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Beyond Burnout: Educators' Experiences of Mental Health Issues, and Stigma in the Workplace

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Abstract

This study examines Ontario teachers' experiences of mental health issues (MHI) and identity management in the workplace. Although numerous local and national initiatives exist to help raise awareness, decrease stigma, and assist teachers in supporting students with MHI, there appears to be an absence of literature that focuses on teachers' personal experiences with MHI and stigma in their professional environment. Two theoretical frameworks, *Framework Integrating Normative Influences on Stigma* (FINIS) (Pescosolido, Martin, Lang, & Olafsdottir, 2008), and Jones and King's (2014) *Managing stigmatized identities in the workplace*, provide a lens for making meaning of the experiences of the participants. A qualitative inquiry approach captures the experience of teachers living with MHI in their own words to foster a better understanding of the ways in which stigma operates within the education system, and to expand understandings of the multiple ways in which MHI impact on teachers' working lives in schools.

Keywords

mental health, stigma, identity management, teacher, education

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CHAPTER 1: INTRODUCTION AND CONTEXT

Chapter one contextualizes the central research questions of this study in the history of anti-stigma work in Canada and the current initiatives and policies that shape the discourse around mental health issues (MHI) nationally and at a provincial level. Stigma theories stemming from the work of Goffman (1963) are presented as valuable lenses for this study. The theoretical frameworks of Pescosolido and colleagues (2008) and Jones and King (2014) are explored to provide nuanced base for interpreting the ways in which stigma is socially constructed, and stigmatized identities are managed in the workplace by the participants in this study.

INTRODUCTION

This study examines Ontario teachers' experiences of MHI and stigma in the workplace in Ontario primary and secondary public schools. Although numerous local and national initiatives exist to help raise awareness of MHI, decrease stigma associated with MHI, and assist teachers in supporting students with MHI (see CAMH, 2001; teenmentalhealth.org), there appears to be an absence of literature that focuses on teachers' personal experiences with MHI and stigma in their professional environment. This study employs a qualitative multiple case study in order to explore the experience of eleven Ontario teachers living with MHI. This study examines the ways in which teachers manage their mental health identities in their workplace, as well as the many ways in which this identity management impacts on their work. The educator voices highlighted in this research provide new insights to the operation of stigma in schools, and may help explore the ways in which individuals are disrupting normative and limiting understandings of MHI and stigma in the workplace.

Mental Health, Stigma, and Education

In this study, the term “mental health issues” (MHI) means “alterations in thinking, mood or behaviour or some combination thereof, that are associated with significant distress and impaired functioning” (Government of Canada, 2006, p.2), and are not necessarily connected to a formal diagnosis. The term *stigma* refers to “a mark separating individuals from one another based on a socially conferred judgment that some persons or groups are tainted and ‘less than’” (Pescosolido et al., 2008, p.431; see also Goffman, 1963), and to the process of identity management that results from societal norms (Jones and King, 2014; Pescosolido et al., 2008).

PURPOSE OF RESEARCH

There exists a discrepancy between the national discourse for MHI, which advocates for a layered understanding of diverse needs and experiences of individuals (Mental Health Commission of Canada, 2012, 2013, 2015), and that of MHI within the teaching profession. Teachers’ mental health is portrayed in current research as anxiety, stress, and burnout caused by workplace stressors, and requiring the same supports with which to cope (Compass Inc., 2006; Martin, Dolmage, & Sharpe, 2012; Ministry of Education, 2013; Naylor, 2008; Rodgers et al., 2014). Teacher MHI is a topic that is gaining momentum, but it is only being discussed as burnout: something that happens *to* teachers, and not something they bring with them, or that requires management of identity.

Surveys from Ontario, British Columbia, and Saskatchewan evaluating the overall well-being of teachers have narrowly defined MHI as stress, anxiety and burnout, caused by factors directly related to teaching (Compass Inc., 2006; Martin et al., 2012; Naylor,

2008). Given the multitude of MHI that exist, and the prevalence of these conditions among Canadians (CAMH, 2014), it is unlikely that teachers would be confined to such limited manifestations of mental illness. Additionally, no distinction is made in the reports between pre-existing mental health issues, those that are exacerbated by the job requirements, and those that arise as a direct result of working conditions.

In this context, this study focuses on two central questions:

- i) How are teachers living with pre-existing MHI describing and understanding their experiences of MHI?
- ii) How do these experiences impact on their teaching and relationships in their workplace?

Thesis Overview

This thesis highlights the experiences of Ontario elementary and secondary school teachers living with MHI and the ways in which this stigmatized identity impacts on their work and work-relationships.

The literature review in chapter two presents existing empirical work pertaining to MHI, stigma, and education. I begin with an overview of the current Canadian climate for mental health in Canada, including national and provincial statistics, initiatives, and policies. Next I explore research that reveals current, stigmatizing beliefs about people living with MHI that are present in Canadian workplaces. These studies serve to situate education within a larger landscape of MHI in Canada. Following this, I explore the current role of the education system in its capacity to act as a site for MHI awareness and prevention as recommended by the Mental Health Commission of Canada (2012), and the Ontario Ministry of Education (2013). Next, studies pertaining specifically to MHI in

education are reviewed. These include studies that contribute to the understanding of mental health at school, and issues of mental health relating to teachers, such as burnout, retention, and readiness in supporting young people with MHI. The body of work examined provides insight into the gap that exists in the conceptualization of teachers and mental health, and stigma in schools. Finally, as empirical data with regards to teachers' mental health 'beyond burnout'-specifically qualitative data (Link et al., 2004)- are limited, I draw on a Canadian study exploring the MHI of mental health practitioners and their experiences of stigma (Moll, 2014) in order to suggest how similar data may be useful in expanding the existing field of mental health, stigma, and education.

Chapter three presents the methodological structure employed in this study. I review the research design and process by which this study was undertaken. After justifying my choice of a qualitative multiple-case study, I describe the sampling, recruiting, and data collection process. Following this, I provide an in-depth exploration of the coding and analysis of the data.

In chapter four, the presentation of the data analysis begins with participant profiles. These provide demographic information about the participating teachers, as well as information that establish the ways in which they understand and experience mental health, as well as their conceptions of stigma. Where it was provided, a participant definition of stigma is included in the profile.

Chapter five delves into the themes that emerged from the data analysis in chapter four. The themes explored include the construction and understanding of mental health identities, understandings of stigma, and the strategies, purposes, and impact of identity management. In the last chapter, I review the purpose and significance of this study and

suggest ways in which the perspectives and experiences examined in this study can challenge the way mental health-related stigma is currently understood in schools, particularly in relation to educators.

CONTEXT AND SIGNIFICANCE OF RESEARCH

Mental Health in Canada: Moving out of the shadows

The statistics for MHI are well known: one in three Canadians will experience some form of MHI in their lifetime (Pearson, Janz, & Ali, 2013), one in five experience MHI any given year (www.camh.com), and one in four people living with MHI do not seek help (MHCC, 2012). In Ontario in 2013, over 230,000 adults seriously contemplated suicide, and 716,000 individuals self-reported poor mental health (CAMH, 2014). While numbers provide some idea as to the magnitude of people affected, they do not account for individual experiences of MHI, or “how stigma is constructed in social interactions and how people interpret their experiences and their behaviour” (Link, et al., 2004, p. 529).

Canadian mental health and anti-stigma initiatives

Since 2006, the Government of Canada has identified raising awareness of MHI, and reducing the associated stigma in order to improve access to mental health services a priority to be addressed across multiple sectors, including education (Government of Canada, 2006). *Out of the Shadows at Last* (Kirby & Keon, 2006), a national study on mental health in Canada, acted as the springboard for subsequent initiatives. Drawing on over 2000 stories of lived experience, this report documented the challenges faced by Canadians living with MHI, and recognized the need for changes in the public understanding of mental illness and in the provision of mental health care. As a result of

the report, the Mental Health Commission of Canada (MHCC) was formed with the mandate of “improving the mental health care system and changing the attitudes and behaviours of Canadians around mental health issues” (MHCC, 2016). The MHCC has worked towards their mandate by assessing the health care system in partnership with people with lived experience of MHI, and identifying barriers that prevent accessing help.

In 2012 the MHCC released *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, which holistically examined areas in need of attention in order to “improv[e] mental health outcomes for all Canadians” (MHCC, 2012). Included in the strategy was the need for increased education about MHI. As part of the MHCC’s work, the *Psychological health and safety in the workplace—prevention, promotion, and guidance to staged implementation* (BNQ/CSA Group/MHCC, 2013), was released. This voluntary standard specifically targets the ways in which a workplace can take responsibility in preventing harm to employee psychological health, thereby “creat[ing] and continually improv[ing] a psychologically healthy and safe workplace” (BNQ/CSA/MHCC, 2013, p.2). Most recently, the MHCC introduced *The Guidelines for Recovery-Oriented Practice* (MHCC, 2015). This framework conceptualizes recovery beyond the idea of ‘curing’ a MHI. It promotes the idea that recovery is an ongoing process with no fixed definition, and that looks different for every single person (MHCC, 2015). Though frameworks are in place to address the different facets of MHI of access and stigma, stigmatizing attitudes and behaviours cannot be expected to disappear overnight because of paperwork (Kirby & Keon, 2006). These national-level documents provide an “overarching ideology by...providing clues to appropriate responses” (Pescosolido et al., 2008, p.435) toward MHI within Canadian society.

The national discourse surrounding mental health and illness is reflected in anti-stigma initiatives that, in partnership with organizations dedicated to MHI such as the MHCC and the Canadian Mental Health Association, take place on various media platforms. Notably, the annual Bell Let's Talk Day utilizes social media and mobile communication to encourage a Canada-wide discussion of mental health spearheaded by communications company, Bell Canada (letstalk.bell.ca, 2016). As part of this campaign celebrity spokespeople share their experiences with mental illness and related stigma to promote conversation about mental illness in order to end the stigma (letstalk.bell.ca, 2016). In addition to pledging a financial donation based on user participation once a year, Bell Canada also provides a number of online and printable resources to "get the conversation started" (letstalk.bell.ca, 2016). Campaigns take place in public forums and are equally taken up in public education with boards celebrating mental health awareness weeks to coincide with national action.

Mental Health and Education

Schools have been identified as ideal sites through which to address MHI and related stigma through curriculum and human resources (Froese-Germain & Riel, 2012; Kutcher, Venn, & Szumilas, 2009). In collaboration with Opening Minds, an anti-stigma initiative of the MHCC, the Ontario developed *Supporting Minds: An Educator's Guide to Promoting Students' Mental Health and Well-Being* (2013). This document acts as a complement to board-specific initiatives for promotion, prevention, and early intervention of child and youth mental health (Ministry of Education, 2013). Teacher roles are clearly defined as promoting mental wellness through creating positive classroom environments, engaging in anti-stigma programming, and personal connection

with students (Ministry of Education, 2013). It is specifically stated that an educator's role is not to diagnose MHI, but to be knowledgeable about MHI and vigilant in watching for students who may be struggling in order to refer them to appropriate services (Ministry of Education, 2013). Despite these resources, teachers overwhelmingly report feeling ill-equipped to support students with MHI as they feel they have neither the time nor training to implement new interventions (Rodger et al., 2014).

Teachers and MHI

Through recent research, the discourse surrounding teachers and MHI appears to be one of stress and burnout (Compass Inc., 2006; Martin, Dolmage & Sharpe., 2012; 2008; Rodger et al. 2014). The MHI that teachers have been reported to suffer from are attributed to workplace stressors such as increased behavioural issues, large class sizes, and an imbalance between work and personal life (Martin, Dolmage, & Sharpe, 2012; Rodger et al., 2014). The discussion about MHI and teachers centres around the impacts on their teaching abilities, job satisfaction, and ultimately issues of teacher retention (Naylor, 2001, 2008; Rodger et al. 2014). Though teachers' MHI are conceptualized as caused by work, and stigma is only mentioned in terms of assisting students to disclose their struggles in order to be directed to services, informal platforms such as blogs and anonymous websites offer insights into alternative ways in which teachers are experiencing MHI and illustrating the impacts of stigma (see PsychCentral.com, 2012; Pryal, 2014). These alternative accounts of MHI suggest that the current construction of teacher-as-victim-of circumstances may be incomplete and inadequate as an explanatory framework for understanding teachers' experiences of burnout.

THEORETICAL FRAMEWORK

I locate myself within a critical interpretive paradigm. The interpretive position embraces realities as multiple, subjective and not generalizable, and knowledge as gained through ‘personal’ experience that is historically, socially and contextually contingent; individuals make sense of their experiences through their social interactions with others in the world, and within their specific contexts (Creswell, 2007; Mack, 2010; Scotland, 2012). The critical interpretive perspective seeks to examine the ways in which individuals are limited by identity- for example race, gender, class, and in the case of this study a stigmatized identity of MHI- and create change through “envisioning new possibilities” (Creswell, 2007, p. 27) and challenge dominant discourses and power structures (Mack, 2010). I am interested in investigating the multiple understandings of stigma, constructed by individuals with lived experience, with the ultimate goal of shedding light on inequities that impact education, and employing that knowledge to make change (Mack, 2010). This ontological and epistemological tradition resonates with me as it reflects the way I understand MHI: a diagnosis may reveal what symptoms can be expected, but will say little about the subjective experience within the context of a life and lived experiences of identity management and unequal power relations. For teachers living with MHI, their construction of MH statuses, their understanding of the ways in which their work lives are affected, and their perceptions of stigma will vary as much as each of their personal contexts and their backgrounds in terms of sexual orientation, gender identity, race, ethnicity, disability, as each of these influence the meaning making associated with their identities (Scotland, 2012). In this section, I acknowledge the contributions of Erving Goffman’s (1963) work *Stigma: Notes on the management of*

spoiled identity, as well as criticism and limitations of his work. I then draw on two frameworks that expand on Erving Goffman's (1963): Pescosolido and colleagues' (2008) *Framework Integrating Normative Influences on Stigma* (FINIS), and Jones and King's (2014) *Managing stigmatized identities in the workplace*.

Goffman

Goffman (1963) presents stigma not simply as a mark of difference, but as a relationship between stereotypes and expectations that are determined by normative society. He stresses that stigma takes many forms, can be known or perceived, is experienced differently by each individual, and that the stigmatized must manage their identities with each social interaction they encounter. The stigmatized is not left to a victim's role; in the chapter on the Self and its Other, Goffman (1963) provides an opportunity for exploring resistance to stigmatization stating that "The stigmatized and the normal are part of each other; if one can prove vulnerable, it must be expected that the other can, too" (p.135). Since its publication, Goffman's (1963) work has been taken up in a wide array of research pertaining to marginalized groups in order to explore the phenomenon of stigma, and the field has grown, but not without encountering challenges and limitations.

In the time since Goffman (1963) produced his work on stigma, the field of stigma theory has developed, and with its uptake comes a need to assess the limits of the work in its original form, and assess its application in a contemporary context to reflect the growth that has occurred in the understanding and application of stigma theory. In *Conceptualizing Stigma*, Link and Phelan (2001) highlight some of the major criticisms of Goffman's (1963) work in relation to its inclusion in numerous studies. This

reconceptualization of stigma serves as a springboard for employing the two theories that I use in my research as they address the gaps identified.

The two major limitations identified are: 1) research on stigma is not explicitly done *by* and *with* individuals of that particular group, but rather *about* them (Fine, 1994); it is uninformed by the lived experience of the people in the study and risks misunderstanding the experience of the people who are stigmatized thereby perpetuating damaging assumptions (Link & Phelan, 2001). The second challenge lies in the focus on the individual experience of stigma while excluding the role of social systems, environments, and contexts that make stigma possible. Through this, stigma has come to be understood as “something *in the person* rather than a designation or tag that others affix to the person” (Link & Phelan, 2001, p.366). In reconceptualising stigma, Link and Phelan (2001) propose that it be defined as the converging points of interrelated components: “stigma happens when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold” (p.366). In the context of this study, these limitations are addressed by making use of theories that account for the components proposed in Link and Phelan’s (2001) elaboration of the social construction of stigma. Included in this reassessment is an examination of how stigma and power are inextricably linked. Link and Phelan assert that “it takes power to stigmatize” (p.375), to mark a person as different, and to have “serious discriminatory consequences” on their lives (p. 376). This perspective is vital to include as the very fabric of education exists on a hierarchy of power between ministry, board, administration, educational staff, and students. The reconceptualization of this concept raises questions pertaining to the definition of the term ‘stigma’. In order to

observe the complexity of this term (Link & Phelan, 2001), participant definitions of stigma are included to contextualize their experiences in accordance with validating their own understandings. This reconceptualization provides leeway for exploring the potential to change the discourse from passive victim to active challenger (Link and Phelan, 2001, p.378).

A Framework Integrating Normative Influences on Stigma

Here, FINIS (Pescosolido, et al., 2008) proves quite useful elaborating on the work of Link and Phelan (2001) and in understanding the multiple elements between the individual and the community that interact and influence the process of MHI stigma. Pescosolido and colleagues (2008) developed this framework to reflect the social construction of behavioural norms that occur at different levels in society (e.g. political, cultural, and social contexts), which “create the possibility of marking and sharing notions of ‘difference’” (p.432). The framework explores the micro, meso, and macro levels of social life in relation to the production of “normative expectations that play out in the process of stigmatization” (Pescosolido et al., 2008, p.433). The levels consider individual contexts and characteristics for both stigmatizer and stigmatized, as well as community elements (national, media, and social network contexts) that interact to impact responses, treatment, and life course for an individual living with MHI (Pescosolido et al. 2008).

