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Hearing the Unheard Voices: an In-Depth Look at Teacher Mental Health and Wellness

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Hearing the Unheard Voices: an In-Depth Look at Teacher Mental Health and Wellness

by

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Abstract

There is very little research available about the mental health of teachers regarding prevalence, coping strategies and impacts on their ability to adequately perform in their position. The current study is an exploration of teacher mental health and wellness to document what teachers are experiencing in terms of their levels of burnout and their beliefs/expectations of seeking help. An online survey was distributed through emails to the members of OSSTF and PHE. Almost 73% of the teachers surveyed reported to have experienced some form of mental health distress since becoming a teacher. Teachers also rated their Quality of Life as high, indicating there is some sort of resiliency factor associated with this relationship. A factor analysis identified three themes related to burnout (Health/Stress, Avoidance, and Disengagement). This preliminary study emphasizes the importance of teacher mental health and wellness and the magnitude it has on their personal and professional lives.

Keywords

Teachers, teacher mental health, teacher mental wellness, burnout, wellbeing, school mental health, stigma, mental health literacy.

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It is estimated that roughly 20% of Canadians will experience a mental health issue at some point in their life (Van Stone, 2013). In 2012, over 9.1 million Canadians aged 15-64 reported to have at some point been diagnosed with a mental illness or a substance abuse issue; despite this prevalence, less than a third of these individuals reported to have sought out mental health services within that past year (Statistics Canada, 2012). It is clear Canadian mental health services are being underutilized; in addition, it is important to note the actual number of Canadians with a mental illness and/or a substance abuse issue is likely higher than what is known, as the majority of these statistics are generated from self-report data.

Of particular importance here is the report that indicates there were nearly 1.2 million Canadians employed in education services, with over 440,000 of them residing in Ontario alone (Statistics Canada, 2012). Applying the prevalence rates reported above to this group, we can estimate that approximately 88,000 people working in the education field may be experiencing mental health challenges. Looking carefully at these Canadian mental illness prevalence rates is necessary and especially important when considering how it may affect the individuals who are responsible for the health, safety, well-being, and learning of our children.

Teacher Mental Health

In the 2011-2012 academic year, the education system in Ontario employed nearly 125,000 full-time elementary and secondary school teachers; however, there was a notable 7% decrease in Ontario teacher positions as this number dropped to approximately 115,000 (Ontario Ministry of Education, 2013; Ontario Ministry of Education, 2014). This information indicates that approximately 10,000 full-time teachers left the education field in one year and while it is difficult to ascertain the numbers due to funding cuts by the province (People for Education,

2012), or the result of natural attrition through retirement, the literature regarding teachers and potential reasons for leaving focuses on the issue of teacher burnout (Betoret & Artiga, 2010; Fernet, Guay, Senecal & Austin, 2012; Guglielmi, Panari & Simbula, 2012; Jiang, 2011).

Teacher burnout.

The term burnout refers to a process in which an individual's natural resources (i.e. stress responses, coping abilities, resiliency, etc.) are being used in excess due to their occupational demands (Betoret & Artiga, 2010; Fernet et al., 2012). Although emotional exhaustion is the defining feature of burnout, depersonalization and loss of feelings of personal accomplishment characterize this experience (Fernet et al., 2012). For the purposes of this paper, these three terms will be used interchangeably to refer to burnout. Burnout can include both physical and psychological impairments, contribute to early retirement or removal from the profession and can influence teachers' rates of absenteeism from school (Betoret & Artiga, 2010; Fernet et al., 2012). The burnout literature is rich and provides a thorough exploration into the detrimental effects that an acquired, chronic stress disorder can elicit in one's life and daily functioning. However, there have been few empirical studies that assess its effects on teachers' perceived self-efficacy, available support systems and resources in their workplace, or disclosing their struggles with colleagues.

Research has estimated that between 30-50% of Canadian teachers are leaving their teaching positions within the first five years due to burnout (Reichel, 2013). A University of Regina study found that upwards of 43% of teachers from Regina and Saskatoon were experiencing emotional exhaustion, and 25% were seeing a general practitioner for depression (Lemstra, 2014). Such findings are now new, however, and an article from the Ottawa Citizen (1991) suggested that upwards of 40% of teacher absences were the direct result of a mental

illness, and posited that this number may have been under represented due to burnout not being classified as a medical diagnosis, in addition to possible under reporting. In line with these reports, research suggests that as many as 12-20% of Québec teachers report experiencing symptoms of burnout at least once a week (Fernet et al., 2012). A very recent University of Western Ontario study looked at burnout rates and symptoms among elementary and secondary school teachers from the region of Southwestern Ontario (Koenig, 2014). The results were consistent with previous research, reporting that 41% of respondents reported high levels of emotional exhaustion, 16% reporting high levels of depersonalization, and 12% experiencing a lack of personal accomplishment with respect to their role as a teacher (Koenig, 2014).

Efforts have been made to identify the factors that contribute to the development and maintenance of teacher burnout (Betoret & Artiga, 2010; Fernet et al., 2012). Betoret & Artiga (2010) noted that instructional barriers and obstacles were able to explain up to 20% of the variance associated with teachers' emotional exhaustion rates. These include a perceived lack of autonomy, insufficient financial compensation, large class sizes, and a lack of shared decision-making opportunities amongst all faculty members (Betoret & Artiga, 2010; Reichel, 2013). Fernet et al. (2012) found that teachers' perceptions of school resources, including principals' leadership qualities, are associated with teacher burnout. The influence of organizational resources was shown to be salient to teachers' perceptions of self-efficacy and self-determinism during times when their own internal resources were minimal (Fernet et al., 2012).

Prevalence of Mental Illness in Schools

The area of school mental health has generated an enormous amount of interest over the years and has an expansive accompanying body of literature. The World Health Organization estimates that 20% of students in a classroom are currently facing an issue with their mental

health (Kutcher, Venn & Szumilas, 2009), which is consistent with the existing literature that between 15%-20% of Canadian youth currently suffer from some form of mental illness (Meldrum, Venn & Kutcher, 2009). Rates higher than the average have been found, as a study by Roberts et al. (2008) reported a 29% mental illness prevalence rate among a sample of high school adolescents; however, their small sample size limits the generalizability of these results. Flett & Hewitt (2013) noted that less than 25% of a sample of children and adolescents with psychological issues actually received some form of treatment, and Herinkangas et al. (2011) found this number to be less than 20% in students with an anxiety, eating or substance abuse disorder. In addition, 50% of children and adolescents with some form of psychological issue have dual-diagnoses, in that they suffer from multiple mental health issues simultaneously (Waddell et al., 2005).

Although the body of literature regarding school mental health is rich, its primary focus is on the students. When reviewing the literature, it appears as though students are the only individuals in the educational system that are important in terms of their mental health. A simple literature search with the keywords “student”, “school” and “mental health” retrieved over 33,000 results, ranging from scholarly journal articles to dissertations, and to articles in the popular media. Titles such as “What do we know about school mental health promotion programs for children and youth?” (O’Mara & Lind, 2013), “Self-stigma of mental illness in high school youth” (Hartman et al., 2013), and “High school mental health survey: assessment of a mental health screen” (Roberts et al., 2008) are just a few of the literally thousands of articles written about student mental health.

A commonality among these studies is that each specifically notes how social stigma surrounding mental illness is one of the largest obstacles students are faced with when

considering seeking help for their issues. Israelashvili & Ishiyama (2008) conducted a study that assessed the emotions students associate with when seeking help from a school counsellor. The results indicated that students, especially males of lower socioeconomic status, link counselling with negative emotions and are skeptical of counselling as being beneficial in general. Consequently, students are failing to utilize the mental health services available to them (Israelashvili & Ishiyama, 2008). The researchers' proposed solution was heightened mental health literacy and help-seeking advocacy, which has also been endorsed by numerous other researchers (Rüsch et al., 2012; Toth, 2012).

It is interesting to note a literature search that uses the exact same keywords ("school" and "mental health") but replaces "student" with "teacher" returns less than 14,000 results. While this number of articles is not small, it is important to note the foci of these articles. With the keywords "school", "teacher" and "mental health", results included titles such as "Teacher perceived mental and learning problems of children referred to a school mental health service" (Little & McLennan, 2010), "The feasibility of a mental health curriculum in elementary school (Kutcher et al., 2004), and "English boards can do better to improve results; but they need the help of governments, universities, teachers and parents" (Horrocks, 2008).

It is evident the foci of these articles is on the students' mental health, and not that of their teachers. An article from the Canada NewsWire (2012) stated that Canadian teachers would like to be a part of the movement involving the promotion of acceptance and openness of mental health in schools, however, there is currently little evidence that suggests the promotion of acceptance and openness of *teacher* mental health has been, or will be, a part of this movement.

Teacher Mental Wellness

Although there is a limited amount of empirical research regarding teacher mental illness, there is ample information pertaining to which factors contribute to or influence a teacher's ability to promote, maintain, or enhance the components that facilitate living a healthy life (Guglielmi, Panari & Simbula, 2012; Jones, 2006; Vesely, Saklofske & Leschied, 2013; Vesely, Saklofske & Nordstokke, 2014). For example, contrary to its negative connotation, Guglielmi et al. (2012) found mental fatigue to mediate the relationship between work conflict/family conflict/psychological & physical burnout symptoms and work satisfaction. The researchers noted mental fatigue as a potential protective factor, in that it gave warning to the individual that their natural resources were depleted and it was time to step back and allow themselves the opportunity to recuperate (Guglielmi et al., 2012).

Wright, Cropanzano & Meyer (2004) identified that the balance and interplay amongst two factors, stable and unstable characteristics of one's place of employment and colleagues, influences an individual's occupational well-being. It is important to note that working conditions can vary from day to day and, therefore, some studies that only focus on a single time point to assess wellness may only be seeing a small part of a very large picture. Taking this into account, Britt, Castro & Adler (2005) conducted a longitudinal study that assessed occupational well-being, and found that high levels of well-being were predicted by high levels of work engagement, and that those with increased work engagement also displayed significantly less physical distress symptoms than those with lower levels of work engagement. In relation to this, the literature also suggests that a colleague's support not only increases work engagement, but that it also was noted as one of the most important factors in a teacher's professional and personal development (Halbesleben, 2006; Kelchtermans & Strittmatter, 1999). Surprisingly, it

has also been demonstrated that emotional exhaustion can be spread amongst colleagues and contribute to facilitating a state of lowered well-being throughout an entire faculty; this phenomenon has been termed as a "crossover" effect and is described as "emotional contagion" (Westman, 2001).

Given the importance and significance of an individual's well-being, especially in relation to their area of employment, researchers have posited that since individuals are encouraged to find their "authentic Self" (through reflection, experience, etc.), it should be a necessity (i.e. "a duty of care") for both the individuals as well as their employers to protect their authentic selves (Kelly & Colquhoun, 2005). With dangerous influences and environments constantly compromising the authentic Self (i.e. the media), it is seen as an ethical responsibility for employees and employers to work together to ensure the protection, preservation and continued growth of their authentic Selves (Kelly & Colquhoun, 2005).

Whether or not an individual views wellness as a state or an omnipresent entity, it is something that has been shown to significantly impact one's personal, social and work lives. Therefore, wellness and well-being should be given the opportunity to expand and grow if necessary, especially in work environments where the presence of stress can significantly and negatively impact one's life (i.e. teachers). Poulin (2009) organized an eight-week program that taught teachers mindfulness techniques with the hope that it would increase personal awareness about their social, physical, cognitive, psychological and emotional health or ill-health. Upon completion of the course, participating teachers noted an increase in physical and emotional health, as well as teaching self-efficacy - some even experienced decreased levels of psychological distress (Poulin, 2009). The teachers stated how although some struggled with

engaging fully in the individual mindfulness exercises, nearly all benefited from the group participation activities, most notably those involving physical activity (Poulin, 2009).

A more recent program meant to enhance wellness and well-being focused on Acceptance and Commitment Therapy (ACT) with kindergarten through to grade 12 teachers, where the 236 teachers were assigned to read an ACT workbook and complete six online quizzes within an eight week time frame (Jeffcoat & Hayes, 2012). The program demonstrated its success, as it was shown to positively influence depression, anxiety, stress, and all over psychological and physical health (Jeffcoat & Hayes, 2012).

Although efforts to increase wellness and well-being have been shown to be successful the implementation of these programs within the workplace is not common. From what is known in terms of the physical and psychological benefits well-being can provide, it is discouraging these programs have not been more readily embraced, especially when taking into account their positive influence on self-efficacy and self-esteem (Jeffcoat & Hayes, 2012; Poulin, 2009; Westman, 2001). Goetz, Ehret, Jullien & Hall (2006) found that individuals with low levels of subjective well-being tended to rate themselves as below average in comparison to others, which speaks towards the noted relationship between self-esteem and well-being. Furthermore, the opposite effect was found amongst to those with high levels of subjective well-being, as they tended to rate themselves as above average when compared to others (Goetz et al., 2006). Perhaps it is the case that self-esteem and self-efficacy are directly linked to corresponding perceptions of well-being; however, there are other factors speculated to mediate this relationship, most notably, those involving emotional intelligence.

Emotional intelligence.

An area that has been identified as a protective factor against teacher burnout as well as a facilitator of mental wellness is that of Emotional Intelligence. Emotional Intelligence describes an individual's competencies in being able to regulate, identify and process emotions, and has been associated with facilitating one's psychological well-being (Vesely et al., 2014). Heightened Emotional Intelligence has been linked to improved stress management and decreased occupational anxiety, which contributes to improved self-efficacy amongst teachers (Stough, Saklofske & Parker, 2009; Vesely, 2013). In addition, Emotional Intelligence has also been associated with factors directly related to the education field, such as motivation, leadership skills, conflict de-escalation and workload management (Gardner & Stough, 2002).

For example, teachers who hold high levels of self-efficacy in conjunction with high levels of Emotional Intelligence appear to interpret job-related demands more so as a challenge as opposed to a threat, which facilitates teacher engagement and occupational involvement (Schwarzer & Hallum, 2008). In addition, teachers who were more adept at regulating their positive and negative emotions were shown to be both more effective and productive while present in a classroom (Sutton, Mudrey-Camino & Knight, 2009).

