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Exploring the perceptions of Māori Psychologists of Providing Psychological Assistance to Māori via VC Technologies.

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Abstract

Accessibility issues, stigma and lack of culturally appropriate interventions are among barriers that have limited access to help for Māori who have mental health concerns. Videoconference therapy (VC) is well supported in research however its use has not been explored with Māori. Technology is ubiquitous and VC therapy has the potential to mitigate some of the barriers that limit access to effective evidenced-based therapy for those experiencing mental health difficulties.

Semi-structured interviews were conducted with 8 Māori clinical psychologists in various professional roles, to explore perceptions towards VC technology as a medium for conducting therapy with Māori clients. Data analysis involved reflexive thematic analysis with an inductive approach to coding.

The following five themes emerged out of data analysis: (1) Accessibility; (2) Safety; (3) Therapy Space; (4) Diverse Realities, and; (5) Culturally Competent VC therapy with Māori.

The perceived benefits of VC included: visual access, the potential to ameliorate accessibility barriers and client comfort/ engagement. There were concerns about conducting therapy from a distance which included: technology limitations, loss of assessment information, and safety concerns and crisis management.

Māori culture places importance on physical presence, however, participants felt it was feasible to conduct some cultural processes via VC. Questions were raised about the suitability of VC therapy for different individuals, therapists, areas and severity of distress and therapy type. All participants felt a meaningful therapeutic relationship could be established online although, preferences were for in-person therapy over VC therapy.

Preface

The purpose of this project was to explore how Māori psychologists perceived VC therapy and whether this was feasible with Māori clients.

This thesis is original, unpublished, independent work by the author.

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher named in this document is responsible for the ethical conduct of this research.

This research was conducted prior to the COVID-19 pandemic.

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Chapter One: Introduction

This chapter introduces the topic of this thesis and provides a summary of the context to which it is based. The parameters and organisation of this thesis are also outlined. This thesis explores the perceptions of Māori psychologists of providing psychological assistance to Māori via Videoconference technologies (VC).

Māori have proportionally higher rates of mental illness, increased severity of mental illness and proportionally lower rates of help-seeking, compared with the non-Māori population in New Zealand. Various barriers prevent engagement in mental health services for Māori including accessibility issues, discrimination, stigma and fear of culturally inappropriate interventions. Māori are a relatively young population, with higher proportions of individuals living in rural areas compared with the general population. Māori youth from rural and deprived areas have particularly poorer mental health outcomes. This reflects the wider issue of rural mental health as rural communities have limited access to mental health services owing to geographical barriers, lack of available resources and stigmatising attitudes towards mental health.

Māori culture has been significantly affected by the intergenerational trauma of colonisation including through deculturation, land alienation and destabilisation of social, economic and political institutions. Cultural erosion has contributed to the disparities that continue to disadvantage Māori, including in wellbeing outcomes. Tikanga Māori has always differed amongst whānau, hapū and iwi and cultural changes over time have further engendered the development of diverse lived experiences of Māori. Extrinsic influences, including the ongoing effects of colonisation and discrimination as well as intrinsic factors, continue to influence Māori identity.

There is no single Māori worldview, however prevailing conceptions of Te Ao Māori tend to encompass a holistic worldview with an emphasis on collective wellbeing and importance placed on whānau and whakapapa. Spirituality underpins this worldview as wairuatanga connects people, places and the natural environment. Further important values within Te Ao Māori include whanaungatanga and manaakitanga, which form the foundation of social relationships, including those beyond kin relationships. Kānohi-ki-te-kānohi denotes the importance of physical presence in relationships for the exchange of cultural information.

Technology is ubiquitous in this modern world and Māori have readily adopted technology use from very early on. The internet, in particular, has affected how people connect and consequently, aspects of culture are increasingly practised online. The use of Videoconference technology as a tool to conduct therapy from a distance, has the potential to overcome accessibility impediments to evidence-based, mental health resources and talking therapies including geographical barriers. Another advantage of VC therapy is the ability to recreate face-to-face communication, which gives both the therapist and client visual feedback. Feasibility studies have shown VC therapy to be an effective modality for various age groups and areas of distress. Anxiety, which is the most common disorder experienced by Māori, is an area particularly well supported in previous studies. However, few studies have focused on the feasibility of VC therapy with Indigenous populations including Māori.

The therapeutic relationship is fundamental in the therapy process, especially with Māori clients, as it becomes a space in which healing can occur. Particular methods, such as the hui process, are appropriate when working with Māori and it is important to build a solid therapeutic relationship by connecting in culturally appropriate ways.

Research has shown that individual clients have different preferences for VC therapy or in-person therapy. Due to the diverse realities experienced by Māori, particular individuals may be better suited to VC therapy than others. Likewise, studies exploring therapist attitudes towards VC have yielded mixed reviews with some feeling positively and others with hesitations towards VC therapy. Previous experience, as well as perceptions of usefulness, affected perceptions towards VC. Therapist resistance to VC therapy was due to concerns about its effectiveness including impaired rapport building, missing cues, privacy issues, interruptions, technical limitations and concerns about emergency management. Blended therapy has been suggested as a way to bridge the gap between in-person therapy and VC therapy, which might especially be appropriate for Māori as it enables space for the physical exchange of cultural information.

Thesis Parameters

This project explored the feasibility of VC therapy with Māori and to do so required an understanding of the state of Māori mental health, along with the historical and contemporary influences on mental health. An understanding of Māori culture, identity and the historical context in which culture and identities have emerged helped to contextualise Māori mental health and explained the wider cultural and social contexts of Te Ao Māori.

There is a limitation of studies of internet interventions relating particularly to Māori so this thesis canvassed the general research previously conducted on VC therapy whilst keeping in mind how these might be relevant for Māori.

This thesis analysed the perceptions and attitudes eight Māori clinical psychologists had towards the use of VC therapy with Māori clients.

Thesis Organisation

This thesis is organised into six chapters.

Chapter two, *Exploring Māori Mental Health, Culture and Identity* outlines the current state of Māori mental health. Accessibility barriers to mental health care are discussed, which ultimately highlights the nature of the need to improve Māori mental health outcomes. The rural and urban divide in terms of access to mental health services is explored. The historical context of Māori culture is then discussed as well as the nature of and influences on cultural identity. Next, the nature of Māori culture and relationships are explored and finally, the relationship between Māori and technology.

Chapter 3, *Exploring VC* canvases prior research about the use of VC therapy in general including on the therapeutic relationship along with client and therapist experiences of VC and areas of distress supported by prior research.

Chapter 4, *Methods* describes the approach that informed the methodological process of this research, including a summary of participants and procedures carried out. Kaupapa Māori informed the conduct of this research. Data analysis involved reflexive thematic analysis with an inductive approach to coding. The nature of thematic analysis is discussed as well as how the process fits into Kaupapa Māori research.

Chapter 5, *Results*, canvases the findings after thematic analysis and summarises five themes that emerged from the data analysis process, which were (1) *Accessibility*, (2) *Safety*, (3) *Therapy Space*, (4) *Diverse Realities*, and (5) *Culturally Competent VC therapy with Māori*.

Chapter 6, *Discussion*, synthesises results from data analysis. The five themes identified are discussed in-depth and conclusions are stated. The limitations of this study are discussed, along with future directions.

Chapter Two: Exploring Māori Mental Health, Culture and Identity.

This chapter delves into the state of Māori mental health. The historical context of Māori mental health will also be discussed, along with some of the barriers that prevent Māori access to mental health care. Identity and diverse realities of Māori will be then be explored, along with the nature of Māori culture and relationships as well as the relationship between Māori and technology.

Māori Mental Health

In New Zealand, Māori represent a higher proportion of rural dwellers compared with the general population and rural areas have higher proportions of Māori language speakers compared with the general population (Little et al., 2013). Although Māori are more likely than non-Māori to have an anxiety or depressive disorder in both urban and rural areas (Ministry of Health, 2012), Māori are less likely to seek help for mental health issues than non-Māori (Oakley Browne et al., 2006). Māori not only have proportionally higher levels of mental illness than non-Māori, but they are also more likely to experience more severe levels of mental illness (Baxter, 2008). The mental health survey, Te Rau Hinengaro (Oakley Browne et al., 2006), indicated that of Māori with mental health problems, 84% with mild disorders, 74% with moderate disorders and 52% with serious disorders, had no contact with health services. Additionally, Māori were more likely to be hospitalised through the justice system than through general practice or mental health services.

An understanding of barriers can seek to understand disparities and serve to inform measures to reduce gross disparities (Zambas & Wright, 2014). Several factors are barriers to treatment-seeking for Māori with mental health issues, including financial reasons such as travel

costs; communication barriers, structural issues such as availability of appointments, travelling and time-constrained appointments; and cultural issues and values, tikanga and kaupapa not being taken into consideration (Inquiry into Mental Health and Addiction, 2019; Mauri Ora Associates, 2008).

Fear of stigma for needing and attending therapy, as well as discrimination, have been identified as barriers to accessing treatment (Deane et al., 1999; Oakley Browne et al, 2006). In a study of mental health with Māori participants, many reported that they felt a sense of whakamā (shyness) about divulging their limitations and impairments (Te Pou, 2010).

Māori are a relatively young population. This has implications for mental health needs (Baxter, 2008) as the age groups of 15 to 24 years and 25 to 44 years have a higher prevalence of mental disorders (Oakley Browne et al, 2006). New Zealand has one of the highest youth suicide rates in the OECD with young Māori disproportionately affected by mental health issues and suicide. Higher proportions of Māori youth live in those particularly high-risk areas, including isolated rural areas where access to services is limited. Youth living in deprived areas have increased rates of mental illness. (Ministry of Health, 2019). The far north and east coast have been identified as particular areas where disparities occur in terms of access to mental health services (RHANZ). Younger males have particularly lower rates of engagement in mental health services. Furthermore, there is a discrepancy in services that employ Kaupapa Māori methods, for Māori youth (Ministry of Health, 2016).

Evidence suggests that those living in rural environments experience at least the same rates of psychological distress as those living in urban environments (Beautrais et al., 2018). There is a significant deficiency of treatment for people with mental health disorders, which is even more pronounced in rural communities, as those in rural areas have limited access to

suitable help, including mental health specialists (Berryhill et al., 2019) and effective talking therapies (Te Pou, 2010). There are proportionally lower rates of visits to mental health facilities for those in rural areas compared with those in urban environments (Oakley Browne et al., 2006). Geographic barriers limit access to services, as travelling to specialised clinics incurs financial and time costs, especially if regular attendance is required (Simpson, 2009). Moreover, Māori forced into urban locations for mental health care may be disconnected from whānau support (Inquiry into Mental Health and Addiction, 2019). These reflect the wider issues experienced in rural communities in New Zealand.

Key findings in a recent survey called 'The state of the rural nation' (2018) illustrated the extent of the need for more mental health resources in general rural communities in New Zealand. Results revealed 70% of participants living in rural communities had experienced increased personal stress in the last five years. Almost half of the participants said they find it difficult to talk about stress or anxiety, with the dominant reason being they would prefer to deal with personal issues themselves. The second reason was due to the perceived stigma attached to mental illness. The majority of participants felt there were limited resources available in rural areas for those who have mental health issues.

In summary, Māori experience higher proportions of mental health difficulties as well as proportionally lower rates of access to suitable mental health services. This is especially pronounced for Māori youth in rural communities where access to services is particularly limited. This is a reflection of the wider context of rural mental health in general in that suitable mental health care is limited.

Historical Context and Māori Identity

An understanding of Māori culture, identity and the historical context in which contemporary identities have emerged (Te Huia, 2015) can help to contextualise the historical and contemporary influences on Māori mental health. This is important as awareness of disparities helps to inform interventions.

Historical Context

Post-colonial peoples, sometimes named fourth wave peoples, such as Māori in New Zealand and Aboriginal peoples in Australia and Canada, are those who have remained in their lands but have had their cultures and identities impacted upon by colonising powers (Doyle, 2011). The effects of colonisation have been seen across all Indigenous populations, such as in the disparities seen in many Western[1] markers of health and wellbeing (Doyle, 2011). The effects of colonisation on health and wellbeing are enduring and are "grounded in unresolved grief associated with multiple layers of trauma spanning many generations" (Doyle, 2011, p. 22). Pihama et al (2014) similarly highlighted the significance of the intergenerational impact of historical trauma on Māori wellbeing, including the disparities seen in social statistics such as sexual abuse, violence, incarceration and mental health. Kingi (2005) summarised that colonisation and deculturalisation, as well as rapid urbanisation, were catalysts in the decline of traditional cultural practices. Efforts were made to assimilate Māori into non-Māori communities under the misguided idea that assimilation would be beneficial to Māori. In the process, many urban Māori became isolated and thus various traditional cultural practices declined.

[1] Western culture includes norms and values inherited from European colonisation and settlers, a worldview that tends to emphasise the individual and science compared with a Māori worldview which tends to be holistic, spiritually and socially oriented.

Precolonial Māori social structure comprised three basic units of organisation; iwi, hapū and whānau. Iwi were the largest political units with members often descended from common ancestors and comprised groups of hapū. Hapū, or sub-tribes, were based on whakapapa and location ties and formed an important social unit, with groups of whānau living and working together. Hapū had special spiritual ties to whenua (land), with particular natural features representing whakapapa and ancestors.

Spirituality or wairuatanga is evidenced in the connection Māori have with the whenua and environment. The loss of land through colonisation, therefore, had a profound effect on the evolution of culture and identity, as it separated people from their whenua and consequently "destabilised place based whānau, hapū and iwi identities" (Moewaka Barnes & McCreanor, 2019, p. 24). According to Reid et al (2017), structural and psychosocial challenges resulted from the dismantling of Māori political, economic and social institutions through the loss of land which had served economic and political independence and contributed significantly to cultural identity. Settler colonialism was traumatising for Māori and the colonising environment was reinforced by the trauma of land loss, poverty and disenfranchisement resulting in cultural erosion. The structural changes resulting from the weakening of the Māori bases of whānau, hapū and iwi reduced Rangatiratanga or self-determination (Rangihau, 1986).

The decline in cultural identity due to disconnection and social exclusion continues to manifest, including in susceptibility to mental health difficulties (Kingi, 2017). Additionally, Durie (2001) identified despair and despondency as threats to Māori health. The effects of colonisation have directly affected the health status of Māori as well as the utilisation of healthcare (Zambas & Wright, 2014). The ongoing effects of colonisation continue to affect whānau as socioeconomic hardships, poverty, fragmented and dispersed whānau and

disconnection to whenua manifest poor health outcomes for Māori (Inquiry into Mental Health and Addiction, 2019). Historical trauma theory can help to explain Māori experiences and help to inform self-determined solutions to the issues that continue to manifest, including to challenge the ideologies and policies which perpetuate such issues (George et al., 2014).

Identity and Diverse Realities

Māori culture has continued to evolve since colonisation and it continues to change as evidenced in more recent trends towards reclaiming culture and movement towards Indigenous ideologies (Sciascia, 2016). The evolution of culture over time due to historical contexts explains the development of various realities experienced by different people.

An understanding of Māori culture would be helpful to those who are tasked with developing interventions which aim to reduce the disparities experienced by Māori. This is difficult due to the diversity of the Māori population (Houkamau & Sibley, 2010). Data from the 2013 census revealed the variation and complexity of Māori individual identity in the reporting of ethnicity. For example, 16% of those with Māori descent did not affiliate to the Māori ethnic group; Māori were more likely than other ethnicities to identify with more than one ethnicity, and; 16.5% of those with Māori descent were unable to name their iwi (Statistics New Zealand). This illustrates that whilst individuals might be ethnically Māori or have Māori ancestors, their individual experience and Māori cultural identity may differ.