Underpinning FINIS is an understanding that stigma is socially constructed in and through relationships, but also exists within a larger political and social context that shapes norms and “create[s] possibility for marking difference” (Pescosolido et al., 2008, p.432). The influences presented in this framework, broken down into three levels- the

micro, macro, and meso- draw from a number of disciplines to “synthesise the variety of theoretical influences on stigma” (Pescosolido et al. 2008, p.433) and begin to untangle how stigma is shaped. The micro level of this model takes into account the individual- both stigmatizer and stigmatized- and the characteristics, which influence their responses to mental illness. In this study, the micro level can help make meaning of how and why a participant understands their label and experience in the way that they do. The macro level of the model provides a foundation for understanding stigma as a production of a larger national context. FINIS notes how the views established at a national level dictate legitimacy of health concerns, which then trickle down to impact the ways in which an individual may internalize those messages. Like Link and Phelan’s (2001) conceptualization of stigma, FINIS notes the role of power in “embed[ding] normative expectations in and through economic development, social organization, and cultural systems” (p.435), which suggests the to the general populous the appropriate responses to stigmatized groups by means of discourse created through policy. Of particular interest in this framework is the integration of the impact of media on community beliefs (Pescosolido et al., 2008). As previously mentioned, the Government of Canada has worked for the past decade to redress the macro-level discourse surrounding mental illness, and to promote a culture of understanding and acceptance (MHCC, 2012). Through the MHCC, media has played a prominent role in this change of discourse through Canada-wide anti-stigma media campaigns advocating for education and humanization of mental illness (MHCC, 2012). Given these initiatives, FINIS provides a portion of the framework dedicated to theorizing the role of media influence on mental illness-related stigma. Outlined in this section is a brief history of how media has

constructed the mentally ill person as dangerous, unpredictable, and incompetent, and the ways in which media messaging impacts directly and indirectly on the consumers' beliefs about people living with MHI (Pescosolido et al., 2008). Pescosolido and colleagues (2008) note:

information about mental illness learned from a life-time of media use will be a source of stereotypes, impacting judgements people make in their everyday life when they encounter situations related to mental illness, mental health care, or persons with mental illness (p.435).

Media also features in the meso level of FINIS where the role of social networks is explored. Here, contact hypothesis-the notion that stigmatizing beliefs and attitudes can be curbed through exposure to members of the stigmatized group- is taken up and critiqued (Pescosolido et al., 2008). The framework addresses the inconsistency in this field of research, noting that even with “voluntary equal, intensive and/or rewarding, prolonged” (p.436) exposure, results are inconsistent. There is no one-time vaccine that eradicates stigmatizing beliefs. To address this, FINIS proposes that a combination of media and real-life interactions with individuals living with mental illness can work together to redress negative preconceptions of mental illness that are a product of messaging from different sources. One such source highlighted in the meso level is the treatment system. The authors comment on the irony that even within the health care systems designed to support individuals living with MHI, “organizational norms, even unintentionally, increase prejudice and discrimination” (p.436), as no part of a society can be divorced from its historical context-in this case, a history of institutionalization of the mentally ill (Pescosolido et al., 2008).

Schools are at the heart of where all of these levels converge, having been designated as sites for enacting the government's socio-political stance pertaining to

mental health and illness. This framework is key in exploring the experiences of educators, that shape and are shaped by these many layers, and in broadening understanding of how intersecting factors impact on the production of stigma in schools (Pescosolido et al., 2008).

Stigma Identity Management

To supplement FINIS (Pescosolido et al., 2008), I make use of Jones & King's (2014) *Stigma Identity Management Theory*. Similar to FINIS, this theory pulls together a number of theoretical models from across disciplines in order to formulate a multilevel framework, which focuses on the unique ways that a stigmatized identity is managed in the workplace, and the ways in which identity management impacts the individual. Central to the model is the understanding that a concealable stigmatized identity is one of degrees in that, given different times and circumstances, the same individual will manage their identity differently (Jones & King, 2014). This framework recognizes that disclosure is a “multifaceted *process* of concealable stigma management...ongoing decisions employees much make about concealing, signalling, and revealing their stigmas” (Jones & King, 2014). It also outlines the detrimental consequences of concealing a stigmatized identity on the person and their work (Jones & King, 2014). This framework provides a means for understanding the varying degrees to which educators express their identities at work, and insight into the processes and relationships that impact the choice to *conceal*, *reveal* or *signal*, in different interactions (Jones & King, 2014).

This theory has been selected as a complement to the more holistic approach of FINIS, and to address the need for a bound definition of stigma (Link & Phelan, 2001).

This theory is selectively used, and not in its entirety, for a number of reasons. While it is useful in examining the process of concealment, it does present some arguments that are contradictory to its central point. Firstly, this model contradicts itself fundamentally in how it talks about the process of revealing a stigmatized identity, specifically in how it represents the process in a binary. Though Jones and King (2014) advocate for a definition of identity management as a fluid and continuous process, assumed in their exploration of 'revealing' is that, once a stigmatized identity is made visible, the psychological well-being of the individual managing their identity will improve (Jones & King, 2014). As it appears in their argument, the act of revealing negates any kind of process, as an 'end' to identity management is implied with the anticipated improvement in mental wellness. While this outcome may indeed transpire, presenting 'revealing' in this manner truncates the proposal that all parts of identity management are a process; in reality the process doesn't end with a disclosure as this assumes that human interactions are fixed, that relationships are not complex and volatile. This explanation does not take into account that that relationships, certainly work relationships, are subject to change at any time for any number of reasons; 'revealing' does not guarantee a positive reaction, or that the confidant's reaction will not change over time.

Secondly, though stigmatized identities used to construct this framework are bound in context of the workplace, the examples used to illustrate the framework are not comparable. Although Jones and King (2014) discuss identity management and stigma as a matter of varying degrees, they fail to take into consideration that the studies compiled to illustrate the model do not carry the same weight in terms of required identity management, whether that be actual or perceived. For example, the stigma

associated with pregnancy in the workplace cannot be compared to the stigma of a HIV positive status. Furthermore, the level of stigma will depend on the workplace, and the individuals' intersectional identities: the stigma and identity management for a pregnant teen will be different than that attributed to an adult in a monogamous, cisgender, and heterosexual partnership, which will again be different from that attributed to a trans* person who is pregnant. Within the norms discussed by Pescosolido and colleagues (2008) it is understood that levels of acceptability exist within society, and the stigma attributed to an individual will be far more complex than a simple degree based on their stigmatized identity. In this regard such a model is limited in its dichotomous framing of revealing stigma in the workplace as it fails to address the multilayered and complex dimensionality of identity management and its contextual specificity and temporality (Jones and King, 2014).

Underpinning the theories that I have selected is a mixture of critical and interpretivist assumptions that are necessary to support this research. They recognize that the current knowledge surrounding MHI in education is the result of research constructed by a "pre-existing system of consensus" (Scotland, 2012, p. 13), which has not historically highlighted the voices of marginalized groups, thereby "unwittingly contribut[ing] to systems of oppression" (Scotland, 2012, p.13). Built into the frameworks is a sensitivity to the role of power imbalances, relationships, media and other institutions and norms that permeate society. This sensitivity permits the examination of normative constructions of reality as related to MHI that limit the ways in which alternative experiences of MHI and stigma can be known. The frameworks identify the ways in which stigma is produced and experienced, and deconstruct how that

reality is defined in society, what knowledge is considered valuable, and make space for marginalized voices to be heard in order to challenge and change the dominant and limited understandings of stigma (Mack, 2010).

Conclusion

In this chapter, I demonstrated a need for the research problem of gathering perspectives of teachers living with MHI that are not a result of workplace stressors and their experiences of stigma in the workplace. The underutilization of qualitative methods to investigate stigma (Link and Phelan, 2001), and the narrow understanding of teacher mental health provide a solid rationale for this study. 'Burnout' related MHI are legitimate concerns, but they are only one side of what is experienced by educators. With over 1,000,000 full time educators in Ontario (www.edu.gov.on.ca), it is statistically impossible that teaching as a profession is exempt from MHI unrelated to job stress (Pearson, Janz, & Ali, 2013). By omitting the experiences of the one-in-five, understandings of the operation of stigma are truncated, and identities are reduced to a simplistic cause-and-effect explanation. Through privileging voices that have been absent to date, this study may bring new insights into 'personal' and institutional experiences of stigma. A focus on the lived experiences of teachers with MHI is needed to move beyond the burnout discourse to a more nuanced understanding of the implications of MHI stigma in schools.

CHAPTER 2: LITERATURE REVIEW

This chapter provides an overview of the mental health landscape in Canada and Ontario through literature pertaining to MHI and its related stigma. As stated earlier, the statistics that illustrate the current state of mental health issues in Canada are well documented. Therefore, this chapter will focus more specifically on studies that form the current understanding of MHI in education. These will be examined for their contributions, and also for the way in which they position teacher mental health as an issue primarily of burnout and stress. As the existing literature on teacher mental health is limited, a review of a Canadian study exploring the experiences of mental health care workers and stigma in their workplace is presented as an entry point for broaching the topic of teacher mental health as more than burnout.

The Cost of MHI

MHI affect each individual differently and as such, the impacts on individual lives vary depending on a range of biological, social and background factors (Kirby & Keon, 2006; MHCC, 2013). Despite the individuality of experiences of MHI, stigma has widely been recognized as a central experience and barrier to accessing help (Kirby & Keon, 2006; MHCC, 2012). Stigma related to MHI has been characterized by systemic discrimination and perceptions of dangerousness (Kirby & Keon, 2006; Hinshaw & Stier, 2008; Pescosolido, et al., 2008). Stigmatizing behaviours and attitudes including self-stigma, internalized negative beliefs regarding MHI, have been connected to inhibited help-seeking behaviours, feelings of isolation, and poor physical health (Hinshaw & Stier, 2008; Levy, Celen-Demirtas, Surguladze, & Sweeney, 2014; Rüschi, Angermeyer, and Corrigan, 2005; Wahl, 1999). A continuously evolving area of research in the intersection of MHI and society is the impact on work. 'Impact' is understood as direct

cost, referring to financial burdens on health care and social services, and indirect cost, referring to loss of productivity either as a result of absenteeism or presenteeism (MHCC, 2013). Absenteeism takes into account the days that workers miss due to mental health concerns, whereas presenteeism talks about the time that workers show up for work despite having a significant drop in productivity- in other words, where individuals elect to 'push through' despite their mental health issues (MHCC 2013; Moll 2014). In application, absenteeism and presenteeism combined account for keeping 500,000 working Canadians away from their jobs on any given week of the year due to mental health concerns (MHCC, 2016), at a financial cost of billions to the Canadian economy (Dimoff and Kelloway, 2013; MHCC, 2013).

The Personal Cost

Not included in the discussion of cost as it pertains to supporting mental wellness in the workplace, is the cost that individuals bear. Where mental illness can negatively impact on workplace productivity and profit, so can work negatively impact on an individual's mental health. Individual cost can relate to wages lost for days not worked due to mental illness (MHCC, 2013), whether that be attending appointments, or inability to be present at work. Although for some, the workplace can be a site that benefits their recovery of mental health challenge by providing structure, social support, income, and purpose (Kirby and Keon, 2006); it can also present conditions such as high job strain and effort-reward imbalance, that foster mental illness (Kirby and Keon, 2006; LaMontagne, et al., 2014). Independent of mental health issues, factors such as effort-reward imbalance, job insecurity, and increased workloads have been shown to deter individual psychological wellbeing in the workplace (Bolo et al. 2013; Dimoff &

Kelloway, 2013; Moll, 2010; Szeto & Dobson, 2013). For individuals living with MHI that are not a result of their occupation, the workplace can present a different set of challenges that stem from stigma and discrimination.

Stigma

As explored in chapter 1, stigma is a process by which societal norms create an environment where an individual may be marked as different (Pescosolido et al., 2008). This process can be experienced either in the behaviours and beliefs of others, or self-stigma, whereby a person may have a lowered sense of self-worth based on internalized societal messaging and may feel the need to conceal their mental health status from those around them for fear of status loss (Hinshaw & Stier, 2008; Jones & King, 2014; Pescosolido et al. 2008; Rush, Angermeyer, & Corrigan, 2005). Stigma has also been reported to be detrimental to physical and emotional health (Levy, Celen-Demirtas, Surguladze, & Sweeney, 2014), as well as connected to higher risks of suicidality (Farrelly, et al., 2015). Stigma, in all its forms, has been identified as a major barrier that keeps individuals from seeking support for their MHI (Kirby & Keon, 2006). When stigmatizing beliefs are enacted in the workplace, the resulting tangible and intangible impacts such as discrimination (Szeto & Dobson, 2010) and increased emotional stress (Jones & King, 2014), may negatively impact an individual.

Stigma in the Workplace

In the workplace, the impacts of stigma towards individual with MHI can take many forms including perceptions of incompetence and irresponsibility, and loss of support from colleagues and managers (Dewa, 2014; Levy et al. 2014; Koschade & Stevenson, 2011; Wahl, 1999). A recent Canadian study that surveyed over 2000

working adults revealed that 64% of Ontario workers, when asked about perceptions of colleagues with MHI, expressed fear for safety of themselves and others. Workers also voiced doubt concerning reliability of individuals with MHI (Dewa, 2015). Of the respondents, one third reported that they would not disclose their mental health status to their managers (Dewa, 2014). This reluctance to disclose is not surprising given the risk of stigmatization associated with speaking openly about personal experiences of mental illness (Dewa, 2014; Dewa & Hoch, 2015; Corrigan, Druss, & Perlick, 2014). One of the implications of these barriers to accessing supports at work is illustrated in this example: attitudinal barriers may prevent an individual from disclosing their need for help with mental health issues, yet that disclosure is essential in accessing the resources available through the workplace (Dewa, 2015; Dewa & Hoch, 2015). Barriers are not limited to beliefs, but also include structural factors such as the cost of treatment and investment of time (Dewa & Hoch, 2015). Corrigan and colleagues (2014) note that the cost of stigma plays a central role in whether an individual chooses to seek help or not. They state:

Costs include stigmatizing labels that arise from treatment and worsened self-stigma and shame. The ‘why try’ result of self-stigma may lead the person into believing treatment will not have any real positive impact: ‘I am not worthy of treatment, or I am unable to really participate.’ (p.44)

In a study of barriers to mental health services among workers living with depression, over half of the participants did not identify a need for treatment (Dewa & Hoch, 2014). This study “suggests that the greatest barrier is related to the recognition of the need for services” (Dewa & Hoch, 2014). According to Corrigan et al. (2014), the ability to acknowledge the need for help is linked to mental health literacy, and de-stigmatizing attitudes towards mental health issues. The barriers identified by Dewa and Hoch (2015) come into sharp relief when examined alongside Bolo and colleagues’ (2013) study

exploring the long-term impact of accessing workplace accommodations (e.g. workload management and flexible hours) on employees living with depression. This study compared two groups of employees living with depression with some receiving workplace accommodations and others who were not. The results of the study showed that, a year later, accessing supports through work was associated with better mental health outcomes for those individuals (Bolo et al., 2013). In the workplace, mental health and stigma interact to present a variety of challenges which can be counteracted by increasing mental health literacy through education for all employees (Corrigan et al. 2014; Lamontagne et al. 2014)).

Mental Health and Education

The key role of education in addressing the stigma related to MHI in order to promote help-seeking and improve conditions for people living with mental illness has been identified by many sources, notably the government of Canada (MHCC, 2012). Schools in the Canadian public education have become the focus for anti-stigma work, early identification, and developing the competencies of adults in those schools to better serve the children and youth they work with (Ontario Ministry of Health and Long-Term Care, 2011; Ontario Ministry of Education, 2013). In this context, the image and role of the teacher in regards to mental health and education has centred around the capacity to support young people with their mental health issues. Through this lens, numerous studies have emerged documenting educator's attitudes and experiences with their new role. More recently, studies have focused on teachers' well-being, but these studies have not addressed teacher mental health outside of the challenges faced as a result of their

work, nor is stigma a topic that is explored outside of mentioning it as a barrier to students' help-seeking.

Teacher Mental Health

The research addressing teachers and mental health falls into two broad categories: burnout, which relates directly to an educator's emotional well-being; and support, which encompasses teacher capacity to help students, and teacher attitudes towards mental health. Neither category considers MHI that teachers may experience that are not a result of workplace stressors, or that stigma may impact their work and relationships. The current lens establishes that teacher mental health is valuable to the education system in regards to the support they provide to their students.

Teachers are perceived to be in a unique role where they can identify warning signs of impending MHI and refer their students to supports provided through the school (Johnson et al., 2011; Ontario Ministry of Education, 2013). With directives coming from the Ministry of Education, as well as individual school boards, the expectation is that a teacher will be well-versed in the warning signs for MHI, and be prepared to respond and refer (Johnson et al. 2011; Ball & Anderson-Butcher, 2014). Undeniably, an educator who is educated on mental health issues and resources is an invaluable asset in a school setting; however, simply being a teacher does not automatically guarantee that an individual has the motivation or the capacity to act in this role. In studies that explore the relationship between a teacher's ability to carry out this expected role and a teacher's well-being, discussion is centred around job stress (Ball & Anderson-Butcher, 2014; Sisak et al., 2013). Teacher stress-and by extension their ability to support students- is characterized as arising from the overwhelming mental health needs of their students,

lack of confidence in being able to help students (e.g. they don't have the proper training), and by pressures from other job demands (Ball & Anderson-Butcher, 2014; Collie, Shapka, & Perry, 2012; Sisak et al., 2013; Rodger et al., 2014).

