PARENTS AS PARTNERS: PERSPECTIVES OF SCHOOL SUPPORTS IN PARENTS OF ADOLESCENTS WITH INTERNALIZING DISORDERS

by

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Abstract

The purpose of this study was to identify, describe, and categorize the experiences of child and family school supports in parents of adolescents with internalizing mental health concerns. Few studies have asked parents about their experiences with their child’s school, particularly in relation to their child’s mental health needs. Furthermore, the needs and involvement of parents of youth with internalizing disorders have not been examined specifically at the secondary school level, where academic and other school-related requirements may differ from elementary school. This research was conducted to add to the limited literature in understanding the school-based needs of parents of youth with internalizing disorders. Eleven parents of adolescents diagnosed with an internalizing disorder were interviewed and asked about aspects of school support that they perceived as being helpful or hindering to their child or family. Data were analyzed using the enhanced critical incident technique (ECIT; Butterfield, Borgen, Maglio, & Amundson, 2009), which has been adapted from Flanagan’s (1954) critical incident technique (CIT). Critical events (n=215) were recorded and sorted into emergent unitary clusters based on content analysis. These categories were subjected to rigorous reliability and validity checks including analysis by another researcher, calculation of interrater agreement, and participant feedback. This process yielded seven categories that represented the participants’ experiences of school support. The categories were: Individualized Support, Communication Between Home and School, Understanding and Support, a Team Approach, A Safe Place at School, Having an Advocate in the School System, and Understanding Mental Health. Participants were asked to generate a wish list of supports they would find helpful if available. Thirty-one wish list items were generated by eight of the participants. Wish list items embodied
four categories, which were: Counselling and Learning Supports, Resources and Services, Communication, and Professional Development.
Preface

The thesis and original research presented here were undertaken by the graduate student with advisement from her research supervisor. The graduate student was the primary person responsible for the data collection, recruitment, analysis, and writing, and therefore this thesis characterizes her work as a lead researcher and author. Ethics approval for this research project was procured from UBC Behavioural Research Ethics Board (BREB). The UBC BREB certificate number is H12-01362. Ethics approval was also procured from Vancouver Coastal Health Research Institute, certificate number V12-01362, and Children’s & Women’s Health Centre of British Columbia, certificate number CW12-0142.
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CHAPTER I: Introduction

Introduction to the Problem

Mental health disorders are a leading health concern in children (McEwan, Waddell, & Barker, 2007; Waddell, McEwan, Shepherd, Offord, & Hua, 2005). Epidemiological studies have estimated that between 12 and 20% of North American children are affected by mental health disorders, and fewer than 25% of these children receive specialized treatment services (Breton et al., 1999; Costello et al., 1996; Shaffer et al., 1996; Waddell et al., 2005). As noted by Rones and Hoagwood (2000), “It is now well documented that, insofar as children receive any mental health services, schools are the major providers” (p. 223). As children spend a substantial portion of their day in the school system, there is an opportunity for schools to provide mental health support to these children, as well as support to their families. Many families may not be receiving sufficient supports elsewhere (Rones & Hoagwood, 2000).

Mental health disorders often have a tremendous impact on families. Having a child with mental health concerns may result in financial strain, role changes, anxiety and uncertainty, difficult decisions, fear and self-blame, and stigma and isolation (Ferriter & Huband, 2003; Kirby & Keon, 2006). A family’s ability to cope with and manage their family members mental health concern may influence the individual’s outcomes (Townsend, Biegel, Ishler, & Rini, 2006). Research indicates that receiving support from professionals helps families cope with having a child with a health concern, and that collaboration with professionals is a key component in reducing the potential negative effects associated with having a child with a health concern (Gordon, 2009; Langridge, 2002; Melnyk et al., 2001). Families are also more likely to report that their child’s needs are being met if they are involved in collaborating with service planning (Koren, Paulson, Yatchmonoff, Gordon, & DeChillo, 1997). However, research
examining the needs of parents, and ways to support parents of children with internalizing mental health concerns and engage them in their child’s treatment is scant, especially with regards to how families are supported in the school system (Hoagwood et al., 2010).

The Honourable Senators Kirby and Keon (2006) in their report on the status of mental illness and addiction services in Canada, entitled *Out of the Shadows at Last*, note that the system of care addressing the needs of children and youth is “fragmented and under-funded, that intervention occurs far later than is necessary, that there is a critical shortage of mental health professionals, and that young people and their families are not being involved in workable, long-term solutions to their serious mental health problems” (p. 135). This report recommends that mental health intervention become a collaborated effort between all sectors involved, that system changes are initiated to support such collaboration, and that consumers and their families be involved in all aspects of care as equal partners (Kirby & Keon, 2006).

Recently, the National Association of School Psychologists adopted the *Model of Comprehensive and Integrated School Psychological Services* (NASP, 2010a), where 10 domains of best practice for school psychologists were recommended. Notable is domain seven, which encourages *Family-School Collaboration Services*. Family-school partnering is rooted in Bronfenbrenner’s bioecological systems theory, which views child development as being influenced to different degrees by individual characteristics, as well as family, school, and community factors (Bronfenbrenner, 1986; Bronfenbrenner & Morris, 2006). This model provides a framework for understanding why communication and collaboration between a child’s home and school is so important for a child’s development (Beveridge, 2005). Family-school partnering involves a relationship between the primary caregiver(s) of a student and
members of the school community that is collaborative, and that is based on trust and open communication and shared responsibility for student success.

The goal of family-school partnerships is to enhance the academic and social-emotional outcomes of all children (Esler, Godber, & Christenson, 2008). A few decades of research on family-school partnerships has demonstrated that the partnership improves student outcomes in areas such as attendance, academic achievement, morale, and parental satisfaction with their abilities to support their children (Esler et al., 2008). The recommended best practice for school psychologists is to adopt a multi-tiered family-school partnership framework, in which students receive support based on their individual needs (i.e., students with high needs, such as those with a diagnosed mental health concern, receive intensive intervention (Miller, Arthur-Stanley, & Lines, 2012). Family-school partnerships are especially important for students with mental health concerns, as these children typically experience poorer outcomes (e.g., lower grades, poor attendance, lower graduation rates) compared to their peers with and without special needs (Landrum, Tankersley, & Kauffman, 1996). Although there is an increased awareness of the mental health needs of students and an increase in universal social-emotional learning programs particularly at the elementary school level, there is a gap between awareness of students’ needs and services provided to support students and their families (Elias, Zins, Gracyk, & Weissberg, 2003; Koller & Bertel, 2006).

**Purpose**

Although research indicates that having a child with a mental health disorder may have a negative impact on the family system, and that it is beneficial to develop family-school partnerships to support children with mental health disorders, there is a need for research to understand parents’ perspectives of school supports. Research is needed to understand what
parents find helpful and unhelpful about the supports received from the school system in managing their adolescent’s mental health concern and to ask parents about the types of support they desire from this system, because studies have indicated that family support and involvement in service planning improves parents’ abilities to manage their child’s needs and improves children’s outcomes (Esler et al., 2008; Hoagwood et al., 2010).

The purpose of this study therefore was to explore aspects of school support that parents’ of adolescent’s with internalizing mental health disorders found helped or hindered their ability to manage their youth’s needs. This study focused on the needs of adolescents with internalizing disorders (i.e., mood and anxiety disorders), as more research is needed with this specific population (Hoagwood et al., 2010). Research examining parents’ experiences of school supports has typically combined data from parents of children with internalizing and externalizing disorders, and often includes a wide age range of children and adolescents, rather than looking at elementary versus secondary supports (e.g., Jivanjee, Kruzich, Friesen, & Robinson, 2007; Tarico, Low, Trupin, & Forsyth-Stephens, 1989). This study was conducted to examine the needs of parents of adolescents with internalizing disorders, and to explore if these parents have unique needs compared to parents of children with general mental health concerns. It is possible that due to the overt and visible nature of externalizing disorders, in comparison to internalizing disorders that may be more difficult to detect, that parents’ interactions and experiences with their youth’s school may differ. It is important when researching parents’ experiences to examine this population of parents of children with internalizing disorders separately, to evaluate if their needs differ based on several factors. Youth with anxiety and mood disorders (a) account for a greater percentage of the school-based mental health concerns (Waddell et al., 2005), (b) rates of anxiety and depression concerns escalate in the teen years, (c) anxiety disorders, if left untreated,
have a significant and deleterious wide ranging host of poor outcome (Landrum et al., 1996), and 
(d) teachers often report the greatest difficulties supporting children with internalizing disorders
at school (Koller & Bertel, 2006).

It was anticipated that this research may contribute to our understanding of parents’ needs
of school systems and may provide information to schools on the strengths and weaknesses of
support provided for families of a youth with internalizing mental health concerns. The findings
may provide a greater understanding of which components of school-level support are perceived
as useful to such families.

An underlying goal of this research was to provide the parents of adolescents with
internalizing mental health concerns with an outlet to express their needs and opinions, thus
making them more visible and involved in the delivery of services. It is ultimately hoped that this
research will contribute to the well-being and support of families of adolescents with mental
health concerns.

**Definition of Key Terms**

*Parent.* The British Columbia (BC) Ministry of Education defines a “parent” as “(a) the
guardian of the student or child; (b) the person legally entitled to custody of the student or child;
or (c) the person who usually has the care and control of the student or child” (BC Ministry of
Education, 2011, p. VI). The term “parent” will be used in this study to refer to the primary
caregiver(s) who is (are) most involved in supporting the child who has a diagnosed internalizing
mental health disorder.

*Support.* There is no consistent definition of family support in the literature. Hoagwood et
al. (2010) defined parent support as having the “explicit purpose of helping parents/caregivers
(a) clarify their own needs or concerns; (b) reduce their sense of isolation, stress, or self-blame;
(c) provide education or information; (d) teach skills; and (e) empower and activate them, so that they can more effectively address the needs of their families” (p. 3). In this research, support will be defined as behaviours, attitudes, processes, events, activities, or experiences in the school system that meet the perceived needs of parents of children with internalizing mental health disorders. Aspects of support can therefore include anything that parents perceive as being helpful or not helpful in managing their adolescent’s mental health disorder.

**Internalizing Disorders.** A diagnosed anxiety or depressive disorder using the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM*-5; American Psychiatric Association, 2013) criteria. Depressive disorders (e.g., disruptive mood dysregulation, major depressive disorder, persistent depressive disorder) embody the presence of a sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect ones functioning. The depressive disorders vary according to duration, timing, or etiology. Anxiety disorders (e.g., separation anxiety, selective mutism, specific phobia, social anxiety disorder, panic disorder, generalized anxiety disorder), embody characteristics of excessive fear and anxiety, which may be reduced by avoidance behaviours. Anxiety is the anticipation of a threat, whereas fear is the emotional reaction ones has to a threat, regardless of whether it is actual or anticipated.

**Secondary School.** In British Columbia, a secondary school refers to an educational institution designed for students in Grades 8 through 12.

**Significance of Study**

Understanding parents’ experiences in receiving support from the school system in managing their adolescent’s internalizing mental health concerns is important for several reasons. First, a body of research highlights best practice for psychologists in the schools in supporting children with mental health needs and their families, including involving the family
and outside community agencies in understanding student and family needs, and in developing supports for students (e.g., NASP, 2010a). However, there is scant literature that examines parental perceptions of this process and of the supports parents and their adolescent child receives from the child’s school.

Second, although there is research on the challenges and experiences parents have in managing their child’s mental health needs, little research specifically examines parental perceptions of what supports would be helpful from their child’s school system in aiding their child and their family through this process. Having a better understanding of what is perceived to be helpful or hindering by parents may influence how psychologists approach how they support families.

Third, understanding the perceived needs of parents of adolescents with internalizing mental health disorders may provide schools with information on both what parents find helpful and hindering about the support they are receiving and what they perceive is missing that may be helpful. Therefore, this research may inform school or district level systems change.

Finally, parents are the constant figures in their children’s lives not only at home, but also as they progress through the school system. As the research indicates, a parent’s ability to cope with his or her child’s health needs can be an influential factor in their child’s outcomes (Melnyk, et al., 2001; Townsend, et al., 2006). Therefore, the more parents are supported to manage their child’s mental health needs, the better able they may be to provide support to their child.
CHAPTER II: Literature Review

The purpose of this chapter is to highlight the research relevant to parents’ perceptions of school supports. This will include literature on parents’ experiences supporting a child’s mental health concern, understanding the role of family-school partnerships, and summarizing key literature on parents’ experiences collaborating with service providers to support their child.

Parents’ Experiences Supporting a Child’s Mental Health Concerns

Parents of children diagnosed with mental health disorders often experience substantial stress managing their child’s mental health concerns and accessing supports and services (Hoagwood et al., 2010). Families may experience a range of emotions including loss, fear, and guilt, and experience stigma associated with their child’s diagnosis (Ferriter & Huband, 2003; Teschinsky, 2000). Having a child with a mental health concern may result in families feeling isolated and blamed (Teschinsky, 2000). A range of effects that mental health concerns can have on a family are described in the literature, including impacts on daily living, health and well-being, social and family relations, and career and finances (Cochrane, Goering, & Rogers, 1997; Teschinsky, 2000). For example, Cochrane et al. (1997) found that caregivers of an individual with a mental health disorder are twice as likely as non-caregivers to use mental health services, and the authors report high rates of anxiety and mood disorders amongst these caregivers.

Several studies that examined variables that helped families manage their child’s health concerns generally presented two aspects of support that families considered helpful. Parents reported that high quality information and support received from health professionals regarding the diagnosis and treatment plan helped them cope emotionally (Graungaard & Skov, 2007; Pain, 1998). Families who reported having strong forms of support (e.g., family cohesion, social support, community support) were better able to manage their child’s health concerns (Beresford,
In a qualitative study in which eight families of adolescents 12 to 17 years old who had either a chronic illness or disability were interviewed regarding factors that helped them cope, families indicated that having acceptance and support from others, obtaining information from professionals, and seeking engagement in the community were all critical factors (Taanila et al., 2002). Overall, having a strong support network and having access to relevant information appear to be key factors that families perceive to be helpful.

Parents’ Perceptions of Professional Collaboration

Over the last few decades the model of service delivery for families of children with mental health concerns has been evolving. Traditionally, the service model was one in which mental health professionals were viewed as the experts who imparted information to a family, and whose primary role was to determine the best mode of treatment (Chovil, 2009). The more current service model of mental health delivery has evolved to a family engagement model of care, in which the focus is on engaging the family in the process of determining the most appropriate treatment and services for the child and the family, and empowering families and building family and community capacity (Chovil, 2009).

Family-centered care is an ecological approach that focuses on establishing collaborative relationships between parents and service providers, focusing on family strengths and encouraging family choice and involvement in decision making (Blue-Banning, Summers, Frankland, Nelson, & Beegle, 2004). Family-centered interventions result in parents reporting greater satisfaction with services and a feeling of greater personal control (Applequist & Bailey, 2000; Trivette, Dunst, Boyd, & Hamby, 1995). At the school-level, family-centered collaborations recognize that joint planning between school and home enhances schools’
effectiveness to support students as well as contributes to parents supporting and reinforcing school practices at home (Anderson-Butcher & Ashton, 2004). Other benefits of family-centered practice are that parents report feeling more supported, families often have access to more resources and services, and families are more likely to view the school as part of their support network (Anderson-Butcher & Ashton, 2004). As the model of service delivery has shifted to being family-centered, there is a growing emphasis in the literature, particularly in the field of school psychology, to understanding the characteristics of successful family-professional collaborations.

When parents obtain support from mental health professionals and other professionals, it is not fully understood what aspects of the support received are helpful or not. Families often perceive a lack of support from mental health providers (Chovil, 2009; Ferriter & Huband, 2003). Generally the literature on parents’ experiences of professional partnerships to support children with health concerns or disabilities suggests that parents value the importance of quality communication, emotional expression and support, and acknowledgment of their parental expertise (Meyer, Ritholz, Burns, & Truong, 2006; Prezant & Marshak, 2006; Summers, Behr, & Turnbull, 1989).

In one study in which 22 parents of individuals diagnosed with schizophrenia were interviewed on their experiences receiving support, parents indicated that they perceived the help received from family, self-help groups, or the police to be the most helpful, and the support received from psychologists, social workers, and psychiatrists to be the least helpful (Ferriter & Huband, 2003). Furthermore, parents indicated frustration with the challenges they had obtaining information about their child’s diagnosis and treatment. This finding has been supported by other studies examining perceptions of support in parents of children with mental health concerns (e.g.,
Friesen, Koren, & Koroloff, 1992), and parents have reported that regardless of the professional from whom they receive support, they value characteristics of honesty, a non-judgmental attitude, supportiveness, and involvement in the decision-making (Friesen et al., 1992; Holden, 1982; Rose, 1998). Families therefore value both the process of interacting with professionals and the content of communication between themselves and mental health professionals (Hoagwood et al., 2010; Rose, 1998). It is important that service providers working with families with mental health concerns understand families’ needs during this potentially challenging period, and that families receive services that they perceive as being helpful.

