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Providing Trauma and Violence Informed Care to Preservice Teachers: A look into perceived behaviours and self-efficacy when working with children impacted by interpersonal and structural violence

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Abstract

Trauma-and-violence-informed-care (TVIC) and its active and anti-oppressive lens, allows for a thorough understanding of traumatic experiences and the impacts these experiences have had on student behaviours (EQUIP Health Care, 2017). Giving preservice teachers education on how to employ TVIC, may help to shape their attitudes towards student mental health behaviours and feelings of self-efficacy in the classroom. Understanding student behaviours empowers teachers to create better connections with their students, resulting in the classroom being a safe space for all students (EQUIP Health Care, 2017). As part of the Bachelor of Education program at a large Canadian university, second year teacher candidates (N =248) were required to take a mandatory mental health course which focused on concepts of structural and interpersonal violence using a TVIC lens. Discussion forums, quizzes, videos, and case studies were used to engage preservice teachers with the knowledge and strategies in the course. Participants completed pre-post measures related to attitudes towards trauma informed care (ARTIC-25; Baker et al., 2016) and self-efficacy for inclusive teaching practices (TEIP; Sharma, Loreman & Forlin, 2011). Both the participant's attitudes towards student mental health behaviours and their feelings of self-efficacy in the classroom increased significantly between the pre-and post-test administration. The findings support the inclusion of topics such as mental health as important to include in teacher education programs. Implications for teacher practice and student outcomes are discussed.

Keywords: trauma, structural violence, interpersonal violence, teacher education

Lay Summary

Trauma-and-violence-informed-care (TVIC) helps shape the way people understand traumatic experiences and respond to the impacts of these experiences (EQUIP Health Care, 2017). Oftentimes, children who have experienced traumatic events experience challenges in the classroom such as learning difficulties and behaviour management classroom (Blodget & Lanigan, 2018). There is a lack of teacher education and preparation surrounding these issues and as such, teachers are left ill-equipped to respond effectively to the needs of such children although positive relationships between students and teachers can help buffer some of the effects of trauma on the child (Canadian Federation of Teachers, 2011; Center on the Developing Child, 2007). Preservice teachers enrolled in a Bachelor of Education program at a large Canadian university were required to take a course which aimed to fill in these gaps of knowledge, and help teachers engage in TVIC, in order to help shape their attitudes towards student mental health behaviours and their own feelings of self-efficacy in the classroom. To examine the impact of the course on their learning, preservice teachers completed measures at the beginning and end of the course, looking at their attitudes towards trauma informed care (ARTIC-25; Baker et al., 2016) and self-efficacy for inclusive teaching practices (TEIP; Sharma, Loreman & Forlin, 2011). It was found that the course increased participant's understanding of student behaviours and feelings of self-efficacy in the classroom. This demonstrates the need and importance for further education in these areas provided to teachers, as positive student-teacher relationships can often work to lessen the impacts of trauma for children, helping them succeed (Center on the Developing Child, 2007).

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Introduction

The evidence is clear about the prevalence of both mental health problems and experiences of violence among children and youth (Polanczyk et al., 2015; Trocme et al., 2010), and the number of these children who receive support not from within the health care system, but at their schools (Waddell et al., 2019). In acknowledging these crucial findings regarding child and youth wellness and access to care, it is also important to recognize that most teachers do not have access to any formal learning about child and youth mental health in their initial teacher education programs (Rodger, Hibbert & Leschied, 2014). The purpose of the present study is to examine the effectiveness of a mandatory course on mental health for preservice teacher education students at a large Canadian university in understanding mental health, exposure to violence and the effects of these experiences on children and youth in the classroom.

Literature Review

Healthy Child Development and Effective Learning

Research surrounding healthy child development typically characterizes this period of growth as consisting of a secure formation of relationships, appropriate emotion expression and regulation, and world exploration (Yates et al., 2008). The crux of the development of these skills depends on biological composition, but also positive enriching experiences with primary caregivers, peers, and other adults such as a teacher (Denham, 2006). Competencies in these areas are linked to future academic success and better overall health in childhood (Moffit et al.,

2011). However, environments and situations which impede healthy child development are recognized as contributing factors to the inability to function effectively and positively in school, family life, or with other peers (Campbell, 2006; Sroufe, 2005). The growing evidence in this area suggests that healthy development, which promotes the prosocial relationships and behaviours, is a key factor in school success and thus future success (Raver, 2002). Therefore, the conclusion can be drawn that child development outside of the classroom vehemently influences school performance.

Within school systems, children are categorized into grades based on age, not developmental abilities. Thus, a child may be in a grade level class but performing academically at a lower developmental age. As general curriculum is catered to meet the needs of students at the grade level, the students that are not at this benchmark, perhaps having a lower developmental capacity for example, are set up to experience difficulties succeeding (Hitchcock & Stahl, 2003). Students then find barriers in learning and succeeding, further leaving them behind in terms of their development (Hitchcock & Stahl, 2003). With such a wide range of abilities within the classroom, the construction of an instructional approach for teachers, “Universal Design for Learning (UDL)”, was designed and tested to meet the diverse needs of the full range of students in the classroom (Hitchcock & Stahl, 2003). This equity-oriented approach posits that UDL is flexible to accommodate for a range of preferences and abilities, in terms of the way information is taught to students, the way students can respond and demonstrate knowledge, and the ways that students are engaged (Hitchcock & Stahl, 2003). Implementation of this approach can improve learning outcomes for all, including the students whose development has been atypical, more than the traditional instructional pedagogy (Hitchcock & Stahl, 2003).

Trauma and Adverse Childhood Experiences (ACEs)

Trauma is an experience connected to physical, emotional and psychological distress which is perceived to be a threat to one's safety and stability (Lieberman, 2008). It has been suggested that society believes childhood is a safe period wherein children are not exposed to traumatic events, nor suffer the consequences of them (Lieberman & Van Horn, 2008). However, research shows that approximately 85,000 Canadian children have been exposed to a traumatic event within a one-year period (Trocmé, 2010). Studies show that children whom have experienced trauma have twice as many mental health concerns, impairments in relationships, and reduced school performance compared to children not exposed to trauma (Copeland, Keeler, Angold & Costlello, 2007).

The Adverse Childhood Experiences (ACE) Study conducted in 1998 by Felitti et al., sought to categorize and quantify the types of traumatic experiences children were experiencing as well as the short and long-term impacts of these events. Seven categories of childhood exposures of abuse/dysfunction were used for analysis including psychological, physical, and sexual abuse as well as exposure to substance abuse, mental illness, gender-based violence, and criminal behaviour in the household (Felitti et al., 1998). 52% of respondents in this study reported experiencing more than one category of adverse childhood exposures while 6.2% respondents reported more than four exposures (Felitti et al., 1998). A strong relationship was found between the number of exposures and the number of health risk factors for disease or death in adults such as heart disease, cancer, and skeletal fractures (Felitti et al., 1998). Linking childhood exposures to risk factors in adulthood lies within the coping devices (i.e. alcohol and drug abuse, smoking, sexual behaviours) used by children and adolescents as a result of their exposure to these ACEs and the formulation of anxiety, anger and depression in these children

(Felitti et al., 1998). Felitti et al., suggests that prevention and interventions need to be put in place to reduce the prevalence of negative coping strategies adopted by children experiencing these issues (1998).

While for many years the use of ACEs focused on the identification of exposures experienced by individual children and trying to both measure and mitigate the risk for negative outcomes, more recently scholars and practitioners are calling for equity-based approaches that recognize the impact of systemic or structural violence, using a population health approach (Ellis & Deitz, 2017). Felitti et al.'s inclusions of what an "ACE" is, is inherently individual; conceptualizing ACEs as being individual experiences is somewhat problematic. Research argues that these individual experiences fails to acknowledge broader processes that are additional correlates of children distress (Finkelhor, Shattuck, Turner & Hamby, 2013). Furthering this, ACEs exclude current experiences of psychosocial risk factors (Racine, Killam & Madigan, 2020). These broader processes and psychosocial risk factors are forms of interpersonal and structural victimization and include, but are not limited to intimate partner violence, peer and property victimization, exposure to community violence, parental job loss, natural disasters, and homelessness (Finkelhor et al., 2013). Assigning individuals into the binary categories of "having experienced" or "not having experienced" an ACE, does not consider the timing or chronicity of an individual's experience (Lacey & Minnis, 2019), where the inclusion of interpersonal and structural victimization seeks to do so, leading to a more equitable and "whole" formulation of the individual's experience.

Structural violence

EQUIP Health Care, an interdisciplinary research team consisting of professionals in a variety of areas including nursing, medicine, and community health, has been working on

promoting a client centered approach to patient care, rooted in care tailored to the user, particularly those at great risk – marginalized populations of people (EQUIP Health Care, 2017). The organization has focused on incorporating structural violence into their trauma work to better provide patient care and improve patient experiences (EQUIP Health Care, 2017). The incorporation of structural and interpersonal violence into their work examines the prevalence, historical significance and ongoing experiences, the impact on development, coping and adaptation and considers trauma a risk factor for other issues.

In recent years, there has been an increase in the attention to a child's exposure to violence within the research literature (Trocmé, 2010). Interpersonal violence, that is physical/emotional mistreatment, physical and sexual abuse, and neglect is most commonly thought of when considering violence (Klingbeil & Maiuro, 2007). Although the word violence evokes thoughts of physical occurrences, one must also consider violence at a broader level; structurally (Brofenbrenner, 1997). Structural violence includes constraints to human potential such as unequal access to resources, education or health care (Dubee, 2017). This violence denotes the systematic ways that social structures and institution prevents people from meeting their needs; examples of structural violence include racism and classism (Dubee, 2017). The theory of structural violence has been cited in literature as a way to fully understand the pervasive ways that educational outcomes for children who have experienced adverse childhood experiences are impacted (Muthukrishna, 2011).

The possible roots of negative classroom behaviour and the physiological, cognitive, social and emotional impacts of trauma cannot be addressed fully by ignoring systemic issues that lead to interpersonal and structural violence, as exposure to such has been linked to attentional problems, classroom behavioural issues, lower cognitive function and lower attendance rates

(MacNevin, 2012). A study conducted by Muthukrishna (2011) with 117 students in South Africa who came from poor and low-income families and had lower academic achievements than their wealthier counterparts. It was found that a lack of transportation, lack of electricity, minimal access to food, absentee parents, and social stigma from their socioeconomic status, were deterrents from these children both attending and excelling in school as well as keeping up with homework and studying outside of school hours (Muthukrishna, 2011). Researchers concluded that structural and interpersonal violence whose mechanisms are often invisible, creates barriers to children accessing and excelling in education (Muthukrishna, 2011). Thus, similar to EQUIP Health Care and their ideas about patient care, the conception of trauma and its impacts on student experience must include an emphasis on the experiences of structural and interpersonal violence to help explain the relationship between trauma, violence, and academic outcomes (EQUIP Health Care, 2017). Through the inclusion of the structural and interpersonal factors that impede student development and outcomes, this lens roots itself in equity.

Trauma impacts

Toxic stress response, which is prolonged activation of the stress response, can disrupt typical development of the brain, particularly altering brain chemistry and development (Center on the Developing Child, 2007). This response often occurs when children experience on-going interpersonal and structural violence (Center on the Developing Child, 2007). Due to the toxic stress response, these children experience disturbances in their abilities to have relationships with others as their feelings of trust and safety have been disrupted (Vicario, Tucker, Adcock and Hudgings-Mitchell, 2013). After exposure to interpersonal and structural violence, children may "develop negative expectations for current and future relationships", according to Vicario, Tucker, Adcock and Hudgings-Mitchell (2013). Children exposed to interpersonal and structural

violence may begin to live their lives using strategies such as lying, hypervigilance and distrust as survival tactics (Vicario, Tucker, Adcock and Hudgings-Mitchell, 2013). Children may exhibit withdrawn, aggressive, or anxious behaviours towards their caregivers and others, making it challenging for caring adults to engage and form relationships with these children (Vicario, Tucker, Adcock and Hudgings-Mitchell, 2013).

