2-1-2016 12:00 AM

Teachers' Help-Seeking Perceptions and Workplace Psychological Safety

Sheila M. Linseman
The University of Western Ontario

Supervisor
Dr. Susan Rodger
The University of Western Ontario

Graduate Program in Education
A thesis submitted in partial fulfillment of the requirements for the degree in Master of Arts

Abstract

This objective of this study was to investigate teacher mental health, attitudes toward psychological help-seeking, and perceptions of psychological safety within schools. Findings from this study of 600 Canadian educational professionals revealed a higher frequency and severity of distress than in the general population, warranting intervention. Attitudes toward psychological help-seeking were generally positive, though less favorable than comparable published studies. Overall, participants rated their workplaces as "somewhat" psychologically safe. However, there were low ratings of work-life balance and respectful treatment of mental illness by leadership. Implications and recommendations of these findings were discussed.

Keywords: teacher mental health, help-seeking, workplace psychological safety

ACKNOWLEDGEMENTS

First and foremost, I wanted to express my gratitude to the Ontario Secondary School Teachers' Federation and Physical & Health Education Canada, especially all of the teachers and educational professionals who took the time to share their experiences so that we could share their story.

I also wanted extend my appreciation to my advisor, Dr. Susan Rodger. Your global perspective, patience, and guidance helped me to find my way through this very meaningful research. Your support and unfailing belief during graduate school motivated me to persevere, teaching me valuable lessons that encouraged me to grow as a person, student, and professional. A special thanks to both you and Dr. Jason Brown for your feedback and flexibility. It was truly appreciated!

Lastly, I would like to thank my family, friends, and colleagues who supported my application to graduate school and stood by me during the challenging moments. Thank you for your faith in me, kind acts, and words of encouragement. I am fortunate to have you in my life and I look forward to celebrating this accomplishment with all of you.

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Literature Review

Mental Illness in Canada

Approximately one in five Canadians will be identified with a mental illness over the course of their lifetime (Health Canada, 2002). More recently, a Community Health Survey found that one in six Canadians identified a need for mental health treatment in 2012, and 71% of those who identified this need were seeking counselling (Sunderland & Findlay, 2013) which speaks to the demand for mental health intervention. However, this study concluded that mental health care needs may be even greater since the data did not capture all mental health diagnoses or include institutionalized populations (Sunderland & Findlay, 2013). In addition, these statistics may not reflect the full picture of mental illness in Canada, since they do not account for 1) sub-clinical mental health issues 2) undiagnosed or undisclosed mental illness or 3) individuals who may benefit from professional treatment but do not elect to pursue mental health services.

Detection and Prevalence of Distress

The Kessler 6, K6, is a validated and widely used scale that measures non-specific psychological distress and has been used to screen for serious mental illness in community samples (Prochaska, Sung, Max, Shi & Ong, 2012). In an epidemiological study in the US, it was estimated that approximately 6% of adults met the criteria for serious mental illness, not including substance use diagnoses, based on a cut-score of $K \geq 13$ in 1996 (Kessler, 1996 as cited in Prochaska et al., 2012).

In a more recent study designed to establish cut-off scores for moderate distress, a health survey of 50, 880 Californians found a slightly higher prevalence of distress with, 27.9% of

adults falling in the range of moderate distress and 8.6% meeting the criteria for serious mental illness (Prochaska et al., 2012). Lastly, in the 2012 Canadian Community Health Survey, 21% of respondents scored in the range of moderate distress and 2% scored in the range of serious mental illness in a sample of 25, 113 Canadians aged 15 or older (Sunderland & Findlay, 2013).

In terms of functioning, there is research to suggest that those who fall in the severe range of distress have typically reported "a lot" of impairment in various areas of their lives including work performance, household duties, leisure, and relationships with friends and family, while those in moderate distress have reported a tendency toward "some" impairment (Prochaska et al., 2012), as compared to those with little to no distress.

Moreover, the greater the level of distress on the K6, the higher the level of smoking, obesity, and sedentary lifestyle (Prochaska et al., 2012). There is also an increased risk of binge drinking among those with moderate and severe levels of distress compared to those with little to no distress. Also, since there were no significant differences in binge drinking rates among those with moderate or severe levels of mental health distress, even moderate distress was correlated with substance abuse issues (Prochaska et al., 2012)

In terms of treatment needs, significant differences have also been found between those with serious, moderate, and little to no level of distress (Prochaska et al., 2012) When controlling for other variables, participants who met the criteria for serious mental illness (SMI) accessed nearly five more visits to professionals per year ($p<.0001$) in order to treat psychological issues and substance use than those in moderate distress, and those with moderate distress, averaged an additional 1.3 ($p <.0001$) visits per year comparative to those with little to no distress. However,

only one in three people who met the criteria for SMI had been referred to, or were accessing, treatment (Prochaska et al., 2012).

Distress and Mental Health Care Needs

In Canada, data from the 2012 Community Health Survey-Mental Health, indicated a correlation between distress levels and perceived mental health needs in Canada, irrespective of mental health diagnoses (Sunderland & Findlay, 2013). Individuals with higher distress levels (moderate and severe categories) endorsed more need for mental health care, such as the need for information, medication, or counselling and other mental health care needs, than those in low distress. Moreover, higher distress levels were predictive of partially or fully unmet mental health needs (Sunderland & Findlay, 2013). For example, those in the high distress category were more than twice as likely to have a partially or fully unmet need for counselling compared to those the low distress group. However, the researchers caution that the directionality of this relationship is unclear (Sunderland & Findlay, 2013).

Physical and Mental Health Implications of Workplace Stress

Research pertaining to workplace stress has suggested that working conditions have significant personal and professional implications for employees (Shain, Arnold, & GermAnn, 2012). Staff who work in psychological unsafe conditions are two times more likely to experience substance dependence and issues with conflict, two to three times more likely to report injuries, infections, and mental health problems (e.g., anxiety, depression, and burnout), three times more likely to experience back pain and cardiovascular disorders, and five times more likely to develop certain types of cancers comparative to employees who work in psychologically safe environments (Shain et al., 2012).

Organizational Implications of Workplace Stress

Aside from personal impacts, workplace stress has significant implications for the workplace and Canadian economy such as employee turnover, detrimental effects on client care, absenteeism, presenteeism (unproductive work performance due to exhaustion), turnover, performance issues, and treatment costs (Bamber, 2006; Castillo-López, Gurpegui, Aysuo-Mateos, Luna, & Catalan, 1999; Cimiotti, Aiken, Sloane, &Wu, 2012; Mood Disorders Society of Canada, 2014). Nationally, research completed by the Mental Health Commission of Canada (MHCC) (2013) found that approximately 500, 000 people per week were absent from work due to issues associated with mental illness. This report also estimated that mental health concerns resulted in approximately $51 billion in annual economic losses in Canada, which is projected to increase to $88.8 billion within 10 years (MHCC, 2013). These costs were evident in statistics regarding teachers' benefits plans. For example, the Ontario Teachers Insurance Plan estimates that over 40% of their long-term disability claims are related to mental disorders (OTIP.com).

Teacher Mental Health Disorders and Risk Factors

In a study of 26 occupations, teaching was identified as one of the six most stressful professions (Johnson, Cooper, Cartwright, Donald, Taylor & Millet; 2005). In specific, teaching has been associated with burnout, stress-related symptoms, and mental disorders (Grayson & Alvarez, 2008; Johnson et al., 2005; Kovess-Masféty, Rios-Seidel, & Sevilla-Dedieu, 2006). Despite the psychological risks of the profession, a review of the literature revealed limited published research focusing on the mental health and wellbeing of teachers compared to students. However, based on the prevalence rates of mental illness in Canada approximately 19,633 educators in Ontario would be expected to be impacted by a mental health or substance abuse disorder over their lifetime (Health Canada, 2002; Ministry of Education, 2012). As such a

large sector in the workforce, it is important to understand their risks as well as the potential impacts on their students and school climate.

A review of the literature revealed several demographic and environmental factors (including interactive effects) within schools that placed teachers at risk of burnout, psychological distress, and mental illness.

In 2008, Grayson and Alvarez examined demographic and school climate factors in respect to three aspects of burnout; Depersonalization, Emotional Exhaustion, and Personal Accomplishment. They (2008) described Emotional Exhaustion as a progressively developing fatigue that develops as a teacher's resources become depleted. Depersonalization was defined as "cynical attitudes towards parents, students, and the workplace" (Grayson & Alvarez, 2008, p. 1350), whereas Personal Accomplishment was considered a teacher's perceptions about their influence on student development (Grayson & Alvarez, 2008).

Findings demonstrated that Emotional Exhaustion was most associated with school climate factors such as parent-community and student-peer relations, while Depersonalization was most correlated with a teachers' relationships with students and administrators as well as their students' academic orientation, and Personal Accomplishment was most linked to instructional management issues (Grayson & Alvarez, 2008). However, Emotional Exhaustion and Depersonalization were mediated by teachers' satisfaction levels. Based on these findings, researchers recommended that detrimental school factors could be targeted to produce a more positive school climate and improve teacher well-being (Grayson & Alvarez, 2008).

In terms of demographic factors, Grayson and Alvarez (2008) found gender and income level were significantly related to burnout or feelings about school climate, whereas years of experience, age, marital status, and educational level were found to be non-significant factors.

For example, females scored significantly higher on Emotional Exhaustion and rated student academic orientation as more important than their male counterparts (Grayson & Alvarez, 2008). Also, teachers' ratings of positive school climate increased with salary (Grayson & Alvarez, 2008). Identifying that female teachers experience more Emotional Exhaustion is particularly beneficial information for intervention, given its strong association with Total Burnout scores on the Maslach Burnout Inventory.

In a study of teacher psychological distress and mental illness, Kovess-Masféty, Rios-Seidel, and Sevilla-Dedieu (2006) found that gender and aspects of the school environment were associated with teachers' mental health problems. They identified that teaching level, age, and family status were also potential risk factors. Male teachers in nursery, intermediate, and special education classrooms were more likely to experience a higher prevalence of psychiatric disorders over their lifetime as were female high school teachers (Kovess-Masféty et al., 2006). The same findings applied to the prevalence of psychological distress, except that teaching level became insignificant for females (Kovess-Masféty et al., 2006). There was also an increased level of psychiatric disorders as male teachers aged or when they worked in an underprivileged area, whereas seniority level increased the prevalence for female teachers (Kovess-Masféty et al., 2006). Lastly, widowed, separated, and single teachers were at greater risk for mental health issues than their married colleagues, regardless of gender (Kovess-Masféty et al., 2006).

Kovess-Masféty et al., (2006) identified three primary occupational risk factors that were associated with a greater risk of mental health issues and psychological distress among teachers, with some variations depending on gender. First, the probability of developing any mental health disorder, including anxiety or depressive disorders, and the prevalence of psychological distress was substantially increased by a lack of colleague support in both male and female educators

(Kovess-Masféty et al., 2006). This is unsurprising in light of a Canadian-wide survey in which 40.7% of teachers reported leaving the profession due to relations with administration, while 51.8% also endorsed problems with colleagues, albeit to a lesser extent (Karsenti & Collin, 2013).

Secondly, student abuse and violence were also identified as occupational risk factors (Karsenti & Collin, 2013; Kovess-Masféty et al., 2006; Wilson, Douglas, & Lyon, 2011). A fear of verbal abuse was associated with increased diagnoses of mental health disorders and psychological distress, regardless of gender (Kovess-Masféty et al., 2006). However, female teachers had a particularly increased prevalence of depressive disorders over the prior year and during their lifetime. In contrast, concerns regarding physical abuse only had an impact on female teachers, resulting in a higher risk for psychological distress and anxiety disorders (Kovess-Masféty et al., 2006).

The experience of student violence (overt, covert, and other) and fear of violence were also predictive of adverse physical, mental health, and occupational symptoms in a study of 731 teachers in British Colombia (Wilson, Douglas, & Lyon, 2011). Covert violence was defined as harassment (e.g., insults and intimidation), while overt violence involved behaviors such as threats and physical abuse (with or without a weapon), and "other" violence referred to acts such as stalking or sexual harassment. Overall, Wilson and colleagues found that the more violence a teacher experienced, the greater their adverse symptoms. In specific, covert violence was a predictor of detrimental physical (e.g., headaches, fatigue), emotional (e.g., shame) and career (e.g., job satisfaction, morale) symptoms, while overt violence was a significant predictor of physical symptoms, and stalking experiences were predictive of emotional and physical effects (Wilson et al., 2011). Moreover, there was a significant relationship between teachers'

experiences of violence and their severity of fear; however, a hierarchical regression analysis revealed that both made unique contributions to teachers' symptoms (Wilson, Douglas, & Lyon, 2011).

