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Internalizing Mental Health Disorders: Examining the Connection Between Children's Symptoms and Parent Involvement and Autonomy Support.

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INTERNALIZING MENTAL HEALTH DISORDERS: EXAMINING THE CONNECTION BETWEEN CHILDREN'S SYMPTOMS AND PARENT INVOLVEMENT AND AUTONOMY SUPPORT

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ABSTRACT

The primary purpose of this study is to examine the connection between parent involvement and autonomy support, as well as the combined construct of autonomy supportive parent involvement, with internalized mental health symptoms. A secondary purpose of this study is to determine how certain parent demographics relate to attitudes and behaviors towards both parent involvement and autonomy support. Similarly, this study seeks to examine how certain how student demographics relate to internalized mental health symptoms.

The participants in this study were parents with one or more children in grades K-8 at three different schools in the suburbs of a large Midwestern city. Participants completed an online survey consisting of Grolnick, Deci, and Ryan's (1997) Perceptions of Parents Scale (POPS), Epstein and Salina's (1993) *School and Family Partnerships: Survey of Parents of Elementary and Middle Grades,* and Thomas Achenbach's (2001) Child Behavior Checklist (CBCL) for Ages 6-18. The results of this study indicate that a significant relationship does not exist between parent involvement and internalized mental health symptoms. Similarly, a significant relationship does not exist between autonomy support and internalized mental health symptoms. These results of this study refutes the common concern noted by school personnel that over-involved parents lead to higher anxiety levels in students.

CHAPTER ONE

INTRODUCTION

Parent involvement has been widely recognized as enhancing students' school success. The literature demonstrates that parent involvement is strongly associated with improved academic and social outcomes for children (e.g., Epstein, 2008; Gutman & Midgley, 2000; McWayne, Hampton, Fantuzzo, Cohen, & Sekino, 2004). Not only has parent involvement received considerable attention in the literature, but federal legislation including the reauthorized Elementary and Secondary Education Act (ESEA) and the No Child Left Behind Act (NCLB) have both called for increased parent involvement in the schools. It is clear that parents play a critical role in their child's school success.

School psychologists are in a unique position to facilitate parent involvement opportunities in the schools. As such, it is important that school psychologists have an understanding of the specific benefits of parent involvement. Similarly, school psychologists should be aware of the specific types of parent involvement that are most effective when working with students. While the literature has continually demonstrated that the *amount* of parent involvement is important (with the general acceptance that more involvement leads to better outcomes), there continues to be a gap in the literature on *how* parents can best involve themselves (Pomerantz, Moorman, & Litwick, 2007).

School psychologists play a critical role in providing mental health services to students in schools. Not only do school psychologists provide services to students with ongoing mental health issues, but they are also in a position to create prevention programs to enhance the well-being of all students. As such, school psychologists should be aware of factors that may lead to better mental health outcomes. One such factor is parent involvement. The research is clear that parent involvement is linked with children's academic and social functioning. However, there has been little research to date that links parents' involvement with their children's schooling to their children's emotional functioning (Pomerantz et al., 2007). Thus, more research is needed to extend the parent involvement literature beyond academic and social functioning to topics representative of school psychologists' other responsibilities, including promoting mental health.

Mental health is a term that encompasses many facets. One such facet includes students who internalize their mental health symptoms. Internalizing disorders are conditions whose central feature is disordered mood or emotion (Kovac & Devlin, 1998). Examples of these disorders include anxiety, depression, and somatic complaints. One argument made in schools is that students who internalize their mental health symptoms often go overlooked or unnoticed because they do not cause as much disruption as students who externalize their mental health symptoms. Because externalizing students are possibly more distracting to teachers, they may be more readily referred than students whose symptoms are not as disruptive. Because of this, it is highly likely that internalizing students are underserved in the school setting (e.g., Gudino, Lau, Yeh,

McCabe & Hough, 2009). As such, more attention should be paid to factors that prevent internalized mental health symptoms, including parent involvement.

Understanding the connection between parent involvement and internalized mental health symptoms may be helpful for school psychologists when designing interventions. However, as previously mentioned, it would be helpful for the research on parent involvement to extend beyond simply looking at the amount of parent involvement that occurs in a student's life. One way to determine *how* parents involve themselves is to examine this idea through the perspective of parenting style.

According to Baumrind (1966), there are three styles of parenting—authoritarian, authoritative, and permissive (these three styles will be described in more detail in Chapter Two). The literature has consistently demonstrated positive outcomes for children of authoritative parents (e.g., Baumrind, 1967; Karavasilis, Doyle, & Markiewicz, 2003; Maccoby & Martin, 1983). One specific behavior and attitude that is associated with authoritative parenting is autonomy support. Autonomy support is the extent to which parents facilitate independent problem-solving, choice, and self-determination in their children (Wong, 2008). Students who have parents who are autonomy supportive appear to have increased school success in terms of academic functioning and behavioral control (Wong, 2008).

Furthermore, parent involvement that is autonomy supportive has also been associated with academic success (Cooper, Lindsay, & Nye, 2000); however, no research exists, to the best of this author's knowledge that connects parent involvement and autonomy support with students' emotional functioning. This gap in the literature proves

problematic for school psychologists who are seeking to involve parents to enhance their students' mental well-being. It is particularly important to understand the connection between parent involvement and autonomy support with internalized mental health symptoms because this is a population that may continue to be underserved in the school setting.

Statement of Purpose

The purpose of this study is to fill the gap in the literature on parent involvement and students' emotional functioning. There is evidence that parent involvement is related to academic and social success; however, there is less research available on how parent involvement is related to mental health outcomes in the school. There is even less research on how parent involvement is related to mental health outcomes for students who internalized their mental health symptoms. Because schools are a venue where mental health services can be readily available, the research needs to focus on factors that contribute to positive outcomes for students with internalized mental health symptoms.

Factors that may be related to internalized mental health symptoms are parent involvement and autonomy support. Parent involvement and autonomy support can be connected to internalized mental health symptoms as their own constructs. Furthermore, the factors parent involvement and autonomy support can be combined to create the idea of autonomy supportive parent involvement (Pomerantz et al., 2007). This study seeks to examine the connection between parent involvement and autonomy support, as well as the combined construct of autonomy supportive parent involvement, with internalized mental health symptoms. In addition, this study seeks to provide greater understanding

for school psychologists of the factors associated with the development and/or prevention of internalized mental health symptoms.

While this study seeks to examine parent involvement and autonomy support in connection to internalized mental health symptoms, the researcher also has some secondary research questions that can be used to provide further information about each construct. Specifically, the researcher is interested in how certain parent demographics relate to attitudes and behaviors towards both parent involvement and autonomy support. The researcher is also interested in certain student demographics to determine if one population is particularly affected by internalized mental health symptoms. The following are the research questions guiding this study.

Research Questions

1. What, if any, relationship exists between parent involvement behaviors and internalized mental health symptoms in children?
2. What, if any, relationship exists between autonomy supportive parenting behaviors and internalized mental health symptoms in children?
3. What, if any, parent involvement behaviors correlate with autonomy supportive parenting behaviors?
4. What, if any, constellations of autonomy supportive parent involvement (e.g. high on parent involvement, low on autonomy support) are correlated with internalized mental health symptoms?
5. What, if any, parent demographics are associated with higher levels of parent involvement behaviors and autonomy supportive behaviors?

6. What, if any, student demographics are associated with higher levels of internalized mental health symptoms?

CHAPTER TWO

LITERATURE REVIEW

The purpose of this literature review is to provide an overview of the topics this study seeks to examine. Specifically, this section will discuss parent involvement, school-based mental health, and parenting styles. This literature review seeks to define the terms and provide an in-depth look at research findings related to these topics.

Overview of Parent Involvement Literature

This section of the literature review will provide an overview of what parent involvement looks like and how it affects a child's education. In order to provide the most thorough review possible, this section will entail several components. First, relevant terms will be defined. Secondly, a brief history on parent involvement as it has continually evolved will be provided. Third, the characteristics of effective parent involvement will be provided. Fourth, the specific benefits of parent involvement will be provided in order to demonstrate the importance of parents and educational outcomes. Lastly, the literature review will discuss other aspects of parent involvement that would be beneficial to examine as the research base continues to grow.

Definition of Parent Involvement. There has been increasing evidence that both the school and home environments play a role in educating children. While research has indicated that such factors as family background and parent education can predict school achievement, parent involvement represents a more active view of the parent that extends

beyond family characteristics (Grolnick & Slowiaczek, 1994). One important distinction to make is the difference between parent involvement and home-school partnerships. According to Christenson (1995), a home-school partnership requires mutually agreed upon goals by school and home, thus creating a two-way flow of information. Both the home and school share responsibility in reaching these goals. With parent involvement, parents are not necessarily seen as equal partners because the school directs how parents can be involved (Christenson, 1995). Thus, parent involvement is a one-way flow of information (Fishel & Ramirez, 2005).

The most commonly used definition of parent involvement in the literature is based on Joyce Epstein's typology (e.g., Epstein, 2008, 1995; Fishel & Ramirez, 2005; Waanders, Mendez, & Downer, 2007). This framework of six types of parent involvement provides a range of activities that parents can do to participate in their child's schooling. According to Epstein (2008), schools can use this framework to create programs that enable all parents to be engaged in the schooling process and to allow parents to be involved without having to be present at the school. Because work schedules or cultural differences can prevent parents from coming to the school, parents need different involvement options. This framework is a blueprint for schools to help parents become more involved, which then aids in developing family-school partnerships. The following are Epstein's six types of involvement with examples of how schools can create opportunities for parents to become involved in each specific way:

- Type 1: Parenting - Provide workshops for parents on child development or pertinent child issues.

- Type 2: Communicating - Provide updates about the school using a variety of mediums, including phone, letters, email, and meetings at the school.
- Type 3: Volunteering - Identifying parents to serve as mentors for students or as neighborhood translators for other parents.
- Type 4: Learning at home - Provide guidelines and/or skill workshops for parents that provide information on how to help with the child's homework.
- Type 5: Decision-making - Ensure that there is an active parent organization or that parents are included on advisory boards with school and community members.
- Type 6: Collaborating with the community - Create a directory of after-school programs, health services, and job opportunities.

While Epstein's typology is primarily based on parent involvement behaviors, other definitions view parent involvement as being multidimensional. According to Grolnick and Slowiaczek's (1994) extensive literature review, parent involvement is "the dedication of resources by the parent to the child within a given domain" (p. 238). For purposes of school psychology research, the "given domain" that is examined is the educational domain. In separating domains, a clear differentiation between a parents' overall involvement with their children versus involvement specifically related to their children's education is defined.

There are several dimensions of parent involvement within this definition. According to Grolnick and Slowiaczek (1994), parent involvement in education can be manifested in three specific ways. Below, each manifestation of parent involvement is

defined and, an example of a way a parent may exhibit this type of involvement is provided:

- Behavioral - overt behaviors of the parents that model the importance of school. Examples include attending parent-teacher conferences or going to an open house,
- Personal - the child's affective experience that the parent cares about school and enjoys interacting with the child about school. Examples include a child feeling happy that his parent praised his homework or a child feeling overwhelmed when his parent calls the teacher. It is an *emotional* experience for the child.
- Cognitive/Intellectual - parents exposing children to cognitively stimulating materials and activities, thus bringing home and school closer together. Examples include reading the newspaper with a child or taking a child to a museum.
- These manifestations of parent involvement require the parent to be the active component in initiating these behaviors.

Both Grolnick and Slowiaczek's (1994) and Epstein's definitions (1995) demonstrate that parent involvement can be exhibited in a variety of ways. One way to define parent involvement in a broader context is differentiating between parent involvement that is based at school and involvement based at home. School-based involvement requires that parents make contact with the school; home based involvement refers to parents' practices related to school that take place outside of the school

(Pomerantz et al., 2007). While these types of involvement practices differ, both home-based and school-based involvement have positive effects on student achievement (Swap, 1992). Because the home and the school are often the main environments for children, it is critical to recognize the involvement practices that occur within these different contexts. Recognizing both school-based and home-based involvement allows the literature to extend beyond behaviors that are specifically related to school (e.g., helping with homework). According to Waanders et al. (2007), parent involvement is—"parents' participation in the education of their children through behaviors that range from ideological support of education to active communication with school personnel" (p. 62). This definition supports the idea that involvement practices can vary from helping with specific school tasks to attending school functions to simply conveying that education is important.

Parent Involvement and Academic Benefits. It is important to discuss why including parents in children's education is important. Collaborative relationships between home and schools have continually demonstrated school success for students. One reason these relationships are so important is that schools alone cannot meet all children's needs due to the intensity of students' needs and constantly changing demographics in today's society (Christenson, Rounds, & Franklin, 1992). The responsibility for educating children cannot be left solely to the schools, requiring parents to take an active role. This active role, defined as parent involvement, is an important educational priority. Similarly, parent involvement in their child's education can create continuity between home and school. This continuity reduces conflict for children,

reinforces learning, and allows for an easier transition between the home and school environment (Swap, 1992).

Furthermore, the research demonstrates that involving parents in children's schooling is the single fastest way to improve a child's academic functioning (Sandell, 1998). This positive effect on academic achievement is important both to students and to society at large because "developing children's academic skills is beneficial for national advancement given that such skills are often important to areas (e.g., teaching, science, education) critical to the successful functioning of society" (Pomerantz et al., 2007, p. 294). Because of cultural values and the contingencies of federal funding, academic achievement is stressed in the schools. Promoting parent involvement is an effective way to increase academic performance for students.

Because parent involvement is so intertwined with school success, it is strongly recommended that both parents and schools adopt an ecological perspective (Bronfrenbrenner, 1979). This perspective views children as being embedded within different social contexts. Each child has a microsystem (e.g., family, friends, school activities) and the ways in which these microsystems interact with each other is the mesosystem. Thus, parents are part of a child's microsystem, and their involvement with the school makes up the child's mesosystem. According to Woolfolk (2007) "All relationships [within the mesosystem] are reciprocal—the teacher influences the parents and the parents affect the teacher, and these interactions affect the child" (p. 73). In adopting this perspective, both schools and parents recognize that there are several spheres of influence in a child's life, and the interaction among these spheres is

influential as well. In an interview with Ron Brandt (1979), Urie Bronfrenbrenner—the father of the ecological perspective, revealed his perspective on education today as he asserted “we need to bring adults and children back into each other’s lives” (p. 462).

Brief History of Parent Involvement. The rationale for involving parents in education can also be understood from a historical standpoint. Throughout the history of public education, the roles of both parents and the schools have changed not only in their interactions with the children, but also in their interactions with each other. The development of formal education, and parents’ role in this process, has been largely contingent on child-rearing philosophies that emerged during specific time periods. As child-rearing and parenting philosophies continued to change, so did the level of involvement parents demonstrated in their child’s education.

