AN EXPLORATION INTO HOW FAMILY FUNCTIONING IMPACTS ADOLESCENT MENTAL HEALTH DURING LOCKDOWN

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Abstract

The mental health of adolescents is found to be impacted by many factors, with one of the most predominant being the way their families function. However with the ongoing COVID-19 pandemic and subsequent lockdowns being a reasonably new phenomena, understanding this relationship in the context of lockdown has not currently been investigated, yet remains necessary. Thus this qualitative research underpinned by critical realism, aimed to be the first to understand the impact of family functioning on adolescent mental health during lockdown, namely the two New Zealand lockdowns.

Seven families that consisted of an adolescent in New Zealand were recruited via social media to participate in semi-structured interviews. Data from these interviews were recorded and transcribed to then conduct thematic analysis. Four key themes were identified which were; (1) *adolescent roles changed during lockdown which benefited their mental health,* (2) *poorer problem solving during lockdown negatively impacted adolescent mental health,* (3) *increased emotional responsiveness allowed for greater emotional support during lockdown which benefited adolescent mental health* and (4) *emphasis of family values during lockdown benefited and maintained adolescent mental health*.

These findings highlight that family functioning did change during lockdown, which more often than not benefited adolescent mental health. This may then have important implications in dealing with the repercussions of the current lockdowns as well as providing insight into possible future lockdowns when specifically dealing with the mental health of adolescents in New Zealand. However no research is without its limitations, which will be discussed along with recommendations for future research which focus on encouraging further research within this area.

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Introduction

This thesis aims to understand how family functioning impacts adolescent mental health during the COVID-19 lockdowns, in New Zealand. However, in order to achieve this aim, it is not only necessary to understand it, but also recognise the reasoning behind it. Thus the following chapter, the literature review, allows for this and concludes that this research is the first of its kind that seeks to address the current limitations within literature. This then leads to chapter two, where the methodology and method outline the research approach to achieve the aim, followed by chapter three which describes the findings of this research. Finally, chapter four discusses these findings in relation to previous literature, along with the implications, limitations and recommendations for future research.

Chapter One: Literature Review

This literature review contains all forms of literature, from qualitative and quantitative research articles, to general review articles, to past theses, to books. The first section of this literature review focuses on the definition of mental health, followed by the characterisation of adolescence and finally adolescent mental health, specifically prior to COVID-19 lockdowns. From here, the second section focuses on the definition of family, family functioning, and most importantly relating family functioning to adolescent mental health. The third section then focuses on lockdown, in particular the New Zealand lockdowns, which is followed by the general impacts of lockdown on adolescent mental health and family functioning. This finally leads to the current research.

Section one

Mental health

The term mental health is frequently misunderstood and for this reason, finding a definitive definition for mental health is difficult. Mental health has been, and still is used as

either a euphemism for having a mental illness/problem (Galderisi et al., 2015; Maddux et al., 2004; Manwell et al., 2015), or to describe the absence of mental illness(es)/problem(s) (Iasiello et al., 2020; Keyes & Lopez, 2002; Westerhof & Keyes, 2010), which has resulted in a prevalent negative view of mental health (Norriss, 2010).

This is despite the emergence of positive psychology in recent decades and its and continued emphasis, which disputes this view of mental health, expressing mental health should also be seen as a positive construct that includes and aligns with wellbeing (Keyes, 2002, 2007; Lewis & Alexandrova, 2021; Seligman 2002; Seligman & Csikszentmihalyi, 2000; Slade 2010). Consequently, wellbeing is another problematic term to define (Schultze-Lutter et al., 2016). However for simplicity, wellbeing is a broad and holistic term that not only comprises of several smaller, intertwined components of wellbeing, for instance physical, social, emotional, spiritual and psychological wellbeing (Stoewen, 2017), but can be divided into two key areas (Ryan & Deci, 2001). The first area of wellbeing is often referred to as hedonic wellbeing and focuses on pleasure, happiness and satisfaction, or in other words, feeling good and experiencing positive emotions (Kahneman et al., 1999; Ryan & Deci, 2001). The second area of wellbeing is often referred to as eudaimonic wellbeing and focuses on self-realisation, reaching full potential and developing, in other words functioning well or doing good (Ryan & Deci, 2001; Ryff & Singer, 2006). Hence to understand and define mental health as a term that is inclusive of wellbeing within my research, mental health will be seen as being on *"a continuum"* which can constantly change and range from good mental health to poor mental health (Galderisi et al., 2015; Keyes, 2002; Peter et al., 2021).

Firstly, good mental health, positive mental health, mental wellbeing, subjective wellbeing, psychological wellbeing, flourishing, or even just wellbeing are the multitude of terms used synonymously and simultaneously to refer to the same aspect, which can no doubt

make it confusing (Huppert & So, 2011; Jackson & Haslam, 2022; Keyes, 2003). However, for simplicity, the term *"good mental health*" will be used to refer to these many terms throughout this literature review, but due to the nature of literature, this will at times be infeasible. Nonetheless, good mental health along with these many terms has commonly been referred to as encompassing our psychological, emotional, and social wellbeing, which subsequently has a positive impact on how we think, feel, and act (Huppert, 2005; Huppert & So, 2011; Keyes, 2003; Keyes & Waterman, 2003). This also aligns with the definition of mental health by the World Health Organization (WHO) (2022),*"mental health is a state of wellbeing in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."*

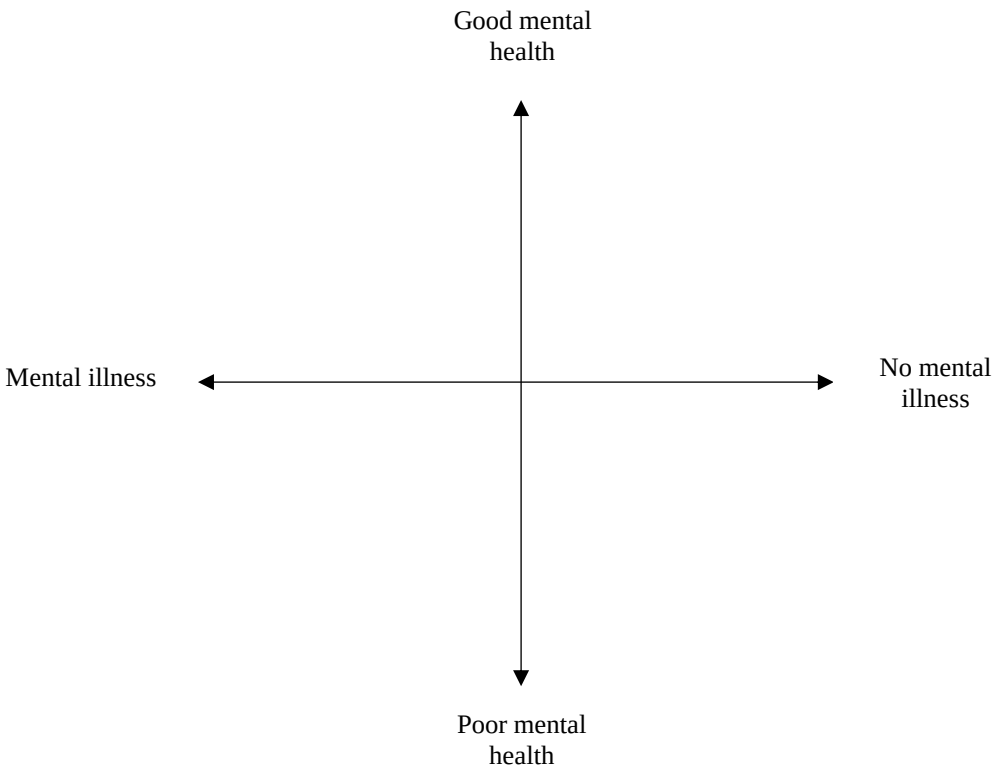
Poor mental health just like good mental health also has a few terms to refer to the same aspect, these being negative mental health, poor mental wellbeing and languishing (Keyes, 2002; McGaffin et al., 2015). However, once again, for simplicity, the term *"poor mental health"* will be used to refer to these many terms, only when possible, and is seen as the opposite of good mental health. Thus, poor mental health refers to the absence of our psychological, emotional and/or social wellbeing, which has a negative impact on how we think, feel, and act (Keyes, 2003).

An important aspect to recognize is that poor mental health should not be mistaken with mental illness(es), which is a diagnosable disorder with a standard set of criteria (Keyes, 2005; Westerhof & Keyes, 2010). This is also highlighted by the dual continua model of mental health and illness as seen in Figure 1, where mental health and mental illness are considered related but distinct constructs. This firstly means individuals can experience high levels of good mental health even with the diagnosis of a mental illness, which then aligns with New Zealand's anti stigma campaigns that tell us to not generalise experiences of

mental illness as always negative or debilitating (Norriss, 2010). It also means individuals can experience high levels of poor mental health even without the diagnosis of a mental illness (Franken et al., 2018; Keyes 2003, 2005; Westerhof & Keyes, 2010; Wang et al., 2011). However, it would be ignorant to not consider the studies which have found mental illness(es) does increase the likelihood of poor mental health, while constant low levels of mental health can also lead to mental illness(es) (Keyes, 2005; Keyes et al., 2010; Kuettel et al., 2021; Venning et al., 2013).

Figure 1

The Two Continua Model of Mental Illness and Health



Nonetheless, there are a number of indicators, many of which will become apparent throughout this literature review, that can contribute to and help provide insight into whether an individual is experiencing levels of good mental health, poor mental health, or a state in-between. However, Keyes et al., (2010) does emphasise that despite mental health

encompassing how we think, feel and act, it can look different for each individual and to each individual, thus, should be understood in relation to the individual when possible.

This finally leads to my definition of mental health which can be summarised as *a dynamic and subjective state encompassing how one thinks, feels and acts that can range from good to poor. However, is related but distinct to mental illness, where the absence of mental illness(es) is not required for good mental health, or vice versa.*

Adolescence

Adolescence is often defined as a stage that begins with puberty and ends with the transition to adulthood (Jaworska & MacQueen, 2015). However, this stage has also evolved historically, with evidence indicating it is lengthening, where individuals start puberty earlier and transition to adulthood later (Curtis, 2015; Kinghorn at al., 2018). Subsequently while the ages of 13 to 18 have previously been referred to as the stage of adolescence, it is now the ages of 10 to 24 which then encompass three smaller key stages (Kinghorn at al., 2018). These include early adolescence which comprises of 10–13-year-olds, middle adolescence which comprises of 14–17-year-olds, and late adolescence which commonly comprises of 18–21-year-olds, but in some instances up to 24-year-olds (Christie & Vinner, 2005). Additionally, adolescence is a stage recognized by almost all cultures and societies, however, may differ in length due to cultures and societies characterising the end of adolescence differently (Jaworska & MacQueen, 2015). Some may characterise the end of adolescence as an independent stage of life that enables for the acceptance of responsibility as well as financial independence and autonomous decision-making, as commonly seen in Western countries (Branje, 2022; Gowers, 2005). While others may think of it as a stage that ends with a biological or social marker such as the completion of puberty as seen in Muslim culture, or marriage as seen in many African cultures (Ember et al., 2017).

Nonetheless adolescence is generally seen as a stage of growth and development where many significant and intertwined biological, physical, cognitive, emotional and/or psychosocial changes occur (Best & Ban, 2021; Christie & Vinner, 2005; Jaworska & MacQueen, 2015; Yurgelun-Todd, 2007). Some of the most significant changes within these domains, beginning with physical changes involve the rapid growth in height and weight as well as reproductive maturation (Gowers, 2005). Cognitive changes involve metacognition and the increased capacities for relativistic, abstract and hypothetical thinking (Yurgelun-Todd, 2007). While emotional changes begin with increased emotionality due to the surges in hormones associated with puberty, however go on to involve increased emotional awareness and more complex emotional regulation strategies (Carr, 2016; Gowers, 2005; Jaworska & MacQueen, 2015). Finally, psychosocial changes involve the increasing importance and influence of peers, greater autonomy, less reliance on family, increased awareness of sexuality, and the development of an independent identity (Gowers, 2005; Papalia et al., 2006).

These numerous changes of adolescents then happen in a dynamically changing social environment which can impact adolescent development (Zahn-Waxler, 1996). These social environments can then range from more proximal social environments, such as friends, romantic partners, and family, to more distal social environments such as communities, societies, and cultural norms (Steinberg & Morris, 2001). However, the most profound or powerful social environments that impact adolescent development, are those that are closest or most *"proximal"* to the individual, i.e., family, school, and local neighbourhood and community. This is based on the Bronfenbrenner Ecological Systems Theory of Development, where these social environments are conceptualised into five key systems, which are then embedded within each other (Darling, 2007).

Whilst these changes accompanied with the environments they occur in can characterise adolescence as a challenging and vulnerable life stage with new risks, it can also present opportunities to positively influence how adolescents will view and interact with the world. This will then have important and long-lasting implications for adolescents, particularly in the way of their health and wellbeing, which by extension, has long-lasting implications for an entire society (Kieling et al., 2011). Therefore, it only makes sense that the mental health of adolescents is an area of great research, policy, practice, and community interest (Benton et al., 2021; Bjørnsen et al., 2017; Kleinert, 2007; Shoshani & Steinmetz, 2013; Wright et al., 2006). However, in saying this, it has only been within the last decade or so that adolescent mental health, particularly within these areas, is slowly becoming recognized as a related yet distinct construct to mental illness (Keyes, 2002, 2007; Mansfield et al., 2020).

Adolescent mental health prior to COVID-19 lockdowns

Understanding adolescent mental health, particularly before the COVID-19 lockdowns, provides a necessary overview of its state before such a profound and worldwide phenomenon. There has however been a lack of research around the levels of good mental health in adolescents prior to lockdown which is largely due to the slow yet increasing recognition around the concept of mental health, as previously mentioned (Keyes, 2007). Nonetheless, there is still some research that suggests many adolescents prior to lockdown experienced extended levels of good mental health (Keyes, 2007; Kapphahn et al., 2006; Lavik et al., 2018; Levin et al., 2009; Patton et al., 2012; Van Schalkwyk & Wissing, 2010). Keyes (2007) specifically found that levels of good mental health in American adolescents aged 12 to 18 were seen in the way of participating in their families, schools, friendships and social organisations, while forming and sustaining relationships. This was also consolidated by Van Schalkwyk and Wissing (2010) in relation to South African adolescents aged 15 to

17. However, Keyes (2007) also found that adolescents aged 12 to 14, followed by adolescents aged 15 to 18 felt valued, had a hopeful view of the future, and experienced a growing sense of competence, self-esteem and autonomy. Many other studies also go on to exemplify that these qualities are prominent within the adolescent population to indicate levels of good mental health (Kapphahn et al., 2006; Lavik et al., 2018; Levin et al., 2009; Witten et al., 2019). Finally, in New Zealand, a series of surveys called Youth2000 focus on the health and wellbeing of New Zealand adolescents' aged 12 to 18, with the most recent Youth2000 survey being the Youth19 survey, conducted in 2019. Thus the Youth19 survey established that overall most adolescents do experience levels of good mental health as they were happy or satisfied with their lives (Fleming et al., 2020).

However, while levels of good mental health are evident within adolescents, levels of poor mental health are unavoidable, with a significant amount of literature focussing on this. Prior to lockdown, levels of poor mental health were not only becoming more prominent, but found to be increasing globally (Currie et al., 2012; Patel et al., 2007; Venning et al., 2013). This was also in conjunction with disparities for certain adolescent populations (Clark et al., 2014; Valdez et al., 2019). Currie et al. (2012) firstly exemplifies this, where approximately one fifth of adolescents aged 11 to 16 reported levels of poor mental health in a large international survey of 43 nations, which is higher than previous years. Furthermore, the Centres for Disease Control and Prevention (CDC) (2019) found that nearly 36.7% of adolescents aged 12 to 18 in America reported feelings of sadness, poor satisfaction, and/or hopelessness. For girls, the number was higher at 46.6%, and in the case of lesbian, gay, or bisexual adolescents, the number was even higher at 66.3%. The overall average in such feelings that constitute levels of poor mental health, represents a 40% increase over the last 10 years. Finally, the mental health of New Zealand adolescents has also declined compared

to the Youth2000 surveys of 2001, 2007, 2012 and even 2019, with this decline being more prominent within Māori than any other ethnic group in New Zealand (Fleming et al., 2022).

The mental health of adolescents is governed by multiple psychological, cultural, personal, environmental, physical and/or social factors, which whilst aren't clear categories, do encompass many pertinent factors, that then interact in turn with an adolescents developmental stage (Patel et al., 2007; WHO 2021). Examples of some common factors within these categories are; coping skills, ethnicity, gender, sexual orientation, socioeconomic status, childhood experiences, housing conditions, appearance, amount of sleep, diet, and most recently social media, (Currie et al., 2012; Goodman et al., 2007; Hartis, 2019; Klineberg et al., 2006; Natsuaki & Yates, 2021). These factors can then, in some form, either negatively or positively impact adolescent mental health (Robinson et al., 2010). Thus the mental health of adolescents is found to be decreasing, as many are faced with multiple factors which serve to negatively impact their mental health (Eriksson et al., 2019).

However, it has been found that it is usually an adolescents social factors, which is also often referred to environmental or social environmental factors that can either negatively or positively impact their mental health (Allen et al., 2014; Balvin & Banati, 2017; Currie et al., 2012). Previous studies have indicated that while peers and schools are important social and/or environmental factors of adolescent mental health, the most common, integral and consistent social and/or environmental factor associated with adolescent mental health is the family. (Barber, 1992; Bögels & Brenchman-Toussaint, 2006; Levin & Currie, 2010; Keijsers et al., 2012; Kenny et al., 2013).

This is because the family is found to be the single greatest influence on an adolescent's life, as it is in this context that an adolescent's basic emotional needs for security, belongingness, support and intimacy are satisfied and maintained (Claveirole & Gaughan, 2011; Guevara et al., 2021). It is also within this context that they learn and develop to thrive

in the world, as also previously highlighted by Bronfenbrenner's Ecological Systems Theory of Development (Darling, 2007). Additionally, despite the transformation from childhood to adulthood involving a focus on independence, family is still found to play the most salient role in adolescent mental health (Claveirole & Gaughan, 2011; Levin & Currie, 2010).

Thus, honing in on such factors is not only crucial for understanding how to prevent the development of adolescent mental illness, but more so to promote adolescent mental health (van der Westhuizen et al., 2022). This can be through a number of interventions, initiatives, approaches and/or strategies that enable adolescents to increase control over, and to improve their mental health, which can then have many benefits (Jané-Llopis et al., 2005; WHO, 2020). Firstly, it can have individual benefits such as increased resilience, creativity, inner peace, improvement of social relationships and physical health. All of which are essential for the holistic functioning, health, and wellbeing of adolescents, as mirrored in the Māori model of Te Whare Tapa Wha (Arslan et al., 2022; Norriss, 2010). Secondly, it can also be "*a key benefit and resource for the long-term social and economic prosperity of society"* (Barry, 2009).

Section two

Family

The concept of family is said to be universal because it is found, in some form, within every society (Murdock, 1949). It can even date back thousands of years to tribes, which is a notional form of a family (Killsback, 2019; Sneath, 2020).