The more serious impact of high job stress is well documented: burnout-the result of a lengthy exposure to stress, and the "endpoint to coping unsuccessfully with chronic stress" (Skaalvik & Skaalvik, 2010, p.1060). International studies confirm that working conditions can adversely affect teacher mental health, which then impacts on job satisfaction, and on commitment to the profession (Borelli, Benevene, Fiorilli, D'Amelio, & Pozzi, 2014; Fisher, 2011; Hakanen, Bakker, & Schaufeli, 2005; Skaalvik & Skaalvik, 2010). Across Canada, teachers' unions have reported on the well-being of their membership in similar terms. The British Columbia Teachers' Federation (BCTF) reported the effects of teacher burnout caused by heavy workloads and lack of resources impact on teacher retention and physical health (Naylor, 2001). It called for government support in exploring options such as flexible work hours and telecommuting to reduce the existing sources of stress (Naylor, 2008). Similarly, surveys from the Saskatchewan Teachers' Federation (2012) and the Ontario College of Teachers (2006) showed that teachers were suffering from burnout and stress caused by workplace stressors, despite also expressing a deep passion for their career. The picture that comes together of teacher mental health through these studies and reports is one that depicts teachers as stressed and burned out because of their work. Here, my study hopes to add to this picture by providing new insights into the ways in which teacher mental health is currently conceptualized.

Health Care Workers Living with MHI: An Entry Point to Exploring the Impacts of MHI

Stigma

MHI and experiences of stigma for teachers are invisible in the current discourse of teacher burnout. Moll (2014) provides an entry point to begin thinking beyond the burnout discourse to what teachers may be experiencing. In her investigation of a prominent Canadian mental health organization, Moll (2014) examined the experiences of mental health workers who live with MHI, and their observations and encounters with stigma in the workplace. Parallels between teachers and mental health workers can be drawn in both the care-giving roles they play, and professional discourse of their milieu that equates mental wellness with professional competence. The theme of silence was prevalent through interviews conducted with health care workers living with MHI (Moll, Eakin, Franche, & Strike, 2013). Silence impacted all aspects of workers' relationships and processes from social tension to accessing supports (Moll, 2014). The fear of being 'found out' and discredited highlighted an unspoken understanding that MHI do not belong in a professional image (Moll, 2014). Mental health workers and mental health organizations arguably have an extensive understanding of the barriers associated with MHI-related stigma, and yet, workers in this study felt silenced and undermined because of their conditions (Moll et al., 2013).

Conclusion

This chapter reviewed relevant literature in the field of mental health, stigma in the workplace, and education. The studies examined revealed that there is a strong relationship between the workplace and mental well-being, and that workplaces in Canada are not free of stigmatizing beliefs about MHI. Additionally, the studies specific to mental health and education situated teachers simultaneously as support systems for

young people with mental health concerns and suffering from burnout due to this expectation and several other workplace demands, but not as individuals who experience MHI outside of those parameters. In the next chapter, I outline the methodological approach employed in my study.

CHAPTER 3: METHODOLOGY

A qualitative inquiry approach was employed in this study in order to explore the largely hidden voices of teachers living with MHI and to “reflect the intricacies of the lived experience of stigma” (Link et al., 2004, p.529) that may not be as apparent in quantitative studies. Drawing on qualitative research methods which seek to “uncov[er] the meaning...subjects [bring] to their life experiences” (Denzin & Lincoln, 2011, p.11), this study gathered the experiences, perceptions, and opinions of participating educators (Patton, 2002) in order to explore the multiple ways in which MHI is understood and stigma constructed and experienced. Link and colleagues (2004) emphasize how essential qualitative methodologies are to the field of MHI stigma. At the same time, they note that these methods are significantly underutilized. MHI-related stigma research has been largely dominated by Western, quantitative research methodologies. Conversely, the rich insight that is the product of in-depth interviewing opens a window into the “subjective experience of stigma and the complexity of social systems that produce stigma” (Link et al. 2004). The rich descriptions (Denzin & Lincoln, 2011) provided by participants and articulated in their words (Patton, 2002) offer a layered, multi-dimensional overview of MHI and stigma, which pulls together overlapping themes, while honouring the context of each participant’s intersectional history and particular circumstance. Additionally, the specifics of each particular contribution (Denzin & Lincoln, 2011) serve to deconstruct the ways in which each individual constructs their understandings and interpretations of stigma (Link et al. 2004). Link and colleagues write:

These methods are essential for appreciating the subtle, damaging effects of stigma. Structural discrimination, for example, can only be understood when the institutions through which it operates are well characterized, the history of the relationship with the stigmatized group understood, the policies of the institution examined, and the attitudes of its leaders explored (p.529).

A qualitative approach may provide a different way of gaining an understanding of a larger system and the operation of stigma process within it through the observations of those directly experiencing it. In this sense, each individual narrative of MHI and stigma exists and has value in its own right, but also contributes to a larger emerging narrative of stigma within the workplace. For the Ontario-wide context of this research, it was essential to ground the study in a methodology that would allow for the particulars of each case to be highlighted, and not to generalize experiences or flatten the dialogue, but tease out the nuances, and work to bring a new dimension to research about MHI in education, and its stigma. Finally, the decision to employ qualitative methods was purposefully made for its capacity to disrupt the history of MHI being *about* a stigmatized group, and privilege writing *with* them in their words (Fine, 1994; see also Link and Phelan, 2001).

Research Design and Method

With the purpose of exploring the realities and experiences of teachers with MHI across Ontario, a multiple-case design was employed (Yin, 2014). Here the *cases* were the participants- teachers experiencing MHI that are not solely the result of workplace stressors. The *contexts* varied in relation to participants' location and school board (Yin, 2014). A multiple-case study comprised of several voices offered insight into the unique ways in which each teacher understood their mental health and related stigma within the context of their life and work (Link et al., 2004). A multiple-case study allowed for these individual perspectives to be layered, compared, and contrasted in order to draw out major themes relevant to the inquiry through the process of analysis (Patton, 2002).

The sample for this study consisted of 11 teachers from elementary and secondary panels, residing within Ontario. The inclusion criteria for this purposive sample was limited to teachers- long-term occasional or contract- who self-identified as living with MHI that fell 'beyond burnout'- that is to say those who are not solely experiencing stress and anxiety as a result of workplace stressors. Individuals experiencing stress and burnout in addition to self-identified MHI were not excluded from this study. Participants were not required to have a formal diagnosis in order to participate, as one of the barriers of stigma is that people do not seek help for fear of what that label can bring with it (Hinshaw and Stier, 2008). Consistent with the approach taken by Moll (2010), to be considered for the participation, teachers were required to be "willing and able to reflect on and describe their experiences..." and "competent to provide consent" (p.51). Inclusion in the study was decided on a first-come-first-serve basis so as to ensure equitable participation (Yin, 2014).

As the fear of stigma was a potential barrier to teachers interested in participating, recruitment for this study was undertaken via online platforms as opposed to disseminating advertisements through school boards (Jones & King, 2014). Social media (i.e. Facebook and Twitter) served to share posters advertising the study. A Facebook page entitled *Beyond Burnout: A study about teachers and mental health* was created to serve as a static platform from which individuals could view information about the research project such as the Letter of Information, poster, and researcher contact information. Unlike a Facebook group, a page does not require visitors to 'like' or 'join' lists, nor does it track individuals who visit the page. No identifying information was stored on the public page other than the informative files, and the 'likes', 'shares', and

comments that individuals added of their own volition. Individuals who expressed interest in the study via the group private message board were given the option to communicate via email, or to continue communicating through Facebook messaging. As an administrator, I did not have access to who viewed the page. Contact was solely initiated by individuals interested in participating. In order to advertise the page, I asked education-specific Facebook groups to which I already belong (e.g. Ontario Secondary School Teachers' Federation (OSSTF)) through private messaging or email, to repost a direct link to my Facebook page on their group and Twitter feeds. Through this communication, the page was reposted to a number of OSSTF district Facebook groups, and an Ontario-wide email was sent out to OSSTF membership informing them of this study. Following the completion of the study, the page was permanently deleted. The use of social media provided a platform from which interested teachers could initiate contact independent of their workplace and served to reach a more diverse representation of teachers as these sites had the potential of reaching teachers all across Ontario.

Once participants indicated their desire to be involved in the study, interviews were scheduled at their convenience. Participants were free to select a comfortable location, either in-person, or virtually (i.e. Skype or Google Hangout); of the 11 interviews, two were conducted virtually. Interviews followed the *general interview guide* approach outlined by Patton (2002) to ensure that the same pre-determined set of issues were explored by each participant, while allowing flexibility to “explore, probe, and ask questions that will elucidate and illuminate that particular subject” (p.343). By taking this approach, interviews were focused and allowed attention to be drawn to areas

that resonated with participants. In addition, I was able to probe more deeply into topics that emerged over the course of the interview (Patton, 2002).

Given that a stigmatized identity was the very topic being explored in the interview, informed consent and confidentiality were of utmost importance and were given special attention at the onset of the interview (Patton, 2002). Participants received a letter of information and consent both electronically and in hard copy (Patton, 2002; Yin, 2014), which were reviewed prior to beginning the interview (Patton, 2002). Points emphasized to them included their right to stop the interview, to take breaks at any time, and to opt out of the study even after the completion of the interview. The limits of confidentiality were explicitly stated and participants made aware that, should they disclose the intent to hurt themselves or others, I had a duty to report to appropriate authorities in order for them to access the support they required (Patton, 2002). Following this consent procedure, participants had the opportunity to indicate on a form separate to the consent form, whether they were interested in participating in member checking by reviewing the transcript of their interview, and receiving a two-page summary of the research once the study was complete (Cohen, Manion, & Morrison, 2011). The interviews commenced after the consent form was signed and lasted anywhere from 20 minutes to two hours depending on the participant.

The semi-structured interview (Link et al., 2004) consisted of open-ended questions so as to not “presuppose which dimensions of feeling or thought will be salient for the interviewee” (Patton, 2002, p., 354). Link and colleagues (2004) suggest that semi-structured interviewing lends itself particularly well to the study of MHI stigma because by attending to the insider perspective, it “permits the investigator to understand

how stigma is constructed in social interaction and how people interpret their experiences” (p. 529). The interview guide was designed to collect a variety of information from participants and encourage description through the use of open-ended questions and careful sequencing (Patton, 2002).

The interview guide was sequenced to ease participant through questions that encouraged reflective responses (Patton, 2002). By engaging the participants immediately in speaking descriptively about themselves and their unique contexts the introductory questions yielded demographic information while bypassing a long list of boring and possibly uncomfortable questions (Patton, 2002). As recommended by Patton (2002), participants were asked about their experiences followed by questions about opinions and feelings. Patton (2002) notes that these follow up questions, which provide a deeper understanding of the participants’ thoughts and judgements, are more likely to be “grounded and meaningful once the respondent has verbally “relived” the experience” (p.352). Open-ended questions were used in order to allow participants the freedom to form responses, which are not bound by implied limits and were used to elicit a more complete picture of participant experiences (Patton, 2002). The closing question of the interview was an opportunity for the participant to have the final say by opening the interview up to issues they were overlooked in the interview process (Patton, 2002).

Though great care was taken to not cause the participant distress by working to make them a “partner in how deeply to pursue the matter” (Patton 2002, p.415), given the sensitive nature of the interview, participants were provided with a debriefing form at the close of the interview. This form consisted of a list of mental health resources available 24 hours a day that they could access if at any point they are feeling emotionally unwell

after the interview. Prior to beginning the interview, teachers received a \$20 gift card for their participation as a token of appreciation for their valuable time (Patton, 2002). All interviews were audio-recorded with participant consent to be transcribed later for analysis.

Data Analysis

Data analysis unfolded in four parts: pre-coding, First Cycle coding, post-coding, and Second Cycle coding (Saldaña, 2013). In the following section I elaborate on these processes, as well as the measures that were taken in order to keep in check my own assumptions and biases in order to reduce the likelihood of colouring the analysis and interpretation (Saldaña, 2013).

Recordings and transcripts were stored on a personal, password-protected computer. During the transcription process pseudonyms replaced all participant names and all identifying information was removed. All consent forms were stored in a locked desk separate from the computer in order to protect the privacy and confidentiality of the participants (Yin, 2014). While transcribing, an organizational table was created to keep track of quotes and passages that stood out (Saldaña, 2013). This tool was useful in reconstructing a focused overview of each participant's narrative, in linking narratives together as a holistic data set, and in beginning to connect the data to theory. Transcripts were typographically pre-coded by bolding, underlining, and highlighting the text to identify quotes that addressed the central questions of the study as well as experiences of stigma (Saldaña, 2013). As part of the pre-coding process, special attention was paid to defining the parameters of each research question.

The first question addressing teachers' description and understanding of their experiences of MHI was bound by paying attention to the word 'understanding'. This word denotes a process of knowing that can change and develop over time and in relation to a context. With this in mind, the question was pre-coded for understandings of past experiences in relation to MHI, the coming to current understandings of MHI in their life and work, as well as the descriptive segments that qualified these accounts.

Pre-coding for the second question aimed to highlight areas where participants discussed the intersection of interaction of their MHI with the teaching process (e.g. formal teaching and teaching-related activities), individuals in their workplace, and identity management. Stigma was identified and pre-coded using the theoretical frameworks that facilitated the mapping out of clues that indicated that an experience represented stigma as more than a simple "mark of shame", and stigmatizing incidences as the product of socially constructed rules which define which behaviours are "normal" (Pescosolido et al., 2008). Clues included identity management and reference to differential treatment (Jones and King 2014; Pescosolido et al., 2008). Once pre-coding was complete, transcripts were printed for manual coding (Saldaña, 2013).

In first cycle coding, In Vivo was purposefully selected as the primary coding method for its alignment with the purpose of the study, which was to explore the personal experiences of participants, and "address the nature of participants' realities" (Saldaña, 2013, p.61). The purpose of using language generated by participants was to prioritize and honour the participant's voices in a manner similar to the report published by Kirby and Keon (2006) which emphasized the unedited voices of lived experience in order to ground the work. Transcripts were separated into smaller units of text indicated by a line

break, as topics changed throughout the interview (Saldaña, 2013). The units of text were labeled with a parent code (Saldaña, 2013), then children codes, or sub-codes, were identified using ‘splitter codes’ (Saldaña, 2013, p.23) that divided the data into “smaller codable moment...generating a more nuanced analysis” (Saldaña, 2013, p.23).

In post-coding, code mapping was used to assemble codes from across the data into categories (Saldaña, 2013). The In Vivo parent codes from each interview were extracted and compared to “reorganized into a selected list of categories, and then condensed further into the study’s central themes or concepts” (Saldaña, 2013, p. 194).

In Second Cycle coding, the primary objective was to synthesize the categories from the code mapping into a smaller number of codes that would then become the categories explored in the discussion section of this study (Saldaña, 2013). Pattern Coding developed “category label[s] that identified[ed] similarly coded data” (Saldaña, p.209), organized the body of data, and began to develop meaning of the categories as a whole. The themes derived from triangulating participant accounts served to increase understanding about the lived experience of teachers with MHI (Patton, 2002).

As suggested by Saldaña (2013), a considerable amount of time was spent on reflexive journaling during the coding and analysis process in order to “track [my] assumptions... positionality... to track the tensions within [my] value, attitude, and belief system” (p. 22) in relation to the process and emerging findings. Saldaña (2013) proposes that one question that can help address this is “what surprised me?” (p.22), and I focused on this question as I found it difficult to answer. My understanding is that surprise is rooted in assumption (Saldaña, 2013). Surprise occurs when assumptions are confronted to a reality not yet thought of, and when taken-for-granted attitudes are

challenged. Through journaling simultaneously with coding and analysis, I came to understand that two possibilities could explain my struggle with this question: either I was not surprised because I had no assumptions about what would transpire in this study, or the assumptions I had were not challenged.

Patton (2002) notes the “observers do not enter the field with a completely blank slate” and that individuals are ‘sensitised’ to particular topics. Indeed, I did not elect to study teacher mental health on a whim, but rather as a result of my relationship with the profession, and my long-standing awareness and sensitivity to MHI. From the onset of this study, acknowledging my positionality to the topic of research assisted me in careful design of research questions. During data collection, acknowledging my prior understanding that stems from a context unique to my experience, led me to carefully probe and elicit detailed definitions from participants so as to avoid grafting my understanding of a concept onto their experience. During the coding and analysis, reflecting on my relationship to the data, I deliberately chose to use In Vivo coding (Saldaña, 2013) to honour participant voice keeping their words intact as long as possible, and made a conscious and dedicated effort not imbue them with a personal interpretation but to remain true to the sentiments and experiences expressed by participants (Saldaña, 2013). Packer (2011) (as cited in Saldaña, 2013), emphasized that themes do not ‘simply emerge’ but are the product of the researcher’s particular position. Making use of stigma theories to inform and guide data analysis served dually to acknowledge my position and to lessen the impact of my pre-existing beliefs and biases. My positionality to this research topic made it possible to design a data analysis process that was at once rigorous and sensitive to the historical context of mental health research.

This combination allowed me to be receptive to new narratives related to teaching and mental health.

Conclusion

In this chapter, I described the design, execution, and analysis of the research project, and demonstrated the alignment of all of its parts to the theoretical and methodological traditions that underpin the study. In the following chapters, I present the results of the analysis beginning with participant profiles, followed by a discussion of the implications of the findings.

CHAPTER 4: DATA ANALYSIS: UNDERSTANDINGS AND EXPERIENCES OF MENTAL HEALTH IDENTITIES, AND STIGMA

This chapter presents the analysis of the experiences and understandings of mental health identities and stigma shared by the 11 participants of this study. These individuals were Long-term Occasional (LTO, n=2) and Contract teachers (n=9) in elementary and secondary panels, who self-identified as living with MHI that were not result of workplace stressors, but in many cases were exacerbated by it. The analysis of these interviews focuses on the ways in which participants construct understandings and make meaning of their MHI, stigma, and identity management. The voices of participants are privileged throughout the analysis in order to illustrate the themes that are explored in the analysis. Then I will examine the major themes that came up during analysis. These themes centre around the process of identity management including strategies, purposes, and impacts on participants.

PARTICIPANT PROFILES

Included in this section are profiles that present information about participant lives, careers, and mental health statuses. These profiles provide information that contextualize participant responses and contributions within their unique life experiences, and provide insight into the influences that help shape participant views and understandings. All participant names have been replaced with pseudonyms.