Blue-Banning et al. (2004) indicated that one barrier to achieving ideal family-professional partnerships to support children with special needs may be a lack of research that operationally defines the construct of the partnership, and the components that make partnerships successful. To address this barrier, they conducted a qualitative study in which parents (n=137) of children with disabilities and professionals (n =53; i.e., administrators and direct service providers) were separately interviewed in focus groups and/or individually and asked about the characteristics of successful relationships (Blue-Banning et al., 2004). Both groups emphasized the importance of communication, commitment, equality, skills, respect, and trust as being key features of a successful family-professional relationship in supporting a child with a disability (Blue-Banning et al., 2004). One difference in opinion between parents and professionals was that parents had an increased desired for professionals to “go the extra mile” and “be like family” (p. 180). It should be noted that this study included participants from a range of cultural and socio-economic backgrounds, and no differences were evident across groups.

As highlighted by Blue-Banning et al. (2004), further research is needed to evaluate characteristics of partnerships that parents and service providers perceive as being important in
supporting children with special needs. Specifically, while there is increasing awareness of families needs from professional partnerships with mental health providers, there is scant research examining parents’ needs from their adolescent’s school or school system to support their family and their youth who has internalizing mental health concerns. The field of school psychology has been evolving over the last few decades regarding how services are delivered to children and youth with mental health concerns and their families (Esler et al., 2008). With the growing acknowledgement of social and emotional needs of students in today’s schools, the role of the school psychologist is evolving from a traditional model, which focused on assessment, to one in which the psychologist engages in collaborative practice to meet the learning and social-emotional needs of students and their families (NASP, 2010a). In accordance with best practices, psychologists are encouraged to create family and school partnerships for students with mental health needs, and therefore to engage these students’ primary caregiver(s) in addition to members of the school community in a collaborative process of support and service delivery (NASP, 2010a).

In both Canada and the United States, policy has been created to ensure that children with social-emotional needs are supported in schools, and that parents are involved in this process. The U.S. Department of Education recognized the importance of parental involvement in education in the No Child Left Behind Act (No Child Left Behind Act, 2002), and in British Columbia, the Ministry of Education’s Special Education Services manual outlines how the government will support students with special needs, which includes students with mental health concern (BC Ministry of Education, 2011). In British Columbia, this process involves identifying students by assigning a BC Ministry of Education special services designation and creating an Individual Education Plan (IEP). The IEP outlines the academic and social supports a student
will receive as well as the academic and social-emotional goals for the student, based on individual needs (BC Ministry of Education, 2011). It is recommended by the ministry that a student’s IEP is developed in collaboration with teachers, administration, parents, and the student, and specifically that parents be active participants in the process (BC Ministry of Education, 2011). For a child to be designated as a student with a serious mental health concern (‘H’ designation, BC Ministry of Education, 2011), the student must have a diagnosed mental health condition that interferes with the student’s academic progress and results in negative internalizing behaviours. The student is considered ‘at risk’ for negative outcomes in the classroom without intensive support. Furthermore, the student must be receiving intervention outside of the school system in order to qualify for this designation. For a child to be designated as a student with a serious mental health concern, parental involvement is required, and collaboration between the school and the family is recommended (BC Ministry of Education, 2011).

**Family-School Partnerships**

Family-school partnering is rooted in Bronfenbrenner’s bioecological model of human development, which views child development as being influenced to varying degrees by individual characteristics, as well as family, school, community, cultural, and political factors (Bronfenbrenner, 1986; Bronfenbrenner & Morris, 2006). According to Bronfenbrenner’s model, there are five ecological systems (Bronfenbrenner & Morris, 2006). The microsystem is composed of all the settings in which a child personally interacts and is directly influenced by (e.g., family, peer group). The mesosystem is the interaction between Microsystems that influence the child (e.g., parent involvement with the school). The exosystem is a system in which the child is not involved in the construction of experiences, but these experiences have an
impact on the microsystems the child is part of (e.g. changes in a parent’s workplace). The macrosystem is an overarching context in society that impacts the child (e.g., health policy, laws). Finally, the chronosystem is related to the dimension of time, and is concerned with experiences a person has during his or her lifetime that impacts development. The four defining characteristics of the bioecological model include process factors (e.g., interactions between a person and her environment), characteristics of the person (e.g., dispositions, resources, and demand characteristics), context, and time (Bronfenbrenner & Morris, 2006). A child’s learning and development is therefore shaped by individual characteristics, processes, and interconnected systems.

The bioecological model of human development provides a framework for understanding why communication and collaboration between a child’s home and school is important for development (Beveridge, 2005). There is growing awareness that providing mesosystemic support through developing family-school partnerships is essential to supporting children’s academic, social, emotional, and behavioural development (Bronfenbrenner & Morris, 2006). Providing mesosystemic support, or family / school support, is particularly important for children with special needs (Christenson & Sheridan, 2001).

There have been three models of family-school partnerships described in the literature, all grounded in Bronfenbrenner’s bioecological systems theory: Epstein’s overlapping spheres of interpersonal relationships (1995, 2001); Hoover-Dempsey and Sandler’s (1995, 1997) views on factors promoting parental involvement in schools; and Christenson and Sheridan’s (2001) “four A’s” (i.e., Approach, Attitude, Atmosphere, and Action). These models will be discussed briefly.

According to Epstein’s model, overlapping spheres of interpersonal relationships across children’s environments (i.e., home, school, community) impact development (Epstein 1995,
Children thrive when key stakeholders across environments collaborate and create plans to support development. According to this model there are six essential areas for successful partnerships, including parenting, communicating, volunteering, learning at home, decision-making, and collaborating with the community. Notably, regular two-way communication and involving and supporting families in activities and decision making are emergent factors from Epstein’s research that are deemed important to support child development through developing successful partnerships (Epstein, 1995, 2001).

Hoover-Dempsey and Sandler’s (1995, 1997) work has focused on understanding the factors influencing parents’ decisions to be involved in their child’s school and education. Five key factors have been suggested, including: (a) personal motivation; (b) parent mechanisms (e.g., modeling certain behaviours); (c) students’ perceptions; (d) students’ attributes (e.g., motivation); and (e) student achievement.

The most recent framework of family-school partnerships stresses the importance of the quality of interpersonal relationships between families and school personnel, and recognizes influential factors in home and school contexts (Christenson & Sheridan, 2001). According to this model, there are four interrelated conditions necessary for partnerships: Approach, Attitudes, Atmosphere, and Actions; these are commonly referred to as the “four A’s” (Lines, Miller, & Arthur-Stanley, 2011). Approach elements include policies and frameworks at the school that invite interpersonal relationships between educators and the family (e.g., principles of shared responsibility and working together to develop shared goals). Attitude features include the perceptions parents and educators have regarding partnerships (e.g., respecting opinions, non-judgmental communication) that influence effective problem solving and working together as a team to plan supports and services for a student. Atmosphere elements embody the climate in
which interactions occur (e.g., schools being welcoming to parents). Action elements include school-level or district-level initiatives that encourage partnership between schools and families. This model embodies values such as having a positive outlook on partnership, working on building trust in relationships, working with families to create shared goals, improving parent-teacher communication, and working towards managing conflicts that arise (Christenson & Sheridan, 2001; Lines et al., 2011).

The literature supports the goal of family-school partnerships to enhance children’s academic and social-emotional outcomes by ensuring optimal conditions for students’ learning (Christenson & Sheridan, 2001; Esler et al., 2008). Research indicates that parental involvement in children’s learning improves student’s outcomes across domains (Cappella, Frazier, Atkins, Schoenwald, & Glisson, 2008). Family-school partnerships extend beyond including parents in school-based activities, to creating an environment encouraging mutual collaboration, respect for skills and knowledge, open communication, creating mutually agreed upon goals, and working together in the planning and decision making for a student (Christenson & Sheridan, 2001). Such partnerships exemplify a student-focused philosophy, shared responsibility for student outcomes, and ongoing connection and dialogue between the school and the family (Christenson & Sheridan, 2001). Having an ongoing relationship is essential in order for the family and educators to work together to support the student’s development (Christenson & Sheridan, 2001). According to Christenson & Sheridan (2001), having constructive values are a key aspect of the relationship. This includes listening to each other’s opinions and perspectives, planning and making decisions as a team, addressing conflict or problems that arise, being nonjudgmental, and engaging in a two-way sharing of information, which allows families and educators to understand and work together to design appropriate interventions and supports for the student.
An overarching goal of family-school partnerships is therefore to support student’s optimal learning and development. Research validates that involving families in school-based decision-making improves student outcomes, including increasing academic achievement, work completion, attendance, self-esteem, and attitude towards school, decreasing school dropout, and improving behaviour (Christenson, 2002; Christenson & Buerkle, 1999; Esler et al., 2008; Henderson & Mapp, 2002).

Support for family-school partnerships comes from research demonstrating that school-based interventions that lack parent support are less effective in improving student outcomes (Christenson, 2002). Children with emotional or behavioural difficulties particularly benefit from home-school collaboration as research has demonstrated that these children show greater response to intervention when strategies are consistently used across environments (Christenson, 2002). Having a liaison at school that connects families with resources and provides parental support is a helpful aspect of partnerships (Smith et al., 1997).

Most research on the role of the school psychologist as it relates to parental participation at school has been quantitative and has examined parents’ involvement in special education and in the IEP process (Flanagan, 2001; Katsiyannis & Ward, 1992). Most studies examining parents’ experiences with special education have focused on the perceptions of parents of children diagnosed with learning disabilities, intellectual disabilities, or autism spectrum disorders, in spite of paediatric internalizing disorders (i.e., mood and anxiety disorders) being more prevalent than other disorders (Flanagan, 2001; Waddell et al., 2005). Studies examining the perceptions of parents of children with special needs (e.g., learning disabilities, intellectual disabilities) suggest that parents seek greater involvement with their child’s school, particularly

In a qualitative study in which parents (n=9) were interviewed about their experiences collaborating on their child’s IEP, parents indicated that they did not feel included at the level they desired and they conveyed their desire for greater understanding and participation (Flanagan, 2001). Other similar studies, where parents were interviewed about their perceived needs from special education service providers, highlighted that parents reported the importance of having professionals who were accessible, nurtured the relationship, and showed they cared by going beyond their job description (e.g., Nelson, Summers, & Turnbull, 2004).

Literature examining the specific and unique school-based needs of parents of an adolescent with a mental health concern is scant compared to the general special education literature or literature examining specific populations (e.g., children with autism spectrum disorders). It is important to examine the unique needs of parents of children with internalizing mental heath concerns, as they may differ from the general special education population (Petr & Allen, 1997). In a study evaluating parents’ perceptions of family-centered professional behaviour in 443 parents of children with internalizing mental health concerns versus other special needs, results indicated that there was variance in what parents of children with internalizing concerns view as being significant in professional relationships compared to parents of children in the general special education population (Petr & Allen, 1997). Specifically, parents of children with internalizing mental health concerns place greater focus on the value of professionals listening to their opinions and concerns as well as involving them as team members and with decision-making. These parents also placed more emphasis on obtaining information, and accessing formal services and school supports. In this study, parents of children with
internalizing mental health concerns reported seeking greater individualized services compared to parents of children with other special needs. Finally, parents perceived that school personnel supporting children with internalizing concerns are less family-centered than personnel supporting children with other special needs (Petr & Allen, 1997).

In another study, 35 parents of children with mental health concerns (e.g., paediatric difficulties with anxiety, depression, aggression, and conduct were reported) were interviewed about their experiences with the special education and community health systems (Tarico et al., 1989). Most parents reported that the system did not meet the mental health needs of their children. In this study, 45% of parents reported that they had been invited to collaborate with the team on their child’s treatment plan. Parents reported wanting whole-family support, open communication, to be involved in collaborating on a service delivery team, and more information from service providers (Tarico et al., 1989). This latter theme, that families of individuals with mental health concerns desire more information from service providers, had been supported by other studies (e.g., Gantt, Goldstein, Pinsky, 1989). More recently parents’ perspectives (N=200) of their needs in relation to their child’s mental health services were evaluated, and having professionals share information was one of the primary areas that parents indicated needed improvement (Wrobel, 2004). Overall, 67% of parents participating in this study indicated that finding mental health services for their children was challenging (Wrobel, 2004). When parents have been asked about their school-based experiences in supporting their children, parents indicate that consulting with school psychologists about their children’s needs is a helpful aspect of support (Christenson, Hurly, Sheridan, & Fenstermacher, 1997).

Family participation in educational planning for children receiving mental health services was evaluated in a sample of 133 parents of children with emotional disorders (Jivanjee et al.,
Parents reported having challenges obtaining an IEP for their child and once obtained, challenges having this plan implemented appropriately. Not having their child’s individualized goals carried out was attributed to school personnel not having knowledge of mental health, and parents indicated that this negatively impacted their child’s educational progress. Parents further indicated that because of educators’ limited knowledge about mental health, they found themselves in the position where they, the parent, conducted meetings and educated staff on how to best support their child. Parents who had positive experiences with their child’s school indicated that they worked well as a team with school personnel, that the district had been accommodating of their families’ needs, and that they had been included in educational planning (Jivanjee et al., 2007). The finding that parents’ perceive it to be unhelpful when educators have limited knowledge about mental health has been supported in the literature (Koller & Bertel, 2006). Teachers typically receive little training in understanding mental health concerns, and teachers often report feeling unprepared to support mental health concerns in the classroom, such as assisting an anxious student (Koller & Bertel, 2006).

One study on perceptions of family-school collaboration in parents of children with mental health concerns was conducted using the participatory action research method, in which parents participated in a five-month research process aimed at increasing family-school collaborations (Ditrano & Silverstein, 2006). Through this process parents reported becoming empowered and learning to cope with the emotions they had experienced related to their involvement with their child’s school, such as feeling powerless and alienated (Ditrano & Silverstein, 2006). A similar study examining parents’ perceptions of collaboration through using a wraparound service approach similarly indicated that collaboration and support contributed to the family feeling empowered and feeling less alone (Painter, Allen, & Perry, 2011). In this
study parents also reported that having support for the whole family and learning new skills were helpful (Painter et al., 2011).

Studies examining parents’ perceptions of school support of children’s mental health needs versus those examining perceptions of community support generally present common findings, including parents’ desire for their opinions to be heard, and parents’ wish to have greater involvement on service teams and with decision making / service planning (e.g., Flanagan, 2001; Petr & Allen, 1997; Rose, 1998). Parents also desire access to information from both school and community service providers (e.g., Petr & Allen, 1997; Wrobel, 2004). With regards to parents’ perceptions of school supports that are unique from their experiences with community supports, parents indicate that they have a greater desire for individualized services and supports, and to be involved in planning their child’s individual education plan (e.g., Anderson-Butcher & Ashton, 2004; Flanagan, 2001; Jivanjee et al., 2007).

There have been few studies that have examined perceptions of school supports in parents of children with mental health concerns. As expressed by Hoagwood et al. (2010), few studies have described what the specific components of support are, or have assessed the outcome of different types of support. Research is necessary to better understand the needs of families, with regards to providing school-level support and creating family-school partnerships.

**Barriers to Family-School Partnerships**

Although engaging parents of children with mental health concerns is important for children’s positive outcomes (Turnbull & Turnbull, 2001), it is important to explore the complexities of such partnerships. As stated by Christenson (2002), “although shared responsibility for educational outcomes is the rhetoric, school policies and practices are not always aligned with this notion” (p. 3). She suggested that diminishing resources, the current
political climate, challenges reaching out to all families, particularly non-English speaking families, and not enough attention being given to conditions that result in strong relationships are all factors that need to be considered with regard to how they impact the creation and sustainability of partnerships. Other school-related factors impacting partnerships include lack of school policies and systems supporting partnerships and personnel attitudes towards collaboration with families (Christenson, 2002; Christenson, 2004). For example, potentially stigmatizing families from different backgrounds may prevent outreach to diverse families, or teachers’ beliefs of their limited role in working with families at the secondary academic level may create barriers to effective partnerships. It has been suggested that schools have the most difficulty supporting the needs of children with emotional and behavioural concerns and in involving these children’s parents (Osher, Quinn, & Hanley, 2002). In addition to stigmatizing parents of children with mental health concerns, not creating an inclusive collaborative environment are factors that reduce participation in special education and in the IEP process, although this has improved in recent decades (Osher et al., 2002).

