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Parent Mental Health Literacy Needs in Aotearoa New Zealand

A thesis presented in partial fulfilment of the requirements for the qualification of

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Abstract

The current study is situated within the context of increasing rates of mental distress amongst young people in Aotearoa New Zealand (Fleming et al., 2020; Ministry of Health, 2018; Ngā Pou Arawhenua et al., 2020); challenges with meeting demand for mental health services (Elliott, 2017; Skirrow, 2023); and the global Covid-19 pandemic impacting on both population mental health and service access. This research aimed to explore the mental health literacy needs of parents and caregivers of children aged 5-10 years in Aotearoa New Zealand, and to develop a framework for a podcasting intervention to increase parent mental health literacy.

Albeit drawing on a small number of studies, systematic review evidence suggests low levels of mental health literacy amongst parents of children aged 5-10 years (Johnson et al., 2023). These studies have focused on the recognition of child mental illness without investigating mental health literacy as it relates to promoting positive mental health of a child, an equally important construct when determining overall mental health (Keyes, 2002, 2005).

Reflexive thematic analysis of interviews with 11 practitioners who work with parents and caregivers of primary school aged children established that parents could benefit from further knowledge related to child mental health in a number of areas. These included: general parenting knowledge (such as knowledge of child development and the importance of the parent/caregiver-child relationship and parental wellbeing); understanding of behaviour and emotion; and knowledge pertaining to help-seeking for mental health difficulties. Practitioners perceived a proposed mental health literacy

resource for parents of children of primary school age to be valuable, and considered podcasting to be a feasible mode of communicating knowledge to parents and caregivers.

The findings of the qualitative research are discussed in the context of the relevant literature which informed the development of a framework for a podcasting intervention for parents and caregivers in Aotearoa New Zealand. Feedback from practitioners suggested they perceived the proposed podcast to be a feasible, acceptable and useful resource for parents and caregivers. Further consideration needs to be given to the specific content of some of the proposed episodes and how to develop the intervention further so it is appropriate for Māori and Pasifika families. Learnings from the research process and outcomes, plans for the next phase of the development of the resource, and areas for future research point to the next steps in supporting mental health literacy in parents to further enhance wellbeing in young people.

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¹ Māori for parents.

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Table of Contents

Abstract	i
Acknowledgements	iii
Table of Contents	v
List of Figures	x
List of Tables	xi
Glossary of Māori Words	xii
Chapter One: Introduction	1
<i>Research Context</i>	1
<i>Aims of the Research</i>	6
<i>Thesis Outline</i>	6
Chapter Two: Contextual Approaches to Development and Health	8
<i>Development During Middle Childhood</i>	8
<i>Summary</i>	14
Chapter Three: Defining Mental Health	15
<i>World Health Organisation Definition of Mental Health</i>	15
<i>Dual Continua Model of Mental Health</i>	16
<i>Summary</i>	20
Chapter Four: A Contextual Approach to Determinants of Mental Health	21
<i>Child factors</i>	21
<i>Parental Factors</i>	23

<i>Other Environmental Factors</i>	27
<i>Summary</i>	29
Chapter Five: Mental Health Literacy	30
<i>Defining Mental Health Literacy</i>	30
<i>Child and Adolescent Mental Health Literacy</i>	33
<i>Parent Mental Health Literacy</i>	35
<i>Summary</i>	37
Chapter Six: Mental Health Interventions	39
<i>Mental Health Prevention and Promotion</i>	39
<i>Interventions with Parents</i>	41
<i>Digital Mental Health Interventions</i>	43
<i>Parent Mental Health Literacy Interventions</i>	44
<i>Podcasting to Increase Parental Knowledge</i>	46
<i>Summary</i>	48
Chapter Seven: Rationale for the Present Research	49
<i>Rationale</i>	49
Chapter Eight: Research Methodology	52
<i>Ontological and Epistemological Positioning</i>	52
<i>Social Context of the Research</i>	54
<i>Research Approach</i>	57
<i>Summary</i>	60
Chapter Nine: Phase 1 Method	61

<i>Design</i>	62
<i>Ethical Considerations</i>	62
<i>Participants</i>	63
<i>Interview Guide</i>	69
<i>Procedure</i>	71
<i>Summary</i>	79
Chapter Ten: Results	81
<i>Introduction</i>	81
<i>Theme 1: General Parenting Knowledge</i>	83
<i>Theme 2: Understanding Behaviour and Emotion</i>	92
<i>Theme 3: Help-seeking Efficacy</i>	100
<i>Theme 4: Podcasts may be Effective</i>	109
<i>Theme 5: Podcasts Need to be Acceptable</i>	111
<i>Summary of Themes</i>	116
Chapter Eleven: Discussion	117
<i>Introduction</i>	117
<i>General Parenting Knowledge</i>	118
<i>Understanding Behaviour and Emotion</i>	130
<i>Help-seeking Efficacy</i>	143
<i>Podcasting to Increase Mental Health Literacy</i>	152
<i>Conclusion</i>	161
Chapter Twelve: Practical Implications	163

<i>Approach to Podcast Development</i>	163
<i>Approach to Delivering Podcast Content</i>	164
<i>Content of Podcast Episodes</i>	165
Chapter Thirteen: Development of Podcast Framework	168
<i>Approach to Developing Podcast Framework</i>	168
<i>Podcast Framework</i>	170
<i>Practitioner Consultation</i>	182
<i>Analytic Approach</i>	185
<i>Ethical Considerations</i>	185
<i>Summary</i>	186
Chapter Fourteen: Practitioner Feedback on Podcast Framework	187
<i>Main Findings</i>	187
<i>Summary</i>	193
Chapter Fifteen: Overall Discussion	194
<i>Learning From the Research</i>	194
<i>Limitations and Future Research Considerations</i>	201
<i>Reflections on the Research Process</i>	205
<i>Concluding Comments</i>	208
References	210
Appendix A: Interview Guide	254
Appendix B: Participant Information Sheet	260
Appendix C: Participant Consent Form	263

Appendix D: Practitioner Feedback Questionnaire 264

Appendix E: Participant Information Sheet for Phase 2 271

Appendix F: Research Case Study 274

List of Figures

Figure 1 Visual Depiction of the Meihana Model	13
Figure 2 Overview of Research	57
Figure 3 Thematic Map of Parent Mental Health Literacy Needs	82
Figure 4 Thematic Map of Views of Podcasting.....	83
Figure 5 Process for Developing Podcast Framework	170
Figure 6 Extent to which Participants Agreed Each Topic Could Benefit Child Mental Health	188
Figure 7 Practitioner Perceptions of Proposed Podcast Framework.....	190

List of Tables

Table 1 Participant Information.....	67
Table 2 Structure of the Podcast	171

Glossary of Māori Words

Aotearoa	Māori name for New Zealand (literally, long white cloud)
Hapū	Sub-tribe, political unit in traditional Māori society
Hinengaro	Mind, thought, consciousness, feelings
Iwi katoa	Support services and systems
Karakia	Prayer, incantation
Kanohi ki te kanohi	Face to face
Kaumātua	Elderly man, grandfather, of status within the whānau
Kaupapa Māori	Māori approach
Koha	Gift, donation
Kuia	Elderly woman, grandmother, female elder
Mahi	Work
Mātua	Parents
Mauri ora	Essence of life
Pākehā	New Zealander of European descent
Pūrakau	Spiritual story about the natural and human worlds
Rāhui	Temporary prohibition of access as a means of social control
Rangatahi	Teenager, young person, young people
Taiao	Physical environment

Tamariki	Child, children
Taniwha	Water spirit or power creature, often considered a guardian
Te ao Māori	Māori worldview
Tikanga	Customs, traditions
Tinana	The body (physical)
Waiata	Song, singing
Wairua	Spirit, soul of a person
Whakapapa	Family and ancestral history, geneology
Whakatauki	Māori proverb
Whakawhanaungatanga	Establishing connections and building relationships
Whānau	Family, extended family
Whenua	Land

Chapter One: Introduction

This thesis was conceptualised and developed during a time when the Covid-19 pandemic shone a light not only on physical health but also the importance of maintaining mental health. On a personal level I was considering the intersection of my roles as a parent, researcher and a developing clinical psychologist. In this chapter I describe the social and personal contexts within which the design and conduct of this research took place. I then detail the aims of the research and outline the structure of the thesis.

Research Context

Social Context

In 2020 Aotearoa² New Zealand's mental health system was described as being "in crisis", with the country's youth suicide rate being ranked fourth highest out of 38 countries in the Organisation for Economic Co-operation and Development (OECD) and European Union (EU) countries (Anderson, 2020; Roy & Jong, 2020; UNICEF Innocenti, 2020). The deterioration in youth mental health over the past decade is not unique to Aotearoa New Zealand. Internationally, the World Health Organisation (WHO) reported a 13 per cent increase in mental and substance use disorders in the 10 years to 2017, and suicide was the second largest cause of death amongst young people (World Health Organisation, 2023). Prevalence estimates suggested 13% of children and adolescents worldwide experienced mental illness, most commonly in the form of anxiety, conduct, attention-deficit/hyperactivity and depressive disorders (Polanczyk et al., 2015). Furthermore,

² Māori name for New Zealand (literally, long white cloud).

systematic review evidence shows that the Covid-19 pandemic and pandemics in general precipitate a decline in child and adolescent mental health (Meherali et al., 2021).

Research in Aotearoa New Zealand suggests the mental health of our rangatahi³ is declining. The most recent findings from the Youth2000 study (Fleming et al., 2020) which surveyed 7891 secondary school aged students across northern regions of New Zealand, showed fewer students reported “good” emotional wellbeing in 2019 (69%) than in 2012 (76%). Alongside a decline in mental wellbeing, prevalence of mental illness amongst adolescents is also increasing. In the 2019 survey, a total of 23% of young people reported experiencing clinically significant depressive symptoms, compared with 13% in the 2012 survey. Inequities exist between rangatahi Māori, Pasifika youth, and Pākehā/European young people in the prevalence of depressive symptoms. For example: 28% of rangatahi Māori, 25% of Pasifika youth and 20% of Pākehā youth reported symptoms of depression. The inequities in youth mental health in Aotearoa are also seen in youth suicide, with suicide rates amongst rangatahi Māori being approximately three times higher than amongst non-Māori (Ngā Pou Arawhenua et al., 2020).

Researchers investigating the prevalence of mental health difficulties in tamariki⁴ in Aotearoa New Zealand - based on parent/caregiver responses to the Strengths and Difficulties Questionnaire (Goodman, 1997) - suggest there is a need for early intervention. According to this research, 8% of children between 3 and 14 years of age have a *concerning* score (i.e., experience *high levels* of difficulty) in relation to peer relationships, emotional, hyperactivity and/or conduct behaviours (Ministry of Health, 2018). When analysed by

³ Māori for teenager, young person, young people. Unless otherwise specified, in this thesis rangatahi refers to young people of secondary school age.

⁴ Māori for child or children. Unless otherwise specified, in this thesis tamariki refers to children of primary school age.

ethnicity, large disparities between Māori and non-Māori were revealed. Māori tamariki were found to be 1.8 times more likely to have a *concerning* score in one or more of these areas than non-Māori children, and 2.1 times more likely to have a *concerning* score for conduct problems. There are disparities also between Pasifika and non-Pasifika children, particularly in relation to peer difficulties. Pasifika children were found to experience *concerning* levels of peer difficulties at a rate of 1.7 times more than non-Pasifika children. The levels of distress New Zealand tamariki and rangatahi are experiencing is also reflected in reports of large numbers of referrals to child and adolescent mental health services and private clinics, and increasing concerns about access to services (Elliott, 2017; Health and Disability Commissioner, 2018; Skirrow, 2023).

Experiencing mental illness during childhood has a negative impact on a child's functioning and quality of life. Celebre et al. (2021) found that depressive symptoms in children and adolescents in Canada were associated with lower autonomy, overall health and social functioning. However, mental illness not only has a negative impact on a young person's functioning at the time; it also increases the likelihood of mental illness and other poor social outcomes in adulthood (Copeland et al., 2015; Shalev et al., 2014). Indeed the prevalence of child mental illness has been described as a "silent pandemic of mental morbidity amongst the global youth population which will have adverse life course consequences" by researchers investigating determinants of child mental health in Aotearoa New Zealand (Menzies et al., 2020).

In response to these concerns, the New Zealand government launched an inquiry into mental health and addiction. Released in 2018, the inquiry detailed a number of unmet needs across the mental health sector and made a series of recommendations for

improvements. Recognition of the need to focus on improving the wellbeing of tamariki and rangatahi is illustrated by this quote “A flourishing New Zealand will prioritise the wellbeing of children and young people” (Government Inquiry into Mental Health and Addiction, 2018). The case is clear for the need to adequately resource specialist child mental health services to support those experiencing mental illness.

However, in addition to supporting those experiencing mental illness, there is much to be done to prevent mental illness and enhance child mental health. The public voice (as presented in the People’s Mental Health Report) echoes the notion that enhancing mental health is as important as treating mental illness. This report called for a focus on prevention, and greater access to resources to enhance mental health, as well as provision of adequate services for those experiencing distress (Elliott, 2017).

The Covid-19 pandemic has shone a spotlight on population mental health, with some suggesting it has increased public appetite for knowledge about maintaining individual and whānau⁵ mental health (Johal et al., 2020; Officer et al., 2022). The New Zealand government recognised that the Covid-19 pandemic and its ‘go hard and early’ measures taken in response would have a significant psychosocial impact on the population. Accordingly, one of the New Zealand Government's aims for psychosocial and mental wellbeing recovery was for people to be equipped with knowledge to maintain their mental health (Ministry of Health, 2020).

Personal Context of the Research

It was against this rapidly changing social environment that the Covid-19 pandemic necessitated, and a backdrop of increasing youth mental health difficulties worldwide and in

⁵ Māori for family and extended family, also includes others providing a support role for the individual.

Aotearoa New Zealand that I embarked on a new professional pathway. Prior to commencing my clinical psychology training I had a well-established career as a social researcher working in policing organisations in Aotearoa and the United Kingdom. This mahi⁶ taught me the importance of grounding practice in evidence and integrating evaluation measures alongside implementation of new initiatives. It also taught me the value of designing interventions in close collaboration with key stakeholders to enhance the acceptability, utility and effectiveness of an intervention.

I balanced a number of voluntary support roles alongside my paid employment as a social researcher, including telephone counselling for a parenting helpline and teacher support in a primary school. Alongside my own parenting experiences, this voluntary experience gave me insight into common emotional and behavioural difficulties presenting in early and middle childhood. I also reflected on gaps in parent/caregiver⁷ knowledge – including my own - of how to recognise and manage these difficulties. I realised that if I did not hold much of this child mental health knowledge until embarking on my clinical training then many other parents/caregivers may also have gaps in their knowledge of child mental health.

With a passion for prevention and early intervention, I felt strongly that not only should I use my skills and knowledge to help others in distress (as was the focus of my clinical training) but also to help others to prevent distress and maintain mental health. Accordingly, I wanted the learning from my thesis to be useful for mātua to prevent mental illness and support the overall mental health of their tamariki. In this way I drew on the learning from my personal and voluntary experiences related to parenting, my clinical

⁶ Māori for work, employment.

⁷ Throughout this thesis the terms parent, caregiver, and mātua are used to refer to adults in a parenting role.

training and my research experience to design a research study that would contribute to addressing gaps in the mental health literacy of parents in Aotearoa New Zealand.

Summary

In sum, my research is situated within the social context of an increasing public appetite for knowledge and resources about how to support and maintain good mental health. Child mental health has been recognised as a national priority in Aotearoa New Zealand, particularly following on from the Covid-19 pandemic. Finally, my own personal motivation (as a parent and researcher) for supporting mātua to improve tamariki mental health was also a driver for this research.

Aims of the Research

The overall aim of the research was to develop an intervention to increase the mental health literacy of parents/caregivers of primary school aged children. The first phase was to explore the gaps in parent knowledge of child mental health. The second phase aimed to use the findings of Phase 1 to inform the development of a psychoeducational podcasting resource for parents/caregivers to support the mental health of their tamariki. Accordingly, there are two questions that this research aimed to address:

1. What are the mental health literacy needs of parents and/or caregivers of primary school aged children?
2. How could these needs be met through a podcasting intervention?

Thesis Outline

This thesis consists of 15 chapters; these cover the relevant background literature informing the research, the two phases of the research and an overall discussion. The

current chapter introduces the thesis, the background to developing the research questions, the research aims and provides an outline of the remaining thesis chapters. Chapter Two outlines development during middle childhood and describes contextual approaches to development and health. Chapter Three sets out how mental health is defined in the thesis and a discussion of the literature that supports this definition. Chapter Four uses a contextual framework in discussing the key factors influencing child mental health. Chapter Five introduces mental health literacy and provides a review of the literature regarding population level as well as child, adolescent and parent mental health literacy. The last of the literature chapters - Chapter Six - focuses on the development and effectiveness of interventions with parents, mental health literacy interventions and discusses the potential use of podcasting to increase mental health literacy. Chapter Seven then sets out the rationale and aims of the research and Chapter Eight describes the overarching methodology.

The subsequent section of the thesis concerns Phase One of the research. Chapter Nine describes the methodology and Chapter Ten provides the results of the reflexive thematic analysis, which are then discussed in relation to the literature in Chapter 11. Chapter 12 summarises the practical implications of the findings of Phase One for the development of a podcast. Phase Two of the research concerns the development of the podcast which is detailed in Chapter 13; Chapter 14 summarises and discusses the results of the consultation with practitioners. Finally, the thesis concludes with reflections and overall discussion in Chapter 15.

Chapter Two: Contextual Approaches to Development and Health

A child's mental health is closely related to their development. Whether a child's behaviour is outside of the realm of what is socially and culturally normative cannot be determined without an understanding of the developmental context within which it is experienced. As this research is concerned with the parents of children of primary school age, this chapter begins by briefly outlining key developmental changes that occur during this middle childhood period. This is followed by a description of the key contextual models of development and health that provide the theoretical framework for the research.

Development During Middle Childhood

Middle childhood is a time of significant physical, social and emotional and cognitive development (Carr, 2005). During this period, children become more adept at fine motor skills such as writing, and their motor coordination and gross motor skills become more developed which enables their participation in a wide variety of physical activities. In terms of cognitive development, a child's vocabulary expands rapidly during this period, and their language and communication becomes more sophisticated. Alongside this, they are increasingly able to use logic and reasoning in everyday life and their problem-solving skills develop. In terms of their social capabilities, this period of development sees the increasing salience of peer relationships, development of interpersonal skills and the developing identity of self in relation to others. Middle childhood is a key period during which a child gradually becomes more able to regulate their behaviour without the support of caregivers (Carr, 2005).

Contextual Models of Development

Contextual models of development purport that multiple interacting factors in a child's physical, cultural and social environments play a significant role in how a child develops. That is, the type and frequency of reciprocal interactions a child has with their environment and significant others within their different environmental systems shapes their cognitive, physical and social and emotional development.

Bioecological Model. Bronfenbrenner was a prominent developmental psychologist renowned for his work recognising the importance of environmental influences on a child's development; notably he developed ecological systems theory (Bronfenbrenner, 1979). Ecological systems theory considers a child's development within different levels of environmental systems ranging from environments and influential factors that are closest to an individual (their microsystem) to those which are more indirectly influential (their macrosystem). At birth a child's microsystem includes their family, the environment in which they live and people with whom they have frequent contact. As the child grows, their microsystem is expanded to include their school, friends and other contexts within which the child lives.

Bronfenbrenner also recognised the influence of connections between these different systems and termed this the mesosystem. A mesosystem could be for example the relationships between the child's parents/caregivers and the school; and/or relationships between a child's family and his/her friends. Ecological systems theory proposes the next layer of influence on the child is the exosystem. The exosystem includes factors which impact on the child's microsystem indirectly. For example, a caregiver's work satisfaction and/or stress, as this would impact on how they feel and behave at home, thereby

impacting on the child. Finally, the macrosystem encompasses all other systems as well as broader cultural contexts within which the child lives, for example, political systems and welfare policies as well as religious or indigenous customs and beliefs.

Bronfenbrenner later expanded his theory to account for the influence of time across all systems, referred to as the chronosystem. In terms of child development, the chronosystem refers to the changing experiences a child may have in relation to significant events over time, such as the addition of a new baby in the household, a child's sibling experiencing a chronic illness, parental separation and the experience of the family moving house. Bronfenbrenner has since acknowledged the significance of the child's biological make-up to their development and thereby included biological factors into his ecological model, renaming it the bioecological model (Bronfenbrenner & Ceci, 1994). He also recognised that it is not just these systems that impact on a child but also the qualities of the reciprocal interactions that occur between the child and their environmental influences (which he termed *proximal processes*) which impact development. An example of *proximal processes* is the interactions between a parent and child which play a fundamental role in child development (Bronfenbrenner, 2000; Bronfenbrenner & Ceci, 1994).

In summary, it is the interaction of a child with influences in the child's environmental systems, and the interactions of these systems with each other that contribute to how a child develops. Just as a bioecological approach can be taken to understand a child's development, a bioecological approach can help understand influences of development on mental health and the development of mental illness (Currie & Morgan, 2020).

Sociocultural Theory. Vygotsky was another developmental psychologist who emphasised the significance of a child's interactions with their environment on their development (Cole et al., 1978). Sociocultural theory purports that a child's development is the result of the social learning process that occurs with the support of significant others in the child's immediate environmental context (Cole et al., 1978). At the heart of this theory is that through a process of social learning, a child's particular cultural context shapes how they behave and think (e.g., the importance of learning to read in Western cultures, the importance of waiata⁸ in Te ao Māori⁹).

Interestingly, Vygotsky viewed the process of cognitive development as a social phenomenon in that an individual acquires knowledge and develops cognitively through their social interaction with others (Cole et al., 1978). That is, children initially learn how to think through how they interact with others. He proposed that the process of problem solving for example is initially a social one, and then becomes internalised as it is developed.

With a focus on social learning or learning from others, Vygotsky defined the *zone of proximal development* as the difference between a child's ability on their own (i.e., what they can do alone) and their potential capabilities if they were to be supported (i.e., what they can only do with the support of others) to learn from more capable others within the same cultural context. It is within this zone of proximal development that Vygotsky suggested was the optimal point at which to facilitate a child's learning and development (Hall & Rieber, 1998).

⁸ Māori for song, singing.

⁹ Māori worldview.

A sociocultural approach to development therefore emphasises the importance of cultural context and social learning on child development, both of which also have a significant influence on the maintenance of mental health and protection against mental illness (Carr, 2005; Williams et al., 2018).

Māori and Pasifika Models of Health in Aotearoa New Zealand. Māori models of health and well-being also situate individual and family health within a wider sociocultural context. Te Whare Tapa Whā (Durie, 1985), and the Meihana (Pitama et al., 2014) models identify a range of dimensions of significance in Te Ao Māori that impact health. Within Te Ao Māori, the strong emphasis on family and extended family or whānau¹⁰ - compared with the individual – means that any focus on individual health must consider this within the context of whānau. Te Whare Tapa Whā and Meihana models highlight that an individual's health, and that of their whānau, is determined by the strength of functioning in a number of domains. These domains include tinana (physical body), wairua (spirituality and connectedness to people, places and objects of spiritual significance), hinengaro (psychological, including mind, thought, consciousness, feelings) health and whenua (land).

As in the bioecological model, broader contextual influences are also reflected in the Meihana model of health, such as taiao (physical environment) and iwi katoa (access to and support from appropriate services). This is shown in Figure 1 below. Examples of the influence of taiao include the quality of housing, neighbourhood safety and access to natural resources (Pitama et al., 2014, 2017). Less tangible but entrenched and wide-reaching macro influences - such as the impact of colonisation, racism, marginalization and migration throughout Aotearoa - are also reflected in this model. Finally, Māori models of health place

¹⁰ An individual's whānau may include family members as well as others providing key support role to the individual.

emphasis on balancing assessment of deficits with that of individual and whānau strengths across each domain (Durie, 1985).

Figure 1

Visual Depiction of the Meihana Model



From “Improving Māori Health Through Clinical Assessment: Waikare o te Waka o Meihana”, by S. Pitama, T Huria, and C. Lacey, 2014, *New Zealand Medical Journal*, 127 (1393), 107-119. <http://journal.nzma.org.nz/journal/127-1393/6108/>. Copyright 2014 NZMA. Reprinted with permission.

As in Te Ao Māori, a holistic view is necessary for meeting health needs of Pasifika communities. This holistic view is represented in the Fonofale model of health (Mental Health Commission, 2001). The Fonofale model was developed by Fuimaono Karl Pulotu-Endemann and is based on consultation with a number of different Pasifika communities including Samoan, Cook Island, Tongan, Niuean, Tokelauan and Fijian (Ministry of Health, 1995). As with sociocultural theory and Māori models of health, the Fonofale model emphasises the importance of family (including extended family and close connections with

others who are not family members), and equally important is the strength of cultural values and beliefs.

The Fonofale model is represented by a Samoan fale (house) with the foundations of the house representing family, and roof as cultural values and beliefs. As in a fale, where pou (posts) connect the foundations to the roof, four pou connect and support the interactions between family and culture. These pou represent: spiritual wellbeing (which may include traditional concepts relating to nature, language, beliefs and history and/or Christianity), physical wellbeing, mental wellbeing and other determinants of health. Similar to Te Whare Tapa Whā, this model highlights the need for balance between spiritual, mental and physical elements of one's life in order to be in a state of wellbeing (Ministry of Health, 2008; Suaalii-Sauni et al., 2009). Akin to the Meihana model, the fale is surrounded by influences of the physical environment, contextual environment and time (Mental Health Commission, 2001).

Both Māori and Pasifika models of health consider mental health within the context of health more broadly, and health within the context of the individual, family and wider social and cultural contexts.

Summary

Middle childhood is a time of significant physical, cognitive, social and emotional change and a child's behaviour and mental health needs to be considered within this context. Common to the contextual models discussed in this chapter is the significant role the child's social and cultural environment plays in shaping their development, including their mental health.

Chapter Three: Defining Mental Health

Although the term mental health is in everyday lexicon, how it is used and interpreted varies from having positive connotations to being used in reference to psychopathology. This chapter discusses different definitions of mental health. It then provides an overview of the dual continua model of mental health which is the model used in this thesis, and the evidence to support mental health and mental illness as two separate but related constructs.

World Health Organisation Definition of Mental Health

The dominant psychiatric focus on psychopathology, the social and economic burdens of this, and a consequent public health focus on mental illness, has tended to dominate research and public interest in mental health (Keyes, 2007). However, in a scoping review of mental health, Fusar-Poli et al. (2020) found that one of the most commonly used definitions is that of the World Health Organisation (WHO) which makes no reference to mental illness. The WHO defines mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (World Health Organisation, 2013, p. 3).

In applying this definition to children, the WHO refers to identity, healthy thoughts, behaviours and relationships and an interest in learning as key aspects (World Health Organisation, 2013). This definition places a strong emphasis on wellbeing, resilience and realising potential, and again makes no reference to mental illness. Mental illness – also referred to as mental disorder and/or mental distress – involves difficulties with emotions, thoughts and/or behaviours that cause significant distress and impact on functioning

(American Psychiatric Association, 2018). Whilst it is apparent the two constructs of mental health and mental illness are related, they are not necessarily polar opposites. It is in fact possible to have mental health whilst experiencing mental illness (World Health Organisation, 2004).

Dual Continua Model of Mental Health

The theory that mental health and mental illness are separate constructs (instead of two extremes on the same continuum) has been rigorously tested by Keyes and colleagues over the past two decades. In these studies, an individual's complete state of mental health is assessed by measuring presence of mental illness as well as the extent to which they experience positive mental health (also called flourishing). Keyes (2002, 2005) operationalised flourishing through measures of emotional, psychological and social wellbeing. Keyes defined *emotional wellbeing* as feelings of happiness and satisfaction with life. *Psychological wellbeing* was defined as having a positive perception of self and others, feeling a sense of purpose to life, self-determination, believing in one's own abilities and meaningful relationships with others. Finally, components of *social wellbeing* included an individual having a positive perception of society, a sense of belonging and of being able to make a valuable social contribution (Keyes, 2002, 2005). Defined in this way, the construct of emotional wellbeing reflects hedonic wellbeing and psychological and social wellbeing reflect eudaimonic (i.e., realisation of self-potential) aspects of wellbeing (Seow et al., 2016).

Keyes (2002, 2005) determined that an individual who scored low on these aspects of well-being was considered to be languishing, and someone scoring highly was flourishing. Whereas mental illness was assessed as the extent to which symptoms of mood, anxiety or

substance use disorder were present. In applying these measures of flourishing to data from the Midlife in the United States study of adults aged 25 to 74 years, Keyes showed there are varying levels of positive mental health amongst adults both with and without a diagnosed mental illness, thereby providing evidence that mental health and mental illness are two separate constructs. Consequently he proposed that one's overall state of mental health must take into account the dual components of mental health and mental illness (Keyes, 2005).

In a review article providing evidence to support investment in mental health promotion, Keyes (2007) showed that individuals who had languishing mental health but *were not* experiencing mental illness measured either similar or worse on physical health and psychosocial functioning, than those with moderate or flourishing mental health who *were* experiencing a mental illness. Even more interesting is the findings of longitudinal research using these constructs with adults in the United States (Keyes et al., 2010, 2020). These studies provided evidence that languishing is associated with later development of mental illness – and was an even stronger predictor than prior experience of mental illness – suggesting that positive mental health is a protective factor against developing mental illness. Research in Singapore using an alternative measure of positive mental health - the Positive Mental Health Instrument - also provides support for a dual continua model. Seow et al. (2016) found varying levels of positive mental health amongst adult outpatients with affective disorders, with those reporting higher positive mental health also reporting higher life satisfaction and functioning in everyday life.

Keyes' model has been further tested and is supported by research with non-western populations, and with young people (Hides et al., 2020; Howell et al., 2013; Iasiello

et al., 2020). A recent review by Iasiello et al. (2020) investigating the evidence for and against the dual continua model of mental health found overwhelming support for this model. However, the authors of this review noted that the appropriateness of the model for individuals experiencing severe mental illness, particularly depression, was inconclusive.

Dual Continua Model of Mental Health in Children

Early support for considering both positive and negative mental health indicators to understand child mental health comes from a study by Greenspoon and Saklofske (2001). These authors were interested in children (average age of 10 years) with different temperaments, personalities, self-concepts, locus of control and interpersonal functioning skills; and the relationship between these factors and extent to which they experienced mental illness and positive mental health. In particular, Greenspoon and Saklofske found support for a relationship between neuroticism, interpersonal relations and locus of control, and the extent to which a child experienced mental illness and positive mental health. When children with low levels of neuroticism and an internal locus of control were faced with difficult situations (such as poor relationships with peers) their subjective wellbeing suffered. However, these children were less likely to develop mental illness than those with higher neuroticism and an external locus of control.

More recent research provides support for the appropriateness of a dual factor model of mental health in children. These studies also illustrated the relationship between mental health and development, in particular academic and physical developmental outcomes (Shaffer-Hudkins et al., 2010; Smith et al., 2020; Suldo et al., 2011). A study by Smith et al. (2020) assessed children aged 8-12 years on subjective wellbeing measures as well as frequency of internalising and externalising behaviours and assigned into one of four

groups. These groups were: complete state of mental health (average -high subjective wellbeing and low internalising and externalising behaviours); troubled (high levels of externalising and internalising difficulties and low subjective wellbeing); symptomatic but content (high levels of internalising and externalising behaviours but high subjective wellbeing) and vulnerable (low internalising and externalising behaviours but also low subjective wellbeing). What was particularly interesting from their findings was that there were significant differences in the children's social and academic engagement outcomes (assessed by teachers and the children themselves on affective and behavioural dimensions) depending on which of the different mental health groups they fell within. Children in the 'symptomatic but content' group rated themselves more highly on social and academic engagement outcomes than children in the 'troubled' group (Smith et al., 2020). The study provided support for the dual factor model of mental health in that some children experienced high levels of internalising and externalising behaviours at the same time as relatively high levels of subjective wellbeing. The study also suggests that subjective wellbeing can be a protective factor in children with high internalising and externalising behaviours. Finally, the study highlighted the potential risk of overlooking children with low levels of internalising and externalising behaviours but also low levels of subjective wellbeing (i.e., those in the vulnerable group). That is, higher subjective wellbeing was associated with positive social and academic outcomes regardless of presence of internalising or externalising behaviours, but these children are unlikely to be identified as at risk using screening tools solely focused on symptoms of mental illness.

Summary

The research discussed in this section provides support for the notion that mental health (or flourishing), and mental illness are related but separate constructs. Evidence for a dual continua model of mental health comes from studies with both adults and children. This chapter also highlighted the risk of overlooking the importance of efforts to increase flourishing, and not just prevent illness, in order to improve overall mental health.

Chapter Four: A Contextual Approach to Determinants of Mental Health

Decades of research provide evidence that there are multiple interacting factors that impact on a child's mental health in terms of both constructs of the dual continua model.

Taking a contextual approach, risk and protective factors can be grouped into factors directly relating to the child, factors related to the child's parent/caregiver and factors in the child's wider environment. This chapter describes some of the key child, parent and environmental factors known to influence child mental health.

Child factors

Child specific factors that have shown to be associated with increased risk of mental health difficulties or to be protective of mental health can be further categorized into biological (i.e., those occurring within the individual's body) and psychological (i.e., characteristics of the individual that influence behaviour and emotion).

Biological

Biological influences on the development of psychopathology include prenatal, postnatal, genetic and neurobiological factors. For example, in terms of prenatal factors there is evidence that maternal stress, maternal illness and maternal use of substances while pregnant can contribute to the emergence of child mental health difficulties such as attention deficit hyperactivity disorder (ADHD) and obsessive-compulsive disorder (Geller et al., 2008; Pohlbeln et al., 2017).

Familial and genetic studies have determined that there is a genetic component to the development of serious mental illness such as schizophrenia, depression and bipolar disorder, although family history remains a more powerful predictor (Sandstrom et al.,

2019). Some disorders have been shown to be more likely to be heritable than others, for example autism and ADHD (Pettersson et al., 2019; Thapar & Rutter, 2021).

Finally, impairments in neuropsychological functioning can lead to an increased risk of developing some mental health difficulties. For example executive functioning difficulties can play a part in externalizing disorders (Wakschlag et al., 2018) and these have also been found to be a transdiagnostic risk factor for psychopathology more generally (Lynch et al., 2021).

Psychological

Psychological variables relating to the individual child including intellectual ability, and ways of thinking and behaving can all influence the development of mental health difficulties in a child. In particular, lower cognitive ability has been shown to be a child-specific risk factor for mental illness and higher intelligence is considered to be a protective factor. Similarly, low self-esteem, neuroticism and external locus of control are risk factors for mental health difficulties (Carr, 2005; Greenspoon & Saklofske, 2001). A recent systematic review of empirical models of psychopathology found consistent evidence that high negative affectivity and low effortful control were transdiagnostic risk factors for onset of mental health difficulties amongst young people aged 10-24 years (Lynch et al., 2021). A child's temperamental tendencies, such as fussiness and fearfulness have also been shown to be risk factors for development of externalising and internalising difficulties (Lahey et al., 2008; Nigg, 2006). Conversely, adaptive emotion regulation skills have been found to be protective for mental health (Compas et al., 2017; Daniel et al., 2020).

Consistent with a sociocultural approach, research in Aotearoa New Zealand has found cultural identity to be protective against mental health difficulties amongst Māori secondary school students (Williams et al., 2018).

Parental Factors

The role that parents and whānau play in supporting a child's mental health is understood to be one of the most significant influences on a child's mental health in the bioecological, sociocultural, as well as Māori and Pasifika models of development and health. Four parental factors that can have a significant impact on child mental health outcomes are outlined below.

Parenting Styles

The effect of parenting styles on child behaviour has been the subject of a significant body of research which has informed the content of a number of parenting programmes. The originator of this body of research, Diana Baumrind (Baumrind, 1966) proposed that there are three main styles of parenting: authoritarian, permissive and authoritative. The authoritarian parenting style is characterised by high levels of control and low warmth. Parents using this style tend to be strict and expect unquestioning obedience. The permissive parenting style on the other hand tends to be low in terms of controlling behaviours and high in warmth. These parents tend to be very accepting of any behaviour and have few rules, boundaries or consistent discipline. Finally, authoritative parenting tends to demonstrate high levels of both control and warmth. This style of parenting is responsive to the child's needs while setting limits and being consistent in maintaining boundaries. Research has shown a stronger association between characteristics of

authoritarian and permissive parenting with childhood externalising difficulties than is seen with authoritative parenting styles (Pinquart, 2017; Yap et al., 2014).

Attachment

Taking a bioecological approach to parenting it can be seen that there are many factors that play a part in the way a caregiver may parent a child. For example, the way the parent themselves was parented, any experiences they have had with parenting (or of observing other children), and any additional learning they have engaged in to support their parenting practice, other adults caregiving for the child and the stressors impacting on their lives. The type of parenting style is also related to the type of relationship a child has with their parent. According to attachment theory, humans have an innate need to form connections or attachments with those who play a significant role in their lives, such as a mother or father figure (Bowlby, 1958). The type of attachment a child forms with their caregivers is based on the type of interactions they have with their caregiver over time. The type of attachment influences a child's views of themselves, others and the world and influences how they interact with others throughout their lives.

In their studies of attachment behaviour in children, Ainsworth et al. (1978, 2015) identified three main attachment styles: secure, anxious-ambivalent and avoidant. A secure attachment forms when a caregiver is available, sensitive and responsive to meeting a child's needs and this type of attachment supports healthy development. Whereas a child with an anxious-ambivalent attachment with a caregiver has most likely experienced inconsistency in responsive parenting and therefore displays heightened distress when separated from a caregiver and ambivalence when the caregiver returns. A child who has repeatedly been ignored or rejected in their attempts to have their needs met is likely to

develop an avoidant attachment style in which the child will then ignore or avoid the caregiver as a means of coping with the distress they experienced of not having their needs met. In studying child attachment styles and noting that some children exhibited behaviours associated with distress that were not exhibited with avoidant or anxious types of attachment, a fourth attachment style was proposed by Main and Solomon (1990) as disorganised attachment. These children tend to display contradictory patterns of attachment behaviour. A child who has repeated disruptions to their primary caregiver or experienced trauma or their parent has unresolved trauma may experience disorganised attachment. Disorganised attachment is characterized by contradictory behaviour, fear responses and apparent disorientation (Granqvist et al., 2017).