Dylan

Dylan has been teaching for about 8 years and has taught in both primary and secondary panels and currently teaches a grade 6/7 class. She holds a Specialist in Special Education qualification. Dylan has two children and a husband who is also a teacher.

Dylan identifies that she is “severely depressed, with severe anxiety”, which she describes as “a very hard mix”. Dylan explains that unexpected change is often a trigger for anxiety:

A lot of the times, mine starts off with ‘something’s gone wrong’...if it’s at school, if it’s at home, something’s gone wrong and my plans change. [...] For those days that I can’t seem to get over that, I escalate quickly...I can’t control my thoughts and they just go five different directions. My brain’s looking to anchor somewhere and it’s finding more problems than it is anchor at that point...I go into flight mode.

For Dylan, ‘flight mode’ means removing herself for a period of time, usually sleeping, in order to calm down and ‘reset’. She notes that though this strategy is effective, it is difficult with two children at home, but that her husband is very understanding and supportive.

Dylan’s depression “usually stems from the constant inability to complete things in a day.” She explains that work presents a particular challenge in this area:

...School goes home with me...I try to get everything prepared and I can’t get it done. And so I drag it into the next day, and I drag it into the next day, and I’m behind in marking...it’s a snowball effect and that makes me more depressed, makes me more anxious because I can’t control this big ball of stuff...it’s just this everlasting thing.

Dylan takes medication to help with her anxiety and depression and says that medication provides her the “three seconds of should I or shouldn’t I? Is this important or can I hold off? Should I try?”

Paige

Paige is a school teacher in the elementary panel who teaches in French immersion and Special Education. She has been teaching for ten years and currently works at a larger school. Paige participates in many extra curricula activities in her school, and has facilitated workshops for her school boards. She is married and a mother of two children, enjoys traveling, and “leads a balanced life”.

Paige suffers from hypomania, which she describes as “just a little bit of dissociation... So, I’m not like, say, really manic, or, and I don’t suffer from bipolar, like I don’t have depression or anything... I just go off in like a little bit of a state.” Paige notes that lack of sleep is one of the major triggers. She had her first episode at 14, and has had more episodes in the last number of years, which she attributes to teaching. Paige takes medication to help her with sleep and is working with different strategies to work to maintain her mental health.

Sal

Sal has been teaching for 25 years in a small community that she describes as “very rural”. Sal began teaching at a high school level French, and has since taught at all grade levels. She currently teaches a grade 7/8, and is an active member of her union. In the past Sal has also worked for her school board.

In her 9th year of teaching, Sal was diagnosed with depression, a label which she rejected at first. Based on personal research, she feels that she also has anxiety as she is “not a selective worrier” and “worr[ies] about everything”. Sal describes depression like this:

It had become a real struggle for me not to get upset. But I had a lot of patience in the classroom...outside of the classroom? It was hell, it was hell...I just wanted to curl up on weekends and not see anybody or do anything

Since being diagnosed Sal has been on medication for depression, which she says has made a “difference of night and day”.

Chris

Chris is a Long-Term Occasional (LTO) teacher who is qualified to teach at primary and junior level classes. He holds Additional Qualifications (AQs) in Primary/Junior Math and Kindergarten. Prior to entering teaching, Chris completed a

Police Foundations program. In addition to daily supply work, Chris has had a number of LTO placements in elementary classrooms. Chris is married, with two young children.

In his second year of teaching, Chris was diagnosed with anxiety and depression. Chris describes himself as someone who had “always sweat the small stuff.” For Chris, anxiety means that he is unable to sleep, cannot shut or turn his mind “off”, becomes “emotionally exhausted, as well as physically ill. He remarks: “if my brain doesn’t have something...a challenge, then I start to go a bit crazy...after a little while, it really starts to wear on me.” At worst, his anxiety becomes depression, which he associates with feelings of hopelessness. Chris’ doctor diagnosed him with anxiety, stating that he was “genetically predisposed”, and that his work situation was exacerbating his MHI. Chris takes prescribed medication for his anxiety, and also sees a counsellor, though he mentioned that, with the unpredictable schedule of daily supply work, it is difficult to book appointments.

Frances

Frances is an elementary teacher and has been teaching for 13 years at the same school, which she describes as “needy” in terms of students “whose lives are so unstable that they’re not ready to learn”, and where “calling the Children’s Aid Society is a pretty regular occurrence.” Frances worked for a children’s social service organization before perusing teaching as a career. Frances is married and has a 7-year old son.

Frances describes her mental health as being “mostly depression and anxiety” which she believes originates on her father’s side of the family; she notes that several family members on her paternal side struggle with a variety of MHI. Though never formally identified, Frances feels that her MHI began when she was in her teens.

Frances’ doctor confirmed to her that she also has “obsessive compulsive disorder

tendencies.” Frances describes living with depression and anxiety “like carrying a bag of gravel...to do all the things that everyone else does, but you’ve got a bag of gravel to lug around...” For Frances, anxiety is triggered by, and also causes sleeplessness, and depression she links to crying and sadness. Frances states that medication has helped her with emotional regulation. As therapy has helped her in the past, she is currently seeking a counsellor. Frances engages in independent reading and research to manage the ways in which her work impacts negatively on her mental health.

Alex

Alex has been teaching since 2001 as an occasional teacher (OT) and LTO; this was her first year doing contract. She is a teacher/librarian who also works in system operations for the school’s technology. She has chosen to work part-time. Alex was diagnosed with diverticular disease at a young age.

Alex classifies herself as a “functioning individual who works with depression and anxiety issues, and some minor OCD.” Alex specifies that *functioning* indicates that she has “rarely missed work because of depression or anxiety” and that she is aware enough of her triggers and symptoms that she is able to be proactive in managing her MHI. Alex’s OCD has never been diagnosed, but she links it to a need for perfectionism that has been with her since childhood. Alex describes her depression the following way:

I know I’m getting bad when I wake up in the morning and my first impulse is wanting to vomit... And my theory behind it is, I wake up in that anxiety, that panic, and I have those negative thoughts going through my head and if I vomit, maybe I am releasing that negativity out of me so that I can move on.

Alex’s experience of anxiety is closely linked to a need for control, and has developed a wide range of coping mechanisms that allow her to feel in control of situations. (e.g. taking a subway versus taxi). Alex’s OCD tendencies manifest in “little weird quirks here and there” such as needing certain tasks to be completed in a specific manner, that

“at times it does impede slightly on ...functionality and timeframes of completing things.” Alex takes medication to help with her MHI and also sees a psychiatrist.

Casey

Casey has been teaching for 16 years and is currently in guidance at a secondary school. In guidance, Casey supports and advocates for students to receive support based on their needs, and helps youth transition into and out of high school. Casey has taught elementary school abroad, and worked as a firefighter and as a paramedic. Casey is married and has two children.

Casey’s family has a history of MHI, and has experienced anxiety intermittently since adolescence. She has also been diagnosed with ADHD, which she feels contributes to her anxiety. Casey describes ADHD as something that is present “every day, all the time” and impacts her memory, attention, and ability to complete tasks. She explains that there is “always activity in [her] head” which becomes quite overwhelming. Anxiety comes into play when tasks don’t get completed because of interruptions or because it is so big that she burns out. Casey saw a therapist in the past, but has since stopped going, stating “I haven’t met anyone since that has helped me so much and that was as good...it’s hard to find somebody else once you’ve found a therapist that’s really good.” Casey does not take medication for anxiety or ADHD.

Aidrian

Aidrian currently teaches high school, but taught elementary previously. She recently moved to Ontario and is now in an LTO placement teaching grade French. She holds a Bachelor and Masters in Education. Her husband works for the military, and they have a son together. In addition to her teaching duties, Aidrian coaches and is involved in school activities. In terms of extracurricular involvement at school, she states that she is “still trying to get [her] feet wet.”

Aidrian describes her mental health as a “rollercoaster.” After a difficult pregnancy and delivery, she suffered postpartum depression and was started on medication. Recently, due to converging challenging circumstances in her life, she noticed a decline in her mental health and her doctor recommended she begin taking medication again. For Aidrian, school and work provide stability in her life when she is feeling sad, lonely, and overwhelmed:

I feel like school is the one place that...I go through the motions, I plan, I teach, I put my 110% in...and when it stops, then I start to think about everything else I have to do. So I think that the school part is the thing that keeps me sane.

Sylvie

Sylvie is an elementary teacher of 11 years. She has been at her school for 8 years and currently Special Education and Early Literacy Intervention. She has been married for 10 years and has two daughters. Sylvie describes her school as one with a lot of challenges and needs in terms of a student population.

Sylvie is currently seeing a counsellor, and has in the past been on a very low dosage of anti-depressants. Through her doctor, she completed a survey, which placed her at “the very bottom of severe depression,” and was referred to counselling for

Cognitive Behavioural Therapy for anxiety. Sylvie describes her experience with anxiety and depression this way:

Sometimes it's a heaviness on my chest...and I can't, talking with the counsellor, I don't necessarily know which has come first...whether it's the anxiety part or the depression part, which one is driving the other. I still, within myself, can't figure out, 'Am I experiencing this because I am anxious about this or because of the other feelings I'm having that's causing me to feel anxious.' So I mean, sometimes it'll be like a heaviness on the chest, I can't breathe right...where I can breathe, like I'm not actually having any trouble breathing, but it feels like I am. I often feel like I'm just kind of in a fog, in a cloud...um, can't really keep information straight sometimes, poor memory...tired *all* the time...I could sleep all the time. And some of those days where I think it is more the depression when I can't figure out why I'm feeling the way I'm feeling...I just want to curl up and go to sleep and not see anybody

Through personal readings, the identity of introvert has come to resonate with her in terms of being more than just a shy person.

Sarah

Sarah is an "18-year veteran in teaching," who teaches English, history, gender studies, and has a special interest in equity and diversity work. She has worked at three high schools in her career, and is in her fourth year at her current school, which she says has a "really eclectic, wonderful culture." Sarah teaches in a traditional classroom, as well as online classes. She is actively involved in the union, as well as student clubs, yearbook, and the school's Rainbow Alliance. Sarah has never been married and does not have children.

Mental health is something that Sarah has struggled with for approximately 13 years, specifically with anxiety, depression, and 'Seasonal Affective Disorder'. To Sarah, these diagnoses are experienced the following way:

I find it very difficult to get motivated, I sleep more, I procrastinate, the house doesn't get as clean as it should be, and it's just... it's a fight sometimes to just go out and be social with people. And this all seems to be, I mean... it happens more

in the winter months than in the summer months. At its worst, there are thoughts of suicide, but for the most part it's just a struggle to get through everyday life that really shouldn't be a challenge to get through. I have a good life, so there's also the struggle with that, is that I know I have a very good life, and I'm very privileged, and yet, um, I sometimes find life difficult to deal with

Sarah is vigilant about her mental health and works constantly to take care of herself, which includes taking medication and seeing a psychologist.

Quinn

Quinn is an elementary school teacher who has been working as an occasional teacher for the past 10 years and was recently offered contract work with her school board. She began as an Early Childhood Educator (ECE), and later went back to school to become a teacher. Quinn teaches grade 4 at the moment, in a large city school which she describes as having a “dynamic mixture of kids,” and also “very hard to break into” as a new teacher, given the size of the staff.

Quinn identifies that she lives with depression and anxiety, though she has not received a diagnosis and hesitant to express her feelings to a doctor for fear of the stigma associated with it. For Quinn, depression and anxiety are experienced this way:

I can get very withdrawn in the sense that I don't want to see other people. I don't want to do the things that I would usually enjoy doing... I'm someone who likes to spend time on my own anyway, that's just my personality, but it's even more so ...it's not that I struggle to get out of bed in the morning or things like that, it's just sort of an overall feeling of like, hopelessness of sorts. And like, 'are things going to get better? Are things going to get...is this what life is all about?' ...And then from the anxiety perspective I get more sort of physical symptoms where I'll get sort of, um, a heart-racing um, I'll get almost... I'll get like, panic attack type things... Like you feel really hot or like, things are going on around you and you feel like you are in your own little world type of thing. ...I describe it as an 'out of body experience' where you're watching yourself do things... You're... you're going through the routine of things, but you're not really there in spirit.

Though Quinn has not sought out medical support, she participates in online courses to help her better understand her experiences, as well as accessing counselling services

through her Employee Assistance Plan (EAP).

These profiles were presented to contextualize the perspectives shared by participants within the frame of their experience. Attention was paid to their specific experiences of MHI within their social context. The perspectives arising from these contexts will now be used to explore their experiences of mental health-related identity management at work.

UNDERSTANDING IDENTITY

The construction and understanding of a social identity occurs over the course of a life in a number of ways, but always in relation to a social setting (Goffman, 1963). Similarly, the construction and understanding of a stigmatized identity happens “in and through social relationships” (Pescosolido et al., 2008, p.432) which dictate what is considered ‘normal’ and ‘different’. The learning of these rules occurs over time and via several societal levels, which change over time (Pescosolido et al., 2008).

Understandings of identity are dynamic and have the potential to evolve over time relative to social norms, either as influenced by them or in response to them (Jones & King, 2014). In this section, the range of ways in which participants came to understand their MHI identities, and make meaning of them in the context of their workplace are explored.

PROMPTS: Catalysts for understanding mental health identities

Participants developed understandings of their MH identities in a range of different ways, and at different points in their lives. Prompts took the forms of conversations, life-events, or media, and alerted participants to the need to manage their identity (Jones & King, 2014). Though prompts or situations that led them to reflect on their mental health were different for each participant, their reactions and reflections illustrate the normative influences at play, which shape their understandings. For participants, recognizing an identity counter to the norm (Pescosolido et al., 2008) led them to initially attribute stigma to their MHI. In some cases, the prompts revealed self-stigma, or internalized negative beliefs about MHI (Hinshaw & Steir, 2008).

Prompt: Conversation

One factor that prevents individuals from seeking help with their MHI is self-stigma. Self-stigma is characterized by lowered self-esteem or feelings of shame (Hinshaw & Stier, 2008; Jones & King, 2014). Sal and Sarah recognized that they were struggling more than usual, but found that an outside perspective was necessary in helping them take the next step in seeking help. After struggling with her emotional well-being for some time, Sal was finally confronted by her doctor:

I was in my ninth year of teaching and I was just a mess...I had tried some self-help books...I think it was Dr. Phil at the time... and it just wasn't working and I was just frustrated with everyone and everything and I just wasn't happy. So he wanted me to meet with him after hours, which was kind of odd...we just went for coffee cause he's a nice guy, and he just went through a checklist with me, and then showed it to me. And then he says, 'You're depressed.'

Sal immediately refused this diagnosis emphatically responding, "Nah! There's nothing for me to be depressed about!" Despite her initial rejection of this label, Sal did see a

counsellor for a period of time which she states "...didn't work well," and began taking medication which made a "difference of night and day" for her.

Sarah also came to the identity through conversation. Sarah states:

When I initially realized there was something wrong with me...I was struggling just to kind of get myself going in the morning, and get myself into work, and it didn't have anything to do with the challenges that I faced in the day ahead, it was simply a kind of reluctance to want to get going. I spoke about it to a few people and someone said, 'you know, it really sounds like you're depressed, actually'. And this was someone who suffered and talked openly about his struggle with depression.

The label of depression, suggested to her by a colleague was met with a firm refusal from Sarah. Despite this reluctance to embrace the term, she did seek help from a medical professional and began counselling and medication.

For both Sal and Sarah, self-stigma was at the root their reluctance to accept a mental health label. These educators internalized negative messaging about MHI which created barriers in their willingness to access help (Corrigan, Druss, & Perlick, 2014).

Sal and Sarah identified that they associated the label with a great amount of shame.

Sarah explains that prior to her diagnosis, she believed individuals with MHI used this as an excuse for not working, and that it took time for her to develop "a more healthy attitude towards mental health."

Corrigan et. al. (2014) note that self-stigma impacts on help-seeking; Sal and Sarah did not identify with the labels that were proposed, and wanted to avoid association with them, which resulted in hesitance to seek help beyond their immediate resources. Despite their initial reluctance, the insight provided to them by their respective confidants helped them seek care.

Prompt: Life-Event

Dylan grew up normalizing her experiences of anxiety and depression, and it was a life-event that caused her to question the quality of her mental health. While experiencing post-partum depression and anxiety, Dylan realized that her regular coping strategies were no longer enough to get by. As she explains it:

Growing up, I just thought it was normal...Because my husband and I had many conversations about, like, I would cry for no apparent reason or I would just be so stressed out or I would clean the house and yell at him because his socks were on the floor. And now that I have my daughter and now that I have my son, it's just a whole whack of crazy and it's gotten to the point where I need to either, to put it bluntly, shit or get off the pot. I need to go get help because what I'm doing isn't working and even though I've tried to make it work it isn't working, and finally it was that realization that, if I can't take care of myself, I can't take care of my daughter.

While it had been normal for her growing up, relative to the new role of *mother* she was taking on, it became clear to Dylan that her 'normal' way of doing things was incompatible with taking care of a small child.

Dylan had what she described as a "light bulb moment" that changed her perception of her mental health from *knowing* that her coping mechanisms weren't working anymore, to *accepting* that she needed help. Though the national-level influence at the time was moving towards acceptance of MHI, the dominant influence shaping her attitude towards MHI while she was growing up was her family (Corrigan, Druss, & Perlick, 2014; Pesocosolido et al. 2008). In that environment, she learned and internalized the messaging that "you had to support yourself." In that moment of acknowledgement, Dylan was overwhelmed by the unknown:

It was a scary moment [...] the unknown, the 'now what?'. Where theoretically I can tell you exactly what I'm supposed to do?[...]part of my job as a resource teacher was to know all that stuff[...] so now it's: how do I apply this to me? [...] What's it going to look like for me? And where do I go so that people don't know me?

