Dreaming of a Solution: D.R.E.A.M.-O.F. a Mental Health Promotion Program for Children and Their Families on Mental Health Waitlists

by

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ABSTRACT

The mental health rights of Canadian children are severely under met. To date, social policies advocate for strategies to reduce mental health service wait times, but little action has been taken to meet the needs of children and their families on waitlists. D.R.E.A.M. is a program that focuses on educating children about mental health, reducing stigma attached to mental health illness, and teaching tools for resilience. D.R.E.A.M. does not, however, currently address families. The current study involved the development of an adapted version of the D.R.E.A.M. program; D.R.E.A.M.-O.F. Through the creation of five family-based units, grafted onto the existing D.R.E.A.M. program, D.R.E.A.M.-O.F. aimed at providing families on mental health waitlists with the skills to begin addressing concerns associated with resilience promotion. The developed units were grounded in a literature-based and stakeholder-engaged needs assessment. A comparison of pre- and post-measure results from this pilot study indicated an improvement in child mental health symptoms, an increase in family functioning, and promotion of daily meaning for both children and adults. Given the encouraging findings from the pilot study of the program, further research regarding the application of this program is warranted. Future directions may include a program delivery in a web-based format, with video instructions and downloadable activities, with the goal of enhancing wellbeing, prior to standard mental health care services. The online format should make it more easily accessible for families and was recommended by stakeholders. Ultimately, the goal is for children and families to develop mental health-enhancing skills and reduce service time needed, thus hopefully shortening therapy waitlists.

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CHAPTER ONE

INTRODUCTION

The mental health needs of Canadian children are severely under met (Canadian Institute of Health Research [CIHR], 2010). More than 1.25 million Canadian children require support for their mental health concerns (Statistics Canada, 2013); many are met with delays in receiving treatment due to barriers such as long waitlists. Long waitlists ultimately result in considerable psychological, developmental, social, and fiscal costs (CIHR, 2010). It is estimated that mental health issues cost the Canadian economy roughly 50 billion dollars per year (Lim, 2008). This number is extremely high especially when considering that less than one in four Canadian children who need services receive treatment for their mental health concerns (Waddell, Hua, Garland, Peters, & McEwan, 2007). Many of these children have to wait months or more for an initial appointment with a mental health professional (Mental Health at CHEO, 2013). A Canadian study investigating wait times for child and family mental health services found only 8.6% of the agencies surveyed reported no wait times at all (Waddell, McEwan, Hua, & Shepherd, 2002). In addition, across recent decades, only 31.4 % of the agencies surveyed met the “mostly able to” benchmark for the wait time standards set by the Canadian Psychiatric Association (Loebach & Ayoubzadeh, 2017; Waddell et al, 2002;). On average, “high priority” children and families may wait nine months for mental health services, while those deemed “lower priority” can wait up to a year (Schraeder & Reid, 2015). Specifically, a recent survey conducted by Children’s Mental Health Ontario explored mental health service wait times for clients ages six to 18 and found that wait times generally vary from three months up to one and a half years (Loebach & Ayoubzadeh, 2017). These findings are extremely discouraging, particularly when considering that the number of children requiring mental health services has

increased by 45% from 2006 to 2014 (Kowalewski, McLennan, &, McGrath, 2011). Another barrier to seeking services that many families face is an inability to navigate the system (Representative for Children and Youth [RCY], 2013). Many families are unsure where to begin, what services are available to them and what programs would best suit their child's needs; in general, families have poor mental health literacy (RCY, 2013). Additionally, caregivers and mental health practitioners report that the absence of a circle of care and the lack of communication between professionals makes it difficult to establish a consistent treatment plan, with a number of mental health professionals claiming they are only informed 50% of the time if their client is admitted to the Emergency Room for a mental health crisis (RCY, 2013). Families also report that due to the long waitlists, it is not uncommon that children "age-out" of the youth system before receiving treatment (RCY, 2013). Thus, they have to begin the waiting process again while trying to access adult services.

Significant levels of stress are associated with childhood mental illness. In fact, according to Waddel et al. (2002) "no other group of disorders has such a profound effect on the development and wellbeing of children and youth, and on their families and communities" (p. 4). This is understandable, given that mental health issues can affect every aspect of a child's life, including their family and peer relationships, as well as their social and academic functioning (CIHR, 2010; Waddell et al, 2002). The earlier the onset of the disorder, the higher the probability it will persist into adulthood, if not appropriately addressed by treatment or other mental health programming (Copeland, Angold, Shanahan, & Costello, 2010). Given the long waitlists and low service access, prevention or early intervention is recommended for child mental illness (Mental Health Commission of Canada, 2012).

The Present Study

The present research is a mixed-methods design with the purpose of developing a mental health promotion program for children, ages 6 to12, and their families on mental health waitlists with the goal of providing early intervention. The study highlights four important areas related to the focus of the research:

1) What are the needs of children, ages 6 to 12, and their families on mental health waitlists: This was explored through both primary and secondary sources using needs assessment methodology;

2) The importance of including stakeholders in the program development process. Specifically, families and mental health practitioners were personally engaged and invited to help guide decision-making on the program development process;

3) To create a mental health promotion program for families to use when experiencing delays in accessing standard mental health services. The mental health promotion program was devised to meet the scientific standards of a good program: that is, the program is acceptable, credible, feasible and sustainable (Armstrong, 2009; Armstrong, 2018; Armstrong, Desson, St. John, & Watt, 2018; Armstrong, Watt, St. John, & Desson, 2019; Armstrong, Watt, St. John, & Desson, *in press;* Joint Committee on Standards for Educational Evaluation, 1994; Judd, Frankish, & Moulton, 2001). Further the program was pilot tested with families who were involved in the program design, who had experienced delays in accessing standard services;

4) Future use and implications. The family program created was designed to add family units to an existing program for children (the D.R.E.A.M. program: Developing Resilience through Emotions, Attitudes and Meaning), with the aim of reaching those on mental health waitlists.

The Fallout of Childhood Mental Illness: The Individual, the Family and What Can Be Done

Risks for the Individual. The risks of mental illnesses, such as depression and anxiety, following an individual from childhood into adulthood are well documented. Without proper mental health treatment, an individual is twice as likely to experience depression in their adolescence if they presented with it in childhood, with that adolescent then being at twice the risk of experiencing depression into adulthood (Costello & Maughan, 2015). There is a high level of comorbidity associated with youth depression and anxiety, with a number of studies citing that early onset depression is predictive of anxiety and in turn early onset anxiety is a predictor of depression (Benjamin, Harrison, Sttipani, Brodman, & Kendall, 2013; Costello, Mustillo, Keeler, & Angold, 2004;). It has been documented that youth depression and anxiety can be associated with negative adulthood outcomes in the following areas: health, education and income, social relationships, self-harm and criminal behavior (Angold & Costello, 1993; Berndt et al., 2002; Brent, Edelbrock, Costello, Dulcan, & Conover, 1986; Chansky & Kendall, 1997; Hetrick & Mcgorry, 2007; Keyes, 2006; Smith & Carlson, 1997). Furthermore, depression in young people is associated with a number of later life psychosocial issues including: divorce, relationship violence, and the contracting of sexually transmitted diseases (Copeland et al., 2010; Keenan-Miller, Hammen, & Brennan, 2007). Ultimately, children who struggle with depression or anxiety are more likely to engage in substance abuse, drop out of school, have difficulty with peer and social relationships, experience suicidal ideation, and exhibit Conduct Disorder, than children who are appropriately treated or do not experience these illnesses (Angold & Costello, 1993; Berndt et al., 2002; Brent et al., 1986; Chansky & Kendall, 1997; Hetrick & Mcgorry, 2007; Keyes, 2006; Smith & Carlson, 1997). These findings are similar to other issues diagnosed

in children, such as behavioural learning difficulties.

Following mood and anxiety disorders, behavioural learning difficulties such as Attention Deficit [Hyperactivity] Disorder (ADD/ADHD) are the third most common diagnosed mental health classification for children and youth in the Diagnostic and Statistical Manual ([DSM-5] RCY, 2013). Academically, childhood ADD/ADHD is strongly associated with a number of learning challenges and academic issues (Costello & Maughan, 2015). Psychosocially, it is not uncommon for children who are affected by ADD/ADHD to experience peer rejection and struggle with forming peer relationships (Costello & Maughan, 2015). The disruptive behaviour frequently associated with childhood ADD/ADHD often continues into adolescence with many ADD/ADHD youth exhibiting risky behavious such as driving violations and substance abuse disorders (Biederman et al., 2012; Costello & Maughan, 2015). ADD/ADHD rarely appears on its own and is associated with a number of other mental health concerns including, depression, anxiety, suicidality and other mental health issues such as Oppositional Defiant Disorder and Conduct Disorder (Biederman et al., Hinshaw et al., 2012). Children who develop Oppositional Defiant Disorder and Conduct Disorder are at a high risk of developing Antisocial Personality Disorder in adulthood (Costello & Maughan, 2015). Overall, whether children experience an internalizing or externalizing mental illness, approximately 50% of untreated childhood disorders persist into adulthood (Horstra, Van der, & Verhulst, 2000).

Another factor that severely affects children suffering from mental illness is the negative stigma surrounding mental disorders. Stigmatization attached to mental illness can result in serious social, psychological and even economic burdens (Mukolo, Heflinger, & Wallston, 2010). Stigma also inhibits help-seeking behaviour and receptivity to mental health information (Armstrong & Young, 2015). As many as 70% of adults living with mental health issues said

they identified having symptoms before the age of 18 but avoided seeking help due to the negative stigmatization surrounding mental illness (Mental Health Commission of Canada, 2012). The majority of research looking at the effects of mental health stereotyping tends to focus on adults, but more recently some studies have begun to close this gap by focusing on the stigmatization exhibited by adolescents and children towards their peers with mental illness (Mukolo et al., 2010). Findings from these studies demonstrate that children who struggle with emotional and behavioural illnesses are more likely to be rejected by peers due to stigmatization, especially for children suffering with depression (Mukolo et al., 2010). The developmental effects of stigmatization can be profound, potentially contributing to low self-esteem, isolation, helplessness, and high school dropout rates (Mukolo et al., 2010; Walker, Coleman, Lee, Squire, & Friesen, 2008). Thus, for individuals, the key risks of mental illness include challenges associated with stigmatization, concerns that persist into adolescence and adulthood, and the potential for concurrent mental illnesses to develop without proper skills to address concerns.

Risks for Siblings. The relationships formed between brothers and sisters can be some of the most significant relationships experienced. These relationships can be sustained throughout one's life and are unique due to their shared history, mutual experiences and typically, genetic composition. There has been an extensive amount of research centering on the challenges of growing up with siblings who struggle with mental illness.

Parents and caregivers can often expend the majority of their time and energy on a child with mental illness. Consequently, siblings can end up feeling invisible, ignored and sometimes neglected (Griffiths & Sin, 2013; Leith & Stein, 2012; Sin, Moone, Harris, Scully, & Wellman, 2012). "I feel invisible' because so much of my mother's time and energy was focused on my brother" (Lukens, Thorning, & Lohrer, 2004, p, 494). Experiences, such as the one described

above, can lead to resentment toward the mentally ill sibling (Griffiths & Sin, 2013; Sin et al., 2012). These feelings potentially result in guilt, as the sibling may want to be empathic but find it difficult due to their perception that their own needs are being disregarded (Leith & Stein, 2012; Sin et al., 2012). Siblings may not only feel that their needs are being overlooked, but may consider that their role is to function as the "perfect" child and consequently are unable to express their own personal concerns and struggles (Zeilinger, 2015). This may be a result of a perceived need to compensate for the familial stress being experienced and associated with the mental illness (Zeilinger, 2015). Due to the pressure of maintaining this façade and a perceived inability to express their true feelings, siblings may feel the need to live a "double-life," affecting their capacity to connect with friends and other potential sources of support (National Alliance on Mental Illness [NAMI], 2013). Developmentally, this can lead to issues with identity as these children mature into adolescents (Lukens, et al., 2004; NAMI, 2013). One study, examining how a sibling's self and family were altered by childhood mental illness, reported that the participants' personhood was severely affected on a regular basis (Lukens, et al., 2004). Participants remarked that growing up with a brother or sister struggling with mental illness can have a profound influence on their development and personality (Lukens, et al., 2004). One participant remarked, "The illness affected the direction of my entire life" (Lukens, et al., 2004, p. 495). Areas of life such as career choice, romantic relationships, and plans for the future were all changed in some way by growing up with a sibling struggling with mental illness (Lukens, et al., 2004).

In addition to the potential changes to a sibling's developmental path that can occur, the social stigma associated with mental illness and fear of judgment from peers, can potentially challenge a sibling's ability to maintain a healthy social life (Sin et al., 2012). Siblings of

children with mental illness report stigma surrounding mental health issues as one of the greatest factors affecting their ability to maintain a normal social life (Lukens, et al., 2004; Sin et al., 2012). Siblings have reported feelings of embarrassment, the inability to engage in healthy discussion regarding their sibling and their discomfort in sharing thoughts and feelings with friends about their brother or sister's mental health concerns (Lukens, et al., 2004; Sin et al., 2012). Some children have reported fear of, or avoiding inviting friends over, in order to keep their sibling's mental illness hidden (Sin et al., 2012), resulting in self-isolation (NAMI, 2013).

As sibling relationships can be such intimate and close relationships, having a brother or sister diagnosed with a mental illness can generate feelings of grief, loss and even despair (Lukens, et al., 2004; Sin et al., 2012). This is sometimes due to the sibling's coping mechanism to separate themselves from the mental illness, ultimately distancing themselves from the family member with a mental illness (Sin et al., 2012). These feelings of loss may be a consequence of the changes taking place in the brother or sister, as a result of the mental illness (Sin et al., 2012). Feelings of mourning can also arise from "losing" the image of what their family used to be. This can include a loss of sense of family normalcy and also, at times, financial resources (Leith & Stein, 2012, Sin et al., 2012) Loss may also be felt from the sibling's inability to form social relationships. For example the emotional burdens and additional time commitments of care giving duties can impact on the sibling's opportunities to invest in their own social life. (Leith & Stein, 2012; Sin et al., 2012).

Without the proper resources and support, siblings may ultimately fall victim to experiencing mental health concerns themselves (Griffiths & Sin, 2013; Sin et al., 2012) or engage in dangerous activities such as substance abuse (NAMI, 2013). Therefore, barriers to mental health service access for the child and family, including long waitlist times, can have a

tremendous impact not only on a child suffering from mental illness, but also the siblings of the struggling child.

Risks for Parents and Caregivers. Many of the experiences described for siblings are similar to those felt by some parents and caregivers of children with mental illness. Unlike siblings, whose role of caregiving is generally more variable (March & Dickens, 1997), the strain placed on the family by the presence of mental health concerns may be intensified for parents and caregivers who assume the majority of the care responsibilities. Having a child who struggles with mental illness commonly leads to long-term effects on the parents or caregivers physical and psychological wellbeing (Ferriter & Huband, 2003). The long-term, potentially negative, implications for caregivers, associated with mental illness in children, is associated with both physical and mental exhaustion (Mohr & Regan-Kubinski, 2001). Caregivers of individuals with mental illness can often experience a significant amount of stress associated with the burden of caring for their loved ones, thus potentially triggering parental mental illness (Rose, Mallinson & Gerson, 2006). Research documents that parental mental health issues can have an impact on the whole family, affecting both of the caregivers' ability to parent as well as child wellbeing (Freeman, Newland, & Coyl, 2008; MacKenzie, Nicklas, Brooks-Gunn, & Waldfogel, 2011; Sawyer, Gale, & Lambert, 2006). Therefore, distress can potentially be worsened by the added stress on relationships within the family (Rose, 1989b). In addition, strains and tensions that existed prior to the onset of the mental illness can be intensified by its manifestation (Delaney & Engels-Scianna, 1996). The additional stress associated with the emotional, financial and psychological burdens derived from the mental illness can lead to a variety of negative outcomes, including, anxiety and depression. One study stated that 60% of participants who cared for children with a mental illness reported being anxious and depressed

(de Silva & de Silva, 2001). In addition to depression and anxiety, some parents report feeling overwhelmed, resentful, and helpless (Rose, 1989b; Wade, 2006).

Negative stigma surrounding mental illness can contribute significantly to a caregiver's inability to seek social support and accordingly feelings of isolation (Wade, 2006). In fact, the judgment and blame experienced by some caregivers from mental health practitioners throughout the 1900's is a large contributor to the stigma associated with mental health issues today (Lefley, 1992). Until the late 1900's, the position held by many therapists was that a child's mental illness stemmed from poor parenting (Goldstein, 1981) and parents were viewed as contributors to the problem. To allow the therapist to fully intervene and provide the appropriate care needed, the protocol was to exclude parents from the therapeutic process (Goldstein, 1981). Although much improvement has been made over the past couple of decades, some parents still report feeling blamed by mental health practitioners (Corrigan & Miller, 2004). Today, there still remains some societal predisposition to categorize mental illness as something weak or dangerous (Rose et al., 2006), with many caregivers continuing to perceive they are being judged and blamed for their child's condition (Ferriter & Huband, 2003; Geraghty, McCann, King, & Eichman, 2011; Hinshaw, 2005; Wade, 2006). Perception of blame from family and friends, coupled with self-blame can lead parents to feel guilty regarding their child's mental illness (Ferriter & Huband, 2003; Geraghty et al., 2011).

The stigma surrounding a child's mental illness can impact parenting and ultimately the development of the child (Hinshaw, 2005). For example, some parents may avoid social domains such as neighbourhood functions, churches, community centres, even family and friends due to the perception of judgment (Hinshaw, 2005). The stigma experienced and personal time displaced by caring for a child with mental health concerns may affect a caregiver's ability to

seek the social support they need. Some families convey uncertainty as to how to discuss their child's mental illness with other family members and friends (Ferriter & Huband, 2003; Geraghty et al., 2011), leaving many parents feeling isolated and alone (Wade, 2006). Self-blame is also common with parents frequently questioning if they are in some way responsible for the onset of the mental illness (Ferriter & Huband, 2003; Geraghty et al., 2011). In fact in a study by Ferriter & Huband (2003) found that over 50% of the sample reported blaming themselves for their child's mental illness.

Comparable to experiences reported by siblings, caregivers can also experience feelings of loss. These feelings of loss can be accompanied by sadness and grief, but, unlike the sympathy associated with losing a child to death, "losing" a child to mental illness does may not warrant the same level of support that is generally received from friends, family and community (Howard, 1998). Feelings of loss may manifest themselves in a variety of ways. Parents convey that this loss can include mourning the loss of dreams for their child's future and their own (Johansson, Anderzen-Carlsson, Ahlin, Andershed, & Skondal, 2012), as well as loss for their child's capacity to lead a normal life (Ryan, 1993). Some caregivers also report experiencing personal feelings of loss, such as loss of social life and previous relationships (Ambikile & Outwater, 2012; Stein, Aquirre, & Hunt, 2013), loss of freedom (Ryan, 1993) and loss of former self (Stein et al., 2013).

Barriers to Service Access and Prolonged Risks of Child Mental Illness on Parents and Caregivers. As many children struggling with mental health concerns are unable to access appropriate mental health services, family members often become a significant source of support in dealing with the mental health issues (Leith & Stein, 2012; Lukens, et al., 2004). The stress surrounding childhood mental illness is intensified by the perceived and assumed sense of

responsibility adopted by family members in providing instrumental and emotional support for their loved ones (Hatfield 1994). Therefore, families who care for loved ones struggling with mental health issues can also be affected, with some experiencing feelings of loss, grief, self-blame and fear of social judgment, and stigmatization (Dyck, Short, & Vitaliano, 1999; Rose et al., 2006; de Silva & de Silva, 2001). Family wellbeing, personal sense of meaning, and functioning can also be significantly challenged by child mental illness and treatment wait times (Canadian Institute of Health Information [CIHI], 2015; Leavey, 2005; Schraeder & Reid, 2015).

With appropriate, timely, evidence-based treatment, children and families can work to become more resilient and the problems described here may be prevented or minimized (Westin, Barksdale, & Stephan, 2014). One of the greatest barriers to service utilization is the length of mental health waiting lists (Barwick et al., 2013). Although great strides have been made in evidence-based practice and quality assurance, these advances are limited if treatment cannot be accessed when needed the most (Herschell et a., 2004; Weisz & Kazdin, 2010). Prolonged wait times have been found to have a profound impact on a child and family's engagement in treatment (Westin et al., 2014). In fact, with long waiting lists, 48% to 62% of families fail to attend a first therapy session (Harrison et al., 2004; McKay et al., 1996), even though longer wait times can mean a worsening of the problems (Carr et al., 2008). Mental health concerns may be exacerbated, a family's distress may be prolonged, and occasionally death or divorce can occur in times of crisis (Barwick et al., 2013). Moreover, if a family does utilize evidence-based psychotherapy services, children and families indicate lower levels of satisfaction with the services provided relative to the length of time that they spent on a waiting list (Tahhan et al., 2010). Furthermore, many of the aforementioned associated mental health issues can be

compounded by barriers to accessing mental health services, such as long waiting lists. With cost-efficient, evidence-based, timely services, or helpful information provided to families while on waiting lists, concerns can be addressed in an accessible manner and the tremendous difficulties that some parents often experience can be prevented or minimized (Barwick et al., 2013).

What Can Be Done?

Stress and Resilience. Given the findings surrounding childhood mental illness and the risks for the family unit, it is evident that lack of mental health resources and long service use wait times can be particularly detrimental for child and family wellbeing. The stress associated with childhood mental illness can be, in itself, a pervasive and significant risk factor (Compas et al., 2001). Children who experience prolonged stress in the early years of life are at risk of experiencing a variety of long-term mental health issues (Stanley & Siever, 2010). By contrast, the ability to properly manage and cope with stress can be an invaluable skill for future functioning and healthy development.

Protective factors are measurable characteristics that predict positive outcomes in the context of risk (Masten & Reed, 2002). The presence of protective factors can help to mitigate risk for children and families; this is known as *resilience* (Barankin & Khanlou, 2009). As such, protective factors can exert their influence on a potentially negative outcome through their inverse relationship with risk factors for the outcome or through their direct inverse relationship with the outcome. Resilience is a term often discussed when considering how well someone is able to change and adapt to stressful situations (Oliver, Collin, Burns, & Nicholas, 2006). "Resilience refers to the process during which a person achieves positive outcomes despite negative experiences by coping successfully and avoiding the negative development that

often follows traumatic experiences" (Askeland, Hysing, Aaro, Tell, & Silversten, 2015, p. 49). Individuals who possess skills for resilience are generally more emotionally stable, are better at managing their automatic arousal and are more likely to use social and environmental sources of support (Compas et al, 2001; Kowalewski et al, 2001). Resilience is positively correlated with higher levels of life satisfaction and negatively correlated with adverse indicators of mental health, such as depression and anxiety (Roesch et al., 2005). A study investigating resiliency in youth, found that higher scores of resiliency were correlated with fewer symptoms and mental health problems including: ADHD, Obsessive-Compulsive Disorder, and depression (Askeland et al., 2015). Given the benefits of promoting resilience, what can be done to promote resilience in families where a child experiences mental illness in a system where long waiting lists are prevalent?

Resilience and Meaning. There are many factors that can contribute to mental health resilience in children, including the experience of meaning and meaningful child engagement (Armstrong & Manion, 2013; Bartko & Eccles, 2003; Resnick, 2000). Meaning-centered child engagement involves anything from partaking in a brief solo enjoyable activity to a structured extracurricular activity involving "meaningful participation and sustained involvement of a young person in an activity that has a focus outside himself or herself" (Pancer, Kransor-Rose, & Loiselle, 2003, p. 49). Meaningful child engagement is positively correlated with good mental health and developmental outcomes such as: reduction of risky behaviors, increased self-esteem, higher academic functioning, and overall positive psychological functioning (CIHR, 2010; Armstrong & Manion, 2013; Busseri, Rose-Krasnor, Willoughby, & Chalmers, 2006; Kumpfer, 2002). The experience of meaning or purpose is associated with decreased risk for suicidal ideation and enhanced wellbeing (Frankl, 1986a). In addition, exploring meaning can assist an

individual in gaining insight into how emotions may be connected to stressful events (Stanton, Kirk, Cameron, Danoff-Burg, 2000). Exploring meaning can be achieved through positive reappraisal, which is the ability to see a stressful situation more optimistically (Carver, Scheier, & Weintraub, 1989). This capacity has been linked to the development of life meaningfulness, which is associated with improved quality of life and positive wellbeing (Reocsch et al., 2005). Therefore, positive reappraisal and exploration of meaning are tools that can help individuals understand the personal outcomes associated with challenging situations, such as mental illness (Leith & Stein, 2012).

Existing Programs. Mental health programs that focus on the enhancement of meaning and meaningful engagement, could be pertinent for increasing resilience and promoting mental health in children. For example, a 2006 study (Rose-Krasnor et al., 2006) examined a variety of developmental spheres and how breadth and intensity of youth engagement were related. The sample consisted of Canadian youth from 25 high schools and examined areas of development including: psychological functioning, interpersonal functioning, risky behavior involvement and academic orientation. Breadth of engagement was measured through the range of activities the youth participated in and intensity consisted of the average frequency of activity engagement. The outcomes yielded some very encouraging results, demonstrating that youth engagement was positively associated with healthy psychological and interpersonal functioning, greater academic orientation and reduced involvement in risky behaviour (Rose-Krasnor et al., 2006).

A 2013 study investigated the relationship between meaningful engagement as a moderator between risk factors and suicidal ideation (Armstrong & Manion, 2013). This was a cross-sectional study consisting of Canadian participants, ranging in age from 13 to 19 years. The researchers were interested in exploring whether personally meaningful youth engagement

would be successful at reducing negative mental health outcomes, in comparison to breadth of engagement and intensity of engagement. A number of mental health outcomes were measured including: depressive symptoms, suicidal ideation, self-esteem, perceived social support and risk behaviours. As expected, the findings were encouraging and personal meaning in engagement was significantly associated with fewer self-reported depressive symptoms and risk behaviors, as well as less self-reported suicidal ideation. Enhanced self-reported self-esteem and social support were also reported. Further, if a young person was at greater risk for suicidal ideation due to low self-reported self-esteem and social support, and high self-reported depressive symptoms, risk behaviours, then meaningful engagement was found to help moderate the risk for self-reported suicidal thoughts (Armstrong & Manion, 2013). Being engaged in a personally meaningful activity was found to be more relevant for youth wellbeing than breadth or intensity of engagement (Armstrong & Manion, 2013). Armstrong and Manion (2013) concluded that "meaningful youth engagement acts as a buffer between wellbeing concerns and suicidal ideation" (Armstrong & Manion, 2013, p. 23). Studies such as these highlight the importance of utilizing meaningful child and youth engagement as a potential strategy for reducing negative mental health outcomes and promoting positive development. Further research exploring meaning with children, in a study grounded in Logotherapy theory, defined meaning as: self-reported positive self-concept, hope for the future, agency over thoughts and behaviours, and openness to experience (St. John, 2017). This study yielded findings that high self-reported meaning was associated with positive internalizing and externalizing mental health (St. John, 2017). Thus, for both children and youth, meaning and meaningful engagement are associated with mental health. Therefore, meaning is a resilience factor for young people.

Developing Resilience Through Meaning-Making

As briefly discussed in the previous section, one method for developing resilience is through meaning-making (Ivtzan, Lomas, Hefferon, & Worth, 2016; Wong & Fry, 1998; Wong, 2010, Wong & Wong, 2006). Meaning-making is correlated with the development of resilience factors such as: coping, optimism, openness, positive affect, positive psychological adjustment and a decreased need for therapy (Ivtzan et al., 2016; Wong & Wong, 2013). One such avenue for creating meaning-making is through forming connections and developing secure relationships with others (Frankl, 1986). Interventions that support families in developing open avenues for communication could result in the development of more effective communication, fostering opportunities for emotional connection (Ivtzan et al., 2016). Emotional connection is linked to meaning-making (Ivtzan et al., 2016), joy, secure attachment and positive attitudes (Cassidy & Shaver, 2016) all of which give hope for the future (Snyder, Cheavens, & Michael, 2000). Additionally, for both children and adults, positive attitudes, such as personal agency, create a belief of available choices, ability to solve problems and control over individual wellbeing, promoting resilience (Ivtzan et al., 2016). In fact, these concepts are core tenets of Second Wave Positive Psychology (PP 2.0) (Ivtzan et al., 2016; Wong, 2011). Attachment and Logotherapy theory are further theoretical approaches that can promote meaning-making and resilience development (Frankl, 1986; Wong & Wong, 2013).

Attachment Theory. As attachment is one of the key pathways to the experience of meaning (Frankl, 1986), Attachment theory can provide a framework through which to develop this pathway. Attachment theory is a development-based theory that empirically documents specific behaviours such as emotional attunement and parental consistency, that result in positive family functioning and the optimal outcome of secure attachment: a state that can promote a

number of positive attributes associated with healthy adaptive behaviours, including resilience (Cassidy & Shaver, 2016; Rovers, 2006). The literature describes secure attachment associated with a healthy balance of both individuation and intimacy (Cassidy & Shaver, 2016; Bowbly, 1969, Meier & Boivin, 2006; Rovers, 2006). Someone who is securely attached is able to emotionally regulate in times of distress but also seek closeness and support when needed (Cassidy & Shaver, 2016). In addition to emotional regulation and resiliency, empathy, openness and constructive communication are just some of the positive attributes associated with positive family functioning and secure attachment development (Cassidy & Shaver, 2016). Attachment theory approaches the phenomenon of secure attachment from the context of an attachment system (Rovers, 2006). Attachment theory states that a child seeks proximity and security from their caregiver, and it is the experiences of these interactions that form the attachment system (Cassidy & Shaver, 2016; Meier & Boivin, 2006; Rovers, 2006). The purpose of the attachment system is to develop what is referred to as a "felt security", a result of a secure attachment bond (Cassidy & Shaver, 2016). Behaviours developed within the system are behaviours that the child has found to be the most useful in eliciting responses from their caregivers in particular moments of need (Cassidy & Shaver, 2016). The behavioural selection of this process heavily relies on the emotional aspects of the system (Cassidy & Shaver, 2016). Emotions are important regulatory mechanisms of the attachment behavioural system. Differences in attachment security are linked to the alternative ways a family functions and how caregiver-child dyads respond to one another, communicate and regulate emotions (Cassidy & Shaver, 2016). Cognitively, the attachment behavioural system involves an individual's mental representation of the self, attachment figure and environment (Bowlby, 1969). These representational models are what Bowlby (1969) referred to as Internal Working Models (IWM). A securely attached individual has an IWM of

self as being loveable and of others as being dependable and reliable (Bowlby, 1969; Rovers, 2006). At the other end of the spectrum is a relational state, linked to negative developmental trajectories, defined as insecure attachment (Bowlby, 1969; Rovers, 2006). Attachment theory illustrates a number of parent-child interactions, such as authoritarian parenting, emotional dysregulation and a rejecting of the child's needs that can lead to insecure attachment (Cassidy & Shaver, 2016). Children with insecure attachment styles may display negative, behavioural functioning including poor emotional regulation and social disintegration (Cassidy & Shaver, 2016).

Resilience is fostered in families by healthy communication and adaptability (Green, 2010). By contrast, several behavioral symptoms associated with childhood mental illness originate from a breakdown in communication and adaptability within the family system, potentially leading a child to experience frustration with unsolved problems and unaddressed issues (Green, 2010). Many children and their families who remain on mental health waitlists for longer periods of time experience a worsening of symptoms (Carr et al., 1996), which can contribute to a deterioration in effective communication, and therefore, opportunities for secure attachment development decrease (Costello & Maughan, 2015; Greene, 2010). Children who behave in avoidant or resistant ways can fail to elicit nurturance and positive responses from caregivers; a lack of positive family functioning (Green, 2010). This type of situation can result in the child experiencing an environment that may be less than positive, potentially affecting their expectations of their caregivers and how they see themselves; their IWMs (Bowlby, 1969). Children struggling with mental illness often respond to problems with strong emotional reactivity rather than through logical cognition and can become overwhelmed with difficulty in communicating their needs or addressing issues (Green, 2010). The child's emotionally reactive

communication can often elicit a negative emotional reaction from the caregiver, which can perpetuate a cycle of emotional reactivity and poor communication (Green, 2010). This cycle of maladaptive communication prevents opportunities for positive interactions within the caregiver-child dyad thus possibly challenging the secure attachment bond of the parent-child relationship (Costello & Maughan, 2015; Greene, 2010). Elements of an intervention approach for families on mental health waitlists could, therefore, be well-served by incorporating Attachment theory in order to address issues of communication, adaptability and flexibility towards problem solving, helping build or re-build positive family functioning, thus potentially enhancing meaning in this area. Furthermore, interventions that focus on developing positive family functioning could be of particular importance for addressing the reported perceptions of family disintegration and individual struggle described by some siblings and caregivers of families with children who have mental health difficulties. Furthermore, greater use of emotional regulation and stress management strategies are associated with the promotion of parental mental health (Coyl, Roggman, & Newland, 2002; McCarty & McMahon, 2003; Nelis, Quoibach, Hansenne, & Mikolavjczak, 2011), which in turn is associated with better family functioning (Coyl, et al., 2002; Freeman et al., 2008; MacKenzie, Nicklas, Brooks-Gunn, & Waldfogel, 2011). In addition to Attachment theory, another theoretical framework that aims to enhance pathways to meaning is PP 2.0 (Wong, 2011).

Second Wave Positive Psychology (PP 2.0). PP 2.0 emphasizes the importance of looking beyond what is immediately available, in order to derive meaning from experiences, good or bad (Wong, 2011). PP 2.0 emphasizes a relationship of dynamic growth between positive and negative experiences; one cannot exist without the other (Ivtzan et al., 2016). With this idea, PP 2.0 suggests that out of the darkness of negative experiences, there is a potential for

positive growth (Wong, 2011). PP 2.0 emphasizes the importance of meaning in order to make sense out of negative, distressing situations; a concept referred to as post-traumatic growth (Ivtzan et al., 2016; Wong, 2011). Post-traumatic growth is the process by which an experience of positive transformation results from the struggle with a difficult event (Ivtzan et al., 2016). PP 2.0 postulates that the notion of growth is linked to meaning-making, emphasizing the importance of meaning in order to see the true potential of the self and the situation; essentially resilience development (Ivtzan et al., 2016). PP 2.0 also views meaning-making as an active process (Ivtzan et al., 2016). Through making sense of a situation, actualizing self-worth and identifying what is significant, people can direct energy towards what is meaningful (Ivtzan et al., 2016). PP 2.0 presents “meaning” as providing an answer to the “why” in life and “purpose” as the goal-directed “how”. For families on waitlists with a child who has a mental health concerns, a prevention approach with elements grounded in a PP 2.0 framework—elements that identify significance and direct energy in meaningful directions—may help families to move towards positive growth from the potentially “dark” experience of mental illness.

Logotherapy Theory. Logotherapy is meaning-focused therapy that can be psychoeducational in nature, aimed at promoting hope, creativity and the ability to make personal choices and responsible decisions in order to live a meaningful life (Frankl, 1986; Marshall & Marshall, 2012). It was developed by Viktor Frankl who viewed pathology as developing from an emptiness of purpose and personal meaning in life; ensuing in existential frustration (Frankl, 1986). Logotherapy conceptualizes and treats from a premise of finding meaning in order to address existential suffering (Marshall & Marshall, 2012). Logotherapy highlights hope, openness to meaningful experience, personal choice and a belief that one is capable of personal choice (positive self-concept), and agency and emphasizes three important

pillars when conceptualizing and treating existential frustration. 1. *Meaning in life*: people are free to shape their own lives. 2. *Will to meaning*: humans are motivated to find meaning. 3. *Freedom of will*: meaning can be found in any situation (Marshall & Marshall, 2012). The meaning of life pillar represents the idea that life is unconditionally meaningful. In times when meaninglessness is experienced, it is not that meaning is absent, rather meaning has been removed from human comprehension (Marshall & Marshall, 2012). It is through incidences of pain, suffering and despair that intuition and comprehension of meaning are threatened (Marshall & Marshall, 2012). It is in times such as these, that Frankl highlighted the importance of freedom; freedom to consciously decide the individual position one will take towards a difficult event (Frankl, 1986):

- Agency over thoughts. The freedom of will pillar argues against viewing human behaviour as deterministic or reductionistic, and instead argues that humans have the capacity to choose their response to their environment, however limiting their environment may be (Marshall & Marshall, 2012).
- Agency over behaviour. For Frankl this meant rising above "what is given", to a state of "what can be" (Frankl, 1986).