Bowlby (1973) proposed that a lack of secure attachment can contribute to the later development of psychopathology. This theory is supported by longitudinal research demonstrating the impact of specific patterns of attachment on normal development and developing psychopathology (Sroufe, 2005).

Parent Emotion Regulation

The type of attachment style a child develops with their caregivers - and the parenting style the caregivers use - strongly influences a child's social-emotional development. One aspect of social development that is associated with mental health and illness is ability to regulate emotions (Compas et al., 2017). As discussed above, the emotional environment and the parental response to a child's emotions will likely be influenced by many factors in the child's bioecological system. Not surprisingly, systematic review evidence has shown that parental socialization of emotions in the family environment, parental use of strategies for managing their own emotions and how they

respond to their child's expression of emotion are all factors that influence a child's emotional development and the development of strategies to regulate their own emotions (De Raeymaecker & Dhar, 2022; Eisenberg et al., 2010).

Parental Wellbeing

A further parental factor influencing child mental health is the wellbeing of the caregiver themselves. A caregiver who is under increased stress and/or experiencing mental health difficulties themselves may be less able to engage in effective parenting practices and not as available to meet their child's needs (Cooklin et al., 2012; Mensah & Kiernan, 2010). Conversely, positive mental health and wellbeing of a parent/caregiver is a protective factor for healthy child development amongst children who have experienced adverse events (Walsh et al., 2019).

In Aotearoa New Zealand, researchers have been interested in the construct of flourishing in relation to Māori whānau. With similarities to the Keyes (2002, 2005) model, flourishing in Te ao Māori is considered a state of mauri ora¹¹ in which whānau experience fulfilment in relation to relationships, spirituality and psychological and physical strength (Durie, 1985). Research exploring the factors contributing to flourishing whānau has identified the dimensions of heritage, wealth, capacities, cohesion, connectedness and resilience as being important (Kingi et al., 2014). Although considered tentative at this stage, based on their research Kingi et al. (2014) described the dimension of heritage as being strength of connection to whakapapa¹² and cultural identity. Wealth was defined as financial wealth in terms of assets and investments. Whānau cohesion and connectedness

¹¹ Māori term meaning essence of life.

¹² Family and ancestral history, geneology.

was considered to be quality of whānau relationships and ability to participate in whānau life, and use community facilities and resources. Finally, whānau capacities included the levels of health, education and employment within whānau, and resilience referred to positive change and leadership and planning for the future. Albeit it is still an emerging body of literature, the research suggests that a flourishing whānau is dependent on a number of factors related to the strength of social and cultural connections as well as internal and external resources. These relate to eudaimonic aspects of wellbeing which is also one of the core constructs in Keyes (2002) concept of flourishing.

Other Environmental Factors

Beyond factors relating to the individual child and their parents and whānau, factors in the child's wider socioeconomic environment can also have a significant impact on their mental health. These factors include the type of household and community the child lives in and the reciprocal interactions within these environments. For example, the number of people living in the same household and relationships between them (Buist et al., 2013; Westrupp et al., 2018), peer relationships and support (Liu et al., 2021; Matthews et al., 2015) and the socio-economic resources in the family and community (Peverill et al., 2021) have all been found to impact on child mental health outcomes.

Adverse Childhood Experiences (ACEs)

Negative events or factors within the child's micro and mesosystems can impact on mental health. Some of these have been mentioned earlier in this thesis, and include child abuse, witnessing violence and caregiver separation or bereavement, all of which are associated with mental health (Hayden & Mash, 2014). These and other potentially traumatic events impacting a child have been collectively termed adverse childhood

experiences (ACEs) and have been shown to have lasting impacts on physical and mental health outcomes. The original ACEs study (Felitti et al., 1998) found that the majority of the population has experienced at least one ACE, and almost a quarter have experienced three or more. There is now considerable evidence that experiencing one or more ACEs impacts on developmental outcomes and the risk of developing a range of adult mental and physical health conditions (Centres for Disease Control and Prevention, 2019; Gilbert et al., 2015; Metzler et al., 2017). Researchers have found that it is the chronic stress associated with ACEs that contributes to the development of poor health outcomes. Chronic stress causes physiological changes in the brain that alter an individual's executive function abilities, stress response and the body's immune response (Shonkoff et al., 2012). ACEs can also lead to patterns of thinking, health behaviours and interpersonal relationships that can negatively impact on wellbeing (Waite & Ryan, 2019).

However, there is evidence to suggest protective factors within a child's bioecological system (particularly within the whānau) can influence the impact of adverse childhood experiences. For example, whānau strength of connection to their cultural and spiritual beliefs can impact a child's sense of identity (Williams et al., 2018). Recent systematic review evidence also suggests social support from both within whānau and beyond (e.g., friends, hapū¹³), particularly during the adolescent period, is protective for mental health following childhood adversity (Buchanan et al., 2023).

Supporting a child to meet their physical health/tinana needs such as adequate nutrition, sleep and exercise also helps to maintain mental health (Carr, 2005). Whānau are also instrumental in helping a child to develop effective social and communication skills and

¹³ Sub-tribe, political unit in traditional Māori society.

problem solving skills, all of which are associated with positive mental health (Hayden & Mash, 2014).

Summary

In considering determinants of child mental health within a contextual framework, micro system level factors may be considered the most influential. In particular, the influence that mātua and whānau have on child mental health is paramount. Whānau flourishing, parent-child relationships and parenting style have an impact on child mental health both in terms of prevention of mental illness and promotion of mental health.

Chapter Five: Mental Health Literacy

Based on the literature reviewed so far, it follows that parent knowledge of child mental health can be beneficial for promoting mental health and identifying mental health difficulties in children. This chapter provides an overview of the evolving definition of mental health literacy. It then provides a discussion of the mental health literacy literature, including a summary of the evidence base regarding mental health literacy of children, adolescents and parents.

Defining Mental Health Literacy

Mental health knowledge is a core construct of mental health literacy. Mental health literacy as a concept has been adapted from that for health literacy. It was first coined by Jorm and colleagues as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm et al., 1997, p. 182). This definition encompassed knowledge of causes and symptoms of mental illnesses, as well as knowledge of appropriate places to seek help. Jorm (2012) later expanded this definition to include knowledge of help-seeking options, including self-help and mental health ‘first aid’. He also clarified that mental health literacy goes beyond knowledge about mental illness, to use of that knowledge to take action to prevent or help manage mental illness, to improve mental health outcomes.

As health literacy is a determinant of health outcomes, mental health literacy is a determinant of mental health. There is international evidence to support the association between mental health literacy, mental health status, help-seeking and attitudes towards treatment. For example, survey research with adolescents in China has found there to be an association between mental health literacy and mental health status, particularly depression

(Lam, 2014). Researchers investigating mental health literacy amongst university students in the United Kingdom established a relationship between ability to recognise mental health problems and help-seeking behaviours (Gorczyński et al., 2017). Finally longitudinal research with adults in Switzerland has shown that components of mental health literacy, such as knowledge of depression, attitudes towards seeking psychological services, and perceived need for help were predictive of uptake of psychotherapy and medication (Bonabi et al., 2016).

As a result of this research, there has been a recent policy shift towards increasing population level mental health literacy in an attempt to improve mental health outcomes (Ng, 2020). A review by Furnham and Swami (2018) found there is a large body of literature that suggests there are low levels of mental health literacy amongst the general population. This review also identified variations in the levels of mental health literacy between specific populations; in particular, there are particularly low levels amongst older adults, those living in rural areas and ethnic minorities. Mental health literacy has also been found to be higher amongst women and for more common disorders such as depression (Furnham & Swami, 2018; Jorm, 2012). The majority of these studies have been conducted in western countries; studies in non-western countries tend to show even lower levels of population mental health literacy although show a similar pattern of gender differences and differences in literacy levels between mental disorders (Furnham & Hamid, 2014; Li & Reavley, 2020). Interestingly an earlier study in Aotearoa New Zealand found high levels of depression literacy amongst adults and no differences in the levels of depression literacy between Māori and non-Māori (Marie et al., 2004).

Despite a burgeoning of mental health literacy research since Jorm et al. (1997) first coined the term, the operational use of the term has been inconsistent between studies. Some researchers operationalise mental health literacy as mental health knowledge only, whereas others focus on help-seeking behaviours. In addition, a range of tools have been developed to measure mental health literacy, although they measure different aspects and few, if any, are comprehensive (Wei et al., 2015). Furthermore, over the past five years, the definition of mental health literacy has expanded to encompass positive mental health rather than only mental illness, and to consider stigma as well as help-seeking efficacy (Bjørnsen et al., 2017; Kutcher et al., 2016).

Balancing the emphasis on mental illness with a focus on mental health has expanded the definition to be more aligned with evolving health literacy definitions, as well as the WHO definition of mental health (World Health Organisation, 2013). However, this ever-expanding conceptualisation of mental health literacy - and the differing uses of the term between studies - makes accurate interpretation and comparison of findings difficult. Spiker and Hammer (2019) have called out these inconsistencies, stating that the continuing expansion of Jorm's (1997) definition jeopardises its qualities as a construct, and is at risk of confusing outcomes with the components of the construct itself (e.g., help-seeking). These authors propose that mental health literacy should be conceptualised as a theory. In this way researchers can attend to single or multiple constructs (and multiple concepts within a construct) within the overarching theory. Therefore, the effects of the individual constructs on mental health outcomes (and relationships between these) can be tested, leading to further theoretical developments. Accordingly, throughout the rest of this thesis, reference to specific constructs of mental health literacy will be made when discussing mental health literacy, wherever possible. Aligning with the dual continua model of mental health, the

constructs of knowledge of how to obtain and maintain good mental health and prevent mental illness and help seeking efficacy are of particular interest in this research.

Child and Adolescent Mental Health Literacy

The literature provides a case for investing in interventions to increase mental health literacy of communities as a pathway to improving population mental health. Research attention has tended to focus on determining levels of mental health literacy and identifying effective interventions. Some research has investigated interventions targeting the mental health literacy of specific populations - such as those caring for people with mental illness (Mendenhall & Frauenholtz, 2015), or those at greater risk of developing mental health problems (for example refugee populations, Byrow et al., 2020). Given that mental illness commonly first presents during childhood or adolescence (Caspi et al., 2020), increasing the knowledge and skills of young people to recognise and seek help for mental health problems provides greater opportunities for prevention.

With the increasing focus on mental health in schools, there is a growing body of research investigating the mental health literacy of adolescents (Mansfield et al., 2020), and to a lesser extent, the mental health literacy of younger children (Georgakakou-Koutsonikou et al., 2019). A systematic review by Mansfield and colleagues (2020) found that of all the studies investigating the mental health literacy of adolescents, about a third focused on knowledge, in particular the ability to recognise symptoms of different mental illnesses. A review of depression literacy amongst adolescents found that although there was variation across studies, most studies reported that less than half the adolescents were able to recognise depression (Singh et al., 2019). In contrast, a recent study of adolescents in Aotearoa New Zealand found relatively high levels of mental health literacy, particularly in

relation to depression (Tissera & Tairi, 2020). In this study 16–18-year-olds (predominantly female New Zealand European) were presented with a vignette of an adolescent with depression and another with schizophrenia and asked what if anything was wrong with them. Almost three quarters of participants correctly identified depression and half identified schizophrenia.

Research investigating younger children’s mental health literacy is scarce. A study in Scotland using the vignette method with children aged 8-12 years found the children were able to identify the child had a problem but were unable to label it as depression or a mental health difficulty (Georgakakou-Koutsonikou et al., 2019). Analysis by age showed that sophistication in conceptualisation of depression increased with age. In accord with sociocultural theory, this research suggests children need the help of more informed others to help them interpret signs of mental distress, lending support for the significant role parents can play in supporting child mental health.

A number of systematic reviews investigating mental health literacy amongst adolescents and the barriers and facilitators for help-seeking have been conducted in recent years (Gulliver et al., 2010; Radez et al., 2021; Singh et al., 2019). In a systematic review of barriers and facilitators for adolescents seeking help for a mental disorder Gulliver et al. (2010) found that inability to recognise mental illness was a common barrier. Other barriers to young people seeking help for mental health difficulties include concern about stigma associated with mental illness, lack of knowledge about options for help, accessibility and trust and confidence in specialists (Gulliver et al., 2010; Radez et al., 2021; Singh et al., 2019). Further systematic review evidence suggests adolescents’ preferred source of support for concerns about their mental health is from family and friends, but negative

attitudes held by family and peers are perceived as a barrier to seeking their help (Georgakakou-Koutsonikou & Williams, 2017; Singh et al., 2019). Strong relationships with significant adults in the young person's life and having had a positive experience with mental health services have been identified as facilitators to seeking help for mental illness (Aguirre Velasco et al., 2020).

It is notable from the research summarised thus far, that whilst adolescent (and to a lesser extent child) knowledge of mental illness and help-seeking for mental illness is frequently measured and reported, knowledge of how to prevent mental ill-health and promotion of mental health is not. Although scarce, there is some research investigating the relationship between positive mental health literacy amongst adolescents and wellbeing. Research in Norwegian secondary schools investigating the provision of information to students on how to obtain and maintain positive mental health provides support that interventions with adolescents that are inclusive of psychoeducation about positive mental health (rather than solely prevention of mental illness) can have a positive effect on wellbeing (Bjørnsen et al., 2019).

Parent Mental Health Literacy

Consistent with sociocultural theory, the literature indicates that children and young people can benefit from the help of knowledgeable adults in preventing mental illness and promoting mental health. Furthermore, research with young people suggests their preferred source of support is their family (Georgakakou-Koutsonikou & Williams, 2017; Singh et al., 2019). In considering a bioecological approach, parents/whānau are well positioned to promote positive mental health and identify signs of poor mental health in their children and they can also help to facilitate access to professional support. Therefore,

the mental health literacy of parents and whānau is a key determinant of child and youth mental health. However, there is currently only a small body of research investigating parental mental health literacy and effective interventions to increase the mental health literacy of parents.

A systematic review by Hurley et al. (2020) determined that the current state of parent/caregiver mental health literacy is limited. Most of the studies included in this review had been conducted in Australia, the United States and the United Kingdom and covered three areas of mental health literacy: knowledge and understanding of mental health, attitudes and beliefs towards mental illness, and help-seeking. The review found that findings relating to levels of parental knowledge of mental health were mixed with prior experiences with mental illness being associated with higher levels of mental health literacy. Prominent barriers to help-seeking were inadequate knowledge about mental health, financial difficulties and availability of services. Furthermore, severity and type of child mental health difficulty was related to help-seeking: parents were more likely to seek help for disruptive behaviour or personality changes, or when the problem had a greater impact on the child's life. Finally, sources of help identified included family and friends, self-help approaches and general practitioners.

Most of the research on the mental health literacy of parents has been conducted with parents of adolescents: one study with parents of pre-schoolers (Cormier et al., 2020) also shows low levels of mental health literacy and there is a paucity of mental health literacy research with parents of children aged 5-10 years (Tully et al., 2019). In recognising the limited evidence base pertaining to caregivers of younger children, Johnson et al. (2023) conducted a systematic review of parent and teacher (of children aged 5-12 years old)

knowledge of child mental health problems. The findings of this review suggest parents' recognition of childhood mental health difficulties is low. Interestingly, both parents and teachers were able to more accurately recognise a mental health problem when presented as vignettes rather than in relation to their own children/children they teach. It was suggested that the presentation of mental health problems in vignettes is clearer than it is in real children. Finally, a study exploring the views of social workers as to their perceptions of the mental health literacy of parents of children they worked with considered them to have low levels of mental health literacy, and that parents sought their information from informal sources such as friends and family (Frauenholtz et al., 2015).

Recent research in Aotearoa New Zealand investigated the mental health literacy of mātua of tamariki and rangatahi aged 5 to 18 years (Barnes, 2023). Using an online survey and vignettes, this study measured parental ability to recognise mental illness in 8- and 14-year-olds. In contrast with the international evidence base, Barnes (2023) concluded that parents in Aotearoa New Zealand have excellent levels of mental health literacy. It may be the case that parents in Aotearoa New Zealand are highly literate in mental health, although it should be noted that two thirds of participants also rated their mental health knowledge as moderate or higher and a large proportion either had personal or professional experience with mental health difficulties. As researchers elsewhere have found, recognition of mental illness is influenced by prior mental health knowledge (Johnson et al., 2023; Mendenhall & Frauenholtz, 2015).

Summary

In summary, research into the mental health literacy of parents of adolescents is growing but there are currently few studies investigating the mental health literacy of

parents of pre-adolescent children (Johnson et al., 2023; Tully et al., 2019). Recent research in Aotearoa New Zealand has found high levels of parental mental health literacy (in parents of children aged 5 to 18 years) and suggests the gap between number of children experiencing mental illness and those engaged in services may be due to perceived barriers to accessing those services rather than gaps in parent mental health literacy. However, further research using different methods is necessary to confirm these findings. In addition, there has been a lack of research investigating parental knowledge of how to promote positive child mental health, rather than recognition of mental distress and accessing support.

Chapter Six: Mental Health Interventions

The literature discussed so far has been focused on understanding the context of child mental health in Aotearoa New Zealand, the theoretical models guiding the research and describing the key influencing factors on child mental health, including parent mental health literacy. The literature reviewed provides an evidence base for *why* it is important to increase the mental health knowledge of parents and caregivers. Chapter Six provides an overview of the literature regarding *how* parent mental health literacy may be increased. The chapter starts by defining mental health prevention and promotion and then focuses on interventions with parents that seek to promote child mental health, including interventions focusing specifically on increasing parent mental health literacy. Finally, the use of technology, in particular podcasting, as a potential mode of delivering a mental health literacy intervention is discussed.

Mental Health Prevention and Promotion

The constructs of both mental health and illness are important factors in determining the overall state of mental health (Keyes, 2002, 2005). However, mental health interventions are often focused on either prevention of illness or promotion of health. Prevention frameworks are largely concerned with reducing the risks of illness. Three commonly used levels of intervention in public health prevention frameworks are primary, secondary and tertiary (Caplan, 1964). With respect to preventing mental illness, this framework distinguishes between types of interventions that focus on reducing the incidence of mental illness, interventions to reduce illness severity and interventions to reduce impacts or impairments associated with mental illness, respectively. In an alternative framework, Gordon (1983) defined prevention interventions as those that are developed for

individuals not experiencing illness, and proposed three different types of prevention interventions. Universal interventions were defined as those that target the whole population irrespective of risk of developing the illness, selective interventions were defined as interventions designed to target populations with an increased risk of developing the illness, and indicated interventions were those targeting individuals at high risk of developing an illness (Gordon, 1983). These classifications are commonly used in the parenting and mental health intervention literature (Anna-Kaisa et al., 2022; Pollak et al., 2023; Yap et al., 2016).

In contrast, mental health promotion takes a bioecological approach and focuses on modifying individual, social and the wider environmental determinants of positive mental health (Barry et al., 2019). As such, mental health promotion interventions are concerned with increasing the resources of individuals and building supportive environments in which the individual can flourish (Barry et al., 2019). Mental health promotion therefore is about enhancing competence rather than reducing illness. As discussed above however, flourishing can be a protective factor against developing mental illness (Keyes et al., 2010, 2020), therefore the promotion of mental health can also serve to reduce illness.

Using a bioecological framework, interventions to reduce mental illness and increase mental health can take many forms. For example, at the individual level, interventions may be designed to promote healthier pregnancies which can influence positive mental health outcomes for the child. Parenting programmes are one example of microsystem level interventions that promote child mental health. Also at the microsystem level mental health promotion in schools is becoming more commonplace, with an increasing focus on social emotional development being integrated into the primary school curriculum (Ministry

of Education, 2022; World Health Organisation, 2021). Considering a child's wider social context within a child's microsystem, there is becoming an increasing interest in (and growing evidence base in relation to) mental health promotion through youth sports clubs (Petersen et al., 2023).

The mental health promotion and implementation science literatures suggest that interventions should be underpinned by relevant theory and research evidence and subject to evaluation of integrity, user quality and outcomes to ensure effective implementation, uptake and outcomes (Barry et al., 2019; Durlak, 2016). Drawing on principles of user centred design, collaborating with key stakeholders and using an iterative approach can help ensure interventions are accessible and responsive to participant needs (Lyon & Koerner, 2016). These principles have underpinned the development of many interventions with parents and caregivers to support healthy parenting practice (Sanders, 2019).

Interventions with Parents

The type of parenting environment a child grows up in has been shown to be a strong predictor of healthy development (Belsky et al., 2007). Parenting programmes generally aim to increase parental knowledge and use of effective parenting strategies to promote a healthy whānau environment. There are a range of different parenting interventions, some of which are universal (i.e., applicable to all parents/caregivers such as antenatal parenting programmes) and others that are selective and target particular parenting populations or particular child behavioural or parenting challenges. For example, there is a growing body of evidence that supports the effectiveness of interventions that promote the mental health of children of parents with mental illness (Giannakopoulos et al., 2021; Wirehag Nordh et al., 2023).

Behaviour-focused parenting programmes (such as the Triple P-Positive Parenting Programme and Incredible Years Programme) have been well-researched (Overbeek et al., 2021; Sanders et al., 2014; Sturrock et al., 2014). These programmes are grounded in social learning theory and developmental and cognitive-behavioural principles. The Triple P-Positive Parenting Programme includes both universal interventions and interventions targeted at specific populations. The universal programme is available to everyone and has been delivered via television, radio and online. The programmes then become more targeted and involve group and/or individual sessions either face-to face, over the telephone or online, and vary in intensity. These programmes are targeted at parents of children aged 0-12 years, pre-adolescents and parents of teenagers. There are programmes for common parenting problems, more serious behavioural problems, difficulties with anxiety, parents of children with a disability and family relational problems. A meta-analysis that combined data from 101 evaluation studies of all levels of the Triple P programme found it to have a positive effect on a range of outcomes including parenting practices and child social/emotional and behavioural difficulties (Sanders et al., 2014).

A similar evidence-based programme delivered in Aotearoa New Zealand is the Incredible Years Programme. This programme provides interventions for parents, teachers and children that aim to reduce or prevent child behaviour problems and increase social emotional competence. The programmes are targeted at parents and teachers of children aged 0-12 years and are offered as group sessions and at two levels: basic (universal) and advanced (indicated/high risk populations). Evaluations of the Incredible Years programme both in Aotearoa New Zealand and internationally have shown positive changes in the areas of parent reported child behavioural difficulties, parenting practices and family relationships

following completion of the programme and at a 2.5 year follow-up (Overbeek et al., 2021; Sturrock et al., 2014).

Indeed there are a raft of other parenting interventions also with a robust evidence base, such as Parent-child interaction therapy (Thomas et al., 2017) and Circle of Security (Yaholkoski et al., 2016). However, there are barriers to accessing these programmes, as most programmes either require a referral (often a result of difficulties already being present) or the parent/caregiver needs to pay for access. Interventions that are free and available to all parents irrespective of a child's risk of mental health difficulties are needed, as they can help to normalise help-seeking behaviour for parenting support and in turn reduce barriers associated with stigma.

Digital Mental Health Interventions

Qualitative research with stakeholders of parenting programmes by Finan et al. (2018) found that constraints on parent time and resources can lead to less than optimal engagement in such interventions. It is therefore important to consider differing parent needs and offer a range of modalities for parents to engage in these programmes.

Digital health interventions have the potential to increase the accessibility of interventions. There is a growing body of research investigating the use of technology to improve mental health outcomes. The Covid-19 pandemic precipitated a significant demand for the development and implementation of e-mental health interventions. Prompted by this demand Rauschenberg et al. (2021) conducted an extensive rapid meta-review of research on digital public mental health related interventions to determine theoretical underpinnings of these types of interventions, user quality assessment and effectiveness. Key findings of this meta-review were that the usability, safety, acceptance and

effectiveness of these types of interventions was well-supported. The researchers found that outcomes (only short-term outcomes were measured) were enhanced if a blended care approach was taken; that is, the digital intervention was complemented with contact with a mental health professional. These findings applied both to digital interventions seeking to prevent mental illness and those promoting mental health. David et al. (2023) conducted a meta-analysis to investigate the impact of online parenting programmes on child emotional problems and found these programmes can result in improvements in child and adolescent emotional difficulties at both a clinical and non-clinical level. Finally, a systematic review of web-based interventions to increase adult mental health literacy found that these are most effective when they were evidence-based, targeted to their audience, followed a structured programme and promoted interactivity (Brijnath et al., 2016).

Parent Mental Health Literacy Interventions

Just as there are few studies investigating levels of parental mental health literacy, there are also few evaluations of mental health literacy interventions with parents. A recent systematic review of mental health literacy interventions for parents of adolescents found only nine studies reporting quantitative outcomes (Kusaka et al., 2022). Several studies were assessed to be effective in increasing mental health knowledge and parental confidence in helping adolescents with mental health difficulties. However, these researchers made a call for further robust evaluations of parental mental health literacy interventions.

Hurley et al. (2021) are among the few researchers who have developed and robustly evaluated mental health literacy interventions specifically designed for parents. Their intervention targeted parents of adolescents and was advertised and delivered at community sports clubs. The intervention content and delivery was informed by qualitative

research and findings of a pilot intervention (Hurley et al., 2017, 2018), and aimed to increase awareness of how to support adolescent mental health. A matched control trial of the intervention provided evidence of improvement in some aspects of mental health literacy but not others. Parents participating in the intervention increased their confidence and knowledge of how to help someone experiencing a mental illness, and their likelihood of formal help-seeking more than parents in the control group. However, there was no difference between parents in the intervention and control groups in relation to stigmatising attitudes, increased ability to recognise anxiety and depression, or intentions to seek help. Interestingly this was due to an increase in mental health literacy amongst parents in the control condition (who resided in a similar community but received no intervention), as well as those receiving the intervention.

Other mental health literacy interventions with parents have been conducted using digital technology. Evaluations of these interventions have shown improvements in parent mental health literacy albeit the evidence on which these findings are based is of low quality (Deitz et al., 2009; Peyton et al., 2022).

A mental health literacy intervention targeted at parents of adolescents in Aotearoa New Zealand delivered via text-message and has shown promising results (Chu et al., 2018). In this study, parents of children aged between 10 and 15 years were randomly allocated to a 28-day daily text-message intervention adapted from a parenting programme that aimed to reduce risk of anxiety and depression; or a control group receiving no intervention. Chu et al. found a positive effect of the intervention on parental competence, knowledge of help-seeking, communication and parental distress, at one- and three-month follow-up periods, compared with a control group.

Podcasting to Increase Parental Knowledge

In terms of digital modes of delivery for psychoeducational interventions, podcasting is a viable option to consider. Podcasting involves the development of one or more audio files that is accessible to consumers via the internet and has been suggested to be a “21st century form of radio broadcast” (Singer, 2019, p. 574). Research conducted from 2006 to 2017 has shown an increase in podcast use in America from 22% to 60% (Edison Research, 2017). According to this research consumers are mostly between the ages of 18 and 54, with slightly more males than females using podcasts. Podcasting offers an easily accessible and portable way of communicating knowledge that still involves an interpersonal connection. Furthermore, other intervention barriers associated with time and money as well as stigma are minimised in podcasting interventions (Harter, 2019; Nelson & Faux II, 2016; Singer, 2019). In the counselling sector Casares and Binkley (2021) argue for the use of podcasts as an extension of bibliotherapy. That is, they suggest that as bibliotherapy can be integrated into the therapeutic process (by selecting books with theoretically grounded content relevant to client needs to complement therapy), a podcast could be selected to achieve the same purpose.

Although there is a multitude of podcasts discussing mental health, few podcasts seeking to increase mental health literacy have been evaluated and reported in the academic literature. There is however a small amount of academic research investigating the effectiveness of communicating health related information via podcast. For example, a study by Turner-McGrievy et al. (2013) compared a podcasting approach to communicating weight loss information with presentation of the information on a web-page. The researchers found no differences between the two methods in the knowledge gained

suggesting the method is as effective as other digital methods of communicating knowledge. A Ugandan study using podcasting to increase health literacy of parents of primary school aged children found a positive effect on increased knowledge in the short-term, although this effect was not sustained a year later (Semakula et al., 2020). Accordingly, the researchers suggested a follow-up episode or more active component to the intervention may be required for longer-term knowledge retention.

One study that has evaluated podcasting as a method of delivering a parenting programme has been reported in the literature. Morawska et al. (2014) found that the delivery of the Triple P Positive Parenting Program via podcast was effective in reducing child behavioural difficulties and increasing the use of effective parenting styles, parental confidence and self-efficacy both immediately after the intervention and at a six-month follow-up. Further benefits of using podcasting as identified by parents in this study included that it was more accessible in that it placed lower demand on parents' time and finances and its portability meant they could listen to the episodes multiple times.

A recent evaluation of a podcast series offering advice for parenting during the Covid-19 pandemic provided a number of implementation learnings (Morawska et al., 2022). In particular, the study found that engagement with the initial podcast episode was higher than with other episodes and parents appeared to select the episodes of most interest to listen to rather than listen to them sequentially. The researchers concluded that further qualitative and quantitative evaluation is required to determine the most appropriate content, structure and length but that podcasting as a mode of delivery had a number of potential benefits (Morawska et al., 2022).

Summary

The mental health promotion and prevention literature, alongside principles of implementation science, provide guidance for maximising effective design and implementation of mental health interventions. The parenting programme literature provides examples of application of these principles in practice and learning from this evidence base includes a need to offer interventions in a variety of different modalities.

Mental health literacy interventions with parents are few but show promising results, including those using digital methods to communicate knowledge. Podcasting is increasing in popularity and offers a way of communicating information that involves an interpersonal connection but allows for anonymity. This may provide an effective way to increase the mental health literacy of parents. This small but growing evidence base suggests using podcasts to deliver an intervention to parents to increase their mental health literacy has potential.

Chapter Seven: Rationale for the Present Research

This chapter provides a summary of the main findings from the literature discussed so far to present a rationale for the present research and the focus of the research questions.

Rationale

At the time this research was conceptualised and designed, the number of children and young people in Aotearoa New Zealand who were experiencing mental distress was increasing, and mental health services were unable to meet the demand (Elliott, 2017; Fleming et al., 2020; Health and Disability Commissioner, 2018; Ministry of Health, 2018). The pressure on mental health services was exacerbated by the impact of the Covid-19 pandemic on population mental health. In response, one of the goals of the government's Covid-19 psychosocial recovery plan was to equip people with knowledge to maintain their mental health (Ministry of Health, 2020).

Although mental health is sometimes used synonymously with mental illness, research suggests there are two related but separate constructs that make-up one's overall mental health: mental illness and mental health (or flourishing) (Keyes, 2002, 2005). The mental health literacy literature suggests there is an association between mental health literacy levels and attitudes towards and help-seeking behaviour for mental health (Bonabi et al., 2016; Gorczyński et al., 2017; Lam, 2014).

The role of parents, caregivers and whānau in supporting a child's development and mental health is significant (Bronfenbrenner & Ceci, 1994; Durie, 1985; Mental Health Commission, 2001; Cole et al., 1978). A number of parenting factors, including the mental health literacy of parents and caregivers have been shown to contribute to child mental

health outcomes. There are few studies investigating parent mental health literacy and of those, even fewer are focused on parents of primary school aged children (Hurley, Swann, Allen, Ferguson & Vella, 2020; Johnson et al., 2023). Systematic review evidence suggests low levels of mental health literacy amongst parents of children aged 5-10 years (Johnson et al., 2023). However, these studies have focused on the recognition of child mental illness without investigating mental health literacy as it relates to promoting positive mental health of a child, an equally important construct when determining overall mental health (Keyes, 2002, 2005).

Evidence from the parenting programme literature provides a strong basis from which to conclude that interventions to increase parents' knowledge and skills can effect positive outcomes for children (Overbeek et al., 2021; Sanders et al., 2014; Sturrock et al., 2014). There is a small but growing body of literature concerned with evaluating interventions seeking to increase parent mental health literacy specifically, which have shown some positive outcomes (Hurley et al., 2021). As the parenting environment and parenting challenges become increasingly complex, there is a need to diversify delivery methods to maximise parental engagement. Use of a range of digital methods to deliver parenting and mental health interventions are showing promising results (Chu et al., 2018; Peyton et al., 2022; Rauschenberg et al., 2021). Podcasts offer a flexible and anonymous way of consuming information. There is an emerging evidence base regarding the effectiveness of podcasting to communicate information to parents that is promising (Flujas-Contreras et al., 2019; Morawska et al., 2014, 2022; Semakula et al., 2020).

In sum, the literature suggests parents and caregivers are well-placed to support the mental health of their tamariki, but they are not always equipped with the necessary mental

health knowledge to do so. Knowledge of how to enhance mental health and how to identify symptoms of, and seek help for, mental distress are core constructs of mental health literacy (Jorm et al., 1997; Kutcher et al., 2016). There are few mental health literacy-specific interventions developed for parents, particularly at a universal¹⁴ level, and a lack of interventions targeting the mental health literacy needs of parents of primary school aged children. The purpose of this research is to develop a stakeholder-informed, evidence-based podcasting intervention that aims to increase the mental health literacy of parents and caregivers of primary school aged children. The questions the present research will address are as follows:

1. What are the mental health literacy needs of parents and/or caregivers of primary school aged children?
2. How could these needs be met through a podcasting intervention?

This research responds to public interest in interventions that promote and maintain mental health, and will make an important contribution to the literature regarding parent mental health literacy and the use of podcasting as a method to increase mental health literacy at a universal level (i.e., for all parents irrespective of a child's risk of mental illness).

¹⁴ Throughout this thesis the term 'universal' has been used to mean an intervention that is designed for the entire parenting population without regard to the presence of individual risk factors for mental health difficulties or the presence of mental illness in a child (Gordon, 1983; Yap et al., 2016).

Chapter Eight: Research Methodology

Chapter Eight provides an overview of the paradigmatic worldview and epistemological positioning underpinning the research, the approach taken to address the research questions and theoretical framework guiding the research.

Ontological and Epistemological Positioning

In conducting this research, I acknowledge my overarching worldview has influenced the decisions made throughout the research process. Therefore, it is important to be explicit about the ontological and epistemological underpinnings and reflect on how this worldview may have influenced the research process.

In believing that one's reality is determined by one's own construction of reality I consider myself to hold a relativist ontological view of the world. In this sense, it is asserted that multiple realities rather than one true reality exists (Guba & Lincoln, 1989). That is, each person's version of reality is likely to be influenced by multiple factors, including their social and cultural contexts. This perspective is reflected in my decision to use a qualitative research approach to explore parents' mental health literacy needs and inform the development of a mental health literacy intervention for parents. In doing so, it is acknowledged that the knowledge generated through the research process is at the intersection of the differing realities and world-views held by the researcher, research participants and those interpreting the research (Braun & Clarke, 2022).

A social constructionist view of the nature of knowledge is the predominant epistemology underpinning the research design. Social constructionism considers that knowledge and meaning are made through an individual's social actions (Gergen, 1985). Contrasting this view with positivism, Crotty (2020, p. 42) states that 'meaning is not

discovered but constructed' in social constructionism. If we are therefore active agents in making sense of what we see, it becomes apparent that we do not do this in a void, but through a lens developed through the multiple social systems into which we are each born. Although the literature is at times inconsistent when it comes to defining social constructionism, it is generally accepted that the way in which our knowledge is constructed is dependent on the social, cultural and political contexts within which each of us lives and therefore differs depending on the social perspective of the individual (Savin-Baden & Howell Major, 2013).

A social constructionist perspective has influenced my view of mental health, how I understand the development of mental distress, and therefore the selection of theoretical frameworks informing this research. Social constructionists view an individual within their multiple social contexts and influences therefore situating understanding of positive mental health and mental health challenges within social contexts, compared with viewing a problem as residing within the individual or pathologizing the individual (Gergen, 1985). The bioecological model (Bronfenbrenner, 2000; Bronfenbrenner & Ceci, 1994) offers a way to view the multiple contextual influences on an individual, as do Māori and Pasifika frameworks for considering the influences on health and wellbeing such as Te Whare Tapa Whā (Durie, 1985) and the Fonofale (Ministry of Health, 2008) models. Also grounded in social constructionism, sociocultural theory emphasises the importance of parent-child interactions within a particular cultural context, on development and mental health. These models were used in the present research both as frameworks for considering the influences on mental health of a child and their whānau and also for considering parent mental health literacy needs.

Social constructionist approaches to research inquiry place emphasis on exploring the social context within which individuals construct their sense of the world and takes care to interpret meaning within this context. Furthermore, as my interpretation of knowledge is socially constructed, I acknowledge that I played an active role in the generation of knowledge through the research process. The research inquiry process and generation of knowledge was a collaborative process between myself as the researcher and those contributing to the research, rather than a process of the researcher collecting data from research participants (Burr, 2015). Therefore, the social contexts within which the research was designed, those of the participants contributing to the research and that which surround the processes of gathering and interpreting data are inherent in the knowledge that has been generated through this research. In acknowledging these multiple influences and perspectives, the research process aimed to generate a shared meaning of knowledge to address the research questions (Patton, 2015).

Social Context of the Research

This section presents a summary of the contextual influences on the research and researcher.

Sociocultural Context

As discussed at the beginning of this thesis, this research was designed and conducted within two prominent sociocultural contexts: the increasing demand for mental health services in Aotearoa New Zealand and the Covid-19 pandemic.

The research was conducted during a time in Aotearoa New Zealand that has been described by professionals and the media as a 'mental health crisis' due to increasing prevalence of mental distress and inability to meet demand for services. Secondary mental

health services employing triaging processes ultimately meant resources had to be directed to clients experiencing the most severe psychological difficulties, with those with mild difficulties often being unable to access services. Many private psychological practices were not taking on new referrals, or were servicing long waitlists, during which time mental health difficulties could have become more severe (Skirrow, 2023). The media narrative reflecting the inability of services to meet demand may have raised concern and fear about the inability to be able to access help. On the other hand, it may have also increased awareness of the importance of mental health.

In addition, the ongoing impact of the Covid-19 pandemic on population mental health added further challenges for meeting the demand for and delivery of mental health services. Changes in financial circumstances, reduced social contact, lockdowns and online schooling at home added stress to whānau. However, there may also have been positive consequences of living through a pandemic. National campaigns may have increased awareness of the importance of maintaining wellbeing and taking steps to recognise and address stress and signs of poor mental health. It may also have prompted some changes in employment and personal wellbeing practices. It could be argued the pandemic has raised awareness of the importance of engaging in activities to support positive mental health as well as a need to seek help for mental health difficulties.