Due to the variation in Māori identity, efforts have been made to understand and effectively measure Māori identity. This is especially difficult to quantify in contemporary times given the multiple realities that contribute to individual experiences as Māori (Kingi, 2017). Prevailing conceptions of identity and culture include strong social relationships and

connections, the use of te reo and wairuatanga (Houkamau & Sibley, 2010). Durie (1994) observed three categories of Māori identity: culturally Māori, bicultural, and marginalised. Culturally Māori are those who understand whakapapa, te reo and tikanga; bicultural Māori engage with numerically dominant population practices and Māori culture; and finally, marginalised includes individuals who relate with neither numerically dominant population nor Māori culture. Similarly, Williams (2000) categorised identity into three groups: those with a traditional Māori core, who are fully immersed in Māori cultural practices; those who are primarily urban and largely bicultural; and finally, those who are unconnected as they do not engage in Māori culture despite being ethnically Māori. Houkamau (2006) also described three subgroups of Māori identity: Enculturated or protected are those who have traditional Māori values; detached and bicultural are those who grew up in urban environments, have assimilated into the dominant culture and are detached from Māori culture. Finally, renaissance Māori are those who have made efforts to become actively engaged in culture as it became more socially acceptable to do so. Houkamau and Sibley (2010) developed 'The Multi-Dimensional Model of Māori Identity' to assess identity and cultural engagement of Māori. The model broadly includes assessing self-identification and cultural engagement in the socio-political context, enculturated experiences of Māori identity traditions, and constitutive representations of being Māori. Information from these measures could be helpful when working with Māori, to help to understand their experiences better. Perhaps such measures of identity could be utilised as a tool to measure cultural or identity healing for those who have impairments to wellbeing exacerbated by being culturally disconnected.

Māori culture tends to take a holistic worldview that emphasises on the wellbeing of the collective. Te Huia (2015) identified whakapapa as the key component in the development of

Māori identity. Also of importance are self-identification as Māori as well as other's recognition of one as belonging in the group. Affirmation by others, including whānau and the wider Māori community, may especially assert an individual's positive Māori identity due to the interdependent nature of Māori culture. Other forms of external input affect the development of identity, including racism and discrimination, which have been identified as factors that influence some Māori to refrain from engaging in activities which enhance aspects of their Māori identity, such as speaking te reo (Te Huia, 2015). Te Huia highlighted the multiple realities experienced by Māori, but also the dynamic nature of identity development within the individual, which can evolve and change over time. These factors demonstrate how various intrinsic and extrinsic variables can affect an individual's Māori identity and influence how this might change over time. Due to this, measures of cultural identity might not account for identity as an evolving process. Moreover, measures of identity might not explain those intrinsic or extrinsic influences on cultural identity. These are important factors, especially for those with impaired wellbeing. It is important to understand cultural identity as it influences wellbeing and mental health. According to Durie (1998), access to cultural identity is a fundamental right and the development of positive identity enhances mental health. Moreover, mental health services can support or diminish positive cultural identity. Williams et al. (2018) asserted that Indigenous cultural identity is undermined by dominant cultural perspectives.

The nature of identity is important in understanding therapeutic interventions. Māori who have high levels of enculturation and positive Māori identities might feel more comfortable with interventions that reflect Māori values. As outlined, ethnicity does not wholly dictate identity, therefore it cannot be assumed that an ethnically Māori individual might benefit best from

interventions suitable for Māori culture. Therapeutic interventions are best customised to an individual's experienced reality and self-concept.

Nature of Māori Culture and Relationships

Te Ao Māori, the Māori world, is governed by tikanga which, according to Mead (2016) "refers to the ethical and common law issues that underpin the behaviour of members of whānau, hapū and iwi as they go about their lives and especially when they engage in the cultural, social, ritual and economical ceremonies of their society" (p.19). There are rituals connected to tikanga which need to be performed correctly in order to uphold tikanga. Tikanga continually evolves and can vary amongst whānau, hapū and iwi. Often rituals are guided by Pūrākau (Māori creation stories and mythology). Pūrākau represent the Māori worldview, especially the importance of the relationship humans have with the natural world and they provide models of behaviour (Royal, 2005).

Values that underpin tikanga include manaakitanga and whanaungatanga, both of which require nurturing. The core of manaakitanga involves raising and uplifting the mana of others through nurturing relationships, showing respect, caring for and supporting others. An example of this could be seen in how one might offer food or drink to manuhiri (visitors) to help them to feel welcome or comforting someone when they are upset. Mauri is the life force or energy that connects all things and enables mana to flow into a person (Royal, 2009). Manaakitanga is an acknowledgement of mauri as demonstrating respect, kindness and humility give reverence to mauri (Tūpara, 2009). Whakamanawa means to encourage and instil confidence.

Whanaungatanga refers to the importance of whakapapa and relationships and is a reflection of the collective nature of Māori culture. Whanaungatanga extends beyond kin

relationships to include those who have a shared experience (Mead, 2003). It involves making connections with others through whakapapa or through shared experiences, which could be finding common ground with people or places to connect in a meaningful way (Mead, 2003).

Kānohi ki te kānohi is a fundamental concept that underpins Māori practices related to communication. It translates to 'face-to-face' and emphasises the importance of physical presence in relationships and for communication. Physical presence is a demonstration of respect as it reflects the effort put in by someone to be physically present, it gives credibility to a point of view, helps to build trust (O'Carroll, 2013), is a reflection of the mauri of a person and wairuatanga. Wairuatanga is a value deeply ingrained in tikanga. It refers to the spiritual side which connects people and places (O'Carroll, 2013). Spiritual elements are significant to connections and are sensed in the physical body (Mead 2016). Kānohi kitea is a similar notion to kānohi ki te kānohi as both are forms of physical interaction. Kānohi kitea denotes the importance of being seen and is required to maintain the bonds of whanaungatanga (Mead, 2016).

Milne (2005) highlighted the importance of wairua in relationships and therapeutic endeavours by quoting a tōhunga (traditional healer) in their study who stated "We start with the wairua first, then the hinengaro, then tinana, the healing of whakapapa and then deal with the trauma; whereas these others, they start with the trauma first and may or may not deal with the wairua, hinengaro, tinana, and whakapapa. There should be recognition of healing the wairua first, then the mind" (p. 19). This illustrates how typical interventions based on individualistic interventions might not be culturally appropriate for Māori as important cultural values might be missed. Therefore, a holistic approach is required when collaborating with Māori clients with particular emphasis on wairuatanga, the spiritual side.

Māori and technology

Online technology use is prevalent in contemporary society and Māori have readily embraced its use. With the development of online technologies including the evolution of social networking sites, Māori have shifted aspects of culture and tikanga into the virtual space, including identity construction, identity reconstruction, the sharing of knowledge, preservation of culture and the revitalisation of some aspects of culture (Sciascia, 2016). The internet has affected the way people connect and communicate with each other, including the maintenance of whanaungatanga. Social networking sites have affected communication in various positive ways, including the reconnection of Māori living in urban dwellings or overseas, to their marae, hapū and iwi. Those from older generations are utilising social networking to connect with younger generations, to keep up to date with their children and grandchildren (Sciascia, 2016). This is especially constructive as urbanisation, time, distance and financial concerns have made it difficult to achieve face-to-face communication (O'Carroll, 2013).

Online methods of communication contrast with traditional methods of communication, which challenges the importance of face-to-face communication and being seen but creates opportunities for face-to-face communication to be repurposed to suit the needs of contemporary realities and circumstances. Many have accepted the inevitability that in-person therapy will be required less as virtual communication becomes more prevalent. O'Carroll (2013) found social networking sites provided an opportunity for individuals to maintain connections and nurture relationships.

According to Ohia (2006), particular aspects of Kaupapa Māori are enduring and unchangeable, including notions of mana (prestige, spiritual power), tapu (sacred), aroha (love), tino rangatiratanga (self- determination), and whanaungatanga. Other aspects are variable

including knowledge, thinking, karakia and āhuatanga (aspects and circumstances). However, both enable Māori to comply with tikanga Māori while also fitting in with the modern world. Mead (2016) stated, “Tikanga Māori is adaptable, flexible, transferable and capable of being applied to entirely new situations” (p. 255). “There is really no end to the range of non-traditional activities that Māori may adopt and into which tikanga Māori can be injected” (p. 262). Mead further stipulated the key to debating phenomena that challenge existing customs or traditions is to engage tikanga Māori and draw from the Māori knowledge base.

O’Carroll (2015) researched how Māori culture is increasingly being practised online, as seen in the uptake of social networking sites as means for maintaining whanaungatanga, as well as aspects of tangihanga (the ritual of burial) increasingly being practised online. Financial, geographical and time constraints may be barriers to physical attendance of tangihanga, therefore web-based engagement can enable those who cannot be physically present to be involved. Technology has impacted on many areas of tangihanga from the initial notification that a death has occurred to, in some cases, the funeral being streamed online. Online updates enable people to be kept up to date with plans and to feel involved in the process. However, there were some concerns about authenticity as well as the capacity for virtual tangihanga to convey the depth and richness of tikanga. Many participants felt there were limits to the appropriateness of some aspects of online tangihanga, especially in aspects that are rich in tapu, such as the sharing of photos of the tūpāpaku (body) and wairuatanga. The ability to connect spiritually was felt to be missing in a computer-mediated experience of tangihanga. Learning a loved one had died via social networking was felt to be positive and negative for different participants. Some appreciated being kept up to date and others felt it was insensitive to find out information regarding deaths through social media. Kaumātua (elders) had trouble envisaging the adaptation

of tapu from the physical presence to the virtual space. This highlights how differently people feel about culture being practised in virtual spaces and ultimately, the diverse realities experienced by Māori.

Tangihanga is extremely rich in tikanga and how the process of tangihanga is being brought into the digital space provides insight into how Māori culture evolves to fit into the modern world. This shows support for the feasibility of novel measures such as videoconference (VC) technologies for therapy. Another example is sometimes after someone has died, their Facebook page remains and becomes a virtual memorial for the deceased, which enables loved ones to pay tribute online and to feel connected to their loved one. This suggests there is an authentic and meaningful representation of the person in virtual spaces which family and friends feel a tangible connection with. A study of virtual memorials showed that people engaged with memorial pages to process the death of a loved one, remember them and continue the connection (Bouc et al., 2016).

These ideas hold promise for the successful use of VC technologies when working with Māori clients experiencing psychological distress, including the ability to engender a positive therapeutic relationship in the absence of physical presence, so long as principles of tikanga are upheld. If principles of whanaungatanga and manaakitanga are upheld, as well as a respect for the mana, tapu, self-determination and autonomy of a person, it seems computer-mediated methods of intervention may be feasible for Māori. As stated, it is important to keep in mind that not all Māori are the same and individuals may differ in their practices of traditional and or contemporary culture. It is therefore important to treat Māori as unique, rather than as cultural stereotypes (Huriwai, et. al., 2001).

Chapter Three: Exploring Videoconference Therapy

This chapter focuses on the context of VC therapy. The significance of the therapeutic relationship is discussed, along with prior research on the feasibility of internet interventions. Client preferences, therapist experiences and barriers to VC therapy are then explored.

The Therapeutic Relationship

There are important aspects of evaluating the feasibility VC therapy that is not related to ethnicity and identity. The therapeutic relationship is a critical part of the therapeutic process and the relationship itself can be a context in which interventions can occur (Okamoto et al., 2019). The therapeutic relationship between therapist and client is a key feature of therapy such as cognitive behavioural therapy (CBT) and involves collaboration, modelling behaviour, efforts to promote a client's autonomy and provides the foundation for case conceptualisation (Okamoto et al., 2019). Perceptions of therapist empathy and genuineness contribute to the therapeutic relationship (Nienhuis et al., 2018). A repeated finding in multiple studies and meta-analyses is therapist empathy positively affects the therapeutic relationship and client outcomes in psychotherapy (Elliot et., 2018). These findings hold across treatment orientation, treatment format and client problems. Empathy is expressed in what the therapist does or says as well as in how the therapist listens and receives, respects and attends to the client. Empathy is a co-created experience in which understanding is sought between the therapist and client. At its core, it involves individualising and personalising responses to individual clients, and for empathy to be effective it needs to be grounded in authentic caring and genuineness on the part of the therapist (Elliot et al., 2018).

Therapist empathy promotes client engagement, which contributes significantly to the success of interventions with Māori, and especially for creating longstanding changes (Te Pou, 2010). Engagement with Māori is thought to be more effective when interventions reflect Māori health and wellbeing values and dimensions which involve: the use of bicultural therapy models; engaging culturally appropriate values such as whanaungatanga, whakamanawa (encouragement) and mauri (Durie, & Hermansson, 1990); utilising Māori mythology (O'Connor & MacFarlane, 2002); being aware of cultural diversity with regards to identity; refraining from generalising cultural wants and needs; and recognising the importance of promoting a strong cultural identity (Hirini, 1997). An example would be to utilise the formal processes of respect when interacting with Māori clients, for example employing the hui process, which involves mihimihi (greetings and introductions), whakawhanaungatanga (building a relationship), communication of kaupapa (purpose and agenda) and finally, whakamutunga or poroporoaki (conclusions and parting remarks) (Lacey et al., 2011). As stated, connecting in culturally acceptable ways has been shown to promote client engagement (Te Pou, 2010), which in turn can increase the likelihood of building a solid therapeutic relationship. Perhaps engaging with Māori in culturally appropriate ways during VC sessions, such as engaging the hui process, are factors in whether VC could work with Māori.

Prior research on Internet Interventions

A plethora of research has emerged regarding the feasibility of internet-delivered therapeutic interventions for people experiencing psychological distress. Interventions can be categorised as either synchronous, where communication occurs in real-time such as through webcam and audio; or asynchronous, communication which does not occur in real-time such as

through email and forums. There is a multitude of online means for assistance with psychological problems using self-help tools online and asynchronous communication and some evidence to support such measures, however, questions remain about their efficacy (Renn, 2019; Yuen et al., 2013). The focus of this research is on synchronous communication which might mitigate the shortcomings of asynchronous communication.

VC therapy is also known as cybertherapy, online or web-therapy, e-therapy, and teletherapy and uses synchronous communication. The major advantages of VC therapy are that it facilitates spontaneous and immediate interaction, enables the therapist to observe visual information, non-verbal communication and body language (Cipolletta et al., 2018; Yuen et al., 2013), and is the most like traditional therapy. For VC therapy to be successful it needs to be delivered just as thoroughly as psychotherapeutic interventions are in person (Munz, 2019). As discussed above, the therapeutic relationship between therapist and client is fundamental to the treatment process and evidence suggests a successful therapeutic alliance can be established through VC (Berger, 2017).

Studies have largely been conducted amongst Western, English speaking populations, which might reduce the generalisation of results across other cultures (Berryhill et al., 2019). However, recent studies have emerged from other cultures including Japan. There is also a lack of feasibility research for VC therapy in rural communities, as the majority of studies have been conducted mainly in urban areas or academic hubs (Chou et al., 2017). It is evident there is a lack of studies exploring the acceptability of VC therapy for Indigenous populations, including Māori. This is problematic because there are limitations in utilising Western tested methods of therapy without adaptation to Indigenous populations owing to the differences in cultural world

view. Western worldview tends to be individualistic with emphasis on science, while Māori worldview tends to be whānau centred with an emphasis on wairuatanga (Bennett, 2009).

There has been a study conducted on providing telemedicine via VC with Indigenous Australians and another on Māori experience of an asynchronous online therapeutic intervention. Similar to VC therapy, telemedicine enables geographically removed health care practitioners and patients to connect via VC and has been used in the medical field to decrease accessibility barriers and promote clinic attendance and treatment completion. Australian Indigenous health outcomes, mental health outcomes and access to care are reportedly poorer than non-Indigenous individuals. As with Māori, this has been attributed to a lack of culturally derived interventions, especially ones that take into account diverse realities (Westerman, 2010). As stated above, few studies have explored Indigenous experiences of VC therapy, however a study with Indigenous Australians that found support for the use of VC for providing telemedicine, specifically cancer care. Overall, participants preferred VC consultation over face-to-face consultation mainly due to the reduction of wait time, cost and burden of travel. Importantly participants felt they could receive care close to home where their family and community supports are. Participants, therefore, reported they would happily utilise VC telemedicine again. Families and health workers alike were also satisfied with VC telemedicine (Mooi et al., 2012). These results hold promise for acceptability of VC for Māori due to certain similarities of core values and culture between Indigenous Australians and Māori, namely the potential for family and local supports to be involved in care. Both are fourth wave peoples who have been significantly influenced by colonisation and both cultures are underpinned by the spiritual realm, kinship, genealogy and the land (Westerman, 2010). It is important to note that just as Māori individuals, whānau, hapū and

iwi experience diverse realities and tikanga, Aboriginal Australian peoples also have complex and diverse societies (Mullins, 2007).