Lastly, vocational choice and interest were predictors of occupational risk in the profession. In male and female teachers, the absence of a teacher vocation was significantly associated with mental disorders, while a lack of interest in teaching was only associated with an increased prevalence of mental illness in female teachers (Kovess-Masféty et al., 2006)

Teacher Job Satisfaction, Physical Health and Quality of Life

In addition to the threat of burnout, emotional distress, and psychiatric disorders, teachers were also at risk for a lower quality of life, a greater prevalence of physical health issues, and greater job dissatisfaction (Akomlafe and Ogunmakin, 2014; Johnson et al., 2005; Yang, Hu & Wang, 2009). In comparison to the Chinese population, Yang et al., (2009) found that teachers reported less physical wellbeing, greater levels of physical pain, impaired work performance due to physical and emotional issues, and poorer interpersonal functioning. However, female teachers reported more occupational stress and poorer health, which were attributed to greater teaching and caregiving responsibilities as well as potential gender differences in psychological characteristics (Yang et al., 2009). While all eight dimensions of quality of life correlated with physical and mental health, role insufficiency, interpersonal strain, and social support were considered the greatest predictors of mental health concerns among this sample of teachers (Yang et al., 2009).

Akomlafe and Ogunmakin (2014) conducted a study with 398 secondary school teachers and discovered that self-efficacy, emotional intelligence, and occupational stress, in combination, were positively related to teacher job satisfaction. However, an analysis of their relative

contribution, revealed that emotional intelligence had a greater effect than self-efficacy, and occupational stress had no effect on job satisfaction (Akomlafe & Ogunmakin, 2014). This finding is consistent with Vesely, Saklofske and Leschied's (2013) contention that there is an overlap in these competencies and that the core elements of teacher efficacy are encompassed by emotional intelligence.

Emotional Intelligence and Treatment Interventions

An awareness of teachers' risks for mental health problems, lower quality of life, and job dissatisfaction is essential to promoting protective factors and implementing targeted treatments that mitigate some of these risk factors. For example, psychological interventions have been recommended to teach emotional intelligence skills, specifically interpersonal skills, adaptability, mood regulation, and stress management (Akomlafe & Ogunmakin, 2014; Yang et al., 2009). Emotional intelligence training has also been supported by Vesely et al., (2013), who suggested it may improve teacher mental health and competency in the classroom as well as decrease job dissatisfaction and stress. Social support from colleagues (Kovess-Masféty et al,, 2006; Yang et al., 2009) and addressing behavioral concerns, such as physical and verbal abuse from students (Kovess-Masféty et., 2006) have also been suggested to improve teaching conditions. In addition to social support, Yang et al., (2009) recommended coping strategies such as recreation, self-care, and rational coping strategies because they had positive effects on teachers' physical health and made an even greater contribution to their mental health.

Helping Professionals and Help-Seeking

Though preventative interventions have been proposed to ameliorate teaching conditions and build mental health resiliency, teachers who are experiencing mental health concerns or disorders may still require tertiary interventions such as counselling or psychotherapy. Therefore,

it is imperative to develop an awareness of their actual experiences with psychotherapy and attitudes toward seeking professional psychological assistance. A review of the literature revealed a significant gap in studies on teachers' perspectives of seeking mental health treatment. Therefore, similar studies of helping professionals were examined.

Interviews with 14 human service professionals, subsequent to a diagnosis of burnout, clarified antecedents to burnout and barriers to help-seeking, in particular professional identity (Putnik, deJong, & Verdonk, 2011). Putnik and colleagues (2011) found these helping professionals possessed a strong work ethic and sense of responsibility to both their clients and colleagues. These providers assumed additional workload to please clients and elected not to seek support from colleagues, concerned they would be burdening their peers. In many cases, these employees were required to assume additional duties following organizational restructuring and found themselves expending more effort for a less rewarding position, as well as having less access to support from management. As employees experienced the progressive symptoms of burnout, they isolated themselves from their social supports and spent less time in leisure activities in an attempt to recuperate. As human service professionals, they conceived of themselves as helpers and felt it was inappropriate to require their own support, viewing help as a sign of weakness and professional incompetence which endangered their professional identity. The majority of participants did not approach their employer to discuss workload issues. However, those that did recounted being validated, but not supported due to organizational constraints, or blamed for not meeting job demands (Putnik et al., 2011). Though participants experienced both physical and psychological symptoms, they typically delayed treatment until their symptoms impeded their functioning or they were forced to seek help by employers. Some participants dismissed their symptoms and warnings from colleagues, families and friends, while

others had not been able to recognize that they were experiencing symptoms of burnout due to their non-specific symptoms. This study also found that the majority of participants sought medical assistance, rather than psychological support, except for those with a prior history of burnout, which was associated with employee's subscription to the medical model or possible stigma.

Lastly, Putnik and colleagues (2011) found that employers and doctors had more influence than friends, colleagues, or family on employees' help-seeking behavior, which was speculated to be due to their authority role. While over half of these participants were teachers, the sample size makes it challenging to generalize to teachers as a subgroup or helping professionals overall. However, this thematic analysis is consistent with elements of work-stress models such as job demands, support, reward, and effort.

The findings also yielded similar results to a large study of helping professionals, which also found a relationship between role identity and seeking professional help for distress. Siebert and Siebert's (2007) study of 751 social workers in the United States suggested that greater identity as a professional caregiver reduced help-seeking. In contrast, significant levels of depression and professional licensure increased the likelihood of help-seeking. Interestingly, burnout scores, impaired performance, and years of experience were not significantly related to seeking care (Siebert & Siebert, 2007).

According to role identity theory, individuals assume identities in various aspects of their life, including their professional lives (Siebert & Siebert, 2007). In the case of helping professionals, they adopt the professional identity of a caregiver, someone who gives rather than receives support. Professional identities are personally contrived and are often idealized images of self, which acts as standards of performance. However, some identities become more

predominant because they are reinforced by internal and external rewards, such as the satisfaction that is derived from supporting someone or the authority of a helping position. A caregiver identity is also sustained by "social supports" such as clients, who have high expectations of the caregiver. Based on this theory, when a helping professional is unable to live up to these ideals they perceive themselves as failures and attempt to overcompensate to prove their competency and maintain their professional identity and the social recognition of the position by others. Siebert and Siebert (2007) contended that role identity theory was an effective model to explain helping professionals' distress, and lack of help-seeking, because it explained the shared issues of a caregiving profession, yet still accounted for individual differences and the influences of both personal and professional demands on standards. Most importantly, the theory explains why helping professionals may be unable to draw upon their competencies to address their own mental health issues and avoid seeking professional support (Siebert & Siebert, 2007).

This theory is also an important consideration for intervention as it proposed that effective interventions would have to address these internalized self-images and expectations, in addition to external behavior, in order to effect change (Siebert & Siebert, 2007).

Perhaps the most comprehensive study of helping professionals investigated the views and practices of 1122 general practitioners and 132 psychiatrists (Adams, Lee, Pritchard, & White, 2010). Adams et al., (2010) found that nearly half of these doctors, 46.2%, had reported at least once incident of depression during their lifetime, while 13.7% had experienced depression over the last year. More importantly, only 11.6 % of participants that experienced depression within the last year had taken more than a week off for that specific reason (Adams et al., 2010). They also found that those with greater levels of perceived stigma and a past history of depression were less likely to seek help. The majority of participants said they would seek

help from friends and family (Adams et al, 2010). Their second choice was their doctor, followed by colleagues, then counsellors. However, gender differences were noted and female participants were significantly more likely to approach friends, family, or counsellors as opposed to colleagues (Adams et al., 2010).

In addition, when participants in Adams's et al., study (2010) were asked to contemplate possible reasons why they would not seek treatment for their stress, five themes emerged. Participants were particularly concerned about disappointing their colleagues (70.6%) and their patients (51.9%) (Adams et al., 2010). Other significant barriers included concerns about privacy, work coverage, and career advancement (Adams et al., 2010).

An article written by an Associate Dean of a medical school in the UK made similar contentions (Garelick, 2012). He suggested that doctors were hesitant to seek services due to confidentiality and stigma, fearing disclosure would harm their career. Similarly to the articles on human service professionals and social workers he contended that doctors commonly view themselves as selfless caregivers, who according to the norms of the profession, should be able to manage the problems in their work and personal lives and essentially "heal" themselves. Ultimately, the need for professional mental health support was perceived as a weakness. Furthermore, it was suggested that when the positive attributes of physicians, such as conscientiousness, drive, or the tendency to question oneself are excessive, physicians may become anxious or question their competency with patients (Garelick, 2012).

In fact, it is believed that the professional norms that inhibit physicians from seeking help may begin as early as medical school (Chew-Graham, Rogers, & Yassin, 2003). Interviews of medical students indicated reservations about help-seeking because it may influence their reputation in medical school or future relationships with other medical students as prospective

colleagues. They also were reluctant to seek help for stress and distress due to concerns about confidentiality and its ultimate effect on their future career. Themes of shame, embarrassment, and stigma were expressed in regards to seeking-help. As such they were more likely to see support from friends and family than services offered through the medical school (Chew-Graham et al., 2003).

While these studies suggest a common theme of mental health risk in the helping professions and barriers such as stigma, privacy issues, role expectations, and fears of being viewed as incompetent, these findings may or may or may not be generalizable to teachers. Therefore, a study of teachers' perceptions of seeking and receiving mental health services is warranted.

Stigma as a Barrier to Help-seeking Behavior

Despite effective prospective treatments for mental illness, people are still hesitant to seek treatment (Corrigan, Benjamin, Druss, & Perlick, 2014). Corrigan et al., (2014) and Vogel, Bitman, Hammer, & Wade (2013) have suggested that stigma is largely to blame. However, there has been debate about whether public stigma actually affects the use of treatment services and to what degree.

Due to the criticisms regarding the intangible definitions of stigma, Link and Phelan (2001) developed a four component model of stigma. They proposed that stigma occurs when people begin to notice differences in others and attach labels to those qualities (Link & Phelan, 2001). Negative stereotypes are then linked to these labels, which creates an estrangement (Link & Phelan, 2001). The final component of stigma involves diminishing a person's worth, sometimes to the degree that prejudice occurs (Link & Phelan, 2001). A caveat of Link and Phelan's (2001) model is that stigma occurs as a function of power.

The majority of studies regarding the phenomenon of stigma suggested there was a significant relationship between measures of public stigma and attitudes toward help-seeking (Elhai et al., 2008; Komiya et al., 2000; Pinto, Hickman, & Thomas, 2014; Vogel et al., 2013). However, a study by Golberstein, Eisenberg, and Gollust (2009) found no relationship between social stigma and the use of mental health services. A comparison of methodologies suggested a few possible differences that may account for these disparate findings. Golberstein et al., (2009) had correlated social stigma (SSRPH) scores with actual use of mental health services, whereas the other studies had correlated SSRPH scores with the ATSPPH or ATSPPH-SF scales, which measure beliefs about using mental health services but not actual use. Secondly, Golberstein et al., (2009) removed the word psychologist from SSRPH items. This adaptation may have flattened the social stigma effect thereby influencing its relationship with use. Lastly, mortality effects were possible since baseline social stigma scores were correlated with actual service use two years later (Golberstein et al., 2009). Though Elhai et al., (2008) found that ATSPPH-SF scores were predictive of intent to seek help within 1-6 months, receptivity and intent do not equate to actual use. Therefore, it would be useful to examine teachers' ATSPPH-SF scores in respect to their actual use of psychotherapy services.

However, research has identified factors that promote help-seeking. For example, one study found that those who sought psychological support were more likely to have been encouraged to seek treatment by relatives and friends or to have relatives and friends that had also participated in treatment themselves (Vogel et al., 2007). Perhaps the opportunity to be authentic and receive the unconditional positive regard of loved ones, counterbalanced the effects public stigma?

In terms of variance, Komiya et al., (2000) indicated that four variables, including perceived stigma, accounted for 25% of the variance of attitudes toward seeking mental health services. While Pinto et al. (2014) discovered that perceived stigma alone accounted for only 15% of this variance. Consequently, both studies (Komiya et al., 2000; Pinto et al., 2014) concluded that additional items may be warranted on the scale to comprehensively measure help-seeking behavior.