Nonetheless, family has traditionally been defined as a group of persons who are related by blood, marriage, and occasionally adoption (Murdock, 1949), with the most standard version of the traditional family being one that consists of a man, woman, and one or more biological or adopted children (Sharma, 2013). However, this traditional definition of family has been criticised as being too narrow. This is because modern families, especially those in

industrialised societies exist in many forms, including single parent families, foster families, families with same-sex parents, childfree families, and many other variations that differ from the traditional definition. Subsequently, what is found to be common to each of these family forms is commitment, caring, and close emotional ties, which are increasingly becoming the defining characteristics of family (Benokraitis, 2015)

Therefore, for my thesis, family will be defined as being *"those persons who are biologically and/or psychologically related, who are connected by historical, emotional, or economic bonds, and who perceive themselves as part of a household"* (Gladding, 2007). This definition then encompasses the variety of families that are prevalent today.

Family as a system

Just as Bronfenbrenner conceptualised the social environments adolescents develop in as systems that are embedded within each other, families themselves are also often seen as systems, which is a concept that stems from systems theory (Cox & Paley, 2003). Systems theory is based on the idea that all things exist within a system of interacting set of units, parts, or persons that make up a whole arrangement or organisation (Gladding, 2007). Each unit, part, or person in the system is affected by whatever happens to others within the arrangement or organisation, making systems interrelated and interdependent. This definition is based on the work of Ludwig von Bertalanffy (Gladding, 2007).

Thus, conceptualising families as systems essentially means members are constantly interacting, and mutually affecting one another, as they are in relationships with each other. (Cox & Paley, 2003). Consequently, when change or movement occurs in any of the members or circumstances that make up the family system, all aspects of the family are affected, for better or worse.

Whilst this concept is the lens through which the majority of family therapists have traditionally viewed, assessed, and treated families (Gladding, 2007), it does provide for a useful perspective when understanding families and the ways in which they function.

Family functioning

Family functioning is another difficult term to define, the key reasons being the multiple ways it is generally depicted throughout literature, as well as more specifically, within theoretical models of family functioning (Beavers & Hampson, 2000; Dai & Wang, 2015; Epstein et al., 1978; Haines et al., 2016; Olson, 2000; Roman et al., 2016; Ubaidi, 2017; Walsh, 2016). There are firstly many aspects or areas which have been identified within literature as to what constitutes *"a functioning family,"* such as clear roles and routines, resilience, effective problem solving, clear boundaries, cohesiveness, good relationships and many more (Haines et al., 2016; Roman et al., 2016; Ubaidi, 2017; Walsh, 2016). Furthermore, there are also multiple models of family functioning which while form the foundation for many assessment measures and clinical treatment approaches, have different foci around what areas and aspects are essential for a family's functioning (Walsh, 2016). For example, there is The Olson Circumplex Model which recognises family functioning as *"a family's intimacy, flexibility and communication"* (Olson, 2000), or the Beavers Systems Model of Family Functioning which recognises family functioning *as "a family's competence and family style"* (Beavers & Hampson, 2000). This all evidences that family functioning is truly a complex term to understand and investigate, as there are numerous aspects or areas can be utilised to make up the term family functioning.

Hence, for the purpose of my thesis, I will not only define family functioning as a broad multidimensional term that encompasses any areas or aspects that provides insight to how a family *"works,"* but build on this definition to create more clarity and coherency around what family functioning can entail. This is especially pertinent because many families

themselves find it difficult to understand what family functioning encompasses because of the term being so poorly defined. This then leads to them being unaware of how to explain and express their family functioning (Sumari et al., 2019; Zwane et al., 2012). Thus, the second part of my definition will be based on a family functioning model, in particular The McMaster Model of Family Functioning (MMFF).

To give some background the MMFF is a theoretical model which has evolved from systems theory (Epstein et al., 1978; Epstein et al., 2003). Thus, the first part of the MMFF focuses on systems theory and how it relates to families, which has already been highlighted in the above section. Whilst this concept is insightful, it is not the focus of my definition. It is instead the second part of the MMFF which identifies six key aspects of family functioning, these being, problem solving, communication, roles, affective responsiveness, affective involvement and behavioural management (Epstein et al., 1978; Epstein et al., 2003).

These six aspects are found in many other definitions of family functioning as well as within family functioning literature, research and other family functioning models, despite these models having different foci, e.g., aspect of communication (Olson, 2000; Walsh, 2016; Wong et al., 2022). In addition, the six aspects of the MMFF translate to key qualities of what constitutes a functioning family not only within Western interpretations but within other cultural interpretations, which is of importance as New Zealand is a multicultural nation (Durie, 1994). For example, the six aspects of the MMFF align with Māori conceptions of whānau wellbeing. This can be demonstrated by the aspect of affective responsiveness which aligns with the Māori conception of capacity to care (Durie, 1994).

However, it has been made evident that these six aspects of family functioning can interrelate, i.e., problem-solving often requires communication, yet are seen as separate aspects (Epstein et al., 2003). According to Walsh (2016) this is likely to be the case with many areas and aspects of family functioning. Subsequently these six aspects of the MMFF

still provide substance into common, culturally aligned, relevant and important aspects of family functioning that can provide guidance around a broad term, even if they are investigated as interrelated concepts.

Hence, family functioning within this research will be seen as *"a broad, multidimensional and interrelated term that encompasses any aspects or characteristics that provides insight into how a family "works." A focus will however be placed on a family's ability to problem solve, communicate, have roles, manage behaviour and be affectively responsive."*

Impact of family functioning on adolescent mental health

Despite the difficulties in defining family functioning, there is widespread recognition that it is essential for understanding the quality of the family environment (Walker & Shepherd, 2008). Subsequently, since it has already been established that the family is one of the most significant factors to impact adolescent mental health (Bögels & Brenchman-Toussaint, 2006; Levin & Currie, 2010; Keijsers et al., 2012), this then makes family functioning just as significant to adolescent mental health (Cheng et al., 2017; Walker & Shepherd, 2008).

Thus, the reminder of this section will focus on the current and general literature around family functioning and its impact on adolescent mental health, as evidenced below, it does not account for the new phenomenon of lockdown. Furthermore, despite concerted efforts to locate literature that not only perceived adolescent mental health as a related yet distinct construct to mental illness, but did so in relation to family functioning, was at times infeasible. Subsequently, because some symptoms of mental illnesses, these being anxiety and depression, can mimic indicators of poor mental health (Kuettel et al., 2021; Yin et al., 2012). I have made the decision to include literature which measures mental health in relation to symptoms of depression and anxiety, which may also in instances be referred to as

psychological distress, to indicate levels of poor mental health. This will then provide greater substance below.

Consequently, just as families can have a positive or negative impact on adolescent mental health (Levin & Currie, 2010; Keijsers et al., 2012), the same is found to be true for family functioning, where good or effective functioning families enable better mental health in adolescents. Shek (2002) examined the association between family functioning and adolescent adjustment and found family functioning was significantly related to good mental health in adolescents, in the way of existential wellbeing, life satisfaction, self-esteem, and a sense of mastery. This is similarly established by Muyani and Fatimah (2015), where there was a highly significant correlation between family functioning and good mental health in adolescents aged 18 to 21. This correlation was further investigated to find that family functioning can *"contribute"* around 20% to the levels of good mental health experienced by adolescents (Muyani & Fatimah, 2015). Moreover, adolescents with well-functioning families also score significantly higher on emotional wellbeing, a common indicator used for good mental health (Leeman et al., 2016). Finally, Rask et al. (2003) examined the impact of general family functioning on life satisfaction of Finnish adolescents aged between 12 and 17. Analyses revealed adolescents' perception of family functioning was positively related to their mental health (Rask et al., 2003).

Conversely, poor or ineffective functioning families create levels of poor mental health in adolescents, which is a consistent finding throughout many studies (Mastrotheodoros at al., 2020; Shek, 1998; Zargar et al., 2007). For instance, Shek (1998) longitudinally examined the relationship between family functioning and adolescent psychological wellbeing in a sample of Chinese adolescents. Results showed that poor family functioning was predictive of poorer adolescent mental health across time. Additionally, Zargar et al. (2007) indicated that there is a significant relationship between poor family

functioning and poor adolescent mental health in the way of anxiety and depression symptomatology. Therefore, family functioning is a crucial factor that can negatively or positively affect adolescents' mental health.

However since family functioning is such a broad and multidimensional term. It is also important to have a greater understanding into the many areas or aspects of family functioning that may impact adolescent mental health, which the above studies have not done. Therefore, the remainder of this section will focus on this while also being inclusive of the six key aspects of the MMFF; problem solving, communication, roles, affective responsiveness, affective involvement and behavioural management.

Problem solving and resolving conflict. The first aspects that will be discussed in relation to adolescent mental health is a family's ability to problem solve and resolve conflict. However, whilst family problems and conflicts may slightly differ in what they mean, where a problem is seen as an issue that a family has trouble finding solutions to and can threaten the integrity of the family (Esptein et al., 2003), while conflicts refer to the active opposition between family members (Madalina, 2016). They are often used interchangeably within family functioning research. This is because they both typically describe negative situations or matters (Madalina, 2016), where family problems also often turn into family conflicts that can impact adolescent mental health (Lee et al., 2018).

Family problems and conflicts can arise for a multitude of reasons, from cultural or generational differences, to dealing with the effects of excessive stress such as bereavement (Chan & Leong, 2016). Nonetheless, the study by Chung et al. (2009) used a qualitative method of daily diary to assess daily frequencies of parent-adolescent conflict and problems longitudinally over a 2-week period within a sample of adolescents from Latin American, Asian, and European backgrounds. It was found that while family conflicts and problems remained fairly infrequent among all ethnic backgrounds, its impact on mental distress, i.e.,

poor mental health, was significant across ethnicity and gender. Parra et al. (2013) also conducted a longitudinal study with a group of adolescents. However in this study, the relationship between adolescents and their parents were analysed over a period of 10 years. The results indicate that continuous and unresolved conflict may result in serious self-esteem, autonomy and self-control deficiencies in adolescence, all which indicate levels of poor mental health. Furthermore, Chappel et al. (2014) investigated the association between interparental conflict, life events and life satisfaction in adolescents aged 11 to 15 years in the United States. The results indicated that interparental conflict was moderately and negatively associated with adolescent life satisfaction, an already mentioned indicator of mental health.

However, Eccles & Gootman (2002) express that as adolescents mature, they often seek more independence and autonomy, as well as begin to question the way their family functions, which can lead to conflicts of various kinds. This conflict, creates a distancing in the parent-adolescent relationship, which in turn may have great functional value for the adolescent (Eccles & Gootman, 2002). It may foster adolescents' individualisation from parents, which allows them to try more things on their own, and develop their own competence and efficacy necessary for good mental health (Eccles & Gootman, 2002).

The ways in which families solve problems and conflicts have also been found to be crucial (Capaldi et al.,1994; Carpenter & Mulligan, 2009; Holth 2017; Molinari & Everri, 2021). For instance, Carpenter and Mulligan (2009) found families which allowed for all members to be included within the problem solving process, as opposed to the domination of this process by one or two family members, benefited adolescent mental health by providing confidence and satisfaction. In addition, when negative emotions, particularly anger and frustration are apparent when problem solving or resolving conflicts, not only is there failure when solving problems and/or conflicts, but more mentally distressed adolescents (Capaldi et

al.,1994). Therefore, these studies emphasise how problems and conflicts in its many forms may not only have negative impacts on adolescent mental health, but positive impacts.

Communication. Communication refers to the way verbal and non-verbal information is exchanged between family members, however, a focus will be placed on verbal information (Epstein et al., 2003). It has been found to be one of the most crucial aspects within family functioning, as it helps to express opinions, share assumptions, and inquire into an individual's mode of thinking which can then impact adolescent mental health (Berlo, 1960; Zhang et al., 2021). Consequently, there are many ways communication can impact adolescent mental health, one being effective communication when resolving familial conflict and problems (McGuigan et al., 2014; Nguyen et al., 2020). This can then maintain effective family functioning as well as adolescent mental health in numerous ways such as happiness (Berlo, 1960; Segrin & Flora, 2019). Family communication outside of resolving conflict and problems is also evidently necessary, so much so that Maenle and Herringshaw (2007) argue that family communication should be used to build self-confidence and develop positive relationships in adolescents' lives which are pertinent to adolescent mental health. In addition, several studies consolidate the importance of communication on protecting and enhancing adolescent mental health (Elgar et al., 2013; Sanavi et al., 2013).

However poor communication or communication issues are inevitable, and often encompass yelling, keeping secrets and blaming, which has subsequently been found to negatively impact adolescent mental health in numerous ways (Estévez et al., 2005; Levin & Currie, 2010). Firstly, Estévez et al. (2005) analysed the influence of family communication (with father and mother separately), as well as school adjustment (school self-esteem and victimisation problems) on adolescents' mental health. Results showed a direct influence of poor family communication on the degree of distress experienced in adolescents. In other words, adolescents who reported poor communication with their mothers and/or fathers,

showed more depressive symptoms and stress. This is also consolidated by Levin and Currie (2010) where dysfunctional parent-child communication is associated with poorer emotional wellbeing and life satisfaction in adolescents. However, in this instance the impact of family communication on adolescents' mental health has been found to depend on the gender of both the parent and child (Levin & Currie, 2010).

Communication is also an aspect which has been concurrently been investigated with family support, where a prospective study showed that family support and good parent-child communication could significantly benefit the mental health of adolescents through self-esteem (Bireda & Pillay, 2017). Furthermore, Tabak and Mazur (2016) found increased family support and communication were associated with less stress in adolescents. Hence family support is consequently found to be another important area of family functioning. Whilst support is a broad term, it is often understood, measured, or at the very least inclusive of the emotional support within a family (Canty-Mitchell & Zimet, 2000; Moore et al., 2018). Thus the following section will focus on the emotional support of a family which can be defined as the intentional verbal and nonverbal ways to show care and affection which often entails being reassuring, accepting, encouraging, as well as making one feel valued and important (Burleson, 2003).

Emotional support and cohesion. Firstly, Moore et al. (2018) tests the independent and interacting roles of emotional support within families, peers and schools in predicting substance use, mental health and mental illness symptoms among 11 to 16 year olds in Wales. It was subsequently found that emotional support from family, unlike the emotional support from peers and schools was consistently associated with significantly better mental health in the way of greater life satisfaction. Moreover, adolescents who reported higher levels of family support, particularly emotional support in their schooling, were significantly less likely to report indicators of poor mental health compared to those who reported low

levels of emotional support (Social Policy Research and Evaluation Unit (Superu), 2016). It was also found that adolescents indicated their most likely source of emotional support in times of need were family (Superu, 2016). Additionally, several other studies enforce the importance of emotional support on adolescent mental health (Boudreault-Bouchard et al., 2013; Camara et al., 2014; Friedman & Kutash, 1992) including those who have just identified as being part of LGBTQ+ communities (McConnell et al., 2016; Shilo & Savaya, 2011).

Emotional support within family functioning research is also closely aligned with family cohesion, which is defined as the emotional bonding that family members have toward one another (Rivera et al., 2008). Subsequently, it is often investigated together with emotional support to understand adolescent mental health. Rawatlal et al. (2015) investigated adolescent-parent attachment, adolescent-perceived emotional support from parents, and family functioning as correlates of depressive symptom presentation within this age group. Positive family communication, cohesion and emotional support reduced the risk of a depressive symptom outcome. Furthermore Vandeleur et al. (2009) investigated whether higher cohesion and satisfaction with the emotional support of families were associated with the daily experience of emotional wellbeing, concluding higher cohesion within the family is associated with greater emotional wellbeing and consequently mental health in adolescents.

Affective responsiveness. The importance of emotions within family functioning is further exemplified by the aspect of affective or emotional responsiveness. Affective responsiveness is defined as the ability of the family to respond to a range of stimuli with the appropriate quality and quantity of feelings (Epstein et al., 2003). While often measured in conjunction with other aspects of family functioning, it is still important to consider when assessing family functioning as it has still often been found to be related to various child and adolescent mental health outcomes (Cash, 2019; Ghanizadeh & Shams, 2007; Leeman et al.,

2016; McNamara & Loveman, 1990). Specifically, Cash (2019) highlights that children and teens are more likely to develop symptoms related to worry, insecurity, sadness and hopelessness when affective responsiveness is lacking from parent(s) within the family. In addition, Leeman et al. (2016) found parents who avoided showing emotion, had trouble being responsive to adolescents' emotions which negatively impacted adolescent mental health, in instances leading to mental illness(es).

Affective involvement. The aspect of affective, emotional or simply involvement is the degree to which the family as a whole shows interest in and values the activities and interests of individual family member (Epstein et al., 2003). Whilst involvement within family members is necessary, an *"appropriate"* level of involvement is required for good adolescent mental health (Bogenschneider, 1997; Deb et al., 2015; Harris & Marmer, 1996; Lindqvist et al., 2007). Specifically, Lindqvist et al. (2007) explored factors associated with the mental health in adolescents aged 11 to 17 and found that communication, problem-solving skills, and most significantly, affective involvement, were predictive of healthy family and adolescent functioning. However, it is often found that parents are over involved with adolescents which can have a negative impact on their mental health. For example, Deb et al. (2015) examined relationships among home environment, parents' personality and mental health of adolescents in the way of anxiety, self-concept and self-confidence. A quarter of the adolescents thought their parents were overly involved in their personal affairs which had a significant negative effect on their mental health by creating anxiety and poor self-concept.

Behavioural management. Another key aspect within family functioning is behavioural management and simply refers to the ways in which behaviour of family members are managed (Epstein et al., 2003). Behaviour can be managed in a multitude of ways, however most literature has focused on the use of rules, boundaries and or standards

which have been found to allow for a sense of consistency, predictability, safety and belonging that correlates with good mental health in adolescents (Cottrell & Boston, 2002; Johnson et al., 2014; Rachel et al., 2022). Furthermore, Tafa and Baiocco (2009) specifically established that healthy family functioning in the way of high flexibility in rules, along with other aspects of family functioning such as good family support and adequate emotional responsiveness are important factors that contribute positively to the mental health of adolescents.

Values. Closely aligned with behavioural management is that of family values which are seen as beliefs and/or ideals that are meaningful and bind a family together (Meca et al., 2022). They are subsequently found to help shape personal values and morals, which then helps define an individual and how they make their way in society (Meca et al., 2022). Therefore, values have been found to be beneficial for the mental health of family members, particularly for children and adolescents (Cervantes et al., 2013; Edgar-Smith & Wozniak, 2011; Garnier & Stein, 1998). Edgar-Smith and Wozniak (2011) found adolescents that had values instilled within them, learnt to express themselves, grow from their mistakes, problem-solve and develop abilities and skills that helped them to become productive members of society which then had a beneficial impact on their mental health. Similarly, Garnier and Stein (1998) discovered that traditional values such as honesty, respect and kindness have helped with the functioning of a family that then benefits the mental health of those within the family, including adolescents. Furthermore, different families will have different values, however that does not deter from the fact that they are pertinent to each family (Cervantes et al., 2013; Neto, 2010). For example, family values play a key role in adolescent mental health within immigrant families, where Neto (2010) found immigrant adolescents, despite having different family values due to their cultural context, still perceived family values beneficial for their mental health in the way of satisfaction.

Roles. The aspect of roles refers to the recurrent patterns of behaviour by which individuals fulfil responsibilities and/or duties within the family (Epstein et al., 2003). Having appropriate roles within the family has been found to create structure which not only enables for the effective functioning of a family but benefits adolescent mental health in the way of recognizing stability and safety within the family (Torre et al., 2017). This finding is similar to the impact rules, boundaries and/or standards have on adolescent mental health (Cottrell & Boston, 2002; Johnson et al., 2014; Rachel et al., 2022). Nonetheless, in contrast, Zagefka et al. (2020) discovered if the roles family members assumed were *"problematic"* or *"inappropriate,"* it resulted in depressive symptoms within adolescents.