Christenson (2003) has outlined barriers for families, educators, and the family-school relationships, which can be categorized in terms of structural and psychological aspects. Educator barriers include both structural barriers (e.g., not training educators on how to work with families, lack of funding to support partnership initiatives) and psychological barriers (e.g., stereotypic views, negative communication regarding the student). Family-school partnerships similarly can have both structural (e.g., limited contact with families, limited skills on how to collaborate, only communicating in a crisis situation) and psychological (e.g., resistance to collaboration, not believing in partnership orientation, blaming attitude) barriers (Christenson, 2003).
Beyond school factors that impact partnerships, parental factors must also be considered, both structural or status-related (e.g., socio-economic, time restrictions) and psychological or process-related (e.g., role conceptions, cultural and / or linguistic differences, attitudes, communication style; Christenson, 2002; Christenson, 2003). For example, parental belief of their role with their child’s school, can impact involvement. It has been suggested that family process variables (i.e., what parents do to support their child’s learning) are better predictors of student outcomes than variables such as socio-economic status (Christenson, 2002). One barrier to family involvement identified in the literature may be recent immigration, particularly if the family has different views on education and is unfamiliar with North American school policies and practices (Bempechat, 1998). This is an area that needs to be better understood.

It is important for educators to understand family barriers to involvement so schools can respond with sensitivity when engaging families. While educators typically focus on understanding structural factors that may impact family involvement, such as a family’s socio-economic status, more attention should be paid to understanding psychological barriers (Christenson, 2003). For example, parents’ beliefs of the education system and beliefs of their role in this system are all factors that can impact involvement (Christenson, 2003).

**The Need for Qualitative Research**

This literature review highlights factors influencing parents of children with mental health concerns, and it explores characteristics of professionals that may influence parental involvement with their child’s school. The need for collaborative support systems to help families is expressed. However, research is needed to understand which aspects of school-level system support parents perceive to be both helpful and hindering, as well as aspects of support desired by parents that they perceive will help them in supporting their child. Collecting
information on parents’ perceived needs will add to the literature on understanding the factors that help families of children with mental health needs, as well as understanding factors of family-school partnerships and other school supports that may help this process.

There is a need for a qualitative approach to investigating parent experiences. Many prominent researchers recognize the need for diverse methods of exploration, as “qualitative studies… shed light on unanticipated consequences of current practice, and thus can lead to better conceptualization of interventions and reappraisal of practice” (Gersten et al., 2004, pp. 330-331). Qualitative measures can be used to sensitively describe parents’ experiences with school support, and to potentially give voice to families. As suggested by Barnes, Stein, and Rosenberg (1997), research rarely includes the perspectives of families even though systems of care for children with complex mental health needs often involve using collaborative approaches. Qualitative inquiry may contribute to closing the gap between sciences of discovery and implementation through obtaining rich information on individuals’ experiences and perceived needs.

The goal of qualitative research is to, “understand and represent the experiences and actions of people as they encounter, engage, and live through situations” (Elliott, Fischer, & Rennie, 1993, p. 216). Unlike quantitative methods that are focused on testing a specific hypothesis, qualitative methods are often descriptive or exploratory in nature. This study explored the perceptions of school support in parents of adolescents with internalizing mental health concerns. A qualitative approach was useful in this area of research, as there is a dearth of research on this topic, particularly that which solicits in-depth information from parents on their perceived experiences. Through the use of an open-ended, in-depth interview format, qualitative research can provide a richer understanding of participants’ experiences that is beyond what can
be obtained from quantitative research techniques. In the context of this study, the use of qualitative methods helped determine if the support parents received met their perceived needs. As qualitative methodology is exploratory and inductive in nature, and results are not limited to assessing pre-determined hypotheses (McMillan, 2004), an inductive analysis of the results allowed for a fuller understanding of the impact of school supports on parents and their children. Lastly, as it is considered best practice for schools to engage parents in all aspects of supporting a child’s learning and emotional well-being, it was important to solicit information directly from parents on which aspects of support were perceived to be helpful, which were not, and other aspects of school support that they would like to see implemented in the future.

Although there are several qualitative methodologies that encompass the characteristics described above, this study utilized the Enhanced Critical Incident Technique (ECIT; Butterfield et al., 2009), which has been revised based on Flanagan’s (1954) Critical Incident Technique (CIT). ECIT is a qualitative research method grounded in the sociological perception that the participants’ experiences, behaviours, words, and actions provide useful information regarding substantive problems (Creswell, 2007). This method acknowledges that reality cannot be separated from the naturalistic context, and the interactional relationship between the data and the researcher. Within this methodological tradition, theoretical insights are often subjectively generated, described, and illustrated. The language of the participants interviewed becomes central to the construction of knowledge, which in part is represented through using first person quotations to describe key findings.

This approach has many useful purposes including, understanding factors that help or hinder one’s experiences in a situation, obtaining a rich understanding of the characteristics of what is being researched, and allowing for differences or turning points to be explored. The
ECIT also encourages the practical applications of study findings, for example, by mental health practitioners (Butterfield et al., 2009).

**The Present Study**

This study examined parents’ perceptions of helpful and hindering aspects of support received from their adolescents’ school or school system while managing their adolescent’s internalizing mental health concern. The specific research questions that were explored in this study included: (a) Which aspects of school-based family and child support did parents perceive as helpful and unhelpful in coping with their adolescent’s mental health concerns?, (b) Why did parents report these aspects as helpful or not helpful?, and (c) What did parents perceive as missing from the support children and families received that might have helped the child and family cope? For the purposes of this study, “aspects” of support are defined as behaviours, attitudes, processes, events, activities or experiences parents of children with mental health concerns have in the school system that meet the perceived needs.
CHAPTER III: Method

This chapter summarizes study procedures, including a description of the enhanced critical incident technique (ECIT; Butterfield et al., 2009). Data collection and analysis procedures follow, and strategies for establishing rigour are presented.

Overview of the Critical Incident Technique

The Critical Incident Technique (CIT) was developed by Flanagan (1954), and has subsequently been used in many fields, including industrial/organizational psychology, nursing, counselling, and education (Butterfield, Borgen, Amundson, & Maglio, 2005). Critical incident technique was initially developed during World War II in studies of air force pilots, and it was notably the first systematic attempt to investigate aspects or incidents of behaviour perceived to be effective or ineffective (Butterfield et al., 2005; Flanagan, 1954). These aspects of behaviour that were analyzed became known as critical incidents (CIs). Although Flanagan (1954) is recognized for developing this methodology, Woolsey (1986) is credited for applying it to the field of counselling psychology. Woolsey (1986) proposed that CIT is an appropriate method for psychological research due to its ability to “encompass factual happenings, qualities or attributes, not just critical incidents... its capacity to explore differences or turning points... its utility as both a foundational/exploratory tool in the early stages of research, and its role in building theories or models” (Butterfield et al., 2009, p. 266).

Critical Incident Technique was developed during a period when the positivist paradigm was dominant in the social sciences. Although CIT was established as a qualitative research method, CIT also encompassed aspects from the quantitative research tradition, which was then dominant (Butterfield et al., 2005). For example, CIT was proposed as a method that could help uncover truths that were measurable, and to gain credibility, this approach was designed drawing
from aspects of quantitative research by using quantitative language and by having methods to establish validity and reliability of the results. As summarized by Bedi, Davis, and Williams (2005), “Although Flanagan’s approach is consistent with a constructivist understanding of human psychology (e.g., he established validity in qualitative terms), he often wrote using postpositivistic language (e.g., referring to “accuracy” and “objectivity”). Despite having positivistic roots, the CIT can best be understood to fall in the middle of the quantitative–qualitative continuum because it incorporates both qualitative and quantitative elements into a single method” (p. 312).

Although today the post-modern research paradigm is prevalent, it has been suggested that the CIT method can be applied within different qualitative research paradigms (Butterfield et al., 2005). This method is likely situated on a continuum between a postpositivist and a constructivist framework. Some elements of CIT are more aligned with a constructivist paradigm, such as its focus on understanding the sense that people make of their everyday lives, and the move away from a desire to remain neutral and to remove personal biases or political motives from the research process (Haverkamp & Young, 2007). Rather, researchers are encouraged to engage in a process of ongoing reflexivity where one acknowledges and explores how personal assumptions and beliefs affect the research process (Haverkamp & Young, 2007). However, many of the core features of CIT are aligned with a postpositivist paradigm, such as the process of establishing credibility and trustworthiness of the results through having an expert in the method check the researcher’s process. Furthermore, the process of quantifying the results by calculating the participation rate is also aligned with CITs positivist roots (Butterfield et al., 2005).

Critical Incident Technique proposes a systematic and yet flexible set of interview
procedures for gathering information from participants about their direct observations of their own or others’ behaviour that either help promote or detract from an experience with a situation or event (Woolsey, 1986). Although this methodology was initially designed by Flanagan (1954) to focus on overt critical behaviours that were observable, CIT has been revised over the last several decades to include collecting information on beliefs, attitudes, feelings, and perceptions (Butterfield et al., 2005; Woolsey, 1986). The CIT was therefore well suited to this research, examining the effective (helpful) and ineffective (unhelpful) aspects of school support perceived by parents of adolescents with mental health concerns. This study adopted a broad understanding of CIs to be any behaviours, attitudes, activities, processes, or experiences that were perceived to be helpful and not helpful to participants.

This study used an expanded form of CIT (i.e., the Enhanced Critical Incident Technique; ECIT) that has been applied by researchers in recent years to explore the meanings associated with CIs (Butterfield et al., 2009). Therefore, in addition to exploring the content of CIs that arise from the analysis of results, the meanings that participants associated with the helpful and unhelpful aspects of school support were also examined. Meaning associations were determined by asking participants to explain how or why the CIs they identified were helpful or hindering to their adolescent and / or family.

Data Collection

Recruitment of Participants

Participants were recruited through various community partners (e.g., child and youth mental health offices) after obtaining University ethics approval. Recruitment primarily occurred through posters and electronic mailing lists to potential participants. The researcher also attended staff meetings at various agencies to promote the study to clinicians and to provide recruitment
materials (i.e., posters and a participant information letter; see Appendices A and B). Interested persons were asked to contact the researcher for further information.

Individuals were eligible to participate in this study if they were a parent of an adolescent diagnosed with an internalizing mental health concern (e.g., mood or anxiety disorder), who did not have significant externalizing behaviours (e.g., aggression). Only parents whose adolescents were currently in grades 8 through 12 and were attending school regularly were included. As the goal of this research was to understand parents’ perceptions of school support, all participants were parents who indicated they had significant experience and involvement with the school in relation to their adolescent’s mental health needs. Potential participants were eligible if they were able and willing to articulate the meaning of their perceived experiences. Participants were screened on the phone prior to participation to ensure they met the above criteria.

**Description of Participants**

Ten interviews were conducted, with a total of 11 parents interviewed. Nine youth attended public school, and two attended private / independent schools. Nine interviews consisted of the adolescent’s mother participating, and one interview involved both the adolescent’s mother and father participating together. In the one interview where the mother and father participated together, they worked together to generate critical incidents, and they did not report differing experiences or perceptions. This interview with both parents therefore did not differ from the interviews with only one parent participating.

At the end of the interview, participants were asked if they were interested in completing a brief demographic questionnaire (Appendix C). This information was collected as a means of describing the participants and providing relevant background information. Participants had the option of not completing the questionnaire in order to respect the privacy of the family, if
desired. All participants agreed to complete the questionnaire, although three participants did not complete all items.

Results from the demographic questionnaire indicated that participants had adolescents attending schools from six different school districts (boys: n = 6; girls: n=4). Eight participants indicated that their adolescent had an anxiety disorder, with three of these parents indicating their child had comorbid depression and one of these parents indicating that bipolar disorder was being queried. One parent reported her adolescent’s primary diagnosis was major depressive disorder and one parent indicated her child had been diagnosed with bipolar disorder. In addition, one parent indicated her child had been diagnosed as having a learning disability, three parents indicated their child had undiagnosed learning difficulties, and two parents reported their children had also been diagnosed with attention deficit/hyperactivity disorder in elementary school. Parents indicated that their child’s diagnosis was made by a psychologist or psychiatrist. Documentation was not requested from parents to verify their youth’s diagnosis. Most parents indicated that their child had had mental health difficulties since elementary school.

Six parents reported that their teen had a British Columbia Ministry of Education special needs designation for being a student with a moderate or severe mental health concern (R / H designation, BC Ministry of Education, 2011), two indicated their child had not been designated by their school, and two participants did not respond to this question. With regards to a family history of mental health concerns, eight participants reported a significant history, and two participants did not respond to this question. Finally, participants were asked about the frequency of their involvement with their adolescent’s school. Three participants reported weekly involvement, six reported biweekly involvement, and one participant did not respond to this question. The demographic questionnaire was optional; if parents did not respond to all items,
there was no follow-up procedure to determine why they may not have completed the questionnaire in its entirety.

**Sample Adequacy**

The number of participants selected was determined when exhaustiveness or redundancy in the data occurred, as recommended by the ECIT method (Butterfield et al., 2009). Redundancy is the point at which no novel CIs, or CI’s in need of new categories were described by participants (Butterfield et al., 2009). The number of participants required in ECIT to achieve an exhaustive set of categories is therefore dependent upon when new findings stop emerging from the data (Butterfield et al., 2009). By using a log, I was able to watch as new categories emerged with each interview. After four interviews, it appeared that new categories stopped emerging from the data. Although redundancy occurred after the fourth interview, I continued to interview more participants to explore the emergent categories in as much detail as possible. While new incidents emerged in the interviews conducted following establishing redundancy, all incidents were represented by the existing seven categories.

The 10 interviews generated 215 CIs for analysis. Flanagan (1954) emphasized that the fundamental motivation for having a sufficient number of incidents is not to be able to make statistical generalizations, but rather an effort to ensure that the domain of interest is fully represented. The collection of 100 incidents is considered adequate when the features of the activity are fairly straightforward (Flanagan, 1954; Radford, 1996; Voss, 2009). It can also be assumed that adequate coverage has been achieved when only two or three new CIs emerge from 100 incidents gathered (Flanagan, 1954). Thus, the 215 CIs obtained in this study appears sufficiently representative in breadth to capture effectively the content domain of the activity under study (Flanagan, 1954; Bedi et al. 2005).
Procedure

Interviews with Parents

Semi-structured interviews with individual study participants are particularly useful when participants have varying thoughts, experiences, and perspectives, as a well-conducted interview allows for a richer and more meaningful account of participant experiences (Fontana & Frey, 2005). Individual interviews with consenting parents were scheduled at a location chosen by the participant that was private and appropriate. Seven interviews were conducted in either a private office (e.g., a Child and Youth Mental Health office) or private meeting room in a public library, and three were conducted in the participants’ home.

Interviews followed a semi-structured format and varied from 48 minutes to 105 minutes in length. At the outset of the interview, participants were read the consent form (Appendix D), which outlined the purpose and significance of this study, the study procedures, and the rights of the participant. Participants were invited to ask questions. Written consent was obtained.

A brief overview of the interview protocol will be provided here, but a detailed account can be found in Appendix E. Interviews began with general questions about the participants’ experiences regarding their adolescents diagnosis and their involvement with the school. Initial questions were meant to build rapport and encourage the participant to recall background information (i.e., related to their child’s diagnosis and their involvement of the school) that may facilitate later recollection of CIs. Participants were then asked to recall aspects of school support (including attitudes, behaviours, events, activities, processes, and/or experiences) that they perceived to be helpful or not helpful in supporting their adolescents mental health needs and their family.
As this study used the ECIT method, participants were asked to discuss the significance of each CI identified. Follow-up questions were posed to participants regarding specifically why or how the CI had been helpful. After exploring all CIs related to what parents perceived as being helpful or unhelpful in the support received from their adolescents’ school, consistent with the ECIT approach, participants were asked to create their wish list of supports that they believed would be helpful.

Flanagan (1954) suggested that the accuracy of self-reports could be inferred from the level of full, precise details given by the participants (as cited by Butterfield et al., 2005). To facilitate the identification and full expression of CIs, throughout the interview open-ended questions were asked and the researcher engaged in active listening skills, such as paraphrasing, empathy, and exploring and probing responses. Face to face interviews allowed the researcher to ask clarifying questions and to explore how causal meaning was attached to the events or why the interviewee perceived the incident to be critical. Follow-up questions allowed the same content areas (i.e., helping and hindering factors) to be examined at the same level of detail across all participants (Butterfield et al., 2009).

Data Analysis

All interviews were audiotaped and transcribed verbatim by a professional transcriptionist who had signed a confidentiality agreement (Appendix F). Audiotaping and transcribing the interviews ensured that the researcher was able to gather as much information as possible to investigate the meaning of participants’ experiences and analyze themes. All identifying information was removed, and participants were assigned identity numbers. The raw data were organized and CIs were extracted from the transcripts using a method modified from Butterfield et al. (2009). Data were analyzed manually, and not by using a data analysis software program.
An incident was judged critical if the participant was able to provide details of the experience and recall why the incident was a helpful or unhelpful experience. To analyze the data, each transcribed interview was saved in a password protected Microsoft Word document. First, the interviewer used two different colours in Microsoft Word to delineate the helping and hindering categories. Next, distinct CIs were identified by underlining the text in Word. These extractions represented the statements (incidents), together with examples, context and source (Butterfield et al., 2009). All extracted CIs were then cut and pasted into two separate Microsoft Power Point documents (i.e., helpful and hindering documents). Power Point slides were printed and then organized into a classification system (described below).