Barriers Associated with Help-Seeking Behavior

There were several barriers to help-seeking noted in the helping professions and stigma literature, in particular gender. In a study of 163 student teachers in Singapore, Ang, Lim, Tan, & Yau (2004) found that females were more positive about using mental health services and were more likely to admit their need for this type of support than their male counterparts. Studies of the Social Stigma for Receiving Psychological Help (SSRPH) and the Attitude Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF) scales also found that males reported less positive attitudes toward seeking or receiving mental health treatment (Elhai et al, 2009; Komiya, 2000)

This finding was also consistent with Adams et al., (2010), who used an alternative measure of stigma. Not only did female physicians and psychiatrists report more favorable attitudes toward seeking mental health treatment, they were also more willing to acknowledge a need for professional support than male doctors or psychiatrists (Adams et al., 2010).

In contrast, Elhai's et al., (2008) only detected gender differences, as measured by ATSPPH-SF scores, in one of his sample groups. Female college students had significantly higher total scores on the ATSPPH-SF than male college students, suggesting females had more

positive views of mental health services; however this effect was not evident in their study of primary care patients (Elhai et al., 2008).

Aside from gender and perceived stigma, the degree of distress and receptivity to emotional vulnerability were also found to be predictors of help-seeking behavior (Komiya et al., 2000). Moreover, Cohen and Peachy (2014) proposed that inadequate funding was a barrier to help-seeking because psychological treatments were not funded by provincial health care plans nor sufficiently covered by private insurance plans.

Lastly, Elhai et al., (2008) found that college students, who were older, married, or had higher educational levels, scored higher on the ATSPPH-SF, suggesting they were more receptive to mental health treatment. In their patient sample, there was also a relationship between age and years of education and help-seeking, but race and marital status had no effect on help-seeking attitudes (Elhai et al., 2008).

Psychologically Safe and Healthy Workplaces

In a Canadian Ipsos Reid poll of 6,804 employees in 2009, 20% of respondents identified their workplaces as psychologically unsafe (Shain, 2009). However, further research would be required to identity sector specific perceptions, as rates may be even higher in demanding professions such as teaching. A study of educators' perceptions would also prove useful since the emphasis on education in schools may detract from the notion of schools as workplaces and the rights of staff in schools to psychological safety as employees. Moreover, it would be important to investigate the relationship between help-seeking and perceptions of workplace psychological safety, since it is reasonable to believe that psychologically unsafe workplaces would exacerbate the effects of stigma and role identity on help-seeking.

There was a significant overlap in the literature regarding the workplace factors that impact an employee's physical and psychological health, albeit some variations in theoretical models and terminology. In a review of this literature, Sauter, Murphy, and Hurrell (1990) identified six primary categories of potential risk which included workload and pace, role stressors, work duties and employee control, scheduling, fears regarding career, and work relationships (as cited in Kelloway and Day, 2005). From Vézina's (2010) perspective, employees have specific human needs which need to be fulfilled in the workplace, such as a sense of belonging, self-worth, psychological and physical safety, equality, and independence, otherwise they are at risk for physical and mental health problems (as cited in Shain, Arnold, & GermAnn, 2012).

These needs were categorized into five types of risk; job demands and required effort, job control, reward, fairness, and organizational support. These risks form the foundation of two empirically validated work-stress models, the Demand-Control-Support Model (DCS) and the Effort/Reward Imbalance (ERI), which have been developed to explain the process of how psychosocial risks in the workforce can contribute to psychological distress or well-being (Shain et al., 2012).

In the Demand-Control-Support model, psychologically healthy workplaces balance their workload expectations, making sufficient demands to challenge employees versus excessive demands that tax their resources (Gilbreath, 2012). According to this model, healthy workplaces permit some level of employee autonomy, enabling employees to decide how to manage their workload, as well as sufficient support (emotional or resources) from supervisors to cope with job requirements (Gilbreath, 2012). Whereas, in the Effort-Rewards Imbalance model an employee is at risk for physical and mental health problems when they perceive they are

receiving insufficient recognition and compensation comparative to their level of investment, especially if they are making excessive effort (physical and or mental) to achieve organizational expectations (Shain et al., 2012). In contrast, in healthy workplaces there is more reciprocity between employer and employee, with a balance between reward and effort (Gilbreath, 2012). While this imbalance can arise from excessive organizational demands with low rewards, it can also occur when employees are excessively dedicated or passionate about their work (Gibreath, 2012), similar to the high professional standards found in role identity theory. Thus, it may be particularly important to monitor employees who have strong professional caregiving identities.

An alternative to work-stress models, are healthy workplace models (Grawitch, Gottschuk, & Munz, 2006; Kelloway & Day, 2005). While these are very reminiscent of work-stress models, Kelloway and Day (2005) stipulated that their conception of healthy workplaces was unique because they viewed antecedents to workplace stress as potential risks or suppressors. They described their approach as "holistic" because it considered the physical and psychosocial elements of healthy workplaces. According to their model, healthy workplaces offered a physically safe work environment such as ergonomic workspaces. On a psychosocial level, they were supportive, respectful and fair, and they encouraged healthy interpersonal relationships among staff and supervisors. Employee involvement and development, as well as work characteristics and content were also integral healthy workplace practices. Lastly, it was stressed that healthy workplaces encouraged work-life balance (Kelloway & Day, 2005).

A subsequent model, the Pathways for Achievement of Total Health (PATH) model was also developed through an extensive review of interdisciplinary research on healthy workplace practices (Grawitch, Gottschuk, & Munz, 2006). In this model, healthy workplaces were defined as those which implemented health promotion programs and practices that contributed to

organizational performance as well as the physical and mental well-being of employees (Grawitch, Trares, & Kohler, 2007).

Based on the literature, Grawitch et al., (2006) proposed that there were five primary types of healthy workplace practices, employee involvement, employee growth and development, employee recognition, as well as work-life balance, and health and safety. The second part of the model focused on employee well-being outcomes suggested by the literature; physical and mental health, stress, commitment, motivation, job satisfaction, employee morale, and work climate. The final part of the model noted the empirical, organizationally anticipated outcomes of healthy workplaces; competitive advantage, performance or productivity, absenteeism, turnover, injury rates, hiring selectivity, cost savings, product and or service quality, and customer satisfaction (Grawitch et al., 2006). However, they recommended future research was needed to measure the comprehensive effect of all five workplace practice changes. They also suggested that it was vital to have an effective communication system within the organization for employers to communicate workplace initiatives and how to access them, and for employees to provide feedback and recommendations. Ensuring healthy practices were consistent with organizational values, goal and mission was also recommended for success (Grawitch et al., 2006).

As evidenced in these models and workplace research, individual and organizational factors have been correlated with employee burnout, psychological distress, and mental disorders (Grayson & Alvarez, 2008; Kovess-Masféty, 2007). However, the majority of studies that have been evaluated interventions for teacher stress have been person-oriented which precludes the investigation of workplace stressors (Naghieh, Montgomery, Bonell, Thompson, & Aber, 2015) and essentially places the responsibility on employees for their mental health status and recovery.

However, in 2013 the Bureau de normalisation du Québec (BNQ) and Canadian Standards Association Group (CSA Group) released a voluntary standard, "Psychological Health and Safety in the Workplace - Prevention, Promotion, and Guidance to Staged Implementation" commissioned by the Mental Health Commission of Canada (MHCC) (BNQ et al., 2013) that emphasizes a shared accountability for employee well-being (BNQ, CSA Group, & MHCC, 2013).

Within this standard, psychological safety was defined as "one that promotes employees' psychological well-being and does not harm employee mental health in negligent, reckless, or intentional ways" (Shain, 2009, p.42). The foundation of this workplace psychological safety standard are psychosocial factors, aspects of the work environment or working conditions that may evoke psychological reactions resulting in either resilience or mental health concerns (Samra et al., 2012). Thirteen psychosocial factors were identified by the Centre for Applied Research in Mental Health and Addiction (CARMHA), which were considered pertinent to Canadian organizations, irrespective of size or sector, and consistent with the literature on workplace psychosocial risk (Samra et al., 2012). These included psychological support, organizational culture, clear leadership and expectations, civility and respect, recognition and reward, employee involvement and influence, growth and development, workload management, engagement, work-life balance, psychological competencies and requirements, psychological protection and protection of physical safety (Samra et al., 2012).

While this psychological standard has yet to be studied within the school system, some related research has been conducted in schools, specifically studies of positive school climate and psychosocial safety climate. Overall, the findings have demonstrated that a positive school

environment is important to the well-being and success of teachers, students, and schools as a whole, which is consistent with the philosophy of psychologically safe workplaces.

Though definitions vary, school climate commonly involves four elements within schools; safety (physical and social-emotional), teaching and learning, interpersonal relationships, and physical environment and organizational structure (Cohen, McCabe, Michelli, & Pickeral, 2009). Within this literature, there is strong and evolving evidence that a positive school environment promotes a student's motivation to learn and their subsequent academic performance, as well as overall school effectiveness (Cohen et al., 2009). The literature has also suggested that there is a relationship between a positive school climate and a student's normal social development, violence prevention, and teacher retention (Cohen et al., 2009).

In fact, Cohen and colleagues (2009) contended that school climate factors such as relationships and perceived feelings of school community are directly linked to known turnover factors such as insufficient administrative support, student misconduct, and a lack of teacher involvement in school decisions; they argued that in healthy school environments administrators would support teachers and that educators would have a sense of influence on school operations (Cohen et al., 2009).

A similar concept to workplace psychological safety, psychosocial safety climate (PSC), has been investigated within the educational system. PSC has been described as "policies, practices, and procedures for the protection of worker psychological health and safety" which occur when organizational leaders value their employees enough to balance their health and mental well-being with demands (Dollard & Bakker, 2010, p. 580). In high PSC environments, job demands are reasonable and there are systems in place that permit employees to request additional resources when required, which mitigate workload risks; whereas in organizations

with low PSC, managers make excessive demands without providing sufficient resources to accomplish goals (Schaufeli, Bakker, & Van Rhenen, 2009 as cited in Garrick et al., 2014).

In one study of 288 Australian educators, from elementary to university teaching levels, and a smaller group of administrators, researchers examined the effect of PSC on job demands, resources, psychological safety (psychological distress, emotional exhaustion) and teacher engagement at three points over the course of a year (Dollard & Bakker, 2010). PSC was measured by a four-item scale including questions on leadership support and involvement for stress prevention, stakeholder involvement in health and safety, shared accountability within school for stress prevention, and reception to employees' health and safety recommendations. As predicted they found that when PSC scores were low, job demands were high, resulting in higher rates of psychological problems among employees, both distress and emotional exhaustion. PSC also moderated the influence of job demands on emotional exhaustion. A final finding was that PSC could predict the relationship between a teacher's skill discretion (e.g., skill development and utilization) and their ability to engage in their work (e.g., energy, enthusiasm) (Dollard & Bakker, 2010).

In a second study of 61 Australian teachers and principals, elementary and high school level, researchers studied the effect of PSC on psychological variables such as acute fatigue, teacher engagement, and recovery from work-related stress (Garrick et al., 2014). Similar to the previous study they found that strong PSC moderated the harmful effects of job demands, specifically teachers' fatigue and engagement. In strong PSC schools, there were also a more significant effect of work recovery on fatigue and engagement. Surprisingly, they also found a positive relationship between workload and teacher engagement in strong PSC schools. Overall

this suggested that PSC protected teachers from the negative effects of work demands and enhanced their recovery effects (Garrick et al., 2014).

Given the promising findings of both of these studies, particularly the longitudinal support for strong PSC in Dollard and Bakker's (2010) study, they urged administrators consider it as a workplace practice to promote psychological well-being (Dollard & Bakker, 2010; Garrick et al., 2014).

An investigation of teachers' perceptions of workplace psychological safety is also timely with the release of Canada's new psychological safety workplace standard, which appears to be influencing the policy of Ontario school boards. For example, in May 2013, the Hamilton-Wentworth District School Board (HWDSB, 2013) passed a healthy school and workplace policy. Within this policy they defined a healthy school and workplace as occurring "when the culture, climate and practices create an environment that promotes student and employee health and safety as well as organizational effectiveness" (HWDSB, 2013, p.3). Even more relevantly the Bluewater District School Board (BDSB) developed an administrative procedure in 2015 for a psychological health and safety management system, which utilizes the psychosocial factors and implementation process recommended by the national standard (BDSB, 2015).

Overall, all of these workplace models have attempted to explain the risk process or ameliorate employees' mental and psychological safety in workplaces, including schools, using empirically based workplace risk and protective factors. However, (Gratwich, Gottschalk, & Munz, 2006 as cited in Grawitch, Trares and Kohler (2007) proposed that healthy workplace initiatives may not be universally successful because employees are unique in their values, experiences, family situations, and expectations of their workplaces. Therefore, they advised that effective interventions required employee involvement and evaluation (Grawitch et al., 2007).