The final pillar, the will to meaning pillar, is the pillar that formulates the majority of Logotherapy theory underlying psychotherapy, it emphasizes healing through meaning and highlights human motivation to find meaning (Marshall & Marshall, 2012). Frankl posits that people have to also recognize their own responsibility to choose meaningful attitudes and behaviours, as well as an openness to the experience of meaningful moments (Frankl, 1986). Further, having a "why" to live for (hope for the future) and a positive view of the self that one is capable of solving problems and making choices (self-esteem) is also important in Logotherapy

theory as components of meaning (Armstrong, 2009; Armstrong, 2018; Armstrong, 2018; Armstrong et al., 2018, Armstrong et al., 2019; Armstrong et al., *in press*; Frankl, 1986; Wong, 2010). Thus, in addition to building attachment and fostering growth from darker experiences in the other theoretical frameworks discussed, interventions for families on mental health waitlists for incorporating Logotherapy theory would aim to enhance agency over thoughts and behaviours, positive self-concept, hope for the future, and openness to meaningful experiences. These issues can be relevant for families on mental health waitlists, given that mental illness often involves negative thinking or unhealthy behaviours, potentially poorer self-esteem in family members, and a sense of hopelessness (Leavey, 2005; Schraeder & Reid, 2015; Sin et al., 2012).

Attachment theory, PP2.0 and Logotherapy theory could be helpful in addressing child and family mental health concerns because each approach utilizes interventions that promote psychological development, positive family functioning and foster meaning-making; all of which are linked to the development of resilience (Cassidy & Shaver, 2016; Frankl, 1986; Ivtzan et al., 2016; Wong & Wong, 2013).

Application of the Theoretical Framework to D.R.E.A.M.-O.F.

Incorporating Attachment Theory into the Program Units. Attachment theory provides a framework in which to view family therapy. Conceptually, family functioning can be viewed from a relational perspective (Rovers, 2006), with therapeutic goals aimed at providing an environment that fosters opportunities for positive interactions such as communication and meaningful engagement. Therefore, strategies suggested by attachment theorists were of particular value when developing the units in the attempt to optimize outcomes for children and their families delayed in accessing mental health services.

Green (2010) developed an approach, known as Collaborative Problem Solving (CPS) that encompasses many of the tenets of Attachment theory, as a way of addressing child behavioural issues through promoting adaptive behaviours and communication strategies. Highlighting the idea that, when given the choice, children will choose adaptive behaviours over maladaptive behaviours. Green (2010) promoted the idea that through attachment strategies such as those addressing emotional regulation, communication, empathy and attunement, it is the caregiver's responsibility to guide their child in developing these adaptive behaviours. CPS aims to address the problems underlying the behavioral outburst affecting the secure bond of the parent-child dyad (Green, 2010). Using empathy, communication and partnership, CPS improves opportunities for the secure-bonding to take place that can lead to emotional regulation, communication, adaptability, openness; potentially fostering the development of resilience.

Preliminary design of the D.R.E.A.M.-O.F. program units incorporated many aspects of CPS, however, following stakeholder feedback, this element of the units was replaced by an attachment exercise born out of IMAGO therapy theory. IMAGO therapy is a relational style therapy (Reichlin, 2019) that is typically used with adult couples. However, certain interventions derived out of IMAGO theory, designed for addressing empathy, adaptability and communication issues (Reichlin, 2019), can be modified to use within the family context, such as the IMAGO dialogue wheel (Reichlin, 2019). This exercise was adapted to be more family-friendly, so to fulfill the desired Attachment theory aspects of the program aimed at addressing positive family functioning.

Incorporating PP 2.0 Theory into the Program Units. Incorporating PP 2.0 treatment models into the design of the units aims at supporting optimal outcomes for families, because PP2.0 models promote the development of adaptive coping skills, social support systems and

positive behavioural changes (Ivtzan et al., 2016; Wong, 2011). As PP 2.0's philosophy involves embracing rather than negating negative life events, the focus is to acquire aspects of personal growth from difficult experiences, such as growth from struggling with mental illness, rather than feeling helpless (Ivtzan et al., 2016; Wong, 2011). Examples of this could include identifying strengths and existing coping methods that have supported families through the difficult experience of childhood mental health concerns and delayed access to services. Additionally, an application of interventions to develop posttraumatic growth could be helpful in giving power back to a family and for creating opportunities to apply Cognitive Behavioral Therapy (CBT) exercises used for creating cognitive flexibility, adaptability and stimulating the process of growth. It is common for PP 2.0 approaches to utilize CBT forms of treatment, especially since PP 2.0 works to put cognition into action through promoting action focused growth behaviours (Ivtzan et al., 2016). This can be particularly helpful in addressing child and family mental health concerns, as the formation of automatic, negative patterns of thinking and behaving are often associated with distress and mental health illnesses.

Incorporating Logotherapy Theory into the Program Units. Logotherapy theory was incorporated into the design of the units so to implement interventions directed at bringing new meaning to an experience. Each of Logotherapy's three domains of meaning were considered when designing the program units because each domain proposes ways in which individuals can search for meaning: The creative domain, the attitudinal domain and the experiential domain (Frankl, 1986; Marshall & Marshall, 2012). The creative pathway to meaning encourages agency, self-determination and freedom of choice, and emphasizes the importance of goal striving and achievement in order to create a meaningful life (Frankl, 1986; Marshall & Marshall, 2012). It involves contributing something to the world through individual

accomplishment that is attained through actualizing one's potential by creating something significant (Frankl, 1986; Marshall & Marshall, 2012). The experiential pathway to meaning focuses on being open and willing to receive what life has to offer (Frankl, 1986; Marshall & Marshall, 2012). Rather than giving something to the world, it centers on looking to see what meaning can be derived and what we can take from our experiences (Frankl, 1986; Marshall & Marshall, 2012). Finally, the third pathway, the attitudinal pathway, can be particularly relevant for people who are experiencing incidences of distress or suffering. This final pathway to meaning promotes the belief that every experience in life, every distressing situation, represents an opportunity for personal growth, with the right attitude (Frankl, 1986; Marshall & Marshall, 2012). If an individual is able to rise above their immediate situation, beyond themselves and be devoted to something bigger, then no situation no matter how troubling, can destroy a life (Frankl, 1986; Marshall & Marshall, 2012). For families struggling with mental health difficulties and long wait times, developing attitudinal values could potentially promote the ability to reflect upon the distress, so to adapt and grow from it.

Finally, Logotherapeutic interventions exist to support the spiritual development of meaning-making. One such Logotherapeutic intervention is the use of meaning-oriented art therapy (Marshall & Marshall, 2012). Abstract Logotherapy exercises such as these are shown to promote hope and can be used for promoting goal directed behaviour through defining therapeutic objectives.

All of the D.R.E.A.M.-O.F. program activities use creative, hands-on engagement. Play and creativity are the language of children (Malchodi, 2014), therefore, potentially fostering meaningful family engagement in the program. Meaningful engagement, as noted, is associated with positive mental health (Armstrong, 2009; Armstrong, 2018; Armstrong, 2018; Armstrong et

al., 2018, Armstrong et al., 2019; Armstrong et al., *in press;* Ivtzan et al., 2016; Marshall & Marshall, 2012).

Incorporating Attachment Theory, PP2.0 and Logotherapy Theory into Existing Interventions and Family Therapy Approaches

A number of existing interventions and family therapy approaches were explored and adapted in order to incorporate elements of the aforementioned theories. Prior to refinement of the units, based on stakeholder feedback, the initial draft of the program explored the following ideas (below). Detailed descriptions of the final five family program units can be found in **Appendix A**, as well as further elaborated on in the Discussion, as all units were refined or altered following a stakeholder focus group.

Assessment and Goal-setting. Assessment can be an important educational tool for families hoping to establish whole-family objectives aiming to promote positive goal directed behaviour and improve family functioning. A Family Portrait (Lowenstein, 2010) is a tool used to help families assess their current family functioning, while defining hopes and directions in which they desire to move their family towards. The family is asked to draw a picture depicting the current state of the family, followed by a drawing of what they would prefer their family to be. The Gottman Institute's (2012) Sound Relationship House exercise, as well as the Family Portrait, were together adapted to create the mapping of the D.R.E.A.M.-O.F. Family Tree and the Family Tree Roots exercise that incorporates elements of Attachment theory, PP2.0 and Logotherapy theory. Like the Family Portrait, the Family Tree Roots unit, the first unit involved in "growing" the Family Tree, is an assessment tool with creative engagement for the whole family. This initial unit aims to support families in identifying the foundational goals needed to grow their Family Tree. Similar to the Sound Relationship House, the Family Tree Roots unit

supports opportunities to create moments of shared meaning, positive and optimistic attitudes and the development of personal dreams and aspirations in order obtain optimal family outcomes (Gottman Institute, 2012), especially for families who are struggling on mental health service waitlists where these opportunities may be limited or non-existent. In the Sound Relationship House, the goal "opportunities to create shared-meaning" (Gottman Institute, 2012) can facilitate meaning-building exercises to promote positive interactions within the family. Building on this, "positive and optimistic attitudes" can be obtained through incorporating PP 2.0 techniques and "development of personal dreams and aspirations" can be adapted to create personal, meaningful goals through Frankl's three domains of meaning. Finally, the Gottman Institute's (2012) Sound Relationship House promotes the development of trust, conflict management, attunement and the sharing of positive emotional interactions. Each of these is linked to the development of secure attachment, and can be potentially obtained through including attachment exercises such as CPS. The Family Tree Roots was created with the aim of developing goals consistent with Logotherapy theoy, Attachment theory and PP 2.0 theory literature that promotes meaning-making and therefore, hopefully, resilience.

Goal Development and Follow-through. Supporting families in committing to the whole-family objectives, as defined by families in the Family Tree Root exercise, could be invaluable for promoting positive family functioning. Therefore, the program units were designed to support the fruition of these goals through adapting or borrowing theory from a number of validated, currently existing techniques.

The Family Memory Branch unit, another aspect of the program supporting the development of the Family Tree, works to highlight the benefits of meaningful engagement while potentially promoting opportunities for families to reflect upon existing memories and to

create new meaningful memories. Highlighted in this unit is the importance of meaningful engagement and how it can be derived from positive attitudes, identifying what aspects of a situation are important and from striving to create things in life, such as significant memories. Originally based on an idea derived from the Box of Memories exercise (Lowenstein, 2010), a technique used to enhance family communication skills and increase cohesion among family members. Through expressive art therapy, each family member shares a positive memory of something they have experienced together as a family unit. A series of questions guide the family in deciphering what about the selected memory was positive for them.

Another branch supporting the development of the Family Tree is the Family Strengths and Growth Branch unit. This branch shares some similarities to the Family Memory Branch in that the goal of the branch is to foster meaningful engagement with the addition to potentially promote the development of resilience through deriving meaning from experiences that are both good and/or challenging. Highlighted in this unit is the importance of when circumstances are challenging, how it can be helpful to explore a difficult situation and focus on what strengths were utilized or what aspects of personal growth may have occurred or can occur from the experience. This unit is originally based on an idea derived from the Family Strengths and Needs game (Lowenstein, 2010) that aims to identify strengths and needs within the family and increase opportunities for communication and connection. Through the use of flash cards, a family is asked to identify strengths in relation to certain areas in their life. When a family struggles to identify strengths it is an indicator of an area in need.

For families struggling on long mental health service lists, it can sometimes be difficult to identify positive memories and strengths. Using techniques derived out of PP 2.0 theory and Logotherapy theory, the Family Strengths and Needs Game and the Box of Memories exercise

interventions were together adapted to incorporate elements of meaning-making and post-traumatic growth. For example, one of the ways the Box of Memories exercise was adapted was by asking the family to identify a meaningful memory, rather than limiting selection to positive memory. Following a post-traumatic growth model (Ivtzan et al., 2016), personal strengths, family cohesion and new life possibilities could be developed in relation to the selected memory. Similarly, the Family Strengths and Needs game was adapted to support goal development through not only identifying strengths but also areas of growth.

Both of the above mentioned exercises are aimed at fostering family connection and attunement, potentially promoting secure attachment development. Dream Enacting with a Family is another exercise that can help to facilitate positive emotional interactions, communication and family connection. This exercise can help a family be empathic and attuned to one another's needs. Dream Enacting (Lowenstein, 2010) was originally designed to help parents develop attunement and empathy with their child, as it is the child who leads this activity and it is the parents who follow the child's lead, but similar to Virgina Satir's family sculpting (1983), this activity can be adapted to allow every member of the family take the part of the director. This could be achieved by having each member of the family describe a dream and the associated emotions. Then, different members of the family would be selected to play the objects and parts in their dream, aimed at creating empathy, emotional attunement and promoting the development of trust. The exercise appears to use both aspects of CPS and play therapy and also allows for creativity and authenticity to develop, two characteristics important for meaning-making. The Family Apple-y Ever After unit, another aspect of the program contributing to the development of the Family Tree, highlights the importance of developing an environment that fosters opportunities for positive interactions such as addressing issues of difficulty through

communication and adaptability, as these are shown to be important elements for healthy family functioning. This unit was originally designed around properties of CPS, with the belief being that an exercise based on CPS, like the Dream Enacting or family sculpting exercise, could be particularly useful for families struggling on mental health service waitlists, as disconnection and family distress often contribute to lower levels of felt empathy and attunement (Greene, 2010). Following stakeholder feedback, this exercise was instead replaced by the IMAGO dialogue exercise. The IMAGO dialogue exercise follows three steps to effective communication: listening, understanding and empathizing (Reichlin, 2019). Each member of the communicating-duo takes a turn playing the part of the sender or the receiver while discussing a particular issue. This ensures that both members of the duo feel validated and heard, promoting communication and problem solving (Reichlin, 2019). Through creating an experience of safety with one another, it allows the duo to move beyond conflict and difficult topics in order to work together to identify and meet each other's needs (Reichlin, 2019).

The final unit of the program, May the Forest Be with You, was designed to address issues of parental-isolation, and difficulties of navigating the mental health system, that were identified through primary and secondary needs assessments. As navigating the mental health system is one of the biggest barriers faced by families trying to seek support services, through creating a parent-friendly platform for personal testimonies, forums, events and resources, this unit was designed to educate parents on the types of resources available and how to advocate for their child. For the purpose of the pilot study, families were provided with a list of local resources, both fee and non-fee based, that could be helpful for addressing some of their needs.

The D.R.E.A.M. Program. Although there are few existing mental health promotion programs centering on meaning-making, aiming at resilience promotion, one such program

known as D.R.E.A.M. has been developed. This program combines principles of Logotherapy, PP 2.0, Rational Emotive therapy and Attachment theory, including meaningful engagement in creative activities (art, drama, games, and music), to develop broad-scale resilience through targeting internalizing and externalizing symptoms of child mental illness, as well as stigma reduction and enhanced mental health literacy (Armstrong, 2016). One gap in D.R.E.A.M. is that it does not include family-based mental health promotion strategies, as strategies are child-centred and classroom or community group-based. This program does, however, include a take-home parent manual of child homework activities to discuss with parents, but no parent-directed strategies. As child mental illness and long waitlists can create significant, whole-family stress, fostering whole-family resilience may be critical (CIHR, 2010; Waddell et al, 2007). Thus, building on the D.R.E.A.M. program, the current study aims to carry out this program with whole families in addition to adding specific family-directed units founded in Attachment theory, PP 2.0, and Logotherapy theory.

Novel Contributions

The Mental Health Commission of Canada (2012) recommends that the aim of knowledge mobilization be prevention programs targeted at resilience and optimizing child and youth mental health development. According to Mrazek & Haggerty (1994), regardless of the type of prevention program, whether family programs, at-risk youth programs or universal programs, all could be strengthened through a committed effort to promote resilience (Mrazek & Haggerty, 1994). Despite these recommendations and an increasing amount of literature focused on the importance of resilience, very few of these types of programs exist (Lean & Colucci, 2013). The programs that do currently exist narrowly focus on singular disorders. In addition,

many of them lack effective program implementation, a critical factor in determining the success of a program (Kumpfer, 2002; Lean & Colucci, 2013).

Mental illness is defined as internalizing and externalizing behavioural symptoms (DSM-5, 2013) and an unnecessary amount of Canadian children continue to struggle with mental illness into adulthood (Kessler et al., 2005), even though research continues to demonstrate that childhood mental illness and the issues associated with it could be significantly reduced through effective promotion and prevention programs (Compas et al., 2001). To date, few mental health promotion approaches exist for children and their families on long waiting lists. Those emerging programs that do exist tend to be hospital-based and not aimed at those waiting for mental health services in the community. Collectively, based on the literature, *positive family functioning* can be defined as constructive family interactions including, but not limited to, effective communication, identification of family strengths and adaptive coping skills (Bowlby, 1969; Cassidy & Shaver, 2016; Ivtzan et al., 2016; Stratton, Bland, Janes, & Lask, 2010). Furthermore, many of the aspects identified as necessary for development of positive family functioning are related the meaningful engagement. *Meaning in daily life* can be defined as agency over thoughts and behaviours; openness to feelings, social connection, learning, creativity and engagement in meaningful pursuits; hope for the future; and positive self-concept (Armstrong et al., 2019; Frankl, 1986; Marshall & Marshall, 2012; Ivtzan et al., 2016). As previously noted, few programs for families that work to enhance “meaning” in order to improve wellbeing exist. Therefore, a lack of programming for families on mental health waitlists can result in a worsening of symptoms, a requirement for more in-depth treatment, and consequently, longer wait periods for others. Ideally, a mental health education program for children and families on waitlists would provide educational tools that could reduce symptoms, increase child and family

resilience, decrease service time needed and, in turn, shorten waitlists. Such educational tools could be aimed at enhancing positive family functioning and meaning in daily life.

Family Systems Theory & Why the Family Needs to be Engaged in Program Design. Family Systems Theory postulates that all members of a family are interconnected through a series of multifaceted interactions (Broderick, 1993). In order to understand the actions of one individual, the family needs to be regarded as a system (Broderick, 1993). Due to the family being an interdependent unit, a variation in one person's behavior can influence the functioning of another, which can systematically have consequences on the family as a whole (Broderick, 1993). Considering the family from this perspective, it is easy to argue that children's therapy should be viewed as family therapy. Low family engagement and family retention in the therapeutic process is a significant issue (Ingoldsby, 2010). Many of the programs that exist today, including the ones described previously, are catered towards the child as an individual rather than the family as a whole. Lack of family involvement in the treatment process is cited as one of the main barriers to effective treatment (Ingoldsby, 2010). Additionally, the viewpoint that the family is part of the problem, rather than including them as part of the solution, is a perspective still held by many professionals today (Corrigan & Miller, 2004). Other barriers to family involvement and retention in therapy include: waitlists, time demands, costs, deficiency of addressing family needs with a treatment approach and a lack of guidance in how to navigate the system (Ingoldsby, 2010). Although a number of studies have made suggestions on how to overcome these obstacles (Beeber et al. 2007; Watt & Dadds, 2007), many programs fail to incorporate them (Ingoldsby, 2010). This is, a further gap in the research literature and in mental health promotion programming that the D.R.E.A.M-O.F. program aims to address.

Stakeholder Engagement and Needs Assessment Methodology. The importance of engaging families is now recognized as the "gold standard" in providing quality child mental health services (Ingoldsby, 2010). Therefore, when developing a program for families who are delayed in accessing child mental health services, it is important to consider what some of the needs of those families may be. In the current study, one way that the needs of families on waitlists were identified was through needs assessment methodology. Needs assessment methodology can be used to form part of the evaluation piece of a program, and is critical for determining program design and implementation, such as the development of a program logic model (McDavid, Huse, & Hawthorn, 2018). Logic models can help guide the development of research and program design. Specifically, program strategies and goals are simplified and organized through logical flow, demonstrating how anticipated outcomes can be achieved (Public Health Ontario, 2016). Depending on the type of research conducted and desired program outcome, different types of logic models can be used (McDavid et al., 2018; Public Health Ontario, 2016). Most logic models follow a similar sequence of steps and stages, outlining a number of components including: goals, inputs, activities, audience, outputs and outcomes (Public Health Ontario, 2016). Given that this program is modeled and designed around the primary needs assessed of Ontario residence, for the purpose of the current study, the same components outlined by Public Health Ontario for program evaluation (2016) were used for the creation of a logic model (See **Figure 1.)**

Needs assessment methodology can also be useful for recognizing overlooked groups of society (McDavid et al., 2018), such as families on mental health waitlists. Through completing a needs assessment, the discrepancy between the current condition, delayed access to mental health services and the desired condition, accessible, timely interventions for families struggling

with mental illness, could be clearly identified and defined (McDavid & Hawthorn, 2006; McDavid, et al., 2018). Through identifying and defining needs, it can be determined what is required to address the gaps in research and service delivery (McDavid & Hawthorn, 2006; McDavid, et al., 2018). This can be of particular importance when developing a program for children and their families who are delayed in accessing services, in part due to the fact that few programs exist for families struggling on mental health waitlists.

When developing a program for families on mental health waitlists, such as a mental health promotion program, it is vital that families be included in the program evaluation process. This is consistent with current research demonstrating that when program consumers take part in the evaluation process, a program is more likely to meet users needs (Armstrong, 2009; McDavid & Hawthorn, 2006; McDavid, et al., 2018). As a result, program improvements and decision-making are more likely to be effective (Armstrong, 2009; McDavid & Hawthorn, 2006; McDavid, et al., 2018). One way this can be achieved is through adhering to the steps of Patton's Utilization-Focused Evaluation (UFE) model (1984), including the completion of a needs assessment (Armstrong, 2009). UFE approaches program evaluation by including individuals who will be using the program in the evaluation process. UFE embodies the philosophy that how useful a program is should be judged by its usefulness to the program's intended users (Armstrong, 2009; Patton, 1984). UFE has five fundamental elements: First, identify primary intended users in this case families on mental health waitlists. Second, personally engage these individuals so to clearly identify their needs for a program. In this case, families were engaged in the program development through a focus group. Third, ensure that users and stakeholders are well informed to what the active role they will play in program development process is. In the present study, through the distribution of a recruitment letter (See **Appendix B**), recruitment

poster (See **Appendix C**) consent form (See **Appendix D**) and informative discussions, stakeholders were informed what role they could play. Fourth, incorporate recommendations and implement suggestions made by the users. In this case, modification was made to the original design of the program units in order to incorporate user feedback. The final and fifth stage is to incorporate evaluation standards to ensure the program meets the requirements of a good program. In the present study, the research followed a Knowledge Translation-Integrated (KTI) model (Armstrong, 2009; Armstrong, 2018; Armstrong, 2018; Armstrong et al., 2018, Armstrong et al., 2019; Armstrong et al., *in press*; Graham et al., 2006). KTI is collaborative approach to program development involving an interactive relationship between the program developers and program users (Armstrong, 2009; Armstrong, 2018; Armstrong, 2018; Armstrong et al., 2018, Armstrong et al., 2019; Armstrong et al., *in press*). Program users are involved throughout the program development process and their feedback is incorporated into the program model (Armstrong, 2009; Armstrong, 2018; Armstrong, 2018; Armstrong et al., 2018, Armstrong et al., 2019; Armstrong et al., *in press*). Involving key decision-makers in the knowledge creation and action process helps to promote continued stakeholder involvement and investment, potentially leading to more effective results that are needed to support change (Armstrong, 2009; Armstrong, 2018; Armstrong, 2018; Armstrong et al., 2018, Armstrong et al., 2019; Armstrong et al., *in press*; Patton, 1984). Therefore, a KTI approach aims to promote that the research and resulting developed program accurately reflects the needs of those most likely to use the program. This can help maximize the potential that the developed program will meet the utility and scientific standards of a good mental health promotion program: that is, the program is acceptable, credible, feasible and sustainable (Armstrong, 2009; Armstrong, 2018; Armstrong, 2018; Armstrong et al., 2018, Armstrong et al., 2019; Armstrong et al., *in press*; McDavid &

Hawthorn, 2006). For the purpose of this study, these terms can be defined as follows: *Acceptability* is in reference to how appealing a program is to families. *Credibility* refers to how well the program actually meets the needs of families. A credible program also has face validity, therefore a program appears that it will meet the needs of families and they are more likely to try using it. *Feasibility* refers to ease in implementing and using a program. *Sustainability* refers to the likelihood that a family will continue to use a program. A KTI approach helps to promote program acceptability, credibility, feasibility and sustainability through addressing potential program usage barriers (Armstrong, 2009; Armstrong, 2018; Armstrong, 2018; Armstrong et al., 2018, Armstrong et al., 2019; Armstrong et al., *in press*). The families who took part in the focus group were then invited to participate in the program that incorporated the recommendations and suggestions they gave to help address the mental health needs of families who are delayed in accessing child mental health services. Furthermore, families provided feedback after having completed the program units so that their suggestions and recommendations could be further incorporated into the evolving program design. Therefore, identified needs of the program users guided the decisions made throughout the whole program development process.

Conducting needs assessment methodological research, engaging families in the program development process, not only ensures the feasibility that the mental health promotion program meets the family's needs but also enhances acceptability through face-validity, thus potentially creating initial program user buy-in. Furthermore, it ensures the program does what it should, leading to sustained knowledge usage (Graham et al., 2006). Credibility can then likely be expected when assessing, qualitatively and quantitatively, whether program application has resulted in the desired outcome. Thus, engaging stakeholders in program design and providing

ongoing feedback to knowledge users can potentially lead to greater buy-in, use and success of the mental health promotion program for families on waitlists.

Research Question and Hypothesis. In addition to building on the D.R.E.A.M program, the overarching purpose of the proposed research was to develop a brief mental health promotion approach for families, specifically, on mental health waitlists. Ultimately, the goal of this research was to examine whether family units, grounded in Attachment theory, PP2.0 and Logotherapy theory grafted onto the existing D.R.E.A.M. program would promote meaning, positive family functioning, and also reduce self-reported and parent-reported child mental health symptoms. While adhering to the KTI model, supporting the development of acceptability, credibility, feasibility and sustainability of a program, five family-based units were developed to make the D.R.E.A.M. program more applicable for both children and their families who had experienced delays in accessing services. The units were grounded in a literature-based and stakeholder-engaged needs assessment.

It was hypothesized that the new, adapted version D.R.E.A.M. program, D.R.E.A.M.-O.F. (Online for Families), would provide families on mental health waitlists with the skills to begin addressing concerns, aimed at promoting resilience. Specifically, it was expected that this program would promote child mental health, positive family functioning, and meaning through targeting: child symptoms of mental illness (internalizing and externalizing behavioural symptoms), family interactions noted in the literature as important for positive functioning (communication, family strengths and adaptive coping skills), as well as child and adult perceptions of meaning in daily life (defined previously as perceived agency over thoughts and behaviours, hope for the future, self-esteem, and openness to experience). Furthermore, previous research findings show that child self-reported meaning in daily life is predictive of child mental

health scores (Armstrong, 2009; Armstrong, 2018; Armstrong, 2018; Armstrong et al., 2018, Armstrong et al., 2019; Armstrong et al., *in press*; St. John, 2017), and meaning is also predictive of adult mental health (Wong & Fry, 1998; Wong, 2010, Wong & Wong, 2006; Frankl, 1986). In turn, adult mental health is predictive of child mental health (Coyl, et al., 2002; Freeman et al., 2008; Mackenzie et al., 2011; Sawyer et al., 2006). Therefore, it is expected that in the present study, self-reported child and parent daily meaning in life will predict self- and parent-reported child mental health scores. Longer-term outcomes not measured in the present pilot study would hopefully include reducing service time needed and ultimately shorter waitlists.

Due to the short-term nature of this study, although it was expected that the D.R.E.A.M.-O.F. program would be associated with the promotion of daily adult meaning in life, aspects of personal meaning such as overall purpose in life may be less likely to change during the short duration of the study. Adult purpose in life has been used to measure more stable aspects of a person such as their personality (Zika & Chamberlain, 1992) and, therefore, may be less likely to change over a short period of time. If measures of daily meaning in life demonstrate positive change from pre-program to post-program, while purpose in life remains stable, then it can potentially be assumed that participants did not simply respond favourably to please the researcher. Thus, it is expected that self-reported meaning in daily life scores will improve, hopefully as a function of the program, while purpose in life will remain stable.

Finally, given the value previously noted in the literature of engaging whole families, rather than children alone, it is expected that the addition of the five family units may yield a larger effect size than found in previous research with the D.R.E.A.M. program alone.

CHAPTER TWO

METHODOLOGY

Study One

The needs assessment methodology was completed through combining primary and secondary sources of data, including a focus group with stakeholders and a literature review. Specifically, a literature review formed the secondary source of data through the construction of a meta-needs assessment. A meta-needs assessment is often composed of secondary sources of data and allows for a comprehensive examination of valuable information used to identify public needs, and how they can best be addressed (Gaber, 2008; McDavid & Hawthorn, 2018) The meta-needs assessment for the current study was synthesized in the form of a literature review using data from relevant studies such as demographic statistics and government reports. For example, informational data was extrapolated from relevant sources of information on the following: rates of childhood mental illness, Canadian mental health wait times, the effects of mental illness on children and their families, optimal outcomes for families struggling with mental illness and delayed access to services, effective e-therapies, existing family interventions and information on Attachment theory, Logotherapy theory and PP2.0. To date, programs for families on waitlists are limited, but best practices from treatment programs and prevention literature in general can be synthesized in the needs assessment. The needs assessment from existing research comprises the literature review of this dissertation. To access primary sources of data, and engage stakeholders themselves in program development, a focus group was conducted.

The focus group portion of the needs assessment, forming the primary source of data, was held on a Saturday afternoon, during an hour and half time slot, at the Saint Paul University

Counselling and Psychotherapy Centre. On the day of the assessment, prior to commencing with the focus-group discussion, consent forms were distributed to each adult participant. This allowed for time to address any questions or concerns regarding participation, including that the focus group discussion would be auditorily recorded. During the focus-group, open-ended questions (See **Appendix E**) were used to guide discussions and to answer the particular evaluation question: How to develop an effective online, mental health promotion program for families, who have experienced delays in accessing or using mental health services that would meet their needs? Specifically, through a KTI framework, to meet stakeholder needs, the questions served to address the utility standards of a good program: What would make the program acceptable, credible, feasible, and sustainable for families on waitlists. The experiences and needs of the families were then integrated to collaboratively develop program objectives and a program logic model. Families were also presented with suggested family unit activities, grounded in the theoretical research literature, and stakeholder feedback was used to refine these activities in order to better fit their needs.

Participants. The majority of childhood mental illnesses manifest, and become evident, during the development period between the ages of 6 to 12 (Morrison, 2014), with a documented median age of 11 for both anxiety and impulse control disorders (Kessler & et al., 2005). Therefore, children ages 6 to 12, and their families who had lived experience of being on mental health waiting lists, were recruited. Participants came from a variety of sources including local health clinics such as the Children's Hospital of Eastern Ontario and Family Services Ottawa, an organization which has a longstanding relationship with Saint-Paul University. Furthermore, both rural and urban psychological private practices were contacted. It is recommended that a minimum of eight to 10 participants be recruited to meet the ideal focus group size (Morgan,

1977). In order to account for potential attrition, 10 to 12 families were sought out with four families taking part in the focus group discussion, for a total of 13 participants. The 13 participants came from one single parent family, one blended family and two nuclear families. The children (*n*= 6) *ranged* in age from 6 to 11 and all families reported some form of difficulty in accessing or using mental health services.

Transcribing and Coding. In order to minimize potential bias, a scribe was used to take field notes and a research assistant was engaged to code the data. This allowed for an interpretive phenomenological approach to be taken and rich experiential data to be collected, ensuring that the experiences of the families and their needs could be fully understood. Furthermore, an auditory recording device was used to create an exact transcript of the focus group discussion. Fereday & Muir-Chochrane (2006) suggest coding segments of data when conducting thematic analysis. Following these recommendations, the transcript was segmented into sections and the data was coded using Braun & Clarke's (2006) six steps to thematic analysis. Further, the software program NVivo (QSR International, 2018), which allows for extensive levels of analysis, aided in placing data into thematic categories. Adhering to suggestions made by McDavid & Hawthorn (2006), and the six steps to thematic analysis (Braun & Clarke, 2006), coding was completed by the lead researcher by hand and also a research assistant who used NVivo (QSR International, 2018). The results of the coding were then discussed amongst three knowledge user mental health practitioners, including the lead researcher and research assistant, so to collaboratively agree on collective interpretation. This multilevel analysis approach helped to reduce any potential bias and address any incidences of coding discrepancies. It is important to note that, because this methodology follows a grounded theory approach, some natural bias can be expected. For example, if coding discrepancies are

identified, Blair (2015) suggests attending to this normative occurrence by addressing potential rater assumptions and subjectivity through acknowledging this within the manuscript. The next step in the analysis involved constructing narratives to promote the accuracy and authenticity of depicting the experiences reported by the focus group members (Fereday & Muir-Chochrane, 2006): families who experienced delays in accessing mental health services.

Study Two

Following the completion of the focus group, using data, feedback and suggestions from the families, a first-draft of the program was created. In addition to the feedback collected from the families, a class of 25 Graduate level Psychotherapy students, who could be potential future users of the D.R.E.A.M.-O.F. toolkit when they have waitlists, were also consulted around the design of program implementation and components. More specifically, they were consulted in this needs assessment to make sure that the program met the scientific standards of a quality program for use by mental health practitioners with clients on waitlists: Is it acceptable, credible, feasible, and sustainable (Armstrong, 2009; Armstrong, 2018; Armstrong, 2018; Armstrong et al., 2018, Armstrong et al., 2019; Armstrong et al., *in press*)? The program unit descriptions (the five new units) were given to the Psychotherapy graduate students, who formed into groups and assessed the preliminary program. Following the individual group discussions, a whole-group discussion was held in which the psychotherapy graduate students collaboratively shared and discussed ideas and provided constructive feedback for the program. A collective agreement was made on which changes were imperative and should be implemented in order to enhance the acceptability, credibility, feasibility and sustainability of the program.

Using the information gathered from all sources of primary and secondary needs assessments, the program was designed, refined and constructed, resulting in five-family based

units to graft onto the existing D.R.E.A.M. program.

Participants. Upon refinement of materials, based on the stakeholder feedback, a *pilot* evaluability assessment was carried out with nine families, with children ranging in age from 6 to 11, who had lived experienced of delays in accessing services, for a total of 24 participants. Of the 24 participants, 11 were children: five boys and six girls. Each family participating indicated having a child who had been delayed to accessing mental health services for a minimum of a year or longer or was currently on a mental health waitlist. The same 13 participants from the focus group were invited to participate in the program so that they could provide further constructive suggestions on the program administration procedure and content. A total of three out of the four families from the focus group took part in the pilot assessment of the program.