As early traumas affect brain development, they also increase a person's likelihood to develop chronic and physical diseases as well (Centers for Disease Control and Prevention, 2012). The stress response which produces adrenaline and cortisol that helps mobilize the bodies energy stores, enhance memory and activates immune response, is often prolonged in children who experience toxic stress (McEwen, 2008). Prolonged exposure to toxic stress can alter neural systems which leads to a suppression of the immune system, bone mineral loss, muscle atrophy and impairs the metabolic system (Sapolsky, Romero & Munck, 2000). Research has been able to connect childhood exposure to traumas to chronic health conditions including gastrointestinal, cardiovascular, and neurological disorders (Centers for Disease Control and Prevention, 2012).

The more interpersonal and structural violence a child experiences, the more likely they are to suffer from physical health problems as well as face mental health concerns (Center on the Developing Child, 2007). A study by Lipman and Boyle (2008) compared children living in low-income households to their peers who were not living in poverty. They found that children in poverty were three times more likely to develop mental health problems than their counterparts (Lipman & Boyle, 2008). Exposure to interpersonal and structural violence increases a child's likelihood of experiencing externalizing behaviours, mental health diagnoses, and engaging in at-risk behaviour (Kisiel, Fehrenbach, Small & Lyons, 2009). Further research supports that students with mental health difficulties struggle in terms of behavioural functioning, academic

achievement and social-emotional learning (Gibson, Stephan, Brandt & Lever, 2014). Consequently then, students who experience trauma, structural and interpersonal violence are more likely to develop mental health issues, which subsequently interferes with their academics.

Trauma impacts in the classroom

One in every four students have been exposed to a traumatic event, which can their school performance, impairing learning, and causing physical and emotional distress (NCTSN, 2008) and yet there has been limited research of the short- and long-term effects of interpersonal and structural violence on mental health and its impacts in the classroom (Blodget & Lanigan, 2018). It has been found that a combination of three or more exposures to interpersonal and structural violence influences school attendance, behavioural issues, and failures to meet curriculum standards (Blodget & Lanigan, 2018). The potential cognitive effects of interpersonal and structural violence may manifest as language delays, IQ deficits, learning disabilities, inability to concentrate or complete assignments, inability to learn from experience, or difficulty preparing for events (Plumb, Bush, & Kersevichm, 2016). These symptoms are exacerbated by a student's feelings of safety and trust in relationships which have been skewed after unsafe experiences (Courtois & Ford, 2009). Due to toxic stress, children become hypersensitive to feelings of threats and operate on "flight, flight, or freeze" as defense mechanisms (Terr, 1991). Students may misread teacher movements or verbal cues because their chronic, unsafe experiences have conditioned them to be hypercritical of adult behaviour (Terr, 1991). When students feel that their safety is being threatened, they then rely on these defense mechanisms to protect themselves instinctively. This behaviour manifests differently but commonly looks like outbursts, cries, peer difficulties, or a cessation in participation which all ultimately interferes with student-teacher relationships, academic achievements and performance (Terr, 1991).

While 20-50% of all students have experienced adversities, these students within the classroom need more attention and support and can be more difficult to engage (The Illinois Aces Responses Collaborative, 2017). Teachers are then responsible for not only teaching to the curriculum, but also informally supporting students with difficulties as a result of trauma or mental health challenges (Gibson et al., 2013). Considering the evidence that supports the impacts of trauma and structural and interpersonal violence on academic life, it is essential that teachers receive training on how to employ best practices to teach and to meet these diverse student needs, seeing as there has been evidence to support trauma informed teaching but not trauma informed schools (Maynard, Farina, Dell & Kelly, 2019).

Trauma and violence informed care

Within literature, a popular way to try to reduce the influence of negative experiences and trauma is the utilization of a trauma informed approach. This approach addresses what has happened to a child and refers to an individual traumatic event. While this is important to note, it does not give a full picture of a child's life and their experiences. By incorporating an equity-oriented lens on the issue of trauma, it is imperative that the consideration of the impact of structural violence is also included when targeting trauma. As previously stated, structural violence refers to the systemic barriers, and chronic or on-going events (Dubee, 2017). The explicit usage of "violence" denotes a more inclusive look at both complex an historical trauma, and on-going marginalization (Ponic, Varcoe & Smutylo, 2016). Encompassing structural and interpersonal violence allows the following question to be considered: what is still happening in a child's life? When taking a trauma and violence informed lens, one is effectively considering all of the structural and environmental conditions and how trauma intersects with these conditions.

With applicability to the classroom, teachers need to recognize that not all children come to school with the same experiences or will behave in similar ways. TVIC and its active and anti-oppressive lens, allows for a thorough understanding of traumatic experiences and the impacts these experiences have had on student behaviours (EQUIP Health Care, 2017). Understanding student behaviours empowers teachers to create better connections with their students, resulting in the classroom being a safe space (EQUIP Health Care, 2017). The classroom is oftentimes the only safe space these students may have. TVIC also utilizes a strengths-based approach which encourages teachers to adopt more inclusive teaching strategies within their classroom, which leads to better student outcomes (EQUIP Health Care, 2017).

Trauma informed teaching

Understanding the complexities of trauma, as well as the impact of trauma, categorizes one as being trauma-informed (Kamara, 2017). Impacts of trauma are being integrated into deconstructing organizational systems and practices (Berger & Quiros, 2016). These impacts can be seen within the educational setting. Trauma-informed systems have the potential to help individuals affected by interpersonal and structural violence to feel safe, recover from trauma, and regain developmental trajectories (Baker, Brown, Wilcox, Overstreet, & Arora, 2016). A trauma-informed lens within the classroom includes being aware of the impact of trauma on the cognitive, social, and emotional well-being of students, which is effective in helping students succeed as a result (Plumb et al., 2016). While the prevalence of trauma-informed approaches within school systems is increasing, it is difficult to discern the actual body of evidence to support the efficacy of such approaches. A systematic review conducted in 2019 set to evaluate the effects of trauma-informed approaches in schools (Maynard, Farina, Dell & Kelly, 2019). Upon examination of 9,102 references, no studies met inclusion criteria (Maynard, Farina, Dell

& Kelly, 2019). It was concluded that schools vary widely in both their practice and implementation of a trauma-informed approach (Maynard, Farina, Dell & Kelly, 2019). While the number of studies yielded in this area is large, it is clear that none are rigorous enough to serve as evidence for trauma-informed approaches. Therefore, there is no research to support that trauma-informed approaches are effective in the lives of students and worth the cost for stakeholders (Maynard, Farina, Dell & Kelly, 2019) . Future studies must be rigorous and follow standardized implementation procedures to ensure analyses can be done (Maynard, Farina, Dell & Kelly, 2019). Proceeding methodically, teaching the teachers about trauma-informed practices is considered an appropriate next step for this line of research.

Teachers and mental health-based knowledge

Nearly four thousand Canadian teachers participated in a study conducted in 2011 with the Canadian Teachers' Federation and the Mental Health Commission of Canada, to capture an understanding of teacher perspectives on mental health (Canadian Teachers' Federation, 2011). Teachers were asked to respond to questions about stigma, and level of preparedness to deal with mental health issues of students. Over two-thirds of teacher respondents reported not receiving any prior professional development to address mental illness in the classroom (Canadian Teachers' Federation, 2011). Six in ten of the teachers who reported having undergone professional development indicated that training had come from an outside source (health care professional), whereas only 24% of respondents indicated their training had come from a school based professional (school board, colleague or principal) (Canadian Teachers' Federation, 2011). 97% of all respondents specified the need for knowledge and skills training in mental health, with 69% of those respondents citing this need as "very important" (Canadian Teachers' Federation, 2011). Furthermore, 96% of teachers reported a need for more training with children

with externalizing behaviours problems (i.e. physical aggression, disobeying rules) and strategies to work with these children (Canadian Teachers' Federation, 2011). This study illustrates the gap that exists within knowledge surrounding mental health, as well as a clear desire from teachers to receive this training.

Relational-Cultural theory

Teachers are some of the most prominent figures within a child's life. The majority of a child's time is spent within the class (Wei & Kutcher, 2011), and as such, the relationship that exists between teachers and students is essential to a student's wellbeing (Davis, 2003). Teachers have an important opportunity to engage in supportive relationships with children who have experienced interpersonal and structural violence. The Relational-Cultural theory asserts that growth-fostering relationships are necessary in formulating healthy mental well-being (Jordan & Hartling, 2002). These ideas suggest that all growth occurs in empathetic and empowered relationships (Jordan & Hartling, 2002.) Increasing vitality, empowerment, clarity around the self and others, increased sense of worth, and a desire for more relationships are outcomes of this growth-fostering relationship (Jordan & Hartling, 2002). Students who have been impacted by interpersonal and structural violence typically experience harmful relationships that are categorized by relational violations, injuries, and empathic failures (Jordan & Hartling, 2002) which trigger the toxic stress response causing mistrust and hypervigilant behaviour in the classroom (Center on the Developing Child, 2007). Through positive interactions, teachers can cultivate these growth-fostering relationships which have been proven to be essential to student's wellbeing (Longobardi, Prino, Marengo & Settani, 2016). A healthy and positive growth-fostering relationship in a child's life will mitigate the negative impacts of interpersonal and structural violence seen in the classroom and also in their personal lives as caring adults act as

"buffering protection" from the toxic stress response (Center on the Developing Child, 2007). By educating our preservice teachers on how to employ TVIC, the 5 outcomes of growth-fostering relationships (a sense of worth, empowerment, active engagement, trust and a desire for more connection), will be met in this student-teacher relationship. This positive relationship in turn will aid in the student's success in future relationship building and academic success.

School as an intervention

As children spend majority of their time within the classroom, school settings may offer the best place for primary prevention and early intervention. The access to youth and the relationship between academic success and child development, make schools historically a good place to begin intervention (Ungar, Connelly, Liebenberg & Theron, 2017). Conversely, the toxic stress that is brought on by complex trauma exposures which harms brain development and leads to the formulation of behavioural and academic issues, can impede a child's success in education (Center on the Developing Child, 2007).

Higher incidences of interpersonal and structural violence are associated with greater risk of lower school engagement and lower overall likelihood of success as seen in a study conducted by Blodget and Lanigan (2018). Moreover, an increasing amount of interpersonal and structural violence exposure was also seen correlating to an increase in the amount of learning and behavioural problems in an earlier study by Burke, Hellman, Scott, Weems and Carrion (2011). Results of these studies examining incidences of exposures and prevalence of learning/behaviour problems (Burke et al., 2011; Blodget & Lanigan, 2018), provide a basis for the idea that understanding interpersonal and structural violence risks and their direct impacts on academic achievements is an essential way for educators to understand and conceptualize why some children in their classrooms may be struggling (Blodget & Lanigan, 2018). Opening up discourse

for educators to discuss the effects of interpersonal and structural violence on students may allow for teachers to access professional development that bolsters knowledge in the topics of mental health. Teachers must then use this knowledge and adapt their teaching pedagogy in hopes of effectively improving teaching in response and improving student outcomes.