From pre-historic times through the development of civilization, parents were the primary educators of children in imparting essential skills, and modeling behaviors (Berger, 1991). Yet as formal education became more common, particularly in the United States, the relationship between the home and school became adversarial as each side attempted to gain control. Prior to the nineteenth century, powerful colonial families controlled the schools; as school bureaucratization and higher professional standards for school personnel developed in the second half of the nineteenth century, educators took control of the home-school relationship (Cutler, 2000). Yet as the 1900’s approached, bureaucratic reform caused educators to build parents into the school’s framework (Cutler, 2000). Society as a whole saw an increase in child-focused research and availability of parent organizations that facilitated parent involvement, such as the

Congress of Parents and Teachers (Berger, 1991). As research became more focused on children's development and educational needs, more programs and initiatives were developed that included parent training and opportunities for educational involvement. Similarly, those who subscribed to the theoretical view that all children are inherently good played a significant role in enhancing parent involvement. According to Berger, these theorists initiated the kindergarten movement, in which kindergartens and early education programs were developed specifically with the idea of involving parents. While initially the parents who were involved in these kindergartens were predominantly middle class, eventually the schools became avenues for acculturating immigrant parents and their children into mainstream U.S. culture (1991).

During the first half of the twentieth century, schools were viewed as extensions of the community and thus a sense of common culture typically existed between families and educators (Gareau & Sawatzky, 1995). While there were increased opportunities for parent involvement, a disconnect still existed between home and school. Due to this disconnect, research in recent years has shifted from the separate responsibilities of family and school to a partnership approach (Adams & Christenson, 2000).

Characteristics of Effective Parent Involvement. The literature demonstrates that parent involvement is strongly associated with improved academic and social outcomes for children (e.g., Epstein, 2008; Gutman & Midgley, 2000; McWayne, Hampton, Fantuzzo, Cohen, & Sekino, 2004). In an extensive review of the parent involvement literature, Pomerantz et al. (2007) contend that there are two sets of models proposed for why parent involvement leads to positive academic outcomes. The first modal, a *skill*

development model, asserts that parent involvement leads to better school outcomes because it enhances children's cognitive and metacognitive skills. This may occur because when parents are involved in a child's academic lives, they can get a better understanding of both the curriculum and the child's abilities (Pomerantz et al., 2007). If parents understand the skill level of their children, they can cater their involvement to be developmentally appropriate.

The second modal, a *motivational development model*, asserts that parent involvement leads to better school outcomes because it provides motivational resources that increase the child's engagement in school. Some of these motivational resources include intrinsic reasons for pursuing academics, sense of control over academic performance, and positive perceptions of academic competence (Pomerantz et al., 2007). Rather than focusing on the behavioral component of parent involvement (i.e., modeling specific skills), this model emphasizes the influence that parents have on the child's perceptions of his/her abilities and the value of school. While these two models are distinct in their components, Pomerantz et al. contend that most both models have effects on children. The authors' state,

> It is likely that parents' involvement in children's schooling enhances children's achievement through both skill and motivational development. Parents may provide resources that simultaneously cultivate children's skills and motivation. Moreover, when parents aid children in developing their skills, children may benefit in terms of their motivation (p. 376).

These models provide insight into how parent involvement relates to school success. There are other components of parent involvement that are particularly effective in helping children achieve. Longitudinal data indicates that greater parent involvement

in elementary school is associated with lower high school dropout rates, increased on-time school completion, and increase in highest grade completed (Barnard, 2004). This finding suggests that parent involvement that begins early is associated with later school success. This is particularly important because parent involvement typically lessens as children enter higher grades, especially high school. Middle level and high school teachers report that they typically only have contact with families when the student is in trouble (Epstein, 2008). Thus, enhancing parent involvement in the early grades is particularly important because it can lead to long-term outcomes at a time when parent involvement typically decreases.

Effective parent involvement is often garnered by the programs and offerings of the school. According to Dauber and Epstein (1995), “schools’ programs and teachers’ practices have important positive effects on parents’ abilities to help their children’s across grades” (p. 53). Thus, much of the responsibility for creating effective parent involvement opportunities falls to the school. This is consistent with Epstein’s six typologies of parent involvement, which consist of actions that school can take to facilitate parent involvement. While the parents are the active components in parent involvement, the schools must provide the opportunities for them to become involved. A Christenson, Hurley, and Sheridan (1997) study asked parents to rank parent involvement activities that they believe the school should offer, and the degree to which they would use these activities. At the same time, school psychologists were asked to rank the feasibility of implementing each parent involvement activity in their school. Overall, the parents and school psychologists had very similar rankings in activity use and feasibility.

For example, the activity “Provide information on how schools function” received the highest rankings from both parents and school psychologists. However, it must be noted that the mean ratings for use from parents and the mean ratings for feasibility from school psychologists was significantly different, with use scoring higher than feasibility. This suggests that while both parents and school psychologists desire the same parent involvement activities, the schools continue to struggle with implementation. While parents and school psychologists’ ideals are similar, the resources may not exist to carry out these activities. It is essential for schools and parents to decide together which activities are most pertinent and realistic.

Christenson, Hurley and Sheridan’s (1997) survey also provided valuable information on the types of involvement activities that parents are seeking. According to their results, parents and school psychologists agreed on eight activities that parents wanted and school psychologists deemed feasible. The themes of these eight activities included providing parents information about schooling, children or community resources, and consultation with school psychologists about children's learning and behavior. Recognizing the involvement activities that parents want is a way for schools to cater their involvement opportunities to maximize parental participation.

Benefits of Parent Involvement. One aspect of school success that parent involvement influences is academic functioning. In terms of specific academic outcomes, increased levels of parent involvement are related to increased school attendance (Epstein & Sheldon, 2002), higher math performance on standardized testing (Epstein & Sheldon, 2005), and higher grade point averages (Gutman & Midgley, 2000). In an extensive

review of parent involvement interventions, Fishel and Ramirez (2005) determined that parent involvement, specifically in the form of parent tutoring, improves students' reading skills; parent tutoring in combination with peer tutoring prevents difficulties in math achievement. The positive academic benefits of parent involvement are long-lasting.

Parent involvement is also associated with social and behavioral competencies for children in the school setting. In a survey of kindergarten children, McWayne, Hampton, Fantuzzo, Cohen, and Sekino (2004) determined that parents who have regular contact with the school and promote learning in the home have children who demonstrate positive engagement with peers. Home-based parent involvement is associated with children's attention and task persistence. Home-based and school-based parent involvement is associated with fewer conduct problems in the classroom for young children (Fantuzzo, McWayne, Perry, & Childs, 2004).

Parent involvement also acts as a buffer for children against negative circumstances. According to Dauber and Epstein (1995), "Children are more successful students at all grade levels if their parents participate at school and encourage education and learning at home, whatever the educational background or social class of their parents" (p. 53). Because parent involvement is more important in school outcomes than background characteristics, children who have parents with lower education levels or income levels can still achieve school success, provided their parents are actively involved. Parent involvement acts as an agent to level the playing field because it is effective for all types of families. However, it must be noted that SES and educational

background can be variables in influencing the amount and type of parent involvement exhibited (Christenson & Sheridan, 2001).

Future Directions of Parent Involvement Research. While the research clearly indicates the benefits of parent involvement, these studies typically examine the amount of parent involvement. However, Pomerantz et al. (2007) contend that simply examining the extent of parent involvement in each child's life is not sufficient. From their extensive literature review on parent involvement, the authors believe that the parent involvement research must broaden its scope. Pomenrantz et al. state:

> To date, the research conducted on parents' involvement in their children's education has generally taken the approach of examining the extent to which parents are involved, with more involvement on the part of the parents being better for children. Although such an approach is a fundamental first step, factors beyond the extent of parents' involvement are of major significance.

Rather than focusing solely on the *amount* of parent involvement, research must now focus on *how* parents are involving themselves in their child's schooling. The research is clear that increased parent involvement promotes positive outcomes for students; however, other factors such as *how* parents interact with their children during the involvement activities must be examined to determine the most effective involvement style, specifically when examining mental health outcomes.

The research is clear that parent involvement is linked with children's academic and social functioning. However, there has been little research to date that links parents' involvement with their children's schooling to their children's emotional functioning (Pomerantz et al., 2007). This gap in the literature is problematic because of the critical role that mental health plays in students' academic functioning. According to Doll and

Cummings (2008) “school mental health goals of promoting psychological wellness in the schools is not ancillary to students’ academic success, but integral to it” (p. 2). Thus, the responsibility of schools is not only to provide adequate instruction, but also to provide an environment for students to develop in an emotionally healthy way. One potential way to promote psychological wellness is to examine parent involvement and students’ mental health outcomes. If parent involvement can be so beneficial to students’ academic success, what connection does it have to students’ emotional health? The gap in the literature calls for researchers to extend the parent involvement literature beyond academic functioning to topics representative of school’s other responsibilities, including promoting mental health.

Overview of School Based Mental Health Literature

This section of the literature review will provide an overview of what school based mental health looks like and how it affects a child’s education. In order to provide the most thorough review possible, this section will entail several components. First, an overview of the current state of school based mental health will be provided. Secondly, it is necessary to explain the barriers to school-based mental health services so mental health advocates can develop a comprehensive understanding of the challenges schools face. Thirdly, the connection between school based mental health and learning outcomes will be described. Fourth, specific ways to enhance school based mental health will be provided. Lastly, the literature review will provide extensive information on school based mental health and internalized mental health symptoms.

School Based Mental Health: A Current Picture. Mental health concerns in children must be defined in ways that relate specifically to their developmental needs. In other words, the symptoms of mental illness in adults are not the same as that for children. In the context of children and adolescents, mental heath refers to functioning in daily life and appropriate development. The Surgeon General's 1999 report on Mental Health (U.S. Department of Health and Human Services, 1999) defines mental health for children and adolescents as "the achievement of expected developmental cognitive, social, and emotional milestones and secure attachments, satisfying social relationships, and effective coping skills." In the school context, children who do not possess all of the above characteristics of a mentally healthy child may have significant barriers to learning.

Mental health issues among children and adolescents are a national concern. The Surgeon General's Report on Mental Health indicates that 20% of children and adolescents have symptoms of a diagnosable mental disorder each year, with 5% of all children experiencing "extreme" impairment in functioning (U.S. Department of Health and Human Services, 1999). According to the Surgeon General's Report, "4 million youth suffer from a major mental illness that results in significant impairments at home, at school, and with peers" (p. 124). While the prevalence of children with mental disorders is high, there continue to be gaps in the mental health services that are available. According to the President's New Freedom Commission on Mental Health (2003), there must be more screening and early intervention for children displaying mental health symptoms, and these interventions must occur in readily accessible settings, such as schools.

The Surgeon General's Report on Mental Health estimates that there are six to nine million youth with an emotional disturbance that do not receive appropriate services

(U.S. Department of Health and Human Services, 1999). As such, schools are an ideal place to provide mental health services because typically, students are more likely to have easier access to mental health professionals. Also, services in the schools are free, accessible, and schools typically provide transportation for the students to and from the building. This removes barriers that normally prevent children from receiving services, such as cost and location. Because of these characteristics, schools are indeed the location where most children receive mental health services. Of the children who receive mental health service, 70-80% of them receive the services in a school setting (Burns, Costello, Angold, Tweed, Stangl, Farmer, & Erkanli, 1995). Despite this idea that schools are the "go-to" places for mental health services, the services within them are actually quite limited (Weist, Evans, & Lever, 2003).

It is also important to note the common misperception that mental health services in the school are simply restricted to counseling and therapy. On the contrary, the school is responsible for providing a variety of programs and services to encourage healthy development for both students and staff. The Center for Mental Health in Schools (2003) determined that there are six components of mental health services that schools should aspire to:

- Providing programs that promote social-emotional development, prevent mental health problems, and enhance resiliency.
- Providing programs and services that intervene early at the onset of problems (including behavior, learning, and emotional).
- Enhancing mental health of families of students and the school staff.

- Building the capacity of staff to promote healthy development and address barriers to learning.
- Examining and addressing matters at schools (such as high stakes testing) that may attribute to students' mental health. This includes systemic evaluations of practices that encourage bullying, alienation, and student disengagement in the classroom.
- Developing a comprehensive continuum of school-community interventions that address mental health needs and barriers to learning.

Thus, mental health services in the schools are not simply a response to psychopathology. Rather, these services must address prevention and promotion of healthy development. The Center for Mental Health in Schools (2003) makes an important distinction in the definition of "mental health." Typically, mental health is defined as the absence of problems; however, this definition does not encompass the idea of promoting positive social and emotional development. This is problematic because "the problems experienced by most youngsters are psychosocial (i.e., stem from socio-cultural and economic factors) not psychopathological and often can be countered through promotion and prevention" (http://smhp.psych.ucla.edu/). As such, schools cannot simply view their students as mentally healthy if they are not exhibiting problems. Rather, they must actively promote healthy development for all students. This is particularly helpful for students who internalize their symptoms and may otherwise fly under the radar for mental health services. Rather than developing effective interventions

for *treating* mental health issues, it is agreed upon by mental health professionals that effective *prevention* programs are vital (Ialongo & Werthamer, 1999).

Barriers to Mental Health Services in the Schools. It is important to discuss the barriers that schools face in providing mental health services for their students. By understanding barriers, mental health advocates can determine realistic solutions for promoting healthy development. The first barrier to promoting mental health services in the schools is funding. Money allotted by schools for mental health services is limited, as are schools' abilities to secure and sustain funding for mental health programs (Weist & Paternite, 2006). While federal law, particularly No Child Left Behind, provides funding, it does not mandate funding for specific programs, thus causing diversion of the funds away from mental health services (Daly, Burke, Hare, Mills, Owens, Moore, & Weist, 2006). Most schools' budgets are already stretched to the limit, so providing funds for additional mental health programs is simply not feasible.

These budget issues also inhibit schools from hiring more mental health professionals than are already on staff. In her research on full-service schools, Dryfoos (1994) contends, "The student/counselor ratio is so high that many students are shortchanged, particularly those in vocational tracks, and many counselors are not trained to deal with the complex psychosocial problems of today's students" (p. 52). Because of the perceived cost and difficulty in implementing mental health interventions, school districts may simply opt not to do them—an obvious disservice to the students. Not only does this disservice have implications for each school, but it also has implications for our nation at large. According Weist (2007), because school mental health staff is so limited,

"our nation contends with significant capacity problems in attempting to meet the unmet mental health needs of children and adolescents" (http://csmh.umaryland.edu/resources.html/SMH%20Congressional%20Testimony%20%205.8.07.pdf).

Another barrier to school mental health services is the school's strict adherence to the instructional mission. Administrators and school personnel often view the school's purpose as educating the students through instruction, and therefore do not connect mental health into this mindset. For schools that cannot break this mindset, school personnel must recognize that enhancing students' mental health also leads to positive academic outcomes. This point of view is represented by from the UCLA School Mental Health Project (2003). The researchers contend:

> Clearly, enhancing mental health in schools in comprehensive ways is not an easy task. Indeed, it is likely to remain an insurmountable task until school reformers accept the reality that such activity is essential and does not represent an agenda separate from a school's instructional mission. For this to happen, we must encourage them to view the difficulty of raising achievement test scores through the complementary lenses of addressing barriers to learning and promoting healthy development (http://smhp.psych.ucla.edu/).

The focus on instruction and academic achievement causes mental health services to be ignored. Not only do schools have this instructional mindset, but No Child Left Behind also limits schools' perspectives to academic success. While there are accountability indicators for academic growth within this law, there are no accountability indicators for social and emotional growth (Daly et al., 2006). Because there are no standards that schools must meet, mental health services are not prioritized. Other barriers to mental health services in the schools include lack of community awareness and lack of

professional collaboration (for review, see Weist & Paternite, 2006, http://smhp.psych.ucla.edu/).