As a result of the noted benefits with teachers from interventions that target Emotional Intelligence, "Emotional Intelligence in the Classroom", an Australian program developed by Hansen, Gardner & Stough (2007), was created with the intention of developing the skills that are related to and involved in Emotional Intelligence, such as emotional awareness, regulation, and control. A recent Canadian pilot of the program was conducted in Canada, from which results yielded an increase in Emotional Intelligence scores amongst teachers upon its completion (Poole & Saklofske, 2009).

As the psychological health of teachers is of such importance for both Canadian children and society as a whole, it is encouraging that interventions such as Emotional Intelligence for teachers are both available and effective in promoting and protecting teacher wellness.

Self-care.

The self-care body of literature is substantial, and includes a diverse range of careers that address the needs of professionals such as nurses, doctors, therapists, counsellors, firefighters, police, and paramedics; essentially, any occupation in which the individual provides some form of care. Teachers, principals, superintendents, and coaches fall into this category and are recommended to engage in self-care strategies in order to facilitate the prevention and reduction of burnout, as well as promote mental wellness (Gentry, 2002; Hansson, Hillerås & Forsell, 2005; Jones, 2006; Williams, Richardson, Moore, Gambrel & Keeling, 2010).

Jones (2006) provides a comprehensive self-care plan that works within a biopsychosocial and spiritual framework, which allows for multiple life dimensions to be assessed and cared for simultaneously. In tending to an individual's psychological well-being, it was found that keeping a log or journal of one's inner dialogue (specifically in terms of their profession) allowed for the identification of negative self-talk and cognitive schemas that could potentially contribute to a maladaptive coping style (Jones, 2006). When assessing one's physical well-being, it was suggested that in addition to ensuring the treatment of any current illness, the individual identifies the ways in which further illness can be prevented and treated (Jones, 2006).

Hansson et al. (2005) assessed which strategies individuals utilized the most in order to improve, maintain and strengthen their psychological and emotional well-being. 871 Swedish

participants aged 20-64 commented that physical exercise was the most commonly used self-care strategy, followed by social supports, making time for enjoyable activities, and finally, relaxation techniques (Hansson et al., 2005). The researchers noted it as interesting that seeking assistance from available social supports was the self-care strategy that was most strongly associated with an individual's well-being, and speculated that social supports may contribute to developing resistance towards an individual acquiring a mental health issue (Hansson et al., 2005).

Williams et al. (2010) took their assessment of self-care strategies one step further as they shifted their focus away from that of the general population and onto individuals who work specifically in a caregiving profession – therapists. Over the span of one to two weeks, four therapists attempted and commented on five different self-care strategies: mindfulness, self-hypnosis, spirituality, music and balance (i.e. between life, work, home, etc.) (Williams et al., 2010). The personalized accounts speak towards mindfulness as allowing them to feel more connected, openhearted, present and calm when with their clients; however, each stated these were small (yet meaningful) changes. Self-hypnosis led to perceptions of ongoing relaxation throughout the day, considerably less stress in respect to deadlines, and reports of feeling less upset when met with client resistance; however, the therapists were the most skeptical of this method, and found it the most difficult to master. Music was also noted as an extremely easy technique that yielded a powerful influence on the therapists' mood states, and balance (or a lack thereof) was seen as one of the most important factors that either negatively or positively influenced their time spent with clients in session (Williams et al., 2010).

In general, self-care can be defined as "the ability to refill and refuel oneself in healthy ways" (Gentry, 2002, pg. 48), and the supportive literature suggests it is of the utmost importance to provide individuals with these strategies in order to promote, maintain and

strengthen both physical and psychological well-being, as well as prevent the emergence of distress in these areas.

The Gap between What Teachers Need and Have

Employed mothers: maintaining mental wellness and life/work balance.

The number of women in Canada who balance the roles of being both a mother and employed worker is staggering: in 2009, nearly 65% of working women had a child who was less than three years old, and this number increased to over 78% when including children aged six through fifteen (Statistics Canada, 2010). Women are a large and active component of the educational workforce, with roughly 66% of elementary and secondary school teaching positions being held by females (Statistics Canada, 2010). Research has demonstrated that an employed mother will experience considerably more stress and work/home conflict than employed women without children (Bower, 1997). Academic mothers in particular find it especially challenging to balance their professional and family lives, and often experience great personal stress as a result (Guendouzi, 2006; Jacobs & Madden, 2004). The Ontario education system employed over 115,000 full time elementary and secondary teachers in the 2012-2013 academic year (Ontario Ministry of Education, 2014). Given that 66% of teachers are female and over 65% of working women have a child and there were at least 76,000 female teachers employed in Ontario last year, this means that in Ontario 49, 400 teachers were also mothers of children ages 0-15 (Statistics Canada, 2010).

It may be the case that women in particular feel varying levels of guilt over balancing their professional and domestic lives because of the traditional models of motherhood that continue to prevail in this current day and age, and Guendouzi (2006) has offered a solution to

facilitate the eradication of an employed, academic mother feeling guilt related to their work/life balance: the creation of an alternative conceptualization of motherhood, and what it means to be a “mother”.

Until then, however, an employed, professional mother is likely to experience high levels of stress, work overload, anxiety, physical illness, insufficient sleep, and a depletion of their natural resources (Bower, 1997; Guendouzi, 2006; Jacobs & Madden, 2004; Vancour, 2005). Vancour (2005) sought to identify positive health behaviours employed mothers could adopt to assist in counteracting these negative outcomes, and found physical exercise, sleep and stress management were the factors most associated with a healthy professional/domestic life balance.

As women are more likely to experience (or at the very least, report) mental health issues than men (Geoghegan, 2006; Maciejewski, Prigerson & Mazure, 2001; Webb & Allen, 1979) and also compose a significant portion of the education workforce (Statistics Canada, 2010), special attention needs to be given to this group of individuals. The factors of being a woman and a teacher place these individuals at particular risk for developing depression, anxiety or burnout.

Employee assistance programs.

Employee Assistance Programs (EAPs) were developed from industrial alcoholism programs created in the 1940s (Canadian Centre for Occupational Health and Safety, 2009). EAPs offer confidential, short-term counselling opportunities to employees experiencing difficulties in their personal lives that are interfering with their quality of life and work (CCOHS, 2009). ComPsych is the largest provider of EAP programs in the world, with services provided to over 53 million employees in 120 countries (ComPsych, 2014). ComPsych’s counselling services, titled Guided Resources, provide short-term counselling with online, telephone, and in-

person treatment options (ComPsych, 2014). It is evident that EAPs are attempting to serve most of their clients online or via the telephone, as their web-based and telephone counselling services are not only displayed but highly encouraged (ComPsych, 2014). With advertised online services such as “Wellness Coaching” and pages entitled “10 tips for dealing with stress”, EAPs are progressing towards a fully digitalized counselling system (ComPsych, 2014).

Although these counselling avenues are cost, time and resource efficient, there are certain issues and circumstances that reach beyond the scope of these services, as well as the general in-person counselling opportunities that EAPs offer. In these circumstances (i.e. the presentation of a mental illness that meets DSM diagnostic criteria), EAPs can refer an employee to an external service or professional agency that specializes in the area they require additional assistance with (CCOHS, 2009). However, whether or not an employee is eligible for a referral to an external counselling service is contingent on the conditions of the benefits plan associated with their place of employment.

Employee benefits/health care coverage.

The Ontario Psychological Association decided at its November 2012 board meeting that rates for a session with a psychologist would be maintained at $220 per hour (Ontario Psychological Association, 2014). However, extended health care coverage through an employee benefits plan is subject to huge discrepancies dependent on coverage provided by the employer, and the Ontario Psychological Association noted these to range from $300-$1000 per year (OPA, 2014). This is without a doubt hugely problematic, as there is the very real potential of an employee in desperate need of specialized psychological assistance to only be eligible for one or two sessions of therapy. Although there is evidence to suggest that brief psychotherapy to this

degree can be efficacious (Nieuwsma et al., 2012), this is not the case for all individuals and remains as an issue with which potentially thousands of employees are being faced.

For example, Green Shield Canada, one of the nation's leading healthcare benefit providers, allows certain employees $300 worth of coverage for therapy with a clinical psychologist per each calendar year (Ventra Group Inc., 2000). The Ontario Public Service Employees Union (OPSEU) provides coverage for $500 worth of sessions in one year (The Ottawa Hospital, 2012). Additionally, the Civic Institute of Professional Personnel (CIPP) allows for an employee to utilize a maximum of $1,250 worth of services; however, this amount is split among nine additional disciplines that comprise what CIPP deems as paramedical services, which includes chiropractors and massage therapists (CIPP, 2013).

It is interesting to note that both Green Shield Canada and OPSEU can revoke an employee's health care benefits if "employee services or supplies are received as a result of disease, illness or injury due to…intentionally self-inflicted injury while sane or insane." (The Ottawa Hospital, 2012; Ventra Group Inc., 2000). Consider the following scenario: a newly employed a teacher has been finding it difficult to adjust to her workload. The principal has put her in charge of two committees, one of which runs late every Monday night, and she also was appointed to lunch duty every other day. She has two special needs children in her class and often stays late to provide feedback to the parents about their progress. She is newly married but her teaching position keeps her at school for longer periods than she anticipated. She does not sleep well, barely finds time to eat, and experiences constant conflict with her husband. She knows she is becoming ill, but chooses to ignore it in order to fulfill her teaching duties and maintain employment. Eventually, she sees a General Practitioner for her constant stomach pains and learns she has an ulcer due to chronic anxiety.

Reflecting upon the statement Green Shield Canada and the OPSEU made, she technically should not have her treatment covered, as she *intentionally* ignored her symptoms until they became debilitating. It appears as though this could potentially be a very gray area, and one that deserves further investigation as to how revocation of health care coverage decisions are made.

Perhaps the most salient to the current topic is that of teacher's health care coverage and benefits. An agreement between the Ontario Secondary School Teacher Federation and an Ontario school board provided teachers with $500 of coverage towards counselling sessions with a psychologist (OSSTF, 2012). As new teachers start with an annual salary approximately between $44,000-$52,000, they most likely will not have had the opportunity to build a reserve of funds from which some may be portioned to additional specialized counselling if their needs went beyond that of the $500 allotment (OSSTF, 2012).

As EAPs provide confidential services, it is difficult to assess the extent and severity of mental illnesses that teachers can possess and silently cope with on a day-to-day basis. However, with the continued utilization of these programs, it cannot be argued that mental illness is an issue that teachers need assistance with yet are not willing to disclose of. Individuals may choose to not disclose of their mental health issue for a variety of reasons, most of which are centered on mental illness and its associated stigma.

Stigma

Stigmatization model.

The vast majority of the stigma literature has concepts whose origins stem from those introduced by Erving Goffman in "Stigma: Notes on the Management of Spoiled Identity"

(1963) (Link & Phelan, 2001). Goffman's definition of stigma, "an attribute that is deeply discrediting that reduces the bearer from a whole and usual person to a tainted, discouraged one" (Goffman, 1963, pg. 3), has since been adopted and modified by researchers and has contributed to the large variations in its modern conceptualizations (Stafford & Scott, 1986). These variations are in large part due to the concept of stigma being applied to an immense array of unique situations and subgroups, which in turn creates a large amount of equally unique stigma definitions (Link & Phelan, 2001).

Link & Phelan's conceptual model of stigma (2001) builds off of the work of Goffman and is comprised of five individual, yet linked, processes: labeling, stereotyping, separation, status loss and discrimination, and a power environment that allows for these processes to occur. The first component, labeling, arises from societal selections of certain human differences that are determined to be of societal concern (Link & Phelan, 2001). A historical example of this process is the stigmatization of African American slaves, from which labeling based off of one's skin colour was the basis of the differentiation.

The second component of Link & Phelan's conceptual model of stigma (2001), stereotyping, occurs when the labeled, differentiated group(s) are linked to a particular stereotype. This is a key component of Goffman's work, and has been a central concept in stigma research since its inclusion (Link & Phelan, 2001; Stafford & Scott, 1986). The third component, separation, is defined by a distinctive "us" versus "them" mentality (Link & Phelan, 2001). This component highly facilitates the process of a stigmatized individual becoming fully enmeshed with their socially-imposed label; this is particularly present in the mental health community (i.e. an individual is schizophrenic rather than they have schizophrenia) (Link & Phelan, 2001).

The fourth component, a loss of status, is one that most definitions of stigma do not include, and is a defining element of the stigma process that separates Link & Phelan's conceptual model of stigma (2001) from others. Druss et al. (2000) put forth that stigmatized groups and individuals, as a result of the stigma against them, become disadvantaged in many aspects of their lives, including education, health care and income. Link and Phelan (2001) built upon this, and noted how status loss, specifically within a hierarchal environment, was an immediate consequence and confirmation of successful discrimination. Hamilton & Carmichael (1967) posited the concept of institutional discrimination, "accumulated institutional practices that work to the disadvantage of a minority group, even in the absence of individual prejudice or discrimination." This notion can be applied within the education system, as the hierarchal structure of a school or school board could unknowingly and unintentionally discriminate against teachers with mental health issues, as there are not many practices put in place to assist these individuals.

Finally, the fifth component is potentially the most important of all, as it is a power situation that allows for this type of stigmatizing behaviour to occur. This power, be it an individual or a group, must have enough force and support to create the "us" versus "them" separation, as well as to maintain the separation (Link and Phelan, 2001). Historical examples of power situations that successfully implemented and maintained stigmatizing beliefs and practices include the Nazi revolt against the Jews, as well as the KKK against African Americans. This power situation also has the potential of occurring within a school or a school board, as, for example, a principal or superintendent who lets go of a teacher due to the teacher's mental health status could emit the impression that "those" individuals do not belong here with "us". Subsequently, these beliefs could transfer throughout the faculty and a) increase the endorsement

and maintenance of these beliefs, and b) deter a teacher with a mental health issue from disclosing of it to colleagues and reduce help-seeking behaviours. In an extremely competitive job market, especially for new teachers, disclosure of a mental illness under the described conditions would not only be unlikely, but also detrimental to their current employment as well as their future teaching career.

The role of mental health stigma.