A study was conducted with Māori youth to explore the design and cultural relevance of a computerised, gamified CBT programme (SPARX) which aims to assist youth to resolve issues themselves through challenges which teach coping skills. The game environment incorporated unique New Zealand features. There were Māori words within the game as well as Māori objects such as waka (canoes). Individuals were able to customise their avatar and the guide avatar was designed to appear with some physical attributes deemed stereotypical of Māori. The Māori features in the game increased its relatability to Māori youth, promoted engagement and enhanced their Māori identity. The results of the study were positive as wellbeing was enhanced and the researchers emphasised the importance of cultural relevance for engagement in the programme (Shepherd et al., 2018). A meta-analysis by Griner and Smith (2006) found that mental health treatments for racial and ethnic groups were considerably more effective when interventions were adapted to account for specific cultural contexts, compared with interventions that are designed to suit numerically dominant populations.

A trial study by Matsumoto et al. (2018) based in Japan demonstrated the feasibility of utilising VC therapy for the treatment of Obsessive-compulsive disorder (OCD) and anxiety disorders. Japanese culture and Māori culture have typically been described as interdependent cultures where members tend to view themselves as connected and part of a social unit compared with a more independent self-construction. However, individuals may differ in terms of their orientation to the collective. Participants were reportedly satisfied with VC treatment and a successful, mutual relationship was able to be achieved between the therapist and client. As with Māori culture, societal changes have resulted in changes in Japanese identity, especially in the

uptake of modern technology (Kawanishi, 2009). Social changes have instigated changes in attitudes and increased attention towards mental health in Japan, however, there remain some stigmatising attitudes towards mental health disorders (Kasahara-Kiritani et al., 2018) with greater social distance experienced by those with mental health issues (Ando et al, 2013). In Japanese culture it is important to maintain harmonious relationships (Kawanishi, 2009); causing conflict in relationships is an affront to mentsu or 'face' and politeness is seen as upholding mentsu. Consequently, internal conflicts are ignored in favour of maintaining an outward focus (Kawanishi, 2009). Perhaps the trial study by Matsumoto et al. (2018) could be attributed to how VC therapy might enhance the privacy of seeking treatment and mitigate the social stigma associated with mental illness, as well as encourage clients to pay attention to internal conflicts without concern for how they might be perceived.

Use of internet-delivered therapy has the potential to overcome accessibility and other barriers that limit access to treatment and reduce costs (Morriss et al, 2019), including social phobia, fear of the stigma of attending psychotherapy in person, movement impediments, distance and transportation issues (Cipolletta et al, 2018). VC therapy is thought to be more cost-effective and have greater efficiency for practitioners and clients (Anton & Jones, 2019). When implemented appropriately, evidenced-based interventions via VC have demonstrated positive outcomes for children, adults and older adults across rural and urban communities and in various settings including in homes and clinics (Berryhill et al., 2019). Previous studies have verified the acceptability of VC therapy for childhood depression, older adults with memory issues, panic disorder, OCD, Post-traumatic stress disorder (PTSD), social anxiety, agoraphobia and other issues with social interactions (Yuen et al., 2013). CBT via VC was found to be effective for those who suffered severe anxiety and for those who had previously been difficult to engage in

treatment because they either were unable to attend in-person sessions or because they were resistant (Morriss et al, 2019). VC therapy was found to be effective with older adults as participants experiencing depressive symptoms showed improved outcomes with VC therapy (Harerimana et al., 2019).

Treatment of OCD via remote treatment has been shown to be effective. Exposure and response prevention (ERP) is the gold standard for treating OCD, and VC treatment for ERP results did not significantly differ in results compared with in-person treatment; in fact, VC based therapy had a slight advantage and participants felt it was more natural. A case has therefore been made for providing ERP treatment in a natural setting, in their own environment where they can experience real stimuli, which is achievable through VC as in-person treatment with therapists in natural settings is not always practicable (Netter et al., 2018). Results also show promise for improving outcomes for youth experiencing anxiety, even more quickly than in-person therapy because as with the treatment of OCD, VC treatment occurs in the child’s natural setting (Carpenter et al., 2018).

Clients may prefer VC therapy due to feeling more comfortable divulging information in this capacity compared with in-person treatment owing to perceived anonymity and distance with VC therapy, as well as the discreet nature of treatment in the comfort of one’s own space. In a study with participants who had received therapy for Bulimia via VC, Simpson, Bill, Knox and Mitchell (2005) found that participants felt VC therapy diminished self-consciousness, led to a greater sense of personal space and increased personal control, which further led to feelings that VC was less intimidating and pressured than in-person therapy. The researchers stated that VC therapy may provide the distance required to minimise shame. A study with participants

receiving therapy via VC for OCD found that participants were less self-conscious during exposure tasks compared with in-person treatment (Himle et al., 2006).

The studies described therefore show promise for areas of distress commonly experienced by Māori as anxiety is the most common disorder amongst Māori with mood disorders and substance use disorders also prevalent. Eating disorders, though less common are experienced by some (Oakley Browne et al., 2006). Furthermore, the distance that VC provides might be enough to mitigate some of the sense of whakamā some experience which prevents them from seeking help for mental health difficulties.

Client Preferences

An Australian online survey with community members found that confidence with computers and the internet was associated with higher rates of preference for online service rather than in-person options. Some personality factors were said to be associated with preferences for in-person support, such as those with extraversion personality traits and those with a doctor-related locus of control (March et al., 2018). Most participants reportedly had an overall preference for in-person services rather than online services, although the intention to use online services was found to be higher despite lower preference. This indicates that strategies to encourage clients into online services may be required to promote confidence and familiarity towards online methods, and to increase the chance of them being comfortable to use such services if required (March, et al., 2018).

The diverse realities and identities experienced by Māori may mean individual Māori may differ in their attitudes to and preferences for VC therapy. As mentioned above Māori have been quick to adopt technology and aspects of culture are being increasingly practised online.

This is promising for the use of VC with Māori since VC is a convenient mode of interaction, however, since kānohi-ki-te-kānohi is an important part of communication, others may prefer in-person therapy sessions. Further resistance to VC could stem from existing feelings towards the health and mental health spaces, as many fear discrimination and tikanga not being taken into consideration, which may be perceived to be especially concerning when working from a distance.

Therapist Experiences of VC

Bengtsson, Nordin and Carlbring (2015) compared therapist experiences of conducting CBT online and individualised in-person. Four themes emerged out of thematic analysis. Firstly, the structure of a more manualised CBT conducted online promoted focus compared with individualised in-person therapy, in which it was reportedly sometimes difficult to achieve structure and focus. Secondly, whilst all participants found online CBT to be satisfactory, some felt that in-person therapy was a stronger experience than online therapy with more reinforcement. Thirdly, online therapy enabled work-time control and flexibility as they could decide where and when to work. Traditional disruptions such as illness did not impact online therapy as much as in-person therapy. Administrative factors such as booking and rebooking and handling cancellations were factors for in-person therapy which reportedly contributed to a strained workload. Lastly, most therapists thought a working alliance was possible in both online and in-person therapies. Some had preconceptions that it would be hard to achieve but found it was easier than expected. Most thought that achieving a working alliance was quicker, richer and stronger in in-person therapy compared with online. One participant remarked, “you have access to the body in some way… gestures… facial expressions and gaze” (p. 474).

Sucala et al. (2013) investigated clinician's attitudes toward therapeutic alliance in VC and found clinicians consider the therapeutic alliance to be important for in-person therapy and online therapy. The therapeutic relationship is especially important for Māori as connections to others reflect the Māori cultural worldview as it acknowledges the connections Māori have to whānau, hapū and iwi. Whanaungatanga as well as incorporating whānau into the therapy process connects the therapist and client, helps to build rapport and form the therapeutic relationship in which healing can occur (Te Pou, 2010).

Potential barriers to successful VC therapy

Concerns regarding the implementation and success of VC therapy include attitudinal concerns, such as practitioner doubts and external concerns such as practical and client concerns (Ramsey et al., 2016).

There remains some resistance from therapists to VC therapy, owing to scepticism about its effectiveness (Ramsey et al, 2016). Manfrida et al. (2017) stated that in-person therapy should always be utilised unless there are severe impediments such as illness. They believe physical proximity facilitates trust which cannot be achieved in a screen-mediated session. They suggest VC technology as a tool for emergency occurrences to maintain continuity of treatment and therefore minimise interruption of the therapy process and not as a means to replace in-person treatment entirely. Bengtsson et al. (2015) suggested that blended therapy would perhaps promote positive outcomes such as an initial in-person session at the start, then following on with online modalities. This might be more appropriate for Māori clients and therapists alike as it allows an initial session to experience kānohi-ki-te-kānohi and to build valuable connections through whanaungatanga, rapport building and experiencing the other's mauri and thus creating

a safe space for future interactions via VC. Further therapist concerns were related to scheduling complications and perceived lack of emergency services (Berryhill et al., 2019). Questions remain about implications for high-risk situations and crisis management (Chou et al., 2017), as well as concerns relating to privacy and security of information (Ramsey et al, 2016). As mentioned above, fear of stigma is a factor that has limited Māori access to mental health care therefore privacy and safety are important considerations for Māori clients. Clients would need to feel as though their information was secure in order to engage with therapy.

Other studies with practitioners yielded more positive perceptions of online therapy. For example, a recent review found that health care practitioners had positive perceptions of the practicalities and benefits of providing assistance via teletherapy to older adults (Harerimana et al., 2019). Whether this finding holds for kaumātua remains to be seen.

Therapists' perceived benefits of online therapy included the potential for those with social phobia and for adolescents who might struggle with therapy to open up more. It might mitigate some stigma and resistance associated with revealing shameful or anxious things (Bengtsson et al., 2015). This is especially promising for Māori as Māori youth continue to experience a higher prevalence of mental health difficulties. Titzler et al. (2018) explored therapists' perspectives towards blended therapies. Blended therapies combine in-person sessions with digital components and might be more suitable for clients of whom purely online therapy might not be appropriate. As other studies have mentioned, participants identified technical issues as a barrier to successful implementation because they resulted in frustration and hindered the therapy process. Many stated that technology improvements would help to mitigate this issue. The success of blended therapies would be enhanced by training and through enabling therapists the autonomy to decide the ratio of online and in-person sessions and to individualise

sessions. Overall, participants had positive attitudes towards blended therapy, however, they expected their colleagues to be sceptical of the new approach and many felt that online or blended models might not be suitable for some disorders. Participants in the study reported that having experience with blended models of therapy increased their intention to work with such models again. This supports other research findings which identified lack of experience as a barrier to utilisation. Titzler et al. (2018) suggested that workshops and training might encourage exposure and subsequent use of blended models and that perhaps an awareness of client positive attitudes towards online models might also encourage use. Ultimately, digital and blended therapies rely on the acceptance of therapists (Titzler et al., 2018).

Perceived barriers to developing a strong therapeutic relationship in online therapy included: missing cues, conveying warmth and empathy, and technical barriers such as connectivity interruptions. Skills they thought would overcome such barriers were online communication skills and increased computer and technology skills. Participants suggested training would increase confidence and intention to utilise e-therapy. There are various personal attitudes towards VC therapy and some practitioners are open to it and others more hesitant towards VC therapy. Due to diverse realities experienced by Māori, this too may be the case for Māori practitioners. Perhaps those with more experience in VC therapy might feel more positively towards it than those with less experience. Concerns about developing the therapeutic relationship may especially be worrying since building relationships is fundamental in working with Māori.

There is also some resistance from clients and potential clients towards VC therapy. Renn (2019) found that some clients still preferred in-person treatment, as they felt that sessions had more authenticity and privacy and others feel hesitant to use VC therapy as they believe it would

be too artificial or uncomfortable. Renn (2019) further summarised participant concerns regarding VC therapy. There were concerns about the same barriers as in-person therapy, including scheduling conflicts and competing demands such as family obligations. There were concerns about its relative effectiveness compared with in-person therapy, as well as concerns related to access such as costs involved. Some were confused about what equipment they would need, as well as the frequency of sessions and duration of treatment. Other concerns were rooted in fear of stigma, including a lack of trust in the security of internet-delivered interventions, lack of privacy, especially when technology is shared at home, fear of data breaches, unwanted recording or otherwise sharing of private information. According to an Inquiry into Mental Health and Addiction (2019), there is a lack of trust in the mental health system to provide suitable support for Māori. Some Māori are already hesitant to access services which would be a barrier no matter the medium of therapy.

There are external concerns related to the practical limitations of technology use in the provision of computer-mediated therapeutic interventions. Essentially the quality of the interaction depends on the functionality of the tool. If the tool does not work it impacts on the relationship, such as through a loss of synchronicity (Cipolletta et al., 2018). Interruptions can occur from limitations in the technology as well as from physical interruptions and disruptions from the individual's setting due to the nature of experiencing VC therapy in the home, which can, in turn, disrupt the flow of the therapy session (Carpenter et al., 2018). Home visits by psychologists might also have issues with interruptions.

Whilst VC therapy enables the exchange of visual information, this method might lack some physical feedback that would be more evident in physical settings, such as subtle reactions and body language cues. The quality of the video and camera view might make it harder to

identify non-verbal communication (Yuen et al., 2013). Such factors are important in the cultural exchange of information including mauri and as such may be difficult to achieve for Māori through VC.

Further barriers to successful use include the cost of technology, lack of equipment, technical literacy or connectivity, which may be an issue in rural communities where internet connectivity might be insufficient to support VC capability (Berryhill et al., 2019; Ramsey et al, 2016). Economically disadvantaged communities have poorer access to advanced technologies (Chou et al, 2017), therefore those who need it still might miss out on access to treatment. As stated above, Māori feature prominently in negative social statistics, so it raises the question of whether the technology would be a barrier for Māori to engage with VC therapy. Remote sites might be a suitable option in such instances, although they have shortcomings as well.

Summary

To summarise, mental health inequalities for Māori have been widely reported and have been attributed to several causes including accessibility and structural issues, especially in rural communities, as well as attitudinal issues and fear of stigma.

Māori culture is governed by tikanga and procedural rituals, though these vary amongst Māori. There is an emphasis on making connections and respect for people. Physical presence is important in relationships and for communication, including in therapeutic endeavours. That said, online technologies are increasingly ubiquitous and many Māori have adopted the use of technology to practise culture and to maintain relationships. Research suggests that culture and relationships can be carried out in virtual spaces as long as cultural values are upheld, such as consideration for wairuatanga, whanaungatanga and manaakitanga. Many Māori are already

using online technologies, even amongst older generations to connect with children and grandchildren, as such; cultural practices have already been modified by technology. The COVID-19 pandemic has truly demonstrated the benefit of VC technologies for maintaining contact with whānau as lockdowns or other restrictions across the world has prevented many from kānohi-ki-te-kānohi interactions. It may have highlighted perhaps who had access to such technologies and perhaps those who did not.

VC therapy is widely supported in research. VC tools have the potential to overcome barriers to accessing mental health services for rural Māori as it reduces the accessibility and structural barriers, and potentially stigma. VC therapy confronts the ideal of physical presence that has traditionally been of importance in building relationships with Māori, however, Māori culture has been shown to evolve with technology. As long as therapy is conducted in a manner that promotes cultural sensitivity, with consideration for Māori values, VC therapy with Māori may be feasible. It is important to keep in mind that while VC therapy might align with Māori values and philosophy, Māori experience diverse realities so there are individual differences that might influence whether VC therapy is suitable. Māori psychologists, who have experience working with Māori clients are well placed to inform the feasibility and suitability of VC therapy for Māori, as well as provide some guidance on strategies or factors that might enhance the successful implementation of VC therapy with Māori. With this in mind, the present study sought to address the following questions.

Research questions

- What are Māori psychologists perceptions about the use of VC technology for therapy
- Do Māori psychologists think it is appropriate to conduct VC technology with Māori clients and would VC therapy be consistent with tikanga Māori
- Do Māori psychologists think that a meaningful therapeutic relationship between psychologists and Māori clients can be established in the absence of kānohi ki te kānohi/ face-to-face interaction?
- What factors/ methods/ guidelines should be kept in mind if doing VC with Māori

Chapter Four: Methods

This chapter describes the approach which informed the methodological process of this research, including a summary of participants, procedure, analysis carried out. Kaupapa Māori informed the methodology of this research and data analysis involved reflexive thematic analysis with an inductive approach to coding.

