Young People with Anxiety Disorders Attending the Aotearoa/New Zealand Regional Health Schools: Barriers and Facilitators to Reintegration, As Reported by Regional Health School Teachers

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Abstract

Anxiety is one of the most common experiences of psychological distress experienced by young people in Aotearoa New Zealand (Ministry of Health, 2018). This thesis explored the barriers and facilitators to reintegrating young people with anxiety disorders into regular school, tertiary education, or other vocational pathways, when they are attending the Aotearoa New Zealand Regional Health Schools (RHS). This research was conducted within a qualitative framework with a realist/essentialist epistemology. Nine RHS teachers from across Aotearoa New Zealand participated in semi-structured interviews, asking about their experiences of working with young people with anxiety disorders, and what they perceived to be the barriers and facilitators to reintegration for young people with anxiety disorders attending RHS. The data was analysed using Thematic Analysis with a focus on semantic content. Several themes were identified based on interpretations of the RHS teachers' accounts. RHS teachers perceived that the whānau, regular schools, and regular school teachers of young people with anxiety disorders need more assistance to be able to support these young people in their reintegration. RHS teachers also spoke of needing more training specific to anxiety disorders, as well as more support around their professional wellbeing due to the unique nature of their role. This thesis emphasises the importance of providing wider and more systemic support to facilitate successful reintegration into education of young people with anxiety. It would be beneficial to conduct further research exploring the experiences of the whānau, regular school teachers, and young people themselves with anxiety disorders attending RHS; along with the current study, this would provide a holistic view of the needs of the support systems for young (school-aged) people experiencing anxiety in Aotearoa New Zealand.

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Glossary of Te Reo Māori Terms

Definitions are direct quotes from www.maoridictionary.co.nz, as indicated by quotation marks; additional information is included in parentheses and is derived from Moorfield (2020).

Hauora	**"**Be fit, well, healthy, vigorous, in good spirits." (This term is commonly used to refer to wellbeing, specifically four aspects which include physical, mental, social, and spiritual)
Koha	"Gift, present, offering, donation, contribution - especially one maintaining social relationships and has connotations of reciprocity."
Manaakitanga	**"**Hospitality, kindness, generosity, support - the process of showing respect, generosity and care for others."
Whānau	**"**Extended family, family group, a familiar term of address to a number of people - the primary economic unit of traditional Māori society. In the modern context the term is sometimes used to include friends who may not have any kinship ties to other members."
Whanaungatanga	"A relationship through shared experiences and working together which provides people with a sense of belonging. It develops as a result of kinship rights and obligations, which also serve to strengthen each member of the kin group."

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Chapter 1: Introduction

1.1 Anxiety Disorders in Young People

Anxiety is characterised by cognitive, emotional, and physiological arousal that is due to recurrent and excessive perceptions of threat and/or danger (Essau et al., 2012). There are three main response systems involved in the experience of anxiety: cognitive, physical, and behavioural. These components make up the common symptoms of all anxiety (Essau et al., 2012). The cognitive component of anxiety involves distortions in thinking, perceptions, and learning, which leads to other cognitive symptoms such as fear, worry, anticipation, nervousness, confusion and distraction (Essau et al., 2012). The physical component involves the constant and unwarranted arousal of the body's sympathetic nervous system (SNS) in preparation for mobilising the body for 'fight or flight', to protect oneself in the eventuation of future danger (Sadock et al., 2014). Arousal of the SNS has a number of effects on an individual's physiological state, such as an accelerated heart rate, sweating, headache, nausea, trembling, shortness of breath, and muscle tension (American Psychiatric Association, 2013). The behavioural component of anxiety involves pervasive avoidance of the stimulus or situation that has been appraised as threatening, which in turn reinforces the anxiety (Sadock et al., 2014).

Anxiety is a normal part of human experience and development (Carr, 2016). As children mature and develop, their anxieties adapt according to their developmental stage, with old anxieties diminishing and new ones developing (Carr, 2016). Many anxieties (such as a fear of blood, being in an enclosed space, animals, or separation from a parent) can serve adaptive functions for survival and may not warrant a clinical diagnosis. Therefore, it can be challenging to discern 'normal' from 'abnormal' anxiety. Carr (2016) suggests that normal and adaptive anxieties are characterised by an accurate and/or nonconflictual appraisal of a threat posed by a stimulus or situation, whereas maladaptive anxieties are based on an inaccurate and/or conflictual appraisal of a threat.

1.1.1 The Diagnostic and Statistical Manual of Mental Disorders

The Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5), or its previous version (DSM IV-TR), is used by most mental health organisations and clinicians in New Zealand to diagnose mental illness. The DSM-5 outlines criteria for determining what type of anxiety an individual is experiencing and whether their anxiety is clinically significant; or in other words, a diagnosable anxiety disorder that is not a developmentally normative experience of anxiety (American Psychiatric Association, 2013).

There are nine main anxiety diagnoses in the DSM-5: separation anxiety disorder, selective mutism, specific phobia, social anxiety disorder, panic disorder, agoraphobia, generalised anxiety disorder, other specified anxiety disorder, and unspecified anxiety disorder (American Psychiatric Association, 2013). These diagnoses are similar in that they all include extensive experiences of anxiety, physiological reactions, and behavioural disturbances. The diagnoses differ in regards to the stimuli or situation that elicits the anxiety response, the content of the individual's thoughts, and the anticipated harm (American Psychiatric Association, 2013).

Once a specific type of anxiety has been identified, there are further criteria for establishing whether the anxiety is clinically significant. These criteria are: the anxiety is excessive and persistent in nature, it endures beyond a developmentally appropriate level, and it causes significant impairment in a young person's ability to function and engage in tasks of daily living (American Psychiatric Association, 2013). Further, a diagnosis can only be made once the clinician has determined that the symptoms are not attributable to another medical condition or mental illness, and are not the direct effects of a medication or substance (American Psychiatric Association, 2013). Young people are typically referred to a mental health organisation or clinician when their symptoms begin to interfere with their ability to complete daily tasks such as spending time with whānau/family and attending school (Carr, 2016).

1.2 Secondary Effects of Anxiety Disorders - Life Satisfaction and Functioning

Aside from the symptoms of anxiety disorders, the associated interference in the individual's daily functioning also causes significant distress and suffering; in some cases this impairment in functioning has been found to be more debilitating than the actual anxiety symptoms (Kreuze et al., 2018). It has been argued that as anxiety symptoms increase in severity, so does the associated impairment and interference in functioning (Seligman & Gahr, 2012).

There are a number of different domains of functioning; the main ones for children are family, social, and academic functioning (Sadock et al., 2014). Functioning refers to a young person's ability to participate fully, without interference, in each of these specific domains (Kreuze et al., 2018). A young person's expected level of functioning is based on what is considered appropriate for their age and/or developmental level (Kreuze et al., 2018). Swan and Kendall (2016) have proposed that in order to 'cure' anxiety disorders, there needs to be a focus on not only reduction of symptoms, but also concurrent reduction in the associated impairments in functioning.

Closely associated and related to functioning, is an individual's overall life satisfaction. Life satisfaction can be simply defined as one's subjective wellbeing (Swan & Kendall, 2016). Life satisfaction differs from functioning due to its subjective nature, meaning it is based purely on the affected individual's perception of their life. Despite these differences, life satisfaction is intimately related to the domains of functioning, in that functional impairment contributes to one's subjective view of their wellbeing (Fergusson et al., 2015; Swan & Kendall, 2016).

Therefore, when a young person experiences functional impairment as a result of anxiety, their overall life satisfaction and/or wellbeing is likely to also be affected in both the short and long term (Essau et al., 2014; Fergusson et al., 2015). Though a majority of the literature and research focuses primarily on functioning and functional impairment, it can be inferred as to what the research

findings on functional impairment might mean for a young person's overall life satisfaction and wellbeing.

1.2.1 Family Functioning

The family environment is where most young people spend a majority of their time and therefore is highly likely to be influenced and affected by childhood anxiety disorders. Family dysfunction has frequently been associated with anxiety disorders in young people (Davila et al., 2019; Essau et al., 2014; Swan & Kendall, 2016). Research consistently finds this relationship to be bi-directional in that individual circumstances dictate which occurs first, the family dysfunction or the anxiety disorder (Essau et al., 2014; Kreuze et al., 2018; Swan & Kendall, 2016). It has been argued that as anxiety severity increases, so does family dysfunction; conversely, as family dysfunction increases, so does anxiety severity (Essau et al., 2014; Swan & Kendall, 2016). Families with a young person with an anxiety disorder have been found to have poorer family cohesion and higher levels of conflict (Kreuze et al., 2018). This poor cohesion and conflict has been found to continue on into adulthood and may result in poor relationship quality between family members later in life (Essau et al., 2014; Kreuze et al., 2018).

Dysfunctional parenting practices have also been found to occur both as a predictor, and as a result, of having a child with an anxiety disorder in the family (Hughes et al., 2008; Thompson-Hollands et al., 2014). In regards to anxiety disorders, dysfunctional parenting practices prevent young people from building resilience and learning how to cope with their anxiety independently (Davila et al., 2019). Parents naturally want to prevent their children from experiencing distress, and by sheltering and protecting their child from their anxiety, they believe they are helping and supporting the child.

There are multiple ways that parents may attempt to alleviate their child's anxiety symptoms, with the two most common being accommodation of the symptoms and behavioural control (Hughes et al., 2008; Thompson-Hollands

et al., 2014). These methods are usually successful in the short term but inevitably lead to increased anxiety severity and distress in the long term (Davila et al., 2019).

1.2.2 Social Functioning

Positive social functioning and peer relationships are intimately related to wellbeing and life satisfaction, and are integral aspects of healthy social and emotional development for young people (Seligman & Gahr, 2012). Research has found that young people with anxiety disorders frequently experience impairment in social functioning, ranging from decreased social competence and lower quality and quantity of peer relationships, to complete peer rejection, victimisation, and social withdrawal (de Lijster et al., 2018; Kreuze et al., 2018; Pedersen et al., 2007; Swan & Kendall, 2016). This impairment in social functioning has been found to increase as the severity of the anxiety increases (Settipani & Kendall, 2013).

Peer rejection and social withdrawal have many negative effects on young people, namely loneliness, behavioural outbursts, the development of comorbid mental illness, adolescent substance use and dependence, and the maintenance and development of more severe anxiety symptoms (Bierman, 2004; Hawker & Boulton, 2000; Hoglund et al., 2008; Nangle et al., 2003).

School is the main environment where young people are likely to experience this peer rejection, and this may be a contributing reason as to why young people with anxiety disorders withdraw themselves from school. Young people who have difficulties with peers and are socially withdrawn are said to be more likely to have academic difficulty, skip school, and drop out (Seligman & Gahr, 2012; Swan & Kendall, 2016).

1.2.3 Academic Functioning

It has been argued that young people with anxiety disorders have increased impairment in academic functioning, and as a result are more likely to experience academic underachievement (Kreuze et al., 2018; Mychailyszyn et al., 2010; Woodward & Fergusson, 2001). This has been found to be especially true for young people with severe levels of anxiety and/or a comorbid mental illness (Kreuze et al., 2018; Mychailyszyn et al., 2010; Van Ameringen et al., 2003).

Aside from academic underachievement, teacher reports state that non-anxious children appear happier in the classroom, are more engaged in their learning, and seem to work harder and learn better (Mychailyszyn et al., 2010). The excessive worry and attention to threat cues associated with anxiety disorders results in concentration difficulties and could explain why students with anxiety disorders appear less engaged and have overall poorer performance than their peers (Wood, 2007).

Research has demonstrated that when anxiety symptoms are reduced, academic functioning is improved (Nail et al., 2015). Reduction in anxiety symptoms has been found to result in improved GPA, higher scores on standardised achievement tests, and better overall school functioning (Keogh et al., 2006; Nail et al., 2015; Weems et al., 2009).

1.2.4 School Removal

Young people with anxiety disorders are more likely to remove themselves from school, or be removed by someone else, than their non-anxious peers, especially when their anxiety symptoms and associated functional impairments are severe (Van Ameringen et al., 2003; Wittchen et al., 1998; Wood, 2007). The combination of increased severity of symptoms, associated impairments in functioning, and academic and social demands, has been said to lead to avoidance or complete withdrawal from school in an attempt by the young person, or their whānau, to alleviate the anxiety (Wittchen et al., 1998).

When this occurs frequently, these young people quickly fall behind their peers academically and become more isolated from their peer group. This sequence of events has been said to lead to eventual school removal for young people with anxiety disorders, resulting in further isolation and academic underachievement (Van Ameringen et al., 2003; Wood, 2007).

School removal has been found to have a significant impact on career options and subsequent life satisfaction later in life. School removal results in a lower educational status based on the highest grade completed at school, which can have a number of implications for that young person's career options and subsequent wellbeing (Wittchen et al., 1998). Swan and Kendall (2016) stated that anxious young people are also less likely to explore different career options and more likely settle for a career that does not make them happy, resulting in decreased life satisfaction. Further, non-anxious young people have been found to be 2.5 times more likely to attend tertiary education than young people with severe anxiety, which was defined by the diagnosis of three or more anxiety disorders (Woodward & Fergusson, 2001). However, research has found that there is no significant difference between non-anxious young people, and anxious young people with 1-2 diagnoses, demonstrating the importance of the relationship between comorbidity, severity, and impairment (Essau et al., 2014; Woodward & Fergusson, 2001).

Due to the short and long term consequences of school removal, it is imperative that young people with anxiety disorders are assisted to remain in school. Such assistance is available to young people in Aotearoa New Zealand through the Regional Health Schools.

1.3 The Aotearoa New Zealand Regional Health Schools

The Aotearoa New Zealand Regional Health Schools (RHS) were established in the year 2000, following a review of New Zealand special education, to provide education services to young people with high health needs (Ministry of Health, 2014). These schools were originally called 'Hospital

Schools' but were renamed as 'Health Schools' to reflect the growing number of students who were taught in the community rather than in hospitals (Ministry of Health, 2014). There are three RHS' in New Zealand: Northern, Central, and Southern. These three schools collectively provide teaching across all of Aotearoa New Zealand, in settings appropriate to each individual student, such as the community, hospitals, the student's home, and mental health and youth justice facilities (Ministry of Health, 2014). In 2018, 70% of the 530 students enrolled with one of the RHS' were in attendance due to a mental illness (Anonymous 2019, personal communication, 9 October).

RHS' provide education services to young people who are too unwell to attend their regular school (for an extended period of time), due to a physical or mental illness (Ministry of Health, 2014). To be eligible for support from the RHS', students must meet one of the following criteria - the student: has missed school, or is expected to miss school, for more than ten days in a row due to the illness; has been in hospital, or is expected to be admitted, six or more times in one year; has missed school, or is expected to miss school for more than 40 days in one year due to the illness; has been recuperating at home after being unwell; has been previously unwell and needs support returning back to school; or has been, or is currently, in a state funded mental health programme/ inpatient unit (Ministry of Health, 2014). The student must also be in active treatment for their condition in order to be enrolled with RHS. The student must have a medical certificate from an appropriate health professional who specialises in the presenting condition, which states the young person's condition, the treatment plan, how it stops them attending regular school, and a time frame for when the student is expected to return to regular school, either part time or full time (Ministry of Health, 2014).

The student remains enrolled with their regular school while attending RHS, unless they do not have a regular school, in which case there is a special agreement (Ministry of Health, 2014). Students stay on the RHS roll for varied lengths of time depending on their health needs, ranging from a minimum of two weeks to multiple years. Students who are sitting the National Certificate of

Educational Achievement (NCEA) can be dual enrolled with Aotearoa New Zealand's Correspondence School, Te Aho o Te Kura Pounamu (Te Kura, 2019). The RHS' and Te Kura work collaboratively and are bound by the Dual Provider Partnership Agreement [DPPA] (Te Kura, 2019). The DPPA ensures that there is a mutual understanding between the RHS' and Te Kura regarding the responsibilities of each provider (Te Kura, 2019).

1.3.1 Individual Learning Plans

RHS' are responsible for delivering an education programme that is created in collaboration with regular schools, health professionals, Te Kura, the young person themselves, their family/whānau, and any other relevant stakeholders (Ministry of Health, 2014). This programme is referred to as an Individual Learning Plan, or ILP. Students' ILPs are individually tailored to meet their health and educational needs. The main purpose of ILP's is to assist students to return to their regular school, tertiary education, or other vocational pathways (Ministry of Health, 2014). The term 'reintegration' will be used throughout this thesis to refer to any of these three reintegration sites.

The success of a student's ILP is not the sole responsibility of the RHS teacher, but rather all relevant stakeholders who assisted in the development of the ILP. It is likely that the inclusion of all relevant agencies and individuals will increase the probability of students achieving their goals through their ILP's, which results in higher success rates of reintegration. These multi-dimensional relationships can undoubtedly become quite complex and may have implications for the successful implementation of a young person's ILP.

1.4 Conclusion

This chapter introduced the symptoms of anxiety disorders and their secondary effects, which impact multiple domains of functioning in a young person's life. One such domain that may be impacted by an anxiety disorder is school. In Aotearoa New Zealand, when a young person's anxiety becomes so

severe that they are unable to attend regular school, they may be eligible for support from the RHS'.

The next chapter provides a literature review of the current literature relevant to this research. It specifically focuses on anxiety prevalence in Aotearoa New Zealand, and the barriers and facilitators to treatment outcomes in clinical settings for young people with anxiety disorders. It then outlines the purpose of the current study. The chapters that follow discuss the methodology, results, and discussion.

Chapter 2: Literature Review

2.1 Literature Review Introduction

This literature review begins by discussing the breadth and depth of anxiety disorders in young people in Aotearoa New Zealand. As is demonstrated in Section 2.2, multiple studies and surveys in Aotearoa New Zealand have found that anxiety disorders in young people are highly prevalent, and the number of diagnoses has drastically increased over the past decade. Due to the high prevalence rates and increasing magnitude of diagnoses, anxiety disorders have been selected as the specific experience of mental distress that will be examined in this research. Not only are anxiety disorders highly prevalent amongst young people in Aotearoa New Zealand, they also commonly co-occur with comorbid mental illnesses, namely other anxiety and mood disorders. Comorbid mental illnesses have been associated with a more severe form of psychological distress; thus, it is likely that students on the RHS roll, who experience severe levels of anxiety, experience distress from a comorbid diagnosis. Anxiety disorders are the main focus of this thesis but it should be noted that comorbid diagnoses might also impact how successful a young person's reintegration is.