Societal constructions of stigma play an integral role in how the general populace views and responds to the issue of mental health. Link and Phelan (2001) define stigma as the result of the simultaneous influences of stereotypes, labels, status loss, and discrimination, all of which require an element of exercised power in order to occur. From these factors, stigma shapes not only how society views mental illness, but also how those suffering from mental illness view themselves.

Traditional and current views of mental illness have remained fairly consistent in terms of its negative connotations. Public perceptions of dangerousness, accountability, blame, incompetence, deficits of character, and contamination continue to influence the ways in which individuals regard those with a mental illness (Bos et al., 2009; Corrigan et al., 2004; Corrigan et al., 2012; Schomerus & Angermeyer, 2008). Rüsch et al. (2012) recently noted conflicting views in terms of what the general populace perceive as being a mental illness. Their study on an English adult population revealed two distinct constructions of the issue: one which saw only major psychiatric disorders (i.e. schizophrenia, bipolar) as being mental illnesses, and the other view which included drug addictions as well as stressors. In terms of gender differences regarding societal perceptions of mental health, it was found that women and men tend to demonstrate the same level of like and dislike towards individuals with a mental illness

(Holzinger et al., 2012). However, the same meta-analysis also demonstrated that men more so than women are rejected on the basis of their mental health, despite an overall improvement in people's attitudes towards themselves or others seeking mental health treatment. Even with the advancements society has made in terms of being more accepting of mental illness, the stigma associated with it is still very much a reality and an omnipresent, driving force behind our present zeitgeist.

The consequences of stigma towards mental illness are vast and broad, affecting all personal, family, social and spiritual aspects of a being. One of the most prevalent, if not most important, consequences of stigma is its ability to deter an individual with a mental illness from engaging in help-seeking behaviour or in seeking treatment services. Noted as one of the largest obstacles against effective help-seeking, stigma continues to create barriers to treatment that remain unperturbed in the face of both gender and race (Kutcher et al., 2009; Link & Phelan, 2001; Meldrum et al., 2009; Schomerus & Angermeyer, 2008).

The Prevalence of Mental Illness in the Workplace/Workforce

Little information is known about mental illness in terms of the workplace's employees. Dewa, Lesage, Goering & Caveen (2004) noted a portion of payroll was being allotted for employees with a mental illness who were frequently absent from work. Of those employed in the workforce (aged 15-64), at least 12% will suffer from a mental illness or substance abuse issue within a given year, and are most likely to be middle aged women who suffer from depression (Dewa et al., 2004). These statistics, though valuable, are preliminary and do not clearly outline what mental health looks like in the work place environment.

Toth (2012) assessed mental health disclosure strategies of current employees of a Canadian university with the intention of building upon the limited body of knowledge, as well as developing a model of decision making that could be applicable to a larger employee population across various organizations. Through semi-structured, one on one interviews, the qualitative study provided insight as to what factors employees consider when contemplating whether they will disclose their mental illness to a co-worker, reasons for and conditions of their disclosure, as well as the perceived consequences of them disclosing. The results provided support to the established literature in regards to the stigma surrounding mental illness, as the employees outlined concerns of stigmatization, power loss, discrimination, labelling, power relationships, stereotyping, incompetency, accountability and responsibility of their mental illness (Toth, 2012). Toth noted that the conditions under which an individual is most likely to disclose is in a supportive, accepting environment to an open, understanding, trustworthy and supportive co-worker.

Mental Health and Working Professionals

Ledet (2009) surveyed three groups of individuals (college students, mental health professionals and mental health service consumers) to assess the nature and severity of the stigma they endorse in regards to mental illness. Of these three groups, the college students endorsed the most stigmatizing values and behaviours as they desired the greatest amount of social distance from anyone with a mental illness, regardless of the diagnosis, in comparison to the two other groups studied (Ledet, 2009). While the various reasons behind this are not pertinent to the current review of the help-seeking literature, the researcher found that the greatest predictor of help seeking was the level of education a person has attained. Individuals with higher levels of education (i.e. a Masters degree or PhD) were noted to participate in

significantly fewer help-seeking behaviours than people who attained either a BA or a college diploma (Ledet, 2009).

For example, college/university level student athletes tend to seek less help with mental illnesses and underutilize the mental health services available to them (Watson, 2005). It has been speculated that due to the competitiveness associated with both entrance to and maintenance in an elite athletics program, student athletes are highly motivated to not seek mental health assistance due to the fear of losing their athletic position from perceptions of inadequacy and questions of competency (Etzel & Watson, 2007; Maniar, Curry, Sommers-Flanagan & Walsh, 2001).

Relatedly, a study by White, Shiralkar, Hassan, Galbraith & Callaghan (2006) found that at least 87% of a sample of psychiatrists indicated reluctance towards disclosing a personal mental health issue to a colleague or service provider out of fear for being seen as weak, hindering career progression, maintaining professional integrity and experiencing the stigma associated with mental illness, which included discrimination and isolation from their colleagues. When asked why mental illness was so highly stigmatized within psychiatry between colleagues, psychiatrists stated there is an immense pressure to maintain congruency with the group norm of being free and completely devoid of any psychological condition, as well as upholding of the image of a collective, composed and competent healer (Bennett, 2011).

It appears as though disclosing of a mental health issue carries significant personal, occupational and societal consequences when that individual is also a working professional. The literature suggests that the more education an individual attains, in conjunction with a competitive working environment, the less likely that individual is to engage in help-seeking behaviours (Ledet, 2009; Watson, 2005; White et al., 2006) Ledet (2009) noted that help-seeking

behaviours significantly increased when one's concerns over how they physically and psychologically appear to others reached an internally critical level. Whether this increase in help-seeking behaviour is related to reducing anxiety or is attributable to an alternative reason, it also indicates that people are mostly seeking help when their mental illness is becoming unmanageable and the individual's functioning is significantly affected. This trajectory of events is not ideal for anyone in any occupational position; however, this issue is of particular concern when taking into account the internal struggle and significant psychological, physical and cognitive deterioration a teacher can experience while attempting to maintain an acceptable image in an extremely competitive field of employment. As individuals who engage in everyday contact with children and are an integral component of a child's success, learning and well-being, it is imperative that the mental health stigma surrounding teachers be assessed to maintain the safety and wellness of all those who are a part of the school.

Gaps in the Literature

Very little research has looked exclusively at teacher mental health and mental illness. Articles returned from the literature search that did address teacher mental health were focused mostly on the psychological impact associated with school-based violence (Wilson, Douglas & Lyon, 2011; Zimmer, 2012). The most predominant noted effects were associated with emotional, physical and job-related dysfunctions as a result of witnessing or experiencing student elicited, school-based violence. One article went so far as to state that school counsellors should also assist teachers, but only in the event that their mental health issues are in connection with a particular student, or the classroom as a whole (Persi, 1997). The article suggests a teacher's mental health needs should only be addressed if it is related directly to the scope of their work,

which would consequently disregard illnesses such as schizophrenia, bipolar, PTSD or any mental health issue that was external and unrelated to their profession as a teacher.

It is evident that there is very little research available in terms of the mental health of teachers regarding prevalence, classifications, beliefs, coping strategies and impacts on their ability to adequately perform in their position. Toth (2012) identified the lack of information surrounding employee mental health disclosure in the workforce, and was able to build on this body of literature; however, only one participant from the sample was a university faculty member. Schomerus & Angermeyer (2008) also recognized a gap in the help-seeking literature, as it was noted that depression is the predominant mental illness addressed when assessing the impact of stigma on an individual's help-seeking behaviour. As was noted in the literature review how stress, burnout, anxiety and a multitude of other mental illnesses could be affecting the 6.7 million Canadians aged 25-64 who identified as having been diagnosed with a mental health or substance abuse issue at some point in their lives (Statistics Canada, 2012). A large percentage of these individuals belong to the workforce, and this group certainly contains thousands of individuals who comprise the Canadian high school teacher population. Teachers are vital societal figures, as they are on the front lines in schools and are responsible for many aspects of their students' success. It is important to address teacher mental health, as it is a topic that has been seemingly ignored and needs to be recognized.

Methods

The current study is an exploration of teacher mental health and wellness to document what teachers are experiencing in terms of their levels of burnout and their beliefs/expectations of seeking help. Consultations with teachers and teacher unions were held to finalize a questionnaire that was relevant to both the professional community as well as the literature. An online survey was developed with Qualtrics software through the secure domain at a large, comprehensive university. No identifying information of the participants was collected. One teachers union and one professional association (Ontario Secondary School Teachers Federation, Physical and Health Education Canada) assisted in the distribution of the questionnaires to their members through email and hosting a link to the study on their main web page. The following questionnaires were used in the online survey (please see Appendix A for the entire survey).

Questionnaire/Survey Information

Demographic information.

This information includes: a teacher's age, gender, employment status, position, years employed, number of schools they have taught in, the location of the schools they have taught in (rural or urban areas), marital status, whether or not they have children and if so how many, whether they engage in school related and/or non-school related volunteering, if they care for/support minor children, ageing parents or other family members, and information regarding their past experience(s) with mental health and the mental health system.

The K-6 Mental Health Screening Tool.

The K-6 Mental Health Screening Tool is a 6 item assessment that seeks to distinguish individuals with serious mental illness and those without. Questions are answered on a 5 point

Likert scale, with answers ranging from 0 (all of the time) to 4 (none of the time) with a suggested cut-off score of 13+ as indicative of the presence of severe mental illness (Kessler, et al., 2011). The K-6 has demonstrated excellent validity amongst various populations, including individuals with substance abuse issues (Hides, et al., 2007), postnatal women (Baggaley, et al., 2007), and primary caregivers (Haller, Sanci, Sawyer, & Patton, 2009).

The Teacher Burnout Inventory.

The Teacher Burnout Inventory is a widely used measure of teacher burnout that assesses levels of burnout, emotional exhaustion, depersonalization and the health effects of burnout (Richmond, Wrench, & Gorham, 2001). The 20 item questionnaire calculates scored based off of responses from a 5 point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). Scores between 20-35 suggest one is experiencing a few burnout symptoms, 36-55 indicate some strong feelings of burnout, 56-70 implies substantial burnout feelings, and a score between 71-80+ signifies that an individual is experiencing burnout.

The World Health Organization Quality of Life Scale – Brief (WHOQOL-BREF).

15 international field centers associated with the World Health Organization developed the Quality of Life (Brief) questionnaire, which aims to acquire information regarding quality of life that is both internationally and cross culturally comparable. This tool measures quality of life and the areas of general health, physical health, psychological well-being, social relationships and environments. The 26 items are answered on a 5 point Likert scale from 1 (not at all) to 5 (completely). Raw scores are then transformed to a standardized 100 point scale, where higher scores indicate more satisfaction with one's quality of life. It is a widely used measure with excellent content validity and construct validity (Skevington, Lofty, O'Connell, & WHOQOL

Group, 2004; Trompenaars, et al., 2005), as well as intra-rater and inter-rater reliability (Jang, Hsieh, Wang, & Wu, 2004; Lin, Hwang, Chen, & Chiu, 2007).

Attitudes Towards Seeking Professional Psychological Help- Short Form.

The ATSPPH scale is a 10 item questionnaire used to assess treatment attitudes and treatment-related stigma. Questions are answered on a 4 point Likert scale, ranging from 1 (disagree) to 4 (agree). Higher scores indicate more positive attitudes towards seeking professional psychological help, while low scores reflect a presence of stigma and negative attitudes towards seeking help of this kind. This questionnaire is a widely used measure of mental health treatment beliefs and attitudes, and has good reliability and validity, as well as adequate internal consistency (Elhai, Schweinle, & Anderson, 2008; Palmer, 2010).

Sources of stress.

This 18 item scale was developed by the researchers after a comprehensive literature review, and recurring, prominent elements and issues noted in the literature were incorporated into this scale. The scale items seek to address and highlight these key issues. These questions ask about an individual's source(s) of stress: home, work or work-life balance. Questions are answered on a 5 point Likert scale, ranging from 1 (never) to 5 (always). Higher scores indicate a greater amount of stress the individual perceives a certain item is contributing to their lives. This information is important, as it can contribute to the development of future interventions or promotion activities.

Workplace health.

This 7 item scale was developed by the researchers using, as a guide, the Canadian Psychological Health and Safety Standards developed by the Health Commission of Canada

(Mental Health Commission of Canada, 2015). The measure seeks to assess an individual's place of work is perceived as a mentally healthy environment (i.e. accepting, supportive) from a legal, personal, occupational and social standpoint. Questions are answered on a 5 point Likert scale, with answer options ranging from 1 (no) to 5 (definitely). Higher scores indicate perceptions of a more positive, supportive, inclusive and non-judgemental work environment.

Social Stigma Scale for Receiving Psychological Help.

The SSRHP is a 5 item scale intended to assess the attitudes and beliefs an individual holds in regards to their perception of the social stigma associated with receiving psychological help. Questions are answered on a 4 point Likert scale, ranging from 1 (disagree) to 4 (agree), where higher scores indicate greater perceptions of social stigma related to receiving psychological help. The SSRPH has been shown to have good reliability, with alphas between .73-.76 (Komiya, Good, & Sherrod, 2000; Vogel, Wade, & Haake, 2006). The current researchers were interested in stigma beliefs within the context of work and the work environment, and an additional question was added to the scale to reflect this area of interest. The addition of the sixth question increased the overall alpha from .82-.84, suggesting an increased reliability of the overall scale with the inclusion of the workplace stigma question.

Trait Emotional Intelligence Questionnaire – Short Form.

The TEIQue-SF is a 30 item scale developed by Petrides and Furnham (2006) that measures emotional intelligence on 4 different factors of: well-being, self-control, emotionality and sociability. Participants respond to each item using a 7 point Likert scale, with answers ranging from 1 (completely disagree) to 7 (completely agree). Higher scores indicate a greater level of global trait emotional intelligence. Research suggests this measure has good

psychometric properties, with high criterion validity, internal consistency, test-retest reliability, and a Cronbach's alpha of .88 for males and .87 for females (Cooper & Petrides, 2010; Mikolajczak, Luminet, Leroy, & Roy, 2007; Petrides, Perez-Gonzalez, & Furnham, 2007).