Participants

Participants comprised 8 individuals; 4 female and 4 male. All participants were Māori Clinical Psychologists, had experience working with Māori clients and incorporated mātauranga into their practice. Participants varied in their own identities of Māori culture; had different abilities in Te Reo and comfort in their own competency of working with Māori. All participants had experience with building or maintaining relationships online whether that be in supervisory roles, at work or in their personal lives. Participants' roles are outlined in Table 1.

Table 1

Participants' roles and experience of VC therapy

Participant	Role	Experience with VC therapy
A	Teaching, private practice, researcher	A few sessions
B	Primary Health Organisation	None
C	Teaching, Clinician, researcher	A few sessions
D	Teaching, Clinician, researcher	Several sessions
E	Primary Health Organisation	A few sessions
F	Primary Health Organisation	None
G	Teaching, private practice	Several sessions
H	Teaching, private practice, researcher	None

Procedure

This study utilised purposeful and criterion-based sampling. The target sample was a non-clinical sample of Māori clinical psychologists who had experience conducting therapy with Māori clients. Māori psychologists who had experience working with Māori were the target sample because they would be more likely to understand the cultural context of both being Māori and working with Māori.

Participants were recruited through word of mouth and email distribution. Potential participants were emailed an information sheet (see Appendix A) with details of the study along with requirements for participation. It was stipulated that confidentiality and anonymity were guaranteed and that they could choose not to answer any questions. The study was conducted in compliance with ethical requirements, and written informed consent (see Appendix B) was obtained from all participants, who did so voluntarily before the interview commenced. Six interviews were conducted in-person and two were conducted via VC owing to location differences. All were audio-recorded and later transcribed by the researcher and no participants were personally identified in the report. Interviews ranged between 16 and 100 minutes and the average interview time was approximately 50 minutes long.

Analysis

Principles drawn from Kaupapa Māori research guided the topic of this project as well as the conduct of this research. The core of the research is to investigate the thoughts, perceptions and attitudes that Māori clinical psychologists have towards the utility of VC therapy with Māori clients to assess the feasibility of VC for Māori. This is important as VC therapy has the potential to overcome accessibility barriers which continue to disadvantage Māori. According to Smith

(2015), Māori have "a distinct knowledge tradition which lies outside of western views of knowledge. It is still located in a cultural framework and lived by real people" (p. 50). The current research, therefore, aimed to analyse this project through a lens of enhancing understanding of Māori perspectives.

Participants would need to draw from their own experiences being Māori and working with Māori clients and consider whether they believe it is feasible and appropriate to bring therapy to an online space with Māori clients. This seemed fitting with a qualitative approach and specifically semi-structured interviews to seek views on VC from key informants who have experience working with Māori clients. For this topic, qualitative research aligns suitably with Kaupapa Māori in that it involves gathering stories and gathering information from participants' own perspectives and experiences. Semi-structured interviews provided structure and ensured similar types of information could be gathered from each participant as well as they allowed flexibility and adaptability to get the story behind perceptions and attitudes and allowed room to probe for follow up questions.

Data analysis involved reflexive thematic analysis outlined by Braun and Clarke (2006, 2013) with an inductive approach to coding. Thematic analysis aims to find patterns of meaning across data. Inductive thematic analysis seemed appropriate because little research has been conducted on VC therapy specifically with Māori, so it enabled an openness to potential unknown patterns. Inductive thematic analysis also fits within a Kaupapa Māori scope because it involves drawing meaning from the data itself and not solely against existing theories, which opened up space for specifically Māori perspectives and not those confined to a non-Māori perspective paradigm.

The rigorous process of data analysis involved six specific phases: (1) *Familiarisation with the data,* which involved going through the transcripts and becoming familiar with the data; (2) *Coding*, which involved identifying important features of the data, coding the dataset and grouping codes; (3) *Generating initial themes*, which involved reviewing codes to identify broader potential themes and collating data into relevant theme; (4) *Reviewing themes*, which involved reviewing themes against the data and refining themes; (5) *Defining and naming themes,* which involved developing an analysis of each theme and naming each appropriately; and finally, (6) *Writing up the report*, which involved integrating the analysis and contextualising it against the existing literature.

Chapter Five: Results

This chapter states the findings from data analysis, including the five themes which emerged along with sub themes and codes.

The major themes that emerged from the data were

1. Accessibility
2. Safety
3. Therapy Space
4. Diverse Realities
5. Culturally Competent VC therapy with Māori

Each have sub-themes which are displayed in Table 2.

Table 2
Themes that emerged from thematic analysis of perceptions towards VC therapy

Theme	Sub theme	Code
Accessibility	Overcoming barriers	Geographical barriers Modern realities Mental health system Stigma
	The Changing World	The need for change
	Māori culture online	
Safety	Distance	
	Ending Sessions	Severity of Distress
	Loss of Information	
	Technology	Security Quality
	Cultural Safety	
Therapy Space	Physical space	Significance

		Therapy in the Home Community hubs Blended therapy Kānohi-ki-te-kānohi
	Therapeutic Relationship	Feasibility Loss of information Clinician Skill
	Existing space for Māori	Māori and Psychology Cultural Practices online
Diverse Realities	Personal Preferences	In-person versus VC Client and whānau preference
	Suitability	Individuals/ whānau Generations Therapists Areas/ Type of Distress Severity of Distress Type of therapy
Culturally Competent VC therapy with Māori	Feasibility	Evolving Māori culture Kānohi-ki-te-kānohi
	The Process Relationship Cultural safety Whānau Creativity	

Theme 1: Accessibility

Participants felt novel methods such as VC therapy would promote access to mental health services, as they would help to mitigate certain barriers that have prevented individuals from seeking help, including accessibility issues, stigma and the mental health system. On the major benefit of VC therapy, Participant F stated:

> "increasing accessibility, which from a Māori perspective is huge given we want to open the doors more for Māori"

Participant D also stated:

> "that people who wouldn't ordinarily be able to be seen can be seen."

VC therapy enables a form of visual communication between a therapist and client, which is an advantage compared with email and telephone sessions. Visual access is an important part of therapy for assessment as expressed emotions can be seen as well as for rapport and relationships building. Visual communication is culturally important for Māori. The visual nature of VC was felt to contribute to the potential for VC therapy success and consequently the potential to increase accessibility to mental health services. The importance of visual access is stated by Participant A:

> "It's essential to be able to have a visual, not just do it over the phone or email, being able to hear somebody's voice, see their face. Kānohi ki te kānohi is important for us as Māori whether it's in-person or over Skype."

Participant E similarly stated:

> "I think having somebody be seen on a screen would be more effective than over the phone. Being able to see someone's face changes the whole dynamic, me seeing them, them seeing you"

The Potential to Overcome Barriers

The major benefit identified by all participants was that VC therapy would increase accessibility to mental health services, especially for those who have geographical barriers that limit access to resources. Modern realities, stigma and some restrictions in the mental health system were also identified as barriers that might be overcome by VC therapy.

Geographical barriers. Geographical barriers hinder people's ability to access mental health services. According to participants, people outside of the main centres and in rural and remote areas are not able to access their services as readily as urban dwellers. The potential for VC to overcome geographical barriers was highlighted by Participants C, A and D who stated respectively:

> "I think much like social media it connects you across oceans. You have more access to more people, and it gives us access to people who don't always come into town."

> "Especially with geographical distance, it's important to be able to have this technology and I think a lot of the time people are isolated so it's even more important to be able to have this connection."

> "If you don't develop these technologies then people won't get seen. If you live in an urban area you're more likely to be seen. A lot of Māori live in rural smaller areas, things that are going to make it easier to access well-being services are going to be a benefit."

Another perceived benefit for clients is that despite the geographical distance, VC might be able to increase the possibility of a client being able to access a compatible therapist who is appropriate for their individual needs. Participant B felt there was the potential for:

> "…more psychologists available with different backgrounds, different skill sets, different approaches, likeabilities".

Not only was VC therapy thought to offer benefits to clients, but it was suggested that there may be tangible benefits for service providers. Examples were financial benefits and increasing the capacity of therapists to see more clients due to having more time available. Participant D proposed that:

> "VC cuts down on travel time. There's the ability to see more people…[it] cuts down the services cost as well [and]…there's not too much money going around for mental health."

Modern realities. The flexible and convenient nature of VC therapy was considered beneficial in current times where modern realities may restrict people's ability to attend services in-person. Examples of modern realities identified by participants included work, transport issues and family commitments. Participants G and A summarised respectively:

> "[VC therapies are] flexible, useful, convenient modes of interacting."

> "It's about fitting in with people's lives, people are busy and have all sorts of different responsibilities, they can't take time out of mahi. It's the modern world."

Socioeconomic and social determinants of health were factors thought to influence mental health seeking behaviours, including financial factors and compounding health conditions. Participant D suggested:

> "Money is often a difficulty and sometimes potential clients can't afford the travel, time off work and might not have transport."

The Mental Health System. The current state of the mental health system places barriers on some people's ability to receive help. As described above, participants have stated that resources are limited for mental health. Participant F suggested a benefit to VC could be temporary utilisation whilst an individual is waiting for in-person resources to become available.

Furthermore, particular thresholds must be met to receive help. There is also a lack of awareness for some around what services are available to them. Participant E summed up:

> "A lot of individuals or their whānau will bear the burden on their own. It's not until they reach a severe and a moderate to severe level that they will engage with a service and by then they have to be critical enough or acute enough to be accepted into secondary mental health."

Stigma. Stigma and self-stigma were also identified as barriers to access to mental health services.

Participant A stated:

> "Going to the building could be anxiety-provoking. Clients that I've worked with have said that mental health is seen as something that can be perceived as a weakness and the stuff around pride and not wanting to appear as not coping. Self-perceptions and psychological barriers are amplified if there are all sorts of other practical issues at the same time."

The Changing World.

Participants felt that change was inevitable because society and culture continue to change. They felt that VC therapy will become more common in the future to fit into the changing world and increase access to mental health care. To illustrate this,

Participant D stated:

> "For me, it seems inevitable that a lot of services will go that way. There are some quite dynamic changes happening in psychology. Within society really, seems to be there is an embracing of culture".

Participant E stated:

> “The resources are quite limited right across the board in terms of therapists, psychologists… so we have to be a bit broader in terms of how we approach the need”

Participant E said:

> “I think that’s probably the next step, we don’t have enough therapists in the world to be able to do what we need to do.

The Need for Change. Participants highlighted how Māori are not accessing treatment for mental health issues, how this needs to change and that addressing the need could entail the utilisation of novel methods of therapy in order to meet this need.

Participant H said:

> “I think with the need being there and going forward, it does make sense. It’s a new world you have to adapt and develop these protocols to fit the service that you’re providing.”

Participant E stated that:

> “Māori are under-represented in terms of accessing services, why not try something different. Every whānau has somebody who has a phone, we’ve got a whole population who have phones, so if we’re able to tap into that resource it just broadens the reach that we have.”

Participant A said:

> “And for Māori and doing it online: we have to be able to offer it as a tool, as an option for people and we have to be able to adjust our tikanga and the way that we work so that we are able to enact those things”.

Some participants stated that in some cases, some help such as via VC rather than in person is better than no help, for example, Participant E said:

> “Whānau have told us that something is better than nothing, even if it’s just somewhere where they can go and watch a video… It is more informative than them not having anything at all”

Accessing Culture Online. Māori culture has changed and adapted as access to modern technology has become more prevalent. Participants felt that many Māori access technology to engage with whānau and access cultural connections.

According to Participant D:

> “Māori are not stagnant, we’ve never been stagnant people, they’ve always adapted in some cases had to, not through choice”

Participant A stated:

> “Historically Māori have been quick to grasp technology from the beginning way back to the times when reading and writing was introduced in New Zealand. Māori grasped that really quickly and I think it’s the same with technology, and if I think about rangatahi and how they are they on their phones all the time.”

Participants identified changes to cultural practices as well as the challenges that technology has had on Māori culture and the relationship between Māori culture and technology.

Participant H said:

> “I think there’ll always be tensions there in terms of the different place that Māori may have”

Participant D wondered:

> “How much tikanga would be lost in adapting to that, much like anything that we’ve adapted to, we’ve lost our tikanga along the way because we’ve adapted to this”

Along with tangihanga being streamed online, participants mentioned other examples of how culture is being practised. For example, Participant D stated that:

> “Iwi have their own pages so people can learn at a distance, more accessibility.”

Participant E said:

> "Online learning is everywhere as well. People have access to information all over the show, so I think we need to be adaptable. Māori wānanga via VC have been very effective, the message is still having the impact. I think there's still the variable of being in the room at the time, which I don't think could ever be replaced."

Theme 2: Safety

Safety was the major concern participants had about VC therapy as a primary mode of therapy. Safety concerns identified were geographical distance, the ability to end sessions more readily than in person, loss of information that contributes to the assessment process, type and severity of distress and cultural safety.

Distance

Working with a client via VC from a different geographical area would present issues of safety, as it diminishes the ability to influence the therapeutic situation. Participants felt that if a safety risk did present, they could influence and deescalate a situation more easily in-person than via VC, particularly if the client was in a more remote area. Local connections are important and could include service providers, iwi, or negotiating with the client who could provide social support for them, such as whānau or friends. Some examples of statements that demonstrate this concern include those by Participants A, D and G respectively:

> "Risk and safety: those things need to be negotiated because if I'm doing therapy with somebody at a distance and I had some risk concerns, I'd need to be sure that I had an idea of what the services were in that area because that comes up along"

> "If you're going to be working at a distance with somebody there then you probably need to have some connections with the local services and some of the more rural areas usually have limited mental health services. I think time and distance is the barrier and how long is it going to take for somebody to be seen. Connect with local services, local iwi, and try and get somebody else involved: a support person could be family could be friends, making a plan around working with them"

> "Negotiating with them who are some of the other people in their lives that they can lean on in vulnerable times of their lives and then, creating the space to have that conversation with them so that you together can negotiate what the next steps might be" (Participant G).

Software Security. A couple of participants mentioned their concerns about the security of therapy via VC in terms of the safety of third party software, including data tracking and data sovereignty of Māori. This is summed up by Participant A:

> "That whole argument around data sovereignty for Māori comes in here, especially if there's no guarantee that that platform is secure. It is up to us as therapists to uphold that because our clients are the ones in the vulnerable position, it's their information and their privacy and the kōrero is tapu to them. I think we need to really think about that."

Ending Sessions.

At times therapy can expose people to uncomfortable feelings and part of the constructive therapy process is working through those difficult feelings. All participants had strong concerns about the ability to close the screen and end the session abruptly much more easily than they would be able to walk out of a clinic or therapy room. This also demonstrates the concern about not being able to control the situation of VC therapy as readily as in person. Participants felt there was potential for clients to feel empowered and have more autonomy over the session and questions around risk could still be asked. Equally, there is potential for clients to end the session

abruptly if they become uncomfortable, which consequently reinforces avoidance behaviour. This issue might be particularly relevant to youth or those with impulsive tendencies. The following are some examples of statements from Participants that highlight this concern:

According to Participant B:

> "Although clients can walk out of our rooms and can tell us to leave home visits, I think it would be easier to close things down. I think it is empowering to be able to do that. The downside is that it is reinforcing avoidance quite well, particularly if they're impulsive. People tend to avoid uncomfortable stuff and I guess one of the benefits is that sometimes it's good that we can't just get up and walk out because we should learn to sit with some of that discomfort."

Participant C stated:

> "Our role is to help clients to deal better with all of the things that are helping them feel unwell so often that means triggering things. A computer makes that more difficult I have to be careful what I trigger and how I trigger it just in case it sets them off and they go well I'm going to go kill myself. If I'm in the room with them that's different, I can stop it. Whereas if there's a screen between us they have more ability to become avoidant."

Similarly, Participant D stated:

> "Part of seeing somebody is that exposure to your own thoughts and feelings regardless and people can have difficulty with that and one of the biggest difficulties we find around that is plain avoidance. People are human beings and uncomfortable thoughts and emotions make them uncomfortable. There's the ability to avoid but if people feel uncomfortable they can take time out."