In acknowledging the need for help, Dylan began breaking down the layers of internalized stigma that she had collected over the years that taught her that asking for help was a weakness (Hinshaw & Stier, 2008), and she was able to begin the process of coming to terms with her mental health needs.

Prompt: Media

Media played a large role in how Quinn came to understand her MHI. Like other participants, she reflected on her upbringing and noted that her family's attitudes towards anything related to emotions shaped her beliefs that strong feelings should not be expressed (Corrigan, Druss, & Perlick, 2014). In discussing the *Bell Let's Talk Day*, an annual anti-stigma campaign for mental health sponsored by Bell Media, Quinn observes that the attention being brought to mental health is changing discussions about mental illness by making it more visible in a society where invisible illness is not taken as seriously as physical illness (Pescosolido et al., 2008):

Again, going back to what you can see and what you can't see. You know, you can see somebody who's walking with a cane, you can see someone who has a cast on their hand or a cast on their leg, or someone who's an amputee, or any of those physical things, you can see it. And I think we, as humans, are hard-wired that if you can't see it, it doesn't exist. And unfortunately, mental health you can't see.

Quinn notes that she worries about approaching a medical professional with her mental health concerns for fear of not being believed, despite the headway being made in the fight against stigma. In order to understand her MHI, Quinn uses alternative sources that do not require her experience to be legitimized by a doctor or mental health care provider. Using pamphlets and literature found in doctor's offices, personal online research, and online courses, she is developing an understanding of her current MHI, and how her

upbringing contributed to the beliefs about MHI that she is attempting to unlearn (Pescosolido et al. 2008).

Participants' initial understanding of MHI occur in a wide range of ways, each influenced by the normative rules that guide the individuals' social context. These examples illustrate the evolution of a mental health identity over time and the process of dismantling self-stigma. As teachers are understanding their MHI within their life, they also negotiate this identity within the context of their work. In the following section I examine the ways in which their understandings of their MHI shape their identity in the teaching profession.

NEGOTIATING 'MENTAL HEALTH' AND 'TEACHER' IDENTITIES

After accepting their mental health challenges, teachers are faced with the task of investigating what that identity means for them in their workplace. Many schools are in position to challenge the norms that influence mental health-related stigma (Kirby & Keon, 2006; Pescosolido et al. 2008). Despite school and board-wide initiatives, participants revealed that mental-health related stigma is still present in their workplace. Participants explained that considerable amounts of investigation were necessary to determine how a MHI would impact their identity as an educator. They found clues to assist with their assessment in the media, in people-oriented careers, and by observing their own workplaces. By comparing the information gathered about representation, reaction, and understanding of MHI, it helped them anticipate how they might be received if they were to disclose their mental health status at work (Jones & King, 2014).

MHI in Media

Teachers with MHI negotiate a double identity. Media informs public opinion of the profession and guides beliefs about MHI. Media has historically portrayed people

living with MHI as dangerous, violent, and unpredictable (Corrigan, Druss, & Perlick, 2014; Pescosolido et al. 2008). Teachers who identify with a mental health label are aware of these portrayals and how that might impact on the way in which they are perceived. In turn, this informs their understanding of what it means to be a teacher living with MHI. Dylan explains:

...you read in the newspaper and whatever all these people who have done crazy and extreme things out of stress and frustration, and then depression or other...it's been chalked up to other health issues that have been portrayed negatively in media. And then all of a sudden...you, you look at your profession and how it impacts so many people...and what is going to happen if that all kind of comes out. Is it going to be embraced? Is it going to be 'we need to support our educators?' or is it going to be 'we can't have these people teaching these kids...we can't trust them'?

Dylan's observation recognizes that stakeholders in education are influenced by the media, and that despite recent efforts to change the narrative that equates MHI with instability (Corrigan, Druss, & Perlick, 2014; Pescosolido et al. 2008), there is no guarantee that this shift in the national context has made any permanent change in the way MHI are perceived by the general public.

Sylvie explains that in addition to negative perceptions held about MHI, teachers are also scrutinized publicly based on their career. At the time of the interview, teachers across Ontario were engaging in job action. Sylvie commented that teachers were "not looked upon kindly," and that she had noticed an increase in degrading comments in public forums such as comment sections in online newspapers:

I kick myself when I make of, you know, I'd read an article of what seems kind of in our favour and kind of positive towards teachers, and I would go down too far and see the first couple of comments by people and go, [sigh] 'Oh really...that's really what you think?' you know? People who think we come to work at 9, we leave at 3:30...that whole, 'you don't even work a full 8-hour day', and think we do glorified babysitting, and you get the summer off, and you get time off at Christmas, and March break, and I wish people could see what it's

really like. And then to be able to understand...and even those people that do seem to be supportive, to be able to understand what it's then like for somebody who is struggling with a mental health issue.

Sylvie illuminates the challenge these overlapping identities present: if an educator is already seen by the public as enjoying privileges that most do not benefit from such as financial compensation and vacation time, and individuals living with MHI are often seen as being to blame for their illness (Corrigan, Druss, & Perlick, 2014; Pescosolido et al. 2008), a teacher struggling with mental health challenges might not expect empathy from stakeholders in education such as parents. Through media, teachers learn that should they choose to disclose, they risk judgment, given their awareness of the public discourse that surrounds both their teacher identity and mental health identity (Dewa, 2014).

MHI in People-Oriented Careers

People-oriented careers served as a benchmark for teachers in this study to gauge how a MHI might be accepted and respected in their profession. Aidrian and Dylan remark that certain careers would not be associated with MHI. Aidrian's understanding of stigma formed through her intimate knowledge of how mental health concerns are addressed in the military: her brother is enlisted and also suffers from mental illness. Aidrian has witnessed first-hand how MHI are seen as a sign of weakness and incompetence. Dylan expands on the difference between *people jobs* and others:

If my dad, for instance, who works at the plant, if he had to take a mental health day, he doesn't have to deal with the public, he can take his MH day, he gets as many sick days as he wants. But if I were to take mental health days, people would kind of start questioning: can I keep myself together? How organized am I in class? Am I affecting my class? Do I yell at my class? Do I cause them to have breakdowns of their own? Like...so, it's...it doesn't just affect me, my MH affects everybody. But if I were to come out and say 'I am severely depressed and have severe anxiety', they're going to doubt my ability to do my job because I deal with people. My job is people. My job isn't pipe fitting or pizza making or

fixing cars...it's people. So again, the same question would be would you...would you go to a social worker who has severe anxiety and depression?

By comparing jobs that require high levels of interaction with vulnerable populations and responsibly to their own career, Dylan and Aidrian are able to draw parallels and anticipate the challenges they might expect were they to open up about their own struggles in the workplace (Jones & King, 2014). The lesson that is learned through this critical comparison is that an individual holding a position of power and influence will not be regarded in the same way as a mentally well counterpart, and that their identity may be perceived as dangerous to those they work with.

MHI in Schools and School Boards

Teachers look to their own workplaces to learn about how their identity is understood by colleagues and educational stakeholders. Through observation and conversation, participants gather information about how identities similar to theirs had been received in the past. Casey describes the reactions she has witnessed at her school:

At work, say someone goes off on a leave because of mental health issues, they are labeled in the school, there is absolutely no way around that, and they are looked down upon, and they are not treated respectfully by teachers and also administration.

When asked to elaborate on this, Casey continues:

I know people who have gone off because they're not mentally well and...well, I mean, they weren't treated well when they were here...people would call them basket cases, they['d] use derogatory terms for them...people just aren't respected when they have mental health issues...and they're taken advantage of...they're not given the best work assignments when they come back.

Similarly, Alex reports hearing colleagues speak negatively of a coworker who was struggling to come back to work after taking a mental health leave: "It was an ongoing process with her where they tried to get back to work... and many times I would hear, "Ugh, she just needs to get over it or just quit." Paige comments on how disclosure of a

mental health condition could result in negative repercussions for a teacher's career. She states that giving school administration the impression that "you can't do your job properly [...] may affect the assignment that you are given the following year...they may overload you."

The construction of understanding of identity is not a fixed and static undertaking. Even for participants living with their condition since their youth, understanding of their identity develops based on societal changes that occur around them. As the discourse surrounding mental health changes at different societal levels, so does participant understanding. These understandings allow individuals to modify their identity management accordingly; however, the connection between mental illness and stigma so far remain fixed.

STIGMA

It's thinking less of someone because of something...who they are beyond their control

-Sylvie

Stigma is...it's like a mark that you carry around with you that might wind up working against you

-Sarah

I define stigma as stereotypes and biases...basically not embracing that this is for real, that this is an actual diagnosed disease

-Alex

We're afraid to say that depression is real, that anxiety is real, and that people have these things that we can't see.

-Quinn

Understanding an identity includes making sense of the way in which that it exists within the world. In the case of MH identities, nearly all participants connected mental illness to a definition of stigma. All participants directly or indirectly identified that in

their experience, MHI both in life and at work were linked to shame and judgment. Participants understood stigma in both abstract and concrete ways. Evident in the definitions provided by Sarah and Sylvie is the well understood and discussed notion of stigma as an attribute that sets an individual apart from mainstream society, and extends that understanding further to encompass the fact that this difference needs to be legitimized and recognized in order to be taken seriously. Quinn and Alex define stigma related to mental health in relation to physical health issues. Quinn, relates MHI-related stigma to an injury she incurred while at work:

Perfect example: when I had my fall at work I injured my hand and I also injured both my legs; the legs' injury you can't see. Whereas this [hand] has a physical thing you can see [arm brace]. And that's sort of how I relate it back: you can't see mental health issues, you can't see those things. So anytime someone sees me they're like, 'Oh, how's your arm doing? How's your hand doing?' cause that's the immediate thing people see, so it's 'real'...again, you can't see anxiety so it doesn't exist, you know?

Quinn's experiences of illness being perceived as legitimate by has impacted on the way in which she accesses help for her MHI. Quinn expresses that she is afraid to bring up her concerns with a doctor for fear of not being taken seriously and being dismissed as imagined because this is something that has happened to people she knows. In her experience, legitimate health concerns-the ones that are taken seriously both at work and in the medical field- are the ones that are visible (Hinshaw & Stier, 2008).

Frances echoes this sentiment while relating the process for taking a leave of absence. When applying for a three-month stress leave, Frances described her thought process this way:

I remember thinking that saying 'I'm on stress leave' or saying 'I'm too stressed out to manage' didn't seem like a good enough reason, so I would add diabetes as the extra reason because that is more justified.

Frances felt that this invisible illness, needed to be accompanied by a more visible health issue in order to be validated. France expressed the same fear as Quinn that without a more *justifiable* reason, she might be denied (Dewa, 2014).

This issue of *legitimate* illness is taken up by Sylvie and Casey as well as they discuss the difference between receiving treatment for cancer and treatment for a MHI.

Casey puts it this way:

So let's say if you had cancer, they would be *far* more understanding than if you had mental health because they would think, 'well you didn't ask for that, you don't deserve it, you didn't cause that', which I believe is *different*: I think how you've lived your lifestyle, or genetics too, but there's different causes for cancer, and I'm not blaming anybody, but it's no different for mental health: we're born with it or it happens in our life due to circumstances, so no different. There's far more compassion for accidents or disease than there is for mental health. People just... I don't know... there's still this huge stigma around mental health. They just don't understand it; they think that you're weak. And I don't know why.

Here Casey identifies that in both circumstances, nobody *asks* to get sick, both illnesses are caused by any number of reasons, but that in the case of MHI, there is a lack of understanding, which translates into less support for the individual suffering (Corrigan, Druss, & Perlick, 2014). Sylvie expands on the reasons why the two illnesses may be treated differently:

Something like that [cancer] is easy to get behind and support because that's...that's *really* scary. Like you hear that and it's like, that's life or death. And I know that for some people struggling with mental health it's life or death, too... when it's something like cancer, it's like, 'OK, this person can't help it, they *have* to go get treatment' somebody else is the one who has to fix it. Whereas I feel with a mental health issue you... it's not going for chemo treatments, you're not going for radiation, there's nothing to see that's wrong with you, and it's not like you can say, 'somebody else has to fix this for you, you can't fix it yourself'. Whereas with a mental health issue there is a component of yourself to fix it. You may need help fixing it, but I mean, if I have cancer, I can't fix cancer.... you've seen people go through it. You know: it's going to this to your body, and it's going to be tough, and so you know, 'you're not going to be able to make dinner, so I'm going to make dinner for you.' Whereas when it's a mental health issue, they don't know that you can't make dinner tonight cause all

you want to do is be curled up in a ball. And I don't think that it's necessarily that they don't want to be kind, but they don't understand. There could be other people hiding it, like me. But it's harder to understand than, 'You need to go for chemo treatment, you need to go for surgery.' and have the doctor fix it for you. You can tell them, 'yes, you have to be strong and you have to fight', 'Yes, I have to try and keep a positive attitude' but really the doctor has to take care of it for you, right?

This shows the way two life-or-death situations are dealt with, and it comes down to an attitudinal stance, a question of fault and judgment (Corrigan, Druss, & Perlick, 2014; Hinshaw & Stier, 2008). Sylvie expresses that an illness like cancer carries with it the understanding that nobody *asks for it*, whereas for a MHI, it is a personal flaw or weakness, which has resulted in the deterioration of their mental health. In identifying the 'responsible party' for fixing the health issue, Sylvie highlights how the comparison between cancer and MHI comes back to the prevailing assumption that mental illness *is* within the scope of an individual's control, and that 'failure' to manage it is an indication of personal weakness (Corrigan, Druss, & Perlick, 2014; Hinshaw & Stier, 2008).

Ultimately, for teachers one specific quality of stigma was identified as being linked to the profession, that of competency. Several teachers expressed that were they to be honest about their mental health, it would reflect poorly on their ability to teach. Sarah explains the risks she perceives in disclosing MHI:

You never know if a principal is then going to turn to other people and say, 'Well there are things that I know about Sarah that you don't know and perhaps she's not the person that we should give this responsibility to, or that responsibility to.' I think there are still a lot of people, and I mean I was one of those people when I was younger, that do judge people who struggle with mental health issues very harshly.

Jenny: So if we're thinking about teachers and mental health, what kind of stigma, if any, do you think would be attached to teachers who live with mental health and addictions issues?

Sarah: Well, I suppose it's because we are entrusted with kids, right? And so parents want to know that they are leaving their kids with people who are fully in control and not dealing with struggles of their own. And you know, I have worked with people who have struggled very openly with mental health issues and have had to take repeated leaves and stuff like that, and there is gossip about those people behind their backs, and eye-rolling and things like that, and you just don't want to be *that* person.

Dylan elaborates on this, making the connection between media, public opinion, mental health, and the ability to teach:

Right now already we don't have a lot of public support just based off of the things that were going on in September and the strike positions and all that stuff. Like, we are painted in a very negative light. Our union, our profession is not in the best political and public frame of mind. All of a sudden if you were to add in the complex idea of MH issues I am sure we'd get a lot of people saying that we're incapable of teaching their children because all of a sudden I'm going to just pull out a fire arm and shoot everybody or I'm going to have a mental breakdown and it's going to impact my whole class, or it...The same rules don't apply.

Dylan ties the creation of stigma through the media and to how people learn that individuals with MHI shouldn't be trusted with children and applies it to how that might impact on how teachers with MHI are viewed (Corrigan, Druss, & Perlick, 2014; Hinshaw & Stier, 2008).

Several participants spoke about stigma as a matter of degrees, suggesting that in general some MHI were more likely to be accepted or embraced than others. Frances suggests that more complex MHI such as bipolar disorder or schizophrenia would be more difficult to admit to in a work setting. Sarah further discusses the stigma associated with addictions issues which also qualify as mental illness: "Like it's *that* much more acceptable to be talking about your mental health struggles than to say, 'I'm teaching kids and I have problems with alcohol,' or 'I have problems with drugs'". Identifying that, as a society, certain MHI have attained a level of acceptability, and others are more

stigmatized, particularly in a setting where an individual's job is to care for young people (Link & Phelan, 2001).

What the data in this section illuminates is that teachers form their understanding of their identity by drawing from a number of sources, which collectively inform how they come to understand themselves as professionals and individuals living with MHI. Their understandings, in turn, impact on their *identity management*. The ways in which teachers reported managing their identity at work will be explored in the following section.

STIGMA IDENTITY MANAGEMENT

Identity management at work encompasses a wide range of strategies and purposes. Different teachers have different strategies that serve different purposes. Through the interviews, a number of strategies emerged as common between participants. These were concealing, signaling, and revealing strategies (Jones and King, 2014).

STRATEGIES

CONCEALING

When teachers wished to keep their MHI separate from their workplace, they employed *concealing* strategies (Jones and King, 2014). Though these strategies were discussed in many ways, they tended to fall into two broad categories: 'locking it down', and the 'teacher persona'.

Lock it down

When referring to their ability to exert some control over the symptoms and experiences of the MHI in order to prioritize the classroom needs, teachers spoke about 'locking it down'. For set periods of time, Chris and Aidrian both find that the classroom can provide relief from their experiences of their MHI because the school and classroom

environment actually provide them with the stimulus they need in order to do that. Chris explains:

I'm really good at hiding it and I can...as long as I can focus...like when I'm in the class I'm so focused on my teaching on the lesson, on the students, and on...I'm so busy working with them that I don't have time to think about it. And so, unless it's been, like, I'm exhausted and it's been a rough week or something...then maybe I'll...I might be a bit grumpy or then it might come out a little bit. But for the most part I can control it enough because I'm busy

Aidrian concurs:

I think if you asked my colleagues at school, they would have no idea that any of this was going on. So I feel like school is the one place that... I go, I go through the motions, I plan, I teach, I put my 110% in... and then when it stops, then I start to think about everything else I have to do...so I think that the school part is the thing that keeps me sane.