Section 2.3 focuses on research relating to the main aims of this thesis- the facilitators and barriers to reintegration for young people with anxiety disorders attending RHS. Due to the unique nature of the RHS', there is currently no research on this area and it is therefore not possible to write a review of the literature on this topic. However, there is a large volume of literature regarding the barriers and facilitators to treatment outcomes for young people with anxiety disorders in clinical settings. It might be that the variables that affect treatment success for young people with anxiety disorders in clinical settings may also affect the success and implementation of ILP's, and subsequent reintegration for young people with anxiety disorders attending RHS. Thus, barriers and facilitators to treatment outcomes for young people with anxiety disorders in clinical mental health settings may provide insights into the

potential barriers and facilitators to reintegration for young people with anxiety disorders attending RHS, and accordingly, are covered in this section.

Section 2.3 examines the literature on the predictors of treatment outcomes in clinical settings with inferences made to the predictors of reintegration in RHS settings. Current research on treatment outcomes of young people with anxiety disorders generally uses the term predictors, rather than barriers and facilitators. This appears to be because there are mixed findings and little consensus as to whether certain variables act as barriers or facilitators. Thus, section 2.3 discusses more generally the predictors of treatment outcomes without specifying whether a certain variable acts as a barrier or facilitator. This literature review focuses on four main predictors of treatment outcomes for young people with anxiety disorders: type of anxiety disorder, comorbid disorders, parental involvement, and parental characteristics.

2.2 Breadth and Depth of Anxiety Disorders in Young People

Worldwide, anxiety is one of the most common forms of psychological distress in childhood and adolescence, with global prevalence estimates of 7.3%, equating to approximately 1 in 14 young people globally (Baxter et al., 2013; Clark et al., 2013; Essau & Ollendick, 2013; Whiteford et al., 2015). Anxiety disorders have also been reported to be the most common cause of disability for young people aged 10-24 years (Whiteford et al., 2015). Alarmingly, Aotearoa New Zealand is consistently highlighted in global research as having some of the highest rates of childhood anxiety in the world, with 1 in 5 young people meeting diagnostic criteria for an anxiety disorder by the age of 19 (Baxter et al., 2013; Patton et al., 2012; Social Policy and Evaluation Research Unit, 2016). The following section discusses the breadth and depth of anxiety disorders in young people, and draws (where possible) on research from Aotearoa New Zealand. Prevalence, age of onset (AOO), and comorbidities are examined in detail in this section, as they are fundamental aspects in understanding the magnitude and severity of anxiety disorders in young people in Aotearoa New Zealand.

2.2.1 Prevalence

The New Zealand Health Survey measures a variety of health indicators each year, to ascertain trends over time in the health of New Zealanders (Ministry of Health, 2017). The survey has been taking place under its current name since 2006, and is becoming well respected in Aotearoa New Zealand (Ministry of Health, 2019). The survey is carried out over a year long period (from July to June the following year) by trained administrators at the participant's house, either face-to-face or via a computer programme (Ministry of Health, 2019). In 2017-2018 the survey had a 79% response rate for children and was estimated to be representative of 74% of young people in Aotearoa New Zealand. The survey covers a broad range of health topics; thus, there are few questions regarding mental health, let alone experiences of anxiety. For this reason, the New Zealand Health Survey does not provide a deep analysis of anxiety in young people in Aotearoa New Zealand, but rather a snapshot of the magnitude of the problem.

The New Zealand Health Survey has found that anxiety is one of the most common forms of psychological distress in young people in Aotearoa New Zealand (Ministry of Health, 2018). The Ministry of Health (2017) stated that of the estimated 39,000 (4.9%) children aged 5-14 years that were diagnosed with an emotional or behavioural disorder (in July 2017- June 2018), 24,000 of those children had an anxiety disorder. This equates to approximately 62% of the emotional and behavioural disorder diagnoses that were made. A further estimated 50,000 children were identified as being highly likely to reach diagnostic criteria for an emotional or behavioural disorder at some point during their childhood or adolescence (Ministry of Health, 2018). In the 15-24 years old age group, of the estimated 79,000 (11.8%) young people that stated they experienced psychological distress, 65,000 (9.6%) young people's distress was due to an anxiety disorder. In other words, approximately 82% of the experiences of psychological distress in the 15-24 year old age group were due to an anxiety disorder.

The Health Loss in New Zealand Report stated that anxiety and depressive disorders (combined) were the second leading cause of health loss for New Zealanders in the year 2016; mental illnesses were the leading cause of health loss for youth in Aotearoa New Zealand, accounting for 31% of health loss in this age group (Ministry of Health, 2016). The Health Loss in New Zealand Report drew data from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, which is a systematic analysis of healthy years lost in New Zealanders due to early death, illness, or disability (Ministry of Health, 2016).

The data from this study was gathered from a variety of different sources and it was reported that 75% of the sources used were robust (Ministry of Health, 2016). However, it is important to consider that this research did not include confidence intervals. Confidence intervals provide estimates of uncertainty, and without these reported it is difficult to determine the reliability of the research findings (Field, 2018). Yet, more recent statistics from the New Zealand Health Survey supported the findings of the Health Loss in New Zealand Study and reported that in the 15-24 years age group, anxiety disorders accounted for 35% of all health loss, a 4% increase from 2016.

Data from surveys in Aotearoa New Zealand over the past decade have demonstrated that anxiety disorders have drastically increased over time for young people in Aotearoa New Zealand (Clark et al., 2013; Fleming et al., 2014; Ministry of Health, 2007, 2017). In 2007, anxiety prevalence for New Zealander's aged 15-24 years was 2.6%, which is approximately 16,000 young people (Ministry of Health, 2007). In 2017, a decade later, the prevalence tripled to 9.6%, approximately 65,000 young people (Ministry of Health, 2017).

Likewise, for New Zealanders aged 5-14 years old, there has been a substantial increase in anxiety prevalence over the past decade. In 2007 the prevalence of anxiety disorders for young people aged 5-14 years old was 0.9%, approximately 2000 young people; a decade later in 2017, prevalence rates increased drastically to 7.1%, which equates to approximately 23,000 young people (Ministry of Health, 2007; Ministry of Health 2016, Ministry of Health,

2017). When the two age groups are combined to encompass ages 5-24 years old, the prevalence of anxiety disorders in all young people in Aotearoa New Zealand in 2017 was 16.7%, which equates to approximately 88,000 young people.

The data from the New Zealand Health Survey has been supported by three other reports and studies in Aotearoa New Zealand; the Health Loss in New Zealand Study (Ministry of Health, 2016), the Prime Minister's Youth Mental Health Project (Social Policy and Evaluation Research Unit, 2016), and the Youth 2000 Survey Series (Clark et al., 2013). The consensus among multiple studies in Aotearoa New Zealand provides strong support that the findings regarding the increase of anxiety diagnoses are accurate and representative of the population. For this reason, anxiety disorders have been selected as the focus of this thesis.

It is evident that anxiety disorders impact a substantial number of young people in Aotearoa New Zealand, but it is unclear how many individuals experience anxiety that is so severe that they must be removed, or remove themselves, from school. There is currently no research providing data or estimates on anxiety disorder severity; however, although exact figures could not be obtained, information provided from one of the RHS' stated that in 2018, out of the 70% of students with mental illness on the roll, there were twice as many students on the roll with a primary anxiety disorder diagnosis than with a primary depressive disorder diagnosis (Anonymous 2019, personal communication, 9 October). If a young person is on the RHS roll, it is likely that their experience of anxiety is severe in order to meet criteria to be in the RHS.

Thus, the ratio of young people on the RHS roll with anxiety as a primary diagnosis gives one estimate of the amount of young people in Aotearoa New Zealand who experience severe levels of anxiety. This estimate does not encompass all RHS', students who choose alternate options for education, or students who withdraw from school completely, so it is only a rough guide. However, it does demonstrate that there are likely significant numbers of young people with severe levels of anxiety who are receiving assistance from the RHS'

to return back to regular school, enter into tertiary education, or enter into other vocational pathways.

2.2.2 Comorbidities

Not only is anxiety one of the most common experiences of psychological distress in childhood and adolescence, it also frequently co occurs with other mental illnesses, especially other anxiety and mood disorders (Al-Asadi et al., 2015; Essau et al., 2014; Essau & Ollendick, 2013; Leyfer et al., 2013). McConaughy and Achenbach's (1994) international meta-analysis of clinical samples found that more than half of the young people with an anxiety disorder had another comorbid anxiety disorder; 16.2% had a comorbid depressive disorder, 14.8% had comorbid conduct disorder, 11.8% had comorbid ADHD, and substance abuse occurred in 11% of cases.

In Aotearoa New Zealand, more recent research from the Christchurch Health and Development Study (CHDS), alongside diagnostic interviews, supported McConaughy & Achenbach's (1994) research (Woodward & Fergusson, 2001). The research in Aotearoa New Zealand found that adolescents who had an anxiety disorder were at increased risk of having comorbid anxiety, depressive, and conduct disorders, and also later developing comorbid anxiety and depressive disorders, substance dependence, and suicidal behaviour by the age of 21 (Woodward & Fergusson, 2001).

The CDHS is a longitudinal study of 1,265 New Zealanders born in Christchurch in mid-1977 (Otago University, 2019). Prospective, longitudinal studies, such as the CDHS, are extremely valuable types of research as they allow for the study of developmental trends, etiology of mental illnesses, and periods of general ill health over time (Otago University, 2019). In regards to the research by Woodward and Fergusson (2001), the longitudinal nature of the CDHS provided the researchers with comprehensive data on the social and personal backgrounds of the participants, which allowed for these factors, or confounds, to be controlled for through logistic regression. The ability to control

for confounding factors in this way gave the researchers some degree of certainty that the comorbid diagnoses were due to a pre-existing anxiety disorder, not some other shared vulnerability factor.

However, a limitation of the CDHS, and other longitudinal research using a cohort study, is cohort effects. Cohort effects refer to research results that occur due to particular shared social and historic characteristics of a group, such as geographic location, place and year of birth, and historic and generational events (Hoffnung et al., 2016). Therefore, caution must be made in generalising these research findings to the young people in Aotearoa New Zealand today due to the potential cohort effects.

Comorbid mental health diagnoses have also been associated with a more severe experience of mental illness (Carr, 2016; Essau & Ollendick, 2013; Sadock et al., 2014; Scott, 2006). Severity refers to both the symptoms and associated impairments in functioning (Sadock et al., 2014). According to research from Te Rau Hinengaro: The New Zealand Mental Health Survey, over half of the interviewees who had at least one other comorbid diagnosis were classified as having severe mental illness; in contrast, only 11.7% of those with only one diagnosis were classified as severe (Scott, 2006). Further, only 4.6% of people with at least two comorbid diagnoses were classified as mild, compared to 43.5% classified as mild for those with only one diagnosis.

The target population of Te Rau Hinengaro was people who were at least 16-years-old, living in permanent, private residences in Aotearoa New Zealand (Oakley-Browne et al., 2006). Therefore, the survey excluded those who are arguably the most likely to experience severe mental illnesses, such as those in hospitals and mental health facilities. Thus, it is likely that the rates of comorbidities and associated severities are higher than was reported in Te Rau Hinengaro. Further, this study focussed on people who were 16-years and older, so does not provide information about comorbidities and the associated severities of young people under the age of 16 in Aotearoa New Zealand.

The research on anxiety disorder comorbidity consistently demonstrates that young people with an anxiety disorder are likely to experience a comorbid mental illness (Al-Asadi et al., 2015; Essau et al., 2014; Essau & Ollendick, 2013; Leyfer et al., 2013). Therefore, it can be inferred that a young person enrolled at RHS with an anxiety disorder will experience comorbid mental illness. The main focus of the present research is RHS students with anxiety disorders; however, it would be unwise to ignore the possibility that students attending RHS due to an anxiety disorder may be experiencing distress and impairment from a comorbid mental illness. These comorbid mental illnesses may potentially have implications for reintegration. Comorbidities are just one of many potential predictors of successful reintegration for young people attending RHS. The following section of this literature review discusses the current research on some of the main predictors of treatment outcomes in clinical settings for young people with anxiety disorders, with inferences made to the RHS setting.

2.3 Predictors of Treatment Outcomes

Examining the predictors of treatment outcomes allows for better understanding regarding with whom, and under what conditions, treatment is more, or less, likely to be successful (Herres et al., 2015). Predictors of treatment outcomes are baseline variables that exist prior to the commencement of treatment and have an effect on post treatment outcomes, regardless of which type of treatment is received (Compton et al., 2014; Farrell et al., 2013). The study of these predictor variables provides insight into what variables may act as facilitators and barriers to successful treatment outcomes (Farrell et al., 2013).

Research on predictors of treatment outcomes attempt to identify which variables result in poorer treatment outcomes in order to refine treatment to be more successful for those who have experienced poorer treatment response (Hudson, Rapee, et al., 2015; Kazdin, 2007). As research shows that some young people, under certain conditions, have a better response to clinical treatment than others, it might be then that a similar phenomenon occurs at the RHS', with ILP's and reintegration more likely to be successful for certain young people,

under certain conditions (Farrell et al., 2013; Herres et al., 2015). Having a better understanding of with whom, and under what conditions, reintegration is less successful may shed light on new methods and strategies to improve reintegration for those who have poorer responses to their ILP's, increasing the overall success rate of reintegration for young people with anxiety disorders attending RHS.

In order to maintain consistency, the following predictors of treatment outcome have all been based on literature regarding cognitive behavioural therapy (CBT). CBT is a well-established treatment method for anxiety disorders and has been shown to be effective by numerous RCT's (Cartwright-Hatton et al., 2005; Hudson, 2005; In-Albon & Schneider, 2007; Ishiwaka et al., 2007; James et al., 2013; Silverman et al., 2008). As CBT is considered a first line treatment for treating anxiety disorders, most research on the predictors of treatment outcomes has focussed on CBT specifically (Bennett et al., 2016; Higa-McMillan et al., 2016; Hill et al., 2016). CBT is based on the theory that the interaction between thoughts, feelings, and behaviours maintains psychological distress (Hill et al., 2016). CBT focuses on what maintains the avoidance behaviours commonly associated with anxiety disorders and how to break this unhelpful coping style.

There are a number of variables that have been proposed to impact on the efficacy of treatment for young people with anxiety disorders. Predictor variables have been selected for this literature review based on their relevance and inferred transferability to the RHS setting. The variables that have been included in this literature review are: type of anxiety, comorbidities, parental involvement, and parental characteristics. The premise of this section of the literature review is that these same variables may also impact successful reintegration of young people attending RHS into regular school, tertiary education, or other vocational pathways.

2.3.1 Type of Anxiety Disorder

In the past, researchers have largely used a transdiagnostic approach when examining predictors of treatment outcomes for young people with anxiety disorders. This is due to the premise that all anxiety disorders have very similar underling constructs, and can therefore be treated within the same common set of CBT principles (Waters et al., 2018). Transdiagnostic approaches have also been commonly used due to the high rates of comorbidities among anxiety disorder diagnoses, as differentiating them for the purposes of research can become challenging and impractical (Hudson, Rapee, et al., 2015). However, in recent years research has slowly emerged on particular disorders and whether these particular disorders have more favourable outcomes after therapy than other anxiety disorders (Hudson, Rapee, et al., 2015). As this topic is relatively new in the literature, there are limited findings regarding whether particular anxiety disorders predict treatment outcomes.

Research has typically focused on social anxiety disorder, generalised anxiety disorder (GAD), and separation anxiety disorder (Compton et al., 2014; Ginsburg et al., 2011; Kennedy et al., 2018; Kerns et al., 2015; Kodal et al., 2018), and in fewer cases research has extended to include specific phobia (Waters et al., 2018) and obsessive-compulsive disorder (Hudson, Rapee, et al., 2015). Some anxiety diagnoses have received no, or very minimal, research and therefore results must be interpreted as tentative and emerging theories. With this in mind, current research provides tentatively strong evidence that particular anxiety disorders may predict poorer response rates to treatment than other anxiety disorders.

Social anxiety disorder has been found across multiple recent studies, in both clinic and community settings, to predict poorer treatment outcomes than other anxiety disorders (Compton et al., 2014; Ginsburg et al., 2011; Hudson et al., 2015; Kennedy et al., 2018; Kerns et al., 2013; Kodal et al., 2018; Waters et al., 2018). According to Compton et al. (2014) remission rates for social anxiety disorder were 2.5 times lower than other anxiety disorders. Further, Hudson et

al. (2015) found that only 31% of young people with a primary diagnosis of social anxiety disorder achieved remission, compared to 56-58% for GAD, specific phobia, and separation anxiety disorder. Likewise, the chance of remission from a primary diagnosis has been found to be significantly lower for those with social anxiety disorder (Kodal et al., 2018). Poorer treatment outcomes has also been proposed to also apply to subclinical levels of social anxiety, with research discovering higher levels of social anxiety disorder symptoms post treatment than other anxiety disorder symptoms (Kerns et al., 2013). Even at a seven year follow up, those with a primary diagnosis of social anxiety disorder were less likely to have maintained gains from treatment than those with other primary anxiety disorder diagnoses (Kerns et al., 2013).

Research comparing different types of anxiety disorders has utilised two modes of CBT treatment, individual and group CBT. It is possible that those with a social anxiety disorder diagnosis might have had fewer positive treatment outcomes compared to those with other types of anxiety disorders due to the aversive nature of group CBT for those specifically with social anxiety disorder (Hudson, Rapee, et al., 2015; Kennedy et al., 2018; Waters et al., 2018). However, at this stage it appears unlikely that group CBT was the reason for poorer treatment outcomes. Research using individual CBT has supported the conclusions of research using group CBT; namely, that those with social anxiety disorder diagnoses have poorer treatment outcomes than those with other anxiety diagnoses (Compton et al., 2014; Ginsburg et al., 2011; Kerns et al., 2013). Further, Kodal et al. (2018) examined both group and individual CBT and found no difference between the two treatment modes in regards to social anxiety disorder symptom reduction.

In comparison to social anxiety disorder, GAD has been reported to predict higher rates of successful treatment outcomes than other anxiety disorders (Compton et al., 2014; Hudson, Rapee, et al., 2015; Knight et al., 2014; Kodal et al., 2018). Hudson et al. (2015) found that those with a primary diagnosis of GAD were more likely to experience a reduction in both symptoms and severity compared to those with other anxiety diagnoses, especially those

with social anxiety disorder. This also remained the case when controlling for age and comorbid depression (Hudson, Rapee, et al., 2015).