Consequently, Grawitch, Trares and Kohler's (2007) conducted a study of 152 faculty and staff at a Midwestern United States university to gauge their level of satisfaction with programs and policies using Grawitch's healthy workplace practices, employee involvement, growth and development, recognition, health and safety, and work-life balance. Satisfaction was gauged by employee's reported satisfaction and engagement in the practice as well as their perceived success of the practice and its importance to organization (Grawitch et al., 2007). Satisfaction was then examined with respect to faculty and staff members' commitment to their organization, emotional exhaustion, intention to leave their position within the year, and mental well-being. Overall they found that all five healthy workplace practices were predictive of employee outcomes including organizational commitment (31.2%), well-being (22.5%), turnover intention (20.1%) and emotional exhaustion (29.5%) after controlling for demographic variables (Grawitch et al., 2007). However, employee involvement was identified as the primary predictor for all four employee outcomes, which was speculated to have occurred due to the democratic nature of this particular work environment (Grawitch et al., 2007). This raises the question of whether employee involvement in a common factor to other healthy workplace practices or whether the value placed on these practices is not only unique to individuals but also to settings.

This research is timely in light of the recent release of the Canadian standard for psychologically safe and healthy workplaces and the imminence of school based mental health care which will only add to teachers' scope of practice (Manion, Short & Ferguson, 2012). The continually increasing demands on the profession are likely to pose significant risks to teachers' mental well-being. Given the personal, organizational, and financial impacts of mental health and the potential impact on students' development and academic achievement, a thorough study of educator's help-seeking behaviors and their views of psychological safety in their schools will

enhance the understanding of teachers' experiences in their workplaces and provide valuable information for future intervention.

An initial review of the literature revealed occupational risks associated with teaching, yet limited published research on teacher mental health in comparison to student mental health, with even more limited research in Canada. The intervention component of this research precipitated a search for articles on teacher help-seeking, which produced only one article that included seven teachers. However, this search yielded a small body of research on helping-seeking among helping-professionals, which suggested a potential reluctance to seek professional help due to a variety of barriers including stigma and concerns regarding the impact on one's career. Given my employment experiences in the helping professions, I queried whether workplace psychological safety may be associated with help-seeking barriers. A review of workplace literature reviewed extensive studies on various models associated with psychological safety, but few related to teaching, and none specific to teachers and the Canadian national standard. Consequently, given the limited published research on teacher help-seeking and workplace psychological safety as well as access to secondary data from a study of Canadian teachers' and educational professionals, exploratory research seemed warranted.

Method

The primary objective of this study is to describe teachers' receptivity to mental health treatment, as well as their actual use of mental health services, including the sources of professional help, the effectiveness of their experiences with psychotherapy or counselling, and potential barriers to accessing these interventions. The secondary goal is to investigate teachers' perceptions of their psychological safety within their respective schools and whether there is any relationship between workplace psychological safety and help-seeking behaviors. Within this we

also wanted to explore whether there was a relationship between job retention fears and help-seeking, since fears regarding career advancement and job loss have been identified as barriers to help-seeking (Adams et al., 2010; Chew-Graham et al., 2003; Garelick, 2012).

Participants

A convenience sampling technique was used. Inclusion criterion was membership with the Ontario Secondary School Teachers Federation (OSSTF) or Physical Health and Education Canada (PHE Canada). Though the majority of participants were teachers (occasional, part-time and full-time), educational professionals such as principals, vice principals, child and youth workers, social workers, psychology staff, chaplains, educational assistants, and guidance staff were also invited to participate. For ease of description, participants will be referred to as teachers. However, the results will be reflective of all the educational professionals who participated.

Procedure

Ethical approval was received from the University's Non-Medical Research Ethics Board (Appendix A). Prospective participants were emailed a letter of information through their respective teachers' federations (Appendix B) with a link to a Qualtrics online survey. This survey contained demographic questions and several self-report scales associated with teacher mental health and well-being and was estimated to take 20-25 minutes to complete (Appendix C). Surveys were submitted electronically to a secure server system and submission was considered implied consent.

Measures

Demographic Data. Demographic information such as age, gender, teaching level, staff role, marital status, years of experience, number of positions, locale (urban or rural), and

caregiving and volunteer commitments were collected. Participants were also queried about their previous experience with psychotherapy, sources of professional assistance, reasons for counselling, the effectiveness of therapy, and potential reasons for not engaging in treatment. These questions are anticipated to be informative because variables in other studies such as gender, level of distress, perceived stigma, and openness to emotional vulnerability have been unable to account for all the variance in help-seeking behavior (Komiya et al., 2000). Quotes from these questions and additional comments made about the K6 and ATSPPH-ST scales were visually examined for themes and used to illustrate statistical results and additional findings.

Kessler 6 (K6). The K6 was used as a general mental health screener, to gauge participants' levels of non-specific distress. It is an abbreviated version of the K10 and has been found to be significantly correlated with serious mental illness (SMI), with a specificity of 0.36 and a specificity of 0.96 (Kessler et al., 2003). Participants were asked to rate how frequently they felt "nervous", "hopeless", "so depressed that nothing could cheer you up", "restless or fidgety", "worthless", or that "everything was an effort" during the past 30 days. Items were scored on a 5 point Likert scale from 0 (none of the time), to 4 (all of the time). The maximum score on the K6 is 24, with higher scores representing a greater probability of mental disorder. Reliability analysis indicates a high level of internal consistency, with an alpha coefficient of .89 (Kessler et al., 2003).

Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF). The ATSPPH-SF was used to measure educational staff members' perceptions about seeking mental health treatment. This scale is an abbreviated and contemporary version of Fischer and Farina's 29 item professional help-seeking scale (Elhai et al., 2008). The ATSPPH-SF is comprised of ten items and uses a four point Likert Scale ranging from 0 (disagree) to 3

(agree) (Elhai et al., 2008). Higher scores were associated with more positive views of psychological treatment (Elhai et al, 2008). A review of the literature confirmed Elhai's et al., (2008) contention that the ATSPPH-SF was a popular measure of help-seeking. In their study of 296 college students and 389 primary care patients, Elhai et al., (2008) found that it was a reliable and valid measure of professional help-seeking. Good internal consistency was evidenced with a coefficient alpha of 0.77 among the college student sample and a coefficient alpha of 0.78 among primary care patients (Elhai et al., 2008). Two factors were confirmed; the first was receptivity to seeking professional mental health support and the second was a regard for treatment (Elhai et al., 2008). The ATSPPH-SF was not correlated with a depression scale (CES-D) or the Mental Health Component Score from a health survey suggesting discriminant validity; however, ATSPPH-SF scores were significantly correlated with intentions to seek mental health services within one or six months, suggesting evidence for construct validity (Elhai et al., 2008).

Workplace Health. This seven item scale directly corresponds to guiding principles of the national Psychological Health and Safety in the Workplace standard in Canada (BNQ, CSA Group, & MHCC, 2013). Participants were asked to rate each of the principles on a five point scale; responses ranged from no (score of 1) to definitely (score of 5) for a maximum score of 35. Higher item and total scale scores represented more psychologically healthy workplaces. An example of items on this measure was "Do you feel your workplace would provide appropriate and adequate assistance if you came forward with a mental health issue or while in psychological distress?"

Results

Demographic Factors

This survey was completed by 600 educational professionals from the Ontario Secondary School Teachers' Federation (OSSTF) and Physical Health and Education Canada over the course of six weeks from December, 2014 to January, 2015. The participants in this study were predominantly teachers (N = 496, 82.5%). However, the sample also included educational support staff (N = 60, 10%), educational assistants (N = 44, 7.3%), and administration (N = 1, 0.2%). The majority of participants identified as married or common-law (77.3%). Respondents were requested to identify every teaching level they taught. Results indicated that all teaching levels were represented, in particular the Senior (67.6%) and Intermediate (44%) levels.

The demographics of this sample were found to be largely comparable to Canadian, or Ontarian statistics on teachers when Canadian statistics were unavailable. This sample was primarily female (71.1%) similar to the 73.5% rate of female teachers reported by Statistics Canada (2015) and the 72.6% rate published in 2008 by the Canadian Teachers' Federation (2015). Since figures reported by Statistics Canada did not include transgender rates among teachers, this studies' data was compared to prevalence rates in the general population in the US and Ontario. This study's rate of 1.2% was slightly higher than the 0.5% rate in a Massachusetts study in 2012 (Bauer & Scheim, 2015) and the .003% rate reported in Ontario (Sher, 2015). Respondents ranged from 20 to 70 years of age (M = 43.41). The mean age of 43.4 years was very similar to the average age of teachers in Ontario, which has been reported as 43.6 years (full-time teachers) and 42.4 years (full-time, occasional and part-time teachers) (S. Bradley, OTF Records & Information, personal communication, June 24, 2015). This sample were somewhat more experienced than the Ontarian teachers. They had been employed in their

respective professions for 15.52 years in 3.84 positions versus the 13.8 year of service in full-time teachers in Ontario and 11. 7 years of service in a blended sample of full-time, occasional and part-time teachers (S. Bradley, OTF Records & Information, personal communication, June 24, 2015). Further demographic information is provided in Table 1.

Teachers' Mental Health

The mental health experiences of these professionals were investigated to identify the severity of their distress and its reported impact on daily functioning. An awareness of these professionals' distress was essential to identifying the prospective need for mental health treatment. This was measured by a survey question that examined the prevalence of mental health interference with this sample. When participants were asked "Since becoming a teacher or educational professional, have you ever experienced mental health distress that interfered with your ability to engage in activities of everyday life (such as work, relationships, health-promoting behaviors)?", 72.7% (N = 413) responded "yes". Participants were also asked to complete a general mental health screener, the K6, to assess their level of mental health distress during the past 30 days. The mean score of the 523 participants who completed this measure was 6.83 (SD = 4.72). The descriptive statistics for individual K6 items are provided in Table 2. A frequency distribution of participants' total scale scores on the K6 (Figure 1) indicated that 49.7% of this sample fell in a recently proposed range for moderate mental health distress (Prochaska et al., 2012), while an additional 12.8% met the well-established cutoff of ≥ 13 for serious mental illness (Kessler et al., 2003).

To obtain a context for these distress scores, 140 clarifying comments regarding this scale were examined. Several themes emerged from a visual inspection of these participants' comments; these included physical health issues, anxieties about job security due to temporary

positions, workload demands and new initiatives, exhaustion, issues with administrators or school climate, poor self-care such as lack of sleep or exercise, stressful life events, the impact of work on personal life, and inability to take sick days.

Subsequent to this, we selected comments from participants who received the highest distress scores on this scale (K6 = 19-24), to illustrate the issues experienced by those falling in the highest end of the serious mental illness range; my "*mental health is suffering more in the last 3 years of teaching than the 30 I suffered from Depression and PTSD after a rape. The environment is toxic*", "*I think stress creates the physical health problems, I did not have stress problems until I moved to a new school this year*", "*Cannot miss work, not enough sick days or coverage, not worth the added stress of going back to a mess*", and

> Teaching in our current conditions is an absolute disaster. Jobs are very scarce. Teachers are teaching in such distant locations and in jobs that are very demanding because it is the only way to keep employment if you are lucky enough to get any form of a job. I have had to supply teach for the first time in 7 years-requiring getting a phone call at 6 in the morning and having to drive 1hr 15min to get to a school, get kids to daycare etc. If you are lucky you only have to review your whole life every 5 months when a new semester starts and you inevitably lose your job. Extremely terrible time for young teachers right now. I did have permanent work then lost it due to layoffs.

With respect to impairment, there were also a few comments that described the need for recovery time from work:

> I push through my day at school, however after I get home my routine has changed drastically since I have started teaching. I am no longer looking forward to the things I used to because I don't have as much energy. I often skip activities I used to participate in. Weekends are used as a time for recovery and I tend not to do much (no shopping, no social activities etc).