Analyses

Data from the online survey was collected from December 9, 2014 to January 22, 2015. The data was entered and analyzed using SPSS version 21, where frequencies and descriptive statistics were run for each of the scales and their items. A factor analysis was performed on the Teacher Burnout Inventory to identify factors of burnout by grouping items that held the highest associations amongst one another.

Results

Table 1 highlights general information of the Ontario teachers and education professionals who completed the online survey. There were a total of 600 teachers/education professionals who filled out the Teacher Mental Health & Wellness online survey that was hosted on the OSSTF main web page. The online survey was active from December 9, 2014 – January 22, 2015.

There were more female participants (69.5%) than males (26.8%), and 1.2% of the sample identified themselves as transgender. The mean age was 43, with a wide range from 20-70. Teachers/education professionals are likely to be married (67.2%) and have at least one child (71.5%). 14.3% are single, followed by roughly 10% as common law, 5% divorced and almost 3% separated, with less than 1% of the sample being widowed. For those who have children, they are most likely to fall between the ages of 12-18 (23%) and 19-25 (22%), with an average of one child in their respective age cohorts.

Most of the survey participants live in an urban community (36.5%), with the majority living in a city with a population between 100, 001 – 200, 000 people (27.2%), followed by those from a city with a population between 50, 001 – 100, 000 (12.3%). The remaining participants reside in rural (26.5%) and remote (3.3%) locations.

More than 78% of the sample does not currently support any ageing parents. For those who provide support (21.9%), the majority do so by checking in on their parents at their houses on a regular basis (14.5%), followed by advocating for their health and well-being needs with health care providers (8.2%). Lastly, it was noted the majority of the teachers/education professionals do not engage in non-school related volunteering activities (58.4%).

Table 1

Teacher Demographics: General Information

General Information	N	%	M	SD	Range
Gender	585	-	-	-	-
Male	161	26.8	-	-	-
Female	417	69.5	-	-	-
Transgender	7	1.2			
Age	580	-	43.41	9.345	20-70
Marital Status	594	-	-	-	-
Married	399	67.2	-	-	-
Common-Law	60	10.1	-	-	-
Divorced	30	5.1	-	-	-
Separated	17	2.9	-	-	-
Single	85	14.3	-	-	-
Widowed	3	.5	-	-	-
Children	596	-	-	-	-
No	170	28.5	-	-	-
Yes	426	71.5	-	-	-
Ages 0-2	66	11	1/8.8	-	-
Ages 3-6	101	17	1/13.3	-	-
Ages 7-11	112	19	1/11.8	-	-
Ages 12-18	136	23	1/12.8	-	-
Ages 19-25	129	22	1/11.2	-	-
Ages 26+	68	11	2/4.2	-	-
Features of community	-	-	-	-	-
Remote	20	3.3	-	-	-
Rural	159	26.5	-	-	-
Urban	219	36.5	-	-	-
Support Ageing Parents	575	-	-	-	-
No	449	78.1	-	-	-
Yes	126	21.9	-	-	-
Checking in	513	14.5	-	-	-
Advocating	551	8.2	-	-	-
Volunteer work outside school	573	-	-	-	-
No	306	53.4	-	-	-
Yes	267	46.6	-	-	-

Note. For ages of children, M column reflects mode and % of participants with same number of children as mode.

Table 2

Teacher Demographics: School Information

School Information	N	%	M	SD	Range
# of years teaching	572	95	15.52	8.115	0-43
# of schools taught at	569	95	3.84	2.465	0-10
Level(s) currently teaching					
Primary	59	9.8	-	-	-
Junior	38	6.3	-	-	-
Intermediate	264	44	-	-	-
Senior	407	67.8	-	-	-
Alternative	54	9	-	-	-
Other	80	13.3	-	-	-
Volunteer work at school	566	-	-	-	-
No	141	23.5	-	-	-
Yes	425	70.8	-	-	-

Table 2 outlines school information pertaining to the sample of teachers/education professionals. The majority of the sample has been working for an average of 15.52 years, ranging from 0-43 years of teaching or education-related experience. They have also been employed at approximately 4 schools, some of whom have worked up to 10 schools. 67.8% of participants currently teach at the senior levels, followed by 44% at the intermediate level, 13.3% at “other”, 9.8% at primary level, and 9% at alternative. Participants who are employed at the junior level were the least represented in this sample (6.3%). Lastly, Table 2 highlights that over 70% of the participants are involved in some sort of school-related volunteering activities, a notable difference from the 46.6% of non-school related volunteering outlined in Table 1.

Graph 1 illustrates a visual representation of an occupational breakdown of the sample of teachers/education professionals who completed the online survey. The majority of participants are full time (FT) classroom teachers, shaping 52.8% of the total sample. The second largest

occupancy group noted was “other (FT)” (11.9%); as this option online asked for a description, the researchers were able to determine that this group consisted largely of physical education teachers, speech language pathologists, department chairs/heads, early childhood educators and secretaries.

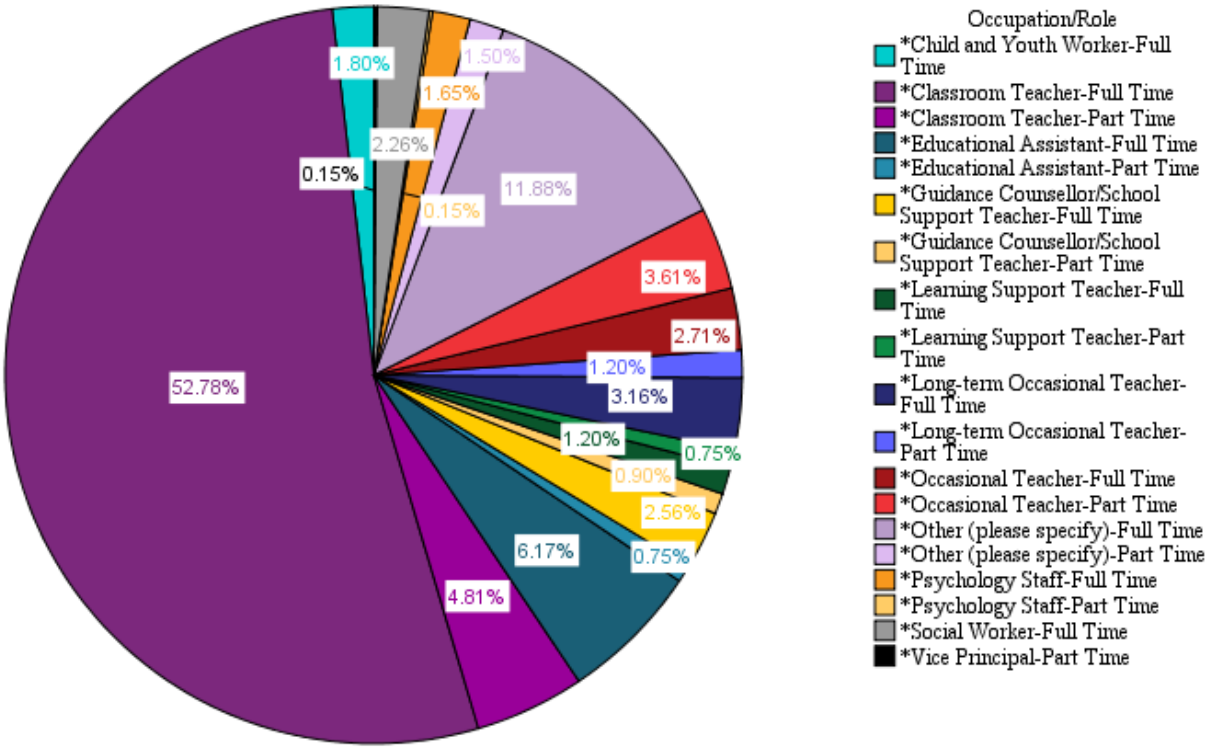


Figure 1. A pie chart displaying the sample’s occupations within the school system.

The two occupations with the lowest representation in the study are part time (PT) Psychology Staff members (.15%) and PT Vice Principals (.15%). The remaining occupations are broken down as follows (in descending order from most to least prevalent): FT Educational Assistant (6.8%), PT Classroom Teacher (4.8%), PT Occasional Teacher (3.6%), FT Long-term Occasional Teacher (3.2%), FT Occasional Teacher (2.7%), FT Guidance Counsellor/School Support Teacher (2.6%), FT Social Worker (2.3%), FT Child and Youth Worker (1.8%), FT Psychology Staff (1.7%), PT Other (1.5%), PT Long-term Occasional Teacher (1.2%), FT

Learning Support Teacher (1.2%), PT Guidance Counsellor/School Support Teacher (.9%), PT Learning Support Teacher (.75%), and PT Educational Assistant (.75%).

Table 3

Teacher Demographics: Mental Health Information

Mental Health Information	N	%
Mental health distress as a teacher	568	-
No	155	27.3
Yes	413	72.7
Received counselling	566	-
No	278	49.1
Yes	288	50.9
Privately paid therapy	165	27.5
Family doctor	179	29.8
Clergy member	26	4.3
Psychiatrist	62	10.3
EAP	164	27.3
Telephone crisis/help line	14	2.3
Walk-in clinic	19	3.2
Other	27	4.5
Was it helpful	281	-
No	25	8.9
Yes	204	72.6
I'm not sure	52	18.5
If never counselled but wanted to be, reason why	187	-
Financial restrictions	63	10.5
Not available in community	19	3.2
Privacy issues	54	9
Other	51	8.5

Table 3 outlines demographic data pertaining to the participants' mental health information. When asked if, since becoming a teacher, mental health distress has interfered with their work and everyday activities, a staggering 72.7% responded that this was the case.

50.9% of teachers/education professionals reported to have received some form of counselling to address issues with their mental health and wellness, which was fairly evenly split

between those who have not sought out or received counselling (49.1%). For those who did, the majority saw a family doctor (29.8%), which was followed closely by privately paid therapy (27.5%) and Employee Assistance Programs (27.3%). Among the least utilized resources were clergy members (4.3%), walk-in clinics (3.2%) and telephone crisis/help lines (2.3%). The consensus from the participants who did receive counselling was that they had found it to be helpful (72.6%), although 8.9% reported it was not, and a notable 18.5% were not sure whether their therapy had been beneficial.

187 participants reported they have never received counselling but wished that they could have. The majority of these individuals outlined their reason for this as being related to financial restrictions (10.5%), followed by privacy issues (9%) and not having therapy available in their community (3%). 8.5% have not received counselling for "other" reasons; the text input option for this question online permitted the researchers to determine the issue of time as the largest contributing factor to not receiving therapy, in addition to stigma from their partners or employers/colleagues and poor past experiences with therapy.

Table 4

Key Results from Scales used in the Teacher Mental Health & Wellness Online Survey

Scales & Subscales	N	%	M	SD	Range	α
K-6 Mental Health Screening Tool	523	87	17.2/18	4.71	0-24	.868
Depressed	-	-	3.32/4	.93	-	-
Worthless	-	-	3.29/4	.98	-	-
Teacher Burnout Inventory	471	78.5	43.86	13.98	20-83	.920
Stressed at work	-	-	3.47	1.29	1-5	-
Frustrated at work	-	-	3.45	1.22	1-5	-
Weary of job responsibilities	-	-	3.28	1.26	1-5	-
Hostile communication	-	-	1.54	.827	1-5	-
Avoid looking at students	-	-	1.37	.714	1-5	-
Students make me sick	-	-	1.35	.748	1-5	-
WHO Quality of Life Survey						
Overall Quality of Life	493	82.2	70.36	20.44	0-100	.726
Physical Health	497	82.8	66.54	17.66	7.14-100	.804
Able to get around	-	-	4.50	.744	1-5	-
Phys. pain prevents daily life (+)	-	-	4.12	.994	1-5	-
Capacity for work	-	-	3.48	1.06	1-5	-
Psychological Health	495	82.5	61.93	18.65	12.50-100	.860
Life is meaningful	-	-	3.67	.949	1-5	-
How much life is enjoyed	-	-	3.64	.848	1-5	-
Accept bodily appearance	-	-	3.35	1.188	1-5	-
Social Relationships	495	82.5	57.96	24.35	0-100	.781
Sex life	-	-	2.93	1.305	1-5	-
Environment	491	81.8	68.77	15.06	15.63-100	.777
Transportation	-	-	4.29	.768	1-5	-
Safe in daily life	-	-	4.05	.853	1-5	-
Attitudes Towards Seeking Professional Psychological Help Scale – Short Form	470	78.3	22.25	4.573	6-30	.804
Obtain help if having breakdown	-	-	2.49	.772	0-3	-
Obtain help if upset for long time	-	-	2.36	.723	0-3	-
Therapy no value (+)	-	-	1.97	.876	0-3	-
Talking: bad way to solve issues (+)	-	-	1.94	.979	0-3	-
Social Stigma Scale for Receiving Psychological Help 5 Item Scale	491	81.8	11.08	3.487	5-20	.822
Seeing psychologist carries stigma	-	-	2.78	.993	1-4	-
If seeing psych., less favourable	-	-	2.49	.929	1-4	-
If seeing psych., inadequate/weak	-	-	1.54	.775	1-4	-

Scales & Subscales	N	%	M	SD	Range	α
6 Item Scale	489	81.5	13.37	4.214	6-24	.841
Worried about job security	-	-	2.3	1.101	1-4	-
TEIQue-SF						
Global Trait	451	75.2	20.51	4.186	10-28	.666
Highly motivated person	-	-	5.34	1.410	1-7	-
Difficulty staying motivated (+)	-	-	4.88	1.640	1-7	-
Well-being	448	74.7	32.32	6.628	9-35	.849
Possess number of good qualities	-	-	5.83	1.208	1-7	-
Things in life will work out fine	-	-	5.06	1.495	1-7	-
Self-Control	444	74	27.30	6.139	11-42	.697
Able to control emotions	-	-	4.96	1.459	1-7	-
Others admire me as relaxed	-	-	4.01	1.820	1-7	-
Emotionality	446	74.3	41.14	7.083	19-56	.652
People treated right (+)	-	-	5.84	1.453	1-7	-
Pause and think of feelings	-	-	4.24	1.624	1-7	-
Sociability	439	73.2	27.95	5.967	11-42	.711
Deal effectively with people	-	-	5.36	1.352	1-7	-
Difficult to stand up for rights (+)	-	-	4.28	1.900	1-7	-

Note. For the K6 Mental Health Screening Tool, M column reflects mean and median scores. TEIQue-SF = Trait Emotional Intelligence Questionnaire: Short Form. Items in italics indicate individual scale questions. (+) indicates an item that has been reverse scored.