Furthermore, adolescents having roles suited towards their age is beneficial in that they provide responsibilities which allow them to grow and thrive which increases mental health through self-esteem (Yoon, 2012). Whilst there has also been a lack of research on roles as an independent aspect of family functioning, it has often been examined in conjunction with other aspects of family functioning. Ma et al. (2012) explored the mental health among adolescents in conjunction with their families' levels of function or dysfunction. The study showed that inappropriate affective responsiveness, poor affective involvement and low ability of problem solving in the family were significantly associated with increased risk for both poor mental health and mental health problems, with the aspect of roles being the only significant predictor of poor mental health in girls.

Relationships. It is important to highlight that while family relationships were a substantially researched area within family functioning research which was then related to adolescent mental health. It is a broad term that is understood and assessed through many aspects already discussed, such as cohesion, communication, emotional support and responsiveness (Deb et al., 2015; Eccles & Gootman, 2002; Maenle & Herringshaw, 2007; Moore et al., 2018; Parra et al., 2013). Hence, while family relationships do provide insight

into how family functions, it is more so the aspects that make up the relationship that are pertinent to family functioning and subsequently adolescent mental health (Haines et al., 2016).

Limitations. As evident, there are a number of aspects and areas to family functioning that can impact adolescent mental health, with the ones discussed above being the most prominent. However, there are a few critical limitations within this existing literature.

Firstly, since family functioning is defined so differently throughout research, the way family functioning is measured, and areas and aspects focused on varies immensely. Family functioning is also rarely understood qualitatively, thus understood quantitatively through quantitative measures. These quantitative measures then vary on the aspects and areas focused within family functioning. Some of the most common measures used in the above studies were the McMaster Family Assessment Device (FAD) which assesses the six aspects of the MMFF (Ma et al., 2012; McNamara & Loveman, 1990; Lindqvist et al., 2007; Zagefka et al., 2020) and the Family Adaptability and Cohesion Evaluation Scale (FACES-IV) which assesses family cohesion and adaptability (Tafa & Baiocco, 2009; Parra et al., 2015). There are then measures that are also specific to those of other cultures such as the Chinese Family Assessment Instrument (C-FAI) (Shek, 2002), and measures that only focus on one aspect of family functioning such as communication, e.g., the Parent-Adolescent Communication Scale (PACS) (Bireda & Pilay, 2018; Levin & Currie, 2010). Furthermore, a review by Pritchett et al. (2011) collated the vast range of available quantitative measures for family functioning and found over 100 measures that can be used to measure the different aspects and areas of family functioning. Whilst this emphasises the broadness and multidimensionality of family functioning, areas and aspects of family functioning are also evidently interrelated, yet when assessed through quantitative measures this interrelation is not accounted for.

A lot of the family functioning research was also lacking understanding through multiple perspectives. One limitation of this is that each perspective from the family provides a different insight into family functioning. Subsequently both quantitative and qualitative research has shown that adolescents tend to have more negative perceptions of their family than parents (Callan & Noller, 1986; Feldman et al., 1989: Noller et al., 1992). For instance, Noller et al. (1992) found that adolescents between 13 and 16 years old reported higher levels of family conflict and lower levels of intimacy among family members than their mothers reported. Furthermore, Callan and Noller (1986) observed that, compared with fathers and mothers, adolescents between 13 and 17 years old were less satisfied with the flexibility of their family and perceived their family as less cohesive. Finally, Feldman et al. (1989) found that sons described their families as less cohesive than their parents.

In addition to these limitations, there were a few regarding how adolescent mental health was understood within the above literature. As previously mentioned, I have had to include symptoms of depression and anxiety to indicate levels of poor mental health within this section. This is largely due to the common quantitative research approach, which results in many measures that then focus on depression, anxiety and its symptoms. Common measures utilised were the Beck Anxiety Inventory (BAI) (Deb et al., 2015), Patient Health Questionnaire Depression Scale (PHQ) (Zagefka et al., 2020; Zargar et al., 2007), General Health Questionnaire (GHQ) (Torre et al., 2019), Youth Self-Report (YSR) (Lindqvist et al., 2007) and Kessler Psychological Distress Scale (K10) (Boudreault-Bouchard et al., 2013; Rivera et al., 2008).

A second issue surrounding quantitative measures is that even though a few studies utilised measures of good mental health, for instance, life satisfaction assessed by The Satisfaction with Life Scale (SWLS) (Chappel et al., 2012; Moore et al., 2018) and the Rosenberg Self-Esteem Scale (RSE) (Bireda & Pilay, 2018). These measures only focus on

specific aspect(s) of good mental health or *"psychological wellbeing"* as often referred to in literature. Thus, understanding good mental health was limited to what the measures were assessing, as opposed to the large range of indicators that can contribute to and subsequently impact it, particularly since mental health does look different for everyone (Keyes et al., 2010).

While family functioning and its many key areas and aspects, inclusive of problem solving and/or resolving conflict, communication, family support and cohesion, affective responsiveness and involvement, behavioural management, values, and roles have been reasonably researched on its impacts on adolescent mental health. It does come with limitations which need to be addressed.

Section three

Lockdown and lockdown in New Zealand

Lockdown is a new phenomenon referring to a set of restrictions that drastically reduce movement, particularly of individuals (Onyeaka et al., 2021). They were implemented by governments worldwide, because of a disease called COVID-19 which resulted in a pandemic (Haider et al., 2020). While the implementation of lockdowns can take on various approaches, ranging from *"tough and timely"* as seen in India, to a graduated phased lockdown as seen in the United Kingdom, they can then also range in length, depending on each country's COVID-19 circumstance (Alfano & Ercolano, 2020). However all lockdowns had, and still have the same goal of reducing the transmission of COVID-19.

In light of this, lockdown in New Zealand was determined by the four-level Alert system (New Zealand Government, 2020), which is outlined in the table below, Table 1.

Table 1

COVID-19 Alert System of the New Zealand Government

Alert Level	Name	Description
Alert Level 1	Prepare	COVID-19 is contained in New Zealand
Alert Level 2	Reduce	COVID-19 is contained in New Zealand, but the risk of community transmission remains
Alert Level 3 (inclusive of Steps 1, 2 and 3)	Restrict	High-risk that COVID-19 is not contained in the country; multiple cases of community transmission
Alert Level 4	Lockdown	COVID-19 is not contained within New Zealand; widespread outbreaks

The lowest level, Alert Level 1 was applied when COVID-19 was contained within New Zealand, meaning there were no restrictions in movement (New Zealand Government, 2020). Alert Level 2 applied when cases of COVID-19 were occurring but were still contained (New Zealand Government, 2020). During Alert Level 2, there were restrictions to the number of people that could gather, and New Zealanders were required to practise physical distancing when out in public. Alert Level 3 then came into force when there was community transmission of COVID-19 within the country (New Zealand Government, 2020). In New Zealand, both Alert Level 3 and 4 are often informally referred to as *"lockdown,"* despite the name for Alert Level 3 being *"restrict."* Subsequently, lockdown within my research will be seen as both Alert level 3 and 4 within New Zealand, as there were very few differences between the two, as outlined below.

Under Alert Levels 3 and 4, New Zealanders were instructed to stay home and isolate in their *"bubbles,"* which was a term used in New Zealand to refer to the members of a single household (Burnette & Long, 2022). Firstly, under Alert Level 4, New Zealanders were only allowed to leave their bubble for essential personal movement, such as a trip to the supermarket, pharmacy, or medical centre. All non-essential services were closed under Alert

Level 4, including businesses, pools, libraries, and educational facilities (New Zealand Government, 2020). Consequently, all children in New Zealand were home from school, while their parents were expected to work from home unless they worked in an essential service, e.g., a pharmacy, hospital, or supermarket. In the media, New Zealand's Alert Level 4 Lockdown was described as one of the *"strictest"* lockdowns in the world (Cousins, 2020; Gunia, 2020; Walter, 2020).

Under Alert Level 3, the above-mentioned restrictions remained mostly the same where New Zealanders were still instructed to stay home and only leave their bubble for essential personal movement, but with a few exceptions. New Zealanders were allowed to slightly extend their bubble to include close family, a caregiver, or to support isolated people (New Zealand Government, 2020). Children needed to remain at home unless this was impossible, for instance the children of essential service workers. Thus, educational facilities reopened only for parents who worked in an essential service or employed parents with no other caregiver options.

However, from the 4th of October 2021, the New Zealand Government announced a *"three-step plan"* to ease restrictions within Alert Level 3 for Aucklanders (New Zealand Government, 2020). Many speculated this was a way to allow for compliance after the *"never-ending"* lockdown (Baker et al., 2020). Steps 1 and 2 were the only steps initiated from this plan, hence will be the only steps that will be described. Level 3 step 1 allowed for a few minor changes, where outdoor gatherings between 2 households were allowed and outdoor exercise classes could go ahead, both having restrictions to the number of people allowed (RNZ, 2021). Additionally, Aucklanders were able to travel throughout the Auckland region to do an expanded range of outdoor recreation activities. Level 3 step 2 allowed for public facilities and retail to open with face coverings and physical distancing requirements (RNZ, 2021).

This alert system was first introduced on the 21st of March 2020, where New Zealand moved straight into Alert Level 2 (Strongman, 2020). Two days later on the 23rd of March 2020, New Zealand moved into Alert Level 3, as it was determined by the New Zealand Government that community transmission was occurring in the country (New Zealand Government, 2020). Only two days after this on the 25th of March 2020 a National State of Emergency was declared and New Zealand moved into the most restrictive and strictest level, Alert Level 4 (New Zealand Government, 2020). This lasted for more than a month, until the 27th of April 2020. New Zealand subsequently moved back to Alert Level 3 for another two and a half weeks until the National State of Emergency was lifted on the 13th of May 2020, where New Zealand then moved back into Alert Level 2 (Strongman, 2020). Finally on the 8th of June 2020 there were no more active cases in New Zealand which consequently allowed for New Zealand to move to Alert Level 1 (New Zealand Government, 2020). This meant the lockdown period spanned 7 weeks.

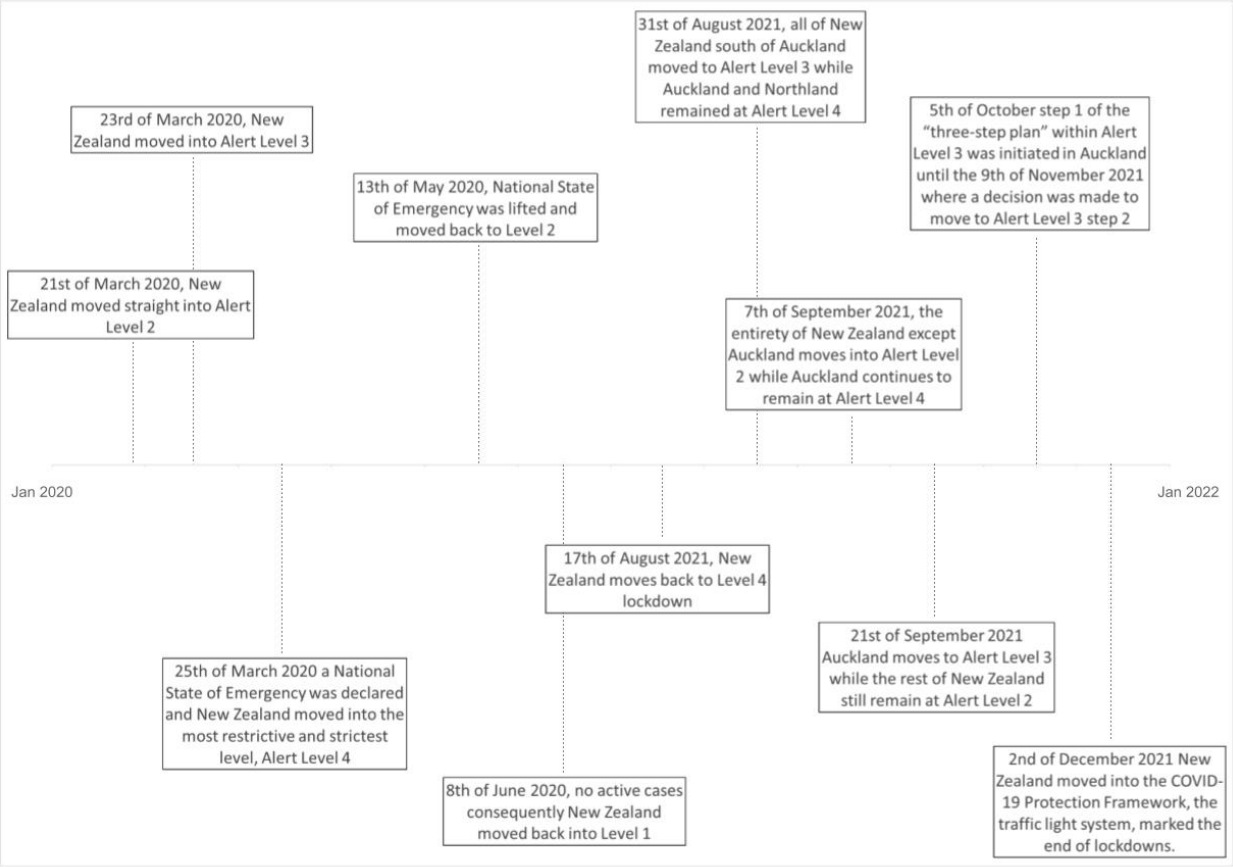
During my thesis, New Zealand was once again placed into Alert Level 4, where a second lockdown commenced on the 17th of August 2021 (New Zealand Government, 2020), about a year and three months after the completion of the first lockdown. The whole of New Zealand remained at Alert Level 4 until the 31st of August 2021 (New Zealand Government, 2020). It was at this point Alert Levels would differ for each region within New Zealand subsequently creating an exceedingly difficult timeline to follow. Hence only the dates which are of relevance to my thesis will be outlined. From the 31st of August 2021, all of New Zealand south of Auckland moved to Alert Level 3 while Auckland and Northland remained at Alert Level 4 (New Zealand Government, 2020). On the 7th of September 2021, the entirety of New Zealand except Auckland moves into Alert Level 2 while Auckland continues to remain at Alert Level 4 (New Zealand Government, 2020). After three weeks on the 21st of September 2021 Auckland moves to Alert Level 3 while the rest of New Zealand

still remain at Alert Level 2 (New Zealand Government, 2020). On the 5th of October, step 1 of the *"three-step plan"* within Alert Level 3 was initiated in Auckland until the 9th of November 2021 where a decision was made to move to Alert Level 3 step 2 (New Zealand Government, 2020). During this time the majority of New Zealand remained in Alert Level 2. Finally on the 2nd of December 2021 New Zealand moved into the COVID-19 Protection Framework, also known as the traffic light system, meaning Auckland moved out of Alert Level 3 step 2, and according to the New Zealand Government, also marked the end of lockdowns (New Zealand Government, 2020).

Ultimately New Zealand went through two major lockdowns, the first lockdown spanned around two months for everyone in New Zealand, while the second lockdown spanned 3 weeks for the majority of those outside of Auckland. However, the second lockdown spanned around 3 and a half months for those within Auckland. It is important to note while Auckland did move to Alert Level 3 on the 14th of February 2021 to the 17th of February 2021 (New Zealand Government, 2020), this has not been included as a lockdown period within my thesis due to its length. Nonetheless, a summary of the specific dates on which the different Alert Levels came into force in New Zealand will be displayed in the figure below, Figure 2, for clarity.

Figure 2

Timeline of New Zealand's Alert Levels



Impacts of lockdown

With COVID-19 and the subsequent lockdowns being a reasonably recent phenomena, it is likely to take years and many more studies to fully understand the impacts of COVID-19 and lockdowns on the population (Oneyeaka et al., 2021). This results in literature being somewhat limited and lacking. Nonetheless, literature around both COVID-19 and lockdowns can still be utilised to provide some insight into the impacts of lockdown in relation to adolescent mental health and family functioning, due to the pertinent role these areas hold within my research.

Firstly, there are conflicting findings when it comes to the impacts of lockdown on adolescent mental health, where lockdown has negatively impacted, positively impacted, or

had no impact on adolescent mental health (Ahrens et al., 2021; Gassman-Pines et al., 2020; Janssen et al., 2020; Meherali et al., 2021; Wang et al. 2020). For instance, Gassman-Pines et al. (2020) utilised daily survey data collected before and after lockdowns to investigate whether lockdowns had worsened parents' and children's, those aged 15 and under, levels of mental health. Both parents and children experienced poorer mental health that was exacerbated by multiple hardships related to COVID-19 (Gassman-Pines et al., 2020). While Meherali et al. (2021) undertook a knowledge-synthesis study to identify the impact of the pandemic and COVID-19 lockdowns on children's and adolescent's mental health. These studies reported that pandemics and lockdowns caused stress, worry, helplessness, and social and risky behavioural problems among children and adolescents which indicate levels of poor mental health (Meherali et al., 2021).

However, Janssen et al. (2020) measured the impacts of lockdowns on mental health through emotional wellbeing in families with adolescents in the Netherlands. This was accomplished using daily reports from before and during the lockdowns (Janssen et al., 2020). It was found that adolescents' negative affect and positive affect did not change from these two timepoints displaying adolescent mental health was largely unaffected by the circumstances of lockdown (Janssen et al., 2020). Additionally, a study surveyed 1738 Chinese participants at two time points following the commencement of lockdowns and found no significant changes across time in levels of good mental health and stress for both adolescents and adults (Wang et al. 2020).

In Germany, mental health status significantly improved over the entire post-lockdown period within both adults and adolescents, which was in part due to everyday stressors being reduced. (Ahrens et al., 2021). Consistently in New Zealand, The Office of the Children's Commissioner (OCC) (2020) launched a national online survey for children and adolescents aged 8-18 years. This survey focussed on current wellbeing and subsequently

mental health at Alert level 2, as well as experiences New Zealand's first lockdown (OCC, 2020). Many positive effects of being within lockdown were found for this population which related to levels of good mental health (OCC, 2020). For example, lockdown was a time of independence and opportunity to learn new skills which have been found to increase the mental health of some adolescents (OCC, 2020). This was also corroborated by Walker et al. (2021) who also undertook a survey during the first lockdown in New Zealand. Additionally, McNeill and Gillon (2021) focused on the experiences of those aged 10-13 (early adolescence) also during New Zealand's first lockdown. While not explicitly stated, findings suggest that lockdown was once again beneficial for the mental health of many interviewed (McNeill & Gillon, 2021).

The impact of lockdown on family functioning has also received some attention, particularly since lockdowns for many families created cumulative stressors, including economic insecurity, loss of social support, and balancing childcare, schooling and work at home (Morelli et al., 2020). While it has been found that family functioning is likely to be impacted by COVID-19 and the subsequent lockdowns, findings around how family functioning changed are also conflicting.

Findings exemplify that the COVID-19 pandemic and lockdown exacerbated family conflicts and problems (Overall et al., 2022; Prime et al., 2020; Chung et al., 2020; Westrupp et al., 2021). Specifically, Chung et al. (2020) conducted a study in Singapore which demonstrated concurrent links between work-family conflict and higher levels of parenting stress and couple conflict in parents juggling work while supervising children aged 10 to 16 during lockdown. Overall et al. (2022) examined changes in parents' health and family functioning, being the only study to do so over the first 1.5 years of the pandemic in New Zealand, and found declines in couple and family functioning in the way of reduced family cohesion.