Connecting School Mental Health and Learning Outcomes. The emphasis on academic achievement in schools overshadows the importance of mental health. Thus, in order to increase the likelihood that school personnel will devote more resources to mental health, it is important to demonstrate the connection between mental health and learning outcomes. While school psychologists are in a unique position to provide mental health services in the school, they are not responsible for every student's mental health concerns. Rather, within the schools, mental health interventions occur when a student's learning is directly affected. In their report on the President's New Commission on Mental Health, the UCLA School Mental Health Project (2004) contends:

> [P]revailing school accountability pressures increasingly have concentrated policy on instructional practices – to the detriment of all matters not seen as *directly* related to raising achievement test scores. Those concerned with enhancing mental health in schools must accept the reality that schools are not in the mental health business. Then, they should develop an understanding of what school leaders currently are doing to achieve their mission and clarify how agendas for mental health in schools help accomplish that mission. (http://smhp.psych.ucla.edu/pdfdocs/Newsletter/Winter04.pdf).

Thus, these authors argue mental health advocates must readily accept that the primary mission of educators is instruction. This mindset is pervasive among educators, due to accountability standards and federal law requiring effective instruction. From a historical perspective, this mindset may be due parents originally sending their children to school to receive a formal education (for review, see Cutler, 2001). Despite this instructional mission, the research consistently demonstrates that mental health is connected to

academic achievement (e.g., Catalano, Haggerty, Oesterle, Fleming, & Hawkins, 2004; Repie, 2005). Therefore, when schools do not emphasize social and emotional growth, academic achievement is compromised (Daly et al., 2006). Although the research demonstrates a relationship between academic achievement and students' mental health, there continues to be a disconnect in school interventions that address both of these concepts. In Hoagwood, Olin, Kerker, Kratochwill, Crowe, and Saka's (2007) examination of school interventions, the authors found that only 24 of the 64 articles reviewed examined outcomes for both mental and academic achievement. In order to increase school-based mental health services, the connection between mental health and academic achievement must be emphasized to educators.

Enhancing School Mental Health. The President's New Commission on Mental Health (2003) concluded that many children who need mental health services are simply not receiving them. Similarly, the research indicates that there are many barriers for schools in providing mental health services (e.g., Daly et al., 2006; Weist & Paternite, 2006). Despite these bleak insights, the research also indicates ways to enhance mental health services in the schools. The UCLA School Mental Health Project (2004) contends that in order for school based mental health to be enhanced, schools must comprehensive in the services offered. In a 2004 article that integrates mental health in the schools with the President's New Commission on Mental Health, the UCLA School Mental Health Project describes the following five components to a comprehensive school-based mental health framework:

- *Define mental health broadly*—this includes focusing on both strengths and deficits and considering the mental health of school staff and students' family members.
- *Enhance partnerships among school, community, and home*—including communication with parents to address barriers to learning.
- *Confront equity considerations*—using mental health services to level the playing field for students who may be at a disadvantage due to outside variables.
- *Address the related problems of marginalization, fragmentation, and competition for sparse resources*—revamping policies to better use resources.
- *Address the challenges of evidence based strategies and achieving results*—building on current school practices to achieve better results.

The Center for Mental Health in Schools' (2003) research on improving school based mental health clearly stresses systemic changes within the school, as well as collaborative efforts. While their framework provides several suggestions that can be done within the school, they also argue for increased collaboration with community agencies and students' homes. This idea of collaborating with community agencies to improve student's mental health is a recurring theme in the research (e.g., Weist, 2003; Weist & Albus, 2004). The Center for School Mental Health at the University of Maryland agrees with this perspective that examining systems and encouraging collaboration are essential to good mental health services in the schools. The Center for School Mental Health stresses that both teachers and mental health professionals must examine the obvious and

subtle features of the school system that will create or impede institutional changes (http://csmh.umaryland.edu/).

Enhancing school-based mental health requires each school to re-assess their infrastructure for providing services as well as their community connections with outside agencies. In order for both of these actions to occur, the school must initiate some type of change or behavior. However, according to Mark Weist (2007), the director of the Center for School Mental Health at the University of Maryland, the responsibility of improving school mental health cannot be left to the schools alone. In his school mental health congressional testimony on May 8, 2007, Weist asserts:

> Many of the federal agencies are playing a very important role in guiding and supporting this agenda and there is increased collaboration between these agencies, national organizations and states in moving forward. We need to build from this progress to develop a *federally supported national school mental health plan* that involves federal agencies in close collaboration with each other, with states and with nongovernmental organizations (http://csmh.umaryland.edu/resources.html/SMH%20Congressional%20Testimony%20%205.8.07.pdf).

Thus, the schools are in need of assistance from both the community and the government at large when creating mental health initiatives. A federally supported national school mental health plan would help create uniformity in the services and would reduce some of the current barriers that students face when seeking help.

In addition to collaborating with community and federal agencies, several models exist that demonstrate the importance of collaborating with parents in designing mental health services. Atkins and his colleagues (Atkins, Graczyk, Frazier, & Abdul-Adil, 2003) studied the Positive Attitude Towards Learning in School (PALS) intervention—a mental health intervention that included a community component. The goal of this

program, according to the authors, was to engage families, and "to approach families in ways that encouraged the development of an on-going working relationship and to identify treatment goals consistent with family priorities" (p. 505). Their results suggest that collaborating with families significantly increased access to mental health services (Atkins et al., 2003). This program effectively demonstrates that involving parents and families in school mental health increases the probability that students will receive the services they need.

An extensive review of the literature on school-based mental health interventions (Hoagwood & Erwin, 1997) contends that future mental health services must include variables related to family perspectives, and must evaluate the impact of mental health services when linked to home-based interventions. Including families in mental health services must be a priority. Similarly, Williams (1994) contends that schools must adopt a systems perspective when designing mental health services, and provide family systems therapy on school grounds. He stresses family therapy because schools, as well as community agencies "must not only understand the connection between a child's life at home and life at school, but must learn how to communicate better with parents to bring them into the educational process in a helpful way" (p. 360). Much research stresses the strong benefits of collaboration between schools and community mental health agencies. Embedded in this collaboration is the idea of including parents because they are active members of both the school and the community. In order to enhance mental health services, schools must include parents and cater to their priorities.

Despite the importance of involving parents in mental health initiatives, some schools may be hesitant to include them due to specific challenges if involving parents. Some of these challenges include: scheduling difficulties, concerns about confidentiality, stigma related to receiving mental health services, and pre-existing tension between family and community members (Center for School Mental Health Assistance, 2002). Because schools face many challenges when involving parents in the therapeutic process, it is imperative that parents have a clear understanding of ways they can encourage their child's healthy development at home.

The literature is clear that mental health in the schools is essential for positive student outcomes. However, one argument that is often made by school personnel and parents is that the students who act-out and have noticeable behavior differences from their peers are the ones who garner the most attention from the mental health staff. One possibility that this occurs is because acting-out students are more distracting to teachers and other students, and thus may be referred more readily. Certainly, these students are in need of mental health services. However, another population of students—those who internalize their symptoms—are also in need of mental health services in the school.

School Based Mental Health and Internalizing Disorders. The field of mental health defines internalizing disorders as conditions whose central feature is disordered mood or emotion; externalizing disorders are conditions where deregulated behavior is the central feature (Kovacs & Devlin, 1998). This term is widely used when referring to various forms of depression and anxiety, both of which are prevalent in childhood. It is estimated that 8-10% of the child population suffers from some sort of anxiety disorder;

1-6% of children and 13% of adolescents have some form of depression (Hibbs & Jensen, 1996). Because of the high rates of comorbidity for anxiety and depression, a growing interest in the shared aspects of these disorders has become more prevalent in the literature (Hammen & Rudolph, 2003). While it is certainly possible for children to exhibit both internalizing and externalizing symptoms, Beyer and Furniss (2007) found that 27.3% of a large sample of elementary school children had exclusively internalized symptoms. Despite the significant amount of students with internalized symptoms, school districts continue to take notice of the acting-out students. These internalizing children may be less noticeable than their externalizing peers because their cognitive processing ability may appear no different than their peers with no parent reported problems (Brunnekeef, De Sonneville, Althaus, Minderaa, Oldehinkel, Verlhulst & Ormel, 2007). Thus, because certain cognitive abilities are not deterred by their symptomology, internalizing students may appear “normal” to school personnel.

It is particularly important for children’s internalized mental health symptoms to be addressed early in their academic careers. The longitudinal effects of mental health symptoms have been documented. Ialongo (2001) determined that a depressed mood in first grade was predictive of the need for and use of mental health services, suicide ideation, and a diagnosis of major depressive disorder by age 14. Thus, it is critical that schools provide proactive mental health services to elementary students. Longitudinal studies on high-anxious first graders indicated that by eighth grade, they had difficulties with academics and peer acceptance, and higher levels of depression. However, they had lower levels of aggression, which relates to the idea that highly anxious students do not

display as many externalizing behaviors (Grover et al., 2007). Not only do mental health issues have profound impacts on the student, but they also create stressors for the parents such as additional responsibilities and difficulty with parenting (Owens, Hoagwood, Kellam, & Ialongo, 2002).

The trajectory for young students with internalized disorders appears bleak. Children who have these disorders typically have multiple problems and impairments in multiple areas of life (Kovacs & Devlin, 1998). In their extensive review of the research surrounding children and internalizing disorders, Kovacs and Devlin determined that young people who have an episode of depression are more likely to develop another episode of depression than any other disorder. Similarly, students with an anxiety disorder have a very high risk of developing another anxiety disorder. Thus, it is imperative for mental health professionals to be aware of the future implications of an internalizing disorder diagnosis. However, treatment outcomes are bleak for this population as well. Kovacs and Devlin also found that traditional interventions used with this population typically have very low response rates. Because the trajectory for these students is poor, particularly if treatment is ineffective, prevention of these disorders is vital.

These internalizing disorders are very common in childhood and can lead to long-term effects if not properly treated. So who is responsible for addressing these internalizing disorders? Because anxiety is so prevalent in childhood, recent research has identified the school as an appropriate setting for both the treatment and prevention of anxiety disorders (McLoone, Hudson, & Rapee, 2006). Schools are natural venues for

mental health interventions because of their ready access to children. However, as mentioned previously, mental health experts agree that *prevention* is critical, as opposed to treatment of mental health concerns. Specifically for anxiety and depression in early adolescents, Locker and Cropley (2004) found evidence of the need for schools to *proactively* increase students' self-esteem and ability to handle stress.

The literature supports the idea that parents play an important role, whether through genetics or child-rearing practices, in the development of anxiety and depression symptoms in children. In a longitudinal study, Grover, Ginsberg, and Ialongo (2005) found that a negative family environment was a significant predictor of childhood anxiety symptoms. Similarly, parent-child dysfunctional interactions are positively correlated with internalized mental health symptoms, and a lack of externalized symptoms in children when controlling for parent psychopathology (Costa et al., 2006). Because parents' interactions with their children may contribute to the development of internalized mental health symptoms, more research on how parents interact with their children specifically with school-related matters must be conducted.

Overview of Parenting Style Literature

This section of the literature review will provide an overview of Baumrind's (1966) models of parenting style. In order to provide the most thorough review possible, this section will entail several components. First, it is necessary to provide a brief history on parenting practices as they influence Baumrind's original research. Secondly, the characteristics of each parenting style will be provided. Third, autonomy, a specific component of authoritative parenting style, will be described. Lastly, the literature review

will provide an in-depth review of the connection between parent involvement, autonomy support, and internalized mental health symptoms.

Parenting Style from a Historical Perspective. Child-rearing practices have changed throughout history, varying from strict obedience models to models where total freedom of the child was encouraged. While parenting practices differed, they were largely based on religious values or humanistic beliefs rather than science (Baumrind, 1966). Yet, in 1966, Diana Baumrind's research on parental control yielded three distinct models—permissive, authoritarian, and authoritative (to be described shortly). Her conceptualization of these models at this time identified particular typologies of parenting based on the factors of freedom and control. While these prototypes of parenting have been come to be known as parenting styles, Baumrind's (1967) work refers to them as prototypes of adult *control*. Thus, this idea of parental authority, as well as autonomy support, was critical in the development of Baumrind's more recent conceptualizations of parenting styles.

Baumrind's early model of parental authority differed significantly from previous researchers in that it used a more contingency approach—meaning that one aspect of parenting is contingent on all other aspects (for review, see Baumrind 1966, 1967; Darling & Steinberg, 1993). In Darling and Steinberg's history of parenting style, they point out that "although in theory the authoritative-authoritarian-permissive typology was based solely on variations is patterns of parental authority, in reality the distinction was associated with other parenting attributes as well." Baumrind's models of parental authority not only allowed her to extend her own research, but they also allowed future

researchers to focus on the other attributes, including autonomy support, associated with these specific prototypes.

As more research was done on parenting styles, the idea that the authoritative-authoritarian-permissive typology was based on the variables of demandingness and responsiveness emerged (for review, see Maccoby & Martin 1983). As such, Baumrind (2005) also incorporated these variables into her parenting styles and derived definitions for each. According to Baumrind:

> *Responsiveness* refers to the extent to which parents foster individuality and self-assertion by being attuned, supportive, and acquiescent to children's requests; it includes warmth, autonomy support, and reasoned communication. *Demandingness* refers to the claims parents make on children to become integrated into society by behavior regulation, direct confrontation, and maturity demands (behavioral control) and supervision of children's activities (monitoring).

While other models of parenting style are based solely on the variables of demandingness and responsiveness (for review, see Maccoby & Martin, 1983), Baumrind's current model extends to other factors beyond just demandingness and responsiveness. Baumrind's definitions of these parenting styles include other factors such as warmth and autonomy support. As Darling and Steinberg (1993) contest, using models that rely solely on demandingness and responsiveness may not capture all the qualities of parenting styles because they do not include other important distinguishing features, including autonomy support. Thus, Baumrind's current model of parenting styles provides a more in-depth look because it includes several factors that may influence parenting style.

Parenting Styles. The first style, permissive, involves parents that are low on demandingness and high on responsiveness. They give the child few responsibilities and

allow children to regulate their own activities. The permissive parent behaves in ways that are nonpunitive and acceptant of the child's desires and impulses (Baumind, 1966). After three months of observations and interviews with nursery school students and their parents, Baumrind (1967) found that the permissive parents were those who were noncontrolling, nondemanding, and relatively warm. These permissive parents had children who were the least self-reliant and self-controlled.

The second style, authoritarian, describes parents who demand maturity from their children and greatly value obedience. According to Baumrind (1966), the authoritarian parent "attempts to shape, control, and evaluate the behavior and attitudes of the child in accordance with a strict standard of conduct" (p, 890). In her 1967 study, Baurmind found that authoritarian parents are detached, controlling, and less warm than other parents; their children are discontent, withdrawn and distrustful when compared to their same-age peers.