Table 4 highlights key information from six of the eight scales used in the Teacher Mental Health & Wellness online survey. The K-6 Mental Health Screening Tool has a suggested cut-off score of 13, where a score of equal or higher value indicates the individual is experiencing significant disturbances in their mental well-being. Results from the 523 participants who responded to this portion of the survey indicate a mean score of 17.1 – 4 points above the suggested cut-off score. The questions that yielded the highest means were "During the past 30 days, about how often did you feel…so depressed that nothing could cheer you up?" (m=3.32), and "…worthless?" (m=3.29).

The Teacher Burnout Inventory (TBI) has predetermined categories in which an individual's scores can fall under: a score between 20-35 indicates a few burnout symptoms, between 36-55 points some strong feelings of burnout are presents, between 56-70 points there

are substantial burnout symptoms, and between 71- 80+ points an individual is experiencing burnout. On average, the teachers/education professionals involved with this study experience some strong feelings of burnout, as indicated by a mean score of 43.86. The questions with the highest scoring means were “I feel stressed at work” (m=3.47), “I feel frustrated at work” (m=3.45), and “I’m weary of my job responsibilities” (m=3.28). The questions with the lowest scoring means were “My students make me sick” (m=1.35), “I avoid looking at students” (m=1.37), and “I communicate in a hostile manner” (m=1.54).

The World Health Organization’s (WHO) Quality of Life Survey is composed of four subscales pertaining to specific areas of life, and one overarching scale regarding an individual’s quality of life in general. The teachers/education professionals who completed this portion of the online survey rated their overall quality of life at 70.36 on a 100 point scale. Participants were most satisfied with their environment/environmental conditions (68.77), particularly with their satisfaction associated with their means of transportation (m=4.29), and how safe they feel in their daily lives (m=4.05). This was followed closely by satisfaction with their physical health (66.54), especially with regards to how well they are physically able to get around (m=4.5), and how satisfied they are with their capacity to work (m=3.48). It was noted that the extent to which they felt physical pain prevented them from doing what they needed to do yielded a mean item score of 4.12.

Participants were less satisfied with their psychological health (61.93); the extent to which they feel their lives are meaningful (m=3.67) and how much they enjoy life (m=3.64) yielded the highest means, with the lowest being in their ability to accept their bodily appearance (m=3.35). Lastly, teachers/education professionals reported that they were the least satisfied with

the quality of their social relationships (57.96), in particular, their satisfaction with their sex lives (m=2.93).

The Attitudes Towards Seeking Professional Help (ATSPH) scale has a possible score range of 30, with 0 being the minimum score (negative attitudes towards seeking help) and 30 as the maximum score (positive attitudes towards seeking help). On average, the teachers/education professionals have a fairly positive view towards seeking professional help (m=22.25). Items identified as encompassing the most favourability were "I would obtain professional help if I was having a breakdown" (m=2.5), and "I would obtain psychological help if I was upset for a long time" (m=2.36). Items that the teachers/education professionals identified as unfavourable towards positive help seeking attitudes were "Psychotherapy would not have value for me" (m=1.97) and "Talking about psychological problems is a poor way to solve emotional problems" (m=1.94).

The Stigma Scale for Receiving Professional Help consists of 5 items with scores that range from 5-20. And the teachers/education professionals reported a mean of 11, displaying that they hold a moderate amount of stigmatizing beliefs. From this 5-item scale, "Seeing a psychologist for emotional/interpersonal problems carries social stigma" (m=2.78), and "People will see a person in a less favourable way if they know he/she was seeing a psychologist" (m=2.49)" yielded the highest means, which suggest higher levels of agreement with these stigmatizing statements. The question that revealed the lowest mean, and the least agreement with amongst the group, was "It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems" (m=1.54).

The researchers were interested in stigma beliefs within the context of work and the work environment, and an additional question was added to the scale to reflect this area of interest.

The new item, “I would be worried about keeping my job, or getting another job with my employer, if an administrator knew I was receiving psychological help” yielded an average score of 2.3, with 25.1% of individuals in probable disagreement, 25.3% in probable agreement, 31.5% in disagreement, and a startling 18.1% in agreement with this statement. With the new 6 item scale, the scores ranged from 6-24 with a mean of 13.37, suggesting the additional question holds particular significance amongst this specific sample of teachers/education professionals. Lastly, with the addition of the sixth question the overall scale’s alpha increased from .822 to .841, suggesting an increased reliability with the inclusion of the workplace stigma question.

The Trait Emotional Intelligence Questionnaire (TEIQue-SF) is a 30 item scale comprised of 4 subscales (Wellbeing, Self-Control, Emotionality and Sociability) as well as a measure of Global Trait Emotional Intelligence. The subscale that indicated the highest level of Emotional Intelligence (EI) was Emotionality, with a mean scale score of 41.14. Of the 8 items within this subscale, the question that yielded the highest mean was “Those close to me often complain I don’t treat them right” (m=5.84). This question was reverse scored, which indicates favourability towards the inverse of this question (i.e. those close to them do not complain of being treated properly). The question from Emotionality with the lowest EI mean was “I often pause and think about my feelings” (m=4.24).

Wellbeing was reported to have the second highest level of EI, as the mean score from its 6 items was 32.32, the highest being “I feel I have a number of good qualities” (m=5.83), and the lowest from “I generally believe that things will work out fine in my life” (m=5.06). The 6 items associated with Sociability provided a mean scale score of 27.95, with the highest mean item score being derived from “I can deal effectively with people” (m=5.36), and the lowest from “I often find it difficult to stand up for my rights” (m=4.28).

Lastly, the Self-Control 6 item subscale had the lowest level of EI (m=27.3), the highest mean item score being from “I am usually able to control my emotions when I want to” (m=4.96). The lowest item mean score from this subscale was “Others admire me for being relaxed” (m=4.01). The Global Trait subscale contains 4 items that assess EI from an overall perspective, from which it was revealed this sample has a mean Global Trait scale score of 20.51. The highest item mean score for this subscale was “On the whole, I’m a highly motivated person” (m=5.34), and the lowest being “I normally find it difficult to keep myself motivated” (m=4.88).

Table 5 highlights key results from the Workplace Health scale and the Sources of Stress scale. Both scales were created by the researchers after a comprehensive literature review, and recurring, prominent elements and issues noted in the literature were incorporated into these scales. See Table 5 for full item questions and results.

It should be noted the online survey had a number of questions that allowed participants to manually enter text when appropriate (i.e. comments/opinions about each section of the survey’s content/subject matter). Although this information has been gathered, a review and interpretation of the comments is beyond the scope of this exploratory analysis, and will therefore not be addressed in this particular project.

Table 5

Key Results from the Workplace Health scale & Sources of Stress scale

Scales	M	SD	Range	α
Workplace Health	-	-	-	.938
…meets and adheres to legal requirements of a psychologically safe & respectful workplace	3.22	1.225	1-5	-
…promotes/encourages/enforces respectful language/attitudes/behaviours towards mental health/mental illness	3.43	1.186	1-5	-
…provides employees with appropriate knowledge & means of protecting/supporting one's mental health	3.08	1.231	1-5	-
…provides/facilitates a supportive/safe atmosphere where one could turn to a colleague if experiencing psychological distress	3.03	1.238	1-5	-
…is overseen & led by one who is respectful towards mental illness & promotes/implements mental health literacy	2.94	1.366	1-5	-
…promotes/encourages/provides means for employees to maintain a healthy work-life balance	2.70	1.253	1-5	-
…would provide appropriate/adequate assistance if one came forward with mental health issue/while in psychological distress	3.16	1.227	1-5	-
Sources of Stress	-	-	-	.943
Work-life (other)	3.90	1.273	1-5	-
My work-life overall	3.35	.976	1-5	-
Policies	3.35	1.132	1-5	-
My responsibilities at work	3.25	1.122	1-5	-
Lack of resources	3.18	1.167	1-5	-
Work-life balance	3.05	1.120	1-5	-
My leadership team	2.98	1.118	1-5	-
My students	2.89	.971	1-5	-
Work-life balance (other)	2.84	1.500	1-5	-
Personal life (other)	2.81	1.469	1-5	-
My responsibilities at home	2.75	1.018	1-5	-
Financial difficulties	2.49	1.160	1-5	-
My personal life overall	2.48	.932	1-5	-
My co-workers	2.39	.903	1-5	-
My relationship with my spouse/partner	2.33	1.032	1-5	-
Caring for children	2.08	1.028	1-5	-
My relationship with my children	2.03	.909	1-5	-
Caring for other family members	2.02	1.023	1-5	-

Note. α = Cronbach's alpha.

Table 6

Key Results from a Factor Analysis of the Teacher Burnout Inventory

Factors	N	F.L	KMO	Cum. %	M	SD	Range	α
Factors 1, 2, 3	-	-	.910	-	-	-	-	-
Factor 1: Health	488	-	-	40.57	25.49	8.853	10-49	.901
Ill at work	-	.769	-	-	2.13	1.166	1-5	-
Sick to stomach when think of work	-	.764	-	-	1.90	1.163	1-5	-
Stressed at work	-	.705	-	-	3.47	1.296	1-5	-
Dread going to school	-	.702	-	-	1.97	1.158	1-5	-
Wish to be left alone at work	-	.697	-	-	2.09	1.198	1-5	-
Problems concentrating	-	.663	-	-	2.67	1.292	1-5	-
Frustration at work	-	.639	-	-	3.44	1.228	1-5	-
Avoid communication with colleagues	-	.638	-	-	2.17	1.139	1-5	-
Feel alienated at work	-	.618	-	-	2.36	1.269	1-5	-
Weary of job responsibilities	-	.507	-	-	3.29	1.274	1-5	-
Factor 2: Avoidance	508	-	-	50.85	9.85	3.851	6-24	.817
My students make me sick	-	.833	-	-	1.36	.749	1-5	-
Think of calling students names	-	.816	-	-	1.69	1.074	1-5	-
Avoid looking at students	-	.813	-	-	1.38	.709	1-5	-
Avoid communication with students	-	.592	-	-	1.57	.772	1-5	-
Tired of students	-	.530	-	-	2.31	1.184	1-5	-
Hostile communication	-	.369	-	-	1.55	.826	1-5	-
Factor 3: Disengagement	516	-	-	59.01	8.68	3.739	4-20	.858
Bored with my job	-	.860	-	-	2.05	1.076	1-5	-
Job doesn't excite anymore	-	.845	-	-	2.39	1.143	1-5	-
Dislike going to my job	-	.646	-	-	2.24	1.120	1-5	-
Apathetic about my job	-	.556	-	-	2.00	1.125	1-5	-

Note. Items in italics indicate individual scale questions. F.L = factor loadings. KMO = Kaiser-Meyer-Olkin measure of sampling adequacy. Cum. % = cumulative percentage of variance explained for by the factors. α = Cronbach's alpha.

Table 6 demonstrates the key results found by a factor analysis conducted on the Teacher Burnout Inventory (TBI). The TBI is available through public domain, and was necessary for this project due to financial restrictions. The researchers were unable to locate any previously

existing scale statistics on the TBI, therefore a factor analysis was conducted to establish dimensionality and to develop an understanding as to how it may be similar to the Maslach Burnout Inventory. A Principal Component factor analysis was conducted using Varimax rotation with Kaiser normalization. A visual inspection of the scree plot of data indicated three distinct factors, and subsequent analysis confirmed this.

Discussion

The current project was an exploratory study, with the goal to examine mental health and wellness, and attitudes towards seeking professional help with teachers in Ontario, Canada. Information was collected using an online survey tool, and the survey link was distributed via the Ontario Secondary School Teacher Federation's homepage and emails from Physical and Health Education Canada to its members. In this section, results from the online survey data will be discussed.

Information from the demographics data collected suggests that the average survey participant was a 43 year old married female, with at least one child between the ages of 12-25. She most likely lives in an urban community, in a city populated with 100,000-200,000 people. She is most likely a full time classroom teacher, teaching intermediate or senior grade levels, has been teaching for roughly 15 years at approximately 4 different schools, and contributes by doing volunteer work at her school. It is very likely she has experienced mental health distress since becoming a teacher, and is most likely to have sought help from either their doctor, or has paid to obtain private therapy.

Almost 73% of the teachers/education professionals surveyed reported to have experienced some form of mental health distress since becoming a teacher. As the K-6 Mental Health Screening Tool has a suggested cut-off score of 13 to imply serious mental illness, this raises concerns as three quarters of the sample has greatly surpassed this. It appears as though the vast majority of teachers are currently experiencing significant forms of mental health disturbances. However, it was also reported that approximately half of these individuals received some sort of therapy or counselling – from the half that did not, less than one third were able to provide a reason as to why this was the case. This poses an issue, as it makes it difficult to

develop a service or program when the reasons as to why teachers did not receive counselling were not made well known.

Work-Life Balance: Resiliency Factor

Although teachers are experiencing significant mental health distress, they rate their quality of life as fairly high according to the WHO Quality of Life survey. This suggests there must be some factor in the teachers' lives that is creating resiliency amongst this population. The majority of teachers (67%) are married, and almost 72% have children. They reported their personal lives as the factor that contributed the least to their stress, which included caring for other family members, relationships with their children, caring for their children, and relationships with their spouses/partners.

In stark contrast to this, teachers reported their greatest sources of stress as stemming from their work life, in terms of their work life overall, policies and the internal politics of their individual schools. Although teachers noted their schools met the legal requirements for creating a psychologically safe and respectful workplace and that overall their schools are respectful of mental health, 40% stated their employers are not necessarily respectful towards or understanding of mental health issues. This lack of respect and understanding from an employer (i.e. a principal, superintendent) to an employee (i.e. a teacher) regarding a mental health issue was a recurring theme in the comments submitted from this particular section of the survey.