Schools to build resilience

Better student outcomes may look like a student succeeding after they experience a stressor. The ability for a student to return to "normative functioning" can be defined as resilience (Ungar 2011; Allan & Ungar, 2014). Resilience is a byproduct of the interplay between individuals and their resources or environments that allows people to overcome the negative influence of interpersonal and structural violence (Ungar, Connelly, Liebenberg & Theron, 2017). Taking an ecological standpoint, positive and supportive interactions between the child and the school can make it more likely that the child will successfully cope in response to a stressor (Kassis et al., 2013). The probability that individuals will achieve desirable outcomes, or social capital, is also facilitated by positive relationships (Ungar et al., 2017). Supportive teachers play an important role in the success of students (Voelkl & Frone, 2000), and by default improve their behaviour, psychosocial functioning, and academic performance (Ungar et al., 2017). A supportive teacher: may be aware of the challenge's students experience beyond the school environment, is understanding of behaviours exhibited in the classroom, and also feels that they can make a difference in the classroom. Accordingly, there are good reasons to believe that teacher knowledge and belief changes as a result of TVIC may have many positive implications for students within the classroom. For example, American studies conducted on the benefits of a positive and supportive relationship have found that these youth achieved more

academically, were socially competent and had better problem-solving skills compared to participants who did not (Morrison & Allen, 2997; Sharkey et al., 2008).

It has been found that racially or ethnically diverse students benefit from positive relationships leading to better outcomes for students, according to research conducted by Johns (2001) and Thompson (2003). Students whose teachers were verbally abusive or humiliated had higher rates of oppositional or withdrawn behaviours thereby impacting their ability to be resilient, as reported by both a study conducted on Jamaican youth by Pottinger and Stair (2009) as well as Israeli youth by Geiger (2017). Moreover, students experiencing both individual challenges and structural disadvantages have recognized teachers in playing an important role in their success (Theron & Theron, 2014). This is supported by Wooley and Bowen's (2007) study examining over 8000 marginalized students in America, in which the presence of a supportive adult positively impacted their school achievement, even when accounting for differences in race and class in the sample.

Mental health literacy for teachers

Teachers are often the primary intervenors, identifiers, and partners in mitigating mental health challenges within students, as caused by interpersonal and structural violence or otherwise (Whitley et al., 2013). Teachers should be equipped with a well-rounded understanding of mental health and be literate in this area in order to be the most effective caregiver (Whitley et al., 2013). Mental health literacy can be defined as "the knowledge, beliefs and abilities that enable the recognition, management or prevention of mental health problems" (Canadian Alliance on Mental Illness and Mental Health [CAMIMH], 2007, p. 4). Educators should be aware that the challenges that present themselves within the classroom are either caused or exacerbated by interpersonal and structural violence. Given that the prevalence interpersonal and structural

violence are associated with learning challenges and can impact overall functioning, students impacted by interpersonal and structural violence often are less engaged, have reported lower grades, and poor relationships (Whitley et al., 2013).

Educators must be literate and well-versed in supporting the needs of students who have experienced the difficulties mentioned. Research has indicated that while educators consider mental health important for student outcomes, they do not however feel confident in helping students, as they have a lack of mental health literacy training (Kutcher, Wei, McLukie & Bullock, 2013). Providing preservice teacher education training in the format of a course is posited to allow future educators to be better equipped to recognize symptoms of mental health problems, as well as provide support to these students and refer out if needed (Kutcher et al., 2013). One example of such professional education for practicing teachers is found in The Mental Health & High School Curriculum Guide, which was developed by Dr. Stan Kutcher to address the gap in teacher education on basic mental health. Researchers recruited 83 experienced teachers to test the curriculum, consisting of basic mental health concepts, epidemiology, and stigma (Kutcher et al., 2013). A program evaluation showed an increase in mental health knowledge and decrease in stigma towards mental illness (Kutcher et al., 2013). Furthermore, the results show that the training provided improved teachers' confidence in dealing with mental health within the classroom (Kutcher et al., 2013). This evidence indicates that improving teachers' mental health literacy has fundamental improvements for both student success and teachers' attitudes and feelings of self-efficacy.

Preservice teacher mental health education

Teachers face many challenges both in understanding behaviours of children impacted by interpersonal and structural violence and feeling like they are teaching in a way that promotes the

success of these children. How can it be expected of teachers to understand behaviours of children in the classroom, and teach to each of these unique needs (Koller & Bertel, 2006) without any foundational knowledge on how to do so? Teachers are left ill-equipped to deal with the diverse needs of their students, with teachers ranking mental health problem identification and behavioural management as being the top needs for professional development (Coalition for Psychology in Schools and Education). Research illustrates that teachers feel knowledge of students' mental health needs is critically important, as they feel a duty to help but feel unprepared to actually intervene (Koller, Osterlind, Paris & Westen, 2004; Rothi et al., 2008). A call for training in mental health and understanding behaviours is necessary to meet the needs of teachers, so they can meet the needs of students.

To address this, a mandatory online course on mental health literacy for preservice teachers was created by Dr. Rodger at Western University, with five learning objectives addressing mental health, impacts of interpersonal and/or structural violence, as and teacher wellness. Prior research in teacher education supported the need for preservice teachers to develop and become literate in mental health (Arens & Morin, 2016). Targeting preservice teachers during their teacher education can be an effective strategy to educate incoming teachers as to the adversities and struggles that students may be coming into the classroom with, as well as how exactly they impact student behaviours in the classroom (Atkins & Rodger, 2016). By knowing the past and present challenges students who have faced adversities experience, teachers may find an improvement in their attitudes towards behaviours exhibited in the classroom.

Inclusive teaching

Students who have experienced interpersonal and structural violence are at a heightened risk for difficulties in the classroom (Whitley, Smith & Vaillancourt, 2013). Teachers need to be mindful of the challenges and presenting problems these students face. Teacher training primarily focuses on 'healthy' child development and systemically ignores the very real experiences of interpersonal and structural violence which consequently impacts a child's development (Rothì, Leavey, & Best, 2008). There has been much emphasis on managing behaviours that are disruptive, but nothing about the emotional and psychological causes of these behaviours (Rothì et al., 2008). To mediate this, teachers need to embody an inclusive pedagogy in their practice (Rothì et al., 2008). Teaching inclusively requires teachers to be aware of the wide range of abilities and exceptionalities within their classroom and teach to this broad range of learners (Rothì et al., 2008). A teaching design that best incorporates this idea is the UDL framework (Katz & Lamoureaux, 2018). Teachers may not know student's experiences with trauma and violence yet the incorporation of UDL within the classroom accounts for learning environments to support all learners, consistent with a TVIC approach (Katz & Lamoureaux, 2018). A teacher's enriched understanding of interpersonal and structural violence and mental health in general will allow better implementation of inclusive practices, UDLs, by demonstrating a thorough understanding of behaviours, adjusting expectations, and delivering appropriate interventions (Rothì et al., 2008). As a result of this equity-oriented practice, the diverse needs of children within the classroom will be met and students will be more prepared to meet their potentials.

Attitudes towards classroom behaviours

Enhancing teacher confidence when dealing with students impacted by interpersonal and structural violence, would be best done through the process of by improving teacher's knowledge of behaviours exhibited by children with interpersonal and structural violence and increasing their efficacy in responding to these behaviours. Attitudes towards behaviour of students is closely related to a teacher's perceived self-efficacy in the classroom. Attitudes are often drivers for behaviour, thus if attitudes towards children impacted by interpersonal and structural violence improve, then it could lead to meaningful changes in teacher's self-efficacy in working with these children. Little has been studied on teachers' support within the classroom, of children who have been exposed to interpersonal and structural violence. A study conducted in the Netherlands examined teacher experiences when working with children after traumatic events with a sample size of *N*=765 (Alisic, Bus, Dulack, Pennings, & Splinter, 2012). This study showed elementary school teachers reported uncertainty surrounding working with and meeting the needs of these children. Only nine percent had participated in a training they identified as relevant to supporting children after trauma (Alisic et al., 2012). Sixty three percent of the teachers did not know when children need mental health care and fifty one percent did not know where to go to ask questions about traumatic stress (Alisic et al., 2012). Evidently, there is a significant gap in both knowledge and training available to teachers surrounding these areas (Alisic et al., 2012).

The more recent study conducted by Anderson, Blitz and Saasatomoinen (2015) utilized focus groups and surveys for 16 school staff (classroom teachers and additional support) to examine their experiences within professional development to explore trauma-informed approaches with students. It was found that although some staff were aware that behaviour was

in response to stress, they often were unsure, overwhelmed, or believed that behaviour exhibited by these students could not be changed (Anderson et al., 2015). After the engagement within the trauma-informed workshop, participants cited that they had gained a greater perspective on student behaviour, understanding the connection between external stressors and behaviour, while being able to label this behaviour as an adaptive purpose (Anderson et al., 2015).

The importance of teachers' attitudes is also pointed out by Avramidis and Norwich (2002). It was found that teacher's attitudes and perceptions of behaviours is influenced by the nature of the presenting problem (i.e. mental illness, disability etc.), as well as the professional background (Avramidis and Norwich, 2002). Respondents rated that students with emotional and behavioural difficulties were the most difficult to teach and meet their needs (Avramidis and Norwich, 2002). Teachers reported less favourable attitudes towards students with these difficulties (Avramidis and Norwich, 2002). Supporting the notion that training improves attitudes, Beh-Pajooh (1992) found that that teachers who had been trained to teach and deal with students with learning difficulties reported more favourable attitudes towards these children compared to other teachers who did not complete training. Therefore, it can be concluded that a lack of preparation to deal student difficulties can impact teachers' attitudes towards these students.

Self-Efficacy

Teacher's perceived efficacy can be defined as the "influences both the kind of environment that teachers create for their students as well as their judgements about different teaching tasks they will perform to enhance student learning," (Sharma, Loreman, & Forlin, 2012). When working with this idea of an inclusive education practice, teachers who have high efficacy feel that they can effectively teach a high needs student within a regular classroom

(Sharma et al., 2012). On the reverse, teachers who feel that they have poor efficacy may feel that they cannot do anything or want to do anything at all to try to help these higher needs students (Sharma et al., 2012). For example, within Anderson, Blitz and Saasatomoinen's study, teachers felt overwhelmed by student behaviour, and felt that they lacked efficacy, power and authority within the classroom, thus resulting in most teachers avoiding implementing strategies, or asking for help from others (2015).

A study conducted by Gibson and Dembo (1984) found varying differences in teaching practices between teachers with high and low self-efficacy. Researchers developed the Teacher Efficacy Scale consisting of 53 items and administered it to 90 teachers to measure the construct. It was found that high self-efficacy teachers used better teaching strategies, humanistic approaches and hands on methods leading to better student outcomes (Gibson & Dembo, 1984). Contrarily, low efficacious teachers employed less teaching strategies that hindered their success (Gibson & Dembo, 1984).

Newmann, Rutter, and Smith's (2017) study on self-efficacy and teachers indicate that 'good' student behaviour impacts a teacher's measure of their own efficacy. As PTSD of interpersonal and structural violence impact performance in school and in the classroom, which include affect dysregulation, attention/ concentration, negative self-image, impulse control, and aggression/ risk-taking (Blodget & Lanigan, 2018), teachers may find difficulty in managing student behaviour, and by default, feel that they have low self-efficacy. It is relevant to hypothesize that when dealing with affected students who display problematic behaviours, teachers may find that they are ineffective, or not good at their job. A greater sense of efficacy leads teachers to invest in professional developments, and put more effort in teaching, leading to a better outcome for student achievement as well (Newmann et al., 2017).

Present study

The purpose of this study was to aid preservice teachers in better meeting the needs of their students specifically by taking a trauma and violence informed lens while dealing with populations of students who have undergone interpersonal and structural violence. The current study addressed the gaps in research as there has been limited research done in Canada on these issues. Previous research takes an individualized approach to the concept of trauma and lacks a trauma informed care approach and excludes an interpersonal and structural violence lens. By incorporating a trauma and violence informed lens, teachers will better understand, recognize and respond to effects of trauma (interpersonal and structural violence) within their classroom.

The current study examined the following research question:

- Will completion of a course influence preservice teacher's attitudes towards mental health behaviours and self-efficacy for teaching students who may have experienced exposure to interpersonal and/or structural violence?