However, a contrary position has been taken by Waters et al. (2018), who found that alongside social anxiety disorder, those with GAD were also significantly less likely to experience positive outcomes post treatment compared to those with separation anxiety disorder and specific phobias. Of note, this study is one of the first to use a community sample, which arguably makes it more generalisable to the general population. However, the research by Waters et al. (2018) is undermined by the 6 and 12-month follow up response rate of only 50%, which severely affects the validity of reporting post treatment outcomes. Because of this, examination of the existing literature points towards GAD being predictive of more successful post treatment outcomes, although there is a need for more literature in this area.

The research on particular types of anxiety disorders as predictors of treatment outcomes raises the question of whether reintegration is more or less successful for students who are attending RHS with certain types of anxiety disorders. Research on types of anxiety disorders as predictors of treatment outcomes that have taken place in a clinic setting cannot be simply transferred to ILP's and reintegration in the RHS school setting; however, it can be inferred what these research findings might mean for young people with anxiety disorders attending RHS. It may be that, as with CBT treatment, reintegration is less successful for those with social anxiety disorder and more successful for those with GAD, compared to other anxiety disorders. The current research aims to provide insights (from teachers' perspectives) into whether certain types of anxiety disorders impact how successful reintegration is for young people with anxiety disorders.

2.3.2 Comorbid Disorders

As has been discussed earlier in this literature review, comorbidities are a common occurrence for young people with anxiety disorders (Al-Asadi et al.,

2015; Essau et al., 2014; Essau & Ollendick, 2013; Leyfer et al., 2013). It is therefore no surprise that comorbidity has been extensively researched over the past few decades in regards to whether it acts as a predictor of treatment outcomes for young people with anxiety disorders. This extensive body of research has been condensed into two systematic analyses that have been conducted in the years 2010 and 2018.

An analysis by Olatunji et al., (2010) of 61 treatment samples from the years 1972-2010 concluded that comorbid disorders did not significantly impact treatment outcomes for people with anxiety disorders. However, this analysis included both adult and child populations, with only 21 out of the 61 articles included pertaining specifically to anxiety disorders in young people. Consequently, the transferability of the research findings to a population of young people is limited.

Conversely, Walczak, Ollendick, Ryan, and Esbjørn's (2018) analysis of 33 publications, which included studies from the year 2007-2017, did not support the conclusions of Olatunji et al. (2010), and instead argued that there is still mixed findings regarding the role of comorbidity as a predictor of treatment outcomes for anxiety disorders. This analysis used only publications regarding child and adolescent populations, making it more transferrable to a population of young people.

Though at face value it appears that there is little consensus regarding whether comorbidity is a predictor of treatment outcome for young people with anxiety disorders, it may be that inconsistencies in the way that comorbidity has been categorised that has contributed to the differences in research findings. Some studies have grouped comorbid disorders together into categories such as ‘other anxiety disorder’, ‘internalising disorder’, and ‘externalising disorder’. Other studies reported results based on specific diagnoses such as depression, attention deficit/hyperactivity disorder (ADHD), and social anxiety disorder.

Studies that group comorbid disorders together as one categorical predictor variable have generally found mixed results for the effects of comorbidity on treatment outcomes. For example, studies using the categories of general comorbidities (internalising disorders and externalising disorders) have consistently shown differences in findings over the past decade; some studies have found comorbidities to predict poorer treatment outcomes, and others found no significant effect on treatment outcome (Compton et al., 2014; Ginsburg et al., 2011; Hancock et al., 2018; Hudson, Keers, et al., 2015; Liber et al., 2010; Ollendick et al., 2010; Rapee et al., 2013; Ryan et al., 2017; Silk et al., 2018; Thirlwall et al., 2017; Wergeland et al., 2016). Thus, the current lack of consensus may be due to differences in the way that comorbidity has been operationalised and categorised by different researchers.

When comorbid disorders were separated and analysed as individual, specific diagnoses, there appears to have been higher rates of consensus amongst research for each specific disorder. Studies on the effect of comorbid depression on treatment outcomes for young people with a primary anxiety disorder have consistently found that depression is a predictor of poorer treatment outcomes (Berman et al., 2000; Crawley et al., 2008; Lundkvist-Houndoumadi & Thastum, 2017; Rapee et al., 2013; Southam-Gerow et al., 2001). Likewise, a comorbid diagnosis of social anxiety disorder, alongside a separate primary anxiety disorder diagnosis, has been found to be predictive of poorer treatment outcomes, though this may be due to findings that suggest that those with social anxiety disorder are less responsive to treatment as either a primary or secondary diagnosis (Hudson, Keers, et al., 2015; Hudson, Rapee, et al., 2015; Kennedy et al., 2018; Kerns et al., 2013; Wergeland et al., 2016).

Similarly, though there are significantly fewer studies available for comparison, research on ADHD specifically has found comorbid ADHD to be predictive of poorer treatment outcomes for young people with anxiety disorders (Halldorsdottir et al., 2015; Halldorsdottir & Ollendick, 2016). These findings provide support for the argument that comorbid disorders are predictive of poorer treatment outcomes for young people with anxiety

disorders. However, the current research should be considered as only tentative support, as there is not enough research to draw strong and convincing conclusions.

The current lack of consensus in the literature regarding the effect of comorbidities on treatment outcomes leads to difficulties in drawing conclusions regarding the effects of comorbidity on successful reintegration of young people attending RHS. Despite this lack of consensus, when separated out and analysed as specific disorders, research tentatively shows that comorbid depression, ADHD, and social anxiety disorder predict poorer treatment outcomes than those people with no comorbid diagnoses. Though there is not enough research to draw solid conclusions, the current research tentatively indicates that reintegration could be less successful for young people with a primary anxiety attending RHS who have a comorbid mental illness. The current research aims to explore teachers' perspectives as to whether comorbid disorders may be predictive of poorer reintegration success rates for young people with anxiety disorders.

2.3.3 Parental Involvement

There are many factors that potentially impact treatment outcomes for young people with anxiety disorders. However, according to Ginsburg, Siqueland, Masia-Warner and Hedtke (2004), none are as influential as parental and/or family factors. It is generally accepted in psychology that anxiety disorders have both a heritable and an environmental component (Bodden, Bögels, et al., 2008). Due to this intimate relationship between parental and/or family factors and anxiety in young people, it has been argued that involving parents in the treatment of anxiety disorders in young people is vital in order to ensure both short and long term treatment success (Brendel & Maynard, 2014; Taboas et al., 2015).

Parental involvement has been argued to result in better generalisation of skills learnt in treatment to the home environment and the daily routine of the

family and affected young person, which in turn is said to lead to better treatment outcomes (Brendel & Maynard, 2014; Taboas et al., 2015). Further, Yap et al, (2016) state that parental involvement in treatment may improve treatment outcomes, as parents have insights and experiences with their child that may help make the treatment more realistic and applicable to the young person's life.

These same arguments for the importance of involving parents in anxiety treatment can be tentatively applied to the importance of having a young person's parents or caregivers involved in their ILP while attending RHS. The RHS require that at least one parent or caregiver, though preferably both, be involved in the initial development and continued implementation of their young persons ILP in order to ensure that all key stakeholders are in agreement in regards to the plan for the young person's reintegration. However, it is likely that the level of family involvement is variable from one family to another, and it may be that these varying levels of parental involvement affect how successful a young person's reintegration is.

Despite the importance of parental and/or family factors in the etiology of anxiety disorders in young people, parental involvement in treatment has not been found to result in better treatment outcomes than individual treatment. In the following paragraphs, parent cognitive behavioural therapy (PCBT) will be used to refer to any form of CBT based treatment that includes parents, whether that is as a co-therapist, a co-client, or a combination of both. Individual cognitive behavioural therapy (ICBT) will refer to any form of CBT based treatment that includes only the affected young person.

Multiple studies have found that there is no significant difference between ICBT and PCBT in regards to treatment outcomes; this indicates that parental involvement in treatment for young people with anxiety disorders is not predictive of better treatment outcomes than ICBT (Bodden, Dirksen, et al., 2008; Hudson et al., 2014; Jongerden & Bögels, 2015; Kendall et al., 2008; Marin, 2010; Schneider et al., 2013; Simon et al., 2011; Spence et al., 2000; Waters et al.,

2009). This was found across a variety of different PCBT methods, such as the parents as co-clients in treatment with the child (Kendall et al., 2008; Marin, 2010; Spence et al., 2000), individual parent treatment or education (Simon et al., 2011), and a combination of individual parent treatment or education and the parents as co-clients in treatment with the child (Hudson et al., 2014; Schneider et al., 2013; Waters et al., 2009).

Conversely, some studies have found parental involvement in treatment with young people with anxiety disorders to be predictive of better treatment outcomes, specifically lower post-treatment anxiety symptoms (Brown et al., 2017; Cobham et al., 2017; Pereira et al., 2016; Smith et al., 2014; Thirlwall et al., 2013, 2017). However, the studies that found parental involvement to be predictive of better treatment outcomes used a waitlist group as their control group rather than an ICBT group; this raises serious questions the validity of the conclusions drawn from the research. The positive treatment outcomes might not have been due to PCBT, but rather just CBT in general; hence, the results do not indicate whether PCBT is more successful than ICBT. As a result, the conclusions drawn from these studies may be slightly misleading and inaccurate. Thus, current literature does not support the theory that parental involvement in treatment with young people with anxiety disorders is predictive of better treatment outcomes, as the research that directly compared ICBT and PCBT has found no significant differences in regards to treatment outcomes.

It may be that the current literature has not found PCBT to be any more predictive of treatment success than ICBT because the operationalisation of parental involvement has been too broad to find any conclusive results. Breinholst et al. (2012) have suggested that perhaps research should more specifically focus on certain parental and family characteristics that are said to be involved in the etiology of anxiety in young people. These characteristics include, but are not limited to; parental anxiety, family dysfunction, parental beliefs about anxiety, and negative parenting behaviors such as criticism, rejection, lack of warmth, and over-, or under-, involvement (Breinholst et al., 2012; Carnes et al., 2019; Meyer et al., 2018).

These characteristics could be involved in both whether parents choose to be, or are capable of being, involved in therapy in the first place, and how successful treatment is with ICBT and/or PCBT. By this logic, certain family and parental characteristics, rather than parental involvement in general, may impact on how successfully the RHS teachers, and all other key stakeholders, can reintegrate young people with anxiety disorders into regular school, tertiary education, or another vocational pathway. It may be that certain family and parental characteristics influence and shape how involved a young person's family is with the development and continued support of their young persons ILP, which has subsequent implications for the success of reintegration.

2.3.4 Parental Characteristics

Research on the impacts of parental characteristics on treatment outcomes for young people with anxiety disorders is very sparse. Therefore, some of the research in this section of the review was published up to two decades ago and is potentially out-dated. However, the research available on the impact of parental characteristics on the treatment of anxiety disorders in young people provides insights into factors that may be further inferred to the factors that might affect the implementation of ILP's for young people with anxiety disorders at the RHS'. There are essentially two main contributing parental factors that have been highlighted across the literature: parental psychopathology and parenting behaviours (Walker, 2012).

2.3.4.1 Parental Psychopathology

Research has generally found mixed results regarding the association between parental psychopathology and treatment outcomes. Some research found that parental psychopathology predicted poorer treatment outcomes when there was psychopathology in one of the parents (Berman et al., 2000; Bodden, Dirksen, et al., 2008; Cobham et al., 1998, 2010; Kendall et al., 2008). Research has focussed on both the father specifically (Liber et al., 2008; Rapee, 2000), or the mother specifically (Creswell et al., 2008; Southam-Gerow et al.,

2001). However, other research found no effect when either the young person's father (Crawford & Manassis, 2011; Legerstee et al., 2008; Victor et al., 2007), or mother (Crawford & Manassis, 2011; Liber et al., 2008; Rapee, 2000; Victor et al., 2007) had a form of psychopathology.

The methodology used varied across the studies, but not in a way that directly correlated with certain trends of results. Most studies included both or either parents in the treatment (Berman et al., 2000; Bodden, Dirksen, et al., 2008; Cobham et al., 1998, 2010; Crawford & Manassis, 2011; Kendall et al., 2008; Legerstee et al., 2008; Liber et al., 2008; Rapee, 2000; Victor et al., 2007). Although Creswell et al. (2008) used only mothers, and a few studies didn't involve parents in treatment at all, but rather measured parental characteristics retrospectively (Festen et al., 2013; Kley et al., 2012; Southam-Gerow et al., 2001).

Treatment outcomes were measured in a variety of different ways, predominantly reduction in anxiety symptoms or severity (Crawford & Manassis, 2011; Kley et al., 2012; Legerstee et al., 2008; Rapee, 2000; Victor et al., 2007), a complete absence of the anxiety disorder (Bodden, Dirksen, et al., 2008; Creswell et al., 2008; Kendall et al., 2008), or a combination of both (Berman et al., 2000; Cobham et al., 1998, 2010; Liber et al., 2008). The differences in methodology do not appear to vary systematically with any particular result; however, these differences may contribute to the lack of consensus amongst research findings.

A methodology that was largely consistent across all the studies was the mode of measuring treatment outcome. The majority of research in this area utilised self reports, especially in regards to measuring parents' own psychopathology (Berman et al., 2000; Cobham et al., 1998, 2010; Crawford & Manassis, 2011; Kendall et al., 2008; Kley et al., 2012; Liber et al., 2008; Rapee, 2000; Southam-Gerow et al., 2001; Victor et al., 2007). Self-reports are an inexpensive and efficient way of gathering data, and are especially useful when a diagnostic interview is not practical, such as in these studies where the primary client was the child (Haeffel & Howard, 2010; Hoskin, 2012).

However, self-reports have a few disadvantages that affect the validity of the information gathered from them. The main problem with self-reports is that people may be biased when reporting their own experiences and actions (Haeffel & Howard, 2010; Hoskin, 2012). This bias may occur because some people genuinely are not able to rate themselves accurately (Haeffel & Howard, 2010). It may also occur because many people are influenced, either consciously or unconsciously, by social norms and social desirability; thus, they may report answers that are generally considered more acceptable in their society and culture (Hoskin, 2012).

This issue is especially paramount when studying mental illness, as it is commonly stigmatised in society, making people less likely to report mental illness or downplay the extent of the illness (Mulfinger et al., 2019; Reavley et al., 2018). Unfortunately, time and cost restraints make it difficult for researchers to assess and diagnose parental mental illness, so self-reports are a necessary part of research on this topic. This may partly explain why the research in this area has failed to find any consensus regarding the impacts of parental characteristics on treatment, despite the use of similar methodologies across the studies.

2.3.4.2 Parenting Behaviours and Other Characteristics

Due to the limited amount of research on the impacts of parental characteristics on the treatment of anxiety disorders in young people, there have been minimal research contributions that have examined parenting characteristics other than parental psychopathology. Nonetheless, the limited research findings that are available may give indication of the parental characteristics that affect young people with an anxiety disorder who are attending RHS, so they are worth noting. Certain parenting behaviours such as anxious rearing, overinvolvement, overprotection, rejection, and lower levels of both maternal and paternal warmth have been associated with poorer treatment outcomes for young people with anxiety disorders (Creswell et al., 2008; Festen et al., 2013; Liber et al., 2008).

With regards to family characteristics, overall family dysfunction has been associated with poorer treatment outcomes, whereas balanced family types, as defined by families with high cohesion and adaptability, has been associated with better treatment outcomes (Crawford & Manassis, 2011; Victor et al., 2007). Marital quality and marital satisfaction have not been found to be related to treatment outcomes for young people with anxiety disorders (Berman et al., 2000; Rapee, 2000). However, parental stress and frustration has been argued to result in poorer treatment outcomes (Crawford & Manassis, 2011).

Overall, research does not paint a clear picture as to whether parental characteristics, such as parental psychopathology and parenting behaviour, act as predictors of treatment outcomes for young people with anxiety disorders. Thus, it is also unclear whether parental characteristics are predictors of success rates of reintegration for young people on the RHS roll. The current research aims to provide insights into whether certain parental characteristics act as barriers or facilitators to reintegration.

2.4 Summary

This literature review discussed the breadth and depth of anxiety disorders in young people in Aotearoa New Zealand. According to the New Zealand Health Survey, anxiety is one of the most common forms of psychological distress in young people in Aotearoa New Zealand, with anxiety accounting for 62% of emotional and behavioural diagnoses for young people aged 5-14 years, and 82% of the experiences of psychological distress in young people aged 15-24 (Ministry of Health, 2017, 2018). Further, anxiety prevalence drastically increased between 2007 to 2017 from 0.9% to 7.1% of the population for young people aged 5-14 years old, and from 2.6% to 9.6% for young people aged 15-24 years (Ministry of Health, 2007, 2017). Due to this high prevalence, and increased magnitude of diagnoses, anxiety disorders were selected as the specific experience of mental illness to be examined in this research.

The literature review considered comorbidities to anxiety, and the impact on outcomes. Not only are anxiety disorders highly prevalent amongst young people in Aotearoa New Zealand, they have also been found to commonly co-occur with comorbid mental illnesses, namely other anxiety and mood disorders (Woodward & Fergusson, 2001). Comorbid mental illnesses have been associated with a more severe form of psychological distress. According to research from Te Rau Hinengaro: The New Zealand Mental Health Survey, over half of the interviewees who had at least one other comorbid diagnosis were classified as having severe mental illness (Scott, 2006). It is likely that students on the RHS roll, who experience severe levels of anxiety, experience distress from a comorbid diagnosis. Anxiety disorders are the main focus of this thesis, but it should be considered that comorbid diagnoses might also impact the success of a young person's reintegration.

The final section of this chapter focussed on research relating to the main aims of this thesis- the facilitators and barriers to reintegration for young people with anxiety disorders attending RHS. Due to the unique nature of the RHS' there is currently no research specifically on this topic; however, there is a large volume of research regarding predictors of treatment outcomes for young people with anxiety disorders in clinical settings. Predictors of treatment outcomes for young people with anxiety disorders in clinical mental health settings were examined, with inferences made to the potential barriers and facilitators to reintegration for young people with anxiety disorders attending RHS.

The predictors discussed in this section were: type of anxiety disorder, comorbid disorders, parental involvement, and parental characteristics. Emerging theories posit that social anxiety disorder is associated with poorer treatment outcomes, and generalised anxiety disorder is associated with more successful treatment outcomes (Compton et al., 2014; Ginsburg et al., 2011; Hudson et al., 2015; Kennedy et al., 2018; Kerns et al., 2013; Kodal et al., 2018; Waters et al., 2018). Research has tentatively found that comorbid depression, ADHD, and social anxiety disorder predict poorer treatment outcomes for young

people with a primary anxiety disorder diagnosis, than those with no comorbid diagnoses (Halldorsdottir et al., 2015; Halldorsdottir & Ollendick, 2016; Hudson, Keers, et al., 2015; Hudson, Rapee, et al., 2015; Kennedy et al., 2018; Kerns et al., 2013; Lundkvist-Houndoumadi et al., 2014; Rapee et al., 2013; Wergeland et al., 2016).