In addition, 46% of teachers who responded to the Workplace Health survey hold the belief that their workplace does not promote, encourage or provide the means for its employees to maintain a healthy work-life balance. It appears as though schools are giving the impression of providing an inclusive and non-judgemental work environment, but that when mental health issues from staff are brought forward they are not being addressed appropriately.

A stressful job but a good home life with a high Quality of Life rating suggests that teachers/education professionals are equipped with fairly effective coping skills. There are issues with the workplace placing onus on its employees to ensure they create their own work-life balance, as it appears that many workplaces from which our sample are employed at do not provide them with the means to do so. With personal life being rated as the lowest source of stress, it may be the case that this factor plays an important role as to the resiliency noted in this sample of teachers who are experiencing mental health distress yet still enjoying their lives.

How Stress is Experienced in the Workplace

The job market for teachers is extremely competitive in terms of both finding and maintaining employment. There is a perspective within the teaching community that associates how busy one is with how hard working or successful they are. The more projects they are able to juggle and the more hours they can put in, all while maintaining a smile and no complaints, is seen as a positive and a direct reflection of their competency as a teacher. It is a difficult position to be in, as there is also the mentality that if a teacher cannot meet these expectations then there are ten others who are waiting to replace them. It is almost as though teachers who are not able to keep up with an extremely heavy workload are perceived as disposable. This creates a multitude of issues, as not only are teachers experiencing stress from physically and mentally exerting themselves within their work capacities, but they are also constantly having to monitor their job security.

This could also help explain the reason as to why teachers reported they do not often pause and reflect upon their feelings, as the anxiety around meeting increasingly busier schedules and workloads takes precedence over examining whether they are in a mentally healthy state. The results of the teachers' global trait emotional intelligence revealed that they see themselves

as highly motivated individuals, but that they find it difficult to keep themselves motivated. This could be speaking towards their intrinsic motivation of wanting to teach because they enjoy it, as well as the fear associated with job security, which may be being met with low extrinsic motivation from the lack of acknowledgement or appreciation for their efforts. With these factors influencing one another, it may be causing great psychological distress which is manifesting itself as burnout.

Burnout Factors

Results from the Teacher Burnout Inventory indicate that the average teacher/education professional is experiencing some strong feelings of burnout. Further analysis on the TBI provided a greater understanding of where this was stemming from, as three main factors, health/stress, avoidance and disengagement were identified after the Kaiser-Meyer-Olkin measure verified the sample was adequate and appropriate for this type of analysis. The health/stress component of burnout was best characterized by feeling ill at work and becoming sick to ones stomach when thinking of work, which is interesting as these are physical as opposed to psychological disturbances. It may be the case that these physiological responses are linked to the anxiety related to their job expectations and security, while also being the result of cumulative effects of not enough sleep, inadequate nutrition or eating habits, and a general lack of exercise.

The job avoidance factor of burnout was most highly associated with claiming that their students make them sick, and how they think of calling their students ugly names. It is important to remember that teachers are seeing the same students every day for months at a time, and that students, naturally, become an integral part of their jobs. As being frustrated at work and being weary of job responsibilities scored 3.44 and 3.29 out of a possible 5 (strongly agree), it could be

that teachers have begun associating their students as a source of their job dissatisfaction. This type of scapegoating may place unmerited blame on the students, which in turn could incline teachers to not enjoy their students as much as they potentially could.

The final burnout factor identified, job disengagement, was characterized most by teachers reporting being bored with their jobs and that their jobs do not excite them anymore. These responses could be related back to the emphasis on maintaining a large workload, as teachers are being pressured to get tasks done rather than being challenged in a way that mentally fulfills them. With the lack of opportunities to satisfy this intrinsic need being met with endless tasks and accompanied by high expectations from others, it is not surprising teachers are not excited about their jobs as they are being undervalued and not adequately compensated for their efforts.

It appears as though burnout is more so being experienced internally (i.e. through stress, frustration) and is less likely to be outwardly expressed (i.e. hostile communication while at work). The combination of not expelling these feelings while also failing to take the time to acknowledge and address them could be contributing to their noted dissatisfaction with their capacity for work, as well as to the high level of mental health distress they are experiencing. The lack of emotional recognition and reflection could be a key factor in teachers' mental health and well-being, as there seems to be some sort of relationship between this, levels of mental health distress, physical health, burnout symptoms and job satisfaction.

The Role of Stigma

43% of teachers/education professionals stated that they would be worried about keeping their job or getting a new job with their employer, if an administrator knew they were receiving professional psychological help. Nearly half of the teachers from the sample felt that a mental

health issue was a detriment to their already threatened job security. However, the highest ratings of mental health stigma implied societal stigma as opposed to an individual's own internal/personal stigma beliefs. This suggests most individuals hold the mentality that there is a significant element of social stigma associated with mental health. However, as ratings of individual stigma were lower than those of perceived societal stigma, it seems as though there is a discrepancy between the nature of and the amount of stigma there is surrounding mental health. As is heavily noted in the mental health literature (Israelashvili & Ishiyama, 2008; Rüsch et al., 2012; Toth, 2012), this speaks towards the importance of mental health literacy in decreasing stigma and increasing education surrounding the misconceptions, assumptions and realities of mental health and wellness.

Limitations

The current study was an exploratory analysis of teacher mental health and wellness, as there is a significant gap in literature regarding this subject. As the online survey was hosted through the Ontario Secondary School Teacher Federation's main web page, as well as through emails to Health Education Canada's members, the sample over represents certain populations of teachers/education professionals, which in turn creates a response bias.

The online survey was also only available in English, which potentially limits responses from teachers whose first language is not English. The survey was designed to be completed in one consecutive sitting, in that it would not allow users to return back to previous pages as well as would time out after a certain period of non-activity, and the survey was subject to some participant attrition. Lastly, as this survey sought to explore issues that have little to no prior empirical research, it remains undetermined as to whether the scales were used in the present study were the most appropriate and viable options. While the Maslach Burnout Inventory would

have been more fitting as a measure of burnout than the Teacher Burnout Inventory, the limited budget of the study permitted only the use of publicly available assessment scales and tools.

Strengths

The present study is the first of its kind that has assessed teacher mental health and wellness via an online survey in Canada. The study was able to be completed by a very large amount of individuals, as it was administered through The Ontario Secondary School Teachers Federation as well as Physical and Health Education Canada. In addition, the current project assesses both stress and well-being, which is unique as it is often the case that a study will focus on either one issue or the other.

Implications

Future research.

As this is an exploratory study, a brand new data set was constructed for the purposes of this project. Being composed of eight measures as well as a demographics section, the data set is rich with both quantitative and qualitative data, and can serve as a source of numerous additional research projects.

Professional practice.

The present study's results are beneficial not only to the academic world, but also the facilities of which the teachers/education professionals who completed the survey are employed. School administration can utilize the information provided with the hopes of better serving their employees (i.e. creating a different kind of work day – teachers with small children could be assigned first period prep so they are able to arrive at work at a later time. This solution is of no monetary cost and could alleviate some of the stress associated with balancing a busy schedule.).

Counselling.

The results from the current study could be utilized by a multitude of individuals, however, Employee Assistance Program counsellors in particular could benefit from these results. With an increased awareness as to the issues affecting teachers/education professionals as well as areas that perhaps deserve more attention than others, EAP counsellors will be better able to serve and support their clients.

Closing Remarks

Overall, the research study revealed important preliminary information of teachers' mental health and well-being, as well as their beliefs and expectations towards seeking psychological help. This preliminary study emphasizes the importance of these issues and the magnitude they have on teachers' lives. Additional research needs to be conducted in order to gain a deeper and greater understanding as to how to best assist and treat this specific population.

Bibliography

Adams, E. F. M., Lee, A. J., Pritchard, C. W., & White, R. J. E. (2010). What stops us from healing the healers: A survey of help-seeking behaviour, stigmatisation and depression within the medical profession? *International Journal of Social Psychiatry, 56*(4), 359-370.

Baggaley, R. F., Ganaba, R., Filippi, V., Kere, M., Marshall, T., Sombie, I., . . . Patel, V. (2007). Detecting depression after pregnancy: the validity of the K10 and K6 in Burkina Faso. *Tropical Medicine and International Health, 12*, 1225-1229.

Bennett, C. A. (2011). *The stigma of mental illness as experienced by mental health professionals as patients: A phenomenological study.* (Order No. AAI3534531, *Dissertation Abstracts International: Section B: The Sciences and Engineering.*

Betoret, F. D., & Artiga, A. G. (2010). Barriers perceived by teachers at work, coping strategies, self-efficacy and burnout. *The Spanish Journal of Psychology, 13*(2), 637-54.

Beutler, R. L. (2012). *The relationship between clinician burnout and self-care activities offered on-site at outpatient community mental health agencies.* (Order No. 3530625, Argosy University/Seattle). *ProQuest Dissertations and Theses*, 120.

Bos, A., Kanner, D., Muris, P., Janssen, B., & Mayer, B. (2009). Mental Illness Stigma and Disclosure: Consequences of Coming out of the Closet. *Issues in Mental Health Nursing, 30,* 509-513.

Bower, B. (1997, Aug 23). Working moms: Stressed to excess. *Science News, 152*, 122.

Britt, T. W., Castro, C. A., & Adler, A. B. (2005). Self-engagement, stressors, and health: A longitudinal study. *Personality and Social Psychology Bulletin, 31*(11), 1475-1486.

Bula, F. (1991, Oct 19). HEALTH; teachers have worst burnout rate, Quebec union says. *The Ottawa Citizen*.

Canadian Centre for Occupational Health and Safety. (2009, June 11). Employee Assistance Programs (EAP). ON, Canada.

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology, 56*(2), 267-283.

Chaplain, R. P. (2008). Stress and psychological distress among trainee secondary teachers in England. *Educational Psychology, 28*(2), 195-209.

ComPsych. (2014). *ComPsych: Guidance Resources Worldwide*. (ComPysch Corporation). Retrieved from http://www.compsych.ca/

Cooper, A., & Petrides, K. V. (2010). A psychometric analysis of the Trait Emotional Intelligence Questionnaire-Short Form (TEIQue-SF) using item response theory. *Journal of Personality Assessment, 92*(5), 449-457.

Corrigan, P. W., & Miller, F. E. (2004). Shame, blame, and contamination: A review of the impact of mental illness stigma on family members. *Journal of Mental Health, 13*(6), 537-548.

Corrigan, P. W., & Rao, Deepa, (2012). On the self-stigma of mental illness: Stages, disclosure, and strategies for change. *Canadian Journal of Psychiatry, 57*(8), 464-9.

Dewa, C., Lesage, A., Goering, P., & Caveen, M. (2004). Nature and Prevalence of Mental Illness in the Workplace. *Healthcare Papers, 5*(2), 12-25.

Druss, B. G., Bradford, D. W., Rosenheck, R. A., Radford, M. J., Krumholz, H. M. (2000). Mental disorders and the use of cardiovascular procedures after myocardial infarction. *Journal of American Medical Association*, *283*, 506-511.

Elhai, J. D., Schweinle, W., & Anderson, S. M. (2008, June 30). Reliability and validity of the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form. *Psychiatry Research, 159*(3), 320-329.

Etzel, E. F., & Watson, J. F. (2007). Ethical challenges for psychological consultations in intercollegiate athletics. *Journal of Clinical Sports Psychology, 1,* 304-317.

Fernet, C., Guay, F., Senecal, C., & Austin, S. (2012). Predicting intraindividual changes in teacher burnout: The role of perceived school environment and motivational factors. *Teaching and Teacher Education: An International Journal of Research and Studies, 28*(4), 514-525.

Flett, G. L., & Hewitt, P. L. (2013). Disguised distress in children and adolescents "flying under the radar": Why psychological problems are underestimated and how schools must respond. *Canadian Journal of School Psychology, 28*(1), 12-27.

Folkman, S., Lazarus, R. S., Dunkel-Schetter, C., DeLongis, A., & Gruen, R. J. (1986). *Ways of coping—revised.*

Gardner, L., & Stough, C. (2002). Examining the relationship between leadership and emotional intelligence in senior level managers. *Leadership & Organization Development Journal, 23*(2), 68-78.

Gentry, J. E. (2002). Compassion fatigue: A crucible of transformation. *Journal of Trauma Practice, 1(3/4)*, 8-11.

Geoghegan, L. (2006). *A psychological profile of patients with mental health difficulties.* (Order No. U216563, University College Dublin (Ireland).

Goetz, T., Ehret, C., Jullien, S., & Hall, N. C. (2006). Is the grass always greener on the other side? Social comparisons of subjective well-being. *The Journal of Positive Psychology, 1*(4), 173-186.

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ. Prentice Hall.

Guendouzi, J. (2006). "The guilt thing": Balancing domestic and professional roles. *Journal of Marriage and Family, 68*(4), 901-909.

Guglielmi, D., Panari, C., & Simbula, S. (2012). The determinants of teachers' well-being: The mediating role of mental fatigue. *European Journal of Mental Health, 7*(2), 204-220.

Halbesleben, J. R. B. (2006). Sources of social support and burnout: A meta-analytic test of the conservation of resources model. *Journal of Applied Psychology, 91*(5), 1134.

Haller, D. M., Sanci, L. A., Sawyer, S. M., & Patton, G. C. (2009). The identification of young people's emotional distress: a study in primary care. *British Journal of General Practice, 59*, 61-70.

Hamilton, C., & Carmichael, S. (1967). *Black Power*. New York. Random House.

Hansen, K., Gardner, L., & Stough, C. (2007). Improving occupational stress through emotional intelligence development. *Organizations and People*, *14*, 70-75.

Hansson, A., Hillerås, P. & Forsell, Y. (2005). What kind of self-care strategies do people report using and is there an association with well-being? *Social Indicators Research, 73*(1), 133.

Hartman, L. I., Michel, N. M., Winter, A., Young, R. E., Flett, G. L., & Goldberg, J. O. (2013). Self-stigma of mental illness in high school youth. *Canadian Journal of School Psychology, 28*(1), 28-42.

Hides, L., Lubman, D. I., Devlin, H., Cotton, S., Aitken, C., Gibbie, T., & Hellard, M. (2007). Reliability and validity of the Kessler 10 and Patient Health Questionnaire among injecting drug users. *Australian and New Zealand Journal of Psychiatry, 41*, 166-168.