The third style, authoritative, describes parents who demand maturity but are also nurturing. They direct the child using rationality and provide reasoning for the child when making demands or limitations. Authoritative parents enforce the rules, but are willing to make exceptions when certain circumstances arise. These parents are controlling and demanding, but also warm, rational, and receptive to the child's communication (Baumrind, 1967). They positively encourage a child's autonomy, and their children tend to be self-controlled, self-reliant, and content with themselves (Baumrind, 1967). Research has painted a consistent picture that children raised in authoritative homes generally score higher on measures of self-perception and mental health (Maccoby &

Martin, 1983). The research has also demonstrated a positive association between authoritative parents and secure attachment with their children (Karavasilis, Doyle, & Markiewicz, 2003).

Autonomy Support. The literature clearly points to positive mental health outcomes for the children of authoritative parents. One particular behavior that is essential to authoritative parenting is autonomy support (Baumrind, 1966, 1971, 2005). A definition of autonomy support as it relates to parents is the degree to which they are "responsive, reflective, validating of the child's opinions, feelings, and perspectives" (Clark & Ladd, 2000). Similarly, it is the extent to which parents facilitate independent problem-solving, choice, and self-determination in their children (Wong, 2008). Authoritative parents encourage their child's autonomy by recognizing the child's personal interests and by avoiding restrictions that inhibit the child's exploratory nature and decision-making processes.

The benefits of autonomy support are widely recognized in the literature. While there is much research on autonomy support as it relates to the home (e.g., Clark & Ladd, 2000; Steinberg, Blatt-Esengart, & Cauffman, 2006) there is also research available on parental autonomy support as it relates to the school setting. Wong (2008) examined student perceptions of parent involvement and parent autonomy support and their relationship with self-regulation, academic performance, substance use, and resilience. She determined that perceptions of greater parental involvement and parental autonomy support were linked to better academic functioning and less disruptive behavior in the classroom (Wong, 2008). Similarly, Soenens and Vansteenkiste (2005) examined

autonomy support and its connection to adolescent self-determination (the belief that one is making a choice of his/her own free will). They determined that adolescents who have parents who are highly autonomy supportive have increased self-determination in the realms of school, social competence, and job-seeking behaviors.

One specific avenue that links autonomy support and the school environment is the connection between parenting style that enforces autonomy and parent involvement. Specifically, the research has examined autonomy-supportive parent involvement, which essentially combines Baumrind's theories of parenting style with the educational perspective on parent involvement. Research that has explored this connection has demonstrated that autonomy supportive parent involvement is associated with academic success. Parents who are autonomy supportive have children with higher standardized test scores, higher grades, and more homework completed (Cooper, Lindsay, & Nye, 2000). Grolnick, Gurlan, DeCourcey, and Jacob (2002) determined that children whose mothers were autonomy supportive when helping them with school tasks demonstrated more creativity and more accuracy for the task at hand. These results suggest that autonomy supportive parent involvement relates to more intense learning and cognitive exploration by the child.

The relationship between autonomy supportive parent involvement and internalized mental health disorders has not been specifically studied in the literature, to the best of my knowledge. There is data suggesting that a high level of maternal psychological control (argued to be the opposite of autonomy granting) is associated with internalizing disorders in children. A study done with first and second grade students

found that for some students, high levels of maternal control were associated with internalizing problems, whereas high levels of maternal hostility were associated with externalizing problems (Morris, Silk, Steinberg, Sessa, Avennevoli, & Essex, 2002).

There is a clear connection between psychological control and internalizing disorders. Much of this research has presumed that psychological control is the opposite of autonomy granting (Silk, Morris, Kanaya & Steinberg, 2003). Thus, conclusions drawn from research about psychological control have been applied to autonomy granting. For example, psychological control has been associated with an increase in internalizing disorders in adolescents. Thus, the presumption has been that autonomy support, being a distinct opposite of psychological control, must decrease internalizing symptoms. However, recent research by Silk et al. has indicated that these constructs are not distinct opposites and thus cannot be used to counter-balance each other. Silk et al. determined that psychological control and autonomy granting have discrete factors and differential effects on internalizing disorders. They are distinct constructs, not merely opposite ends of a parental control spectrum. As such, past research that has drawn conclusions about autonomy support by studying psychological control may be flawed. Thus, while there is school-based research indicating that psychological control may affect internalizing symptoms, there must be more school-based research using autonomy support and parent involvement as distinct constructs.

It is clear that there is a need for more research on autonomy support as its own construct. It is also clear that there is a need for increased research on the *how* of parent involvement (Pomerantz et al., 2007). One type of parent involvement that has shown

positive outcomes is autonomy supportive parent involvement. However, these positive outcomes are related to academic, behavioral, and social success. More research on this topic and its relation to internalized mental health symptoms would benefit the field of school psychology as we continue to move towards a preventative mental health model. By understanding the types of parent involvement that impact students' mental health, school psychologists are in a position to help parents in their involvement and to create parent involvement initiatives to maximize students' mental health in the school environment.

CHAPTER THREE

METHODOLOGY

The purpose of the methodology section is to describe in detail the steps that will be taken to answer the six research questions addressed in the Introduction. The intention of this study was to explore what role parent involvement and parent autonomy support have in the development of internalized mental health symptoms in children. Specifically, this study explored the following research questions: (1). What, if any, relationship exists between parent involvement behaviors and internalized mental health symptoms in children? (2). What, if any, relationship exists between autonomy supportive parenting behaviors and internalized mental health symptoms? (3). What, if any, parent involvement behaviors correlate with autonomy supportive parenting behaviors? (4). What, if any, constellations of autonomy supportive parent involvement (e.g., high on parent involvement, low on autonomy support) are correlated with internalized mental health symptoms? (5). What, if any, parent demographics are associated with higher levels of parent involvement behaviors and autonomy supportive behaviors? (6). What, if any, student demographics are associated with higher levels of internalized mental health symptoms?

Participants

The participants in this study were parents with 1 or more children in grades K-8 at three different schools in the suburbs of a large Midwestern city. The researcher did not recruit parents of older children for this study because, as previously stated, the research on autonomy support has focused mostly on adolescents (e.g., Steinberg, Blatt-Esengart, & Cauffman, 2006; Baumrind, 2005, Gray & Steinberg, 1999). Thus, it was necessary that autonomy support research be extended to the elementary and middle school population. The researcher included three different schools to recruit a minimum of 50 participants.

Description and Demographic Profile of the Participants. The researcher had each principal at two of the three participating schools email parents a survey as well as a letter of introduction about the researcher. At the third school, the survey was posted on the school's website again with a letter of introduction about the researcher. The approximate current enrollment of students for the three schools is 363, 232, and 346, respectively. Assuming that all students come from a two parent home, the approximate number of participants the email was sent to is 1882. However, it is highly likely that this total number is actually much smaller because not all students have two parents. Similarly, this total number does not take into account that parents may have several children in the school, and therefore the total enrollment of students does not indicate the total number of parents. Because of these reasons, the researcher is estimating that approximately half of 1,882 potential participations were emailed, making the total 941.

Of the approximately 941 parents emailed, a total of 94 parents (9.9%) completed the majority of the survey and 78 parents (8.3%) were included for data analysis.

Of the participants, the majority reported that they were the child's mother (91%), while the remaining 9% reported that they were the child's father. Most participants (91%) reported being married. The remaining participants reported being single (1.3%), divorced (2.6%), or separated (1.3%). A significant majority of parents in the sample were White (92.3%), whereas 3.8 % were African American, 2.6% were Hispanic, and 1.3% were Asian. As far as highest level of education achieved, the majority of the participants held a Bachelor's degree (38.5%). The highest level of education by the remaining participants was as follows: 2.6% held a high school diploma, 17.9% went to some college, 10.3% held an Associate's Degree, and 2.6% held a graduate degree. In terms of average yearly household income, 47.5% of participants reported that they made in the range of $51,000-$200,000 per year. However, 30.8% of participants chose not to answer this question. Table 1 displays the demographic characteristics of the sample.

In addition to collecting demographic data about the participants, the examiner also collected demographic data about the participants' children. Each participant was asked to complete the survey about his/her oldest child at the school. Fifty-four percent (53.8%) of the oldest children were boys and 44.9% were girls. As far as the oldest child's grade level, the following percentages comprised the sample: 3.8% Kindergarten, 6.4% first grade, 14.1% second grade, 23.1% third grade, 16.7% fourth grade, 15.4% fifth grade, 3.8% sixth grade, 5.1% seventh grade, and 11.5% eighth grade. Lastly, the majority of the participants (50.0%) reported that the average academic performance of

Table 1

Demographic Characteristics of Participants

Characteristics	Frequency	Total Percentage of Respondents
Relationship to Child		
Mother	71	91.0
Father	7	9.0
Ethnicity		
African American	3	3.8
Asian	1	1.3
Hispanic	2	2.6
Multiracial	0	0
White	72	92.3
Marital Status		
Single	1	1.3
Married	71	91.0
Divorced	2	2.6
Separated	1	1.3
Highest Level of Education Obtained		
High School Diploma	2	2.6
Some College	14	17.9
Associate's Degree	8	10.3
Bachelor's Degree	30	38.5
Graduate Degree	21	26.9
Average Yearly Household Income		
0-$50,000	5	6.4
$51,000-$100,000	19	24.4
$101,000-$150,000	11	14.1
$151,000-$200,000	7	9.0
$251,000-$300,000	5	6.4
$301,000-$350,000	3	3.8
$351,000-$400,000	0	0.0
Over $400,000	4	5.1
No Response	24	30.8

their oldest child was excellent, whereas 39.7% reported good, 5.1% reported average, and 1.3% reported below average. Table 2 displays the demographic characteristics of the participants' oldest children.

Table 2

Demographic Characteristics of Participants' Oldest Children

Characteristics	Frequency	Total Percentage of Respondents
Gender of Child		
Boy	42	53.8%
Girl	35	44.9
Grade Level		
Kindergarten	3	3.8
First Grade	5	6.4
Second Grade	11	14.1
Third Grade	18	23.1
Fourth Grade	13	16.7
Fifth Grade	12	15.4
Sixth Grade	3	3.8
Seventh Grade	4	5.1
Eighth	9	11.5
Average Academic Performance of Child		
Excellent	39	50.0
Good	31	39.7
Average	4	5.1
Below Average	1	1.3

Sampling, Measures, and Procedures

Sampling. The participants in this study were from three suburban schools located in Illinois. Both mothers and fathers with a child in the school were invited to participate in the study. For students who do not live with a parent, their male and female primary caregivers were invited to participate. At two of the three, the respective principals

emailed an online survey and a letter of introduction about the examiner to all the parents. The only criteria for receiving the survey were to have at least one child currently enrolled in the school and to have an email address on file. At the third school, the principal did not email the parents due to a very low number of email addresses on file. Email is not the primary mode of communication at this school. Therefore, the principal at this school posted the survey on the school's website along with a letter of introduction about the examiner.

Measures. There were three different surveys used in this study, in addition to qualitative questions and collection of demographic information. The first survey was used to assess parents' involvement behaviors as well as their autonomy supportive behaviors. One well-known survey that does this is Grolnick, Deci, and Ryan's (1997) Perceptions of Parents Scale (POPS). There are four scales within this measure. The first two scales measure parent involvement, with the first scale measuring maternal involvement and the second scale measuring paternal involvement. The third and fourth scales measure autonomy support, with the third scale measuring maternal autonomy support and the fourth scale measuring paternal autonomy support. Upon constructing these scales, Grolnick, Deci, and Ryan (1997) determined that they were reliable; Internal consistency data (Cronbach's alpha with raw scores), for urban and suburban samples, respectively, were .70 and .67 for maternal autonomy support, .66 and .58 for maternal involvement, .66 and .55 for paternal autonomy support, and .66 and .67 for paternal involvement.

While this survey has been validated in the literature (e.g., Grolnick, Deci, & Ryan, 1997; Wong, 2008), it was originally constructed to be answered by children. Thus, for this study, the wording was altered to make it applicable for parents to answer. Adapting the survey for parents has not been validated in the literature, so it cannot be assumed that this adaptation had the same reliability as Grolnick, Deci, and Ryan's survey. The *Procedures* section will outline the precautions the researcher took in regards to this issue. (Please see Appendix A for the items on this survey.)

The second survey that was used in this study was Epstein and Salina's *School and Family Partnerships: Survey of Parents of Elementary and Middle Grades* (1993). This is a well-validated instrument for measuring parent involvement, particularly at the elementary and middle school level. For purposes of this study, the researcher used 1 scale from the survey—Parent Involvement on All Types of Activities. According to Epstein, Salinas, and Horsey (1994), the reliability of this scale is .77. This survey was used as a supplement to the POPS to expand the parent involvement information. (Please see Appendix B for items from this survey.)

The third survey that was used was Thomas Achenbach's (2001) Child Behavior Checklist (CBCL) for Ages 6-18. This survey obtained information from parents/ guardians about their child's behavioral and emotional well-being. Typically, this survey includes five major scales, including Total Competence, eight cross-informant syndromes, Internalizing, Externalizing, and Total Problems. The CBCL is a commonly used in both research and school settings due to its validity and reliability. The reliability statistics for test-retest value, inter-rater reliability, and internal consistency are 0.95-

1.00, 0.93-0.96, 0.78-0.97 (Achenbach & Rescorla, 2009). Because the researcher was focusing on internalizing disorders, the Internalizing scale of the CBCL was used in this study. Within the total Internalizing scale, there are three smaller scales. These scales, along with respective reliability statistics for each scale are Anxious/Depressed (0.84), Withdrawn/Depressed (0.80), and Somatic Complaints (.78) (Achenbach & Rescorla, 2009). (Please see Appendix C for the items on each scale.)

The researcher also asked qualitative questions about parents' autonomy support so that parents could voice any concerns or issues that they felt were not encompassed by the survey responses. The first qualitative question was: How independent do you believe your child should be? This question was selected because it assesses parents' attitudes towards autonomy beyond the realm of a specific 4 point scale. The second and third qualitative questions were: In what ways do you encourage your child's independence? and In what ways do you restrict your child's independence?, respectively. These questions were selected because they assess parents' behaviors. The ideas of encouragement and restriction were used in these questions to provide a whole spectrum of behaviors and to potentially eliminate socially desirable responses. The qualitative questions are listed in Appendix D.

Furthermore, the researcher also asked parents to provide demographic information. The demographics included the parents' gender, age, race, highlest level of education, and average household income. The researcher also asked the parents to provide demographic information about their children, including age, gender, grade level,

and average school performance. This demographic data was used to answer research questions 5 and 6. A full listing of the demographic questions is listed in Appendix E.

Procedures. In order to answer all the posed research questions above, the researcher constructed an online survey consisting on the survey items listed previously. At two of the participating schools, the respective principal sent an email to all parents through the school's listserve of parent provided email addresses (see Appendix F). The email explained the purpose of the study and that all responses are anonymous. It asked parents to participate, and directed them to click on a link to complete the survey. At the third school, the survey was posted on the school's website again with a letter of introduction about the researcher and a link to the survey. The third participating school posted their survey on their website because the respective principal did not have a large collection of parent email addresses. Because the survey was different for mothers and fathers, the survey immediately asked the parents' gender. Once this question was completed, the survey used logic to direct survey participants to different survey questions based on how they responsed to gender. These surveys were be identical with the exception of gender-based language.

When the parent clicked on the link, he/she was directed to the secure host-server Survey Monkey. No identifying information from the parents was available to the researcher. The first page of the survey was a reminder that the survey was completely voluntary and that all responses were anonymous. All parents were insturcted to answer the survey questions for their oldest child in the school in order to keep responses consistent.