Multiple studies have found that there is no significant difference between ICBT and PCBT in regards to treatment outcomes; this indicates that parental involvement in treatment for young people with anxiety disorders is not predictive of better treatment outcomes than ICBT (Bodden, Dirksen, et al., 2008; Hudson et al., 2014; Jongerden & Bögels, 2015; Kendall et al., 2008; Marin, 2010; Schneider et al., 2013; Simon et al., 2011; Spence et al., 2000; Waters et al., 2009). It has been argued that research should instead focus on parental characteristics that are said to be involved in the etiology of anxiety disorders (Breinholst et al., 2012).

There are two main contributing parental characteristics that have been highlighted across the literature: parental psychopathology and parenting behaviours. Research has generally found mixed results regarding the association between parental psychopathology and treatment outcomes, with some studies suggesting that parental psychopathology predicted poorer treatment outcomes (Berman et al., 2000; Bodden, Dirksen, et al., 2008; Cobham et al., 1998, 2010; Kendall et al., 2008), and others finding no effect when either the young person's father (Crawford & Manassis, 2011; Legerstee et al., 2008; Victor et al., 2007), or mother (Crawford & Manassis, 2011; Liber et al., 2008; Rapee, 2000; Victor et al., 2007) had a form of psychopathology. There is limited research on parenting behaviours and other characteristics; however, certain parenting styles such as anxious rearing and overinvolvement have been associated with poorer treatment outcomes (Creswell et al., 2008; Festen et al., 2013; Liber et al., 2008).

2.5 Purpose of the Study

The unique nature of the RHS' means that there is currently little research on reintegration for young people, let alone research regarding the reintegration of young people with anxiety disorders. Therefore, the current research attempts to fill this gap and provide insights into the facilitators and barriers to reintegration for young people with anxiety disorders attending RHS. The present study will hopefully lay the foundations for improving services, best practice guidelines, and reintegration for young people with anxiety disorders attending RHS. School drop out has been associated with a number of aversive outcomes such as social isolation, academic under achievement, and decreased life satisfaction, which is why it is vital that young people remain engaged in schooling (Swan & Kendall, 2016; Van Ameringen et al., 2003; Wood, 2007). The main research objectives in this study are:

1. To explore the barriers facilitators to reintegrating young people with anxiety disorders into regular schools, tertiary education, or other vocational pathways.
2. To explore RHS teachers experiences of working with young people with anxiety disorders, and determine whether RHS teachers would find further training useful in working with these young people in order to improve reintegration.

Chapter 3: Methodology

3.1 Introduction to Methodology

This chapter discusses the methodology and method of data collection of the current research. It begins by broadly defining qualitative research and then discusses the epistemological assumptions used in this research. Data collection is then discussed, which involves a description of the participants, procedure, and interview type. Following this is a discussion of ethical considerations and how trustworthiness can be assessed in qualitative research. The chapter concludes by discussing Thematic Analysis, the method of data analysis that was used in this research.

3.2 Qualitative Research

Qualitative research is a research paradigm that aims to gain an understanding of peoples' values, beliefs, and experiences about a certain phenomenon, within the natural environment of those people and phenomenon (Braun & Clarke, 2013). According to Schneider (2013), qualitative research has the potential to raise awareness around issues that need further attention and potential interventions. Qualitative research is based on a number of ontological and epistemological assumptions. It values subjectivity and posits that there are multiple realities that people experience in a variety of different ways (Braun & Clarke, 2013). It also argues that knowledge, or data, is co-constructed between the participant and the researcher, and can only be understood within the context it was created in. Because knowledge is co-constructed, researchers must be aware of the effects that their values and biases may have on the data, during both collection and analysis (Braun & Clarke, 2013; Creswell & Poth, 2018).

There are many different interpretive styles in qualitative research that serve different purposes, and aim to understand different aspects of human experience. The current research was exploratory and the data was understood

within a realist/essentialist epistemology. The epistemological assumptions of realism/essentialism will be discussed later in this chapter.

3.3 Data Collection

3.3.1 Preliminary Consultation

Preliminary consultation was conducted with: the principals of the three RHS', an assistant principal of a RHS and a senior teacher from an RHS. This consultation took place to ensure that the research aims were appropriate, targeted areas of need, and were relevant and useful to the RHS'. After an in depth conversation with these key stakeholders, the interview schedule was created and was approved by the Principals. In order to protect the confidentiality of the individual RHS', it was requested that the schools be researched as one whole school rather than three distinct schools. In accordance with this, anything that identified which school the participant belonged to was omitted and replaced with '[Location]' during transcription.

3.3.2 Participants

All of the RHS teachers in Aotearoa New Zealand were sent an invitation, via email, to participate in the research, from the Principal of their school. This email contained written approval from the RHS Principals for their teachers to be involved with the research, an information sheet, and a consent form. The information sheet provided details about the aims of the study, what participation would entail, and what their rights were if they chose to participate. Participants were given my email address and phone number to contact me if they wished to participate. The research invitation was sent on the 7th of July 2019; however, only one teacher responded to the initial invitation. This was potentially because the invitation was sent during the first week of school holidays, when many of the teachers were not at work; thus, the invitation might have been missed. A second invitation was sent on the 26th of July 2019, which received 10 responses by the 9th of August 2019.

Thus, there was an initial response of 11 teachers; however, one teacher felt their experiences with young people with anxiety was too limited, and another teacher was unavailable for an interview until later in the year. Consequently, a total of nine teachers participated in the study. The participants were all women and there were at least two participants from each of the three RHS' (Northern, Central, and Southern). I had aimed to conduct between 8 and 10 interviews, as Braun and Clarke (2019) state that this is a desirable number of interviews for Masters level research using Thematic Analysis . Hence, nine interviews were ideal in order to gather enough information for analysis, with the aim of achieving data saturation.

3.3.3 Procedure

Once the participants contacted me expressing their willingness to participate in the study, an interview time and mode was established. The interviews took place from the 2nd of August until the 15th of August 2019 and lasted 30-60 minutes. Two of the interviews took place face-to-face at RHS locations, and seven took place via the video conferencing software called Zoom, in a location convenient and comfortable for the participant. All of the interviews were done in private, to maintain confidentiality, with no interruptions. Teachers were sent a reminder about their interview 24 hours prior to its commencement.

Semi-structured interviews were used for this research. The interviews were designed and carried out using the five phases recommended by Robson (2011). The five phases involve 1) introduction and recap of the research aims, 2) warm up by starting with easy questions, 3) questions regarding the main topic, 4) cool off by asking another easier question, and 5) close by thanking the participants.

It is important that interviewees felt comfortable and had a sense of connectedness prior to commencing the interview (Alsaawi, 2014). Whanaungatanga, the process of making connections with one another, is a key process in Māori culture- the indigenous culture of Aotearoa New Zealand

(Durie, 2001). Though ethnicity was not ascertained, this was an important process for anyone who identified as Māori (Durie, 2001). Whanaungatanga took place upon meeting the teacher, either in person or when the video chat started. This was a way of making both the teachers and myself more comfortable, connected, and relaxed prior to commencing the interview. After this process I reminded the teachers of their rights, went through their consent form again, and checked if they had any questions. I then confirmed that the teacher was ready for the voice recorder to be turned on, and for the interview to begin.

In accordance with Robson (2011), after whanaungatanga the participants were asked some 'warm up' questions about what their role as an RHS teacher entailed. The interview then moved on to the main aims of the research and asked teachers about what they believed the facilitators and barriers to reintegration were for young people with anxiety disorders attending RHS. The 'cool off' question asked teachers whether they felt there was any specific training needed for RHS teachers relating to young people with anxiety disorders. After this, teachers were asked if there was anything else they would like to add that hadn't been touched on. The full interview schedule is provided in Appendix A. Once the interview was finished, the voice recorder was turned off and some informal conversation concluded the interview process.

Interviews were voice recorded using an Olympus Digital Voice Recorder for transcription purposes. Once transcription was completed, the audio files were permanently deleted. The participants were all given the opportunity to review and edit their transcript before it was used for analysis. Five teachers chose to review their transcripts, and one of those teachers provided some modifications, which took the form of additional clarifications. The interview transcriptions generated 151 pages for analysis, averaging 17 pages per interview. The interviews were transcribed verbatim, and included laughter, pauses, and words such as 'um', 'yeah', and 'you know'. This style of transcription assisted in maintaining expressions of emotions.

Participants were offered a koha for their participation. The participants who had face-to-face interviews received the koha in an envelope with a thank-you note. Participants who had interviews via Zoom were offered a koha via internet banking; however, all participants declined the offer.

I typed some brief notes immediately after each interview. These notes entailed my overall thoughts of the interview, what I felt went well, and what I felt I could have improved on. This was very important in ensuring that I was being reflexive and improving on my interviewing skills, and also capturing my immediate impressions of the interview content and key points (Braun & Clarke, 2013).

3.3.4 Interviews

Originally the data collection method for this research was going to involve a survey; however, it became clear that this would not gauge the significant level of depth and complexity key stakeholders and I wished to get from this research. Thus, semi-structured interviews were chosen as the most appropriate data collection method for the current research. According to Braun and Clarke (2013) interviews can be defined as a professional conversation, on a pre-determined topic, with a person whose experiences and stories are perceived to be of value.

There are many advantages of using interviews over other data collection methods such as surveys. Most importantly, interviews allow for rich and in-depth data to be collected (Braun & Clarke, 2013; Moser & Korstjens, 2017). They provide researchers with the opportunity to probe for more information, which allows for deeper discussion that might not have occurred in a survey. Interviews also allow more room than a survey for participants to raise issues of importance to them (Braun & Clarke, 2013; Ellis, 2016). Talking with someone face-to face (whether in person or through video chatting) is advantageous in that it allows the researcher to pick up on non-verbal cues such as body language (Ellis, 2016). Body language can be very informative and can help the researcher

ascertain when an interviewee might be holding something back, or there might be an underlying meaning to what they are saying. This can help guide the researcher when they should, or conversely should not, probe for more information (Ellis, 2016). Interviews also allow for researchers to rephrase questions or explain them in a different way if they are not fully understood by the interviewee, which cannot be done in a survey.

3.3.4.1 Semi-Structured Interviews

Interviews can be structured, semi-structured, or unstructured. Semi-structured interviews are the middle ground between structured and unstructured interviews. The questions are pre-planned but the interview is relatively flexible; the participant is encouraged to discuss topics in depth, including those topics that are perceived to be important by the participant that are not necessarily on the interview schedule (Braun & Clarke, 2013). Semi-structured interviews provide the researcher with the opportunity to tailor the interview as needed during the interview, while still adhering to a set of underlying questions that help answer the research questions- which in the case of the current research were quite specific in focus. Semi-structured interviews are appropriate when the researcher has an overview of the topic, but wants to gain more detailed data (Alsaawi, 2014).

Semi-structured interviews were chosen over structured interviews, because structured interviews limit the depth of data that can be gathered due to strict adherence to an interview schedule. This strict format limits the variation of responses from participants. It is suggested that structured interviews are best for those researchers who know exactly what kind of information they want to receive (Alsaawi, 2014). The current research had a specific focus- barriers and facilitators to reintegration for young people with anxiety disorders- but did not have specific responses from participants in mind. Rather, this study aimed to gather any information the participants felt were relevant, thus making structured interviews inappropriate.

Semi-structured interviews were chosen over unstructured interviews as the current research aims had a specific focus- gaining an understanding of some of the barriers and facilitators to reintegration for young people with anxiety disorders. Unstructured interviews are guided by certain themes and topics rather than specific questions (Alsaawi, 2014). Unstructured interviews are generally recommended for explorative research; however, because the topic of this research was quite specific, we felt it better aligned with semi-structured interviews. Using semi-structured (over unstructured) interviews also ensured consistency across the interviews, in that variations of the same questions were discussed in all interviews, with flexibility to move around these depending on each person's experiences. This allowed interviewees to highlight areas they thought were relevant; it is noted, however, that Ellis (2016) cautions that people may still be either consciously or unconsciously guided by the interview questions as they imply a pre-conceived idea about what is relevant to discuss. This can limit true exploratory research and was considered when reporting the results.

3.4 Ethical Considerations

Ethical considerations in this research were guided by Massey University's Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants, and the Code of Ethics for Psychologists working in Aotearoa/New Zealand. The ethical considerations included autonomy, informed consent, confidentiality, manaakitanga, avoidance of harm, and beneficence. These ethical considerations were discussed with key stakeholders from RHS, and my supervisor Dr Kirsty Ross. The research ethics proposal was submitted to peer review and was evaluated to be low risk, by the reviewer and subsequently, the Massey University Human Ethics Committee.

Confidentiality was important in order to protect participants' identities. In line with this, any identifying information about the teachers (such as their name, location, years teaching, and specific teaching role) was replaced with a pseudonym or markers such as '#' and 'City 1'. My supervisor, Dr Kirsty Ross,

and myself were the only people to view these transcripts. Confidentiality was further protected through the use of thematic analysis (TA). In TA, results are not reported based on excerpts from specific participants. Rather, the results are reported as themes that are integrated from accounts across the interviews, with excerpts selected from any of the interviews to demonstrate the theme. This further protected the participants' confidentiality, as the results did not identify experiences or excerpts relating to only one teacher (Braun & Clarke, 2006).

Prior to beginning the interview, participants were reminded of their rights. Participants had indicated on their consent form that they consented to the interview being voice recorded; however, prior to the commencement of the interview they were asked again if they were still happy for this to happen. The participants were informed that the voice recording would be deleted after transcription, that the transcription would remove any identifying information, and that they could have access to their transcription to review and edit if they wished to do so. None of the participants declined to answer any of the questions, requested the voice recorder be turned off, or requested to finish the interview early. The transcriptions and consent forms were stored on a password-protected computer, in accordance with Massey University's Code of Ethical Conduct.

3.5 Trustworthiness in Qualitative Research

As with all research, it is important that qualitative research is trustworthy. Historically the trustworthiness of research was evaluated based on its reliability, validity, objectivity, and generalisability (Tracy, 2010). Though these measures of trustworthiness fit well within quantitative research, they do not fit within qualitative research, as this type of research does not aim to generate data that is generalisable. Qualitative research instead has its own language and set of tools for establishing trustworthiness (Tracy, 2010). There are a variety of different qualitative research methods, and thus a variety of different trustworthiness models and criteria have been established (Krefting, 1991).

According to Korstjens and Moser (2018) the most well known and widely used set of criteria/strategies for determining and establishing trustworthiness in qualitative research is that of Lincoln and Guba (1985). These criteria/strategies are credibility, transferability, dependability, and confirmability. The following bullet points demonstrate how Lincoln and Guba's (1985) strategies were used in the current research in an attempt to conduct research that is trustworthy.

- Credibility
    - Use of whanaungatanga to build rapport with participants in an attempt to minimise the Hawthorne effect.
    - Taking notes throughout the research process on my own thoughts and areas of interest in order to remain aware of my own biases.
    - The whole data set was analysed, including data extracts that did not appear to fit within any of the emerging themes.
    - Relevant literature and direct quotes from the interview transcripts were used to support my interpretations of the data.
    - The interview transcripts have been stored securely and can be provided to an independent auditor if requested.

- Transferability
    - The aim of this project is to provide insights into a very specific population, the RHS' in Aotearoa New Zealand. Thus, for this research, transferability relates to whether the experiences of the participants are representative of all RHS teachers.
    - There were at least two teachers from each of the three RHS, which ensured that all three of the RHS' schools were represented.
    - Information regarding the RHS context has been provided in detail in the introduction section of this report, which allows others to assess how transferable the current research findings are to their own settings.

- Dependability
    - A thorough description of data collection and analysis methods have been provided so that another researcher could repeat this study within the RHS context.
    - A code-recode procedure was completed. This involved coding the data and then revisiting and re-coding the data two weeks later. This process helped to highlight the strongest codes in the data.
    - All interviews were conducted based on the same semi-structured interview schedule.
    - All interviews were transcribed verbatim by one person- myself.

- Confirmability
    - Direct quotes from transcripts, from which I based my interpretations, have been provided throughout the results section so that others can make their own interpretations based on the data.
    - Final themes were checked back to each individual transcript.
    - I engaged in reflexivity throughout the analysis in order to remain aware of my influence on the data.

All qualitative research is seen as subjective and thus, the results produced in the current research will in some way reflect my own subjectivities. According to Braun and Clarke (2013), subjectivity does not pose a threat to the trustworthiness of the study as long as the researcher appropriately engages in reflexivity. Reflexivity refers to the researcher's acknowledgement and critical self-awareness of their own biases, preconceptions, values, and mannerisms (Braun & Clarke, 2013; Korstjens & Moser, 2018). Researchers must be aware of these personal factors in order to draw conclusions about the effects they have on the collection, analysis, and interpretation of data. Researchers need to also be aware of the role their personal factors have in the co-construction of knowledge and data with their participants. For example, my relationship with the participants could have influenced their responses, depending on how they

viewed me- as a professional peer, an outsider, or an academic (Korstjens & Moser, 2018).

There are multiple ways that a researcher can practice reflexivity. I kept a field journal where I documented my own thoughts and perceptions throughout the writing of this research. This helped me to remain consciously aware throughout the whole research process of how my subjectivity had an influence on the research.

3.6 Thematic Analysis

Thematic analysis (TA; Braun & Clark, 2006) is an approach for identifying and analysing themes across a dataset. TA was chosen as the most appropriate method of analysis for this research for two main reasons, as discussed in Braun and Clark (2006, 2013). First, TA is especially useful when researchers want to provide an overarching picture of an issue that is under-researched. Second, TA is a useful approach when doing applied research, as it is relatively simple to understand. The current research aims to provide guidelines to the RHS, interested health agencies, and potentially the New Zealand Government on how we can better support young people with severe anxiety disorders to remain engaged in education and reintegrate them back into their regular school, or other vocational pathways. Thus, it is important that results can be easily understood and interpreted by different audiences.

The current research was based in a realist/essentialist epistemology, and accordingly focussed on semantic content of the data. This approach assumes that what participants say explicitly is what they mean (Braun & Clarke, 2013). Using a realist/essentialist approach means that the direct experiences and meanings given by the participants were prioritised when analysing and reporting the data (Braun & Clarke, 2013). Focussing on semantic content meant that I did not look underneath what participants had said, but rather focussed on the explicit surface meanings of what the participants said. Thus, an inductive, or bottom-up, approach was used to analyse the data set. This means that the

themes reported in the results were strongly related to direct quotes from the participants. This form of analysis does not aim to fit data into preconceived codes and themes, but rather aims to build and create themes based explicitly on the data (Braun & Clarke, 2006). Inductive analysis requires the researcher to have no pre-conceived notions about how the data might fit into themes; however, researchers cannot entirely remove themselves form their theoretical and epistemological assumptions (Braun & Clarke, 2013).