In sum, at the time this research was conducted these sociocultural contexts meant that mental health was a prominent topic in social discourse. Both dimensions of the dual factor model of mental health (Keyes, 2005) were being socialised. Mental health was being discussed as an asset needing to be invested in and maintained, and awareness was raised as to the signs of mental ill-health and importance of seeking help. Accordingly, both these

dimensions of mental health literacy were explored in interviews with parenting practitioners in the current research. Furthermore, practitioners discussed parent mental health literacy needs in the context of the current demands on mental health services and impact of living through a pandemic.

Social Context of the Researcher

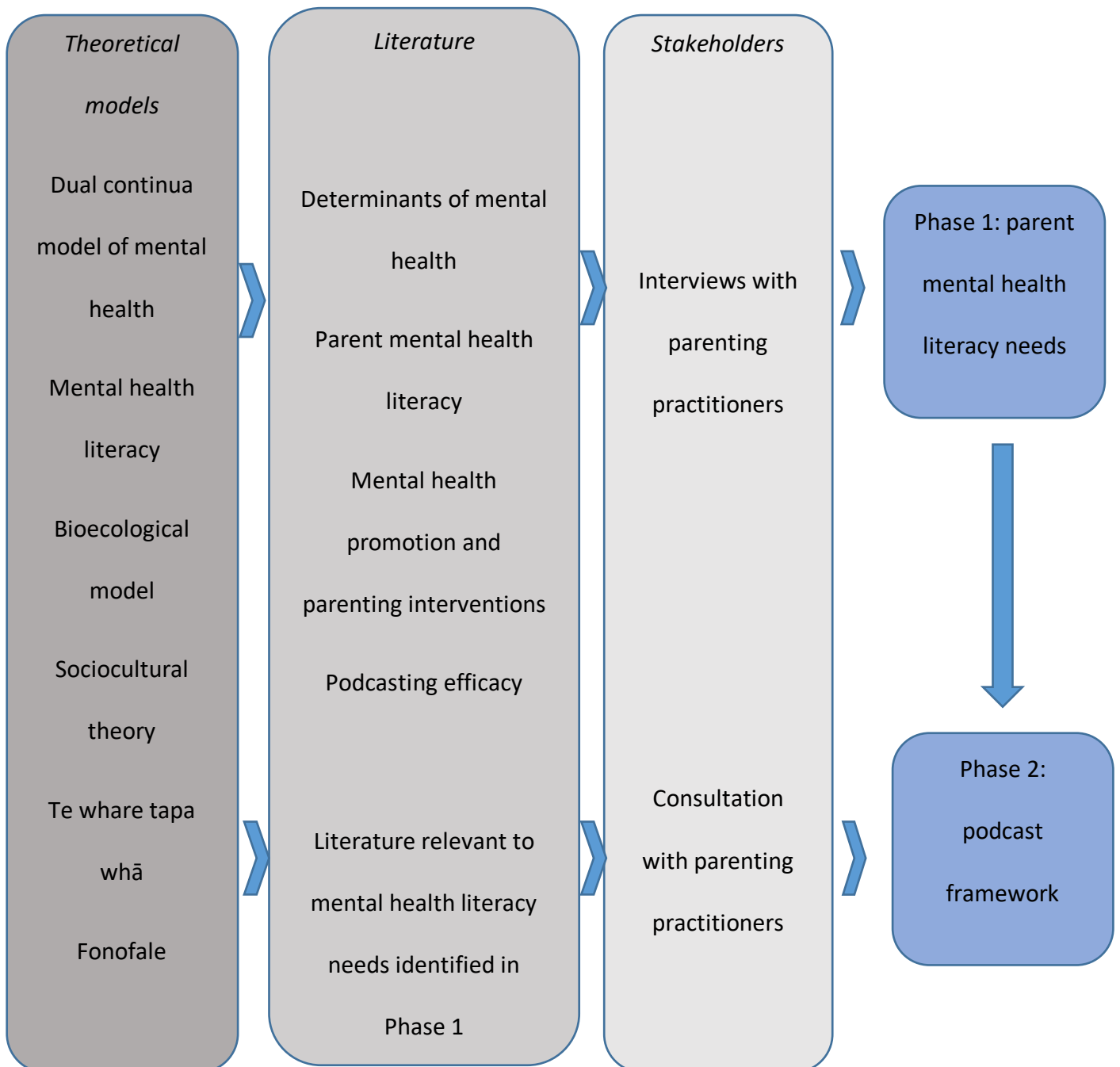
The inherent subjectivity of knowledge generated within a social constructionist worldview is acknowledged. Within this paradigm I acknowledge my own social context and personal positioning has influenced the research. As the researcher, I acknowledge my perspectives are from the privileged position of being a well-educated New Zealand Pākehā female. My mother's feminist views and contribution to social justice were early influences on the way I view the world and my desire to make a contribution to improving child wellbeing. I also bring my own experiences of vulnerability due to serious physical and mental ill-health as a parent. In addition, twenty years as a social researcher within the criminal justice sector has taught me the benefits of valuing differing perspectives and how strongly people's social contexts influence their perspectives. This has informed the social constructionist lens I view the world through. In relation to my research aims, I appreciate that as a parent of two primary school-aged children I have brought my own views of parenting approaches and parents' understanding of child mental health to the research. As a clinical psychology trainee, the emphasis in my training on preventing, assessing and treating mental ill-health and the social influences on this work has influenced my worldview. In my researcher role, I needed to keep these positions and influences in mind and consider how they impacted the research development process and the process of analysing and interpreting the research findings.

Research Approach

The theoretical framework and overview of the purpose and components of each phase of the research is summarised in Figure 2 below.

Figure 2

Overview of the Research



Theoretical Framework

Placing equal emphasis on positive mental health and mental ill-health, Keyes' (2005) dual continua model of mental health underpins the exploration of parent mental health literacy in this research. As detailed in earlier chapters, the definition of mental health literacy has evolved over the past couple of decades. For the purposes of this research the following mental health literacy constructs were used: knowledge of how to obtain and maintain good mental health and recognise and prevent mental distress in children as well as help-seeking efficacy (Kutcher et al., 2016). Knowledge gaps against these constructs were explored using a social constructionist lens through interviews with practitioners who work with parent and caregivers of children aged 5-10 years. Consideration was given to sociocultural theory (Cole et al., 1978), the bioecological model (Bronfenbrenner, 2000; Bronfenbrenner & Ceci, 1994), Te Whare Tapa Whā (Durie, 1985) and the Fonofale model (Ministry of Health, 2008) during the interviews and guided analytical and reflective processes of the research.

Overview of Research Phases

Phase 1 of this research involved interviewing practitioners working with parents and caregivers to explore their perceptions of the mental health literacy needs of parents and caregivers of children aged 5-10 years. Phase 2 of the research builds on the findings of Phase 1 and draws on the literature and expertise of practitioners to develop content and approach for a parental mental health literacy podcast. As such, this research employed an iterative qualitative approach drawing on the experience of practitioners firstly to explore and identify mental health literacy needs, and then to contribute to the development of a resource to meet the mental health literacy needs of mātua.

Enhancing Research Quality

In adhering to the qualitative research validity principles of Yardley (2015), I maintained sensitivity to context throughout the research planning, data collection and analysis phases. In particular the sociocultural context of the research, of myself, and the participants in the study were explored and reflected. A systematic approach to data collection and analysis and regular reflection enhanced the research rigour, as well as the approach of discussing the findings of the present research in the context of the national and international evidence base. In relation to the principle of transparency of the research, the methods selected have been carefully considered, were implemented with integrity, and are explicitly detailed (Yardley, 2015). The limitations of the research are also reflected on and discussed.

Qualitative methods of inquiry acknowledge and value the subjectivity of the research process and researcher reflexivity is one approach to enhancing research quality (Braun & Clarke, 2013). Reflexivity is sometimes confused with reflection in qualitative research (Savin-Baden & Howell Major, 2013). In the present research, reflection was used in the planning phases of the research, whilst developing the research tools and collecting data and during the analytic and interpretive processes. I have been reflexive in considering how my own personal experiences and worldview may have impacted on the research process and these were captured as reflections throughout the research. Finally, I have been intentional in my efforts to develop a practical resource that is grounded in theory and research evidence, to make a contribution to supporting mātua to improve mental health outcomes of tamariki.

Summary

A relativist ontological worldview and social constructionist perspective underpinned the conceptualisation, design and conduct of the present research. Sociocultural and bioecological theories and indigenous models of health influenced the approach taken to the research and definition of constructs used. An iterative approach utilising predominantly qualitative methods of inquiry has been used to draw on the experiences and knowledge of a range of practitioners in addressing the research questions.

To enhance the integrity of the research careful consideration was given to the methods used and the key elements of the methods are comprehensively described in the thesis. The influence my own experiences and worldviews have on the research process are acknowledged and have been reflected on throughout the conduct of the research.

Chapter Nine: Phase 1 Method

This research aimed firstly to explore the mental health literacy needs of parents and caregivers of primary school aged children in Aotearoa New Zealand as perceived by practitioners who work with them. Secondly, the research sought to understand how some of these parent mental health literacy needs could be addressed through a podcasting intervention. The research contributes to the growing evidence base concerning parent mental health literacy. The findings of this phase of the research were used to inform the development of a framework for a podcast aiming to increase parent mental health literacy.

Obtaining user or stakeholder perceptions to inform intervention design is considered good practice in developing mental health promotion initiatives (Barry et al., 2019). In order to develop an intervention that is relevant and useful for parents, the input of informed stakeholders was a necessary first step. The purpose of Phase 1 of the research was to explore practitioner perceptions of mental health literacy needs of parents and caregivers of primary school aged children, and addressed the following question: What are the mental health literacy needs of parents and/or caregivers of primary school aged children? A further goal was to gather information regarding the acceptability of podcasting as a mode of delivering an intervention for increasing mental health literacy. Reflexive thematic analysis was used to explore the perceived mental health literacy needs of parents and caregivers of primary school aged children and how these may be able to be met through podcasting. Reflexive thematic analysis allowed for both inductive and deductive analysis, both latent and semantic development of themes and consequently both a descriptive and interpretive approach to understanding and explaining the themes.

Design

Semi-structured interviews with practitioners working with parents allowed for guided exploration of their perceptions of parents' mental health literacy needs. Furthermore, a semi-structured interview guide allowed for a collaborative approach to the interview as employed by social constructionist researchers (Savin-Baden & Howell Major, 2013). Given the limited time practitioners had available, this method of data collection allowed for in-depth exploration of practitioner perceptions of mental health literacy needs using preset questions.

Ethical Considerations

This research was evaluated and judged by my supervisors and I to be low risk in relation to any ethical concerns. Accordingly, a low-risk ethics notification was made to the Massey University Human Ethics Committee (4000022899). Ethical issues pertinent to this research included the principle of Autonomy (Massey University, 2017), in particular in relation to informed consent to participate and participant confidentiality. Efforts to ensure voluntary consent included recruiting participants through a third party (e.g., organisational or other contact), providing clear information about the purpose of the research and how participant information would be stored and used, and requesting that participants provide written consent prior to interview. Confidentiality was maintained by conducting the interview in a private space, anonymising the transcripts and securely storing interview data.

Several steps were taken to ensure the research was conducted with integrity in relation to Te Tiriti o Waitangi. I sought to build a collaborative approach into the research

design and development of the resource. Tikanga¹⁵ of whakawhanaungatanga¹⁶ and karakia¹⁷ were incorporated into the research activities, and I made efforts to learn and incorporate reo Māori throughout the research process. The perceptions of practitioners working with Māori whānau were explored in the initial Phase of the research and further consulted during the development Phase. Practitioners shared their perceptions of effective approaches when working to improve whānau wellbeing and I sought to increase my knowledge of these approaches (e.g., creation stories, pūrakau¹⁸, waiata, karakia, whakatauki¹⁹, metaphor, Māori wellbeing models) in order to understand how these may inform or contribute to research outputs. I continually reflected on how I positioned myself as a researcher and how this may have impacted on interactions with practitioners contributing to the research. In seeking the knowledge of others, I saw my role as a ‘learner’ but also respected the tika of the reciprocal sharing of knowledge in this process. In accordance with Vision Mātauranga (Ministry of Research, Science and Technology, 2007), this research sought to draw on the knowledge and expertise of practitioners working with Māori whānau to explore effective ways of improving mental health literacy of Māori whānau. Finally, I sought cultural supervision from my primary supervisor throughout the process of designing, conducting, analysing and writing up my research.

Participants

In qualitative research, participants are carefully selected based on their having specific characteristics of interest to the study. In contrast with quantitative research, the

¹⁵ Māori customs or traditions.

¹⁶ Establishing connections and building relationships.

¹⁷ Māori prayer or incantation.

¹⁸ Māori spiritual story about the natural and human worlds.

¹⁹ Māori proverb.

focus is to obtain a depth of information from these carefully selected participants (Crouch & McKenzie, 2006). A purposive sampling approach was used to identify participants likely to be able to provide in-depth and rich contributions to the study (Braun & Clarke, 2013). Multiple purposive sampling approaches were used to recruit participants for this research. Firstly, I presented my research to a Werry Workforce Whāraurau Triple P parenting programme practitioner forum and requested interested practitioners contact me. Two participants were recruited through this approach. Using my own networks and those of one of my supervisors, I recruited a further ten participants. Two participants with experience working with Māori whānau were recruited using this approach. In expressly seeking the perspectives of practitioners working with Pasifika whānau, I approached Le Va (a New Zealand organisation focused on supporting optimal health and wellbeing outcomes for Pasifika communities), and a further participant was recruited this way.

The number of practitioners interviewed for this research was guided by the concept of information power (Malterud et al., 2016). Qualitative researchers purport that the sample size for a qualitative study should be guided by the amount of relevant information provided by the sample. How relevant the information is will depend on a number of variables concerning the research design, including the specificity of the sample, whether the research is theoretically guided, the quality of the interviewing and the analytical approach taken (Malterud et al., 2016). Based on these considerations, an initial sample of 10-12 participants was considered likely to be appropriate for offering insight and understanding in relation to the research question. In practice, after conducting interviews with 11 practitioners experienced in working with parents and caregivers of children aged 5-10 years, it was decided that sufficient information power for the purposes of the study had been achieved.

Practitioners who work with parents (rather than parents themselves) were chosen as participants for three reasons. Firstly, these stakeholders were well-positioned to consider needs that commonly arise in their interactions with multiple parents. As experienced practitioners they were considered to also have perceptions of needs that may not arise directly (if the parents themselves were interviewed), but may be recognised by the practitioner as a gap in knowledge. Lastly, interviewing practitioners working with parents rather than interviewing parents themselves reduced the risk of the research process causing any harm (e.g., interviewing parents themselves may have elicited anxiety about their child's mental health). Seeking the perspectives of practitioners working with parents as a method to explore parent mental health literacy has been used in previous research to usefully contribute to this growing body of literature (Frauenholtz et al., 2015).

Demographic and Occupational Information of Participants

A total of 11 practitioners working with parents/caregivers were interviewed. Table 1 below provides a summary of the characteristics of the parenting practitioners contributing to the research, providing greater context to the analysis. The table illustrates that practitioners were predominantly female, aged 40 years and older and working in mental health related services in the North Island across a mix of regional and urban settings.

It is worth noting that the majority of participants worked in primary or secondary mental health services. Whilst in some ways this was a necessity given that the practitioner required some expert knowledge about child mental health to be able to comment on parent mental health literacy gaps, it did mean the perspectives obtained were dominated by those working with children experiencing (differing degrees of) difficulties with their mental health, rather than those who were not.

In striving to obtain information pertaining to perspectives of fathers/male caregivers' knowledge gaps concerning child mental health, participants were specifically asked to comment on the mental health literacy needs of fathers. Also, male practitioners were sought out for interview with a view that they may have more contact with fathers, and three male practitioners participated. Finally, one Samoan and two Māori practitioners were interviewed to explore parental mental health literacy needs from these cultural worldviews, and any differences between cultures in their mental health literacy needs was explored where practitioners had experience of working with whānau from a range of cultures.

Table 1

Participant Information

Pseudonym	Gender	Ethnicity	Age group	Occupation	Experience (yrs)	Region	Populations working with
Liz	F	British/ Pākeha ²⁰	40-50	Rural nurse practitioner	6-10	Rural South Island	Children/families with physical and mental health needs
Megan	F	NZ Pākeha	40-50	Psychologist	16-20	Metro Upper North Island	Children/families with complex mental health difficulties
Pip	F	Indian	30-40	Telephone counsellor	6-10	Metro Lower North Island	Adults with parenting challenges
Ala	F	Samoan	50-60	Family worker/ parenting programme facilitator	16-20	Urban Lower North Island	Pasifika families with parenting and mental health difficulties

²⁰ New Zealander of European descent.

Aria	F	Māori	50-60	Social worker	21-25	Regional Lower North Island	Children, adolescents and families with mental health difficulties
Lauren	F	Latin American	60-70	Counsellor	11-15	Urban Lower North Island	Children and families with mental health difficulties
Jean	F	English	40-50	Counsellor	16-20	Regional Lower North Island	Children/families with mental health difficulties
Graham	M	Pākeha	50-60	Social worker	30+	Urban Upper North Island	Children with mental health and behavioural difficulties
Sam	F	Pākeha/Māori	40-50	Special needs coordinator	6-10	Urban Lower North Island	Children/parents of children with learning and behavioural difficulties
James	M	Pākeha	60-70	Psychiatrist	21-25	Urban Lower North Island	Māori whānau with mental health difficulties
Rawiri	M	Māori	U/K	Cultural advisor	U/K	Urban Lower North Island	Māori whānau with mental health difficulties

In sum, eight of the research participants were female practitioners; two were based in metropolitan centres in New Zealand; one was based in a rural area of the South Island and the remaining participants worked in the urban and regional areas of the North Island (mostly the lower part). Participants had varied occupational histories, predominantly working in the mental health sector (as social workers, counsellors, psychologists, and a psychiatrist) but also nursing, education and a cultural advisor. Aside from one participant for which the information was unknown, three of the participants had worked extensively with Māori whānau and another with Pasifika families (predominantly Samoan). Another participant had experience working with former refugee and Asian families and the remaining participants worked predominantly with New Zealand Pākeha/European families.

Interview Guide

There were two overarching objectives of the interviews:

- To explore areas of mental health literacy needs for parents
- To inform the development of a podcasting intervention regarding acceptability and approach to intervention content.

The interview guide is attached as Appendix A, and an outline of the interview guide follows:

Section 1: context

- Background and current role
- Common concerns parents/caregivers have about their primary school aged children

- Approach to talking to parents about child mental health, models/ worldviews of child mental health

Section 2: perceptions of parents' mental health literacy

- Areas/topics that parents'/caregivers' have good knowledge about in relation to child mental health problems, how they talk about distress in their children and what they do to support them
- Potential gaps in parents'/caregivers' knowledge of child mental health problems, concerns and/or advice commonly sought by caregivers, how these gaps could be met at a community level
- Parent/caregiver understanding of positive mental health in primary school aged children and areas/topics in relation to positive child mental health that parents'/caregivers' have good knowledge about, how caregivers are enhancing their child's mental health
- Potential gaps in parents'/caregivers knowledge of positive mental health of primary school aged children, advice commonly given to caregivers in relation to how they can enhance their child's positive mental health, how these gaps could be addressed at a community level
- Differing needs for different cultural groups in relation to each of the areas above
- Any other comments in relation to parent mental health literacy

Section 3: perceptions of podcasting

- Advantages/disadvantages of using podcasting to communicate information about child mental health to parents/caregivers
- How to enhance the acceptability of a podcasting resource for parents/caregivers

Demographic attributes (gender, ethnicity, age group) were collected at the end of the interview.

Procedure

To enhance the quality of the research the interview guide was piloted prior to use and I carefully reviewed richness of participant responses to the interview questions in the first few interviews (Braun & Clarke, 2022). I piloted the interview guide with two colleagues. As a result of this process, I chose to take a flexible approach to the interview: this allowed me to focus on the overarching questions and use sub-questions as prompts where relevant to guide the interview dialogue within the main purposes of the interview. My reflections following each interview resulted in further adjustments to the interview guide, in particular for interviews with Māori and Pasifika participants (e.g., in relation to understanding how the term mental health is perceived in these communities).

Once potential participants were identified (through the approaches described above), I first provided them with further information about the research (Information Sheet attached as Appendix B). If the participant indicated willingness to be interviewed, a suitable time was arranged, and participants completed and returned the consent form (attached as Appendix C) prior to the interview. I conducted the interviews *kanohi ki te kanohi* (face to face) where possible; otherwise over the telephone or using

videoconferencing software. With participant consent, interviews were all digitally recorded.

Interviewing Approach

Using a semi-structured interview guide allowed for a flexible and conversational style of interview whilst also ensuring a systematic approach to collecting information relevant to the purpose of the research (Patton, 2015). In recognising that each participant comes from a different worldview, a flexible approach to using the interview guide allowed me to tailor interview questions to suit the participant's view of mental health whilst adhering to the research aims. Grounded in social constructionism, I recognised the influence I had over the data in terms of the questions I asked in the interview, how I asked these questions and how I interpreted the experiences and perceptions they shared with me (Holstein & Gubrium, 2008). In this way, rather than simply trying to elicit knowledge from practitioners at a surface level, I actively explored the knowledge the practitioner was sharing in order to co-construct meaning in such a way that could be used to inform potential areas of content for a podcasting intervention (Gubrium & Holstein, 2003). I continually checked my understanding and interpretation of what each participant was sharing with me as a form of researcher reflexivity (Braun & Clarke, 2022). In sum, the data I obtained through my interviewing process is inherently subjective as all parts of the process were influenced by my own interests, experiences, and world-views. I engaged in reflexivity throughout the research process as a core strategy to enhance the integrity and quality of my research. This process involved being continually reflective of my positionality and how this influenced the research conduct, analysis and interpretations (Berger, 2015).

In line with the principles of social constructionism, as well as good ethical practice I made attempts to address any power imbalance between myself and each participant by being transparent about my roles as a parent and student of clinical psychology and my conceptualisation of mental health. In this way I hoped each participant would be more willing to be open with me in their responses and to be comfortable with the process of co-constructing meaning from the data they provided. I also outlined the purpose of the research and how the information obtained would be used at the start of the interviews as well as in the information sheets. Finally, I emphasised the importance of the experience and knowledge shared by the participant in contributing to the aims of the research.

A social constructionist perspective places emphasis on the importance of culture as one of many social contexts influencing experiences and interpretations of experiences. I undertook cultural consultation with my supervisor to explore how I could enhance the cultural safety of how I interviewed participants. Karakia (use of prayer/incantation to formally open and close interactions to help provide spiritual safety) and whakawhanaungatanga (establishing connections and building relationships) were incorporated into the interview process with Māori participants. In interviews with Māori and Pasifika participants, I made efforts to explore cultural worldviews and practices and use greetings and terms in the participant's first language to better understand parental mental health literacy within these contexts.

As a means of expressing gratitude to participants for sharing their knowledge and time a koha (gift) in the form of a \$40 supermarket gift card was given to participants at the end of the interview. Following the completion of each interview, I spent a few minutes reflecting on the interview and making notes on the sense I made of the interview. This

included how I felt the interview went, adaptations/changes to the guide that may be useful in further interviews, notes on what I felt were the key learnings from the interview, the thoughts and feelings the interview evoked in me and how my values and subjectivity may have influenced the interview course and information shared. Patton (2015) refers to this period of post-interview reflection as a 'ritual' that contributes to the rigour of the research and is an important part of qualitative research. These reflective notes helped improve the ongoing development of the interview guide, helped me to identify gaps in data collection, maintain close alignment of the purpose of the interviews with the overall purpose of the research, inform development of initial analytic codes and helped me to develop my reflexivity skills.

Transcription Approach

Consent was obtained from all participants to digitally record their interviews and the process of transcribing this recording was integral to my immersion in, and increasing my familiarity with, the data. Shelton and Flint (2019) note that there are further opportunities for reflection and reflexivity throughout the transcription process. Accordingly, during the transcription process I kept a record of thoughts arising from the interviews as well as how I may have influenced the information the practitioner chose to share and how they shared the information. For example, I noted if they emphasised specific points during the interview and I reflected on the main messages that were being conveyed throughout the interview.

In that the interview process itself is a social construction of meaning, so too is the process of transcribing as it involves a number of decisions about what to record. The transcription itself should be considered a construction rather than an accurate written

record of the interview (Braun & Clarke, 2022; Hammersley, 2010). Approaches to transcription vary depending on the aims of the research, the theoretical underpinnings and methodology and methods employed.

Decisions around what to include in the written record of the interview were made with the overarching purposes of the research in mind. A 'verbatim' approach to transcribing was used in this research given the language the participants used was considered to represent their perspectives based on their own experiences and worldviews. However, given the ambiguity in the literature as to what a 'verbatim' approach involves (Savin-Baden & Howell Major, 2013), a clear description of what was and was not included in the transcript follows. Given the purpose of the interviews was to explore practitioners' perceptions of parents' mental health literacy needs, it was determined that accurate transcription of every non-verbal utterance (such as 'um') or minimal encourager (such as 'mmm') was not required. Paralinguistic features of the data, such as words in which a speaker was cut-off, laughter and pauses were reflected in the transcript using notation suggested by Braun and Clarke (2013) to provide an indication of interview pace and tone. Inaudible speech was noted as such and minimal punctuation was added only where it seemed obvious from the way the person spoke during review of the audio recording. To ensure anonymity, a code letter instead of the participant's name was used in the transcript, potentially identifying information was anonymised and a pseudonym was used in this thesis.

Practitioners who contributed to the research were asked if they wished to review and/or edit their transcript prior to analysis and all provided endorsement of their transcript as reflecting their views in the interview.

Analytic Approach

I used Braun and Clarke's (2006) framework to undertake thematic analysis of the data to develop themes from within and across interview data in relation to parents' mental health literacy needs, taking into account social and cultural contexts. A reflexive approach was taken in that I continually reflected on the role and influence I had on the research throughout the research process (Braun & Clarke, 2022). Reflexive thematic analysis is a flexible method that can be applied within a social constructionist perspective (Braun & Clarke, 2022). The theoretical flexibility of reflexive thematic analysis allowed for the analysis to be guided by the dual continua model of mental health and the constructs of mental health literacy, and interpreted within a bioecological framework.

Reflexive thematic analysis allows for data driven in-depth exploration of themes both within and across interviews. However, in keeping with the purpose of and theoretical framework for the research, knowledge strengths and gaps in the mental health literacy constructs of interest formed the overarching framework for the analysis. Accordingly, the analysis was both deductive and inductive in nature.

I was guided by Braun and Clarke's (2006, 2022) six-phase framework in how I approached the analysis. Reflexive thematic analysis is an iterative process and involves a number of steps in developing meaningful themes. The initial stage of analysis involved review and reflection on the transcripts. The purpose of this stage was to become deeply familiar with the data (Braun & Clarke, 2022). Notes that I made immediately after the interviews and during transcription were also reviewed. During this stage I held the purpose and questions of my research at the forefront of my mind. I considered both my own and the participants' interpretation of the interview questions. I also considered the meaning of

the data in relation to the social context at the time, that of the participants and in relation to my personal social context. I made notes on possible insights into what may have been underlying some data as well as notes on what was actually being said. In addition, at the end of each transcript I reflected and made notes on the overall points that stood out to me from the data. This stage was conducted with pen and paper (i.e., I wrote notes on the print-outs of the transcripts).

The second stage involved systematically reviewing each section of interview data and applying a code (and in some cases multiple codes), both inductively and as relevant to the research questions (deductively) as appropriate. I also reviewed the notes I made after each interview, during transcription and the familiarisation stages and added further codes as relevant. The interview segments against each code were then reviewed again to refine and add codes. Some of these codes reflected surface level interpretation (semantic) of the data and some represented deeper insight (latent). I used a peer debriefing approach (Watters, 2014) to enhance my reflexivity and the quality of the coding whereby my two supervisors reviewed and coded two transcripts, and discussed potential themes. The coding stage of the analysis was conducted using the qualitative data analysis software package NVivo.

Following this stage, a review of all codes and coded data was undertaken with the purpose of grouping codes and identifying underlying meanings to develop initial meaningful themes. I found this process difficult during the early stages as there was a large number of codes and they could be grouped in multiple ways. Initially, I developed too many themes although a number of these lacked depth. I recognised that I was trying to represent all of the data which was unnecessary, and I reconsidered how I could group my

codes into themes. I also noted that my personal experiences with navigating child mental health in my own parenting context were influencing how I viewed the data. For example, I was placing more emphasis and insight into codes and initial themes relating to childhood anxiety than what may have been warranted from the data. As a result of this reflection, although anxiety remained a theme throughout my analyses it was ultimately situated within the context of understanding what is normal for a child and when to seek help, rather than being an overarching theme on its own.

Consultation and discussion of the initial and revised themes with my supervisors, and how these related to the research questions was a key stage in refining the analytic themes. Ensuring my themes related to the purpose of the research (and using a bioecological framework for organising codes against developing themes) helped in the process of reducing the number and refining the analytic themes. I used NVivo's conceptual mapping tools to assist with this stage and to develop a smaller set of overarching and sub-themes that better fit the codes and data. Following the development of these revised themes, I conducted a further analysis of each transcript against the themes. I reflected both on the relationship of the data with analytic codes and the appropriateness of the initial analytic themes to ensure the themes were reflective of the data set overall. This process led to reorganisation of the overarching themes and sub-themes. Unless otherwise specified, final themes and sub-themes were supported by data from interviews with at least five of the practitioners.

Finally, as each section of the analytic findings was written up, the bounds of each theme were defined and the essence of each was supported by relevant extracts from the data. In reflecting on the process of reflexive thematic analysis I came to appreciate the

value and influence of my reflexivity activities on the analysis and the need to be flexible in working through each phase of the analysis, as the process was iterative (and sometimes felt circular!) rather than linear. Social constructionist research acknowledges that the themes generated from the analysis are a result of an interaction between the researcher's experiences, influences, skills and own knowledge, frameworks used and the information generated through the interviews (Braun & Clarke, 2006, 2022). The themes I developed and discussed in this thesis are those that through a social constructionist lens I consider form a coherent narrative that addresses the research questions within the theoretical frameworks that informed the research. The final stage of the analysis involved both a descriptive explanation of the themes supported by deeper discussion and relevant extracts from the interviews. Themes were also discussed with respect to the social context of the data and within the theoretical context of the constructs of mental health literacy, the dual continua model of mental health and bioecological model.

Summary

This chapter has described the methods I used in designing and conducting a study that addressed the research questions of 'what are the mental health literacy needs of parents and/or caregivers of primary school aged children?' and 'how could these needs be met through a podcasting intervention?'.

The study involved conducting semi-structured interviews with 11 practitioners who work with parents of children of primary school age. A purposive sampling strategy was used to identify appropriate practitioners. The majority of participants worked in mental health services and worked in urban or rural centres in the North Island. There was diversity in participant age, gender and ethnicity. I transcribed and analysed the data myself using

reflexive thematic analysis in which my continual reflection of the influence I had on the research process was used to enhance the quality of the research.

Chapter Ten: Results

Introduction

This chapter presents the findings from reflexive thematic analysis of the transcripts of interviews with parenting practitioners. The purpose of the interviews was to explore practitioners' perceptions of the mental health literacy needs of parents and caregivers, and how these needs could be met through a podcasting intervention. The research is grounded in social constructionism. Accordingly, it is recognised the interpretation of the analysis is influenced by the sociocultural context within which the research has been conducted, those of the 11 participants contributing their knowledge to the research, and my own worldview and beliefs. Consistent with social constructionism, an ecological approach has informed the analysis in identifying themes relating to parental mental health literacy needs.

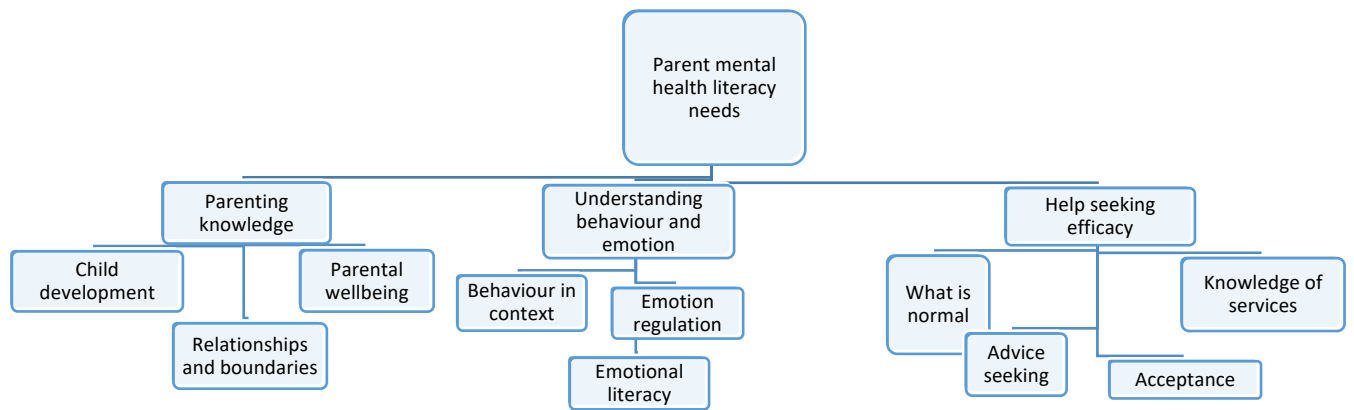
In addressing the first research question "What are the mental health literacy needs of parents and/or caregivers of primary school aged children?" three overarching themes were developed:

- general parenting knowledge,
- understanding of behaviour and emotion, and
- help-seeking efficacy.

The sub-themes within each of these overarching themes are presented in the thematic maps in Figures 3 and 4 below.

Figure 3

Thematic Map of Parent Mental Health Literacy Needs



In response to the second research question, “How could these needs be met through a podcasting intervention?” two themes were developed:

- podcasts may be an effective intervention mode, and
- podcasts need to be acceptable.

The sub-themes within each of these overarching themes are presented in the thematic map below.

Figure 4

Thematic Map of Views of Podcasting



Each of the key themes in relation to parent mental health literacy needs, and use of podcasting to meet mental health literacy needs are discussed in the remainder of this chapter.

Theme 1: General Parenting Knowledge

This theme covered knowledge of child development and how this can impact child mental health, the importance of the relationship between a child and their parent/caregiver and awareness and practice around parental wellbeing.

Parental Mental Health Literacy is Related to Knowledge of Child Development

Developmental psychopathology is concerned with how developmental processes and interactions with environmental factors contribute to mental illness and health (Sroufe & Rutter, 1984). Parental knowledge of what good mental health looks like in a child is influenced by their understanding of the developmental needs and abilities of children.

Practitioners emphasised the need to consider child wellbeing through a developmental lens.

It was generally accepted that child mental health was closely linked to healthy development. However, practitioners explained that parent and caregiver knowledge of what normative development looked like (or rather, what was not normal development) was variable, and often limited. Caregiver knowledge of child development was noted to be dependent on learning from their own parents/whānau, and caregiver experience with children of similar age, for example the number of other children the caregiver had or opportunities to observe their child's peers.

Having a base knowledge of child development is fundamental for parents/caregivers being able to align their expectations of a child with what they are capable of at the age they are at, and in turn realising potential and supporting mental health. Practitioners spoke about difficulties arising when there is a disconnect between a child's cognitive abilities and parental expectations of the child. When a caregiver's expectation is beyond the developmental capabilities of the child, the caregiver may misinterpret the child's behaviour as problematic (e.g., as non-compliant). For example, consistent with Piaget's theory (Carr, 2005), a practitioner working predominantly with children with conduct difficulties stated that:

People often don't know that children under about 6 are cognitively they're egocentric so a parent will come in and say 'oh he lies all the time, he lies, he lies', and actually I'm sitting there thinking that developmentally he's not capable of the things that you're suggesting that he's doing. *Megan*

A practitioner who regularly worked with Samoan families made a similar point:

With the Incredible Years when they come a lot of our Pacific people don't know about developmental stages. Like they talk to the child a two year old as though they are talking to a seven year old. *A/a*

In addition, parents' benchmark for what good mental health looks like was perceived to be closely linked to their expectations of a child's cognitive, social and emotional abilities. For example, the absence of any concern at school, academically or in their relationships with peers, was noted as an indicator that all was well with a child's mental health.

The parents that are concerned about their children's mental health there's usually an outward sign of something that's happening for their child that they've noticed (.) ... refusing to come to school or tummy aches or self-harming yeah usually there's an outward sign when they're worried about their children's mental health. If everything's going nicely we all think it's going great. *Sam*

Two points arise in relation to this quote. Firstly, a lack of knowledge of child development may lead to a misinterpretation that there is an underlying mental health concern. The second is that it appears parents/caregivers generally conceptualised mental health as the default state, in that if a child was meeting developmental milestones according to the parent/caregiver's expectations, it was assumed the child had no mental health concerns. In this way having good mental health was not seen as something to actively work to maintain. Another practitioner made a similar point that good mental health was perceived to be the absence of indicators of illness.

Practitioners emphasised a need for caregivers to understand a child's developmental capabilities particularly in relation to communication and language. Many

practitioners discussed the need for parents to reconceptualise how they interpret a child's behaviour. Whilst a parent may perceive a child to be "acting out", it can be helpful to view the behaviour as the child communicating that there is a need they are not getting met. Developmentally, primary school aged children may not yet have the cognitive ability to express this using verbal language.

Well yeah their inability to have the words to communicate how they're feeling, what's going on for them. Usually if (.) they act out because something has happened to them (.) right and they've been unable to communicate what was actually going on so that loss of power and then they just reflect in the behaviour so they'll lash out or they'll just you know lose it you know. *Graham*

I suppose not not doing as they're told or not wanting to go certain places or not getting on with other kids or even you know temper tantrum things like that. But you know trying to support parents to look at what's the need behind the behaviour what might be the reason what is your child trying to communicate to you that they don't have the language for? *Jean*

Equally, if unaware of different behaviours at different developmental stages, a parent may be unnecessarily concerned by something a child is doing that may actually be a normal part of their development. As Pip mentioned, sexual curiosity and masturbation may be interpreted as "my child has been interfered with" when it may be within the bounds of normal developmental behaviour. Parental misinterpretation of these behaviours and subsequent actions of the parent (albeit with good intentions) may also negatively impact a child's mental health.