Program Implementation. Each of the D.R.E.A.M.-O.F. units were adapted to incorporate elements of a simple artistic craft in order to promote child-friendly usability and promote visual appeal, and were completed with a print out of a large tree (See **Appendix F**). Each family group was provided with an envelope containing a series of materials to create their "Family Tree" and a handout with instructions. However, verbal instructions were delivered as well. Each of the five whole-family units were labeled in accordance to their objectives: 1. Family Tree Roots (Goal-setting), 2. Family Memory Branch, 3. Apple-y Ever After, 4. Family Strengths and Growth Branch and 5. May the Forest Be With You. Content of the units was woven in with facts related to needs of participants' Family Trees to promote further educational development and family fun. Finally, each of the five whole-family units were grafted onto the original D.R.E.A.M. program (See **Appendix G**). As mentioned, the D.R.E.A.M. program combines principles of Logotherapy, Second Wave Positive Psychology, Rational Emotive therapy and Attachment theory aimed at developing broad-scale resilience through targeting internalizing and

externalizing symptoms of child mental illness. Through 10 brief units, the D.R.E.A.M. program aims to provide mental health information to counter stigma and myths, develop emotional regulation through teaching emotion recognition skills as positive signs for action or attitudinal change and how to develop healthy actions and attitudes in order to create self-discovery, personal agency, and awareness of responsibility to find both short-term and long-term meaningful goals. The D.R.E.A.M. program may be helpful for family mental health as it uses songs and hands-on activities that foster self-esteem, openness to experiences, perceived choice and hope. All of these elements are associated with meaning-making and resilience and therefore positive mental health promotion (Armstrong, 2009; Armstrong, 2018; Armstrong, 2018; Armstrong et al., 2018, Armstrong et al., 2019; Armstrong et al., *in press*). However, as mentioned, the original D.R.E.A.M program is not a whole-family program, therefore the development of whole-family units for D.R.E.A.M.-O.F., derived from Attachment theory, PP2.0 and Logotherapy theory were determined to be potentially optimal for building whole-family resilience, as previous research noted the importance of whole-family inclusion and specific topic areas relevant for family wellbeing (Ingoldsby, 2010).

The program was conducted for three, 2-hour sessions ranging across three Saturdays, spanning over a month. The first Saturday consisted of only the five new D.R.E.A.M.-O.F. units. The purpose of running the family units first, in isolation from the rest of the program, was to evaluate the participant's satisfaction regarding the five family-units. At the end of the first 2-hour session, each participant, including children, were administered a visual analog satisfaction scale (See **Appendix H**). The surveys were designed to assess the five family units' acceptability, credibility, feasibility, and sustainability based on the participants' feedback. Feedback for refinement was also sought from participants in a group discussion and the families

were given the opportunity to make written suggestions on ways in which the program could improve to better suit their needs and those of other families in similar situations. The surveys were completed anonymously and the lead researcher exited the room during the time of their completion. The following two Saturdays consisted of running the original D.R.E.A.M. program's 10 units. The first six D.R.E.A.M. units were carried out on the second Saturday and the final four units were run on the third Saturday.

At the completion of each program administration day, the families were given take-home notes or booklets to support the continued use of the program while in the family-home environment. Furthermore, the families were provided with a list of local and online mental health resources to further support them following the completion of the program.

Measures. To assess program credibility, pre- and post-test measures were administered to the families via online questionnaires using the platform Survey Monkey. Before commencing with the first survey, families were asked to complete an online consent form (See **Appendix I**). The following pre-post measures were used to provide a preliminary evaluation of the D.R.E.A.M. program with the addition of the family units (D.R.E.A.M.-O.F.). These measures can be found in **Appendix J**. All measures were selected given their alignment with the definitions discussed previously in the literature review:

- Resilience to internalizing and externalizing behavioural symptoms (measured by the Interactive Symptom Assessment [I.S.A.]) (Armstrong et al., *in press*). The ISA is a 12-item self-report measure of internalizing and externalizing mental health symptoms, with each item ranging on a 10-point sliding scale from problematic to optimal functioning in a given area. The measure is used to assess optimal psychological and behavioural functioning in children ages six and older (vs. symptoms). Specifically, for 6 to 12-year-

olds, this measure assesses: mood symptoms, conduct concerns, anxiety symptoms, obsessions and compulsions, attention deficit symptoms and issues with self-esteem. Internal consistence reliability was good (α = .88), and the measure displayed convergent validity with self-esteem (i.e., measured by the Single Item Self-Esteem Scale) and other mental health measures (i.e., ONS Personal Wellbeing Scale; Short Warwick-Edinburgh Mental Wellbeing Scale), and good test-retest reliability ($r = .86$, $p < .001$). Both the I.S.A. child form (self-report) and the adult form (reporting on child) were used. This measure was used in previous research to evaluate the original D.R.E.A.M. program;

- Resilience to internalizing and externalizing behavioural symptoms (measured by the Strengths and Difficulties Questionnaire [SDQ]- parent-version and self-report version)(Goodman, 2001). This 25-item questionnaire assesses positive and negative behavioural attributes in children and youth aged four to 17, spanning across five categories including: emotional symptoms, peer problems, hyperactivity/inattention, prosocial behaviour and conduct problems. Questions are answered using a three-point Likert scale. For example, in response to the question "Often loses temper" the respondent can choose: 1. Not true, 2. Somewhat true or 3. Certainly true. Respondents are asked to complete the questionnaire in reference to behaviours over the past six months or previous school year. The SDQ is found to have good concurrent and discriminant validity, with differing findings on internal consistency ranging from strong to satisfactory (Goodman, 2001);
- Positive family functioning was measured by the (Systemic Clinical Outcome and Routine Evaluation [SCORE]) -15 Index of Family Functioning and Change. The SCORE-15 is a derivative, short-form version of the SCORE-40 (Stratton et al., 2010)

and measures changes within family interactions that are found to be important for therapeutic change or in need of therapy. This self-report scale is designed to be completed by each individual family member, aged eight or older, or together as a group. The scale is organized into three dimensions, strengths and adaptability, overwhelmed by difficulty, and disrupted communication. The respondent answers questions relevant to each dimension from their perception of the situation within the family along a continuum of responses on a Likert scale 1 to 5. For example, a question from the strength's dimension is "we trust each other". The respondent can then choose from: Describes us 1. Very well, 2. Well, 3. Partly, 4. Not well and 5. Not at all. The SCORE-15 demonstrates good internal reliability with a Cronbach's alpha of .90 and good criterion validity, distinguishing between non-clinical and clinical cases (Stratton et al, 2010);

- Meaning in daily life (measured by the Child Identity and Purpose Questionnaire-Interactive ([Ch.I.P.-I]; Armstrong et al., 2019). The Ch.I.P.-I (short-form) is a measure of "meaning in daily life" for children (ages 6 to 12) via a 12-item self-report scale. Included in this measure are aspects of meaning such as: agency over thoughts and behavior; openness to feelings, social connection, learning, creativity and engagement in meaningful pursuits; hope for the future; and positive self-concept. Scores for each item range from 0 to 10. A button slider for respondents to select their answer lies beneath a still image that appears at the end of each video clip. For example, "When things aren't going well for Chip, he thinks he can come up with ways to fix the problem / when things aren't going well for Ceira, she thinks she can't come up with ways to solve the problem." If a child was completely like Chip this week for this item, this child was

verbally instructed to move the slider to the far end under Chip (score of 10). If a child was a bit like Chip this week for this item, then this child would click part way along the line under the image of Chip. If they were more like Ceira, then they would be instructed to move the slider under Ceira instead. For children who can or prefer to read, the item text is also provided under each video recording, so that children may use the text instead of watching the videos. The Ch.I.P.-I measure has demonstrated good internal consistency reliability with a Cronbach's alpha of .81. Furthermore, good criterion-related validity was determined, as the Ch.I.P.-I significantly correlated with other measures of agency, self-esteem, hope, and openness to experience ($p < .05$). In regard to predictive validity, the Ch.I.P.-I significantly predicted mental health scores ($p < .05$). Test-retest reliability over a 1-week period was also assessed and pre-test and post-test results were significantly correlated ($p < .05$). Both the Ch.I.P.-I child form (self-report) and the adult form (self-report) were used. The Ch.I.P.-I measure was used in previous research to evaluate the original D.R.E.A.M. program. Assessment of meaning in daily life for adults also included agency, positive self-concept, hope for the future and openness to experience (Adult Identity and Meaning Scale [AIMS]; Armstrong, *unpublished data*). The AIM is a self-report, text-based measure in which Ch.I.P.-I content was slightly re-worded for better application to adults, involving the same sliding scale and scoring system as the Ch.I.P.-I. The measure has displayed convergent validity as it was correlated with a related concept (overall meaning in life): $r = .84$, $p < .001$, as assessed by the Purpose in Life Test ([PIL] Crumbaugh & Maholick, 1964). The PIL will also be administered to adults in the current study to further support the validity of the AIMS in the present research. This initial validation of the AIMS yielded a

Cronbacks alpha of .96. (Armstrong, *unpublished data*);

- Adult perceptions of purpose in life (Adult Purpose in Life Questionnaire [PIL])(Craumbaugh and Maholick, 1964). This 20-item, self-report scale is used to assess a variety of life purposes including the measure of relationship between the existential concept of purposes in life and existential frustration. Derived from Logotherapy theory (Frankl, 1959), this measurement operates from a score continuum of 1 to 5 with lower scores representing low purpose and higher scores representing high purpose. Respondents are asked to select a response to a statement that is most true for them in the current moment. For example, for the statement "Life seems to me" a respondent could choose 1. Completely routine---2---3---4---5. Always exciting. For the statement "My life is" a respondent could choose 1. Empty filled only with despair---2---3---4---5. Running over with exciting things. The PIL has a Cronbachs alpha of .91 with good convergent and discriminate validity. This measure was included as a means of further validating the adult version of the Ch.I.P.-I (called the Adult Identity and Purpose Scale, AIMS).

The above measures were re-administered to the participants following the completion of the 3-week program.

Data Analysis. Data was analyzed using the Statistical Packages for the Social Sciences version 25.0 (SPSS). Paired sample t-tests were calculated on data representing child mental health symptoms (internalizing and externalizing behaviours), family interactions important for positive functioning (communication, family strengths and coping skills), child and adult perceptions of meaning in daily life (openness, self-esteem, hope for the future, agency over thoughts and behaviours), and adult perceptions of purpose in life. As reported by Winter (2013),

the application of a parametric analysis verses a non-parametric analysis can be carried out with a small sample if the expected effect sizes are large. Thus, parametric t-test analyses were selected for the present study, as past research with the D.R.E.A.M. program yielded medium to large effect sizes. Furthermore, due to the small sample size, an alternative version of Cohen's D was used in order to determine the effect sizes. As suggested by Durlak (2009) the use of the alternative version of Cohen's D is common with samples with less than 50 participants in order to avoid over inflated effect sizes. Finally, a regression analysis was carried out to further explore the potential influence of self-reported child and adult meaning in daily life on adult- and self- reported child mental health concerns.

Results of the data screening and cleaning revealed that several participants had pieces of missing data. The data was categorized as Missing At Random (MAR) and in other cases such as these, it can be suggested to replace the missing data, such as was done with this study (Papageorgiou, Grant, Johanna, Takkenber, & Mokhles, 2018). Due to the fact that less than 20% of the data was missing and that it was MAR, missing values were replaced with regression imputation to prevent significant attrition from the elimination of a participant. Furthermore, missing data patterns were not consistent by family. In some instances, a point of datum was missing from a parent but not from the child of that family or vice versa. Additionally, some measures yielded a higher response rate at both post and pre measure-time then other measures. For example, more parents completed the measures about their child than the children completing the same measures, but the self-report version. This potentially was due to issues with time, as this was a consistent theme throughout the study process with several families inconsistently being able to attend each weekend session (e.g., during the duration of the three weekends of the program, two families were absent due to illness, one family due to serious

injury, one family due to a funeral, two families due to summer camp and one family unknown). However, all families received all of the program units, but some received it at home if they were absent.

CHAPTER THREE

RESULTS

Qualitative Analysis: Thematic analysis

Through an assessment of the focus group transcript, a number of statements were identified and coded by three knowledge user mental health practitioners. This thematic analysis of the focus group transcript (See **Appendix K**) generated three main themes: recommendations, validations and criticism. Triangulation of agreement between the three knowledge user practitioners yielded the following definitions: *Recommendatio*ns can be defined as what the families think they need and what would be helpful for achieving these needs as reported by the participants. *Validations* are what the families report are currently meeting their needs or agreeing that the suggestions made for a program would meet their needs as reported by the participants. *Criticisms* can be defined as what is not currently meeting the needs, would be difficult to meet the needs or a difficulty in seeing how something could meet the needs of families delayed in accessing standard mental health services as reported by the participants.

Each of these themes was then organized by the lead researcher, acting supervisor and a research assistant (using NVivo) into categories following the KTI model which aims to foster acceptability, credibility, feasibility and sustainability. For the purpose of this study, as noted previously but expanded below to specifically refer to families, each aspect of this model can be defined as follows: *Acceptability* is in reference to how appealing a program is to families. For example, the overall appearance or premise of the program is acceptable to families and therefore they are likely to try using it. *Credibility* refers to how well the program actually meets the needs of families. For example, a program is credible because families can rely on the fact that it does what it is supposed to do and is successful in meeting their needs. A credible program

also has face validity, therefore a program appears that it will meet the needs of families and they are more likely to try using it. *Feasibility* refers to ease in implementing and using a program. For example, a good program can be implemented and is easy for families to use. *Sustainability* refers to the likelihood that a family will continue to use a program. For example, sustained use of a program is because a family has found it to be reliable in meeting their needs.

Each of these themes and categories are organized into sections pertaining to the program unit design and secondary needs assessment. Please note: due to the fact that several quotations from the focus group address more than one theme or category, for the purpose of organization, some sentences may have been divided and organized accordingly.

Existing Structure and Delayed Access to Services. The following quotations were either in response to the specific question pertaining to family mental health wait times and mental health services or were otherwise coded as relevant to family mental health wait times and mental health services.

Recommendations. No recommendations were coded in response to questions pertaining to family mental health wait times and mental health services. However, please see below for recommendations made by families for programs for families delayed in accessing child mental health services.

Validations. In response to questions pertaining to family mental health wait times and mental health services, regarding concurrent learning issues, families validated that mental health services, provided for children identified as “intellectually gifted”, are higher in acceptability for meeting their needs than resources for learning disabilities. Furthermore, private mental health sources of support were coded as more credible in meeting the families’ mental health needs than publicly-funded resources (note: see criticisms below for comparison).

Acceptability.

- A2 parent: *"This was a learning disability versus a gifted potential, my experience with the gifted potential has been much more positive [Services were more easily accessed via gifted potential supports]."*

Credibility.

- C2 parent: "*We've sought out counselling due to traumatic experiences that have occurred and so the family doctor was very supportive and we found private counselling quite helpful – for both family and individual-we go in as a family and have a counsellor that is for children."*
- B2 parent*: "I sought private psychology assessment for three of my kids, they were diagnosed for gifted potential and I got the IEP* (Individualized Education Plan) *and IPRC* (Identification, Placement, and Review Committee) *immediately."*

Criticisms. The following were coded as a criticism to what the families determined were not currently meeting their needs in response to questions pertaining to family mental health wait times and mental health services. General practitioners and school resources for mental health services were coded as not reliable and, therefore, were not perceived as credible in meeting the families' needs.

Credibility.

- A2 parent*: "Our GP was not very much help, so if there was something that they could point to, to say start here, that would be helpful [GP was not helpful in supporting family's needs in accessing mental health services]."*

- A2 parent*: "With the school [In accessing mental health supports]? Horribly difficult. Meeting with them was never a problem but they'd have these long to do lists that I'd never see or hear to the point that by the end of the school year the resource teacher was actively avoiding me, and it took nearly two years from the date of assessment to actually get the IEP… nearly two school years"*
- D2 parent: *"We've had different experiences between school boards [In accessing mental health supports], yeah very slow. I think it's also different with their funding or capabilities I don't know, but that's why we went privately. When we went privately it was much quicker, we had assessments done in two months we had results. But it was because the school board was so slow it forced us to go privately. And even through his doctor it was very slow, we waited a year and a half for an appointment."*
- A2 parent: *"Yeah we did the private assessment [for child mental health evaluation], but it was from the private assessment to the IEP that it was nearly two years.*

Goal-setting. The following quotations were either in response to the question pertaining to goal-setting or coded as relevant to the process of goal-setting as part of a family program.

Recommendations. Recommendations for implementing goal-setting into a program centered on whole-family agreement for goal-creation and goals that parallel current family life. Recommendations such as these were viewed as feasible by the families for meeting their needs, particularly if mental health and behavioural issues were addressed first. It was coded as recommended that goals would be sustainable if they revolved around activities that the families enjoyed doing.

Feasibility.

- C2 parent: *"Once we take care of some of those barriers [metal health/behavioural issues] we can sit down and try and focus on something".*
- C1 parent*: "It could be [easier to do] if we identified a natural leading course [to a goal], we see this portion of our lives are so broke we've got to work on it and focus on it."*
- D2 parent*: "Working together though and getting everyone's input [on goals] especially really based on how the children spend time, you know from your own children what they're in to or not, child D2 is nine now and it's nice as he gets older getting his input a little more now in certain situations"*

Sustainability.

- C2 parent: *"And we realize that one of our family goals is to be active. It's not us telling her to be active it's us doing it and her learning by example. We do the long bike rides, swimming. We're out there talking, enjoying, sharing in what it is we're taking part in"*
- C1 parent: *"We have to identify what it is she likes to do, 3km hike in the forest she hates that, but 10km bike ride, she's all over that."*

Validations. The families identified the idea of goal-setting as acceptable in meeting their needs because goal-setting was viewed as important and valuable. The idea of whole-family goal-setting was acceptable because it involved the children's input, and this was identified as important to the families.

Acceptability.

- A2 parent: *"I could see a lot of value in that [goal-setting], including the children and basically getting their buy in, they having a say."*
- C1 parent: *"I think it's important [goal-setting], but I don't think it's something we'd necessarily discuss directly, it's just silently agreed upon, naturally, we don't sit down and say we want to strive for this goal."*
- C2 parent*: "Because it is incredible how they can/ Yes and we kind of underestimate how much they really [trails off][children's desire to share their input]."*
- B1 parent: *"Our family is into music, my kids play various instruments and I find that it's been very supportive to demonstrate to them about growth mindset, setting small goals, looking for short term works."*

Criticisms. The acceptability of goal-setting was challenged in consideration to the fact that it was seen as potentially difficult and not something that was generally discussed. The feasibility of goal implementation was questioned due to the chaotic, reactive functioning of the families.

Acceptability.

- C1 parent: "*But that's not something we generally sit down and discuss over dinner [setting goals]".*
- C2 parent: *"We're up against so much, how can we set a goal when there are so many barriers I have no control over."*

Feasibility.

- C2 parent: *"I think in situations our life is in chaos or turmoil and were striving to dig our way out and figuring out the best way to support our family, it's more of a reactive mode instead of goal oriented."*

Family Communication and Conflict Resolution. The following quotations were either in response to the question pertaining to family communication and conflict resolution or coded as relevant to the process of family communication and conflict resolution as part of a family program.

Recommendations. Families shared recommendations for implementing family communication and conflict resolution exercises in order to address their needs. Acceptability of using the exercises would reportedly be higher if there was a felt sense of security in using the exercises, including connection and respect for opinions. Communication exercises would reportedly have a higher level of feasibility if they were used more often and both child and parent were equally involved in the communication dyad. Conflict resolution would be more likely to be successful if well-established limits were set.

Acceptability.

- D2 parent: *"I think it's really important to take that step if they're at the stage where they want to voice their opinion then they feel like they're heard. We take in a lot."*
- C2 parent: *"She [child C2] is able to able to feel a sense of security and safety in sharing what it is that's bothering her, what she's proud of. That's a big focus for*

us. That she feels that connection that she's able to speak what she's experiencing"

- C2 parent*: "Just last week she said, 'You know, I didn't tell you something a while ago because I thought that I was going to get in trouble, so I didn't want to tell you.' So, we had that discussion that sometimes we make choices that we're not proud of, but we can still share because we love each other."*

Credibility.

- A2 parent: *"We ended up setting hard limits [conflict scenario]. You log out at this time, the wireless goes out at this time. Because they were sneaking. I would find devices in the bedroom and you're not allowed to have devices in the bedroom. So it just happens automatically I don't have to police it."*
- C2 parent: *"We've created a tally system for what she has to contribute to herself, the house and her school and so that's done during the week so she can get screen time on the weekend. She enjoys seeing the tally"*

Feasibility.

- C1 parent*: "We don't always focus on the child either, we say what happened to me during the day or what happened to mommy."*
- C1 parent: *"If we make it a regular occurrence [open communication], then she's more likely to make a follow up. It'll just be a common thing that we do."*

Validations. Families validated communication exercises as acceptable because communication reportedly meets the families' needs of creating healthy dialogue and open discussions.

Acceptability.

- A2 parent*: "Something I was told that keeps me going is that my dialogue with them now becomes their inner dialogue as they grow.*
- C2 parent*: I asked her once if she wanted to go to counselling or do this, like she had that options and she chose to go so she could show her feelings."*

When discussing the idea of incorporating aspects of CPS into the program the families reported the following criticism based on previous experiences with using the model.

Criticism. The idea of incorporating CPS into the program units was viewed as lacking credibility because the process had been ineffective in meeting the needs of the families in the past, specifically using the agreed upon solution when needed and because of the generation of unrealistic solutions.

Credibility.

- A2 parent: *"It doesn't help in the moment [CPS], you have to wait for emotions to settle and sometimes they don't want to go back to that place and like I said sometimes the solutions can be absurd. And you know, when you try and put something that might actually be helpful, and it gets shot down. I know it's a process, but it doesn't really seem to help yet."*
- B1 parent*: "Yeah, but it's hard to get past absurd solutions [generated by CPS], the solution to everything is to buy me this big expensive thing. We Try."*

Identifying Strengths and Difficulties. The following quotations were either in response to the question pertaining to family strengths and difficulties or coded as relevant to the addressing family strengths and difficulties as part of a family program.

Recommendations. In order to promote the successful development of family strengths, it was recommended that frequent and consistent conversations take place centering on strengths.

Credibility.

- D2 parent: *"I think that's why what we're saying when there is a strength, we need to be working on them [identifying strengths] regularly because they are so hard on themselves, whether it could be an altercation with another friend, or marking they received that day, or recess if something happened at recess. Then it really empowers everything else in their day. So, we try to bring it out so that he [D2 child] sees that at the time."*
- D2 parent: *"And what we see, like a lot of the times if it's something concrete like [D2 child] loves trains… we saw the lovely train comic that you made. I try, and again you can't always it's not easy. But I try to just find something we can show him he's creative."*
- B1 parent*: "Even there might be small challenges that might be there with the right support, practice and attitude the children seem to be doing very well. I am very consistent in saying use music as an outlet right now you might not appreciate it but when you get older you will see the benefits. And I think they do see the benefits at such a young age because they play and preform in solos and also in group settings. I've never thought of using an outside activity for that, but we have certainly lots of that for the kids of well. But I find that my family finds the most pride in musical expression"*

Validations. The idea of incorporating an aspect of focusing on strengths and difficulties into a program for families was shown to have acceptability in meeting the needs of the families.

Specifically, families appeared to recognize a need to identify strengths and sharing, and that they already try to balance the discussion of strengths and difficulties.

Acceptability.

- D2 parent*: "And what we see, like a lot of the times if it's something concrete like child [D2 child] loves trains… we saw the lovely train comic that you made. I try, and again you can't always it's not easy. But I try to just find something we can show him he's creative."*
- D1 parents: *"They [the children] always compare themselves to others, all kids have their own strengths."*
- D2 parent*: "Exchange, we talk about our highs and lows, what happened in your day, has something happened."*
- D1 parent*: "Everyone is there to help each other, reflect something good that happen in your day or if something bad happened then we can help each other out and talk about it"*
- *D1 parent: "We always ask if something nice happened that day or something not so nice, did something bad happen today?*

Criticisms.

Sustainability of having an aspect of a program looking at strengths and difficulties was questioned due to the view held by the families that difficulties can overpower strengths and positives can be hard to identify.

Sustainability.

- C1 parent: "*It's a part of the struggle [identifying positives]."*

- A2 parent: *"We [as parents] have a hard time pulling out the positives, and the negatives are so many and so strong that they can't get past that. Now I'm glad that they're open and willing to tell me these things, they never get in trouble for it, but it gets wearing."*

Meaningful Engagement. The following quotations were either in response to a question pertaining to meaningful engagement and significant experiences or coded as relevant to the topics meaningful engagement and significant experiences as part of a family program.

Recommendations. The following is a list of activities recommended by the families to increase the acceptability of a program in order to meet the families' needs of promoting meaningful engagement and significant experiences. Activities that support whole-family engagement, self-expression and connection without screen time were suggested. Activities that support child expression were recommended as a way of increasing the credibility of the meaningful engagement aspects of a program. Implementing activities centering on meaningful engagement and significant experiences were identified as more feasible if they could be done on a weekend.

Acceptability.

- *All parents except B1 parent*: **"***Games."*
- D2 parent: *"No screen, don't get me wrong we love our movie nights, pjs movies and being together. We played a board game yesterday, it was that innocent having fun in the moment no screens no interruptions."*
- C2 parent: *"Mondays is coloring."*
- D2 parent: *"We love going outside, we're very active together"*

- D1 parent: *"Dinner exactly, dinner, having everyone together for dinner [in agreement with A1 & A2]."*
- A2 parent: *"There's no screens, forced eye contact [during dinner]."*
- D2 parent: *"Bike rides are really important to us, because we're out and active.*
- C1 parent*: "Screens are very personal, one thing, whereas board games we have to work together. We do the same thing movie nights on Friday, board games."*
- D2 parent: *"It's very important to us that we have dinner together every day. I mean your son [older D2 child] is x years old and it gets hard, he works and hangs out with friends."*
- D1 parent: *"It's free play too, it's not structured [going outside]"*
- D2 parent: *"We usually use store bought games [for meaningful engagement] or whatever we see out there, we just go online and see. But if there was a resource that had games…."*
- B1 parent: *"They draw a lot. They do a lot of comic book writing the scenarios in comic books, I'm just shocked at what they express. And sometimes the themes that they express are far more mature than I would expect them to be expressing at. To your point having that opportunity to draw, and looking at other artists and looking at how they express their attitudes, their philosophies. Need to have someone to facilitate that. We've had phenomenal teachers that; especially with aboriginal art, the vocalization of frustration, and then having the children reflect on that."*

Credibility.

- C1 parent: *"When trying to access the child's mind, we don't have the tools to tell us what's happening so games could be helpful in that [in relation to meaningful engagement]."*

Feasibility.

- A2 parent: *"So most of our family time is on the weekends [differing schedules for meaningful engagement]"*

Validations. A program that promotes meaningful engagement and significant experiences was more likely to be accepted in meeting the families' needs if the program used games. The credibility of a program that promotes meaningful engagement and significant experiences was validated because the families have found these types of experiences to be effective in meeting their needs in the past.

Acceptability.

- D2 parent: *"We usually use store bought games or whatever we see out there, we just go online and see. But if there was a resource that had games…"*

Credibility.

- D1 parent: **"***Thursday was the first time this week we sat down and had dinner together that felt special."*
- A1 parent*: So [in reference to meaningful engagement] time at the cottage teaching the kids how to fish, and kid A1 how to use a motor – something I liked to do as a kid- they started curling this year. Just being able to take stuff that I like taking it to teaching them how to do it."*

Criticisms.

Ease of implementing the program called into question how feasible it would be to have meaningful engagement and significant experiences as a whole family, due to differing caregiver work schedules.

Feasibility.

- *A1 parent: "I work at night, I'm almost never around when the kids go to bed, parent A2 is always around, she's [A2 parent] basically like a single parent."*

Online Access and Program Implementation. The following quotations were either in response to a question pertaining to online access and program implementation or coded as relevant to the topics of online access and program implementation as part of a family program.

Recommendations. The following recommendations were made to support need fulfillment and increase acceptability of an online support program for families, and included educational features, child resources and parental support forums. The more resources available, the more likely the program would appear to be credible in meeting the families' needs. Furthermore, including families in the ongoing development of the program was viewed as increasing the program's credibility to meeting the families' needs. To increase feasibility of the program, it was recommended the program be well advertised, easily accessible through local avenues such as schools and doctor's offices, and implemented or followed by a professional. Furthermore, it was suggested the program be brief and concise.

Acceptability.

- BI parent: *"Yes [online access to supports], on this Facebook group they will help identify which psychologist you should go to, what to put in the IEP letter, what to expect, what you should say to your principal."*

- C1 parent*: "It's also helpful that group [Facebook group] she's talking about has a "no grief" policy, so you can only say positive things. You're not allowed to call people out on stuff."*
- A2 parent: *"I think it would also be very helpful to have a children's resources of the same [online resources]. Somewhere where they [the children] could go to have a safe space to say I'm feeling this, I'm dealing with this or just vent."*
- B1 parent*: "If you could help me with short little podcasts or apps or some programs so I can have scenarios that I can talk about. Right now I watch Netflix. Some of the programs have social situations that I use for teaching moments like on the spot. If you had things that addressed bullying, apathy, or anxiety. Somethings that my whole family could relate to."*

Credibility.

- *C1 parent: "Honestly more [online resources] is better"*
- C2 parent: *"I think including the families in the ongoing structure of the program, ensuring that there's always a little board or committee of families that input how it's going."*

Feasibility.

- C2 parent*: "I think it [the program] needs to be in doctor's offices, it has to be in schools [verbal agreement by many focus group members]."*
- C1 parent: *"That comes down to money [program accessibility], advertising, getting the word out there to people, so they can spread it."*
- D2 parent*: "Schools need to have that [the program] resource so that they can let us know."*

- A2 parent*: "If it [program administration/awareness] could be at different spots around Ottawa so that it could be local."*
- C2 parent*: "Public health [program accessibility/implementation]."*
- A2 parent: *"As long as there's a professional resource - as long as it's [the program] not another one of those things where you hand something to the parents and say do to it. There's have got be a support structure."*
- C2 parent: *"Yeah like if the program comes from a professional, and the peer support is support in implementing where there's a portal where we can reach out and say we're struggling with this activity and how did you do this? Cause nobody is going to get paid to do that."*
- A2 parent: *"Maybe to schedule a quick call [mental health professional/ program administer], I have a program for emotional control for the kids that's an app. But I pay for the monthly support calls. We do regular check ins, one is the app running, how are the kids, how are you implementing it? If I have any questions, knowing I have the phone call makes a big difference."*
- D2 parent: *" Maybe if there's feedback if there was an online program, if there was a discussion or scenario, we were discussing that there would be a professional there giving feedback."*
- C2 parent*: "Reviewing [family program progress]."*
- D2 parent: *"Give some insight from a professional stance on a regular basis [family program progress]. Relevant or recent information"*

- B1 parent: "*It [the program] should be simple or straight forward, look at how old these kids are, it should be something they can practice frequently in 15 minutes, if I can work with him frequently with small goals that add up to a larger goal. Not something that is long."*
- D2 parent*: "Maybe add in to the program make it brief or concise."*
- B1 parent*: "If there's a program please do indicate how long it will take. Also make it appropriate for the amount of parental support for the age group. Less with older kids and more with younger kids."*

Validations. Acceptability in using an online program for families delayed in accessing mental health services was high. The focus group members validated the idea that families were looking for something like this to meet their needs. Specifically, if it could meet many of the recommendations made in the previous section, the program would be highly acceptable and likely to be used. Furthermore, the credibility of such a program was well validated because other online avenues had been effective in meeting some of the families needs in the past.

Acceptability.

- C1 parent: *If that [online program access] was available that would be a help for some people maybe not all people. But those are some resources I would definitely like to access."*
- D2 parent: *"I think of any situation that was difficult that we went through I would just go on online and try and google the problem. I would try any words that might bring up a journal or something that another parent wrote about a similar experience. I tried so desperately to see if another parent had gone through the same thing and see what they experienced."*

- C2 parent*: "So I think it would be extremely beneficial if that portal [online program access] was there because it's on the outside."*
- D2 parent*: "Technology is becoming bigger and bigger in everyday lives, tech is going into more and more part of their lives. It's not sure much that if they had to watch something beneficial to them would bother us it's more of the video games. Even after 30min I see a difference."*
- B1 parent: *" I resonate with that completely [D2 above comment], too much of this stimulation is not great for my kids. I find my teachers right now are very much incorporating using video, iPad, online things for teaching and even for adult learning were using simulation for learning. We might as well keep embracing it."*
- A1 parent: *"I have no issues for the learning devices at school for the learning disability she [A1 child] has a chrome book and at school that's not a problem."*

Credibility.

- C2 parent: *"I'm in a Facebook group Ottawa Moms, it is phenomenal how many parents are out there searching for something for their children that is not attainable, they're searching everywhere, and they can't find it so they come to this group. Moms are like "oh I know, I went through the same thing" So its mom's helping moms saying this is what we went through and this is what helped us. And so, it's that idea but women came together and build it for themselves."*
- B1 parent: *"I would echo, I have a network of moms, and parents on Facebook. They are the services or supports that we need. They're very*

efficient and they can drill down very quickly and they're so supportive. And chances are, if you put something out there, they will hit you back and someone will respond saying do this, this and this."

- C2 parent*: "And in the moms' group [Facebook group], the individual reaching out you know you come at it like there's probably some guilt in there, oh my child isn't what it's 'supposed' to be and so to hear someone else's story and hear oh I know what you're talking about, so it's like a validation. So, when you're sharing similar lives and stories then validation is really helpful in times of crisis"*
- C1 parent: *"That's [academic journals/ online resources] also a good resource for the right kind of people that would know to look there"*

Feasibility.

- *D2 parent: "Because it [technology] is becoming more of their lives it's important to incorporate it."*

Criticisms. Criticism towards an online program meeting the needs of families delayed in accessing mental health services included a potential public lack of awareness about the program. Furthermore, acceptability of such a program was criticized, due to potential lack of program use by children, and a reluctance to use outside sources of influence for emotional development if only children were engaged in the online program, rather than whole families.

Acceptability.

- C1 parent: *"I can see that being useful, but you need to train the child to express their feelings and that happens at home with us."*

- *C2 parent: "My child [C2 child] has her own computer has her own user but she only has access to her learning games and she can have it whenever she wants but she doesn't."*
- C1 parent: *"That's also a good resource for the right kind of people that would know to look there."*

Feedback from the Psychotherapy Graduate Students. The following are recommendations made by a class of psychotherapy graduate students (*n*=25). The recommendations were coded into categories following the knowledge translation model: acceptability, credibility, feasibility and sustainability.

Recommendations. Recommendations made by a class of psychotherapy graduate students, when viewing the proposed program, included the use of more child-friendly language and a greater game-like feel to increase program acceptability. Addressing a wider range of mental health concerns was recommended in order to promote program credibility. Furthermore, it was suggested to shorten the allotted time for completing each unit in order to promote program feasibility.

Acceptability.

- More child-friendly language and greater game-like feel is needed in the units to increase the element of "fun".

Credibility.

- Increased therapeutic application through addressing issues of trauma, grief therapy and teenage developmental issues.

Feasibility.

- Shorten time of units for easier implementation and use.

Satisfaction Surveys. Following the thematic analysis of the focus group transcript, anonymous responses on the satisfaction questionnaire were assessed:

"What did you like?" and "Do you have ideas to make the program better?" were organized into the themes: recommendations, validations and criticisms and coded into the categories following the KTI model: acceptability, credibility, feasibility and sustainability. Similar to the focus group transcript, some of the responses were coded as addressing more than one KTI model requirement.

Recommendations. Recommendations following the completion of the five family units included adding more game-based activities and crafts to improve acceptability and sustainability. Changing some of the language in the program was suggested in order to improve feasibility and sustainability. Increasing the element of emotional literacy taught throughout the units was suggested as a way of improving credibility.

Acceptability.

- *"Make unit one game-based to keep kids on the spectrum engaged"*
- *"I think you should change the program so there's more active and art stuff."*

Feasibility.

- *"Talking about future memories is a bit odd. Rewording might be good."*
- *"Some activities were more of a challenge for some families but I think that this allowed both kids and parents to brainstorm and compare their thoughts."*

Credibility.

- *"More exercises to help children identify when they are 'starting' to feel these big feelings."*

Sustainability.

- *"Talking about future memories is a bit odd. Rewording might be good."*
- *"Keeping kids busy throughout- maybe colouring the tree."*

Validations. The acceptability of the five family units was validated with participants responding that they enjoyed the visuals, whole-family engagement and unit content. Many aspects of the program were identified as credible in addressing the families' needs, including aspects of the program targeting goal development, communication, resilience development, meaning-making and problem-solving. Furthermore, skills learned were viewed as useful and insight-oriented, creating immediate value. Feasibility of program was supported by the fact the program could be easily implemented and content allowed for children of varying developmental backgrounds to participate. The whole-family approach, games and success of the exercises were identified as reasons for the sustained use of the program.