This strategy of hiding serves the dual purpose of helping them cope with and allowing them to continue “weighing the costs and benefits of disclosure to inform the ultimate decision to reveal or conceal” (Jones & King, 2014, p. 1474).

Teacher persona

For other teachers, it is a matter of putting on a different hat and stepping into their job not as themselves, but as an actor playing a part. Quinn and Dylan frame this separation as a matter of professional responsibility. Quinn explains it like this:

as a teacher in elementary, you are an actor on a stage basically. You know, I have to go in there and I have to um, I have to pretend to be happy, and I have to pretend to be excited about things that I probably am not very excited about. Because if I'm not, then the kids are going to pick up on that and it's going to make it a horrible day for everybody. And at the end of the day, I'm being paid to do a job; as a professional I have to do that job.

Dylan expands on this saying:

I'm at work. This is my job. My job is to function and to control a classroom of 26 kids that are going through puberty...Um, each kid brings their own issues from home. We all bring issues from home. I just have to be the adult and push past mine to help them because they can't, or they're trying. So I'm supposed to be functioning, and to be able to deal with my own crap, and leave my crap at the door...but who can?

Other teachers refer to this strategy as “the happy face”, which suggests putting on a mask in order to conceal the underlying struggle. Sarah clarifies that, similar to Quinn and Dylan, this strategy is used to uphold a professional image that she feels would be tainted if the mask were to slip:

Well I supposed it’s just, again, I want to look like everything’s ok in front of everyone [laugh]. I want to look like I’ve got total control when I’m at work. My principal last year for example, when I went to him, he had no idea and was quite shocked that I was dealing with all this because I think I do... my exterior is that everything is ok, everything is great.

In concealing by separating the real person from the teacher persona the teachers feel better able to fulfill their duties, but unwittingly contribute to the propagation of a stigma that they feel trapped by. The stigma that equates MHI to being ‘unprofessional’ is rooted in the belief that people struggling with their mental health are unreliable (Dewa, 2014; Pescosolido et al. 2008). By ‘wearing the mask’, this belief remains unchallenged, and the myth of the mentally healthy professional endures.

SIGNALING

As noted by Jones and King (2014), signaling was a prominent strategy amongst participants as a way of gauging how revealing a MHI might be received by their colleagues. Participants spoke about the careful observation and the ways in which they use conversation as a precursor to revealing and concealing (Jones & King, 2014).

Sal describes how the process by which she gathers information that which helps her analyze situation and establish whether or not she can trust a particular individual. Sal remarks that the trust required for her to disclose her MHI to somebody can take years to establish. In order to build trust she “feel[s] the water first”:

...for example we may be talking about a TV episode or even a child... How sympathetic are they to that student? It tells me a lot about them first of all,

because if they're going to degrade the student, then that tells me a lot too. So it's how they approach others, and how they...how they react to things as well.

By broaching topics that require a certain amount of empathy and sensitivity to deal with, Sal makes certain assumptions as to how others might respond to her disclosure.

"Feeling the waters" also involves observation in her workplace to determine how accepting coworkers and supervisors to be (Jones & King, 2014). This hinges on taking a passive, observer role, and listening the ways in which people interact in a casual work context, when they do not feel they are being watched or judged:

Jenny: So then alternatively, how do you know who not to disclose to, like, what would be the red flags for you?

Sal: I listen. I listen to what they say. The staff room...I don't go there very often...I usually go there with a purpose...either to eat or to learn something. So if a new staff comes or new principal, I listen, because if they are going to talk about others in the staff room, or to others about others, then they're going to do it with me to others. So that's a big indication for me. I also listen to what they say, you know, about students... you know, are they going to pre-judge students, are they going to say 'Oh well you know, that's John Smith and I taught his sister and blah, blah, blah, blah, blah...' are they going to compare that? That tells me a lot. Cause it's my belief that everybody's different...I don't want to be compared to my brothers...so yeah, I listen. And then I watch too, I watch how they interact with others.

By silently observing, Sal is able to determine which of her coworkers would be likely to respond in a positive way to her should she choose to disclose.

Similarly, Sylvie discusses a process she refers to as "read[ing] people". Like Sal, Sylvie makes use of observations to decide on her course of action for revealing or concealing. In this example, she describes how a colleague's experience informed her decision:

Sylvie: And I have spoken to somebody who...she's an itinerant teacher here and works with us, and she divulged to me that she herself, she actually had a breakdown at work... she really had to... she said, really almost get in the face of the principal...I guess whatever happened, happened at school, and so that put a

bad taste in the principal's mouth towards her and her ability to do her job. And so I'd always had, kind of, that fear that there's people out there like that, that would hold that over you.... And then to hear that, you know, and I mean she's wonderful and she has herself under control. And she did get the principal to realize that she was better.... But I don't like confrontation, and I would hate to have it come to that with anyone. And that current principal...I don't know, she's new... I'm still reading her.

Jenny: Can you tell me about how you read people? You said that with the previous principal...

Sylvie: She was easy to read because she wore her heart on her sleeve. Like, she would do anything for anyone...any kid here at the school, any staff. I mean if you had a problem with your kid, you had to leave, you know, half an hour early, she would make sure your class was covered. Where our current principal you know that that's not the case, no. 'You're here at work you will be at work until this time.' And not that people are asking to be off, you know? But... our previous principal, she would go into her own pocket to provide money for families for things they needed...she was easy to read! Very easy. This one...harder...harder to read. More by the book.

Sylvie described how the actions of the two principals speak volumes as to what

she can expect from them in terms of support should she choose to disclose her mental health status.

By using these signaling strategies, participants are able to anticipate to some extent the reaction they can expect from their colleagues, and adjust their identity management accordingly (Jones & King, 2014). Ultimately, participants agreed that the relationships they had with an individual were the most important factor in deciding whether or not they revealed their MHI. In relationships with administration and colleagues, a person's capacity for empathy and trust featured as essential characteristics in selecting confidants (Jones & King, 2014).

REVEALING

In revealing, individuals willingly disclose their mental health status. Though this was not a common identity management strategy amongst participants in this study, Alex and Frances talked about the ways in which they chose to reveal. Alex and Frances

discuss how this is not a strategy that they engaged with lightly, but rather was years in the making. Frances explains:

I would be open with most people and... I wouldn't have been so much in the past, but now, I'm so sick of bottling it up and pretending like it's all hunky-dory...that it's almost like I don't need to be probed too much, like I'll just tell people. And if I feel that it's appropriate, I'll mention it. Not too much, you know. I don't want to be like, 'Oh, there's Frances, going off again...', but I don't want it to be not talked about anymore.

Likewise, Alex asserts that:

I'm very, very open about it because I feel that I'm not going to hide in the closet about it and I think it's ok to say, 'Listen, I'm not having a good day.' Or um...I think it just makes people more aware or maybe why some things happen, or if I am away...and I have no problem saying, 'Ok, I just need a break.' And I'm very open with people to say... and I encourage them when they are at their breaking point, 'You know what? You just need to take the day off tomorrow.'

Being vocal about their experiences opens a door for communication between the participants and their colleagues. Their openness challenges notions that people with MHI are victims to their illness (Link & Phelan, 2001), and highlights the agency that is inherent and vital to changing social norms (Corrigan, Druss, & Perlick, 2014)

PURPOSE BEHIND STIGMA IDENTITY MANAGEMENT STRATEGY

The choice to conceal, reveal, or signal is accompanied by a reason for that particular strategy. As Jones and King (2014) suggest, the choices were made consciously to manage perceptions or access social support. Participants also used identity management for a reason not mentioned by Jones and King (2014): in order to challenge stigmatizing behaviours that they witnessed in their workplace.

Managing Perceptions from Others

Casey outlined the ways in which her MHI impacts her relationships and duties at work. It is this awareness of forgetting things that prompted Casey to begin selectively disclosing to coworkers she worked directly with:

I didn't start letting people know until probably quite recently... probably with the pre-menopause, it felt like everything was getting a little bit harder and I felt like was making more mistakes... But it got to a point where I wouldn't even be aware of it and then I'd realize that I'd forgotten to do something, did it wrong...wrote something down wrong, which...people are *very* critical in education. People are *extremely* critical ... I realized that part of it was hormonal changes—which I cannot control for without taking medication, which I refuse to do, and I won't for the ADHD either—coupled with, you know, just getting to know myself better, and realized, 'You know what? I'm doing the best I can, and people just need to understand that.'... I started sharing with a few people because I cared about them and I wanted them to know that it wasn't forgetting or being disrespectful of our communication that I didn't do something, it was just that sometimes I forget.

Though Casey says that, as time goes on, the way people perceive her bothers her less and less, she still feels that her disclosure can be viewed as an excuse by some and states: "I don't think it increases respect for a person. I don't feel more respected because I've shared it."

As a supply teacher, Chris is working his way towards a contract position which he can only get with the recommendation of a principal, he states: "your career rests in the hands of others: it doesn't matter what you do, it's how you are perceived." Chris opts to conceal his MHI in certain situations in order to manage the way in which he is perceived as a professional:

For the lowly supply teacher... we're disposable...so this is the thing, if there's even just the slightest hint of something, they'll [administration] just pass on you and take somebody else cause there's 400 other people that want to take your spot... you know, you can't be...you're a risk, right?... everything has to be perfect all the time, cause if it's not they'll pick somebody else. And whether or not it's perfect has nothing to do with you, it has to do with how you're perceived.

In his early career, his anxiety was exacerbated by the pressure related to the uncertainty of how he was being perceived by administration, and this caused him considerable physical illness (Jones & King, 2014). The pressure of constantly concealing his MHI,

paired with a sense of constantly being observed and judged contributed to the deterioration of his mental health.

Establishing Relationships

Identity management was used by participants in order to establish relationships that led to supportive networks. Dylan discusses the development of a trusting relationship with a colleague which began as a conversation about physical health issues:

the guy across the hall [...] he'd talked about the fact that he was going off on surgery, and this was in September last year where I just started meeting people, I just started working here. And I said, 'Oh! Well how long do...is it, is it serious? I hope it's not serious...' and at this point he's like...well, he started talking about his heart and I'm like 'Oh, is it heart surgery?' and he's like, 'No, it's for my butt.' And I'm like, '...oh'. He's like, 'Yeah, I have this anal fissure...' and I'm like, 'Ok! Enough, friend, cool?' And then, my husband had the same issue. So we had, all of a sudden, we had the weirdest connection. And at that point, when you're talking about your own ass *anything's* open!

Bonding over a 'weird connection' and a topic that may appear to be socially unacceptable at work, Dylan felt safe to disclose her mental health concerns with this person, and is now able to have honest conversations person-to-person, and feel supported at work.

Challenging Stigmatizing Attitudes

Finally, identity management was used by participants to respond to and disrupt stigmatizing attitudes towards MHI that participants noticed in their workplace. Alex spoke about how using examples from her own experience allowed her to educate her colleagues and halt stigmatizing behaviours:

I will often times use myself as an example and they back right up. They back off because it's now putting a person to it, it's not just something that's out there, it's, 'Woah, now so-and-so...you're right. They *do* have depression or anxiety' or 'they *do* have schizophrenia' or 'they *are* transgender'. And quashing it before it gets going any more, and having that courageous conversation. I truly don't believe that anyone intends to be rude or ignorant, they're just not educated, or they lack empathy, and they just don't have the tools.

Alex identifies harmful comments not as something rooted in malice, but stemming from a lack of education. She has the opportunity to trouble preconceptions and biases by taking the idea from abstract to concrete by using her own experience to challenge stigmatizing notions. By having what she terms *courageous conversations* she hopes to prompt people to interrogate their own biases and becoming more knowledgeable and “educating yourself on a different level than what you’re doing.”

Frances has also revealed her mental health status to a colleague with the intention of prompting them to rethink their stance on stress leaves. In one instance, she confronted a coworker who was speaking negatively about another teacher who was taking a stress leave. At that point, Frances was on a reduced timetable as part of her own stress leave, and addressed her colleague in the following way:

Well, I’m on a stress leave, that’s why I work four days a week.” And he says, ‘Yeah, but you have diabetes.’ I said, ‘So it’s ok to be stressed and have diabetes, but not just to be stressed or have issues like that?’

Frances believes many people assume that her leaves are related to diabetes, but clarifies “if anyone’s ever asked me, it’s not the diabetes. It’s maybe a little part of it, but not the main part.”

These examples of challenging stigma are not done haphazardly. Alex is an active member of her teachers’ union and feels well protected by it, and Frances’ excellent relationship with her current principal helps her to feel confident that she is supported (Jones & King, 2014). Revealing can be a very powerful tool in addressing stigma in the workplace, but the appropriate supports need to be in place for that to happen with minimal negative impact to the individual who is disclosing. These participants are quite willing to come forward, but as mentioned previously, revealing is

not an all-or-nothing situation (Jones & King, 2014); there are still instances in which Alex and Frances engage in different forms of identity management depending on the context in which they find themselves.

IMPACT OF IDENTITY MANAGEMENT

The impact of identity managements is both personal and professional (Jones & King, 2014). In negotiating their identity relative to their past, present and future, participants reveal the ways in which they experience the outcomes in their lives.

The decision to conceal by *locking it down* or adopting a *teacher persona* takes a toll outside the workplace. In the experience of Dylan and Casey, the trade-off of using concealing strategies at work spills over into their family life. For Dylan uses this example to demonstrate how concealing at work affects her home-life:

...as a teacher in the actor sense I can pretend to be flexible, I can joke it off, I can say 'it's ok!', and I move on because I can act my way out of it. Whereas I compartmentalize it and release it all at home. So when I go home tonight, I'm going to tell my husband. 'this shit doesn't work, I now have to deal with *that* pile of crap'...and then I just explode. Whereas here at work I'm like 'Oh! My Smartboard doesn't work! That's ok!'. And, so, the kids don't[...]actually see the true anxiety part to it because it is all compartmentalized for home.

Dylan reveals that the cost of concealing her MHI at work does not simply have an effect on her attitude towards her job (Jones & Kind, 2014), but spills over into her personal life because the pressure of hiding has to be released. For Casey, concealing means spending additional time at work in the evenings in order to proactively organize herself so that her MHI remains invisible:

I set it up with my wife that I work late... I was working late. I was working late one time a week I was working late until midnight, so it would give me peace and quiet so I could just organize stuff and that would help me with my anxiety or just give me more time... that's what I need.

This strategy that allows her to perform more efficiently at work has ramifications over the summer as well: “And last summer I came in, I was in probably for three weeks, but that’s my time... that’s time with my kids...they’re in day care, they’re getting older and I don’t want to do that again, you know?” While identity management at work would suggest that the impacts are confined to the worksite (Jones& King, 2014), Dylan and Casey illustrate how these strategies have real-life implications for them beyond the walls of their schools.

To understand the importance of identity management in her life, Aidrian reflects on a time when signaling and revealing could have helped her access social support. While completing a Master’s degree in education, Aidrian and her colleagues waited almost until the end of the program before opening up about their MHI to each other:

...it had never come up before, and the reason it did come up was because there was a principal doing a presentation as to why he had stepped down from the principalship. And it wasn’t until he was like ‘this is my story’ that we were all like ‘Wow, we’re all in the same boat’, and we had done our Master’s together for almost three years before anybody brought it up. So we were pretty close friends. It was a room full of principals and vice principals and seasoned teachers who were all very professional and respected in, in our area, and we’re all just kind of blown away at ‘we’re all in the same boat, but nobody has ever said anything’. Maybe if, if that had come up earlier, then maybe that principal wouldn’t have been in that position. Or maybe if I was more comfortable asking for help last year, then I wouldn’t have had to go back, um, on medication. Or maybe if I was OK and I had gone to see a therapist I wouldn’t be back on medication...like, you know what I mean?

Implicit in this reflection is a commentary on how identity management, both experienced and observed, may in the moment influence a decision to conceal or reveal, but that these experiences do not predict with any certainty whether or not an individual will later be able to apply that to their lives. Following the principal’s revelation, Aidrian experienced a moment where she too was able to open up (Jones & King, 2014);

however, this feeling did not last and conflicting narratives of internalized stigma later inhibited her from seeking help.

Revealing can have a deep impact on changing the culture of a workplace, but it has important consequences on the career and personal life of the stigmatized individual. Frances, for example, has been quite open about her MHI at her current school, however she wonders if it is affecting her ability to be hired at a different school now that she is looking to transfer out of her current position. Frances took a three-month leave of absence to take care of her mental health, and has also had a reduced workload. In the paperwork for her leave of absence, she notes that it does not specify what kind of leave is requested, but that it would be simple enough in her small community for administration to discover the reason.

I went to my principal in the fall of this year and I said, 'Well, because I've taken those three months off and the last two school years I've done four days a week, is there... does another principal, who my name can come to... if they're looking to hire me, do they know, can they know that I've taken a stress leave?' She said no. And I said, 'How would they not know? Don't they have access where they can go and look at my file and see that I've not worked that much?' Because this guy, so his wife is a VP at another school, he says that they can, and that's probably why I'm not getting jobs. And I said, 'Well, (principal) says they're not' and he said, 'I don't believe it.' He said, 'They can find out if they want to.' So I'm wondering if I've screwed myself over now by having leaves.

Frances worries that in accessing support she will draw attention to her MHI and potentially cost her a job transfer. Frances has expressed that if she cannot move into a different work site, she is considering leaving the profession. Frances' experience illustrates how identity management is not fixed but ongoing (Jones & King, 2014), and in this case Frances feels that the choice to reveal or conceal is no longer hers to make; Frances states that her work history may cause administrators to speculate as to the reason for her leave, and seek out answers covertly.