In order to facilitate healthy child development, practitioners discussed the need to increase awareness of how meeting a child's basic physiological needs (appropriate to their stage of development) may impact on their mental health. Practitioners commented on how inadequate sleep and/or diet can impact on a child's behaviour and wellbeing and may be communicated by the child through challenging behaviour. *Megan* discussed examples of parents who had concerns that their child was anxious or having difficulties with their behaviour. When she explores these difficulties with a parent, she sometimes finds that the child is getting an inadequate amount of sleep and nutrition. She described how a parent's expectations of a child's behaviour under those circumstances can be unreasonable. She stated "I wouldn't necessarily pathologise it in that [parent's] way, I would say we need some more sleep and we need some more snacks." Equally important, *Megan* noted was how the type of food a child consumes can impact their behaviour, citing a parent describing their child as "bouncing off the walls" and then finding out the child was consuming a lot of soft drinks. In addition to nutrition and sleep, practitioners mentioned the importance of having a regular routine in supporting the behaviour and mental health of children aged 5-10 years.

Relationships and Boundaries

Irrespective of the nature of their work, fostering a strong relationship between the parent/caregiver and their child was commonly mentioned by practitioners as the most important thing a parent/caregiver can do to support their child's mental health. The development of a strong relationship between a child and parent/caregiver provides a foundation from which a child's needs can be better understood. If a child is secure in their relationship with a parent/caregiver, the child will be better able to communicate their

physical and emotional needs. Moreover, the parent/caregiver will be better able to understand what is driving the behaviour and support adaptive regulation of behaviour and emotions (Bowlby, 1982).

Practitioners emphasised that the connection between a child and their parent/caregiver is vital to the child's emotional development; a close connection allows a child to feel secure in exploring the world and allows the parent/caregiver to be able to notice changes in their child and pick up on any mental health concerns.

I guess just staying connected know your child you know spend time with them ... kid's now got behavioural issues because Mum's allowed things to slip for a long time and they've got school refusal, now it's become a mental health issue because the kid's got a mood disorder and you know so it's all so that's what I'm saying connection is everything. (*Aria*)

Professionals working within a Te ao Māori service also reflected on the impact of wider whānau relationships on a child's mental health, consistent with Māori models of wellbeing such as Te Whare Tapa Whā and Meihana (Durie, 1985; Pitama et al., 2007). Attachment disruptions can contribute to the development of mental health difficulties; as identified by *Rawiri* below, attachment disruptions can also have intergenerational impacts.

Yeah lots of warmth care and attention connection using the wider whānau ((pause)) doing stuff parents/caregivers valuing their role in their young children's lives and knowing that actually it will make much more difference for the child to have not necessarily a huge amount of their time but some of their time really focused on the child. I think it's difficult for people especially people who've lived lives where they've not felt valued themselves to realise what value that they can have for their

child ((pause)) and yes as you say that might be useful for a child you might conceptualise has a mental illness but it's really for positive mental health in all children. *Rawiri*

Whilst practitioners emphasised the importance of expressing unconditional love for a child, they also mentioned the need for a parent to recognise and maintain firm relationship boundaries. Relating both to meeting a child's need for a sense of safety and security, as well as respecting the boundaries of the parent-child relationship, a healthy relationship also requires the parent to be consistent in maintaining limits appropriate to the child's age to allow healthy development (e.g., setting appropriate bed-times to ensure adequate sleep). Practitioners noted this as a common skill-deficit in the parents/caregivers of children they worked with.

Problems with maintaining boundaries extended to clarifying roles of the parent and a child. Consistent with Structural Family Theory (Minuchin, 2012), a number of practitioners mentioned that blurred relationship boundaries can lead to lack of role clarity within the family and the consequent development of mental health difficulties. This was illustrated by examples of when the parent/caregiver started to turn to the child to get their emotional needs met.

So I think I'd be wanting to a bit like what I said Incredible Years concentrating on the relationship as the important thing in the first place and the boundaries around that as well so parents also need to be able to let their children go and probably although they aren't the most problematic young people we see I think that there is an issue in the West of parents wanting their child to be their friend as well as their child.

James

I often tell parents to explicitly say to children, 'kids look after kids and adults look after adults, kids don't need to look after adults'. And that sounds incredibly simple but parents can somehow get into a situation where a child is becoming their caretaker emotionally especially where the parent themselves is struggling. And that's overwhelming it's too much for a young child and so I feel like often we're saying to parents just make it really explicit with your child because we assume as adults that kids know this stuff but they don't "I've got a friend who's looking after me" or "I've got such and such" so kids just need to look after kids, kids don't need to look after adults, adults look after other adults'. *Megan*

Parental Wellbeing

In order to be able to parent effectively and promote mental health in their child, parents/caregivers need to ensure their own needs are being met. A few practitioners noted that parents' ability to recognise when they needed to seek support for getting their own emotional needs met was integral to being able to form a healthy relationship with their child. Being able to recognise and prioritise their own emotional and mental health needs was viewed as a potential mental health literacy gap in the parents/caregivers they worked with. In line with Maslow's hierarchy of needs (Maslow, 1943), practitioners emphasised that if parents/caregivers were able to get their own emotional needs met, the relationship with their child would be less likely to be impacted and they would be more effective in supporting their child's mental health.

We just need to really shift our thinking to really address that family health that parental health if you're thinking about cost burdens on a health service and on a nation socially if we get the parents right we get the kids right ((laughs))... I think if

we honestly did and got the parents managing themselves better mentally it would instantly affect the way that their children handle it because that's where we learn it.

Liz

If a Mum has just come out of a really violent relationship and she's still staying with friends and got nowhere to live and she's worried because her child's struggling like it would make more sense to say to the Mum "Look, how do you look after you? What do you need? Who are your supports?" ... the work might be even just with the parents around what is their stuff that's getting in the way? How can they then recognise it, park it to one side and be with the child for what the child needs? *Jean*

In addition to parents/caregivers looking after their own wellbeing, practitioners recognised that wairua²¹ of the whānau was key to supporting child mental health. Practitioners working with Māori and non-European families spoke of ways they encouraged parents/caregivers to enhance their wairua through connecting to their culture, and to draw on the strengths of their culture in supporting their child.

... I suppose from a cultural point of view there's (.) connecting them back to Iwi so work that I've done is actually whakapapa work. Registering our whānau with their tribal connections with their tribal areas to keep them in contact and linked in with activities that are happening in those areas. *Rawiri*

I say to the mother you have a gift from the Indian culture you are not using your identity your culture and your gift to support language is your chanting. So I

²¹ Māori for spirit or soul of a person.

recommend before he goes to sleep please chant chant chant ((pause)). And thanks to that she developed closeness with him. She developed attachment. *Lauren*

Summary

In sum, practitioners considered parental perceptions of what good and poor mental health looked like in a child to be closely linked to their developmental expectations of a child. Practitioners noted a gap in parent and caregiver knowledge of child development, and the analysis illustrated how child mental health difficulties can arise from limited knowledge of child development. In addition, the relationship between a child and parent/caregiver and the parent/caregiver ensuring they take care of their own wellbeing needs, was considered fundamental to developing and maintaining child mental health.

Theme 2: Understanding Behaviour and Emotion

Increasing parental understanding of behaviour and emotion is the subject of the second theme. Based on their work with parents and caregivers, practitioners reflected that it would be helpful for them to have more knowledge around what may be driving a child's behaviour and their emotional literacy and regulation skills.

Behaviour in Context

Practitioners noted that some mātua tend to focus on what the child needs to do to change their behaviour whereas the practitioners encouraged parents/caregivers to consider external factors that may be driving that behaviour. Viewing a child's behaviour through an ecological lens may be helpful as a way of considering the factors that may be contributing to their behaviour.

it could be that what is happening in the child's environment might be impacting on the child's behaviour. It could be something happening at school, something happening in the home environment that is impacting on the child's behaviour.....But children are so attuned to the parents' needs and they pick all these cues that are happening in the house so quickly and so well because they're intelligent that it impacts their development so definitely there's a lack of again I'm using the same word there's a lack of awareness around that there could be other things in the child's life that could impact a child's mental health and that could be coming from the home and family environment, family relationships, family dynamics, school, bullying (.) their own parenting. *Pip*

This view was supported by other practitioners who had noticed parents and caregivers were sometimes looking for a diagnostic label to explain their child's behaviour. Whilst accepting diagnoses are appropriate in many cases, practitioners emphasised there were many cases where a child's behaviour may be changed by making changes to the child's environmental system.

They are assuming that their children need a label (.) autism, ADHD oppositional defiance disorder etc "he just won't do it I can't control him"... it may not be an organic thing it may just be a behavioural change because their emotional needs weren't met so their behaviour has changed because they're still getting someone attend to them emotionally but they are having to ask for it in a different way. *Liz*

Consistent with a possible misinterpretation of a child's behaviour is that parents engaging with a child mental health service tend to have an expectation that the service will be able to "fix" the child to resolve the behavioural problem. Practitioners' themselves

tended to look beyond the child for reasons that may explain their behaviour. They stated that often the goal was to support mātua to change some of their own behaviours or parenting practices that may be contributing to the difficulties the child is experiencing. In doing so, they encouraged the parent/caregiver to look beyond the child and try to understand what may be influencing the behaviour.

it's related to the needs of the particular whānau you've got isn't it because most of the time ((pause)) you're hoping that parents might be able to do something a bit different and you might be able to help them in doing that without them feeling blamed for you suggesting that they might be usefully doing something a bit differently.... generally you are looking to for the initiative to change to come from the adult in children of this age. *James*

But predominantly one of the things we've always found is that the families are more than happy to let you work with the young person but their usual view around that is "here he is, sort him out", "he's the one with the problem" you know "he just happened to be like this" you know "I don't know where it comes from, it's happened in a vacuum" what they don't acknowledge is it's not just the young person that needs to change but they do too you know. *Graham*

One practitioner gave an example of how a small change in a parent's behaviour helped a child feeling anxious about leaving their parent when going into school:

what you say to your child when you leave them you know like not "I'll see you soon" but "I'll see you at three o'clock" and just some of those clear things that we say that we don't even realise we say that to a child they think we're coming back quite soon.

Sam

Emotional Literacy

It was clear that practitioners saw that a fundamental gap in parent mental health literacy was their limited emotional literacy. The importance of parents and caregivers teaching their children adaptive emotion regulation skills was noted by many practitioners as being important for child mental health. This sentiment was summed up in the quote below.

One of the gaps or probably the gaps in knowledge that I guess anybody working within the mental health in a child/adolescent even here is parents that don't have the knowledge around emotional intelligence, emotional regulation, those sorts of things. And that's really huge in primary aged children...So so teaching whānau about how to deal with emotions for young children. And it's okay to feel emotions a lot of parents don't understand that. And a lot of parents won't allow a child to express themselves. So we see a lot of that. But I think that's a big key area for promoting for parents. *Aria*

Increasing parent and caregiver understanding of emotions and regulation of emotion was perceived to be useful for improving wellbeing of all children and whānau (both Māori and non-Māori). *Aria* elaborated on emotional literacy in the context of Māori whānau as follows:

I guess in a Māori setting if we're looking from an emotional intelligence from a traditional point of view ((pause)) that wouldn't have been an issue back in the day that I guess pre-colonisation you know our parenting practices were beautiful you know our kids had emotional intelligence. You know they everything was based under tikanga you know that informed the way that we kept safe, our values, our

protocols. You know we were told that we wouldn't go down near that river because there's a taniwha²². So there's a rāhui²³ put on that as in there's restrictions on different areas. Those sorts of things were there for safety... But you see I guess for me through colonisation we've we've lost all that you know so now we've got blurred whakapapa that have different different ways you know we've got trauma coming in from all sides you know down through the generations so. But traditionally we had ...our own way of promoting that I guess through our values and our practices you know ((pause))...so working with whānau I guess you'd be using our values our tikanga to bring those things back into their lives you know if they didn't already have that. *Aria*

Practitioners indicated that many parents and caregivers tended to have an expectation that their children should be happy all the time, or that any expression of negative emotion should be kept to a minimum. Practitioners viewed this as an underlying gap in parental emotional literacy. They stressed the importance of validating a child's emotions to help them accept a range of emotions as normal, and to learn that emotions serve a purpose.

A huge part of my work is helping parents to have realistic expectations developmentally and in terms of wellbeing. So parents might for example say that they want their child to have no anxiety ever again and so we have a conversation about how anxiety has a function and a purpose and it's necessary for a rich and full life. *Megan*

²² Māori for water spirit or power creature, often considered a guardian.

²³ Māori word meaning temporary prohibition of access as a means of social control.

Parents (.) struggle to tolerate a child's distress and think that there's something wrong (.) or that if a child isn't happy 24/7 then that's abnormal. And it's not. You know there are times it's appropriate to be sad or mad. You know that sort of validating an emotional rainbow. If a child receives a message that they should be happy all the time well that's not normal (.) I don't think that's conducive to feeling okay when you're not okay (.) or being accepted that it's okay to not feel okay. *Jean*

Whilst practitioners were clear about the need for parents and caregivers to validate emotions, they were also clear this did not necessarily mean validating the behaviour associated with the emotion. They commented that much of their work involved encouraging parents and caregivers to recognise the function of the emotion, and to separate out the behaviour from the emotion and to put boundaries around the behaviours.

And I would suggest we need to be saying well I am stressed for a reason, it makes sense that I am stressed, I'm allowed to feel stressed and these are some of the things I can do about it...They're allowed to feel angry but they're not allowed to do those things. And we spend a lot of time in therapy trying to differentiate those two things giving the child permission to feel the feeling in fact validating the feeling but setting a limit around the behaviour at the same time. *Megan*

Emotion Regulation

Practitioners gave examples of skills they teach parents to help them support their child to regulate their emotions. *Sam* mentioned that a part of this was about encouraging parents to “talk through those emotions and how you feel and actually showing your children that we have those feelings as well and that's normal and this is how I deal with it you know like I feel much better if I put music on”. Other practitioners highlighted how they

helped the child to identify the physiological signs associated with an emotion as a way of recognising and naming an emotion. In this way parents are helping to give their child the language to communicate the emotion they are feeling rather than the child having to communicate their feelings through their behaviour.

Look the reason why he's anxious is because he's worried right. So rather than yelling at him forcing him to do something because he's just he can't communicate, just sit down with him and maybe but they're going to have to have the skills to be able to do that and say "OK are you anxious do you, have this feeling in your tummy, is this what's happening with you?" and focus on the issue not the behaviour or the acting out. (*Graham*)

The scaffolding is really more what I think can be helpful for parents to do is to just start to label emotions it's really useful for parents to say "I'm wondering if you're feeling dot dot dot" to give children a language around that so that they can communicate with words down the track rather than behaviour. (*Megan*)

Finally, but perhaps most importantly, practitioners invariably noted that the difficulties they saw in children were also present in the child's parent/caregiver. If a parent/caregiver has never learned to accept and manage their own emotions, it is unreasonable to expect they have the knowledge and skills to support their child to do this. Accordingly, practitioners emphasised the importance of parents and caregivers learning emotion regulation skills for themselves as a first step in helping their child with their emotional health. This was highlighted by *Liz* when discussing her experiences working with parents who had not learned how to regulate their own emotions due to limited opportunity to learn these skills from their own parents (again highlighting the

intergenerational impact of parenting practices on child mental health). She gave an example of one woman saying “I didn’t get angry because I didn’t feel like I could get angry [as a child]” and noticing she experienced distress whenever her child displayed anger. Other practitioners commented that although the focus of their work is on the child, the change really needs to start with the parents changing their own beliefs and behaviours in relation to their emotions.

Sometimes I mean I think often one of the things we're trying to do is to help children to understand and find labels for their own emotional experiences and sometimes we're helping the adults to find those labels for themselves and certainly encouraging them to find them for their children. *James*

You know like sitting with it feeling it's okay when when your child cries or so you're really teaching parents and so if you seeing that in the room with that child you're working through it with the parent and that child, you're modelling that. So it's just staying calm you know staying calm using using the words ((pause)) it depends what what the child's going through ((pause)) and just saying to Mum you know just encouraging parents to actually sometimes just sit with that and don't react don't react. Because that's when they start to get into that unhelpful you know. *Aria*

Summary

Two key gaps in parent mental health literacy were understanding of behaviour and emotions. Practitioners saw a need to increase awareness of developmental stages children typically go through, that a child’s behaviour may be their way of communicating that a need is not being met, as well as the importance of looking beyond the child to what it is in the child’s environment that might be contributing to the behaviour. Relating to

understanding a child's behaviour is the importance of teaching emotional literacy and regulation. Being able to normalise emotions and emotional experiences, supporting a child to accept a range of emotions and work effectively with distressing emotions were identified as key skills parents and caregivers need to support child mental health.

Theme 3: Help-seeking Efficacy

The theme of help-seeking efficacy related to knowledge that parents and caregivers need to be able to seek help for a child experiencing mental health difficulties when needed. Relating to earlier themes, this theme covered knowledge of when it might be necessary to seek professional help, navigating the advice of non-specialists, how parent/caregiver attitudes can impact on help-seeking and limited awareness of what mental health services are available (by both parents/caregivers and mental health practitioners).

What is Normal?

A fundamental parent mental health literacy need that practitioners identified was having the knowledge to be able to identify when a child's behavioural or emotional problem becomes a mental health concern. Before making a decision to seek help in some way, parents and caregivers need to be able to determine that what their child is experiencing is outside the bounds of what may be considered normal for their developmental stage. Practitioners themselves acknowledged that this is not easy.

I think they often are (.) sometimes it's difficult to (.) to know where to draw the line between what's ordinary and what's not and indeed I think particularly in this age group there's most things that happen are kind of an extreme of what you might think of is normal. *James*

Practitioners indicated that parents tended to have quite 'all or nothing thinking' about mental health concerns whereas they themselves recognised behavioural and emotional difficulties exist on a continuum. At one end, all children experience challenging behaviours and emotions; it was when the severity and frequency meant it had a negative impact on the child's life or was too much to be managed within the whānau that it was considered outside the bounds of normal.

Interestingly, what practitioners perceived that parents consider to be normal was different in boys and girls. Some practitioners who made diagnoses and others with a support role perceived that some diagnoses and behaviours were considered to be more accepted by parents and caregivers of boys.

Yes I don't know where it comes from, where it stems from, but definitely parents or their caregivers talk more about boys being into that autistic spectrum or ADHD or ODD, all these developmental disorders, parents usually talk about boys being into that not a lot of girls as compared to the boys. *Pip*

Yeah much more tolerance for hyperactivity and impulsivity and boisterousness with boys. And I think less tolerance with girls, girls are seen as stroppy or difficult if they display the same sorts of things. *Megan*

Anxiety. Uncertainty of the where the bounds of normal emotional experience ended was noted to be a particularly common problem for parents and caregivers concerned about their primary school aged child's anxiety. Practitioners noted that some parents and caregivers were quick to pathologise what mental health professionals might consider to be within the bounds of normal experience. Practitioners emphasised parent education was needed on how to help a child manage normal anxiety as well as how to

recognise when anxiety extends beyond the bounds of normal and what to do in these circumstances. Sometimes the way the parents recognised and responded to a child's anxious behaviour was noted by practitioners to be perpetuating a problem.

You know or anxiety (.) and you've got to track mental health back you know it would be good to have education around how how you deal with anxiety I mean anxiety is a normal thing it's a part of our everyday life you know everybody has anxiety but it's whether it crosses that line and it actually starts to impact on your function your daily functioning aye. So (.) so it would be really great if there was some more promoting around how to deal with a child's anxiety especially with COVID. *Aria*

Advice From Non-Specialists

Consistent with a bioecological model (Bronfenbrenner & Ceci, 1994), mātua draw on their own knowledge (for example, if they themselves had experience of mental illness) and advice from those within their own support networks before seeking specialist advice. Practitioners noted that different types of support were accessed depending on the degree of concern and the social and cultural context of the whānau.

Seeking advice from friends and whānau was commonly mentioned as a first port of call. However, practitioners noted that this advice was not always helpful and depended on the attitudes of the advice giver, their experience and their accuracy of knowledge. *James* noted in many cases, family and whānau advice is helpful, but that he had seen the negative impact of this also with the caregiver finally arriving at an appropriate specialist service after being advised and pointed in a number of different directions first. Another practitioner mentioned that in general people have a narrow view of developmental disorders and their

knowledge tends to be based on their own limited experience. For example, family members or friends may make a judgement that a child does not have a mental disorder based on how the child compares to a child they know with the disorder, when in fact disorders can present quite differently in different children.

I think people's views are quite narrow about those different disabilities ... with ADHD we often get "my Mum said no he hasn't got ADHD cause he's nothing like what my brother was when we were kids"...sometimes it's knowledge from other people (.) other family members that's really strong or lack of knowledge that comes through really strongly that discourages them from going further and getting help too. *Sam*

A few practitioners mentioned that when parents and caregivers first become concerned about their child's mental health they seek advice from the internet, be it specialist pages or social media forums. They perceived the advantages to be that this advice is easy to access and the parent and caregiver can remain anonymous should they wish to.

I think that the foremost thing that the parents would have tried working out is doing a lot of research on the Google (.) doctor Google is the answer doing a lot of research and trying to find out concrete solutions and ways to deal with it. *Pip*

Of course there are things like coffee groups and your close girlfriends but if you're feeling as though you might not be doing something you should be doing, you're feeling a bit vulnerable and you're wondering if something is up with your child you may not share that with friends or family. I would suggest the first port of call would probably be the internet. *Megan*

A few practitioners noted that schools were approached for advice and help when mental health difficulties impacted on learning and behaviour at school. It was recognised however that the learning support available at schools was limited, particularly for children with difficulties who are at the mild to moderate (rather than severe) end.

Resources through schools so in particular it starts off with Resource Teachers of Learning and Behaviour and moves up through the Ministry of Education after that. But often they feel a bit overwhelmed and sometimes the schools themselves have a sense that there's not much point to it but yeah certainly there's some resource there but the schools are saying that we have more students with difficulty than we used to have. *James*

And there's some parents who genuinely want help for their kid but they can't access it because it's not extreme enough and same with OT²⁴ you know you go to OT because they're at that extreme end but they have the resources to be able to deal with it but as you drop further down the line where do you go? There's a few generic ones that are around and about but there may be some community ones and that it just varies in what area you are too what's available. *Graham*

Parenting programmes were mentioned as a useful first step in supporting parents and caregivers to learn strategies and a few practitioners mentioned that whānau they had seen had often completed or tried to complete a parenting programme such as the Incredible Years or Triple P. They noted that parenting programmes are very useful interventions for learning fundamental principles and strategies for parenting a child with

²⁴ Oranga Tamariki, the government department with responsibilities for child well-being, children at risk of harm and/or offending.

emotional or behavioural health difficulties. However, it was acknowledged that these programmes may be of limited help for those with more complex needs.

I might mention the Incredible Years programme actually sometimes people have done that before they get to us and sometimes people have recommended that so that (.) has the kind of building on lower levels the primary level being a good emotional connection with the child then behavioural approaches. *James*

Often the parents we see have done a group programme like Incredible Years but due to their own complex needs say we have a Mum who has been diagnosed with borderline personality disorder ... or a highly anxious parent who sits in that group and isn't really able to connect with the material or retain the material because of what's going on for her as a Mum she's just overwhelmed and as we know your retention of information and being able to make good use of information is compromised when you are just absolutely overwhelmed in a group context. *Megan*

Finally, Ala also mentioned some whānau will seek cultural explanations for behavioural difficulties and would seek help from traditional healers before presenting to a child mental health service. This was mentioned in the context of discussing how the term 'mental' in 'mental health service' can be a barrier for some families seeking professional help, and the importance of incorporating cultural and spiritual dimensions into mental health assessments so they are more appropriate and acceptable for whānau.

A lot of them will go to the traditional healer before they come here...because they prefer the traditional treatment...for behavioural problems because they think it's a curse they think it's a breach of something...people need to understand that for Samoan people mental ill-health is seen as a (.) breach of sacred relationship. *Ala*

Acceptance Before Help-Seeking

When it came to accessing help for their child from professionals, a few practitioners had observed that parental views of mental health and mental health difficulties could present challenges to seeking appropriate help for their child. Practitioners spoke of challenges for parents and caregivers in coming to terms with accepting their child is having difficulties and may need specialist help. As noted above, before a family seeks help from a specialist mental health service, practitioners noted they have often tried many strategies themselves and sought advice from many avenues. Practitioners noted the toll this can take on the whānau. By the time the whānau seeks help formally, the problems may have become much worse.

Even when a parent/caregiver may be starting to accept that their child is experiencing a mental health problem practitioners noted it can be a large step for them to accept they may need to seek professional help for their child.

That's where I think that notion of a parent feeling as though they've failed or they are somehow inadequate if their child is struggling especially with a very young child comes in to play because often parents will sit on concerns for a while before seeking help because they are concerned that they will be seen as a failure or that they haven't done enough or they should be doing more. *Megan*

I think parents go through a really big process a grieving process when they find that their child isn't managing at school and so sometimes they're they're not really ready to kind of look at what they could perhaps do to help their child because they don't feel like there's a problem and that maybe it's just the school that's the problem so

sometimes I think it's a long process I often think parents aren't ready to hear that news about their child. *Sam*

These internal struggles parents may have were noted as even more prominent for male caregivers. Most commonly practitioners mentioned that male caregivers appeared to be less comfortable seeking help for emotional issues and were less likely to be the ones actively seeking help for their child.

I think that they also often feel somewhat out of their depth with emotional business and sometimes feel a bit awkward about coming to a service like this and have that sense of being exposed. Yeah and I guess there's a stereotype which isn't isn't entirely untrue of men tending not to talk about the emotional stuff and sometimes (.) women deal with things by talking and men deal with things by drinking or fighting it's obviously a stereotype and untrue for many but I think it holds some truth. *James*

In light of these barriers, *Rawiri* spoke of the importance of capitalising on the opportunity when a father does attend a service to reinforce the value of the role a father has in their child's life.

Knowledge About Mental Health Services

Compounding the issue of accepting that a child may be experiencing difficulties that require specialist help is a lack of knowledge of what specialist mental health services do. Lack of knowledge was noted as a barrier for parents and caregivers but also amongst practitioners working in these services themselves. It was commonly noted that there was a lack of clarity around what different services can offer which can lead to several steps being required before a whānau is referred to the appropriate service. Practitioners identified

gaps in their own and other referrers' knowledge of different services available but also a lack of coordination between services, recognising the services are difficult for practitioners to navigate let alone for parents and caregivers to navigate.

It appeared that the narrow focus of many services (e.g., particular criteria needing to be met to access the service) may exacerbate the problem of gaining timely access to appropriate services. It was noted that this often meant working with one service and then being referred to another and having to engage with a new service and so on. This was seen in stark contrast to what may be considered as more of a child and whānau centred approach in which the services would collaborate with other services and with the child and whānau to address their mental health needs.

...even now I'm kind of like well probably a referral to CAMHS²⁵ but sometimes we refer and then they come back and say "oh no we don't do that we don't that testing for that kind of thing" so or "we don't support children with that" so yeah I don't know I think that's where the gap is knowing what different services offer and where you can go for help. *Sam*

Yeah so I don't know what other the referrers (.) what they tell the family what our service is about. If they had said something a little bit negative about mental health services then that will scare the hell of the family and not wanting to come and they will have ideas in their head that no I don't want to and they have a fear that their child will be put in a mental home ((pause)) yeah (.) and the other fear is medication... *Ala*

²⁵ Child and adolescent mental health service.

And I think honestly that's the answer is that collaboration between OT and health and education and all of these working together to really support and help these parents to navigate the emotional roller coaster that is being a parent. *Liz*

Summary

Building on earlier themes, increasing knowledge of child development and understanding of behaviour and emotion in this context would increase parent and caregiver ability to determine what is outside the bounds of normal. Parent and caregiver acceptance of mental health needs and concerns can be a barrier to accessing services.

There are a number of places parents and caregivers go to seek advice and help for their child if they are experiencing difficulties with their mental health. In line with the ecological model practitioners noted that this tended to be from sources easily accessible such as the internet, friends and family initially, and then potentially the school and in some cases traditional healers. A particular concern of practitioners was the limited awareness of mental health services available both by parents/caregivers and practitioners themselves.

Theme 4: Podcasts may be Effective

Practitioners noted that increasing the knowledge base of parents and caregivers concerning foundational parenting knowledge and skills can help to prevent the onset of mental health difficulties and promote mental health. In particular, it was noted that interventions to help parents support their child's mental health before they get to adolescence (i.e., during their primary school aged years) were limited and therefore targeting parents/caregivers of the primary school age group would be beneficial.

So there's not a lot of services and resources I would say for the primary even for the intermediate age around that mild to moderate (.) you know mental health, you

know anxiety, fears, phobias those sorts of things, feelings and emotions... you know the primary age school one is a good one because (.) all of our referrals when we're at the school most of them hardly any of them have been suspended from school, they may have been stood down for a day or a few days but they're back and they'll stay at school. Then they'll hit intermediate and high school and pretty much then they'll be excluded right. *Graham*

Practitioners saw a mental health literacy resource using podcasting as having value in contributing to increasing knowledge. They noted that a universal intervention can be more acceptable than an intervention that is targeted, which may result in people feeling like they are getting it because they have a problem.

What often happens with mental health interventions is that if people feel it is not just for them cause they're a problem they are more likely to take them up. *James*

Aside from the need for an internet connection to be able to access podcasts practitioners had only positive views on use of podcasting to communicate knowledge to parents and caregivers. Akin to the comment above, one perceived advantage of podcasts was that they can be a way of introducing a topic in a non-threatening way.

I think that would open the door for a lot of parents to think about the issues or to think about the concerns that they might have been that they might be going through but were unable to talk through. *Pip*

Practitioners spoke about podcasts being able to be accessed in a parent's own time, and as a resource that can be listened to again. Recognising that parents/caregivers are often time-poor and are managing multiple demands, an advantage of podcasts was that they can be listened to while they are doing other things. Practitioners commented that

having it freely available with content that is applicable to all parents may help to destigmatise it and it may be perceived more positively.

It's less threatening they have a choice of whether they use it or not... you know they could do it in their own sort of time *Graham*

Theme 5: Podcasts Need to be Acceptable

Simple is Best

'Keep it simple' was the main message practitioners had when it came to advice on how to make a podcast acceptable for parents and more likely to engage with. 'Keeping it simple' applied to the topics, messages and in particular the language used. Specifically, practitioners noted that the resource needed to be evidence-based and informed by psychological principles whilst using language that parents and caregivers could relate to rather than clinical terminology.

Well for me it's simple language ((laughs)) breaking it down, cause it needs to be language that they can understand ((pause)) and it's also about keeping them engaged, sometimes using our cultural narratives and or stories (.) if you start using language that's very clinical then it's easy to lose whānau, so breaking it down is important. *Rawiri*

I don't use I guess ((pause)) yeah health terminologies you know? And if I do then I break it down I'll explain it to them. Because you know a lot of a lot of clinicians may do that or the psychiatrists may you know go off on to another tangent and you think actually can you just bring it down a bit? *Aria*

For Pasifika families in particular it was noted that the term 'mental illness' has negative connotations (may be interpreted as a breach of a sacred relationship) so care needs to be taken to explain what is meant by this term and/or use alternative terms. The term 'mental health' was also noted as being laden with stigma for whānau, with mental wellbeing and/or hinengaro being preferable terms. These practitioners also noted the need to define more medical terms (e.g., depression, emotion dysregulation) in terms of behavioural descriptors, and to model language that parents/caregivers can then use with their children (e.g., 'big feelings', 'worries', feeling 'low').

So the language that is being used wherever (.) medical terms especially is not an everyday language that our people hear and know (.) they will just shut off. *Ala*

Practitioners were clear that a podcast delivering messages about parent mental health literacy should be short. They felt parents would want to be able to take away the main points without them being lost in conversation or having to make a big commitment in terms of their attention and time.

But yeah I think shorter is best but then you just don't want to give them too much information but you don't want to make it too much of a commitment that they have to commit to little bit little bit little bit over long periods of time. *Liz*

Holistic Approach

Practitioners working in both mainstream as well as specialist Māori or Pasifika services emphasised the use of holistic models of health to guide their assessments and interventions with whānau. In particular, they mentioned *Te Whare Tapa Whā* (Durie, 1985), and the need to consider wellbeing in the context of what is going on for the

whānau, the whānau's tinana (physical health) and strengthening the wairua, as a pathway to enhance wellbeing rather than focusing solely on hinengaro (psychological) factors.

...looking at all those domains and unpacking them... looking at the positives and the negatives of all those domains. And what what's unbalanced you know and usually it's the wairua... And how it's affecting not only the young person but how it's impacting on the whole whānau. *Aria*

Practitioners in specialist cultural services noted the importance of self-determination and on supporting parents and whānau to find solutions within families, with one citing the Samoan proverb, E fofo a le alamea, le alamea (the solutions to our issues lie within our families/own communities). In this way, they encouraged an approach of “walking alongside whānau”. Linking content to tikanga and values, use of story-telling, pūrakau and metaphor to help make psychological concepts more understandable was noted as one way of doing this. A few practitioners commented on the need for a podcast to be translated into different languages for it to be truly accessible to all.

As discussed in earlier themes, encouraging parents and caregivers to ensure their own needs were being met was seen by practitioners as integral to supporting child mental health. In addition, a focus on building on whānau resilience and strengths was inherent in practitioners' views about how to engage and facilitate change with parents and caregivers.

The strengths, the potential not the deficits that is the key. *Lauren*

I also talk to parents of dyslexic children about promoting the strengths that their children have got so getting them involved in sports if they're good at sports or dancing or giving them those other outlets where they can have positive experiences cause school is so hard for them. *Sam*

Whānau have their own solutions and they have so it's walking beside them to bring that out. Because they all have different (.) doesn't matter they all have their own personal strengths in courage and solutions. So it's about walking alongside and really for me it's so much about self-determination. Yeah, you're trying to give the parents the tools to be able to manage because they're teaching their kids life skills.

Aria

Relatable Content

Ensuring podcast content, and the people presenting it are engaging and relatable was emphasised as key to being able to effectively communicate messages to parents and whānau. Practitioners emphasised that the podcast content needs to be conveyed in a way that parents and whānau can connect with. Practitioners talked about how this could be achieved in different ways. Using narrative to illustrate a common parenting challenge, and/or a presenter who is a parent themselves who can talk about personal experience were suggested as a good way to engage listeners. Another way that practitioners suggested could improve the relatability of the content was to ensure the presenters use the language that parents use (e.g., “she’s all over the place”) and to discuss a common parenting experience or challenge in a way that the podcaster is seen to ‘get’ the challenges of parenting. In addition, using an ‘influencer’ to enhance appeal or perceived reliability of the information was mentioned.

Practitioners mentioned the importance of modelling how to respond to challenges and to include “tips and tricks” to help transfer knowledge and skills using podcasting. For example, going through the process of unpacking a common situation to model how parents might do this themselves to understand the need driving the behaviour and support a child

to learn to identify and name emotions. In relation to anxiety, working through how to manage different real-life situations was suggested as being a practical approach.

The tone of the messages being conveyed was also mentioned as an important consideration. Practitioners warned of messaging that may be interpreted by the parent that they were doing something wrong or that they were to blame for a child's behaviour which may be off-putting to parents and whānau. Finding ways to normalise a child's behaviour or normalise parental reactions to challenging behaviour was suggested as being helpful for getting the right tone. Above all practitioners noted the importance of maintaining a non-judgemental stance.

One practitioner who was experienced in contributing psychoeducational material to different forums offered some useful suggestions:

You have to do a lot of softening of messages (.) what I mean is parents read into something and immediately feel that they have done something wrong so I talk about transitions for example where kids shift change from day care to school or parents move home or parents separate, you know those times can be stressful for kids but you don't necessarily want to say it that directly to a parent because the parent then feels immediately awful for having swapped their child's bedroom with their brother's bedroom ((laughs)) "oh no I've ruined my child" ... *Megan*

Summary

In summary, based on the knowledge and experience of practitioners working with parents and caregivers, it appears that a resource tailored to meet the mental health literacy needs of parents and caregivers of primary school aged children could be beneficial. It was suggested that targeting the intervention at a universal level (i.e., for all parents

irrespective of a child's risk of mental illness), and delivering key messages in a way that is non-judgemental would enhance acceptability of a podcasting intervention. A podcast delivering accurate information about child mental health in a simple, holistic and relatable way may enhance acceptability of the intervention.

Summary of Themes

A number of parent mental health literacy needs were identified through this research. These included knowledge of child development, behaviour and emotional intelligence, the importance of the relationship between the child and parent/caregiver and a need to recognise parent self-care needs. In addition, increasing parental knowledge of developmentally normal behaviours and emotions, and when it would be appropriate to seek help from specialist services would be helpful. Finally, clarity as to what mental health services can provide is needed both for those working within the sector as well as the parenting and general population. In light of these themes, practitioners endorsed the suggestion that a mental health literacy resource for parents would be valuable, noting that the younger the age group targeted by the resource the better, and that podcasting could be an effective way to increase knowledge.

Chapter Eleven: Discussion

Introduction

The aim of Phase 1 of the research was to explore practitioner perceptions of the mental health literacy of parents and caregivers of primary school aged children. It also sought to understand how parent mental health literacy needs could be addressed through a podcasting intervention. Reflexive thematic analysis of interviews with 11 practitioners working with parents/caregivers identified five key themes. In relation to the first research question “What are the mental health literacy needs of parents and/or caregivers of primary school aged children?” three overarching themes were developed:

- general parenting knowledge,
- understanding of behaviour and emotion, and
- help-seeking efficacy.

Regarding the second research question, “How could these [mental health literacy] needs be met through a podcasting intervention?” two themes were developed:

- podcasts may be an effective intervention mode, and
- to maximise effectiveness, podcasts need to be acceptable and engaging.

This chapter presents a discussion of each of the key themes from Phase 1 of the research in relation to the current literature, and is followed by practical implications for a podcasting intervention. The purpose of this discussion is to situate the analytic findings within the wider literature on each topic and provide a broader evidence-based foundation from which to inform the podcast intervention.

Within a bioecological framework (Bronfenbrenner & Ceci, 1994), the factors in a child's microsystem (i.e., parents/caregivers, teachers and peers) would be considered to have the most influence over a child's development and mental health. The findings of the present research can be considered within a bioecological framework to understand the importance of equipping parents/caregivers with relevant knowledge to support their child's mental health. The most recent evolution of Bronfenbrenner's model reflects the importance of interactions between the person, processes, contextual factors and time. This is of particular relevance to a number of themes in the present research (e.g., relationships and attachment), in that it is the proximal processes (or interactions between contextual systems and factors) that are the most significant in terms of influencing a child's development (Mercon-Vargas et al., 2020).

General Parenting Knowledge

One of the key themes identified in this research was that parents/caregivers have gaps in aspects of general parenting knowledge that is foundational to promoting child mental health and preventing mental illness. These knowledge gaps included awareness of the importance of a quality relationship with a parent/caregiver, parent wellbeing and knowledge of child development and are discussed within the context of the current literature.