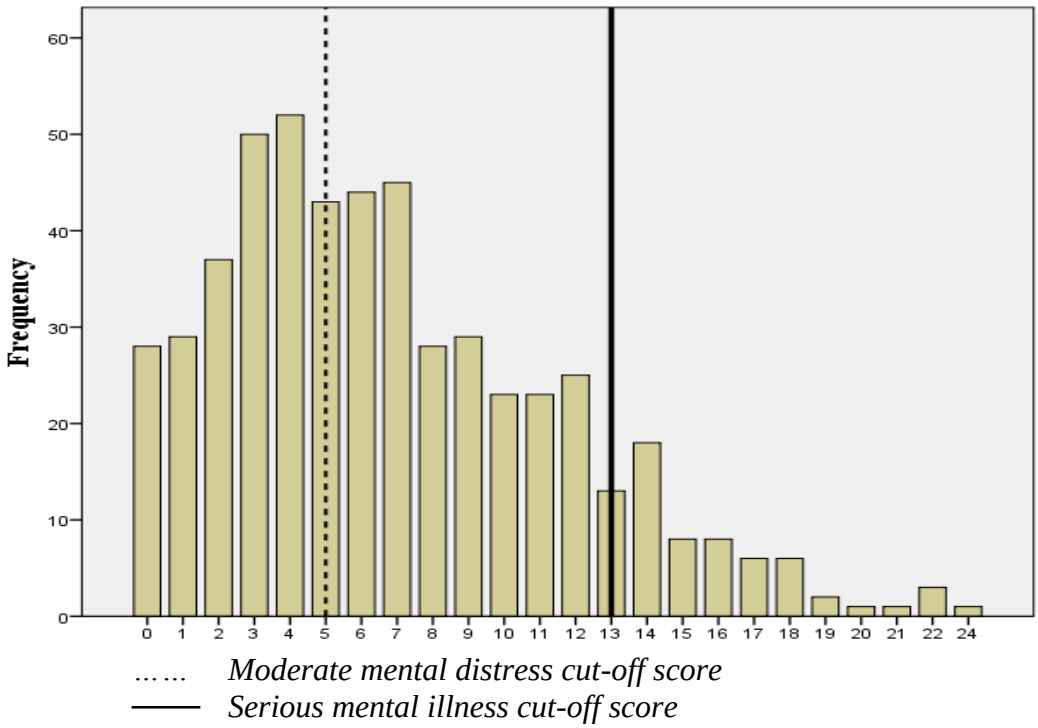

Figure 1. A frequency distribution of total K6 Scale scores in a sample of Canadian teachers from December 2014 to January 2015.

Table 1
Demographic Features OSSTF and PHEC Sample Group

Demographic	Demographic Categories	N	Percentage	
Gender	Female Male Transgender	416 162 7	71.1 27.7 1.2	
Position	Full-time teacher Part-time teacher Full-time occasional Part-time occasional Full-time school support Part-time school support Full-time educational assistants Part-time educational assistants Full-time leadership Part-time leadership	406 39 33 18 53 7 40 4 0 1	67.7 6.5 5.5 3 8.8 1.2 6.7 .7 0 0.2	
Marital Status	Married Common-law Divorced Separated Single Widowed	399 60 30 17 85 3	67.2 10.1 5.1 2.9 14.3 .5	
Teaching Level	Primary Junior Intermediate Senior Alternative Other	59 38 264 407 54 80	6.5 4.2 29.3 45.1 6 8.9 /902 (responses)	9.8 6.3 44 67.6 9 13.3 /600 (participants)
Location	Remote Rural Urban <5000 5,001-15,000 15,001 – 50, 000 50,001 - 100,000 100,001-200,000 200,001-500,000 500,001-1,000,000 >1,000,000	20 159 219 62 65 69 74 163 57 31 32	2 16.7 23 6.5 6.8 7.3 7.8 17 6 3.3 3.4 /971 (responses)	3.3 26.5 36.5 10.3 10.8 11.5 12.3 27.71 9.5 5.2 5.3 /600 (participants)

Table 2
Descriptive Statistics for Individual K6 Scale Items from a Sample of Canadian Teachers from December 2014 to January 2015

Item	*N*	*M*	*SD*
1. Nervous	523	1.41	.98
2. Hopeless	523	.96	.99
3. Restless or fidgety	523	1.51	1.04
4. So depressed that nothing could cheer you up	523	.68	.93
5. That everything was an effort	523	1.56	1.15
6. Worthless	523	.71	.98

Note: Participants were asked how often they experienced these symptoms over the past 30 days on a 5 point Likert scale from none of the time (0) to all of the time (4).

Psychological Help-seeking Practices

In addition to exploring educational professional's prevalence of mental health interference and the severity of their distress, quantitative data and comments were examined from four survey questions to describe participants' help-seeking practices. When asked, "Have you ever received psychotherapy or counselling since you became a teacher or educational professional?" 50.9% of respondents identified that they had received these services; additionally, 30.5% of the sample indicated that they had "never wished to receive psychotherapy". Those who acknowledged seeking help were asked to review a brief list of mental health supports (e.g. psychiatrists) and check every service they had accessed. They were also given the opportunity to identify alternative sources of counselling they had received. While respondents identified a broad range of supports, they typically sought psychotherapy or counselling through three primary sources: medical services (30.8%); employee programs (27.8%); and privately paid mental health professionals (27.5%) (Table 3).

Those who endorsed receiving psychotherapy were asked to describe why they had accessed psychotherapy or counseling. This question generated 264 comments which were coded into six categories: anxiety, depression, stress and burnout, work-related stressors, family and grief, complex issues, and addiction (Figure 2). A complex category was also developed to capture those who had listed more than one reason for attending psychotherapy or had identified an issue impacting multiple life domains. A noteworthy finding was that seven respondents commented they had sought therapy for their own suicidal ideation or suicide attempts, or for attempts or completed suicides, by students and colleagues.

Table 3
Sources of Psychotherapy Support Accessed by Educational Professional Sample

Source	**N**	**Percent**
Family doctor/health team	185	30.8
EAP/Work benefits	167	27.8
Paid Professional (psychologist, social worker, counsellor)	165	27.3
Psychiatrist	62	10.3
Clergy	26	4.3
Mental Health Distress Line	14	2.3
Alternative Care	13	2.2
Total	**632**	**105**

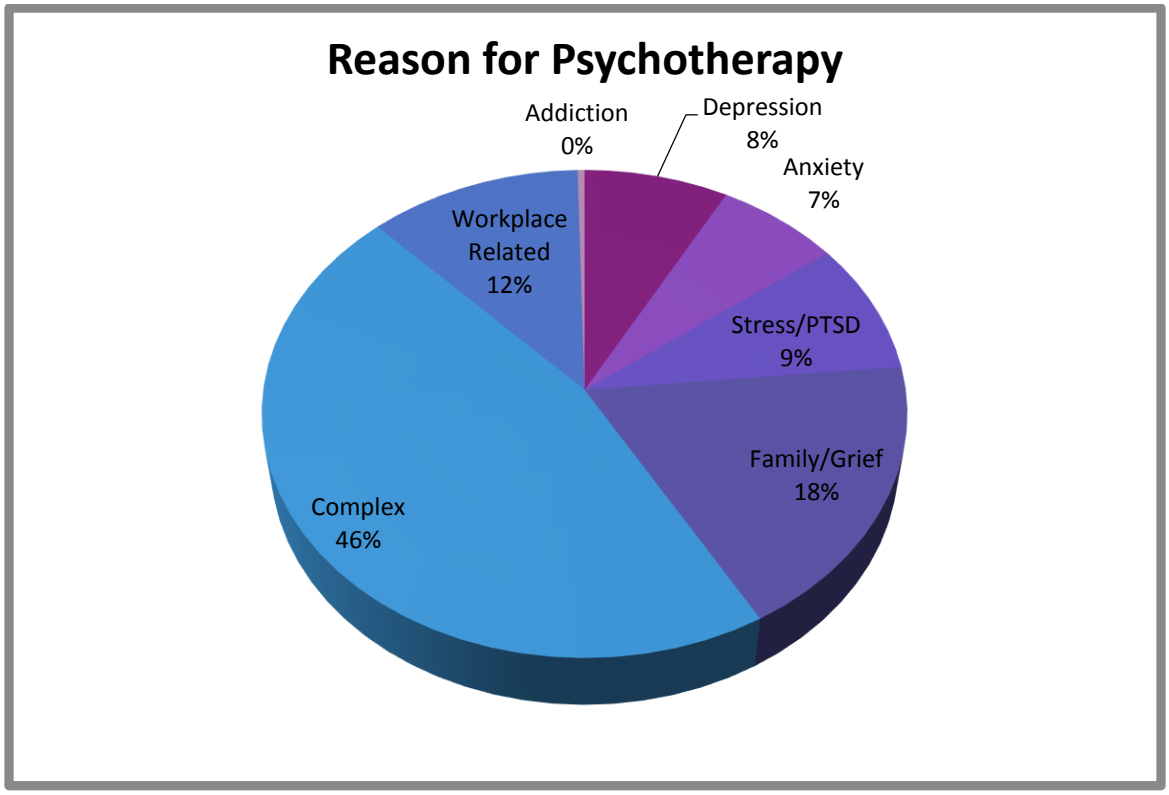

Figure 2. Self-reported reasons for counselling or psychotherapy use during educational career among a sample of Canadian teachers.
Note: The depression category included comments about depression, suicidal ideation and attempts. The stress category included stress, PTSD, comments about coping, burnout, feeling overwhelmed, or experiencing a breakdown. The family and grief category included marital breakdown, parenting issues, and coping with the deaths of family or friends. Workplace related reasons were defined as any issue in the workplace such as workload, bullying, skills deficit, or interpersonal issues resulting in any type of mental health distress. The complex category was defined as comments that listed two or more reasons for therapy or complex issues that pervasively impacted all areas of life such as brain injury, disclosure of sexual orientation, and health issues. Data is rounded to closest percentage.

Lastly, those who had accessed psychotherapy (N=281) were also surveyed about its effectiveness. The majority, 72.6%, indicated that psychotherapy was effective, 18.5% reported they were "I'm not sure" and an additional 8.9% identified that the services they received were ineffective.

Barriers to Help-Seeking

Respondents' barriers to seeking treatment were also examined in a survey question. Those who had not accessed counselling or psychotherapy, but had wished to attend, were asked

to identify all of the factors that had prevented them from attending psychotherapy. This checklist included potential barriers such as finances, availability, and privacy as well as an "other" category, which gave participants the option of entering an alternative reason. Based on checklist responses (N = 187), 33.7% of participants indicated that finances were a barrier, 28.9% endorsed privacy issues, and 10.2% identified that the service was not available in their community. An additional 27.3% selected "other". When reviewing the comments within the "other" category, 26 (51%) responses indicated that time was a prohibitive factor in accessing psychotherapy.

However, a more explicit picture of these professionals' barriers emerged when participants were asked to, "Please briefly describe your situation with regards to your reasons for not receiving counselling or psychotherapy when you wished you could have". This generated over 170 comments which elaborated on the specific aspects of time, finances, availability, and privacy that inhibited participants from seeking mental health treatment. These comments also illustrated additional or associated barriers. It was notable that responses to this question often included multiple barriers. Consequently, illustrative comments reflect overlapping themes.

Finances. Financial restrictions were frequently identified as a barrier in this section. In specific, participants expressed an inability to afford psychotherapy due to limited incomes or alternate financial priorities. One individual reported they "*Couldn't afford the number of sessions" they "would have liked to attend. Supporting children in postsecondary, helping parents etc*." while another commented on their "*fixed budget (huge student loan on a single income)*". For a few, having sufficient funds to pay for the service and wait for reimbursement posed a barrier,

> Well I guess once the divorce was in full swing I couldn't even afford to pay for the psych help upfront, even if I was going to get my money back, because I needed the money to pay for my lawyer. No lawyer = no children = no point.

The cost of treatment was also identified as a barrier,

> If you were to seek help, most professionals charge over $150 per hour which is not affordable to the average person. It seems odd that only those who have money are the ones who can receive counselling and not those who need it most.

In addition to the cost, participants reported that a lack of coverage through EAPs, provincial health plans and work insurance benefits posed challenges to accessing counselling or the desired amount of therapy. This was evidenced in comments such as, "*We're not covered well in Manulife for psychology help. It ends up being like $120/hr*", "*…OHIP pays for 'Neck Down' services but the financial costs of psychological counselling and testing are often up to the individual*" and "*I do wish I could have had psychotherapy outside of psychiatry. Benefit plan does not cover costs and costs are too high for regular visits".*

Stigma, Confidentiality and Job Security. Concerns about stigma, confidentiality, and anxiety about the consequences of seeking professional help were also frequent and overlapping concerns:

> I'm scared that if I get counselling I will be labelled 'having issues' and never be able shake it. I don't want to have it on my records following me around. I'd rather not admit to it than have it potentially affect possible future employment or other opportunities. The financial aspect is also very difficult as a starting teacher. I'm also not sure about getting time off to do so. However, it's the label that will remain forever that bothers me the most".