Approximately three weeks after the first email was sent to parents, another email was sent (see Appendix G) to remind parents of the survey and/or thank them for already completing it. It contained the same instructions to clink on the link at the bottom of the email. The school that posted the survey on its website did so for approximately 4 weeks.

Data Analysis

To analyze the data that was collected, the researcher used SPSS. First, the researcher ran descriptive statistics to get an idea of how the participants responded, including mean, variance, and standard deviations. Reliabilty co-efficients were calculated to ensure that the scales in each of the instruments were a reliable indication of the constructs this study sought to examine.

The first research question was: What, if any, relationship exists between parent involvement behaviors and internalized mental health symptoms in children? To address this question, three scores of parent involvement were computed. The first score was the total score from the Maternal/Paternal Involvement scale from the POPS instrument. The second score was the total scores from Parents' Involvement on All Types of Activities scale from the *Family and School Partnerships* survey. The third scale was the Total Involvement scale, which combined the two previous scales to obtain a total score. A correlational analysis was run to determine if there were any significant findings between parent involvement behaviors and internalized mental health symptoms, as measured by each scale compared with the total score on the CBCL. These three parent involvement scales were also compared to the scores on each individual scale within the Internalizing scale—Anxious/Depressed, Withdrawn/Depressed, and Somatic Complaints.

A correlational analysis was also run to answer the second research question which was: What, if any, relationship exists between autonomy supportive parenting behaviors and internalized mental health symptoms? The researcher determined if there were any significant relationships between autonomy support and internalized mental health symptoms, as measured by a total score on the Maternal/Paternal Autonomy scale of the POPS and the total score on the CBCL internalizing disorders scale, respectively. The total score on the Maternal/Paternal Autonomy scale was also compared to the scores on each individual scale within the Internalizing scale—Anxious/Depressed, Withdrawn/Depressed, and Somatic Complaints. In the event that the researcher found significant correlations, a stepwise regression would have been conducted to determine how much parent involvement/autonomy support can be said to predict and account for internalized mental health symptoms.

The third research question was: What, if any, parent involvement behaviors correlate with autonomy supportive parenting behaviors? To analyze this data, a correlational analysis was conducted to compare the Maternal/Paternal Involvement Scale and the Maternal/Paternal Autonomy scale on the POPS. Furthermore, a correlational analysis was conducted between the Maternal/Paternal Autonomy Scale on the POPS with the Parents' Involvement on All Types of Activities scale from the *Family and School Partnerships* survey. The purpose of this research question and the analysis associated with it was to determine if the two constructs that potentially influence internalized mental health symptoms also influence each other. Furthermore, each item on the Autonomy Scale was correlated with each item on the three involvement scales

(Maternal/Paternal Involvement, Parents' Involvement on All Types of Activities, and Total Involvement) to determine if any specific component of autonomy support is associated with a specific involvement behavior.

The fourth research question was: What, if any, constellations of autonomy supportive parent involvement (e.g., high on parent involvement, low on autonomy support) are associated with internalized mental health symptoms? In order to analyze this, first a total score was calculated for both the parent involvement and autonomy support scales. The individual participant was assigned to a category based on this total score. Categories were created relevant to other participants' scores upon gathering the data. Each participant was assigned to 1 of 4 categories.

1. High in Parent Involvement and High in Autonomy Support
2. High in Parent Involvement and Low in Autonomy Support
3. Low in Parent Involvement and High in Autonomy Support
4. Low in Parent Involvement and Low in Autonomy Support

After all participants were assigned to a category, a analysis of variance (ANOVA) was run to determine if significant mean differences exist between each category and internalized mental health symptoms, as measured by the four scales on the CBCL.

The fifth and sixth research questions respectively were: What, if any, parent demographics are associated with higher levels of parent involvement behaviors and autonomy supportive behaviors?; and what, if any, student demographics are associated with higher levels of internalized mental health symptoms? For both research questions, a one-way analysis of variance (ANOVA) was conducted to determine if differences exist

between parent/student demographics and reported parent involvement and autonomy supportive behaviors. To measure this, individual parent/student demographics was compared to the total score on each scale—Maternal/Paternal Autonomy Support, Maternal/Paternal Parent Involvement (as measured by the POPS), Parents' Involvement on All Types of Activities (as measured by the *Family and School Partnerships* survey), the Total Involvement Scale, and the four scales on the Internalizing Scale of the CBCL (Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, and Total). A post hoc comparison test, Tukey's Honestly Significant Difference (HSD) was run to determine which specific demographics were associated with autonomy supportive behaviors, parent involvement, and internalized mental health symptoms. Lastly, the qualitative questions were analyzed using coding to determine prominent themes.

CHAPTER FOUR

RESULTS

The purpose of the current study was to investigate the relationship between both parent involvement and parent autonomy support and internalized mental health disorders. Additionally, the examiner was interested in particular parent demographics associated with specific involvement and/or autonomy supportive behaviors. This chapter will present an in-depth analysis of the survey data collected to answer the following research questions: (1). What, if any, relationship exists between parent involvement behaviors and internalized mental health symptoms in children? (2). What, if any, relationship exists between autonomy supportive parenting behaviors and internalized mental health symptoms? (3). What, if any, parent involvement behaviors correlate with autonomy supportive parenting behaviors? (4). What, if any, constellations of autonomy supportive parent involvement (e.g., high on parent involvement, low on autonomy support) are correlated with internalized mental health symptoms? (5). What, if any, parent demographics are associated with higher levels of parent involvement behaviors and autonomy supportive behaviors? (6). What, if any, student demographics are associated with higher levels of internalized mental health symptoms? The findings will be presented in chronological order of the research questions.

Before discussing the results of each research question, it is first important to discuss the reliability of the autonomy support and parent involvement measures used in

the survey. As discussed in Chapter Three, Grolnick, Deci, and Ryan's (1997) Perceptions of Parents Scale (POPS) was used to assess both parent autonomy support and parent involvement. Because this measure was originally designed for children to answer, the questions had to be adapted for parents to answer. To determine the reliability of the autonomy scale and involvement scale, a Cronbach's Alpha was calculated. The Cronbach's Alpha (.350) for the autonomy support scale on the POPS is lower than preferred, likely due to the relatively small number of participants in the study. An item-scale analysis was run by the examiner to determine if the reliability increased if one or more items were removed. However, results of this analysis indicated that the Cronbach's Alpha was highest (.350) when all items were included. Due to the relatively low Cronbach's Alpha (.350), the reader is cautioned when interpreting results that this scale's reliability is relatively low. On the parent involvement scale of the POPS, the Cronbach's Alpha (.167) was deemed by the examiner to be too low to be used in statistical analysis. Therefore, this scale was not used in any statistical calculations. Rather, the involvement scale from Epstein and Salina's *School and Family Partnerships: Survey of Parents of Elementary and Middle Grades* (1993) was used as the measure of involvement support due to its acceptable Cronbach's Alpha (.81)

Research Question One

This study sought to explore the relationship between parent involvement and internalized mental health disorder in children. In order to determine if a relationship exists, correlational analyses were conducted with the total score on the Epstein and Salina's (1993) involvement scale and the 4 scales on the CBLC—Anxious/Depressed,

Withdrawn/Depressed, Somatic Complaints, and Total Internalizing. The correlational analyses did not yield any significant results between the involvement scale and any of the 4 scales on the CBCL. Table 3 summarizes the correlational findings.

Table 3

Correlational Findings Between Internalizing Mental Health Scales and Involvement Measures

	Anxious/Depressed	Withdrawn/Depressed	Somatic	Total
Involvement Scale	.155	.082	.089	.134

Research Question Two

This study sought to examine if a relationship exists between autonomy supportive parenting behaviors and internalized mental health symptoms. In order to do this, correlational analyses were run to compare participants' responses on the POPS autonomy scale and the CBCL. The total score on the autonomy scale was correlated with each of the 4 scales on the CBCL-Anxious/Depressed, Withdrawn/Depressed, Somatic, and Total. No significant correlations were found, thus indicating that there is not a significant relationship between parents' autonomy support and children's internalized mental health symptoms. A summary of the correlational findings is presented in Table 4.

Table 4

Correlational Findings Between Parent Autonomy Support and Internalized Mental Health Symptoms

	Anxious/Depressed	Withdrawn/Depressed	Somatic	Total
Autonomy Support	- .028	-.118	-.011	-.053

Research Question 3

In addition to determining if parent autonomy support and parent involvement had relationships with internalized mental health symptoms, this study also sought to examine if parent involvement behaviors and autonomy support behaviors had relationships with each other. In order to determine what, if any, relationship existed, correlational analyses were run. First, a correlational analysis between the autonomy support scale as a whole and the parent involvement scale as a whole was fun, but did not yield significant results ($r(78) = .079$). For a more in-depth analysis, each item on the autonomy scale was correlated with each item on the involvement scale to determine if specific autonomy supportive behaviors were associated with specific parent involvement behaviors. There was a significant relationship ($r(78) = .439$, $p < .01$) between an autonomy scale item endorsing explaining behaviors to children (i.e., "Some mothers always explain to their children about the way they should behave") and the involvement scale item endorsing listening to a story that a child wrote. This relationship indicates that parents who are highly autonomy supportive by explaining behavior to their children (as oppose to forcing them to behave) are also highly likely to listen to a story their child wrote.

Similarly, a significant correlation ($r(78) = .234$, $p < .05$) was found between the autonomy scale item endorsing understanding children's behavior (i.e., "Some mothers always try to understand why their children don't do what they're supposed to right away) and the involvement scale item endorsing reading to a child. This relationship indicates that parents who are highly autonomy supportive by understanding their child's behaviors are also highly likely to read to their children. No other significant correlations were found between autonomy scale items and involvement scale items.

Research Question 4

This study sought to examine how specific constellations of autonomy supportive parent involvement are associated with particular internalized mental health symptoms. In order to determine this, first the constellations of parents had to be defined. In order to encompass the various autonomy supportive and parent involvement behaviors among parents, the following four constellations were created:

1. High in Parent Involvement and High in Autonomy Support
2. High in Parent Involvement and Low in Autonomy Support
3. Low in Parent Involvement and High in Autonomy Support
4. Low in Parent Involvement and Low in Autonomy Support

After data was collected, each participant was placed in one of the four categories. In order to place participants in the categories, the median scores for the Autonomy Support Scale and the Parent Involvement Scale were determined. Participants who were above the median score on Autonomy Support (M=17) were considered high in autonomy support, while participants below the middle were considered low in autonomy support.

Similarly, participants were deemed high in parent involvement if their total Parent Involvement Scale score was above the median (M=36.5). Participants who scored below the median were deemed low in parent involvement. After these determinations were made, each participant was placed in the respective constellation of autonomy supportive parent involvement. As such, four groups with an approximately equal number of participants were created.

Once each participant was placed in the respective autonomy supportive parent involvement constellation, an analysis of variance (ANOVA) was run to determine if significant mean differences existed among these constellations and the four scales of the CBCL--Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, and Total Internalizing. The ANOVA did not yield any significant mean differences among any of the four constellations and the four scales on the CBCL. Table 5 summarizes the ANOVA findings.

Table 5

Analysis of Variance Findings for Autonomy Supportive Parent Involvement Constellations and Measures of Internalized Mental Health Symptoms

Source	Sum of Squares	df	Mean Square	*F*	P	
Constellation and Anxious/Depressed	Between	19.546	3	6.515	.498	.685
	Within	967.800	74	13.078		
	Total	987.346	77			
Constellation and Withdrawn/Depressed	Between	6.687	3	2.229	.553	.648
	Within	298.300	74	4.031		
	Total	304.987	77			
Constellation and Somatic Complaints	Between	5.649	3	1.883	.458	.713
	Within	304.300	74	4.112		
	Total	309.949	77			
Constellation and Total Internalizing	Between	70.449	3	23.483	.512	.675
	Within	3391.500	74	45.831		
	Total	3461.949	77			

Research Question 5

In addition to examining any relationships that exist between autonomy support, parent involvement, and internalized mental health symptoms, this study also sought to examine what, if any, parent demographics were associated with higher levels of parent involvement behaviors and autonomy supportive behaviors. In order to answer this research question, a one-way analysis of variance (ANOVA) was conducted. The

demographic variables included in the ANOVA were relationship to the child, marital status, average income, race/ethnicity, and highest level of education. These demographics were compared to the autonomy scale as well as the parent involvement scale; these demographics were also compared to the four scales on the CBCL to determine if specific parent demographics are associated with clusters of mental health symptoms.

In terms of significant results, there significant mean differences were found between parents' highest level of education and autonomy support ($F(1,78)=2.74$, $p<.05$). A post hoc comparison test, Tukey's Honestly Significant Difference (HSD), was utilized to determine which groups of parents differed on the autonomy support scale. However, results could not be determined due to a minimal amount of variance in the cases. However, an examination of the means on the autonomy support scale for each level of education provides some helpful information. Parents whose highest level of education was graduate school endorsed engaging in highly autonomy supportive behaviors ($M=17.8$, $SD=1.57$). The comparison of means indicated that there was not an increase in means as the level of education increased. Rather, parents whose highest level of education was a Bachelor degree ($M=16.8$, $SD=2.10$) or parents whose highest level of education was a high school diploma ($M=17.3$ $SD=1.15$) endorsed higher levels of autonomy supportive behaviors than parents who endorsed having some college ($M=15.8$, $SD=2.42$) or an Associate's degree ($M=15.5$, $SD=3.38$). Figure 1 below provides a visual of the mean autonomy support score as it varies by parents' self-reported highest level of education.