The influence a parent has on a child's development can be considered within the framework of Bronfenbrenner's bioecological model (Bronfenbrenner & Morris, 2006). Individual factors such as genetics, temperament and personality all contribute to a child's developmental pathway, and can be predisposing and/or protective towards developing positive mental health or illness. These child factors influence the proximal processes

between the child and those in their environment (e.g., a child's temperament can influence how others respond to them). Proximal processes that are frequent and consistent contribute most to development. Consistent with attachment theory (Ainsworth et al., 2015), the frequency and type of these interactions between a child and parents/caregivers contribute to the type of attachment a child forms.

Parents and caregivers play an important role in supporting the child to develop an internal representation of quality relationships and this occurs through proximal processes. As discussed above, the knowledge a parent/caregiver has about child development contributes to their understanding of what a child's needs are and therefore influence parenting practice in relation to meeting these needs (e.g., routines around bed-times, providing adequate snacks). The developmental knowledge of the parent will have been influenced by the proximal processes in their own environmental systems (e.g., interactions with other parents, children of the same age etc) and therefore influence their expectations of the child (e.g., whether a child can take the perspective of the parent to accommodate the demands on their time).

As per the bioecological model, the type of environmental systems and proximal processes that contributed to the parent's own development (i.e., the influence of the chronosystem), the interactions between a child's temperament (e.g., active), whether their needs have been met (e.g., if they are over-tired) and parenting knowledge about developmental needs (e.g., bed-time) all determine the type of parenting practice of the parent (e.g., sensitive to needs) and are all factors that influence a child's mental health.

Knowledge of Child Development

Analysis of interviews with practitioners identified that increasing the parent/caregiver knowledge base of child development would be helpful in supporting child mental health. This is consistent with previous research that found parental knowledge of child development to be low, and that enhancing parent knowledge about normative development can have beneficial outcomes for child mental health (Leung & Suskind, 2020; Marshall et al., 2016). With adequate knowledge of normative development and developmental processes, parents/caregivers are better equipped to parent in a way that supports their child's development (Bornstein et al., 2018; McKee et al., 2021; September et al., 2017). Developmental principles are a cornerstone of many interventions which seek to improve outcomes for children by increasing parent knowledge of child development so that parents are better informed and more able to respond to their child's needs (Sanders et al., 2014).

Child development is a very broad topic which can be categorised as physical, social and emotional, and cognitive development. Knowledge of normative development is important across all three dimensions and there is much overlap between them. With reference to the present research, practitioners noted that parental expectations of a child were not always aligned with what they were developmentally capable of, particularly in relation to cognitive and social skills, nor were they aware of some of their basic developmental needs. This finding is supported by systematic review evidence that suggests that increasing parenting knowledge of child development contributes to improved child mental health outcomes as it helps to align parental expectations with a child's developmental capabilities (Pedersen et al., 2019). A brief outline of some of the key

theories regarding developmental needs and capabilities of children aged 5-10 years and a discussion of the relationship to child behaviour and mental health follows.

Developmental Milestones in Middle Childhood. Much of the research into increasing knowledge of child development has focused on developmental milestones and competencies of infants and preschool children, with less of a focus on the developmental changes occurring in middle childhood. According to Piaget's theory of cognitive development, during middle childhood children begin to use more sophisticated language, are able to start to infer what others may be thinking, be responsive to others needs and use more logic (rather than intuition) to solve problems (Carr, 2005; Gruber & Voneche, 1977). Consequently, a child with more mature language abilities who is able to consider another's perspective may be more able to articulate and solve problems themselves, and regulate their emotions as appropriate to context, than a child who has yet to reach this developmental stage.

In terms of social development during the middle childhood period, the development of peer relationships, emotional competence and self-identity comes to the fore (Carr, 2005). Erikson (1980) considers the middle childhood stage of psychosocial development to be the identity versus inferiority stage. In this stage parents and caregivers play a crucial role in supporting their child to build confidence in their abilities and in turn their self-esteem, which is important for mental health. Sociocultural theory (Cole et al., 1978) and social learning theory (Bandura, 1977) explains how through a child's observations of a parent's interactions in their own relationships and their own emotion regulation practices play a significant role in a child's social development. The importance of

the parental relationship with a child, attachment theory (Bowlby, 1958) and research will be discussed later in this section but it is important to note its relevance to this theme also.

Basic Needs. Ensuring a child's physiological and other basic needs are met is essential for healthy development. Inadequate meeting of these needs can have a profound impact on behaviour and can exacerbate difficulties caused by misalignment of parental expectations and developmental abilities. Maslow's (1943) theory of human motivation offers a useful framework for conceptualising a child's needs in the context of their development. This theory states that motivating behaviour is driven by five underlying needs: physiological, safety, love and belonging, esteem and self-actualisation. Physiological needs include basic survival needs such as rest, nutrition, water and warmth. Safety needs include physical safety but also include such things that make us feel secure in our lives such as familiarity, routine and predictability which are particularly important for children. The need for love includes affection and belonging and both giving and receiving love.

In building on this theory further, the neurosequential model (Perry & Hambrick, 2008) illustrates how an inability to routinely meet a child's needs for safety, security and attachment can disrupt healthy neurodevelopment and can contribute to more severe emotional and behavioural difficulties. Finally, the remaining two needs of esteem (including a sense of competence and mastery but also respect from others) and self-actualisation are required for self-confidence and fulfilment. In using this framework to understand a child's behaviour, it is appreciated that a child cannot function optimally unless these basic needs are met. Within the context of a child's behaviour this may translate as if a child's needs for adequate sleep, nutrition and security of routine are not

adequately met, their ability to behave as may be expected given their developmental stage is compromised.

Practitioners gave examples of this in their clinical work such as educating parents that their child's problematic behaviour may in part be caused by inadequate sleep and/or nutritional deficiencies. An association between sleep difficulties in children and internalising and externalising behavioural problems is supported by the literature (Calhoun et al., 2017). A systematic review of studies investigating parental knowledge about their children's sleep needs have found this to be poor (McDowall et al., 2017). Therefore, it follows that increasing parental knowledge of a primary school aged child's physiological needs and how these needs can impact regulation of their behaviour may be helpful for improving child mental health outcomes.

Summary. The parent mental health literacy gap in knowledge of child development as identified in the present research is supported by the academic literature, albeit the previous research has focused on the developmental stages of younger children (Leung & Suskind, 2020). Increasing parental knowledge of a child's basic needs during middle childhood, their changing cognitive abilities and how to support a child to develop and maintain peer relationships and emotional competence may help improve mental health outcomes for children of this age. Having a close connection with a child is one of their fundamental needs, and also enables a parent to be more aware of a child's developmental abilities and emotional and social needs and this theme is discussed in the next section.

Relationships and Attachment

Viewed through an ecological lens, the nature of a relationship a child has with a parent/caregiver – given the parent's proximity to the child and the frequency of the

interactions between them – has a profound influence on their development and developing mental health. Practitioners participating in the present research consistently emphasised a need to reinforce this message to parents/caregivers of children in middle childhood.

Not surprisingly, the importance of the relationship between a child and parent is strongly supported in the literature as helping to facilitate a child's social and emotional development and a vast amount of this research is grounded in attachment theory (Goldberg, 2014). As well as a standalone theme, the importance of a parent/caregiver having a secure relationship with their child was a finding that underpinned all other themes. In particular, practitioners mentioned the importance of a parent/caregiver's relationship with their child in relation to understanding their child's development, their behaviour, and supporting their emotional competence. The research that provided the foundational evidence for the importance of a secure attachment with parents/caregivers, the nature of the relationship between a parent and child during middle childhood, and attachment in collectivist cultures, is briefly discussed with respect to the analytic findings of the present research.

Attachment Theory. Attachment theory (Bowlby, 1958, 1982) states that a child's relationship with a key caregiver informs the development of internal representations of relationships with others, which then influence the way they view and approach relationships with themselves, peers and adults throughout their life. The child's relationship (attachment) with and their behaviours towards (attachment behaviour) a caregiver is integral to their social and cognitive development; it is also essential to mental health (for an overview, see Allen, 2023). Ainsworth et al. (2015) made a significant

contribution to the attachment literature in their studies identifying different types of attachment styles based on observations of different types of attachment behaviour. Specifically, they found that when a primary caregiver is available, sensitive and responsive to meeting their child's needs for safety and security the child develops a secure attachment (Ainsworth et al., 2015; Smith & Pederson, 1988). Whereas, when a child has experienced a relationship where their needs have not been (or inconsistently) met, they may develop an insecure attachment. Different types of insecure attachment (e.g., avoidant, resistant, disorganised) have also been defined depending on the type of attachment behaviour (Ainsworth et al., 1978; Main & Solomon, 1990). However, with respect to the present research, the key finding from years of research is that a secure relationship with a parent/caregiver (which responsive and sensitive caregiving can help foster), contributes to better mental health outcomes.

Attachment in Middle Childhood. Whilst there is decades of research on attachment during infancy, and considerable research interest in adolescent attachments, the focus of research on attachment in middle childhood has been more recent (Bosmans & Kerns, 2015). Evidence suggests that although peer relationships are significant during this developmental period, the primary attachment figures remain the caregivers (Seibert & Kerns, 2009). However, in contrast to the early childhood period, attachment with a child of primary school age is more about being available to them (i.e., the child knows they can seek support from the parent if needed) rather than being close in proximity. This reflects the shift in the child towards gaining greater independence that occurs during this developmental phase. Although responsive and sensitive parenting is still key to secure attachment during this developmental phase, the literature suggests that to support this developmental stage, the relationship between the caregiver and child needs to move to a

more collaborative problem solving approach. Accordingly, the relationship allows for the child to express their own feelings and opinions, taking a stronger role in problem solving and self-regulation, with the security of being able to refer back to the caregiver for advice and support as necessary. This stage of attachment has been coined the 'supervision partnership' and is garnering support in the recent literature as a key stage of attachment that occurs towards the latter part of middle childhood (Koehn & Kerns, 2022).

Attachment in Collectivist Cultures. A vast amount of the attachment literature is concerned with attachment to a single primary caregiver which is a predominantly Western model of parenting. However, in collectivist cultures the concept of attaching to a single primary caregiver (monotropy) is less relevant. Cultural psychology proposes that attachment can be formed with multiple caregivers, as relevant to the child's ecological context (Becke & Bongard, 2018; Keller, 2014) and acknowledges the significant role peer and sibling relationships play in the formation of healthy attachments. As referred to by practitioners in the present research, traditional Māori approaches to caring for a child involve many people within the whānau, including grandparents, aunts and uncles as well as siblings. Attachment in Te ao Māori posits that multiple attachments (rather than with a single caregiver) with other whānau members carrying different roles as well as the mother, are necessary for healthy development and emotional security (Mikahere-Hall, 2019). Attachments and relationships with multiple caregivers and across generations is a core part of Pasifika culture also (Maiava, 2014).

Intergenerational Transmission of Attachment. Finally, attachment theory purports that the type of parenting response a caregiver provides to their child is strongly influenced by the relationship with, and the type of parenting experienced with, their own caregiver. In

the literature this is termed the intergenerational transmission of attachment (van IJzendoorn & Bakermans-Kranenburg, 2019). This transfer of attachment styles through generations was evident in comments made by practitioners. Practitioners reported noticing emotional difficulties that may be due to intergenerational patterns in attachment styles and in parent/caregiver relationship modelling. They reflected that a caregiver's approach to their relationship with their child often reflected their own experiences of being parented (as noted earlier, caregivers did not always value the role they played in their child's life, in part due to not feeling valued by their own parents).

Summary. Knowledge of just how important the relationship between a parent/caregiver and their child is was one of the most salient mental health literacy gaps identified in this research. The significance of this part of parenting was discussed in relation to other mental health literacy gaps identified in this research and is supported by the literature. For example, caregiving relationships with primary school aged children need to take into account and support developmental changes during this age. In considering relevance for Māori and other collectivist cultures within Aotearoa New Zealand, the messaging around the importance of the relationship between a caregiver and child needs to be inclusive of multiple caregiving relationships. Intergenerational attachment difficulties place a further imperative on parent mental health literacy interventions to include clear messaging around the importance of relationships between a child and caregivers and how this can influence a child's mental health.

Parent Wellbeing

One of the factors known to contribute to the transmission of attachment styles through generations is the wellbeing of the parent (Risi et al., 2021). A gap in parents'

awareness was the impact that their own mental wellbeing had on their child; this was a sub-theme relating to parenting knowledge gaps identified in this research. It is estimated that as many as 15% of children are living with caregivers experiencing mental health difficulties (Statistics New Zealand, 2012), not to mention those experiencing sub-clinical difficulties and/or stress. As the metaphor goes, 'put your own oxygen mask on before helping others'; practitioners noted that they often made recommendations that parents themselves addressed their own mental health needs as part of the process of supporting their child's mental health.

The impact of the parent's own wellbeing on a child's mental health can also be conceptualised in terms of the bioecological model. Parental wellbeing is a factor in a child's exosystem; stressors in a caregiver's environment (and a parent's ability to cope with these) influence the parenting practice, including how they regulate their own emotions, and therefore the proximal processes between a child and parent which in turn impact on a child's mental health.

A summary of the literature associating parental wellbeing with child mental health is presented below.

Parental Wellbeing and Child Mental Health. Evidence to support the recommendation that caregivers ensure their own mental health needs are addressed (to be better equipped to support their child's mental health) comes from studies investigating relationships between a range of constructs. For example, there is evidence for a relationship between poor self-care, higher parental fatigue and stress and poorer parenting practice (Cooklin et al., 2012). Studies also show a relationship between parental mental illness and poorer child cognitive and social development and mental health (Low et al.,

2022; Mensah & Kiernan, 2010; van Santvoort et al., 2015). Further support for the contribution parental wellbeing can make to child mental health comes from research investigating the stress and challenges associated with the Covid-19 pandemic and its impact on child wellbeing, which has found a direct relationship between parental strain and child problem behaviours and emotional wellbeing (Essler et al., 2021).

The Family Wellbeing Model (Newland, 2015) suggests that parental wellbeing influences parenting practice which impacts on child mental health. This model is supported by emerging evidence that the positive mental health of a parent contributes to parenting practices that are important for healthy child development (Phua et al., 2020). Finally, research in New Zealand investigating resilience against the negative outcomes associated with adverse childhood experiences (ACES) identified parental health and wellness as one of the strongest protective factors (Walsh et al., 2019).

Practitioners spoke of the need for parents to strengthen their wellbeing through supportive relationships, enhancing their spiritual and cultural wellbeing and addressing physical health needs as well as their own mental health difficulties. These findings make sense within Te Whare Tapa Whā framework in considering the influence whānau hauora (including spiritual, mental and physical components) has on parenting practice. It also aligns with the bioecological model given that parental wellbeing influences the parenting a child experiences within their microsystem.

Summary. The international literature supports the views of practitioners that parental wellbeing is important for supporting child mental health. As suggested both by practitioners - and evidenced by the literature - improving parental wellbeing includes increasing self-awareness of a parent's own mental health needs, addressing sources of

stress and/or increasing support and engaging in self-care practices to maintain positive mental health.

Understanding Behaviour and Emotion

A need to enhance parent/caregiver understanding of a child's emotions and behaviour was a key theme of the present research. Sub-themes developed from analysis of interviews with practitioners concerning contextual influences on behaviour, emotional literacy and regulation are discussed and expanded on in relation to the literature pertaining to emotional development during middle childhood.

Behaviour in Context

The discussion so far has focused on gaps in knowledge of child development, the importance of caregiver relationships with a child and the wellbeing of parents/caregivers. These parent mental health literacy gaps have been discussed in relation to how they can impact on child mental health. Parenting knowledge, wellbeing and practice are all factors in a child's environment which are able to be changed, and changes in these factors can have an impact on the child's mental health. This goes to the essence of the next mental health literacy gap identified by practitioners which was a need for parents/caregivers to take a broader view of behavioural difficulties and to view these in the context of their child's life.

Practitioners commented that the parents/caregivers they worked with had a tendency to assume the cause of a child's problematic behaviour lay within the child, rather than to consider environmental factors that may contribute to the child's behaviour. In brief, the *child* was perceived to be the problem. An alternative perspective is to view the *child's behaviour* as the problem and seek to understand what may be underlying the child's behaviour. In this way, behaviour may be viewed as a way of communicating a need that is

not being met. Contextual models of wellbeing provide useful frameworks for considering possible underlying causes of a child's behaviour or mental health difficulties.

A bioecological approach may be a helpful framework for parents to consider factors that may be driving a child's behaviour. The influence of parenting knowledge, the relationship between a child and parent, and parental wellbeing has already been discussed. Practitioners mentioned encouraging parents to think beyond the child themselves when considering what may be influencing a child's behaviour. They noted factors in the child's microsystem in particular; that is, changes within a child's home environment or at school, can have a profound impact on a child's behaviour. Difficulties with peer relationships, conflict between parents and/or the experience of emotional or physical harm from others in a child's environment can impact behaviour and mental health (Felitti et al., 1998).

Practitioners (both Māori and non-Māori) mentioned Te Whare Tapa Whā as a useful framework for considering a child's difficulties in the context of their life. Te Whare Tapa Whā considers individual wellbeing in the context of the health of whānau and in relation to spiritual, physical and psychological factors (Durie, 1985). From a Western perspective, much attention is paid to physical and psychological aspects of wellbeing and these have already been mentioned in the discussion of meeting developmental needs. However, of equal importance in Te Ao Māori are the spiritual and whānau dimensions.

Evident in the interviews with practitioners and in key Māori health texts is that an individual's health is dependent on the wellbeing of the whānau. Whānau is considered fundamental to recovery from illness and the maintenance of health. The significance of whānau is reflected in the writings of prominent Māori mental health specialists and researchers. For example, Elder (2017) purports that 'whānau are the functional unit of

healing’ and includes this as one of her seven principles of practice in working in Māori mental health. Consistent with the bioecological model, recent research in Aotearoa New Zealand is exploring the impact of the health of, and connection to, wider social structures in Te ao Māori such as hapū and iwi on individual wellbeing (Greaves et al., 2023; Thom & Grimes, 2022).

Another dimension of Te Whare Tapa Whā which may be more likely to be overlooked in non-Māori health settings is wairua (Valentine et al., 2017). Perhaps consistent with this point, only a few practitioners mentioned concepts related to wairua as being an important influence on behaviour. Whilst the relationship between wairua and wellbeing is well recognised in Te ao Māori, it is acknowledged that there is a diversity of views of what wairua means for an individual (Valentine et al., 2017). For example, taha wairua includes spirituality in terms of religious faith and connection to ancestors and also connection to the land, natural environment and places of cultural significance (Bennett, 2018). Strengthening wairua, or spirituality of whānau was mentioned as important by a few practitioners - be it through connection to whakapapa or cultural practices – and was viewed as a significant factor that influences a child’s mental health.

In addition to considering four dimensions of wellbeing, the model takes into account strengths across each dimension not just weaknesses or deficits. This way of viewing mental health is aligned with Keyes’ (2005) dual factor model of mental health, in which the dimension of flourishing-languishing is of equal importance as mental health-illness. In investigating the concept of flourishing with Māori whānau Durie (2018) proposed that flourishing is a state of mauri ora (life essence). With respect to Te Whare Tapa Whā, Durie stated that flourishing occurs when “there is spiritual and cultural fulfilment,

emotional and mental strength, physical aptitude and positive relationships within and beyond families” (Durie, 2018, p. 75). In other words, one may be considered to be in a state of flourishing when all dimensions of Te Whare Tapa Whā are strong.

Summary. In sum, encouraging parents/caregivers to take a contextual or holistic view of a child’s wellbeing may assist them to be able to recognise when underlying needs may not be being met and be able to act on these before they compound with other factors to become a mental health problem. Te Whare Tapa Whā and the bioecological models provide a framework around the contextual layers of influence on each component of whānau wellbeing. With whānau being considered the functional unit for wellbeing, knowledge of child development within whānau would be expected to enhance mental health outcomes for tamariki. Whānau wellbeing is closely connected to whānau wairua and is influenced by one’s connectedness and attachments with others, with whenua (land) and places of cultural and/or spiritual significance (Bennett, 2018; Reweti, 2022). With adequate knowledge of developmental abilities and the emotional and physical needs of tamariki, whānau are better equipped to enhance a child’s tinana, and a child’s physical and emotional environment and foster good physical and mental health outcomes for tamariki.

As reflected in both Te Whare Tapa Whā and the bioecological models, factors identified as parent mental health literacy gaps in the present research do not operate in isolation, and all interact with each other to impact on a child’s development and their mental health.

Emotional Literacy and Regulation

One of the gaps in the mental health literacy of parents/caregivers that practitioners highlighted most emphatically was limited knowledge of how to support their child to

understand and regulate their emotions. This theme was multifaceted: practitioners mentioned gaps in parental ability to help their child to recognise and name different emotions, to help them accept and understand the role of emotions and to support their children to use developmentally appropriate strategies to regulate their emotions. Furthermore, closely related to gaps in knowledge of how to help their children with their emotions, practitioners noted that the parents/caregivers themselves often had difficulties with emotion regulation too. For example, practitioners reported that parents/caregivers had made comments that they had been brought up in an environment where emotions were not validated and poor regulation strategies were socialised (e.g., to suppress anger or sadness).

Limited parental understanding of their child's and their own emotions also related to other themes previously discussed in the present research. For example, fundamental to the process of supporting and scaffolding a child's developing emotion regulation skills is the quality of the relationship the child has with parents/caregivers. With a secure attachment a child is better equipped to learn to express their emotions and more likely to draw on parental support in learning how to express and regulate their emotions. Furthermore, increased emotional literacy may help parents to contextualise and understand the underlying reason for a child's problematic behaviour.

This theme is discussed in relation to the current literature pertaining to parent/caregiver emotional literacy and regulation, implications for child mental health, how it relates to knowledge of child attachment and development, and the role of a parent/caregiver in supporting a child's emotional development.

Definitions of Emotional Literacy and Emotion Regulation. A range of terms are used to refer to emotional literacy, often interchangeably, and these are not often well-defined (Eisenberg et al., 2010). In the current research, practitioners mostly used the term emotional literacy.

The construct of *emotional literacy* was coined by Claude Steiner in the late 1990s, and defined as ‘the ability to understand your emotions, the ability to listen to others and empathise with their emotions, and the ability to express emotions productively’ (Steiner & Perry, 1997, p. 11). Hence according to this definition emotional literacy is considered an umbrella term that covers knowledge and skills about understanding one’s own and others’ emotions, and increasing emotional literacy is thought to be associated with many positive outcomes.

Reviews of research into *emotion regulation* suggest that the use of this construct commonly draws on the definition of Thompson (1994). This definition of emotion regulation covers the processes of monitoring, evaluation and modification of emotional responses (Compas et al., 2017). It is based on the premise that emotions are useful and serve a function, and that emotions can be regulated through a number of processes.

Commonly used in the literature, Gross’s (1998) model of emotion regulation builds on Thompson’s (1994) definition. Gross (1998) proposed that five types of processes are involved in emotion regulation: situation selection, situation modification, attentional deployment, cognitive change and response modulation. The first, situation selection, involves the individual actively choosing (or not) to put themselves in a particular situation in which it is likely they will experience a particular emotion (e.g., watching a comedy to experience joy) (Gross, 1998). Situation modification does not involve actively selecting a

situation. Rather, it requires making a change to the situation one is in (e.g., attending class but sitting at the back of the room to avoid being asked a question for fear of embarrassment). A third type of emotion regulation is attentional deployment which involves redirecting attention either to particular aspects of a situation or away from a situation to alter emotional experience. One of the most common forms of attentional deployment is to distract attention away from the emotion-evoking stimulus. Cognitive change (as its name suggests) requires a change in how the situation is appraised (before, during or after) in order to engender a change in emotional state. Finally, response modulation involves the individual making changes to their emotional response (which could be behavioural, physiological or experiential).

The process model of emotion regulation was later expanded to include an individual's use of valuation systems to act at various stages of emotional arousal (Gross, 2015). The extended model involves identifying when there is a need to regulate an emotion, consideration of a range of external and internal strategies to regulate emotions, and implementing a selected strategy in emotionally arousing situations. In sum, the process of regulating emotions is complex and requires a number of skills. Accordingly, parents can play a significant role in supporting a child to develop a number of skills to self-regulate their emotions.

Emotion Regulation and Mental Health in Children. Although the study of emotion is not new, research into the ability of children to regulate their emotions has been more recent, with a significant increase in the past 20 years as the field of developmental psychopathology has taken an interest (Eisenberg et al., 2010; Southam-Gerow & Kendall, 2000).

Practitioners in the present research noted patterns in how clinical problems they see in clients are underpinned by emotion regulation difficulties and that adaptive emotion regulation skills are fundamental for supporting mental health. This notion is well-supported in the academic literature. For example, a meta-analytic study by Compas and colleagues (2017) investigating relationships between coping, emotion regulation and symptoms of psychopathology in childhood and adolescence found that less adaptive emotion regulation strategies such as suppression, avoidance and denial are associated with increased psychopathological symptomology. This study is supported by a recent systematic review (Daniel et al., 2020) in which emotion regulation skills were found to be a protective factor against internalising and externalising symptomology, psychological distress broadly and a range of clinical disorders (e.g., depression, PTSD). Finally, in terms of promoting wellness, emotion regulation skills in children of primary school age have been found to be associated with social competence and building resilience (Gülay Ogelman & Önder, 2021; Monopoli & Kingston, 2012).

Emotional Development During Middle Childhood. As previously discussed, increasing parent knowledge of child development can help parents to have expectations of their child that are developmentally realistic and support their child's mental health. Accordingly, parental knowledge of a child's social and emotional developmental abilities is fundamental for promoting good mental health.

Consistent with the attachment literature referencing middle childhood as a period of growing independence (Koehn & Kerns, 2022; Seibert & Kerns, 2009), research suggests that during middle childhood there is a gradual transition of emotion regulation abilities from the child seeking this from the parent to being able to regulate their emotions without

parental support (Pan & Zhang, 2023; Thompson & Goodman, 2010). With increasing language development during this stage, the child is able to start to progress from behavioural expression to use of language to express their emotions (e.g., “I am scared”). Language development also allows for emotions to be socialised in discussions of everyday situations. As practitioners reflected in the present research, parents/caregivers can increase their child’s emotional understanding by naming an emotion the child may be experiencing so the child learns to be able to identify their emotions themselves (a critical step in regulating emotions).

Children can then learn to recognise their own emotions, differences in intensity of emotional experience and the lability of emotions and start to learn more sophisticated ways of regulating their emotions. Rather than removing themselves from a situation or seeking out a parent to soothe themselves, during this developmental stage children are more able to use cognitive strategies such as distracting themselves or thinking through different interpretations of events. They also start to apply relaxation strategies to reduce arousal such as deep breathing (Thompson & Goodman, 2010).

Parental Emotional Literacy and Children’s Emotional Development. Practitioners in the present research identified both constructs of emotional literacy and emotion regulation as gaps in parent mental health literacy. Emotional literacy is associated with an ability to adaptively regulate emotions; emotion regulation in turn is associated with improved mental health outcomes (Compas et al., 2017; Gross, 2013). As discussed above, middle childhood is a crucial developmental period where children become more emotionally literate and able to start to regulate emotions without the support of their parent/caregiver. Whilst there has been increasing research into the emotion regulation of

children, there is limited research investigating the emotional literacy and regulation skills of parents (Rutherford et al., 2015).

One recent study of particular relevance to the present research investigated the influence of parent emotional literacy on child emotion regulation (Bozkurt Yükçü & Demircioğlu, 2021). These researchers found that parents' level of emotional literacy was predictive of the child's emotional regulation abilities, and of the child's difficulties associated with emotion dysregulation. Although it is acknowledged that this study targeted parents of children that were slightly younger (4-6 years) than those of interest in the present research, the findings provide support for one of the key themes in the present research - increasing the emotional literacy of parents/caregivers may be beneficial for child mental health.

Parental Support of Child's Emotional Development. Practitioners noted that they commonly made a number of suggestions to parents/caregivers as to how they can support the emotional development of their children during middle childhood. These suggestions included allowing the child to express their emotions openly and responding in ways that are accepting and validating of their experiences, helping them to learn to recognise emotions (e.g., recognise physiological signs and label their emotions), and to support their learning about the purpose of emotions. A further suggestion was encouraging parents to work on developing their own emotion regulation skills and to actively model these so their child can learn adaptive emotion regulation skills through observation. The suggestions made by practitioners can be summarised as advice on how parents/caregivers react to their child's emotions, how they talk about emotions with and around their child and their

own emotion regulation skills, and are supported by systematic review evidence (De Raeymaecker & Dhar, 2022; Eisenberg et al., 2010).

The impact of parent emotion socialisation on child emotion regulation has been well-researched (De Raeymaecker & Dhar, 2022; Eisenberg et al., 2010). Findings from systematic reviews determined that parents/caregivers can influence a child's developing emotion regulation skills in at least four ways: the parent's meta-emotion philosophy, how they react to a child's emotional states or their emotion-related socialisation behaviours (ERSBs), the parent/caregiver's own expression and regulation of emotion and how the family relate to each other, talk about and express emotions (emotional climate).

Parental meta-emotion philosophy (PMEP) or the development of parental beliefs and attitudes about emotions is informed by the parent/caregiver's own experience of how their emotions were reacted to and supported (or not) as a child themselves (Gottman et al., 1996), which in turn influences their ability to regulate their own emotions. Findings of the present research provided support for PMEP as an influencing factor on a parents' emotional literacy and their ability to support their child's emotional development. For example, practitioners mentioned noticing supportive and non-supportive attitudes towards emotions through comments that parents/caregivers made in relation to their own emotions or their child's behaviour.

It follows that a parent/caregiver may be more or less emotionally expressive and effective in regulating their own emotions depending the type of beliefs or PMEP they may hold. The PMEP is therefore an influencing factor on parental emotion regulation and parental reactions to a child's emotional expression. A key finding of the review by De Raeymaecker and Dhar (2022) was that a child's own emotion regulation skills were strongly

influenced by their observations of parent regulation. Indeed, they recommended the first stage in supporting a child's emotional development was for the parent/caregiver to develop effective emotion regulation skills themselves. Practitioners noted that in some cases this was a gap in the toolkit of parents/caregivers they work with also. Parental reactions towards their child's emotional expression that are supportive, validating, and sensitive are associated with increased emotion regulation skills in a child, whereas non-supportive or dismissive reactions tend to lead to negative beliefs about emotions and emotion dysregulation.

In terms of the emotional climate of a family, there was evidence that children of emotionally expressive parents were often emotionally expressive themselves (De Raeymaecker & Dhar, 2022). Conversely there were an association between children of parents with depression and child emotion dysregulation, providing evidence of the influence that parental modelling of emotional expression can have on a child. Parent-child attachments are also reflective of the emotional climate of the family: secure attachments and an authoritative parenting style have been found to be associated with higher levels of self-regulation. Furthermore, the findings of this review supported the notion that when parents discuss emotions with their children they teach them about emotions - which in turn increases emotional understanding and is associated with adaptive regulation.

The findings of these systematic reviews complement the practical pointers practitioners in the present research made regarding the specific mechanisms by which parents/caregivers can support a child's emotional literacy and regulation skills. The effectiveness of parenting interventions to support children's emotion regulation is supported by a meta-analysis by England-Mason et al. (2023). This meta-analysis provides

evidence that parenting interventions to develop emotion socialisation parenting skills can be effective in increasing these and other positive parenting behaviours. This research also found interventions to increase emotion socialisation behaviours also contributed to enhancing parent wellbeing and the child's emotional competence and had a positive impact on behavioural difficulties of the child (England-Mason et al., 2023).

Father's Role in a Child's Emotional Development. Although there is a growing research focus on the role of parents in a child's developing emotion regulation skills, most of the studies to date have focused on the mother's influence on a child's emotional development. Practitioners in the present research also made reference to their work being mostly with female caregivers and therefore their perspectives should be considered through this lens. In recognising there are multiple types of family group structures of which some may include one or more male caregivers, it is important to consider the role of fathers/male caregivers on a child's emotional development. Islamiah et al. (2023a) conducted a systematic review to investigate whether the paternal role in a child's emotion regulation development is different to the maternal role, and to identify how fathers can influence their child's emotion regulation development. In this review, four paternal parenting factors were identified as being associated with a child's emotion regulation development. The strongest factor – especially for school-aged children – was the way the father reacts to a child's expression of emotion (Islamiah et al., 2023b). That is, a father's positive reactions to a child's expression of emotion (e.g., warmth, sensitivity, encouragement of emotional expression) was associated with higher emotion regulation skills in the child. How a father modelled emotion regulation skills was also related to school-age children's and adolescent's emotion regulation skills. Islamiah et al. found that a secure attachment between a father and child, and positive parenting behaviours such as

sensitivity and engagement were associated with good emotion regulation skills in a child, whereas negative parenting practices were associated with poorer regulation. Of specific relevance to fathers' parenting styles was the finding that physical play with a child provides an opportunity for the child to become emotionally aroused and for the father to support the child practicing regulation strategies. The findings of this review highlight the significant role fathers play in their child's emotional development.

Summary. The ability to regulate emotions in an adaptive way is associated with good mental health, and parental emotional literacy is associated with a child's ability to regulate their emotions. During middle childhood children start to regulate their emotions without parental assistance, are able to develop more sophisticated emotion regulation skills and apply problem solving. With this knowledge, the expectations of parents/caregivers are aligned with a child's developmental capabilities and are therefore better placed to support their child's emotional development. The findings of the present research and the international literature suggest parents with children in middle childhood can support their child's emotional development by modelling adaptive emotion regulation skills themselves, reacting to a child's expression of emotion in a supportive and validating way and teaching them about the usefulness of emotions. In addition, fathers play a significant role in a child's emotional development.

Help-seeking Efficacy

Parental help-seeking efficacy was perceived by practitioners to be influenced first and foremost by parental knowledge of when a child may require professional help for difficulties with mental health. Knowing when a mental health difficulty was beyond the bounds of normal developmental behaviour was perceived to be influenced by parents'

initial reliance on informal sources of information and advice and their attitudes and beliefs regarding mental health. Finally, in addition to a need to increase knowledge about how to recognise when a child was experiencing problems with mental health was the need to increase awareness of where to go to seek help.

What is normal?

One of the themes identified in the present research was that parents/caregivers found it difficult to recognise when their child was experiencing problems with their mental health. Practitioners had noted that parents/caregivers sometimes were not able to recognise a problem when there was one but also had difficulties in thinking there was a problem when there was none. Practitioners themselves noted that in many cases mental health difficulties for children of this age group could be considered at the extreme end of what is normal. Given that the ability to recognise a mental health problem in a child is strongly associated with intentions to seek help (Thurston et al., 2015), upskilling parents/caregivers so that they may be better able to recognise a mental health problem in their child is a key step towards improving child mental health.

This particular gap in parental mental health literacy has been found elsewhere. For example, a national survey in Australia determined that only a third of parents of children aged 0-17 years were confident they could identify a mental health difficulty in their child (Rhodes et al., 2018). Furthermore, a systematic review by Johnson et al. (2023) found low levels of recognition of mental health problems amongst caregivers of children aged 5-12 years (albeit there were only five studies that investigated mental health literacy of parents of children in this age group). This review also found that adults were more accurate in recognition of externalising problems such as ADHD or ODD in boys than in girls, which was

consistent with the present research. Practitioners in the present research commented that parents/caregivers appeared to be more accepting of a diagnosis of ADHD in boys than girls.

However, some studies investigating parental recognition of both ADHD and anxiety, including in New Zealand, have found higher levels of parent mental health literacy (Barnes, 2023; Davidson et al., 2022). It is noted that both studies used vignettes to assess parental recognition of mental disorders. That is, these studies did not investigate the ability of parents/caregivers to recognise mental health problems in the parent/caregiver's own child. A study using both methods (Villatoro et al., 2018) found that recognition of mental health problems in their own child was lower than that of a child presented in a vignette. As proposed by the authors, this may be due to parents' concerns about stigma, but could also be influenced by the way the problem was presented in the vignette, ecological factors in real-life settings (e.g., parent stressors) and the way a parent may interpret their own child's behaviour compared with that of another. Regardless, the differences in methods used may go some way to explain the discrepancy in research findings relating to parental mental health literacy.

Anxiety. Anxiety disorders are one of the most prevalent types of mental disorder and onset often starts during childhood (Kessler et al., 2005). If parents/caregivers are aware of the signs and symptoms of a child experiencing difficulties with anxiety, they can then support their child to seek professional help for problems with anxiety if necessary. Practitioners were of the view that parents/caregivers had difficulty determining what was normal behaviour within the context of a child's development and what constituted a mental health problem, and they made particular reference to problems with anxiety as one of the most common mental health difficulties in this age group. As mentioned above,

systematic review evidence has found that parents are less able to recognise signs of internalising mental health difficulties than externalising difficulties (Johnson et al., 2023).

Practitioners stressed it is important to accept that some anxiety is normal and that sometimes parents/caregivers had a tendency to overreact when their child experienced anxiety. On the other hand, they reported that they notice other parents/caregivers may miss signs and symptoms of an anxiety disorder in their child. A lack of parental awareness of some signs of difficulties with anxiety has been found in other studies. For example an Australian study reported that a quarter of parents were not aware that ongoing physical complaints can be a sign of mental health problems in a child (Rhodes, 2017). Qualitative research investigating parental knowledge of child anxiety has found parents have difficulty in recognising symptoms of anxiety and also recognising when these may be considered outside of the realms of normal and in need of professional help (Reardon et al., 2018). Supported by the present research, the findings of Reardon et al.'s study indicated parents/caregivers drew on their own experience of mental health difficulties and the researchers found that this sometimes helped aid recognition, but at other times parents' concern they were being overprotective then hindered the identification of the problem.

Summary. The present research adds to the growing body of literature that further work is needed to increase parental understanding of mental health difficulties in children and to recognise when these may be present in their *own* children. The literature suggests parents are less likely to recognise internalising than externalising problems, and the findings of the present research suggest increasing parental awareness of anxiety in children would be particularly beneficial given this is one of the most prevalent types of mental illness for this age group. In relation to anxiety, the findings were two-fold. Firstly, there is a

need to help parents to be able to recognise when their child may be experiencing anxiety and to be better equipped to support their child to manage their anxiety. Secondly, parents need to be able to recognise when a child's anxiety may be beyond the realms of normal and in need of professional help.