Moreover, another educational professional indicated "*I do not choose to go to the employee health services because I am concerned it would not be confidential*".

There were also a few comments in this section that were consistent with the proposed concept of a helping professionals' role identity. One respondent indicated that they eventually received counselling but it *"…Took a long time for me to convince myself that I needed it…I looked at it as being weak".* Another participant described becoming overwhelmed by personal and professional expectations but fearing repercussions, "*I'm supposed to be a teacher, a professional and be able to handle 75 essays, coaching committee meetings, rehearsals and still be a father/husband. It got to be too much but I feared backlash from those who didn't understand*".

In addition to self-identity, some comments reflected a more systemic stigma, "*In the culture where I am working it is not considered to exist, therefore there are very few opportunities to get counselling".* There was also a perceived double standard for help-seeking in the educational system:

> Even though we encourage the kids to seek help and that it's ok not to be ok, the stigma around mental health problems still very much exists among the professionals in our field. If you seek help, there is always fear that someone will find out and it will be held against you either officially or not.

Location and Availability. As noted earlier, the availability of services was identified as impeding psychotherapy. Comments revealed that a participant's location or the location of the service had implications for access. For example, some respondents from remote and rural areas commented on having limited or no access to services in their community, the need to travel distances to other communities for service, and long wait lists. One participant indicated that the waitlist was approximately one year long. Participants also indicted that there were particularly long waits "… *if you need a referral from your non-existent doctor*", "*can only attend in the*

evening" or only require "*non-urgent (e.g. life-threatening) visits*". Moreover, in some areas counselling was "*Only available locally via teleconference or video conferencing".*

Familiarity with mental health professionals was also a concern in smaller communities, "*The psychological community is small. It would be challenging to find a psychologist that I do not know or will never know professionally*". Similarly the lack of privacy of the location was a deterrent to help-seeking, "*it did not feel right…had to walk into a building middle of town where I teach…students walking by on sidewalk*".

Time. Various aspects of time posed a barrier to receiving therapy in this study. One individual clarified that counselling took "*Time away from school and family*". Another person reflected on the conflict between balancing time for self-care with workload and professional standards:

> I just don't have time to go. I barely have time to make a lunch or workout like I used to. Shifting into elementary school has been a huge change for me as my teacher's college background was in the high school division. It is a continual struggle to just do the bare minimum in my class to my standards. I should spend time taking care of myself but I have 29 other people to take care of first it feels.

Delays in service were also evident in responses such as the, "*Mental health team provided by employer was scheduled months later*". Scheduling time off work to attend counselling was also described as a barrier, "*Our jobs are inflexible and often it is more difficult to take time off as you have to prep to miss your class*". In the end one respondent questioned whether the outcome was even worth the time and effort of the process, "*I felt as though the time it would take to find a counsellor, schedule visits, commute and the stress of paying for counselling would outweigh the benefits of finding a counsellor and going to counselling".*

EAP/Work Insurance Benefits. In addition to financial, stigma, time, and accessibility obstructions, participants also commented on service delivery barriers within employee assistance and employee and family assistance programs (EAP and EFAP) that impacted access. One individual recounted how they "*contacted the 800 number from posters at work and NEVER received a follow up response!*" Ineligibility for EAP services as "*occasional teachers and adult education staff*" was also noted. There were also a few comments pondering how to access EAP services, "*I am aware that counselling services are available through the school board I work for. However, I am not sure how to access this counselling and would prefer not to have to call the board to get the information (privacy issues)*". There were also references to service limitations:

> I have gone for counselling, but there have been times when I should probably go but do not. The EAP is only three sessions a year, which is very limited. Otherwise counselling is outrageously priced! My family doctor is helpful, but only to a certain extent.

Another example of a service delivery barrier was a change in EAP contracts,

> Currently I am restricting the number of counselling session because my school board changed the firm covered on our insurance. I of course have a bond with my counselor and am not prepared to suddenly switch to another care provider. I think this change was very insensitive on the part of the school board and I know it has affected many teachers. My provider had NOT increased their fees.

The value of EAP psychotherapy was also questioned, "*eap program is a waste of time, as it is a crisis intervention service*". The limitations of insurance benefits for treatment upon a return to work was also noted, "*Our benefits only pay for 10 sessions. OTIP only pays when you are off work. When you return, no benefits when you really need them".*

Quality of Counselling. While less prevalent, the prospective quality of counselling was raised as a barrier to treatment. For example, factors such as the inability to choose a therapist,

poor fit, and questions regarding competency were noted as barriers to help-seeking as reflected in comments such as "*…I would like to select my own counselor rather than have one assigned to me*", "*I have gone for therapy but the counsellors were not good at what they did", and "Long wait lists. Finally met someone I did not feel comfortable with".*

In particular, negative experiences in counselling were described as barriers to treatment. This included past psychotherapy experiences, "*...I did an EAP program when I was a teenager, too, and didn't like the counsellor/therapist I was paired with, so I have a bit of a sour taste in my mouth for it*". More recent experiences also contributed to negative perceptions of counselling:

> I talked to someone for 2 sessions – he wanted to know all about my relationship with my father. I thought: 1) it wasn't dealing with the problem I was having; 2) it was going to take more time than I had; 3) it was giving him a chance to practice his craft more than it intended to help me and felt like I was being "snowed" – so I quit.

Ambivalence. Comments also revealed that ambivalence was occasionally a barrier. This was reflected in comments such as "*I am not sure I can trust them"* and "*I am just not ready to ask for help*". Possible ambivalence about the need for counselling was also articulated in responses such as "*unsure if it was true 'burn-out*" *or just a "badspell*" and,

> Not sure what the counselling process would be like and how useful it would be. I've had periods of stress resulting in things like grinding teeth and dealt with the stress through my own process ie golf, video games, relaxing with family, etc. before needing further help with the issue.

However, reservation about the capacity to cope with counselling was also questioned:

> Both of my parents became terminally ill within a two year span of each other. Having to look after both of them and keep my family supported, I didn't feel I could seek counseling as I was afraid once the damn (sic) opened I might not be able to cope.

Family and Friends. Lastly, a few respondents reported they did not attend counselling due to family and friends. Either they "*didn't feel supported by family and friends*", their spouse refused to participate, or did not want their "*spouse to know/find out*". One respondent also disclosed that their "*husband is a very private man and would not have been comfortable with me going"*.

Scale Measures

Attitude Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF). Participant's receptivity to accessing mental health services was measured through the Attitude Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF). This scale exhibited good internal consistency with a Cronbach alpha co-efficient of .82, which is within the .77 to .84 range reported in earlier reliability and validity studies (Elhai et al., 2008; Fischer & Farina, 1995). The variance in this sample (Table 4) was smaller than in reported studies (Table 5) and the mean ATPPH-S score of 16.45 (N = 470, *SD* = 4.53) (Table 4) was closer to published means for undergraduate student studies than more similarly aged samples of graduate students and medical patients from community settings (Table 5). Consequently, independent t-tests were performed, using Welch's correction for unequal variances and sample sizes, with the most similar sample groups. A t-test comparison with a group of 217 graduate students with a mean of 21.52 (SD = 5.28) revealed significant differences between group means, $t(368) = 12.22$, $p < .001$, 95% CI {4.25, 5.89) such that the current sample reported lower scores. A second comparison with a sample of 187 medical patients ($M = 20.45$, $SD = 5.97$) also indicated statistically significant differences between the groups $t(290) = 8.81$, $p < .001$, 95% CI {3.12, 4.89}. This sample's lower total mean score on the ATSPPH-SF may lend support to the

hypothesis that teachers are less receptive to pursuing psychological services for mental health supports than similarly aged samples.

In addition to statistics and t-score comparisons, participants' comments (N=39) about ATSPPH-SF scale questions and the topic of help-seeking were examined. Consistent with this sample's mid-range mean score, the vast majority of comments were ambivalent or supportive. Ambivalent responses included alternative options to counselling, personal barriers or doubts, and specific situations in which participants may consider accessing counselling. For example, some participants suggested exercise, support from friends and family, and self-help strategies were sufficient or additional options for addressing concerns, "*Continuous support from family and friends, motivational help, self-help can also help a person a lot. It does not always have to be with a counsellor or psychotherapy*". More extreme situations such as long-term distress or feeling a lack of control were identified as circumstances in which counselling may be considered, "*Generally I am pretty good about finding the aspects of my life that are overwhelming me and can dial them back without professional help. It's only when things are beyond my control (school initiatives, administration) that I become overwhelmed".* Barriers such as acknowledging the need for help and stigma were evident in the following comments, "*I believe in counselling but I think I would have a hard time opening up for it to be useful for me. I am too perfectionistic to admit to a stranger that things are tough*" and,

> While I do seek professional help, I do not like discussing this with others or having to take leaves as they do affect your professional life, even if they shouldn't. I am also someone who has learned to function really well so that others are rarely aware of my actual state.

Those who were supportive of counselling made comments such as "I have found counselling to be incredibly helpful over my adult life. I have learned that counselling works

when you trust your counselor and have a counselor who is skilled in cognitive behavior therapy" and "*I am a great believer in talk therapy, and I think there can be benefits in medication too, although I think talk and medication can be the best treatment*".

Table 4
Descriptive Statistics and Alpha Co-efficients for all Scale Measures

Measure	N	Minimum	Maximum	Mean	Standard Deviation	Cronbach Alpha
K6	523	0	24	6.83	4.72	.87
ATSPPH-SF	470	2	24	16.45	4.53	.82
Workplace Health (WH)	477	7	35	21.56	7.45	.94

Note: The ATSPPH-SF is the Attitude Toward Seeking Professional Psychological Help- Short Form scale and the K6 is the Kessler 6 scale.

Table 5
Descriptive Statistics and T-Score Comparisons of ATSPPH-SF in Reported Studies

Study	Sample Composition	Age Range	Mean	SD
UWO Study	470 teachers	20-70	16.45	4.53
Elhai et al., (2008)	296 college students	18-42	17.77 (F) 15.90 (M)	5.05 5.44
Elhai et al., (2009)	187 primary care patients	18-90	20.45	5.51
Fischer & Farina (1995)	389 undergraduate psychology students N=214 (F) N=175 (M)	Modal age of 18 (74% freshman)	17.45 19.08 (F) 15.46 (M)	5.97 5.45 6
Komiya, Good & Sherrod (2000)	311 undergraduate students	Mean age of 18.4	14.66	6.05
McCarthy, Bruno, & Sherman (2010)	217 graduate students	19-65 47% were over 30	21.52 21.81(F) 19.31(M)	5.28 5.26 5.26

Note: The ATPPSH-SF is the Attitude Toward Seeking Professional Psychological Help-Short Form scale. F=female, M=male. The age range is reflective of the entire sample within these studies. Comparisons were made with studies that utilized Fischer and Farina's (1995) 0-3 point scoring system.

Table 6
Descriptive Statistics of individual scale items on the ATSPPH-SF

Item	N	M	SD
1. I would obtain professional help if I was having a breakdown	470	2.37	.71
2. Talking about psychological problems is a poor way to solve emotional problems	470	1.52	.69
3. I would find relief in psychotherapy if I was in an emotional crisis	470	2.19	.74
4. A person coping without professional help is admirable	470	1.04	.82
5. I would obtain psychological help if I was upset for a long time	470	2.29	.74
6. I might want counselling in the future	470	1.97	.88
7. A person with an emotional problem is likely to solve it with professional help	470	1.05	.66
8. Psychotherapy would have no help for me	470	1.20	.72
9. A person should work out his/her problems without counselling	470	1.37	.69
10. Emotional problems resolve themselves	470	1.43	.64

Note: Items were scored on a 4point Likert scale from disagree (0) to agree (3) with higher scores reflecting more receptivity to professional help. Items 2, 4, 8, 9, and 10 are reverse scored.

Workplace Health Scale. The Workplace Health Scale was administered to this sample of teachers to measure their perceptions of psychological safety within their schools. The scale demonstrated high reliability with an alpha coefficient of .94. The mean item score was 3.08 on this 5 point scale, with item means ranging from 2.70 to 3.43 (Table 7). Since this is a newly developed scale, individual items were examined in addition to descriptive statistics. In terms of

relative strengths within these questions, 51% of the 477 respondents endorsed that their school "promotes, encourages and enforces respectful language attitudes and behaviors toward mental health and mental illness" (Figure 3) and 45% identified their school as meeting the legal requirements of a psychologically safe workplace (Figure 4). However, 46% of participants indicated that their workplace did not facilitate work-life balance (Figure 5) and 40% of sample identified that their leadership did not promote mental health literacy among faculty and was not respectful of mental illness (Figure 6).