The TA in this research was conducted according to Braun and Clarke's (2006) six phases of TA, as outlined below:

1. Familiarisation with the data. This step involved the transcription of data and then reading and re-reading the transcripts. After transcription was completed I printed the fully copy transcriptions so I had hard copies to write my initial thoughts and ideas on.
2. Generating initial codes. This step involved highlighting any interesting features in the data set and collating relevant data, or quotes, into codes. I used coloured penicils and pens to highlight interesting aspects across and within transcriptions with written notes of why I felt the aspects were interesting. I then used these aspects to generate codes. I physically generated the codes by typing the data extracts relating to each code into it's own Microsoft Word document on my laptop. I went and re-coded the data two weeks after the initial coding which helped to highlight the strongest codes in the dataset.
3. Searching for themes. This step involved collating codes into relevant themes. I looked at each code and copied and pasted codes into new documents with other codes that had shared similarities, until I had clear and distinct themes.
4. Reviewing the themes. This step involved checking that each theme was distinct, and that the themes worked with both the codes and the entire data set. I checked my themes back to each transcript to ensure that the story I was telling is the same one that my participants had told me. I also removed some themes here that I felt fit better as part of other themes.

5. Defining and naming the themes. This step involved the ongoing refinement of themes and the generation of names for each theme. This step was when I started to have a clearer understanding of the overarching picture of my data and how I wanted to structure my results section.
6. Producing the report. This step involved selecting strong examples from the data to support any claims. It also involved relating the analysis back to the research questions and literature review.

3.7 Conclusion

This chapter discussed the methodology, epistemological assumptions, method of data collection, and method of data analysis that was used in the current research. The following chapters provide an analysis of my interpretations of the RHS teachers' reports.

Chapter 4: Analysis- Barriers and Facilitators to Reintegration

4.1 Introduction to Analysis

The aims of this research were to explore the barriers and facilitators to reintegrating young people with anxiety disorders into regular schools, tertiary education, or other vocational pathways. The research also aimed to explore RHS teachers' experiences of working with young people with anxiety disorders, and determine what needs RHS teachers identified they have when working with these young people (such as further training), in order to improve reintegration. In line with these aims, the analysis has been split into two chapters. The current chapter provides an analysis of my interpretations of the teachers' reports on the barriers and facilitators to reintegration for young people with anxiety disorders. The following chapter discusses RHS teachers' experiences of working with these young people, and any additional needs they felt they might have, particularly around training specific to anxiety disorders.

Bronfenbrenner's Ecological Systems Theory has been used as an organisational framework for the themes identified in this analysis. This model posits that young people should be understood as existing within multiple environments, or ecological systems, that inevitably interact to influence the young person's life (Bronfenbrenner, 1979). The ecological systems within this model are the microsystem (environments the young person has direct interaction with), mesosystem (interactions between microsystems), exosystem (environments the young person is not directly involved in but which nonetheless have an effect on their life), and macrosystem (cultural values, customs, and laws within the society that the young person lives in) (Bronfenbrenner, 1979). Each theme and subtheme identified can be understood as a part of ecological systems in a young person's life.

The themes and subthemes discussed in this chapter are as follows:

4.2 Whānau/ Family Factors in Reintegration

4.2.1 Importance of Whānau Support

4.2 Whānau/Family Factors in Reintegration

This theme and subthemes deal with whānau/family factors in reintegration for young people with anxiety disorders. The whānau/family environment is a key microsystem within a young person's life (Bronfenbrenner, 1979). This theme highlights the need for more financial and therapeutic support for families who have a young person with an anxiety disorder attending RHS. Teachers reported multiple aspects related to students' families that they feel contribute to the success of their students' reintegration; accordingly, this theme has been split into subthemes. These subthemes are: importance of whānau support, whānau characteristics, whānau socioeconomic status, and pressure to achieve.

4.2.1 Importance of Whānau Support

This subtheme deals with the importance of the students' whānau in successful reintegration for young people with anxiety disorders. The teachers discussed that working with a young person with an anxiety disorder also meant working with their family.

> *"Not many young people just develop anxiety just because they've developed anxiety, you know? It kind of sits within the family system somehow. So from my perspective, I think when we are working with a student, we're working with the family."*
>
> ~
>
> *So for anxiety... It can often be a family approach that needs to be the focus."*

The teachers' reports of the importance of a 'family approach' is reflective of their understanding of the relevance of the whānau in the causes and maintenance of anxiety, and therefore, also the solutions to managing it (Bodden, Bögels, et al., 2008; Ginsburg et al., 2004).

Teachers talked about how family support is vital in reintegrating students, and in a way that is able to be maintained.

> *"And I think what we're needing to see is the parents standing up to provide those roles, because we've got to look at something that's sustainable."*
>
> ~
>
> *"But most of the time, we're relying on parents to put the structures in place so that you can teach the kids. When we're transitioning them to school, and we want them to go to school everyday, then we need these wonderful parents who will do that."*
>
> ~
>
> *"Because for us to succeed we need support from families."*

In order to create a reintegration plan that is sustainable, teachers understood that the whānau needs to have the capabilities to support their young person to return to school. They felt it is important that these capabilities are ascertained when devising these plans, so they can be enhanced and maintained over a period of time, and subsequently support a successful reintegration.

The literature on family support in regular schools endorses the teachers' reports in the current research. Studies have found that family support positively predicts student engagement in school (Chen et al., 2019; Estell & Perdue, 2013; Gutiérrez et al., 2017; Ramos-Díaz et al., 2016; Roksa & Kinsley, 2019; Virtanen et al., 2014; Wang & Eccles, 2012). According to Simons-Morton and Rusan (2009), young people who perceived higher levels of support from their parents were more likely to take an interest and actively participate in school, and less likely to be truant from school (Simons-Morton & Rusan, 2009; Virtanen et al., 2014). Though none of these studies were specific to young people with anxiety disorders, they demonstrate that family support is an important factor in school engagement.

4.2.2 Whānau Characteristics

This subtheme explores RHS teachers' accounts of some of the whānau characteristics of young people attending RHS, and how these characteristics were perceived by the teachers to impact reintegration. It highlights the family microsystem, the mesosystem (between families and RHS, and families and mental health services), and the macrosystem of young people with anxiety disorders attending RHS.

Teachers talked about how student engagement in RHS sessions and subsequent reintegration can be dependent on the student's family dynamics or characteristics. This encompassed the relationship the young person had with their parent(s), but also the relationships between the parents, and within the wider family system. The importance of modelling from parents and other siblings was noted, as well as ensuring that families understood that when teachers considered these factors, this was done in an attempt to understand contributing factors, rather than attribute blame. The point was made that the teachers have much less contact with the student than their family and therefore, the influence of the family needs to be considered.

> *"It depends who the family is, it depends what sort of relationship they have with their child, it depends what the background is in the home, it depends whether it's a family where mum and dad are together, or mum and mum, whoever, or whether it's a split family, it depends whether there's addiction going on within the family. There's so many variables with it."*
>
> ~
>
> *"The other thing is maybe the family dynamic. So it's not blaming the family. You've got a student that's just not turning up... We can help them understand that and help them see that they're part of the solution as well."*
>
> ~
>
> *"You know, like, it's pretty systemic, in some of them. So when you've got a house full of older brothers and sisters that aren't getting out and going [to school], um then it does create an issue."*
>
> ~
>
> *"If the dynamics maybe in a family are broken down... There might be stuff going*

on in the family background that is causing them a lot of unrest. So they are sort of hard to teach in that way in that a lot of the times I find you don't get good backing from home. So students with anxiety, I think a lot of the time they might be... There's lot going on in the background that doesn't make it easy to move ahead quickly with them academically because we only see them two sessions a week."

It has been proposed that certain family characteristics influence whether a family choose to be, or are capable of being, involved in the young person's treatment, and in the case of the current research, their attendance and reintegration journey at RHS (Breinholst et al., 2012; Carnes et al., 2019; Meyer et al., 2018). The above quotes suggest that teachers in the current study also feel that certain whānau dynamics and characteristics can make reintegration more challenging. The three main characteristics that the RHS teachers' discussed pertained specifically to parenting behaviours that are discussed as follows: under-involvement, over-involvement, and parenting style.

4.2.2.1 Under-involvement

Teachers talked about how it can be challenging to successfully reintegrate students when their families have low levels of involvement with their child and their reintegration journey. This was seen to reflect both barriers to reintegration and potentially a contributing factor for the emotional distress the students were experiencing. The low level of involvement was also discussed as being reflective of parents' levels of wellbeing, which points to parents and the wider family as being additional 'clients' to consider in the RHS service.

"There still are families that aren't fully engaged. But that's also kind of a part of what the issues are for our young people."

~

"There are the parents who, I wouldn't say don't care, but the parents who don't have the energy, or whatever the reason is, to have interest for what's going on. And then you have students who are just kind of left in a 'nothing'. Then you come up with a plan for them going back to school, which they find a bit difficult, and they need somebody at home in the morning to say 'Come on, just get up. Get your breakfast. Get going'. And then that person is lying in bed or doing something

different, and it's tricky."

~

"And it might be things like the family aren't getting them to their appointments with [Mental Health Service] often enough, or the family aren't going to their appointments. And then that in turn is having an impact on their ability to work with us, or they are not turning up to us regularly."

~

"There are some families that we would have amazing relationships with but then still don't get a lot of traction. And some will say all the right things in the meetings but the ability to be able to apply that when they leave the meeting, and in reality and real life... It's more around the family's availability, like you can get really busy parents who are not kind of emotionally there."

~

"And so a lot of them, we'll set them homework, but we don't get that buy in from home."

The teachers highlighted a number of reasons they believe whānau are under-involved in their young person's reintegration such as: lack of energy, difficulties in child-parent relationships, lack of engagement with services, and emotional and physical availability of parents. The teachers' perceptions point to a complex array of possibilities as to why families are under-involved in their young person's reintegration, some of which point to difficulties individually for parents, some between the parent and child, some between the parent and school system, and some bigger societal issues – in line with Bronfenbrenner's Ecological Systems Theory.

Thus, it appears that whānau under-involvement can be understood to be a result of dysfunction in multiple ecological systems in a young person's life, all of which pertain to the family microsystem. Naturally, difficulties within the family microsystem need to be resolved in order for the whānau to fully support their young person; this may also alleviate dysfunction in other ecological systems in the young person's life, many of which the whānau are involved in.

Teachers demonstrated an understanding about the theories around anxiety as being maintained/enabled through the family system and thus, the importance of alleviating difficulties within the family in order to decrease anxiety symptoms and increase whānau support. Teachers highlighted the importance of family therapy for young people with anxiety disorders as it supports the parents to step into a 'coaching' role instead of an enabling role. This was talked about as requiring parents to be able to "hold" their child's emotions, manage their own emotions, and for the child to see their parent as a strong support, rather than someone unable to contain and support them.

> "*The way to treat anxiety is exposure to the thing that they are anxious about. So that's why it's often family work that needs to happen because families can get sort of very caught up in that this is an illness. And yes, there might be a significant anxiety disorder, but the way to treat it is to learn to manage that. So its kind of that graded exposure kind of work that we would do."*
>
> ~
>
> *"But for Mum to be able to hold the emotions her daughter experiences when she's trying to get into school... Mum can't do that, Mum has her own mental health things as well. So Mum needs a lot of wraparound support. So what we've identified out of that is the role of family therapy in there, and some input in the mornings at home, just to help with that kind of coaching. So that one it is Mum's skill base, and Mum's own mental health needs, and kind of the patterns that have formed over time, and the young person's worry about Mum."*
>
> ~
>
> *"And at times Strengthening Families we might get because it's often the systems around the young person that may require the support."*

Teachers' reports in the current study point to them having a sophisticated understanding of the theories of anxiety origins and maintenance and consequently, an understanding of the need for whānau involvement in both therapy and the student's RHS journey. This involvement was argued to play an important role in successful reintegration for young people with anxiety disorders, but required addressing barriers for parents (individually, in terms of their own mental wellbeing; interpersonally, in terms of parental dynamics as

well as the relationship parents have with their child; and between parents and support services, such as mental health and attendance services agencies).

Anxiety disorders are understood to have both a heritable and environmental component, and thus, it has been argued that family therapy is an essential part of treatment for young people with anxiety disorders (Bodden, Dirksen, et al., 2008; Brendel & Maynard, 2014; Taboas et al., 2015). Family involvement has been argued to result in better generalisation of skills learnt in treatment to the daily routine of the family and affected young person (Brendel & Maynard, 2014; Taboas et al., 2015).

However, family involvement in therapy has not been found to improve treatment outcomes in clinical settings using CBT (Bodden, Dirksen, et al., 2008; Hudson et al., 2014; Jongerden & Bögels, 2015; Kendall et al., 2008; Marin, 2010; Schneider et al., 2013; Simon et al., 2011; Spence et al., 2000; Waters et al., 2009). Rather it has been proposed that certain family characteristics may be predictive of treatment success (Breinholst et al., 2012; Carnes et al., 2019; Meyer et al., 2018). In the current study, it appears that these characteristics are parental mental wellbeing, the parent-child relationship, and the parents' relationship with mental health and attendance services.

4.2.2.2 Over-involvement

While teachers reported that low whānau involvement negatively impacted reintegration, teachers also talked about how it can be challenging to successfully reintegrate students when their families are over-involved, with parents becoming another factor to manage in the reintegration process. Just as under-involvement was understood to indicate difficulties parents may have been experiencing (at an individual, interpersonal or systems level), so too was over-involvement seen to potentially point to a way of coping with personal and wider challenges.

> *"So that's definitely a big one. We have some parents that are very strongly engaged with their children who just constantly want to be right- especially with*

the older ones- want to be right on top with it. [They] want to know exactly what's going on. And I find that as a hindrance often."

~

*"All families are different. Some can be too supportive *laughs*, or demanding as any teacher in any class will say."*

~

"I like to give the students the feeling that they're in control and if I constantly have to double check with the parent, to tell the parent, it becomes a very difficult relationship."

~

"And from what I'm seeing a lot of that is a separation from the main caregiver. And it's a two-way thing. It's actually really, really hard for that caregiver to not be here with their child… But I'm really aware that often those anxious students look to their parents all the time before they'll answer a question."

Over-involvement has been found to be more common in families with a young person with an anxiety disorder; it can be both a predictor and a consequence of having a child with an anxiety disorder in the family (Cooklin et al., 2013; Hudson et al., 2009; Hughes et al., 2008; Laurin et al., 2015; Martinez Besteiro & Julian Quintanilla, 2017; Skendi et al., 2013; Spokas & Heimberg, 2009; Thompson-Hollands et al., 2014; Yap & Jorm, 2015). Dysfunctional parenting practices, such as over-involvement, maintain the young person's anxiety disorder by preventing them from building resilience and learning how to cope with their anxiety independently (Davila et al., 2019). Over-involvement reinforces a sense of lack of control and discourages autonomy, which are both associated with the maintenance of anxiety disorders (McLeod et al., 2011; Wei & Kendall, 2014). Parents naturally want to prevent their children from experiencing distress; teachers understood that by sheltering and protecting their child from their anxiety, parents believed they were helping and supporting the child. However, teachers in this study experienced these behaviours as perpetuating difficulties for their students - and themselves.

4.2.2.3 Parenting Style

Teachers talked about how the young person's parents' ability to manage and parent their child impacts the success of reintegration. Teachers explained that parents can find it challenging to manage not only their child who is experiencing severe anxiety, but also their own emotional responses to their child's distress. The teachers' reports demonstrate challenges at a sociocultural level of parents' perceived and actual abilities to effectively take on the role of a parent and put in place reasonable boundaries and consequences. Teachers talked about parents as having a key role in not reinforcing a 'sick role' by facilitating avoidance, inadvertently sending a message that the young person was at risk in an unsafe world.

> *"The family are finding it so hard to hold this and hold the emotion that their daughter experiences. And it's around their parental approach of being able to work together as parents and say 'We want to hold this and say the same message'. Rather than cave in and say 'Gosh you really are very unwell', reinforcing the un-wellness and that the world's a scary place kind of thing."*
>
> ~
>
> *"And when the parents try to put some controls on [them], they get tantrums and hissy fits, all that kind of stuff. And so often kids will be gaming, or on social media late at night. And then they say 'I can't get to sleep, and so I go on my phone'. And I understand that that's actually a really hard thing these days."*

Teachers further discussed how some parents seem to struggle with enforcing parental control and appropriate boundaries, which again at times pointed to sociocultural challenges parents have to manage (such as gaming). This was spoken about as representing parental problems, rather than mental health issues.

> *"Where it's students choosing not to [attend health school], and the parents unable to kind of enforce that or put in, y'know, parental kind of... You know they're up all night or they're running off to their girlfriends and they are not at home. The parents don't know where they are. This is actually a parental thing that's kind of beyond mental health."*
>
> ~

"Because parents allow the kids to [not turn up], and that's not always because they don't care, but also sometimes because they miss the parenting skills to push them there."

~

"Lots of our parents here seem to be good at saying 'Yep we will do that at home'. But then homework will come back and it hasn't been done or 'Oh I forgot', or they've been up gaming all night and only got a few hours sleep. So it's totally variable. The expectations of parents, or lack of, at home, depends how much buy in you get from them."

~

"You know, I'm a parent, I know we all try and cover for our kids. But when you're in a meeting, and you know that the student... You've set the student work, and they haven't done it. And it's not the health side of things. It's because they've been up [at night] or they've been sleeping in, or whatever. Or the parent that phones in and says that the student can't come because they're not feeling well."

Though the teachers did not identify a specific parenting style, their accounts encompass the notion of 'permissive parenting', and point to the pitfalls of this in the reintegration process for young people with anxiety disorders, as well as more generally. Permissive parenting is a parenting style that was first proposed by Baumrind (1966). This parenting style involves high levels of affection and warmth, but low levels of parental control and boundaries (Baumrind, 1966). Permissive parents are generally caring and loving, but they provide limited guidelines and rules and thus, sometimes appear as more of a friend than a parental figure.