Acceptability.

- *"Visuals were great."*
- *"The visualization of the tree is great."*
- *"The relaxed environment- allowing the child to be involved as much as they wanted to be."*
- *"I also liked the visual aids and the focus it gives you at home."*
- *"Lots of good examples"*
- *"Liked making the tree."*
- *"I liked the whole-family approach- to have time to think and work on goals/ strengths/ solutions together."*
- *"Visuals."*

- *"Loved doing this together."*
- *"Good concept for growth"*

Credibility.

- *"Visuals were great."*
- *"I liked the mirror exercise."*
- *"The visualization of the tree is great."*
- *"Mirror communication."*
- *"Liked making the tree."*
- *"I liked the whole-family approach- to have time to think and work on goals/ strengths/ solutions together."*
- *"Mirror communication."*
- *"Roleplaying and active participation."*
- *"Visuals."*
- *"Plans to continue goals over time."*
- *"Resources."*
- *"Short, specific activities with immediate value."*
- *"I liked that we learned how we felt about something that we all experienced and that we learned each others problems and way to fix it."*
- *"Skills were useful."*
- *"Insights were revealing."*
- *"Strengths and areas of growth."*
- *"I liked that each part was very well explained."*

Feasibility

- *"The relaxed environment- allowing the child to be involved as much as they wanted to be."*
- *"Short, specific activities with immediate value."*
- *"Very resistant kids bought into the exercises."*
- *"Some activities were more of a challenge for some families but I think that this allowed both kids and parents to brainstorm and compare their thoughts."*
- *"It was good because it wasn't just for older kids or little kids."*

Sustainability.

- *"I liked the interactive games- it showed us how we could extend this at home. Discussion topics- it was great to hear other perspectives/ from other families/ community."*
- *"Apply-ever after was a good exercise."*
- *"Lots of good examples."*
- *"I liked the whole-family approach- to have time to think and work on goals/ strengths/ solutions together."*
- *"Plans to continue goals over time."*
- *"Resources."*
- *"Skills were useful."*
- *"Insights were revealing."*
- *"Loved doing this together."*
- *"I think that providing live examples was helpful for both the kids and parents in understanding."*

Criticisms. Feasibility of the program was criticized due to some of language used and due to lack of connection between the content and child participants. Similarly, this affected the reported sustainability of the program.

Feasibility.

- *"Some of the concepts- repeating back how others were feeling and coming up with some strategies to improve the situation was difficult for my child."*
- *"Difficult for me to help guide my child (who was quick to say- I can't do this or I don't want to do this)."*
- *"Talking about future memories is a bit odd."*
- *"Some activities were more of a challenge for some families but I think that this allowed both kids and parents to brainstorm and compare their thoughts."*

Sustainability.

- *"Some of the concepts- repeating back how others were feeling and coming up with some strategies to improve the situation was difficult for my child."*
- *"Difficult for me to help guide my child (who was quick to say- I can't do this or I don't want to do this)."*
- *"Talking about future memories is a bit odd."*
- *"Some activities were more of a challenge for some families but I think that this allowed both kids and parents to brainstorm and compare their thoughts."*

Quantitative Analysis: Credibility of D.R.E.A.M.-O.F.

This section details the results from the pilot of the D.R.E.A.M.-O.F. units. The following data was analyzed using the Statistical Packages for the Social Sciences version 25.0 (SPSS).

Paired sample t-tests were calculated on data representing: Child resilience and mental health symptoms (internalizing and externalizing behaviours), family interactions important for positive functioning (communication, family strengths and coping skills), child and adult perceptions of meaning in daily life and adult perceptions of purpose in life. Data was analyzed using a critical alpha of .05. See **Table 1** and **Table 2** for descriptive statistics and correlations.

Credibility: Content Validity.

Child mental health. To determine whether there was an increase in reported child (DSM-5-based) internalizing and externalizing wellbeing between pre- and post-test scores, the ISA scores were analyzed. A significant change was found between pre-test (M= 55.92, SD =30.69) and post-test scores (M=25.35, SD=18.73), $t_{(4.21)} = p<.001$, df=13, $d=1.04$, indicating that an improvement in self- and parent-reported child mental health symptoms was noted. The effect size was large.

Findings from the analysis of the SDQ internalizing and externalizing child behavioural symptom scores resulted in insignificant findings between the pre-test (M=41.10, SD= 9.55) and post-test scores (M=43.20, SD=11.34), $t_{(1.88)} = p<.093$, df=9, $d=-0.16$, in a paired sample t-test comparison, with no significant reduction shown in child-behavioural issues.

Positive Family Functioning. Comparison of pre-test (M=57.28, SD=2.69) and post-test results (M=64.85, SD=6.41) from the SCORE-15 revealed significant positive changes in family functioning, (M=-7.57, SD=4.23) $t_{(-4.72)} = p<.003$, df=6, $d=-1.24$. The effect size was large.

Meaning in Daily Life. The analysis of the self-reported meaning (Ch.I.P.-I and AIMS) yielded significant differences between the pre-test (M=86.50, SD=30.56) and post-test scores (M=101.25, SD= 27.43), $t_{(-2.628)} = p <.023$ df=11, $d=-0.43$ suggesting that there had been an increase in parent and child self-reported daily meaning and purpose. The effect size was small.

Purpose in Life. Pre- and post-test scores on the adult overall purpose in life measure, PIL, were compared using paired sample t-tests. Results indicated that there was no significant change from pre-test (M=79.33, SD=13.03) to post-test (M=80.33, SD=17.69) $t_{(-.492)} = p<.644$, *df*=5, *d=-0.04*. This measure was further included for the purpose of providing convergent validity findings. Specifically this measure significantly correlated with the AIMS, r = .84, p < .001.

Meaning in Daily Life as a Predictor of Child Mental Health. A regression analysis was carried out to analyze the relationship between self-reported child and adult meaning in daily life and self- and adult-reported child mental health concerns. Post-test meaning in daily life scores were measured as a predictor of change on the outcome variable of child mental health. Specifically meaning in daily life inversely predicted mental health concerns, F(1, 12) = 8.42, *p* = .01, $\eta\ p^2$-.64. For every 1-point increase in self-reported child and adult meaning in daily life scores, there was a .64 decrease in self and adult-reported child mental health concerns.

Comparison to the original D.R.E.A.M. program. The effect size for the ISA (resilience to internalizing and externalizing mental health concerns) in the present study involving the five family units plus the 10 D.R.E.A.M. units was large (*d* = 1.04). In research using the ISA with the D.R.E.A.M. program alone (Armstrong et al., 2018), the effect size was medium (*d* = 0.69).

CHAPTER 4

DISCUSSION

The current study, D.R.E.A.M.-O.F., set out to create a family-friendly version of the D.R.E.A.M. program, in order to address some of the needs of children, ages 6 to12, and their families on mental health waitlists. Through primary and secondary sources of needs assessment, and stakeholder engagement, a pilot version of family-friendly units to graft onto the existing D.R.E.A.M. program was created.

This study is one of the first to create a program for families on mental health waitlists. Specifically, the program is designed to promote resilience through enhancing meaningful engagement, as well as healthy attitudes and emotional development, thus with the aim of improving family wellbeing.

Childhood Mental Health Waitlists and Delayed Access to Services.

Mental health service delays for children and their families exist at both the provincial and community level. Data released by Children's Mental Health of Ontario (2016) classifies the need for better access to services for children struggling with mental health difficulties as "urgent". Over the past decade, greater awareness has been paid to this issue, with increased recommendation to implement the appropriate supports for this population of children into community outlets such as the school system curriculum (Mental Health commission of Canada, 2013). Despite the hope for school communities to be a natural source of access for mental health support for children, major gaps still exist between policy vision and implementation (Mental Health Commission of Canada, 2013), and the majority of children will not receive support for their mental health needs (Waddel et al, 2007). The difficulties in accessing appropriate services for children managing mental health concerns were further echoed by the

families invited to participate in the focus group of this study, with some families citing delays of 1.5 to 2 years from the time of an initial assessment or diagnosis to actually receiving the appropriate supports, including the creation of IEPs (Individual Education Plans) for mental health, attentional, and/or learning challenges. These experiences were reported by families who generally noted that they had the means to benefit from private sources of mental health support. Lower income families are less likely to access mental health resources and report having overall lower mental health functioning (Anderssen, 2015), suggesting that the delay may be even greater for families of this demographic.

Navigating the mental health system and advocating for the appropriate supports can be challenging for families (RCY, 2013). Research documents that most families consult their general practitioner for the initial assessment of mental health difficulties (Mental Health Commission of Canada, 2017). According to Anderssen (2015), the majority of patients use their doctor as their main source of support for mental health issues, with doctors reporting that roughly half of their time is dedicated to mental health concerns. The difficulty in navigating the mental health system was discussed by the participants of the focus group, with some families reporting that they did not find their general practitioner to be helpful when addressing their mental health concerns. Furthermore, it was reported that the resources given to them by their practitioner, such as public health websites, were not helpful and difficult to navigate. Many of the families reinforced this as an issue by stating that they often turned to a general online search, Facebook groups, journal articles and parent blogs to seek information on resources, ways to advocate for their child, and overall validation for support in managing difficult times of crises. These findings can lead one to question the current health system's ability to meet the standards of acceptability, credibility, feasibility and sustainability in addressing child and family mental

health needs. Given the fact that so many children and their families are reporting difficulties with mental health and low access to mental health services, the Mental Health Commission of Canada (2017) suggests that alternative avenues for fostering social and emotional wellbeing in youth should be considered.

Managing Difficulties Associated with Child Mental Health Concerns: What Can Be Done?

D.R.E.A.M.-O.F.: Knowledge Translation Integration. Through secondary needs assessment—literature review—and primary needs assessment—incorporating input from a focus group, the D.R.E.A.M.-O.F. program appeared to meet the acceptability, credibility, feasibility and sustainability standards of a good program, at least in pilot findings.

The fallout of childhood mental health issues can be observed at both the individual and familial levels (Compas et al., 2001; Leith & Stein, 2012; Lukens, et al., 2004; Sin et al., 2012). Challenges can result in whole-family difficulties in the area of optimal family functioning. Given this, it is understandable that whole-family approaches to addressing childhood mental health difficulties are now the recommendation of mental health professionals (Ingoldsby, 2010); therefore, D.R.E.A.M.-O.F. was developed. The following are the five family units to graft onto the original D.R.E.A.M. program that were derived from the findings of this study or revised based on pilot-testing. Each of the following five family units were distributed with large 24x18in printouts of blank trees and the accompanying materials for families to use in completing the units. Each of the first four units were designed to complement one another, supporting the completion of a Family Tree diagram which was to be used as a guidance-map in supporting families in completing the program objectives. It was suggested to the families that their Family Tree be placed in a common area of the house in the hopes it would help promote

commitment and consistency in completing the unit activities. Furthermore, each of the five family units were adapted to incorporate stakeholder feedback.

General Suggestions: Satisfaction Questionnaires and Focus group.

Recommendations. Participant feedback documented on the satisfaction questionnaires was to increase the element of playfulness within the units (acceptability). This suggestion was further elaborated on with some families suggesting that the program have a greater game-like feel (acceptability). Future adapted versions of D.R.E.A.M.-O.F. will work to enhance the game-like feel of the units through adding more aspects of play and adding activities that include more materials and movement. Furthermore, it was suggested that greater supports for skill development related to emotional literacy be included. For example, it was suggested that some aspect of the program include a focus to support children in emotional monitoring (sustainability). This suggestions further supports the goal of weaving the D.R.E.A.M.-O.F. units in with the original D.R.E.A.M. program, which includes a unit focused on emotional literacy.

Validations. During the focus group it was suggested that a program be quick and easy to learn. Something that could be implemented within 15-minutes or less (feasibility). Therefore, each of the units were designed to be easily understood and executed, with visual aides to promote child-friendliness and sustained usability. The satisfaction questionnaire validated that the units met this application, with several responses highlighting the helpful examples, "good visual aids" and short specific activities that participants perceived to provide immediate value.

Criticisms. The final suggestion made was by families with children who were diagnosed or suspected by parents to be on the spectrum. These families reported that their children struggled with some of the activities, specifically in reference to communication and sharing (credibility). Through enhancing the game-like feel of the units in the future version of

D.R.E.A.M.-O.F., the hope is that the program will, all around, be more adept in meeting a wide range of child and family needs.

General Suggestions: Psychotherapy Graduate Students. Following the completion of the focus group, using the data collected, a first-draft of the program was presented to a class of psychotherapy graduate students who formed into groups and viewed the program instructions. The Psychotherapy graduate students made several suggestions to enhance the acceptability, credibility, feasibility and sustainability of the program.

Recommendations. Following-up on one of the needs expressed by the families in the focus group, it was suggested that the program units be further shortened to allow for quick implementation and practice (feasibility). Included with this suggestion was to increase the element of "fun" within the units and add a greater game-like feel (acceptability). Other suggestions included revising some of the language to improve the child-friendliness of the units (acceptability), and changing around the order in which the units were completed so to support proper skill building (credibility). Each of these pieces of feedback were incorporated into the version of the program pilot-run with the family participants.

Suggestions made by the graduate students that were not incorporated into the program design centered on further developing the therapeutic application of the units. For example, expanding the units so that they address issues of trauma, grief and death, and common teenage development issues. As the purpose of the D.R.E.A.M.-O.F. program is not to replace standard therapy, nor is it meant to be therapeutic, but instead to promote positive mental health functioning through brief whole-family exercises in order to reduce service time needed, these suggestions were viewed as poor-fitting for the design of the program. Furthermore, the program

is designed for families with children ranging in age from 6 to 12, therefore addressing issues associated with teenage development falls beyond the scope of the program's objectives.

Managing Difficulties Associated with Child Mental Health Concerns: A Whole-family Approach

Unit One: Family Tree Roots (Goal-setting). When discussing issues such as delayed access to child mental health services and supports during the focus group, the idea of childhood mental health difficulties being a whole-family issue were further elaborated on by the families. The focus group discussion reinforced the concept that childhood mental health difficulties were a whole-family issue. Some participants stated that, as parents, they sometimes found it necessary to reach out to their siblings and parents for support, and that they expressed concern that "dealing with all the negatives" can be draining. This, in addition to the internalizing and externalizing symptoms of childhood mental illness, can act as a barrier to positive family interactions such as effective communication and problem solving (Cassidy & Shaver, 2016; Costello & Maughan, 2015; Greene, 2010). Families who are struggling with mental health concerns are often operating from a state of crisis and reactivity rather than preparedness and proactivity (Sheehan, 2017).

Whole-family goal-setting can be invaluable for positive family functioning (Lowenstein, 2010), and is one of the most successful ways families can achieve what they want and promote change; including meeting the needs of all the family members (Parent, Family and Community Engagement [PFCE], 2019). The final product for the first unit combined both Lowenstein's (2010) idea to use a form of art for goal design, and the premise of Gottman's Sound Relationship House (Gottman Institute, 2012) for a clear way to map goals. Aspects of PP2.0 and Logotherapy supported the development of this unit through highlighting the importance of growth. Using goals for families can be helpful tools in supporting them to move beyond what is

immediately available towards the actuating potential and goal-directed “how” (Ivtzan et al., 2016). The goal development for this unit was also presented in a way intended to promote family behaviours that could lead to meaningful engagement and family connection. The final product of unit one contained psychoeducation on the benefits of goal-setting, steps to goal-setting, examples of family-goals and a follow-up piece to help maintain goal-setting and goal completion. The craft aspect of this unit included instructions to write identified goals at the roots of the blank tree provided. Families were also given flower-stickers, to take home, that were to be placed at the root of the tree beside a goal once the family perceived a goal to be completed.

The families participating in the focus group validated the benefits of goal-setting, if certain barriers were addressed and goals could be naturally woven into the family’s current objectives. The participants highlighted the importance of whole-family goal-setting, including child-involvement and input in the goal-decision process. In summary, the families validated the acceptability of the program to have a goal-directed unit, making certain recommendations to increase the feasibility of the unit. For example, based on survey feedback, it was suggested that through addressing barriers to goal-setting and having goal-setting tie in organically to family objectives, the unit appeared to be more successful in:

1. Increasing motivation to want to try and set goals (acceptability),
2. Addressing barriers to have the family be more successful at achieving their goals (credibility),
3. Becoming more readily able to set goals (feasibility), and
4. Becoming more inspired to continue to use the goal-setting unit (sustainability).

In order to incorporate the families' suggestions, the other units were developed to support the desire for family objectives to unfold naturally and address potential barriers to goal-setting. The results of the goal-setting unit were further validated by the feedback provided on the satisfaction surveys after having completed the program. Families reported that they enjoyed the whole-family approach to goal development, the suggested goal examples, the plans for goals to be continued and adapted over time, and the ease of implementing the goals at home.

Unit Two: Family Memory Branch. Meaningful engagement can be anything in which an individual attributes meaning and significance to a situation, no matter how large or small. When exploring the idea of sharing time together as a family, the focus-group participants mentioned several experiences that they had found to bring joy and significance into their lives. Suggestions included outdoor activities, movie nights, family-teaching/learning opportunities, family games, car rides, cottage time, and most important of all was family dinnertime. The participants discussed the process of family dinner time, that there were opportunities to share reflections on each other's day, including the "highs" and "lows" and engage in eye contact, all of which was experienced as an equal family system in that moment without a parent-child hierarchy. Each of these suggestions by the families could be classified as memories that they were calling to mind during the focus group that represented something significant to them, validating the importance of meaningful family engagement. Some of the families mentioned that sitting down to dinner would only occur on weekends or would happen once a week. This parallels some of the findings in the research that document that positive interactions such as these are less common amongst families with children who have mental health difficulties (Costello & Maughan, 2015; Greene, 2010). Opportunities to connect with each other, as a

family, are important for the development of secure attachment, meaning-making and therefore resilience development (Costello & Maughan, 2015; Ivtzan et al., 2016; Wong, 2010).

The importance of resilience development as a protective factor against some of the risks of mental health difficulties has been well documented (Armstrong & Manion, 2013; Bartko & Eccles, 2003; Busseri et al., 2006; Compas et al., 2001; Kowalewski et al., 2001; Resnick, 2000). Meaningful engagement is correlated with resilience development and a reduction of risky behaviors, increased self-esteem, higher academic functioning, and overall positive psychological health (Armstrong & Manion, 2013; Busseri et al., 2006; Kumpfer, 2002). Many of the activities identified by the families as meaningful are common family goals. Creating the Family Memory Branch unit was aimed at supporting organic goal development amongst the families while developing resilience through added reflection and meaningful engagement; ultimately aimed at developing coping skills for managing mental health issues. As noted previously, the second unit adapted Lowenstein's (2010) Box of Memories, through incorporating PP2.0 and Logotherapy theory. Instead of only good memories, the families were asked to select significant memories. Furthermore, the families were asked to share these memories with one another, promoting secure bonding, meaningful engagement and attachment. Adding to the Family Tree, each family member was asked to write a word or two that represented the meaningful memory on one of the paper leaves provided and stick it to the Family Memory Branch. The final product of the second unit included psychoeducation on meaningful engagement, steps for memory selection, guiding questions for memory selection and a follow-up piece for supporting continued meaningful memory development through connecting the memory development back to the family's original goal-selection. Based on

survey feedback, it was suggested that this aspect of the program seemed to be successful in promoting:

1. Enthusiasm from the families wanting to share their memories (acceptability).
2. Sharing of insights and reflections potentially promoting resilience development and family connection, as self-reported meaning and mental health significant increased with the administration of the program (credibility).
3. This activity was identified as well suited for all age groups (feasibility)
4. Feedback from the families included statements such as finding the skills taught to be useful and the insights shared to be revealing. These findings would allude to sustained use of this unit of the program (sustainability)

All feedback was positive, with the exception of one constructive criticism. One participant stated that they found the idea of contemplating future memories for their family to strive towards as "odd," with a suggestion to reword this piece of the exercise. Therefore, to be applicable for all families, a re-wording should be considered (e.g., contemplating future "special family selfie moments," like camera imagery, moments the family wants to capture) for future adaptations of the program.

Unit Three: Apple-y Ever After. The importance of effective communication and positive family functioning was validated by the participants when raised as a topic point during the focus group discussion. Many of the participants emphasized how much they valued open communication as a family, but expressed that some topics were more difficult to discuss than others. The idea of CPS was introduced to the families as a method for addressing conflict resolution to promote effective communication and positive family functioning. Criticism of this approach was immediately received, for the most part due to the amount of time it takes to

complete the collaborative process and to manage the array of suggested solutions. Following-up on this topic was a request for the participants to suggest a number of typical conflict scenarios. Many unique scenarios were suggested that vastly differed from one another.

Due to the negative reaction elicited from the families with regard to the CPS in the focus group the idea of incorporating this tool into the family units was negated. Furthermore, with such a large amount of conflict scenarios generated, it would be unfeasible and unsustainable for a program to attempt to generate solutions for each possible interaction a family using this program may find themselves experiencing. Instead, following the family's highlighted importance and desire for effective communication, the IMAGO dialogue wheel (Reichlin, 2019) was used to form the basis of unit three.

The IMAGO dialogue wheel is a tool used to support emotional connection, adaptability and effective communication (Reichlin, 2019), all of which are important for the relational state of secure attachment (Cassidy & Shaver, 2016). As previously mentioned, secure attachment is linked to a number of positive developmental outcomes (Cassidy & Shaver, 2016). Families of children who are struggling with mental health issues typically have fewer opportunities to engage in behaviours that promote secure attachment (Greene, 2010). These include emotional connection, parental consistency and open communication (Greene, 2010), potentially leading to insecure attachment and negative family functioning (Cassidy & Shaver, 2016). Insecure attachment is correlated with a number of negative developmental trajectories associated with poor mental health functioning (Cassidy & Shaver, 2016). Therefore, the IMAGO dialogue wheel was adapted to be more child- and family-friendly in order to support the development of adaptability, effective communication and emotional connection among families, aimed at promoting positive family functioning. Language typically used to facilitate the dialogue wheel

was adapted to be more inclusive and changes were made in the third step of the wheel aimed at promoting emotional literacy and goal completion. For example, the final stage of the exercise was adapted through adding a behavioral component. Once the family duo had each taken a turn exploring and expressing their perspectives, together they decided on one, small behaviour they each could adopt in order to address the issue that was first discussed using the wheel. This step was furthered through asking both the sender and the receiver to work together to identify what alternative emotions may be experienced through adopting this behavioural change. The purpose of this was to support the family in developing flexibility in perspective towards each other's differing experiences, supporting emotional literacy. In the unit instructions, it was also suggested to the families to consider how this behaviour was related to their initial goal creation in order to support continued goal development and attainment. Furthermore, given the fact that this exercise is typically implemented between adults (Reichlin, 2019), mirror props were also incorporated to increase child-friendly usability. The final product of the third unit included psychoeducation on positive family functioning and communication, steps for completing the dialogue wheel, tips for facilitating the use of the wheel, and a follow-up piece for supporting continued communication development. For this exercise, continuing the development of the Family Tree, each family member engaging in the communication exercise was asked to write the solution-focused behaviour, derived from the communication exercise, on an apple and place it on the Family Tree. Based on survey feedback, it was suggested that this aspect of the program appeared to be successful in:

1. Appealing to children and adults as many stated they liked the mirror exercise including the use of props and visuals (acceptability),

2. Teaching skills that were useful and helpful in promoting communication, empathy and adaptability as many participants stated they learned of each other's problems and how to fix them (credibility),
3. In being implemented in 15 minutes or less (feasibility), and
4. Overall family enjoyment as many stated they really enjoyed the activity (sustainability).

Constructive criticism of the exercise included that repeating back feelings and brainstorming solutions were difficult for some of the children. Therefore, to be applicable for all families, further adaptations of the unit could include some example scenarios with pre-selected responses and solutions for families to work through together before applying the exercise to their own experiences.

Unit Four: Family Strengths and Growth Branch. The importance of identifying the positives and negatives of a situation was a topic explored during the focus group discussion. When on the topic of family dinners, the participants highlighted the importance of discussing the positive and negative occurrences of each other's day, and what could be done to support one another. The significance of this was further explored and the families stated that sharing triumphs and struggles with one another provided a sense of familial connection which allowed for certain strengths to be highlighted. The families shared that they often tried to highlight any unique strength that could be helpful for a situation no matter how small or how large it may be. However, the families remarked that the negatives were often so strong they were hard to move forward from.

Looking beyond what is immediately apparent in a difficult situation in order to derive meaning is one of the methods an individual can use to take an active role in fostering the

development of resilience (Ivtzan et al., 2016; Wong, 2010). The ability to identify the true potential of oneself in a situation promotes cognitive adaptability and growth (Ivtzan et al., 2016). This supports the development of goal-directed behaviour as well as the promotion of adaptive coping skills and positive behavioural changes (Ivtzan et al., 2016).

Given the importance of emphasizing a relationship of dynamic growth between positive and negative experiences highlighted by the families and in the literature, the Family Strengths and Growth branch was created. Based on tenants of the family exercise created by Lowenstein (2010), this unit was originally named Family Strengths and Needs game. However, incorporating feedback from the families in regards to becoming "hung-up" on the "negatives", the word "needs" was replace with "growth" to promote open thinking and cognitive flexibility. The final product of Unit 4 included psychoeducation on resilience promotion through identifying strengths and growth, steps for identifying family strengths and areas of growth, guiding questions for identifying family strengths and areas of growth, and a follow-up piece for supporting continued strengths and growth development through connecting the areas of strength and growth development back to the family's original goal-selection. Adding to their Family Tree, each family member was asked to write a word or two that represented the identified strength on one of the paper leaves provided and stick it to the Family Strengths and Growth Branch. In instances where an area of growth was identified, the families were asked to write a word or two that best represented the identified area of growth on one of the raindrops provided and place it at the top of the page, above the Family Tree. Reception of this activity, based on survey feedback, suggested that it appeared to be successful in supporting:

1. Family's enjoyment of working with the idea of strengths and growth through playful concepts and visuals (acceptability),

2. Identifying strengths and developing areas of growth and using this exercise to facilitate the advancement of goals (credibility),
3. Useful to all ages (feasibility), and
4. Overall success and enjoyment in using the unit (sustainability).

No constructive criticisms were provided for this unit.

Unit Five: May the Forest Be With You. As previously mentioned, navigating the mental health system and overall lack of social and emotional support is a substantial issue for families with children struggling with mental health difficulties, as documented in the literature (Mental Health commission of Canada, 2017; RYC 2013). The fifth and final unit is aimed at addressing such issues. Following the focus group feedback explored at the beginning of this discussion section, the hope is to create an online parent-friendly platform that will address several of these needs (see Future Directions). For the purpose of this pilot-study, families were given a number of fee and non-fee based resource[s] following the completion of the aforementioned four-units. Due to the preliminary nature of Unit 5, feedback regarding satisfaction was limited. However, one participant remarked on the satisfaction questionnaire that they found the resources to be helpful.

A Brief Mental Health Promotion Program

The purpose of creating family-friendly units to graft onto the original D.R.E.A.M. program was not only to foster overall positive family functioning, but also to hopefully improve meaning in daily life and promote whole-family resilience through mental health wellbeing and reduction of child mental health symptoms. Based on participant feedback, each of the units appeared to support family goal development while addressing issues of mental health, positive family functioning, and meaning in daily life. Credibility of the program was further supported

through quantitative analyses, potentially ruling out positive response bias, as measures that should remain stable after a brief time period—i.e., purpose in life (rather than meaning in daily life) —did not significantly change with the implementation of the program. Further, quantitative results suggested that the program enhances mental health, positive family functioning and meaning in daily life. Therefore, through promoting mental health functioning, positive family interactions and meaningful engagement, it is possible that the program supported the development of other positive trajectories, such as resilience to future challenges. Further research should explore D.R.E.A.M.-O.F. longitudinally.

Child Mental Health. Potentially through skill acquisition and meaningful engagement of the D.R.E.A.M.-O.F. program, self- and parent-reported child mental health difficulties were reduced from pre-test to post-test. Results of these measures demonstrated that the program appeared to collectively address issues such as mood symptoms, conduct concerns, anxiety symptoms, obsessions and compulsions, attention deficit symptoms, and issues with self-esteem. In comparison to past research using the D.R.E.A.M. program with children (Armstrong et al., 2018), D.R.E.A.M.-O.F. with families yielded a larger effect size. Therefore, given the previous research to suggest child mental health approaches should be whole-family targeted (Ingoldsby, 2010), the present findings suggest that the family units and inclusion of the whole family in D.R.E.A.M. participation may be beneficial over and above child participation alone.

The quantitative analysis of one of the measures for mental health indicated that evaluation of mental health symptoms did not yield significant results between the pre- and post-test results. The measure in which findings were found to be non-significant has shown to have inconsistent findings in relations to reliability and internal consistency (Child Outcomes and Research Consortium [CORC], 2017) and, therefore, it can be considered that this may have

been the case for the current study. Further, the sensitivity and power of the measure may have been low with a small sample size, with scores only ranging from 1 to 3 for each item. By contrast, the other measure of mental health symptoms used in the present study involved scores ranging from 1 to 10 for each item.

Positive Family Functioning. D.R.E.A.M.-O.F. was created in order to meet the standards and recognized benefits of programs that include whole-family engagement (Ingoldsby, 2010). Through creating a whole-family program, D.R.E.A.M.-O.F.'s units appeared to have supported positive family interactions through addressing issues such as strengths and adaptability, feeling overwhelmed by difficulty, and disrupted communication. Attachment strategies targeting these issues are important for the development of resilience and therefore mental health functioning (Cassidy & Shaver, 2016; Ivtzan et al., 2016). The credibility of the program's units in meeting these goals were further supported by a quantitative measure that assessed family traits such as strengths and adaptability, feeling overwhelmed by difficulty, and disrupted communication. Findings suggested the program appeared to be successful in promoting family abilities to manage issues related to hostility, risk and blaming, while fostering hopefulness, happiness and wellbeing. Given that the measure of family strengths and adaptability, overwhelmed by difficulty, and disrupted communication is often used to assess family qualities associated with significant therapeutic change in the literature (Bland et al., 2010), it could be inferred that D.R.E.A.M.-O.F. is likely to meet its long-term goal of shortening service time needed.

Daily Meaning in Life and Purpose in Life. Sense of meaning in life is now recognized as an essential component of positive mental health functioning (CIHR, 2010; Armstrong & Manion, 2013; Busseri et al., 2006; Kumpfer, 2002; Wong & Fry, 1998; Wong,

2010; Wong & Wong; 2013). Meaningful engagement and purpose in life are correlated with resiliency, which supports positive mental health functioning and a decreased need for therapy (Ivtzan et al., 2016; Wong & Wong; 2013). Logotherapy and PP 2.0 are two theories that propose methods for engaging in meaningful experiences thus supporting resilience development. D.R.E.A.M.-O.F. incorporated elements of both theories such as goal development, post-traumatic growth and Frankl's three pillars to meaning into the design of a family-friendly program to promote mental health functioning via resilience development. Statistical analysis documented that the program appeared to promote a number of traits associated with positive mental health functioning that stem from meaning-making. These included agency over thoughts and behaviours, hope for the future, openness to social connection, openness to meaning and feelings, openness to learning and to creativity and engagement in pursuits, hope for the future, and positive self-concept.

In addition to meaning in daily life, a measure of overall meaning and purpose in life was used to control for any participant bias and provide convergent validity with the adult daily meaning in life measure. Specifically, the program was expected to enhance self-reported daily meaning in life, but longer-term overarching life meaning and purpose was not expected to change, as such overall purpose in life would probably take longer to change than over a 3-week program. Specifically, previous research noted the stability of purpose in life in relation to personality traits (Zika & Chamberlain, 1992). As expected, daily meaning in life scores increased with the implementation of the program, while overall meaning in life did not. These results helped to control for participant's bias of wanting to please the researchers through reporting changes that may not have occurred, thus adding further validity to changes noted as a potential function of the program.

Daily Meaning in Life and Child Mental Health. Wong (2006; 2010; 2011) and Frankl (1986) suggest that meaning should be predictive of adult mental health, and Armstrong (2009; 2018; 2019) and St. John (2017) noted this in previous research with children. Complementing and extending these finding and theory, in the current study with families, self-reported child and adult meaning in daily life predicted child mental health. This finding extends previous research beyond the examination of self-reported meaning and self-reported mental health, as this study explored both child self-reported and adult self-reported meaning in daily life in relation to child mental health. Given the findings on adult meaning in life in relation to positive mental health (Frankl. 1986; Wong & Fry, 2013; Wong, 2010; Wong, 2011), and studies exploring the relationship between parental mental health and child and family wellbeing (Coyl, et al. 2002; Freeman, et al., 2008; Mackenzie, et al., 2001), a finding such as this warrants further exploration. However, further research should include a larger sample size so that child self-reported meaning can be separated from adult self-reported meaning in future analyses. If fostering adult meaning in daily life was found in future research with a larger sample size to enhance child mental health, then this adds further validity to the use of whole-family approaches.

Limitations and Future Directions

Sample. The importance of engaging families in research aimed at developing family-focused interventions is now well understood (Ingoldsby, 2010; Spoth, Goldberg & Redmund, 1999). Unfortunately, family-participant retention and attrition can be highly affected by a number of factors (Spoth et al., 1999; Wolke et al., 2009). Some of these factors include the length of time required by the families to partake in the study, with longitudinal studies demonstrating higher drop-out rates (Wolke et al., 2009) than, for example, a single day study.

Other factors include familial issues such as behavioural problems and lower social economic status (Spoth et al., 1999). Given these findings, it could be logical to theorize that families who are delayed in accessing mental health services due to issues such as long waitlists would have greater difficulty in participating and continuing involvement in a research study. This could be identified as one of the limitations in the current study. Despite the high number of statistics reporting vast amounts of families' waitlisted and delayed in accessing mental health services, participant recruitment for this study was difficult. Furthermore, all of the families participating had experience with mental health waitlists, but some had already undergone treatment, while others had not. Therefore, potentially the severity of those served by the pilot test of the program may not have been as severe as a sample of participants currently, fully on waitlists. Overall, given that this program was designed using data and information from families who have all been waitlisted for nine months or longer, a follow-up, more lengthy study may be warranted to determined the program's effectiveness when implemented for the duration of a family's mental health waitlist time. Thus, further research should involve a more extensive sample of participants on waitlists.

For each weekend the study was run, at least one family was missing. Fortunately, given the detailed instruction manual accompanying the D.R.E.A.M. and D.R.E.A.M.-O.F. version of the program, families were able to follow along at home, and noted that they did so. In one case, a home visit was made in order to implement the program with a family who missed two sessions. Finally, several participants had occasional missing pieces of data. This issue has been described in other studies that document that research involving younger participants can have a higher likelihood of MAR data (Papageorgiou et al., 2018). In cases such as these, it can be suggested to replace the missing data, such as was done in this study (Papageorgiou et al., 2018).

However, it should be noted that this can lead to a bias within the results (Papageorgiou et al., 2018). Nevertheless, significantly less than 20% of the data was missing, so the data met criteria for the appropriateness of replacing missing values.

The accessibility issue discovered while running this program further supports the importance of pairing the five D.R.E.A.M.-.O.F. program units with the original D.R.E.A.M. program and having both of them operate from an online platform, thus increasing accessibility.

Key Future Direction: Bringing the Program Online. To address challenges with attending a program and to make the program more accessible for families at times in which they are available, an online delivery model may be beneficial. Online implementation would also extend program reach to multiple families without requiring train-the-trainer of group facilitators. This would also maximize implementation fidelity, as the program administration would be the same every time a family accesses the program.