Though comments were not solicited for this scale, responses across the survey illustrated that respondents were seeking mental health treatment for organizational issues such as inappropriate placement, excessive job demands, unsafe working conditions, issues with work-life balance, and psychologically unsafe relationships with administrators, colleagues, and or students.

One individual identified how they were being treated for depression and PTSD due to a "*mis-placement in a special needs school without any qualification in Special Education*". Similarly, another individual described pursuing therapy because he/she had a, "*very high needs students in a special education class, violent situations on a daily basis, felt stressed because of responsibility to keep EAs and other students safe, yet their safety was compromised daily*" and he/she experienced a "*lack of control over situation*".

In terms of relationships with colleagues and leadership, one respondent indicated that their reason for attending counselling was " *termed a 'personality conflict' by Administration and the Board with a coworker who was often my dept. head*" and went on to say, "*I term it 'bullying' and a toxic work environment enduring several years.*" Another participant identified

needing treatment due to an interaction with a suicidal student, "*a student attempted suicide and then assaulted me when I attempted to stop him*".

Lastly, the impacts of work-related issues on home life were evidenced in reports that a participant was experiencing "*stress at home because of work (extended hours, planning time etc.)*" and when another teacher commented that they were seeking treatment for "*Anger management at home"* due to *"Stress transferring to home life*".

Table 7
Descriptive Statistics of Workplace Health Scale Items

Item	N	M	SD
Do you feel that your workplace…			
1. Meets and adheres to the legal requirements of a psychologically safe and respectful workplace?	477	3.22	1.225
2. Promotes, encourages and enforces respectful language, attitudes and behaviours towards mental health and mental illness?	477	3.43	1.186
3. Provides its employees with the appropriate knowledge and means of protecting and supporting one's mental health?	477	3.08	1.231
4. Provides and facilitates a supportive, safe, and respectful atmosphere where you could turn to a colleague if you felt you were experiencing psychological distress?	477	3.03	1.239
5. Is overseen and led by an individual who is respectful towards mental illness and seeks to promote & implement mental health literacy amongst your faculty?	477	2.94	1.365
6. Promotes, encourages and provides the means for its employees to maintain a healthy work-life balance?	477	2.70	1.253
7. Would provide appropriate and adequate assistance if you came forward with a mental health issue or while in psychological distress?	477	3.16	1.231

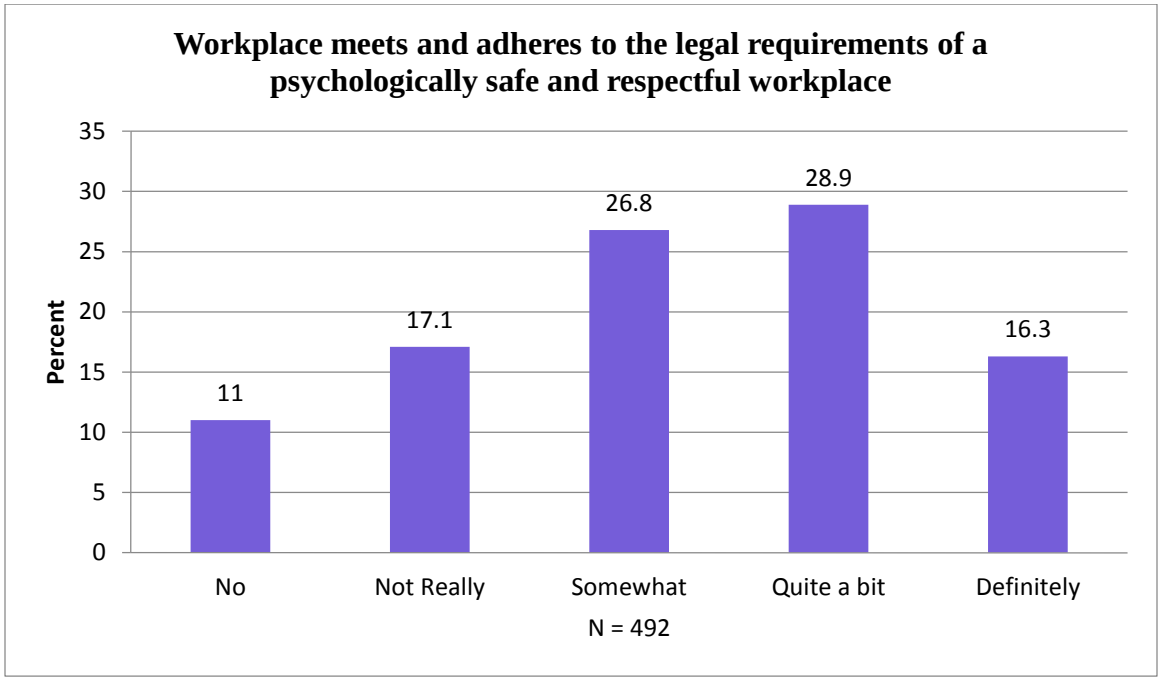

Figure 3. Workplace Health scale: Item 1 response percentages

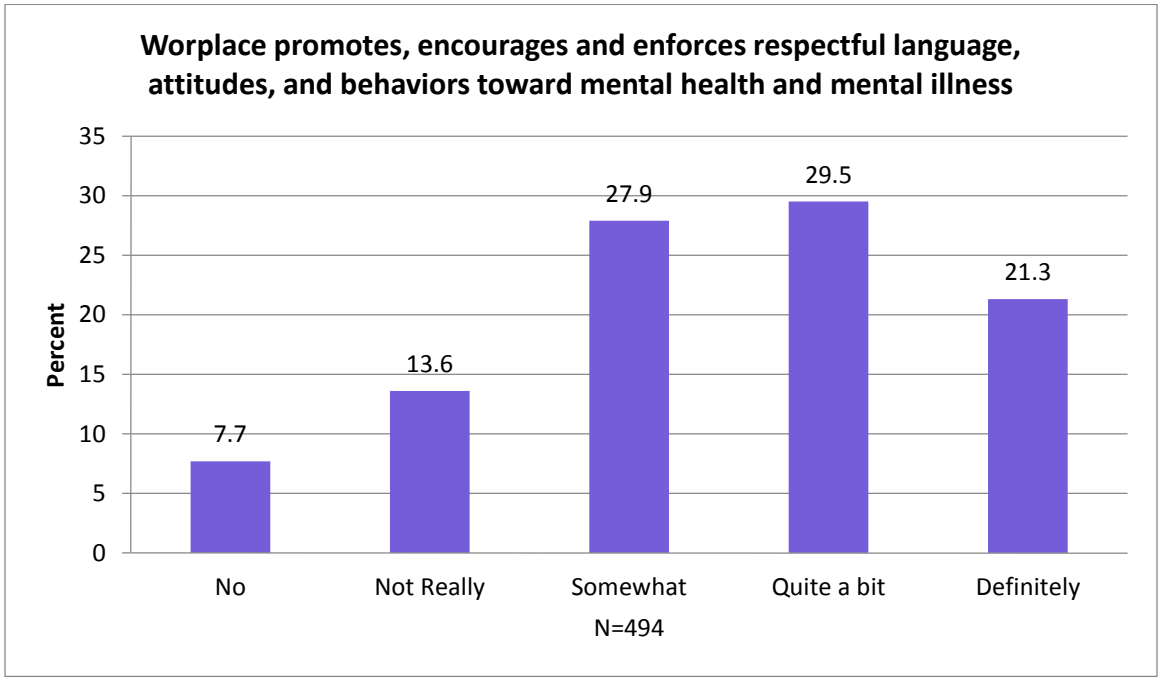

Figure 4. Workplace Health scale: Item 2 response percentages

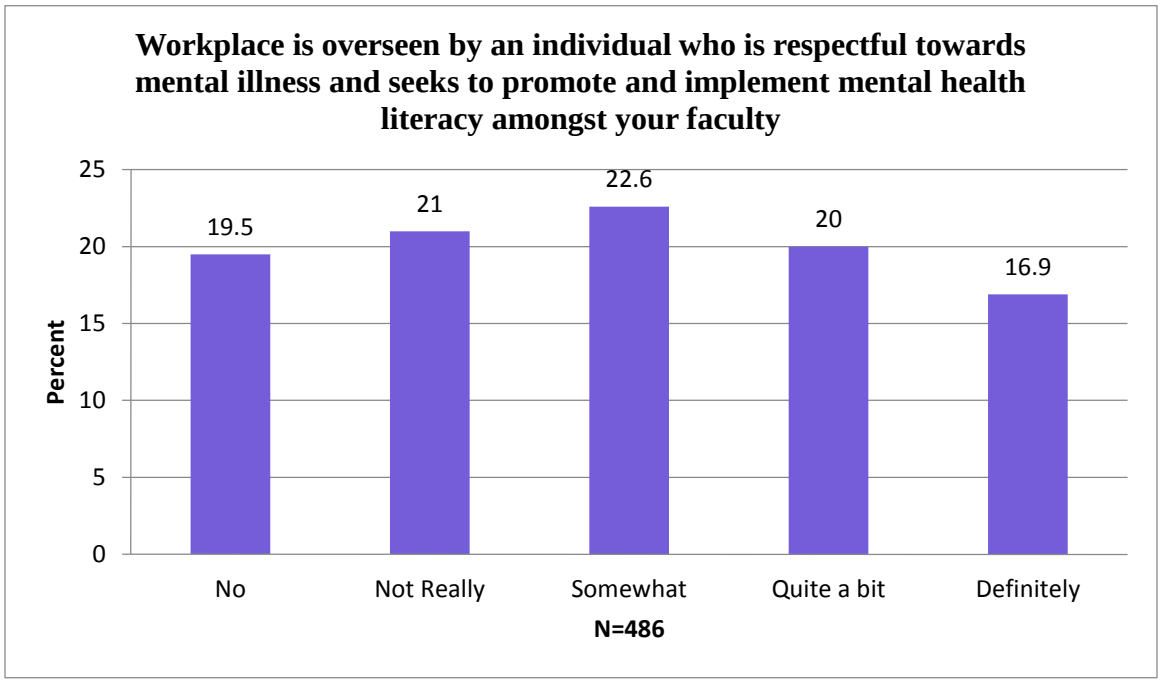

Figure 5. Workplace Health scale: Item 5 response percentages

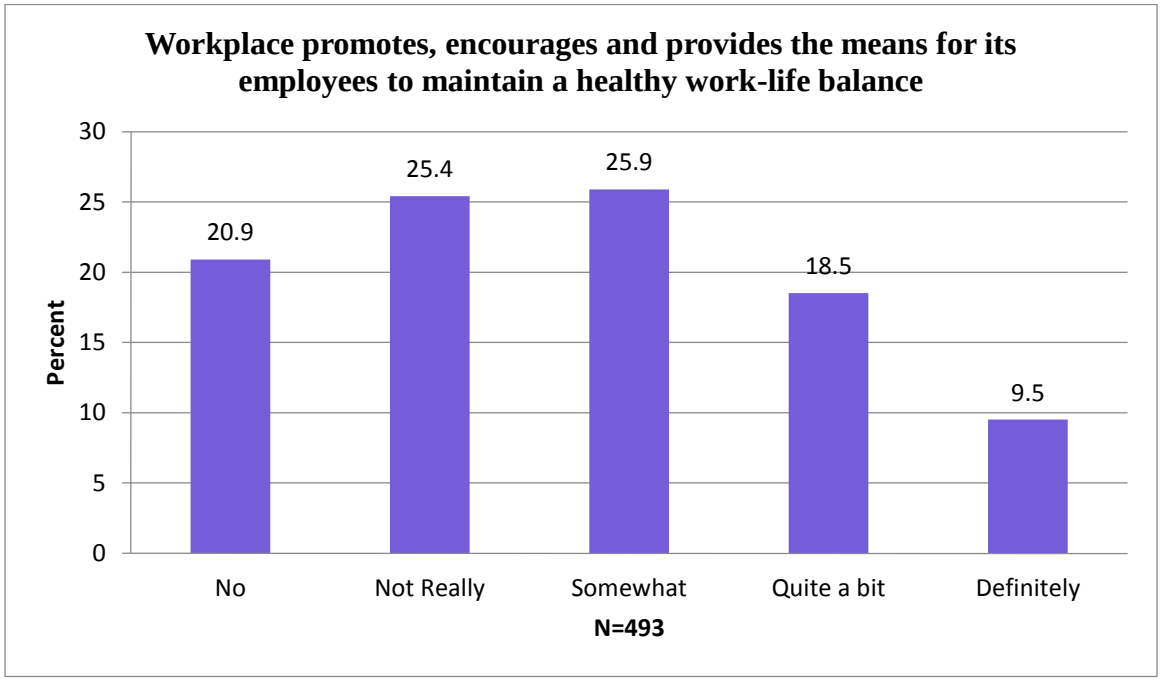

Figure 6. Workplace Health scale: Item 6 response percentages

Correlational Analyses

Workplace Health Scale Inter-item Correlations. There was a significant level of inter-item correlation on the Workplace Health Scale $r = .63$ to .76, $p < .001$. The most significant correlations involved leadership that was respectful toward mental illness and promoted mental health literacy among faculty, and schools that promoted and enforced respectful attitudes and behaviors towards mental health and mental illness. There was a positive correlation between these types of leaders and workplaces that provided relevant and sufficient support when an individual was in psychological distress $r(482) = .73$, $p < .001$ and a healthy work-life balance, $r(485) = .73$, $p < .001$. There was also a positive relationship between these leaders and a school that provided a safe and supportive environment where you could turn to a colleague if you were experiencing psychological distress $r(485) = .71$, $p < .001$. In addition, there was a positive correlation between a school environment that was respectful toward mental health and illness and employees having sufficient information and means to protect their mental health $r(492) = .72$, $p < .001$ and meeting and complying with the requirements of a psychologically safe workplace $r(492) = .76$, $p < .001$. However, these results should be interpreted with caution because this is a newly developed scale.