Participant H suggested:

> "A young person may not have the verbal skills to acknowledge that they're getting frustrated, hōhā (annoyed) with the process so I'm sort of tuned in to their body language whereas via a screen they might get angry and just shut the screen."

Loss of information.

All participants felt that therapy via VC would result in a loss of important information, particularly the loss of important points of assessment they are used to having during in-person experiences of therapy. Ultimately, they felt they would lose access to the whole person including subtle body language, aspects of their appearance and how they might interact with the environment around them. Participants felt they might only have a depiction of clients and not the complete picture.

Participant G summed up:

> "There are certain I guess assessment points or data points that you can identify in person that you might not necessarily be able to find online, body language".

Participant H felt:

> "There might be a few things that you might miss; you can get a sense of their appearance but I still think, depending on the quality, you're getting a representation of someone"

Participant D said:

> "Sometimes what you see on the screen is just a face you don't actually see the body or what's happening around the person or the way they interact with the environment. You might not see the rest of the person so you would lose that information."

Areas/ Type of Distress.

Some areas of distress were considered more suitable for VC therapy, mainly due to safety concerns. Social anxiety was suggested as an area that VC therapy might be suitable, along with lower-end disorders. Those who are housebound with both physical and mental difficulties also might particularly benefit from VC therapy. Participants had concerns about VC therapy for some areas of distress including trauma and high-risk issues, drug abuse, and higher-end disorders.

Participant F felt, for Māori:

> "I think it might be dependent, might be lower-end stuff maybe more CBT"

Participant F said:

> "I wonder about trauma, what it's like for people, again them dissociating, you might miss those cues if people are finding it quite hard or quite tough and then when people are upset in the room. Other areas include care and protection stuff, sexual abuse"

Participant D had concerns about:

> "The higher-end disorders as well, mental health or poor well-being: schizophrenia and psychotic disorders"

Severity of distress. Overall, participants felt VC interventions were most appropriate for providing psychoeducation, for those at the early intervention stage, for mild to moderate levels of distress or as an intermediary step whilst someone was waiting for in-person treatment. All participants had strong concerns about working via VC with clients in high distress or crisis because of the safety issues this would present.

Participant B stated:

> "I do think it would be a good starting point to be able to get some of that more psychoeducation in a comfortable place when you're feeling more active and you're able again to be able to process more."

Participant E stated:

> "I think that teletherapy does have its place, I think there are individuals who just may need somebody to talk to and have themselves be heard. I think that's the value of e-therapy, that early mild stage. It might be just some introduction of behavioural changes or different ways of thinking. Being able to educate the population so that we start to stem the tide of those who come into mild to moderate services which will then stem the tide of those going into the secondary."

Participant B had reservations about working with:

> "…anyone in crisis, with low mood they're much more likely to report suicidal thoughts."

Participant E stated:

> "I think if we were to do teletherapy in terms of the more moderate to severe individuals I'm not sure that that would be effective enough, or safe enough."

Though all participants had concerns about areas and severity of distress, many thought that anything was possible. Participant G stated:

> "With mild to moderate, more complex stuff, I still think can be achieved online but they would probably require some support mechanisms, perhaps a health practitioner at that end"

Moreover, anyone in any area of distress could be tipped over the edge depending on their stressors, because according to Participant D:

> "…anything is possible with any disorder."

Participants concluded that adjustment would need to happen to incorporate VC appropriately into mental health care by having stringent plans and protocols in place. Processes regarding risk assessment, management and safety would need to be established, along with considerations for individual situations and local supports. Participant H summed it up:

> We've got to develop risk protocols specifically around assessing safety: verbally, run through your risk questions but from there, knowing who the psychologist can follow up with whether it's the GP, the practise nurse and I think it depends on your clientele."

Cultural Safety

Participants were concerned about the implications of VC therapy for cultural safety. There are protocols carried out in person that promote cultural connection, and participants felt this might be difficult to achieve online. Concerns were also about wairuatanga and the sharing

of sensitive cultural information online, such as whakapapa, and how to do this in safely. For example, Participant G stated:

> "There are safety issues particularly in the way of cultural safety, people sharing information about whakapapa online. There's no telling what kinds of transgressions are occurring when you're doing that. Just being mindful of those types of tapu and noa, elements that I would say are often missed on that platform."

Theme 3: Therapy Space

The overall theme of space was further split into three meanings, which form the sub-themes. The first is the physical space where the therapy occurs; the second is the metaphorical space where the therapy occurs, which represents the space between client and therapist where the therapeutic relationship exists; and the third is the existing space for Māori, which represents the relationship Māori have with psychology.

Physical Space

Importance. Participants emphasised the importance of the physical space for enhancing a client's comfort during a session. In addition to the physical environment, the therapy space between the therapist and the client needs to be safe so clients can feel comfortable and understood.

Therapy in the Home. Participants felt that providing therapeutic interventions via VC would be beneficial as it would enable clients to be in their own homes, which might promote client comfort as they are in a familiar environment. This was thought to be particularly beneficial for those clients who struggle with anxiety, especially social anxiety. Regarding the comfort of the home environment, Participants B and A stated respectively:

> “You’re in your home, a comfortable environment and if you are more comfortable you’re more likely to take in more information and process it rather than stressing out about the new environment. Online stuff is beneficial at the start because it takes that whole barrier away”

> “The environment is really important… I think one of the advantages of it is I can be in my own home, is somewhere that is a nice environment and still get that input.”

As reported above, a client experiencing a VC therapy session in their own home can be perceived to be comforting for the client, but equally, some questioned how therapeutic those sessions might be given that they are in their usual environment. As this is a non-controlled space, distractions may occur and the mindset shifts potentially required to engage in therapy might be difficult to achieve. Questions, therefore, remain about how to bring psychology into the home as posed by Participant B:

> “How do you bring psychology into the home? There is still a shift in environment, how do you control for it, whether there is a place to talk and people being around or not”

Distractions. Potential distractions in the home could affect the quality of the therapeutic space, which might not factor during in-person, clinic sessions. With that said, distractions can occur online, during home visits and in-person therapy. Distractions have implications for the ability to control the therapeutic space.

Participant A said

> “If the client or the therapist is not in a private space so for example if the client was at home and they had people interrupting or coming in or they couldn’t fully have a private spot”.

Participant D said there are:

> "…interruptions online and in person, you can only so much".

Controlling the Space. The idea arose that you cannot control the physical space from a distance, whereas in person you can control the physical therapy space. The space might not contribute to a therapeutic environment.

Participant A stated:

> "If I was doing a session on VC, I have control over my environment I can make it nice. But then whoever I'm working with, the most private place they could go might not be therapeutic. The environment needs to be something that's containing."

Participant B questioned:

> "That idea of bringing psychology into a normal space, it can be quite hard… a non-controlled space"

Mindset Shifts/ Engagement. Sometimes a mindset shift is required to engage in therapy. Participants wondered how effective it would be to engage in therapy with someone who was in their own home. They questioned whether clients would be able to shift their mindset to the therapy space as they could in a clinical setting because they are in their own space. Being in their own space might have implications for their ability to engage in therapy. Whilst it might promote client comfort, some suggested that the process of getting out to therapy was part of the therapeutic process itself. Some examples of perspectives on engagement and mindset follow.

Participant E said:

> "Whānau live their lives so what we have to be aware of is that they're at home, they're still living their lives, we haven't got a clinical setting where they can distance themselves from that and be fully engaged in the process."

Participant B mentioned:

> "For the client to switch focus into that space, there's pros and cons. Yes it's comfortable but on the other hand, it's their normal routine so it's not necessarily making them think outside or differently"

Regarding getting out as part of the therapeutic process, Participant B stated:

> "What happens with the actual getting out of the house as part of the therapy and making a move out? At some point, they still have to go out and see people"

Technology. VC therapy relies on people's ability to have access to the technology suitable for VC, and an internet connection. People might not have access to suitable technology and socioeconomic factors could therefore limit access to VC therapy. There might also be a lack of awareness around technology and what technology is required. The technology itself would have to enable a high standard of visual communication, including no lag, a good sound system and a camera that enables sufficient light. Participants also had concerns about the internet connection being faulty, especially in remote areas.

Participant D felt:

> "Access to technology is important. Most people have a phone now; that doesn't mean they necessarily have internet"

Community Hubs. Community hubs were suggested by some participants as a means to mitigate some of the barriers to VC therapy, including technological barriers and concerns about the physical space discussed above. Participants had some concerns about community spaces as VC hubs.

Pros. If a client's home is not suitable for the various reasons mentioned above, they can still benefit from the features of VC therapy without needing the technology themselves, as they can rely on the service to provide the technology.

Participant A summed up:

> "If people weren't able to find a suitable space at home or they didn't want to do a session at home and they wanted to go to a hub I think that could work"

Participant D said:

> "You could also look at the ability of other services in the community to provide the technology, so you might have almost like satellite services."

Cons. Participants suggested that hub services would require a lot of set up. Steps would need to be made to ensure that sessions are secure, including potentially requiring a healthcare professional at the site, so no one could overhear the session as that would negatively affect the client. Health care and mental health care can have differences, which might impact the quality of the service provided if it is in a health care service location. Furthermore, there might still be the same barriers as going to in-person therapy.

Participant C outlined:

> "The health services need to understand the protocol by which we work, have respect for someone's privacy and the knowledge that they might share may be trauma-based. There's a whole range of difficulties. They would have to provide space for it they also have to provide somebody who is there all the time so that if a safety issue comes up they can deal with it because we're dealing with people who are on the edge."

Participant B stated:

> "Typical barriers are still present, there's still that approaching service. Being able to get to that space, practical things like a car and childcare and psychological barriers."

Blended Therapy. Some participants had concerns about conducting therapy sessions entirely through VC and felt it would be prudent to facilitate an in-person session, at least initially, and then proceed with VC sessions if appropriate. This would enable them to meet kānohi-ki-te-kānohi, which allows the cultural exchange of information and helps to build connections that could then be built upon in an online capacity.

Regarding blended therapy, Participant H stated:

> "If I could meet with them face to face, kānohi-ki-te-kānohi in a room, I think for me that would be a good initial step and then from there I would feel more comfortable if we wanted to catch up via Skype"

Participant F also highlighted the value for relationship building of an initial in-person session:

> "I've had a philosophy, first of all, I need to meet them first face-to-face and have the time to touch and connect. Once you have established that physical kānohi-ki-te-kānohi connection, because of the realities, if they are comfortable with online, to go from there."

Kānohi-ki-te-kānohi. All participants reflected that in person, kānohi-ki-te-kānohi is highly valued in Māori culture, and is more authentic in person than seeing someone through a screen. Participants felt that there would be more access to the person compared with a VC mediated session and identified particularly important phenomena including whakapapa, wairua, āhua, mauri, physical vibes, nuances, subtle body language and touch as aspects of kānohi-ki-te-kānohi, which broadens and enhances the connection between people. It was felt that a screen would diminish these experiences and thus result in a loss of information for building connections and for assessments. Kānohi-ki-te-kānohi was felt to be a more real and tangible experience, which they felt would not be able to replicate online.

Participant C stated:

> "I do think because of what's not seen and the whakapapa that you bring into the room with you and so those things are what I read and what I connect with it's hard to do that through a screen… the fact that I can see you I can feel you and I can touch you means that I have a lot more access to you as a whole person rather than a screen that blocks me from some of that."

Participant F felt:

> "It's about the tikanga of seeing people it's also about the connection but it's also about the cues being able to see somebody and Māori often talk about the āhua of a person so you can walk into a room and that can be a heaviness a vibe that you can use. I just think it's probably so much stronger face-to-face. That energy: āhua, mauri, wairua. You still pick up uncomfortable vibes online and I'm speculating that will be easier for me to do that in the room, especially the subtle stuff."

Participant H stated that:

> "There's a whole lot of tikanga behind what face to face is about in terms of experiencing someone's mauri, room, āhua. I guess we don't know what we don't know in terms of how do people experience that online. Other differences for Māori: I think some of the unsaid things like body language, I think it's difficult to pick that up on screen, to sense their mauri, their āhua, I think being in the room you can get a sense of where their emotions are at as well, get a sense of their presence, body language, again depending on what you get to see some of that is cut off. You don't get to see what's happening with their hands, are they fidgeting, is there movement happening"

Participants mentioned that there were little things taken for granted about being physically present with a client, including the ability to offer a cup of tea to help them to feel comfortable, and from a Māori perspective offering a cup of tea was said to be a reflection of manaakitanga. The client is in a vulnerable position, therefore they need to feel comfortable to engage with the therapist, so a few participants stated that the client might need to see them in person to decide if they feel comfortable working with them.

Participant F stated:

> I think you can never replace that physical which is very important for Māori”.

According to Participant D:

> “The tikanga is around kānohi ki te kānohi tuatahi (first), and being able to meet somebody in person and it’s not just about me meeting them it’s about them meeting me which is the more important part so they have to feel comfortable. We can mihi, we can talk about who we are and they can decide if I’m a safe person or not to work with them.”

Participant C particularly highlighted wairuatanga and connection:

> “That is a lot deeper for me because it’s about all the unseen stuff as well. Because if I can’t appease the spirit then that person’s going to leave so I communicate with everything that’s in the room. I will connect with some of the things that their spirit knows.”

Therapeutic Relationship

Feasibility. Most participants perceived that a meaningful relationship, connection and therapeutic alliance could be built online provided the therapist is genuine and upholds appropriate tikanga. Overall, they felt that it would b easier and faster to build a relationship in person. The following are some examples of comments on the feasibility of building the therapeutic relationship online.

Participant B stated:

> “I think it still would be able to be achieved, and rapport can be built in a split second or over a longer period. It is all about whanaungatanga and how you do that and that is a skill that is within a clinician. Face to face might maybe increase the chances of that but I don’t think it’s that that’s the active ingredient I think actually the skills within the person.”

According to Participant D:

> "I think you can still build a connection online I don't think there's any doubt about that in terms of the quality of the connection there's nothing quite like face-to-face when you first meet someone but if that's not an option you can still make a connection over the airwaves. I think it would take a little bit longer to make the connection and also to get a better understanding of them because I don't have those other cues around me as well all the other information. I think it's partly because you almost get set in your ways

Participant G stated:

> "Well there's always something about face-to-face, in person, you know the nuances, the kind of wairua of the engagement that you will never be able to duplicate in a video conference setting, but that aside you can still establish good rapport and relationship through videoconference, provided that the intent is genuine and you still undertake a good tikanga."

Loss of Information. As discussed above, whilst many participants felt that VC therapy in the home would promote comfort for the client, others felt that certain aspects could be lost via VC therapy that could potentially impact the relationship-building process, including helping the client to feel comfortable.

Participant E stated:

> "You're just able to form a better relationship when you're talking with someone face to face, you're able to pick up on little mannerisms, you're able to identify whether or not what you're saying is resonating with the individual. There's all those kind of behaviours that an individual will give you. And you can be guided by the little behavioural changes."

Clinician Skill. There were some opinions that clinicians might need to draw on their skills to make the space work and to perhaps utilise their skills differently to compensate for the lack of in-person communication. For example, therapists would need to be more aware as clients could hide more. Therapists would need to be solid in their practice and perhaps a bit more creative in how they interact and conduct interventions over VC. What follows are

statements that highlight how the participants might need to change their interactions to suit a VC mode.

Participant F stated that:

> "I do think it's based on the skill of the therapist to connect with the person."

According to Participant A:

> "If I was just doing therapy with someone face-to-face, I think that they would be able to pick up on a lot more: wairua and mauri and I could also connect to that a lot more in person. I think online I would probably need to put more effort into that, especially initially because there are things we take for granted that we do in person. It might even be something as simple as offering a cup of tea. If I was going in to do some more in-depth work, talking about deep emotions, I might need to be considerate of how I use my voice and my reo to soothe that person, leaning in more, using what I've got within myself like my reo and my āhua. Explaining more as we're going rather than the body language that we take for granted when we do those interactions in person."