Permissive parenting has been found across multiple studies to be directly or indirectly associated with higher levels of anxiety symptoms (Adubale, 2017; Ijaz & Mahmood, 2009; Tabatabaeirad & Balootbangan, 2017; Timpano et al., 2015; Yousaf, 2015). According to Adubale (2017), higher levels of permissive parenting were directly related to higher levels of anxiety symptoms. Conversely, higher levels of authoritative parenting, as characterized by a balance between high demands, emotional responsiveness, and recognition of the child's need for autonomy, were associated with lower reported levels of

anxiety symptoms.

Thus, research points to parenting style appearing to be involved in both the development and maintenance of anxiety disorder symptomology; this, in turn, impacts the young persons' ability to work through their anxiety and reintegrate into regular school

4.2.3 Whānau Socioeconomic Status

Teachers discussed that socioeconomic status (SES) can make utilising and engaging with both RHS and regular school challenging for some students and their whānau. They talked about this being difficult for a number of reasons, which again, cross over multiple systems in Bronfenbrenner's model. Teachers talked about how students from lower SES families generally experience more challenges as a part of their daily life. According to the teachers' reports, these challenges include a lack of security of living and access to resources, which in turn exacerbates the experience of anxiety for young people with anxiety disorders attending RHS. Teachers also highlighted the bi-directional nature of anxiety on the young person and their whānau. They talked about the impact of part-time schooling on the practical functioning of the family (financially), with parents having to give up work in order to support their child, which then contributes to the young person's anxiety. This shifted the focus from what was happening within the family, to what was happening more socially, that impacted on the family, and subsequently the young person.

> "*Then again, once we get to know some of these kids, they have been dealing with some heavy stuff. They've got dysfunctional families or sometimes they are just really poor families, and stuff keeps going wrong, so life just gets really hard for them. And so kids like that, the anxiety has probably started with just general life stuff. And then school becomes the kind of fallout…"*
>
> ~
>
> *"So depending on how far along the spectrum of their anxiety, and depending on their parents, part time school is a real challenge, huge challenge, for parents. So parents have to give up work in order to help these students. So that can be a real issue."*

~

"So I've got students who've got Wi Fi, but no computer at home. So they do [their schoolwork] on their phones, and they've got crappy old secondhand phones. So they don't do much. She's typing on her phone in Google Docs. Or she's writing on a piece of paper, and then when she sees me, I type it up into a Google Doc. You know, that's the socioeconomic stuff. That's not mental health, but it doesn't make mental health any easier."

~

"A student has changed schools, because one school has become too much. Funding uniforms and resources can be huge. I've got one student being yelled at for not having a mathex calculator, but her parents can't afford one. That's increasing her anxiety."

~

"So socioeconomic status and security of living. I've got students who've got the Independent Youth Allowance. It is so complicating. Because you know, home's not a safe place for them. So they've left home."

Teachers highlighted that school is often the 'fallout' of living in a world of socioeconomic disadvantage. Young people from lower SES families are subjected to frequent adverse experiences that in turn negatively impact on their mental health. Further, teachers highlighted that parents, and in some cases students who are living independently, do not always have the resources to be able to support their children, both financially and emotionally. Thus, reasons outside of the whānau result in school not always being a priority for these young people and their families, which may not always be understood by regular schools, and the whānau may still be held responsible.

Maslow's Hierarchy of Needs posits that people are motivated by attaining 'needs', which are understood as being on a hierarchy from basic survival needs (such as physiological and safety), to higher needs, such as belongingness, esteem, and self-fulfilment (Maslow, 1943). According to this model, an individual must fulfil the most basic needs before being motivated by higher needs. For young people and their families living in socioeconomic disadvantage, their behaviour is motivated by the most basic needs such as

access to food, shelter, security and warmth, and freedom from fear. Thus, they are less able to focus on motivation for 'higher' needs such as gaining knowledge, affiliating with peers, and achieving personal growth.

Research supports the teachers' claims that lower socioeconomic status can make school more challenging for whānau. According to Lee and Burkam (2002), lower socioeconomic status limits educational opportunities indirectly, as family members manage seemingly endless challenges such as working multiple jobs and managing public-welfare systems. Greene and Anyon (2010) argue that this understandably decreases the family's expectations around, and enthusiasm towards, schooling. Research has found a relationship between socioeconomic status and academic success, with lower SES associated with lower grades, and higher SES associated with higher grades (Bowen et al., 2011; Lee & Burkam, 2002).

Socioeconomic status has also been found to have a relationship with parental involvement in clinical therapy and schooling. Pereira et al., (2016) found that socioeconomic status significantly correlated with parental involvement in therapy for anxiety disorders, with more socioeconomically disadvantaged families less involved in treatment than more socioeconomically advantaged families. In school settings, Alameda-Lawson and Lawson (2018) found that low income (associated with low socioeconomic status) was associated with lower parental involvement in their child's schooling.

Many teachers gave access to transportation as a specific example of a way in which SES affects a student's ability to fully engage in the RHS 'world'. This leaves the RHS needing to make decisions around resources, such as assisting young people get to their school. While there are government systems and funds ostensibly in place to assist with this, teachers claimed that (in reality), this fell to them to organise and facilitate.

> *"I'll tell you the other thing that is an issue though, is how far away they live from the school, and their transport to and from school."*
>
> ~

"So some of the parents have to work. So I might have to pick them up, or we apply for taxi funding to get them picked up and taken into our world, or taken to school on a part time basis. So we have to go through that. So transporting for part time special education is huge."

~

"We can get transport funding but if you still don't have a car… Officially, I can apply for a taxi, but that never gets approved. I've never had one approved. So then we have a bit of an issue."

~

" The enablers with the whānau is when the parents are engaged, and that's a bit of social economics as well because when students have gone back to school, and if they're gone part time, if they don't live in walking distance to school, that means that they have to be picked up and dropped off. And that is sometimes a bit difficult, of course. So when the parents have transport and are able to transport students, that makes it all easier."

~

"You have to have a parent who is prepared to take that time out to be that person that is going to drop you off."

These examples demonstrate an added complexity of engaging in RHS for lower SES families; transportation is only one of many financial and socioeconomic barriers faced by these families.

4.2.4 Pressure to Achieve

This subtheme deals with the pressure placed on some students from their families to do well at school. It highlights the importance of limiting the academic pressure young people experience from their families, in order to prevent further feelings of anxiousness in students who already experience high levels of anxiety.

The teachers talked about how some students are under a lot of pressure to do well at school, which impacts on their sense of self, but also their ability to complete and submit their work.

"I don't know the proper word for this one, but anxiety towards achieving well in life. When they feel like 'I need to get all excellence, and I need to get everything

and I cannot achieve it. I need to be perfect before I hand it in. Otherwise, I'm not good enough'."

~

"I have two students who are highly, highly intelligent… Both of them are panicking about not passing NCEA."

This pressure to do well at school has been found to have a number of adverse consequences for young people; such as sadness, hopelessness, exhaustion, chronic stress, and suicidality (Conner & Pope, 2013; Villeneuve et al., 2019). In addition to the adverse health consequences, Conner and Pope (2013) found that two thirds of high school students who reported being under pressure to do well at school also reported that they rarely enjoy or value their school work. Villeneuve et al. (2019) refer to this phenomenon as 'doing school', where students are extrinsically motivated by getting good grades and how well they perform, rather than being intrinsically motivated by how much they learn.

The teachers perceived this pressure as coming predominantly from the students' families. This left them needing to balance and challenge these ideas, so that both parents and young people did not feel an overwhelming sense of needing to achieve high grades, or that their lives would be catastrophically (and permanently) affected.

"Yeah, and this doesn't depict the rest of your life. I think that can actually be a barrier. I think the pressure for our young people… They think the decisions they make now determine the rest of their life, and the parents can get so caught up in that. So I think sometimes challenging some of those beliefs is really helpful."

~

"His parents are all agitated about NCEA level [#] 'He needs to get NCEA level [#]'. No all he needs to do is engage in learning."

~

"Or I try to tell the student that it's okay, they don't need to get excellences everywhere and go to university in a straight line, they can go to university when they're older. Then the parents say 'No, no, no, you have to get NCEA level three, you have to go to university'. Those are difficult things."

Academic pressure from a young person's parents has been described as occurring at both a behavioural and emotional level (Putwain et al., 2010; Raufelder et al., 2015). At the behavioural level, parents push their child to spend extensive and intensive time on school work; at the emotional level, parents set high and sometimes unrealistic expectations for their child (Putwain et al., 2010; Raufelder et al., 2015). Academic pressure from a young person's parents has been associated with heightened levels of anxiety (Quach et al., 2015; Ringeisen & Raufelder, 2015; Ritchwood et al., 2015; Saleh et al., 2019) and lower levels of academic self-confidence (Gherasim & Butnaru, 2012; Putwain et al., 2010; Ringeisen & Raufelder, 2015).

Thus, it can be inferred from the teachers accounts that for young people with pre-existing anxiety disorders, such as those attending RHS, academic pressure from parents might further heighten the young person's level of anxiety, and in turn act as a barrier to successful reintegration for that young person.

4.3 Inclusivity and Attitudes Towards Mental Health in Regular Schools

This theme deals with the teachers' discussion around the lack of inclusivity and social connectedness in schools for young people with anxiety disorders. It also looks at how societal attitudes regarding mental health can influence the attitudes of regular schools and thus, successful reintegration into regular schools. Therefore, this theme involves both the young person's microsystem (school) and macrosystem. This theme highlights the importance of inclusion for all young people in schools in Aotearoa New Zealand. It also highlights the need for a shift in attitudes towards mental illness at a societal level.

Teachers discussed that (generally) their students with anxiety disorders have not, and do not, enjoy school, nor do they want to return to their regular school. This suggests that motivation for returning to school does not always sit with the young person.

"That love for school, or that desire to do well, at school has never been there."

~

"Do they really want to be back [at school]? Or is it just everyone else saying they need to be?"

Teachers proposed that one of the reasons that their students with anxiety disorders do not enjoy school is that school has not been a place where they have 'fit' in the past.

"Some of our students, they've been on the outer cusp at school for a long time."

~

"[We have] lots of kids who don't fit the mold of school."

~

"In terms of reintegrating our young people into school, it can be really challenging because school might not always be the place that's safe and best for their education."

This lack of 'fit' that teachers reported their students with anxiety disorders experience has also been found in other studies researching school connectedness. School connectedness is the extent to which one feels respected, accepted, valued, and included within their social school environment (Goodenow, 1993). It is also the extent to which a young person feels that their school genuinely cares for their wellbeing (Resnick et al., 1997).

Shochet, Smith, Furlong, and Homel (2011) found a correlation between lack of school connectedness and more severe anxiety symptoms. They also found that lack of school connectedness predicted anxiety symptoms in girls one year after initial assessment. Further, Foster et al. (2017) found that young people who experienced higher levels of school connectedness were less likely to experience social anxiety, depressive symptoms, and suicidal ideation. Research demonstrates that this relationship between school connectedness and anxiety disorders is bidirectional (Foster et al., 2017; Shochet et al., 2011). Thus, school connectedness is likely an important variable in decreasing anxiety symptoms, preventing the onset of future anxiety symptoms, reducing disengagement with

regular school, and improving reintegration for young people with anxiety disorders attending RHS.

Closely related to school not being a place where young people with anxiety disorders 'fit', teachers also talked about how students with anxiety disorders are often socially isolated and isolate themselves from their peers and friends. This means that teachers spoke of needing to tread carefully around reintegration, to prevent the young person being faced with their lack of social connection upon return to school.

> *"There's a number of students we get who don't have friends, or who have been at home for so long under the duvet that their friends have forgotten them. It's really hard too because you don't want to also set them up to be confronted with the fact they've got no friends [when trying to reintegrate them into their regular school]."*
>
> ~
>
> *"Often young people, and certainly with anxiety, are isolated, and trying to help them with that is hard."*

This social isolation only further decreases the likeliness of successful reintegration into the students' regular schools.

> *"If they haven't got the social connections... All the usual things that happen are just magnified."*

Studies have shown that young people with anxiety disorders frequently experience impairment in social functioning. This impairment ranges from lower quality and quantity of peer relationships, to complete peer rejection and isolation (de Lijster et al., 2018; Kreuze et al., 2018; Pedersen et al., 2007; Swan & Kendall, 2016). Students who have difficulties with peers have been argued to be more likely to have academic difficulties, skip school, and drop out (Seligman & Gahr, 2012; Swan & Kendall, 2016), which is similar to the reports from teachers in the current study.

According to Crawford and Manassis (2011), the presence of an anxiety disorder is predictive of peer victimisation. They also found that poor social skills were predictive of lower friendship quality, which in turn also put young people at risk of peer victimisation. Further, friendship quality has been found to

be predictive of better treatment outcomes for young people with anxiety disorders. Baker and Hudson (2013) found that in a clinical treatment setting, young people with higher perceived levels of friendship quality were more likely to be free of their initial anxiety disorder at post treatment, and more likely to be free from any anxiety disorder at a six month follow up, than those who had lower perceived levels of friendship quality. This demonstrates the protective nature of positive peer relationships. It also demonstrates the importance of anti-bullying initiatives in schools so that peer victimisation does not exacerbate anxiety symptoms and subsequent school removal. In regard to reintegration, teachers understood that it was important that the students feel safe, connected, and a sense of belongingness at their school, so that it is a place that they actually want to return to.

Teachers in this study argued that regular schools should be providing an environment that is inclusive for all young people in Aotearoa New Zealand. Some of the teachers gave examples of how regular schools have supported reintegration for some of their students:

> *"I've got some amazing schools, who will say, 'Hey, let's get you to that club at lunchtime.' 'Let's find someone who will sit with you.'"*
>
> ~
>
> *"We've got two schools with really amazing Student Support Centres, and they are not linked with special needs. And they have a lead SENCO [Special Education Needs Coordinator] person who's working in there as well. They work really closely with our students. Our students have that safe place to go, that safe place to work in and out of. So they can just go to the Student Support Centre, and go home. Or they can go to the Student Support Centre and then go out to morning tea, and then come back in, and the teacher aide will walk them to their class. Or the teacher aide will bring the work from their class over to them in the Student Support Centre at their school. So the schools that have that, that works really, really well."*

Teachers highlighted that whether schools will provide these services authentically, depends on the schools' attitudes towards mental health. Teachers mentioned that some schools have a strong focus on mental health:

"Like the deans, for instance, who are our main port of contact, are all very focused [on mental health]... You know, if a student gets highlighted to them, they actually do something about that student. And whether it's a referral to us, or whether it's a referral on to [Mental Health Services], you seem to get the feeling that they're a lot more in touch emotionally. The whole hauora concept is definitely more so at [SCHOOL NAME]."

However, teachers also mentioned that other schools do not have a strong focus on mental health and holistic wellbeing:

"I would say they'd rather not deal with things."

~

"Schools sometimes don't want you there if you've openly self-harmed... They have to be long sleeves all year round because schools don't want that openly advertised. There's a lot of that sort of stuff as well...."

~

"That concept of well being or hauora, you know your four pillars of well being, all that sort of stuff... [They say] 'Oh yeah we do it'... But they don't really do it."

When describing the schools that do not have a strong focus on mental health, the teachers gave examples of some attitudes apparent at those schools, which promote stigmatisation, and minimise the severity of mental health. These attitudes create a school culture that is discriminatory to those who experience mental illness. At times, that school culture mirrored what is often spoken about as being the "Kiwi [NZ] culture" of "she'll be right", and an expectation of being 'tough' and dealing with things without seeking additional support (Braun, 2008).

"And I think 'she'll be right' is probably part of it. Especially with mental health."

~

"You know, like, 'Suck it up, buttercup. You'll be okay. You don't need anything extra. You don't have a broken leg. You don't have a cancer on your lungs. You are okay'".

~

"It's maybe the school culture. [SCHOOL NAME] have a song, and it's all about being tough and strong. And it's like well... really? Why do we have to be like that? Why do boys have to be like that? Some boys might choose to, but there's lots of boys out there that just... Yeah."

These phrases are commonplace within the macrosystem of young people living in Aotearoa New Zealand society and lead to a societal stigmatisation of mental illness. Stigma is a serious issue faced by those who experience mental illness and has a multitude of adverse consequences. These adverse consequences are related to anticipated discrimination and include decreased wellbeing and disengagement with important activities such as employment, education, and establishing interpersonal relationships (Hansson et al., 2014; Quinn et al., 2015; Schauman et al., 2019; Yoshimura et al., 2018).

4.4 Support for Regular School Teachers

This theme deals with the importance of regular school teacher support for young people with anxiety disorders reintegrating back into school. It involves the student's microsystem (teachers at regular school), exosystem (regular school teachers' job demands), and macrosystem. This theme highlights the teachers' claims that there needs to be more funding and support for regular school teachers who are working with young people with complex needs, such as anxiety disorders.

RHS teachers stated that most regular school teachers genuinely care about their students and their continued engagement in education. The RHS teachers stated that this (in turn) supports a more successful connection with school, and consequently, smoother reintegration for young people with anxiety disorders.

> *"Most teachers, they'll do whatever they can for your student because they know that if they do that extra bit for your student they'll get the work."*
>
> ~
>
> *"But if you do get a good response from a teacher, and you work with the teacher, then that makes a difference to that students connection with the school, and then it will make a difference to their reintegration."*
>
> ~
>
> *"And I'm like 'Hey, so and so is a bit worried about this'. [And they say] 'Oh, we can sort that out. You can do this, this and this'. Thank you. Good. Problem solved."*

The RHS teachers also highlighted the power that a positive relationship between students and their regular teachers has on the students' education and reintegration. The relationship was even considered to influence the choice of classes students took, rather than the content of the course.

> *"Nine times out of ten, the [students] choose the subject because they like the teacher, and that's a really, really big thing. And it's neat, because it means that the teacher has also made an effort to connect with that student. So that's really, really positive and really powerful."*

However, teachers also mentioned that some regular school teachers (as with some school systems/cultures) are less accommodating than others when it comes to meeting the needs of young people with anxiety disorders.

> *"Yeah... I mean, there's lots of really good teachers. But then there seems to be some teachers who... Yeah... Just don't have that wellness concept."*
>
> ~
>
> *"So we have everything from "Oh, look, we'll keep marking your work until the 30th November. You just hand it in anytime, I'll find a teacher to mark it for you" to "No you must be on site, and you've only got a week extension." You're like, that's not fair."*

Teacher support has been found by research to be strongly related to student wellbeing and mental health (Brandseth et al., 2019). Students with anxiety disorders have been reported to be less likely to develop a comorbid depressive disorder when they had higher levels of teacher support (Arora et al., 2017). Additionally, Conner, Miles, and Pope (2014) found that young people who rated their teacher as having higher levels of support were less likely to develop academic anxiety and other internalising disorders than young people who reported lower levels of teacher support.