Furthermore, González-Pasarín et al. (2021) analysed the impact of lockdown on family functioning, focusing particularly on levels of cohesion and adaptability of foster and non-foster families in Spain. It was found that for both types of families, lockdown provided an opportunity to improve their family functioning. This is consistent with the findings of multiple studies where family functioning was improved during lockdown, due to the unique opportunity it presented to families that may not have otherwise been available (Cito et al., 2020; Clayton et al., 2020; Mangiavacchi et al., 2021). While Gadermann et al. (2021) found that lockdown both negatively and positively impacted aspects of functioning within families specifically in Canada, i.e., greater conflicts yet better support.

Sheen et al. (2021) explored the possible changes in family functioning from the perspective of parents in Australia during the COVID-19 pandemic through thematic analysis. It was found that family functioning was impacted in the areas of family roles and boundaries, routines and relationships; opportunities and resourcing; and support and unity. Evans et al. (2020) also investigated the varied experiences of Australian families during COVID-19 lockdowns through thematic analysis and subsequently found themes that related to areas and aspects of family functioning. Six themes were found and ranged from *"a spectrum of emotion"* to *"changing family relationships: the push pull of intimacy."*

While both adolescent mental health and family functioning have had varying and conflicting findings regarding the impact of lockdown, it signifies how lockdown was a different experience for every individual and family. This can be partially attributable to the differing lockdowns around the world, but more so to each individuals and families' circumstances. Thus, while acknowledging this, one key finding was that lockdown did impact family functioning, however that may be. Since research previously outlined has exemplified how adolescent mental health prior to lockdown has been steadily declining over the years globally (Currie et al., 2012; Patel et al., 2007; Venning et al., 2013), and family

functioning is irrevocably a key factor, positive or negative, to adolescent mental health (Cheng et al., 2017; Walker & Shepherd, 2008). With a study undertaken during lockdown corroborating this (Pan et al., 2021). Understanding how family functioning impacts adolescent mental health during lockdown is pertinent, particularly because most adolescents were in lockdown with their families (Ajanovic et al., 2021).

There is only one study by Cusinato et al. (2020) that did aim to analyse the potential risk and protective factors for parents' and children's mental health during lockdown in Italy. The results did show that lockdown along with the changes in daily routine and roles negatively affect parents' psychological dimensions, thus exposing children to a significant risk in their mental health. Whilst Cusinato et al. (2020) did find how an area of family functioning impacted adolescent mental health during lockdown, family functioning is a broad, multidimensional, and interrelated term with many areas and aspects, as already identified. Subsequently meaning they have not been investigated in the context of adolescent mental health during lockdown.

Aside from this, no studies to date have focused on understanding how family functioning impacts adolescent mental health during lockdown. Some have instead focussed on the role of parents or family relationships on children's, not adolescent mental health during lockdown (Pailhé et al., 2022). While others have focused on measuring the impact of lockdown on factors which were inclusive of adolescent mental health and family functioning but not examining the relationship between the two (Singh et al., 2020; Westrupp et al., 2021). For instance, Westrupp et al. (2021) not only examined parents and children aged 1 to 18, mental health and family functioning, but parental substance use, couple conflict and parenting practices during COVID-19, compared to pre-pandemic data. Poorer family functioning was found in the way of higher parenting irritability and lower family positive

expressiveness and poorer levels of mental health in adolescents in the way of decreased functioning (Westrupp et al., 2021).

While previous research after a period of trauma such as, parental mental or physical illness (Crowe & Lyness, 2013; Stanescu & Romer 2011), or sudden death (Kõlves et al., 2019), widespread socioeconomic stress (Margerison-Zilko et al., 2016), and natural disasters such as earthquakes (Cao et al., 2013) and fire (Pujadas Botey & Kulig, 2014) can provide clues into the ways family functioning may differ and impact adolescent mental health. The unique challenge of lockdown is seen by many researchers as an entirely new and unstudied phenomenon in modern history that no previous research relating to *"a period of trauma"* or past pandemics can truly understand and encompass (Oneyeaka et al., 2021). Subsequently there is a clear gap within the literature which leads to the current study.

The current study

The current study is therefore the first to address this gap by aiming to understand how family functioning impacts adolescent mental health during lockdown, specifically during the two lockdowns in New Zealand.

My study will also acknowledge the many limitations that have been found throughout the existing literature, by not only recognizing mental health as a separate but distinct construct to mental illness, but recognizing it may often look different for each individual despite it encompassing how we think, feel and act. Furthermore, family functioning will also be understood as a broad, multidimensional, yet interrelated concept that can then be related to adolescent mental health through multiple perspectives.

It is therefore hoped my research findings can provide insight and understanding into the ways family functioning has changed and impacted adolescent mental health in New Zealand. This could then have important implications, from not only providing relevant and necessary information for any future lockdowns, but also possibly informing interventions,

initiatives, approaches and/or strategies that are specific to families with adolescents designed to deal with the mental health repercussions of lockdown.

Chapter Two: Methodology and Method

In order to achieve my aim of understanding how family functioning impacts adolescent mental health during lockdown, the following section will firstly discuss my research paradigm consisting of my philosophical position and methodological approach, alongside my role as a reflexive researcher. This will then be followed by my selection criteria, recruitment process, participant information, data collection and analysis, and finally, ethical considerations.

Philosophical position

Critical realism is the philosophical position which underpins my research, and is subsequently seen as both an ontology and epistemology (Braun & Clarke, 2021; Gorski, 2013). Firstly, critical realism is ontologically realist meaning there is an assumption that there is an external reality or knowable world that has access to truth which is independent of human minds (Stutchbury, 2021; Madill et al., 2000). However, epistemologically relativist meaning it is impossible to access this reality or truth directly as it is obscured by both subjectivity and processes that produce knowledge (Braun & Clarke, 2021; Stutchbury, 2021). In other words, critical realism conceptualises different perspectives on, and interpretations and representations of, or possibilities for this singular reality or truth (Braun & Clarke, 2021; Sturgiss & Clark, 2020). This then provides the position for me, as a researcher, that there is a real and knowable world of truth which sits *"behind"* the subjective and socially located knowledge I can access (Braun & Clarke, 2013).

Thus, even though my study aims to gain knowledge of the *"truth"* in regard to the impacts of family functioning on adolescent mental health during lockdown, it acknowledges that the data gathered may not provide direct access to this reality or truth. Instead, the answer will always be complex and contextual, where I access my participants' perception of their reality, shaped by their subjectivity, and socially located knowledge. Furthermore, this

interpretation inescapably takes place through the lens of my own subjectivity and socially located knowledge (Braun & Clarke, 2013).

Qualitative research

Qualitative research was the methodological approach of my research because it utilises qualitative methods of collection and analysis that enables for an in-depth and interpreted understanding of the subjective world of my participants, i.e., their experiences and perspectives shaped by social contexts (Aspers & Corte, 2019; Flick, 2018). This is of particular importance since my research is the first of its kind to understand *how* family functioning impacts adolescent mental health during lockdown. Furthermore, qualitative research also aligns with my philosophical position of critical realism.

Role as a reflexive researcher

In order to achieve my aim through a critical realist qualitative approach, it required me, the researcher, to take an active role throughout my research, particularly during the data collection and analysis stages (Aspers & Corte, 2019). As a result, I had to be aware and acknowledge how my perspectives, experiences, knowledge and assumptions, or in other words my subjectivity, shaped the entirety of my research through a process known as reflexivity. (Bradbury-Jones, 2007; Braun & Clarke, 2021; Lazard & McAvoy, 2020).

In this study, reflexivity was engaged in using two methods. First, a reflective journal was kept throughout the research process which was used to write down my thoughts, personal feelings, and challenges that came with hearing sincere and at times unfortunate stories and experiences. This then provided better insight and understanding into how my subjectivity shaped and influenced my research outcomes (Barrett et al., 2020; Braun & Clarke, 2021; Ortlipp, 2008) This was of particular importance since I am an individual who decided on this research because of my own experiences with family functioning negatively impacting my mental health.

Secondly, reflective supervision was also provided by my supervisor, where discussions were primarily had around how my subjectivity impacted my overall research approach and design. Subsequently, alternative perspectives were offered which not only helped with understanding how my subjectivity guided my research approach and design but provided confirmation of the choices made around this. I found this form of reflexivity to be necessary, due to my previous experience of being a purely positivist quantitative researcher focused on objectivity.

Thus, being a reflexive researcher was imperative since subjectivity is an acknowledged and accepted aspect within my research.

Selection criteria

In order to understand family functioning and its impact on adolescent mental health during New Zealand lockdowns, my research required seven families that consisted of an adolescent currently aged 16-18 and parent(s)/caregiver(s)/guardian(s) who lived together, specifically during both New Zealand lockdowns. Please note that the term *"family/families"* may also be used when referring to just the parent(s)/caregiver(s)/guardian(s) and adolescent within the family for convenience purposes, even though I am aware there may be several other members that make up the family.

Adolescents aged 16 to 18 were strategically required for my research when recruiting in January 2022. This was to understand how family functioning impacted 14- to 17-year-olds mental health during the two New Zealand lockdowns which spanned from March 2020, to early December 2021 for many. This meant 14- to 17-year-olds were the true target age group in my research which allowed for the focus on one particular stage of adolescence, middle adolescence, as opposed to the broad stage of 10 to 24 year olds adolescence encompasses.

As already established, utilising multiple perspectives within research provides unique insights, which then provides a *"clearer, more thorough and coherent understanding"* (Reczek, 2014). Hence why my research required the parent(s)/caregiver(s)/guardian(s) of the family as well as the adolescent. I did however make the decision to only include the parent(s)/caregiver(s)/guardian(s) as well as adolescent, not other family members such as siblings. This is because the focus is placed on adolescent mental health in relation to family functioning during lockdown, and parent(s)/caregiver(s)/guardian(s) have the greatest impact on this than any other family member(s) (Harden et al., 2010; McCarthy et al., 2003). A key reason for this is that they are found to be the most stable and consistent members within the family for adolescents (Branje, 2018; Tucker & Updegraff, 2009). Furthermore, when it comes to siblings they can vastly differ in age, where if the sibling(s) were extremely young it would be difficult for them to contribute, while if the sibling(s) were older it is likely they were not living with the family during lockdown (Tucker & Updegraff, 2009). Hence for consistency I decided to only include the parent(s)/caregiver(s)/guardian(s) and the adolescent within the family. Additionally, a decision was made to have seven *"families"* within my research, as after discussion with my supervisor and following the guidelines by Braun and Clarke (2006), this was found to be the appropriate number to allow for data saturation.

Finally, in my selection criteria it was also of immense importance to recognize the diverse population of New Zealand. Hence in an attempt to do so, the selection criteria did not discriminate against what types of families were welcomed; single parent families, same-sex families etc., and did not just conform to what constituted a family in the traditional sense (i.e., father, mother, and child(ren)) (Sharma, 2013). Additionally, as evidenced above not only were parent(s) able to participate but guardian(s) and caregiver(s), in other words the person(s) who the adolescent is under care of, provided they also met the other requirements

mentioned above. This recognition of New Zealand's diverse population was also kept in mind throughout the entirety of the recruitment process outlined below.

Recruitment

Participants were recruited from social media platforms, in particular Facebook and Reddit. Initially 28 Facebook community groups and 11 Reddit community subreddits within New Zealand were joined. On Facebook this was done by searching *"community group"* which brought up a number of community groups located in New Zealand where I joined the community groups around New Zealand with the most members. On Reddit this was done by searching up the key regions in New Zealand which then brought up the community groups of these regions, for example searching *"Bay of Plenty"* brought up the community group for the region. In light of joining these community groups and subreddits, permission was requested from the administrators to post my research advertisement. Once receiving confirmation, I posted my advertisement for my research inviting those who met the criteria to contact me either through email or phone (Appendix A) . I understood in advance the difficulty I would face when recruiting families, hence my advertisement also encouraged others within these community groups and subreddits to share the post to those they knew who would meet the selection criteria.

Within the first two weeks of advertising, I was able to recruit three families from Facebook and one family from Reddit. However, I was also able to recruit another family through a member of one of the community groups from Facebook sharing the advertisement post to this family, making the total number of families recruited five. It quickly became clear that Facebook was the platform reaching the appropriate participants for my research and subsequently my attention focused on advertising purely through Facebook community groups.

To recruit the remaining two families I joined a further 31 community Facebook groups and posted my research advertisement, following the same process outlined above. After joining these 38 community groups, I had joined the majority of community groups within New Zealand. Over a span of a week, I was able to recruit two more families. Unfortunately, one of these two families pulled out a week before their interview was set to begin. In light of this I joined three final community groups as a last attempt to recruit my seventh family. I had consulted with my supervisor who stated that six families will still suffice for data saturation. I was however able to recruit my seventh family after only a few days of the research advertisement being put on the three community group pages.

The recruitment process began once a member of the family made initial contact with me through email or phone after seeing the research advertisement. The family member who made initial contact with me turned out to be the member that all communication was done with for the recruitment of the family, and will be abbreviated as FMIC (family member who made initial contact) to avoid repetition.

Before continuing forward with the recruitment process, I would always check with the FMIC that them and their family met the selection criteria. If they did and if contact was made through phone I would request for their email, so I was able to provide them with the information sheets. Both the adolescent information sheet (Appendix B) and parent(s)/caregiver(s)/guardian(s) information sheet(s) (Appendix D), were sent through to the FMIC who was made aware to pass the one which did not apply to them to the member(s) it did apply to. The FMIC was also informed to make sure the information sheets were read by all required members, including themself and if anyone had questions or concerns to contact me so I could address them. This was also stated on the information sheets. Finally, I stated if there were no questions or concerns from members required to participate, and they were still willing to participate to contact me back through email.

All families recruited did not come back with any questions or concerns. Subsequently the FMIC simply stated that they and the required members of their family were still willing to participate. Following this I then emailed the FMIC the informed consent sheets, which included one for the adolescent (Appendix C), and as many needed for the parent(s)/guardian(s)/caregiver(s) within the family (Appendix E) to fill out and return at their earliest convenience. Once the informed consent sheets were returned and checked, I sent through my availability to the FMIC and advised them to let me know a day and time that would be suitable for all members who were required to participate. Consequently, a meeting time was arranged, and a Zoom meeting link was sent to the FMIC through email. They were also made aware that this link can be sent to the other participating family members if they would like to join on separate devices.

Interviews with the first five recruited families began while I was still in the process of recruiting my final two families. Despite this, recruitment of all seven families took around three and a half weeks.

Participants

The below table, Table 2, outlines all seven families, inclusive of adolescents that were interviewed. Each member within each family has been given a corresponding letter i.e., a,b,c,d,e, which is then used throughout each of the table categories.

Table 2

Table of Participants

Family	Family members that lived together during first lockdown	Family members that lived together during second lockdown	Sex M/F	Members which were interviewed	Pseudonyms for members interviewed	Ethnicity for members interviewed	Age of adolescent at the beginning of first lockdown	Age of adolescent at the end of second lockdown	City in New Zealand family resides
1	a. Parent b. Parent c. Eldest child - **adolescent** d. Middle child e. Youngest child	a. Parent b. Parent c. Eldest child - **adolescent** d. Middle child e. Youngest child	a. M b. F c. M d. F e. F	a. Parent b. Parent c. Eldest child - adolescent	a. Matthew b. Aroha c. Jack	a. Maori/Pakeha b. Maori/Pakeha c. Maori/Pakeha	15	16	Katikati
2	a. Guardian b. **Adolescent**	a. Guardian b. **Adolescent**	a. M b. F	a. Guardian b. Adolescent	a. Sam b. Maria	a. Middle Eastern b. Middle Eastern	15	17	Auckland
3	a. Parent b. Parent c. Middle child - **adolescent** d. Youngest child	b. Parent c. Middle child - **adolescent** d. Youngest child	a. M b. F c. F d. F	b. Parent c. Middle child - adolescent	b. Carla c. Olivia	b. Maori c. Maori/Middle Eastern	16	17	Palmerston North
4	a. Parent b. Parent c. Middle child - **adolescent**	a. Parent b. Parent c. Middle child - **adolescent** d. Youngest child	a. M b. F c. F d. F	b. Parent c. Middle child - adolescent	b. Wendy c. Charlotte	a. Middle Eastern b. Middle Eastern	14	16	Auckland
5	a. Parent b. Parent c. Youngest child - **adolescent**	a. Parent b. Parent c. Youngest child - **adolescent**	a. M b. F c. F	a. Parent b. Parent c. Youngest child - adolescent	a. Bear b. Mamma c. Jeska	a. Pakeha b. Pakeha c. Pakeha	15	17	Auckland
6	a. Parent b. **Adolescent** c. Grandparent	a. Parent b. **Adolescent**	a. F b. M c. M	a. Parent b. Adolescent	a. Gypsy b. Christian	a. Fijian/Chinese b. Pakeha/Fijian	14	16	Auckland
7	a. Parent b. Parent c. Youngest child - **adolescent**	a. Parent b. Parent c. Youngest child - **adolescent** d. Middle child	a. M b. F c. M d. M	a. Parent b. Parent c. Youngest child - adolescent	a. James b. Jamie c. Jace	a. Pakeha b. Maori c. Maori/Pakeha	15	17	Auckland

Data collection

Data was collected from each family through two semi-structured interviews; one with the family which consisted of the parent(s)/guardian(s)/caregiver(s) and adolescent, and one with just the adolescent.

Semi-structured interviews are often described as a *"conversation with a purpose"* (Dearnley, 2005) and was my chosen data collection method for two key reasons. Firstly, I was able to have a predetermined set of open questions which allowed me to feel prepared as a novice interviewer. Secondly, since semi-structured interviews allow for open ended questions, it not only prompts discussion, but enables for flexibility to explore other areas of interest that may not have been elaborated upon, as later evidenced. This is necessary for any qualitative research, including mine, to gain greater access into participants subjective worlds.

All semi-structured interviews were conducted over Zoom due to COVID restrictions. However, there was an unintended benefit to this in that participants would be within an environment that felt safe to them. This then helps to feel more comfortable and relaxed when starting an interview, which has been found to be important for any interview requiring personal information (Bell et al., 2016; Brayda & Boyce, 2014).

The first interview with the family that included the parent(s)/caregiver(s) and adolescent, involved introducing myself and rapport building. Rapport building was especially important as it not only relieved any awkwardness or tension, but was an opportunity to build a connection. This has been found to help build trust and affinity, which within a research context elicits more genuine and open responses (Abbe & Brandon, 2013; Bell et al., 2016; Macintosh, 2009). Thus, rapport building involved making general conversation with the participants and checking how their day was going, to being open and telling the participants something personal about myself, to keeping my camera on the entire

time so facial expressions and eye contact could be maintained throughout. From here all admin and necessary ethical points were covered or reiterated i.e., confidentiality and consent, which is discussed in further detail in my ethical considerations section, before I began recording the interview.

This initiated the start of the interview which usually lasted around 30 minutes but, in some instances up to an hour. Questions were asked about each family's functioning during New Zealand lockdowns, and were designed to not only be based on the six aspects of the MMFF but to provide families with the opportunity to discuss their family functioning in general. This can be found within my family interview schedule in Appendix F. These questions elicited plenty of discussion which gave me the opportunity to further investigate areas of interest. However, I found that whilst I had an interview schedule, it at times was not needed, because of the many other interesting discussions that occurred. Special consideration was also taken to ensure the active participation of all family members. Once the family interview concluded, parent(s)/caregiver(s) were asked to either leave the Zoom meeting or to leave the room, depending on how they had joined the Zoom meeting. This was to allow for the adolescent to be left alone in a quiet safe space.