For the purpose of this study, the following definitions of interpersonal and structural violence, and trauma and violence informed care will be utilized. Interpersonal and structural violence will be defined as “Exposure of children to potentially traumatic events that may have immediate and lifelong impacts,” (Blodget & Lanigan, 2018). Trauma and violence informed care (TVIC) can be defined as “Emphasis on a person’s various experiences of past and ongoing violence as the cause of the trauma and avoids seeing the problem as residing only in an individual’s psychological state,” (Ponic, Varcoe, & Smutylo, 2016).

Methods

Research design

This study used a program evaluation approach with repeated measures analyses to measure the extent to which preservice teachers' attitudes and self-efficacy towards teaching children impacted by interpersonal and structural violence, changes as a result of participation in the course. Specifically, quantitative data was collected from the pre-and post-test measures completed by preservice teachers enrolled in the Mental Health Literacy – Supporting Social-Emotional Development EDUC 5018Q course at Western University. Furthermore, this study also served as a program evaluation for the course to indicate its effectiveness in educating and facilitating change within preservice teacher's pedagogy.

Participants

This study examined the knowledge and attitude outcomes total of 248 participants (N=248), all of whom are preservice teachers, namely those who are enrolled in a Bachelor of Education program and studying and working towards becoming a certified teacher. The participants were in Year 2 of their Bachelor of Education program at Western University, where the Mental Health Literacy – Supporting Social-Emotional Development EDUC 5018Q is mandatory for all second-year students except those who are part of the Psychology in Schools specialized cohort. By definition, teacher candidates in the Psychology cohort have an undergraduate degree in psychology and additional experience working with children with exceptionalities. Students from all other five cohorts were enrolled in the mental health literacy course: International Education, Early Childhood Education, Urban Education, French, and STEM. As seen in Table 1, most participants came from the International Education (25.5%) and Early Childhood Education cohorts (21.1%), with the fewest participants coming from the STEM

(13.4%) and Urban Education cohort (18.2%). Sixty-one participants (24.6%) identified as male, one hundred and eighty-three participants (73.8%) identified as female, with four participants (1.6%) preferring not to specify their gender as shown in Table 1. Half the participants (50%) were enrolled in the Primary/Junior Bachelor of Education program, while the other half (50%) were enrolled in the Intermediate/Senior Bachelor of Education program (Table 1).

Almost all of the participants (95.6%) had just completed an undergraduate degree, prior to enrollment in the Bachelor of Education program, while 3.2% had completed a Master's degree prior to teachers college (Table 1). The sampling method chosen for this study was purposive and convenient as the sample size was the number of students enrolled in the course, which is purposeful as part of this study includes evaluation of the course. Preservice teachers were not financially compensated for their participation in the study. Instead, 10% of the participants' final mark in the course is gained from the completion of the pre-test and post-test measures, which are worth 5% each.

Table 1

Sample Demographics

Measure	*N*	%
Gender		
Male	61	24.6
Female	183	73.8
Prefer Not to Say	4	1.6
Bachelor of Education Program		
Primary	103	41.5
Junior	21	8.5
Intermediate	31	12.5
Senior	93	37.5
Cohort		
International Education	63	25.5
Early Childhood Education	52	21.1
Urban Education	45	18.2
STEM	54	21.9
Previous Degree Obtained		
Undergraduate	237	95.6
Masters	8	3.2
Other	3	1.2

Measures

Participants completed various measures detailed in this section. It should be noted that all measures were completed online through Qualtrics.

Demographics Information. A demographics questionnaire was given to all participants consisting of seven questions (See Appendix A). Demographics collected include gender, cohort, and previous exposure to mental health information. The question format ranged from open responses to multiple choice options.

Attitudes related to trauma-informed care. The Attitudes Related to Trauma-Informed Care Scale (ARTIC-35) measures knowledge and attitudes surrounded trauma informed practices (See Appendix B). The dependent variables of this study include subscale 1 and 4 of the Attitudes Towards Trauma Informed Care which examine the "Underlying Causes of Problem Behaviour and Symptoms", meaning understanding behaviour as adaptations and "Self-Efficacy at Work" which is the ability to meet demands of working with a traumatized population (Klinberg Family Centers, n.d.). Students were asked to complete this standardized measure which has 35 items, that are scored on a "seven-point bipolar Likert scale" (Baker et al., 2015). Participants were encouraged to select the dimension to which they feel represents their personal beliefs at their job in the past two months. The reported reliability for this measure is acceptable (a =.91; Baker et al., 2015). Single-item indicators in this study examining the construct and criterion validity, proved to show meaningful relationships between scores and knowledge of participants with test-retest reliability demonstrating as 'excellent' (Baker et al., 2015). Sample items include: "Focusing on developing healthy, healing relationships is the best approach when working with people with trauma histories" and "Rules and consequences are the best approach when working with people with trauma histories", (Baker et al., 2015).

Equity-Oriented health care scale E-HoCS. Equity-Oriented Health Care Scale (E-HoCS) is an instrument that measures the level of equity included within a health provider's practice (Ford-Giboe, Wathen, Browne, Varcoe & Perrin, 2017). Four items of this measure were adapted and added to the ARTIC (questions 36-39), as the included items enhances and reinforces principles of TVIC. The ARTIC does not encompass inclusive education practices fully. With the addition of these four items equitable inclusive teaching practices are measured more effectively according to principal investigators of this study. The added items are scored on the same seven-point bipolar Likert scale as the rest of the ARTIC. Sample items include, "When offering to help a student, I always explain various options and explain what might happen".

Teacher efficacy for inclusive practice. The Teacher Efficacy for Inclusive Practice (TEIP) is a standardized measure created by Sharma, Loreman & Forlin (2011) to measure teacher's self-efficacy and their ability to teach within inclusive classrooms (See Appendix C). It is based off of three core areas necessary to be skilled in, for inclusive classrooms. These areas include inclusive instruction, behaviour management and collaboration (Sharma, Loreman & Forlin, 2011). These subscales are also included in the data analysis for this study. Students were asked to read 18 statements rated on a 6-point scale ranging from one (Strongly Disagree) to six (Strongly Agree). Sample items include: "I can control disruptive behaviour in the classroom", and "I am able to get children to follow classroom rules" (Sharma, Loreman & Forlin, 2011). Validity was confirmed by six university faculties, and reliability was supported by Cronbach's alpha which was reported to be (a=.89) for the total scale (Sharma, Loreman & Forlin, 2011).

Procedure

All eligible preservice teachers in the Bachelor of Education program at Western University were automatically enrolled in a yearlong course Mental Health Literacy – Supporting

Social-Emotional Development EDUC 5018Q taught by Dr. Susan Rodger which is the first mental health course to become mandatory in a University, across Canada. Data was collected from the 2018-2019 school year for purposes of this studies analysis. The course content relevant to this study included interpersonal violence, structural violence, stigma, and promoting positive attitudes within the classroom through an educational and non-clinical lens. The course mandated to teach preservice teachers on how to support mental health in the classroom and increase their awareness of the presentation of mental health impacts in the classroom through the use of evidence-based school mental health promotional strategies. Preservice teachers were taught skills on how to prevent, recognize and address vicarious trauma as well as build resilience, create mentally healthy classrooms, and address challenges faced by students (See Appendix D).

The course, which ran for 12 weeks and included interactive components and age-appropriate case studies assigned to teacher specialty (primary, junior, intermediate, senior). Preservice teachers learned about course content through the lens of their "student" to emulate what a "real" student in this context may be experiencing over the course of the year and as the student/teacher relationship develops demonstrated through exercises such as a "Trauma Walk-Through" (See Appendix E). Preservice teachers completed weekly modules including interviews, videos, and readings related to the weekly course content through the online platform. To assess learning, preservice teachers were required to respond to weekly forum posts, complete quizzes and post their own videos employing strategies learned in the week. The weekly module content, discussion forum and quizzes were expected to have the students engaged in material approximately 2 hours per week, or 24 hours in total from the start to finish of the course.

6 hours of course time, or 25%, was focused on TVIC including educating students on what it is, why it includes violence, and the four principles of TVIC: building trauma awareness and understanding, emphasizing safety and trust, fostering opportunities for choice, collaboration, and connection, and using a strengths-based and capacity building approach to support students (See Appendix F) . These concepts were reflected through the case study "student" that the preservice teachers worked with weekly. While the course content also focused on strategies to create inclusive and safe learning environments, teachers were tasked to apply these to their case study student specifically, in order to help the student overcome some of the impacts of interpersonal and structural violence seen in the classroom. Moreover, preservice teachers were required to empower students through the use of strategies that give their student choices in their learning as well as refer back to the student's strengths.

A recruitment email was sent out on September 19, 2018 containing a Letter of Information and Consent Form as well as information on how to access the pre-test (See Appendix G). Preservice teachers who agreed to participate in the study acknowledged that their scores on the pre and post tests were going to be used for data analysis. Confirmed participants had until October 17, 2018 to complete measures the pre-test consisting of the demographics questionnaire, TEIP (Sharma, Loreman & Forlin, 2011) and ARTIC (Baker et al., 2015). Near completion of the course, participants were then asked to complete the post-test, which consisted of the same measures as the pre-test, by February 17, 2019. The pre- and post-test take approximately 30 minutes to complete. The tests were accessed through the online learning platform, OWL, that preservice teachers use to access the course, and completed through Qualtrics.

Ethical considerations

This study has been given ethics approval by Western University's REB (See Appendix H). Ethical considerations for this project and the participants include informed consent, withdrawal from participation at any time. Participants completed the pre and post-tests as part of their course requirements but did not have to give permission for their results to be utilized for purposes of the study. Those who participated in this study, filled out an informed consent form prior to participation in the study. Informed consent allows for participants to be fully informed about any potential risks and the procedures of the project at hand as well as being aware of the potential risks and benefits to their participation and research at large. Participants were also made aware that they were welcome to cease participation at any time, without consequences. Other ethical considerations that may have arose in this study included anonymity and confidentiality of participant responses. To mitigate this, participants were given a number to protect privacy when analyzing data. Researchers were aware that preservice teachers may have felt various negative emotions after learning about trauma; whether that is rehashing their own past trauma, or through vicarious trauma. Therefore, participants were allowed to leave up to 10% of items blank and still receive credit for participation. Topics surrounding trauma may be triggering, and such, participants were given access to resources and local agencies that aid in coping with traumatic and stressful situations.

Results

The current study's purpose was to observe changes among preservice teacher's attitudes towards behaviour and feelings of self-efficacy, following engagement in a mental health course. A summary of the descriptive statistics for each variable measured in the study can be seen in Table 2; the 2 subscales of the ARTIC (Baker et al., 2015) and 3 subscales of the TEIP (Sharma,

Loreman & Forlin, 2011). Two hundred and thirty-six participants (95.16%) of the eligible preservice teacher candidates fully completed the pre- and post-tests.

Table 2

Descriptive Statistics for Pre-Service Teachers at the Pre- and Post-Test on the TEIP and ARTIC Scale (n=236)

Scale	Variable	Mean		*SD*	
		Pre-Test	Post Test	Pre-Test	Post Test
TEIP	Inclusive Instruction	4.74	5.21	.480	.464
	Managing Behaviour	4.03	4.83	.561	.548
	Collaboration	4.27	5.00	.616	.513
ARTIC	Self-Efficacy	5.89	6.08	.837	.884
	Underlying Causes	5.33	5.74	.749	.737

To measure the degree of association between the variables of interest, correlations were calculated between all of the variables, and were evaluated at a two-tailed level of significance ($p<0.05$). Inspection of the results reveals associations between all variables with the exception of “Managing Behaviour and Underlying Causes” as seen in Table 3. The correlations between variables were significant at the post-test. Thus, utilizing a MANOVA to analyze outcomes of the course is supported.