Teacher support has also been reported to be important in keeping students with anxiety disorders and other serious health conditions engaged in education. Hopkins, Green, Henry, Edwards, and Wong (2014) conducted a survey on best practice for keeping young people with serious health conditions engaged in education. One factor that young people, and their parents,

highlighted as being important to their continued engagement in education was the actions of supportive teachers. These actions included making special arrangements on a day-to-day basis, providing catch up sessions after extended absences, remaining in frequent contact with the student while absent, and making extensions available when necessary (Hopkins et al., 2014). Moran (2015) proposed other helpful accommodations for re/engaging students in education, specifically for young people with anxiety disorders. These accommodations included encouraging group activities in order to promote positive peer relationships, providing the student with a 'classroom pass' that allows them to leave the class in order to access a 'safe person' or 'safe place' for five to ten minutes while they manage anxiety symptoms, and providing students with alternatives to assessments (Moran, 2015).

In order for regular school teachers in Aotearoa New Zealand to be able to provide these services to students, teachers arguably need to have the time and resources available to them. However, according to the RHS teachers in the current study, this is not the case for regular school teachers in Aotearoa New Zealand. Despite considering that most regular school teachers genuinely care for their students, RHS teachers reported that they feel regular school teachers are overworked and are too busy to be able to fully support their students with anxiety disorders.

> *"Most teachers are just too busy and kind of just don't have the time or the energy to put in that."*
>
> ~
>
> *"Regular schools can be kind of... Not be able to meet the needs of young people going back into their environments. And that's for a number of reasons, mainly funding and teachers. But not teachers attitudes though, I guess it's more teachers ability to work with students with diverse high needs in an already busy and overflowing environment, where they are trying to kind of manage other students."*
>
> ~
>
> *"Some teachers will be really responsive to [having a meeting], and some won't. Y'know, they are busy people. High school teachers are dealing with up to 150 students across different levels, and all of that, so it's a big ask."*
>
> ~

"It's a time thing from teachers, y'know workload stress, and other stuff they have to be involved with, whether it be extracurricular, or just the fact that they are burnt out."

Teacher workload has been reported to have increased in primary, intermediate, and secondary schools. Bridges and Searle (2011) stated that the workload for primary school teachers has increased, with teachers listing meeting special needs as one of the main time increases. A report by the New Zealand Post Primary Teachers Association- Te Wehengarua (PPTA, 2016) also stated that there has been an increase in intermediate and secondary teacher workload. This has involved an increase in both the amount of tasks and the complexities of tasks. One of the main areas that teachers identified as relating to workload pressure was that they do not have enough time to meet all of the existing demands. According to the PPTA (2016), these issues have been identified in previous reports and are intensifying.

4.5 Relationship Between Mental Health Service Workers and RHS Teachers

All nine teachers in the current research reported that they have very good relationships with their students' mental health service workers, whether they are psychologists, psychiatrists, occupational therapists, or case workers. This theme highlights the importance of the mesosystem between the students RHS teachers and mental health service workers. Because the relationship between mental health service workers and RHS teachers was perceived to be so strong and well established, teachers did not talk in depth about the relationship. Nonetheless, this was an important theme to highlight, as this relationship appeared to be an important facilitator in reintegration for young people with anxiety disorders attending RHS.

"We have strong relationships with the case managers, or clinical teams that we're working with, it's really important that they are part of that student's journey."

~

"I think that open communication between us and the mental health team is really positive for the students."

~

"And this model, I think is fantastic, because you have the medical people beside you, guiding you. And If I have any questions... We have a really good relationship, I feel, with them."

Taking this team approach, with disciplines working together, was seen to be crucial. Teachers talked about the relationship with mental health services being one of collaboration and cohesion. This interdisciplinary way of working demonstrates how the RHS teachers and mental health service workers respect each other's expertise.

"*I like to kind of say it's a 'both and together'. So it's kind of like you have your education, and you have your mental health, and you do it together. Bit like a Venn diagram. You want them to carry on doing their work, and they need to be doing their work, and we need to be doing our work with education. And then that bit in the middle is where we both sort of work together, and we support the work they're doing and they support the work we are doing."*

~

"Sometimes we might pick up things that they haven't, because they don't get to see their clients that often. They might see them once a week, or once a fortnight as the student improves. So sometimes they don't have the full picture. And so that's where we work really well as a team."

~

"Often, I will say they cannot begin their work until the student's started to be engaging in school again, because if they are at home avoiding, they're not feeling anxious. They need that work, they need us to be working in that space."

Due to the unique nature of the Aotearoa New Zealand RHS', there is no previous research to compare with the teachers' reports in the current study. The RHS teachers spoke of their efforts and success in forming strong, collaborative relationships with mental health service workers since the establishment of the schools in the year 2000. These relationships at an organisational level facilitated the work done by each professional, which then supported both the family and young person in their return to school.

4.6 Conclusion

This chapter provided an analysis of the themes and subthemes regarding the facilitators and barriers to reintegration for young people with anxiety disorders attending RHS. There are a number of factors the teachers highlighted as impacting students' reintegration, each of which can be understood within Bronfenbrenner's Ecological Systems Theory. These factors include the students' whānau (microsystem), the relationship between the students' whānau, regular school, RHS, and mental health services (mesosystem), support for regular school teachers (exosystem), and attitudes towards mental health in regular schools (macrosystem). According to the teachers' reports, each of these factors contributes to barriers that students with anxiety disorders experience when attending RHS and trying to reintegrate.

The following chapter provides an analysis of the RHS teachers' reports on their experiences of working with young people with anxiety disorders attending RHS.

Chapter 5: Analysis- RHS Teachers' Experiences of Working with Young People with Anxiety Disorders

5.1 Introduction

The previous chapter has highlighted the interrelationships between different levels and systems in an ecological model of young people's schooling when they experience significant anxiety. The role of the RHS teacher in mediating between these systems, working with not only the young person and their family, but also the other professionals involved, positions them as pivotal in the successful reintegration of a young person to regular school. The RHS teachers' perceptions of their capabilities to perform these roles (and what facilitates their successful implementation with regards to what support is needed) is the focus of this chapter. This chapter provides an analysis of the teachers' reports on their experiences of working with young people with anxiety disorders, and the subsequent impact on the teachers' wellbeing. It also explores the RHS teachers' perceptions of the importance of training regarding anxiety disorders for RHS teachers. This chapter relates primarily to the young persons' exosystem. The themes discussed in this chapter are as follows:

5.2 Professional Wellbeing- A Complexity for RHS Teachers Working with Young People with Anxiety Disorders

5.3 Importance of Training Regarding Anxiety Disorders for RHS Teachers

5.2 Professional Wellbeing – A Complexity for RHS Teachers Working With Young People With Anxiety Disorders

This theme deals with the teachers' report of the need for more awareness and training around wellbeing for RHS teachers working with young people with anxiety disorders. Participants pointed out that over the years, the RHS roll has changed in nature and is now largely made up of students diagnosed with mental illness. All the teachers reported that anxiety is the most common diagnosis amongst their students. One of the teachers stated:

"We used to get quite low level anxiety students, but as [Hospital Mental Health services criteria] got more complicated, so has our world."

This increase in students with anxiety disorders on the RHS roll, due to changes in other services, has led to RHS teachers perceiving they have added complexity to their 'world', which has required them to become more than a teacher. This has meant changes in the way they are positioned with the young person, as well as their families.

"It's not just straight teaching. I mean you do get that in mainstream [schools], but you don't have that opportunity to sit one-on-one with a kid. So you do get that time to sit and chat and you build up a different relationship than you would if you were in a mainstream class"

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"And it can become quite blurred where you almost become part of the family because of the role that you're doing. Because you are entering into people's homes, you are entering into their lives.

The primary goal of the RHS' is to assist students in meeting their educational needs while they are unable to attend school full time. However, for those students with anxiety disorders, and other mental illnesses, the RHS teachers perceived that they serve as part of the therapy team, providing an avenue/context for enacting the therapy goals.

"You are part of the treatment, because you're working with all of those avoidance kind of behaviors"

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"I think that we give the mental health team a context for the work that they are doing. Rather than sort of an hour therapy session and there you go. We've given them the context."

Teachers stated that their role in the student's treatment might involve managing gradual exposure in the RHS environment, helping students manage their anxiety in a classroom or home environment, and encouraging coping strategies, as set out by the Mental Health Key Workers. While teachers are not mental health professionals, in their role as an RHS teacher, they talked about

how they are exposed to a variety of tasks and challenges that are similar to those working as mental health professionals.

> *"And as much as we're not [mental health] caseworkers or anything... With lots of our students you are doing a lot of talking about where they're at, and where their family is at. 'Have you thought about this?' or 'Could you try that if you're in that situation?'."*

These challenges are not necessarily specific to anxiety disorders, but rather other factors in the young persons' life that may have contributed to the development and maintenance of the anxiety disorder, including serious traumas.

> *"Sometimes some of the things that students have been through have been quite horrendous. Whether it be because of a rape, or a parent… Just too many things happening in their world at once."*

Alongside being actively involved in aspects of the student's treatment plan, teachers are also talked about being the 'listening ear' for students, akin to a counsellor.

> *"We try as much as we can to just do the teaching. But sometimes we have to just be that listening ear."*
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> *"It's not just being the teacher, but being the listener and the encourager and stuff. And it's such a complex thing that their anxiety can be about so many different things."*

As a part of being the 'listening ear', teachers have to deal with difficult and challenging situations (such as students self-harming) on a day-to-day basis. This expands their daily tasks into such areas as medical advice and care; as one teacher said:

> "*[A student will say] 'I think my stitches are infected', and I will check them and say 'No, no they are fine. Ok we'll carry on'. We get so used to seeing self-harm and things like that."*

Teachers' accounts point to a normalisation of serious mental health issues and behaviours that they are having to manage in their daily work tasks. This experience is not specific to RHS teachers, but rather a phenomenon that

many regular school teachers are experiencing, potentially due to the growing awareness and acceptance of mental illnesses within today's society. Similarly to teachers' accounts in the current study, teachers in a study by Shelemy, Harvey, and Waite (2019) described their role as a 'balancing act' between trying to be a teacher who provides support to students, while not becoming a therapist. Newlove-Delgado, Moore, Ukoumunne, Stein, and Ford (2015) found that two thirds of students with a mental illness reported that they had confided in their teacher about their mental health. Further, teachers have been found to be the most common first point of contact when a parent was concerned about their child's mental health (Ford et al., 2008). Thus, the experience of becoming a mentor, or 'listening ear', is not one that is unique to RHS teachers, but it is potentially more prevalent, as a majority, rather than a minority, of their students experience mental illness, and at a level severe enough that they need specialist support.

These additional tasks and responsibilities come with their own toll on teachers. Teachers' accounts place them in roles akin to a counsellor; however, there are limited structures and systems in place to support their wellbeing. Teachers in the current study stated that (for the most part) they learnt how to look after themselves on the job, and over time learnt how to manage and cope. However, this was something that they had to learn to manage through experience, rather than having systems and supports embedded in training to do this.

> *"When I first started the job, it did impact how I felt- my well being and thoughts around that. But I think that now I'm able to step away from some of the things I see in the environment… The longer you work within this kind of service, the more you're able to step back from what's happening."*
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> *"Initially it was really challenging. It was hard to leave that behind and not get really worried. [It] can be distressing. However, with experience I learnt strategies to help me manage that better."*

Despite being able to better manage their emotions, teachers still reported that at times their job can be very overwhelming. While talking on this

topic, one teacher had tears in their eyes and explained that it can become very overwhelming just thinking and talking about what some of their students have gone through. Other teachers stated:

> *"I think there are times when my role and my job can be a bit overwhelming. In fact, our staff this term are feeling a bit that way. It's just all the things that those kids have gone through... And it's to do with hearing their stories and learning that they're dealing with some really [tough issues]. I find it heartbreaking that kids are going through these things. Sometimes it's just a bit overwhelming"*
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> *"The stress that [your students] feel can really make you feel down too"*

Research has found that regular school teachers report feeling uncomfortable, drained, and helpless when dealing with student's mental health issues (Andrews et al., 2014; Kidger et al., 2010; Shelemy et al., 2019). Due to the nature of their job, RHS teachers are faced with these emotions on a more regular basis as they are working with young people who have been identified (by mental health services) as experiencing mental illnesses so severe that they are unable to attend regular school. Thus, it is likely that RHS teachers are dealing with their students' mental health issues on a more regular basis than mainstream school teachers. This potentially puts RHS teachers at heightened risk of their job negatively impacting on their wellbeing. Systemic support for wellbeing may ameliorate such negative effects, and this can include regular supervision.

Supervision serves many purposes, one of which is maintaining one's professional wellbeing. The RHS' recognise the importance of supervision and it is available for RHS teachers. However, it was only mentioned by a third of participants as a way that teachers could manage and cope. Teachers instead said that they talked to their colleagues and Deputy Principal/ Principal when they had issues that were concerning them.

> *"My colleagues and I have a really good relationship. So we talk about stuff all the time…. We can often deal with stuff as it comes up and support each other."*

Some teachers also mentioned that their students' Mental Health Key Workers have offered to make time for RHS teachers if they ever need to talk something

through.

> *"One of the psychologists that we work with locally has always said that if we feel the need to talk about something, then we can talk to her, she'll make the time for us."*

Though supervision is available, teachers potentially do not realise they have access to it, or may be unaware of its importance in maintaining their professional wellbeing. When one's wellbeing is compromised, potentially, so too is their ability to do their job at optimum capacity (Barnett et al., 2007). Supervision has been recognised as a tool for those working in mental health services to maintain their professional wellbeing, and therefore, maximum capacity in the work they do (Barnett et al., 2007). RHS teachers are dealing with issues that have the potential to have a significant impact on their wellbeing. While they are not mental health professionals, they spoke of taking on an emotional load that appears similar to that of those working as a mental health professional.

5.3 Importance of Training Regarding Anxiety Disorders for RHS Teachers

This theme highlights the importance of training regarding anxiety disorders for RHS teachers. All teachers in the current research reported that professional development (PD) is an important aspect of their job and is something that all three RHS' are very supportive of. The frequency of school-wide PD varies between schools, but it usually happens once or twice a year. Teachers reported that individual PD can take on many different forms, including trainings at staff meetings, online courses, workshops, and seminars. The teachers stated that the RHS' are always happy to fund individual PD, and prioritise this over meeting a particular budget limit.

> *"I know that the maximum of that money gets spent on professional development, but I've never heard no. Whenever I've asked for something they've never said no."*
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> *"We get funding each year, but [my current PD] goes over the funding, but that's fine with them as well. So I just approached them with what I was interested with,*

and they were like, 'yes it's all good.'"

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"And also we are really lucky in that if something say came to [our location] that seemed really interesting and pertinent for us, say regarding anxiety, then we'd definitely be given the go-ahead to go."

The teachers felt that specific training regarding working with young people with anxiety disorders would be beneficial for all RHS teachers, as opposed to relying on learning through experience. They spoke of the changing nature of the challenges their students come with, which has impacted on their teaching. The need to have skills in not only education, but also managing these additional mental health challenges, highlights that this type of work is specialised and unique within education.

"I definitely think that teachers need training for working with kids and anxiety disorders. If I look at myself, from what I did eight years ago, to what I do now it's a huge difference."

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I definitely think training is required because I think students with anxiety are tricky, it's hard to work with these students. Sometimes when you think 'Why are you thinking like that?', or 'How can you think like that?', or 'Why does that make you anxious?'"

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We do need to have that awareness of being able to help someone's situation or being able to say the right sort of thing. We don't give advice in particular, but if they start opening up and chatting, being able to at least give them some ideas like 'Have you tried slowing your breath?', 'Have you tried breathing deep down in your stomach?' So all those things that might help them in situations."

~

At the Health School, we are not specialty teachers. And I think that's a very good thing. But that doesn't mean that there shouldn't be at least some specialised schooling in the students that we work with."

The need for more teacher training around general mental health has been highlighted in other studies. Moon, Williford, and Mendenhall (2017) found that 85% of teacher surveyed reported that they needed further training in

mental health. Close to half of the teachers in another study felt that they did not have adequate skills or knowledge to support their students with mental health issues (Reinke et al., 2011). Further, teachers in a study by Rothì, Leavey and Best (2008) stated that mental health training is a 'need' and should be mandatory for all teachers due to the changing dynamics of the teaching role. Teachers in this study reported sympathising with other teachers who had not received training. Thus, the reports from teachers in the current study are not unique to RHS teachers but likely more prevalent for them as they work one-on-one on a day-to-day basis with young people with anxiety disorders.

Teachers had different personal preferences about what form of training they would like to receive; however, a few teachers stated that it would be good to receive formal recognition for the training they partake in, and their resultant skillset.

> *"I think a format where it's recognised would be really good. I think if you're asking people who are busy in a profession to take on time to train, that would be kind of motivating for them. So for me it would have been cool if that counted toward a postgrad, or something, that would be encouraging."*
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> *You don't come out with a qualification. I can't get a diploma of being a regional health school teacher."*

Alternatively, teachers suggested that this training should be provided as a part of regular teacher training qualifications.

> *"From my perspective I think there's a real missing piece in teacher education around working with students with mental health, and it needs to kind of be bought into teacher education programmes."*
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> *"And ideally, I think that they would have as well…The general teacher knows so little about so many difficult psychological difficulties, but also learning disorders, so little about them. I wish we would learn a lot more. It just makes it easier for students and better understanding.*

5.4 Conclusion

This chapter provided an analysis of the themes and subthemes regarding RHS teachers' experiences of working with young people with anxiety disorders, in relation to previous research. It also discussed RHS teachers' views on the importance of training regarding anxiety disorders for RHS teachers.

The following chapter will provide a discussion of the research findings and their implications, the limitations of the study, and future directions from this research.

Chapter 6: Discussion

6.1 Introduction

This chapter will discuss the research findings in regards to the two main research objectives: to explore the barriers and facilitators to reintegrating young people with anxiety disorders into regular schools, tertiary education, or other vocational pathways; and to explore RHS teachers' experiences of working with young people with anxiety disorders, and their support needs (including further training) around working with these young people. It will then go on to discuss the strengths and limitations of the current study, before concluding with some recommendations for potential future directions from this research.

6.2 Research Objective 1- Barriers and Facilitators to Reintegration

This research objective aimed to explore RHS teachers' perceptions of the barriers and facilitators to reintegration for young people with anxiety disorders attending RHS. It was hoped that the teachers' perceptions would provide insights into the factors that make reintegration more or less likely to be successful. This would then point to recommendations for improving services and subsequent reintegration for young people with anxiety disorders attending RHS.