From here the second interview with just the adolescent took place which usually lasted around 30 to 45 minutes. I decided that a one-on-one interview would be of more beneficence when talking to the adolescent about their mental health and how it related to their family functioning. This is primarily because of their age and how they are more likely to feel comfortable sharing personal information as well as add anything they may not have felt they could in the family interview (Thomas & Hodges, 2010). Once again before the commencement of the adolescent interview they were reminded of all key ethical points as well as checking if they needed a quick break. I found it also was necessary to build further

rapport with just the adolescent at this point for the reasons mentioned above, as well as to show I was genuinely interested in them and what they had to say.

One important aspect of this interview was making sure adolescents understood mental health in relation to the definition within my research. I not only asked to see what they thought mental health was, according to my adolescent interview schedule as found in Appendix G, but I then stated the definition of mental health and explained it in further depth if required. This enabled all adolescents to have an understanding of what mental health was and entailed. Whilst I did have an interview schedule, I found that because interviews with the family brought up so much information about the way they functioned before, during and even after lockdown, it was imperative to investigate this further with the adolescents in relation to their mental health. This once again resulted in the interview schedule not being adhered to as much as I would have thought. Nonetheless all questions asked still gave adolescents the opportunity to talk about their mental health, add anything about their family functioning and relate their mental health to their family functioning during lockdown. I was also once again able to further investigate areas of interest when needed.

At the end of the interview, I thanked the adolescent for their time and carried out any further ethical duties I had as a researcher which will once again be outlined below. I then stopped the recording which concluded the interview process. However in the following days after the interview, families was sent a $100 Prezzy card to compensate them for their time and effort.

Data analysis

Thematic analysis is a form of analysis which involves developing, analysing and interpreting patterns across a qualitative dataset, in my instance interviews. (Braun and Clark 2021; Guest et al., 2012). This is achieved through six key phases; familiarisation of the data, coding, generating initial themes, developing and reviewing themes, defining and naming

themes and writing up. Although there are six phases, thematic analysis is an iterative, non-linear process, with ongoing reflection and refinement being an important and encouraged aspect (Vaismoradi et al., 2013). Hence, thematic analysis was chosen as my method of analysis for a couple of key reasons.

Firstly, thematic analysis allowed for the shift between more inductive and deductive modes which was necessary for my research, particularly because of how the concept of family functioning was utilised. An inductive approach to thematic analysis takes the dataset as the starting point for engaging with meaning, however is never *"pure"* because of what is brought to the data analytic process as theoretically embedded and socially positioned researchers (Braun & Clarke, 2021). In contrast, a deductive approach refers to a more researcher or theory-driven approach, where the dataset provides the foundation for coding and theme development, with codes developed reflecting theoretical or conceptual ideas (Braun & Clarke, 2021). I was able to utilise both approaches, where an inductive approach was initially used, followed by a more deductive approach due to the way my interview questions were designed, but then to ultimately shift back to an inductive approach. This will be discussed in further detail below.

Thus, thematic analysis was unknowingly a forgiving and constantly developing process which allowed me to make sense of how I would approach my data. This not only refers to figuring out whether to code deductively, inductively, or in my case, a combination of both, but whether I would code more semantically, latently or a combination of both.

Finally, not only did the flexible nature of thematic analysis fit into my overall research approach, but many authors suggest thematic analysis is helpful for people new to the research field, which I am. Braun and Clarke (2006), explain that this analysis offers beginner researchers who are learning qualitative techniques, a good thematic approach to analysing qualitative data. Silverman (2011) even talks of how a beginner is likely to become

overwhelmed with the many analytic approaches available and highlights that thematic analysis is a valid approach in which to conduct qualitative data analysis.

Thus thematic analysis was undertaken for this study in line with the six phases outlined by Braun and Clark (2006, 2021) which will now be discussed to provide transparency regarding the development of themes.

The first phase outlined by Braun and Clarke (2006, 2021) involves becoming deeply and intimately familiar with the content of my dataset, through a process of immersion. This process started when I began transcribing each of my interviews into verbatim and continued through to repeated readings of the interview transcripts and repeated listening's of the interview audio recordings to search for brief meanings, patterns, etc. I found that it was especially important to allow for breaks in-between reading and listening of the interviews.

The second phase of coding entailed systematically identifying and labelling relevant features of my interview dataset into codes. Coding was done electronically where any code I identified was firstly labelled on the interview transcript as a comment on Microsoft Word and then copied onto a separate Word document where the collation of my codes would reside. I worked systematically through each of the interview transcripts, giving full and equal attention to each of the transcripts. During this phase I also had to remain conscious that not every piece of data needed to be coded. I firstly decided to code with an inductive approach which meant I coded anything within each of the seven interview transcripts that briefly related to my research question, or I found of interest. However, since my interview questions were also designed to include the six key aspects of family functioning, I did decide to go through each of my seven interview transcripts again and code with a deductive approach. This meant I would see if I could identify and label codes primarily in relation to the six key aspects of family functioning and its subsequent relation to adolescent mental health. However whilst these six aspects were treated as separate aspects within my interview

schedule, I was aware that they may interrelate and overlap, which was evident throughout the interviews. Ultimately, I found an inductive approach to be the most beneficial approach for my research, which resulted in me going through the seven interviews one final time with an inductive approach.

Throughout this process of developing codes, I found I was involved in ongoing decisions, firstly about whether the data constituted a new code. Secondly, whether it fitted into an existing code that I had already developed, or thirdly whether an existing coding category had to be modified to accommodate the new data. This was done to help avoid a large collection of *"unique"* codes with lots of overlap, and exemplifies how coding is an *"organic and evolving process"* (Braun & Clarke, 2013). Additionally, my coding approach was primarily semantic in that my codes captured explicitly expressed meaning but was on rare occasions latent, where codes focused on a deeper, more implicit level of meaning. Ultimately, this is what I found to be most appropriate when coding my data. Once I had coded the data, I then collated all relevant data extracts for these codes in a table within the Microsoft Word document. This then led to the final aspect to this phase which was to go back and re-read through each interview transcript in its entirety to ensure all aspects relevant to answering my research question had been coded for. By the end of the coding process, I had collated just under 60 codes, along with their relevant data extracts, allowing for the focus of analysis to move to the level of themes.

The third phase of generating initial themes firstly began with me truly understanding what a theme was. From here I moved onto sorting the majority of my codes, as well as their relevant data extracts into candidate/initial themes by creating a new table in a separate Microsoft Word document. Just as I had to remain conscious of not coding everything, the same rang true in regard to not including every code within the candidate themes. This is because it ran the risk of creating topic summaries instead of themes. Subsequently, codes,

along with their relevant data extracts that did not appear to fit into any of the candidate themes were kept aside in an *"other"* category and were later re-categorised or discarded once my themes had been refined and finalised. I also adopted a few subthemes to capture important aspects of the theme they sat within. Once I was happy, or so I thought I was with my candidate themes and subthemes, a thematic map was drawn to try gain a clearer understanding of their relationship(s) with one another (Braun & Clarke, 2006; Ryan & Bernard, 2003; Vaismoradi et al., 2013). Throughout this phase there were a couple of aspects I had to keep in mind, firstly, that themes were not considered significant solely on how frequently they appeared within my data, but what was meaningful to my research question (Willig, 2013). Secondly that candidate themes captured my interpretation of the overall *"story"* of the interview data (Braun & Clarke, 2021). Thus, by the end of this phase I had a collection of candidate themes and sub-themes, that was inclusive of my codes and all relevant extracts of interview data.

The fourth phase of developing and reviewing themes was the phase I found the most difficult and time consuming, with one of the reasons being it involved two levels of analysis. The first level of analysis involved reviewing the candidate themes from the level of the coded data extracts, and confirming their internal homogeneity i.e., making sure everything within a theme is similar, and external heterogeneity i.e., making sure different themes have different contents (Byrne, 2021). This was to ensure both internal coherence within candidate themes and a clear distinction between them. This is where I did encounter a key issue particularly in relation to external heterogeneity where my candidate themes would overlap, which I found incredibly difficult to stop happening. This is because aspects and areas of family functioning are inherently related, despite my trying to find a way to account for this. At this point I had to essentially go back to phase three, so I could revise and redevelop my candidate themes and subthemes to make sure I was able to define appropriate boundaries.

This took a long time and required quite a bit of back and forth with my supervisor. Once I finally felt confident with the internal homogeneity and external heterogeneity of my candidate themes, I moved onto the second level of analysis. This level of analysis operated at the level of the data sets themselves, i.e., the interview transcripts, and involved reviewing my candidate themes and subthemes to ensure they were an *"accurate"* representation of my interpretation of the data (Braun & Clarke, 2006). Throughout this phase I once again tried to ensure my themes were rich that both told a *"story"* and addressed my research question by consistently utilising thematic mapping.

The fifth phase of defining and naming themes firstly involved defining and identifying the *"essence"* of each theme as well as of the themes overall to allow for an understanding about the organisation and flow, in other words the overall story my analysis built towards. To do this I wrote up theme definitions, which was also an opportunity to include my subthemes. Once I had written my theme definitions, I found there was still some overlap between themes. This meant I had to further refine my themes as well as adjust my subthemes as necessary, followed by rewriting my theme definitions. From here I moved onto the second part of this phase where I named the themes and subthemes. When naming themes, I had to keep in mind that they were *"concise, punchy, and immediately gave the reader a sense of what the theme was about*" (Braun & Clarke, 2006). Whilst my themes weren't the most *"punchy,"* they did immediately give a good sense of the theme. An important part of this phase was also going back to my interview recordings to do a check on the data extracts I quoted to make sure I did not inadvertently misrepresent what or how something was said. By the end of this phase, my themes and subthemes were fully clarified where I had four themes and six subthemes. From here I was ready to move into the final phase of analysis.

The final phase in the thematic analysis process is writing up. Even though thematic analysis recognises that the process of writing and analysing data occurs throughout the entire process (Terry, 2016), this phase focused on bringing everything together to form a coherent *"report"* of the overall story of my data. In order to do so, for each theme I wrote an analytic narrative which was a commentary that was woven within my vivid data extracts to tell a coherent and persuasive story about my dataset that addressed how family functioning impacted adolescent mental health during lockdown. I did find that my analytic narratives began to paraphrase the content of my data extracts, so I had to focus on either identifying what was interesting about each data extract and why, or simply restricting my commentary to allow for the data extracts to convey the story. Another important aspect to this final phase was situating my analysis within existing research, theory, and wider relevant contexts, as such, I decided my discussion would cover this. This then brought me to the end of my thematic analysis journey.

Ethical considerations

Ethical approval for this study was obtained by Massey University Human Ethics Committee (Northern, Application NOR 21/88), with the letter affirming approval provided in Appendix J. Accordingly, there were a number of ethical considerations identified in relation to my research, these being informed consent, privacy/confidentiality, safety of participants and Treaty of Waitangi obligations, which will be discussed in further detail.

Consent was obtained from every member of every family that participated in the interviews. In order to ensure these family members were able to make informed decisions about their research participation, they each received an information sheet which provided sufficient information of my research aim, risks of the research, what's required from each member of the family, recording requirement, privacy and confidentiality information, right to withdraw consent, as well as their participation being voluntary. In order to fulfil these

requirements, I provided two separate information sheets, one for the parent(s)/guardian(s)/caregiver(s) and one for the adolescent. This was to ensure each member had an adequate understanding of the information sheet and what they were consenting to. They were also given the opportunity to further discuss any queries they had upon receiving their information sheet before signing the consent form. Furthermore, verbal consent was also gained from family members before the commencement of the interview.

Privacy and confidentiality were key ethical concerns in my research, where privacy refers to the control participants/family members had over who can access and manage their personal information. This involved taking consideration during the recruitment process to provide a private opportunity for participants to contact me either through phone or email, as Facebook and Reddit are very public platforms. This was also continued throughout the recruitment process to ensure for the family members and/or family's privacy.

Confidentiality on the other hand focuses on how participants identifiable private information was handled, managed, and disseminated. Firstly, all identifiable participant information gathered, i.e., unedited transcripts, audio files, consent forms were stored on a password protected laptop and backed up on the secure Massey University server, which was only accessible by me and if necessary, my supervisor. Subsequently, extra care was taken with all audio files that were recorded on Zoom, by ensuring they went directly to the secure location of my password protected laptop, as opposed to an unknown storage system. Participants' were also made aware in the process of consent that their data will be securely stored for five years, and then appropriately deleted from my computer and the University server. Furthermore, all participant names were changed to the pseudonyms of their choice during transcription, as well as any distinctly identifying information being removed if used within my research. Finally, participants were also given the opportunity to review their transcripts, which aligns with the consideration of privacy, and return it with edits along with

an *"Authority for the release of transcript"* form (Appendix I). While only two parents and one adolescent requested for this, it was still imperative transcripts were sent directly to those that required a copy. For example, even if I had been communicating with only the parent(s)/caregiver(s) of the adolescent, if the adolescent requested for a copy of their transcript, I ensured they had their own personal email that the transcript could be sent to.

The third ethical consideration relates to harm and how it may occur when people, particularly young people are involved in the discussion of mental health, as seen in my research (Iltis et al., 2013). Hence why the avoidance of harm and subsequent safety of adolescents was of essence within my research. To ensure for this, adolescents were always informed before the commencement of their interview that they were in a safe place and did not have to disclose any information they did not feel comfortable sharing, which also aligns closely to the principle of privacy. I was also prepared with a Word document which contained appropriate resources to provide support if required (Appendix H). Furthermore, I always had my supervisor to consult with if any extra support was needed. However, at the conclusion of each of my interviews every adolescent was asked how they found the process and if they felt they needed any support, every adolescent stated they were *"happy"* and/or *"unaffected"* by the interview, so did not require any further support. Thus exemplifying I was able to appropriately manage any harm.

Finally, as a researcher, I had an obligation to comply with the Treaty of Waitangi principles, these being partnership, participation and protection. This was especially pertinent since my research was open to all ethnicities that met the selection criteria, meaning there was a likelihood I would have Māori families and/or family members. Subsequently several families and family members within my research were either Māori or part Māori. To guide and consult I had my supervisor, who not only has Māori whakapapa, but has been involved extensively with Māori research. Thus in compliance with the Treaty of Waitangi principles,

I ensured all Māori families and/or family members were happy with my research process and if there were any concerns or specific requirements, i.e., opening the interviews with a karakia or whakatauki, to let me know. Furthermore, I have acknowledged the importance and relevance my research may have to Māori communities and have subsequently taken consideration of Māori throughout my research. One example of this being how I defined family functioning. Hence why research findings may be disseminated to relevant areas and agencies.

Chapter Three: Findings

Four themes were developed through thematic analysis describing how family functioning impacted adolescent mental health during lockdown. These were, (1) *adolescent roles changed during lockdown which benefited their mental health*, (2) *poorer problem solving during lockdown negatively impacted adolescent mental health*, (3) *increased emotional responsiveness allowed for greater emotional support during lockdown which benefited adolescent mental health* and (4) *emphasis of family values during lockdown benefited and maintained adolescent mental health*. The below table, Table 3, provides a summary of the themes and the corresponding subthemes. Each of these themes will be described in detail, including supportive quotes. To reiterate, the names used in the below quotations are pseudonyms, and other potential identifiers have been removed to ensure participant confidentiality.

Table 3

Developed Themes and Subthemes

Themes	Subthemes
1. Adolescent roles changed during lockdown which benefited their mental health	1.1 When roles got harder
	1.2 When roles got easier
2. Poorer problem solving during lockdown negatively impacted adolescent mental health	2.1 Communication issues
	2.2 Lacking inclusion
3. Increased emotional responsiveness allowed for greater emotional support during lockdown which benefited adolescent mental health	
4. Emphasis of family values during lockdown benefited and maintained adolescent mental health	4.1 Family time
	4.2 Respect

Theme 1

Changing of adolescent roles during lockdown benefited their mental health

This theme identifies that during lockdown roles for every adolescent interviewed changed. However it didn't matter if the role the adolescent had within the family became easier or harder, as either way it benefited their mental health. Thus the two subthemes are based around *when roles got harder* and *when roles got easier* and how this benefited adolescent mental health.

Subtheme 1.1

When roles got harder

This subtheme focuses on how adolescent roles within the family became harder during lockdown yet positively impacted the mental health of three adolescents.

Firstly, for Olivia, her role becoming *"harder"* wasn't a matter of being told by Carla (Olivia's mother), *"she just assumed that role. I haven't really told her what she needs to do."* It was a matter of Olivia wanting to take on more within her role, particularly during the second lockdown, where Olivia took on more responsibility when it came to her sister, assuming a *"mum-like role,"* where she stated *"I really love my siblings, and I just really want my youngest sister just to, you know, take care of herself more. [...] Other than that, I'm always like you know have to remind her to go shower, "to go like brush your teeth, wash your face, all that stuff."*

Olivia also later mentioned within her individual interview she felt more responsible for the house and her mother, considering all that she had been through. *"I just kinda made sure you know, things were always getting done and, just sorta always being there, especially like after the passing of my grandfather and the divorce and stuff, and being there for my mother when she needed me."*

When Olivia was asked why she assumed this new role with added responsibilities, she responded with, *"um, to a degree it almost made me feel, more, more, alive in a sense. [...] Especially with like you know, with like all the COVID stuff happening I had something like, to always keep my family up on their feet."* This can be summarised as Olivia finding a sense of purpose through her roles during lockdown, with Olivia later stating *"it was probably the best thing I did for my mental health."*

Maria and Wendy's roles also became harder during lockdown, however, this was in part due to their parent(s) and/or caregiver allocating these roles, where Maria firstly stated, *"when I moved houses, I had to start doing it cause Sam (caregiver) can't do it, so he told me to do it."* While Wendy made a similar statement, *"my mum just slowly started to ask me to do more stuff so I just said yes."* Additionally in Wendy's case, it was *"cause like I'm the only girl in the house, like the oldest. So with lockdown I had to do like more stuff than my brother and dad and everyone."* This points to the cultural importance placed on females having specific roles in the family, with lockdown providing an opportunity for this. Nonetheless, both Maria and Wendy found that these roles had a surprising yet beneficial impact on their mental health.

When Maria was asked about her role during lockdown and how she felt about it, she said, *"actually at the start I wasn't really happy with what I had to do. But um yeah, I quickly became happy with my role of cooking and my mental health was good cause like I knew what um, to do for my role and enjoyed it, cooking is one of my hobbies now actually"* Later stating that *"I still love to cook, I cooked today and it made me happy."* This emphasises that despite the reluctance to take on a harder role, it not only helped with Maria's mental health during lockdown in that it was enjoyable, but can turn into a strength/hobby which can benefit mental health in the long term.

For Wendy, her role started to encompass a variety of chores, *"I would always help by doing the dishes and some kind of cleaning, or maybe like, if she doesn't want to cook, maybe I'll like cook something easy. Like, like pasta or something like that or pizza."* Wendy also later admits in the individual interview that, "*I don't want my mum to know but it was actually kind of fun, cause like I had something to do, instead of sitting and thinking about bad things. So I would just like put some music on, like do the cleaning, cooking, laugh and stuff like that, so yeah it helped my mental health when I did it".*

While Wendy admitted these roles helped her and her mental health by having something to occupy her mind, Wendy also mentioned how taking greater care of her sister during lockdown helped her mental health. *"My sister joined our family at the beginning of the second lockdown, and yeah, like sometimes my mum would be like, "take care of your sister." [...] Um, it actually made me happier. [...] She's just so cute. She would just come and sit on my lap and like hug me. Yeah that was pretty cute, it makes me so happy, so yeah, taking care of her really helped my mental health."*

Thus while roles got harder for Olivia, Maria and Wendy, it benefited their mental health by either giving them a sense of purpose or by keeping them occupied and happy.