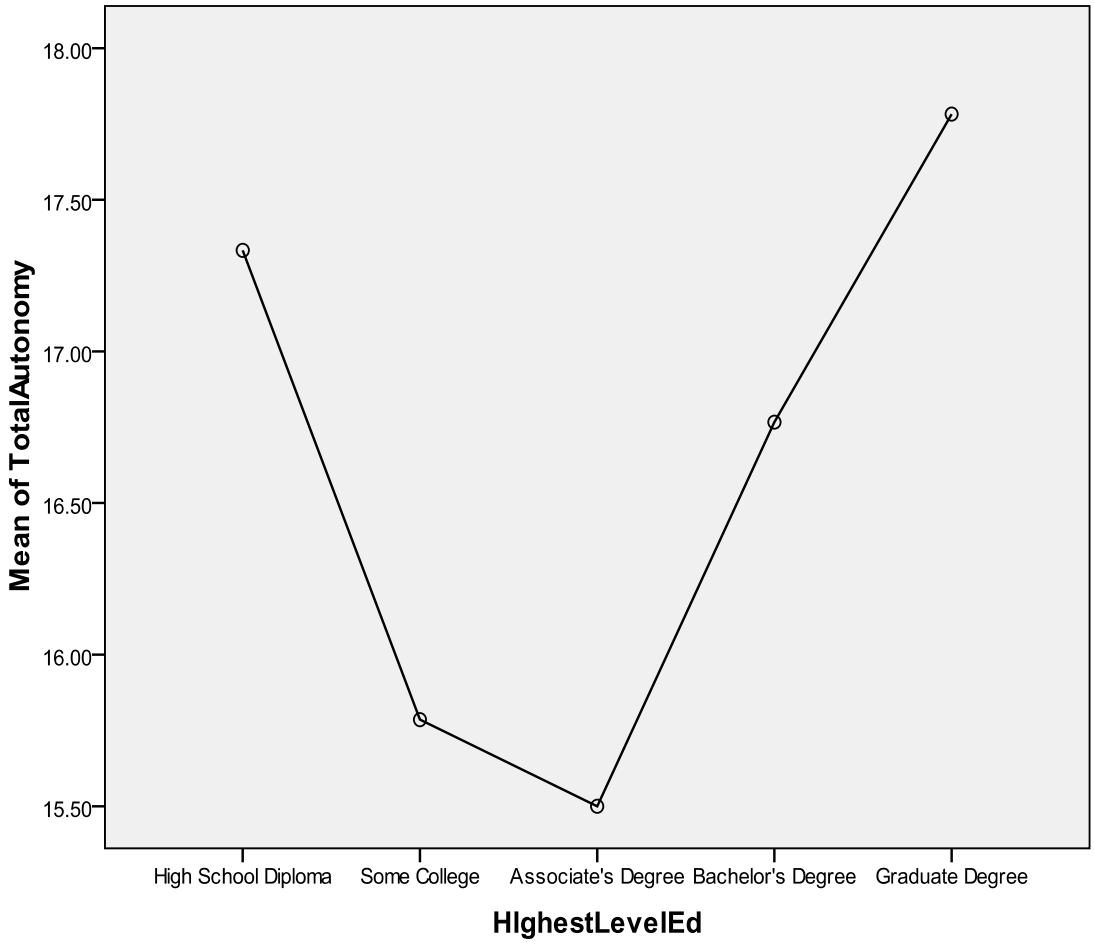

Figure 1. Mean Scores on the Autonomy Support Scale as They Vary by Parents' Highest Level of Education

In terms of non-significant results, the ANOVA calculations revealed the following findings when comparing demographics to the Autonomy Support and Parent involvement scales. In regards to average income, parents with different reported yearly incomes did not differ significantly on measures of Autonomy Support or Parent Involvement. Secondly, parents' self-reported highest level of education did not

significantly impact scores on the Parent Involvement. ANOVA calculations were not run for the demographic variables of relationship to the child, marital status, and race/ethnicity because there was so little variation in these demographics among the participants. Table 6 summarizes these ANOVA findings.

Table 6

Analysis of Variance Findings for Parent Demographic Variables and Measures of Autonomy Support and Parent Involvement

Source	Sum of Squares	df	Mean Square	*F*	P	
Average Income and Autonomy Support	Between	48.383	7	6.912	1.411	.215
	Within	342.912	70	4.899		
	Total	391.295	77			
Average Income and Involvement	Between	433.660	7	61.951	1.752	.111
	Within	2475.327	70	35.362		
	Total	2908.987	77			
Highest Level of Ed and Autonomy Support	Between	50.991	4	12.748	2.735	.035*
	Within	340.304	73	4.662		
	Total	391.295	77			
Highest Level of Ed and Involvement	Between	98.457	5	19.691	.543	.743
	Within	2609.389	72	36.242		
	Total	2707.846	77			

*p <.05

In order to determine any parent demographics were associated with internalized mental health symptoms, the examiner also ran ANOVA calculations comparing

demographics with the following internalized mental health scales: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, and Total Internalizing. ANOVA calculations were not run for the demographic variables of relationship to the child, marital status, and race/ethnicity because there was so little variation in these demographics among the participants. ANOVA calculations were run for average income and highest level of education, but there were no significant findings. In regards to average income, parents with different reported yearly incomes did not differ significantly on their responses on Anxious/Depressed, Withdrawn/Depressed Somatic Complaints, or Total Internalizing. Parents' self-reported highest level of education did not significantly impact scores on the Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, or Total Internalizing scales. Table 7 summarizes these ANOVA findings.

Table 7

Analysis of Variance Findings for Parent Demographic Variables and Measures of Internalized Mental Health Scales

Source		Sum of Squares	df	Mean Square	*F*	p
Average Income and Anxious/Depressed	Between	96.759	7	13.823	1.086	.381
	Within	890.587	70	12.723		
	Total	987.346	77			
Average Income and Withdrawn/Depressed	Between	29.950	7	4.279	1.089	.380
	Within	275.037	70	3.929		
	Total	304.987	77			
Average Income and Somatic Complaints	Between	35.080	7	5.011	1.276	.275
	Within	274.869	70	3.927		
	Total	309.949	77			

Average Income and Total Internalizing	Between	405.699	7	57.957	1.327	.250
	Within	3056.250	70	43.661		
	Total	2707.846	77			
Highest Level of Ed and Anxious/Depressed	Between	30.075	4	7.519	.573	.683
	Within	957.271	73	13.113		
	Total	987.346	77			
Highest Level of Ed and Withdrawn/Depressed	Between	16.839	4	4.210	1.066	.379
	Within	288.148	73	3.947		
	Total	304.987	77			
Highest Level of Ed and Somatic Complaints	Between	5.750	4	1.437	.345	.847
	Within	304.199	73	4.167		
	Total	309.949	77			
Highest Level of Ed and Total Internalizing	Between	97.812	4	24.453	.531	.714
	Within	3364.137	73	46.084		
	Total	3461.949	77			

Research Question 6

This study sought to examine what, if any, student demographics were associated with higher levels of parent involvement behaviors and autonomy supportive behaviors. In order to answer this research question, a one-way analysis of variance (ANOVA) was conducted. The demographic variables included in the ANOVA were the sex of the child, the child's grade level, and the average academic performance of the child. These demographics were compared to the autonomy scale as well as the parent involvement scale; these demographics were also compared to the 4 scales on the CBCL to determine if specific student demographics are associated with clusters of mental health symptoms.

In terms of significant results, significant mean differences were found between a child's grade level and parent involvement ($F(8,69)=3.72$, $p<.01$). Based on this finding,

the researcher conducted a Tukey's HSD test for post hoc comparisons to determine which student grade levels differed on the involvement scale. Post hoc analysis revealed a significant mean difference in parent involvement between the parents of children in second grade versus those in seventh grade. Specifically, parents of second grade students scored, on average, 10.3 points higher on the parent involvement scale. Similarly, there were significant mean differences on parent involvement scales between parents of eighth grade students and parents of second grade students. Significant mean differences also occurred between parents of eighth grade students and parents of third grade students. Specifically, parents of eighth grade student scored, on average, 10.2 and 8.2 points lower on parent involvement measures than parents of children in second and third grade, respectively. Table 8 below provides a summary of post hoc comparisons.

Table 8

Tukey's HSD Comparison of Teacher Endorsement and Reported Partnership Practices

				95% Confidence Interval	
(I) Grade Level	(J) Grade Level	Mean Diff. (I-J)	Std. Error	Lower Bound	Upper Bound
2nd Grade	7th Grade	10.27*	3.05	.48	20.07
7th Grade	2nd Grade	-10.27*	3.05	-20.07	-.48
2nd Grade	8th Grade	10.16*	2.35	2.62	17.70
8th Grade	2nd Grade	-10.16*	2.35	-17.70	-2.62
3rd Grade	8th Grade	8.22*	2.14	1.38	15.07
8th Grade	3rd Grade	-8.22*	2.14	-15.07	-1.38

*$p < 0.05$

The ANOVA also indicated significant mean differences between participants' ratings of their child's average academic performance and autonomy support ($F(4,73)=2.57$, $p<.05$). The researcher conducted a Tukey's HSD test for post hoc comparisons to determine which categories of academic performance differed on the autonomy support scale. However, the Tukey's HSD test could not be completed because there was not enough variance in cases.

In terms of non-significant findings, ANOVA calculations revealed the following findings when comparing student demographics to the Autonomy Support and Parent involvement scales. First, the sex of the child, as reported by participants, did not significantly impact their responses on scales measuring Autonomy Support ($F(2, 75)=1.08$, $p<.05$) or Parent Involvement ($F(2,75)=1.31$, $p<.05$). Secondly, the child's grade, as reported by participants, did not significantly impact their responses on the scale measuring Autonomy Support ($F(8,69)=1.17$, $p<.05$). Lastly, the average academic performance of the child, as reported by participants, did not significantly impact their responses on the scale measuring Parent Involvement ($F(4,73)=0.58$, $p<.05$). A summary of ANOVA calculations is presented below in Table 9.

Table 9

Analysis of Variance Findings for Student Demographic Variables and Measures of Autonomy Support and Parent Involvement

Source		Sum of Squares	df	Mean Square	*F*	P
Sex of Child and Autonomy Support	Between	10.990	2	5.495	1.084	.344
	Within	380.305	75	5.071		
	Total	391.295	77			
Sex of Child and Parent Involvement	Between	91.156	2	45.578	1.306	.277
	Within	2616.690	75	34.889		
	Total	2707.846	77			
Child's Grade and Autonomy Support	Between	46.576	8	5.822	1.165	.333
	Within	344.719	69	4.996		
	Total	391.295	77			
Child's Grade and Parent Involvement	Between	815.223	8	101.903	3.715	.001
	Within	1892.623	69	27.429		
	Total	2707.846	77			
Average Academic Performance and Autonomy Support	Between	48.318	4	12.080	2.571	.045
	Within	342.977	73	4.698		
	Total	391.295	77			
Average Academic Performance and Parent Involvement	Between	83.579	4	20.895	.581	.677
	Within	2624.267	73	35.949		
	Total	2707.846	77			

In order to determine what, if any, student demographics were associated with internalized mental health symptoms, the examiner ran ANOVA calculations comparing student demographics with the following internalized mental health scales: Anxious/ Depressed, Withdrawn/Depressed, Somatic Complaints, and Total Internalizing. However, there were no significant findings. In order to determine what, if any, parent demographics were associated with internalized mental health symptoms, the examiner also ran ANOVA calculations comparing demographics with the following internalized mental health scales: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, and Total Internalizing. However, there were no significant findings. The sex of the child, as reported by participants, did not significantly impact their responses on any of the scales, including Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, or Total Internalizing. The grade that the child is in, as reported by participants, did not significantly impact their responses on Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, or Total Internalizing. Lastly, the child's average academic performance, as reported by participants, did not significantly impact their responses on Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, or Total Internalizing. Table 10 below summarizes these ANOVA findings.

Table 10

Analysis of Variance Findings for Student Demographic Variables and Measures of Internalized Mental Health Symptoms

Source		Sum of Squares	df	Mean Square	*F*	P
Sex of Child and Anxious/Depressed	Between	41.341	2	20.671	1.639	.201
	Within	946.005	75	12.613		
	Total	987.346	77			
Sex of Child and Withdrawn/Depressed	Between	20.130	2	10.065	2.650	.077
	Within	284.857	75	3.798		
	Total	304.987	77			
Sex of Child and Somatic Complaints	Between	2.787	2	1.393	.340	.713
	Within	307.162	75	4.095		
	Total	309.949	77			
Sex of Child and Total Internalizing	Between	151.334	2	75.667	1.714	.187
	Within	3310.614	75	44.142		
	Total	3461.949	77			
Child's Grade and Anxious/Depressed	Between	168.680	8	21.085	1.777	.097
	Within	818.666	69	11.865		
	Total	987.346	77			
Child's Grade and Withdrawn/Depressed	Between	47.058	8	5.882	1.574	.149
	Within	257.929	69	3.738		
	Total	304.987	77			

Child's Grade and Somatic Complaints	Between	30.229	8	3.779	.932	.496
	Within	279.720	69	4.054		
	Total	309.949	77			
Child's Grade and Total Internalizing	Between	552.846	8	69.106	1.639	.130
	Within	2909.103	69	42.161		
	Total	3461.949	77			
Academic Performance and Anxious/Depressed	Between	55.587	4	13.897	1.089	.369
	Within	931.759	73	12.764		
	Total	987.346	77			
Academic Performance and Withdrawn/Depressed	Between	24.854	4	6.214	1.619	.179
	Within	280.133	73	3.837		
	Total	304.987	77			
Academic Performance and Somatic Complaints	Between	26.237	4	6.559	1.688	.162
	Within	283.711	73	3.886		
	Total	309.949	77			
Academic Performance and Total Internalizing	Between	302.764	4	75.691	1.749	.148
	Within	3159.185	73	43.277		
	Total	3461.949	77			

Qualitative Results

In order to gain a fuller picture of participants' perceptions of autonomy support, this study posed three qualitative questions that all participants were invited to answer. The qualitative questions included the following: (1). How independent do you think your child should be? (2). In what ways do you encourage your child's independence?

(3). In what ways do you restrict your child's independence? The findings will be presented in chronological order of qualitative questions.

The first qualitative question was: How independent do you think your child should be? In order to analyze the results of this question, the researcher examined each response for themes. Each prominent theme was coded and totaled to obtain a full perspective of participants' self-described autonomy supportive behaviors. Out of the 65 responses, the researcher determined that there were 73 different phrases coded due to some responses containing more than one theme. The most prominent theme, which was contained in 33.3% of responses was the idea that a child should be fairly or somewhat independent. The second most prominent theme, contained in 20.8% of responses, was that children's independence should be age-appropriate. Another prominent theme, contained in 19.4% of responses was that children should be extremely independent and receive very little help from their parents. An example of a response that contained this code was "he should be able to do the basics alone in life with no help". Conversely, the next prominent theme, contained in 15.3% of responses, was that children should receive some level of guidance or support while learning to be independent. These responses included parents helping their children with decision-making or homework. Lastly, 12.5% of the responses contained the theme that children should be independent enough to complete tasks, including homework and chores. Table 11 below provides a summary of the themes present in this qualitative question.

Table 11

Frequencies of Specific Codes in Qualitative Question #1

	Frequency	Percentage of Total Sample
Fairly/Somewhat	24	33.3
Age Appropriate	15	20.8
No help/Very independent	14	19.4
Guidance/Support	11	15.3
Able to Perform Tasks	9	12.5

The second qualitative question was: In what ways do you encourage your child's independence? In order to analyze the results of this question, the researcher looked for prominent themes throughout the responses and coded them accordingly. Out of the 65 responses, the researcher determined there were 83 different phrases coded due to some responses containing more than one theme. The most prominent theme, which was contained in 40.9% of responses, was the idea of encouraging a child's independence by giving them some type of responsibility, i.e., chores and setting up social events with friends. The second most prominent theme, which was contained in 30.1% of responses, was that parents encourage their child's independence by allowing for independent thinking and/or decision-making by their child. Responses that were coded this way included the idea of letting a child have choices when it comes to friends, activities, etc.

The next theme, present in 16.9% of responses, was the idea that parents encourage their child's independence through some type of reward or acknowledgement of success. The rewards in the responses included verbal praise and extended privileges for demonstrating good choices. The last two themes, contained in 7.2% and 4.8% of responses respectively, encompassed the idea that parents encourage their child's independence by directly teaching them how to make choices and by allowing their child to travel alone (i.e. ride a bike to a friend's house). Table 12 below provides a summary of the themes present in this qualitative question.