Participant G said:

> "I just think that comes down to ensuring good tikanga, good practice, good protocol and that everyone is aware of what the protocol is. The other part to tikanga is just ensuring that we're respectful of relationships and paying more attention where possible to the nuances that might be missed."

Some participants thought that spending time to establish a strong therapeutic relationship, negotiating a strong tikanga or process, and seeking regular feedback from the client, might help to mitigate the safety concern of ending sessions abruptly when they are uncomfortable or not getting what they want from a session.

Participant E stated:

> "I think the key is in the engagement process so if you have an open and honest relationship then they'll tell you before it's going to happen that they're feeling uncomfortable and then it's what will you do with that information afterwards I think that will determine what the outcome will be It's around listening to what it is they want to be helped with, what they have available and what you can do to support them, to get the help they need"

Participant G similarly stated:

> "Tikanga is really important, you establish some of the ground rules and protocols, one of which might be we don't shut down before its time. And you would check multiple times throughout the process but most importantly at the end about how they're feeling and also did they get what they needed in the session. That check-in point at the end is quite crucial because that determines whether the person comes back or not".

Existing therapy space for Māori

Māori and Psychology. As discussed above, participants highlighted the need for change as there is a deficiency in Māori access to mental health services. Some participants mentioned that a reason for this is that Māori have a fraught relationship with psychology and existing clinics, and therapy spaces have not been welcoming or safe for Māori clients. There was felt to be a fear amongst Māori of not being heard and their problems not considered appropriately. There is a fundamental issue with how Māori have been treated in mental health care, without consideration for culture and connection.

Participant D stated:

> "It can be uncomfortable coming into a service, they might not feel completely safe or they might be apprehensive about coming. Sometimes they're not the most welcoming of places, especially Māori who often have that sense of apprehension around those sorts of services."

Participant B summarised:

> "At the current point, what we do, would be able to be transferred but what we do is not necessarily that ideal (for Māori) and that a lot of that would come back down to clinician competence."

Some examples follow of perspectives about Māori and the therapy space, which reflect the wider issues relevant to the relationship between Māori and mental health services.

According to Participant C:

> "Māori are suspicious of psychologists and they should be. We still don't get Māori through the door the way we should so, some of that is because of the ongoing racial interactions some of it, unknown, but mostly because of the blindness to the fact that the space doesn't look like a cultural space. Māori are scared of what the space represents and often when Māori go to see health people, they're marginalised. The connectedness, the conversations that occur: they're abrupt, they don't connect, there's this whole process of pōwhiri that has to happen first, that can be a quick process. Adjustment needs to happen."

Participant D also stated:

> "Māori do have that tendency to distrust around mental health services and I sometimes it's about the stereotypes and the mistrust and the poor research has led to a general mistrust in psychology."

Theme 4: Diverse Realities

All participants had different experiences and perceptions of VC. Participants also highlighted how clients have different experiences and how Māori experience diverse realities. These factors contribute to the theme of diverse realities, with sub-themes of personal preference for VC compared with in-person and suitability of VC. The suitability of VC varies for individuals and therapists, as well as areas of distress and type of therapy.

Personal Preferences

In-person versus VC. Overall, participants were open to using VC as a medium for therapy. Many participants said they would feel comfortable working with a client via VC if they felt it was appropriate, felt they could achieve a connection with clients and make the interaction meaningful. Participants acknowledged the limitations on people's ability to access services and

consequently the need for different methods to overcome accessibility barriers. Despite this, overall personal preferences were for in-person therapy over VC therapy for various reasons. Some examples of personal preferences for in-person therapy were cultural reasons, including the importance of kānohi-ki-te-kānohi and simply years of in-person therapy experience and lack of experience with VC therapy.

Participant A stated that they would be open to it:

> "If it's something that I consider appropriate therapy referral and for people who are presenting with issues that work in the area that I had some expertise or competence in. For me, ideally, it would be face-to-face but I think the reality is in our modern lives it's not always possible".

Participant C felt stated that:

> "It would not replace physical contact for me, it would be a situation I would use if physical contact wasn't available. I wouldn't use it as a primary mode of therapy. I haven't done it so there's a possibility that if I do VC then it will change over time, like anything but in my head, at the moment it just doesn't make sense for me".

Participant D felt that it was:

> "Not my preference but it definitely helped. We can still make the process meaningful and give them the power to control how they would like things to go and what they want to talk about. I think you can still make a connection with somebody online. It's just about degrees of preference about what I would like to do. The way I've been brought up if you want to get to know someone you go and meet them rather than over the phone so you can make more of a connection and that can come down to upbringing culture."

Participant F said:

> "I'm probably edging towards more of the old school even in terms of my own preference. I think it's a little bit cultural but I've also been a therapist for a long time now, over 20 years been working with people, so I think it's just more natural, ingrained"

Client And Whānau Preference. Others stated that despite their preferences, ultimately their priority was for what the client or whānau would like and felt that those factors should instead guide the treatment mode rather than how the therapist may feel about VC. This reflects how the treatment should be individual and whānau centred.

Participant A said:

> "My first position would be whatever works for the person".

Participant E stated:

> "It's about what is most applicable to the individual sitting across from me or sitting on the other side of the screen. If that's what they need and that's going to give them access to the support that they need there and then sure"

Participant F said:

> "Our services should be whānau driven like what is it that our whānau need, would they be happy to do that if that meant they could be seen sooner."

Suitability

Individuals/ Whānau. All participants thought that due to diverse realities, different individuals and whānau might be better suited to and have different preferences for VC therapy than others. A couple of participants felt therapy might be a new experience for some clients, especially Māori, so they might need to be face to face to build trust.

Participant H said:

> "It may be more pertinent to certain groups. I do some work with youth justice system so I would probably be thinking that I wouldn't get very far with a teletherapy".

Participant B stated:

> "I think seeing people in person is more helpful for some people. It depends on the person. We need as many different things out there because there are so many different people."

Participant A summed up that some individuals might have different requirements:

> "In some cases, it is good to be able to do those practices like a pōwhiri like a whakatau and have kai and kapu tī and all of those kinds of things."

An important statement by Participant C was:

> "While I'm saying I need to see them, they need to see me as well. I'm probably more versed in being able to see them than they are in seeing me. So I could do it through technology but they may not."

Participant F suggested that perhaps individual factors including the motivation for seeking treatment would be a factor in individual suitability to VC therapy:

> "Those that have been forced to see someone versus someone that want help right now and is keen, motivated. I think variables of who, what, why would be important."

Generations. Participants suggested that perhaps VC therapy might be better suited to younger generations and perhaps less suited to kaumātua, kuia who might be hesitant to engage due to cultural reasons, lack of trust, or lack of interest or skill in technology. Although there was some concern about keeping the attention of youth, online.

Participants F felt that:

> "It might be the younger generation who are used to being on the phones compared to our kaumātua, kuia"

On the other hand, Participant H had concerns about youth:

> "I do a lot of work with rangatahi and I would be probably concerned about how they keep their attention. It may mean that a typical 50-minute session might only be 20, 30 minutes".

Participant C said:

> "If you think about outlying areas and kaumātua who may or may not know what that is, they're less likely to engage in it unless its someone they trust. If that person says this will be good for you then they'll do it. It's probably more for the millennials, the 90s, generation Z, those generations that would sit with, for our kaumātua and kuia, face-to-face."

Therapists. As with individuals being better suited to VC therapy than others, participants suggested different therapists would be more suited to working with clients via VC than others. Furthermore, participants suggested that it might be more appropriate and safe for VC therapy to be conducted by more experienced clinicians.

Participant F stated:

> "Maybe the mana of who is providing [therapy] could be a factor in whether Māori are more likely to be on board."

Participant C stated:

> "I guess the more experience you have the better you become at it. It takes experience to be able to see all of the different elements that can come out in therapy, so then I'm aware of that I'm a lot more able to deal with it or before I get to the point where I think it's going to be too much for the client.That's one of the difficulties I guess, do you start with an online therapeutic process that only senior clinicians have access to?"

Type of Therapy. Some participants felt that VC might be better suited to particular individual-based therapies such as CBT, and concerns were raised about the practicalities for whānau-based therapies. Perhaps whānau therapy would be hard to facilitate with competing attentions and distractions, and consequently, there is potential for people to disengage.

Participant F felt:

> "It might be dependent on the type of therapy, I'm not sure about how easy it would be for whānau therapy sessions."

Participant H said:

> "That's another interesting dynamic like how would it work, teletherapy for the whānau, whānau in the room, on the other side of the screen."

Participant A stated that VC therapy was:

> "A little bit more individually based so while I don't think there are the barriers of lots of whānau there it's just a little bit more clunky or artificial."

Theme 5: Culturally Competent VC Therapy with Māori

Being Māori clinical psychologists, participants were able to advise about the feasibility of VC therapy with Māori, as well as working with Māori via VC. Sub-themes that emerged included the process of VC therapy, considerations for building a relationship, diverse realities and whānau involvement and finally, adaptability.

Participants discussed the evolving nature of Māori culture and the relationship that Māori have with technology as evidence for the potential feasibility of VC therapy with Māori. Kānohi-ki-te-kānohi was identified as a significant element of Māori culture, and questions remain about the feasibility of VC in the absence of kānohi-ki-te-kānohi. With that said, participants felt it might be possible to implement some practices online in culturally appropriate ways.

Many clients have had negative experiences with healthcare professionals, therefore participants suggested work needed to be done around how these technologies might meet the needs of Māori and how these technologies could be meaningful for Māori. Participants felt that VC would be compatible with some important Māori cultural processes. For example, Participant B felt:

> "Karakia, making the space safe, whanaungatanga and manaakitanga, I think all of that can still be transferred through VC."

Participant F thought that a benefit of VC therapy for Māori could be to connect scattered whānau in a group session despite geographical differences, rather than having to wait for all whānau to be in the same physical place. Participant F stated:

> "We could increase the opportunity for whānau healing through technology."

The Process

Some elements need to be negotiated at the beginning to ensure effective online therapy. Overall, participants felt that the process of online therapy needs to be thorough, including negotiating with clients about this modality and their readiness to engage with the process. They felt it was important for clients to have empowerment, to advise how they would like the process to go, and checking for any concerns so that the space and tikanga are safe. Participants also felt it was important for therapists to have a solid tikanga themselves, to competently conduct therapy via VC, including the use of the pōwhiri process as well as other important processes for Māori. Participants felt that they would need to try and uphold the processes from in-person therapy as best they can in an online space, including the use of Māori models as well as whanaungatanga, mihimihi and karakia. They emphasised the importance of seeking guidance and cultural supervision where necessary to ensure cultural competency.

Participant G highlighted the importance of tikanga or protocol and summarised an ideal process:

> "Don't shy away from technology, it's often used as a barrier when it's just a competency thing. Ensuring that you've got really solid protocol, tikanga for the way you undertake those particular kinds of interactions online: You have karakia, agenda, kaupapa, and whakawhanaungatanga, mihimihi if need be and wrapping it up with some kind of final comments.

Participants highlighted the importance of setting up VC therapy appropriately, for example, Participant A said it is important to have a:

> "…discussion about doing it like this, and if they had any concerns, questions about security and having a good environment. We need to be solid in our practice so that we can make sure that it's safe for the person in this environment."

Participant D stated:

> "Because there's still a process and it's up to the person to how they want to guide that process. The space that belongs to them so they would still be giving over that ability to have a process that meets their needs. You still have your own processes but it's about being upfront with them so they can consent to a process that's going to unfold. The process is about empowering somebody and trying to replicate as much of what you would do in a room with somebody as you would online with somebody."

Participant C said it is important to ensure that:

> "…the elements of the pōwhiri are used and being able to listen to someone so the space in between us becomes smaller and smaller and ensuring that they feel comfortable. Ensuring that their space is safe, their whakapapa isn't diminished."

Participant E summarised:

> "Karakia is to create a safe space so of course, we can have tikanga to a point and we can have karakia, obviously the non-wavering stuff would be around risk, their wellbeing and safety. Just do what we do naturally, be respectful, open and honest, manaakitanga, tautoko, thinking about rangatiratanga. Whatever the client would like to address is what I believe should guide the process and intervention and the time. If it's something that I don't have much experience with, get some guidance around that; you could bring in kaumātua, kuia, tohunga. If we're too rigid in the therapeutic space what will happen is that we might lose them because we're not adaptable, they're not getting what they feel they need to, being able to create a space of positive feedback or focused informed feedback."

The Relationship

Every participant reflected that because the therapeutic relationship is very important in therapy, especially with Māori clients, the need for whanaungatanga and the value of rapport building is fundamental. Consequently, a large part of the initial interaction should be focused on whanaungatanga and thinking about what is important to this person and their tikanga. For example, Participant H said:

> "Good whanaungatanga would be important and maybe the majority of the first appointment might be just about me trying to get to know the client, who they are and their background, whānau connections"

Participant G said:

> "It is whakawhanaungatanga but it's also about ensuring that you value the importance of rapport building and relationships just as much through that component as you would in person, so dedicating and committing a large proportion of the clinical time to the whakawhanaungatanga just ensures that the whānau get the best benefit and outcome they can through that mode."

The relationship was thought to be so important that it would contribute to creating a safe space and help to manage risk. Participant G highlighted the importance of the therapeutic relationship for managing risk:

> "If they do disclose some kind of safety issue how you would mitigate that from a distance, so I've had those on a couple of occasions and what it often comes back to is the power of the relationship"

Participant E similarly stated:

> "Hopefully the therapeutic alliance that you've got with the individual then is quite strong that they'll trust in what it is you're trying to achieve and how you're going to achieve it"

Whānau. Considerations should be put into whānau involvement in the therapy process because according to Participant F:

> "If we're trying to work with Māori we've got to stop thinking individualised."

Participants highlighted the importance of whānau relationships and how they will always encourage Māori clients to focus on their relational wellbeing. Furthermore, they outlined how important it is to encourage whānau to be part of the whole therapy process. This also serves to enhance the safety of therapy from a distance.

Participant E emphasised the importance of whānau for Māori clients:

> "Whānau connectedness or engagement or socialisation are really important in terms of the treatment plan. We put the whānau at the centre of everything. We are guided by what the whānau determine as being the goals for their wellbeing or what they want to address and at times, as psychologists, we can be focused on what we believe we need to focus on in the therapeutic space and that can push us away from what the whānau need."

Participant A stated:

> "If you're going to do any wairua type work it's always good to have whānau available to talk. You negotiate that with the person, having those structures in place."

Adaptability

To compensate for the lack of kānohi-ki-te-kānohi, participants suggested that therapists could get creative in their interactions and processes when working with clients via VC. Participants felt it was about thinking about the processes usually conducted in the physical space and how they could honour those in a VC environment. Participant F gave some examples of how they might creatively enhance the connection in the absence of valuable, in-person interactions:

> "You could create a ritual that addresses that in someway maybe by acknowledging an atua about technology or through karakia and you let them know, hey when I did this karakia or this whakatauki: it was acknowledging this is a new way of therapy for us but it doesn't demean the mana or the potential for

> healing to occur and keep them connected to it. Maybe create a ritual when you sit down, saying right have you got your cup of tea ready or ensuring after the session you have a cup of tea to whakanoa yourself as we've talked about a lot of heavy stuff. I've been able to do a mindfulness exercise where you're both breathing as we think about the hongi, the breathing of the same breath."

Participants felt that therapists would need adaptability to deal with new phenomena as they arise, so they can have the competency to meet the needs of clients. The incorporation of technology into new environments is underpinned by the tension between culture and technology. Māori are embracing technology and participants felt that therapists would need the competency to work with these individuals so that they could get the care they need. Ideas surfaced about being creative to adapt customs to fit the online space. There was some fear however about the potential to lose important cultural elements, for example, Participant C stated:

> "Tikanga is important and the issue for me is that we're always adjusting to Western ways of doing things and we lose things every time we do that."

Participant G stated:

> "I think there are certainly some traditionalists and traditional views that still exist and I think there's still a place for that and they need to be valued. I also think there is a generation of Māori that are embracing technologies more than ever before. It's the responsibility of the clinician to ensure that they've got the competencies to meet them."

Participant D similarly stated:

> "I think there's ideal versus pragmatism and I think we live in a world that is constantly changing and Māori have constantly had to change in order to adapt. If you can kānohi-ki-te-kānohi, there's a tikanga there, it's the ideal. But if I can't do this, then what can I do."