Subtheme 1.2

When roles got easier

This subtheme focuses on how adolescent roles within the family got easier during lockdown, which then positively impacted the mental health of four adolescents. Roles for adolescents got easier for many reasons, in one instance, as seen in Jeska's family it may be because a parent was taking on more within their role. Mamma (Jeska's mother) expressed how *"Bear (Jeska's father) has had to take on cook, cleaner, chef. [laughs] The whole thing. Oh, taxi driver."* This may at times then compromise this parents mental health, where Bear

(Jeska's father) mentioned how *"I just about knackered myself completely with everything I was having to do."*

However another reason also exemplified by, Mamma (Jeska's mother) was understanding the importance of making sure adolescents weren't overwhelmed by lockdown. *"Unfortunately for Jeska, she never went back to school afterwards as well, so she gave up. [...] I think she has suffered the most, yeah through the problems at school and a lot of problems have come about with Jeska. You know, trying to do a course last year [...] and so it was important that she wasn't overwhelmed with lockdown."*

This reason was also made apparent by James (Jace's father), *"I told Jace his role is to like—he's just a school kid at the moment, a student that's your role you know. It wasn't his role to contribute to the cost of running the house and that cause he's only 17, you know that's our role to like nurture him through that. Yeah so just to keep it simple, we tried to give him as much leniency in his role in lockdown, so yeah his role was just to be a school kid."*

The final reason for why roles got easier for adolescents was because lockdown generally allowed for the easing of roles within the family, which can firstly be exemplified by Gypsy (Christian's mother). *"I think for us, uh the roles we had prior to lockdown were so hectic, like the expectations that came with them, you know like "oh we have to go and do this after school, or I have to go and help." I didn't have to go and help a friend which we do a lot of, you know going help a friend do something. So cause we couldn't go anywhere we weren't allowed, our roles just reduced*." Christian also corroborated this later on, *"you know so our roles were very quietened down and it was because of lockdown."*
Jack also expressed a similar remark, *"lockdown was pretty chill, so that kinda translated into my role."*

Thus, through these many reasons, it ultimately allowed for adolescents to have easier roles which then benefited their mental health in varying ways.

Jace revealed in his individual interview that during lockdown, even though his role was only really inclusive of being a *"school kid,"* because this wasn't really enforced by his parents, it got to the point where Jace felt he *"didn't really have a role during lockdown, just like nothing, do nothing. Play video games, go on social media. Yeah pretty much."* However Jace did later state, *"oh yeah I guess you could say my role just turned into making sure I looked after myself."* When Jace was asked about how he felt this impacted his mental health, Jace responded with, *"It gave me time to talk to friends and, and it was just nice having that time with them [...] So yeah it did really help with me cause I was happy that I had time to do that."*

While for Jack having an easier role meant he had time to focus on his hobbies. Aroha (Jack's mother) stated that *"he's (Jack) quite the musician and he's an artist so that's kind of how he spends a bulk of the free time he had drawing and—you'd probably be answering this yourself.*" Jack then also elaborated on this in his individual interview, *"I kind of liked, um, kind of like being by myself a bit, just so that I could like zone in on what I wanted to do, you know with my music and art. [...] Yeah. So, one of the things—like when I'm composing I usually get like—I'll be like in five minutes and then I'll just kind of zone in into it, like a lot. So it was nice that my role wasn't too hectic cause I was left alone for like long periods of time so I could just focus on it. Yeah, so lockdown gave me that time to work on that and my composing skills picked up then. So yeah that of course made me happy and feel good and so I felt my mental health was good."*

For Jeska, having an easier role was necessary to be able to focus on herself which in turn helped her mental health. *"Even though lockdown was hard, having that time to myself was so necessary, like I was able to get into a better space mentally [...] so yeah I guess I'm thankful that my role wasn't so full on during lockdown, like seriously I could get into a*

better space and sit in my room and play with the dog and just feel way more at peace than I had before."

Finally for Christian, having an easier role during lockdown finally allowed for some time to relax, *"The reward of not having such a full on role was simply just being more relaxed, being more chilled even if there was still things to do. It was really easy for us. Like really easy. It was probably one of the better times for my mental health."* However having an easier role also allowed Christian an opportunity to work on his independence, which as indicated below was beneficial for his mental health in realising his abilities, which is a key aspect of mental health. *"Um, because my role wasn't so hectic and I was usually always running around with mum, I could never really focus on doing things independently. [...] So during lockdown I was like going to school on Zoom even if I didn't want to at times. [...] I was independently doing my things, well the things I needed to do for myself or sometimes for the house. I think yeah feeling that sort of independence was awesome, I just felt like I realised what I was capable of and yeah."*

Thus when roles got easier, it benefited adolescent mental health in a multitude of ways. From having time to talk to friends, to focussing on hobbies and themselves, to having the capacity to relax while also being able to build independence. This then signifies the importance of adapting roles to suit adolescent needs during lockdown.

Theme 2

Poorer problem solving during lockdown negatively impacted adolescent mental health

This theme describes how during lockdown families experienced poorer problem solving which negatively impacted adolescent mental health. Whilst *"poorer"* problem solving may look different in each family, it was visible as two particular areas within my research which make up my subthemes; *communication issues and lacking inclusion*.

Subtheme 2.1

Communication issues

This subtheme outlines how two families faced communication issues, specifically within problem solving, which then negatively impacted adolescent mental health during lockdown. Communication issues can encapsulate many things, however in this instance refers to the raising of voice and blaming.

Bear and Mamma (Jeska's parents) state that while communication did suffer during lockdown in the way of *"raising of voice"* when problem solving, with Bear (Jeska's father) specifically stating *"so our house is slightly different because we would probably—we will voice our complaints, and [pause] you know, we might raise our voices but you know, during lockdown our communication did get worse."* This was attributable to the circumstance lockdown created as then expressed by Mamma (Jeska's mother) *"We had the unfortunate event that we got flooded three days into the lockdown last year as well. [...] And us dealing with a flood. Yeah, it was um—it, it sucked for us, it was just the worst possible time with lockdown[...] So uh that, that was really rough. That sucked, and that got me really upset and angry, and every emotion you can think of, I went there, yeah. […] Well, Bear and I—I was bleeting at Bear, you know "argh ra ra ra.""*

Maria also agreed that communication was an issue when problem solving, but in the way of blaming during lockdown, as she voiced, *"Sam (Maria's caregiver) and I didn't usually face problems before lockdown and if we did we were good at working through them [...] But problems we had in lockdown was just hard [...] communicating about them was probably harder because we would I guess just start blaming each other."* Maria then believes that these communication issues were directly attributable to the problem(s) lockdown created, which can be exemplified by the one problem Sam and Maria consistently experienced during the first lockdown, where Maria expressed *"I always wanted to go out and like, um be with my friends and stuff and Sam didn't let me cause like he didn't want me*

to see people and um like get COVID." Maria also continued to state that *"I tried explaining to Sam but Sam would blame me for not being responsible or caring or whatever"*

When Sam was asked about this, he reflected for a little before stating, *"I stand by what I did because I still think it was Maria's fault that we had that problem, but I know I could have tried to be nicer about it [laughs]"* This displays that whilst Sam stuck to his decision, he recognized the problem could have been handled better, so the communication issue they faced would not have occurred. Additionally, as evidenced within the second lockdown, Maria stated that any problems they did face *"never turned into an argument like they had before."*

Nonetheless communication issues were faced during problem solving between Bear and Mamma (Jeska's parents) as well as Sam and Maria which impacted adolescent mental health.

Firstly, Jeska reiterated and revealed within her individual interview that, *"I don't think we really, you know, worked our problems out very well during lockdown as you can see with the flooding issue [...] Like with our family there is like a lot of vocal opinion, but sometimes it got really loud, so I would just be like "shut up, like what is yelling going to do about it?" Well not always like that, but I've always been that mediator, I suppose when I have to be and it happened so much more in lockdown. But like it got to the point that it just got too much and I'd just lock myself in my room because I couldn't deal with it. [laughs]"*

While Maria found that *"it was hard being blamed for something I wanted and thought wouldn't matter [...] And it felt like he didn't care about what I wanted. It made me sad and angry and sometimes not come out of my room."*

Even though Jeska and Maria don't explicitly state their mental health was impacted, it is evident their quotes are indicative of their mental health being negatively impacted. Thus

shedding light on the importance of communication when problem solving, not only for those communicating, but those who are *"bystanders* "of this communication.

Subtheme 2.2

Lacking inclusion

The second subtheme focuses on two particular adolescents not being included within the problem solving process during lockdown which negatively impacted their mental health. Firstly, in Christian's case, Gypsy (Christians mother) communicated that, *"I'm the dragon. So when any problems come up I usually like to decide every little thing. I'm very straightforward with how I deal with these things"* However, Gypsy (Christians mother) does emphasise that she *"will always make sure to go to Christian because you know really he needs a say,"* when referring to making any decisions around problems prior to lockdown.

Christian while acknowledging this, also added that he is aware him and his mother approach problems very differently. *"I think my mother knows that I'd take a route um, differently. Uh I take a more kinda better, quiet—uh not necessarily a better approach, um, for like the outcome but maybe for like other people's emotions. I'm more empathetic I think than my mother. I think I'm a bit more patient."* Thus this difference in approach is carried into lockdown, as verified by Gypsy (Christians mother). *"Yeah I guess the way Christian versus I would solve problems didn't really change during lockdown."* However Gypsy (Christians mother) then proceeded to state that, *"I think generally I'm quite good in a crisis, so any problems during lockdown weren't too bad. Like I don't fall apart, I just get very urgent, so that had to be me, I sorted out all those problems."* Yet Christian in his individual interview elaborated that during lockdown, *"I get that my mum can sort stuff out by herself, but you know like she'd always at least check with me before really doing anything. [...] We're always so close and so her kinda making all these decisions about problems I wasn't*

even aware about, without me, did impact my mental health. I guess it made me feel unimportant and my opinions weren't important to her or something"

Hence it is apparent that Gypsy (Christians mother) essentially felt her approach to solving problems was more suited for any problems that occurred during lockdown, despite what these problems may be. This then left Christian feeling the way he did.

A similar statement to Christian was also made by Olivia, *"I know mum was going through a lot during lockdown, but she never really ran any of the decisions she made past me even though I felt like I was taking more on in the house, so yeah that was a little upsetting and yeah it did ultimately impact me and how I felt."*

Carla (Olivia's mum) admitted in the interview that she was *"trying not to burden the girls with any of the more serious emotional problems going on"* which so happened *"to be happening quite a bit during lockdown."* Thus, Carla was unaware that by not involving Olivia in the problems, she was unintentionally making Olivia feel that the more *"adult role"* she took on during lockdown, as mentioned in the previous theme, was not rewarded by being included in other adult responsibilities, that Olivia seems to place importance on.

Therefore, while Christian and Olivia had slightly different experiences of how and why their mental health was impacted, it was ultimately due to not being included within the problem solving process during lockdown. Christian was usually included prior to lockdown, while Olivia felt it was something she *"deserved"* during lockdown.

Theme 3

Increased emotional responsiveness allowed for greater emotional support during lockdown which benefited adolescent mental health

This theme captures how during lockdown, parent(s)/caregiver(s) from six of the seven families became more emotionally responsive which allowed for greater emotional support that then benefited adolescent mental health. This increase in responsivity and

consequently support was apparent for a number of reasons. One being that some adolescents experienced a lengthy second lockdown which began to take its toll, as exemplified firstly by Wendy. *"I'm not too open with my emotions but I actually cried so much during lockdown. [laughs] My mental health got worse on the second lockdown. It was just the same thing every day and it just got too much and even my mum realised it was getting to me because she's not usually like all caring and stuff."* Charlotte (Wendy's mother) also corroborated that *"I'm not usually the one to be like that I guess."*

Maria also made a similar statement to Wendy within her interview, *"Yeah cause the first lockdown was something new and like we're not used to it and stuff. Then for the second one, like we got sick of the first one and we had to go um, through the thing like we went in the first lockdown, and it was hard like to get outta that feeling you know and even though Sam (caregiver) and I did have our arguments at the beginning, by the second lockdown he did notice how it was just affecting me"*

A second reason parent(s)/caregiver(s) became more emotionally responsive to allow for greater emotional support was because of the circumstance it created in adolescents schooling situations, as exemplified by a couple of parents, beginning with Gypsy (Christian's mother). *"But like for schooling it was hard, you know for Christian and he's quite bright and he likes to learn, but he started to think like, "oh maybe I don't want to go to school next year," you know, after next year or something. [...] So it did take its toll and so I really felt I had to step up not only my support for Christian but how I dealt with the situation."*

This reason was also reiterated by James (Jace's father).*"I think it just really backfired for Jace in terms of schoolwork. Not cause he's—you know he doesn't care about school or whatever, but it just doesn't work for him and like it actually got a whole lot worse than any improvement during that time you know? [...] We always try to be quite supportive,*

like be encouraging and caring and all that in whatever Jace does, but during lockdown we'd cut him quite a bit of slack and tried to be extra supportive. I just felt a bit sorry for him and working in a school with teenagers myself I just know everyone's different and, as long as we're all safe and happy and healthy, there's always time to get a few more credits in the future."

The third reason parents become more responsive to provide greater support, was to make sure their child was coping with lockdown alright. This was evidenced by Jack's parents, where Aroha (Jack's mother) firstly expressed how she *"started to check in with them at least once a day and just see how their day's going and what's— you know if there's been any problems, if there's anything they need me to help them address. Cause you know, things were hard then."* Matthew (Jack's father) also reiterated this, *"with Jack we do have um, yeah some private one on one kinda conversations and talk that (issues) through and just listen through that and then try and understand it and encourage, yeah, a way forward. We haven't had it that often but we have had it when it counts or when it's needed and it did happen more often during lockdown just in terms of making sure he was handling everything okay."* This greater responsiveness and subsequent support was provided despite Jack explicitly stating *"I don't really need that much support"* even throughout lockdown.

The final reason why parents become more responsive to provide greater support was to make sure any problems that happened outside of lockdown were not exacerbated by lockdown. This was specifically seen in Olivia's case, as Carla (Olivia's mother) stated, *"I just needed to make sure my girls were okay during lockdown after everything, because I didn't really know what would happen or what was happening in their minds."* Olivia also consolidated this as she mentioned in her individual interview that, *"yeah a lot happened for all of us in-between the lockdowns, and even though mum was probably going through it more and I tried to also check-in on her, she actually started to check up on me more. [...] it*

honestly amazed me how much my mum has been able to like, manage stuff yet still be there for me."

In light of these many reasons, parent(s)/caregiver(s) were ultimately more responsive allowing for greater support. This resulted in six out of the seven adolescents finding that it was beneficial for their mental health. Thus, the following responses were expressed when asked about how this extra support impacted their mental health.

Firstly, Wendy stated that Charlotte (Wendy's mother), *"actually helped a lot, like really really helped. Like if she didn't like to do that to me, I don't know what would happen to me that day. It got like really, really bad. Yeah and she like really helped me a lot by letting me know she was always there. I was like drowning with those things and like she pulled me out. Yeah and shes not usually like that."*

Maria expressed how Sam (Maria's caregiver), *"actually made me feel better and stuff. He used to tell me to like focus more on other stuff in lockdown and stop thinking about how long it was getting, so I used to listen and feel better. Yeah so I was happy with the more support he kinda provided, it did help my mental health."*

Christian made a similar statement but in relation to how Gypsy (Christian's mother) helped with his schooling situation. *"She was like the red light to tell me to stop thinking like that, and just, you know, that those kinds of things that are not gonna help benefit you now and later, and yeah. So she impacted that, positively. She helped my mental health for school better. [...] She did really encourage and support me through it."*

Jace on the other hand admitted that *"I feel like I'm quite resilient,"* but also acknowledged how *"it was nice my dad took time to understand why I was struggling with school to try and support me a little more, I guess it made me feel a little special and important which was good for my mental health."*

In Jack's case, where he explicitly stated not needing the extra support, he still conveyed that, *"those talks and check-ins did have more of a positive effect. You know just having that extra support and validation during lockdown was needed, so yeah I guess it was good for my mental health."*

Finally, Olivia mentioned that Carla (Olivia's mother) provided *"check-ins"* and *"support"* particularly *"during the second lockdown,"* which Olivia described as " *I feel like, yeah it did have an effect on my mental health but like in a positive way because I didn't know that I actually needed it until I got it and it just felt good and relieved the stress I was feeling [...] The hug or two was also needed despite how tough I may try and be. [laughs]."*

Whilst all adolescents felt their mental health benefited from the responsivity that allowed for greater support, it is evident that this *"greater support"* had an impact on some adolescents more than others. For instance, in Maria's case, her mother had such an impact that she stated how she was *"drowning and her mum pulled her out."* Whilst others such as Jace felt that they *"guess it was good for their mental health."* A key difference between both these adolescents is the sort of emotional responsivity and therefore emotional support they received prior to lockdown. Where Maria stated her mother was *"usually not all caring and stuff,"* while Jace's parents *"always try to be quite supportive."* Thus exemplifying while it may seem that everyone's mental health was benefited, it was benefited in different degrees, which was largely due to the circumstances the adolescent was subjected to prior to lockdown in regard to their parents emotional responsivity and subsequent support.

Theme 4

Emphasis of family values during lockdown benefited/maintained adolescent mental health

This theme recognizes the importance of family values and how during lockdown these were emphasised within the family which seemingly both maintained and benefited

adolescent mental health. Whilst there are numerous family values, the ones which were apparent throughout my research were *family time* and *respect* which are consequently my two subthemes.

Subtheme 4.1

Family time

This subtheme focuses on family time as a prominent family value for four of the seven families, which went on to benefit adolescent mental health during lockdown. For most of the families interviewed, lockdown provided the opportunity to finally spend some time together, however, families always understood the importance of family time and simply utilised the opportunity given. Thus why family time is conceptualised as a value.

Firstly Gypsy (Christian's mother) stated that *"spending time with him (Christian) was usually put on the back burner even though I knew how imperative it was for us, so lockdown was great I think because it allowed us to focus on each other, you know, it allowed for that well needed family time*."

Aroha and Matthew (Jack's parents) also highlighted this, with Aroha expressing how *"lockdown allowed us time to do other things, which just magnified, you know, other areas that we had time for and were important to us, which was spending time with family."* This was then followed by Matthew (Jack's father) stating, *"yeah when we have the spare time sometimes you know we have movie time and sometimes we just gather out of the house and go to the beach for a walk and um yeah family time was always important, lockdown just allowed for it."*

Finally, James (Jace's father), acknowledges that family time may have not been as prominent prior to lockdown, but lockdown provided the needed reminder of having family time. *"I had this Facebook friend down in Christchurch and she was doing the isolation quiz. It was like ten question quiz that would come through each day at around six or seven*

o'clock. And like we don't normally do that sort of stuff together as a family, but we made a point of doing those and we really enjoyed them. We did them together. [...] And we found it a lot of fun, it was kind of like a bonding thing as well and helped us remember why family time is important. Like we always knew it was important to us but yeah lockdown."