Barriers to Seeking Help

According to a model based on qualitative research with parents and caregivers by Reardon et al. (2018), recognising a mental health difficulty (such as anxiety) and then determining that a child needs professional help are the first two stages of help-seeking. The remaining two stages in this model are: making contact with health professionals and receiving appropriate support. As found in the present research and discussed above, barriers to help-seeking in the first couple of stages include a parent/caregiver's ability to recognise the child is experiencing a mental health difficulty and to recognise when it is at a stage where they are in need of professional help.

One of the factors that influences a parent/caregiver's progression through the first two stages of help-seeking is the parent/caregiver's willingness to accept the child has a problem. Further barriers may arise from any informal advice a parent/caregiver may seek and receive, and the parent/caregiver's knowledge of where to seek help.

Acceptance of a Problem. Practitioners reported that aside from other barriers (e.g., lack of recognition of a mental health problem) it can take some time for a parent/caregiver to come to terms with the knowledge that their child is experiencing mental health difficulties. Practitioners talked about this as a process that needed to be worked through before parents/caregivers then felt able to engage with professional support for their child. Parental attitudes towards mental health are likely to influence the level of acceptance they

have in relation to their child's mental distress. For example, as discussed earlier, practitioners in the present research noted that parents/caregivers seemed to be more accepting of externalising disorders in boys than in girls and previous research has found that parents/caregivers are more likely to seek help for externalising than internalising difficulties (Hurley, Swann, Allen, Ferguson & Vella, 2020; Thurston et al., 2015).

Difficulties accepting a problem may in part be related to parental perception of stigma associated with mental health difficulties. A study in which parents of children and adolescents referred to CAMHS outpatient services were interviewed regarding the process of help-seeking supports this notion. In this study, concern about being judged negatively by other parents and their child's peers and the implications of their child receiving a diagnosis were all seen as barriers to seeking professional help for their child (Hansen et al., 2021).

These findings are supported by qualitative research findings also. Reardon et al. (2018) found that parental perception of stigma associated with mental health difficulties, willingness to discuss their concerns with others and attitudes towards treatment influenced their willingness to seek help. In a study investigating the influence of stigma on recognition of a mental health problem, Villatoro et al. (2018) found that stigma (measured by knowledge and attitudes towards, social distancing from, and avoidance of someone with a mental illness) had an impact on parental figures' recognition of mental health difficulty in their own child. Interestingly, stigma did not influence recognition of a problem in another child as described in a vignette. The researchers proposed that parents are less likely to recognise a problem in their own child (or more likely to consider it normal behaviour) as a way of protecting them from the stigma associated with experiencing mental health difficulties.

Finally, feelings of inadequacy or self-blame by parents was also mentioned by practitioners as a possible barrier to help-seeking and is supported by previous research (Boulter & Rickwood, 2013; Hansen et al., 2021; Reardon et al., 2017, 2018). These previous studies also found that parents perceived that professionals blamed them for their child's difficulties, and indeed research investigating the perceptions of mental health professionals found that some professionals themselves attribute a child's difficulties to deficient parenting (Johnson et al., 2000).

Informal Sources of Advice. The findings of the present research suggest that parents/caregivers seek advice regarding their child's mental health from informal sources such as friends and family before they seek advice from a professional. This is consistent with other studies investigating parental mental health literacy which have found friends and family were commonly sought out for support and advice before professionals (Frauenholtz et al., 2015; Tapp et al., 2018). Although this may not be a surprising finding, previous research by Boulter and Rickwood (2013) found that practitioners mentioned that the advice of friends and family was not always helpful. For example, in some cases friends and family had denied the presence of a mental health problem when there was one, or were unsupportive of the benefits of seeking professional help. Fear of negative judgement from family and friends was also found to have a negative impact on seeking professional help.

In terms of culture-specific advice, one practitioner in the present research mentioned Pasifika families may seek help from traditional healers before mental health professionals; this echoes findings in other mental health literacy studies with non-

European populations (Johnco et al., 2019). This advice was not mentioned to be a barrier to seeking professional advice, rather as one avenue in the help-seeking process.

Knowing Where to Seek Help. Practitioners mentioned that a lack of publicly available information about what different mental health services do, and a lack of coordination between services were also barriers to parents/caregivers receiving the appropriate professional support. The finding that parents/caregivers may not be adequately informed about where to seek help is supported by Australian survey research that found less than half of parents/caregivers of children aged 0-17 years were confident they knew where to go to seek help from a mental health professional if they needed it for their child (Rhodes et al., 2018). Previous research investigating the parent help-seeking process has consistently found that a lack of knowledge about mental health services is one of the most frequently cited barriers to parents/caregivers seeking professional help for a child (Hansen et al., 2021; Reardon et al., 2018). This finding is complemented by qualitative research with parents/caregivers exploring their experiences of help-seeking for children with mental health difficulties that found that they were often referred to another service after finding one service did not meet their needs, and therefore had to persist with finding the right service (Boulter & Rickwood, 2013).

Illustrating just how difficult it is to find the right service, practitioners commented that they themselves were sometimes confused about what the right service was for a family or where the family should go to find out further information. For example, some child and adolescent mental health services provide assessments and support for children with autism and others do not. In light of this finding, it is not surprising therefore that the literature suggests that primary care providers who make referrals to mental health services

may not have adequate knowledge to accurately recognise child mental health difficulties such as anxiety, or the ability to refer to the appropriate service (Aydin et al., 2020; O'Brien et al., 2017, 2019).

Indeed, in considering the challenges of multi-agency collaboration, others have suggested that the lack of information about where to seek help may be partly due to difficulties moving between services resourced by different sectors and funding streams (Hansen et al., 2021). Sadly, this was reflected in comments by practitioners in the present research that limited resources meant they were restricted to specific criteria for accepting referrals which meant that some families did not meet criteria for any service.

Summary

Informed by qualitative research, Reardon et al. (2017) developed a model of factors that influence parental help-seeking for a child with mental health difficulties. Reardon et al.'s research identified parental recognition of an anxiety problem and subsequent recognition that a child may need professional help as the first two stages. The present research provides support for mental health literacy gaps in relation to both of these stages. It also identifies a number of factors that influence these stages, such as attitudes and acceptance of mental health difficulties, and influence of advice from family and friends. As has been found in related studies, a lack of information about mental health services may also be a barrier to parents/caregivers seeking professional help for their child (Hansen et al., 2021; Reardon et al., 2018).

The findings of the present research suggest that interventions to increase parental knowledge of how anxiety (in particular, but also other mental health difficulties) may

present in a child and how different specialist services can help with mental health difficulties may increase parental help-seeking efficacy.

Podcasting to Increase Mental Health Literacy

The present research makes a contribution to the small body of knowledge regarding the mental health literacy of parents of children in middle childhood. The findings suggest parents/caregivers of children in this age group would benefit from increasing their knowledge regarding a number of topics concerning child mental health. Accordingly, practitioners in the present research supported the proposed development of a mental health literacy intervention for parents of children in this age group, noting that increasing the mental health knowledge and skills of parents prior to their children entering the adolescent period would be particularly beneficial.

Universal Parenting and Mental Health Interventions

One of the findings of the present research was that practitioners perceived that one advantage of interventions targeted at a universal level (i.e., for all parents irrespective of a child's risk of mental illness) was they do not have the same stigma that may be associated with targeted interventions. Accordingly, an intervention targeted at all parents/caregivers of primary school aged children may be more acceptable. These findings are supported by the views of parenting researchers such as Doyle et al. (2023) who advocate for a population-based approach to providing parenting education, alongside intensive support as required. In this way, parent education is normalised and there is less stigma associated with parenting programmes.

A review by Salarai and Enebrink (2018) noted that there had been an increase in the number of universally offered parenting programmes since 2010. In investigating the

effectiveness of parenting programmes on child mental health outcomes they found a small positive effect on children's mental health overall that could be attributed to universal interventions. They reported that the majority of parenting programmes reviewed had been developed for parents of children with externalising difficulties but noted that many of the components of these programmes were also relevant for children with internalising problems. However, the researchers reported mixed findings in relation to specific effects of universal programmes on internalising compared with externalising difficulties, albeit many of the outcome measures used in the evaluations of these interventions were designed for clinical populations, and therefore effectiveness may be under-estimated. Salari and Enebrink (2018) suggested that measures of more general risk factors associated with psychopathology, such as emotion dysregulation may be more appropriate for evaluations of universal interventions. They also noted universal public health approaches to parenting education are likely to be effective in promoting child mental health, as well as preventing mental illness but measures of such outcomes were not included.

Digital Mental Health Interventions

One way of increasing accessibility to parenting education is to use digital technologies. There has been an increased focus on trialling digital parenting and mental health interventions, with a burgeoning of this effort during the Covid-19 pandemic. Systematic reviews by Corralejo and Rodriguez (2018), Flujas-Contreras et al. (2019) and Thongseiratch et al. (2020) provide evidence of effectiveness of technology-based parenting programmes. These reviews found that technology based parenting interventions were largely focused on parenting children with behavioural difficulties and included well-established programmes such as Triple P, Parent-Child Interaction Therapy as well as other

cognitive-behavioural and psychoeducational focused interventions. Evaluations of these types of interventions tended to report outcomes in relation to parent knowledge and behaviour rather than child outcomes. Of note, increasing parenting knowledge of emotion regulation was noted as a common transdiagnostic component across effective interventions, and the inclusion of a behavioural component alongside psychoeducation appeared to increase effectiveness.

In addition to being effective in addressing child behaviour problems, a meta-analysis conducted by David et al. (2023) provides evidence of online parenting interventions being effective in improving emotional difficulties in children. This study also indicated that intervening with parents of younger children and for longer (i.e., increasing the number of sessions) increased effectiveness. In a rapid review of digital interventions targeting mental health outcomes likely to be associated with the COVID-19 pandemic, Rauschenberg et al (2021) found evidence of effectiveness in terms of improved mental health as well as positive outcomes in relation to the usability, satisfaction and safety of these interventions. Positive outcomes associated with digital interventions were enhanced when the design of the intervention was informed by service users as well as mental health professionals, and included some type of interaction with a mental health professional.

Whilst there are now numerous parenting and mental health programmes that are digitally delivered (e.g., Triple P, Cool Little Kids) there have been few studies that have evaluated digital interventions specifically aimed at increasing parent mental health literacy (Peyton et al., 2022). These few studies show some positive findings in terms of increased mental health literacy. However, Peyton et al. (2022) concluded that as most of the studies to date are of low-quality further research is needed to determine effectiveness.

One potential advantage of digital parenting interventions is that as more males than females are users of podcasts (Edison Research, 2017), male caregivers may be more likely to engage with them. Fathers and male caregivers are typically underrepresented in terms of engagement in parenting interventions (Fletcher et al., 2011). Parenting researchers seeking to understand how to increase engagement of fathers in parenting programmes found that male caregivers tended to prefer brief interventions and those that are delivered using an internet based mode (Tully et al., 2017). Further support for increased engagement of fathers in digital parenting interventions comes from a recent evaluation of an online parenting intervention that was specifically designed to be inclusive of fathers (Piotrowska et al., 2020). This study showed higher levels of participation of fathers than reported in other parenting interventions and no difference in the effectiveness of the intervention on child mental health outcomes between male and female caregivers.

Podcasting to Increase Knowledge. The number of podcasts available and perception of people who listen to podcasts has increased rapidly in the past decade (Edison Research, 2023). The use of podcasting to increase health literacy is increasing and there is a growing body of research that supports the use of podcasting as an effective means of communicating health information and facilitating behaviour change (Casares, 2022; Mailey et al., 2019; Semakula et al., 2017). In relation to parenting education and behaviour change, an evaluation by Morawska and colleagues (2014) provided evidence of the effectiveness of podcast delivery of the Triple P Positive Parenting Program. Specifically, the programme resulted in improvements in measures of parenting practices and child behavioural outcomes. In commenting on learnings from their recent production of the Parenting in a Pandemic podcast, Morawaska et al. (2022) suggested initial engagement in podcasts tends to decrease with later episodes and perceived importance of topic was most

relevant to engagement. These researchers noted further evaluation is needed to identify particular aspects of podcast delivery that enhance parent engagement.

Practitioners in the present research endorsed the idea of using podcasting to increase parent mental health literacy. Specific advantages of podcasts were noted to be that they are able to be accessed privately, in the caregiver's own time and could be listened to repeatedly if desired. Previous research investigating factors that influence engagement with digital mental health interventions support these findings also (Borghouts et al., 2021; Turner-McGrievy et al., 2009). In addition, Borghouts et al. (2021) found the type of content and perceived credibility of the content (e.g., whether it was evidence-based) influenced engagement. Similarly, a study drawing on expert opinion of a range of health professionals to develop quality indicators for podcasts found opinion was heavily weighted to indicators relating to credibility of those involved in the creation of the podcast and the accuracy of the information presented (Lin et al., 2015).

Consistent with the present research, Borghouts et al. (2021) found that offering the information in more than one modality, using a non-judgemental tone of delivery and the inclusion of practical tips was perceived to be important to enhancing user engagement. Making the content relatable and normalising user experiences was perceived to aid engagement. Suggestions by practitioners for how to achieve this were to include culturally appropriate content and to use simple understandable language rather than clinical or technical jargon. Finally, Turner-McGrievy et al. (2009) concluded that interventions with content and delivery grounded in research evidence and theory regarding behaviour change (e.g., social learning theory) were most effective. They also reported that interventions

designed to promote user control, cognitive processing and elaboration of information may increase effectiveness.

Story-telling as Science Communication. The science communication literature frequently discusses different models and frameworks for effective communication. One such approach that has recently received renewed interest is that of storytelling (Cormick, 2019; Davies et al., 2019). Science communication researchers note that the essence of story-telling is to communicate information in a way that is meaningful and resonates with people's experiences and values, and that different stories may be required for different audiences (Cormick, 2019). In line with this, a qualitative study exploring factors that enhance delivery of mental health literacy interventions by Postelnik et al. (2021) found that use of personal stories of real-life experiences helps to communicate messages. Practitioners in the present research noted that incorporating story-telling into a podcast, such as describing a relatable situation to which parenting tips could be applied, may help to ensure engagement with content.

Illustrating how to apply specific parenting strategies to a relatable real-life situation is a form of 'modelling' thereby drawing on social learning theory which in turn may be more likely to elicit positive behaviour change (Turner-McGrievy et al., 2009). Use of story-telling to communicate information may also align with practitioners views that the intervention approach should support self-determination. That is, story-telling may be a way to 'walk alongside whānau' in improving child mental health outcomes, an approach that practitioners emphasised as vital for enhancing engagement.

Summary

Ensuring podcast content is based on research and theory and is perceived to be credible, and communicating information in a way that is relatable and is complemented with practical strategies to apply may enhance engagement. Use of story-telling as part of the approach to communicate content may be a way to model how to apply the information and practical strategies outlined to a relatable situation.

Additional Findings

Two additional findings that do not directly address the research questions are worthy of mention. The first of these describes how the research design influenced the nature of the mental health literacy gaps identified. The second point highlights that the findings of the research should be considered in the context of practitioners' perceptions of parental conceptualisation of mental health.

In departing from the approach taken in previous studies of mental health literacy (which tended to identify gaps in how to recognise and seek help for specific types of mental illness), the present research identified gaps in knowledge of child mental health relevant to both prevention of illness and promotion of health. Aside from a few findings concerning anxiety in primary school aged children, the knowledge gaps identified were at a transdiagnostic level, rather than specific to a particular diagnosis. For example, knowledge gaps were noted in relation to understanding the importance of a secure relationship with a child, supporting the development of a child's emotion regulation skills, and being aware that stressors in a child's environment may influence their behaviour. This may be due to differences in the design of the present research compared with previous research. Whereas other studies have used clinical vignettes accompanied by follow-up questions (for

example, Tissera & Tairi, 2020; Barnes, 2023), the present research used an exploratory approach guided by the dual factor model of mental health (Keyes, 2005) to identify mental health literacy needs. The present research therefore makes a contribution to the literature in identifying parent/caregiver mental health literacy needs that are at a transdiagnostic level.

One of the more latent findings identified through the present research was an indication that parental (as perceived by practitioners) and also some practitioner conceptualisations of mental health were through a deficit lens of health (e.g., “mental health issues”) or as the absence of mental illness. When asked about parent and caregiver knowledge of child mental health there was a tendency to refer to knowledge gaps about what mental illness looks like. In some cases, there was a view that provided there were no apparent problems with a child’s development (e.g., socially, physically or cognitively) the child was mentally healthy. That is, mental health was considered a ‘default’ state. This view may be considered consistent with a developmental psychopathological approach. However, it indicates the dominant discourse around mental health is still in relation to mental illness and that parents and caregivers may not consider the promotion and maintenance of mental health or flourishing to be important in the absence (or presence) of mental illness.

Keyes (2005) defines mental health in the complete state model of mental health as comprising the constructs of both mental illness as well as flourishing. In this body of literature the concept of flourishing was operationalised as functioning well emotionally, psychologically and socially (Keyes, 2002). Keyes and others have contributed decades of research providing evidence that flourishing and mental illness are separate constructs

contributing to one's overall state of mental health (Keyes, 2007; Keyes et al., 2020; Seow et al., 2016). Despite contextualising the research in terms of this model, the discourse tended to focus on perceptions of gaps in knowledge of mental illness.

Research in Aotearoa New Zealand in the last decade has started to focus on the factors contributing to flourishing whānau as a counter discourse to the focus on factors contributing to inequities and poor outcomes for Māori communities (Durie, 2018; Kingi et al., 2014). Te ao Māori, as a collectivist culture, places emphasis on family and whānau rather than the individual. Accordingly, when considering the mental health and wellbeing of Māori, consideration of the wellbeing of the whānau is of particular significance. Recent kaupapa Māori²⁶ research conducted by Rolleston et al. (2022) defined eight factors integral to flourishing whānau being: uaratanga (values); whanaungatanga (kinship relationships); manaakitanga (support); hauora (health and wellbeing); whakapāwera (hardship); kai (food); tikanga (customs), and hangarau (technology). Furthermore, consistent with the bioecological model, the research emphasised the home environment as particularly significant in that being the place where flourishing is learned.

Whilst the purpose and the design of Rolleston et al.'s (2022) research was quite different to the present research, the interest in flourishing is common to both and it is interesting that the importance of relationships and a holistic approach to health were also findings of the present research. Rolleston et al.'s research lends support for the notion that some of the mental health literacy needs of parents/caregivers (as identified by practitioners in the present research) may be considered significant for promoting flourishing as well as preventing illness.

²⁶ Māori approach.

Taken together, the additional findings identified in this research are that parental mental health literacy needs have been identified at a transdiagnostic, relational and contextual level, and that the needs identified may be relevant for both the prevention of mental illness as well as promotion of flourishing.

Conclusion

This research identified a number of mental health literacy gaps of parents/caregivers of primary school-aged children and explores these further in the relevant literature. These included knowledge of developmental changes and needs as they relate to child mental health, parental wellbeing and relationship with the child, factors that may contribute to a child's behaviour and how parents/caregivers can support a child's developing emotional competence.

In addition, gaps in relation to when a behavioural or emotional problem may require professional help and barriers to seeking professional help were identified. Although the practitioners interviewed tended to work with families and children who needed professional help, the gaps in knowledge of child mental health were at a level that could be assumed to be relevant for the non-clinical population of parents of children in this age group, and the findings suggested that a resource targeted at this level may be appropriate.

Finally, a podcasting mental health literacy intervention was considered to have a number of advantages, including enhanced engagement of fathers. Themes relating to how to enhance the acceptability of a podcasting intervention included ensuring the content was perceived as credible and was communicated in a relatable way. The next Phase of the research was to further develop the podcast framework giving consideration to the findings

of Phase 1 of the research. It is intended this framework will inform the subsequent production and piloting of a podcast that will occur following completion of this thesis.

Chapter Twelve: Practical Implications

The purpose of this research was to identify mental health literacy gaps of parents and caregivers of primary school aged children in Aotearoa New Zealand, and to develop a framework for a podcast that aims to address those gaps. In reflecting on the analytic findings and discussion of the literature, some practical implications for the proposed development of a podcast have been identified. These implications include points to consider in relation to the approach to the development and delivery of the podcast, as well as considerations for podcast content.

Approach to Podcast Development

Findings from the present research (as well as the literature) suggest that users of a psychoeducational podcast want to know the information provided is evidence-based. The focus of the present research is formative in nature in that the purpose was to inform the development of a parent mental health literacy podcast. In this way the podcast will be evidence informed. The aim of the podcast is to increase the mental health literacy of parents and caregivers with the intention that this will lead to an improvement in child mental health. In this way the podcast seeks to elicit behaviour change of parents and caregivers and therefore the approach to delivering the content should be grounded in behavioural change theories, such as social learning theory.

Researchers investigating use of podcasting and other digital interventions recommend that key stakeholders are involved in the development of such interventions. The present research is grounded in this principle in that practitioners were interviewed to inform intervention content. In addition, specific content of individual podcast episodes should be informed by the current research evidence and consultation with experts. In

continuing a stakeholder-informed approach to podcast development, parents and caregivers should be involved in piloting and evaluation of the podcasts as they are developed to inform improvements.

Approach to Delivering Podcast Content

The present research suggests that potential parent/caregiver users of podcasts would want assurance as to the credibility of those delivering the podcast and the accuracy of the information provided. Therefore, the podcast presenter should be clear about their experience and qualifications as relevant, and that of the person who developed the podcast content. The introduction to the podcast should summarise the purpose and content of the podcast. Furthermore, the actual podcast content should be based on research and theory.

An intervention that is relevant to mātua of tamariki in middle childhood irrespective of their risk of developing a mental illness may help to reduce any stigma associated with seeking parenting support and advice on child mental health, and increase likelihood of uptake. Therefore, the content of the podcast should be targeted at the universal level and provide information that is relevant for all parents and caregivers of children in middle childhood.

Highlighted in the literature and identified in the present research was a need to identify and incorporate content relevant for fathers and male caregivers and to ensure the podcast approach engages male and female caregivers. Male caregiver engagement with parenting interventions is not as high as females and research has identified the differing role of fathers in their child's development and promotion of mental health is not always reflected in these interventions. Research suggests that fathers may prefer short and digital

modes of parenting interventions, for which the podcasting approach appears to be a good fit. The approach to delivering podcast content needs to be cognisant of, and integrate specific information pertaining to the role of father's in promoting tamariki wellbeing.

The present research, and principles of effective science communication suggests that the information communicated in the podcasts should be done so in a way that resonates with the experiences and values of listeners so that they can relate to the content. This includes ensuring the content of the podcast is reflective of values and practices of Māori and Pasifika as well as Pākeha cultures. In this way, parents and caregivers are more likely to engage with the content and interact with it in terms of applying the knowledge to better support their child's mental health.

Content of Podcast Episodes

Aside from guidance for mātua in relation to when a child's emotional or behavioural difficulty may be considered outside of the realms of normal, particularly in relation to anxiety, podcast content should be designed to be at a transdiagnostic level and therefore relevant to prevention of mental illness and promoting the mental health of all children of middle childhood age.

Based on the findings of the present research, it was apparent that increasing parental knowledge of child development and how it relates to mental health would be beneficial. Clear explanation of the developmental needs of children in this age-group may be helpful for parents in increasing their understanding of a child's behaviour. Alongside this, increasing awareness of other factors that influence a child's behaviour with consideration to their developmental stage would be worthy of a specific podcast episode. A focus on how to support emotional literacy and emotion regulation during this

developmental stage would be a particularly helpful topic for a podcast. Just as important as increasing understanding of a child's needs and how to enhance a child's mental health is the focus on maintaining mātua wellbeing. An episode on parental wellbeing, how it impacts on parenting practice and child mental health was identified as a key mental health literacy gap in the present research. This topic is of relevance to all other topics and therefore these interrelationships should be reflected in this episode and the importance of parental wellbeing integrated into other episodes. Finally, increasing parental knowledge around when an emotional or behavioural difficulty may require professional help, what the different child and family mental health services provide and what support from these services actually looks like would be helpful. This may help to break down barriers in relation to the stigma surrounding treatment for mental illness and potential fear of engaging with services due to a lack of awareness of how these services can support parents/caregivers with their child's mental health.

Content for each of these episodes could include a combination of psychoeducation, advice and strategies that can be implemented in everyday life which are complemented with practical examples. In this way, the content is grounded in social learning theory in that caregiver use of these strategies is then modelled in the podcast.

Summary

In reflecting on and integrating the findings of the present research with the extant literature, a number of key implications for developing a parent mental health literacy podcast have been identified. The findings have been drawn on in highlighting areas of content to include relating to specific topics for individual podcast episodes as well as the approach to delivering information. These practical implications will be used to inform the

development of a framework for a mental health literacy podcast for parents and caregivers of primary school aged children, which is presented in the next chapter.

Chapter Thirteen: Development of Podcast Framework

Phase 1 of the present research aimed to contribute knowledge to the currently small international evidence base regarding parent mental health literacy and interventions to increase parent mental health literacy. In doing so, the study explored practitioner perceptions of the mental health literacy of parents and caregivers of primary school aged children. It also sought practitioners' perceptions of how gaps in the mental health literacy of parents and caregivers could be addressed through a podcasting intervention.

The findings of Phase 1 of the research support the international literature that parents/caregivers may benefit from interventions seeking to increase their mental health literacy (Hurley, Swann, Allen, Ferguson & Vella, 2020; Johnson et al., 2023). A number of topics were identified that may be helpful for mātua to know more about to support the mental health of their tamariki. The purpose of Phase 2 of the research was to use the findings of Phase 1 to inform the development of a framework for a podcast that aims to increase parent mental health literacy. In this way Phase 2 further addresses the second research question: How could these [parent mental health literacy] needs be met through a podcasting intervention?

This chapter presents the methods used to develop a framework for a podcast that aims to increase parent mental health literacy. First the approach to developing the framework is described and then the methods used to consult practitioners on the proposed framework are outlined.

Approach to Developing Podcast Framework

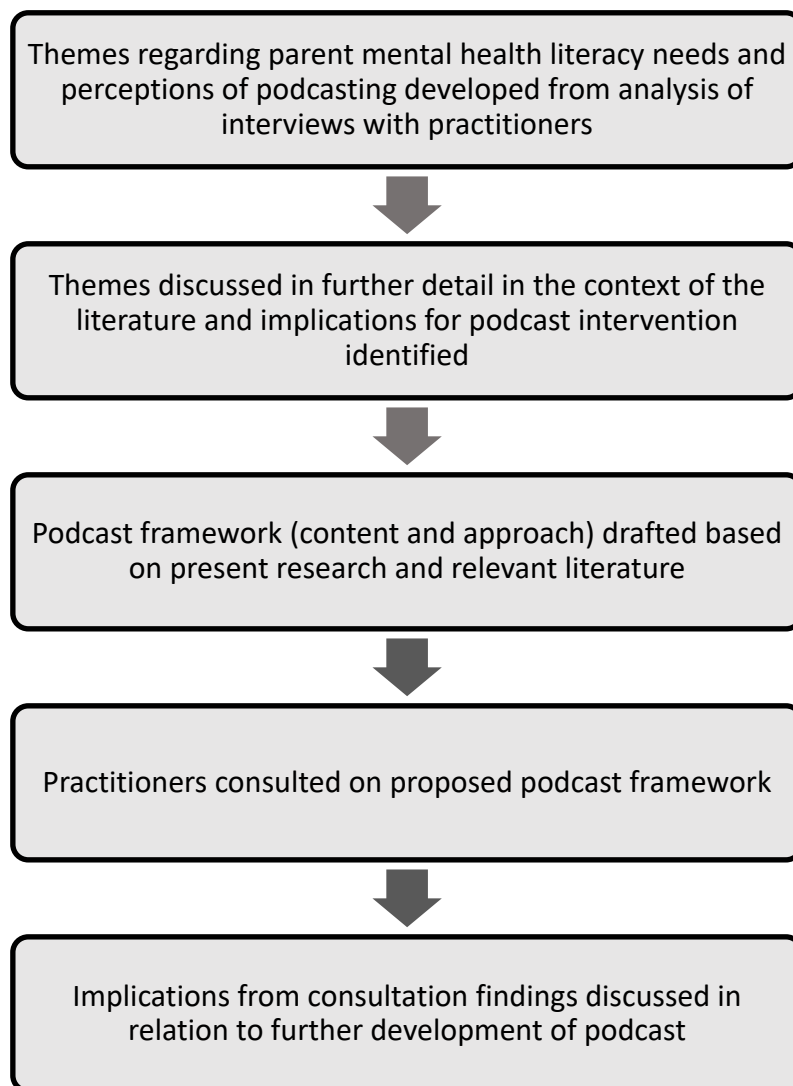
According to mental health promotion and implementation science scholars, effective interventions are underpinned by relevant theory, evidence informed and subject

to evaluation (Barry et al., 2019; Durlak, 2016). The design and conduct of the present research has been informed by a number of theoretical frameworks, in particular the bioecological model (Bronfenbrenner & Ceci, 1994), dual continua model of mental health (Keyes, 2005) and constructs of mental health literacy (Kutcher et al., 2016). These frameworks have informed the design of the research and analysis of the data in Phase 1 and were used to inform the structure and content of the podcasts developed in Phase 2.

In Phase 1 of the research three main topics were identified as potential gaps in parent mental health literacy: general parenting knowledge, understanding behaviour and emotion and help-seeking efficacy. Within each of these topics, sub-themes were identified, (e.g., general parenting knowledge included knowledge relating to child development, parental wellbeing and the relationship between parent and child). In addition, themes were developed in relation to how podcasting could be used to address gaps in parent mental health literacy. Following an analytic discussion of each, the themes were then discussed further in the context of the relevant international research and practical implications in relation to how this knowledge could be used to inform an intervention aiming to increase parent mental health literacy were identified. The main implications identified were grouped into learnings regarding the approach to developing and delivering the podcast and proposed podcast content and have guided the development of the framework. Practitioners involved in Phase 1 of the research were then consulted on the proposed podcast framework and feedback from this consultation was considered in relation to the next steps for the development of the podcast. As such the podcast content and approach is stakeholder informed and grounded in evidence (Thyer, 2006). The process for developing the podcast framework is illustrated in the Figure below.

Figure 5

Process for Developing Podcast Framework



Podcast Framework

Based on the approach described above, a framework for the podcast was developed and is presented below. This framework firstly sets out the components of the overall structure of each podcast episode and the rationale for each of these components (Table 2). Following this table, the key messages to include in each episode are noted against each topic heading (which are based on the findings of Phase 1 of the present research).

Table 2*Structure of the Podcast*

Component	Rationale
Introduction: podcast presenters, authors and podcast content (2.5 minutes)	
<ul style="list-style-type: none"> Greetings in multiple languages (e.g., te reo, Samoan, English) Podcast host (clinician): mihi, introduction in English, relevant qualifications and background, parenting experience, interest in the podcast and introduce co-host (parent) Parent (different for each episode, from a range of cultural backgrounds e.g., Māori, Samoan, NZ European, Asian, refugee) to introduce self and interest in podcast Outline why and how the podcast was developed Overview of content of current episode and aims for what parents/whānau will learn from the podcast 	<p>Establish credibility and trustworthiness of speakers, developers and content</p> <p>Increase acceptability for parents/caregivers from a range of cultures</p> <p>Set expectations</p>
Body: discussion of specific topic (10 minutes)	
<ul style="list-style-type: none"> Whakatauki, discuss connection to current topic 	<p>Establish evidence for impact on mental health</p>

- Clinician to outline main point of topic and how it relates to child mental health
- Parent to ask questions of clinician to elaborate on the topic, for example:
 - Specific aspects of topic
 - Explain theoretical frameworks as relevant
 - How it relates to the developmental stage of middle childhood
 - What parents/whānau can do to support their child's mental health in relation to the topic (e.g., strategies and tips for parents)
- Application of tips/strategies to an example
 - Parent to describe an example of a situation which lends itself to application of the strategies to support their child's mental health in relation to the topic being discussed
 - Clinician to discuss aspects of the situation and when and how to apply the strategies
 - Include identification and reflection of parent and child strengths as well as difficulties as relevant to the example

Normalise developmental changes and parent/caregiver questions

Parents are provided with practical strategies to try

Use of storytelling to communicate messages

Enhance acceptability and relatability

Modelling the behaviour

Ending: summary of main points and practical tips (2.5 minutes)

- Parent to summarise the discussion with clinician input, including
 - Normalising problems as relevant
 - Summary of key points to take away (e.g., why topic is important for child mental health/what is important to know)
 - Summary of actions that parents can take to support their child's mental health in relation to the topic
 - Clinician to thank listeners
 - Direct listeners to where they can find further information, sources and references for podcast content
 - Close and farewell in multiple languages (e.g., te reo, Samoan, English)
- Normalise parenting challenges
- Enhance retention of information
- Increase parent/caregiver self-efficacy
- Provide resources for additional support
- Enhance acceptability and relatability

Episode 1: Relationship Between Child and Parent/Caregiver

The content of the podcast episode regarding the importance of the relationships between the child and their parents/whānau will include:

1. An overview of attachment theory and the impact of secure and insecure attachments on child mental health, for example:
 - 1.1. Definition of secure and insecure attachments
 - 1.2. With a secure attachment the parent/caregiver has a strong connection with a child and is better able to:
 - Understand their child's developmental capabilities and therefore have realistic expectations as to a child's cognitive, social and physical abilities
 - Notice any changes in behaviour which may indicate a change in mental health
 - 1.3. With a secure attachment the child is more likely to:
 - Openly express their emotions and seek support in regulating these
 - Seek help from parent/caregiver regarding difficulties
 - 1.4. An insecure attachment is a risk factor for developing anxiety, depression and other mental health difficulties
 - 1.5. Attachments with other whānau members and across generations is a core part of Māori and Pasifika culture and supports emotional security and healthy child development.
2. What a secure attachment/relationship with parent/whānau looks like during middle childhood:
 - 2.1. Peer attachments become increasingly important but the parent/whānau relationship is still the most important relationship for a child
 - 2.2. Emphasis to be on being available to the child rather than being nearby

- 2.3. The relationship should include collaborative problem solving to support the child's growing independence.
3. Tips for how to strengthen the relationship between a child and whānau:
 - 3.1. Show affection and interest in the child's life
 - 3.2. Be responsive to the child's needs and available to listen when child wants to talk
 - 3.3. Accept the child as they are and encourage them to feel good about themselves
 - 3.4. Make a regular time to spend time with the child
 - 3.5. Support collaborative problem solving to encourage independence
 - 3.6. Establish rules (collaboratively where appropriate) and boundaries and be consistent in maintaining these
 - 3.7. Enable and encourage relationships with other whānau members, other caregivers, parents, coaches, significant adults in the child's life.
4. Illustration of how to apply tips in everyday life parenting/family situations:
 - 4.1. Normalise different family scenarios and include options and suggestions for different family situations.

Episode 2: Parent/Caregiver Wellbeing

The content of the podcast episode regarding the importance of maintaining parent and whānau wellbeing will include:

1. An overview of parental wellbeing and its impact on child mental health, for example:
 - 1.1. Definitions of mental health and wellbeing, including Te Whare Tapa Whā, Fonofale
 - 1.2. Relationship between poor parental wellbeing and poorer parenting practice

- 1.3. Parental mental illness impacts on healthy development of the child, and child's mental health
- 1.4. Parental wellbeing helps to protect a child against negative outcomes associated with adverse child experiences.
2. Nurturing their own wellbeing means a parent/whānau will be better able to:
 - 2.1. Develop a closer relationship with their child
 - 2.2. Support their child to regulate their emotions
 - 2.3. Manage challenging parenting situations
 - 2.4. Recognise difficulties a child may be having earlier.
3. Tips for how to strengthen parental wellbeing, for example:
 - 3.1. Developing and maintaining positive relationships with others
 - 3.2. Taking care of physical needs of self (e.g., adequate sleep and exercise)
 - 3.3. Incorporating small changes to routines to help to manage stress (e.g., mindfulness, deep breathing)
 - 3.4. Engaging in pleasurable activities
 - 3.5. Being compassionate to oneself
 - 3.6. Building in activities to improve spiritual wellbeing (e.g., making time to be near the sea/bush/mountains, engaging in faith activities)
 - 3.7. Taking steps to consider and nurture cultural identity (e.g., exploring whakapapa, learning language, connecting with others).
4. Illustration of how to incorporate tips to support parental wellbeing into family life, including:
 - 4.1. An example that normalises the busy life of parents/caregivers and the challenges (and sometimes guilt) associated with finding time for self

4.2. Emphasis to be on small actions/changes that can be made that may enhance wellbeing.

Episode 3: Behaviour in Context

The content of the podcast episode focused on considering a child's behaviour in the context of their life will include:

1. An introduction to different ways of viewing a child's challenging (or change in) behaviour in the context of factors that may be influencing that behaviour, for example:
 - 1.1. Discussion of Te Whare Tapa Whā as a holistic model of health and wellbeing, and the impact of each pou/dimension on child mental health
 - 1.2. Discussion of the bioecological model as a framework for considering factors that may be influencing a child's behaviour
 - 1.3. Discussion of how these two models may be helpful in considering possible factors underlying a child's behaviour.
2. Consideration of a primary school aged child's needs in relation to Te Whare Tapa Whā and in each of their ecological contexts, for example:
 - 2.1. The connection and sense of belonging to and quality of relationships within whānau (in relation to the child's relationships with parents/caregivers, siblings, extended family), with other significant adults in a child's life (e.g., coaches) and with classmates and friends outside of school
 - 2.2. A child's tinana/physiological needs during middle childhood (e.g., amount of sleep, time spent on devices, diet, exercise) and how behaviour can be impacted when these needs are not met

- 2.3. A child's hinengaro/ psychological needs (e.g., in relation to being active, learning new things at school and outside of school, having people to talk to and laugh with at school and home, engaging in activities that make them feel good)
- 2.4. The wairua of the child and whānau (e.g., how this is supported at school and within whānau).
3. Tips for thinking about different factors that may be contributing to a child's behaviour, for example consideration of:
 - 3.1. Any stressors within whānau relationships? Any difficulties with friends at school?
Any changes in significant adults or friendships outside of school?
 - 3.2. Is the child getting adequate sleep, nutrition and exercise?
 - 3.3. Is the child having any difficulties with learning? How does the child feel about their learning at school? Does the child have opportunities to engage in activities they enjoy/are good at outside of school? Does the child have friends/family they enjoy spending time with? Have there been any changes to these relationships?
 - 3.4. What does enhancing a child's spiritual wellbeing look like within their whānau? Are there any factors that may be negatively impacting on this at school, home or in other contexts?
 - 3.5. How could a child's Te Whare Tapa Whā be strengthened?
4. Illustration of how to consider contextual influences on a child's behaviour:
 - 4.1. For example, a child becomes irritable and on edge
 - 4.2. For example, a child becomes clingier.