Table 3

Pearson Correlation Matrix among Subscales of the ARTIC and TEIP, Time 1

	Inclusive Instruction	Managing Behaviour	Collaboration	Underlying Causes	Self Efficacy
Inclusive Instruction		.621**	.629**	.186**	.376**
Managing Behaviour			.556**	.051	.333**
Collaboration				.162*	.314**
Underlying Causes					.429**
Self Efficacy					

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

In order to test the research question “Will completion of a course influence preservice teacher's attitudes towards mental health behaviours and self-efficacy for teaching students who may have experienced exposure to interpersonal and/or structural violence?”, the data was analyzed using a one-way repeated measures multivariate analysis of variance (MANOVA). All assumptions were met for MANOVA. A statistically significant MANOVA effect for time was obtained, $F(4, 231) = 125.6$, $p < .001$; partial $\eta^2 = .731$). Multiple comparison bias was addressed through the application of the Bonferroni correction. Subsequent univariate analyses revealed a statistically significant difference found between Time 1 and Time 2 on all variables including subscales of the TEIP indicating that scores and understanding improved over time.

Table 4

Repeated Measure MANOVA

Source	*df*	*SS*	*MS*	*F*	*p*	*Partial Eta*	*Observed Power*
time*InclusiveInstruction	1	25.99	25.99	250.48	.001	.516	1.00
time*ManagingBehaviour	1	75.07	75.97	478.82	.001	.671	1.00
time*Collaboration	1	64.64	64.64	329.90	.001	.584	1.00
time*SelfEfficacy	1	4.24	4.24	13.86	.001	.056	.960
time*UnderlyingCauses	1	19.37	19.37	94.21	.001	.286	1.00

Note. Significant at $p < .05$.

Discussion

The research aimed to examine whether preservice teachers' attitudes towards mental health behaviours and self-efficacy while teaching students who may have been impacted by interpersonal and structural violence would change after the completion of a mental health literacy course. The purpose of the research was to evaluate the mental health literacy course and the inclusion of TVIC and examine its effectiveness in impacting attitudes and self-efficacy among preservice teachers. This research chose to examine attitudes and self-efficacy as preservice teachers are entering a job that requires knowledge, skills, and competencies to work with a wide variety of students with differing experiences, backgrounds, and abilities. Furthermore, there is limited research and literature in the areas of teacher preparation and mental health literacy as well as actual professional development opportunities for preservice and licensed teachers in these areas. Thus, this study was undertaken to fill the needs in both the research and actual training.

Preservice teachers from Western University whom had not completed prior degrees within a related field (psychology, social work etc.) experienced a mental health literacy course which focused on topics such as interpersonal and structural violence and inclusive education amongst others. Built into the course, preservice teachers completed pre and posttests consisting of various measures including the ARTIC (Baker et al., 2015) and TEIP (Sharma, Loreman & Forlin, 2011), where they received credit towards their mark in the course. Researchers looked to evaluate the course's impact by examining a potential positive change in preservice teachers' attitudes towards mental health behaviours and their feelings of self-efficacy following completion of the course.

Based upon the data collected from the pre-test and the post-test demonstrated that there were significant changes in both attitudes towards mental health behaviours and feelings of self-efficacy, demonstrating that participation in the mental health literacy course increased understandings of mental health behaviours and feelings of self-efficacy for preservice teachers, thus confirming the researchers hypothesis. The variables examined are reflected in the Canadian Federation of Teacher's (2011) findings where teachers reported feeling not informed about mental health and also not equipped to make a difference. It is clear from the Canadian Teacher's Federation study, demonstrating that 97% of respondents identified the need for a better understanding of mental health, there is a lack of knowledge about mental health and its impacts on behaviour (2011). Where Kutcher et al. (2013) and Wei et al. (2014) found that mental health literacy positively increased and changed preservice teachers' attitudes towards mental health, thus reconciling how to target this big need from the Canadian Teacher's Federation Study (2011), the current research study found results consistent with this as well. The current study conversely extended the existing research by looking at feelings of self-efficacy in addition to attitude.

Beh-Pajooh's (1992) study found teachers who were trained in mental health, reported more favorable attitudes towards children. This mirrored Anderson, Blitz and Saastomoinen's (2015) study that found teachers both felt overwhelmed by student behaviour and felt that they lacked efficacy in the classroom. Based upon past research as well as the current research data, it can be concluded that knowledge acquired through the completion of the course has positively changed attitudes towards mental health behaviours and also increased feelings of efficacy in the classroom. Although one cannot assume causation, it can be inferred that an increase in the knowledge about behaviours and change in attitude about them does influence feelings of self-

efficacy. These changes in attitudes and self-efficacy were reflected in the data collected by this study.

Implications for Teacher Practice

The results of the study support that all preservice teachers experienced an enriching experience, greatly influencing their attitudes and self-efficacy. The Relational Cultural Theory posits that growth occurs through empathetic and empowered relationships and has monumental impacts on one's sense of worth and empowerment, amongst other things (Jordan & Hartling, 2002). Equipping preservice teachers with the knowledge and the skills, by way of education about TVIC and general mental health literacy, to better understand student behaviours and feel efficaciousness in their interactions, will better help them in enacting their roles as a facilitator of a growth-fostering relationship. Furthermore, this education process aids in the formation of identity as a "supportive" teacher who understands student behaviours and feels impactful in their work as a teacher and looks to incorporate inclusive teaching practices to better meet the needs of all students (Voelkl & Frone, 2000). Results of the study illustrate that preservice teachers acquired fundamental knowledge and skills about TVIC, which as supported by various studies (Gibson, Stephan, Brandt & Lever, 2014;Theron & Theron, 2014), is monumental in intervening in the impacts of interpersonal and structural violence on academic achievements and social-emotional learning on students. This new knowledge about TVIC and in-class practical strategies are rooted in equity and inclusivity and mirror the UDL method, which ensures better learning for all (Hitchcock & Stahl, 2003).

Preservice Teacher Population

Equipping teachers with knowledge and skills, preservice teachers' pedagogy may be shaped to be more inclusive in their approach, with positive benefits for students impacted by

interpersonal and structural violence (Blodget & Lanigan, 2008). While preservice teachers are in a time of preparation and formulation surrounding their identities as teachers, they are more malleable. Targeting knowledge about student experiences and their very own value and efficacy in the classroom may be more effective in this point of their career, compared to seasoned teachers with more rigid thoughts reinforced by years of experience. Therefore, this subset of the teaching population is an effective and important step in the larger goal of overall enhancement in teacher knowledge surrounding TVIC and mental health.

Implications for Student Success

Students impacted by interpersonal and structural violence may not always have a "caring adult" present in their personal life, and most students report having poor relationships overall (Whitley et al., 2013). Despite this, all students do have a teacher. By training teachers on TVIC and mental health, needs of students will be better met and shaped by a "caring adult" or "supportive teacher". Consequently, students will have at least one growth-fostering relationship (their teacher), which will be beneficial in mitigating the impacts of interpersonal and structural violence in their lives (Jordan & Hartling, 2002). The "supportive teacher" also bears weight on the student's behaviour, social-emotional functioning and academic performance (Ungar, Connelly, Liebenberg & Theron, 2017). Indirectly, this process builds resilience for the student, which then allows them to better respond to stressors such in the future (Kassis et al., 2013). Studies show that teachers who employ inclusive practices as a result of the TVIC and mental health education can intervene in the lives of these children whose academic achievement, behaviours, and social-emotional well-being are impacted (Burke, 2011; Blodget & Lanigan, 2018). Therefore, it can be concluded that student's academic outcomes and social emotional learning will be impacted by teacher's participation in TVIC and mental health education.

Limitations

While this study produced successful results supporting the hypothesis, it is important to address the limitations within the present study. Preservice teachers participating in this study are from a single teacher education program, so the results may not be generalizable to other programs. Because of the nature of the participants (students in initial teacher education), results cannot necessarily be generalized to teachers already licensed and practicing. Threats to internal validity exist (history and maturation) as the study did not account for any current educational experiences that participants engaged in during the study, such as other course work or professional development opportunities. As a result, knowledge acquired and improvement in scores from the pre- to post-test cannot exclusively be attributed to the mental health literacy course. Furthermore, participants completed the same measures twice, once at the pre-test and once at the post-test. The testing could have affected result outcomes since the same measures were used. Lastly, the study did not include further follow up beyond course completion, which means it cannot be ascertained if knowledge gained and influences on practice will be maintained over time.

Conclusion and Future Study

There is an increasing number of students coming into the classroom dealing with impacts of interpersonal and structural violence and as such, teachers need to be equipped with the necessary knowledge and skills to intervene. However, current teacher preparation programs do not include mental health education, nor do professional development opportunities for practicing teachers. Therefore, teachers are finding themselves both uninformed and ill-equipped to deal with these issues. The current study aims to examine the effectiveness of a mandatory mental health course on preservice teachers' attitudes and self-efficacy for teaching students who

may have been exposed to interpersonal or structural violence. The findings of this study demonstrate the significant efficacy of providing education about TVIC and mental health to preservice teachers, where increased understanding about student behaviours and feelings of self-efficacy were prominent. Through the utilization of a mandatory online course for preservice teachers, researchers were able to achieve such results, consistent with current literature that suggests the necessity of teacher education about mental health (Canadian Teachers' Federation, 2011) and importance of TVIC (Ponic, Varcoe, & Smutylo, 2016).

Further research within the areas of TVIC and mental health literacy and education is needed to continue developing better teaching practices and policies to develop a more robust understanding of impacts of TVIC on teaching practice and student outcomes. Future adaptations of the course content could be modified to explicitly teach inclusive instruction as a method of behaviour management, where results showed there was no significant relationship between constructs. Working beyond this study, policies need to be enacted to mandate mental health education within teacher's college as current research shows its importance. Future research can implement similar studies across the province to support and generalize the research findings further within these settings. While the sample size for the current study is robust it pales in comparison to the large numbers of practicing teachers currently in the province. Thus, future directions should focus on including practicing teachers as well.

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Appendices

Appendix A: Demographics Questionnaire

Q1 Please indicate which best describes your experience.

Q2 Gender

- ○ Male (1)
- ○ Female (2)
- ○ Transgender (3)
- ○ Prefer not to say (4)

Q3 What is your current role?

- ○ Pre-service teacher candidate (1)
- ○ Associate-teacher (2)

Skip To: Q4 If What is your current role? = Pre-service teacher candidate
Skip To: Q6 If What is your current role? = Associate-teacher

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Q4 Grades you are teaching

- ○ Primary (1)
- ○ Junior (2)
- ○ Intermediate (3)
- ○ Senior (4)
- ○ Alternative (5)
- ○ Other (6)

Q6 How many years have you taught for?

_____

Q7 Prior to your education degree, what was your previous degree?

- ○ Science (biology, chemistry, physics, mathematics) (1)
- ○ Psychology (2)
- ○ Child and Family Studies (3)
- ○ Health Sciences (kinesiology, nursing, medicine) (4)
- ○ Social Sciences (geography, sociology, anthropology, economics, politic science) (5)
- ○ Arts and Humanities (english, history, women's studies, philosophy, french) (6)
- ○ Social Work (7)
- ○ Religion/Divinity (8)
- ○ Other (please specify): (9) _____

Q8 Degree Obtained

- ○ Undergraduate (1)
- ○ Masters (2)
- ○ PhD (3)
- ○ Other (please describe): (4) _____

TEACHER EDUCATION AND VIOLENCE

Q9 I have learned about mental health, mental illness and trauma and violence before this workshop?

- ○ Yes (1)
- ○ No (2)

Skip To: End of Block If I have learned about mental health, mental illness and trauma and violence before this workshop? = No

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Q10 If yes, where from? Choose one of the following:

- ○ Training program (such as ASSIST or Mental Health First AID) (1)
- ○ Undergraduate course (2)
- ○ Post graduate course (3)
- ○ Other (please describe): (4) _____

Appendix B: Attitudes Related to Trauma Informed Care (ARTIC) Scale

Q1 People who work in education, health care, human services, and related fields have a wide variety of beliefs about their students, their jobs, and themselves. The term "student" is interchangeable with "client," "person," "resident," "patient," or other terms to describe the person being served in a particular setting. Trauma-informed care is an approach to engaging people with trauma histories in education, human services, and related fields that recognizes and acknowledges the impact of trauma on their lives. For each item, select the circle along the dimension between the two options that best represents your personal belief during the past two months at your job.