The process of adjusting to new technologies is an ongoing process for Māori and for Māori therapists. For example, Participant A stated:

> "As Māori, we are trying to figure out how we can uphold those principles like whakamanawa and acknowledging tapu and moving into noa in a way that is appropriate and genuine, authentic using this medium or this modality."

Results Summary

To summarise, the results of thematic analysis yielded five themes. The major benefit of VC therapy would be to increase accessibility to mental health services. VC is a tool that has the potential to mitigate certain barriers to seeking mental health service use, including geographical barriers, modern realities, shortcomings of the mental health system and stigma. Technology is increasingly prevalent, so VC could be a useful tool to meet the significant need for better access to mental health resources for Māori.

There were major safety concerns about conducting therapy from a distance, especially the ability for clients to close the screen abruptly. Cues might be missed due to the nature of VC therefore a loss of information important in the assessment process. Particular areas and severity of distress were also considered to present safety risks in VC therapy and there were concerns about cultural safety online.

The physical space is fundamental in the therapy process, it helps to engender comfort for the client and VC was thought to provide a comforting environment for clients however there were concerns about therapy in the home. There were also considerations for community hubs and blended therapy. The feasibility of the therapeutic relationship was also discussed along with the existing therapy space for Māori.

Participants highlighted the diverse realities experienced by Māori and consequently how different individuals, whānau, generations and therapists might have different preferences for and suitability to VC therapy than others.

Cultural competency involves making the space meaningful for Māori and participants felt this could be achieved through having solid tikanga and processes with the incorporation of cultural models and values. Furthermore, by paying attention to the therapeutic relationship, considerations for whānau and having adaptability and creativity to develop the competency to meet the needs of Māori through this medium.

Chapter Six: Discussion

This chapter synthesises results from the thematic analysis of the interviews conducted. The five themes, accessibility, safety, the therapy space, diverse realities and culturally competent VC therapy with Māori are discussed in depth. Conclusions are stated, including limitations of this study, as well as directions for future research directions.

Accessibility

The findings from this study demonstrate that the perceptions psychologists' have towards providing psychological assistance to Māori via VC, include both benefits and concerns. Findings suggest synchronous communication utilising VC is preferable to non-synchronous communication, such as phone calls or email, because of the impersonal nature of such modes. Moreover, VC enables visual access, which is fundamental to the therapeutic processes of assessment, relationship building and for important cultural reasons including kānohi kitea. Previous studies have similarly found support for the benefits of the visual component of VC therapy (Cipolletta et al., 2018; Yuen et al., 2013). VC technologies simulate face-to-face interaction, which could increase the chances of replicating traditional therapy. Evidence from this study, along with prior studies, suggests VC interactions and interventions would need to replicate in-person experiences as much as possible to maximise success (Munz, 2019).

The major perceived benefit of VC therapy is the potential to mitigate accessibility issues, as stigma, modern realities, geographical distance and limited local resources in remote areas place barriers on people's ability to access mental health services. The potential of VC therapy to overcome accessibility barriers aligns strongly with previous research findings, including those by Cipolletta et al. (2018) and Morriss et al. (2019). The implications for

overcoming accessibility issues are significant as those who were previously unable to be engaged in therapy, can be seen. This is especially important for Māori in rural communities who have limited access to resources for mental health care, and evidence suggests mental health issues are increasing in rural communities (The State of the Rural Nation, 2018). The potential to increase access for Māori was also felt to be significant, as Māori continue to feature disproportionally in mental health statistics.

The potential for helping individual clients is significant in terms of increasing accessibility to mental health care, but also if implemented appropriately there could be appreciable benefits of VC therapy to the mental health system in New Zealand. Evidence suggests early interventions are associated with better outcomes (McGorry & Mei, 2018) and results from the present study indicate the most suitable place for VC therapy might be in those early stages for either psychoeducation or for mild to moderate cases. Participants from this study outlined that for individuals to enter secondary mental health care, they need to be at a serious enough level to qualify, which diminishes the capabilities of the mental health system to provide early interventions. The use of VC therapy might therefore be suitable for early interventions. If caught early this might stem the tide of those heading into secondary mental health care and consequently ease the burden of the mental health system. This in turn might increase the availability of resources for Māori and for rural Māori in particular.

Safety

The most significant concern that emerged from the participants in this study is the safety concern of working with clients from a distance. This finding is consistent across prior studies (Berryhill et al., 2019; Chou et al., 2017). Concerns centred around the perceived difficulty of

influencing the therapeutic situation from a distance, especially as clients may experience uncomfortable feelings or certain feelings may be triggered. There was also a perceived fear of the client's ability to become disengaged and subsequently end the session abruptly and much more easily than they would be able to do so in person. Participants hoped clients could sit with that discomfort, work through it and make progress, whereas online sessions may be ended at the click of a button. This presents a safety risk because a client may be in distress and it diminishes the ability to intervene, to work through issues, and promotes avoidance. Prior studies have similarly highlighted concerns about crisis management (Chou et al., 2017). Conversely, it could be empowering for clients to have that autonomy over the situation. If the space is not welcoming for Māori due to a lack of cultural competency or lack of culturally appropriate intervention, Māori might become disengaged and end the session and importantly, not receive the help they need.

Findings suggest certain measures could be taken when working from a distance to mitigate safety concerns to a certain extent. The major finding regarding how to work via VC with Māori was the importance of setting a solid protocol or tikanga, such as the hui process, with regular feedback sought to check engagement. This serves to ensure the client is getting help that is meaningful for them, in addition to ensuring their safety and consequently working to avoid the abrupt ending of sessions. Being aware of local services and escalation services was a major factor deemed important to working with clients from a distance, in addition to establishing a foundational relationship and setting a solid tikanga and protocol. It was also suggested that perhaps only those who are highly experienced therapists should be using VC. Due to safety concerns, results showed it might be pertinent to employ VC modes to provide

psychoeducation, for early interventions such as teaching simple behaviour change techniques and mild to moderate levels of distress.

Results from this investigation indicated that therapists had reservations about VC therapy with individuals with certain types of distress and severe levels of distress. Social anxiety was thought to be an area that will be appropriate for VC therapy, a finding that aligns with previous studies (Cipolletta et al, 2018). Whilst these were of strong concern, many agreed that anything was possible and it would require having stringent processes and resources in place for extra support.

Findings suggest VC therapy is suitable for particular areas of distress, including lower-end, mild to moderate areas of distress, for early intervention and to provide psychoeducation. Participants were concerned about conducting VC therapy with those who have higher-end disorders, psychotic disorders, trauma-based distress and drug-induced conditions. Perceptions suggest it is possible to conduct therapy via VC with such areas of distress, however, there were concerns about the safety implications and more considerations would need to be taken, including enlisting local supports. Results further indicate concerns regarding conducting therapy with individuals in severe distress, as the safety implications would make it too risky and difficult to control from a distance. This might especially be an issue in New Zealand since the suicide rate is high, particularly for youth. The potential for whānau involvement might increase the safety of VC therapy and contribute to more culturally appropriate interventions, as whānau involvement is important for many Māori. Limited studies have been conducted that explore the use of VC therapy with serious mental illnesses, although contrary to the current results, initial feasibility studies demonstrate the potential for success (Naslund et al., 2015). Research also suggests more serious disorders might particularly benefit from blended therapy modes

(Granholm et al., 2012). Blended therapy models might particularly suit Māori due to the kānohi-ki-te-kānohi component, along with whānau involvement to support safety during distance sessions. Blended therapy with Māori could be explored in future research.

The majority of remote studies have been conducted around anxiety and depressive disorders, which are areas most commonly affecting Māori; however, there is a lack of thorough evidence about disorders outside of these (Bashshur et al., 2015). Māori are disproportionately represented in substance use statistics, therefore more research could be done for the validity of VC therapy in this area.

'The state of the rural nation' (2018) survey found that people from rural communities preferred to deal with things themselves rather than seeking help with mental health concerns. There is the potential for escalation of distress if treatment does not occur, especially given that any areas of distress may escalate depending on the stressors. As outlined, results from the present study indicated the mental health system in New Zealand is missing the opportunity for early intervention of mental health issues. For example, the route to mental health services for Māori is most often through the justice system rather than through community services. Earlier interventions are therefore needed to stem the escalation of distress. VC therapy could be utilised to provide psychoeducation to equip individuals and whānau with knowledge about what some areas of distress might look like, along with some simple coping techniques to promote self-governance. Evidence suggests that community provision of psychoeducation and early interventions are associated with positive outcomes (Kelly et al., 2007).

Findings also suggest VC might be better suited to particular types of therapy compared with others. The efficacy of CBT via VC is well supported in prior studies, although evidence is lacking for other types of therapy (Bashshur et al., 2015). The present study yielded concerns

regarding the practicality of whānau therapy via VC, as VC may be more individualised and perhaps clunky; however, it was suggested to be an opportunity for whānau healing. Whānau members could come together in a therapy session via VC, rather than having geographical distance limit the ability for whānau to engage in therapy together. As mentioned above, whānau also have the potential to be engaged in the therapy process by being local supports for their whānau member.

Results indicate that interactions via VC compared with in-person therapy would result in a loss of valuable information therapists are used to having in person, which serve to contribute to assessment. Overall, participants felt they would be able to view more obvious body language and emotions, but felt they would miss subtle body language or other behaviours that may be difficult to observe through a screen. They felt it would be easier in the room to see the whole dimension of a person, their emotions, responses and how they interact with the environment around them and not just a representation of them on a screen. This finding aligns with prior studies such as Yuen et al., (2013), who found that VC results in a loss of information for therapists, including diminished physical feedback, subtle reactions and body language cues. There are implications for assessment and potentially a diminished understanding of the client and the potential for a client to hide more. These factors demonstrate the reservations therapists have to providing psychological assistance via VC, and they call into question the ability to replicate in-person therapy online.

In-home VC treatment requires clients to have access to the technology required to support a high-quality video connection along with the internet. This is problematic for particular people who cannot access technology for various reasons, such as lifestyle choices, religious or political reasons. Essentially, the quality of the interaction depends on the functionality of the

technology. Results from this study and previous studies indicate this concern for those in rural communities, as there may be difficulties accessing suitable technical connectivity (Berryhill et al., 2019; Ramsey et al, 2016). This is especially problematic, as Māori in rural communities have diminished access to mental health care. Results also indicate technological disruptions can hinder the therapy process (Titzler et al., 2018; Carpenter et al., Comer, 2018; Cipolletta et al., 2018). Socioeconomic limitations place barriers on access to such technologies, which means those with socioeconomic limitations might still experience accessibility barriers to receiving care. Chou et al (2017) also stated that economically disadvantaged communities have poorer access to technologies. This is troubling as socioeconomic factors play a role in mental health, with lower rates of access with those from lower socioeconomic backgrounds as it is (Pearson et al., 2013). Findings from this study identified community hubs or specialised clinics as a means to account for those who are not able to have the technology themselves.

Results indicate there are concerns centred around the security of utilising third-party software to host VC capabilities, including concerns about data ownership, data storage and selling of information. Security concerns have been identified in previous studies, such as Renn (2019). Ultimately, it is up to therapists to ensure the platform is safe and clients need to feel that their data is safe or else they will not feel able to engage authentically. This is especially important for Māori as data sovereignty remains an issue. This is an area that needs to be explored more in research, especially in light of the COVID-19 pandemic, where people have been more readily utilising VC technologies.

Cultural Safety

Since discrimination and marginalisation were identified as reasons why some Māori do not engage with services, findings from this study suggest the importance of creating a safe cultural space with respect for culturally appropriate interventions. Perspectives from participants echoed the findings by Te Pou (2010), which place importance on engaging in culturally appropriate processes to connect with clients and to promote engagement in therapy. Being aware of Māori health models, invoking Pūrākau, keeping in mind the relevance of diverse realities and specific processes that build a solid connection with people such as hui and pōwhiri processes, were suggested in this study. A significant finding was the importance of seeking cultural supervision if concerns about cultural competence arise. These align with previous studies on how to promote culturally appropriate interventions (Lacey, et al., 2011; Shepherd et al., 2006).

Māori culture tends to be holistic with an emphasis on collective wellbeing (Bennett, 2009). Interdependence was highlighted by participants who all mentioned the importance of either involving whānau in treatment or being guided by what the whānau would like, putting whānau at the centre of everything, and encouraging clients to be mindful of relational wellbeing. This was particularly perceived to be an important safety factor when working at a distance with a client over VC, having a plan with whānau to ensure the client has support around them, especially if concerns about wellbeing were to arise.

Therapy Space

Results show clients can be more comfortable in their own homes than clinical therapy rooms and as such more willing and able to engage in the therapy process. The impact of client

engagement on successful outcomes has been demonstrated in previous research findings (Dixon et al., 2016). Simpson et al. (2005) reported that those who received psychological assistance via VC were less self-conscious and had greater experiences of autonomy, compared with in-person therapy. According to Himle et al. (2006), the distance afforded by VC minimised client experiences of shame and consequently improved client engagement. These findings suggest VC therapy could promote access to therapy for Māori who are whakamā to divulge their difficulties and experience fear of external stigma, self-stigma or psychological barriers to attending in-person therapy. They would be able to experience therapy in a comfortable environment compared with therapy rooms, which traditionally have not been welcoming to Māori according to participants from this study.

This study found support for the importance of the therapy space for client engagement and experience in therapy. Results indicated the space needs to be therapeutic, calming and comfortable for the client. Pearson and Wilson (2012) summarised previous studies and highlighted the importance of the physical therapy space with factors including room size, décor, lighting, use of colour, views of nature, tidiness and soundproofing affecting a client's psychological experience in the therapy room. Distractions can be minimised during in-person sessions at clinics, which is important as distractions hinder the therapeutic process. Therapists can control the physical therapy space for in-person therapy, whereas they are unable to control the space from a distance, via VC. As outlined above there are benefits to a client experiencing therapy in their own home, however, findings also indicate perceived limitations.Their usual environment might not be therapeutic or calming or it might not encourage clients to think any differently as they are in their own space and whānau are living their lives. This brings up implications about the idea of bringing psychology into the home, whether this is tenable for

stimulating mindset shifts as well and the notion that getting out to therapy is an important step in the therapy process.

Results indicate the use of VC clinics in the community could mitigate some concerns regarding the use of VC therapy in the home, as well as the requirement for individuals to have their own technology. Previous studies have demonstrated the feasibility of such services including controlling for camera scope, assisting with the required technology and reducing access barriers based on cost (Yuen et al., 2013). This could also mean those important factors deemed to be therapeutic in a physical space can be controlled for, including the minimisation of distractions and avoidance of potential interruptions that often occur in home settings by nature of being in an uncontrolled environment. Clients might feel more secure sharing information in a clinic compared with at home if others are home and they are unable to talk freely. According to Mooi et al. (2012), efficient coordination of remote sites, smooth functioning of technology and connectivity are factors that maximise the satisfaction of both patients and health workers. Participants from the present study thought there were both advantages and drawbacks to community hubs. There were concerns regarding the set-up, including security, soundproofing for privacy and having appropriate support staff available. Community hubs enable people to overcome geographical limitations and therapy space concerns, however, those same practical barriers as with in-person therapy would still be factors, including those modern realities and elements of whakamā which limit people from accessing services. Results from this study further indicate that, due to diverse realities, there should be various options available for Māori, therefore community hubs might be helpful for some.

This study yielded support for the utilisation of blended therapy modes incorporating at least an initial in-person session and from there, subsequent sessions could be conducted via VC.

Blended therapy, a mix of both online and in-person sessions is well supported in previous studies (e.g., Bengtsson et al., 2015; Titzler et al., 2018). Blended therapy might be more suitable, especially for Māori clients as they would be able to engage in the physical space and experience those important cultural exchanges, including kānohi-ki-te-kānohi, āhua and mauri, which would strengthen the connection and lay the foundation for the therapeutic relationship.