Ease of implementation and sustainability of online programs are two major contributors to the growing popularity of online mental health promotion programs and interventions (Barak, Hen, Nissim, & Shapira, 2013; Donkin et al., 2011). Although research in this area is preliminary, publications document a consistent benefit of online delivered programs and identify a number of factors contributing to the effectiveness of programs such as e-therapies. CBT is a commonly used therapy that treats mental illness through addressing maladaptive patterns of thinking, feeling and behaving and has demonstrated effectiveness in treating a variety of mental health illnesses amongst children (Firestone, 2006). E-therapies are computerized treatment programs that generally encompass the principles of therapeutic techniques, such as CBT (March, Spence, Donovan, 2009; Proudfoot, 2004). CBT, in particular, is especially well adapted for e-therapy due to the fact that it utilizes highly structured processes

(Proudfoot, 2004). Like traditional therapy, the number one determining factor for the effectiveness of a web-based therapy is the individual receiving the services (Barak et al., 2013; Donkin et al., 2011). This factor can also be one of the main limitations of e-therapies (Barak et al., 2013). A number of studies report that one of the greatest limitations of web-based therapy is program adherence (Barak et al., 2013). However, this limitation has been shown to decrease when a program incorporates daily reminders for its users or weekly tracking reminders have also shown to reduce participant dropout (Donkin et al., 2011). Attrition rate can also be affected by length of completion time needed for the e-therapy intervention, with longer e-therapies having higher rates of participant dropout (Donkin et al., 2011). In addition to the client's motivation and openness towards the therapeutic process, research demonstrates that web-based therapies designed to address issues such as depression and anxiety, are more effective than cybertherapies targeting behavioural issues, such as weight management (Barak et al., 2013 Barak et al., 2013). However, a number of studies document the elimination of this limitation when the method of delivery for the e-therapy was less text based and instead used more interactive avenues such as audio and graphic tools (Barak et al., 2013). E-therapies using, real-time, face-to-face therapy with a therapist vs. web-based therapies, using self-help, psychoeducation interventions are shown to be equally as effective depending on the client's needs (Barak et al., 2013). Finally, age of users was documented as a factor contributing to the effectiveness of an e-therapy, with individuals, ages 19 to 39, demonstrating the most success in using web-based therapies (Barak et al., 2013). This finding could in part be due to the fact that limited research has been conducted looking at the effectiveness of web-based therapies and perhaps few e-therapy programs for children and youth have been assessed.

Web-Delivered Programs for Children. The use of technology amongst children is ubiquitous. As much as 37% of Canadian children ages nine to12 have a smartphone and 58% of them use a tablet daily (Shaw Rocket Fund, 2014). The prominent role technology plays in Canadian children's daily lives is likely to continue to be pervasive. It is not just amongst our youth that this surge in the use of technology can be seen. Applications of technology are being incorporated into the classrooms as educational vehicles for teaching across the industrialized world. In part, this is a response to the fact that technology is so widespread amongst Canadian youth.

Knowledge acquisition is more meaningful and lasting when children are able to make connections between previously existing concepts and the new information being presented (Kermani & Aldemir, 2015). Technological aides in the classroom have been linked to the development of collaborative skills, focused attention and increased cognitive understanding; specifically, when education-based computer technology links learning to everyday age-appropriate solution discovery scenarios (Kermani & Aldemir, 2015; Wang, Kinzie, McGuire, & Pan, 2010). Additionally, one study reported that children were better able to comprehend and remember the meaning of words through the use of an age appropriate computer game that allowed children to make connections between the words and their equivalent action in the game world (Gee, 2006).

Existing Online Programs. As previously stated, children are better able to acquire knowledge and form connections with new concepts, when the information being presented is familiar to them (Kermani & Aldemir, 2015). Cyber culture communication avenues such as instant messaging, emails and the overall use of the internet, have become a pervasive facet in the lives of today's youth. Many youth reportedly use the internet to search for information

surrounding issues such as stress, depression and anxiety (Stallard, Velleman, & Richardson, 2010) Therefore, it is not difficult to see how youth may have a preference for E-therapies or online counselling (King, Bambling, Reid, & Thomas, 2006). In recent years, a number of E-therapy programs have been developed to increase child and youth access to mental heath resources (March et al., 2009).

One such program, BRAVE, piloted by the University of Queensland Human Ethics Committee (March et al., 2009), examined the use of E-therapy as an intervention for children on waiting lists seeking out mental health treatment. The 73 participants consisted of children, ages 7 to12, and their parents. Participants were randomly assigned to either a waitlist control group or an internet-based intervention group (March et al., 2009). Participants, including the parents, completed questionnaires and child internalizing behaviours were measured (March et al., 2009). The study was specifically interested in examining whether this E-therapy program would be successful in reducing anxiety symptoms. The overall findings of the study indicate that internet-based CBT was positively associated with lower levels of reported anxiety. Although the effect sizes were small, in comparison to the waitlist control group, the internet-based intervention group showed significantly greater improvement in anxiety (March et al., 2009). In addition to these results, BRAVE's content was rated favourably by families who demonstrated low dropout rates and high compliance (March et al., 2009).

Camp Cope-A-Lot (CCAL) is another computer-assisted program, but differs in that it is implemented with the assistance of a coach (Khanna & Kendall, 2010). The coach's role is to monitor symptoms, compliance and oversee the integrity of the CBT, who in this study was not required to have any previous CBT training. The sample consisted of 45 participants, ages 7 to13, who met the criteria for a number of anxiety disorders (Khanna & Kendall, 2010). Overall

this computer-assisted approach, conducted in collaboration with Temple University & the University of Pennsylvania, was found to be feasible and acceptable by the children and their parents. Additionally, the program was found to be as effective as face-to-face CBT, with participants continuing to show improvements in the 3-month follow-up (Khanna & Kendall, 2010).

SPARX, launched by The Prime Minister's Youth Mental Health Project, is an E-therapy computer game that is very different from CCAL and BRAVE (Bobier, Stasiak, Mountford, Merry, & Moor, 2013). It is targeted towards an older population, typically youth 16 to18 years of age, and is concerned with addressing issues associated with depression, rather than anxiety. This computerised CBT program is a third person, fantasy based computer game. It has only been implemented with youth who currently are residing in mental health facilities and whose conditions are so advanced, they were unable to be treated in other settings (Bobier et al., 2013). Through the use of CBT methods and mood management psycho-educational techniques, participants are required to help their character make their way through the world of "GLOOM" (Bobier et al., 2013). Many of the 20 participants who partook in this preliminary study, sited that learning about their illness, learning to recognize helpful thoughts and how to deal with their anger, were the greatest aspects of the program (Bobier et al., 2013). This study also found SPARX to be feasible for the use to use (Bobier et al., 2013).

In summary, online programs offer several advantages including ease of implementation and accessibility for their users (Barak et al., 2013; Donkin et al., 2011). Participants in the current study's focus group supported these findings, voicing the importance of having a program that is local (easily accessible) and deliverable via multiple avenues (easily implemented). However, the participants wanted the online approach to guide family discussions

and groups games and art activities, as well as to connect them to other families and to resources. Thus, the future directions of D.R.E.A.M. and D.R.E.A.M.-O.F. include a plan to adapt the programs so that they are deliverable via an online platform. D.R.E.A.M. is currently being adapted.

In accordance with the research, programs that are less text-based and more interactive are shown to be more beneficial (Barak et al., 2013). Therefore, the adapted version of this program will include video delivered modules, in both of Canada's official languages, to ensure program user acquisition. The importance of this approach was further alluded to, by the participants of the study, with the feedback on the satisfaction questionnaires reporting that the families enjoyed example demonstrations and role-plays. Furthermore, when information is presented in a child-friendly manner and children are able to form connection between pre-existing information and newly presented concepts, they are better able to absorb the educational content being presented (Gee, 2006; Kermani & Aldemir, 2015). Therefore, child-friendly actors and scenarios will be used during the video modules to deliver the program content. Group-based family craft activities and games would be retained, so that families are not simply passively learning but would be as actively engaged as in the current research.

During the focus group, parents expressed a dislike towards screen time and rejected the idea of using a program that was solely tech-based. Incorporating this feedback into the design of the program suggests the potential for the development of downloadable, printable brief at-home instructions. Therefore, once families have watched and learned the process of the modules via video, they can then print the instructions and engage in the program activities, real-time and face-to-face as a family. However, program instructions could be detailed enough that families could omit the use of the video module, if they prefer. The importance of including alternative

forms of program delivery and play into the program units further supports the goal of inclusion aspired by the program. Video-delivered modules ensure that children with different learning needs are able to participate and benefit from the program's objectives.

Final Comments

Children and their families struggle with many, and varied, issues while on mental health waitlists. During focus group discussions, several of these issues were explored and elaborated upon, with many families highlighting and echoing the need for greater mental health supports. When discussing the initial development of the D.R.E.A.M.-O.F. program, some of the requests from the families in the focus group were for a program that provided on-going support from a professional, follow-up with a professional on a regular basis and feedback regarding users' progress within the program. Many of these suggestions could arguably be services that one would receive from a mental health resource, such as a psychotherapist. Thus, some of these suggestions should be considered when D.R.E.A.M.-O.F. is adapted to its online version. However, the purpose of D.R.E.A.M.-O.F. is not to replace standard mental health services, but to teach skills related to resilience in order to promote positive mental health functioning prior to accessing standard mental health services. Some factors correlated with a family's ability to succeed in therapy include the ability to set and meet goals, self-actualize, lower child behavioural issues, and lower familial dysfunction (Hampson & Beavers, 1996). Each of these can potentially be improved by an increase in resilience development (Ivtzan et al., 2016). Furthermore, families with greater levels of positive family functioning, self-belief, goal-setting abilities and behavioural functioning, are shown to need fewer therapeutic sessions than their counterparts (Hampson & Beavers, 1996). Therefore, based on the positive findings of the

current research in these areas, D.R.E.A.M.-O.F. is likely to meet its long-term goal of reducing service time needed, thus, hopefully reducing waitlists.

An evolving trend in the research literature involves the documented importance in preventative mental health services that promote wellbeing rather than only treating illness (Mental Health Commission of Canada 2012; Slade, 2010). D.R.E.A.M.-O.F. is a first of its kind—addressing internalizing and externalizing mental health concerns, family functioning and meaning—and the pilot study of the program supports that D.R.E.A.M.-O.F. appeared to promote many of the psychological indicators associated with positive mental health function and reduced need for therapy.

References

Ambikile, S, J. & Outwater, A. (2012). Challenges of caring for a children with mental disorders: Experiences and views of caregivers attending the outpatient clinic at Muhimbili national hospital, Dares Salaam- Tanzania. *Child and Adolescent Psychiatry and Mental Health,* 6, 1-11. Retrieved from: http://www.biomedcentral.com/content/pdf/1753-2000-6-16.pdf

American Psychiatric Association. (2013). Anxiety Disorders. In *Diagnostic and statistical manual of mental disorders* (5th ed.). doi:org/10.1176/appi.books.9780890425596.dsm05

Amrstrong, L. (2009). Utilization-focused approach to evaluating a "youth-friendly" mental health program: The youth Net/Réseau Ado Story. *Vulnerable Children and Youth Studies, 4*, 361-356. doi:10.1080/17450120902923213.

Armstrong, L. L. (2018). The D. R. E. A. M. program: Developing resilience through emotions, attitudes & meaning—Program development and evaluation through a knowledge translation-integrated approach. *Counseling et Spiritualité, 36*, 93–120. doi: 10.2143/CS.36.1.3285228

Armstrong, L, L., Watt, E., St. John, E., & Desson, S. (2019). The child identity and purpose questionnaire-interactive: Development and validation of the revised, video-based vrsion using a knowledge translation-integrated approach. *The Humanistic Psychologist,* 1-20. doi:org/10.1037/hum0000147

Armstrong, L. L., Desson, S., John, E. S., & Watt, E. (2018). The D.R.E.A.M. program: Developing resilience through emotions, attitudes, & meaning (gifted edition) – a second wave positive psychology approach. *Counselling Psychology Quarterly,*1-26. doi:10.1080/09515070.2018.1559798

Angold, A., & Costello, E., J. (1993). Depressive comorbidity in children and adolescents: Empirical, theoretical, and methodological issues. *American Journal of Psychiatry, 150,* 1779-1791. doi:10.1176/ajp.150.12.1779

Anderssen, E. (2015). The case for publicly funded therapy. The Globe and Mail, Friday, May 22, 2015.

Askeland, G, K., Hysing, M., Aaro, E, L., Tell, S, G., & Siversten, B. (2015). *Journal of Adolescence, 44*, 48-56. doi: 10.1016/j.adolescence.2015.07.001

Barak, A., Hen, L., Nissim, M., & Shapira, N. (2008). A comprehensive review and as meta analysis of the effectiveness of internet-based psychotherapeutic interventions. *Journal of Technology in Human Services, 26,* 109-160.

Bartko, W. T., & Eccles, J. S. (2003). Adolescent participation in structured and unstructured activities: A person-oriented analysis. *Journal of Youth & Adolescence, 32*, 233-241. Retrieved from http://link.springer.com/article/10.1023/A:1023056425648

Beeber, L, S., Cooper, C., Van Noy, B, E., Schwartz, T, A., Blanchard, H, C., Canuso, R., et al. (2007). Flying under the radar: Engagement and retention of depressed low-income mothers in a mental health intervention. *Advances in Nursing Science, 30,* 221-234. doi: 10.1097/01.ANS.0000286621.77139.f0

Benjamin, C.L., Harrison, J.P., Settipani, C.A., Brodman, D.M., & Kendall, P.C. (2013). Anxiety and related outcomes in young adults 7 to 19 years after receiving treatment for child anxiety. *Journal of Consulting and Clinical Psychology, 81*, 865–876. doi: 10.1037/a0033048

Berndt, E. R., Koran, L. M., Finklestein, S.N., Glenberg, A. J., Korstein, S.G., Miller, I. M. (2000). Lost human capital from early-onset chronic depression. *American Journal of Psychiatry, 157*, 940-947. Retrieved from http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.157.6.940

Biederman, J., Petty, C.R.,Woodworth, K.Y., Lomedico, A., Hyder, L.L., & Faraone, S.V. (2012b). Adult outcome of Attention-Deficit/Hyperactivity Disorder: a controlled 16-year follow-up study. *Journal of Clinical Psychiatry*, 73, 941–950. doi:10.1017/S0033291705006410

Bobier, C., Stasiak, K., Mountford, H., Merry, S., & Moor, S. (2013). When 'e' therapy enters the hospital: Examination of the feasibility and acceptability of SPARX (a CBT programme) in an adolescent inpatient unit. *Advance in Mental Health*, *11*, 282-292. Retrieved from: http://0-web.a.ebscohost.com.mercury.concordia.ca/ehost/pdfviewer/pdfviewer?vid=7&sid=eda39a7e-7687-4b55-9a7e-98be9f82073b%40sessionmgr4005&hid=4212

Brent, D. A., Kalas, R., Edelbrock, C., Costello, A.J., Dulcan, M.K., & Conover, N. (1986). Psychophathology and its relationship to suicidal ideation in childhood and adolescence. *Journal of the American Academy of Child Psychiatry, 25,* 666-673. doi:10.1016/S0002-7138(09)60292-2

Broderick, C. B. (1993). Understanding Family Process: Basics of Family Systems Theory. Thousand Oaks, CA: Sage Publications.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research In Psychology, 3,* 77-101. doi: 10.1191/1478088706qp063oa

Busseri, M., Rose-Krasnor, L., Willoughby, T., & Chalmers, H. (2006). A longitudinal examination of breadth and intensity of youth activity involvement and successful development. *Developmental Psychology, 42*, 1313-1326. doi: 10.1037/0012-1649.42.6.1313

Canadian Institute of Health Research (2010). *Access & wait times in child and youth mental health: A background paper.* Retrieved from http://www.excellenceforchildandyouth.ca/sites/default/files/policy_access_and_wait_times.pdf

Carlfred. B.B. (1993). *Understanding family process: Basics of family systems theory.* London: Sage Publications

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology*, 56, 267–283. doi:10.1037//0022-3514.56.2.267

Chansky, T.E., & Kendall, P.C. (1997). Social expectancies and self-perceptions in anxiety-disordered children. *Journal of Anxiety Disorders, 11,* 347-363. doi:10.1016/S0887-6185(97)00015-7

Compas, E. B., Connor-Smith, K. J., Saltzman, H., Thomsen, H. A., & Wadsworth, E. M. (2001). Coping with stress during childhood and adolescence: Problems, progress, and potential in theory and research. *Psychological Bulletin, 127,* 87-127. doi: 10.1037/0033-2909.127.1.87

Copeland, W.E., Angold, A., Shanahan, L., & Costello, E.J. (2014). Longitudinal patterns of anxiety from childhood to adulthood: the great smoky mountains study. *Journal of the American Academy of Child & Adolescent Psychiatry*, *53*, 21-33 doi: 10.1016/j.jaac.2013.09.01

Corrigan, W.P. & Miller, E. F. (2004). Shame, blame and contamination: A review of the impact of mental illness stigma on family members. *Journal of Mental Health, 13,* 536-548.

Costello, E, J., & Maughan, B. (2015). Annual research review: Optimal outcomes of child and adolescent mental illness. *Journale of Child Psychology and Psychiatry*, *56*, 324-341. doi:10.1111/jcpp.12371

Costello, E.J., Mustillo, S., Keeler, G., & Angold, A. (2004). *Prevalence of psychiatric disorders in childhood and adolescence.* In B. Lubotsky Levin, J. Petrila, & K. Hennessy (Eds.), *Mental health services: a public health perspective* (pp. 111–128). New York, NY: Oxford University Press.

Coyl, D. D., Newland, L. A., & Freeman, H. S. (2010). Predict- ing preschoolers' attachment security

from parenting behaviors, parents' attachment relationships and their use of social support. *Early Child Development and Care*, *180*, 499–512. doi:10.1080/03004430802090463

Coyl, D. D., Roggman, L. A., & Newland, L. A. (2002). Stress, maternal depression and negative mother-infant interac- tions in relation to infant attachment. *Infant Mental Health Journal*, *23*(1–2), 145–163. doi:10.1002/imhj.10009

Crumbaugh, J. C., & Maholick, L. T. (1964). An experimental study in existentialism: The psychometric approach to Frankl's concept of noogenic neurosis. *Journal of Clinical Psychology, 20*, 589-596. doi:10.1002/1097-4679(196404)20:2.

Delaney, K. R. & Engels-Scianna, B. (1996). Parents' perceptions of their child's emotional illness and psychiatric treatment needs. *Journal of Child and Adolescent Psychiatric Nursing*, 9, 15–24. doi:10.1111/j.1744-6171.1996.tb00269.x

Donkin, L., Chritensen, H., Naismith, L, S., Neal, B., Hickie, I., & Glozier, N. (2011). A systemic review of the impact of adherence on the effectiveness of e-therapies. *Journal of Medical Internet Research, 13*. doi:10.2196/jmir.1772

Durlak, J. (2009) How to Select, Calculate, and Interpret Effect Sizes. *Journal of Pediatric Psychology, 34,* 917-28. doi: 10.1093/jpepsy/jsp004

Dyck, D. G., Short, R., & Vitaliano, P. P. (1999). Predictors of burden and infectious illness in schizophrenia care- givers. *Psychosomatic Medicine, 61*, 411–419. Retrieved from http://journals.lww.com/psychosomaticmedicine

Frankl, V.E. (1986a). General existential analysis (pp. 25-175). (4th edition) *The doctor and the soul*. New York: Vintage Books.

Frankl, V.E. (2000b). *Man's search for ultimate meaning* (Rev. ed.). New York: Perseus Publishing.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods, 5,* 1-10.

Ferriter, M., & Huband, N. (2003). Experiences of parents with a son or daughter suffering from schizophrenia. *Journal of Psychiatric and Mental Health Nursing*, *10*, 552–560. doi: 10.1046/j.1365-2850.2003.00624.x

Firestone, P. & Dozois, A, J, D. (2006). *Abnormal Psychology Perspectives (3rd ed.)* Toronto: Persona Education Canada Inc.

Freeman, H. S., Newland, L. A., & Coyl, D. D. (2008). Father beliefs as a mediator between contextual barriers and father involvement. *Early Child Development and Care*, *178*, 803–819. doi:10.1080/03004430802352228

Gaber, J. (2000). Meta-needs assessment. *Evaluation and Program Planning, 23,* 139-147. doi:org./10/1016/S0149-7189(00)00012-4.

Gee, J. P. (2006). Good video games and good learning. *Phi Kappa Phi Forum*, *85*, 34–37. Retrieved from: http://dmlcentral.net/wp-content/uploads/files/GoodVideoGamesLearning.pdf

Geraghty, K., McCann, K., King, R., & Eichman, K. (2011). Sharing the load: Parents and carers talk to consumer consultants at a child and youth health inpatient unit. *Internation Journal of Mental Health Nursing,* 20, 253-262. doi: 10.1111/j.1447-0349.2011.00730.x

Goodman, R. (2001). Psychometric properties of the strength and difficulties questionnaire. *Journal of American Academy of Child and Adolescent Psychology, 40*, 1337-1345. doi:10.1097/100004583-200111000-00015

Graham, I., Logan, J., Harrison, B, M., Straus, E, S., Tetroe, J., Caswell, W. & Robinson, N. (2006). Lost in knowledge translation: Time for a map? *Journal of Continuing Education in Health Professions, 25*, 13-34. doi:org/10/1002/chp.47

Green, R, W., Albon, S., Goring, C, J., Raezer- Blakely, L., Markey, J., Monuteaux, C, M., Henin, A., Edwards, G., & Rabbitt, S. (2004). Effectiveness of collaborative problem solving in affectively dysregulated children with oppositional-defiant disorder: Initial findings. Journal of Consulting and Clinical Psychology, 72, 1157-1164. doi: 10.1037/0022-006x.72.6.1157

Goldstein, M. J. (1981). Family factors associated with schizophrenia and anorexia nervosa. Journal of Youth & Adolescence, *10*, 385-405. http://dx.doi.org/10.1007/BF02088940

Gottman (2017). Building a sound relationship house. Retrieved from: https://www.gottman.com/blog/building-a-sound-relationship-house/

Griffiths, C., & Sin, J. (2013). Rethinking siblings and mental illness. *The British Psychological Society, 26*, 808-810. Retrieved from https://thepsychologist.bps.org.uk/volume-26/edition-11/rethinking-siblings-and-mental-illness

Hatfield, A. B. (1994). The family's role in caregiving and service delivery. In H. Lefley & M. Maswow (eds), *Helping families cope with mental illness* (pp.39-62). New York: Harwood Academic.

Hampson, B, R., & Beavers, W, R. (1996). Family therapy and outcome: Relationships between therapist and family styles. *Contemporary Family Therapy, 18*, 345-370. doi: https://doi.org/10.1007/BF02197047

Hirsch, Z. B. (1995). The application of logotherapy in education. *The international forum for logotherapy, 18,* 32-36.

Hinshaw, P, S. (2005). The stigmatization of mental illness in children and parent: developmental issues, family concerns, and research needs. *Journal of Child Psychology and Psychiatry*, *46*, 714-734. doi: 10.1111/j.1469-7610.2005.01456.x

Hinshaw, S.P., Owens, E.B., Zalecki, C., Huggins, S.P., Montenegro-Nevado, A.J., Schrodek, E., & Swanson, E.N. (2012). Prospective follow-up of girls with Attention-Deficit/Hyperactivity Disorder into early adulthood: continuing impairment includes elevated risk for suicide attempts and self-injury. *Journal of Consulting and Clinical Psychology*, 80, 1041–1051.doi: 10.1037/0022-006X.74.3.489

Howard, P. B. (1998). The experiences of fathers of adult children with schizophrenia. *Issues in Mental Health Nursing*, 19, 399–413. doi:10.1080/016128498249006

Hutchison, T. G., & Chapman, P. B. (2005). Logotherapy- Enhanced REBT: An integration of discovery and reason. *Journal of Contemporary Psychotherapy, 35*, 145-155. Retrieved from: http://link.springer.com/article/10.1007/s10879-005-2696-x

IBM Corp (2017). IBM Statistics for Windows [Statistical Package for Social Sciences] Version 25.0. Armonk, NY: IBM Corp.

Ingoldsby, M, E. (2010). Review of interventions to improve family engagement and retention in parent and child mental health programs. *Journal of Child and Family Studies, 19*, 629-645. doi: 10.1007/s10826-009-9350-2

Ivtzanan, I., Lomas, T., Hefferon, K. & Worth, P. (2016). *Second wave positive psychology: Embracing the dark side*. Routledge: New York.

Johannson, A., Anderzen-Carlsson, A., Ahlin, A., Andershed, B., & Skondal, E. (2012). Fathers' everyday experiences of habing an adult child who suffers from long-term mental illness, *Issues in Mental Health Nursing,* 33, 109-117. doi: 10.3109/01612840.2011.62710

Joint Committee on Standards for Educational Evaluations. (1994). The program evaluation standards: How to assess evaluations of educational programs. Newbury Park, CA: Sage

Judd, J., Frankish, J, C., & Moulton, G. (2001). Setting standards in the evaluation of community-based health promotion programmes-A unifying approach. *Health Promotion International, 16*, 367-380. doi: 10.1093/heapro/16.4.367

Kang, H. (2013). The prevention and handling of the missing data. *Korean Journal of Anesthesiology,64*, 402-406. doi: 10.4097/kjae.2013.64.5.402

Keenan-Miller, D., Hammen, C.L., & Brennan, P.A. (2007). Health outcomes related to early adolescent depression. *Journal of Adolescent Health*, *41*, 256–262. doi: 10.1016/j.jadohealth.2007.03.015

Kessler, C. R., Berglund, P., Demler, O., Jin, R., Merrikangas, R, K., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in national comorbidity survey replication. *Archives of General Psychiatry, 62,* 593-602. doi:10.1001/archpsyc.62.6.593.

Kermani, H. & Aldemir, J. (2015). Preparing children for success: integrating science, math, and technology in early childhood classroom. *Early Child Development and Care, 185*, 1504-1527. doi: 10.1080/03004430.2015.1007371

Keyes, M. L. C. (2006). Mental health in adolescence: Is America's youth flourishing. *American Journal of Orthopsychiatry, 76,* 395-402. doi:10.1037/0002-9432.76.3.395

Khanna, S, M., & Kendall, C, P. (2010). Computer-assisted cognitive behavioural therapy for child anxiety: Results of a randomized clinical trial. *Consulting and Clinical Psychology, 78*, 737-745. doi: 10.1037/a0019739

King, R., Bambling, M., Reid, W., & Thomas, I. (2006). Telephone and online counselling for young people: A naturalistic comparison of session outcome, session impact and therapeutic alliance. *Counselling & Psychotherapy Research*, *6,* 175–181. doi:10.1080/14733140600874084

Kowalewski, K., McLennan & J., McGrath J P. (2011). A preliminary investigation of wait times for child and adolescent mental health services in Canada. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 20*, 112-119. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3085670/

Kumpfer, L. K. (2002). Factors and processes contributing to resilience. *Resilience and Development*, 179-224. Retrieved from http://link.springer.com/chapter/10.1007/0-306-47167-1_9

Lean, D., & Colucci, A. V. (2013). *School-based Mental Health. A Framework for Intervention.* R&L Education.

Loebach, R. & Ayoubzadeh. (2017). Wait time for psychiatric care in Ontario. *University of Western Ontario Medical Journal, 86,* 48-50. doi:10.5206/uwomj.v862i2.2027

Leavey. J. E. (2005). Youth experiences of living with mental health problems: Emergence, loss, adaptation and recovery (Elar). Canadian Journal of Community Mental Health. Retrieved from http://cjcmh.com/toc/cjcmh/24/2

Leith, E, J. & Stein, H, C. (2012). The role of personal loss in the caregiving experience of well siblings of adults with serious mental illness. *Journal of Clinical Psychology,* 68, 1075-1088. doi:10.1002/jclp.21881

Lefley, H. P. (1992). The stigmatized family. In P. J. Fink & A. Tasman (Eds.), Stigma and mental illness (pp 127 –138). Washington DC: American Psychiatric Press.

Lim, K . L ., Jacobs, P ., Ohinmaa, A ., Schopflocher, D ., & Dewa, C . S . (2008) . A New Population-Based Measure of the Economic Burden of Mental Illness in Canada . *Chronic Diseases in Canada, 28*, 92-98.

Lowenstein, L. (2010). *Creative Family Therapy Techniques: Play, art and expressive activities to engage children in family sessions*. Toronto: Champion Press.

Lukas, E. (1986). Guilt and the question of meaning. *Meaning in suffering*. Berkeley, CA: Institute of Logotherapy Press.

Lukens, P, E., Thorning, H., & Lohrer, S. (2004). Sibling perspectives on sever mental illness: Reflections on self and family. *American Journal of Orthepsychiatry, 74*, 489-501. doi: 10.1037/0002-9432.74.4.489

MacKenzie, M. J., Nicklas, E., Brooks-Gunn, J., & Waldfogel, J. (2011). Who spanks infants and toddlers? Evidence from the fragile families and child well-being study. *Children & Youth Services Review*, *33*, 1364–1373. doi:10.1016/ j.childyouth.2011.04.007

Malchiodi, C. A., & Crenshaw, D. (2014). Creative arts and play

therapy with attachment problems. New York, NY: Guilford Press

March, S., Spence, H, S., & Donovan, L, C. (2009). The efficacy of an internet-based cognitive behavioural therapy intervention for child anxiety disorder. *Journal of Pediatric Psychology, 34*, 474 – 487. doi:10.1093/jpepsy/jsn099

McCarty, C. A., & McMahon, R. J. (2003). Mediators of the relation between maternal depressive symptoms and child internalizing and disruptive behavior disorders. *Journal of Family Psychology*, *17*, 545–556. doi:10.1037/0893-3200 .17.4.545

McDavid, J. & Hawthorn, R, L. (2006). Program evaluation & performance measurement: *An introduction to practice.* London: Sage Publications.

McDavid, J., Huse, I. & Hawthorn, R, L. (Eds) (2018). Program evaluation & performance measurement: *An introduction to practice.* London: Sage Publications.

Mental Health at Cheo. (2013). *What parents can do while waiting for mental health services*. Retrieved from http://www.cheo.on.ca/uploads/Waiting%20for%20MH%20services.pdf.

Meier, A., & Boivin, M. (2006). Intrapsychic conflicts, their formation, understanding dynamics and resolution: An objects relations perspective. In A. Meier and M. Rovers (Eds.) Through conflict to reconciliation. Novalis Publications.

Marsh, D. T., & Dickens, R. M. (1997). *Troubled journey: Coming to terms with the mental illness of a sibling or parent*. New York, NY: Penguin.

Marshall, M. & Marshall, E. (2012). *Logotherapy revisited: Review of the tenets of Viktor E. Frankl's Logotherapy*. Ottawa Institute of Logotherapy, Ottawa

Mohr, W. K. & Regan-Kubinski, M. J. (2001). Living in the fallout: Parents' experiences when their child becomes mentally ill. *Archives of Psychiatric Nursing*, *15*, 69–77. doi:10.1053/apnu.2001.22406

Mukolo, A., Heflinger, A, C., Wallston, A, K. (2010). The stigma of childhood mental disorders: A conceptual framework. *Journal of the American Academy of Child and Adolescent Psychiatry, 49*, 92-198. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2904965/ .

Mrazek, P. J., & Haggerty, R. J. (Eds.). (1994). *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*. National Academies Press.

National Assiciation on Mental Illness (2013). Impact of mental illness on well siblings: A sea of confusion. The Alliance on Mental Illness, NAMI Chicago. Retrieved from http://www.namigc.org/documents/ImpactofMIonsiblings.pdf

Nelis, D., Quoibach, J., Hansenne, M., & Mikolavjczak, M. (2011). Measuring individual differences in emotion regulation: The emotion regulation profile-revised (ERP-R). *Psychologica Belgica*, *51*, 49–91. doi:10.5334/pb-51-1-49

Olicver, G. K., Collin, P., Burns, J., & Nicholas, J. (2006). Building resilience in young people through meaningful participation. *Australian e-Journal for the Advancement of Mental Health, 5,* 1-7. doi:10.5172/jamh.5.1.34

Ontario Agency for Health Protection and Promotion (2016). Focus on: Logic models- a planning tool. Retrieved from: https://www.publichealthontario.ca/-/media/documents/focus-on-logic-model.pdf?la=en

Pancer, M. S., Kransor-Rose, L., & Loiselle, D. L. (2003). Youth conferences as a context for engagement. *New Directions for Youth Development, 2002*, 47-64. DOI: 10.1002/yd.26

Patel, V., Flisher, A. J., Hetrick, S., & Mcgorry, D. P. (2007). Mental health of young people: A global public-health challenge. *The Lancet, 369,* 1302-1313. doi:10.1016/S0140-6736(07)60368-7

Patton, M.Q. (1984). An alternative evaluation approach for the problem-solving training program: A utilization-focused evaluation process. *Evaluation and Program Planning, 7*, 189–192

Papageogiou, G., Grant, W, S., Takkenberg, JM, J., & Mokhles, M, M. (2018). Statistical primer: how to deal with missing data in scientific research? *Interactive CardioVascular and Thoacic Surgery, 27*, 153-185. doi:10.1093/icvts/ivy102.

Parent, Family and Community Engagement (2019). The family partnership process: Engaging and goal-setting with families. Retrieved from: https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/engaging-and-goal-setting-with-families.pdf

Proudfoot, G, J. (2004). Computer-based treatment for anxiety and depression: is it feasible? Is it effective?. *Neuroscience & Biobehavioural Reviews,* 28, 353-363. doi:10.1016/j.neubiorev.2004.03.008

QSR International Pty Ltd (2018). Statistical and Qualitative Data Analysis Software [NVivo]. Retrieved from: https://www.qsrinternational.com/nvivo/support-overview/faqs/how-do-i-cite-qsr-software-in-my-work

Reichlin, B. (2019). Imago dialogue: building great communication. Retrieved from: http://webcache.googleusercontent.com/search?q=cache:bI0s2QkVxgwJ:imagoworks.com/the-imago-dialogue/+&cd=1&hl=en&ct=clnk&gl=ca&client=safari

Resnick, D, M. (2000). Protective factors, resiliency, and healthy youth development. *Adolescent Medicine, 11,* 157-164. Retrieved from http://www.savi.uct.ac.za/wp-content/uploads/2013/11/Resileince-and-protective-factors.pdf

Representative for Children and Youth (2013). *Still waiting: First-hand experinces with Youth Mental Health Services in B.C.*.Retrieved from: https://www.rcybc.ca/sites/default/files/documents/pdf/reports_publications/still_waiting.pdf

Rose, L. E., Mallinson, R. K., & Gerson, L. D. (2006). Master, burden, and areas of concern among family caregivers of mentally ill persons. *Archives of Psychiatric Nursing*, *20,* 1, 41-51. doi: 0.1016/j.apnu.2005.08.009

Rovers, M. (2006) Overview of attachment theory: A continuous thread. *Family Therapy Magazine,* 8-11.

Sawyer, D., Gale, J., & Lambert, D. (2006). Rural frontier mental and behavioral health care: Barriers, effective policy strategies, best practice. *National Association for Rural Mental Health*, 1–13. Retrieved from http://www.narmh.org/ publications/archives/rural_frontier.pdf

Slade, M. (2010). Mental illness and well-being: the central importance of positive psychology and recovery approaches. *BMC Health Services Research, 10. Retrieved from:* *https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-10-26*

Sin, J., Moone, N., Harris, P., Scully, E., & Wellman, N. (2012). Understanding the experiences and service needs of siblings of individuals with first-episode psychosis: a phenomenological study. *Early Intervention in Psychiatry,* 6, 53-59. doi:10.1111/j.1751-7893.2011.00300.x

Spoth, R., Goldberg, C., & Cleve, R. (1999). Engaging families in longitudinal preventive intervention research: Discrete-time survival analysis of socioeconomic and social-emotional risk factors. *Journal of Consulting and Clinical Psychology, 67,* 157-163. http://dx.doi.org/10.1037/0022-006X.67.1.157

Stratton, P., Bland, J., Janes, J., & Lask, J. (2010) Developing a practicable outcome measure for systemic family therapy: The SCORE. *Journal of Family Therapy, 32*, 232-258. https://doi.org/10.1111/j.1467-6427.2010.00507.x

Watt, B., & Dadds, R, M. (2007). Facilitating treatment attendance in child and adolescent mental health services: A community study. *Clinical Child Psychology and Psychiatry, 12*, 105-116. doi: 10.1177/1359104507071089

Waddell C., Hua, J, M., Garland, O, M., Peters, R, D., McEwan. (2007). Preventing Metal disorders in children: a systemic review to inform policy-making. *Canadian Journal of Public Health*, *98*, 166-173.