	1	2	3	4	5	6	7	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
Students' learning and behavior problems are rooted in their behavioural or mental health condition.	○	○	○	○	○	○	○	Students' learning and behavior problems are rooted in their history of difficult life events.

Q2 Click to write the question text

	1	2	3	4	5	6	7	

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
Focusing on developing healthy, healing relationships is the best approach when working with people with trauma histories.	○	○	○	○	○	○	○	Rules and consequences are the best approach when working with people with trauma histories.

Q3 Click to write the question text

	1	2	3	4	5	6	7	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
Being very upset is normal for many of the students I serve.	○	○	○	○	○	○	○	It reflects badly on me if my students are very upset

Q4 Click to write the question text

	1	2	3	4	5	6	7	

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
I don't have what it takes to help my students.	○	○	○	○	○	○	○	I have what it takes to help my students.

Q5 Click to write the question text

	1	2	3	4	5	6	7	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
It's best not to tell others if I have strong feelings about the work because they will think I am not cut out for this job.	○	○	○	○	○	○	○	It's best if I talk with others about my strong feelings about the work so I don't have to hold it alone.

Q6 Click to write the question text

	1	2	3	4	5	6	7	

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
The students were raised this way, so there's not much I can do about it now.	○	○	○	○	○	○	○	The students were raised this way, so they don't yet know how to do what I'm asking them to do.

Q7 Click to write the question text

	1	2	3	4	5	6	7	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
Students need to experience real life consequences in order to function in the real world.	○	○	○	○	○	○	○	Students need to experience healing relationships in order to function in the real world.

Q8 Click to write the question text

	1	2	3	4	5	6	7	

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
If students say or do disrespectful things to me, it makes me look like a fool in front of others.	○	○	○	○	○	○	○	If students say or do disrespectful things to me, it doesn't reflect badly on me.

Q9 Click to write the question text

	1	2	3	4	5	6	7	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
I have the skills to help my students.	○	○	○	○	○	○	○	I do not have the skills to help my students.

Q10 Click to write the question text

	1	2	3	4	5	6	7	

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
The best way to deal with feeling burnt out at work is to seek support.	○	○	○	○	○	○	○	The best way to deal with feeling burnt out at work is not to dwell on it and it will pass.

Q11 Click to write the question text

	1	2	3	4	5	6	7	
Many students just don't want to change or learn.	1 (1) ○	2 (2) ○	3 (3) ○	4 (4) ○	5 (5) ○	6 (6) ○	7 (7) ○	All students want to change or learn.

Q12 Click to write the question text

	1	2	3	4	5	6	7	

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
Students are often not yet able or ready to take responsibility doe their actions. They need to be treated flexibly and as individuals.	○	○	○	○	○	○	○	Students need to be held accountable for their actions.

Q13 Click to write the question text

	1	2	3	4	5	6	7	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
I realize that my students may not be able to apologize to me after they act out.	○	○	○	○	○	○	○	If students don't apologize to me after they act out, I look like a fool in front of others.

Q14 Click to write the question text

	1	2	3	4	5	6	7	

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
Each day is uniquely stressful in this job.	○	○	○	○	○	○	○	Each day is new and interesting in this job.

Q15 Click to write the question text

	1	2	3	4	5	6	7	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
The fact that I'm impacted by my work means that I care.	○	○	○	○	○	○	○	Sometimes I think I'm too sensitive to do this kind of work.

Q16 Click to write the question text

	1	2	3	4	5	6	7	

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
Students have had to learn how to trick or mislead others to get their needs met.	○	○	○	○	○	○	○	Students are manipulative, so you need to always question what they say.

Q17 Click to write the question text

	1	2	3	4	5	6	7	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
Helping a student feel safe and cared about is the best way to eliminate undesirable behaviours.	○	○	○	○	○	○	○	Administering punitive consequences is the best way to eliminate undesirable behaviours.

Q18 Click to write the question text

	1	2	3	4	5	6	7	

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
When I make mistakes with students, it is best to move and pretend it didn't happen.	○	○	○	○	○	○	○	When I make mistakes with students, it is best to own up to my mistakes.

Q19 Click to write the question text

	1	2	3	4	5	6	7	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
The ups and downs are part of the work, so I don't take it personally.	○	○	○	○	○	○	○	The unpredictability and intensity of the work makes me think I'm not fit for this job.

Q20 Click to write the question text

	1	2	3	4	5	6	7	

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
The most effective helpers find ways to toughen up-to screen out the pain-and not care so much about the work.	○	○	○	○	○	○	○	The most effective helpers allow themselves to be affected by the work-to feel and manage the pain-and to keep caring about the work.

Q21 Click to write the question text

	1	2	3	4	5	6	7	
Students could act better if they really wanted to.	1 (1) ○	2 (2) ○	3 (3) ○	4 (4) ○	5 (5) ○	6 (6) ○	7 (7) ○	Students are doing the best they can with the skills they have.

Q22 Click to write the question text

	1	2	3	4	5	6	7	

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
It's best to treat students with respect and kindness from the start so they know I care.	○	○	○	○	○	○	○	It's best to be very strict at first so students learn they can't take advantage of me.

Q23 Click to write the question text

	1	2	3	4	5	6	7	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
Healthy relationships with students are the way to good student outcomes.	○	○	○	○	○	○	○	People will think I have poor boundaries if I build relationships with my students.

Q24 Click to write the question text

	1	2	3	4	5	6	7	

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
I feel able to do my best each day to help my students.	○	○	○	○	○	○	○	I'm just not up to helping my students anymore.

Q25 Click to write the question text

	1	2	3	4	5	6	7	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
It's because I am good at my job that the work is affecting me so much.	○	○	○	○	○	○	○	If I were better at my job, the work wouldn't affect me so much.

Q26 Click to write the question text

	1	2	3	4	5	6	7	

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
Students do the right thing one day but not the next. This shows that they are doing the best they can at any particular time.	○	○	○	○	○	○	○	Students do the right thing one day but not the next. This shows that they could control their behaviour if they really wanted to.

Q27 Click to write the question text

	1	2	3	4	5	6	7	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
When managing a crisis, enforcement of rules is the most important thing.	○	○	○	○	○	○	○	When managing a crisis flexibility is the most important thing.

Q28 Click to write the question text

	1	2	3	4	5	6	7	

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
If I don't control students' behaviour, bad things will happen to property.	○	○	○	○	○	○	○	As long as everyone is safe, it is ok for students to become really upset, even if they cause some property damage.

Q29 Click to write the question text

	1	2	3	4	5	6	7	
I dread going to my job because it's just too hard and intense.	○	○	○	○	○	○	○	Even when my job is hard and intense, I know its part of the work and it's ok.

Q30 Click to write the question text

	1	2	3	4	5	6	7	

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
How I am doing personally is unrelated to whether I can help my students.	○	○	○	○	○	○	○	I have to take care of myself personally in order to take care of my students.

Q31 Click to write the question text

	1	2	3	4	5	6	7	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
If things aren't going well, it is because the students are not doing what they need to do.	○	○	○	○	○	○	○	If things aren't going well, it is because I need to shift what I'm doing.

Q32 Click to write the question text

	1	2	3	4	5	6	7	

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
I am most effective as a helper when I focus on a student's strengths.	○	○	○	○	○	○	○	I am most effective as a helper when I focus on a student's problem behaviours.

Q33 Click to write the question text

	1	2	3	4	5	6	7	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
Being upset doesn't mean that students will hurt others.	○	○	○	○	○	○	○	If I don't control students' behaviour, other students will get hurt.

Q34 Click to write the question text

	1	2	3	4	5	6	7	

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
If I told my colleagues how hard my job is, they would support me.	○	○	○	○	○	○	○	If I told my colleagues how hard my job is, they would think I wasn't cut out for the job.

Q35 Click to write the question text

	1	2	3	4	5	6	7	
When I feel myself "taking my work home", it's best to bring it up my colleagues and/or supervisor(s).	1 (1) ○	2 (2) ○	3 (3) ○	4 (4) ○	5 (5) ○	6 (6) ○	7 (7) ○	When I feel myself "taking my work home", it's best to keep it to myself.

Q36 Click to write the question text

	1	2	3	4	5	6	7	

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
It's important that I ask students about basic resources that affect their well-being, such as food, clothing, or shelter	○	○	○	○	○	○	○	Students' personal situation is their own business.

Q37 Click to write the question text

	1	2	3	4	5	6	7	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
Students are a product of their environment and background, so I can expect certain students to behave a certain way.	○	○	○	○	○	○	○	It's important to get to know each student to understand their context and how it might shape their behaviour.

Q38 Click to write the question text

	1	2	3	4	5	6	7	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
I encourage students to come and see me when they need to.	○	○	○	○	○	○	○	Students need to be self-reliant and solve their own problems.

Q39 Click to write the question text

	1	2	3	4	5	6	7	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	
When offering to help a student, I always explain various options and what might happen.	○	○	○	○	○	○	○	Students should do what they're asked to do, with no explanation required.

Appendix C: Teacher Efficacy for Inclusive Practice (TEIP) Scale

This survey is designed to help understand the nature of factors influencing the success of routine classroom activities in creating an inclusive classroom environment.
Please circle the number that best represents your opinion about each of the statements.
Please attempt to answer each question

1 Strongly Disagree	2 Disagree	3 Disagree Somewhat	4 Agree Somewhat	5 Agree	6 Strongly agree

		SD SA	D	DS	AS
1	I can make my expectations clear about student behaviour.	1 5	2 6	3	4
2	I am able to calm a student who is disruptive or noisy.	1	2	3	4 5
3	I can make parents feel comfortable coming to school.	1	2	3	4 5
4	I can assist families in helping their children do well in school.	1	2	3	4 5
5	I can accurately gauge student comprehension of what I have taught.	1	2	3	4 5
6	I can provide appropriate challenges for very capable students.	1	2	3	4 5
7	I am confident in my ability to prevent disruptive behaviour in the classroom before it occurs.	1	2	3	4 5
8	I can control disruptive behaviour in the classroom.	1 5	2 6	3	4
9	I am confident in my ability to get parents involved in school activities of their children with disabilities.	1 5	2 6	3	4
10	I am confident in designing learning tasks so that the individual needs of students with disabilities are accommodated.	1 5	2 6	3	4
11	I am able to get children to follow classroom rules.	1 5	2 6	3	4
12	I can collaborate with other professionals (e.g itinerant teachers or speech pathologists) in designing educational plans for students with disabilities.	1 5	2 6	3	4
13	I am able to work jointly with other professionals and staff (e.g. aides, other teachers) to teach students with disabilities in the classroom.	1 5	2 6	3	4
14	I am confident in my ability to get students to work together *in pairs or in small groups*.	1	2	3	4 5
15	I can use a variety of assessment strategies (for example, portfolio assessment, modified tests, performance-based assessment, etc).	1 6	2	3	4 5

16	I am confident in informing others who know little about laws and policies relating to the inclusion of students with disabilities.	1	2	3	4	5 6
17	I am confident when dealing with students who are physically aggressive.	1	2	3	4	5 6
18	I am able to provide an alternate explanation or example when students are confused.	1	2	3	4	5

Appendix D: Preventing, Recognizing and Addressing Vicarious Trauma Tools

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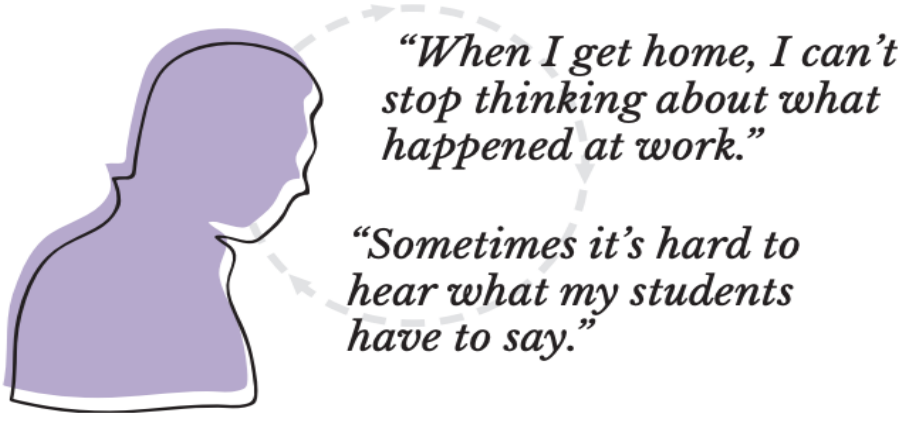
Preventing, Recognizing & Addressing Vicarious Trauma

A Tool for Educators and Schools

- **Anyone working in a schools will encounter students experiencing significant challenges, and we know that hearing distressing stories about students' lives can be taxing.**
- **Teachers often feel helpless in the face of these challenges, and when we consider how complex students' lives can be, there are rarely "easy fixes."**
- **Understanding the nature and effects of vicarious trauma can be a first step in preventing, recognizing and dealing with it.**

What is vicarious trauma?