Table 12

Frequencies of Specific Codes in Qualitative Question #2

	Frequency	Percentage of Total Sample
Denote Responsibilities	34	40.9
Allow for Independent Thinking and/or Decision Making	14	16.9
Rewards and Acknowledgement	14	16.9
Direct Teaching	6	7.2
Allow Traveling Alone	4	4.8

This study sought to examine how parents restrict their child's independence, as is evident in the third qualitative question. In other words, the research was seeking what types of behaviors that parents engage in which may limit the amount of autonomy

support provided to their child. For this question, there were 65 total responses. The researcher coded each response for specific themes. Out of the 65 total responses, the researcher coded 74 phrases because some responses contained more than one theme. Out of these 74 codes, 28.4% of responses contained the theme that independence is restricted by some form of adult contact or interference. For example, several responses coded in this way said that they restrict their child's independence by all decisions must be cleared with an adult first. The second most frequent code, which was contained in 20.4% of responses, involved independence being restricted by an adult monitoring the child's location. An example of a response that contained this code was "I must know where he is at all times". Reponses that contained this code also encompassed the idea that children are not allowed to travel places by themselves.

The third and fourth codes, both of which were contained in 16.2% of responses, encompassed the ideas that independence is restricted by limiting technology and by setting clear boundaries, respectively. In terms of technology, parents reported restricting their child's television and video game choices. The code for setting clear boundaries encompasses such responses as "having well explained boundaries" and "setting limits". In 8.1% of responses, the code for safety issues was contained. More specifically, parents responded that they restrict their child's independence only when they believe there is a safety concern. 6.8% of responses contained the idea that parents restrict their child's independence by enforcing bedtimes and mandating that their child does chores. Lastly, 2.7% of responses contained the idea that parents do not restrict their child's

independence in any way. Table 13 below provides a summary of the themes present in this qualitative question.

Table 13

Frequencies of Specific Codes in Qualitative Question #3

	Frequency	Percentage of Total Sample
Adult Contact	21	28.4
Adult monitoring of location	15	20.4
Limiting Technology	12	16.2
Setting Clear Boundaries	12	16.2
Safety Concerns	6	8.1
Chores and Bedtimes	5	6.8
Not at all	2	2.7

CHAPTER FIVE

DISCUSSION

The purpose of this section is to provide a summary of the study. This section will also discuss the study's findings and the implications of these findings. The limitations of the study will be discussed, as will recommendations for further study on this topic.

Summary

The primary purpose of this study was to examine parent autonomy support and parent involvement and the relationship of these behaviors to students' internalized mental health symptoms. The research is clear that parent involvement is linked with children's academic and social functioning. However, there has been little research to date that links parents' involvement with their children's schooling to their children's emotional functioning (Pomerantz et al., 2007). There is even less research on how parent involvement is related to mental health outcomes for students who internalized their mental health symptoms. Furthermore, students who have parents who are autonomy supportive appear to have increased school success in terms of academic functioning and behavioral control (Wong, 2008). Because both parent involvement and autonomy support have been linked with academic success, this study sought to bridge the gap in the literature that connect autonomy support and parent involvement with students' emotional functioning.

In addition to aforementioned primary research questions, this study also had four secondary research questions. First, the researcher was interested in what parent involvement behaviors correlated with specific autonomy support behaviors. The purpose of this research question was to determine if the two constructs that potentially influence internalized mental health symptoms also influence each other. Because parents vary in their levels of autonomy support and parent involvement, the researcher wanted to determine if specific constellations of autonomy supportive parent involvement (i.e., high on autonomy support, low on parent involvement) were associated with internalized mental health symptoms. The researcher was also interested in how specific demographics of both participants and their children influenced autonomy support and parent involvement behaviors. These demographics were also compared to internalizing mental health disorders to see if particular demographics were associated with particular mental health symptoms. Lastly, the researcher was interested in how parents both encourage and restrict their children's autonomy, and thus qualitative questions were asked about these topics.

Discussion of Findings and Implications

The Impact of Parent Involvement and Autonomy Support on Internalized Mental Health Symptoms. To the best of this researcher's knowledge, the relationship between both autonomy support and parent involvement and internalized mental health symptoms has not previously been studied. In the present study, the researcher found that a significant relationship did not exist between parent involvement and internalized mental health symptoms. Similarly, the researcher did not find a significant relationship between

autonomy support and internalized mental health symptoms. These findings have some potential implications for the school psychologists.

A societal concern often noted by school personnel is that parents who are heavily involved (or "over-involved") in their child's education results higher levels of anxiety for students. A common term among school professionals for over-involved parents is that of the "helicopter parent". According to Manos (2009), a familiar scene of a helicopter parent in elementary and middle school is one in which the student is very anxious to enter school on the first day and the parent in equally as anxious to let the child go. However, this study refutes the common claim that over-involved parents lead to higher anxiety levels in students. The literature has consistently demonstrated that parent involvement leads to better academic and social outcomes for students (e.g., Epstein, 2008; Gutman & Midgley, 2000; McWayne, Hampton, Fantuzzo, Cohen, & Sekino, 2004). However, it is possible that school personnel are hesitant to promote parent involvement due to the recent societal concern that these "helicopter parents" are creating a generation of anxious, dependent children, despite this fear not being supported by data. This concern may also cause school personnel to frown upon highly involved parents, fearing that they are somehow damaging their children. However, this study indicates that concerns about children's internalized mental health and highly involved parents may be unfounded. A significant relationship between parent involvement and internalized mental health symptoms in fact, did not emerge in this study.

While being highly involved in one characteristic of a "helicopter parent", another characteristic of helicopter parenting is granting children very little independence. There

is a societal concern often noted by school personnel that it is common practice for parents to provide their children little autonomy in choosing projects, after-school activities, and even friends. As such, school professionals fear that students who have little autonomy will be anxious and depressed because they are unable to make decisions by themselves. Gibbs (2009) discusses that a common term for college freshman are "crispies"—students who are burnt out from years of their parents emphasizing that they learn specific skills or be involved in specific activities. Another term for college freshman is "teacups"—students who are ready to break because they cannot handle stress on their own because of years of parents handling stress for them (Gibbs, 2009). These specific terms further perpetuate this idea that parents who are not autonomy supportive are creating very emotionally fragile children. However, this study refutes this claim. On the contrary, this study suggests that a relationship between autonomy supportive parenting and internalized mental health disorders does not exist.

The results of this study are the opposite of societal expectations that over-parenting leads to anxious and depressed students. One possible reason for this finding is that these societal expectations are based merely on anecdotal evidence. As mentioned previously, there is very little research that links parents' involvement with their children's schooling to their children's emotional functioning (Pomerantz et al., 2007). Similarly, there is no research, to the best of the researcher's knowledge that connects autonomy support to children's emotional functioning. Not only does this study begin to fill that gap in the literature, but it also provides further evidence that school personnel's perceptions of the children of helicopter parents may be faulty. As pointed out by

Hoover and Beckie (2008), the number of helicopter parents at the college level is typically exaggerated. There is also evidence that highly involved parents at the college level may actually help their children succeed, which challenges the notion that these parents are inhibiting their children's social and emotional growth. Although this study focused on students on the elementary and middle school grades, the results contribute to existing research that indicates that highly involved parents are not stunting their children emotionally.

The rationale for this study was to fill the gap in the literature on autonomy support, parent involvement, and internalized mental health disorders. It was also designed to provide greater understanding for school psychologists of the factors associated with the development and/or prevention of internalized mental health symptoms. The results of this study provide some evidence that school psychologists can move forward in promoting parent involvement without fear that students will develop internalized mental health symptoms from highly involved parents. Similarly, the literature is clear that autonomy supportive parenting leads to higher standardized test scores, higher grades, and more homework completed (Cooper, Lindsay, & Nye, 2000). However, school psychologists may fear encouraging or discouraging autonomy support for fear that this may lead to internalizing symptoms in children. This study provides some evidence that this fear is unfounded. Lastly, the literature is clear that one way for school psychologists to enhance mental health in the schools is to partner with students' homes (The Center for Mental Health in Schools, 2003). Again, this study provides some evidence that school psychologists can involve students' parents to enhance mental health

programming without fear of creating the over-anxious child that is often referred to by school personnel.

This study also examined what specific autonomy support behaviors had relationships with specific parent involvement behaviors. The purpose for examining how these two constructs correlate with each other was to determine how two factors that were potentially related to internalized mental health symptoms were also related to each other. The researcher found two significant relationships between specific items on the autonomy scale and specific items on the parent involvement scale. Specifically, parents who are highly autonomy supportive by explaining behavior to their children (as opposed to forcing them to behave) were found to be significantly more likely to listen to a story their child wrote. Also, parents who are highly autonomy supportive by understanding their child's behavior are also significantly more likely to read to their children. No other significant relationships were found among specific scale items. However, it is likely that these results are a random error because there is no literature, to the best of the researcher's knowledge that demonstrates how specific autonomy support behaviors influence specific parent involvement behaviors.

Impact of Various Demographic Variables on Autonomy Support, Parent Involvement, and Internalized Mental Health Symptoms. Significant results were found between specific demographics (children's average academic performance and parents' highest level of education) and autonomy support. However, there were not enough variance to determine what specific levels of academic performance or level of education had the most influence. However, significant results were found for student

demographics in the areas of children's grade levels and children's average academic performance. In terms of children's grade level, parents of second grade students scored, on average, 10.3 points higher on the parent involvement scale. Similarly, parents of eighth grade student scored, on average, 10.2 and 8.2 points lower on parent involvement measures than parents of children in second and third grade, respectively.

These demographic results indicate that parents of students in older grades may exhibit less parent involvement behaviors. This is an optimistic finding because it is consistent with the literature that finds that parent involvement typically decreases during the middle school years (Epstein, 2008). As such, this finding provides evidence that this sample in this study, while small, is possibly representative of a larger group that follows similar patterns in terms of decreased involvement as students enter middle school.

Autonomy Support: How Parents Promote and Inhibit Their Children's Independence. In order to obtain a larger picture of autonomy support beyond the questions asked in the POPS autonomy support scale, the researcher constructed three qualitative questions. These qualitative questions were able to provide specific autonomy support behaviors that parents engage in that were not necessarily part of the quantitative measures. This study found that parents believe that their children should be only somewhat independent and able to engage in age-appropriate tasks. One way that parents encourage their children's independence, which was contained in 30.1% of responses, was by encouraging independent thinking and/or decision-making by their child. This idea is consistent with the literature, which defines autonomy support as parents giving their children as much choice as is possible (Cianni, Middleton, Summers, & Sheldon,

2010). In fact, the literature further describes this idea of choice-making as the crux of autonomy supportive parenting (Deci & Ryan, 1987). The majority of parents in this study encourage their children's independence by assigning tasks and household responsibilities. On the contrary, parents restrict their children's independence by making final decisions on their behalf and consistently monitoring where the child's location.

Understanding how parents encourage and inhibit their children's autonomy support has important implications for school psychologists. By understanding how parents promote independence at home, school psychologists can mirror those practices in the school setting so that children's autonomy is fostered in both environments. Because parents are giving their children household responsibilities at home as a way teach independence, school psychologists can also create meaningful tasks for students at school. Similarly, school psychologists are at an advantage knowing that parents restrict their children's independence by making final decisions for them. This result may indicate that some students need more help with decision-making, a role which school psychologists can partake.

Limitations

A limitation of this study was the low response rate. In theory, 1,882 parents were emailed, based on each schools total enrollment. However, the researcher is estimating that approximately half of 1,882 potential participations were emailed due to the fact that not all students live in two-parent households and the total number did not take into account that students may be siblings, making the total 941. Of the

approximately 941 parents emailed, a total of 94 parents (9.9%) completed the majority of the survey and 78 parents (8.3%) were included for data analysis. One possible reason for this low response rate is that methodology used—a web-based survey. According to Kaplowitz, Hadlock, and Levine (2004), response rates to web-based surveys may be lower than traditional survey methods because less attention has been paid to developing motivating tools to increase web survey responses.

Another limitation of this study was that the low reliability rates of some of the scales used. The Cronbach's Alpha (.350) for the autonomy support scale on the POPS was lower than preferred, and thus results should be interpreted with caution. On the parent involvement scale of the POPS, the Cronbach's Alpha (.167) was deemed by the examiner to be too low to be used in statistical analysis. It is likely that the reliability of these scales was low due to the relatively low number of participants in the study. Another possibility for the low reliability rates of the POPS scales is that they were originally designed for children to complete while thinking about their parents. It is possible that the scales lost some reliability when they were adapted by the researcher for parents to answer.

Another limitation of this study was that the demographics of the participants were very homogenous. A common limitation to using internet-based survey research is that those with computer access are typically white-collar, better educated, and technologically sophisticated (Daley, McDermott, Brown, & Kittleson, 2003). The majority of participants in this study were married white females with college degrees

and a yearly income between $51,000 and $100,000. The demographics of the participants in this study were too similar to analyze significant variance across cases.

Because this study used an internet-based survey, the limitations associated with this type of research as a whole also apply to this study. When completing a web-based survey, there are outside factors that cannot be controlled or monitored by the examiner. Therefore, there may be outside factors influencing participants' responses (Daley et al., 2003). Because this survey required participants to choose their responses from a given field, it is possible that responses did not encompass fully what the participant intended. The researcher attempted to counteract this by providing qualitative questions for participants to add additional information. Lastly, with all surveys, the researcher runs the risk that participants respond in a way that is socially desirable rather than what they actually believe.

Future Directions

The research is clear that parent involvement and autonomy support leads to positive school outcomes in terms of academic and behavioral success. The research is also clear that schools are an ideal location for the prevention and treatment of mental health issues. As such, research should continue to focus on how autonomy support and parent involvement relates to students' emotional functioning. Because this study had a low response rate and the measures had low reliability, it is suggested that this study be replicated with more participants from varying demographics. A replication of this study may find more significant results or simply confirm that relationships do not exist among autonomy support, parent involvement and internalized mental health symptoms.

In terms of further areas of study for this topic as a whole, both parent involvement and autonomy support should be researched in more detail to determine more specifically how parents are engaging in both behaviors. This study used a measure that examined internalized mental health symptoms with the underlying notion being that the *absence* of these symptoms defines a mentally healthy child. However, future studies should look at how children's mental health is promoted beyond simply the absence of psychopathology. Lastly, future studies should examine more thoroughly how demographic factors play a role in autonomy support, parent involvement, and internalized mental health symptoms so that school psychologists can help promote healthy parent and child behaviors with all populations.

APPENDIX A

ITEMS FROM GROLNICK, DECI, AND RYAN'S (1997)

PERCEPTIONS OF PARENTS SCALE

Your Child is a Boy or Girl (circle one)

Your Child is Age:

Your relationship to the Child is:

We are interested to know more about parents.

Each number is followed by four statements that describe four different types of parents. Read the four statements about the four types of parents, and decide which one is the best description of you. Different parents are different, and we want to know about you!

So, begin with number 1, and read the four descriptions. If you are most like the parents in the first statement, then circle the letter **a** in front of that statement. If you are most like the parents in the second statement, then circle the letter **b** in front of that statement. If you are most like the parents in the third statement, then circle the letter **c** in front of that statement. If you are most like the parents in the fourth statement, then circle the letter **d** in front of that statement.

Mother/Female Primary Caregiver Involvement Scale

1. a. Some mothers **never have enough time** to talk to their children.
   b. Some mothers **usually don't have enough time** to talk to their children.
   c. Some mothers **sometimes have enough time** to talk to their children.
   d. Some mothers **always have enough time** to talk to their children.