Chris encountered a similar situation involving career implications of revealing his MHI at work. Chris was denied a recommendation for contract work after completing the New Teacher Induction Program (NTIP) because he was being “evaluated on his mental health” and not on his teaching ability. Chris had revealed to his NTIP mentor teacher that he was experiencing anxiety, depression, and “sometimes wished [he] was dead”, despite feelings of distrust towards his mentor. The mentor shared this information with the principal without Chris’ knowledge or consent, which resulted in Chris being dismissed for a day. At the end of the year-long LTO, Chris found out that he was not being recommended for contract:

...he [administrator] said, ‘Oh well you know, she [mentor] had some concerns about your mental health.’ And I said, ‘Well first of all, she’s not allowed to talk about me, and second, you’re not allowed to evaluate me on that, period.’ But he wouldn’t back down and he said he’s going to do me a favour by just not completing my evaluation. He had everything typed up and he hadn’t hit ‘submit’ yet, and he was just going to erase it and we could just move on, and my record will be blank, then I can just get an LTO the next year, but he’s not going to recommend me for a contract cause he doesn’t feel that I’m ready because of my mental health and because of [teacher] complaining about me.

Chris pursued this matter with the union, and when he presented the principal with the information he had gathered, the situation escalated.

...he basically ended up blackmailing me. He said, ‘What do you want from me?! You’re not satisfactory! I’m not giving you a satisfactory!’ I said, ‘I want you to evaluate me based on my teaching. You’re only allowed to evaluate me based on my teaching. This other stuff you can’t do, it can’t be included.’ And I said, ‘I talked to these people at the union, and they agree.’ So he says ‘You called the union on me? You come in here and you threaten me?’ And I say, ‘I’m not threatening you, I’m just saying, I talked to these people and it’s true, this is the way it works.’ And so I said, ‘I’d like you to evaluate me based on my teaching, and if not, I’m going to have to leave, I’m going to have to call my union Representative, and we’re going to come back and have a talk with her present.’ He said ‘Are you threatening me? You come in here and threaten your boss? Threaten your principal?’ and I said, ‘No, I’m not threatening, I’m just saying this is the way it is.’ And he said, uh...and he just started screaming at me and he said, ‘You think I’m afraid of them? You think I’m afraid of you? You think I’m afraid

of [union member?]'...He says, 'I got everything right here on the computer, see? All I gotta do is hit 'submit'. So you go ahead, you call the union, and I'll hit 'submit' and give you an 'unsatisfactory' and then you got that black mark on your record. So you think about what's best for you, you think about what's best for your family, and for your career. You call the union, and I'm hitting 'submit', and you're unsatisfactory and that's on your record. But if I don't hear from you by Tuesday—I'm here until Tuesday afternoon—and if I hear from the union before then, then I'm hitting 'submit'. If not, then I'll erase it, and we can just move on and you can hopefully get an LTO next fall.'

At the time of the interview, Chris was about to start a new LTO and was proactively planning a way to secure an evaluation of his teaching as soon as possible and was not pursuing any action with his union. Chris' experience of revealing has caused him to rethink disclosing his MHI at work and would advise new teachers to "Keep your mouth shut, just because it could be the wrong person...I had a principal try to use it against me [...] it had no bearing on my teaching ability, my kids loved me."

Sylvie's experience with revealing her MHI has caused her to think about her future in relation to accessing medical insurance. When applying for a family coverage through her work, she filled out the forms honestly, including information about antidepressant medication that she had taken in the past:

Before we had children, we were both just paying single benefits, didn't make much sense to pay more to have each other covered for what we needed. But once we had kids my husband started to pay for the family plan, and then eventually I did as well, which means we put each other on each other's plans so we have access to the same thing...like double. And normally there's no issue, you say, 'This is my spouse'. There were no major health concerns, but when *he* first switched his to family coverage my daughter obviously went on right away, being a baby no problem. We put the paper work through for me and I was honest and said I had been on Effexor, and then they wouldn't...I had to be off of it for at least three years before I could reapply.

Based on her mental health history, the insurance company sent her a letter informing her that she was being denied coverage on her husband's plan. Eventually she was added to

her husband's plan which now gives her access to increased mental health supports, but has caused her to question how this will impact her after she retires from teaching:

I'm already covered under my husband, but it worries be about in the future, you know? When I'm retired and I'm not getting the board plan, will I have issues because I am or was on it... I don't know what the thinking is, if it's because people go on them and stay on them and that's a lot of money going out constantly...or if there's concerns about other health things because of it... so what if I'm going on it now...I don't retire for 20 years. What if in 20 years I'm still having to be on this to keep my brain balance or whatever, and now I don't have the benefits coverage that I had while working and I have to get something else...is that going to cause a problem?

Alex's experience with being open about her MHI lies at the other end of the spectrum: for her, embracing the label of depression and anxiety is a way to access the supports necessary for her to do her work as a teacher and union member. She states:

...those labels are necessary sometimes to get the added help that is needed. It hasn't done me any harm whatsoever knowing that I have a diagnosis of depression and anxiety... And depending on the situation, I have a doctor's note saying that when I attend ETFO functions I can have a single room accommodation. I don't use that unless I'm going to a function that nobody else I know is going to, so I can't room with them. And that's the *only* time I use it for my own anxiety.

Alex acknowledges that accepting labels and "coming out", as she puts it, can feel scary.

In doing so, she acknowledges that she is more open to having allies who truly understand her at work:

I think if you're... I'm open about it, I'm medicated, I'm... I'm stable. If I went off that medication, that stability is gone. If I lost my social network, that stability is gone. So having that balance... if I didn't tell anybody about it, I might have that social network, but it is not the same social network, I am not going to come out to them. I may not be on meds, and therefore not on meds: I'm not functioning. So being out and open about it allows me to go to that doctor's appointment and to be able to say, 'I don't feel well, this is what is happening.'

Alex identifies that stability comes from a number of sources for her, and that removing one destabilizes her overall well-being. In Alex's case, revealing her MHI is

crucial to ensuring that she is able to do the work that she is passionate about and be healthy. Although Alex recognizes the stigma associated with MHI and the potential risks involved with coming out, she is also well educated in the policies and social supports available to her (Jones & King, 2014). As a result, she is able access support for herself and for her colleagues in her role as a union member.

Conclusion

In this chapter, I examined the ways in which participants made sense of their experiences of MHI, and constructed understandings of the related stigma as it relates to their profession. By way of investigating the normative influences in their lives, teachers developed an understanding of their mental health identity in a professional setting. This continuously evolving understanding in turn influenced their identity management. The process of concealing, signaling, and revealing was recognized as an ongoing process requiring careful calculation for participants. This chapter also drew attention to the tangible implications of identity management such as negative impacts on teaching careers, as well as barriers and benefits to accessing support, for educators.

CHAPTER 5: DATA ANALYSIS: CHALLENGES, LESSONS, AND CHANGE

As shown in the previous chapter, the teachers in this study understand and experience MHI differently based on factors that are learned through societal influences. The ways in which they understand and experience their MHI have practical implications in their lives. In this chapter, I discuss the lessons and challenges that have been gathered from participant responses. Additionally, the overarching need for attitudinal and structural change identified by teachers is examined. The insight provided by the insider-perspective of these teachers allows for an in-depth exploration of the operation of stigma in the education system, and the tensions faced by teachers living with MHI as a result.

CHALLENGES:

Teachers identified a number of areas that presented challenges both in structure and attitudes surrounding the negotiation of MHI identity at work. Specific challenges included the inconsistent mental health discourse in boards and schools and issues surrounding organizational support. This section explores how these barriers and tensions affect teachers' work and lives.

Inconsistent Mental Health Discourses in Education

Participants identified inconsistencies in the ways MHI are discussed and addressed in educational settings for students through their experiences negotiating their MHI at work. The teachers interviewed observed major gaps in the ways that teacher mental health and student mental health are approached and addressed. Participants commented on organizational supports, and the way in which they actually undermine feelings of acceptance for teacher mental health, and further promote identity management that impacts them negatively. Many participants discussed initiatives and services aimed at student mental health, and described the ways in which they work to

support, educate, and reduce stigma associated with MHI in order to promote student wellness and encourage help-seeking. Participants stated that this level of understanding does not necessarily extend to teachers, and that compared to initiatives for students, the services offered to teachers appear minimal and insufficient. The difference in school boards' messages and actions directed towards teachers and students reinforces the notion that living with a MHI requires careful management of that identity.

The discourse for student mental health in education is influenced by numerous macro-levels contexts (Pescosolido et al., 2008). The result of these converging influences that simultaneously advocate for awareness and open dialogue about MHI is well illustrated in the initiatives present in schools and boards across Ontario. Student-oriented mental health initiatives described by participants varied depending on student age. Elementary initiatives focused on students' social-emotional development, and those at the secondary level tended to explore mental wellness, support, coping skills, and help-seeking. Individual teachers took up mental health-related topics in their classrooms in a number of ways. At times they were explicit about talking about mental illness, other times they focused on building social-emotional skills with their students. In secondary schools, teachers saw more targeted programming such as student support groups, meditation clubs, and mental health awareness week programming that corresponded with *Bell Let's Talk Day*.

In addition to school-based programming, students also have access to social workers, school nurses, guidance counsellors, school psychologists, and community supports, although several teachers noted that these resources were not always timely supports for students in need of immediate help. Casey described a shift in student

awareness regarding mental health over the course of her career where students are becoming more aware of signs and symptoms of MHI. In her experience in guidance, she has noticed that students are more likely to come forward and ask for help:

So for the six years I've been in guidance so in the first three-four years they wouldn't do it as much. But in the last couple years they're more willing to help out their friends or themselves...come and talk and seek help. So kids are much more likely to try and seek help than they used to be. So I think that's really helping a lot. So it's a good thing, it's a good thing the school board has done by raising that awareness, now they just need to do it with their staff.

Many teachers shared the sentiment that the steps being taken by school boards to foster an environment of understanding where students can access the help they need is a very important step in ensuring wellness of student populations. When discussing mental health initiatives, teachers observed that initiatives are subject to educational trends; when the momentum from the board moves on to a different topic, so do the resources and burgeoning projects. Participants related that teacher mental health is still a topic around which there is silence, particularly in contrast to the very visible effort for student mental health. Teachers reported that amongst staff, the topic of mental health is not openly discussed: instead of discussing mental health with specific vocabulary, the code word *stress* is used as a catchall. Sylvie relates that *stress* covers any number of struggles that her colleagues face, including mental health struggles, but that specific challenges are never talked about in the open. This silence works to reinforce a binary of 'acceptable' and 'unacceptable' challenges that a teacher may express without running the risk of appearing as though they are unable of managing the duties that their position requires.

Programing for teachers depended on the school and board. In Paige's case, the school board supported mindfulness programming for teachers, two other participants

reported that their schools provided lunchtime yoga, and yet others did not have any programming of which the participants were aware. For the past two years, Frances' school has had a Wellness Team, an initiative started by her school board. In every school, the Wellness Team is headed by a Health and Wellness Champion. Frances stated that upon first hearing about this project she felt frustrated because she felt that it wouldn't "be touching *true* mental health". In her opinion, the Wellness Team should be able to address more complex MHI that occur independent of the workplace as well as those that emerge as a result of work. Frances states:

All that changed was that a little bulletin board in the staff room was the health and wellness bulletin board and recipes started going up, coupons for working out at places, or the ski resort [...] they'll have a special day for teaching families

Though this program strives to be a proactive mental health strategy by providing resources to teachers (Dimoff & Kelloway, 2013), in Frances' opinion it falls short as the program does not explore mental health topics that are relevant to her experience. Many teachers noticed a focus on wellness and on individualized responsibility for coping with mental health, but not on in-depth solutions for individuals with struggles more than general stress.

Issues with Organizational Support

Perceived organizational supports significantly contribute to the identity management path an individual will choose at work (Jones & King, 2014). Organizations can communicate their acceptance and support in a number of ways, for example by including policy that facilitates disclosure of a stigmatized identity, thereby creating an environment that is psychologically safer (Jones & King, 2014). Preventative supports can also be put in place in order to encourage employees to seek help for mental health

challenges (Dimoff & Kelloway, 2013). The Employee Assistance Program (EAP) is an example of one such preventative resource that provides teachers with access to counseling and other mental health supports such as literature (Dimoff & Kelloway, 2013). The EAP signals that the organization and supervisors are supportive, however participants described how the operationalization of the service leads them to feel at times unsupported and isolated in their experience of MHI.

The EAP was a valuable resource to many teachers in this study but also presented barriers. The challenges associated with accessing the EAP was interpreted by many participants as an indication that that teacher mental health is priority to their employer. Some teachers found the EAP helpful at certain times in their lives; however, the overwhelming sentiment was that the counseling provided through the board plan did not provide the in-depth care that many teachers were seeking. Participants agreed that in crisis, the EAP was successful as a first point of contact, and as a springboard for finding help. Corrigan and colleagues (2013) suggest that the success of an EAP rests heavily on the “quality of the match between EAP service and employee needs” (p. 206). For those who had already engaged in various forms of therapy and were looking to develop a deeper understanding about their MHI, the quality of counselling provided by the EAP did not compare. As Sarah put it, the EAP was “a sympathetic ear” whereas her current psychologist challenges her to “work towards being a better version of [her]self”, a challenge that she welcomes and pursues, but at a personal financial cost. Participants described access to care through the EAP as insufficient based on the cap that restricts the number of sessions a teacher is entitled to. As Casey stated, “If anxiety is life-long and depression is life-long, how is 12 sessions going to help me? That’s what the school

board offers.” In some cases, the number of sessions can be extended if the counselor deems that it is necessary. Quinn shared that one of the restrictions she encountered was the inability to continue seeing the same counselor:

So depending on what your situation is, I think the limit is 8 times, like, 8 counselling sessions, but if they feel there's a need to go on, I think they can go up to 12 [...] But then you can finish and you can...you wouldn't be able to go back to the same person, but you could go through the whole system again and start again with somebody else type of thing. But the frustrating thing is, if you've just done 12 sessions with one person and you have to start all over again with somebody else... I think they figure that chances are you probably wouldn't do that.

Quinn expresses that e-counseling is similarly restricted: once an individual has completed their sessions with a counselor, they must wait 30 days before accessing help again, and it must be for a different issue. These restrictions create barriers in the consistency of help that can be accessed through a board plan.

Another challenge faced by those utilizing the EAP services is that of privacy and confidentiality. According to Dylan and Sal, when being scheduled for an appointment, teachers are not to be booked with overlapping times in order to protect their identity; however, this does not always happen. For Dylan, this resulted in running into a colleague in the waiting room, and Sal noted that many people in her board opt to use private services due to scheduling that caused privacy issues. For LTO teachers like Chris and Aidrian, no resources are provided by the school board. While they work in schools with the same duties as contract teachers, they have no access to mental health supports because as occasional teachers, they do not qualify for benefits. Chris was able to access some support through his family doctor, but Aidrian, who has recently moved to Ontario, is still learning to navigate health care system. For those with no supports, an online or in-person EAP counsellor would be most welcomed. An EAP can be a highly

effective preventative strategy for the promotion of employee wellness (Dimoff & Kelloway, 2013). Its existence however does not guarantee that service itself will not re-stigmatize its consumers, or make them feel represented and accepted in their workplace (Jones & King, 2014).

While there are supports in place, teacher living with MHI have identified gaps that need to be addressed in order to provide educators with adequate support in order for them to do their jobs to the best of their ability. These challenges lie within the structure and discourse of schools and boards, and teachers are frustrated with the disparity in the way school boards talk about mental health, and what is actually provided to support staff.

LESSONS IN AWARENESS

Through the interviews, teacher experiences brought to light lessons that can be learned about being a teacher living with MHI. Their lessons centered around awareness in a personal and professional context. Teachers discussed the importance of self-awareness when teaching and living with a MHI; the way that their experience with MHI shapes their awareness of the students and colleagues they work with every day; and the role that alternative supports play in the maintenance of mental health for teachers.

Personal Insight

Participants identified the importance of having an awareness of personal limits for teachers living with MHI. Alex emphasizes that knowing what you want out of a teaching career, as well as knowing your personal limits can help you find a balance between managing a MHI and have a productive and fulfilling teaching career. She notes that for her this meant making a choice to work part-time. She is aware of the way in

which the symptoms of her MHI impact on her well-being, and has elected to have a work schedule that reduces pressure on her so that she can continue to work. Reducing her work load means that she has fewer obligations that allow her to focus on her teaching duties. While discussing mental health challenges, one of Sarah's colleagues observed, "it's a 30-year career, and it's a marathon, and it's very difficult sometimes, so why not? [take breaks]" These teachers highlight that self-care is a critical part of maintaining a long-term teaching career. Accommodations such as reduced work load and temporary leaves can help prolong a teaching career (Bolo et al., 2013; Lamontagne et al., 2014), but it takes a high level of self-awareness and perspective to be able to know when to take a break or change pace in order to refresh and continue.

In order to take the breaks needed to continue working, several participants noted the important role of their union in education and supporting teachers with MHI. The unions to which the participants belong, OSSTF and ETFO, advise their members on taking leaves through local branches as well as through representatives. A number of the participants in this study are active union members. Alex, a union representative, uses her position to recommend that teachers bring their questions regarding mental health support to their local union branch, and to be familiar with their collective agreements in order to understand their rights and responsibilities. In addition to providing personal support to members, teachers in this study discussed the important role that unions played in providing education in the form of workshops. Participants remarked that this educational component is instrumental to developing understanding about MHI amongst their colleagues. The participants' observations are consistent with research that demonstrates that educational programs addressing mental health-related stigma increase

mental health literacy, thereby reducing stigmatizing attitudes (Corrigan, Druss & Perlick, 2014).

A combination of self-awareness and union support help these teachers negotiate their MHI and their teaching careers. Where a knowledge of personal limits and career goals helped participants identify when they needed to reduce their work load or request accommodations, the union ensures that these requests are fulfilled with minimal detrimental professional impact on the individual.