Also known as secondary traumatic stress or compassion fatigue, vicarious trauma is a negative reaction to trauma exposure and includes a range of symptoms that are similar to experiencing trauma directly. Vicarious trauma is common but there are ways to prevent it and limit its impacts.



1 ADVOCATE FOR ORGANIZATIONAL SUPPORT.

Importantly, individual teachers cannot be solely responsible for preventing or dealing with the effects of vicarious trauma. Doing so requires a culture of support, which means a team effort from the teacher to the school level, and adequate resources to provide good care and a safe learning environment. Leaders should engage front-line, administrative/support staff and, as appropriate, students and families in developing organizational supports for vicarious trauma.

The first step is prevention. All school staff will work with students exposed to traumatic experiences; schools that prevent and address vicarious trauma promote a better work environment for staff and, ultimately, a better learning environment for students.

2 TAKE STOCK of the school environment.

Do conditions in the school increase or decrease the likelihood of vicarious trauma having a negative impact?[1] Consider:

- Does the workload allow teachers to attend to their own care needs, as well as those of student; for example, are there adequate breaks?
- How is exposure to trauma acknowledged and dealt with?
- How are teachers expected to act when exposed to vulnerability (in themselves, their colleagues, or their students)? Tough? Distant? Compassionate?
- Is reflective supervision from an administrator formally available?
- Are staff encouraged to debrief informally amongst themselves, perhaps using a "buddy system"?
- How are teachers who are struggling supported? Are people seen as "burned out" (an individual's weakness and problem) or "used up" by the school's/board's practices?
- How is workplace violence - including between staff, or students, or staff-student/student-staff acknowledged and dealt with?

[1] Vicarious trauma can influence your ability to best serve your students, and look after yourself. A trauma- and violence-informed care (TVIC) approach is therefore recommended; see our tool: [URL]

Hearing about the trauma of others can also lead teachers to re-live their own trauma experiences. For example, we know that in female-dominated professions such as nursing, the prevalence of intimate partner violence is higher than in the general population. Supports should include ways for staff to address their own trauma histories.

3 **BE AWARE of the signs and symptoms of vicarious trauma and how to recognize them in both yourself and your co-workers.**

Signs and symptoms can include:

- Extreme or rapid changes in emotions (e.g., involuntary crying)
- Difficulty managing boundaries with students
- Increased sensitivity to violence
- Relationship difficulties
- Physical symptoms (e.g., aches, pains)
- Sleep difficulties
- Intrusive imagery
- Cynicism
- Aggression
- Social withdrawal

4 **IF YOU'RE CONCERNED, take an online self-test, such as the one here: http://www.compassionfatigue.org/pages/selftest.html**

5 **PRACTICE SELF-CARE. Whether for prevention or treatment of vicarious trauma, focusing on self-care is a good idea.**

Anyone who works in a helping profession is at risk. Even if these experiences are currently absent, it's important to take steps to keep well. Everyone is different, but self-care might look like:

- Healthy diet
- Adequate sleep
- Spending time in nature
- Spending time with friends & family
- Exercise (of any kind)
- Relaxation

Adapted from EQUIP Health Care. (2017). *Preventing, Recognizing & Addressing Vicarious Trauma: A Tool for Primary Health Care Organizations and Providers Working with Individuals*. Vancouver, BC. Retrieved from www.equiphealthcare.ca

Appendix E: Trauma Walk Through Exercise

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Trauma Walk-Through

An Exercise for Educators

This exercise will help teachers, at various schools, 'walk through' their space to assess the extent to which the social and physical environment is likely to feel welcoming, culturally and emotionally safe, and reduce potential harm for everyone, but especially for those who are most likely to feel unwelcome and unsafe.

1 Approaching and entering the school and classroom

Think about visiting the school where you work. As you approach and enter, imagine the following, as though it's your first visit:

- In getting there, what is their frame of mind likely to be? Was it a journey that was predictable, safe, and supported?
  - If they are coming on a school bus, is the student experiencing bullying during the ride? Do they have a support, a friendly face?
  - If they are arriving on foot, what was the walk like? Long? Short? Many strangers? Danger?
- Is there good supervision in the playground? Is there bullying or aggressive behaviour?
- What is the entrance like? Crowded? Noisy? Organized?
- Who is present? Are there teachers or other trusted adults standing at the door, welcoming students into the school, into the classroom?
- Who is communicating with who? How are people communicating? What is their tone of voice?
  - What are the sounds present as student enter? Is there calm music? Students who are dysregulated and disruptive?
- Are people making eye contact? And if so, who is making eye contact with whom?

Think about it

- What is welcoming or unwelcoming as you enter?
- What tone does the signage, décor, announcements, convey? Who do you imagine decides about these features? What influences those decisions?
- Who would feel welcome or unwelcome here? Do you feel welcome here? Why or why not?
- What things or people in the space might deter people from engaging with teaching staff? What might be encouraging or supportive to get them to move forward to talk to staff?

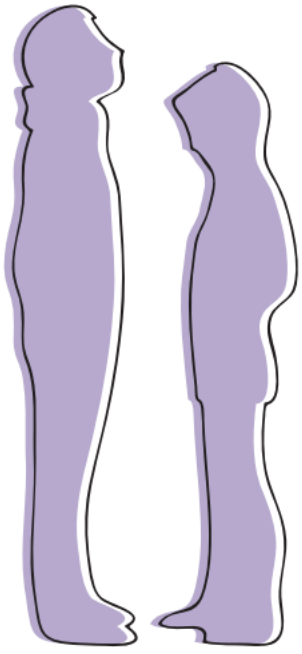
2 Office area

Now imagine approaching the office area/staff.

- Where is it located? How do people (students or parents/guardians) know where it is and how they are supposed to get there?
- How are people greeted and by whom?
- How many people are usually in the reception area? Who are they?
- How private are conversations? What if someone has a sensitive topic to talk about?
- What is allowed? Are children allowed to come in?
- How do students and parents/guardians and other people know what staff roles are? How can you recognize a teacher? A caretaker? A Principal?
- What do staff convey? Consider usual facial expressions, tone of voice, body language, words.
- What stands out about this space?
- What makes you feel comfortable or uncomfortable here? Who would feel most comfortable? Are different people treated differently and if so in what ways and by whom? Based on what?
- What questions are asked? Review the late/attendance policies. What does it draw attention to? From what does it detract attention?

Think about it

- When staff engage with students and families do you think that they consider what is affecting people's well-being? For example, do you think staff account for how hard it might be to even get to school?
- How do staff engage with people who do not speak English as a first language? Does anything about their communication change?
- Do the staff take into consideration student age or physical ability? For example, how do they speak with children with exceptionalities? Are students able to sit in the office, or are they standing in the hall?
- How do staff engage with people who seem to have trouble focusing on questions being asked?



3 Hallways

What is it like to walk through the halls?

- If you had to describe the halls of your school(s) to someone in two words, what would you say?
- What is the strongest feeling you have as you walk the hallways?
- What does it look like? How does it sound? How does it feel (crowded)? What are students doing there?
- Are water and washrooms available, accessible, and easy to locate? Are they clean? How do they smell?
- Are the halls clean?
- Are they safe and well-supervised?
- Are there spaces available for students to sit (e.g., benches, chairs)? Do they seem comfortable?
- What do you notice about the students walking through here? Do they seem comfortable to you, nervous, excited? Are they talking to one another?
- Notice who is helping people in the halls. Who is talking to students? Who is helping if someone appears distressed or uncomfortable? Do some people seem uncomfortable? Why?
- What kinds of things are happening to students here? Are they Getting disciplined, or encouraged?
- What do you see that is relevant to people's privacy, their identity and/or their learning needs and/or well-being?

Think about it

- Who would feel comfortable in this space? Who wouldn't? Why?
- How is privacy and confidentiality protected in this space?

4 Classrooms

What are the classrooms like?

- What is the layout of the room? Would you describe the space? Warm, cold, cozy, sterile?
- Who is in the room?
- What do students hear as they enter the classroom? Are they greeted? What do their first interactions with their teacher look like?
- Are there different areas and materials to accommodate for different learning styles?
- Is a teacher available in the classroom outside of class time to talk to students? Is this made known to students?
- How are decisions made in the classroom? Is this done collaboratively with students? How are student suggestions and ideas received?
- What do you notice about when and how teachers talk with students? How does the encounter begin? End?
- What happens prior to and during instructional time and assessments? What are staff doing and saying? What actions do staff take to ensure students feel comfortable taking learning risks?
- Would you feel comfortable in this space? What might make you feel uncomfortable or unsafe?

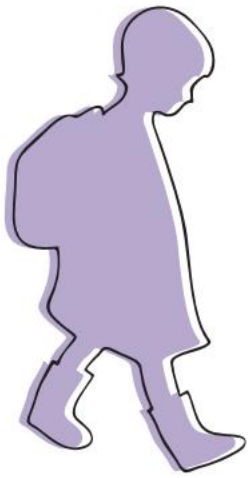
Think about it

- Are the classrooms set-up to best serve students, or teachers?
- Who would feel respected in this space? Who would not? Why?
- What small thing could be changed to make it a more welcoming space?

5 Leaving school

What is the end of the day like?

- What happens when students leave school to go home? Are assignments considered/discussed in the context of resources and experiences at home and in their community?
- Do teachers and staff say goodbye to them at the end of the day
- Is there any understanding that students behaviour at the end of the day might be a reflection of their experiences at home (e.g., acting out before a long-weekend and not wanting to go home)
- What does the end of the day routine look like? What is it like in the halls? How does it sound? How does it feel?
- What do you think student's trips homes might be like? How might this influence their mood and behaviour at the end of the day?



Adapted from EQUIP Health Care: *Equity Walk Through Questions.* Vancouver, BC. Retrieved from https://equiphealthcare.ca/toolkit/equity-walk-through/

Appendix F: TVIC Tools and Principles

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Trauma- & Violence-Informed Care (TVIC)

A Tool for Educators & Schools

What is TVIC?

TVIC is an approach that focuses on **preventing harm by creating safe environments and learning encounters** for students who have experienced (and may still be experiencing) violence and trauma. It is an inter-related set of school policies and educator-level practices based on knowledge about trauma and violence, how student's social conditions can be harmful, and taking a person-centred, strengths-based approach.