Episode 4: Emotions and Emotion Regulation

The content of the podcast episode focused on considering a child's emotional development and regulation will include:

1. An overview of the function of emotion, emotion regulation and the relationship with child mental health, for example:
 - 1.1. Definitions of emotion, emotional literacy, emotion regulation and emotion dysregulation and lay term equivalents (e.g., feelings, understanding feelings, managing big feelings)
 - 1.2. Relationship between emotion regulation and mental health.
2. Emotional development during middle childhood
 - 2.1. Transition from parental support to regulate emotions to self-regulation
 - 2.2. Increasing ability to identify different emotions, use of language to express emotions
 - 2.3. Increasing ability to use cognitive strategies to regulate emotions.
3. Tips for supporting a child's emotional development during middle childhood:
 - 3.1. Working on their own emotional literacy and regulation skills
 - 3.2. Modelling healthy emotion regulation strategies (e.g., using deep breathing, taking a break or talking about feelings when feeling frustrated)
 - 3.3. Providing a safe and supportive environment for expressing emotions openly and talking about them within the family
 - 3.4. Using emotion words and socialising different emotions
 - 3.5. Allowing a child to express their emotions and validating their feelings (e.g., It makes sense that you might feel angry about ...)

- 3.6. Differentiating between emotions and behaviour (e.g., validation of emotions with boundaries around behaviour)
 - 3.7. Naming emotions (e.g., it seems like you might be feeling frustrated at the moment...) to support children to recognise different emotions themselves
 - 3.8. Supporting a child to learn different ways of calming themselves (e.g., deep breathing, mindfulness, taking a break and reading a book/listening to music)
 - 3.9. Supporting a child in their development from co-regulation to self-regulation of their emotions
 - 3.10. Noticing and providing positive reinforcement when their child regulates emotions appropriately
 - 3.11. Importance of all caregivers playing a role in supporting their child's emotional development, in particular a secure relationship, ensuring a warm and sensitive response to a child's emotional expression and modelling healthy emotion regulation.
4. Illustration of how to use the strategies to support a child's emotional development:
 - 4.1. For example, when a child is feeling frustrated with a homework task
 - 4.2. For example, when a child is angry with their sibling.

Episode 5: What is Normal? When to Seek help?

The content of the podcast episode focused on considering when to seek professional help for a child's mental health will include:

1. An overview of the signs and symptoms of when an emotional or behavioural difficulty becomes a mental health problem, for example:
 - 1.1. Changes in mood and/or behaviour that cause distress and are persistent over time

- 1.2. Changes in mood and/or behaviour that interfere with a child's life (e.g., reluctance to attend school and/or engage in activities they previously enjoyed)
- 1.3. Frequent and/or intense physical complaints (e.g., stomach ache, nausea, headache).
2. A discussion of what is outside of the realms of 'normal' during middle childhood and who can provide advice, including:
 - 2.1. Normalising the challenges with recognising a mental health concern in a child (i.e., to reduce stigma and self-blame and encourage help-seeking)
 - 2.2. Emotional and behavioural difficulties in middle childhood can be considered to be on a spectrum in terms of onset, frequency, severity and duration (e.g., anxiety)
 - 2.3. Discussion of different professionals and services that may be able to provide advice, a referral to a specialist and/or specialist help (e.g., GP, Teacher, Special Needs Coordinator, Paediatrician, Child and Adolescent Mental Health Service).
3. Tips to support a child experiencing difficulties with their mental health, including:
 - 3.1. Notice changes in their child (e.g., when things are better and worse) and explore possible underlying causes (e.g., as covered in previous episodes)
 - 3.2. Strengthen the relationship with their child and show support (e.g., spend time with the child, listen, help them to problem solve and continue to engage in their usual activities)
 - 3.3. Consider how to strengthen their child's wellbeing (e.g., using Te Whare Tapa Whā as a guide)
 - 3.4. Take care of their own wellbeing
 - 3.5. Seek advice, resources and/or specialist help from a professional.

4. Illustration of how to use the strategies to support a child experiencing difficulties with anxiety:
 - 4.1. Normalise anxiety and discuss how it can be useful
 - 4.2. How to recognise when the anxiety a child is experiencing is not normal
 - 4.3. Strategies a parent can use to support their child
 - 4.4. Where to seek help and what working with a mental health professional may look like.

Practitioner Consultation

The purpose of Phase 2 of the present research was to develop a framework for a podcast that sought to increase the mental health literacy of parents/caregivers. The content and overarching structure of the framework was informed by the findings and discussion of the relevant literature and implications of Phase 1. Within a social constructionist context, the purpose of the practitioner consultation was to strengthen the validity of the findings of Phase 1 by seeking their level of agreement with the meaning I made of the knowledge they had shared, and to obtain their perspectives on the developing podcast framework to increase user acceptability and utility of the podcast (Barry et al., 2019).

Design

The Theoretical Framework of Acceptability (TFA) for healthcare interventions offers a useful framework for considering the acceptability of mental health interventions during development and implementation phases of intervention development (Sekhon et al., 2017). Key constructs of this framework as well as those used in similar studies guided the development of a questionnaire to obtain practitioner feedback on the proposed podcast

(Brooks et al., 2023). The online survey software, Qualtrics, provided an efficient way of obtaining input from practitioners into the development of the podcast without this being a burdensome task (De Vaus, 2002).

Participants

All 11 practitioners who participated in an interview as part of Phase 1 were invited to review the podcast framework and respond to the questions in the online survey. Of these 11 practitioners, 7 provided responses to the survey. Four of the practitioners who responded to the survey identified as New Zealand European, five identified as female and most of the respondents were aged between 41 and 60 years of age. Practitioners who responded to the survey ranged from having six to more than 30 years' experience in the roles of psychiatrist, psychologist, mental health practitioner, counsellor, public health nurse and social work manager.

Questionnaire

The aim of this phase of the research was to obtain feedback from practitioners regarding the proposed podcast. Specific questions were developed based on the purpose of the research and were guided by the TFA and similar studies seeking stakeholder perspectives at the formative stage of intervention development (Hurley et al., 2018; Sekhon et al., 2017). There were three main parts to the questionnaire: (a) questions regarding the extent to which practitioners agreed that increasing parental knowledge of each topic (identified in Phase 1 of the research) could benefit the mental health of primary school aged children, (b) questions regarding the usefulness, feasibility, acceptability, appropriateness and perceived effectiveness of the proposed podcast, and (c) questions pertaining to demographic information. A total of 11 items in the questionnaire used radio

buttons with Likert scale response options. One item used an open question format to allow practitioners to provide additional comments supporting their responses. Finally, six items captured demographic information of participants using multiple choice and open question formats. The questionnaire used in the online survey is attached at Appendix D.

Procedure

Piloting of the online survey with two colleagues and two supervisors resulted in reducing the questions to a core minimum to minimise burden on respondents.

All practitioners who participated in Phase 1 of the research were contacted by email and invited to participate in Phase 2 of the research. Practitioners were sent the Participant Information Sheet (attached as Appendix E) which provided a summary of findings from Phase 1, and an invitation to participate in Phase 2. The invitation outlined what participation would involve, how participant responses would be used and stored, emphasised the voluntary nature of participation, other participant rights and where to find further information. The Participant Information Sheet made it explicit that submission of a response to the survey would be taken as consent to participate. Finally, the invitation provided a link to the online survey platform.

Within the survey was a hyper-link to a document which introduced and set out the proposed podcast framework. The introduction provided a summary of the overarching aim of the research, and a summary of the purpose of Phase 1 and Phase 2 of the research. The podcast framework as detailed earlier in this chapter was then presented.

On completion of the survey participants were offered a supermarket voucher in appreciation of their time and contribution, and were requested to email me their contact details if they would like to receive the voucher. Most practitioners who responded to the

survey also responded to my email with either further comments on the research or to state they had completed the survey.

The survey was left open for five weeks. One follow-up email was sent to practitioners which elicited three further responses. In total 7 of the 11 practitioners who participated in Phase 1 of the research also participated in Phase 2.

Analytic Approach

Data from the seven survey responses was exported from Qualtrics to Microsoft Excel for analysis. Given the small number of participants, a frequency analysis of each question was calculated and descriptive statistics reported (De Vaus, 2002). Additional comments were analysed for common themes, discussed with my supervisors and reported in summary form.

Ethical Considerations

My supervisors and I evaluated and judged Phase 2 of the research to be low risk in relation to any ethical concerns. Accordingly, a low-risk ethics notification was made to the Massey University Human Ethics Committee (4000027565). Ethical issues pertinent to this research included the principle of Autonomy (Massey University, 2017). For this Phase, this related to informed consent to participate and ensuring participation was voluntary. This was of particular importance in Phase 2 of my research as I sought feedback from practitioners who participated in Phase 1 and in doing so, I sent the invitation to participate to them (via email) directly. To mitigate any undue pressure on participants I emphasised the voluntary nature of their consent to participate in both the covering email and the Participant Information Sheet.

Participant name and/or contact details were not captured anywhere on the survey which allowed for anonymity of responses. After the survey was closed, responses were downloaded and stored securely on my personal computer and deleted from the survey platform.

Summary

The purpose of seeking practitioner feedback on the proposed podcast framework was twofold: to enhance the quality of Phase 1 of the research and to obtain feedback regarding the feasibility of the proposed podcast prior to piloting it with parents and caregivers themselves.

Chapter Fourteen: Practitioner Feedback on Podcast Framework

The purpose of Phase 2 of the present research was to develop a framework for a podcast that aimed to increase the mental health literacy of parents/caregivers of primary school aged children. Chapter 14 presents the findings from practitioner feedback on this framework. Seven of the eleven practitioners interviewed in Phase 1 provided feedback. Findings regarding practitioner perceptions of the topics identified for each podcast episode are discussed first followed by findings in relation to practitioner perceptions of the proposed content and approach for the podcast.

Main Findings

The first set of questions in the survey aimed to seek practitioner views on the extent to which they agreed that primary school aged children could benefit from their parents/caregivers having more knowledge about the topics identified from the qualitative research with practitioners in Phase 1.

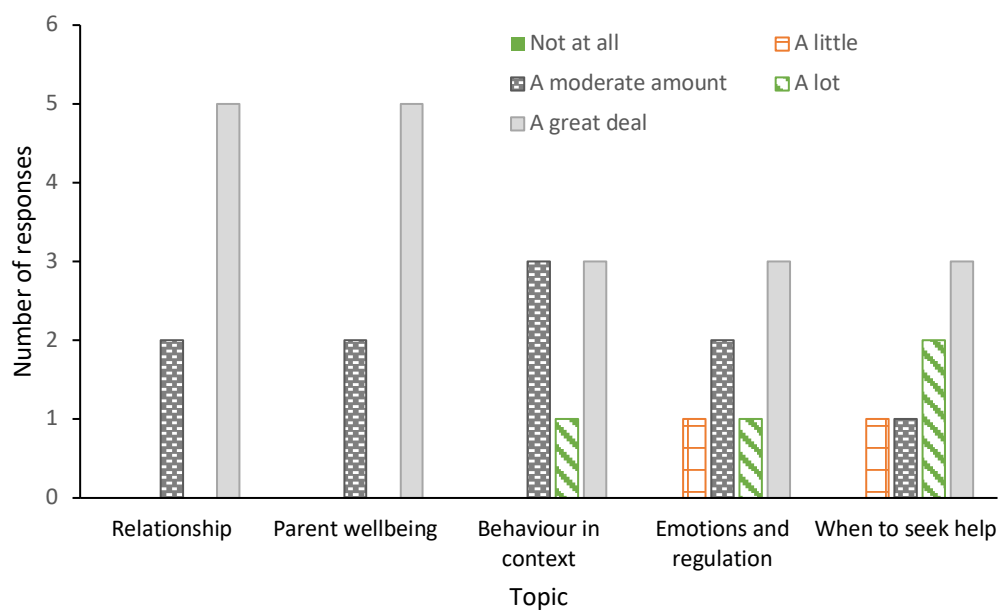
Podcast Topics

As is illustrated in Figure 6, all seven of the practitioners who responded to the survey indicated they thought that increasing parent/caregiver knowledge of three of the topics identified for podcast episodes could benefit child mental health at least a moderate amount. These topics were increasing parent/caregiver knowledge of parental wellbeing, the relationship between the caregiver and child and understanding how contextual factors in a child's environment can influence behaviour. In relation to the topics of emotions/emotion regulation and understanding when to seek professional help for a mental health difficulty, six of the seven practitioners thought increasing parent/caregiver knowledge could benefit child mental health at least a moderate amount. The other practitioner

(notably a different practitioner for each topic) thought that increasing parental knowledge of these topics would benefit child mental health a little. A couple of practitioners qualified their moderate responses by noting that a number of factors contribute to behaviour change and increasing knowledge is only one of these.

Figure 6

Extent to which Participants' Agreed each Topic Could Benefit Child Mental Health



Note. For each topic, this figure shows the number of practitioners who agreed that increasing parent/caregiver knowledge could benefit child mental health and the extent to which they agreed.

Regarding the proposed topics, one practitioner expressed caution about starting with attachment theory given the research on which it has been based is predominantly European. In light of this comment, it may be helpful to emphasise the importance of family and cultural contexts when discussing the research supporting attachment and the importance of child-parent relationships. Indeed, this comment was supported by

comments made by other practitioners regarding the appropriateness of the approach for Māori and Pasifika whānau and/or whether a different version tailored to the needs of Māori and Pasifika should be developed.

Practitioner Perceptions of Proposed Podcast Framework

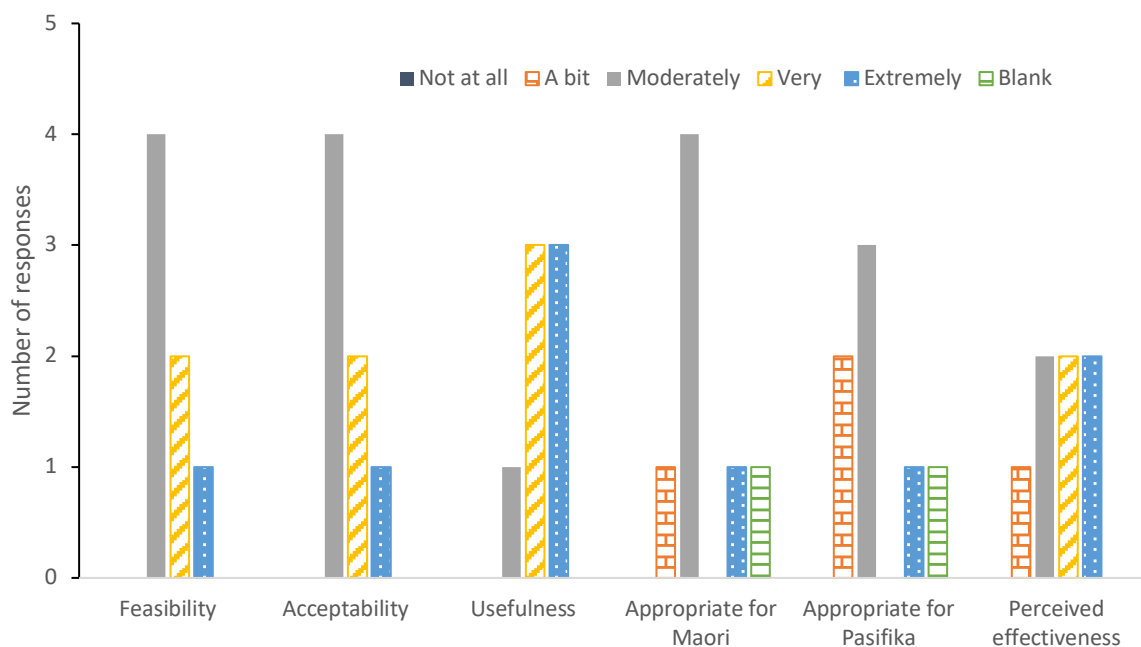
Following the first set of questions about the topics for podcast episodes, practitioners were asked to review the proposed podcast framework overall and indicate how feasible they thought it would be to deliver the proposed content using podcasting as proposed. Practitioners were asked how acceptable and how useful they thought the podcast approach and content would be to parents/caregivers. Practitioners were also asked their perceptions of how appropriate the proposed podcast approach would be for Māori and Pasifika whānau specifically. Finally, practitioners were asked an overall question about how effective the proposed podcast framework would be in increasing parent mental health literacy.

Although there was variation in the perceived feasibility and perceptions of usefulness and acceptability of the proposed podcast framework, Figure 7 below shows that practitioners responding to the survey indicated at least moderate level of endorsement on these items. However there was more variability and less conviction regarding practitioners' responses to whether the proposed podcast framework would be appropriate for Māori and Pasifika whānau. One practitioner did not respond to this item, noting that they did not feel they were in a good position to be able to respond. The responses of the remaining practitioners ranged from 'a bit' to 'extremely' appropriate. Unfortunately none of the practitioners who responded to the survey identified as Māori or Pasifika. With the exception of the practitioner who stated they did not feel able to respond, practitioners

who identified as New Zealand European or British agreed more strongly that the proposed podcast framework would be appropriate for Māori and Pasifika whānau than practitioners who identified as another ethnicity. One non- New Zealand European practitioner commented further that there should be two separate frameworks, one for Pākeha and another for Pasifika and Māori with the latter framework utilising more of a narrative therapy or storytelling approach.

Figure 7

Practitioner Perceptions of Proposed Podcast Framework



Note. This figure illustrates the extent to which practitioners thought the proposed podcast framework was feasible, acceptable, useful, appropriate for Māori and Pasifika and effective in increasing parent mental health literacy.

All practitioners responding to the survey indicated they thought the proposed podcast would be at least ‘a bit’ effective in increasing the parent mental health literacy of

the topics identified. This finding supports the analytic findings of Phase 1 of the research that use of podcasting to increase parent mental health literacy was perceived to be effective. Also, in relation to appropriateness of approach, a couple of practitioners commented on the tone and a need to adopt a non-judgemental approach and incorporate anecdotes. These comments supported sub-themes developed in Phase 1.

Implications of Survey Findings

Overall, practitioners' responses to these questions indicate the proposed framework has potential to be effective in increasing parent mental health literacy. Practitioners indicated they thought the approach was feasible and would be acceptable and useful for parents/caregivers.

Considering the comments of practitioners overall gives rise to a number of implications for further development of the podcast framework. Parents/caregivers have numerous constraints on their time and attention. These points need to be front and centre in considerations for how to ensure the podcasts are acceptable, useful and effective in increasing parent mental health literacy. In addition to keeping the episodes short, the podcasts may be more effective if the delivery of the content is interspersed with humour, anecdotes and practical tips to maintain interest and attention. Furthermore, given the possibility that podcast consumers will not follow the series of podcasts in the order intended, a brief overview of the purpose of the podcast series as a whole, highlighting the other episodes at the start of each podcast may be helpful in ensuring that each episode is also able to be understood independently of the others.

Consideration needs to be given as to how to adapt the framework further to be appropriate for Māori and Pasifika whānau, or whether alternative versions of the podcast

tailored specifically to the needs of Māori and Pasifika whānau would be more appropriate. These findings reflect the differences found in practitioners' perspectives in how to ensure appropriateness of approach for Māori and Pasifika whānau during Phase 1 of the research also. For example, in Phase 1 practitioners endorsed the use of tikanga, indigenous models of wellbeing and storytelling, to support communication of key messages and increase acceptability amongst Māori and Pasifika whānau. However, it may be that attempting to develop one podcast that is appropriate for all is not the best approach. Indeed, a few practitioners in Phase 1 had noted that to be truly accessible for all the podcast would need to be translated into different languages, and some responses to this question in the survey are consistent with this.

One of the implications from the findings of this survey is to acknowledge that increasing knowledge alone does not necessarily contribute to behaviour change. A couple of practitioners considered that the podcasts could only be moderately effective rather than contribute to large changes in behaviour. This point is important. In reflecting on the design of the survey against the aims of the research I acknowledge a limitation of this survey is the inconsistency in the implied outcomes expected from the proposed parent mental health literacy podcast. In the second set of survey questions the concept of perceived effectiveness is defined in terms of increased mental health literacy of parents/caregivers. However, in the first set of questions I asked about whether increasing parent and caregiver knowledge in relation to the topics I identified could benefit child mental health which on reflection implies a direct relationship between increased mental health literacy and child mental health. Whilst this is the ultimate aim of the research – to contribute to improving child mental health – it is acknowledged that there are a number of factors that influence whether increased knowledge would lead to behaviour change (Michie et al., 2011).

Summary

Taken together the responses of practitioners to specific items and open questions regarding perceptions of the podcast framework indicate the approach and content as proposed may be effective in increasing parent mental health literacy. Further consideration is needed in relation to the content of specific topics (e.g., attachment theory in the episode about the parent/caregiver and child relationship), tailoring of content and approach further to respond to the needs of mātua (e.g., time, interest in specific topics rather than sequential listening) and the tone with which content is communicated. Variation in the perceived benefit of each topic may reflect practitioner hesitancy regarding expectations of behaviour change resulting from increased knowledge. Nonetheless, practitioners indicated that the use of podcasting to increase parent mental health literacy is a feasible modality that could be acceptable and useful for parents/caregivers of children of primary school age. Practitioner comments on specific topics and overall appropriateness suggest that further consultation is needed with practitioners working predominantly with Māori and Pasifika whānau to explore how the approach and content can be developed so that it is appropriate for these families.

Chapter Fifteen: Overall Discussion

This chapter provides a discussion of the findings and learning from Phase 1 and Phase 2 of the research. In particular, the findings in relation to the research questions, the theoretical contributions and wider implications arising from the research will be discussed. In addition, areas for future research and reflections on the research process are presented.

Learning From the Research

The present research was conceptualised and designed within the context of the Covid-19 pandemic and a mental health crisis in Aotearoa New Zealand. Within this social environment, personal reflection on my own and peers' parenting experience regarding child mental health and my developing clinical expertise prompted me to question what parents and caregivers of primary school aged children know about child mental health and what else would be helpful for them to know. A contextual approach to child development and mental health and the dual continua model formed the theoretical framework within which my research questions were developed (Bronfenbrenner & Ceci, 1994; Durie, 1985; Keyes, 2005; Cole et al., 1978). Two research questions guided my thesis: what are the mental health literacy needs of parents and caregivers of primary school aged children, and how could these needs be met through a podcasting intervention?

Gaps in the Evidence Base Regarding Parent Mental Health Literacy

Originally defined as the "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (Jorm et al., 1997, p. 182), the concept of mental health literacy has evolved to include the constructs of knowledge of how to obtain and maintain good mental health and help seeking efficacy (Kutcher et al., 2016). The current literature regarding parent mental health literacy is limited to a small number of

studies and the findings of these are mixed. Some studies provide evidence that parents have reasonable knowledge about the signs of specific types of mental illness (Barnes, 2023) and others to the contrary (Hurley, Swann, Allen, Ferguson & Vella, 2020; Johnson et al., 2023). These discrepancies appear to be due to a number of factors, including differences in research design and differences in research participants' prior level of knowledge or experience of mental illness (C. Johnson et al., 2023; Villatoro et al., 2018). Further research is needed to contribute to this growing evidence base. In particular, there is a lack of research investigating the parental knowledge of how to promote positive child mental health. Furthermore, the use of digital technology to deliver mental health literacy interventions is increasing, the evidence base supporting these is small (Chu et al., 2018; Peyton et al., 2022). Use of podcasting to communicate knowledge is perceived to have many benefits and is becoming increasingly common but evidence informed mental health literacy podcasts for parents and evaluations of podcasting as a mode of delivery are few (Morawska et al., 2014, 2022).

Addressing the Research Questions

The present research sought to make a unique contribution to the literature by exploring parent mental health literacy needs in Aotearoa New Zealand. The current research sought the perceptions of practitioners who work with parents and caregivers of primary school aged children regarding parent mental health literacy needs and whether these could be addressed through a podcasting intervention.

The findings of the present research suggest there is a need to increase the mental health literacy of parents in Aotearoa New Zealand regarding the following topics: importance of parent wellbeing and how this and the relationship between the parent and

child can impact child mental health, emotion regulation and supporting a child to develop regulation skills, understanding of developmental needs and how the context of a child's behaviour may influence behavioural challenges, and, knowing when and where to seek professional support.

The evidence for the relationships between each topic and child mental health outcomes has been discussed extensively in Chapter 11. In addition, many of these topics are supported by the evidence base underpinning programmes that aim to improve parenting skills. For example, the foundational stage of the Incredible Years Programme and Circle of Security focuses on developing healthy parent-child relationships (Maiava, 2014; The Circle of Security International, 2022). The Circle of Security programme also has a particular focus on understanding and supporting a child's emotional development and developing the regulation skills of both the child and parent (The Circle of Security International, 2022). Situating the findings of the current research within the broader parenting literature enhances the validity and generalisability of the results to the wider parenting population.

However, the fact that the topics identified in the present research are also found as modules in a number of parenting programmes available in Aotearoa New Zealand raises the question of why this is still recognised as a gap in mental health literacy of our mātua. There are many possible answers to this question from the policy level to implementation issues (Cooper et al., 2022; Doyle et al., 2023). However, the findings of the present research suggest that accessibility of these programmes at a universal level (i.e., for all parents irrespective of a child's risk of mental illness) may be limited. In addition, how well they meet the needs of mātua in an increasingly complex parenting environment may be

worthy of further investigation. One of the key findings of the present research was the perception that podcasting may be an effective way of increasing parent mental health literacy. There were a number of reasons why podcasting was perceived to be a useful mode of delivery, namely accessibility, ability to remain anonymous and user demand flexibility. Exploring the 'how' in the research question of 'how could these needs be met through a podcasting intervention?' led to the development of the themes of simplicity and relatability. The relevance of these findings to the wider parenting population is supported by an emerging body of research concerning podcasting as an effective intervention mode more generally (Morawska et al., 2014, 2022; Semakula et al., 2020).

When considering how parent mental health literacy needs in Aotearoa New Zealand could be met through podcasting it is important to consider the appropriateness of content and approach for Māori and Pasifika whānau. Throughout this research I have sought to understand, analyse and interpret the knowledge and experiences of expert practitioners in order to inform the development of a podcast that may increase the knowledge of parents and caregivers related to child mental health. I have aimed to develop an intervention that is relevant for all whānau. However, it may be that different versions tailored to the specific cultural contexts of Māori and Pasifika whānau may be more appropriate.

In a meta-analysis of culturally adapted digital mental health interventions Ellis et al. (2022) provide robust evidence that adapting existing digital mental health interventions to be more appropriate for specific cultural groups is deemed acceptable, and can result in effective outcomes for these groups. The study showed that cultural adaptations of mental health interventions using a range of digital modalities were effective, including web and app based interventions as well as text to mobile interventions. Interestingly the meta-

analysis showed no difference in outcomes between digital interventions that included an active therapist component and those that did not. The cultural adaptations themselves varied but most commonly involved translation into different languages, incorporating culturally relevant messages and changes to audio/visual components.

In Aotearoa New Zealand the cultural adaptation of the Triple P parenting programme involved integrating tikanga such as karakia and whakawhanaungatanga, the inclusion of kuia²⁷ and kaumātua²⁸ in delivering parts of the sessions, and incorporating culturally relevant examples alongside the core components of the programme. An evaluation of this programme suggested the intervention was acceptable to Māori whānau and showed positive outcomes for tamariki, mātua and whānau (Keown et al., 2017). Research with Pasifika parents in Aotearoa New Zealand identified a number of ways the Incredible Years parenting programme could be adapted to enhance acceptability for Pasifika families. These adaptations included connecting programme principles to how relationships are understood within Pasifika cultures, use of Pasifika facilitators, inclusion of culturally relevant examples and a focus on learning through experience sharing, talking and storytelling (Maiava, 2014). This international and Aotearoa evidence base provides a foundation for considering a cultural adaptation of a parent mental health literacy podcast.

Theoretical Contributions of the Research

In recognition of a lack of focus on the mental health literacy of adults in relation to child mental health, there has been a recent call for a new field of research investigating the concept of mental health literacy for supporting children (Hart et al., 2023). In this article

²⁷ Māori for elderly woman, grandmother, female elder.

²⁸ Māori for elderly man, grandfather, of status within the whānau.

the definition of the concept includes adults' ability to recognise child mental health difficulties, knowledge and attitudes about child mental health and how to seek support, and ability to work with others to support a child's mental health. In identifying some of the mental health knowledge gaps of parents of children in Aotearoa New Zealand, the findings of the present research make a contribution towards this emerging field of study.

The present research also makes a unique contribution to the literature in drawing a theoretical connection between the dual continua model and the constructs of mental health literacy. That is, the focus of the present research was on exploring parental knowledge needs in relation to both the promotion of mental health and the prevention of mental illness in tamariki. In this way, the design and consequently the methodological approach of the present research differed from the majority of other parent mental health literacy studies which tended to focus on parental ability to recognise child mental illness (Hurley, Swann, Allen, Ferguson & Vella, 2020).

Since commencing the present research, Carvalho et al. (2022, p. 3) conducted a concept analysis of positive mental health literacy and defined it as "knowledge and skills to obtain hedonic well-being (based on positive emotional states like happiness) and eudaimonic well-being (focuses on positive individual and social experiences and functioning)". This concept analysis will contribute to future developments in the measurement of positive mental health literacy (Cresswell-Smith et al., 2023). Further research is needed to understand and conceptualise what positive mental health looks like in children, the parental knowledge and skills required to support positive mental health in children, and how to measure this construct of parent mental health literacy. Alongside theoretical utility, such advancements in definitions and measurement of the concept of

positive mental health literacy also has implications for evaluation studies of parent mental health literacy interventions.

Wider Implications of the Findings

The motivation behind the genesis of this thesis was to develop a resource for mātua to help them better support their child's mental health. The intention was that this intervention would take the form of a podcast and would be a standalone intervention that is accessible for all parents and caregivers. However, the resource may also have other practical applications. In the clinical setting, the podcast could be useful as a psychoeducational adjunct for parents and whānau to complement child and family therapy. In an educational context, the podcast may be a useful resource to share with teachers as well as mātua in support of children's social emotional learning in the classroom.

Although the focus of my research was to identify mental health literacy needs of parents to support the mental health of children, the psychoeducational content developed for the podcast is just as relevant for supporting the mental health of the parents and caregivers themselves, as it is for supporting child mental health. The Covid-19 pandemic coinciding with a mental health crisis both in Aotearoa New Zealand and internationally has brought to public awareness the importance of focusing on maintaining mental health as much as addressing mental distress (Blasco-Belled et al., 2022; Ministry of Health, 2020). In considering implications of the research beyond the purpose of increasing knowledge of parents to support child mental health, the findings can be seen to be relevant to the adult population as a whole. As a student of clinical psychology I have reflected on the relevance of the podcast content for all clients I have worked with, and indeed the non-clinical

population also. It is my hope that the future implementation of the podcast informed by my research will make a contribution towards achieving the New Zealand Government's aim to equip the population with knowledge to maintain their mental health as part of the psychosocial and wellbeing recovery plan (Ministry of Health, 2020).

Limitations and Future Research Considerations

Future research considerations identified in this thesis include those arising from limitations of the present research, considerations for others who may conduct similar research, and suggestions for the next Phase of the research. Furthermore, gaps in the literature identified in the present research are highlighted as areas for future research.

Social constructionist research values the experience, knowledge and worldviews of participants and acknowledges that these inform the knowledge that they contribute to the research. All except two of the practitioners contributing to Phase 1 of the research were specialists in working with tamariki and whānau who were experiencing mental health difficulties. As such, practitioner knowledge of the parent mental health literacy needs in this research comes from a place of working with whānau with tamariki who experience moderate to severe mental health difficulties. It may be that these needs differ to those of parents of children who are not experiencing this degree of difficulty with their mental health. An area for future research therefore may be to explore whether the mental health literacy needs identified in this study would differ for parents of children who have not experienced mental health difficulties.

Related to the point made above, one of the limitations of the research is that the perception of parent mental health literacy gaps is based on practitioners' work with parents and caregivers that engage with their services. Firstly, it is acknowledged that some

whānau do not access or engage with mental health services and therefore the parent mental health literacy needs of these whānau may not be reflected in the findings of this research. However, of those who do engage with these services, this tends to be mostly female caregivers. In recognising there are multiple types of family group structures of which some may include one or more male caregivers, it is important to consider the mental health literacy gaps of fathers/male caregivers. Efforts were taken to recruit male practitioners and to elicit perceptions as to the gaps in the mental health literacy of fathers as well as mothers. In addition, research studies exploring the engagement and content needs of fathers in parenting and child mental health interventions has been reviewed and summarised to complement the qualitative findings of the present research. However, in order to enhance the acceptability of the podcast for male caregivers, piloting of the podcast with parents/caregivers should also seek to obtain feedback from as many fathers and male caregivers as possible. Furthermore, investigating whether podcasting interventions for parents are more successful in engaging fathers than other modes of delivery is an area worthy of research.

Developing an intervention that is acceptable to all is not without its challenges. Māori and Pasifika practitioners and practitioners working in services with high numbers of Māori and Pasifika clients were approached and participated in the present research and contributed valuable suggestions for how to tailor the intervention to be relevant for Māori and Pasifika whānau. Practitioners noted a need to reflect cultural values, tikanga and te reo and Pasifika languages in the podcast to increase likelihood of Pasifika and Māori whānau engagement with the resource. However, there was still some hesitancy as to the appropriateness of the proposed one-sized fits all approach to the intervention. On reflection, researchers undertaking similar studies in the future may wish to engage Māori

and Pasifika practitioners when developing the research questions and tools to inform areas of exploration of parent mental health literacy that may be particularly relevant for Māori and Pasifika whānau. For example, it may be relevant to consider how the factors contributing to flourishing whānau (Kingi et al., 2014) may relate to mental health literacy of Māori mātua specifically. In addition, recent doctoral research in Aotearoa New Zealand exploring mental health literacy in a Pasifika cultural context in order to develop a Pasifika mental health literacy framework may provide a foundation for informing future research into mental health literacy needs amongst Pasifika parents (Kapeli, 2022).

Obtaining the perceptions of practitioners rather than parents themselves allowed for a more objective perspective on parent mental health literacy gaps (i.e., as opposed to the perspective of one who may not know what they don't know). A further advantage was that practitioners could comment on patterns based on their experience working with many parents and caregivers and children rather than a parent being able to offer a perspective based on their singular experience. As a result, the findings of this research are based on practitioners' perceptions of parent mental health literacy gaps formed from their work with many mātua and across many whānau contexts. However, the involvement of parents and caregivers, as well as practitioners, in the further development of the podcast is a critical step in a user-centred design approach and has been reported to enhance effectiveness of digital interventions (Lyon & Koerner, 2016; Rauschenberg et al., 2021). Therefore seeking the views of parents and caregivers themselves on the podcast approach and content should be considered in the next phase of development.

Important considerations for selecting a sample of parents and caregivers with whom to pilot the podcast include the extent to which the parent has pre-existing

knowledge from personal or professional experience, the extent to which the parent/caregiver has a child experiencing mental health difficulties, the inclusion of fathers, and including parents and caregivers who identify as Māori Pasifika. Specific areas on which to obtain parent and caregiver perceptions regarding the podcast include the acceptability, appropriateness and usefulness of each episode, the extent to which it increased their knowledge and the acceptability of the delivery approach adopted. In considering the overarching aim of the thesis was to contribute to improving mental health outcomes for children, principles and stages of behaviour change may be useful to consider when designing the evaluation for this next phase (Michie et al., 2011).

The emergence and increasing popularity of podcasting and emergence of use of podcasting as an intervention to increase health and mental health literacy raises the methodological question of how best to evaluate podcasting interventions. Considerations should be given to process measures and implementation effectiveness as well as measuring outcomes. Other researchers have attempted to evaluate the use of podcasting as an intervention but this still stands as a small evidence base (Morawska et al., 2014, 2022; Semakula et al., 2020). Evaluating change in mental health outcomes, and understanding the process for how this is achieved, is integral to ensuring the efficacy of an intervention. Therefore further research regarding how to effectively evaluate podcasting interventions is needed.

Finally, as the practitioners interviewed in this research acknowledged, access to a podcast typically requires an internet connection which may be a barrier for some whānau. Alternative methods of communicating intervention content may need to be considered to increase accessibility.

Reflections on the Research Process

In this section I provide a summary of some of the key reflections on what I have learned during the process of designing and conducting this research. I reflect on my learning as a researcher, as a clinician and as a parent.

Social constructionism appreciates that knowledge is not generated within a clinical vacuum. The knowledge generated from this research has been influenced by the many social and cultural contexts surrounding the researcher, including those of the research participants. The further I reflected on the use of this epistemology the more I recognised the way of viewing the world through this lens influenced the research process. The process of co-constructing knowledge throughout my research became apparent to me not just during my interviews with practitioners but also during the process of transcribing, analysing and interpreting the findings. I quickly learned the importance of exploring meaning and differing interpretation of key terms, and learned the significance that social and cultural context has on attitudes and behaviour (e.g., how the term 'mental health' is interpreted and consequently influences health promoting behaviours).

This epistemological position played a significant role in the design of Phase 2 of my research, in that it was important to me that practitioners had an opportunity to consider and provide feedback on the evolution of a resource that I was developing as a result of their knowledge. I appreciated that the social and cultural contexts of practitioners influenced how they viewed the proposed podcast framework and in turn informed their responses. Now, coming to the end of my role in the research process I am realising how the way in which mātua and whānau - as the users of the podcast - receive, interpret and possibly change behaviour will in turn depend on their own social and cultural contexts.

Indeed, explicit acknowledgement of this reflection may be useful to include in the introductory section of the podcast episodes. That is, being clear to listeners that the intention was for the podcast to be as relevant and useful for as many whānau as possible. However, also acknowledging it has been influenced by the social and cultural contexts of those contributing to the development of the podcast and that it is important that the parent/caregiver reflects on this and considers the information provided within the context of the needs of each individual child, and the values and culture of their own whānau. Furthermore, it is important to acknowledge that the information provided in the podcast provides a foundation from which further information and advice relevant to specific parenting contexts and cultures can be sought out.