**Descriptive Validity**

Four methods were used to confirm the accuracy of data collection according to procedures outlined by Bedi et al. (2005), and Butterfield et al. (2005). First, a fidelity check on the interview process was conducted by having a researcher experienced in the ECIT methodology read the transcripts from two interviews, who confirmed that no leading questions were asked and that an objective protocol was followed (Butterfield et al., 2005). Second, interviews were conducted to the point of “exhaustiveness,” which is the point at which participants stop generating new CIs or CIs in need of new categories (Flanagan, 1954). Although no new categories emerged after the interview with the fourth participant, six additional participant interviews were conducted to flesh out the scope of the categories. Third, at the conclusion of each interview, the researcher briefly summarized the CIs that emerged, and invited the participant the opportunity to add, modify, or clarify a CI. Individual and group member checks were also completed, which are described below. Fourth, to ensure that the CIs were correctly extracted according to the ECIT method, a PhD student with background in
qualitative research and ECIT was given a random sample of 25% of the transcripts and asked to conduct an independent extraction of CIs. Extraction of CIs were compared with the interviewers, and initial results indicated 96% agreement, which upon further discussion, was raised to 100%.

**Coding Categories**

Critical incidents were organized into a classification system to allow the data to be efficiently summarized (Flanagan, 1954). Coding involved examining similarities and differences among CIs in the helpful and hindering categories (Butterfield et al., 2009), using a process similar to open coding, where data is segmented into categories of information best embodying the “persistent ideas” (Creswell, 2003). Extracted CIs were read and reread across participants to determine patterns, commonalities, and differences, and CIs encompassing similar words and phrases shaped emergent categories. Participants’ language was pivotal in shaping the development of the categories during this open coding process (Creswell, 2003). Category construction was an inductive process that was subjective and depended on the researcher’s experience, insight, and judgment (Flanagan, 1954).

Critical Incidents were segmented into categories starting with three randomly selected interviews (Butterfield et al., 2009). After initial categories were identified in these three interviews, the remaining interviews were analyzed one at a time. During this process many categories were reconceptualised and the level of specificity was modified accordingly as the concepts representative of the data were examined. Critical Incidents were clustered into common groupings and were classified under headings representative of the data.

Data were organized using Microsoft Power Point, with each CI on a separate slide. Power Point slides were printed and reorganized when finalizing the categories. The final
selection of categories was completed through collaboration both with a researcher in the field and with participants to ensure that the categories accurately described the persistent ideas in the information collected.

It should be noted that several of the emergent categories were related. Often a participant’s comment would include a string of descriptors related to more than one category. However, each CI was only coded into the category that best represented the participant’s main idea in terms of what was helpful or unhelpful in the incident.

**Rigour**

**Trustworthiness of Data and Interpretations**

Five credibility checks were conducted to enhance the objectivity of the categorization process and enrich the validity or trustworthiness of the results (as recommended by Butterfield et al., 2005).

First, the emerging tentative categories for the data analysis were submitted to a researcher in the field of education and mental health to solicit information on whether she agreed with the categories, if she found them useful, if she was surprised by them, and if she thought something was missing. This step was undertaken to enhance the credibility of the results. Overall, feedback confirmed that the categories made sense and were clear. It was suggested that there was some overlap between two of the categories, and that one category was very specific and could perhaps be incorporated into another one of the categories.

Second, results were compared to themes in the existing literature. This credibility check involved assessing agreement between the emergent categories and the current literature regarding theoretical models of family-school partnership in supporting children with mental health concerns (Butterfield et al., 2009). The majority of elements previously articulated in the
literature review (e.g., the importance of communication, collaboration, information, support, and services) were reflected in the results obtained.

Third, interrater agreement was calculated for sorting CIs into categories. An independent rater with a research background in qualitative education, sorted randomly selected CIs (25%) into the seven categories. The independent rater was provided with the category titles and a brief description of each category and was asked to independently sort the CIs into the categories. Initial results indicated 87% agreement, which upon further discussion was raised to 100%.

Fourth, both an individual (i.e., a summary of the participant’s interview) and a general member check (i.e., all categories were sent to all participants) were completed to examine the interpretive validity of the categories (i.e., the match between the meaning attributed to participants’ experiences and actual participants’ perspectives). This step helped establish the trustworthiness of the researcher’s interpretation of participants’ experiences (Bedi et al., 2005). Participants were provided with a summary of their individual interview as well as a list of the emergent category titles and a brief description of each category. They were phoned approximately one week following being sent the summary and were asked a series of questions relating to their previous interview experience (see Appendix G). Regarding their individual interview, they were asked if their experiences had been accurately summarized, and if there was anything they would like to add or modify. Regarding the emergent categories participants were asked: (1) Do the category titles and descriptions make sense to you? (2) Do the categories capture your experience and the meaning that the incidents had for you? (3) Are you surprised by any of the categories? Participants were asked to elaborate on their responses and follow-up questions were asked accordingly. The goal of asking these questions was to evaluate the consistency between the researcher’s interpretation of the data and participants’ perceived
meaning of their experiences. For the member checks, nine participants were reached, and two were unable to be contacted via phone or email. All of the participants who responded indicated that their experiences were properly summarized. All participants indicated that the category titles and descriptions made sense and that they were completely reflective of their experiences. One participant had some feedback on some of the language used to describe one of the categories. Her feedback was taken into consideration in the revision of the categories.

The fifth and final step to establish trustworthiness was to set a minimum participation rate in a given category. According to Flanagan (1954) a category was valid if “significant frequencies” of CIs are reported under that category. Following the recommendations of Butterfield et al. (2009), categories were deemed valid if a minimum of 25% of the participants reported a CI in that category.
CHAPTER IV: Findings

This chapter presents the results of the study. First, the categories are presented in table format, followed by a detailed description of each of the categories (Table 1). The categories are arranged in hierarchical order, based on the participation rates within each category. The participants’ “wish list” consisting of aspects of school support missing that participants’ perceived would be helpful is then presented (Tables 2 and 3).

Overview

A total of 215 CIs were extracted from the 10 interviews with participants. Of these, 148 incidents were perceived as helpful aspects of support and 67 incidents were perceived as hindering. The CIs were classified into a total of seven categories. Table 1 displays the distribution of the CIs for each of the categories. All of the helpful and hindering CI categories had participation rates that in most cases far exceeded the minimum criterion of 25% for inclusion (Butterfield et al., 2009).

Table 1 Critical Incident Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Helping Incidents (% of Total Respondents)</th>
<th>Hindering Incidents (% of Total Respondents)</th>
<th>Contributing Participants</th>
<th>% of Total Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individualized Supports</td>
<td>55 (100%)</td>
<td>22 (70%)</td>
<td>10</td>
<td>100%</td>
</tr>
<tr>
<td>Communication Between Home and School</td>
<td>31 (90%)</td>
<td>18 (40%)</td>
<td>9</td>
<td>90%</td>
</tr>
<tr>
<td>Understanding and Support</td>
<td>21 (60%)</td>
<td>15 (70%)</td>
<td>8</td>
<td>80%</td>
</tr>
<tr>
<td>Category</td>
<td>Helping Incidents (% of Total Respondents)</td>
<td>Hindering Incidents (% of Total Respondents)</td>
<td>Contributing Participants</td>
<td>% of Total Respondents</td>
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<tr>
<td>--------------------------------</td>
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</tr>
<tr>
<td>Having an Advocate in the School System</td>
<td>17 (70%)</td>
<td></td>
<td>7</td>
<td>70%</td>
</tr>
<tr>
<td>A Safe Place at School</td>
<td>6 (60%)</td>
<td></td>
<td>6</td>
<td>60%</td>
</tr>
<tr>
<td>A Team Approach</td>
<td>18 (40%)</td>
<td>2 (20%)</td>
<td>5</td>
<td>50%</td>
</tr>
<tr>
<td>Understanding Mental Health</td>
<td>5 (30%)</td>
<td>6 (30%)</td>
<td>3</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Individualized Support**

Critical Incidents described as individual support (100% of respondents) refer to school staff tailoring student’s learning. Individualized learning included teachers and support staff taking time to understand the student and provide appropriate accommodations and adaptations to support the student’s unique mental health and learning needs. According to participants, individualizing learning helped to “take the pressure off” their adolescent. This decreased pressure was demonstrated in their adolescent’s decreased anxiety and increased willingness and motivation to go to school. Individualized learning was perceived as contributing to building their adolescent’s self-confidence and increasing productivity. It was also perceived to be helpful for participants in lowering their anxiety and the families stress at home. The following two quotes capture participants’ experiences related to the process of their adolescent receiving individualized support. These quotes are typical of other interviews.
They have given him accommodations. Like I know they stopped him from doing French because he just was not engaging at all. I know that sometimes he doesn’t do good in a group setting and this school unfortunately is built all on group work and they have six, seven, and eight together. So that’s how this school is and he just doesn’t function well. So they would accommodate him by letting him work on projects by himself. It enables him to not feel self-conscious in those groups, so I think it does help him lower that anxiety. (Participant 6)

The fact that they were willing to try a technological thing, like when they had an iPad. They used one from the school to program my son’s activities so that he wouldn’t have to depend on his memory, because in depression your memory just goes too. And so he would forget to bring his lunch, he would forget his bus ticket… So they had an iPad that they programmed a warning type buzzer in it and said, “you now have to go to Math class” or “you have to go out to recess.” So that helped him be independent. (Participant 3)

An important aspect of this emergent category of individualized support for some participants was having their adolescent assessed and being designated through the BC Ministry of Education (as being a student with a moderate or severe mental illness, R or H designation). Parents reported that the assessment was helpful in understanding their adolescent’s strengths and weaknesses, as well as determining appropriate accommodations and supports. Parents stated that their adolescent having a ministry designation contributed to school personnel being aware that the student required special accommodations, and they believed that this might have increased the supports their child received. The following two quotes capture participants’ experiences related to assessment and ministry designation.
Having a psycho-educational test was helpful. I think you always want to know where you’re at, how far you’ve come, and what the limitations are. And really that’s the way of finding out what the adaptations should be. So yeah I think the more information that you have for your child the better. So I think just having a really solid in-depth diagnosis, well not a diagnosis but observation and assessment of your child, and really how they can learn and where you’re at, at this particular point in time really helps. (Participant 4)

They did finally start moving towards a designation and that was helpful. Well I think, and my hope had always been that there had to be a reason why he was like that. People don’t just choose to be anxious. You know maybe genetically he’s predisposed to be it, but when you’re only anxious the majority of your life in that environment, there has to be a reason why. So I was happy with that happening because it then got people around the table, it finally got him at the beginning of grade seven a psycho-educational assessment that I asked for in grade two, grade three, grade four, grade five and was told, “I’m sorry he’s not a behaviour problem.” So the designation got him a bit of support in place. It got some adaptations. So that helps and I know a lot of parents don’t want their kids labeled, but I was all over it. Because I knew that was the only way I was going to get help. (Participant 9)

Beyond adaptations and accommodations, participants expressed that individualized support also included their adolescent’s school providing extra support services, such as one-on-one assistance with work. The following quote captures one participant’s experiences.

In the district they’ve got this program. All I know is it is really individual learning. And they’ve got one teacher and one counsellor basically designed to help these kids. Now he is segregated from the rest of the school, which is not a great thing. The counsellor is
there, but it’s more academic. This individualized program was helpful because well he’d go to school. He’s gone to school this year pretty much every day. He has finished grade eight, and that’s huge. He has done all the curriculum that is necessary for a grade eight to do, and he did tremendously in it. The key thing is he went to school every day. They are being able to teach him. They’re teaching him and it’s one-on-one, and he is not overwhelmed. He is not feeling anxious, and he’s getting it. He’s learning. (Participant 8)

In short, the emergent category of individualized support, which included assessment, ministry designation, accommodations, adaptations, and one-on-one support, was reported by all participants to help improve their adolescent’s productivity at school, which was perceived to decrease anxiety and increase self-confidence. This reduced parents’ stress and anxiety at home.

Some participants reported that school personnel not understanding their adolescent’s needs and providing appropriate accommodations and supports was a hindering aspect. Limited support also included the school not having sufficient individualized resources and services to support their adolescent. Specifically, participants cited frustrations with lack of counselling support, learning resource support, and assessment services. The following two quotes capture participants’ experiences and are typical of other interviews.

I knew the school counsellor couldn’t give us, I felt, couldn’t give my daughter the time. That’s why I went outside because I knew my daughter needed more. It wasn’t helpful because she needed more, more one-on-one intense counselling… We were trying to get to the root of the problem and her counsellor did not have the time I believe, this is me putting words in her mouth, but that’s the way I saw it. She did not have the time. I’m not saying she did not have the expertise, I do not know, but she definitely did not have the time to delve into all that. It would have been handy if my daughter could have had the
same amount of time and attention that she got outside of the school. But you know the big picture is sometimes you need to have a, a variety of support like that so it worked out in the end. (Participant 2)

In the learning skills block they said, “yes I know he needs help but in his skills block there are a bunch of other kids who are always clamouring for help. We try to help him as much as we can but it’s hard when we got these other kids who are asking for help too.” So they knew he was struggling. It wasn’t helpful because he couldn’t help himself and he wasn’t getting the support he needed. He likes to stay under the radar. He’s really good at doing that. It was working perfectly. He wasn’t failing because he’s really bright, so there were no red flags up there. So it was frustrating and I was hoping that it was just him being teenager, being lazy, not wanting to do work but obviously there were other things going on there as well. So the public school system failed for him, which made me sad because I like the public school system. But it just didn’t work. (Participant 7)

Overall, insufficient individualized support was reported by 70% of participants. In this study participants reflected on how their adolescents were not getting enough support at school. This was a source of frustration for parents as they witnessed their adolescents struggling at school academically and emotionally.

**Communication Between Home and School**

Participants reported that routine communication between home and school ensured that the parent(s) and staff had similar understanding and were aware of the student’s progress and difficulties. Routine communication involved the parent(s) informing the school of any changes with their adolescent’s well being, which helped staff better understand the student and provide appropriate supports and services. It also involved the school informing the parent(s) of any
observed changes or concerns with the student either related to mental health or academics, which allowed the parent(s) to support their child at home. The following two quotes capture participant’s experiences related to the importance of routine communication. These quotes are typical of other interviews.

I had regular communication with her resource teacher. It was good because it kept me informed. And I can really help my child, or even know where to go or what to do, but not if I don’t know what the situation is at the school. Yeah so there was ongoing communication, which was helpful both in person and by email. So just having something between me and the actual school, you know a medium to have a conversation, especially in high school. I mean it’s easier in elementary school because again you can kind of just walk into the classroom and chat with the teacher. (Participant 5)

I met with his teachers and I think from the teacher’s perspective what they said to me was great, because you know I would let them know some of the things I was doing at home… and then likewise it was helpful for me to know what they were doing, what the issues were. It was also helpful for them to hear that yes he is being medicated, that yes he is being treated through Child and Youth Mental Health so that they also can categorize him… categorizations I guess that’s how they label him in the school so he has that IEP thing or whatever. (Participant 6)

Participants emphasized at times it was important for communication with their adolescent’s school to be discreet, and for the parent to share information with school personnel without their youth’s awareness. Discretion was important when the information being shared was sensitive in nature yet important for the school to know, and parents believed that their
adolescent would be upset if they were aware of the information being shared. However, sharing important information helped staff understand their adolescent and provide appropriate support. Parents reported that discretion in communication at times was helpful as it enabled their adolescent to maintain a sense of composure at school. The following two quotes are representative of this aspect of the category.

Communication by email was helpful, which actually in dealing with the high school level is much more efficient. I mean when you go to an elementary school it’s smaller and maybe it’s just the teacher and the principal involved, but when you try to navigate at a high school, and then going into a high school when you’re my age is weird anyway. So this is just much easier. It has been helpful. I would say that if I had to go into the school for my daughter and if she felt that kids she knew, knew my mother is coming in to talk about my health potentially with my teachers, then that would be mortifying, especially when you’re 15 year old. So just knowing that that can all be done discreetly and she can maintain some sense of composure in that and trying to support her in that way is helpful too because it’s such a sensitive age anyway. (Participant 1)

It was helpful to make a connection with each teacher and so they’ve got a face to put to a name. You give them a very quick summary of what’s going on, they don’t need to know everything. It even gets to the point where they’re giving you the courtesy of saying, “Your son probably forgot to mention this but he has a report due and he seems kind of down, is there something going on that maybe we should know about?” And I’m like oh yeah I never even thought of how that would impact him. So then I’ll write back to them and say “oh gee he wanted to see his dad this weekend and it didn’t turn out,” or whatever. It really helped us without anybody having to say, oh well your teacher told me
you didn’t hand in this, just say, oh, don’t you have a report that you need some help with? It helped just to kind of get him back on track. So I can be subtle and he didn’t feel like he’s being spied on… It helped just communicating but also my son not knowing that you were communicating. So maintaining his sense of privacy. (Participant 3)

Another aspect of the communication category was that communication between the home and school was at times important for their adolescent’s safety. Participants reported that sometimes their adolescent would leave school unexpectedly when feeling anxious, and it was important that they were informed when this occurred. This element is reflected in the following quote.