Alternatives in Support

In coming to an understanding of teaching and living with MHI, participants sought out supports in a number of non-traditional ways. In Quinn's case the fear of not being believed prevents her from discussing her MHI with her doctor. In the absence of a trusted medical professional with whom to discuss her concerns, Quinn has turned to an online course offered by a renowned professor of social work in order to explore some of the sources of her mental health challenges, and to develop coping skills that benefit her well-being. The work Quinn has undertaken in this course helps her feel empowered to question the ways in which she has internalized negative beliefs about MHI (Rüsch, Angermeyer, & Corrigan, 2005).

Many teachers described themselves as 'DIY-style' [Do-it-yourself] individuals, meaning that they feel more comfortable educating themselves about their MHI without the assistance of a counselor or mental health practitioner. Teachers like Sal and Frances turned to self-help books to explore their mental health, as well as to supplement counseling they were receiving. While they note that exterior supports are available, they are not always timely or easy to access. Independent reading and research served as an

alternative when therapy was not yielding the results they had envisioned. Sal explains that working independently with a list of books gave her a sense of control and the ability to work at her own pace, while Frances states that a workbook exploring cognitive behavioural therapy provided her support during a period where she was not satisfied with the care she was receiving, and no other options were available to her. This access to educational materials resulted in their ability to make choices with regards to work and their mental health in their lives, thereby creating change in their understandings of their MHI (Nelson, Lord, & Ochocka, 2001).

Participants highlighted the importance for alternative supports that provide opportunities for self-determination and empowerment in regards to their mental health. In accessing materials that allowed them to explore mental health care independently, teachers filled a gap that stems from what they perceive as a lack in quality of care. Through self-motivated education, teachers were able to explore their experiences in greater depth and comfort than if they were solely relying on resources provided by their employers.

Sensitized Teacher

MHI have caused many teachers to suffer and struggle; however, their experiences have also afforded them sensitivity towards others. This sensitivity spanned a range of meanings for teachers, from increased patience for listening to the struggles of their colleagues, to an aptitude for identifying students who are experiencing mental health challenges of their own. Virtually all teachers expressed the desire to ensure that their colleagues never feel the isolation of concealing a MHI identity.

The notion of a sensitized teacher does not suggest that every educator who lives with a MHI also has the capacity to identify MHI in others, but rather that through experiences of, and reflections on identity management, the participants in this study developed a sense of deepened empathy and awareness for others (Gray, 2002). Sarah's journey has led to unlearning of stigmatizing beliefs about mental health challenges:

I feel so bad because my friend who struggled since he was a teenager, he'd often come to visit me when he needed a break from his life, and he'd spend all day into the late afternoon sleeping. He had a ton of medication to take and my reaction was always, "Why can't he just get off his butt and get moving?" Like, his life's not that bad. And so to realize later on in life that this developed in me, I guess I realized that I wasn't being lazy, that this was a real obstacle for me to overcome. And then seeing a student struggle, I guess, and realizing that, no, it's not something that people are using as an excuse to get out of work, or it's not a weakness of character, but rather it's something that a lot of people face...

Sarah illustrates the way in which personal struggle can reshape firmly held beliefs. Her experience caused her to develop empathy for her friend whom she had believed to be lazy, and continues to influence her attitudes towards those living with MHI.

Some teachers mentioned that with increased awareness to the multiple negative impacts of MHI, they became more aware of the struggles faced by their students and colleagues. Their perspective on the implications of living with a MHI allowed them to identify those in need of immediate help, and begin a dialogue with those people in order to assist them in accessing help. When asked whether her MHI impact on work and work relationships, Sal stated that she is more apt to spot students who are struggling:

Well I think that I'm more easily apt to spot it in kids whether they are cutting, which...nobody believed me about this one girl...I said 'She is, she is! I know she is...', or whether it's depression amongst kids or anxiety, um, especially when kids start missing a lot of school...I always like to talk to the parents to see what's going on at home...are they hiding in their room? Are they having illnesses that, you know, you can't prove that they have a headache sort of thing. So I think I'm more apt to notice it in my kids, and I'm a lot more sympathetic, that's for sure.

Dylan notes that in addition to being more in tune to accommodations and strategies for helping students, she also engages more actively in supporting her colleagues:

So, like, when somebody talks to me, I'm a very hyper-aware about how people talk because, again, I don't want people feeling the way that I feel, and it's kind of like, taking the extra effort to make sure no one feels ignored, or that, if they are trying to ask for help or talk without saying 'Hey I have anxiety, let me talk to you!', that they are at least heard...and that they can come talk... like I've had people sit here and talk to me before, and it's just talking because they feel like talking. And they're not talkative people. So, do I provide that for people? Yes. Do I wish people provided that for me? Yes, but they don't to this point.

Awareness of the applied effects of MHI and related stigma that cause suffering in their lives also provides these participants with perspective necessary to assist those with whom they work; sensitivity arising from experience turns into a strength which can make life a little easier for those around them. Their awareness leads them to critical reflections on the anti-stigma work that remains to be done in schools and boards with regards to teachers.

DESIRE FOR CHANGE

Participants in this study were unanimous in a call for change in the way in which MHI are viewed for teachers at a number of levels. They identified that resources, attitudes, and relationships needed to be examined for their contribution to the stigmatization of MHI, and impeding access to care for teachers.

As previously discussed, teachers were adamant about addressing the quality of care available through EAP. Several participants referred to EAPs as a 'Band-Aid' solution-something that covers the problem, but does not actively help it in resolution. According to Alex, a major flaw in the current plan is the exclusion of certain staff members. Teachers noted that access to care for all employees is a crucial next step in ensuring the mental well-being of teaching staff. She states that supply teachers and

LTOs, especially those who choose supply work as an accommodation to their MHI, need to be able to access supports from within the school board. Though teachers feel that accommodations in the current system could prove to be beneficial for teachers living with MHI, they are aware of the tensions that exist between boards and teachers, which impede change from taking place.

For Alex, this gap speaks directly to the inconsistent discourse of school boards regarding mental health, and of work relationships that need to be improved in order for teachers to be adequately supported:

The board has a whole mandate about health and wellness and mental health awareness because here in (school board) we have a very, very high rate of suicide. Especially in our high school, it's almost like a cluster. And so one of their focuses is on mental health awareness. But yet it's right in front of them and they have failed to recognize that there is no equality or equity within their own people.

She explains that this dynamic creates issues for non-permanent teachers who find themselves in need of assistance, as school boards and administration do not recognize the needs of all teachers equally in their policy.

A majority of participants spoke to the strained relationship between administration, school boards, and teachers that fuel the fear of disclosing a MHI in the workplace. Teachers did identify the ways in which administrators could be and are supportive, but as a whole felt that concealing MHI was a safer choice career-wise than disclosure. Participants equally connected the strained relationship between administration and teachers to their perceptions of value and worth within their work environment. A common sentiment amongst participants was that they did not want to risk revealing their MHI because of possible repercussions on their career, specifically in terms of being overlooked for advancement opportunities. Casey explains, "Teaching to

me is almost like working in a factory. You're a factory worker, you're a number, and there's no value to you...to a person." Participants did not want to give the impression that they were incapable of fulfilling their role by disclosing a MHI as they were aware of the competitive nature of the teaching profession.

The participants' unanimous desire for change cannot take place with continued silence about teacher mental health. They identified that the conversation has begun, and that they are taking steps to help it grow, but that systemic and attitudinal transformation is necessary. They specifically declare that this change must be led by school boards and administration in a meaningful way by investing in all educational staff.

CHAPTER 6: CONCLUSION AND IMPLICATIONS FOR FUTURE RESEARCH

This thesis explored the experiences of 11 Ontario teachers living with mental health conditions that did not originate solely as a result of workplace stressors. This study aimed to reveal the ways in which these teachers understood and experienced their MHI, and the ways in which their MHI impacted on their duties as teachers, and work relationships. As previous research about teachers and mental health has focused on student-helping, stress and burnout, and teacher retention, this study sought to provide a platform to expand the current understandings teachers and mental health. FINIS (Pescosolido et al., 2008) and Jones and King's (2014) theoretical framework provided a lens by which to understand the experiences of teachers as part of larger social context in which mental health-related stigma is produced.

The literature review highlighted work on mental health and stigma in the context of the educational system. The literature presented the many ways in which MHI and stigma are taken up in research. The review began with associated personal and financial costs of MHI, the role of stigma in accessing support, and the place that MHI hold within an educational context.

This study demonstrated that teachers are experiencing MHI that fall outside of stress and burnout, and more importantly, that they are negotiating their mental health identities in an environment that poses several challenges. Teachers living with MHI beyond burnout are working to overcome attitudinal and structural obstacles and remain engaged with their career. They are aware that these challenges exist because MHI are stigmatized, and that for teachers, stigma means they risk being perceived as professionally incompetent if their MHI is revealed. Given the responsibility associated with teaching, they are hyper-aware of the risks involved with disclosing their MH status

at work, whether that be to access support in the form of a leave of absence, or simply in an attempt to have their experience made visible to their peers. Despite these risks and challenges, teachers are using their experience to assist others who may be in the same or similar situation.

Limitations of the Study

This study was a small-scale, qualitative investigation of the experiences of 11 Ontario teachers living with MHI *beyond burnout* and as such, is bound by certain limitations of scope. The priority from the outset was to gather participant perspectives on their experience of living and working with MHI; therefore, focus was directed towards how teachers made meaning of their stigmatized identities. This study did not explore the teaching ability of teachers with MHI but rather highlighted teachers' personal experiences and understandings of MHI and identity management at work. Additionally, educational stakeholders' perspectives on MHI and stigma were not included. The small sample size presented a number of limitations in terms of representation. This study was not representative of the full spectrum of MHI, as participants were accepted on a first-come-first-served basis, and the number of participants was capped; experiences of teachers living with addictions issues, eating disorders, or psychosis for example, are not represented in this study. The process by which the sample was collected similarly limited representation of intersectional identities across gender, race, class, sexuality, and ability. The findings reflect multiple ways in which MHI and identities are understood and experienced, and are not intended to be generalizable to all teachers living with MHI. The limitations present in this study

can serve as a starting point for further research into the areas that were not encompassed by the scope of this study.

Implications for Further Research

Given the limited information that exists about teachers and MHI within a Canadian context, further research is needed to understand the ways in which this impacts educators in their specific contexts. Due to varying societal norms that depend on location, future research should seek to explore in more detail the experiences throughout Canada from large, urban cities to remote communities. Further research is needed to highlight how teachers are unlearning stigmatizing beliefs, teachers who use their experience to champion MHI at work, and the ways in which school boards, administrators, and teaching staff can work together to encourage understanding and help-seeking for all educational stakeholders. Additionally, studies on the impacts of occasional teaching on mental health would further advance the field of mental health and education, as occasional work presents a number of unique challenges by its irregular nature.

Mental health awareness has progressed greatly for students, but those gains have yet to extend to teachers. As MHI can impact anybody, and mental health-related stigma is a deeply entrenched societal reality, despite best efforts, stigma is still something that those living with MHI contend with, it is equally important to gather the experiences of all educational stakeholders-students, parents and guardians, administrators, educational assistants to name a few- in order to build a multi-faceted picture of the ways in which MHI are experienced and understood, and the ways in which stigma are experienced and understood in educational settings. No one is immune. There is no magic wand to ensure

that stigmatizing beliefs and attitudes stop, but the voices of those who live and teach with MHI are well positioned to help guide the next steps to making educational settings more accepting, empathetic, and supportive spaces.

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Appendices

Appendix A

Letter of Information-Participant

Beyond Burnout: Educators' experiences of mental health and addictions issues.

Invitation to Participate

You are being invited to participate in this research study about the experiences of teachers living with mental health and addictions issues (MHI). In hearing from teacher living with MHI this study hopes to learn about what it is like educator living and working with a MHI.

Purpose of study

The purpose of this study is to generate a deeper understanding of educators with MHI and their experiences at work. There are many studies that focus on the high rates of stress and burnout amongst teachers, but none that focus on issues that are not caused by their work. This study hopes to add to the discussion by highlighting the experiences of teachers who experience MHI that go 'beyond burnout' and reflect a more multifaceted reality of teacher MHI.

How long will you be in this study?

Your participation in this study will be one interview, lasting one hour.

Study procedures

If you agree to participate you will be asked to participate in a one hour interview that will be audio-recorded, with your permission. You can still participate if you do not wish to be audio-recorded. The interview will take place at a location of your choice. You will be asked questions regarding your experiences, opinions, and feelings about MHIA and teaching. Following the interview, if you would like the opportunity to review your transcript and make any revisions, please provide a private email address below where the transcripts should be sent.

Risks and harms of participating in this study

There are no known or anticipated risks or discomforts associated with participating in this study.

Benefits of participating in this study

You may not directly benefit from participating in this study but information gathered may help to broaden the definition and understanding of teacher MHI beyond stress and burnout.

Can I leave the study?

If you decide to withdraw from the study, you have the right to request withdrawal of information collected about you. If you wish to have your information removed please let the researcher know.

Keeping participants' information confidential

Your identity will be kept confidential through the use of pseudonyms, and no identifying information will be collected. All collected data will be stored on a password-protected computer for 5 years, after which it will be destroyed. The researcher will be the only person with access to this information. Any personal quotes included in the final product, publications, or presentations resulting from this study will attributed to a pseudonym and will not contain identifying information.

Limits of confidentiality

We do our best to protect your information there is no guarantee that we will be able to

do so. All information collected during this study will be kept confidential and will not be shared with anyone outside the study unless required by law.

Compensation

In recognition of your participation, you will receive a \$20 gift certificate.

Participant rights

Your participation in this study is voluntary. You may decide not to be in this study. Even if you consent to participate you have the right to not answer individual questions or to withdraw from the study at any time. If you choose not to participate or to leave the study at any time it will have no effect on your employment. We will give you new information that is learned during the study that might affect your decision to stay in the study. You do not waive any legal right by signing this consent form.

Questions

If you have questions about this research study please contact

Appendix B

Beyond Burnout: Educators' workplace experiences of mental health and addictions issues, and stigma in the workplace**CONSENT FORM**

I have read the Letter of Information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

I agree to be audio / video-recorded in this research

YES NO

I consent to the use of unidentified quotes obtained during the study in the dissemination of this research

YES NO

I wish to receive my interview transcript following the interview. Please send to:

(Private email address): _____

Print Name

Signature

Date(DD-MM-YYYY)

Appendix C

INTERVIEW GUIDE

Beyond Burnout: Educators' experiences of mental health and addictions issues.

1. Tell me a little bit about yourself.
2. Tell me about working at your school (e.g. position, length of time there, responsibilities, relationships)
3. How would you describe your MH status? How did you come to identify this way?
4. Can you describe the ways in which you experience your MHI?
5. Have you ever asked for help with your MHI? (e.g. professional, online, friend). Why or why not, describe.
6. Do you feel that your MH affects your work? Describe.
7. With whom have you shared your MHI status with at work?.
8. What were their responses? How did you feel about their responses?
9. Are there supports in place at your work to help you out with your MHI? Are you currently accessing them, or have accessed them in the past?
10. Tell me about your school's MH initiatives. Who is involved? How do you feel about it?
11. How would you describe the understanding/acceptance for teachers with MHI at your work? Does it differ from understanding/acceptance for other health issues?
12. Is addressing MHI at your work something that you engage in? Describe.
13. Are there things that you would like to change/address?
Is there anything you would like to add?

Appendix D Ethics Approval



Research Ethics

Western University Non-Medical Research Ethics Board NMREB Delegated Initial Approval Notice

Principal Investigator:
Department & Institution: Education/Faculty of Education, Western University

NMREB File Number: 107506
Study Title: Beyond Barriers: Educators' experiences of mental health and addictions issues, and stigma in the workplace
Sponsor:

NMREB Initial Approval Date: December 11, 2015
NMREB Expiry Date: December 11, 2016

Documents Approved and/or Received for Information:

Document Name	Comments	Version Date
Other	Appendix E: Contact information	2015/10/06
Recruitment Items	Appendix D: Social media copy	2015/10/06
Recruitment Items	Appendix D: Request for circulation	2015/10/06
Recruitment Items	Appendix D: Recruitment poster	2015/10/06
Recruitment Items	Appendix D: Recruitment email	2015/10/06
Other	Appendix B: Interview schedule	2015/10/06
Letter of Information & Consent	Appendix A: Letter of Information and consent	2015/10/14
Other	De-briefing form, Appendix C	2015/11/15
Western University Protocol		2015/11/15

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the above named study, as of the NMREB Initial Approval Date noted above.

NMREB approval for this study remains valid until the NMREB Expiry Date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario.

Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Chair or delegated board member

Ethics Officer to Contact for Further Information:

This is an official document. Please retain the original in your files.

Curriculum Vitae

Name: Jenny Kassen

Post-secondary Education and Degrees: University of Western Ontario
London, Ontario, Canada
Bachelor of Education with Distinction, 2012

The University of Western Ontario
London, Ontario, Canada
Additional Qualifications, 2012
French as a Second Language, Part1
Special Education, Part 1

OCAD University
Toronto, Ontario, Canada
Bachelor of Design, Illustration, 2011

Honours and Awards: Conference Grant, Centre for School Mental Health
2016

Graduate Student Internal Conference Travel Grant
2016

SOGS/GC Travel Grant
2016

Second Place, Best of Symposium Poster Award, Robert
Macmillan Graduate Research in Education Symposium (GRiES)
2016

Best of Symposium Poster Award, Robert Macmillan Graduate
Research in Education Symposium (GRiES)
2015

Related Work Experience Secondary Teacher
Thames Valley District School Board
2013-present

Publications:

Kassen, J., & Lapointe, A. (2016). Working 'with' and 'within': 'Weaving' queer spaces with cycles of resistance. In S. Miller, & N. M. Rodriguez (Eds.), *Educators queering academia: Critical memoirs* (pp. 69-78). New York, NY: Peter Lang.

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