3. a. Some mothers **always ask** their children what they did in school that day.
   b. Some mothers **usually ask** their children what they did in school that day.
   c. Some mothers **usually don't ask** their children what they did in school that day.
   d. Some mothers **never ask** their children what they did in school that day.

5. a. Some mothers **always have the time to talk** about their children's problem.
   b. Some mothers **sometimes have the time to talk** about their children's problem.
   c. Some mothers **don't always have the time to talk** about their children's problem.
   d. Some mothers **never have the time to talk** about their children's problem.

9. a. Some mothers **never want to know** what their children are doing.
   b. Some mothers **usually don't want to know** what their children are doing.

c. Some mothers **sometimes want to know** what their children are doing.
d. Some mothers **always want to know** what their children are doing.

11. a. Some mothers **always like to talk to their children's teachers** about how they are doing in school.
b. Some mothers **sometimes like to talk to their children's teachers** about how they are doing in school.
c. Some mothers **usually don't like to talk to their children's teachers** about how they are doing in school.
d. Some mothers **never like to talk to their children's teachers** about how they are doing in school.

Mother/Female Primary Caregiver Autonomy Scale

2. a. Some mothers **always explain** to their children about the way they should behave.
b. Some mothers **sometimes explain** to their children about the way they should behave.
c. Some mothers **sometimes make** their children behave because they're the boss.
d. Some mothers **always make** their children behave because they're the boss.

4. a. Some mothers **always get very upset** if their children don't do what they're supposed to right away.
b. Some mothers **sometimes get very upset** if their children don't do what they're supposed to right away.
c. Some mothers **sometimes try to understand** why their children don't do what they're supposed to right away.
d. Some mothers **always try to understand** why their children don't do what they're supposed to right away.

6. a. Some mothers **never punish** their children; they **always talk** to their children about what was wrong.
b. Some mothers **hardly ever punish** their children; they **usually talk** to their children about what was wrong.
c. Some mothers **usually punish** their children when they've done something wrong **without talking to them very much**.
d. Some mothers **always punish** their children when they've done something wrong **without talking to them at all**.

7. a. Some mothers **always tell** their children what to do.
b. Some mothers **sometimes tell** their children what to do.

c. Some mothers **sometimes** like their children to **decide for themselves what to do**.
d. Some mothers **always** like their children to **decide for themselves what to do**.

8. a. Some mothers **always think it's OK** if their children make mistakes.
b. Some mothers **sometimes think it's OK** if their children make mistakes.
c. Some mothers **always get angry** if their children make mistakes.
d. Some mothers **sometimes get angry** if their children make mistakes.

10. a. Some mothers **always get upset** when their children don't do well in school.
b. Some mothers **sometimes get upset** when their children don't do well in school.
c. Some mothers **hardly ever get upset** when their children don't do well in school.
d. Some mothers **never get upset** when their children don't do well in school.

Father/Male Primary Caregiver Involvement Scale

12. a. Some fathers **never have enough time** to talk to their children.
b. Some fathers **usually don't have enough time** to talk to their children.
c. Some fathers **sometimes have enough time** to talk to their children.
d. Some fathers **always have enough time** to talk to their children.

14. a. Some fathers **always ask** their children what they did in school that day.
b. Some fathers **usually ask** their children what they did in school that day.
c. Some fathers **usually don't ask** their children what they did in school that day.
d. Some fathers **never ask** their children what they did in school that day.

16. a. Some fathers **always have the time to talk** about their children's problem.
b. Some fathers **sometimes have the time to talk** about their children's problem.
c. Some fathers **don't always have the time to talk** about their children's problem.
d. Some fathers **never have the time to talk** about their children's problem.

20. a. Some fathers **never want to know** what their children are doing.
b. Some fathers **usually don't want to know** what their children are doing.
c. Some fathers **sometimes want to know** what their children are doing.
d. Some fathers **always want to know** what their children are doing.

22. a. Some fathers **always like to talk to their children's teachers** about how they are doing in school.
    b. Some fathers **sometimes like to talk to their children's teachers** about how they are doing in school.
    c. Some fathers **usually don't like to talk to their children's teachers** about how they are doing in school.
    d. Some fathers **never like to talk to their children's teachers** about how they are doing in school.

Father/Male Primary Caregiver Autonomy Scale

13. a. Some fathers **always explain** to their children about the way they should behave.
    b. Some fathers **sometimes explain** to their children about the way they should behave.
    c. Some fathers **sometimes make** their children behave because they're the boss.
    d. Some fathers **always make** their children behave because they're the boss.

15. a. Some fathers **always get very upset** if their children don't do what they're supposed to right away.
    b. Some fathers **sometimes get very upset** if their children don't do what they're supposed to right away.
    c. Some fathers **sometimes try to understand** why their children don't do what they're supposed to right away.
    d. Some fathers **always try to understand** why their children don't do what they're supposed to right away.

17. a. Some fathers **never punish** their children; they **always talk** to their children about what was wrong.
    b. Some fathers **hardly ever punish** their children; they **usually talk** to their children about what was wrong.
    c. Some fathers **usually punish** their children when they've done something wrong **without talking to them very much**.
    d. Some fathers **always punish** their children when they've done something wrong **without talking to them at all**.

18. a. Some fathers **always tell** their children what to do.
    b. Some fathers **sometimes tell** their children what to do.
    c. Some fathers **sometimes** like their children to **decide for themselves** what to do.
    d. Some fathers **always** like their children to **decide for themselves** what to do.

19. a. Some fathers **always think it's OK** if their children make mistakes.
    b. Some fathers **sometimes think it's OK** if their children make mistakes.
    c. Some fathers **always get angry** if their children make mistakes.
    d. Some fathers **sometimes get angry** if their children make mistakes.

21. a. Some fathers **always get upset** when their children don't do well in school.
    b. Some fathers **sometimes get upset** when their children don't do well in school.
    c. Some fathers **hardly ever get upset** when their children don't do well in school.
    d. Some fathers **never get upset** when their children don't do well in school.

APPENDIX B

ITEMS FROM THE FAMILY AND SCHOOL PARTNERSHIPS SURVEY OF PARENTS IN THE ELEMENTARY AND MIDDLE GRADES

Parents' Involvement on All Types of Activities

Q-3. Families get involved in different ways at school or at home. Which of the following have you done this year with the OLDEST CHILD you have at this school? Please CIRCLE one choice on each item.

NEVER means you do NOT do this or NOT YET this year
1- 2 TIMES means you have done this ONE or TWO TIMES this year
A FEW TIMES means you have done this a FEW TIMES this year
MANY TIMES means you have done this MANY TIMES this year

a. Talk to my child about school.	NEVER	1 - 2 TIMES	FEW TIMES	MANY TIMES
b. Visit my child's classroom.	NEVER	1 - 2 TIMES	FEW TIMES	MANY TIMES
c. Read to my child.	NEVER	1 - 2 TIMES	FEW TIMES	MANY TIMES
d. Listen to my child read.	NEVER	1 - 2 TIMES	FEW TIMES	MANY TIMES
e. Listen to a story my child wrote.	NEVER	1 - 2 TIMES	FEW TIMES	MANY TIMES
f. Help my child with homework.	NEVER	1 - 2 TIMES	FEW TIMES	MANY TIMES
g. Practice spelling or other skills before a test.	NEVER	1 - 2 TIMES	FEW TIMES	MANY TIMES
h. Talk with my child about a TV show.	NEVER	1 - 2 TIMES	FEW TIMES	MANY TIMES
i. Help my child plan time for homework and chores.	NEVER	1 - 2 TIMES	FEW TIMES	MANY TIMES
j. Talk with my child's teacher at school.	NEVER	1 - 2 TIMES	FEW TIMES	MANY TIMES
k. Talk to my child's teacher on the phone.	NEVER	1 - 2 TIMES	FEW TIMES	MANY TIMES
l. Go to PTA/PTO meetings.	NEVER	1 - 2 TIMES	FEW TIMES	MANY TIMES
m. Check to see that my child has done his/her homework.	NEVER	1 - 2 TIMES	FEW TIMES	MANY TIMES
n. Volunteer at school or in my child's classroom.	NEVER	1 - 2 TIMES	FEW TIMES	MANY TIMES
o. Go to special events at school.	NEVER	1 - 2 TIMES	FEW TIMES	MANY TIMES
p. Take my child to a library.	NEVER	1 - 2 TIMES	FEW TIMES	MANY TIMES
q. Take my child to special places or events in the community.	NEVER	1 - 2 TIMES	FEW TIMES	MANY TIMES
r. Tell my child how important school is.	NEVER	1 - 2 TIMES	FEW TIMES	MANY TIMES

APPENDIX C

INTERNALIZING DISORDERS SCALE ITEMS FROM THOMAS ACHENBACH'S CHILD BEHAVIOR CHECKLIST

Below is a list of items that describe children and youths. For each item that describes your child **now or within the past 6 months**, please circle the **2** if the item is **very true or often true** of your **OLDEST** child. Circle the **1** if the item is **somewhat or sometimes true** of your child. If the item is **not true** of your child, circle the **0**. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know)
1 = Somewhat or Sometimes True
2 = Very True or Often True

Anxious/Depressed Scale

0 1 2 Cries a lot

0 1 2 Fears certain animals, situations, or places other than school (describe):

0 1 2 Fears going to school

0 1 2 Fears he/she might think or do something bad

0 1 2 Feels he/she has to be perfect

0 1 2 Feels or complains that no one loves him/her

0 1 2 Feels worthless or inferior

0 1 2 Nervous, high strung, or tense

0 1 2 Too fearful or anxious

0 1 2 Feels too guilty

0 1 2 Self-conscious or easily embarrassed

0 1 2 Talks about killing self

0 1 2 Worries

Withdrawn/Depressed Scale

0 1 2 There is very little he/she enjoys

0 1 2 Would rather be alone than with others

0 1 2 Refuses to talk

0 1 2 Secretive, keeps things to self

0 1 2 Too shy or timid

0 1 2 Underactive, slow moving, or lacks energy

0 1 2 Unhappy, sad, or depressed

0 1 2 Withdrawn, doesn't get involved with others

Somatic Complaints Scale

0 1 2 Nightmares

0 1 2 Constipated, doesn't move bowels

0 1 2 Feels dizzy or lightheaded

0 1 2 Overtired without good reason

Physical problems **without known medical cause:**

0 1 2 a. Aches or pains (not stomach or headaches)

0 1 2 b. Headaches

0 1 2 c. Nausea, feels sick

0 1 2 d. Problems with eyes (not if corrected by glasses) (describe): _____
_____

0 1 2 e. Rashes or other skin problems

0 1 2 f. Stomachaches

0 1 2 g. Vomiting, throwing up

0 1 2 h. Other (describe):

APPENDIX D

QUALITATIVE QUESTIONS FOR PARENTS

Parents have different styles when interacting with their children. Please answer the following questions as honestly as possible. Remember, all responses are completely anonymous.

1. How independent do you believe your child should be?

2. In what ways do you encourage your child's independence?

3. In what ways do you restrict your child's independence?

APPENDIX E

DEMOGRAPHIC DATA

Parents:

1. Age
2. Gender
3. Average household income
4. Racial/Ethnic Category
    - White _____
    - African American _____
    - Hispanic/Latino _____
    - Asian _____
    - Pacific Islander _____
    - American Indian _____
    - Multiracial _____
    - Other:_____ _____

5. Marital Status
6. Educational Attainment
    - <8th grade _____
    - Some High School _____
    - High School Diploma/GED _____
    - Some College or Technical School _____
    - Associate's Degree _____
    - Bachelor's Degree _____
    - Graduate Degree _____

Children:

Please answer the following questions for your **oldest child** at this school

1. Age:
2. Gender:
3. Years at HW School:
4. Average Academic Performance
    - Excellent
    - Good
    - Average
    - Below Average
    - Well Below Average

APPENDIX F

LETTER TO PARENTS

Dear Parent or Guardian,

Schools are always working to improve the ways that families and schools can help each other—and help all children do well in school. We would like your ideas about this. We will use your responses to learn about our students and families and to plan new projects. To do the best job, we need responses from every family.

To help us gather information, Anne Walsh, a 3rd year Doctoral student in School Psychology at Loyola University of Chicago, is conducting research for purposes of her dissertation. Should you decide to participate in our project, you will be asked to complete an on-line survey that is estimated to take no more than 15 minutes to complete. The survey will ask you about the ways you are involved with your child's education and your child's mental health needs. Your participation would be greatly appreciated and your responses will be confidential and anonymous.

If you are interested in participating, please click the link below. Once you click this link you will be taken to a secure site to complete the survey. Your IP addresses will be suppressed to insure there is no way you can be identified. Both mothers/female primary caregivers and fathers/male primary caregivers are invited to participate.

If you have any questions please contact Anne at awalsh3@luc.edu. Morover, should you have any quesitions about your rights as a research partcipant, please feel free to contact Loyola University's Compliance Manager at (773) 508-2689.

Thank you for your voluntary participation and for helping us with research at Hubbard Woods!

Click here to access the survey:
http://www.surveymonkey.com/s.aspx?sm=piHHtKO3ulRbs9UHb_2bBgdQ_3d_3d

Sincerely,
(Principal's Name)

APPENDIX G

FOLLOW UP LETTER TO PARENTS

Dear Parent or Guardian,

(Name of School) is currently in the process of collecting data to improve the ways that families and schools can help each other—and help all children do well in school. For those of you who have already completed the survey, thank you very much for your input. For those of you who have not completed the survey, we invite you to do so at this time.

To help us gather information, Anne Walsh, a 3rd year Doctoral student in School Psychology at Loyola University of Chicago, is conducting research for purposes of her dissertation. Should you decide to participate in our project, you will be asked to complete an on-line survey that is estimated to take no more than 15 minutes to complete. The survey will ask you about the ways you are involved with your child's education and your child's mental health needs. Your participation would be greatly appreciated and your responses will be confidential and anonymous.

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http://www.surveymonkey.com/s.aspx?sm=piHHtKO3ulRbs9UHb_2bBgdQ_3d_3d

Sincerely,
(Principal's Name)

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VITA

Anne Walsh was raised in Elmhurst, IL. In 2004, she obtained a Bachelor of Arts degree in Psychology from Marquette University. In 2006, Anne received her Master of Arts degree in Clinical Psychology from The Chicago School of Professional Psychology. Upon finishing her Master's degree, Anne realized she wanted to pursue a doctorate to combine her passion for both research and practice.

In 2006, Anne began the doctoral program in School Psychology at Loyola University. While pursuing her doctorate, Anne participated on a research team and attended several conferences to present findings on topics including teacher personality traits and home-school collaboration. She completed a practicum with students with low incidence disabilities.

Currently, Anne is finishing an APA-approved internship at Palatine High School in Palatine, IL. Upon completion of her internship, Anne hopes to remain in Chicago and pursue clinical licensure.

DISSERTATION APPROVAL SHEET

The Dissertation submitted by Anne Walsh has been read and approved by the following committee:

David Shriberg, Ph.D., Director
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Pamela Fenning, Ph.D.
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The final copies have been examined by the director of the Dissertation Committee and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the Dissertation is now given final approval by the committee with reference to content and form.

The Dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

_____ _____

Date Director's Signature