Wade, J. (2006). Crying alone with my child: Parenting a school age child diagnosed with bipolar disorder. *Issues in Mental Health Nursing*, 27, 885–903. doi: 10.1080/01612840600842493

Winter, F, C, J. (2013). Practical, assessment, research & evaluation. *A Peer Reviewed Electronic Journal, 18*, 1-12. ISSN 1531-7714

Wong, P.T.P., & Fry, P.S. (Eds.) (1998). *The human quest for meaning: A handbook of psychological research and clinical applications*. Mahwah: Lawrence Erlbaum Associates, Inc. Publishers.

Wong, P.T.P., & Wong, L.C.J. (2006). *The handbook of multicultural perspectives on stress and coping*. New York: Springer.

Wong, P. T. P., & Wong, L. C. J. (2013). A meaning-centered approach to building youth resilience. doi:10.4324/9780203146286

Wong, P. T. P. (2010). Meaning therapy: An integrative and positive existential psycho- therapy. *Journal of Contemporary Psychotherapy*, *40*, 85–93. doi:10.1007/s10879-009-9132-6

Wong, P. (2011). Reclaiming Positive Psychology. *Journal of Humanistic Psychology,51*(4), 408-412. doi:10.1177/0022167811408729

Zika, S., & Chamberlain, K. (1992). On the relation between meaning in life and psychological well-being. *British Journal of Psychology, 83*, 133-145. http://dx.doi.org/10.1111/j.2044-8295.1992.tb02429.x

FIGURE 1.: D.R.E.A.M.-O.F. Program Logic Model

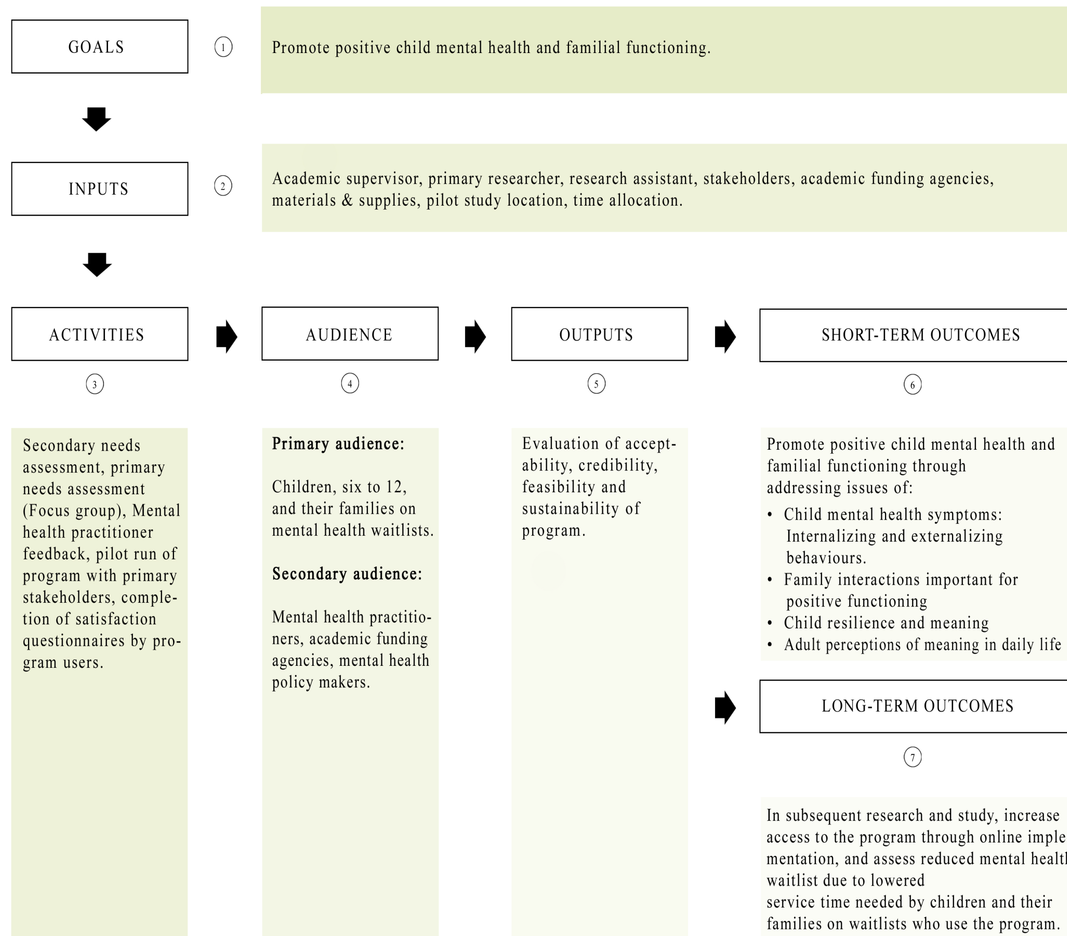


TABLE 1

Descriptive Statistics of Analyses

Table 1

Descriptive Statistics

		Name	Age	Gender	Meaning in Daily Life (PRE)	Child Mental Health (ISA) (PRE)	Purpose in Life (PRE)	Family Functioning (PRE)	Child Mental Health (SDQ) (PRE)	Meaning in Daily Life (POST)	Child Mental Health (ISA) (POST)	Purpose in Life (POST)	Family Functioning (POST)	Child Mental Health (SDQ) (POST)
N	Valid	24.00	11.00	24.00	22.00	25.00	10.00	13.00	19.00	15.00	15.00	7.00	9.00	14.00
	Missing	0.00	16.00	0.00	5.00	2.00	17.00	14.00	8.00	12.00	12.00	20.00	18.00	13.00
Mean			7.73	1.56	83.14	49.60	76.40	54.62	45.16	99.60	25.47	80.86	63.33	42.00
Std. Deviation			1.68	0.51	28.24	27.77	12.68	4.96	8.27	29.70	18.05	16.21	9.07	10.47
Variance			2.82	0.26	797.55	771.25	160.71	24.59	68.47	881.97	325.98	262.81	82.25	109.54
Minimum			6.00	1.00	37.00	3.00	55.00	42.00	33.00	39.00	1.00	51.00	45.00	27.00
Maximum			10.00	2.00	118.00	102.00	93.00	61.00	60.00	120.00	62.00	96.00	71.00	65.00

TABLE 2

Regression Analysis of Meaning in Daily life and Child Mental Health

Table 2

Pearsons Correlation Coefficient

Variable		1	2	3	4	5	6	7	8	9
1. Meaning in Daily Life	PRE									
2. Child Mental Health (ISA)	PRE	-.483*								
3. Purpose in Life	PRE	.840**	0.298							
4. Family Functioning	PRE	.715*	0.244	.866**						
5. Child Mental Health (SDQ)	PRE	-0.433	0.168	-0.061	0.116					
6. Meaning in Daily Life	POST	.780**	-0.157	.816*	0.686	-.676*				
7. Child Mental Health (ISA)	POST	-.706*	0.484	-0.514	-0.019	.759*	-.642*			
8. Purpose in Life	POST	0.931	0.337	.993**	0.847	-0.626	.903**	-0.477		
9. Family Functioning	POST	.913*	0.239	0.775	.882**	-0.668	.891**	-0.319	.779*	
10. Child Mental Health (SDQ)	POST	-0.608	0.199	-0.719	-0.445	.816**	-0.483	.734**	-0.711	-0.356

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

APPENDIX A

D.R.E.AM.-O.F. Family Units

The Family Tree

Unit 1 → Family Tree Roots (Goal-Setting)
Objective:
- Introduce the benefits of collaborative goal-setting
- Provide optional guiding questions to help facilitate goal-setting
- Feedback on activity & program material

Materials:
- Paper Tree
- Markers

Approximate time completion:
- 15-20 minutes

Main Steps	
Psychoeducation About Collaborative Goal-Setting	Committing to whole-family objectives and goals where all family members are in agreement, can be instrumental for promoting positive family functioning. Goal-setting is a good way to ensure that family priorities do not get overlooked in the busy hustle of day-to-day duties. When setting goals it is important to be: 1] specific, 2] realistic, 3] check-in on goal progress and 4] set timelines.
Family Tree Roots (Goal-Setting)	Just like a tree, a family can be seen as a complex system, with many parts working together to create a healthy functioning unit. When a tree's needs are met it grows strong and robust. Setting family goals addresses meeting the needs of the family and helping to make its members grounded and vigorous. Imagine this tree represents your family, what are some goals that might help your family tree to grow and become stronger? Together take 10 minutes to brainstorm a list of whole-family goals. Have one person write the goals down and then decide on 2-3 goals that are most important for the family at this time. Retain the remaining goals, if any, for future review. Write each of goals at the roots of the tree.
Examples and Optional Guiding Questions	**Examples of some family goals:** Spend more time together as a family (game nights, movie nights, crafts nights, take turns reading a book aloud, etc.). Having more family rituals (saying good morning/

	goodnight to each other every day, at least one hug a day, one positive compliment to each other a day). Being more physically active together (at least one walk a week together, 10 family jumping jacks a day, a one song a week dance party). Trying one new thing together a month (cooking a different meal, trying a new craft, special topic selections for dinner conversation). **Guiding questions for goal selection:** What specifically do we want to achieve? How will we achieve it? What steps will we take? When will we know we have achieved it? What might we feel? How will we decide on a time that works for everyone to start the goal? How much time do we think it will take to complete the goal? Is this a goal that everyone likes? What are some things we are already doing that are similar to this goal? How will this goal be different?
Family Discussion	What was this like for you? Talk about when people could use this exercise.
Assigned Homework	Check-in on goals once a week. Are we still on track? Has the goal changed? Is it still meeting our hopes and needs for our family? Have we attained it and do we want to work on a different goal? Once a goal is completed a flower sticker can be placed at the base of the tree beside the completed goal.

Unit 2 → Family Memory Branch

Objective:

- Introduce the benefits of meaningful engagement
- Provide optional guiding questions to help facilitate meaningful memory selection
- Feedback on activity & program material

Materials:

- Paper Tree
- Paper Tree Leaves
- Glue Stick
- Markers

Approximate time completion:

- 10-15 minutes

Main Steps	
Psychoeducation About Meaningful Engagement	Engaging in activities that are meaningful can promote hope, creativity and a positive sense of being in control of situations, decisions and consequently one's life. Meaningful engagement can derive from positive attitudes, identifying what aspects of a situation are important and from striving to create things in life, such as significant memories.
The Family Memory Branch Game	The branches of a tree are home for the leaves that collect sunlight. This enables the tree to produce food and nourishment. Just as the leaves gather sunlight, over the course of our life we create and collect memories that contribute to making us who we are. In this unit, each member of the family takes a turn sharing a memory that is significant for them. Perhaps the memory is important because it is a positive memory or it is noteworthy because of other significant factors. Each family member then writes a word or two that represents these memories on 1 of the paper leaves and sticks it to the "The Family Memory Branch". After each family member has shared a memory from the past, each person in the family has the opportunity to suggest something that they could all potentially do together in the future to create a new memory. This future memory can fall in line with one of the goals created in unit 1.
Optional Guiding Questions for Identifying Meaningful Memories	**Past memory:** What about this memory is significant to you?

	How might this memory be significant to the whole family? When you think about this memory what are the 2 main emotions that you feel? What are some things that you learned from this memory? When reflecting back on this memory, is there anything you wish you had done differently? **Future memory:** What about creating this memory is important for you? How might this memory be important for the whole family? What are 2 feelings you are hoping to have from creating this memory? What are some things you and your family may gain or learn from this creating this memory? Does creating this memory work with any of the goals created in unit 1? If so, which goals and why?
Family Discussion	What was that like for you? Talk about when people could use this exercise.
Assigned Homework	Have any new memories come to mind since initially completing this activity that can be added to the “The Family Memory Branch”? As a family, discuss creating one new family memory together by the end of the week that falls in line with the goals created in unit 1.

Unit 3 → Family Apple-y Ever After

Objective:

- Introduce the benefits of communication & conflict resolution
- Provide guiding tips to help facilitate communication & conflict resolution
- Feedback on activity & program material

Materials:

- Paper Tree
- Paper Apples
- Hand Mirror
- Glue Stick
- Markers

Approximate time completion:

- 15-20 minutes

Main Steps	
Psychoeducation about Communication & Conflict Resolution	Positive family functioning can be viewed from a relational perspective; how does everyone get along with each other? Goals of providing an environment that foster opportunities for positive interactions such as, communication, meaningful engagement and having empathy and concern for fellow family members, are important in a healthy functioning family. Effective communication involves active listening, which is responding to what an individual has said so they know you have been listening and they have been heard. This also provides validation, which contributes to a person feeling valued and understood. Each of these are important for successful conflict resolution.
The Magic Mirror and Apple-y Ever After Game	When you think of what it takes for an apple to grow big and delicious, there are many challenging obstacles it must overcome. Starting from just a small seed, it has to manage bad weather, birds and even pesky squirrels. However, the end of an apple's long journey concludes with something wonderful, sweet and delicious. Family conflict can be thought of in a similar way (maybe not the delicious part). When it seems like things are really rough, proper family conflict resolution can lead to something wonderful, such as healthy bonding and a stronger family. In this unit, two family members will participate in a communication exercise designed at promoting healthy conflict management. If your family is bigger than 2, the

	other family member(s) can observe and offer guidance when needed. In this exercise 1 of the 2 family members will hold up the mirror; they get to start as the message reflector (the mirror). The mirror is to help them "mirror" back everything the sender (the other family member participating in the communication exercise) says to them. In the first step the sender gets to pick a family event or topic that they would like to talk about further. For example, the sender may say: " Sometimes it is hard for me to have to ask ""please get ready for bed"" so many times. It is like I am being ignored" Hearing this, the message reflector would mirror back (almost word-for-word) exactly what they have heard: "Sometimes it is hard for you to have to ask "please get ready for bed" so many times. It is like you are being ignored" The message reflector would then check to make sure they received the full message and if there is anything else the sender would like to add. For example, the message reflector could ask: "Did I get that right?" Sender: "Yes that is right." Message reflector: "Is there anything else that you would like to add?" Sender: "Sometimes it makes me sad." Because the sender has now added something new, the message reflector must mirror this back. Message reflector: "And sometimes it makes you sad." The next step is for the message reflector to convey an understanding of the sender's message. For example, the message reflector may say: "I can understand that you might feel sad and ignored when you have to repeat yourself so many times. Nobody likes to feel sad and ignored." The final next step involves the message reflector suggesting 2 other feelings that the sender may feel in the particular situation: " I can imagine that maybe you also feel frustrated and annoyed." The sender can then agree or add their own emotions. Once the conversation is complete both the sender and message reflector work together to decide on one small behaviour they could each do to help the situation. For example, the message reflector may suggest: "Sometimes

	it is really hard for me to turn off the TV and get ready for bed when it's a show I really like. Maybe you could give me time-warnings? Like 15 minutes, then 10 minutes then 5 minutes. Or maybe if I can get ready fast enough, when I get into bed we can play the Grateful game (identifying 5 things from the day that someone is grateful for) before I fall asleep." The sender may suggest: "Sometimes just knowing what I have said has been heard and acknowledged can help. If a response can be given like ""OK Mom thank you for the reminder! I will start to finish my TV time."" That would help me know that I have been listened to." Once both sender and message reflector have agreed on the one small behaviour both of them work together to identify what new emotions may be experienced from the new behaviours. At this point any of observing family may also make suggestions. Together the family may suggest the new emotions of: "Someone who feels listened to might feel loved and respected." Or "Someone who has someone sit with them for a little bit before bed might feel more comfortable and secure before falling asleep." The new suggested behaviours are written on an apple and placed on the tree. The roles can then be switched with someone else being the sender and someone else being the message reflector.

Guiding Tips to help facilitate communication & conflict resolution.	Tips for Message Reflector: - The goal when mirroring the message is for the sender to feel like the their message has been fully heard. Therefore it is important to mirror back the message exactly how it was said and not try to interpret or change it. - It is important to ask the sender if there is anything they would like to add to their message to ensure that they feel that they have been fully heard. If something new is added then this should be mirrored back. - In the second step when the message reflector conveys an understanding of what they have heard, the goal is to focus on understanding the sender's experience and not whether the message reflector agrees with it or not. Tips for the Sender: - When sending your message, try to keep it concise and simple so that it is easy for the message reflector to mirror back. More can always be added after the first message has initially been mirrored. Tips for Choosing a Small Behaviour: - It should be something that is measurable. - Something that both members agree upon. - Something that is realistic. - Something that would address some of the feelings identified in the final step of the mirroring conversation.
Family Discussion	What was that like for you? Talk about when people could use this exercise.
Assigned Homework	Try using this type of communication in other areas of family interaction; it is helpful for promoting active listening. Think about the apples created in this exercise, have the behaviours been followed? If not, maybe the exercise needs to be revisited. As a family discuss how addressing communication and conflict issues may support you in achieving the goals created in unit 1.

Unit 4 → The Family Strengths & Growth Branch

Objective:

- Introduce the benefits of identifying family strengths
- Provide optional guiding questions to help facilitate strength & growth selection
- Feedback on activity & program material

Materials:

- Paper Tree
- Paper Tree Leaves
- Paper Rain Drops
- Glue Stick
- Markers

Approximate time completion:

- 10-15 minutes

Main Steps	
Psychoeducation about How Strengths & Growth Promoting Resilience.	When circumstances are challenging it can be helpful to explore a difficult situation and focus on what strengths were utilized or what aspects of personal growth may have occurred from the experience. Both positive and negative occurrences cannot exist without the other; the contrast has to be experienced in order to be able to appreciate one from the other. Sometimes it can be helpful to look beyond the event that is immediately before us. Thinking deeper on it can lead to an opportunity of deriving meaning from experiences, good or bad. All encounters can be seen as learning experiences. Adopting this type of attitude can be helpful for developing resilience and adaptive coping skills or, in other words, developing the personal strengths and abilities necessary to deal with many of life's challenging occurrences.
The Family Strengths & Growth Game Branch	Similar to the branch in unit 2 the focus here is to nourish the family tree so it can grow stronger. In this unit the whole family works together to identify individual and family strengths. Each family member takes a turn sharing a challenging day or event they recently experienced. Collaboratively, the family works together to help the individual family member identify what personal strengths were used in that situation. These individual strengths are then written on the individual's leaf. Areas of the event where it is difficult to identify a strength can be recognized as an area in need of growth. This area for growth is then

	written on one of the raindrops and placed at the top of the tree indicating that nutrients are needed to promote growth in this area. After the family has worked together to explore individual strengths and areas requiring growth, they collaboratively explore whole-family strengths and areas for growth following the same procedure with the leaves and raindrops.
Optional Guiding Questions for Identifying Strengths and Growth	Strengths: - What was managed well in this situation (however large or small)? - Has the strength identified been used in other situations? - What about this strength is important? - What does having this strength enable you to do? - What emotions do you feel when you use this strength? - How is this strength important for you as individual? What about for the family as a whole? Growth: - What was the hardest part about this situation? - What might growing in this area allow you to do? - What differences may you notice from having had this growth? - How might you feel from growing in this area? - How is this growth important for you as an individual? What about for the family as a whole?
Family Discussion	What was this like for you? Talk about when people could use this exercise.
Assigned Homework	Have there been any opportunities to use the strengths identified in this exercise? Has there been any growth since completing this exercise? Can you share an example together as a family? How might these areas of strength and growth support some of the goals created in unit 1?

Unit 5 → May the Forest Be With You (For the Adults)

Objective:

- Introduce the benefits of community connection
- Provide suggested resource sources
- Feedback on program material

Main Steps	
Benefits of Community Connection	Mental health concerns can affect every aspect of a child's life, including their family and peer relationships. As many children struggling with mental illness are unable to access appropriate mental health services, family members often become a significant source of support in dealing with the mental health issues. In addition to the stress and isolation sometimes experienced by parents through acting as a main source of support, frustration in trying to navigate the mental health care system is a common occurrence. Many families are unsure where to begin, what services are available to them and what programs would best suit their child's needs.
May the Forest Be With You	FUN FACT: Like humans, trees are extremely social and are able to communicate with each other, even when they are forests apart. The roots of one tree are able to transmit messages to another, allowing them to share resources with other trees in need, such as water and nutrients. In fact, parent trees of one forest have been found to support parent trees of another forest, increasing the resilience of the whole tree community. In this final unit the goal is to connect families to community resources, academic findings and other families who share similar experiences, so to better support families on their journey of advocating for their child and encouraging positive family functioning. These resources would be transmitted via an online platform, so to have it easily accessible for all families.
Examples of Some Resources Via the Online Platform	- Community resources o Ranging from free to fee. o Whole family o Child-centered - Publications o Academic o Journalistic o Opinion articles

	- Community connection o Online forums o Facebook groups

1. Ementalheal.ca

- **Free:**
  - Big Brothers Big Sisters Ottawa
  - Boys & Girls Club Ottawa
  - Child and Youth Friendly Ottawa
  - Community Information Centre of Ottawa
  - Crossroads Children's Center: Mental Health Walk in Clinic
  - Ottawa Children's Coordinated Access and Referral Committee Wraparound Ottawa
- **Fee:**
  - Ausome Ottawa
  - Catholic Family Service Ottawa
  - Scouts Canada
  - Steps and Strides- Social Skills Programs

- **Articles:**
  - Emotions: Helping Young Children Cope with Emotions
  - Gender Identity and Diversity: Information for Parents and Caregivers.

2. Ottawa Academy of Psychology Listing
3. ABC Ottawa
4. Maison de la Famille de Gatineau
5. Kids Help Phone (1-800-668-6868)
6. PLEO/CHEO
8.Family Services Ottawa
9.Wabano Centre
10. Youth Services Bureau
11. Narcity (For local events)

APPENDIX B

Focus Group Recruitment Letter

Dreaming of a Solution: D.R.E.A.M-O.F. a Mental Health Promotion Program for Children and Their Families on Mental Health Waitlists

Research contact:

Emma Watt (Ph.D candidate)

Good Morning,

I am a Ph.D. candidate at Saint-Paul University in the Counselling, Psychotherapy & Spirituality program. I am emailing you to see if your association may know some families who would be interested in participating in a study I am conducting.

Under the supervision of Dr. Laura Armstrong (Ph.D., Clinical Psychologist), I am interested in developing a mental health promotion program for children on mental health waitlists and their families. Many Canadian children require support for their mental health concerns, but many are delayed in receiving treatment due to long waiting lists. The purpose of the proposed research is to develop a brief mental health promotion approach for families to use while on mental health waitlists.

We were wondering if your association would be open to sharing the information of our study with the families connected to your organization. I have attached the advertisement poster we have prepared.

What is involved?

Families will be asked to participate in a focus group discussion in order to support the development of a mental health promotion program designed to meet the needs of families on mental health waitlists. Families will then be offered the opportunity to partake in a trial run of the new family mental health promotion program.

Who can be involved?

Children ages 6 to12 who are on or have been on mental health waitlists, and their families

Amount of time needed at the school to complete this research:

One study day is required, however families have the option to participate in the mental health promotion program at a later date. One study day will involve participation in a focus group and may take approximately 60 minutes of the family's time.

Preferred week/month to start

Saturday January 12th

Where will the study take place?

Saint Paul University's Counselling and Psychotherapy Centre, 223 Main Street.

APPENDIX C

Focus Group Recruitment Poster

Family Participants Needed

Dreaming of a Solution: D.R.E.A.M-O.F. a Mental Health Promotion Program for Children and Their Families on Mental Health Waitlists

Emmalyne Watt (Ph.D Candidate), under the supervision of Dr. Laura Armstrong (Ph.D., Clinical Psychologist), is interested in developing a brief mental health promotion program for families with children ages 6-12 on mental health waitlists.

What is involved? Families will be asked to participate in a focus group discussion in order to support the development of a mental health promotion program designed to meet the needs of families on mental health waitlists. Families will then be offered the opportunity to partake in a trial run of the new family mental health promotion program at a later date.

When will the study take place? Saturday afternoon January 12th 2019 from 12:00-1:00pm.

Where will the study take place? Saint Paul University's Counselling and Psychotherapy Centre, 223 Main Street.

How long will it take? Participation in the focus group may take approximately 60 minutes of your family's time.

Interested?

Please contact: Emma Watt

APPENDIX D

Focus Group Consent Form

Dreaming of a Solution: D.R.E.A.M-O.F. a Mental Health Promotion Program for Children and Their Families on Mental Health Waitlists

Purpose of the Study

Emmalyne Watt, Ph.D candidate in Counselling and Spirituality at Saint Paul University, supervised by Dr. Laura Armstrong, is carrying out a research study examining whether families on mental health waitlists could benefit from a brief mental health promotion program prior to accessing standard mental health services. Key implications of the study involve examining whether promoting resilience and meaning, enhancing family quality of life and family resilience will ultimately result in a reduction of childhood mental health symptoms and, potentially, shorten service time needed.

Procedure

If you and your family agree to take part in the study, you will be asked to participate in a focus group where you will be presented with a series of questions. Your responses to these questions will help us to incorporate the lived experiences and needs of families directly into our program in order to better meet your needs. The focus group will be auditory-recorded so that the content may be further referenced for accuracy. Following the completion of the focus group, at a later date, you will be invited to participate in the family mental health promotion program.

If you or your family members feel uncomfortable answering some of these personal questions, then you or they may refrain from doing so. Participation in the focus group may take approximately 60 minutes of your family's time.

Rights of Participants

If you and your family decide to participate, you will be free to withdraw from the study at any time. In addition, you are free to refuse to answer any question during the focus group or on the questionnaires. Participation in the study is fully voluntary. The information that your family provides will help greatly in our understanding of family meaning and resilience as it related to reducing childhood mental health symptoms and enhancing family coping. All information collected from your family will remain completely confidential and will be stored in a locked office on an encrypted, password protected computer. Questionnaires will be number or letter coded and anonymous. Answers will remain confidential and will be used for research purposes only. If consent for participation is withdrawn, then your family's data will not be included in our analyses and will be securely deleted.

Limits to Confidentiality and Benefits of Participation

Although participation risk is minimal, anonymity isn't guaranteed due to the nature of group-meeting. However, participants may benefit from meeting others experiencing similar concerns. For research purposes, anonymity is guaranteed in all publications, as data will be number coded. Furthermore your son/daughter will have an opportunity to participate in a program that has been shown to promote resilience, reducing internalizing and externalizing symptoms of childhood mental illness. Given this, participation may be beneficial for your child. The addition of family focused strategies are new in the current research. This program, therefore, will hopefully also be

beneficial for the whole family. Participation in the pre-group and post-group questionnaires may also be fun for children, as they get to watch brief video clips.

Contact Information

This research has been reviewed by the Saint Paul Research Ethics Committee. This committee helps ensure and protect the rights and welfare of those participating in research. If you have any other concerns or questions, they can be directed to Dr. Laura Armstrong at ***-***-****, ext. ****. The chair of research and ethics can also be reached at ***-***-****.

Please sign below to provide your consent and the consent of your child to participate.

X____________________________ Date:______________________________

X____________________________ Date:______________________________

APPENDIX E

Focus Group Questions

Part 1:

Many of you have experienced the negative ramifications of long waitlist times for seeking mental health services or other challenges accessing services. More than 1.25 million Canadian children require support for mental health concerns, but many are delayed in receiving treatment due to long waiting lists or other difficulties getting help (e.g., being referred from one mental health practitioner to the next without being put on anyone's waitlist or financial challenges accessing services). Difficulties accessing services ultimately result in considerable psychological, developmental, social, and financial costs. This is understandable, given that mental health issues can affect every aspect of a child's life, including their family and peer relationships, as well as their social and academic functioning.

Questions part 1:

What has been your experience with mental health service waitlist or accessing services for your child/children?

How significant is this problem?

What have been some of the most difficult experiences to manage while waiting to receive services?

Can you give me an example?

When you think of the word family, what comes to mind? (Kids can participate in this question)

Part 2:

The hope here today is to gather your experience in order to support the development of a brief mental health promotion program designed to meet the needs of families on mental health

waitlists. The goal is to develop five family-based units, grafted onto an existing resilience program, to make it more applicable for both children and their families to use while wailing to access standardized services.

The thought was to have one of the unit's center on families collaboratively establishing whole-family objectives to promote positive goal directed behaviour:

Questions part 2:

"Picking goals for the whole family to grow towards can be helpful for creating family cohesion"---On a scale of 1-5 (one being I do not support and five being I fully support), how much do you support this statement?

Why?

What are some of your favourite things to do as a family? (Kids can participate in this question)

What might be some goals for families to make that would promote happiness & wellbeing? (Kids can participate in this question)

Part 3:

The ability to properly manage and cope with stress can be an invaluable skill for future functioning and healthy development. The optimal outcome for children and their families struggling to access services would be to develop resilience through promoting protective factors.

The most basic definition of resilience is " The capacity to recover quickly from difficulties". One method for developing resilience is through meaning-making. Meaning-making is correlated with the development of resilience factors such as: coping, optimism, openness, good mood, positive psychological adjustment and a decreased need for therapy. One such way this is

thought to develop is from identifying strengths and coping mechanisms that are used during difficult times.

Questions Part 3:

Does your family work to identify it's strengths?

If so, do you find it challenging?

If not, do you think that looking for family strengths could increase family resilience?

What might be some strengths that families have/ utilize?

What are some things you have found helpful for your family when you've thought you've been in need of mental health services?

What would be some helpful family strengths to develop?

Part 4:

Another avenue for creating meaning-making is through forming connections and developing secure relationships with others. Interventions that support families in developing open avenues for communication could result in the development of more effective communication, fostering opportunities for emotional connection.

A researcher named Dr. Green (2010) developed a strategy known as Collaborative Problem Solving. In Collaborative Problem Solving, all problems that happen at home are seen as predictable and solvable. Parents and children work together to try to understand concerns and come up with good solutions to common problems.

Questions part 4:

Has anyone heard of this approach?

If so what do you like/not like?

The thought was to maybe have a unit based on this approach to foster the development of family teamwork and secure family bonding. The family may be presented with scenarios that resemble typical family conflict interactions and be asked to brainstorm solutions.

What might be some typical conflict scenarios that arise for families? (Kids can participate in this question)

Possible solutions? (Kids can participate in this question)

Part 5:

Navigating the mental health system is one of the biggest barriers faced by families trying to seek support services. More specifically, families are disconcerted upon entering the mental health system, unsure what services are available to them, and what programs would best suit their child's needs. Through creating an online parent-friendly platform for personal testimonies, forums, events and resources, this unit would help to educate parents on the types of resources available and how to advocate for their child. Furthermore, if desired families could use it to connect with other families and share resources.

Questions Part 5:

Is this something that you could see as being helpful?

If you were to connect with other families online what sort of platform would be helpful? (i.e.- what discussions, resources, tools would be beneficial)

Part 6:

The original program that the family units would be grafted onto involves developing healthy thinking, child problem-solving, social, and behavior skills, as well as meaningful engagement, taught through music, games, art, drama, and other group-based activities. The new family units, based on what we discussed today, might include family goal-setting, family

problem-solving, identifying family strengths, reflecting on meaningful family memories and connection to other families or resources. These units could also include art, drama, or games.

Questions Part 6:

(Acceptability) What sort of activities would make a program fun for the whole family?

(Feasiblity) Do you have any suggestions to make the whole program more accessible to families?

Is there anything that would make families more likely to want to use the program?

(Sustainability) What would help families remember skills learned over the long term?

(Credibility) In addition to learning strategies for healthy thinking and behaviours, social skills, and engaging in meaningful actions, are the proposed units to teach goal-setting, problem-solving, reflecting on strengths and meaningful family memories, and connection to other families or resources fitting for your family's needs?

Is anything missing that should be included?

Final debrief questions:

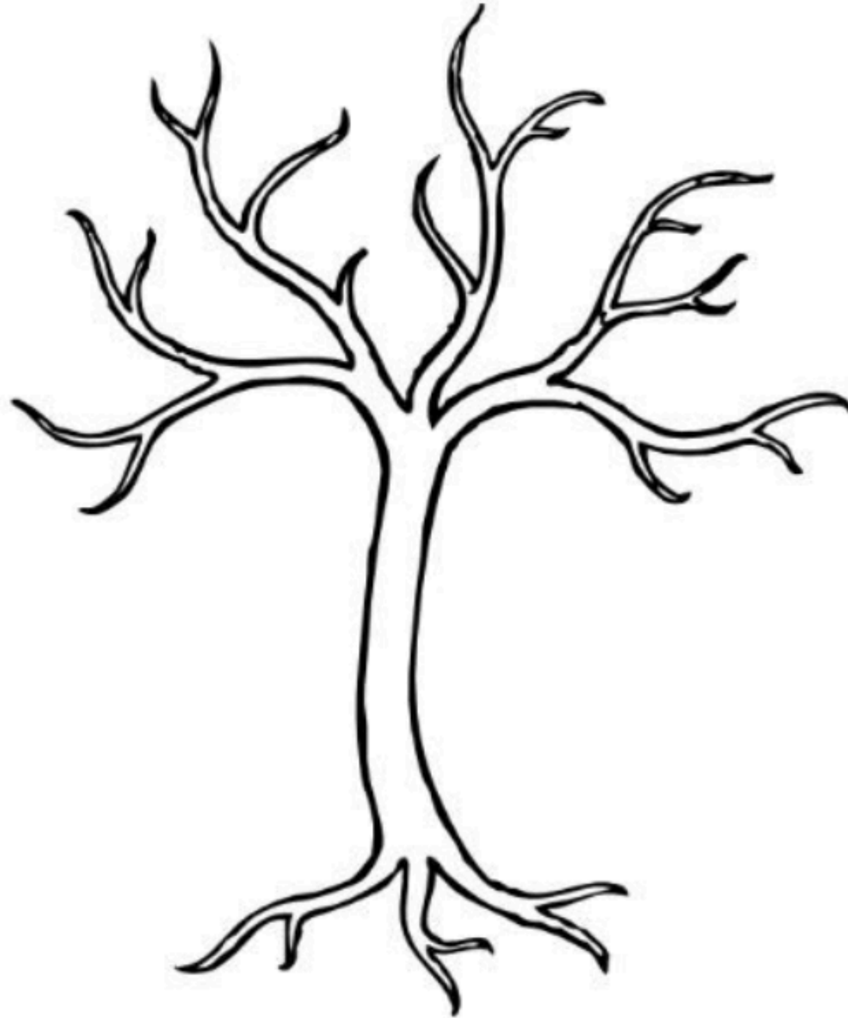
How was it for you today?

Was their anything we missed?

Anything you would like to add?

APPENDIX F

Blank Family Tree



APPENDIX G

D.R.E.A.M Program Administration Manual

PROGRAM ADMINISTRATION MANUAL

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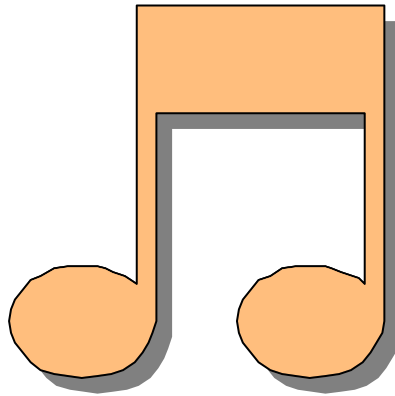
Developing Resilience through Emotions, Attitudes & Meaning:

DREAM Program



Day 1: Unit 1 → De-"Myth"tify

Goals:

- Enhance mental health literacy: Address common myths, negative attitudes, & stigma that children hold toward mental illness
- Learn about different child-friendly mental health services available

Materials:

- Song: "Just Like Me"
- Two large papers (True / False)
- Tape
- Smarties for icebreaker
- Sticker dots
- Timer (3 minutes – phone)
- CD and CD player

Main Steps	
Online Pre-Test Questionnaires	Child Identity & Purpose Questionnaire (Pre-test) Interactive Symptom Assessment (Pre-test)
Group Discussion	What is Mental Health? What is Mental Illness?
Activity	Common myths about mental health & mental illness. Run back and forth between "true" and "false" papers taped to the wall & check off whether each item read aloud is true or false (all are false). Discussion with group about correct answers.
Just Like Me Song	Play song about symptoms of common mental health concerns (anxiety, depression, autism spectrum, schizophrenia). Children sing or move along. Use the song to talk about the symptoms mentioned in the lyrics.
Group Discussion	Where could a child go for help if they were experiencing concerns like those presented in the song?