Bronfenbrenner's Ecological Systems Theory was used as an organisational framework for presenting the themes identified in this study using thematic analysis. This organisational framework was chosen as it was evident from the teachers' perceptions that there are multiple ecological systems that impact on the success of a young person's reintegration. According to this theory, the microsystem, mesosystem, exosystem, and macrosystem influence the lives of all young people; so it is unsurprising that each of these ecological systems could be identified within the themes of the current analysis as influencing the lives of young people with anxiety disorders.

6.2.1 Whānau/ Family Factors in Reintegration

The whānau is a key part of a young person's microsystem. The teachers' argued that improving aspects and experiences of the family microsystem facilitates reintegration. Teachers talked about multiple aspects relating to the young person's whānau that influence the success of reintegration for young people with anxiety disorders. These include whānau support, whānau characteristics, whānau socioeconomic status, and pressure to achieve.

Whānau Support

Teachers highlighted that whanau support is vital for reintegrating young people into regular school in a way that is sustainable. This is supported by previous research that has found that family support positively predicts student engagement in school (Chen et al., 2019; Estell & Perdue, 2013; Gutiérrez et al., 2017; Ramos-Díaz et al., 2016; Roksa & Kinsley, 2019; Virtanen et al., 2014; Wang & Eccles, 2012). Thus, high levels of family support are a facilitator to reintegration. Teachers expressed that it is important to ascertain the family's capabilities to support their young person when devising reintegration plans, so they can be enhanced and maintained over a period of time, and subsequently support a successful reintegration.

Whānau Characteristics

RHS teachers highlighted three main whānau characteristics they perceive influence successful reintegration for young people with anxiety disorders. These factors all pertained to parenting behaviours and were discussed in the results under three sections: under-involvement, over-involvement, and parenting style.

The teachers' perceived that family involvement (in both clinical family therapy and the RHS) facilitate reintegration. However, when a family becomes too involved it was considered to act as a barrier to successful reintegration. In clinical settings, research has not found support for improved treatment outcomes when the family was involved in the young person's therapy (Bodden,

Dirksen, et al., 2008; Hudson et al., 2014; Jongerden & Bögels, 2015; Kendall et al., 2008; Marin, 2010; Schneider et al., 2013; Simon et al., 2011; Spence et al., 2000; Waters et al., 2009). Rather it has been proposed that certain family characteristics may be predictive of treatment success (Breinholst et al., 2012; Carnes et al., 2019; Meyer et al., 2018). In the current study, it appears that these characteristics are parental mental wellbeing (including an ability to manage both their own emotions and their child's, and their ability to tolerate their child's distress), the parent-child relationship, and the parents' relationship with mental health and attendance services.

Overinvolvement is a significant factor in the maintenance of anxiety disorders and (as was reported by the teachers in the current study) can be a barrier to successful reintegration for young people with anxiety disorders attending RHS. Thus, in order to have more successful reintegration, parents need to be assisted to reduce their involvement to a level that facilitates healthy autonomy and control in their child. Few studies have examined whether parental involvement in clinical treatment settings reduces maladaptive parenting behaviour, and only three studies have specifically examined overinvolvement (Bögels & Siqueland, 2006; Esbjørn et al., 2014; Wood et al., 2009).

The current research on whether parental involvement in treatment settings reduces overinvolvement is both sparse and has inconsistent findings. Bögels and Siqueland (2006) found that both children and their parents reported no perceived difference in parental overinvolvement post-treatment, despite reduction in anxiety symptoms. However, Wood et al., (2009) found that families who engaged in FCBT rather than ICBT were more likely to experience a reduction in intrusive parenting behaviours. Further, according to Esbjørn et al., (2014), when therapy focussed on the parent's behaviours rather than the child, fathers' levels of overinvolvement decreased. Thus, the research on whether parental involvement in therapy reduces parental overinvolvement is relatively ambiguous at this stage and more research is needed in this area in order to draw conclusions about whether family therapy would decrease

overinvolvement in parents of young people with anxiety disorders attending RHS.

Based on the teachers' reports in the current study, healthy levels of family involvement in family therapy and RHS facilitate reintegration; thus, a healthy mesosystem between a young person's family and mental health services, and family and RHS, facilitates reintegration. Therefore, this relationship should be nurtured and strengthened in order to facilitate successful reintegration for young people with anxiety disorders attending RHS.

Though RHS teachers did not specify a parenting style, the characteristics they described as being a barrier to successful reintegration appeared illustrative of permissive parenting. Permissive parenting has been directly and indirectly associated with higher levels of anxiety symptoms (Adubale, 2017; Ijaz & Mahmood, 2009; Tabatabaeirad & Balootbangan, 2017; Timpano et al., 2015; Yousaf, 2015). Teachers talked about how the characteristics of this parenting style made reintegration more challenging with some young people. Therefore, in order to improve reintegration, parents being provided with support and advice on how to use a more constructive parenting style, such as authoritative parenting, may be useful.

Whānau Socioeconomic Status

Teachers also discussed how reintegration was more challenging with young people from families of lower socioeconomic status (SES). Interestingly, lower SES has been found to correlate with lower family involvement in both clinical and school settings (Alameda-Lawson & Lawson, 2018; Pereira et al., 2016). RHS teachers specifically highlighted transportation as a big issue for many families with young people attending school part time. Thus, it appears from the teachers reports that within the macrosystem of young people living in Aotearoa New Zealand, more accessible funding is needed for families who are more socioeconomically disadvantaged, in order for them to be able to fully utilise the services provided by RHS, maintain their child's education, and be

involved in reintegrating their child back into regular schooling. It appears that one specific area of importance that needs attention is access to transportation.

Pressure to Achieve

Teachers talked about how many of their students with anxiety disorders are under pressure to achieve well at school in order to go to university. Previous research has associated academic pressure from a young person's parents with heightened levels of anxiety (Quach et al., 2015; Ringeisen & Raufelder, 2015; Ritchwood et al., 2015; Saleh et al., 2019) and lower levels of academic self-confidence (Gherasim & Butnaru, 2012; Putwain et al., 2010; Ringeisen & Raufelder, 2015). Teachers in this study perceived that academic pressure from a young person's family is a barrier to reintegration, with the role of balancing and challenging the beliefs held by the whānau (around the importance of grades) commonly falling to the RHS teachers. It might be that parents need to be informed of the negative impacts of academic pressure on their child's level of anxiety and subsequent reintegration. It might also be beneficial for parents to be provided with assistance to reduce their own levels of anxiety and catastrophic thinking about their child's future if they do not receive top grades.

6.2.2 Inclusivity and Attitudes Towards Mental Health in Regular Schools

School is a part of a young person's microsystem. Teachers' spoke of many schools in Aotearoa New Zealand lacking inclusivity and social connectedness for young people with anxiety disorders, which they felt were barriers to reintegration. School connectedness has been found to be important in decreasing anxiety, preventing future anxiety, and minimising current anxiety symptoms (Foster et al., 2017; Shochet et al., 2011). Further, students who have difficulties with peers have been argued to be more likely to have academic difficulty, skip school, and drop out (Seligman & Gahr, 2012; Swan & Kendall, 2016). Thus, it is important that schools in Aotearoa New Zealand are places that promote inclusivity and social connectedness for all students, in order to facilitate reintegration.

Teachers in the current study gave examples of how some schools have facilitated reintegration for young people with anxiety disorders. One of the recurring examples was schools with dedicated Student Support Centres and SENCOs. Teachers explained how these centres provide students with a safe space to visit with a staff member who (usually) has the resources to assist them. It might be that in order to improve reintegration of young people with anxiety disorders, regular schools need to be providing a dedicated space for students who have extra needs and require extra support, such as those students with anxiety disorders.

This theme also explored the teachers' perceptions of attitudes towards mental health in regular schools. Attitudes regarding mental health relate to a young person's macrosystem. Teachers' claimed that harmful attitudes around mental illness in the Aotearoa New Zealand macrosystem need to be addressed in order to improve reintegration for young people with anxiety disorders. The 'Like Minds, Like Mine' public awareness programme was established in 1996 in response to the Mason Inquiry into mental health services in Aotearoa New Zealand (Vaughan & Hansen, 2004). One of the recommendations out of this inquiry was that the government funded a programme to combat the stigma that is faced by those who experience mental illness. The programme aims to increase inclusion, and end discrimination and stigma.

Thornicroft, Wyllie, Thornicroft and Mehta (2014) conducted research on a representative sample of mental health service users in Aotearoa New Zealand on discrimination and stigmatisation to assess the effectiveness of the 'Like Minds, Like Mine' programme. Just over half of the participants reported that they felt discrimination had decreased in the past five years; however, 89% of participants still reported that they had experienced negative discrimination in the previous year. Alarmingly, the most common environment in the wider society where participants reported being unfairly treated, due to their mental illness, was in their place of education (Thornicroft et al., 2014). Thus, there is a clear need for more education in schools, and wider society, around mental

illness in order to decrease stigma and harmful attitudes that act as a barrier to reintegration for young people with anxiety disorders attending RHS.

6.2.3 Support for Regular School Teachers

This theme relates to the young person's microsystem, exosystem, and macrosystem. The findings in this research point to support from regular school teachers facilitating reintegration. Previous research has found that teacher support is strongly related to wellbeing and mental health (Brandseth, Håvarstein, Urke, Haug, & Larsen, 2019). Further, it has been found that teacher support is important in keeping young people with anxiety disorders engaged in education (Hopkins et al., 2014; Moran, 2015). However, the RHS teachers reported that they believe regular school teachers are overworked and do not have enough time to provide extra support to young people with anxiety disorders attending RHS. Thus, in order for regular school teachers to be able to provide support to young people with anxiety disorders, they need additional support and resources themselves. This would mean more funding for regular schools, and access to valuable resources such as teacher aides and Student Support Centres, which would in turn facilitate reintegration.

6.2.4 Relationship Between Mental Health Service Workers and RHS Teachers

This theme relates to the mesosystem between the young person's mental health service worker and RHS teacher. Teachers spoke of the relationship between RHS and mental health services as one of collaboration and mutual respect. Due to the unique nature of the Aotearoa New Zealand RHS', there is no previous research to compare with the teachers' reports in the current study. The RHS teachers and mental health service workers have clearly worked hard to form strong relationships since the establishment of the schools in the year 2000. This strong mesosystem has undoubtedly acted as a facilitator in the reintegration of young people with anxiety disorders into their regular schools.

6.3 Research Objective 2- RHS Teachers' Experiences of Working with Young People with Anxiety Disorders

This research objective aimed to explore RHS teachers' experiences of working with young people with anxiety disorders, and explore any additional needs RHS teachers identified for their work – including whether further training would be useful in working with these young people in order to improve reintegration. It was hoped that the teachers' perceptions would provide insights into the experiences and complexities associated with being an RHS teacher working with young people with anxiety disorders.

6.3.1 Professional Wellbeing- A Complexity for RHS Teachers Working with Young People with Anxiety Disorders

Due to the changing nature of the RHS role, RHS teachers appear to have become de-facto mental health workers. For those students with anxiety disorders, and other mental illnesses, the RHS teachers serve as both therapists and facilitators of therapy goals. Teachers reported that they have become a 'listening ear' for many of their students. This experience is not unique to RHS teachers, though likely more prevalent due to the students they work with. The additional tasks and responsibilities that are being placed on RHS teachers have the potential to have a significant impact on their wellbeing, especially considering there are currently limited structures and systems in place to support teacher wellbeing.

Barnett, Baker, Elman, and Schoener (2007) argue that when one's wellbeing is compromised, potentially, so too is their abilty to do their job at optimium capacity. RHS teachers are not mental health professionals; however, they spoke of taking on an emotional load that appears similar to that of those working as a mental health professional. It is therefore logical and imperative that RHS teachers receive training on how to manage their wellbeing when working with young people with anxiety disorders, one of which may be through supervision. Supervision has been recognised as a tool for those working in

mental health services to maintain their professional wellbeing, and therefore, maximum capacity in the work they do (Barnett et al., 2007). As RHS teachers are having to act as de facto mental health professionals, the resources that mental health professionals use (such as supervision) to maintain their wellbeing will also be important for RHS teachers. This has the potential to in turn improve reintegration for young people with anxiety disorders attending RHS.

6.3.2 Importance of Training Regarding Anxiety Disorders for RHS Teachers

The teachers reports of the unique nature of their job highlighted the need for them to have more of an awareness and understanding of mental health issues; due to the changing nature of the RHS rolls, all teachers in the current study reported a higher ratio of mental health to physical health students. This was also reported by teachers in a study by Rothì, Leavey and Best (2008), who stated that mental health training is a 'need' and should be mandatory for all teachers due to the changing dynamics of the teaching role.

According to the RHS teachers in the current research, additional training regarding anxiety disorders is necessary for all RHS teachers. They reported that the RHS' do a very good job of providing training and PD opportunities to their teachers; however, this training could be made more valuable to teachers if they received extrinsic motivation such as a qualification that recognised their efforts and the specialised nature of their role. The unique nature of the job they do, combining both education and mental health services, bolsters the argument they make that they need additional training (and recognition) for the work they do.

6.4 Strengths and Limitations of the Current Research

The purpose of this research was to provide insights into the factors that facilitate successful reintegration for young people with anxiety disorders

attending RHS. Thus, support from the RHS' was imperative to the success and ethical conduct of this research. The research was co-created by, and for, the stakeholders (RHS), which means the results have validity and meaning for them. The current research was also the first of this sort and I believe it has provided valuable insights for the key stakeholders. Based on the results of the current research, the stakeholders will have evidence to support any requests for more support for themselves, regular schools and teachers, and students' whānau in order to improve services for young people with anxiety disorders attending RHS.

Though there are many advantages of using interviews, there are some limitations that were considered during the interviewing and analysis process. Due to the considerable amount of time it takes to conduct interviews, I was limited in how many interviews I could realistically conduct (Braun & Clarke, 2013). Further, it was likely that less participants were willing, or able, to be involved in the research. Thus, the sample size was smaller than it would have been if a survey had been used, which potentially resulted in a lack of breadth or responses (Braun & Clarke, 2013).

Another issue is that the interview data is bound up with the time and situation it was collected in. The same question could elicit a different response, if a different person asked it on a different day, in a different situation (Ellis, 2016). There were certain sociocultural factors, such as students spending too much time gaming at night, that were highlighted in the current research that may not have been highlighted by teachers ten years ago.

Interviews can also inadvertently create a power dynamic, with the interviewer being the seeker of knowledge and 'expert' on the topic. This could have led to the Hawthorne effect, where interviewees respond how they think they are meant to respond (McCambridge et al., 2014). For the current research, it was hoped that the process of whanaungatanga helped to alleviate this power dynamic, paired with reinforcement from myself during the interview that any topic the participant discussed was valuable to the research. Further, it was

hoped that the co-creation of this research with the key stakeholders reduced the power differential.

Braun and Clarke (2006) highlight the importance of acknowledging that our own biases as researchers shape which themes are likely to stand out to us. Thus, instead of stating that themes 'emerged' from the data, as it implies that themes are already implicitly in the data, I acknowledge these are my interpretations. I had some preconceived ideas about what the results might find, due to my immersion in the field through my literature review. Despite engaging in reflexivity and having discussions with my supervisor, it is impossible to remove myself from the research, so it is important to recognise that biases likely still affected the themes that both myself and my supervisor highlighted as being the most important, and how we interpreted these themes.

6.5 Future Research Directions

The current research explored RHS teachers' perceptions of the barriers and facilitators to reintegration for young people with anxiety disorders attending RHS, and the RHS teachers' experiences of working with these young people. Common themes included the need for more support in the students' microsystems- their whānau and regular schools. Therefore, I believe it would be beneficial for future research to explore students, families, and regular school teachers' experiences of reintegration for young people with anxiety disorders. It would also be beneficial to explore the perspectives of young peoples' whānau and regular school teachers in regards to what support they need, in order to support a successful reintegration for their young people with anxiety disorders attending RHS.

6.6 Conclusion

This research has explored the barriers and facilitators to reintegration for young people with anxiety disorders attending RHS, and RHS teachers' experiences of working with these young people. This chapter has given a

summary of the themes identified in data analysis as they relate to the research objectives. It then discussed the strengths and limitations of the current research and concluded with some suggestions for future research directions.

This research posits that improvement and enhancement of all ecological systems in a young person's life is vital in order to improve reintegration for young people with anxiety disorders attending RHS. The findings from this research highlight specific areas within each ecological system that need enhancement in order to improve reintegration, and subsequently improve wellbeing and life satisfaction for young people with anxiety disorders living in Aotearoa New Zealand. This shifts the focus of intervention from a simplistic view of changes needed from a young person managing anxiety and their family/whānau, to a more sophisticated understanding of the complexities and responsibilities of multiple systems involved with a young person, to enhance their successful return to school.

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Appendix A

Interview Schedule

(SQ= Stemming Question)

1. Could you please tell me a bit about your job as a health school teacher and what some of your day to day tasks are?
   SQ: What are your roles and responsibilities?
2. What types of students do you predominantly work with?
   SQ: What is the ratio of students with physical versus mental illness?

We are particularly interested in young people with anxiety disorders.

3. When working with these students, who do you work in collaboration with?
   Eg: Mental Health services/agencies/clinicians, other teachers at RHS, the student's regular school, Te Kura, the student's whanau.
4. What are the particular needs of students with anxiety disorders? Are their needs any different from other students?
   SQ: Is this influenced by comorbid diagnoses or the type of anxiety disorder?
5. What are your thoughts about teaching students with anxiety disorders?
   SQ: Is it more/less challenging than other students? Why?
   SQ: How do you feel when your students are being challenged and they express emotional distress?

We are interested in the facilitators and barriers to reintegration for young people with anxiety disorders. In regards to reintegration:

6. What needs do you believe are being met for young people with anxiety disorders while attending the RHS'?

SQ: How do you find the relationship between yourself/RHS and:

- Mental health services/agencies/clinicians
- Regular schools
- The student
- Te Kura
- The student's whanau (does it depend on certain family characteristics how strong the relationship is?)

7. What needs do you believe are unmet for young people with anxiety disorders while attending the RHS'?

SQ: How do you find the relationship between yourself/RHS and:

- Mental health services/agencies/clinicians
- Regular schools
- The student
- Te Kura
- The student's whanau

8. What are your thoughts about whether any particular training is required for teachers working with young people with anxiety disorders? What about in your particular field of teaching? If yes, what would be most useful for you?
9. Is there anything else you would like to share with me in regards to your experience of teaching students with anxiety disorders?