For me it was also almost a safety issue. She had left the school a couple of times. She had told the teacher that she didn’t feel well and was going home. And then I got an email from the teacher letting me know. I had alerted the teachers and the counsellor that she was seeing the counsellor at YY on a regular basis. All of a sudden I get a call from the counsellor (at YY) after school on a day my daughter is supposed to be seeing her. It was just right down the street so she would go directly there after school. Well she didn’t show up but she did call or text the counsellor and said, “I’m not feeling well, I’m going home.” But the counsellor, thank goodness, thought hmm. So I get a message from the counsellor, “I don’t know where your daughter was, I just wanted to see how she is feeling.” Of course I called her right away and I said, “She’s not at your office?” So I went home, and she’s not at home. So then I called the school counsellor, I emailed the teachers, and nobody knows where she is. I was worried, and I thought “oh my god.” I started phoning some of her friends, nobody knew. We did find her eventually. And so it
was a safety thing. So again it was helpful communicating and that everybody was on a track and knew. (Participant 2)

Here we see the interviewee trying to make sense of the happenings and how it was important to have regular communication with school staff to ensure her daughter’s safety. Overall 90% of participants reported that routine communication between home and school was a helpful aspect of support when managing their adolescent’s mental health concerns.

On the other hand, when there was limited communication between the home and school, participants reported that this was a hindering aspect of support. Participants cited that in spite of their efforts to communicate with school personnel, they often did not hear from the school with updates on how their adolescent was doing or with any concerns until a situation had escalated. Limited communication often prevented the parent(s) from supporting their adolescent at home and working with the school to solve problems. Participants reported that they felt like they were often reaching out to the school and that the communication was not reciprocated. The following quote summarizes a typical participant’s experience.

I have found a couple of times that the staff let stuff escalate to a point where I wish they would have notified me sooner. Because I was in this oblivion thinking, well I haven’t heard from them then everything is okay. And then something happens and we go to meet and then they say “well actually there’s been this process of escalation” and I said “well why didn’t you tell me back then instead of here, I could have helped you.” So that I found wasn’t helpful… It’s not helpful because nobody’s closed the loop for me. So I’m assuming everything is great, but in fact it’s not. So I do find that it’s always me reaching out to ask. And I get they’re busy, I’m busy, that’s why I don’t always email as much as I want to, but I would appreciate that loop back faster because it helps me support him on a
daily basis. I know it’s a lot to ask but even daily just sending me an email or weekly saying, yeah good week, not good week, you know, not good because he did X, Y and Z. It wouldn’t take that long, but that would be very helpful for me because otherwise I assume everything is groovy. (Participant 6)

Here we see the interviewee reflecting on her experiences reaching out to her adolescent’s school and perceiving the communication not to be reciprocated at the same level. Participants experienced similar communication patterns to be unhelpful because they were not informed of their adolescent’s difficulties at school, which impacted their ability to be involved with the school and to support their adolescent at home. Overall 40% of participants reported that limited communication was an unhelpful aspect of support.

**Understanding and Support**

Participants cited that it was helpful when the school staff expressed to either their adolescent and / or to themselves that they understood their situation and were supportive. This included staff taking the time to learn about the family’s situation, being approachable, being encouraging, and making oneself available for support. Participants cited that this was helpful because they felt heard and supported. The following two quotes reflect CI’s in this category.

We weren’t in touch with the head of the whole school, but the counsellor passed the information on I guess to her when it was starting to get bad. And then I got a wonderful email from her saying, “I hope, you know I hope he’s going to be okay.” She actually confided to me that her own daughter had mental health struggles and had gone to a therapeutic program in Costa Rica for a few months; that was her own daughter. So there was a lot of support there. (Participant 7)
This was actually a meeting that she had with her counsellor. The counsellor said to her one day, “Hi, it’s good to see you’re here today. I need to have a meeting with you.” And so they went and had this discussion. It’s good to see her being willing to go because she hasn’t always been, if it appears fearful or there’s some expectation that she can’t deal with. So she had a meeting with her and reassured her that she was not going to loose her place in the program. This was helpful because it’s almost given her room now to be in class and just be herself. And then she surprises herself when she does well at something, which is just a positive reinforcement. So it’s taken a great, or appears to have taken a great deal of stress off her, off us. (Participant 1)

From the CIs in this category, it appears that parents of adolescents with mental health concerns find it helpful when school personnel express their understanding and support of their adolescent and families needs. Overall, 60% of participants reported that this was a helpful aspect of support.

On the other hand, some participants reported that school personnel not appearing understanding and supportive was a hindering aspect of support for their child and family. This referred to school personnel not taking the time to understand the student and/or family and their unique needs, which contributed to feelings of not being supported and heard. The following quote is reflective of a CI in this category.

I met with the counsellor and we had to talk about what was going to happen for the rest of the year. This was before my son had stopped going to school you know. So she was spelling out what would happen if he didn’t go and, and what he had to do in order to complete the year. And she was, I mean it was just probably her personality, but maybe not quite as warm empathetic to what was going on. I mean she’s a counsellor so in
theory you should be if you’re in that position. So I mean she wasn’t negative she didn’t say you can’t do this, you can’t do that, just not as pleasant to deal with. She wasn’t very understanding. She wasn’t really responding, she was kind of factual, like this is what you need to do. She didn’t seem to be empathetic. Her attitude was more cut and dry and this wasn’t helpful. (Participant 3)

This participant was reflecting on her experience of interacting with a counsellor that was less understanding and supportive. Overall, 70% of participants reported that staff having limited understanding was an unhelpful aspect of support.

**Having an Advocate in the School System**

Having an advocate in the school system was an important aspect of support for participants. It was helpful for parents to have a “go-to person” with whom they communicated their adolescents needs and who acted as a liaison, facilitating communication between home and school. This advocate helped support parents by communicating their adolescent’s needs to school personnel and working with staff to ensure that these needs were met. This was helpful as it provided participants with a sense of relief knowing that someone else cared and was looking out for their adolescent’s best interests in the school system. The following two quotes typify CIs in this category.

My daughter’s counsellor is the head of the counselling department so she was quite proactive in doing research herself in aspects of my daughter’s diagnosis and medication, because obviously we had to inform the school of what medications she was taking, in knowing what she needed and then them being able to communicate that to the staff. The counsellor then took responsibility for that rather than myself having to dialogue with nine different members of the staff at the high school level, and so that they all
understood. There is a bit of vagueness as a parent when you get to the secondary level in terms of how much teachers can know and how much they can’t know. So the counsellor was great in helping to facilitate that. (Participant 1)

I went in and met with the counsellor a few times. I met with her early on just to explain what was going on so that she knew. I was emailing her regular updates all the time. He’s on a new medication, we’re trying this, I hope this is going to help, etc... She often would be my liaison to other teachers, which was helpful. She would say, “Okay, I’ll let everybody know about this,” or you know, “glad to hear he’s doing better.” So it was nice to feel that there was that support and that she would share information with his teachers. It was a relief to know that there was somebody else who was interested and watching out for your child, you know because you feel really alone and isolated.

( Participant 7)

Overall, 70% of participants reported that it was helpful having an advocate in the school system. As reflected in the above quotes, having an advocate helped parents navigate the school system and facilitate communication with school personnel. Participants reported that the advocate looked out for their adolescent’s best interests and would work with school personnel to ensure that the student was receiving appropriate accommodations and services.

A Safe Place at School

Participants cited that it was helpful when the school identified strategies or created initiatives to “make the school a more friendly, familiar, and safe place” for students with internalizing mental health concerns. An aspect of this category reported by participants was that it was helpful for the school to identify a physical space that was deemed a “safe place” for their adolescent to go when feeling anxious or overwhelmed during class time. Youth with anxiety
disorders may sometimes feel overwhelmed in the classroom, and participants indicated that when this occurred, it was helpful for their child to have a place to go to regain composure. In this safe place the adolescent occasionally was able to meet with a staff member, such as a counsellor, resource teacher, or vice principal who could help the student use strategies to reduce anxiety. Other times the student did not receive individual support in this safe place, but the student was able to take the time to relax prior to returning to the classroom. Some participants reported that the school created opportunities for their adolescent during lunch hour where they could meet with other students in a safe space. Having a safe place for youth to go contributed to students feeling comfortable and safe at school, and feeling a sense of belonging. The following quote is typical of a CI in this category.

If my daughter was feeling so overwhelmed that she had to get out, and instead of leaving the school or hiding in the bathroom where were some safe places she could go? So we made a list. We made kind of a safety plan which was nice. It was helpful knowing that she wasn’t going to be leaving the school. And so I went over it with my daughter, okay here’s what you can do if you’re feeling anxious you can do this, this, this, this. And I think it helped her because she knew she wasn’t alone right, and she knew okay I could go here if I need help. (Participant 2)

As reflected in the above quote, having a safe place at school for the student contributed to the student staying at school and having a place to go to relax and receive help if needed. Overall, 60% of participants reported that having a safe place at school was a helpful aspect of support.
A Team Approach

Participants cited that a helpful aspect of support was working as a team with school staff to identify appropriate strategies to support their adolescent at school and to problem solve when situations arose. Working in partnership was helpful as participants perceived school staff to listen and take their concerns seriously, and to value their expertise as a parent. Participants felt respected and supported, and they perceived that everyone was working together and was on the same page in helping their adolescent. Working as a team with the school contributed to participants’ perceiving shared responsibility for their child. They appreciated that other people were keeping an eye on their adolescent at school and cared for their adolescent’s well-being.

The following quote typifies participants’ experiences.

The level that they’ve involved us, letting us know, stopping things, or communicating before things get way out of control for him has been helpful. So that’s been good that we’ve had a really good relationship with them and they’re open to that. And so I think it’s benefited him because we’ve worked together. So what they do at school I reinforce at home and vice versa. (Participant 6)

On the other hand a hindering aspect of support reported by participants was not taking a team approach. This referred to parents’ perceiving school staff to put responsibility on the family to respond to and solve problems occurring at school, rather than working together as a team. This also included having limited dialogue with the parent(s) regarding their adolescent’s progress on schoolwork, which resulted in responsibility being placed on the family to complete work at home, rather than school personnel and the family working together to create a plan to support the adolescent. This contributed to stress and anxiety at home, and to strain on the parent-child relationship. Below are two quotes reflective of participants’ experiences.
You really get the sense that the school does not want to address issues; they just want to pass them on to the parent. Like they go this is the problem, you figure out a solution. And the trouble is the problems are happening at school. So the parent has very little influence over what happens once they enter those doors. And so it’s quite interesting that they would pass it on and say, “Well your child is not producing you fix it.” And it’s like, well what am I supposed to do? Especially when it is somebody who has been recognized and identified as somebody who needs some extra support or alternate methods of instruction. I found that it increased the anxiety in my home and then once the anxiety level goes up too much for me then problems don’t get solved anymore. It causes a lot of emotional stress in general, which I mean my daughter ends up suffering from. So what would happen is she would end up with getting a build-up of this work that she would have to do and they weren’t able to get her to do it at school so they would say, “Here’s a list of these you know 30 things she has to do, good luck mom here you go.” And that created an incredible amount of tension because now I mean if they can’t teach her at school and they’re teachers and educators and people who are trained to do this, and so what would end up happening is I would have to teach her how to do this stuff in order for her to do it. So now I’ve become her teacher and her mother. I’m teaching it to her and then trying to get her to actually do the work. So the school not working with me on this was not helpful. (Participant 5)

I got a phone call to come and pick up my son. It’s not positive for him, she’s not trying to solve the problem or work with me to solve the problem, she’s not problem solving to help him. She’s basically, “I’ve got a problem, I need to deal with that problem, he’s your problem, come and get him,” or at least that’s how I perceived it. It’s not helpful because
he’s sitting there isolated, he’s not doing any work, he’s not feeling good about himself, and nobody’s helping him. (Participant 7)

From the above quotes, not working as a team with the school to solve problems hinders parents’ abilities to support their adolescent, and it contributes to anxiety and stress at home. When parents are not aware of problems happening at school until things have escalated, it becomes increasingly difficult for them to solve these at home, which creates strain on the family.

**Understanding Mental Health**

Participants cited that it was helpful when school staff had some training in mental health. Having school personnel that understood mental health contributed to their adolescent receiving appropriate supports at school. Overall, 30% of participants reported staff understanding of mental health to be a helpful category. This is depicted in the following quote.

I worked with his counsellor to find ways to support him. The lovely thing is that she understands mental health issues. She’s got a lot of experience dealing with kids with mental health issues and the suggestions that she made, made a lot of sense. What was helpful was just that real support piece and her understanding of mental health. And it hasn’t always been that way. I mean I had one year where I had a new resource teacher, that wasn’t “in the know.” And if a teacher has the idea that this child is causing havoc on her class and they don’t like that child, it’s hell for them. It makes such a big difference. And if the resource teacher can’t kind of bring them around you got a big challenge on your hands because they’re just going to be looked at as a kid that is trying to cause trouble. So it’s integral that the school understands the mental health piece, it is just so helpful. (Participant 4)
Participants reported that staff having a limited understanding of mental health and how mental health concerns impacts student learning was a hindering factor. Participants perceived that limited understanding of mental health contributed to teachers not providing appropriate supports or carrying out accommodations in the classroom as prescribed in the student’s IEP. This was unhelpful because it negatively impacted performance at school and increased anxiety. The following quote summarizes a participant’s experience.

One thing that was not helpful was that the teachers lacked understanding and knowledge about anxiety. When we would discuss his IEP, one of the goals was that my son would need to be front-loaded. So when it comes to a book report he would need to know in advance what the expectations were. Well his teacher didn’t follow that because he didn’t think it was that big of a deal, because he had had a conversation with my son and he thought that he would remember. And then when he stopped going to school, we figured out what the problem was. There was a book report coming up and he was feeling overwhelmed because he can’t organize and he would go from zero to the end, he missed all the steps in between. So even though all of that was there in an IEP the teachers still really didn’t understand the impact of not following it because they did not understand mental health. (Participant 9)

In the above quote, this parent reflected on how school personnel not understanding mental health resulted in not following her adolescent’s IEP goals, which impacted that student’s school attendance and ability to complete schoolwork. Overall, 30% of participants reported that limited understanding of mental health was a hindering factor.

**Participant Recommendations for School Supports**

The wish list is a collection of participant responses to the question, “Was there something
missing for the support you received that you think would have been helpful to you?” Eight participants contributed 31 recommendations for improvements. In Table 2 participants’ recommendations have been organized and reported according to the number of wish list items reported and the participation rate in four categories that embody participants responses to the above question. The four categories that best embody the wish list items are: Individualized Supports, Resources and Services, Communication, and Staff Professional Development. In Table 3, the participants’ recommendations have been paraphrased statements and organized into the four categories.