Detailed description:

1) Have children complete the video-based questionnaires before the group starts (if it's a school group). Otherwise, they will have already completed the questionnaires at home. Thank them for completing the video surveys and explain that we want to see that the program teaches them what we think it will teach them. By completing them before and after the program, we can see if they learned the skill we teach them, or how we can improve the program.
2) Talk about how children sometimes feel big feelings like being excited, or sad, angry, or scared. Sometimes it's hard to know what to do with the strong feelings. Sometimes kids are sensitive in other ways too. Sometimes they are bothered by loud noises or other sounds. Other children may be sensitive to touch and might feel touch or fabrics (like socks) more intensely than other children do. Sometimes kids have big

imaginations, or they have to move around a lot, or they get really interested in something that they classmates may not be interested in. All of these things can be positive, as a lot of famous musicians, artists, book authors, or scientists experienced big feelings or other things that I just mentioned and these experiences can lead to great things. These experiences can also be challenging, as kids might feel different than other children, or might be picked on by others, or they might not have the skills to manage strong feelings.

3) Ask them what they think mental health is. (Is their definition positive or negative, is it full of stigma? Notice this.) Then, ask them what they think mental illness is. Talk about how some kids feel strong feelings for a long time and that this is different than the strong burst of feelings that come and go in everyday life. Talk about how some feelings, like grumpiness or sadness, last for so long that it's hard to feel happy much of the time or to calm down from being worried a lot of the time. This is mental illness.
4) Have the mental health myths (below) written on each of the two large papers on either side of the room. Put the word "True" at the top of one page and "Not True" at the top of the other page. Give each child a sheet of 10 dots, same number as the number of myths. Make sure all the dots are the same colours so that no one knows who is "right" or "wrong." Explain that they will have 3 minutes to decide whether the sentences are true or false. They will run back and forth voting with dots, sticking dots and the true page or the not true page. Say that it doesn't matter if they get the right answer, just try their best and say that it's just helpful to know what the group thinks. Set a 3-minute timer and say, "ready, set, go." When the time is up, let the children know that all the items were "not true" but that they are all things that a lot of kids think are "true." Explain the following facts:
    i. Many people have a mental illness (about 1/5).
    ii. People with a mental illness are not dangerous. Newspapers, radios, and television sometimes make people believe that. In reality, imagine if you were afraid of spiders. If you found out that there were spiders on a dock and you wanted to go swimming, you might find the spiders scary, but you would still go swimming. That's a fear. If you found out that there were spiders on a dock and you wanted to go swimming, but your fear of spiders always stopped you from swimming, that's when a fear becomes something called a phobia. That's when a normal experience shifts to an easy to treat mental illness called "Anxiety." Some mental illnesses like phobias are kind of like having an ear infection: Give people a few strategies to use and the phobia is managed, just like the ear infection is managed with a quick antibiotic. Other mental illnesses take a bit or a lot longer to treat with therapy tools and maybe even medication.

iii. Depression is a real experience. People get in a sad or irritable mood for a long time and they have trouble feeling happy. They might stop doing things that they used to like to do. People can't just "snap out of it," but there are tools that can help them. Through this educational program, you'll be given tools that can help you feel better if you're feeling sad, angry, or scared. Children often have strong feelings and it's nice to have some tools to be able to have some control over these strong feelings, since it doesn't always feel good to have bursts of anger, right? With what you learn from this program, you could maybe even prevent mental illness because you'll have good coping tools. For example, sometimes children find out about a problem in the world and this makes them feel sad and then they don't know what to do with that sad feeling. You'll learn tools that can help.

iv. All of the rest of the sentences are also "not true." Do you have any questions?

5) Tell the children that you have a song about common things that children face, some of which you just talked about, as well as some new ones. Give them the lyrics and invite them to sing along or dance. Tell them that there was one of gym full of 800 teenagers that sung along to one of the songs from this program, so kids often like to sing (just make them feel comfortable participating). Tell them that it's also okay if they just want to listen. Give the "Just Like Me" song lyrics handout. Play the song.

i. Ask them what the characters in the song might be experiencing. In the first verse, the boy might be experiencing depression because he's sad and he quit the things that he used to find fun. He's also having trouble sleeping. There are some kids who want to do things perfectly, sometimes they feel sad or mad if something doesn't go perfectly, so they quit. This isn't the same thing as depression, but the same tools are helpful to feel better.

ii. In the second verse, the little girl character has anxiety. She's been worried for a long time. She doesn't try doing the things that she is afraid to do. She's worried about failure.

iii. In the third verse, the boy is on the autism spectrum. He has trouble understanding other people's feelings. People like psychologists and psychotherapists help children who are depressed, anxious, or even on the autism spectrum. If they ever are feeling sad, mad, or worried for a while and want helpful tools, talking to a family doctor, going to the guidance counsellor at school, or meeting with a psychologist or psychotherapist can be helpful. Let them know that they've put some search information for psychologists/psychotherapists on the handout for their parents. So, they never need to be stuck.

True or False? (Myths)

1) Depression isn’t a real thing. People should just ‘snap out of it:
   True____ False ____

2) Once a friend or family member has a mental illness, they will be sick their whole life:
   True____ False ____

3) Therapy and self-help are a waste of time. Why bother when you can just take a pill?
   True____ False ____

4) Prevention doesn’t work. It is impossible to prevent mental illnesses:
   True____ False ____

5) You can look at someone and see that they have a mental illness:
   True____ False ____

Unit 2 → Recognizing Feelings

Goals:

- Discuss universal feelings
- Help children learn to recognize feelings
- Help children recognize situations in which someone might have a particular feeling

Materials:

- Song: “I Have So Much To Say” & lyrics sheet for all children
- Feeling card deck (happy, sad, angry, fear, surprise, disgust) – printed from power point (2x3 tables, each page has one emotion written 6x; 36 cards)

Main Steps	
Group Discussion	What sorts of feelings do they think everybody in the world show on their face? Discuss the universal feelings: happy, sad, angry, fear, surprise, disgust
I Have So Much to Say Song	Before they listen to the song, as them to think about what the song is teaching them. Listen to it. Ask them what they learned. (Right answer: It’s saying that different people can feel differently even if they face the same situation)
Discussion about Song Using a Story	Discuss how different people might feel (and act) in the same situation: Ernie and Bert metaphor → Both Ernie and Bert write a test, both fail. Their friends invite them to play baseball and eat cake. Ernie goes out with their friends and feels happy at the end of the day despite failing the test. He thinks that he can talk to the teacher and figure out where he went wrong so that he can do better next time. Bert doesn’t go out with his friends. He goes home to mope, thinks that he will never do well, and he feels miserable at the end of the day. Although feelings are universal, different people might feel different things in the same situations, in part, based on how they act in response to the situation or how they think about it.
Emotions Card Game Activity	Have the children in groups play “Emotions Go Fish” (played just like regular Go Fish; e.g., Do you have “sad?” Yes! Or Go Fish). When matched pairs of emotions are collected (aside from pairs in the initial hand of 5 dealt), the child who collected the pair talks about a situation in which kids might feel that feeling (on the matched cards). The rest of the group members then discuss why someone might feel that way. They then talk about how someone might feel differently, what they might feel, and why they might feel that way in that same situation. The game ends when the second last person runs out of cards or when it seems to be a natural end if it’s going on too long.
At-home Activity	Children are provided with brief scenarios. They can talk these over with their parents, or write down their answers and bring them back.

If a group leader gets a “go fish” pair, they can talk about common scenarios in which children might feel sad, angry, happy, scared, surprised or disgusted. For example:

Sad: When working with a classmate, the other student says, “We’re going to use my idea” and does not listen to the other student’s idea.

Sad: A child asks questions in class because they are curious, but the teacher gets annoyed when the child asks so many questions.

Angry: A child likes to have their own space and another child moves into their personal space.

Angry: Someone buds in front of someone in line. This is unfair.

Happy: Someone's teacher said "good job" when they got most questions right on a math assignment (Someone else may be frustrated because they didn't get perfect). Engineering motto: Good enough is better than perfect in the work world!

Surprise: People shout surprise, happy birthday! (Someone else might be bothered by the social attention).

Disgust: Someone is disgusted that a kid said something mean to someone else (someone else might be angry at that person or sad for the child).

Unit 3 → Relaxation

Goals:

- Introduce concept of relaxation
- Teach diaphragmatic breathing
- Teach imagery

Materials:

- Song: "Relaxation"
- Balloon
- Handouts
- Bubble containers

Main Steps	
Body-Feeling Awareness	Tell the kids to imagine that the room is divided into 25%, 50%, 75%, 100%. Show them what this looks like with your hands (a little bit, a bit more, more, a lot more, full out). Have the kids act out just a little bit of anger (5%), while standing close to one wall. Ask them where they feel the anger in their body when they're showing just a little bit of anger. Go to the 25% part of the room. Get them to act out 25% anger – where do they feel that in their body? Then 50% and where they feel that, then 100% and where they feel that. Come back to 5% and where they feel the anger. Ask them why they think it might be helpful to know where they feel feelings in their body when they're feeling it just a bit. Let them know that knowing where they feel the feeling can help them know when to use tools to help them calm down or feel a bit better when feeling sad, angry, or scared. So, next time they feel a feeling, like worries, or sadness, or anger, notice where they feel it. Sometimes, before the feeling gets too strong, if they can be aware of where they feel it (like butterflies in their tummy, clenched fists, headache, etc.), then they can do something to prevent the feeling from becoming so big. Ask them to notice their body feelings this week.
Psychoeducation About Relaxation	Say that you're going to teach them a tool that can help them calm down if they are worried or mad. But first, say that you're going to use an activity to show why the tool works. Use "pink elephant in the room" metaphor. Get children to visualize a pink elephant (is it big or little, is the trunk up or down, are its ears floppy or up, is it's tail long and straight or short and curly). Ask children if they can "see" the pink elephant in their imagination. Make sure they can really see it. Got it? Quickly tell children to stop thinking about pink elephant (most can't). What are they thinking about? The pink elephant! Now, get them to notice what they are sitting on, what their hands are doing, the colours around the room, what they see outside, the sounds they hear, etc. Ask what's going on for them now. What happened to the pink elephant? Pink elephant disappeared. Relaxation exercises work that way to make stressful things become background noise, a little less noticeable.
Introduction to Diaphragmatic (Belly Balloon) Breathing	Blow up balloon, tie it. What would happen if it got too big? Have someone pop it. "Boom!" That's like a big explosion of anger or a worry that makes us run away from what we want to do. Blow up

	another balloon, don't tie it. Ask them how they breathe when they are mad or scared (shallow chest breath). This type of breathing prepares the body for action, but it means we can't think clearly. If they were in the woods and saw a wolf, this kind of fast breathing prepares the body to run or fight the wolf. But, there are ways we can stop the body from preparing for action when we don't want to feel sad or mad. Can let out air (stress) slowly. (Let the air out of the balloon slowly.) Explain that deep breathing helps to calm the body, just like making the pink elephant wander away. Give them small bubble containers. Ask them to take a deep breath in for a count of 4 (filling up their belly like a balloon), hold the breath for a count of 7, and then let it out for a count of 8, blowing the bubbles. Repeat 4x.
Relaxation Song	Put down the bubbles, but try to do the same thing without. Children do "bubble" breathing with the choruses of the song (breathe in for 4, hold for 7, breathe out for 8).
Group Discussion	What was that like for them? Talk about when kids could use that exercise: When they are stressed, scared, mad or having trouble sleeping. Remind them that they might start to feel feelings in their body before the feelings become really big. They can use bubble breathing to calm down.
Assign At-home Activity	Practice bubble breathing. Colour the picture in their handout corresponding to how calm they feel before the exercise and how calm they feel afterwards. They can even practice it when they're not feeling stressed, worried, or mad, just so that it they can use it better when they need it.

Day 2: **Unit 4 → Worry Time, Imagery, & Humour**

Goals:

- Teach children how to create a worry time
- Teach children how to use imagery as a relaxation tool

Materials:

- Song: "Worry Time"
- Drawing paper
- Markers, pens, pencils

Main Steps	
Review At-home Activity	Discuss what the children thought of the relaxation exercise at home. What did they notice about how calm they felt before / after the exercise?
Worry Time Song	Ask the children to listen to the song and think about what 2 things it is teaching. Listen to it. One thing that people can do, if they find they can't get their mind of something – like something they are worried about, or sad about, or mad about, is pick a time during the day (e.g., 6pm-6:15pm) in which they are going to think about the things that make them worry, or be mad, or sad. That way, during the rest of the day, they can think to themselves, "this isn't my worry time/mad time/sad time." Saving things up for a certain time can help people think about things better because it's more organized. Sometimes, when someone is trying to worry hard or be really mad at a certain time, they also end up laughing. When something becomes a bit funny, then people sometimes don't feel as sad, mad, or scared. The song also talks about using something called "imagery." To feel less sad, angry, or scared, people can imagine a safe, relaxing place or a story in their mind, and this can help them to feel a bit better.
Imagery Activity	Have children draw the most relaxing scene that they can imagine. Take a minute to have the children imagine that scene in detail using as many senses as they can (what they would see in the scene, hear, touch, taste…). They can use the picture that they drew to remind them that they can use imagery to calm down or feel a bit better.
Humour Relaxation Activity	Have the children stand up and imagine that they are spaghetti noodles. They jump into the boiling pot. They bounce around as they are cooking, getting softer and softer. When they are cooked, they hop out of the pot and flop onto a plate. What was that like for them? Doing something funny, like this or dancing around to music in a funny way, can be very relaxing.
Progressive Muscle Relaxation	Sometimes when we're feeling stressed, mad, or afraid, our muscles feel all stiff. There's something we can do to feel less stiff. Let's try this. Take a deep breath. Make your face tight like a robot, hold it, make it floppy like a jelly fish. Enjoy that floppy feeling. Make your left arm tight like a robot, hold it, make it floppy like a jelly fish.

	Enjoy that floppy feeling. Take a deep breath. Make your right arm tight like a robot, hold it, make it floppy like a jelly fish. Enjoy that floppy feeling. Make your tummy tight like a robot, hold it, make it floppy like a jelly fish. Enjoy that floppy feeling. Take a deep breath. Make your hands tight like a robot, hold it, make them floppy like a jelly fish. Enjoy that floppy feeling. Make your left leg tight like a robot, hold it, make it floppy like a jelly fish. Enjoy that floppy feeling. Take a deep breath. Make your right leg tight like a robot, hold it, make it floppy like a jelly fish. Enjoy that floppy feeling. Make your feet tight like a robot, hold it, make it floppy like a jelly fish. Enjoy the floppy feeling in your whole body.
Assign At-home activity	Practice imagery (with their drawings), spaghetti dance or other funny dancing, and robot-jelly fish relaxation. Colour the picture in their program notebook corresponding to how calm they feel before the exercises and how calm they feel afterwards.

Unit 5 → Avoidance

Goals:

- Provide information about avoidance versus exposure

Materials:

- Song: "No School Today"
- Popsicle sticks, drawing paper, scissors, glue

Main Steps	
Drama Activity	Have group members volunteer to act out two scenes: Need a "person" and several people to play "dogs." Leader narrates. Scene 1: The person is not afraid of dogs. They are just walking along, minding their own business, when a dog comes along and bites them (tell them not to actually bite). What do they think the person might be feeling? They see another dog that looks the same. What might the person be feeling? What do they do when this other dog comes along (have them run away). Another one comes, and another and another (have them run away each time). What has happened to their fear? Is it little or has it got really big? By avoiding, their fear has got really big. Scene 2: The person is not afraid of dogs. They are just walking along, minding their own business, when a dog comes along and bites them (tell them not to actually bite). Do they have a bit of fear? Other dogs come along. They pet the dogs. What happens to their fear? It gets smaller? When we avoid things that we're a bit afraid of, fear can become really big! Sometimes that fear can even stop us from doing things that we want to do. But, if we take steps to do the things that we're a bit afraid of, then we can learn to have control over our fears.
No School Today Song	Discuss what's going on in the song (avoidance). Highlight that the song is talking about pretending to be sick. Mention that, often when people feel stressed or scared, they can feel it in their heads as a headache or in their tummies as feeling sick. These things, as well as avoiding things, can tell us or our mommies and daddies that something is going on that we might need help with, like being picked on at school, or worries about not making work perfect, or other things that are problems that can be solved with a little help from other people.

Popsicle stick activity:

Sometimes children who don't like the feel of certain fabrics or things they can touch, like socks, tags, or seams on clothes, or other people getting into their space. Sometimes kids don't like certain sounds, like loud noises or other types of sounds. There are other children who feel like they "have" to do things, like having to walk back to where someone picked them up, or redo things over and over again until it feels right, or they think that they have to do things perfectly, rather than just doing their best and enjoying what they are doing. If you ever get stuck in these

situations or others where you feel like your brain is telling you that you have to do something, there's a game that you can play: Let's come up with an animal or an insect that can be kind of annoying (for example, some kids like to choose a mosquito, but as a group, we can come up with whatever animal or bug you think is annoying)….

I'd like you to imagine that the _____________ is creating a game for you and making up the rules. The ____________ is trying to get points to win the game, but you want to win the game. The ___________ gets a point if you react to the touch or the sound that you don't like or if you do or redo something that your brain is telling you that you "have" to do. You get a point if you say, "Ha! That's just the _____________ trying to get a point. I'm not going to do what the _____________ tells me to do. So, I get a point!!" Celebrate your point. Sometimes the ____________ will get points, but you're just trying to get more points than the __________. I'd like you to take one minute to draw a tiny picture of the ____________ and another one minute to draw a quick stick-figure drawing of YOU! We're going to cut these out and stick them to each side of a popsicle stick, so that you can keep this and remember that you want to talk back to the __________ and get a point to win the game!

Unit 6 → Enjoyable Distraction

Goals:

- Provide information about positive distraction activities as another calm-down (emotion-regulation) tool

Materials:

- Song: “Worry Shark”
- Balloons

Main Steps	
Worry Shark Song	What is the song teaching them? Listen to it. It’s teaching about how helpful distraction can be. Discuss situations in which enjoyable distraction can be helpful (e.g., it acts like a time-out when angry, it can make people feel happier when sad, it can make people less worried about things)
Group Game	Tell story about a bad day. Get the children to imagine that they are in a spelling bee and they make a mistake on the first word, so they are out of the competition. Then, on the drive home, a tire on their car goes flat and they aren’t able to make it to their best friend’s birthday party later in the day, as they are stuck waiting in the cold for a tow truck. On top of that, they throw up. They got the flu that was going around school. Imagining that they just had a bad day like that, how do they feel (0-10: 0 = feel so terrible, 10 = feel really happy). Demonstrate 0-10 with hands (small, big). Have 3 balloons. Tell them that, over the next minute, they’re going to try to keep the balloons in the air. If the balloon drops, that’s ok, just pick it up and keep going. Stop the game when they are laughing or smiling a lot.
Group Discussion	0 (terrible)-10 (happy): How do they feel after playing the game?
Generating Helpful List of Distraction Activities	Have the children generate as a group a list of up to 10 enjoyable, brief distraction activities that they could use to feel less sad, angry, stressed, or scared. Mention that this isn’t avoidance, it’s just helping them to feel a bit better so that they can think more clearly about things.

Unit 7 → Meaningful Living

Goals:

- Discuss key things that make life meaningful:
    - Creative pursuits (especially making or doing things for others; work that makes a positive contribution)
    - Captivating experiences (nature, travel, participation in regular, enjoyable activities)
    - Choosing our attitude in any circumstance (to be further discussed in subsequent sessions)
- Introduce meaningful engagement in extracurricular activities
- Feedback on song & program material

Materials:

- Song: "Youth Engagement"
- Paper to make cards
- Markers, pens, pencils, decorations for cards
- Fun Activities Catalogue

Main Steps	
Group Activity & Discussion	Have the children make a card for someone that they appreciate. While making cards, discuss what they appreciate about that person. Talk about how creating something for others or doing something to help other people can make us feel good ourselves. Each person has the potential everyday to make a small difference or big difference in the world, which makes others feel good and also makes us feel good. What sort of things for others do they think they could they could do in their house to make a difference? What kind of things could they do in their classroom to make a difference? What kind of things could they do in their school to make a difference? Is there a problem in the world that bothers them? Is there a way they could help out with this problem to make a difference? Generate a list. Photocopy it if possible so that they can have an action plan in these areas.
Youth Engagement Song	What do we learn from this song. Listen to it. Discussion: How does involvement in a regular, enjoyable activity also make us feel good?
Fun Activities Catalogue	Have the children circle activities on the "Fun Activities Catalogue" that might be fun for them to engage in at some point.

Day 3: Unit 8 → Connection Between Thoughts & Feelings

Goals:

- Learn the connection between thoughts and feelings
- Learn that we can change our thoughts and feel differently
  - Personal choice: Choosing one's attitude in any situation

Materials:

- Song: "Crown of Thoughts"
- Crown templates
- Scissors
- Tape
- Markers, pens, pencils, stickers
- Sticky note paper
- Program notebook for each child

Main Steps	
Review Homework	How did enjoyable distraction work for them?
Left Foot Metaphor	*Imagine that I get up to go get a drink of water. As I'm walking across the room, I step on your left foot. What do you feel? (Pain)* *How long do you think that feeling would last? (Short time)* *Now as I'm walking back across the room to my seat, I step on that same foot again. What do you feel? (Pain)* *How long do you think that feeling would last? (A bit longer)* *I get up one more time to put my paper cup in the garbage and I step on your left foot again. What do you feel? (Pain; Anger) How long do you think that feeling would last? (Long time)* *Isn't it interesting. I did the same thing to you three times. The situation was the same, but you reacted differently the first time than you did the third time. So, what's causing you to feel different? It's not the situation that's different. I would suspect that the third time, thoughts got in your head. As long as you have those thoughts, you're going to continue to be (angry / sad). Those thoughts (she should have been more careful; she did it on purpose – anger / What did I do to deserve that – sadness) block the brief, short-lived emotions. The natural short-lived emotions that we feel are pain and joy. They're important. Holding onto "stinky thoughts" leads to long-lasting anger, sadness, fear. Our "stinky thought" can cause tricky feelings.*
Crown of Thoughts Song	What happened to the boy in the story (song)? Why do you think he lost the races? What "stinky thought" got in the way? What feeling do you think he had then? Why do you think he won? What helpful thought might he have had that helped him win? What feeling do you think he had then?
Crown Activity	Have children cut out and decorate crowns. Provide children with scenarios in which the character has a thought. Write that thought on a sticky note and put it on the crown. Have the children make the "feeling" that goes along with that thought using their faces.
At-home Activity	Give handout of more scenarios to take home.

Crown of Thought Activity

What feelings might the characters have if these were their thoughts? Stick it to the crown and make the feeling with your face.

1) A teacher calls on Jeff in class to answer a question. Jeff thinks: "Oh no! I don't know the answer."

____

2) Devika's friend won a trophy and brought it to school. Devika thinks: "Show off!"

____

3) Ian made a mistake in his math work. He thinks: "I can't do anything right" and he gives up.

____

4) Amal's friend passes her in the hall and doesn't say "hi." Amal thinks: "Does she not like me anymore?"

____

5) Peter comes up with a good idea for a game that he has to create with Lisa. Lisa has a different idea for the game and wants to make hers instead. Peter thinks: "We're going to do it my way because my idea is better!"

____

6) Ines was proud of herself for doing well at a local science competition and she wanted to tell her friends at school. She comes to school and her friends don't want to hear about this. Ines thinks: "They don't care about me."

____

7) Scott is given tricky work at school. He thinks: "I'm going to fail" and he refuses to try the work.

____

8) Loud noises bother Jenna. One of her classmates cries loudly. Jenna thinks: "Make it stop! Go away."

____

9) Cheng to finish writing his story, but his parents want him to come to supper and take his story away from him. He thinks: “This is so unfair! I must finish my story now.”

____

10) James sees a news story about a hurricane that destroyed many homes and businesses. He thinks: “This is terrible and I can’t do anything about it.”

____

videogame character, she becomes really interested in it because she imagines all sorts of stories about that character. Sarah tries talking to her classmates at school about this character every day. Soon, her classmates get annoyed at her for talking about it all the time and say that the character is stupid. Sarah thinks: “Nobody cares about what I’m interested in.”

____

12) Devan is silly in class because he thinks that other kids will like him if he acts silly. His teacher gets mad and no kids ask him to play at recess. He thinks: “Why am I all alone?”

____

Unit 9 → Choosing to Think Differently (Attitudinal Change)

Goals:

- Discuss feelings as "alarm bells"
- Learn how to think in more helpful ways and, therefore, have more control over feelings
- Learn how to also use previously learned distraction and relaxation activities as "slow down skills" to calm down enough to think differently
- Remind them (Emotions Go Fish) how 2 people can have the same thing happen but if they act differently or think differently, then they can feel differently

Materials:

- Song: "Thought Detective"
- Papers with written scenarios and "stinky thoughts"

Main Steps	
Thought Detective Song	Talk about how feelings can be important "alarm bells" like a fire alarm that can tell us we're having a stinky thought. Remind them (Emotions Go Fish) how 2 people can have the same thing happen but if they act differently or think differently, then they can feel differently. Also tell them that they can use their relaxation or distraction tools to calm down a bit in order to be able to think a bit more clearly. Tell them that the group is going to use the song verses and will figure out the stinky thoughts that they characters are having, and the feelings, and then to come up with more helpful thoughts, good reasons for these more helpful thoughts, and the feelings related to the more helpful thoughts.
Group Discussion	What was that like for them? Let them know that, even when something really bad things happens, there are more helpful ways of thinking. Sometimes, even the bad thing can be transformed into something positive. Imagine if someone was bullied. They could have the stinky thought: "This is terrible" and become really sad and mad for a long time. They might even pick on others to bring others down, as it might bother them to see others happy. What might be a more helpful way of thinking about being bullied? Someone might think: "Bullying is really bad. It's a problem in the world. I want to do something about it." They then might come up with something that helps others who are bullied or spreads kindness. This helpful thought and these actions might make someone feel happy because they are making a difference even though the bad thing happened to them.
Detective Activity	Divide children into pairs. Give one person in each group a scenario, "stinky thought," and challenging feeling written on a piece of colourful paper, while the other person in each group leaves the room. The children with the papers hide them. They return and play "hot and cold" (far away from thought is cold, close is hot, hotter, really hot!!). Then, the other person takes a turn to hide their given

	scenario. In pairs, they come up with a more helpful thought, reasons for why the person might think the more helpful thought, and the new feeling. They also might discuss helpful actions that they could take if they had the helpful thought.
Group Discussion	Everyone presents their scenarios and responses to the full group.
At-home Activity	Take the at-home scenarios and write a more helpful thought and, therefore, feeling.

Note: The scenarios/stinky thoughts used in this exercise are the ones that were discussed for the Crown of Thoughts lesson.

Unit 10 → "Act As If," Problem Solving, & Putting It All Together

Goals:

- Learn how to "fake it 'till you make it" ("act as if")
- Apply all tools learned to date to problem solve new situations

Materials:

- Song: "Caped Crusader"
- Pens, pencils, markers
- Paper
- Comic page
- Superhero pages

Main Steps	
Caped Crusader Song	What is this song talking about? (Story below explains)
Fake It 'Till You Make It Story	*When Sara went to school, she shyly walked with her head down as she made her way down the hall. At one point, in English class, Sara read a book in which the main character used to walk shyly down the hall, looking at her feet. The character in the book decided that she wanted to try something different: Pretending that she was confident by looking up at the world as she walked. Pretty soon, other students started to notice this character & she formed friendships. Sara decided to try this: Faking confidence. She walked down the hall with her head held high even though she was feeling nervous. When looking up, other kids began to say "hi" to her and she made new friends. Her confidence grew. She didn't feel as shy anymore.*
Group Discussion	We can choose who we want to be. If we act like the person that we want to be, then we can become that person. What does the group think about that?
Superhero Activity	Have group members come up with qualities that each superhero in the song would have: What would an angershaker superhero have (someone who can control their anger), a fearbreaker superhero (someone who can confront their fears), a joywaker (someone who knows how to make themselves feel a bit better if they're feeling sad or to notice the joy in everyday life), and a peacemaker (someone who spreads kindness and creates connection between others)? They can draw the superheroes if they want.
Problem Solving Comics Activity	Based on the qualities that the children come up with, how would each superhero act in different situations? Draw the comics. If the children wanted to be a superhero, do they think they could choose to act like one of these superheroes? How? Comics: Problem-solving activity incorporates the application of all previously learned skills (relaxation, distraction, engagement, changing thoughts / feelings / behaviour). Ask the children to take everything that they have learned – relaxation, distraction, feel-good activities, and helpful thinking to try to find good solutions in these comics. Be a superhero!
Feedback	Feedback from group on the whole program. What did they like?

	What would they change? Is there anything that wasn't covered that would be helpful to add?
Questionnaire	Children's Identity and Purpose Questionnaire (post-test) Interactive Symptom Assessment (post-test) Challenge-seeking question.

APPENDIX H

D.R.E.A.M.- O.F. Satisfaction Survey

Satisfaction Survey

How happy were you with today's section of the DREAM program? (activities, what you learned, what we did?) Circle the flower that best represents your response.

5 = happy
4 = mostly happy
3 = so-so
2 = mostly unhappy
1= unhappy

What did you like? Do you have ideas to make the program better?

____

____

____

____

____

____

2) Do you think today's exercises give families "tools" to promote positive family wellbeing? Circle the flower that best represents your response.

5 = yes
4 = probably yes
3 = so-so
2 = probably not
1= no

3) Do you think that goal-setting helps to promote positive family functioning? Circle the flower that best represents your response.

5 = yes
4 = probably yes
3 = so-so
2 = probably not
1= no

4) Do you think today's exercises taught families communication strategies for managing conflict? Circle the flower that best represents your response.

5 = yes
4 = probably yes
3 = so-so
2 = probably not
1= no

5) Do you think today's exercises helped promote family bonding? Circle the flower that best represents your response.

5 = yes
4 = probably yes
3 = so-so
2 = probably not
1= no

6) Do you think today's exercises promoted family strength? Circle the flower that best represents your response.

5 = yes
4 = probably yes
3 = so-so
2 = probably not
1= no

7) Do you think today's exercises helped families talk about important things? Circle the flower that best represents your response.

APPENDIX I

Online Consent Form for Questionnaires

Dreaming of a Solution: D.R.E.A.M-O.F. a Mental Health Promotion Program for Children and Their Families on Mental Health Waitlists

We are delivering a socioemotional educational program for families in Ottawa in Winter 2019. DREAM (Developing Resilience through Emotions, Attitudes, and Meaning) is a program developed by Dr. Laura Armstrong, a Clinical Psychologist and Assistant Professor at Saint Paul University. Emmalyne Watt, Ph.D. Candidate, has further designed family units for this program (D.R.E.A.M.-O.F.).

In the program, families will learn social and emotional skills to manage worries, sadness, anger, obsessions, conflict, perfectionism, and much more. The goal is to have fun while learning lifelong, evidence-based skills through games, music, drama, and crafts.

This is the first year that we have offered the family version of this program, so we ask that you and your children complete our pre-group and post-group questionnaires. We will use these questionnaires to measure what the program is doing well and what we can improve upon to refine the program. Ms. Watt will also use the data to complete her doctoral dissertation.

If you agree to participate in our pre and post group questionnaires, please ask your child to complete the 3 online links, which relate to skills taught in the program, both before and after your child takes part in the program activities. Parents have 4 questionnaires to complete. Participation in the surveys will take approximately 20-25 minutes of your child's time.

Rights of Participants

If you and your family decide to participate, you will be free to withdraw from the study at any time. In addition, you are free to refuse to answer any questions on the questionnaires. Participation in the study is fully voluntary. The information that your family provides will help greatly in our understanding of family meaning and resilience as it related to reducing childhood mental health symptoms and enhancing family coping. Although we initially ask you to put your names on questionnaires, our research assistant will only use this to match parent and child data, as well as pre and post group data. These names will then be removed and number-coded. Therefore, all information retained from your family will become completely confidential and will be stored in a locked office on an encrypted, password protected computer. If consent for participation is withdrawn, then your family's data will not be included in our analyses and will be securely deleted.

Limits to Confidentiality and Benefits of Participation

Although participation risk is minimal, anonymity isn't guaranteed due to the nature of group-meeting. However, participants may benefit from meeting others experiencing similar concerns. For research purposes, anonymity is guaranteed in all publications, as data will be number coded.

Participating in this program could promote resilience, reduce internalizing and externalizing symptoms of childhood mental illness. Given this, participation may be beneficial for your child. The addition of family-focused strategies are new in the current research. This program, therefore, will hopefully also be beneficial for the whole family. Participation in the pre-group and post-group questionnaires may also be fun for children, as they get to watch brief video clips.

Contact Information

This research has been reviewed by the Saint Paul Research Ethics Committee. This committee helps ensure and protect the rights and welfare of those participating in research. If you have any other concerns or questions, they can be directed to Dr. Laura Armstrong at ***-***-**** ext:****. The chair of research and ethics can also be reached at ***-***-****.

APPENDIX J

Pre-Post Measure Questionnaires

Interactive Symptom Assessment Questionnaire
(which is accompanied by an audio & video recording, and visual slider that corresponds to scores of 0 to 10):

1) Isa thinks that someone cared about her this week / Eibe doesn't think that anyone cared about him this week.

2) Isa felt good about the friends in her life this week / Eibe didn't feel good about the friends in his life this week**

3) Eibe felt that he did many things well this week / Isa felt that she didn't do anything well this week**

4) Eibe is feeling happy. Over the past week, he has been feeling happy most of the time / Isa is feeling sad. Over the past week, she has been feeling sad most of the time**

5) This week, Isa wanted to do many fun things / Eibe did not feel like doing much this week**

6) Isa had good dreams at night and good day dreams / Eibe had bad dreams at night or scary pictures in his head during the day

7) Isa didn't lie to anyone this week / Eibe told many lies this week**

8) This week, Eibe enjoyed doing lots of his favourite week / This week Isa was bored when doing things that she usually finds fun

9) Isa was cheerful this week / Eibe was grouchy this week**

10) Isa did not have arguments or fights with her family or friends this week / Eibe often had arguments with his family or friends this week**

11) Eibe was not worried this week / Isa was feeling worried a lot this week**

12) Eibe was not feeling nervous or afraid this week / Isa was feeling nervous or afraid often this week

13) Isa had no headaches or stomach aches this week/ Eibe had headaches or stomach aches many days this week

14) This week, Eibe didn't have to do things over and over again until they were perfect or felt right / This week, Isa had to do things over and over again until they were perfect or until they felt right

15) Eibe didn't worry about dirt, germs or getting sick this week / Isa was worried about dirt, germs, or getting sick this week**

16) Isa had no trouble finishing her school work this week / Eibe had trouble finishing his school work this week

17) Eibe was well-behaved and followed the rules at school this week / This week, Isa got in trouble at school for not following the rules

18) Isa was well-behaved at home this week / This week, Eibe got in trouble at home for not following the rules

19) Eibe did not push, hit, or kick any other kids this week / This week, Isa pushed, hit or kicked another child

20) Eibe was nice to everyone this week / Isa said mean things to someone this week**

21) Isa found it easy to sit still in class this week / Eibe found it hard to sit still in class this week**

22) Eibe looked in the mirror this week and felt good about what he saw / Isa looked in the mirror and did not feel good about what she saw**

23) Isa was proud of herself this week / Eibe was not proud of himself this week

**Items that appear in the I.S.A. Short Form

Table 2. Brief Screener Measure Items.