Holzinger, A., Floris, F., Schomerus, G., Carta, M. G., & Angermeyer, M. C. (2012). Gender differences in public beliefs and attitudes about mental disorder in western countries: A systematic review of population studies. *Epidemiology and Psychiatric Sciences, 21*(1), 73-85.

Horrocks, D. (2008, Jul 18). English boards can do better to improve results; but they need the help of governments, universities, teachers, the media and parents. *The Gazette*.

Israelashvili, M., & Ishiyama, F. I. (2008). Positive and negative emotions related to seeking help from a school counselor. *Advances in School Mental Health Promotion, 1*(4), 5-13.

Jacobs, J. A., & Madden, J. F. (2004). Mommies and daddies on the fast track: Success of parents in demanding professions. *Annals of the American Academy of Political and Social Science, 596*, 6-264.

Jang, Y., Hsieh, C. L., Wang, Y. H., & Wu, Y. H. (2004). A validity study of the WHOQOL-BREF assessment in persons with traumatic spinal cord injury. *Archives of Physical Medicine and Rehabilitation, 85*, 1890-1895.

Jeffcoat, T., & Hayes, S. C. (2012). A randomized trial of ACT bibliotherapy on the mental health of K-12 teachers and staff. *Behaviour Research and Therapy, 50*(9), 571.

Jiang, W. (2011). Problems and strategy on teachers' mental health. *Psychology Research,* (2), 32-35.

Jones, D. A. (May 1995) *Depression in a sample of Canadian dentists.* (Order No. AAMNN92220, *Dissertation Abstracts International: Section B: The Sciences and Engineering,* 5073.

Jones, S. H. (2006). Chapter 5: Self-care in caregiving. *Journal of Human Behavior in the Social Environment, 14*(1-2), 95-115.

Kelchtermans, G., & Strittmatter, A. (1999). Beyond individual burnout: A perspective for improved schools. Guidelines for the prevention of burnout. (pp. 304-314) Cambridge University Press, New York, NY.

Kelly, P., & Colquhoun, D. (2005). The professionalization of stress management: Health and well-being as a professional duty of care? *Critical Public Health, 15*(2), 135-145.

Kessler, R. C., Green, J. G., Gruber, M. J., Sampson, N. A., Bromet, E., Cuitan, M., . . . Zaslavsky, A. M. (2011). Screening for serious mental illness in the general population with the K6 screening scale: Results from the WHO world mental health (WMH) survey initiative. *International Journal of Methods in Psychiatric Research, 20*(1), 62.

Koenig, A. (2014). *Learning to Prevent Burning and Fatigue: Teacher Burnout and Compassion Fatigue*.

Komiya, N., Good, G. E., & Sherrod, N. B. (2000). Emotional openness as a predictor of college students' attitudes toward seeking psychological help. *Journal of Counselling Psychology, 47*, 138-143.

Kutcher, S., Lauria-Horner, B., & Brooks, S. J. (2004). The feasibility of a mental health curriculum in elementary school. *Canadian Journal of Psychiatry, 49*(3), 208-11.

Kutcher, S., Venn, D., & Szumilas, M. (2009). Mental health: The next frontier of health education. *Education Canada, 49*(2), 44-45.

Ledet, S. N. (2009). *Differential perceptions of mental illness: An investigation of stigma, attitudes, and help-seeking among professionals, consumers, and college students.* (Order No. AAI3375186, *Dissertation Abstracts International, B: Sciences and Engineering*, 5829).

Lemstra, M. (2014, February 20). Teachers Deserve Public Gratitude. *The StarPhoenix*. Saskatoon, Saskatchewan, Canada.

Lin, M. R., Hwang, H. F., Chen, C. Y., & Chiu, W. T. (2007). Comparisons of the Brief Form of the World Health Organization Quality of Life and Short Form-36 for Persons with Spinal Cord Injuries. *American Journal of Physical Medicine and Rehabilitation, 86*, 104-113.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363-385.

Little, M., & McLennan, J. D. (2010). Teacher perceived mental and learning problems of children referred to a school mental health service. *Journal of the Canadian Academy of Child and Adolescent Psychiatry / Journal De l'Académie Canadienne De Psychiatrie De l'Enfant Et De l'Adolescent, 19*(2), 94-99.

Maciejewski, P. K., Prigerson, H. G., & Mazure, C. M. (2001). Sex differences in event-related risk for major depression. *Psychological Medicine, 31*(4), 593-604.

Mackenzie, C. S., Scott, T., Mather, A., & Sareen, J. (2008). Older adults' help-seeking attitudes and treatment beliefs concerning mental health problems. *The American Journal of Geriatric Psychiatry, 16*(12), 1010-1019.

Maniar, S. D., Curry, L. A., Sommers-Flanagan, J., & Walsh, J. A. (2001). Student athlete preference in seeking help when confronted with sports performance problems. *The Sport Psychologist, 15,* 205-223.

Maslach, C., & Jackson, S. E. (1981). *Maslach burnout inventory--ES form* Mind Garden, Inc.

Maslach, C., Jackson, S. E., & Schwab, R. L. (1996). *Maslach Burnout Inventory – Educators Survey* (MBI-ES). In C. Maslach, S. E. Jackson, & M. P. Leiter, *MBI Manual* (3rd ed.). Mountain View, CA: CPP, Inc.

Meldrum, L., Venn, D., & Kutcher, S. (2009). Mental health in schools. *ATA Magazine, 90*(1), 18-20.

Mental Health Commission of Canada. (2015). *Workplace: National Standard*. Retrieved from http://www.mentalhealthcommission.ca/English/issues/workplace/national-standard

Mikolajczak, M., Luminet, O., Leroy, C., & Roy, E. (2007). Psychometric properties of the Trait Emotional Intelligence Questionnaire. *Journal of Personality Assessment, 88*, 338-353.

Nieuwsma, J. A., Trivedi, R. B., Mcduffie, J., Kronish, I., Benjamin, D., & Williams, J. W. (2012). Brief psychotherapy for depression: A systematic review and meta-analysis. *International Journal of Psychiatry in Medicine, 43*(2), 129-51.

O'Mara, L., & Lind, C. (2013). What do we know about school mental health promotion programmes for children and youth? *Advances in School Mental Health Promotion, 6*(3), 203-224.

Ontario Ministry of Education. (2013). *Quick Facts: Ontario Schools, 2011-2012.* Queen's Printer for Ontario.

Ontario Ministry of Education. (2014). *Quick Facts: Ontario Schools, 2012-2013.* Queen's Printer for Ontario.

Ontario Psychological Association. (2014). *Frequently Asked Questions: Who pays for Psychological Treatment?* Retrieved from http://opajoomla.knowledge4you.ca/index.php/getting-help-faq/who-pays

Palmer, G. J. (2010). Examination of the Reliability and Validity of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) among Jamaican Americans. *ProQuest Information & Learning*.

People for Education. (2012, March 27). Education Funding Cut in 2012 Budget. Toronto, ON, Canada.

Persi, J. (1997). When emotionally troubled teachers refer emotionally troubled students. *School Counselor, 44*(5), 344-352.

Petrides, K. V., & Furnham, A. (2006). The role of trait emotional intelligence in a gender-specific model of organizational variables. *Journal of Applied Social Psychology, 36*, 552-569.

Petrides, K. V., Perez-Gonzalez, J. C., & Furnham, A. (2007). On the criterion and incremental validity of trait emotional intelligence. *Cognition and Emotion, 21*, 26-55.

Poole, J., & Saklofske, D. H. (2009, June). *Increasing teacher efficacy and coping: An emotionally intelligent approach*. Paper presented at the Canadian Psychological Association Conference, Montreal, Canada.

Poulin, P. A. (2009). *Mindfulness-based wellness education: A longitudinal evaluation with students in initial teacher education.* (Order No. AAINR79362, *Dissertation Abstracts International: Section B: The Sciences and Engineering.*

Reichel, J. (2013, February 20). Overwhelmed Canadian Teachers Quitting in Droves. *The Epoch Times.* ON, Canada.

Richmond, V. P., Wrench, J. S., & Gorham, J. (2001). *Communication, affect, and learning in the classroom.* Acton, MA: Tapestry Press.

Roberts, N., Stuart, H., & Lam, M. (2008). High school mental health survey: Assessment of a mental health screen. *The Canadian Journal of Psychiatry / La Revue Canadienne De Psychiatrie, 53*(5), 314-322.

Rüsch, N., Evans-Lacko, S., & Thornicroft, G. (2012). What is a mental illness? Public views and their effects on attitudes and disclosure. *Australian and New Zealand Journal of Psychiatry, 46*(7), 641-650.

Schomerus, G., Angermeyer, M. C. (2008). Stigma and its impact on help-seeking for mental disorders – what do we know? Epidemiologia e Psichiatria Sociale 17, 31–37.

Schwarzer, R., & Hallum, S. (2008). Perceived teacher self-efficacy as a predictor of job stress and burnout. *Applied Psychology: An International Review, 57*, 152-171.

Schaufeli, W. B., & Enzmann, D. (1998). *The burnout companion to study and practice: A critical analysis.* London: Taylor & Francis.

Simbula, S. (2010). Daily fluctuations in teachers' well-being: A diary study using the job Demands–Resources model. *Anxiety, Stress & Coping: An International Journal, 23*(5), 563-584.

Skevington, S., Lofty, M., O'Connell, K., & WHOQOL Group. (2004, March). The World Health Organization's WHOQOL-BREF quality of life assessment: Psychometric properties and results of the international field trial. A Report from the WHOQOL Group. *Quality of Life Research, 13*(2), 299-310.

Stafford, M. C., & Scott, R. R. (1986). Stigma deviance and social control: some conceptual issues. In *The Dilemma of Difference*, ed. S. C. Ainlay, G. Becker, L. M. Coleman. New York: Plenum.

Statistics Canada. (2010). *Employment rate of women with children by age of youngest child, 1976-2009.* Labour Force Survey.

Statistics Canada. (2010). *Women employed as a percentage of all occupations, 1987-2009*. Labour Force Survey.

Statistics Canada. (2012). *Mental Health Profile, Canadian Community Health Survey – Mental Health (CCHS) by age, group and sex, Canada and the provinces.*

Statistics Canada. (2013). *Health at a Glance: Mental and Substance Use Disorders in Canada*

Stough, C., Saklofske, D. H., & Parker, J. D. A. (2009). A brief analysis of 20 years of emotional intelligence: An introduction to assessing emotional intelligence: Theory, research, and applications. (pp. 3-8) Springer Science + Business Media, New York, NY.

Student mental health: Canadian teachers call for more resources and professional development in schools. (2012, Jul 12). *Canada NewsWire*.

Sutton, R. E., Mudrey-Camino, R., & Knight, C. C. (2009). Teachers' emotion regulation and classroom management. *Theory into Practice, 48*(2), 130-137.

The Civic Institute of Professional Personnel. (2013). *Your Benefits Plan*. Ottawa, Canada.

The Ontario Secondary School Teachers' Federation. (2012). *Collective Agreement between the Rainbow District School Board and the OSSTF*. Sudbury, Canada.

The Ottawa Hospital. (2012). *Your Health & Dental Insurance Plan*. Ontario Public Service Employees Union, Ottawa.

Toth, K. E. (2012). *Employee decision-making about disclosure of a mental disorder at work.* (Order No. 3509678, Walden University). *ProQuest Dissertations and Theses*, 266.

Trompenaars, F. J., Fons, J., Masthoff, E. D., Erik, D., Van Heck, G. L., Guus, L., . . . De Vries, J. (2005, February). Content validity, construct validity, and reliability of the WHOQOL-Bref in a population of Dutch adult psychiatric outpatients. *Quality of Life Research: An International Journal of Quality of Life Aspects of Treatment, Care & Rehabilitation, 14*(1), 151-160.

Van Stone, B. (2013, May). Addressing mental health disorders in the classroom. *Teach*, 6-7.

Vancour, M. (2005). *Motherhood ideology, role balance, and health-promoting behaviors of academic mothers.* (Order No. 3166550, New York University). *ProQuest Dissertations and Theses*, 141-141.

Ventra Group Inc. (2000). *Outline of Benefits*. GreenShield Canada.

Vesely, A. K., Saklofske, D. H., & Leschied, A. D. (2013). Teachers--the vital resource: The contribution of emotional intelligence to teacher efficacy and well-being. *Canadian Journal of School Psychology, 28*(1), 71-89.

Vesely, A. K., Saklofske, D. H., & Nordstokke, D. W. (2014). Ei training and pre-service teacher wellbeing. *Personality and Individual Differences.*

Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counselling Psychology, 53*, 325-337.

Waddell, C., McEwan, K., Shepherd, C. A., Offord, D. R., & Hua, J. M. (2005). A public health strategy to improve the mental health of Canadian children. *Canadian Journal of Psychiatry*, *50*, 226-233.

Watson, J. C. (2005). College student-athletes' attitudes towards help-seeking behavior and expectations of counseling services. *Journal of College Student Development*, 46, 442-449.

Webb, L. J., & Allen, R. (1979). Sex differences in mental health. *The Journal of Psychology: Interdisciplinary and Applied, 101*(1), 89-96.

Westman, M. (2001). Stress and strain crossover. *Human Relations, 54*(6), 717-751.

White, A., Shiralkar, P., Hassan, T., Galbraith, N., & Callaghan, R. (2006). Barriers to mental healthcare for psychiatrists. *Psychiatric Bulletin, 30*(10), 382-384.

Williams, I. D., Richardson, T. A., Moore, D. D., Gambrel, L. E., & Keeling, M. L. (2010). Perspectives on self-care. *Journal of Creativity in Mental Health, 5*(3), 320-338.

Wilson, C. M., Douglas, K. S., & Lyon, D. R. (2011). Violence against teachers: Prevalence and consequences. *Journal of Interpersonal Violence, 26*(12), 2353-2371.

Wright, T. A., Cropanzano, R., & Meyer, D. G. (2004). State and trait correlates of job performance: A tale of two perspectives. *Journal of Business and Psychology, 18*(3), 365-383.

Zimmer, C. (2012). *The experience and psychological impact of school violence on rural Alberta teachers.* (Order No. MR93735, University of Lethbridge (Canada)). *ProQuest Dissertations and Theses*, 230.