Table 2 Wish List Categories and Participation Rates

<table>
<thead>
<tr>
<th>Category</th>
<th># Wish List Items (%) of Total Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling and Learning Supports</td>
<td>10 (70%)</td>
</tr>
<tr>
<td>Resources and Services</td>
<td>10 (60%)</td>
</tr>
<tr>
<td>Communication</td>
<td>7 (40%)</td>
</tr>
<tr>
<td>Professional Development</td>
<td>4 (30%)</td>
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</tbody>
</table>
Table 3 Wish List: Summary of Recommendations for School Supports

<table>
<thead>
<tr>
<th>Counselling &amp; Learning Supports</th>
</tr>
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<tbody>
<tr>
<td>● Family counselling and support, including guidelines and information on school resources that may be available.</td>
</tr>
<tr>
<td>● Regular individual counselling for the student at school.</td>
</tr>
<tr>
<td>● Having support groups in the schools, so youth know they are not the only one, and they can talk freely.</td>
</tr>
<tr>
<td>● Increased individualized and / or small group support.</td>
</tr>
<tr>
<td>● Having more counsellors or extra teachers who can support students with special needs.</td>
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</table>

<table>
<thead>
<tr>
<th>Resources &amp; Services</th>
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<tbody>
<tr>
<td>● The school informing the family about outside, community resources.</td>
</tr>
<tr>
<td>● Having a caseworker in the school (similar to in the hospitals), who ensures that the child is receiving the support needed.</td>
</tr>
<tr>
<td>● Having a liaison who can facilitate communication between home and school.</td>
</tr>
<tr>
<td>● Parent education regarding mental health.</td>
</tr>
<tr>
<td>● After school programs targeted to students with mental health concerns.</td>
</tr>
<tr>
<td>● Positive role models in school (similar to the Big Brother program).</td>
</tr>
<tr>
<td>● Alternative learning approaches, such as hands on programs that can draw-in youth with mental health concerns.</td>
</tr>
<tr>
<td>● Psycho-education assessment to identify a student's strengths and weaknesses and to identify strategies to support the student.</td>
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<table>
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<tr>
<th>Communication</th>
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<tbody>
<tr>
<td>● Regular communication from the school so the parent does not always have to initiate contact and pursue the school.</td>
</tr>
<tr>
<td>● Having team meeting with key players at the school, which can inform the family of supports and services.</td>
</tr>
<tr>
<td>● Regular communication between the home and the school. Particularly, parents would like to know what support their adolescent needs at home with homework so they can help support them.</td>
</tr>
</tbody>
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<table>
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<tr>
<th>Professional Development</th>
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<tbody>
<tr>
<td>● Greater awareness about mental health in the schools.</td>
</tr>
<tr>
<td>● Staff knowledge on how to support students with mental health concerns.</td>
</tr>
<tr>
<td>● School staff being trained to identify early symptoms of mental health concerns so there can be early intervention.</td>
</tr>
</tbody>
</table>

**Counselling and Learning Supports**

Most participants reported that it would be helpful to have increased individualized supports at school for their adolescent and family. Participants reported that support could
include individual, group, or family counselling, as well as increased learning support for their adolescent. A common observation across interviews was that participants commented on the substantial workload that school counsellors have, which they perceived to reduce the counsellor’s availability in providing individual counselling to students. Participants indicated that they believed school counsellors served a service coordination role more than a counselling role. Parents indicated that it would be helpful for their adolescent to have increased individual counselling at school. Parents hypothesized that if their youth received personal counselling services at school rather than in the community that this would be advantageous, as the school counsellor has knowledge of the school environment. The counsellor could play a key role in relationship building, and the student could receive regular counselling or brief check-ins at school during the week, compared with one hour a week in the community.

Of note, participants indicated that it would be helpful for students to start receiving counselling in elementary school, before a child’s needs become severe. Parents indicated that group counselling would be helpful so students know they are not the only one with mental health struggles. Finally, parents indicated that family counselling would be helpful, because when a child has a mental health concern, the whole family might experience stress and must adjust and learn coping strategies.

**Resources and Services**

Participants reported wish list items that embodied the desire for additional resources and services. These wish list items varied, and included having a case worker or advocate in the schools who could help coordinate services for the student and be the liaison between home and school. Parents also reported that it would be helpful to have more assessment services, which would provide information regarding their child’s strengths and areas needing additional support.
Parents perceived that having an assessment for their child would help the family and school determine what the appropriate supports and accommodations should be. Finally, parents indicated that having additional services, such as after school programs or mentorship programs for youth with mental health concerns, as well as family education regarding mental health, would be helpful.

**Communication**

Parents reported wish list items that indicated a desire for increased and more regular communication with school personnel. An aspect of desired communication reported by parents was being provided with information. Parents reported wanting to be informed about resources both available through the school and in the community. Parents indicated that this would help them so they, “don’t feel so lost.” Parents reported always searching for resources to help their child and often would “stumble” upon resources. Therefore, it would be helpful if the school could notify parents more intentionally or explicitly about available services or programs inside and outside of school.

**Professional Development**

Participants reported wish list items related to staff professional development. Participants reported that it is important for school personnel to receive training in the area of mental health. Parents believed that additional, focused training in mental health issues of children would enable educators to notice the early signs of mental health concerns, which may lead to earlier intervention.

**Summary**

Overall, a total of 215 CIs (148 helpful, 67 hindering) were extracted from the 10 interviews with participants. This process yielded seven categories that represented the
participants’ experiences of school support. The categories were: Individualized Support (100% respondents), Communication Between Home and School (90% of respondents), Understanding and Support (80% of respondents), Having an Advocate in the School System (70% of respondents), A Safe Place at School (60% of respondents), a Team Approach (50% of respondents), and Understanding Mental Health (30% of respondents). All categories exceeded the 25% response rate. Participants generated 31 wish list items embodying the following categories: Individualized Supports, Resources and Services, Communication, and Professional Development. In the next chapter, these findings are discussed in relation to the research questions that guided the project, and connections to the previous literature are made.
CHAPTER V: Discussion

This study explored perspectives of school support in parents of adolescents with internalizing mental health concerns. The qualitative method, the Enhanced Critical Incident Technique, through richly detailed description, provides a comprehensive picture of aspects of school supports described by parents that help and hinder impaired adolescents in school settings. Data were generated from 10 semi-structured interviews with 11 parents whose adolescent had an anxiety or mood disorder. Participants were asked the following research questions: 1) What aspects of school-based family and child support did you perceive to be helpful / unhelpful in coping with your adolescent’s mental health concerns?, 2) How were these aspects of support helpful / unhelpful?, and 3) What was missing from the support you and your child received that would be helpful? From the 10 interviews, 215 CIs were identified, 148 helpful and 67 hindering. Examination of the data revealed seven categories: Individualized Support, Communication Between Home and School, Understanding and Support, a Team Approach, Understanding Mental Health, a Safe Place at School, and Having an Advocate in the School System. Thirty-one wish list items were generated by eight of the participants. Wish list items embodied four categories, which were: Counselling and Learning Supports, Resources and Services, Communication, and Professional Development.

In this chapter, findings are discussed in relation to the research questions that guided the project, and connections to the previous literature are made. The practical implications of this study are presented, and a discussion of this study’s contributions will follow. Finally, limitations of the study will be reviewed, and directions for future research discussed.
Discussion of Categories in Relation to Previous Literature

The emergent categories from the critical analysis of interview responses are highly interrelated and generally fall under the umbrella of what is considered best practice in the field of school psychology, which is to engage in family-school partnerships to support child development (NASP, 2010a). Family-school partnering is rooted in Bronfenbrenner’s bioecological model of human development, and involves a relationship between the primary caregiver(s) of a student and members of the school community that is collaborative, and based on trust, open communication, and shared responsibility for student success (Bronfenbrenner, 2006; Christenson & Sheridan, 2001). Providing mesosystemic support for children with special needs through partnership development improves student outcomes across domains and increases parental satisfaction with their abilities to support their children (Beresford, 1994; Higgins et al., 2005; Esler et al., 2008; Taanila et al., 2002). Parents who report having strong forms of support indicate that they are better able to cope with and manage their child’s mental health concerns (Beresford, 1994; Higgins et al., 2005; Taanila et al., 2002).

An area of need in the literature is research examining the experiences and unique needs for support of parents of children with internalizing mental health concerns (Hoagwood et al., 2010). Most studies have examined parents’ experiences of support with service providers in the community, and fewer studies have examined parents’ experiences of school supports. The community research emphasizes that parents of children with mental health needs value communication and collaboration, and they have a desire for more information about their child’s diagnosis and treatment (Ferriter & Huband, 2003; Friesen, Koren, & Koroloff, 1992; Holden, 1982; Rose, 1998). School-based research has predominantly focused on the experiences of parents of children with learning disabilities, intellectual disabilities, or autism spectrum
disorders, or parents of children in either early education settings or who are transitioning from secondary to post-secondary institutions. Research on the experiences of school supports for parents of children with mental health concerns is sparse; the few studies conducted have emphasized that parents desire supportiveness, open communication, and access to information (e.g., Friesen et al., 1992). These findings parallel the findings in the community psychology literature. Parents have also reported having difficulty both obtaining an IEP for their child, and having their child’s IEP goals implemented in the classroom, which parents attribute to educators having insufficient training in mental health (Jivanjee et al., 2007).

This study was conducted to further explore parents’ perceived needs from their child’s school system. This study focused on parents of adolescents with internalizing disorders, as more research is needed with this population. Although there are likely some commonalities in parents’ perceived needs across populations of students with special needs, the needs of parents of children with internalizing mental health concerns should be explored to evaluate if they have unique needs, as has been suggested by previous studies (Petr & Allen, 1997).

Overall study results are aligned with Christenson and Sheridan’s (2001) “four A’s” framework of characteristics supporting family-school partnerships, which emphasizes the importance of the quality of interpersonal relationships between families and school personnel. Principles of shared responsibility, working together as a team, respecting opinions, non-judgmental communication, effective problem solving, schools being welcoming, and parent-teacher communication were all aspects of the “4 A’s” framework that were validated by parents in this study (Christenson & Sheridan, 2001; Lines et al., 2011). This study’s findings are discussed below in relation to this framework.
Individualized Supports

Providing individualized supports, such as tailored accommodations to support a student’s mental health concerns was an important emergent category in this research (Rock, Gregg, Ellis, & Gable, 2008; Wang et al., 2004). This category embodies the principles of the “4 A’s” framework. Part of creating successful family-school partnerships is taking the time to understand a family’s unique situation and needs, and then work with the family to plan supports at school and at home. Consistent with current research, parents reported that their adolescents experienced reduced anxiety and increased academic productivity when appropriate learning supports and accommodations were provided (Adelman & Taylor, 1998; Wang et al., 2004). Parents reported that they perceived accommodations to increase a student’s self-confidence, which was related to being able to complete work and experience success at school. Parents emphasized that when their adolescents anxieties regarding school decreased, so did the families stress and anxiety at home. The school providing individualized supports for their adolescent took the pressure off the student and the family.

In a study examining school-system experiences in parents of children with disabilities, parents expressed that it was helpful when the educational system met their child’s unique needs (Wang et al., 2004). Similar to the findings of this study, knowing that their adolescent’s needs were being met at school gave family’s peace of mind and lowered anxieties. Parents were appreciative when teachers followed the goals, strategies, and accommodations outlined in their adolescent’s individualized education plan, ensuring that proper support was received in the classroom (Wang et al., 2004). Other research has also suggested that parents report having individualized service delivery to be helpful (Konrad, 2008). In a study where 11 parents of seriously ill children were interviewed on their perspectives of their relationships with care
professionals, they reported that it was helpful when service providers looked beyond their child’s diagnosis, focusing on their child’s unique needs and how these could be met through individualized supports (Konrad, 2008).

The construct of individualized supports is also supported through research on differentiated learning, which is the process of ensuring that instruction matches students’ particular learning and developmental needs (Rock et al., 2008). Current models of differentiated learning support teachers being responsive to individual student differences, integrating assessment results with instruction, and providing ongoing adjustment of approaches to meet students’ individual needs. A belief associated with differentiated learning that was reflected by parents in this study is that individualized support contributes to students feeling respected and valued, which may increase self-confidence and motivation (Rock et al., 2008).

When parents reported that their adolescent did not receive individualized supports, they stated the lack of support contributed to their adolescent experiencing increased anxiety at school, which impacted the family system and contributed to increased stress and anxiety at home. Other research has reported that parents experience frustration and disappointment when their child does not receive adequate individualized services at school (Jivanjee et al., 2007; Wang et al., 2004). Parents and their children benefit from individualized supports based on their unique strengths and needs; when adequate supports are not provided parents are left to cope with situations independently, which may impact their child and their family (Adelman & Taylor, 1998). It has been suggested that schools may offer limited services to youth with mental health concerns due to sparse resources (Adelman & Taylor, 1998). Parents in this study indicated that overall they hoped for more individual services for their adolescent at school, and they acknowledged that their youth likely did not have as many services at school due to sparse...
resources. Wish list items included increased individual, group, or family counselling, as well as individual or group learning supports.

One resource that some parents indicated was extremely valuable was having their adolescent assessed and being provided with a British Columbia Ministry of Education special needs designation. Parents confirmed this was an important aspect for ensuring that their adolescent’s individualized needs were met at school. Parents expected through assessment they would obtain a better understanding of their adolescent’s strengths and difficulties, and acquire information, resources, and a clear direction in order to best meet their adolescent’s needs. Parents reported that this process was helpful in determining appropriate accommodations and supports. While research has previously examined parental involvement, satisfaction, and emotional reactions during the assessment process, no literature has addressed the personal meaning of having your child assessed and being identified as have a mental health need by the school system in parents of adolescents with internalizing mental health concerns. Parental report however is aligned with best practices of supporting students with mental health needs (Adelman & Taylor, 1999; Wright & Sulkowski, 2013). School psychologists can conduct comprehensive assessments to identify student’s special needs, and then use the results to select appropriate interventions and supports.

**Communication Between Home and School**

Both in the literature and in this study, communication between the home and school has been identified as being fundamental in supporting families of children with mental health concerns (McWilliam, Tocci, & Harbin, 1998; Christenson, 2002). Consistent with the extant literature, in the present study communication between families and professionals was identified as a crucial aspect of supporting children and youth with mental health concerns (Christenson &
When parents have been asked about their experiences with service providers, they report that they desire open communication and access to information (Blue-Banning et al., 2004; Ferriter & Huband, 2003; Friesen et al., 1992). Key aspects of home-school communication according to Christenson and Sheridan’s “4 A’s” framework (2001) include sharing important information with parents, emphasizing shared responsibility between families and schools in communication, and having both formal and informal opportunities to communicate that contributes to building trust between the family and educators.

Communicating with parents creates a positive and welcoming atmosphere at the school, thus encouraging partnerships (Christenson & Sheridan, 2001).

In one study where parents completed a survey evaluating their involvement with their child’s school, they indicated that receiving information from educators was important to them in supporting their child at home (Christenson et al., 1997). The concept of two-way sharing of information was a key feature in this category of communication as an aspect of support that parents indicated was helpful. Parents reported that being informed by educators of any observed changes or concerns with their adolescent empowered them to support their child at home. Parents indicated that communicating important information regarding their adolescent’s health to teachers helped staff better understand their child, which contributed to their child receiving appropriate supports and services at school.

A unique aspect of this communication between home and school category that emerged is the importance of communication being discreet. Some parents emphasized that occasionally it was helpful to communicate with educators without their adolescent’s knowledge, which allowed parents to share important information, while at the same time maintaining their youth’s sense of independence at school. Parents preferred discreet communication if they believed their
adolescent may be upset or embarrassed if he or she was aware of the communication, or if they believed that sharing information with educators could help facilitate understanding of their adolescent’s situation and keep their youth on track academically. Parents believed that sharing this information contributed to teachers being more sensitive to their youth’s situation and to their youth receiving accommodations and extra support.

This aspect of discretion in home-school communication as it relates to supporting adolescents with mental health concerns has not been discussed in the literature. However, the importance of confidentiality of information has been cited as an important characteristic of collaboration (Blue-Banning et al., 2004). In this study, this aspect of communicating important information without the youth’s knowledge raises an important issue around privacy and confidentiality of information. Communication between parents and teachers is a normal and important aspect of supporting child development. When communicating information, it is important to consider if confidential information is being shared. With regards to study findings, parents reported that communicating without their adolescent’s knowledge typically involved parents providing useful information to their youth’s school (e.g., regarding circumstances that influenced a change in the youth’s mood or attendance). Parents did not report that they requested confidential information be provided from school personnel, which could raise concerns around confidentiality of information and create an ethical dilemma for staff. Rather, parents indicated that they were sharing private information that they believed would help school personnel understand their youth’s situation and provide appropriate supports and accommodations. Participants indicated that often with school personnel they were unsure of how much information to disclose or who needed to know what information. Some parents indicated that they typically shared enough information for school personnel to provide
appropriate supports. The ideal situation at the secondary school level is open communication between parents and youth with regard to the type of information shared. The best scenario may involve the youth in communication and decision-making if desired.

In this study and in the literature lack of communication has been identified as a barrier to effective collaboration between the home and school to support children with special needs (Osher, 2002). In this study parents reported that having limited communication with educators was a hindering aspect of support. Some parents indicated that in spite of their efforts to communicate with educators regarding their adolescent’s needs, they often did not hear back from the school with updates on their adolescent’s progress or with information on any concerns until a situation had escalated. This report by parents is supported in the literature, specifically, that parents overwhelmingly report the desire for greater ongoing communication with their child’s school related to their child’s progress and performance (Christenson & Sheridan, 2001). In previous studies where parents have been asked about their experiences, they often report frustration with the challenges they had obtaining information and communicating with professionals (Friesen et al., 1992; Holden, 1982; Rose, 1998).

It has been suggested that limited communication may result in conflict between teachers and parents when they are unaware of each other’s goals, values, and efforts, as well as a tendency for staff to blame parents for students’ difficulties (Epstein & Sanders, 2002; Wang, Mannan, Poston, Turnbull, & Summers, 2004). Parents report that they desire increased regular communication with their child’s school and that they wish to be informed when their child is struggling at school so they can work with the school to find ways to support their child both at home and at school (Epstein & Sanders, 2002).
In this study when parents were asked about aspects of support missing, parents reported that they desired more frequent communication between the home and the school. Parents indicated that they wanted their adolescent’s school to initiate communication more often, as they often felt as though they were contacting the school and less often had their communication reciprocated. Parents also reported wanting more communication regarding how they could support their youth at home, and with homework. These wish list items regarding communication and more specific information on home adaptations align with the “4 A’s” framework of family and school partnerships, where it is recommended that schools use a variety of communication strategies to engage all parents and to share information (Christenson & Sheridan, 2001). Routine home-school communication is a key aspect of family-centered practice (Christenson, 2002), and it is essential in creating a positive school climate that facilitates partnerships and supports student success across domains.