Brief Depression Screener

Isa felt good about the friends in her life this week / Eibe didn't feel good about the friends in his life this week

Eibe felt that he did many things well this week / Isa felt that she didn't do anything well this week

Eibe is feeling happy. Over the past week, he has been feeling happy most of the time / Isa is feeling sad. Over the past week, she has been feeling sad most of the time

This week, Isa wanted to do many fun things / Eibe did not feel like doing much this week

This week, Eibe enjoyed doing lots of his favourite week / This week Isa was bored when doing things that she usually finds fun

Isa was cheerful this week / Eibe was grouchy this week

Eibe looked in the mirror this week and felt good about what he saw / Isa looked in the mirror and did not feel good about what she saw

Brief Anxiety Screener

Eibe was not worried this week / Isa was feeling worried a lot this week

Eibe was not feeling nervous or afraid this week / Isa was feeling nervous or afraid often this week

Isa was cheerful this week / Eibe was grouchy this week

Brief Disruptive Behaviour Screener

Isa didn’t lie to anyone this week / Eibe told many lies this week

Isa did not have arguments or fights with her family or friends this week / Eibe often had arguments with his family or friends this week

Isa had no trouble finishing her school work this week / Eibe had trouble finishing his school work this week

Eibe was well-behaved and followed the rules at school this week / This week, Isa got in trouble at school for not following the rules

Isa was well-behaved at home this week / This week, Eibe got in trouble at home for not following the rules

Eibe did not push, hit, or kick any other kids this week / This week, Isa pushed, hit or kicked another child

Eibe was nice to everyone this week / Isa said mean things to someone this week

Isa found it easy to sit still in class this week / Eibe found it hard to sit still in class this week

Strength and Difficulty Questionnaire (SDQ)
(Parent Report)

Strengths and Difficulties Questionnaire

P or T 4-10

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of the child's behavior over the last six months or this school year.

Child's name .... Male/Female

Date of birth..

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children, for example toys, treats, pencils	☐	☐	☐
Often loses temper	☐	☐	☐
Rather solitary, prefers to play alone	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often offers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets along better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees work through to the end	☐	☐	☐

Signature .... Date ....

Parent / Teacher / Other (Please specify):

Strength and Difficulty Questionnaire (SDQ)
(Self- report)

Instructions: For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of how things have been for you **over the last month.**

	Strengths and Difficulties Questionnaire	Not True	Somewhat True	Certainly True
1.	I try to be nice to other people. I care about their feelings	O	O	O
2.	I am restless, I cannot stay still for long	O	O	O
3.	I get a lot of headaches, stomach-aches, or sickness	O	O	O
4.	I usually share with others, for example CDs, games, food	O	O	O
5.	I get very angry and often lose my temper	O	O	O
6.	I would rather be alone than with people of my age	O	O	O
7.	I usually do as I am told	O	O	O
8.	I worry a lot	O	O	O
9.	I am helpful if someone is hurt, upset or feeling ill	O	O	O
10.	I am constantly fidgeting or squirming	O	O	O
11.	I have one good friend or more	O	O	O
12.	I fight a lot. I can make other people do what I want	O	O	O
13.	I am often unhappy, depressed or tearful	O	O	O
14.	Other people my age generally like me	O	O	O
15.	I am easily distracted, I find it difficult to concentrate	O	O	O
16.	I am nervous in new situations. I easily lose confidence	O	O	O
17.	I am kind to younger children	O	O	O
18.	I am often accused of lying or cheating	O	O	O
19.	Other children or young people pick on me or bully me	O	O	O
20.	I often volunteer to help others (parents, teachers, children)	O	O	O
21.	I think before I do things	O	O	O
22.	I take things that are not mine from home, school or elsewhere	O	O	O
23.	I get along better with adults than with people my own age	O	O	O
24.	I have many fears, I am easily scared	O	O	O
25.	I finish the work I'm doing. My attention is good	O	O	O

SDQ (S) 11-17 FU Self–Report Measure (1 of 2)

Systemic Clinical Outcome and Routine Evaluation (SCORE) -15

Describing your family Date....................

We would like you to tell us about how you see your family at the moment. So we are asking for YOUR view of your family.

When people say 'your family' they often mean the people who live in your house. **But we want you to choose who you want to count as the family you are going to describe.**

For each item, make your choice by putting ☑ in just one of the boxes numbered 1 to 5.
If a statement was "We are always fighting each other" and you felt this was not especially true of your family, you would put a tick in box 4 for "Describes us: not well".

			✓	

Do not think for too long about any question, but do try to tick one of the boxes for each question.

For each line, would you say **this describes our family**:	1. Describes us: Very well	2. Describes us: Well	3. Describes us: Partly	4. Describes us: Not well	5. Describes us: Not at all
1) In my family we talk to each other about things which matter to us					
2) People often don't tell each other the truth in my family					
3) Each of us gets listened to in our family					
4) It feels risky to disagree in our family					
5) We find it hard to deal with everyday problems					
6) We trust each other					
7) It feels miserable in our family					
8) When people in my family get angry they ignore each other on purpose					
9) We seem to go from one crisis to another in my family					
10) When one of us is upset they get looked after within the family					
11) Things always seem to go wrong for my family					
12) People in the family are nasty to each other					
13) People in my family interfere too much in each other's lives					
14) In my family we blame each other when things go wrong					
15) We are good at finding new ways to deal with things that are difficult					
	1.	2.	3.	4.	5.

Now please turn over and tell us a bit more about your family.

SCORE-15 © Association for Family Therapy www.aft.org.uk

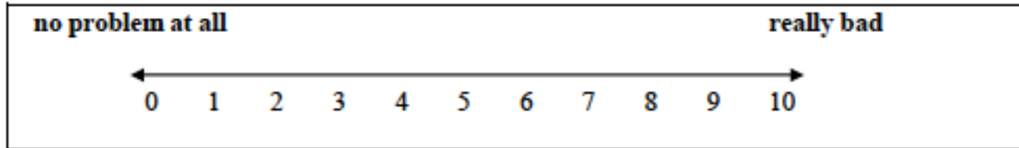
What words would best describe your family?

....
....
....

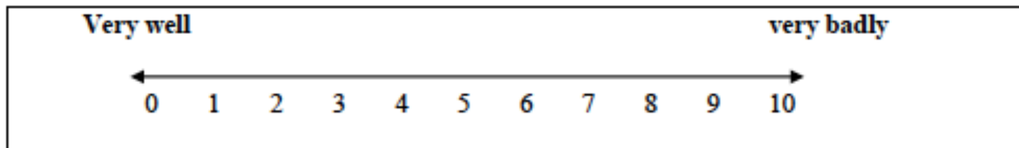
What is the problem/challenge that brought you to therapy?

The main problem is..
....

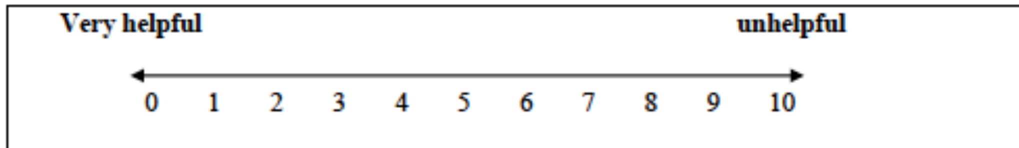
How severe is it? Please mark your answer on the line below:



How are you managing as a family?



Do you think the therapy here will be / has been helpful?



Some basic information about you:

Age

Gender

Ethnicity

Education achieved

Main occupation

People living in your household (type, such as ‘daughter age 12’, no names please).

THANK YOU FOR YOUR TIME

SCORE-15 © Association for Family Therapy www.aft.org.uk

Chip Identity and Purpose Questionnaire-Interactive Questionnaire
(which is accompanied by an audio & video recording, as well as a slider that corresponds to scores of 0 to 10 for each item):

1) When things aren't going well for CHIP, he thinks he can come up with ways to fix the problem / when things aren't going well for Ceira, she thinks she can't come up with ways to solve the problem

2) Ceira believes she can make choices about things in her life / Chip thinks he can't make choices about things in his life

3) When Chip has a difficult feeling like sadness, fear, or anger, he finds it easy to think about things to feel a bit better / When Ceira has a difficult feeling like sadness, fear, or anger, she finds it hard to think about something to feel a bit better***(agency)

4) When Ceira has a difficult feeling like sadness, fear, or anger, she talks to someone or plays with someone / When Chip has a difficult feeling like sadness, fear, or anger, he doesn't talk to someone or play with someone***(agency)

5) When Chip has a difficult feeling like sadness, fear, or anger, he choses to relax, have fun, or create something / When Ceira has a difficult feeling like sadness, fear, or anger, she chooses not to do much of anything***(agency)

6) Chip is happy to be Chip / Ceira wishes that she were a different person***(self-concept)

7) Chip thinks that he is important to other people / Ceira thinks that he is not important to other people***(self-concept)

8) Ceira thinks that she has done many things to be proud of / Chip thinks that he has not done many things to be proud of***(self-concept)

9) Ceira thinks that she can do things as well as other kids / Chip doesn't think that he can do things as well as other kids

10) When things are going badly, Ceira thinks that things will get better / When things are going badly, Chip thinks that things will never get better

11) Ceira knows that good things will happen in her life as she grows up / Chip doesn't know if good things will happen in his life as he grows up***(hope)

12) Chip believes that his life is important / Ceira believes that her life doesn't matter***(hope)

13) Chip likes to make believe or come up with new ideas / Ceira likes to see, hear smell, taste or see things right in front of her, rather than coming up with new ideas

14) Ceira knows that she can find ways to get something that is important to her / Chip doesn't know if he can find ways to get things that are important to him***(hope)

15) Ceira is interested in watching her feelings as well as other people's feelings / Chip is more interested in what he can see, feel, hear, taste, and touch, rather than feelings***(openness)

16) Chip likes to try new things and learn new things / Ceira likes to stick with things that she knows***(openness)

17) Ceira often participates in a very fun activity with other children and one or more adult leaders / Chip does not often participate in a very fun activity with other children and one or more adult leaders***(openness)

The Adult Identity and Meaning (AIM) Questionnaire

1. Please enter your name:

2. Please move the slider to indicate your level of agreement:

When I experience difficult feelings like sadness, fear, or anger, I am able to change my attitude toward the situation so I feel a bit better

When I experience difficult feelings like sadness, fear, or anger, I am not able to change my attitude toward the situation

3. Please move the slider:

When I have a difficult feeling like sadness, fear, or anger, I have a meaningful person in my life who I like to talk to

When I have a difficult feeling like sadness, fear, or anger, I don't tend to talk to anyone

4. Please move the slider:

When I have a difficult feeling like sadness, fear, or anger, I often choose to relax, have fun, or create something to feel a bit better

When I have a difficult feeling like sadness, fear, or anger, I often choose not to do much of anything

5. Please move the slider:

I am happy to be me I wish that I was a different person

6. Please move the slider:

I think that I am valued by other people I don't think that I am valued by other people

7. Please move the slider:

I think that I do many things to be proud of I don't think that I do many things to be proud of

8. Please move the slider:

I know that good things will happen in my life I do not expect good things to happen in my life

9. Please move the slider:

I believe my life is meaningful I believe my life is hopeless

10. Please move the slider:

I know that I can find ways to get something that is important to me	I don't know if I can find ways to get things that are important to me

11. Please move the slider:

I am interested in noticing my own feelings as well as other people's feelings	I am more interested in what I can see, feel, hear, taste, and touch, rather than noticing feelings

12. Please move the slider:

I like to try new things and learn new things I prefer to stick with things that I know

13. Please move the slider:

I participate in regular, meaningful leisure activities	I don't participate in regular, meaningful leisure activities

Purpose in Life Questionnaire

Your Name: ____________________ Personality, Dr. Brian Burke

PURPOSE IN LIFE TEST (Crumbaugh & Maholick, 1964)

Instructions: Write the number (1 to 5) next to each statement that is most true for you right now.

Statement	1	2	3	4	5
1. I am usually:	1 bored	2	3	4	5 enthusiastic
2. Life to me seems:	1 completely routine	2	3	4	5 always exciting
3. In life, I have:	1 no goals or aims	2	3	4	5 clear goals and aims
4. My personal existence is:	1 utterly meaningless, without purpose	2	3	4	5 purposeful and meaningful
5. Every day is:	1 exactly the same	2	3	4	5 constantly new and different
6. If I could choose, I would:	1 prefer never to have been born	2	3	4	5 want 9 more lives just like this one
7. After retiring, I would:	1 loaf completely the rest of my life	2	3	4	5 do some of the exciting things I`ve always wanted to
8. In achieving life goals, I've:	1 made no progress whatever	2	3	4	5 progressed to complete fulfillment
9. My life is:	1 empty, filled only with despair	2	3	4	5 running over with exciting things
10. If I should die today, I'd feel that my life has been:	1 completely worthless	2	3	4	5 very worthwhile
11. In thinking of my life, I:	1 often wonder why I exist	2	3	4	5 always see reasons for being here
12. As I view the world in relation to my life, the world:	1 completely confuses me	2	3	4	5 fits meaningfully with my life
13. I am a:	1 very irresponsible person	2	3	4	5 very responsible person
14. Concerning freedom to choose, I believe humans are:	1 completely bound by limitations of heredity and environment	2	3	4	5 totally free to make all life choices
15. With regard to death, I am:	1 unprepared and frightened	2	3	4	5 prepared and unafraid
16. Regarding suicide, I have:	1 thought of it seriously as a way out	2	3	4	5 never given it a second thought
17. I regard my ability to find a purpose or mission in life as:	1 practically none	2	3	4	5 very great
18. My life is:	1 out of my hands and controlled by external factors	2	3	4	5 in my hands and I`m in control of it
19. Facing my daily tasks is:	1 a painful and boring experience	2	3	4	5 a source of pleasure and satisfaction
20. I have discovered:	1 no mission or purpose in life	2	3	4	5 a satisfying life purpose

SCORING: Add up all the numbers you wrote down (20-100). A score of less than 50 may indicate that you are experiencing an "existential void," a lack of meaning or purpose in your life right now…

APPENDIX K

Family Focus Group Transcript

E: The hope here today is to gather your experience in order to support the development of a brief mental health promotion program designed to meet the needs of families on mental health waitlists. The goal is to develop five family-based units, grafted onto an existing resilience program, to make it more applicable for both children and their families to use while wailing to access standardized services.

Confidentiality- Questions

E: First question. What has been your experience with mental health service waitlist or accessing services for your child/children?

A2: With the school? Horribly difficult.

E: And what about that was so difficult?

A2: Meeting with them was never a problem but they'd have these long to do lists that I'd never see or hear to the point that by the end of the school year the resource teacher was actively avoiding me, and it took nearly two years from the date of assessment to actually get the IP nearly two school years

E: So this sounds like its fairly significant, do other people echo that experience?

B2: No, I have not, I sought private psychology assessment for 3 of my kids, they were diagnosed for gifted potential and I got the IEP and IPRC immediately.

E: Okay so it sounds like as if it's different.

A2: This was a learning disability versus a gifted potential, my experience with the gifted potential has been much more positive.

E: So accessing services has been good for you (b)?

B2: Yeah, so were not moving child b to the gifted program until they're in grade 5, so you know that's kind of a challenge in that what kind of support does he need in the mean time until he leaves the current stream. And I think often times it's a work in progress, it really depends on the administration; the learning reserves teacher and the learning consultant.

D2: We've had different experiences between school boards, yeah very slow. I think it's also different with their funding or capabilities I don't know, but that's why we went privately. When we went privately it was much quicker, we had assessments done in two months we had results. But it was because the school board was so slow it forced us to go privately. And even through his doctor it was very slow, we waited a year and a half for an appointment.

A2: [**clarification**] Yeah we did the private assessment, but it was from the private assessment to the IEP that it was nearly two years.

C2: very different, were not in that position of needing that, we've sought out counselling due to traumatic experiences that have occurred and so the family doctor was very supportive and we found private counselling quite helpful – for both family and individual- we go in as a family and have a counsellor that is for children.

C1: And the families go off in group discussion and we discuss what the children are talking about and what the children are talking about.

E: I have a question for the kids/ parents- gold standard is full family based interventions. When you think of the work family what do you think about?

AK: Cat, uncle.

E: Family is wide- what makes your uncle apart of the family?

AK: Because he lives in our house- we use him as a pillow.

C2: It's a support system, we call our parents regularly, we call our siblings, it takes a village.

C1: I think of it as a team.

DK: I kind of think of events when our family comes in one house.

E: family dinners – so we're really seeing bonding, team work, support system, a village- that's great, the goal of the program is to build 5 family-based program -… the families get together and write goals collaborative ly

"Picking goals for the whole family to grow towards can be helpful for creating family cohesion"

---On a scale of 1-5 (one being I do not support and five being I fully support), how much do you support this statement?

Why?

C1: I think it's important, but I don't think it's something we'd necessarily discuss directly, it's just silently agreed upon, naturally, we don't sit down and say we want to strive for this goal.

E: do you think it would be helpful to sit down and explicitly make that decision?

C1: It could be if we identified a natural leading course, we see this portion of our lives are so broke we've got to work on it and focus on it.

E: Okay.

C1: But that's not generally what we sit down and discuss over dinner.

A2: I could see a lot of value in that, including the children and basically getting their buy in, they having a say.

C2: I think in situations our life is in chaos or turmoil and were striving to dig our way out and figuring out the best way to support our family, it's more of a reactive mode instead of goal oriented. We're up against so much, how can we set a goal when there are so many barriers I have no control over.

Once we take care of some of those barriers we can sit down and try and focus on something.

D2: working together though and getting everyone's input especially really based on how the children spend time, you know from your own children what they're in to or not, child X is nine now and it's nice as he gets older getting his input a little more now in certain situations.

C2: Because it is incredible how they can…

D2: Yes and we kind of underestimate how much they really [trails off].

C2: I asked her once if she wanted to go to counselling or do this, like she had that options and she chose to go so she could show her feelings.

D2: I think it's really important to take that step if they're at the stage where they want to voice their opinion then they feel like they're heard. We take in a lot.

E: What are your favorite things to do together as a family?

D2: Games.

E: What is it about games that you like to do together.

D2: No screen, don get me wrong we love our movie nights, pjs movies and being together. We played a board game yesterday, it was that innocent having fun in the moment no screens no interruptions.

C1: screens are very personal, one thing, whereas board games we have to work together. We do the same thing movie nights on Friday, board games.

C2: Mondays is coloring.

D2: We love going outside, we're very active together.

A1: I work at night, I'm almost never around when the kids go to bed, parent a2 is always around, she's basically like a single parent. So time at the cottage teaching the kids how to fish, and kid a1 how to use a motor – something I liked to do as a kid- they started curling this year. Just being able to take stuff that I like taking it to teaching them how to do it.

A2: So most of our family time is on the weekends.

E: **[goals 2 q]** What might be some goals for families to make that would promote happiness & wellbeing? (Kids can participate in this question)

A1&2: Dinner.

D1: Dinner exactly, dinner, having everyone together for dinner.

D2: It's very important to us that we have dinner together every day. I mean your son is x years old and it gets hard, he works and hangs out with friends.

D1: Thursday was the first time this week we sat down and had dinner together that felt special.

E: What does that allow to happen when your able to sit down and have dinner together, what comes from that that you're looking for?

A2: There's no screens, forced eye contact.

D2: Exchange, we talk about our highs and lows, what happened in your day, has something happened.

A2: Everyone is on equal footing, no one is in charge.

D1: Everyone is there to help each other, reflect something good that happen in your day or if something bad happened then we can help each other out and talk about it

D2: And we have, yeah.

D1: And that's a common part, what's happened in your day?

A1: Yeah that's something that I try and do, because I'm not.. parent a2 drops them off and I pick them up from school and ask them how was their day? Or, what was the best part? But they don't want to deal with that.

A2: They need time to process it.

E: That's a perfect segue – [**Identify strengths**] The ability to properly manage and cope with stress can be an invaluable skill for future functioning and healthy development. The optimal outcome for children and their families struggling to access services would be to develop resilience through promoting protective factors.

The most basic definition of resilience is "The capacity to recover quickly from difficulties". One method for developing resilience is through meaning-making. Meaning-making is correlated with the development of resilience factors such as: coping, optimism, openness, good mood, positive psychological adjustment and a decreased need for therapy. One such way this is thought to develop is from identifying strengths and coping mechanisms that are used during difficult times. Do you think it would be helpful to identify strengths or does your family ever identify strengths?

C1: We always ask if something nice happened that day or something not so nice, did something bad happen today?

C2: Yeah something difficult because she's had to endure a lot of bullying so we're asking about that.

C1: We don't always focus on the child either, we say what happened to me during the day or what happened to mommy.

E: What about that do you think is helpful?

C2: She is able to able to feel a sense of security and safe in sharing what it is that's bothering her, what she's proud of. That's a big focus for us. That she feels that connection that she's able to speak what she's experiencing.

C1: If we make it a regular occurrence, then she's less likely to make a follow up. It'll just be a common thing that we do.

C2: Just last week she said, “You know, I didn’t tell you something a while ago because I thought that I was going to get in trouble, so I didn’t want to tell you.” So, we had that discussion that sometimes we make choices that we’re not proud of, but we can still share because we love each other.

E: What a learning experience.

C2: Yeah, it’s great.

A2: We have a hard time pulling out positives, the negatives are so many and so strong that they can’t get past that. Now I’m glad that their open and willing to tell me these things, they never get in trouble for it, but it gets wearing.

C1: It’s a part of the struggle.

D2: I think that’s why what we’re saying when there is a strength, we need to be working on them regularly because they are so hard on themselves, whether it could be an altercation with another friend, or marking they received that day, or recess if something happened at recess. Then it really empowers everything else in their day. So, we try to bring it out so that he sees that at the time.

D1: They always compare themselves others, all kids have their own strengths.

E: Okay so everyone has a unique strength that they can contribute then.

A2: Something I was told that keeps me going is that my dialogue with them now becomes their inner dialogue as they grow. So I do, “This is good”, yeah but that at moment it doesn’t seem to help much.

C2: But it does, we just don’t see it yet.

A2: Yeah, yeah.

D2: And what we see, like a lot of the times if it's something concrete like child x loves trains… we saw the lovely train comic that you made. I try, and again you can't always it's not easy. But I try to just find something we can show him he's creative.

E: Okay that's great- Another avenue for creating meaning-making is through forming connections and developing secure relationships with others. Interventions that support families in developing open avenues for communication could result in the development of more effective communication, fostering opportunities for emotional connection.

A researcher named Dr. Green (2010) developed a strategy known as Collaborative Problem Solving. In Collaborative Problem Solving, all problems that happen at home are seen as predictable and solvable. Parents and children work together to try to understand concerns and come up with good solutions to common problems. [**Collaborative Problem Solving]** so has anybody here heard of Collaborative Problem Solving?

B1: Yeah, but it's hard to get past absurd solutions, the solution to everything is to buy me this big expensive thing. We Try.

E: So I was going to ask you what do you like or not like about Collaborative Problem Solving?

A2: It doesn't help in the moment, you have to wait for emotions to settle and sometimes they don't want to go back to that place and like I said sometimes the solutions can be absurd. And you know, when you try and put something that might actually be helpful, and it gets shot down. I know it's a process, but it doesn't really seem to help yet.

E: The thought was to maybe have a unit based on this approach to foster the development of family teamwork and secure family bonding. The family may be presented with scenarios that resemble typical family conflict interactions and be asked to brainstorm solutions.

What might be some typical conflict scenarios that arise for families? (Kids can participate in this question)

Everyone Bedtime

C1: Play date and the other people they don't really want to be there.

E: So she wants to have some friends there but not other friends?

C2: No, she always wants to have play dates so it's her initiating all the time, and sometimes she asks why they don't want to play.

C1: I also think that's a function of being an only child.

A2: Sibling conflict but you know, "you love them more than you love me, why do they get to do that but not me" especially with the 10 and 5 year-old.

C2: We have an international student that lives with us and she's obviously much older than child x and she asked yesterday "but why does student x get to stay on the computer all day?" because we limit screen time.

A1: Screen time is another conflict.

ACD: Agree.

D2: We need to set limits. 30 minutes and that's it.

E: So setting limits is a good way that everyone manages the screen time issue?

D2: For us yeah.

A2: We ended up setting hard limits. You log out at this time, the wireless goes out at this time. Because they were sneaking. I would find devices in the bedroom and you're not allowed to have devices in the bedroom. So it just happens automatically I don't have to police it.

C2: We've created a tally system for what she has to contribute to herself, the house and her school and so that's done during the week so she can get screen time on the weekend. She enjoys seeing the tally

C1: On the weekend she gets to use it.

C2: So she's learning tallying in school and she likes to use it. So, you bring in what she's learning in school and use it.

E: Navigating the mental health system is one of the biggest barriers faced by families trying to seek support services. More specifically, families are disconcerted upon entering the mental health system, unsure what services are available to them, and what programs would best suit their child's needs. Through creating an online parent-friendly platform for personal testimonies, forums, events and resources, this unit would help to educate parents on the types of resources available and how to advocate for their child. Furthermore, if desired families could use it to connect with other families and share resources. [**online resources]** Does that sound like something that would be helpful?

C1: Honestly more is better. If that was available that would be a help for some people maybe not all people. But those are some resources I would definitely like to access.

D2: I think of any situation that was difficult that we went through I would just go on online and try and google the problem. I would try any words that might bring up a journal or something that another parent wrote about a similar experience. I tried so desperately to see if another parent had gone through the same thing and see what they experienced.

A2: Our GP was not very much help, so if there was something that they could point to to say start here, that would be helpful.

C1: That's kind of what happened to us.

A2: Even through public health, I didn't find their website very helpful.

C2: I'm in a Facebook group Ottawa Moms, it is phenomenal how many parents are out there searching for something for their children that is not attainable, they're searching everywhere, and they can't find it so they come to this group. Moms are like "oh I know, I went through the same thing" So its mom's helping moms saying this is what we went through and this is what helped us. And so, it's that idea but women came together and build it for themselves.

B1: I would echo, I have a network of moms, and parents on Facebook. They are the services or supports that we need. They're very efficient and they can drill down very quickly and they're so supportive. And chances are, if you put something out there, they will hit you back and someone will respond saying do this, this and this.

C2: So I think it would be extremely beneficial if that portal was there because it's on the outside.

E: And so in addition to the sharing of resources that comes from that is there also a sense of support that is developed from connecting with people with shared experiences?

B1: Yes, on this Facebook group they will help identify which psychologist you should go to, what to put in the IEP letter, what to expect, what you should say to your principal.

C2: And in the moms' group, the individual reaching out you know you come at it like there's probably some guilt in there, oh my child isn't what it's 'supposed' to be and so to hear someone else's story and hear oh I know what you're talking about, so it's like a validation. So, when you're sharing similar lives and stories then validation is really helpful in times of crisis.

C1: It's also helpful that group she's talking about has a "no grief" policy, so you can only say positive things. You're not allowed to call people out on stuff.

A2: I think it would also be very helpful to have a children's resources of the same. Somewhere where they could go to have a safe space to say I'm feeling this, I'm dealing with this or just vent.

E: Like kids help hone maybe but on a less severe level.

A2: Yeah.

C1: I can see that being useful, but you need to train the child to express their feelings and that happens at home with us.

A2: But sometimes they don't want to tell us.

C2: Exactly

C1: I understand

E: It seems with this discussion there is definitely something that could be helpful in terms of additional resources like academic journals something that's been researched and published would that be a helpful thing to have access to?

D2: Yeah.

C1: That's also a good resource for the right kind of people that would know to look there.

E: Meaningful engagement – might include goal-setting identifying strengths. With these units do you think it would be helpful to also include games, cards and drama with the whole family program?

Group yes

D2: We usually use store bought games or whatever we see out there, we just go online and see. But if there was a resource that had games.

C1: When trying to access the child's mind, we don't have the tools to tell us what's happening so games could be helpful in that?

E: Any other forms of connection that might be important? Or different forms of teaching that might be fun?

D2: Bike rides are really important to us, because we're out and active.

D1: It's free play too, it's not structured.

C2: And we realize that one of our family goals is to be active. It's not us telling her to be active it's us doing it and her learning by example. We do the long bike rides, swimming. We're out there talking, enjoying, sharing in what it is we're taking part in.

C1: We have to identify what it is she likes to do, 3km hike in the forest she hates that, but 10km bike ride, she's all over that.

B1: Our family is into music, my kids play various instruments and I find that it's been very supportive to demonstrate to them about growth mindset, setting small goals, looking for short term wounds. Even there might be small challenges that might be there with the right support, practice and attitude the children seem to be doing very well. I am very consistent in saying use music as an outlet right now you might not appreciate it but when you get older you will see the benefits. And I think they do see the benefits at such a young age because they play and preform in solos and also in group settings. I've never thought of using an outside activity for that, but we have certainly lots of that for the kids of well. But I find that my family finds the most pride in musical expression.

C1: That's good for their mind too.

B1: They draw they draw a lot they do a lot of comic book writing the scenarios in comic books, I'm just shocked at what they express. And sometimes the themes that they express are far more mature than I would expect them to be expressing at. To your point having that opportunity to draw, and looking at other artists and looking at how they express their attitudes, their

philosophies. Need to have someone to facilitate that. We've had phenomenal teachers that; especially with aboriginal art, the vocalization of frustration, and then having the children reflect on that.

E: Thank you for that- The original program that the family units would be grafted onto involves developing healthy thinking, child problem-solving, social, and behavior skills, as well as meaningful engagement, taught through music, games, art, drama, and other group-based activities. The new family units, based on what we discussed today, might include family goal-setting, family problem-solving, identifying family strengths, reflecting on meaningful family memories and connection to other families or resources. These units could also include art, drama, or games. Any suggestions on how to make this program more accessible to the family?

C1: That comes down to money, advertising, getting the word out there to people, so they can spread it.

C2: I think it needs to be in doctor's offices, it has to be in schools (everyone chimed in).

D2: Schools need to have that resource so that they can let us know.

C2: Public health.

E: Is there anything else that would make it more likely for families to use? In addition to what we've spoken about today, any suggestions in terms of buy in?

A2: If it could be at different spots around Ottawa so that it could be local.

E: What if it was done in the home?

A2: As long as there's a professional resource- as long as it's not another one of those things where you hand something to the parents and say do to it. There's have got be a support structure.

E: Like an online forum or a tutor or if there was some research back ground.

C2: Yeah like if the program comes from a professional, and the peer support is support in implementing where there's a portal where we can reach out and say we're struggling with this activity and how did you do this? Cause nobody is going to get paid to do that.

A2: Maybe to schedule a quick call, I have a program for emotional control for the kids that's an app. But I pay for the monthly support calls. We do regular check ins, one is the app running, how are the kids, how are you implementing it? If I have any questions, knowing I have the phone call makes a big difference.

D2: Maybe if there's feedback if there was an online program, if there was a discussion or scenario, we were discussing that there would be a professional there giving feedback.

C2: Reviewing.

D2: Give some insight from a profession stance on a regular basis. Relevant or recent information

E: Helping to make sure the skills learned are long lasting, to make sure the children remember. What might be something that could help with that?

C2: I think including the families in the ongoing structure of the program, ensuring that theres always a little board or committee of families that input how it's going.

B1: It should be simple or straight forward, look at how old these kids are, it should be something they can practice frequently 15 minutes, if I can work with him frequently with small goals that add up to a larger goal. Not something that is long.

E: Final question. In addition to learning strategies for healthy thinking and behaviours, social skills, and engaging in meaningful actions, are the proposed units to teach goal-setting, problem-solving, reflecting on strengths and meaningful family memories, and connection to other families or resources fitting for your family's needs?

Is anything missing that should be included?

B1: If you could help me with short little podcasts or apps or some programs so I can have scenarios that I can talk about. Right now I watch Netflix. Some of the programs have social situations that I use for teaching moments like on the spot. If you had things that addressed bullying, apathy, or anxiety. Somethings that my whole family could relate to.

C2: You know what I want after you just talked about that… you know what I want, mental health and bullying are talked about so much, it's the word of the day, buzz word. There is no help from the school or community. I was astounded at what I had to do get help for my child. The schools are so under resourced its incredible, the teachers don't have the time to care for the individuals that way. If we are going to put bullying and mental health out there, then supply the supports needed.

B1: One thing I did, so I work at the XX we do a lot of situational based, make it scenario based, a snippet that Families watch together, and the families choose how they would respond to it, Respect in Sport had good scenarios. Even as a parent, I had to spot and think how would I resolve it? If you looked at that and used similar sim-based scenarios. It would be a helpful tool as a parent to go through, as well with the kids. My kid did it with me and it sparked great conversation. Make it accessible.

A2 You make a good point, it's a buzz word. Bullying conversation. Lack of promotion in mental health in hospital settings

J: Hearing your concerns about screen time- would you recommend airing more on the live discussion side versus the tv/ computer.

D2: Technology is becoming bigger and bigger in everyday lives, tech is going into more and more part of their lives. It's not sure much that if they had to watch something beneficial to them would bother us it's more of the video games. Even after 30min I see a difference.

B1: I resonate with that completely, too much of this stimulation is not great for my kids. I find my teachers right now are very much incorporating using video, iPad, online things for teaching and even for adult learning were using simulation for learning. We might as well keep embracing it.

D2: Because it is becoming more of their lives it's important to incorporate it.

C2: My child has her own computer has her own user but she only has access to her learning games and she can have it whenever she wants but she doesn't.

A1: I have no issues for the learning devices at school for the learning disability she has a chrome book and at school that's not a problem.

J: If the kids were to come home with homework to do with the family could you see yourself engaging with that?

Absolutely.

A1: Yeah because it involves the family.

A1: Sure bring an activity or watch a video.

J So maybe even the more involvement with parents the better?

B1: Yes.

D2: Maybe add in to the program make it brief or concise.

B1: If there's a program please do indicate how long it will take. Also make it appropriate for the amount of parental support for the age group. Less with older kids and more with younger kids.

APPENDIX L

Research Ethics Board Certificate

UNIVERSITÉ SAINT-PAUL UNIVERSITY

04-09-2018
dd-mm-yyyy

Bureau de la recherche et de la déontologie
Office of Research and Ethics

Comité de la déontologie | Certificat d'éthique
Research Ethics Board | Ethics Certificate

REB File Number **1360.9/18**

Principal Investigator / Thesis supervisor / Co-investigators / Student

Last name	Name	Affiliation	Role
Watt	Emmalyne	Faculty of Human Sciences	Student-Principal Investigator
Armstrong	Laura	Faculty of Human Sciences	Thesis Supervisor

Type of project Doctoral Thesis

Title Dreaming of a Solution: D.R.E.A.M-O.F. an Online Mental Health Promotion Program for Children and their Families on Mental Health Waitlists.

Approval date	Expiry Date	Decision
04-09-2018 dd-mm-yyyy	**03-09-2019** dd-mm-yyyy	**1 (Approved)**

Committee comments

The Research Ethics Board (REB) approved the project.
The researcher is invited to use the reference number 1360.9/18 when recruiting participants.

In accordance with the Tri-Council Policy Statement, the Saint Paul University Research Ethics Board has examined and approved the application for an ethics certificate for this project for the period indicated and subject to the conditions listed above.

The research protocol may not be modified without prior written approval from the REB. This includes, among others, the extension of the research, additional recruitment for the inclusion of new participants, changes in location of the fieldwork, any stage where a research permit is required, such as work in schools. Minor administrative changes are allowed.

The REB must be notified of all changes or unanticipated circumstances that have a serious impact on the conduct of the research, that relate to the risk to participants and their safety.
Modifications to the project, information, consent and recruitment documentation must be submitted to the Office of Research and Ethics for approval by the REB.

The investigator must submit a report four weeks prior to the expiry date of the certificate stated above requesting an extension or that the file be closed.

Documents relating to publicity, recruitment and consent of participants should bear the file number of the certificate. They must also indicate the coordinates of the investigator should participants have questions related to the research project. In which case, the documents will refer to the Chair of the REB and provide the coordinates of the Office of Research and Ethics.

Louis Perron
Chair
Research Ethics Board

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