The majority of the existing literature on parent mental health literacy and my clinical training has focused on mental illness. It was through this lens that I expected the mental health literacy needs of mātua to be weighted towards a need to recognise and seek help for different presentations of child mental health difficulties. Therefore, when it became apparent to me that practitioners perceived the mental health literacy needs regarding the prevention of illness to be at a transdiagnostic level - and that these needs would have as much benefit to the promotion of mental health as to the prevention of illness - I was surprised. I had expected my findings to warrant further exploration of how to increase parental knowledge so they can support a child experiencing anxiety or an externalising difficulty. However, as I developed my themes further and explored the literature more deeply, I came to appreciate how valuable my findings were because the knowledge needs identified were relevant for both the prevention of illness and promotion of mental health.

In the clinical setting also I have now seen how useful the content of the podcast resource may be for increasing the mental health literacy of many clients and not just parents. The topics identified are all areas I consider in my clinical formulations of difficulties my clients experience (i.e., I consider the influence of formative and current relationships, the influence of stressors and other contextual influences on their behaviour, and the emotion regulation strategies they use). This clinical reflection on my research findings gave me further confidence in the ecological validity of this resource. That is, if parents and caregivers can be more knowledgeable about these topics and encourage practices and skill development in their children to support their mental health, this will have longer term benefits for these children also (i.e., throughout adulthood as well as childhood).

Finally, and of most significance to me personally, is the experience of my own parenting challenges with children's mental health that I had alongside my thesis journey. As a parent I place strong emphasis on engaging my children in activities to promote their mental health. However, with the nature of its waxing and waning developmental course I did not identify the signs of mental distress in my child until its impact was such that it was glaringly obvious. The irony of this experience occurring alongside a research study exploring parent mental health literacy needs was not lost on me, and the harsh judgement my clinical psychology student-self made on my parenting self that I had not picked up on the signs earlier was hard to bear. However, this personal experience has endorsed the main topics identified in my research as being helpful for parents to know more about. A couple of sub-themes from my research also resonate strongly with me as a parent as a result of this personal experience. Namely that mental health difficulties in a child move up and down the continuum of normal, sub-clinical and clinical difficulties which can be very confusing in deciding if and when to seek professional help. Also, that taking a normalising

and non-judgemental approach to supporting parents and communicating knowledge is well-received. However much I wish I had not had this personal experience, the implications of this lived experience for my research and my clinical work have been significant. This experience has motivated me even further to use the learning from my research personally, and to help other parents support their child's mental health.

Concluding Comments

This research has made a unique contribution to the parent mental health literacy literature in identifying a need to increase parent and caregiver knowledge in areas that support both the prevention of mental illness at a transdiagnostic level, and promote mental health. Furthermore, the research has provided an evidence base for how a podcasting intervention may be developed to meet these parent mental health literacy needs. In the context of a mental health crisis and focus on wellbeing recovery post-pandemic, the development of a resource to increase parent mental health literacy makes a contribution towards equipping the parenting community in Aotearoa New Zealand with much needed knowledge to support child mental health.

Using a reflexive approach to the research process has benefited the research process and outcomes. It has also benefited me personally as a parent, clinician and a researcher. The next steps are to share this knowledge with mātua, whānau and the wider community so they may use it to support the mental health of our tamariki.

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Appendix A: Interview Guide

Mental Health literacy of parents/caregivers of primary school aged children

INTERVIEW GUIDE

Introduction (5 mins)

- Whakawhanaungatanga
- Explain the following:
 - Purpose of research and use of interview data
 - Interviewing practitioners about their perceptions of parents/caregivers knowledge of mental health of primary school aged children
 - Use the information you share, alongside that from other interviews and the research evidence to develop content for a podcasts that aims to meet some of the gaps in parents' knowledge
 - Confidentiality
 - Type up a transcript – share with you – anonymise it and keep it electronically with a password for up to 5 years
 - May use quotes but these will be anonymised
 - Consent to interview and to record it
 - Thanks for your consent form and being willing to record it
 - Happy to go ahead?
- Any questions
- Overview of questions:
 - Start with obtaining an understanding of with wider context within which you are sharing your perceptions with me (eg the types of people you work with, your prior experience)
 - Focus mostly on your perceptions of where there are strengths and weaknesses in the knowledge of parents/caregivers in relation to child mental health. I am interested in both positive mental health and mental health problems
 - A few questions about what I could do to ensure a podcast about child mental health would meet parents needs
 - Final questions on demographics

Section A: context (15 mins)

Explain purpose of this section:

- *It is important for me to understand the wider context from which you are sharing your knowledge so that I can ensure I interpret and analyse the information you share through this lens. For example, the type of work you have done in the past or the type of parents you work will influence your responses.*

1. I would like to learn about what your current work involves but before we do that could you tell me a bit about your background and previous roles?
2. Can you describe your current role to me?

Explore the following:

- a) Core activities
- b) Nature of parent contact - intensity/frequency/episodic or continuous
- c) Parenting populations worked with

3. What are the most common reasons for parents/ caregivers of primary school aged children contacting your service?

Explore the following:

- a) Most common concerns about their children
- b) Perceptions of most common information needs of parents

4. What kinds of distress do parents ask for help with for their children?
5. Do you talk about mental health with the parents you work with? How do you talk about mental health with the parents you work with? A focus on poor mental health or positive mental health or both? What terminology do you use – wellbeing, good/positive mental health, poor mental health/problems, mental distress

Explore the following:

- a) In relation to positive mental health, mental distress and mental illness
- b) In relation to primary school aged children

Section B: mental health literacy of parents of primary school-aged children (30 mins)

Explain purpose of this section:

- *I'm using a dual-factor model of mental health which places equal focus on positive mental health and poor mental health/mental illness. So I am interested in knowledge gaps of parents in relation to identifying and enhancing positive mental health of their child as well as mental health problems in childhood.*
 - *In this section I have a number of questions about the areas where parents have adequate knowledge and where there are gaps in their knowledge in relation to both positive mental health and mental health problems so there may be some overlap in the questions but we can jump around. We'll start with knowledge of and gaps in knowledge about child mental illness.*
6. Can you tell me what parents typically already know about child mental illness and distress? In what ways do parents talk about mental distress in their children? How do they describe any concerns?

Explore the following:

- a) How aware do you think parents are of signs of mental illness and distress in children – probe is this universal or differences between cultures
 - b) When to seek help, what prompts them to seek help, what action do they take when they have concerns?
 - c) Where and who to seek help from
 - d) What parents/caregivers do to support children experiencing mental distress – before they seek out professional help?
 - e) Examples?
 - f) Probes: different cultures, parenting context (eg single parent), child age/gender, where they get their knowledge from, in context of Te Whare Tapa Whā (eg expression of emotion, connection with whānau) and Fonofale dimensions of wellbeing
7. Can you tell me where there are gaps in parents' knowledge of child mental illness and distress?

Explore the following:

- a) Why do you think there are these gaps?
- b) How you try and meet these gaps in your work?
- c) What would help meet these gaps at a community level?
- d) Concerns/questions raised/advice commonly sought

- e) Parents' awareness of signs of mental distress in children (internalising and externalising)
- f) How to know when to seek help
- g) Where and who to seek help from, what have you suggested?
- h) Examples?
- i) Probes: different cultures, parenting context (eg single parent), child age/gender, in context of Te Whare Tapa Whā and Fonofale dimensions of wellbeing

8. Can you tell me what areas of child mental health parents have adequate knowledge about? What types of things do you hear parents talking about in relation to their child's positive mental health? In what ways do you think parents are aware of what contributes to a child's positive mental health?

Explore the following:

- a) Parents' perceptions of good mental health
- b) Parents' awareness of indicators of a primary school aged child having good mental health
- c) What types of things parents are doing to enhance their children's mental health
- d) Examples?
- e) Probes: different cultures, parenting context (eg single parent), child age/gender, where they get their knowledge from, in context of Te Whare Tapa Whā (whānau, physical, psychological/emotional expression, spiritual) and Fonofale dimensions of wellbeing

9. In what ways/areas do you think there are gaps in parents' knowledge of child mental health?

Explore the following:

- a) Why do you think there are these gaps?
- b) How you try and meet these gaps in your work?
- c) Is there anything you can think of (that could be delivered) at a broader community level that would help meet these gaps (in a way that is able to be accessed by all parents)? What are parents needing at a broader community level?
- d) How do parents currently seek out/ receive information about child mental health?
- e) Advice you commonly give parents in relation to how they can enhance mental health of children (e.g., sleep, exercise, whānau relationships, whānau wellbeing, communication skills, friendships, spiritual, emotional expression/regulation, identity, connection with school)
- f) Other gaps noticed

- g) Examples?
- h) Probes: I know we touched on this earlier but I am interested in whether there are different needs for different cultural groups (eg is that something you've noticed with parents from particular cultures or parenting contexts or across many?), or parenting context (eg single parent), child age/gender, in context of Te Whare Tapa Whā and Fonofale dimensions of wellbeing

10. Is there anything else you'd like to mentioned in relation to parents' mental health literacy?

Section C: podcasting characteristics (10 mins)

11. What do you see as the advantages and disadvantages of using podcasting to communicate knowledge about child mental health to parents?

Explore the following:

- a) Parents' attitude towards podcasting
- b) Perceived burden of listening to a podcast
- c) Perceived risks to parents of using podcasts to obtain information

12. How do you think I could enhance the acceptability of a podcast for parents in NZ?

Explore the following:

- a) Appropriate length
- b) Preferred approach (e.g., narrative, dialogue, interviewing parents, interviewing experts)
- c) How to incorporate tikanga
- d) Terminology (eg mental distress vs illness vs mental health problems in relation to their own child)

13. Are there any other comments you'd like to make in relation to developing a podcast to increase the mental health literacy of parents?

Participant attributes

- Gender:
- Ethnicity:
- Age: 20-30 31-40 41-50 51-60 61+

Closing

- Express thanks, emphasise usefulness of information obtained to inform research
- Next steps: transcribe, opportunity to review, interest in being consulted on podcast development
- Any questions
- Suggestions of useful resources for parents about child mental health
 - Beyond Blue Parents Guide (reducing risk of anxiety and depression in your child)
 - Healthy families – Beyond Blue
 - Sparklers at Home website
 - Triple P Website
 - SPARX: free online computer game intended to help young people with mild to moderate depression, stress or anxiety
- Koha

Appendix B: Participant Information Sheet

Mental health literacy of parents/caregivers of primary school aged children

INFORMATION ABOUT THE RESEARCH AND INVITATION TO PARTICIPATE

Introduction

Kia ora, I am Sonia Barnes, a doctoral student at Massey University training to be a clinical psychologist. I am interested in what parents and/or caregivers of primary school aged children know about child mental health, what their knowledge gaps are and how we can help them increase their knowledge of child mental health. By knowledge of mental health, I mean what parents and/or caregivers know about maintaining good mental health, as well as preventing and responding to signs of mental distress and illness.

This document explains my research and invites you to participate in an interview as part of my research. My research is supported by my two supervisors: Dr Matt Shepherd and Dr Kirsty Ross, in the School of Psychology at Massey University.

Purpose of the research and invitation to participate

The purpose of my research is to develop a short podcasting series that helps to meet some of the gaps whānau may have around child mental health knowledge. To inform this work, I would like to talk to practitioners who work closely with parents and/or caregivers of primary school aged children about their perceptions of parent/caregiver mental health literacy.

You are invited to participate in an interview with me. I am interested in obtaining your perceptions of: parent/caregiver mental health literacy (i.e., knowledge about maintaining good mental health, and preventing and responding to signs of mental distress and illness) and use of podcasting as a means of communicating knowledge to parents/caregivers.

If you are happy to, I would like to audio-record the interview so that I have an accurate record. I would then transcribe the recording, anonymise it, and you would be able to check the transcript for accuracy if you wish before it is analysed and used in my research.

If you are interested in contributing to this research, please read the information in this document which provides more detail about what participating in an interview would involve. Participation in this research is voluntary. If you choose to participate, please email me (sonia.barnes.1@uni.massey.ac.nz) and I will send you a consent form to complete and then we can arrange a time and place for the interview that suits you.

Information about participants and the recruitment process

I want to talk with practitioners who have *regular contact with parents and/or caregivers of primary school aged children through their work*. I am providing information about my research to organisations providing services to parents/caregivers and hope to interview 8-10 parenting practitioners. Each interview will take about an hour and I will provide participants/ organisations with a voucher in appreciation of the time they have taken to share their knowledge and contribute to my research. The interviews will provide rich information to inform the content of the podcasts. Following the interviews, I will provide an opportunity to take part in follow-up consultation to ensure the content I develop reflects practitioner perspectives.

Use of interview information

I will use your interview information alongside that of other participants' interviews to identify topics helpful for parents and/or caregivers of primary school aged children to know more about. I will then research each topic and develop a podcast to communicate what the research evidence says in relation to how best to support child mental health.

My analysis of the interviews will also be written up as part of my thesis and may be included in any articles I publish. I may use quotes from your interview to illustrate themes arising from analysis. If so, I will make sure you are not able to be identified from these quotes or in any write-up of the analysis. If you wish to have a summary of the findings from the study, please let me know and I will arrange this. Your feedback on the study is also welcomed.

Storage of interview information

I will anonymise the transcript of your interview, password protect it and store it electronically. I will then delete the audio file of the interview. All interview data and analysis files will be deleted after five years, following completion and any publication of the research.

Your rights

Participation in this research is voluntary. *You are under no obligation to accept this invitation.* If you decide to participate, you have the right to:

- provide information on the understanding that you will not be able to be identified in the research unless you give permission to the researcher;
- ask any questions about the study at any time during participation;
- decline to answer any particular question;
- decline to have your interview recorded or have the recorder be turned off at any time;
- review and edit the transcript of your interview;
- withdraw from the research completely, as long as it is not later than a week after the transcript is sent to you for review (if agreement to record the interview is given) or a week after the interview is conducted (if it is not recorded);
- be given access to a summary of the research findings when it is concluded if you wish.

Further information

If you have any questions about this research, please contact:

Sonia Barnes, Lead Researcher, Doctoral Clinical Psychology Student, Massey University

sonia.barnes.1@uni.masse.ac.nz

Dr Matt Shepherd, Research supervisor, Senior Lecturer in Psychology, Massey University

M.shepherd1@massey.ac.nz

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

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researchers, please contact Prof Craig Johnson, Director, Research Ethics, telephone 06 356 9099 x 85271, email humanethics@massey.ac.nz.

Appendix C: Participant Consent Form

Mental health literacy of parents/caregivers of primary school aged children RESEARCH PARTICIPANT CONSENT FORM

I have read, and I understand the Information Sheet attached. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction. I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study. I understand participation is voluntary and that I may withdraw from the study completely as long as it is no later than:

- one week after the transcript is sent to me for review if agreement to record the interview is given or,
- one week after the interview is conducted if the interview is not recorded.

1. I agree/do not agree to the interview being recorded.
2. I agree to participate in this study under the conditions set out in the Information Sheet.

Declaration by Participant:

I _____ hereby consent to take part in this study.

Signature: _____

Date: _____

Appendix D: Practitioner Feedback Questionnaire

Parent mental health literacy podcast research

Thank you for contributing to my research.

The aim of Phase 1 of my research was to explore practitioner perceptions of the mental health literacy of parents and/or caregivers of primary school aged children. I also sought to understand how gaps in the mental health literacy of parents and/or caregivers could be addressed through a podcasting intervention. Reflexive thematic analysis of interviews with 11 practitioners working with parents and/or caregivers identified five key themes.

In relation to the first research question “What are the mental health literacy needs of parents and/or caregivers of primary school aged children?” the following themes were developed

- 1) general parenting knowledge
- 2) understanding of behaviour and emotion, and
- 3) help-seeking efficacy.

Regarding the second research question, “How could these [mental health literacy] needs be met through a podcasting intervention?” analysis of interviews identified that practitioners perceived that

- 1) podcasting may be an effective means of communicating information to parents/caregivers in relation to child mental health, and
- 2) to maximise effectiveness, podcasts need to be acceptable and engaging.

I am now completing Phase 2 of my research which is to use the findings of Phase 1 and the relevant literature to inform the development of a podcast that aims to increase the mental health literacy of parents/caregivers of primary school aged children. Accordingly, I have developed a framework for the podcasts. This framework includes the structure and content for a series of 5 podcast episodes, and is attached below. I would be very grateful if you would take a few minutes to review this framework and complete the feedback questionnaire.

Responding to this questionnaire indicates your consent to participate in this research. I will use the feedback you provide to further develop the podcast framework.

Q1 How much do you agree that increasing parent/caregiver knowledge of each of the following topics could benefit the mental health of primary school aged children?

	Not at all	A little	A moderate amount	A lot	A great deal
The importance of the relationship between parent/caregiver and child	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parent/caregiver wellbeing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Considering behaviour in context	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emotions and emotion regulation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When to seek professional help for a child's mental health difficulty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Q2 Please review the proposed podcast framework attached above and indicate your responses to the following questions:

	Not at all	A bit	Moderately	Very	Extremely
How useful do you think the proposed content (against each of the topics) would be for parents/caregivers?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How feasible do you think it is to deliver the content to parents/caregivers via podcast as proposed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How acceptable to parents/caregivers do you think the proposed podcast would be?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How appropriate do you think the proposed podcast approach would be for Māori whānau?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How appropriate do you think the proposed approach would be for Pasifika families?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How effective in increasing parent mental health literacy do you think the proposed podcasts would be?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Q3 If you have any comments to make on your responses to the survey questions or the proposed podcast framework please make these below

Q4 Which of the following best describes your ethnicity?

- Asian
 - Māori
 - Middle Eastern/Latin American/African
 - New Zealand European
 - Pasifika
 - Other _____
-

Q5 How do you define your gender?

- Male
 - Female
 - Non-binary / third gender
 - Prefer not to say
-

Q6 What is your age?

- 21-30 years
 - 31-40 years
 - 41-50 years
 - 51-60 years
 - Older than 60 years
-

Q7 What type of service do you work for?

- Child/adolescent/adult health
 - Child/adolescent specialist mental health
 - Child/adolescent education
 - Other _____
-

Q8 What is your current occupation?

Q9 How many years experience do you have working in your current or similar role?

- 1-5 years
 - 6-10 years
 - 11-15 years
 - 16-20 years
 - 21-25 years
 - 26-30 years
 - More than 30 years
-

I am very grateful to you for sharing your time and knowledge with me to contribute further to my research. If you would like me to send you a gift voucher please email me your address. This will ensure your response remains anonymous. Thank you.

Appendix E: Participant Information Sheet for Phase 2

Mental health literacy of parents/caregivers of primary school aged children: Summary of Phase 1 findings and invitation to participate in Phase 2

Introduction

Kia ora and thank you again for sharing your time and knowledge with me to inform my research on parent mental health literacy in Aotearoa. You may recall the aim of Phase 1 of my research was to explore practitioner perceptions of the mental health literacy of parents and/or caregivers of primary school aged children. I also sought to understand how gaps in the mental health literacy of parents and/or caregivers could be addressed through a podcasting intervention. Including yourself, I interviewed a total of 11 practitioners who work with parents/caregivers of children in a range of different roles across Aotearoa. In using reflexive thematic analysis, I developed a number of themes that addressed each of my research questions. I have used the findings of Phase 1 to inform Phase 2 which is the development of a framework for a podcast that seeks to increase parent/ caregiver knowledge against each of the identified topics.

This document provides a *summary of findings from Phase 1* (interviews with practitioners) and *invites you to participate in Phase 2* (feedback on podcast framework) of my research. My research is supported by my two supervisors: Associate Professor Matt Shepherd and Associate Professor Kirsty Ross, in the School of Psychology at Massey University.

Summary of Phase 1 findings

Regarding the first research question “What are the mental health literacy needs of parents and/or caregivers of primary school aged children?” three themes were developed:

- **general parenting knowledge:** in particular knowledge of child development (including developmental capabilities, needs and expectations of a child of primary school age), the importance of the relationships between caregivers and children during middle childhood, and the impact of parental wellbeing on child mental health (and consequently the importance of caregivers attending to their own needs to maintain their own mental health).
- **understanding of a child’s behaviour** in the context of their life (e.g., factors in the child’s environment that may be influencing their behaviour), **and emotions** (including understanding of emotional development during middle childhood, how to support a child in their developing emotional literacy and regulation skills and recognition of how a parent’s own emotion regulation skills influence their child’s emotional development)
- a number of sub-themes relating to **help-seeking efficacy**, including how to recognise when a problem is beyond the realm of normal development (particularly in relation to anxiety), and barriers to seeking professional help (including parent/caregiver

acceptance of a child's mental health difficulties, navigating informal sources of advice and knowing where to seek help in relation to what different services do).

Regarding the second research question, "How could these [mental health literacy] needs be met through a podcasting intervention?" two themes were developed:

- **podcasts may be an effective way to increase parental mental health literacy** given there are a number of advantages including that they can be implemented at a universal level, are able to be accessed privately, in the caregiver's own time and can be listened to repeatedly if desired
- to maximise effectiveness, **podcasts need to be acceptable and engaging** for example they should be perceived to be credible, messages should be communicated in a way that is relatable to parents/caregivers and includes practical strategies.

Invitation to participate in Phase 2

Phase 2 of my research involves the development of a framework for a podcast that helps to meet some of the knowledge gaps whānau may have around child mental health, as identified by practitioners in Phase 1. The content included against each topic has been informed by relevant literature.

You are invited to review the podcast framework and complete a short feedback questionnaire about the proposed content and approach for the podcast. The questionnaire asks about perceptions of the content, usefulness, feasibility and acceptability of the proposed podcast for parents/caregivers, followed by some questions about demographic information of participants. It is anticipated it would take approximately 15 minutes to review the framework and complete the questionnaire. Participation is voluntary. Completing the questionnaire and submitting your responses will indicate your consent to participate. Should you choose to participate I would like to send you a supermarket voucher in appreciation of your contribution to my research.

Use of your responses

I will use your responses alongside the responses of other practitioners to inform further development of the parent mental health literacy podcast. Results will be written up as part of my thesis and may be included in any articles I publish. I may use quotes from your responses to illustrate points of feedback. I will report the results of the feedback questions and the demographic information separately, and I will make sure you are not able to be identified from any quotes or in the write-up of the analysis.

If you wish to have a summary of the research, please let me know and I will arrange this.

Storage of information

Responses to the survey will be saved on the Qualtrics platform until one week after the survey closing date. The response forms will then be downloaded, password protected and

stored electronically. Response forms will be reviewed by myself and my research supervisors. Data and analysis files will be deleted five years after completing the research.

Your rights

Participation in this research is voluntary. *You are under no obligation to accept this invitation.* If you decide to participate, you have the right to:

- provide information on the understanding that you will not be able to be identified in the research unless you give permission to the researcher;
- ask any questions about the study at any time during participation;
- decline to answer any particular question;
- withdraw from the research completely (within one week of the survey closing date);
- be given access to a summary of the research findings when it is concluded if you wish.

Thank you

Thank you for considering this invitation. I would greatly appreciate your contribution to this phase of my research. If you choose to participate, please click on this link https://massey.au1.qualtrics.com/jfe/form/SV_eqGTYH2HWAh7fUy which will take you to the Qualtrics survey platform to complete the questionnaire.

If you have any questions about this research, please contact:

Sonia Barnes (Researcher)

Associate Professor Matt Shepherd (Supervisor)

sonia.barnes.1@uni.massey.ac.nz

M.shepherd1@massey.ac.nz

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

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researchers, please contact Prof Craig Johnson, Director, Research Ethics, telephone 06 356 9099 x 85271, email humanethics@massey.ac.nz.

Appendix F: Research Case Study

Parent Mental Health Literacy: Reflections as an Intern Psychologist

Research Case Study

Sonia Barnes

This case study represents the work of Sonia Barnes during her doctoral research project from 2020 to 2022 and internship at the Massey Psychology Clinic, Wellington during 2022.

Candidate:

Sonia Barnes

Signed:




Date:

15 November 2022

Research Supervisor:

Dr Matt Shepherd

Signed:



Date: 16 November 2022

Abstract

The following case study is a reflection on how my doctoral research has contributed to my work as an intern psychologist. The aims of my research were to explore the mental health literacy needs of parents/caregivers of children aged 5-10 years in Aotearoa and how these needs may be addressed through a podcasting intervention. The first section of this case study provides an overview of the literature informing my research, the methods used and a brief summary of the findings. The second part of the case study provides reflections on how some of the literature, learnings from the research process and my research findings have informed my development as a clinical psychologist during my internship at the Massey Psychology Clinic.

Parent Mental Health Literacy: Reflections as an Intern Psychologist

A brief summary of the key bodies of literature informing my doctoral research is presented in the following section. This is followed by an overview of the aims, method and key findings from my qualitative research.

Mental Distress in Children

Experiencing mental distress during childhood not only has a negative impact on a young person's functioning at the time; it increases likelihood of mental distress and other poor social outcomes in adulthood (Copeland et al., 2015; Shalev et al., 2014). Prevalence estimates suggest 13% of children and adolescents worldwide experience mental distress, most commonly in the form of anxiety, conduct, attention-deficit/hyperactivity and depressive difficulties (Polanczyk et al., 2015). Research in Aotearoa has found that 8% of children aged between 3 and 14 years were reported by parents/caregivers to be experiencing *significant* levels of difficulties in relation to peer relationships, emotional, hyperactivity and/or conduct behaviours (Ministry of Health, 2018). Disparities between Māori and non-Māori were such that tamariki Māori were 1.8 times more likely to experience significant difficulties than non-Māori children, and 2.1 times more likely to experience conduct problems. There was some disparity also between Pacific and non-Pacific children, particularly in relation to peer difficulties, which Pacific children experience at a rate of 1.7 times more than non-Pacific children. The levels of distress tamariki and rangatahi in Aotearoa were reported to be experiencing were also reflected in anecdotal reports of large numbers of referrals to child and adolescent mental health services, and reports of increasing concerns about access to services (Elliott, 2017; Health and Disability Commissioner, 2018).

Improving specialist child mental health resourcing to support those experiencing mental distress is necessary but so too is a public health response. There have been public calls for more focus on prevention and greater access to resources to enhance good mental health (Elliott, 2017). One way to do this is to increase mental health literacy, both in terms of knowledge of mental illness and health.

Defining Mental Health and Mental Health Literacy

Psychiatric focus on psychopathology tends to dominate research and public interest in mental health (Keyes, 2007). However, definitions of mental health do not necessarily reflect this emphasis. One of the most commonly used definitions of mental health is that of the World Health Organisation (WHO; Fusar-Poli et al., 2020) which states mental health is “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (World Health Organisation, 2013, p. 3). In applying this definition to children, the WHO identifies identity, healthy thoughts, behaviours and relationships and interest in learning as key aspects. This definition places a strong emphasis on wellbeing, resilience and realising potential, and makes no reference to mental illness. Mental illness – also called mental disorders or mental distress – involves significant difficulties with emotions, thoughts and/or behaviours that cause distress and negatively impact on functioning (American Psychiatric Association, 2018). Whilst the two concepts of mental health and mental illness are related, they are not necessarily opposite ends of a single construct.

The theory that mental health and mental illness are separate constructs (instead of two extremes of the same continuum) has been rigorously tested by Keyes and colleagues

over the past two decades (Keyes 2005; 2007; 2010; 2020). In these studies, an individual's mental health (complete state of mental health) is assessed by measuring extent of mental illness as well as their positive mental health (also called flourishing).

Originally mental health literacy was coined as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm et al., 1997, p. 182). However, definitions of mental health literacy have evolved to reflect knowledge and beliefs around both mental illness as well as health. The definition has expanded to include action to prevent or help manage mental illness in order to improve mental health outcomes, encompass positive mental health and to consider stigma as well as help-seeking efficacy (Bjørnsen et al., 2017; Kutcher et al., 2016; Jorm, 2012). Research on mental health literacy has demonstrated an association with help-seeking behaviours and mental health outcomes (Bonabi et al., 2016; Gorczynski et al., 2017; Lam, 2014).

Parental Mental Health Literacy

Although research investigating the mental health literacy of children and young people is scarce it suggests that inability to recognise signs of mental illness is a barrier to seeking help (Gulliver et al., 2010). In addition, tamariki need the help of more informed others to help them interpret signs of mental distress and one of their preferred sources of support about mental health is family (Georgakakou-Koutsonikou & Williams, 2017). This research lends support for the significant role parents can play in supporting child mental health. Parents/whānau are typically best placed to promote positive mental health and identify signs of poor mental health in their children and they can also help to facilitate access to further support. Therefore, the mental health literacy of whānau can be a key determinant of child and youth mental health. However, research investigating parental

mental health literacy and effective interventions is limited (Tully et al., 2019). International research has found that barriers to help-seeking by parents include inadequate knowledge about mental health, financial difficulties and availability of services. Furthermore, severity and type of child mental health difficulty was related to help-seeking: parents were more likely to seek help for disruptive behaviour or personality changes, or when the problem had a greater impact on the child's life. Finally, sources of help identified included family and friends, self-help approaches and general practitioners (Hurley, Swann, Allen, Ferguson & Vella, 2020).

Although research into the mental health literacy of parents of adolescents is growing, there are still very few studies investigating the mental health literacy of parents of pre-adolescent children (Tully et al., 2019). Furthermore, there is a lack of focus on interventions increasing parental knowledge of positive child mental health as well as mental health literacy interventions for parents at a universal level (Hurley, Swann, Allen, Ferguson & Vella, 2020).

Podcasting

Podcasting offers an easily accessible and portable way of communicating knowledge that still involves an interpersonal connection (Harter, 2019). There are only a small number of studies exploring effectiveness of podcasting to deliver mental health interventions. One of these was a version of the well-researched parenting programme, Triple P Positive Parenting, delivered via podcast. The evaluation found it was effective in reducing child behavioural difficulties, increasing use of effective parenting styles and parental confidence and self-efficacy both immediately after the intervention and at a six-month follow-up. Benefits of using podcasting as identified by parents in this study included

that is was more accessible in that it placed lower demand on parents' time and finances (although it did require an internet connection which can be a barrier for some) and it's portability meant they could listen to the episodes multiple times (Morawska et al., 2014).

Doctoral Research Rationale and Aims

The literature discussed suggests that increasing the mental health literacy of parents and/or caregivers can better equip them to enhance mental health and prevent mental distress in tamariki. Podcasts are widely accessible yet privately accessed and may offer an effective means of increasing parent mental health literacy. My doctoral research explored the mental health literacy needs of parents/caregivers in Aotearoa and aimed to use these findings to develop content for an intervention to increase their mental health literacy via podcast. The overarching questions the research sought to address were:

1. What are the mental health literacy needs of parents and/or caregivers of primary school aged children?
2. How could these needs be met through a podcasting intervention?

Method

In the first stage of my doctoral research I explored stakeholder perceptions of the mental health literacy needs of parents and/or caregivers of primary school aged children, and the acceptability of podcasting as a mode of delivering an intervention for increasing mental health literacy.

Using a qualitative approach, I conducted semi-structured interviews with 11 practitioners working with parents/caregivers of tamariki aged 5-10 years in mental health professions. Eight of the research participants were female practitioners; two were from the

upper North Island, eight from the lower North Island and one from the South Island. Three of the participants had worked extensively with Māori whānau and one with Pasifika, predominantly Samoan families. Another participant had experience working with former refugee and Asian families and the remaining participants worked predominantly with New Zealand Pākehā/European families. The purpose of the interviews was to explore areas of parent mental health literacy need and understand perceptions of podcasting as a possible means for intervention. The interviews were recorded and written transcripts were agreed as an accurate record by participants. Braun and Clarke's (2006) framework was used to conduct a reflexive thematic analysis of the interviews.

The research is grounded in social constructionism. Accordingly, it is recognised the interpretation of the analysis is influenced by the socio-cultural context within which the research has been conducted, those of the participants contributing their knowledge to the research and the researcher's own worldview and beliefs.

Findings

In addressing the first research question "What are the mental health literacy needs of parents and/or caregivers of primary school aged children?" themes regarding a number of mental health literacy gaps for parents/caregivers were developed. These themes included: knowledge of child development, behaviour and emotional intelligence, the importance of the relationship between the child and parent/caregiver and a need to recognise parent self-care needs. In addition, increasing parental knowledge of developmentally normative behaviours and emotions, and when it is appropriate to seek help from specialist services was a theme related to parent mental health literacy needs. Finally, clarity as to what mental health services can provide is needed both for those

working within the sector as well as parenting and general population. In light of these themes, practitioners endorsed the suggestion that a mental health literacy resource for parents would be valuable, noting that the younger the age group targeted by the resource the better, and that podcasting could be an effective way to increase knowledge.

In response to the second research question, “How could these needs be met through a podcasting intervention?” two themes were developed. The first related to ways to enhance the acceptability of podcasts by ensuring messages are relevant to all parents/caregivers (i.e., targeted at a population level), using a holistic framework and delivering key messages in a way that is non-judgemental. Secondly, making sure the content is acceptable and delivered in an engaging way may help ensure podcasts are an effective mechanism for enhancing parent mental health literacy.

Clinical Psychology Internship

My 12-month clinical psychology internship was based at the Massey Psychology Clinic in Wellington. During 2022 the Clinic was staffed with two Senior Clinical Psychologists and two Intern Psychologists. Clients of all ages are referred to the Clinic for assessment and/or therapy for a range of presentations and are generally for mental distress of mild to moderate severity. Common presenting problems for clients seen at the Clinic include difficulties with anxiety, depression, trauma, obsessive compulsive disorder, eating disorders, phobias, autism and attention-deficit/hyperactivity disorder.

The following section is a discussion of reflections on how my research experiences have informed my developing clinical practice. I firstly discuss my reflections of how my personal social context within a social constructionist paradigm has influenced my research

as well as my clinical practice. I then discuss how some of my research findings have influenced my clinical practice, and vice versa.

Social Context: Researcher and Clinician

As I designed and conducted my doctoral research I realised just how much influence I had over the direction it took and the resulting findings. For example, the decisions I made about how I recruited practitioners and conducted interviews influenced the information I subsequently obtained. Furthermore, my own personal knowledge and experiences of parenting and mental health influenced my views on where the gaps in parental mental health literacy were, and therefore the lens through which I analysed my data. Regardless of the steps I took to ensure objectivity, research is a subjective process.

I have also had similar reflections on my role as an intern psychologist. I am becoming more comfortable in the knowledge that how I practice as an intern psychologist is not only influenced by my proficiency in clinical knowledge and skills but also by my past experiences and personal world views. Just as it is important to acknowledge the influence of my own worldviews on my research process and findings, it is important that I respect that my worldviews and corresponding perspectives on a problem may be very different to those of a client. I am learning that what is important is not to try and separate myself from my experiences, but to be open in recognising how these influence my own worldview, and to remain curious in seeking to understand a client's problems and how they make sense of these according to their own experiences and worldviews.

A Holistic View of Mental Health

Over the course of my clinical psychology training, I have frequently been struck with the deficits focus of the discipline. Whereas my clinical practice has tended to reinforce a

view of mental health as being about diagnosing problems and treating illness, my doctoral research has helped me to balance this with the importance of promoting flourishing. The Complete State Model of Mental Health (Keyes, 2007) places equal emphasis on health and illness and I have taken this view into my intern work this year in actively seeking out and celebrating clients' strengths, resourcefulness and what is going well in their lives alongside exploration of their difficulties.

Māori models of wellness such as Te Whare Tapa Whā and the Meihana model, as well as Pasifika models such as the Fonofale model also place emphasis on health and strengths alongside weaknesses and illness (Durie, 1985; Ministry of Health, 1995; Pitama et al., 2017). During my interviews I was fascinated to learn how practitioners use these models in their work with children and parents/caregivers. These insights into other's practice have motivated me to take a more holistic approach in my own clinical work. In my own practice I am learning to more thoroughly explore aspects of a client's physical health, social and spiritual wellbeing as well as assess the impact wider socio-cultural factors have on a client's presentation, and to integrate these influences into psychological formulations.

Environmental Context of the Problem

One of the mental health literacy needs of parents/caregivers identified in my research was to be able to consider a child's problem in the context of their environment. That is, practitioners emphasised an important aspect of their work was to help increase parent/caregiver understanding of the factors in a child's environment that may trigger a problem and contribute to the problem being maintained. I have reflected on the simplicity yet significance of this finding as I see the usefulness of increasing this understanding repeatedly in my work with clients.

For example, in an assessment of a child struggling with impulsive and disruptive behaviour I explored how the difficulties developed and changed over time in response to others' reactions to the child's behaviour. I came to understand how the parents' and teacher's responses to the child's impulsivity may have been contributing to maintaining the problematic behaviour, and also that some of the ways the child had been responded to over time had led to the onset of other problematic behaviours. I worked collaboratively with the client's parents to change their perspective on the problem from it being the child that was the problem towards recognition that the behaviour was a result of an interplay of triggers and behaviours of others in the child's home and school environments.

In a similar vein, I used functional analysis to explore challenges an older adult was having with irritable behaviour. Together we learned how a lack of communication about underlying stressors in the client's relationship led to unhelpful thoughts and subsequent emotions relating to rejection and frustration, which manifested in his making "snarky" comments. In recognising this pattern of behaviour across multiple incidents, the client came to understand how it was being maintained and identified the changes he could make at different points in the chain that would then contribute to his aim to better manage his irritable behaviour.

These clinical experiences have reinforced to me how valuable it is for any parent (irrespective of whether their child has mental health difficulties) to be able to understand a child's behaviour in the context of their environmental systems. I am learning through the integration of my research and clinical work that many of the skills that we use with our clients – regardless of the nature or severity of their problems - can also be helpful to promote at a population level.

Emotion Regulation

A theme from my qualitative analysis that was perhaps the most prominent need was to increase parental knowledge and skills in relation to emotion regulation. This theme applied to supporting a child to regulate their emotions as well as the parent themselves learning to regulate their emotions. To a certain extent this theme has been paralleled in my clinical practice. That is, a recurring component of my clinical work has been helping clients to identify emotions, to accept their emotions and to learn strategies for managing their intense emotional experiences. One of the biggest learnings from my internship has been that no matter what the presenting problem is, almost all clients can benefit from skill-building in emotion regulation. This realisation emphasises to me the importance of emotional regulation skills as a mental health literacy gap amongst parents. My clinical experience has further motivated me to address this gap in the second stage of my doctoral research which will be to develop content for a population-level intervention for parents using podcasting.

Summary

In reflecting on how my doctoral research has informed my clinical practice, I have realised it is more of a reciprocal relationship. There are many ways the literature and my qualitative findings are informing my development as a clinical psychologist. However, I also recognise that many of my experiences as an intern psychologist are providing a different perspective on my research findings. The learnings I am gaining through my clinical work are also reinforcing to me the importance of equipping parents/caregivers with knowledge and skills to promote mental health in their tamariki.

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