**Understanding and Support**

A related emergent category in the present study is that of school personnel expressing their understanding and support to the family regarding their unique needs. Being understanding and supportive is a component of establishing trust in family-school partnerships (Blue-Banning et al., 2004). Participants’ perceptions of being understood and supported included staff taking time to learn about the family’s situation, being encouraging, and making themselves available for support. The abovementioned characteristics of this emergent category are validated in the literature (Gordon, 2009; Langridge, 2002; Melnyk, et al., 2001; Nelson et al., 2004). It has been suggested that parents prefer service providers who are understanding and who do not keep professional distance in the relationship (Wang et al., 2004). In a study where 11 parents of seriously ill children were interviewed on their experiences with service providers, they indicated
that they valued professionals who took time to listen to the family and who expressed interest in their point of view (Konrad, 2008).

When educators express that they are understanding of the families experiences and needs, parents report feeling heard and supported. Parents emphasize the importance of having professionals who are accessible, show they care, and go above and beyond their job description at times (Nelson et al., 2004). Receiving support from professionals is a key factor that helps parents cope with a family member’s mental health concerns (Gordon, 2009; Langridge, 2002; Melnyk, et al., 2001).

This category of being understanding and supportive embodies the principles of successful family-school connections proposed by the “4 A’s” model (Christenson & Sheridan, 2001). Specifically, parents reported that it was helpful when school personnel were willing to listen to their concerns and offer support in a non-blaming manner. Parents were also appreciative when educators were friendly, encouraging, and conveyed their genuine care for the child and the family. These aspects of support reported by parents contribute to the “Attitude” element in their framework. Attitudes that school personnel hold regarding families and partnerships impacts how school personnel think about families and vice versa. Having positive attitudes is reflected in educators’ behaviours and in parents’ perceptions of the school (Christenson & Sheridan, 2001). On the other hand, a lack of understanding that can be demonstrated through poor empathy or not being able to take the parents’ perspective can be a barrier to establishing effective partnerships (Christenson & Sheridan, 2001).

**Having an Advocate in the School System**

When parents indicated that they were having difficulties communicating with school personnel, they reported that it was helpful to have an advocate in the school who could help
them navigate the system and obtain supports for their adolescent. Parents expressed that communication at the secondary school level could be overwhelming, and that they often did not know who to speak with or found that communicating with eight or more different educators was challenging. Previous literature has suggested that school counsellors can play an important role as advocates in the school system (Bryan, 2005; Reese & Sears, 2002). The advocate’s role involves working with school personnel and families to support students learning and social-emotional needs. The school counsellor can play a pivotal role in advocating for families needs and in creating family-school partnerships (Bryan, 2005). The findings of this study are consistent with parents reporting that having an advocate in the system helped them feel supported, and that their advocate was typically the school counsellor. It was helpful for parents to communicate their needs for their adolescent to their advocate, who then acted as a liaison for the family, facilitating communication and sharing information between parents and school staff (Griffin & Steen, 2010). Parents indicated that the advocate worked with school personnel to ensure their adolescent’s needs were being met. Having an advocate provided parents with a sense of relief knowing that someone else cares and is looking out for their adolescent’s best interests in the school system. Having an advocate in the school system, a unique finding that emerged in this study, is indirectly related to the “4 A’s” framework, which stresses the importance of the quality of interpersonal relationships between families and school personnel, and recognizes influential factors in home and school contexts (Christenson & Sheridan, 2001).

When parents in this study were asked about aspects of support that were missing, they indicated that it would be helpful to have an advocate or caseworker in the school who could help coordinate services for the family, inform the family of resources, and act as a liaison between home and school. This wish list item validates parental beliefs of having an advocate as
a key aspect of support at the secondary school level as they manage their youth’s mental health concerns.

A Safe Place at School

A unique emergent category in this research was parents reporting that it was helpful to identify a physical space that was appropriate and agreed upon at school for their adolescent to go when feeling anxious or overwhelmed. The identified safe place was often the office of the counsellor, vice principal, or resource support personnel. Having a safe place at school provided the adolescent with a place to go to relax and potentially seek help from a trusted adult who could facilitate deescalating the student’s anxiety. Some participants reported that the school created other opportunities for their adolescent during lunch hour where they could meet with other students in a safe space. Having a safe place contributed to a student feeling comfortable and safe at school, as well as experiencing a sense of belonging. It also decreased parents’ anxieties knowing that their child was supported at school.

Although this category of a safe space does not directly fit with the “4 A’s” framework, indirectly it demonstrates that the school has attempted to understand the needs of the individual student, which the parents have perceived as being helpful. In this category participants emphasized that creating a safe place contributed to their child feeling safe at school, and a sense of belonging. One of the components of the “4 A’s” model is “Atmosphere”, which embodies creating a welcoming and inclusive environment. Participants reported that the school created a safe and welcoming environment for their youth; a modification unique to this need for emotion management may have been a factor that contributed to creating positive partnerships.

This aspect of having a safe place at school for adolescents with internalizing mental health concerns is a unique finding in this research. As there is scant research asking parents of
adolescents with internalizing mental health concerns about their experiences of school support, this finding has not been discussed in other studies. Future research is required to further explore the nuances of this category. Although no research studies have reported that parents perceive their child having a safe place to go at school to be a helpful aspect of support, research on students’ relationships with school personnel suggests that having positive relationships can serve as a protective factor for students (Murray & Greenberg, 2000).

**A Team Approach**

Taking a team approach was an emergent category in this research. In the partnership literature there is an emphasis on sharing in planning and decision-making activities, which involves creating mutually agreed upon goals (Christenson, 2002; Vosler-Hunter, 1989). Attributes such as reciprocal respect for skills and knowledge, and honest and clear communication contribute to working as a successful team and having a joint problem-solving orientation (Christenson, 2002; Christenson, 1995). When parents perceive that they are working as a team with their adolescent’s school they feel optimistic, respected, and supported (Minke, 2000). As highlighted in the literature and supported by this study’s findings, this encompasses characteristics of encouraging mutual collaboration, respect for skills and knowledge, open communication, and joint-decision making (Christenson & Sheridan, 2001). When working in partnership, parents report that school staff are listening and taking their concerns seriously, and that they value their expertise as a parent. Partnerships exemplify a student-focused philosophy and as reported by parents in this study, a key aspect of partnerships is that everyone is on the same page and is sharing the responsibility to support the student (Christenson & Sheridan, 2001). Working as a team best embodies the characteristics of “Actions” proposed in the “4 A’s” framework of key elements for partnerships. Specifically, when schools provide opportunities for
families and educators to work together and collaborate regarding a student’s educational plan or to resolve a common concern, these actions foster shared responsibility for student learning (Christenson & Sheridan, 2001). Participants in this study reported that working as a team contributed to them having a shared responsibility for their adolescent, and that everyone was in agreement to support their youth’s development.

Working as a collaborative team is a key component for parents managing a child’s mental health concerns, and contributes to families experiencing less worry and strain (Landridge, 2002). When parents and educators work cooperatively to identify appropriate strategies to support the student and to problem solve when situations arise, they are more likely to report that their child’s needs are being met and that they feel supported (Christenson & Sheridan, 2001; Friesen, et al., 1992; Koren, et al., 1997). In this study, parents reported relief, knowing that everyone was working together to problem solve and make decisions, and that other people were looking out for their adolescent’s best interests. When parents perceive they are working as part of a team with their child’s school, it contributes to becoming empowered and feeling less alone (Ditrano & Silverstein, 2006; Painter et al., 2011).

However, in some research evaluating parents’ perceptions of working as a team with their child’s school, for example being part of their child’s IEP team, it has been suggested that parents do not feel included at the level hoped (Flanagan, 2001). Parents often convey their desire for greater understanding and participation with their child’s school, particularly related to service planning (Flanagan, 2001; Tarico et al., 1989; Wrobel, 2004). Feelings of powerlessness and alienation can emerge when parents do not perceive that they are working as a team with their child’s school (Ditrano & Silverstein, 2006). When parents perceive a lack of partnership they experience having minimal communication with educators regarding their child’s progress
and they perceive that the school is not open to working with them to make decisions and solve emerging situations. In this study, parents reported that this lack of partnership impacted both their adolescent and their family, resulting in increased stress at home, and strain on the parent-child relationship.

When parents were asked about aspects of school support that were missing, parents indicated that it would be helpful to have team meetings with key personnel at their adolescent’s school, which would enable everyone to work together to support their adolescent. Parents’ desire for working as a team embodies the framework of conjoint behavioural consultation (CBC; Sheridan, Kratochwill, & Bergan, 1996). In CBC, parents and educators work together and assume shared responsibility in addressing a student’s social, emotional, behavioural, or academic needs. The CBC process is guided by a consultant, such as a school psychologist, who facilitates the problem solving process (Sheridan et al., 1996). Conjoint behavioural consultation embodies both ecological (e.g., focus on mesosystem interactions between home and school) and behavioural theories (e.g., conducting direct behavioural observations and assessments). Family-school partnering is considered an essential aspect in CBC, and there are several strategies that can be implemented to establish successful relationships (Christenson & Sheridan, 2001). Strategies include taking steps to understanding the family (e.g., identify strengths, be supportive, validate needs and check for understanding), establish partnerships (e.g., use language that emphasizes working as a team), promote joint responsibility for problem solving and outcomes, strengthen relationships and commitments amongst team members, and increase the diversity of available resources (Christenson & Sheridan, 2001). There are four steps in CBC, which include problem identification, problem analysis, treatment implementation, and treatment evaluation (Christenson & Sheridan, 2001). Conjoint behavioural consultation is a strategy that
fits with the “4 A’s” framework of creating health school and family partnerships. It is also an approach that parents in this study are requesting from schools.

**Understanding Mental Health**

Another emergent category in this research was that of understanding mental health. Parents emphasized the importance for school personnel at the secondary level having knowledge and understanding of mental health concerns, including appropriate training on how to support youth with anxiety and mood disorders. Parents reported that when school personnel understood their adolescent’s mental health concerns they were better equipped to provide appropriate supports and accommodations. Conversely, perceiving school personnel to have a limited understanding of mental health was attributed to educators not providing appropriate supports and accommodations to meet their adolescent’s unique needs. According to parents in this study, when educators did not understand mental health, they did not understand the implications of not providing certain accommodations. Parents cited situations where this was problematic as it negatively impacted adolescents’ academic performance and increased their anxiety at school and home. This in turn impacted families’ anxiety and stress at home. If educators understand a student’s mental health concerns, and if they create a welcoming, respectful, inclusive, and supportive environment, then this may foster an atmosphere that encourages partnering, an indirectly related characteristic of the “4 A’s” framework of successful partnerships (Christenson & Sheridan, 2001).

Service providers’ perceptions of mental health difficulties have been identified as a barrier to supporting children and families and to creating successful-partnerships (Owens et al., 2002). Staff having knowledge of mental health is important in order to provide appropriate supports for students with special needs (Jorm, Kitchener, Sawyer, Scales, & Cvetkovski, 2010).
When school personnel have limited knowledge of mental health, parents perceive that their child does not receive appropriate individualized supports and that parents are put in a position where they are educating educators on how to support their child at school (Jivanjee et al., 2007). Studies have demonstrated that providing teachers with a training course in mental health contributes to greater understanding of mental health, reduced stigma, and greater confidence in teachers’ beliefs in their abilities to support students with mental health needs (Jorm et al., 2010).

In this study when parents were asked about aspects of school support that were missing, they emphasized the importance of school personnel receiving training in mental health. Parents indicated that it is important for educators to have knowledge on how to support a student’s mental health concerns. When students receive appropriate accommodations and supports at school, parents perceive this to have a substantial impact on productivity and well-being, which they indicated positively impacts the family members anxiety and stress at home. Furthermore, when asked about desired supports, parents indicated that it would be helpful if elementary school educators received training in mental health. Parents believed that mental health education for elementary school personnel could contribute to the early identification of mental health concerns. Parents indicated that if a child’s mental health concerns were identified in elementary school and early intervention was offered, then this may impact the child’s outcomes. Finally, parents indicated that it would be helpful to have an overall greater awareness of mental health in the schools, and for parents to be provided with information on mental health.

**Research Contributions**

This qualitative study demonstrates a unique and pragmatic methodology that can be used to investigate perceptions of school supports in parents of adolescents with internalizing mental health concerns. The established utility of ECIT in task investigation and process evaluation
demonstrates that ECIT is well designed to reveal underlying realities (Flanagan, 1954). Embedded participant quotes allow one to contextually comprehend the process and meaning made of the events. Furthermore, the scientific rigor of this study, with its various credibility checks, allows parents’ unique experience of to be authentically represented.

This research makes several significant contributions to the extant literature. First, the summative and descriptive structure of the seven categories is both theoretically and pragmatically useful to both practitioners and researchers working in education and mental health. Although several of the emergent categories cluster within isolated studies in the extant literature, this research offers a holistic view of the categories as seen through a qualitative lens. The current ECIT study adds detailed information about helping and hindering factors to the literature consistent with emergent conceptual models on family-school partnerships. Specifically, this study replicates the findings in other studies on parents’ perceptions of supports and services received for their family and child with mental health concerns, suggesting that the characteristics of communication, taking a team approach, being understanding and supportive, and providing individualized supports for example, play a pivotal role in family-school partnerships (Blue-Banning et al., 2004; Flanagan, 2001; Nelson et al., 2004; Tarico et al., 1989).

With regards to specific unique research contributions, this study makes three unique contributions, including the categories of having an advocate in the school system and creating a safe place at school, as well as the aspect of discretion in the communication between home and school category. First, the category that parents find it helpful to have an advocate in the school system is a unique finding in this research, and has not been discussed in other studies evaluating parents’ perceptions of school support. It is unknown if this aspect of support is unique to parents of adolescents with internalizing mental health concerns, or if it is a common amongst parents of
adolescents with special needs. It is also unknown if parents of elementary school children with special needs also find it helpful to have an advocate in the school system. As parents in this study emphasized that they found the secondary school system to be overwhelming, and that they were often unsure with whom to speak or how to access services, it is likely that having an advocate may be an aspect of support that parents perceive to be increasingly helpful at the secondary school level. More research is needed to further explore the role of having a school-based advocate to support parents of youth with mental health concerns.

Second, having a safe place at school for adolescents with internalizing mental health concerns is another interesting and unique finding in this research. Parents believed that it was helpful for their adolescent to have pre-arranged room or area to go to at school when feeling anxious or overwhelmed. Future research is required to further explore if this finding is unique to youth with internalizing disorders, and if it is unique to the secondary school environment.

Third, in the communication between home and school category, parents reported that at times it was helpful for communication to be discreet, and therefore for dialogue to occur between parents and educators without the student’s knowledge. This unique aspect of the communication category has not been discussed in the literature. Parents indicated that there is vagueness at the secondary school level regarding what and how information should be shared with school personnel. Future studies could explore the nuances of communication in family-school partnerships. This may include exploring teachers’ and parents’ perceptions of what information they can or should share, the content of communication, and methods of communication.

Participants’ perspectives on aspects of school support that are helpful in managing their adolescents internalizing mental health concerns is similar to existing theoretical
conceptualizations of family-school partnerships (Christenson & Sheridan, 2001). Specifically, findings are aligned with the “4 A’s” framework of characteristics of successful partnerships. Characteristics of this framework, such as principles of shared responsibility, working together as a team, and parent-teacher communication were all aspects of the “4 A’s” framework that were validated by parents in this study (Christenson & Sheridan, 2001; Lines et al., 2011).

**Limitations and Future Directions**

First, helpful and hindering incidents were subjectively recalled by participants, which could be biased (e.g., by response sets or attributions; Gilovich, Keltner & Nisbett, 2006). Future studies could validate the critical incidents reported by participants by including data collected from direct behavioural observations, interviews with school personnel, and analysis of permanent records, such as school files. Although such critical incidents recalled based on personal reconstructions differ from the correlational factors derived from empirical studies, the experiences reported by participants may have had important implications for their later cognitions and actions (Bedi et al., 2005). Second, this research relied upon retrospective self-reports, which may be selectively or imperfectly recalled. However, the critical factors that participants tend to recollect are those experiences that were most memorable and impactful for them. Third, for several reasons, the results of this study are not generalizable, but instead are intended to document meaningful insights that might guide future practice. Future research using quantitative methods, and a larger sample size that is representative of the population will be needed in order to establish the external validity of these findings. Lastly, participants were not randomly selected to be part of this study, which may create some bias in the results as certain people may be more likely to participate (Gerhard, 2008).
Given the nature of the ECIT method, which outlines steps to be followed, it is likely that study results could be replicated. Although parents have unique experiences, similar experiences were evident across participants. Future qualitative and quantitative studies could further examine the perspectives of parents of children with mental health concerns on the unique components of family-school partnerships. For example, research could examine parents’ perceptions of decision-making processes and communication patterns between parents and school personnel.