- Trauma-informed care (TIC) seeks to create safe care environments based on knowing the effects of trauma.
- Trauma- and Violence-Informed Care (TVIC) expands on this by:
  1. emphasizing that interpersonal violence, especially in the family, is particularly harmful
  2. highlighting that harm comes not only from peoples' experiences, but can also come from our social conditions
- TVIC shifts the focus from "what's wrong?" (problem is located within the student) to "what's happened, and is still happening?" (problem is located within the student's life).
- TVIC makes us examine not only the effects of ongoing violence, but also social structures and practices that can be harmful, and look for ways to improve practices, and consider social conditions, to provide a better, safer educational environment.

Everyone needs to feel physically and emotionally safe; this is especially true for those who've experienced violence and trauma. Many people are currently in unsafe relationships or may live in unsafe conditions. Others may be feeling the effects of previous interpersonal, collective and/or historical violence or trauma.

This tool offers actions you can take to implement TVIC in your teaching practice, and advocate for this approach in your school.

4 WAYS TO TEACH AND WORK IN A TRAUMA- & VIOLENCE-INFORMED WAY

1 BUILD TRAUMA AWARENESS & UNDERSTANDING.

All services taking a TVIC approach begin by building awareness of:

- The high prevalence of trauma and violence
- The significance of historical (collective and individual) and ongoing violence (interpersonal and systemic)
- How the impact of trauma can be central to one's development
- The wide range of coping strategies that people use
- The relationship of trauma and violence with substance use, physical health and mental health concerns

Consider trauma a risk factor.

- Students who experience(d) abuse and neglect are at higher risk of a range of physical injuries, and adverse mental and physical health outcomes in adulthood.
- Children's exposure to intimate partner violence (IPV) is associated with physical health and mental health problems, alterations in mood, attention, concentration, relationship skills, intrusive memories, compromised learning outcomes, emotional distress and avoidance behaviours (such as school refusal).
- Students with a childhood history of abuse and neglect are more likely to smoke, misuse substances, and engage in risky sexual behaviours.
- Experiences of interpersonal violence, racism and discrimination can change neurobiological patterns and genetic structures that affect mental and physical health.

Consider intersections.

For example, children who experience abuse and live in poverty:

- have families or caregivers with less access to resources for financial independence; therefore, have fewer 'choices'
- are likely to experience stigma related to poverty and violence and may face stereotypes and assumptions about the parents' ability to care for them
- may not have the financial resources that their families need to afford childcare, lawyers, transportation etc., all of which increase their vulnerability to abuse, and;
- have disadvantages that compound if they experience additional forms of discrimination, e.g., related to race, age, literacy, ability or size (poverty and neglect can often look similar, and assumptions that students are neglected when they are living in poverty can further add to stigma)

2 EMPHASIZE SAFETY & TRUST.

You don't need to know a person's history of violence or trauma to provide TVIC. Everyone should be included in the classroom:

Teachers can:

- Create a welcoming environment, including through language (see below)
- Examine the welcoming procedures that consider students' possible trauma histories
- Adapt the physical space for comfort
- Be non-judgmental: make people feel accepted & deserving of your best care
- Communicate clear & accurate expectations about their classroom
- Help students and their caregivers think about safety
- Seek input from students and families about safe & inclusive strategies

Teachers can support their own safety and mental health through:

- Education & resources specific to vicarious trauma[1]
- Accessing support resources (e.g., Employee Assistance Programs)
- Engaging in self-care (e.g., eating healthy, exercise, spending time with friends and family)

Language Matters!

Instead of:
"difficult child" or "child with behavioural problems"

Use:
"child who is struggling" or "child is trying to communicate the best way they can"

Instead of:
"abused child" or "abused youth"

Use: *"child" or "youth"*

Instead of:
"she doesn't want our help"

Use: *"our help may not be meeting her needs"*

[1] For more information on vicarious trauma, see our tool: [URL]

3 FOSTER OPPORTUNITIES FOR CHOICE, COLLABORATION & CONNECTION

Teachers can:

- Develop and use practices and relationships that allow for flexibility and encourage shared decision-making and participation
- Involve students in their learning
- Provide appropriate and meaningful learning options
- Consider choices collaboratively with students
- Actively listen, and privilege the student's voice
- Notice and support students in need

Think of TVIC as "universal precautions" to ensure that students in your care are not re-traumatized or harmed.

4 USE A STRENGTHS-BASED & CAPACITY-BUILDING APPROACH to support students.

Teachers can:

- Allow sufficient time for meaningful engagement
- Provide learning options that can be tailored to student's needs, strengths and contexts
- Seek out ongoing opportunities for development of knowledge and skills with respect to trauma- and violence-informed teaching and classroom management
- Help students identify their own strengths
- Acknowledge the effects of historical and social conditions
- Teach students skills for recognizing triggers, calming, and centering that are developmentally appropriate

Trauma- and violence-informed care requires you to examine your own experiences, power & assumptions, and adjust these to provide the safest and most appropriate learning environment.

Adapted from EQUIP Health Care. (2017). *Trauma-and-Violence-Informed Care (TVIC): A Tool for Health & Social Service Organizations and Providers*. Vancouver, BC. Retrieved from www.equiphealthcare.ca

Appendix G: Letter of Information and Consent Form

Email Script

Subject Line: Baseline knowledge about Mental Health Literacy

Dear Students:

The instructor of course you are enrolled in (5018Q:Mental Health Literacy) measuring how effective this course is in increasing your knowledge about mental health literacy and trauma-informed teaching. Among the ways that you will receive marks for the course is through the completion of a pre-test and a post-test. There is no need to prepare for either of these tests; they will not be graded. Only your participation is required. More information is available on how this is done, once you click on the survey link. Another way your participation is counted in the course is through your weekly online posts in the "Discussion forums".

In addition to having this pre- and post-test data and Discussion forums to measure how well the course met its learning objectives, a PhD student is going to be using the data to evaluate how online courses can help teacher education students learn about these topics.

No matter if you decide to share your data or not, you still need to complete the pre- and post-tests and Discussion Forum posts in order to receive the participation grades.

Below, you will find a link to the secure survey site. DO NOT SHARE THIS LINK, as it is unique to you.

You have until October 17 at 11:59 pm to complete the pre-test. Please be aware that it takes approximately 25 minutes to complete, so leave yourself ample time.

Please follow the instructions below to access the pre-test:

Follow this link to the Survey: (link to be inserted)

Or copy and paste the URL below into your internet browser: (link to be inserted)

For more information about this pre-test please visit our course website on OWL. Please see the e course outline. For any technical difficulties accessing the pre-test, please contact TA Richelle Bird.

version date: September 19, 2018

Letter of Information &Consent

Research team
Principle Investigator-Dr. Susan Rodger, Ph.D. , Faculty of Education
Co-Investigator-Richelle Bird, M.A., Ph.D. Candidate, Faculty of Education
Research Support Staff- Anna Zuber, Faculty of Education

Purpose of the Study

You are invited to participate in this research because you are a Bachelor of Education student enrolled in EDUC 5018Q. This study is part of a PhD dissertation that will use the results from the course evaluation of this course. All students will complete pre and post-tests and discussion forum posts for the purpose of quality improvement to ensure the course is meeting learning objectives, and will receive marks for participation. We are asking your permission to share your responses to the quizzes for this PhD dissertation exploring the effectiveness of an online platform for providing pre-service educators information about mental health literacy and trauma-and-violence-informed care. We are also requesting your permission to collect and analyze information from your discussion forum posts for the purpose of identifying themes related to your experience of the course.

Your participation in this research is voluntary. There are no limitations to withdrawal, you can withdraw any or all of your information and have the right to withdraw your consent at any point during the study until final course grades are submitted, at which point the data will be anonymized. You may withdraw for any reason, and without any penalty by emailing Anna Zuber.

Confidentiality

The information collected will be used for research purposes only, and neither your name nor any identifying information will be used in any publication or presentation of the study results. These identifying pieces of information will be used solely for the purpose of matching up survey responses to participants so you are able to receive your participation grade. All data used in the research will be de-identified following the submission of final grades by the IT department, thus the identities of those who consented to share data and those who did not will not be known to the research team. All information collected for the study will be kept confidential in the possession of Western's research; only whole group findings and themes will be shared. Please note that answers from your pre and post-tests will not be linked to your forum posts. Your decision to participate will in no way impact your grade in this course or your relationship with faculty.

All data will be retained for a minimum of 7 years. Representatives of Western University's Non-Medical Research Ethics Board may require access to your study-related records to monitor the conduct of the research. The results of the study will be disseminated through publication in a peer reviewed journal and/or through presentation at relevant conferences.

You do not waive any legal rights by consenting to this study

Risks & Benefits

There are no known risk to participating in this study. While there are no direct benefits to participating, study data will be utilized to fill important gaps in the literature with respect to mental health education for teachers.

Questions

If you have any questions about the conduct of this study or your rights as a research participant you may contact the Office of Research Ethics, Western University. If you have any questions about this study, please contact Dr. Susan Rodger

Please print/save a copy of this letter for future reference

Sincerely,
The Research Team,
Dr. Susan Rodger Ph.D., Richelle Bird M.A., Ph.D. Candidate, and Anna Zuber, Manager Teacher Education, Faculty of Education

This section is to ensure that we have your informed consent to participate in this research.

Principal Investigator: Dr. Susan Rodger Ph.D., Faculty of Education, Western University
Co-Researcher: Richelle Bird M.A., Ph.D. Candidate, Faculty of Education
Research Support: Anna Zuber, Manager Teacher Education, Faculty of Education

I give permission for my responses from my pre and post-tests to be used in this research.
__Yes
__No

I give permission for my discussion forum responses to be used in this research.
___Yes
___No

Appendix H: Ethics Approval Form

Western Research

Date: 25 September 2018

To: Dr. Susan Rodger

Project ID: 112483

Study Title: Evaluating a Mental Health Literacy Course for Pre-Service Teachers

Application Type: NMREB Initial Application

Review Type: Delegated

Full Board Reporting Date: 05/Oct/2018

Date Approval Issued: 25/Sep/2018 10:58

REB Approval Expiry Date: 25/Sep/2019

Dear Dr. Susan Rodger

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the WREM application form for the above mentioned study, as of the date noted above. NMREB approval for this study remains valid until the expiry date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

This research study is to be conducted by the investigator noted above. All other required institutional approvals must also be obtained prior to the conduct of the study.

Documents Approved:

Document Name	Document Type	Document Date	Document Version
Email Script_rev_CLEAN	Recruitment Materials	19/Sep/2018	2
LOI_Sept. 19th Version_CLEAN	Implied Consent/Assent	19/Sep/2018	2
Open_Access_Mental_Health_Literacy_Course-Post-Test-2018-2019	Online Survey	06/Sep/2018	1
Open_Access_Mental_Health_Literacy_Course-Pre-Test-2018-2019	Online Survey	06/Sep/2018	1

No deviations from, or changes to the protocol should be initiated without prior written approval from the NMREB, except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

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.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Katelyn Harris, Research Ethics Officer on behalf of Dr. Randal Graham, NMREB Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

CV

Christina Marie Amico

Education

MA	Western University, Counselling Psychology	June 2020
B.Ed.	York University, Primary/Junior Education	June 2018
BA	York University, Honours Psychology	June 2018

Teaching Experience

Thames Valley District School Board 2018-2020
Occasional Teacher
York University 2017-2018
Teaching Assistant, Department of Music
York Catholic District School Board 2015-2017
Student Teacher

Research and Professional Experience

Graduate Student Clinician 2019-2020
Child and Youth Development Clinic
Crisis Counsellor 2019-2020
Kids Help Phone
Research Assistant 2018-2020
Centre for School and Mental Health, Western University
Research Assistant 2016-2017
Neuropsy Lab, York University

Professional Affiliations

Ontario College of Teachers: *686641*