The Therapeutic Relationship

According to the results of this study, the relationship between therapist and client is very important in the therapeutic process, a finding widely accepted in previous studies (Sucala et al., 2013). Because the relationship is fundamental, especially for Māori, VC therapy would have to enable the therapist and client to achieve a solid therapeutic relationship for VC therapy to be successful. All participants felt a meaningful therapeutic relationship could be established through VC. This aligns with the abundance of evidence that supports the use of VC as a valid mode for building a solid therapeutic relationship (Berger, 2017). Findings suggest, in addition to a loss of assessment points, VC therapy would result in a loss of valuable information therapists are used to having in person. Information that contributes to rapport building, such as subtle body language and subtle behaviours, may be difficult to observe through a screen. Rapport building was perceived as being easier to achieve in person compared with via VC because therapists and clients have access to the other person in a way that cannot be simulated through a screen and it would be easier in-person to see whether what the therapist is saying is resonating with the client. For Māori, this includes the physical vibe, āhua, mauri and wairua. Findings suggest VC changes the whole interaction and clues and responses might be missed. Consequently, it was perceived that therapists and clients would be able to form a better

relationship in person. Bengtsson at al. (2015) also found support for achieving a relationship via VC to be possible, however, concluded that in-person is a richer and stronger experience. The implications of missing information is that it might take longer to establish a relationship or it might diminish the ability to understand and connect culturally with the client, due to the absence of those important cultural experiences such as mauri.

Kānohi-ki-te-kānohi

Kānohi-ki-te-kānohi was identified by all participants as a significant cultural process in the formation of strong relationships, a finding which reflects commentators on tikanga Māori. O'Carroll (2013) emphasised the importance of kānohi-ki-te-kānohi as a reflection of mauri and wairuatanga and results from this study demonstrate the importance of this for rapport building with Māori clients in clinical practice. It helps to build trust, which is especially important given the existing, troubled relationship between Māori and psychology. Results show the importance of not only therapists being able to kānohi with clients, but even more importantly for kānohi kitea, for the client to see the psychologist to build that connection and to know that they are someone they can trust. Additionally, being physically present is important in order to experience and communicate with particular cultural phenomena, which are felt but are unseen including mauri, āhua, wairuatanga and the whakapapa they bring into the room with them. Working at a distance with Māori presents particular concerns for these cultural phenomena, as there will be information missing and potentially the inability to connect with the whole person, including their wairua. O'Carroll (2015) found that some Māori questioned the richness of the experience of online tangihanga compared with in-person experiences and felt wairuatanga was

missing, similarly the present study raised concerns about the richness of the relationship online compared with kānohi-ki-te-kānohi.

The core question in this research is whether VC therapy would be feasible with Māori clients and whether VC therapy can align with tikanga Māori. Ohia (2006) identified mana, tapu, rangatiratanga, wairuatanga, whanaungatanga and manaakitanga as enduring aspects of tikanga Māori. The results of this study indicate that some aspects of culture can indeed be feasibly carried out safely via VC, including whakawhanaungatanga, manaakitanga and karakia, as well as considerations for mana and tapu and noa. Findings suggest whakamanawa and rangatiratanga can be carried out via VC, through enabling a process that is meaningful for the client and having them guide the process. These findings suggest therapists should not shy away from using technology with Māori and echo Mead's (2016) statement about how tikanga can be applied to new situations. Whether VC therapy is suitable, ultimately depends on the individual and their whānau; as Māori experience different identities, and diverse realities including diverse experiences of traditional and contemporary culture (Houkamau & Sibley, 2010).

Clinician skill.

Results indicate that despite it being perceived to be more difficult to achieve rapport and a solid relationship online than in person, this ultimately comes down to the skill of the clinician to be adaptable and engage with the client whether it is in-person or online. Rapport can be instant or it can be built and results indicate rapport might take longer to achieve through VC or require clinician skills to be used differently. This might involve being more aware, paying particular attention to body language, and especially laying the foundation through whakawhanaungatanga. Creativity was identified as a way for therapists to compensate for some

of those lost features in VC therapy; for example with Māori, drawing on particular Pūrākau or the use of breathing exercises to simulate the hongi. Technology has the potential to complement therapy in new and creative ways. Some examples were virtual whiteboards and interactive activity sheets that both the client and therapist could fill out in between sessions. Ultimately, results indicate that with some adjustment and creativity, there is the potential for Māori to receive meaningful help through novel methods of therapy.

Existing therapy space for Māori

The results from this study outline concerns regarding the wider context of Māori and health services. The manifestation of colonisation can be seen in health care spaces as Māori experience marginalisation, racial tensions and interventions that are not culturally relevant, or practitioners who put little effort put into manaakitanga and whanaungatanga. Existing health and therapy spaces are not welcoming for Māori and many Māori feel uncomfortable entering those spaces as they have had negative experiences in health or mental health services, have negative perceptions of psychology or a general mistrust in psychology. Moreover, findings suggest many Māori who enter mental health services are disconnected from culture, however they enter with a whakapapa so there is still the potential to connect on a cultural level. As Te Huia (2015) stated, external inputs such as racism and discrimination influence Māori identity. Findings further suggest Māori are reluctant to engage with mental health services due to a fear of not being understood, fear of appearing as not coping, as well as fear of tikanga not taken into consideration. These findings align with prior research on Māori health (Te Pou, 2010). The implications of these factors are that Māori have added barriers to accessing treatment, which needs to be taken into consideration when exploring the feasibility of VC therapy with Māori.

Evolving Māori culture and culture online

Participants agreed that Māori are quick to embrace and grasp technology and aspects of culture are increasingly conducted online. Some noted how there are wānanga held via VC, tangihanga are streamed online, and relationships are maintained on social media and over the phone. This aligns with previous commentary about how culture is increasingly being practised online (O'Carroll, 2013). Participants' reflected that previously online practises such as tangihanga live streams were met with resistance, but over time they have become normalised and participants thought this would apply to VC therapy; eventually, it would become more prevalent and people would get used to it. This sentiment aligns with O'Carroll (2013) who felt there was an inevitable move towards cultural interactions online. Findings also identified the tension between traditionalists and those with contemporary ideals, a reflection of the diverse realities experienced by Māori and the evolution of culture. The tension between idealism and pragmatism was also identified, due to the strong need for increasing access to mental health services; however, the ideal of kānohi-ki-te-kānohi is not feasible with everyone, therefore new technologies could meet the need. Technology would have to be employed utilising culturally appropriate considerations because results suggest there are concerns about losing important cultural values as a result of technology and participants' acknowledge Māori have been forced to change in the past. This aligns with Kingi (2005) who stated colonisation and deculturalisation forced Māori cultural changes.

Diverse Realities

Despite a general openness of all participants to conducting VC therapy, almost all participants from the present study had personal preferences for in- person therapy over VC

therapy for various reasons. Some prefer being face-to-face due to cultural reasons, such as to experience those elements that build a connection including whakapapa and mauri. Others simply appreciate that it is because they have been therapists for a long time therefore feel more comfortable with traditional, in-person therapy. Previous studies, including that by Ramsey et al. (2016), have demonstrated therapist doubt about the utilisation of VC therapy. Overall, participants felt that the world has changed and will continue to change and as such, VC therapy would become more commonplace. This is due to the significant need to overcome accessibility issues and consequently, the need for services to make adjustments to meet the needs of those who are unable to access treatment.

Some participants felt the value of VC was for those who could not make it into a session and that otherwise in-person sessions are best. The results partly align with the study by Manfrida et al. (2017) who felt that in-person therapy should always be conducted unless there are severe impediments to in-person attendance. Conversely, notions of whakamanawa and diverse realities were important considerations that emerged out of the present study. Some felt that their personal preference for providing care via VC depends on the individual client and they and their whānau should have the empowerment and autonomy to decide which mode would work best for them.

Suitability of VC Therapy

The findings from this study indicate particular individuals, whānau and therapists may be better suited to VC than others, due to individual preferences and different experienced realities. Renn (2019) also found support for the idea that individual clients differ in preferences for in-person treatment compared with VC therapy. Individual preference might affect

motivation and engagement, and results indicate novel measures such as VC therapy should be offered because there are varying preferences. As mentioned, the type of distress, severity of distress and therapy type may be appropriate for VC therapy than others.

Results from this study regarding the use of VC therapy with youth was mixed. It was proposed that VC may be more suited to the younger generation for whom technology is second nature and pervasive compared with the kaumātua generations and evidence suggests VC therapy works well for youth especially in minimising shame (Bashshur et al., 2016; Bengtsson et al., 2015; Carpenter et al., 2018). According to March et al. (2018), individuals who have confidence with computers and the internet were more likely to prefer online services rather than in-person sessions. This is promising because as outlined above, Māori have higher proportions of younger people and younger people have a higher prevalence of mental health disorders, therefore mediums utilising technology could enhance engagement in treatment. Conversely, results from the present study raised concerns about keeping youth engaged in a VC therapy environment. A further concern related to working with youth via VC was the perception that they might lack the ability to articulate when they are feeling frustrated, and consequently more likely to end the session abruptly.

Culturally Competent VC Therapy

Few studies have been conducted on the use of VC therapy with Māori. It therefore seemed appropriate to investigate potential guidelines from Māori psychologists, who have experience working with Māori clients about working with Māori via VC. Questions were asked about how to keep the space safe, along with techniques which might enhance the experience for

Māori clients online. Findings suggest consideration for the process, the relationship, cultural safety, whānau and creativity are important aspects that should guide therapy with Māori.

Improving mental health care for Māori should entail those involved in care to recognise the impacts of cultural alienation, generational deprivation and the indigeneity of Māori along with an increase in Kaupapa Māori services and improved cultural competence (Government Inquiry into Mental Health and Addiction, 2018).

The Process

According to Mooi et al. (2012), the following strategies should be employed when working with clients from a distance: Client consent should be sought and clients should have the option to request in-person at any time; practitioners should undergo competency training for technology, cultural awareness and further education to overcome practitioner barriers to participation. These similarly align with what the present study found; clients need to fully comprehend and consent to a process and the individual and their whānau should guide that process, ensuring they have access to the right technology and have support mechanisms in place. A study by Renn (2019) found that client confusion contributed to a reluctance to engage in VC therapy, so it is imperative that the process is clear and any questions answered. Findings suggest perhaps experienced therapists might be better suited to VC therapy and competency training could be utilised to build confidence working via VC.

To maximise success with VC therapy, individual factors need to be taken into consideration and interventions should be appropriate for an individual's experienced reality. For example, for older adults, their cognitive function and experience with technology use ought to be taken into consideration (Harerimana et al., 2019).

The Relationship

Results demonstrate the importance of the therapeutic relationship for Māori. The visual nature of VC enables a simulated version of kānohi-ki-te-kānohi and the processes of whanaungatanga and manaakitanga are fundamental cultural processes that can be carried out via VC to build connection. VC therapy compared with in-person sessions would result in missed opportunities to demonstrate manaaki, such as providing a cup of tea. Suggestions were therefore made about the creative potential to fulfil manaakitanga via VC therapy such as through karakia; utilising mindfulness, and; creating a personal ritual such as completing breathing exercises together to simulate the connection of hongi.

This study is about perspectives and attitudes towards VC therapy, which are subjective. Participants were recruited by approaching contacts so participants might have been restricted by this methodology. Most participants had at least some experience with VC though some participants had no experience with VC therapy and perspectives and attitudes might change with more experience. Future research could therefore explore the experiences of Māori therapists who have greater experience with conducting VC therapy, as well Māori clients who have experienced VC therapy, to gain further insight into the feasibility of VC therapy with Māori clients.

Conclusions

Various barriers limit access to effective, evidenced-based interventions for those experiencing mental health difficulties including accessibility issues, stigma and cultural issues. These are especially limiting in rural areas and for Māori. It is important to strive for a mental health system that allows equitable access to mental health services for all, not just for those who

are privileged or who experience severe disorders (Williams et al., 2017). Moreover, interventions and interactions with mental health professionals should support the development of positive cultural identities and not diminish cultural identity in any way. Evidence-based and culturally appropriate interventions need to be developed using new methods of delivery, such as digitally supported means, to foster a sustainable mental health system that encourages the recovery and wellbeing of generations to come (Williams et al, 2017). VC therapy has the potential to ameliorate existing barriers to mental health care. All participants from this study are open to VC therapy, especially if it is a client's preference and all acknowledged that a meaningful therapeutic relationship could be achieved with clients via VC. However, all participants had personal preferences for in-person therapy owing to cultural reasons, professional experience, perceptions that in-person therapy gives a therapist access to more information, and perceptions that in-person is safer than working by distance. Perceptions also centred around the scope of suitable treatment, which included anxiety disorders and psychoeducation, early interventions and mild to moderate levels of distress.

Participants conceded that with adjustment coupled with processes put in place to protect the safety of the client, VC therapy would become more prevalent in the future and treatment may widen in scope. Participants hoped that if Māori clients could start to experience meaningful interactions and culturally appropriate interventions via VC, then that would engender positive outcomes for Māori.

Māori are not one homogenous group and to reiterate, diverse realities are experienced by Māori. Results are therefore to be taken with that in mind because individuals differ in their experience and practice of traditional and contemporary culture.

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Appendix A

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Exploring the perceptions of Māori mental health workers of providing psychological assistance to Māori via videoconference technologies.

PARTICIPANT INFORMATION SHEET

He aha te kaupapa o tēnei rangahau? / What is this research about?
Accessibility issues, cultural issues and stigma have been identified as barriers to accessing help for Māori who may have mental health concerns. Videoconference therapy is well supported in research, however its use has not been explored with Māori. Technology is ubiquitous and therapy via videoconference has the potential to mitigate some of the barriers that limit access to effective evidenced based therapy for those experiencing mental health difficulties. The purpose of this project is to explore the perceptions of Māori mental health professionals towards videoconference technology as a medium for therapy with Māori clients, as well as to investigate potential guidelines for practitioners considering implementing videoconference technology with Māori clients in the future.

Mawai e mahi tēnei rangahau? / Who is doing this research?
Ko Jo Kirk ahau, Ko Panguru te maunga, Ko Whakarapa te awa, Ko Waipuna te marae, Ko Te Rarawa te iwi. My name is Jo, I am undertaking this research as part of my Master of Science thesis at Massey University.

Mawai ngā tāngata e whai wāhi tēnei rangahau? / Who can take part in this research?
If you are 18 years and older, identify as Māori, and have experience with counselling Māori clients, you are welcome to take part in this research.

He aha āku mahi mo tēnei rangahau? / What will I be asked to do?
Simply have a kōrero about your opinions and feelings about the suitability of providing psychological assistance via videoconference technology with Māori clients. Generally what I am interested in is whether you believe videoconference technologies can align with tikanga Māori.

Preferably our kōrero will be arranged for kānohi ki te kānohi however online is also an option, whatever is most convenient for you.

Any information obtained will be used only for the purposes of this research and will be stored securely in a password protected computer. Our kōrero will be recorded and transcribed. To guarantee anonimity, names will be changed when transcribing interview data.

If you would like to receive a summary of the results you can provide your email address so the summary can be emailed to you.

He aha ōu tika? / What are my rights as a participant?

Feel free to ask any questions at any time. You can choose to refrain from answering any questions you are uncomfortable with and you can choose to withdraw up until one week after our kōrero.

Mēna he patai au, ko wai ngā tāngata e whakapā ana? / Who can I contact about the research?

If you have any questions or concerns please feel free to contact any of our team:

Researcher:
Jo Kirk
Jo.Kirk.2@uni.massey.ac.nz

Supervisors:
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This project has been evaluated by peer review and judged to be low risk. Consequently it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research.
If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Professor Craig Johnson, Director (Research Ethics), email humanethics@massey.ac.nz.

Appendix B

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Exploring the perceptions of Māori mental health workers of providing psychological assistance to Māori via videoconference technologies.

Participant Consent Form

- I have read and understood the details of the project as set out in the Participant Information Sheet.
- I confirm that I have had the opportunity to ask questions and that my questions have been answered to my satisfaction. I understand that I may ask further questions at any time.
- I understand that my participation is voluntary and that I am free to withdraw from the study at any time up until one week after our kōrero.
- I agree to participate in this study under the conditions set out in the Participation Information Sheet

Name ________________________

Signed ________________________

Email address (if you would like to receive a summary of the results) ___________________________

This project has been evaluated by peer review and judged to be low risk. Consequently it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Professor Craig Johnson, Director (Research Ethics), email humanethics@massey.ac.nz.