Three unique findings emerged in this study, including parents’ perceptions that it is helpful to have an advocate in the school system, to have a safe place for their youth to go when feeling anxious, and at times to communicate with school personnel without their youth’s knowledge. Further research could further explore parents’ experiences in these areas. For example, a study could explore parents’ experiences of navigating their child’s school system and seeking resources for their child at the elementary versus secondary school levels. Another study could explore the perceptions that parents of youth with mental health concerns have on how and what they should communicate with school personnel. Furthermore, a study involving obtaining information from multiple raters (e.g., parents, educators, support staff) would be useful.

Finally, in this research parents did not describe their own characteristics that contributed to their child being supported at school. For example, parents did not discuss the value of their own advocacy skills or other attributes that contributed to supporting their child or working with school personnel to ensure their child received appropriate supports at school. This finding is likely because of the nature of this study’s research questions, asking parents specifically about
their experiences of school supports. Future research could also explore unique characteristics that parents bring to partnerships.

**Conclusion**

The emergent categories from this study illuminate some activities and conditions that parents perceive as being helpful to their child and family in coping with their adolescent’s internalizing mental health concerns. Empirical efforts alone may be inadequate in describing complex elements of partnerships. Multi-methods of research are beneficial to fully understand the multi-layered construct of family-school partnerships related to evidence-based practices in schools. Exploration of aspects of school personnel activity that parents of children with mental health concerns perceive to be helpful, and awareness of barriers that may hinder cooperation, may lead to increased success in family-school partnerships. Field-based research using practical methodologies may help educators decide how best to target resources and efforts based on lessons learned in the real world.
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PARENTS OF SECONDARY SCHOOL-AGED CHILDREN

Are you a parent of an adolescent with a mental health concern?

You are invited to participate in a research project that will ask you about your experiences with accessing services and supports from your adolescent’s school. This information that you share about your experiences may help schools better serve the needs of children and their families in the future.

WHAT’S INVOLVED:
• A confidential individual interview (approximately 1.5 hours)
• A follow-up telephone interview (approximately 15 minutes)
• You will receive a gift card as a thank you

INCLUSION CRITERIA:
• You have an adolescent with a diagnosed mental health concern (e.g., anxiety or mood disorder)
• Your adolescent currently attends secondary school
• You are open to discussing your experiences and needs

If you would like more information, please call or email the research team:

Dr. Lynn Miller, R. Psych.
The University of British Columbia
Phone: XXX-XXX-XXXX

Alexandra Percy, M.A., M.Ed.
The University of British Columbia
Phone: XXX-XXX-XXX
XXXXXXX@gmail.com
Appendix B – Participant Information Letter

Title: Perceptions of School Support in Parents of an Adolescent with an Internalizing Mental Illness

Principal Investigator: Dr. Lynn Miller, Department of Educational and Counselling Psychology, and Special Education, University of British Columbia, Tel. (XXX) XXX-XXXX

Co-Investigator: Alexandra Percy, Department of Educational and Counselling Psychology, and Special Education, University of British Columbia, Tel. (XXX) XXX-XXXX

Dear Parent/Guardian:

I am a researcher from the University of British Columbia. I would like to hear about your experiences of support with your adolescent’s school. I will ask you questions about what parts of school support were helpful to you in managing your child’s mental health concern, which were not helpful to you, and what you think was missing that could be helpful in the future. The reason why we are asking this information is to learn about what ways to improve school support to children and their families.

I would like to meet with you for about one hour and a half to ask you questions about your experiences. There are no right and wrong answers. Whatever you tell me is okay, and if you are unsure about a question and do not have an answer, that is also okay. You can choose a place to meet that is most comfortable for you. I will tape record our conversation so that I don’t forget anything you said. Later I will send you a letter that summarizes the themes that emerged from my research. I will call you on the telephone to ask you for your feedback on these themes.

The information you share will be kept private and stored in a safe place. I will not use your name when I am writing the research report. I will also not be meeting with your child, and I will not contact your child’s school or school district to provide them with information. Identifying information, such as your name or the name of your child’s school will not be written in the report. If you had a bad experience, it might upset you to talk about it. If you feel upset or uncomfortable talking at any point, you can end the interview at any time.

Participating in this research is your choice. If you decide to take part, I will explain this information to you again at the beginning of the interview. I will ask you to sign a form that says you want to participate. To thank you for taking the time to talk to me, you will be given a $10 gift card.

If you are interested in learning more about this project I can be reached at (XXX) XXX-XXXX.

Sincerely,
Alexandra Percy
Appendix C – Demographic Questionnaire

THE UNIVERSITY OF BRITISH COLUMBIA

Educational & Counselling Psychology, & Special Education
2125 Main Mall
Vancouver, B.C. Canada V6T 1Z4
604-822-8539 Tel

Demographic Questionnaire

Title: Perceptions of School Support in Parents of an Adolescent with an Internalizing Mental Illness

Principal Investigator: Lynn Miller, Ph. D., R. Psych. Department of Educational and Counselling Psychology, and Special Education, University of British Columbia Tel. (XXX) XXX-XXXX

Co-Investigator: Alexandra Percy, Department of Educational and Counselling Psychology, and Special Education, University of British Columbia Tel. (XXX) XXX-XXXX

As discussed in the consent form, we are gathering some background information about your child and your family. This information is being collected in order to describe the participants who take part in the study. We will protect you and your child’s identity. None of the answers provided will be linked to you or your child’s name. Only answer the questions that you feel comfortable answering. If you do not complete some or all of the items in the questionnaire, your may still participate in this study.

Gender: M_________ F________

Grade: 8________ 9_______10________11_______12________

Ethnic background: ______________________________________

School District: _________________________________________

Which BC Ministry of Education designation(s) does your child have, or has your child previously had? (Please Describe)

Please describe any additional health, mental health, or other diagnoses your child has.

Please describe any family member’s mental health history
Overall, how would you characterize your involvement with your child’s school?
   a. I am involved with my child’s school several times each week
   b. I connect with my child’s school a couple times a month
   c. I connect with my child’s school once every semester
   d. I rarely connect with my child’s school, only as needed
Appendix D – Parent/Guardian Consent Form

THE UNIVERSITY OF BRITISH COLUMBIA

Educational & Counselling Psychology, & Special Education
2125 Main Mall
Vancouver, B.C. Canada V6T 1Z4
604-822-8539 Tel

Parent/Guardian Consent Form

Title: Perceptions of School Support in Parents of an Adolescent with an Internalizing Mental Illness

Principal Investigator: Lynn Miller, Ph. D., R. Psych. Department of Educational and Counselling Psychology, and Special Education, University of British Columbia Tel. (XXX) XXX-XXXX

Co-Investigator: Alexandra Percy, Department of Educational and Counselling Psychology, and Special Education, University of British Columbia Tel. (XXX) XXX-XXXX

Dear Parent/Guardian:
You are invited to participate in a research project that will ask you about your experiences with your adolescent’s school. The purpose of this project is to determine which aspects of school support are helpful or not helpful to your child and to your family in managing your child’s mental illness. This information that you share about your experience may help school better serve the needs of children and their families in the future.

Study Procedure:
To be eligible, your child must be diagnosed with an internalizing mental illness (e.g., anxiety or mood disorder) and must not have significant externalizing behaviours (e.g., aggression). Your child must currently be attending secondary school regularly. It is also important that you have had involvement with your child’s school and are open to discussing your experiences and needs.

The co-investigator will interview you about your experiences. A time and location that is convenient for you will be chosen. Potential interview sites include libraries, community centres, or an office at the University of British Columbia. The interview will be approximately one and a half hours, but the length may vary depending on your experiences discussed. At the beginning of the interview, the researcher will seek your written consent.

Interviews will be audiotaped and transcribed for analysis. The researcher will analyze the interviews for common themes related to the value and usefulness of the support received. The researcher will mail you a letter summarizing the study findings. The researcher will then contact you by telephone a week after this letter is mailed to ask for your feedback on the findings.
**Demographic Questionnaire:**
You will be invited to complete a background information questionnaire. The purpose of this questionnaire is to collect basic information about your child, your family, and your involvement with your child’s school so that we may be able to describe the participants in the study. If you do not wish to complete some or all of the items in the questionnaire, you may still participate in this study.

**Time Commitment:**
The total time required from you to participate is approximately one and a half hours for the interview, and 15 minutes for the follow-up telephone call. The demographic questionnaire will take less than 5 minutes of your time to complete.

**Confidentiality:**
All names and identifying information will be changed in the transcript to protect the identity of you, your child, and other names mentioned in the interview. You will be assigned an identity code in place of your name. Your name, your child’s name, the name of your child’s school or school district, and any other identifying information will not be used in any future publications or presentations of the study results. Members of the research committee, and a transcription clerk may have access to the raw data. All data entered into a computer will be password protected. Audiotaped interviews will be stored electronically in a password-protected file, and deleted after 5 years. All paper documents will be kept in a locked filing cabinet and shredded five years following the completion of this study.

During the interview, if child abuse or neglect is reported than confidentiality will be broken. The researcher is then obligated to contact Child Protection Services.

**Risks and Benefits:**
There are no direct benefits for participating in this study. However, it may be intrinsically rewarding to know that the information provided on your experiences may help other children and families in the future. This research may result in increased knowledge of the needs of children and families who are coping with mental illness. This information may help us improve supports for children and families in the future. Depending on your experience, you may experience positive and/or negative feelings while talking about your experiences. If you become distressed for any reason during the interview, we may take a break or discuss whether you wish to continue. You are free to withdraw from this study at any time. The researcher will have a list of services for children and families if there is a need for further support or counselling.

**Results:**
This research study is for a thesis, which is being conducted to fulfill a requirement for a Doctor of Philosophy degree at the University of British Columbia. You will be informed of the study findings, upon completion of the study. These results may be published in the future.

**Compensation:**
You will be given a $10 gift card to compensate you for your time.

**Inquiries:**
If you have further questions or concerns, please feel free to contact Alexandra Percy at (XXX) XXX-XXXX, or Dr. Lynn Miller at (XXX) XXX-XXXX.

If you have any concerns about your treatment or rights as a research participant, please contact the Research Subject Information Line in the University of British Columbia Office of Research Services, at (XXX) XXX-XXXX.

Consent:
I understand that my participation in this study is voluntary and that I may withdraw from the study without consequences at any time. I have read and understood the description of the study, and have received a copy of this consent for my own records. By signing below, I consent to my participation in this study and give the researcher permission to contact me at a later date to verify the accuracy of the information collected during the interview.

Please check one of the following:

_____ Yes, I agree to take part in this part of the project.

_____ No, I do not wish to take part in this part of the project.

Participant’s signature (please sign):

Participant’s name (please print your name):

Date:

Your signature indicates that you have received a copy of this consent form (Pages 1-3) for your own records.
Appendix E – Interview Protocol

Perceptions of School Support in Parents of an Adolescent with an Internalizing Mental Illness

Consent to Participate
The consent form will be read aloud to participants, and any questions the participant has will be discussed. If the participant gives his or her consent, the interview will begin. If the participant seems reluctant or does not want to participate, the interview will be terminated in a respectful manner.

Icebreaker
“Before we begin talking about your experiences in detail, it might be nice to get to know each other a little better. I was wondering if you could tell me about yourself and your background.” To build rapport I will share something about myself with the participant.

Setting the Scene (sample questions)
“I want you to think back to when you first recognized that your child was having emotional difficulties.”
- Tell me about what this was like for you? What type of treatment or support did you seek?
- How old was your child when he or she was formally diagnosed?
- Has this diagnosis changed?
- What type of treatment or support has your child and your family received?
- Tell me about the involvement of your child’s school throughout this process?
- How did you feel about the school becoming involved with your child?
- Did your feelings change with time?

“Now I want to talk more specifically about the involvement of your child’s school. I want you to try to remember what happened and how the school became involved. I want you to think of examples of things that were helpful and not so helpful for your child and for your family.”

Helpful Incidents – General Focus
“Let’s begin with the aspects of school support that were helpful to your child and your family in managing your adolescent’s mental illness. Aspects of support can include behaviours, attitudes, processes, events, activities, or experiences. Examples can include just about anything that helped you or anything that you thought did not help you. There are no right or wrong answers, and anything you say is okay. Take your time to think about a specific example. When you are ready, I’d like you to tell me about it in as much details as possible.”

Follow-up Questions:
"Can you say more about...?"
“Can you give me a specific example of...?”
“Why was this helpful/useful/important to you?”
“How does it help you in your life now?”
“How does this help you cope with your child’s mental illness?”

(Subsequent helpful incidents will be identified and clarified using the above format.)

Unhelpful Incidents – General Focus
“Now, I’d like to switch to talk about the aspects of school support that were not very helpful for your adolescent and your family as you were managing your child’s mental illness. Think back to specific examples of things that did not help you or your child, or that were not useful. Take your time to think about a specific example, and when you are ready please tell me all about it in as much detail as possible.”

Follow-up Questions:
"Can you say more about...?"
“Can you give me a specific example of...?”
“Why was this not helpful/useful/important to you?”
“How did that not help you/your family/your child cope with your child’s mental illness?”

(Subsequent hindering incidents will be identified and clarified using the above format.)

Wish List:
“We have talked about different aspects of school support that were helpful and not so helpful for you adolescent and your family in managing your adolescent’s mental illness. Was there something missing for the support you received that you think would have been helpful to you?”

Follow-up Questions:
"Can you say more about...?"
“Can you give me a specific example of...?”
“Why would this have been helpful/useful/important to you?”

Demographic Questionnaire:
“I was wondering if you could complete this questionnaire. It asks you some questions about your child and you family’s mental health history. Having this information will help us describe our participants when we write up the results. Is this something you are comfortable with? Please let me know if you have any questions while completing this?

Debriefing:
“Before we finish, is there anything else you would like to say? How did this go for you? Was it easy or hard to answer the questions? Is there something I can do to improve the interview in the future?”

“We have talked about some sensitive things. Are you feeling upset at all? I have a list of resources that families and individuals can access for support. I would like to give you a copy, just in case you need to talk to someone about your child’s mental illness. I am going to listen to the tape of our conversation and write down the things you told me. Then I am going to send you a letter that summarizes what you told me. When you receive this letter in a few months, I would
like you to check it to make sure that I wrote everything down right. If it is okay, I will call you
to follow up and to ask you if I need to make changes to what you said. Is it okay if I call you?”

“Thank you very much for participating today. Your feedback is really important and I hope that
this will help improve the support offered to children and their families at school.”
Appendix F – Transcriptionist Confidentiality

THE UNIVERSITY OF BRITISH COLUMBIA

Educational & Counselling Psychology,
& Special Education
2125 Main Mall
Vancouver, B.C. Canada V6T 1Z4
604-822-8539 Tel

Transcriptionist Confidentiality Agreement

Title: Perceptions of School Support in Parents of an Adolescent with an Internalizing Mental Illness

Principal Investigator: Lynn Miller, Ph. D., R. Psych. Department of Educational and Counselling Psychology, and Special Education, University of British Columbia Tel. (XXX) XXX-XXXX

Co-Investigator: Alexandra Percy, Department of Educational and Counselling Psychology, and Special Education, University of British Columbia Tel. (XXX) XXX-XXXX

I understand that all information learned through the transcription/analysis of this research data is confidential, including the names and personal information of research participants. I swear that I will not reveal such information to anyone, and will only discuss this information with this study’s investigators. I am aware and agree that this Oath of Confidentiality continues even after the study has concluded.

Print your name _______________________________________________________

Signature _____________________________________________________________

Date _________________________________________________________________

Witness’s signature ___________________________________________________
Appendix G – Telephone Interview Protocol

Follow-Up Telephone Interview Protocol

“Hi _______________. This is Alexandra, the researcher from UBC. We spoke about your experiences with your adolescent’s school ____ month(s) ago. I am calling to follow up on the letter I recently mailed you, and I would like to review the results of the study with you. Is now a good time to talk?”

I would first like your feedback on the summary of our interview. Do you feel as though the summary accurately represents your experiences? Is there anything you would you to change or add?

I would also like to get your feedback on these categories that emerged from my research. Have you had the opportunity to review the categories?

1) I would like your feedback on if you think the category titles and descriptions make sense to you? (Participants will be asked to elaborate on their responses and follow-up questions will be asked accordingly)
2) Do the categories capture your experiences?
3) Are you surprised by any of the categories?

“Thank you very much for talking to me today. Your feedback is really important, and it is the hope that at this will improve the support families and children in the future.”