Lockdown providing that reminder for family time was also mentioned by Charlotte (Wendy's mother). However she also brought up an important point that as children grow up, it is difficult to enforce such a value, *"we try and always do something as a family because it is good for us. But everyone getting older it is hard so lockdown was good for that, it helped. We do need to do it more."*

Despite lockdown being the instigator for many to have family time, it still benefited adolescent mental health in a multitude of ways from feeling like it allowed them to feel close with their family, where Christian emphasised during his individual interview that, *it was nice finally having time to spend together because prior to lockdown it was so rare [...] and it definitely helped with feeling closing with mum [...] I know she tries to spend more time with me and it's important to her but she can't help how busy she is."* This feeling was also reciprocated by Gypsy (Christian's mother), *"I think it certainly has strengthened our relationship because you know, we managed to fit in a bit more quality time be it just sitting in the garden, or, or you know having a leisurely meal together or, "hey you know what movies on tonight" and you know "let's have a sit down together on the couch and have a snuggle and you know watch the movie." We could focus on mother and son."*

Wendy also admitted in her individual interview that despite family time being something that is important to her family, because *"we got more into about what's actually going on in our lives, especially me and my brother. [...] Like we used to have so much time together,"* it isn't as enforced now that they're out of lockdown. "*Like now when I get back from school, I would like just like take my plate, go to my room, watch a movie or something.*

This is despite Wendy explicitly stating how "*it did help my mental health."* However Charlotte (Wendy's mother) communicated they needed to *"have more family time."*

Family time for other adolescents was about simply enjoying their family's company which helped their mental health by feeling happy as seen by Jack and Jace. Jack said it *"was nice being around them and I actually missed that when I went to school [...] so yeah at the time maybe I didn't realise it but looking back it did help my mental health"* Jace on the other hand referred to family time as the quizzes that was mentioned by James (Jace's father) earlier, *"I miss that quiz. I actually loved that quiz. That was a good time. That was fun. Yeah."* When further promoted into whether it had any impact on his mental health, Jace responded with, *"yeah I guess because it was a good time, I actually enjoyed spending time with the fam, it was almost like wow I can have a good time with them too and it makes me happy."*

Hence, whilst family time as a value was not necessarily emphasised by the families themselves and more so the circumstance lockdown created, it did provide families with a reminder of the importance of family time despite already recognizing this. This then benefited adolescent mental health primarily in the way of feeling close to their family and enjoying the company of their family.

Subtheme 4.2

Respect

The second subtheme focuses on the emphasis of the family value respect during lockdown which benefited and maintained adolescent mental health. Whilst respect can be defined differently by each individual or family, it was often seen *as "treating somebody as you would like to be treated"* within the families interviewed. Thus, respect was a common family value and was subsequently emphasised throughout lockdown by three families in particular.

This is firstly evidenced by Jamie (Jace's mother) through family discussions, *"I know when we first went into lockdown, I think we started having more frequent family conversations around coming together and making sure we dealt with this as a family and so a crucial part of these family conversations was to push being respectful to each other. [...] which was important because we were always together and could get on each other's nerves."*

Matthew (Jack's father) on the other hand emphasised how values/principles were fundamental to their family, regardless of whether they were in lockdown or not. *"I think the way we've constructed the family unit um, and the principles we based them on really mitigate a lot of that. By constantly having our religious studies as a family, discussing those principles and how they apply in their lives,"* and later mentioned how *"respect is definitely one of those principles"* Aroha (Jack's mother) at a later stage then stated that despite having these fundamental values/principles, respect did need to be emphasised during lockdown, however did not specify how. *"I think we've just helped them to recognize that, you know, we all want to be happy, but it takes effort to all kind of, you know, respect each other and we can't just turn our music up loud and ignore everyone else cause it affects everyone, so that was reinforced during lockdown"*

Like Jack's family, respect was also emphasised in Olivia's family but was not specified how, where Olivia expressed that her *"mum (Carla) always taught us the importance of respect and caring to one another in tough times and mum definitely made that super clear during lockdown."*

Nonetheless this focus on respect during lockdown did benefit and maintain adolescent mental health. For Jace it was a matter of *"respect"* maintaining his mental health where he stated it made him *"feel more appreciative of my family, you know because we are around each other 24/7 you forget that everyone is going through what you are. [...] it helped*

me realise there is no point in having petty arguments with my brother, and that did keep my mental health stable."

Olivia also found that the enforcement of respect necessary when it came to sibling quarrels, which then benefited her mental health, as she stated, *"this may just be like part of having a sibling and all that, but during lockdown it sometimes got hard to remember to be respectful of everyone, like you almost lost that boundary because you were around each other constantly [...] yeah so I thank mum for that push in being respectful. It allowed me to take a different perspective which was kinda necessary for my mental health if you know what I mean."*

Finally, Jack went to the extent of mentioning that, *"I think there's like—yeah I can see the differences between the families that I see at school and ours, cause like ours are—I consider my family like top tier, yeah. [laughs] With the way they've I guess put these values in us and enforced them consistently and whenever necessary."* Jack also specified how respect *" is huge"* for his family and that he was glad that is was "*cause without it I would have had a very different outlook during lockdown, like a worse one which wouldn't have been good for my mental health."*

Therefore, the emphasis of respect was necessary to not only enable the maintenance of mental health but to benefit it, as it helped provide adolescents with a new perspective and appreciation for those around them. This seemed necessary because of the continuous family interactions adolescents had during lockdown.

Chapter Four: Discussion

The present study aimed to explore, understand and describe how family functioning impacted adolescent mental health during lockdown. Seven families consisting of an adolescent and their parent(s)/caregiver(s) participated in semi-structured interviews which were analysed using thematic analysis. As a result four themes were developed that described patterns around how family functioning impacted adolescent mental health during lockdown. They were: (1) *adolescent roles changed during lockdown which benefited their mental health,* (2) *poorer problem solving during lockdown negatively impacted adolescent mental health,* (3) *increased emotional responsiveness allowed for greater emotional support during lockdown which benefited adolescent mental health* and (4) *emphasis of family values during lockdown benefited and maintained adolescent mental health*. In the following section, each of these themes will be discussed in relation to relevant literature, however this may prove difficult due to a few reasons as highlighted within my literature review. Firstly since lockdown is such a recent phenomenon, there is currently little to no research into how family functioning impacts adolescent mental health, particularly in New Zealand. Whilst this provides the need for research, this results in a lack of literature that my themes can be discussed in relation to. In addition, research around family functioning and how it impacts adolescent mental health not within the context of lockdown, often conceptualises mental health synonymously or in relation with mental illness. Furthermore, quantitative research is the key research approach utilised which not only restricts which areas of family functioning and mental health are measured, but how each aspect and/or area within family functioning are measured in relation to mental health. Consequently while my themes will be discussed in relation to relevant literature, it will be done so as feasibly possible.

This section will then be followed by a discussion of the study's implications, limitations, and finally, recommendations for future research directions.

Summary of findings related to relevant literature

All findings within my research were consistent in that lockdown did create a change in family functioning for the families that participated. Hence, the particular ways lockdown changed family functioning, which then impacted adolescent mental health will be discussed in relation to my themes and subsequent subthemes.

Theme 1

Adolescent roles changed during lockdown which benefited their mental health

This theme evidently encompasses how the roles adolescents held within their family changed during lockdown, which benefited their mental health. However, as importantly reflected within my subthemes, regardless of whether these roles became harder or easier, it still remained beneficial for adolescent mental health. To the best of my knowledge these are new findings, with very limited literature that these findings can be discussed in relation to. This is especially since a lot of literature has generally focused on the importance of families having appropriate roles for adolescent mental health, which whilst significant, is not directly relevant to my findings (Torre et al., 2017; Ma at al., 2012; Yoon, 2012; Zagefka et al., 2020).

Nonetheless, my first subtheme of roles getting harder for adolescents during lockdown is consolidated by Singh et al. (2020) who found that some parents asked children to assume extra home duties. However my subtheme then goes on to relate this to adolescent mental health. Consequently Evans et al. (2020) established families that contained adolescents were struggling to *"juggle a difficult balancing act of multiple, competing roles"* during lockdown. While Sheen et al. (2021) found that roles, including those for adolescents changed during lockdown, as encompassed in the theme of *"shifting family roles and boundaries,"* where families *"strained to balance their multiple roles."* Although mental health is not explicitly mentioned by either study, it is likely that the use of words i.e., struggling, difficult and

straining, relates to a possible negative impact on family members mental health. This does also correlate with findings after a period of trauma (Crowe & Lyness, 2013), particularly when a parent has had a traumatic brain injury (TBI) (Stanescu & Romer, 2011). Stanescu and Romer (2011) found that roles did change to become more demanding for everyone within the family including adolescents. This then created levels of poor mental health for those in the family, particularly adolescents. (Stanescu & Romer, 2011). Thus, this literature does contrast with my subtheme that adolescents who assumed a harder role during lockdown found it benefited their mental health in the way of giving them a sense of purpose or by keeping them occupied and happy.

Additionally, since some of the above research has focussed on the roles of all family members becoming harder, which is then inclusive of parents (Evans et al., 2020; Sheen et al., 2021). Cusinato et al. (2020) specifically went on to find that harder roles for parents, which was largely attributable to greater responsibility of house duties, managing work and children's new way of schooling, negatively affected their mental health. This then also increased the risk of their children, whom were aged 5 to 17 having their mental health negatively impacted. While I did find that this occurred for some parent(s)/caregiver(s) within my research, it did not negatively impact adolescent mental health. It in contrast had a beneficial impact on adolescent mental health as they had an easier role.

Thus, literature around roles for families inclusive of adolescents becoming easier during lockdown was also evident, but very scarce. For instance, Evans et al. (2020) found that family routines changed, particularly in relation to their morning routine of *"getting up early, getting ready and rushing to work or school,"* which allowed for a relaxation in responsibilities or roles for the entirety of the family. However, literature was unable to link it to adolescent mental health. Consequently, my research went on to find that this relaxation or leniency in roles not only benefited adolescent mental health by allowing them to finally have

the capacity to relax but also have the time to talk to friends, focus on their hobbies as well as themselves.

Theme 2

Poorer problem solving during lockdown negatively impacted adolescent mental health

To the best of my knowledge there is currently no literature which has focussed on poorer family problem solving during lockdown negatively impacting adolescent mental health. There has been literature during lockdown which has focussed on the exacerbation of family problems and conflict, which was also found within my research (Prime et al., 2020; Westrupp et al., 2021). However none of which are able to relate it back to adolescent mental health. In light of this, limited literature has generally focused on how poor problem solving or resolution of conflict within a family can impact adolescent mental health (Chappel et al., 2014; Chung et al., 2009; Parra et al., 2013).

My research went on to find that poor problem solving was a result of communication issues. More specifically that communication issues emerged during lockdown which resulted in poorer problem solving and adolescent mental health, as reflected in a subtheme. Research by Evans et al. (2020) and Sheen et al. (2021) support that it was common for families to have greater communication issues during lockdown. Evans et al. (2020) also found that because families felt they were always *"contained"* or *"isolated"* within the same area or space, communication suffered. However these greater communication issues have not been a result of poor(er) problem solving, nor been related to adolescent mental health.

Taking this into account, literature generally consolidates that communication is pertinent to family problem solving (McGuigan et al., 2014; Nguyen et al., 2020), as communication enables the expression of opinions, sharing of assumptions, and inquiry into one's mode of thinking (Berlo, 1960). Thus when families encounter poor problem solving, it is largely due to families having communication issues, which were found within my

research to be particularly in the ways of yelling and blaming. Research which was not conducted in the context of lockdown then links the importance of communication when families problem solve to adolescent mental health (Berlo, 1960; Segrin & Flora, 2019). For instance, Segrin and Flora (2019) emphasise that poor communication or communication issues when problem solving in families negatively affects adolescent mental health by causing unnecessary distress. However my research did go on to find that this not only impacted the mental health of adolescents who were communicating, but adolescents who were *"bystanders"* of this communication.

The second finding or subtheme which caused both poorer problem solving and adolescent mental health during lockdown, was the lack of inclusiveness. As found within my research this could be because adolescents were included prior to lockdown, or feeling it was something that was deserved during lockdown. This is another new finding, however literature has found the importance of including adolescents within the problem-solving process (Capaldi et al.,1994; Holth 2017). Carpenter and Mulligan (2009) found that including adolescents within family problem solving specifically benefited adolescent mental health in the ways of promoting confidence and satisfaction. While Molinari and Everri (2021) confirm this by specifically finding parents who included adolescents were not only able to solve problems more effectively, but enabled for better mental health in adolescents through greater self-esteem.

Thus, even though both my subthemes found lockdown was the circumstance that resulted in greater communication issues or lack of inclusivity in families when problem solving, literature has generally been able to substantiate the main essence of my subthemes. This being that communication as well as inclusiveness during problem solving is pertinent to adolescent mental health.

Theme 3

Increased emotional responsiveness allowed for greater emotional support during lockdown which benefited adolescent mental health

Research has often focussed on emotional responsiveness and emotional support separately, despite both being aspects that are closely linked to emotions in family functioning. Consequently when combining both aspects together and relating it back to adolescent mental health in the context of lockdown, as my theme has, makes for both a specific and new finding within literature, yet again. Thus these two aspects of family functioning will need to be discussed separately in relation to my theme.

While, no research has focussed on the importance of affective responsiveness on adolescent mental health specifically during lockdown, there is some research which generally has, i.e., not within the context of lockdown (Cash, 2019; Leeman et al., 2016; Ma et al., 2012; McNamara & Loveman, 1990). This research shows there is consistency around *"appropriate"* or *"adequate"* affective responsiveness being an important aspect that contributes positively to the mental health of adolescents. Despite lockdown creating the circumstance for the increase in parent(s)/caregiver(s) emotional responsiveness, as apparent within my theme. This increase was still *"appropriate"* or *"adequate"* for adolescent mental health during the lockdown period.

Research which has focussed on the importance of emotional support is more vast, and has subsequently been understood in the context of lockdown. While it is was found that parents/caregivers during lockdown were unable to give greater emotional support to adolescents due to their own increased stresses, which contrasts my theme (Morelli et al., 2020; Singh et al., 2020). Gadermann et al. (2021) did find that some parents were able to give greater support. Mangiavacchi et al. (2021) went on to find that this greater support was in part due to the adolescents' schooling situation. My research also found this, alongside

other reasons such as, ensuring adolescents were coping with the circumstance of lockdown, particularly when lockdown started to lengthen for some.

While this has not been specifically related back to adolescent mental health, previous literature that doesn't account for lockdown has enforced how support is necessary for adolescent mental health (Boudreault-Bouchard et al., 2013; Camara et al., 2014; Friedman & Kutash, 1992; Moore et al., 2018; Rawatlal et al., 2015; Superu, 2016). In addition, Tafa and Baiocco (2009), while not examining emotional support and emotional responsiveness together, is still one of the few studies to find that both were required for healthy family functioning which was pertinent for the mental health of adolescents.

Furthermore, there have been situations or circumstances besides lockdown where adolescents required greater family support as seen within my theme. One example being those just coming to terms with identifying as LGBTQ+, where greater family support was found to be beneficial for their mental health (McConnell et al., 2016; Shilo & Savaya, 2011). While completely different circumstances, lockdown did seem to create that same requirement, thus supporting a pertinent area of my theme.

Theme 4

Emphasis of family values during lockdown benefited and maintained adolescent mental health.

The first family value and subsequent subtheme found to be emphasised during lockdown was family time, which benefited adolescent mental health. Firstly, there has been a reasonable amount of research which has focussed on family time being emphasised during lockdown because of the circumstance it created. This was also the case for many families within my research, however because it was conceptualised as a value in my research, families always understood the importance of family time and simply utilised the opportunity lockdown gave, in contrast to the following literature.

Nonetheless, there has been conflicting information on how family time during lockdown impacted adolescent mental health which can be exemplified by the studies by Evans et al. (2021) and Sheen et al. (2021). For instance Evans et al. (2021) found many families, inclusive of adolescents, could not appreciate family time during lockdown as it seemed to create feelings around being *"stuck"* or *"trapped"* at home. This is because family time was usually spent out doing activities or at events which was found for these families to maintain *"structure, wellbeing, and happiness."* Sheen et al. (2021) similarly found the increased family time resulted in unneeded tension and/or conflict, and created *"feelings of exasperation, tiredness and sadness,"* for those in the family, many being adolescents. While the mental health of families including adolescents was not explicitly stated in either studies, the use of words indicates it likely did.

While this vastly contrasts with my finding, Sheen et al. (2021) and Evans et al. (2021) found this was not the case for all families, as did Clayton et al. (2020) and Walker et al. (2020). For instance, Sheen et al. (2021) found lockdown finally gave families the time to spend time together which was becoming a rare occurrence due to their busy and differing schedules. This is also supported by Evans et al. (2021) who discovered participants described having more family time had many benefits that can be summarised as feeling close to their family and enjoying the company of their family. These same benefits were then the reasons adolescents found their mental health was positively impacted during lockdown, thus supporting my finding.

My second subtheme was the emphasis of the family value respect benefiting and maintaining adolescent mental health during lockdown. Once again this is a new finding, however there is literature which has generally focussed on the importance of *"traditional family values"* such as respect being pertinent for adolescent mental (Cervantes et al., 2013; Garnier & Stein, 1998). Additionally, Kolves et al. (2019) found when families were going

through the grief of suicide, or any other form of sudden death, family values inclusive of respect are a necessity to uphold to enable for the wellbeing and health of the family. While this does not explicitly state if this was the case for families with adolescents, it can still corroborate my finding to some extent, in that emphasising family values such as respect is beneficial or in my instance, also maintains the mental health of adolescents.

Implications

My study yielded many implications, beginning with an immediate implication that I had not realised until a family member explicitly stated *"wow, now you've really gotten us to reflect on things."* Thus my research provided families with an opportunity to look back and reflect on their family functioning during lockdown which may hopefully promote positive and possibly long-term change within these families if necessary.

Since my research investigated the impacts of family functioning on adolescent mental health, it contributes to a lot of the previous research, national and international, in regards to the importance of family functioning and its particular aspects or areas on adolescent mental health. However, my research did investigate this explicitly in the context of lockdown and discovered that family functioning changed in its many areas and aspects because of the circumstance lockdown provided for families. While numerous studies have also identified this, my research was the first to do so qualitatively and find how these changes impacted adolescent mental health, as a subjective and dynamic state that is related yet a distinct construct to mental illness, as reiterated several times. This resulted in new findings that not only provided for ways that family functioning can negatively impact adolescent mental health but more so positively impact it. For instance, the emphasis of family values such as family time, or greater responsiveness and emotional support benefiting adolescent mental health in numerous ways. Thus these findings may be able to be also utilised in several ways.

It can help with the current repercussions of lockdown, where my findings could inform or even tailor many future interventions, initiatives, approaches and/or strategies in New Zealand which are targeted to families with adolescents that focus primarily on the promotion of adolescent mental health. Furthermore, since Māori families were also included within my study, this may also provide relevance for promotion interventions, initiatives, approaches and/or strategies which specifically target Māori families with adolescents.

In addition, since the COVID-19 pandemic is still unfortunately ongoing, the possibility of future lockdowns is very probable as reiterated by the New Zealand government on numerous occasions (New Zealand Government, 2021). Thus my research findings can hopefully provide insight into where support and resources should be placed for families during such circumstances to benefit adolescent mental health. One example is ensuring mental health services remain open during future lockdowns to help families deal with the problems they may face, as it could exacerbate areas of their family functioning such as poor communication that may then negatively impact adolescent mental health. As one of my research findings explicitly found how *poorer problem solving during lockdown negatively impacted adolescent mental health*. Another example is also ensuring targeted advice via websites, leaflets, or television advertising, focus on ways to allow for greater family functioning, as this has a knock on impact on adolescent mental health. In addition, my research findings may also be relevant, in some form, for other future situations that create similar circumstances as lockdown.