Appendix A

Teacher Mental Health and Wellness: Online Survey

1. Demographic Section (20): PAGE 2
   These questions are asked to get a sense of who the responder is, the job and life circumstances, and their experience with seeking help for mental health distress

2. K-6 Mental Health Screening Tool (6): PAGE 4
   This is a 6-item mental health screening tool developed by the World Health Organization, for use with general adult populations. It is widely used, with excellent psychometric properties and is described in the research literature as an efficient and useful screening tool.

3. Teacher Burnout Inventory (29): PAGE 6
   This measures the level of burnout, emotional exhaustion, depersonalization and health effects of burnout. It is a widely used measure of teacher burnout.

4. Quality of Life Survey (26): PAGE 7
   This measure, from the World Health Organization, measures quality of life and general health, physical health, psychological well-being, social relationships, and environments. It is a widely used measure with excellent psychometric properties.

5. Attitudes Toward Seeking Professional Psychological Help – Short Form (10) and Stigma Scale for Receiving Psychological Help (6): Page 13
   It is important to understand what barriers people may experience to seeking help. Results of this measure will help us examine for the presence of the barriers and, if found, we will then have some direction about how to address them.

6. Sources of Stress (3): PAGE 14
   These questions ask about the source of stress: home, work, or work-life balance. Again, for future interventions or promotion activities, this is important information.

   .

   Total: 98 items, taking 15-25 minutes

Peering Into The Well: An Exploration of the Mental Health of Educators

1. Demographic Section: Please complete the following items. If you would prefer not to answer any item, just skip it.

1	Gender M F Transgender
2	Level(s) currently teaching :
	Primary Junior Intermediate Senior Alternative other
3	How long have you been teaching (including this year)?
4	How many different schools have you taught in?
5	What is your role in the school? Is this role full time (FT) or Part-time (PT)? Occasional Teacher FT PT Long-term Occasional Teacher FT PT Classroom Teacher FT PT Learning Support Teacher FT PT Guidance Counsellor/School Support Teacher FT PT Chaplain FT PT Psychology staff FT PT Social Worker FT PT Educational Assistant FT PT Child and Youth Worker FT PT Principal Vice-Principal Other (please explain)
6	Please indicate the features of the community where you work: (please check all that apply) Remote Rural Urban <5,000 people 5001-15,000 people 15001 – 50,000) 50,001 – 100,000 100,001 – 200,000 20001-500,000 500,001-1,000,000 Over 1,000,000
7	Relationships: Married Common-law Divorced Separated
8	Do you have children? Yes No

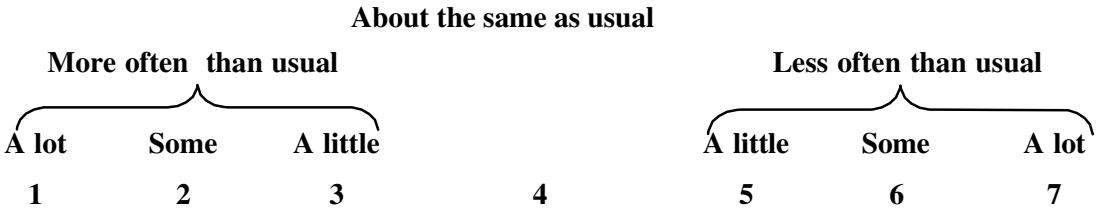
9	If yes, how many children do you have in each of these age groups? ___0-2 ___3-6 ___7-11 ___12-18 ___19-25 ___26 and older
10	Do you currently care for aging parents or adult siblings? Yes No
11	If yes, what type of support do you provide? (please check all that apply) ___ they live with me ___they live on their own and I visit them on a regular basis to check on them ___ they live in a supported care facility. ___ I advocate for their health and wellbeing needs to with health care providers ___ Other (please explain)
12	Please estimate the number of hours per month you spend caring for your aging parent or sibling.
13	Do you do any volunteer work outside of your school? Y N
14	If yes, please estimate the number of hours per month you spend doing this work.
15	Do you do any volunteer work at your school? Y N
16	If yes, please estimate the number of hours per month you spend doing this work.
	Since becoming a teacher or education professional, have you ever experienced mental health distress that interfered with you ability to engage in the activities of everyday life (such as work, relationships, health-promoting behaviours)? Y N
17	Have you ever received psychotherapy or counselling? Y N
18	If yes, where did you go for help? (check all that apply) Privately paid therapy (psychologist, social worker or counsellor) Family Doctor Clergy member Psychiatrist EAP (Employee Assistance Plan) Mental Health Distress Crisis Line (telephone) Walk in Clinic
19	If you have received psychotherapy or counselling, please briefly describe the reasons why:
20	Was it helpful?
21.	If you have never gone for counselling or psychotherapy, but you wished you could, what prevented you?
	Tick boxes, free response

The K-6 Mental Health Screening Tool – 6 item

The following questions ask about how you have been feeling during the **past 30 days**. For each question, please circle the number that best describes how often you had this feeling.

Q1. During the past 30 days, about how often did you feel …	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. …nervous?	**1**	**2**	**3**	**4**	**5**
b. …hopeless?	**1**	**2**	**3**	**4**	**5**
c. …restless or fidgety?	**1**	**2**	**3**	**4**	**5**
d. …so depressed that nothing could cheer you up?	**1**	**2**	**3**	**4**	**5**
e. …that everything was an effort?	**1**	**2**	**3**	**4**	**5**
f. …worthless?	**1**	**2**	**3**	**4**	**5**

Q2. The last six questions asked about feelings that might have occurred during the past 30 days. Taking them altogether, did these feelings occur More often in the past 30 days than is usual for you, about the same as usual, or less often than usual? (If you never have any of these feelings, circle response option "4.")



The next few questions are about how these feelings may have affected you in the past 30 days. You need not answer these questions if you answered "None of the time" to **all** of the six questions about your feelings.

Q3. During the past 30 days, how many days out of 30 were you totally unable to work or carry out your normal activities because of these feelings?

_____ (Number of days)

Q4. **Not counting the days you reported in response to Q3**, how many days in the past 30 were you able to do only half or less of what you would normally have been able to do, because of these feelings?

_____ (Number of days)

Q5. During the past 30 days, how many times did you see a doctor or other health professional about these feelings?

_____ (Number of times)

All of the **time**	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**

Q6. During the past 30 days, how often have physical health problems been the main cause of these feelings?

Teacher Burnout Inventory

Directions: This measure is designed to determine how you currently feel about your job and its related aspects. There are no right or wrong answers. Work quickly and circle your first impression. Please indicate the degree to which each statement applies to you by marking whether you:

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

_____1. I am bored with my job.

_____2. I am tired of my students.

_____3. I am weary with all of my job responsibilities.

_____4. My job doesn't excite me anymore.

_____5. I dislike going to my job.

_____6. I feel alienated at work.

_____7. I feel frustrated at work.

_____8. I avoid communication with students.

_____9. I avoid communication with my colleagues.

_____10. I communicate in a hostile manner at work.

_____11. I feel ill at work.

_____12. I think about calling my students ugly names.

_____13. I avoid looking at my students.

_____14. My students make me sick.

_____15. I feel sick to my stomach when I think about work.

_____16. I wish people would leave me alone at work.

_____17. I dread going to school.

_____18. I am apathetic about my job.

_____19. I feel stressed at work.

_____20. I have problems concentrating at work.

Richmond, V. P., Wrench, J. S., & Gorham, J. (2001). *Communication, affect, and learning in the classroom.* Acton, MA: Tapestry Press.

The World Health Organization Quality of Life Survey Instructions

This questionnaire asks how you feel about your quality of life, health, or other areas of your life. Please answer all the questions. If you are unsure about which response to give to a question, please choose the one that appears most appropriate. This can often be your first response.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in the last two weeks. For example, thinking about the last two weeks, a question might ask:

	(Please circle the number)				
Do you get the kind of support from others that you need?	**Not at all** 1	**A little** 2	**Moderately** 3	**Mostly** 4	**Completely** 5

You should circle the number that best fits how much support you got from others over the last two weeks. So you would circle the number 4 if you got a great deal of support from others.

	(Please circle the number)				
Do you get the kind of support from others that you need?	**Not at all** 1	**A little** 2	**Moderately** 3	**Mostly** (4)	**Completely** 5

You would circle number 1 if you did not get any of the support that you needed from others in the last two weeks

Please read each question, assess your feelings, and circle the number on the scale that gives the best answer for you for each question.

	(Please circle the number)				
	Very poor	**Poor**	**Neither poor nor good**	**Good**	**Very Good**
1. How would you rate your quality of life?	**1**	**2**	**3**	**4**	**5**
2. How satisfied are you with your health?	**1**	**2**	**3**	**4**	**5**

The following questions ask about **how much** you have experienced certain things in the last two weeks.

		(Please circle the number)				
		Not at all	**A little**	**A moderate amount**	**Very much**	**An extreme amount**
3.	To what extent do you feel that physical pain prevents you from doing what you need to do?	**1**	**2**	**3**	**4**	**5**
4.	How much do you need any medical treatment to function in your daily life?	**1**	**2**	**3**	**4**	**5**
5.	How much do you enjoy life?	**1**	**2**	**3**	**4**	**5**

		(Please circle the number)				
		Not at all	**A little**	**A moderate amount**	**Very much**	**An extreme amount**
6.	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		(Please circle the number)				
		Not at all	**Slightly**	**A Moderate**	**Very much**	**Extremely**
7.	How well are you able to concentrate?	**1**	**2**	**3**	**4**	**5**
8.	How safe do you feel in your daily life?	**1**	**2**	**3**	**4**	**5**

9.	How healthy is your physical environment?	**1**	**2**	**3**	**4**	**5**

The following questions ask about **how completely** you experience or were able to do certain things in the last two weeks.

		(Please circle the number)				
		Not at all	**A little**	**Moderately**	**Mostly**	**Completely**
10.	Do you have enough energy for everyday life?	**1**	**2**	**3**	**4**	**5**
11.	Are you able to accept your bodily appearance?	**1**	**2**	**3**	**4**	**5**
12.	Have you enough money to meet your needs?	**1**	**2**	**3**	**4**	**5**

		(Please circle the number)				
		Not at all	**A little**	**Moderately**	**Mostly**	**Completely**
13.	How available to you is the information that you need in your day-to-day life?	**1**	**2**	**3**	**4**	**5**
14.	To what extent do you have the opportunity for leisure activities?	**1**	**2**	**3**	**4**	**5**
15.	How well are you Able to get around?	1	2	3	4	5

The following questions ask you to say how **good** or **satisfied** you have felt about various aspects of your life over the last two weeks.

		(Please circle the number)				
		Very dissatisfied	**Dissatisfied**	**Neither satisfied nor dissatisfied**	**Satisfied**	**Very satisfied**
16.	How satisfied are you with your sleep?	**1**	**2**	**3**	**4**	**5**
17.	How satisfied are you with your ability to perform your daily living activities?	**1**	**2**	**3**	**4**	**5**
18.	How satisfied are you with your capacity for work?	**1**	**2**	**3**	**4**	**5**

		(Please circle the number)				
		Very dissatisfied	**Dissatisfied**	**Neither satisfied nor dissatisfied**	**Satisfied**	**Very satisfied**
19.	How satisfied are you with yourself?	**1**	**2**	**3**	**4**	**5**
20.	How satisfied are you with your personal relationships?	**1**	**2**	**3**	**4**	**5**
21.	How satisfied are you with your sex life?	**1**	**2**	**3**	**4**	**5**

22.	How satisfied are you with the support you get from your friends?	**1**	**2**	**3**	**4**	**5**
23.	How satisfied are you with the conditions of your living place?	**1**	**2**	**3**	**4**	**5**
24.	How satisfied are you with your access to health services?	**1**	**2**	**3**	**4**	**5**
25.	How satisfied are you with your mode of transportation?	**1**	**2**	**3**	**4**	**5**

The follow question refers to how often you have felt or experienced certain things in the last two weeks.

		(Please circle the number)				
		Never	**Seldom**	**Quite often**	**Very often**	**Always**
26.	How often do you have negative feelings, such as blue mood, despair, anxiety, depression?	**1**	**2**	**3**	**4**	**5**

Attitudes Toward Seeking Professional Psychological Help Scale-Short Form

Directions: Read each statement carefully and indicate your agreement or disagreement, using the scale below. Please express your frank opinion in responding to each statement, answering as you honestly feel or believe.

0 = Disagreement 1= Probable disagreement 2= Probable agreement 3= Agreement

_____1. I would obtain professional help if I was having a breakdown.

_____2. Talking about psychological problems is a poor way to solve emotional problems..

_____3. I would find relief in psychotherapy if I was in an emotional crisis.

_____4. A person coping without professional help is admirable.

_____5. I would obtain psychological help if I was upset for a long time.

_____6. I might want counselling in the future.

_____7. A person with an emotional problem is likely to solve it with professional help.

_____8. Psychotherapy would not have value for me.

_____9. A person should work out his/her problems without counselling.

_____10. Emotional problems resolve by themselves.

Stigma Scale for Receiving Professional Help

_____1. Seeing a psychologist for emotional or interpersonal problems carries social stigma.

_____2. It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems

_____3. People will see a person in a less favourable way if they knew he/she was seeing a psychologist.

_____4. It is advisable for a person to hide from others that she/she has been seeing a psychologist.

_____5. People tend to like less, those who are receiving professional psychological help.

_____6. I would be worried about keeping my job, or getting another job with my employer, if an administrator knew I was receiving professional psychological help.

Sources of Stress: these items attempt to locate the source of stress:

To what extent do the following parts of your life contribute to stress that you may be experiencing?

1 (never) 2(seldom) 3(quite often) 4(very often) 5(always)

1. My work life overall:___
   - My students___
   - My leadership team___
   - My coworkers___
   - Policies___
   - Lack of resources___
   - Other (please specify)_____ ___
2. My personal life overall:___
   - My relationship with my spouse or partner___
   - My relationship with my children___
   - Caring for children___
   - Caring for other family members___
   - Financial Difficulties___
   - Other (please specify)_____ ___
3. Work-Life Balance:___

Curriculum Vitae

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