41602370

Park, M. (2012). Filial piety and parental responsibility: an interpretive phenomenological study of family caregiving for a person with mental illness among Korean immigrants. *BioMed Central Nursing, 11*(1), 11-28. doi:10.1186/1472-6955-11-28

Pearlman, V., & Holzhausen, E. (2002). *Adding Value: Carers as Drivers of Social Change.* London: Carers, UK.

Petriwskyj, A., Parker, D., O'Dwyer, S., Moyle, W., & Nucifora, N. (2015). Interventions to build resilience in family carers of people living with dementia: A systematic review protocol. *JBI database of systematic reviews and implementation reports, 13*(7), 238- 273. doi:10.11124/jbisrir-2015-1994

Phillips, R., Durkin, M., Engward, H., Cable, G., & Iancu, M. (2022). The impact of caring for family members with mental illnesses on the caregiver: a scoping review. *Health Promotion International,*, 1-21.

Pinquart, M., & Sorensen, S. (2005). Ethnic Differences in Stressors, Resources, and Psychological Outcomes of Caregiving: A Meta-Analysis. *The Gerontologist, 45*(1), 90-106. doi:https://doi.org/10.1093/geront/45.1.90

Pusey-Murray, A., & Miller, P. (2013). 'I need help': caregivers' experience of caring for their relatives with mental illness in Jamaica. *Ment Health Fam Med, 10*(2), 113-121.

Ravenswood, K., Douglas, J., & Teo, S. (2015). *The New Zealand aged care workforce survey in 2014.* Auckland: New Zealand Work Research Institute. Retrieved from https://www.hrc.co.nz/files/2614/3019/0144/NZ_Aged_Care_Workforce_Survey_rep ort.pdf

Ryan, R. M., & Deci, E. L. (2001). On Happiness and Human Potential: A Review of Research on Hedonic and Eudaimonic Well-Being. *Annual Review of Psychology, 52*(1), 141- 166. doi:10.1146/annurev.psych.52.1.141

Sachez-Tereul, D., Robles-Bello, M. A., Sarhani-Robles, M., & Sarhani-Robles, A. (2022). Exploring resilience and well-being of family caregivers of people with dementia exposed to mandatory social isolation by Covid-19. *Dementia, 21*(2), 410-425.

Satorius, N., Leff, J., Ibor, J. L., Maj, M., & Okasha, A. (2005). *Families and Mental Disorders: From Burden to Empowerment.* The Atrium, Southern Gate, Chichester, West Sussex England: John Wiley & Sons.

Shah, A. J., Wadoo, O., & Latoo, J. (2010). Psychological Distress in Carers of People with Mental Disorders. *British Journal of Medical Practioners, 3*(3), a327.

Shaban, R. Z., Considine, J., Fry, M., & Curtis, K. (2017). Case study and case-based research in emergency nursing and care: Theoretical foundations and practical application in paramedic pre-hospital clinical judgment and decision-making of patients with mental illness. *Australasian Emergency Nursing Journal, 20*(1), 17-24. doi:http://dx.doi.org/10.1016/j.aenj.2017.01.002

Sikes, P., & Everington, J. (2001). Becoming An RE Teacher: A Life History Approach. *British Journal of Religious Education, 24*(1), 8-19. doi:https://doi.org/10.1080/0141620010240102

Stowell, J. (2003). The Influence of Confucian Values on Interpersonal Communication in South Korea, as Compared to China and Japan. *Intercultural Communication Studies, 12*(4), 105-116. Retrieved from https://web.uri.edu/iaics/files/06-Jessica-A.- Stowell.pdf

Travers, A. F. (1996). Caring for older people. *British Medical Journal, 313*(7055), 482-486. doi:https://doi.org/10.1136/bmj.313.7055.482

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