Finally, my findings could provide mental health practitioners, specifically those who work with families and adolescents a greater insight and understanding into the importance of family functioning both when dealing with the repercussions of lockdown or in the instance of another lockdown. A possible application may be insisting parent(s)/caregiver(s) to become more responsive and supportive to the ever-changing adolescent needs to improve

their mental health, as my study found that *"increased emotional responsiveness allowed for greater emotional support during lockdown which benefited adolescent mental health."*

Limitations

No research is without its limitations, and the same applies to my research. A key limitation I believe is around including both New Zealand lockdowns within my research. Since the first lockdown was almost a year and a half prior to the second lockdown, it meant the second lockdown was far more recent by the time interviews were conducted a couple of months later. This caused difficulty when it came to families remembering their experiences of the first lockdown. In addition, some families did report differences in functioning between the first and second lockdown, however I tried my best to take this into account, i.e., the length of the second lockdown being a reason for greater responsiveness and support to benefit adolescent mental health.

Another limitation was my sample of families. Whilst I tried to make my recruitment process as inclusive as possible, it is still likely that I may have disregarded some populations. For instance those of lower socioeconomic status due to their possible constraint in accessing the internet. Furthermore it is likely that the nature of my research put off some families, thus further impacting my sample. This could be for many reasons, for instance that my research was around a personal and private topic for many families and adolescents, which could particularly exclude those of certain ethnicities. Secondly if these families, or families in general had a more stressful or conflicting experience during lockdown it may be an area they are not willing to share. Consequently, having interviews could pose a further deterrent for these families, as well as those who are unfamiliar with technology and Zoom, and those with the sharp time constraints. Thus while my research was aiming to target the general population of New Zealand, that may have been unfeasible.

Additionally while the sample of my families were small and can be seen as a limitation, it was a purposeful research choice. This is for the obvious reason that my research was qualitative in design which then provided in-depth insights into the functioning of families and its impact on adolescent mental health during lockdown in New Zealand. However, having a research which is qualitative in design does mean findings are by no means generalisable. This in conjunction with my research being the first of its kind which was undertaken in the current dynamic and ever-changing nature of COVID-19 that could possibly warrant further future lockdowns for New Zealand, means all my findings also need to be interpreted with caution.

Finally whilst not a limitation per say, I do believe it is important to add that since my research aim was so specific in that it contained three components; family functioning, adolescent mental health and lockdown, as well as the definition of each of these three components being reasonably under researched. It created difficulty for me as a researcher throughout the research process. I firstly struggled finding relevant literature and research for my literature review. I also struggled when undertaking my analysis as it required my themes to address these three components. Furthermore, while this resulted in new findings, they were evidently specific like my aim. This meant it then limited how I would write my discussion in relation to the literature that did not specifically align with my findings. Finally I felt anytime I would need to make a statement about my aim I would need to continuously reiterate these three components before getting to the point of the statement.

Nonetheless, despite these many limitations, I do believe I have been successful in achieving my aim to the best of my ability.

Future research

Based on the limitations and findings of this study, several recommendations exist for future research. Firstly since my research to the best of my knowledge is the first of its kind,

it would be of benefit if future research replicates my research to some extent, particularly within other countries, cultures and populations to allow for further understanding into how families function during lockdown and its impact on adolescent mental health. For instance a focus on vulnerable families, since their mental health is likely to be at most at risk from COVID-19 and the subsequent lockdowns. Whilst this can be done through a qualitative research design, this can also be done through a quantitative research design which then also goes on to answer the limitations I had around my family sample. For instance a quantitative research design would not only increase the sample size but demographic diversity, meaning data would be much more generalisable to populations. Furthermore, families may also feel more comfortable answering questions on a questionnaire, than discussing topics such as family functioning and mental health through an interview, despite the limitations around the quantitative measures around family functioning and mental health.

Secondly, since my research was concerned with the ways family functioning impacted adolescent mental health there was little room for understanding if these changes were something families adhered to and if so, did it provide any long term benefits or implications. Hence future research quantitative and qualitative may focus on the long term adherence to these changes in family functioning and its impact on adolescent mental health which can be accomplished through longitudinal and developmental studies.

Finally throughout and on reflection at the conclusion of this study, many other research questions arose which firstly focus on the impact of other factors as opposed to family functioning on adolescent mental health during lockdown. For example, schooling, social media and friends. Secondly, whilst changes in family functioning had a reasonably positive impact on adolescent mental health, what were the impacts for the rest of the family, for instance parents, children and young adults who still live at home, was there an overall

increase in family mental health during lockdown? Additionally, understanding these questions longitudinally may also have many further beneficial implications.

Conclusion

This research was the first to investigate how family functioning impacted adolescent mental health during the New Zealand lockdowns. It not only understood the mental health of adolescents as a dynamic and subjective state that was a distinct yet related construct to mental illness. It also understood family functioning as a multidimensional, broad and interrelated concept, all through a qualitative approach. While having such a specific aim in conjunction with under-researched and utilised definitions created a challenging task for me throughout this research. My research did go on to elicit new perspectives and understandings which would have not otherwise been found. This was accomplished through semi-structured interviews from seven families and adolescents, which were then analysed thematically to give my findings.

These findings emphasised that family functioning was not only pertinent to adolescent mental health during lockdown, but that it changed in its many areas and aspects. This not only negatively impacted adolescent mental health, where poorer problem solving in families created communication issues and lack of inclusion, but more often positively impacted adolescent mental health. This was seen when the roles of adolescents changed to either become harder or easier, or when parent(s)/caregiver(s) became more responsive which enabled them to provide greater emotional support, or finally when there was an emphasis of family values such as respect and family time.

This can have important implications from hopefully informing any future interventions, initiatives, approaches and/or strategies in New Zealand which are targeted at families with adolescents that promote mental health, particularly when dealing with the repercussions of lockdown. To then also providing further insight into where support and

resources should be placed for families to benefit adolescent mental health in future lockdowns.

However, future research is still needed to allow greater knowledge into these findings, that is inclusive of understanding whether any changes in family functioning during lockdown created any long term implications. Finally, my research, like many others, also brings attention to the importance of lockdown and how it created a completely different circumstance. This then necessitates research into the other impacts of lockdown which not only focus on the mental health of adolescents but those of other populations.

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Appendices

Appendix A: Content of social media posts

Hi all!

My name is Avita and I am a student at Massey University studying towards a Master of Science in Psychology. As part of my studies, I am conducting a research project on how family functioning impacts adolescent mental health during lockdown in New Zealand and am interested in hearing the perspectives of New Zealand adolescents (aged 16-18) as well as their parent(s)/caregiver(s).

This research will consist of:

- A family interview through zoom which will focus on family functioning. This will last approximately 30 minutes.
- An individual interview with the adolescent in the family through zoom. This interview will focus on mental health and how this relates to their family functioning. This will last approximately 20-30 minutes.

Everything said during these interviews is subject to confidentiality and be assured you and your family's identities will be protected.

To thank you for your time and effort, each family will be compensated with a $100 Prezzy card.

If you are interested or know a family who would be interested, please contact me either on my mobile ([redacted]) or email ([redacted]) for more information regarding the research project.

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 21/88. If you have any concerns about the conduct of this research, please contact A/Prof Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800, x 43347, email humanethicsnorth@massey.ac.nz

Appendix B: Adolescent information sheet

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

FAMILY FUNCTIONING AND ADOLESCENT MENTAL HEALTH DURING LOCKDOWN

ADOLESCENT INFORMATION SHEET

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 21/88. If you have any concerns about the conduct of this research, please contact A/Prof Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800, x 43347, email humanethicsnorth@massey.ac.nz

My name is Avita and I am a student at Massey University studying towards a Master of Science in Psychology. As part of my studies, I am conducting a research project on how family functioning impacts adolescent mental health during lockdown and am interested in hearing the perspectives of adolescents as well as their parent(s)/guardian(s)/caregiver(s).

I would like to invite you to participate in this research project. If you agree to take part, you will be asked to do the following:

- Take part in a family interview through zoom which will focus on your family functioning during lockdown. Questions asked will cover aspects from problem solving to communication to behavioural control within your family, however, remains open to other aspects or areas of family functioning that may come up within the interview. This interview will last approximately 30 minutes.
- Take part in an individual interview through zoom which will focus on your mental health and how this relates to your family functioning during lockdown. This will last approximately 20-30 minutes. There is the possibility that discussing your mental health may cause for discomfort, however support will be provided.

Within this research five to eight other families which include an adolescent aged 16-18 will take part. They will also be asked to participate in a family interview as well as an individual interview.

Your participation in this research project is voluntary. If you decide to participate you have the right to withdraw from the research, however this should be done no later than a week from your scheduled

interview. You also have the right to not answer any questions you do not feel comfortable answering. Everything said during these interviews is confidential, unless I think it is harmful to you.

Your interviews will be audio recorded with your consent to ensure responses are recorded accurately. Your names will not be used in any written material (including interview transcript), instead a chosen pseudonym will be used to refer to you. Particular care will also be taken to make sure any further identifying details are changed. Additionally, you will have the opportunity to review the interview transcript.

Information collected will be stored in a password protected laptop which will then be locked in a secure location when not in use. Information will not be accessed by anyone other than myself and my supervisor. All information will be destroyed after five years.

As a thesis is a public document, the research will be available through the Massey University library and may also be published in academic journals. You will also be provided with a summary of the research.

To thank you for your time and effort, each family will be compensated with a $100 Prezzy card.

If you have any questions about this research project please don't hesitate to contact myself or my supervisor on the details given below. If you have any concerns about the conduct of this research, please contact Dr Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 43347, email humanethicsnorth@massey.ac.nz.

If you agree to participate in this research please complete the attached consent form and return it to me via email. Thank you again for considering to take part in this research project.

Yours sincerely

Avita Ram
Mobile: [redacted]
Email: [redacted]

Supervisor: Dr Matthew Shepherd
Mobile: (09) 414 0800 ext 43094
Email: M.Shepherd1@massey.ac.nz

Appendix C: Adolescent consent form

Family Functioning and Adolescent Mental Health During Lockdown

ADOLESCENT CONSENT FORM

I have been given an information sheet about this research study and I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time.

1. I agree/do not agree to the interview being audio recorded.
2. I wish/do not wish to have my interview transcript returned to me.
3. I agree to participate in this study under the conditions set out in the Information Sheet.

Declaration by Participant:

I _____ [print full name] hereby consent to take part in this study.

Date of Birth:
Ethnicity:

Signature: _____ Date: _____

Appendix D: Parent/Guardian/Caregiver information sheet

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

FAMILY FUNCTIONING AND ADOLESCENT MENTAL HEALTH DURING LOCKDOWN

PARENT/GUARDIAN/CAREGIVER INFORMATION SHEET

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 21/88. If you have any concerns about the conduct of this research, please contact A/Prof Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800, x 43347, email humanethicsnorth@massey.ac.nz

My name is Avita and I am a student at Massey University studying towards a Master of Science in Psychology. As part of my studies, I am conducting a research project on how family functioning impacts adolescent mental health during lockdown and am interested in hearing the perspectives of adolescents as well as their parent(s)/guardian(s)/caregiver(s).

I would like to invite you to participate in this research project. If you agree to take part, you will be asked to do the following:

- Take part in a family interview through zoom which will focus on your family functioning during lockdown. Questions asked will cover aspects from problem solving to communication to behavioural control within your family, however, remains open to other aspects or areas of family functioning that may come up within the interview. This interview will last approximately 30 minutes.

Your child will also take part in an individual interview through zoom which will focus on their mental health and how this relates to their family functioning during lockdown. This will last approximately 20-30 minutes.

Within this research five to eight other families which include an adolescent aged 16-18 will take part. They will also be asked to participate in a family interview while adolescents will also take part in an individual interview.

Your participation in this research project is voluntary. If you decide to participate you have the right to withdraw from the research, however this should be done no later than a week from your scheduled interview. You also have the right to not answer any questions you do not feel comfortable answering. Everything said during these interviews is subject to confidentiality.

Your interviews will be audio recorded with your consent to ensure responses are recorded accurately. Your names will not be used in any written material (including the interview transcript), instead a chosen pseudonym will be used to refer to you. Particular care will also be taken to make sure any further identifying details are changed. Additionally, you will have the opportunity to review the interview transcript.

Information collected will be stored in a password protected laptop which will then be locked in a secure location when not in use. Information will not be accessed by anyone other than myself and my supervisor. All information will be destroyed after five years.

As a thesis is a public document, the research will be available through the Massey University library and may also be published in academic journals. You will also be provided with a summary of the research.

To thank you for your time and effort, each family will be compensated with a $100 Prezzy card.

If you have any questions about this research project please don't hesitate to contact myself or my supervisor on the details given below. If you have any concerns about the conduct of this research, please contact Dr Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 43347, email humanethicsnorth@massey.ac.nz.

If you agree to participate in this research please complete the attached consent form and return it to me via email. Thank you again for considering to take part in this research project.

Yours sincerely

Avita Ram
Mobile: [redacted]
Email: [redacted]

Supervisor: Dr Matthew Shepherd
Mobile: (09) 414 0800 ext 43094
Email: M.Shepherd1@massey.ac.nz

Appendix E: Parent/Guardian/Caregiver consent form

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Family Functioning and Adolescent Mental Health During Lockdown

PARENT/GUARDIAN CONSENT FORM

I have been given an information sheet about this research study and I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time.

1. I agree/do not agree to the interview being audio recorded.
2. I wish/do not wish to have my interview transcript returned to me.
3. I agree to participate in this study under the conditions set out in the Information Sheet.

Declaration by Participant:

I _____ [print full name] hereby consent to take part in this study.

Age:
Ethnicity:

Signature: _____ Date: _____

Appendix F: Family interview schedule

Introduction

- Start with breaking the ice (having a normal conversation) to make sure the family feels comfortable and safe.
- Ensure they have understood everything in the information sheet and consent to this. Begin recording.

Admin

- Ask for pseudonym, which can be emailed at some stage after the interview.
- Elaborate on Prezzy card details. *"I have had a look at their options and unfortunately there I no way to send it through email and will require a physical address, is this ok?"* If so, let families know they can email this to me as well. If not, find alternate option for family they are comfortable with.

Check eligibility

"I just wanted to check a couple of things before we begin."

- Which area of New Zealand is family from?
- Was adolescent living at home during both lockdowns?

Defining terms – family functioning and lockdown

- Family functioning is a term to commonly used to evaluate the family environment. It is a complex term to define with many differing definitions. However for the purpose of my thesis family functioning is "*a broad term that encompasses any aspects or characteristics that provides insight into how a family "works." However, a focus will be placed on a family's ability to problem solve, communicate, have roles, manage behaviour and be affectively responsive."*

Commencement of interview

1) General family and family functioning questions

- Tell me a little bit about your family? Members?
- Generally, how do you think your family functioning is?
- How do you think your family functioning was during lockdown?
- Why do you think your family functioning was like this during lockdown?

2) Questions around problem solving (*start with definition)*

- Generally, do you as a family encounter many problems?
- Same or different problems encountered during lockdown?

If it changed,

- What sort of problems?
- How did you deal with these problems during lockdown? Process?
- Did it differ to how you would deal with problems prior to lockdown?

3) Questions around communication (*start with definition)*

- Generally, what is your communication like as a family?

- What was communication like during lockdown?

If it changed,
- Why do you think it became this way?

4) Questions around roles (*start with definition)*

- Does each member have a specific role in the family? What are these roles?

- Have these roles changed or stayed the same during lockdown?

If it changed,
- Why?

- How did you feel about these roles during lockdown?

6) Questions around affective responsiveness (*start with definition)*

- Generally, how responsive do you think you are to each other's emotions? Changed during lockdown?

- Generally, how affectionate are you as a family? Changed during lockdown?

If it changed,
- How was this affection expressed during lockdown?

7) Questions around affective involvement (*start with definition)*

- Generally how invested are you in each other's lives? Changed during lockdown?

If it changed,
- What are the sorts of things you are invested in?

- Were there any instances of over investment, if so how?

8) Questions around behavioural management/control (*start with definition)*

- Generally, how is behaviour managed in the family, in other words do you have certain rules or set standards?

- Can you explain this more in depth?

- Has this changed during lockdown?

If it changed,
- How so?

- What do you think of these new changes?

9) Is there anything you would like to add that hasn't been covered in regards to your family functioning?

Appendix G: Adolescent interview schedule

Introduction

- Check if they need a quick break.
- Start with breaking the ice (having a normal conversation) to make sure the adolescent feels comfortable and safe.
- Ensure they have understood everything in the information sheet and consent to this.

1. What do you think mental health is?

THEN Give a brief overview of what mental health and how it is defined in my thesis.

2. How would you say your mental health is right now?

3. How had your mental health been during lockdown?

4. Do you think the way your family functioned during lockdown impacted your mental health during this period? How?

More specifically,

5. Is there anything you would like to add about your family's ability to resolve problems before or during lockdown?
   How do you think your family's ability to resolve problems impacted your mental health during lockdown?

6. Is there anything you would like to add about your family's ability to communicate before or during lockdown?
   How do you think the way your family communicated impacted your mental health during lockdown?

7. Is there anything you would like to add about your family's roles before or during lockdown?
   How do you think the roles within your family impacted your mental health during lockdown?

8. Is there anything you would like to add about your family's affective responsiveness before or during lockdown?
   How has your family's affective responsiveness (ability of to respond with appropriate feelings) impacted your mental health during lockdown?

9. Is there anything you would like to add about your family's involvement in you before or during lockdown?
   How has your family's involvement during lockdown impacted your mental health during lockdown?

10. Is there anything you would like to add about the way behaviour(s) is managed in your family before or during lockdown?
    How has the way behaviour(s) is managed within your family impacted your mental health during lockdown?

11. Is there anything else you would like to add?

Appendix H: Support services information

If any further support is needed the below services can be contacted.

Youthline
Youthline is there to support all young people - which includes young people who are struggling with their mental health or other issues.
Free call: 0800 376 633
Free txt: 234
Email: talk@youthline.co.nz

Lifeline
Helps all New Zealanders who may be in distress and/or crisis.
Free call: 0800 LIFELINE
Free txt: 4357

What's up
A free, nationally-available counselling helpline and webchat service for children and teenagers.
Free call: 0800 942 8787
Chat online: whatsup.co.nz

1737
Free call or txt 1737 to talk to a trained counsellor peer support worker.

Depression and anxiety
Talk to a trained counsellor particularly about anxiety and/or depression.
Free call: 0800 111 757
Free txt: 4202

Appendix I: Authority for the release of transcript form

Family Functioning and Adolescent Mental Health During Lockdown

AUTHORITY FOR THE RELEASE OF TRANSCRIPT

I confirm that I have had the opportunity to read and if needed, amend the transcript of the interview(s) conducted with me.

I agree that the transcript and extracts from this may be used in reports and publications arising from the research.

Signature: ..... **Date:** .....

Full Name - printed .....

Appendix J: Massey University Human Ethics Committee (MUHEC) approval

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

3/02/2022
Dear: Avita Ram
Re: Ethics Application - NOR 21/88 - Family functioning and adolescent mental health during lockdown.

Thank you for the above application that was considered by the Massey University Human Ethics Committee:

Human Ethics Northern Committee at their meeting held on Thursday, 9 December 2021
On behalf of the Committee I am pleased to advise you that the ethics of your application are approved.

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

Research Ethics Office, Research and Enterprise
Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand T 06 951 6841; 06 95106840 E humanethics@massey.ac.nz; animalethics@massey.ac.nz; gtc@massey.ac.nz