Correlations. Since perceptions of stigma and concerns regarding career advancement have been identified as barriers to seeking psychological help, correlational analyses were conducted to examine these possible relationships among this sample. First, attitudes toward help-seeking, as measured by total scores on the ATSPPH-SF, were correlated with perceptions of psychological safety, as measured by total scores on the Workplace Health Scale. Secondly, ATSPPH-SF scores were correlated with a supplementary item added to the SSRPH scale, "I would be worried about keeping my job, or getting another job with my employer, if an

administrator knew I was receiving professional psychological help". Lastly, total scores on the Workplace Health scale were correlated with the job retention item on the SSRPH scale. Results indicated that workplace psychological safety was not significantly related to help-seeking receptivity among this sample, $r(453) = .001$, $p = .984$. Similarly, there was no correlation between the fear of losing employment opportunities and attitudes towards professional treatment, as measured by scores on the ATSPPH-SF, $r(466) = -.064$, $p = .166$. However, there was a significant negative correlation between fears about job retention and level of workplace psychological safety, $r(474) = -.367$, $p < .001$.

Further analyses were performed to examine the relationship between previous psychotherapy experiences and help-seeking attitudes. A one-way analysis of variance was conducted to explore whether there was a relationship between attending psychotherapy and positive attitudes toward professional psychological treatment. The sample was divided into those who endorsed or denied receiving psychotherapy. A Levene test indicated significant variances between groups, $p = .452$. A subsequent analysis of variance revealed that receiving psychotherapy was associated with more favorable attitudes toward seeking professional help, $F(1, 466) = 95.1$, $p < .001$ (Table 8). The perceived effectiveness of past psychotherapy experiences was also related to attitudes toward seeking psychological help. A Levene test revealed significant variances between those who responded "yes", "no" and "I'm not sure", $p = .109$. When an ANOVA was performed, there was a between groups effect of psychotherapy effectiveness on receptivity to seeking professional psychological help, $F(2, 240) = 28.595$, $p < .001$. A Tukey's HSD comparison revealed differences between the "yes" and "no" groups and between the "yes" and "I'm not sure groups" (Table 9). There was also a positive correlation

between experiencing mental health interference and receiving psychotherapy, $r_s(565) = .331$, $p < .001$.

Table 8
Teachers' ATSSPH-S Descriptive Statistics Related to Psychotherapy Use

Received Psychotherapy	N	M	SD	SE	95% CI for Mean	
					Lower Bound	Upper Bound
Yes	240	18.25	4.00	.258	17.75	18.76
No	227	14.51	4.29	.285	13.95	15.07
Total	467	16.43	4.55	.210	16.02	16.85

Note: ATSPPH-SF= Attitudes Toward Seeking Professional Psychological Help-Short Form scale

Table 9
Tukey HSD Multiple Comparisons of Psychotherapy Effectiveness on ATSPPH-SF Scale

Dependent Variable	Psychotherapy Effectiveness Response	Comparison Group	Mean Difference	Std. Error	Sig.
ATSPPH-SF Scale	Yes	No	4.58*	.78	.000
		I'm not sure	3.60*	.64	.000
	No	Yes	-4.58*	.78	.000
		I'm not sure	-.98	.94	.553
	I'm not sure	Yes	-3.60*	.64	.000
		No	.98	.94	.553

Note: ATSPPH-S= Attitudes Toward Seeking Professional Psychological Help-Short Form scale
* Significant at the .05 level

Lastly, a multivariate analysis was conducted to determine if there were significant differences between reported levels of mental health distress, as measured by the K6, and measures of psychological help-seeking and workplace health. Based on established cutoff scores for severe mental illness and newly proposed cutoffs for moderate mental distress in the K6 literature (Kessler et al., 2003; Prochaska et al., 2012), the sample was divided into three

groups representing low, moderate, and high mental health distress. There was a significant multivariate omnibus effect $F(1, 2) = 17.3$, $p < .001$. Tests of between subject effects revealed a significant difference between groups on the Workplace Health Scale $F(1, 2) = 37.47$, $p < .001$ but not on the Attitudes Toward Seeking Professional Psychological Help-Short Form $F(1, 2) = .133$, ns (Table 10). A post hoc analysis was performed with a Tukey HSD. Results indicated that all comparisons with the Workplace Health scale were significant (Table 11).

Table 10
Descriptive Statistics for ATSPPH-SF and WH Scales Related to K6 Comparison Group

Scale	K6 Comparison Group	M	SE	95% CI for Mean	
				Lower Bound	Upper Bound
ATSPPS-S	Low (0-4.9)	16.61	.353	15.92	17.30
	Moderate (5-12.9)	16.41	.308	15.80	17.01
	Hi (13-24)	16.31	.586	15.64	17.47
WH	Low (0-4.9)	24.90	.530	23.86	25.95
	Moderate (5-12.9)	20.20	.464	19.29	21.12
	Hi (13-24)	17.02	.882	15.28	18.75

Note: ATSPPH-SF= Attitudes Toward Seeking Professional Psychological Help-Short Form scale.
WH=Workplace Health Scale
* Significant at the .05 level

Table 11
Tukey HSD Multiple Comparisons of K6 Groups on Workplace Health Scale

Dependent Variable	K6 Groups	Comparison K6 Group	Mean Difference	Std. Error	Sig.
Workplace Health Scale	low (0-4.9)	moderate (5-12.9)	4.7008*	.70408	.000
		hi (13-24)	7.8869*	1.02856	.000
	moderate (5-12.9)	low (0-4.9)	-4.7008*	.70408	.000
		hi (13-24)	3.1861*	.99595	.004
	hi (13-24)	low (0-4.9)	-7.8869*	1.02856	.000
		moderate (5-12.9)	-3.1861*	.99595	.004

Note: K6 groups were categorized into low, moderate and high levels of mental distress based on participants' total K6 score.
* mean difference is significant at the .05 level.

Discussion

The primary objective of this study was to describe teachers' attitudes toward help-seeking as well as their actual help-seeking practices. The secondary objective of this study was to explore teachers' sense of psychological safety in their schools and whether there was any relationship between these perceptions and attitudes toward seeking psychological help. The relationship between job retention fears and help-seeking was also explored, since it has been reported to be a barrier to help-seeking (Adams et al., 2010).

This exploratory research was important to enhance our understanding of teacher's mental health, their needs, and their receptivity to help-seeking, given the mental and physical health risks associated with the profession (Grayson & Alvarez, 2008; Johanson et al., 2005; Kovess-Masféty et al., 2006; Wilson et al, 2011). It was also vital to understand teachers' sense of psychological safety since schools are workplaces and school climate has been linked to student motivation, development, and academic achievement as well as teacher turnover (Cohen et al., 2009).

The Unheard Voices

Survey data indicated that participants in this sample were a group of professionals with demanding schedules, often balancing work, caregiving, home, and volunteer responsibilities (including volunteering at their school). Despite reported time conflicts, fatigue, and higher than average distress levels, participants invested approximately 20-25 minutes of their time to complete this extensive survey. In addition to completing survey scales and demographic questions, nearly one third of respondents wrote optional comments, which also demonstrated their commitment to telling their story. At times, there was a tone of urgency, frustration, and helplessness in these comments and it was evident that some participants felt silenced by stigma, invalidated, or fearful of the long-term consequences of mental health disclosures.

Teachers' Mental Health Interference and Distress

The findings of this study suggest that a significant proportion of this sample were experiencing moderate to severe mental health distress. These results are consistent with previous studies that have identified psychological risks in the profession, such as stress, burnout and mental disorder (Grayson & Alvarez, 2008; Johanson et al., 2005; Kovess-Masféty et al., 2006).

However, since almost one sixth of the sample indicated that they were experiencing "a lot" more frequent symptoms than usual, we can presume that a portion of the sample was experiencing atypical levels of distress. A few comments suggested this was a seasonal issue due to impending holidays. However, given the fluidity of distress ratings, it may be beneficial to consider interventions that address peak times of distress (e.g. during report card deadlines).

Regardless, the rates of moderate distress and severe mental illness in this study were notably higher than published studies using the same cut-off criteria, even a study (Prochaska et al., 2012) that reported peak levels of distress in participants within the past 12 months. With approximately twice the rate of moderate distress and 1.5-6 times the rates of serious mental distress than other published studies, Canadian teachers appear to be experiencing significantly more mental health symptoms than the general population.

The high prevalence of mental health interference found among this sample of teachers was unsurprising in light of the levels of distress identified in this group. The co-existence of elevated levels of distress with mental health interference is consistent with Prochaska et al.'s (2012) findings that greater levels of distress were associated with higher reported ratings of impairment in work, social lives, household duties, and relationships with friends and family. High distress levels were also correlated with higher rates of impairment days, physical health issues, lifestyle concerns, and mental health care access (Prochaska et al., 2012).

The implications for our sample are substantial on an individual and systemic level. According to the K6 literature, we would expect "some" level of impairment in half of our sample and "a lot" of impairment in more than one-tenth of our participants. At this level of impairment we could anticipate presenteeism, absenteeism (including leaves), work-life balance challenges, reduced self-care, difficulty completing housework, relationship issues, greater levels of sedentary lifestyle and obesity, and increased smoking and substance among two-thirds of our sample, many of which were evidenced in participants' comments throughout the survey. However, given some participants reservations to take sick days, impairments from distress may take the form of presenteeism. These effects are likely to be highest among those who met the

criteria for SMI, followed by those with moderate distress levels, aside from substance use which was found to comparable among those with moderate to severe levels of distress (Prochaska et al., 2012).

In keeping with figures from OTIP (Otip.com) this level of distress should pose financial implications in terms of medication, treatment, absenteeism and leaves. However, an even greater concern is the potential impact on students' academic achievement and development.

Perhaps the most important implication for practice is that even moderate levels of distress may warrant intervention due to its pervasive impact. The severity of distress must also be a consideration for intervention. For instance, those who experience more moderate symptoms may require interventions such as psychoeducation, since sometimes helping professionals delay seeking treatment due to a lack of symptom recognition, especially if symptoms are subtle (Putnik et al., 2011). However, those who meet the requirement for severe mental illness are likely to require more extensive treatment than is available through an EAP program. For example, evidence-based treatments for anxiety and depression, frequently mentioned as reasons for seeking therapy, typically require 12-16 sessions. However, since (Prochaska et al., 2012) found that only one in three people who met the criteria for SMI had been referred, or were accessing treatment, it is feasible to expect that at least some teachers with serious mental health issues will not be receiving treatment.

Help-seeking Attitudes and Practices

Attitudes Toward Help-Seeking. Perhaps some of the most hopeful findings of this study were that half of the sample had already accessed psychotherapy and three-quarters of those who had accessed this service found it effective. Moreover, receptivity toward help-

seeking was positively correlated with effective experiences in psychotherapy but was not associated with distress levels, perceptions of workplace psychological safety, or fears of job loss. Taken together, this suggests that psychotherapy may be a feasible and effective intervention. However, it is still important to address the reasons why approximately one quarter of the sample found psychotherapy ineffective or were unsure if it was effective. Some clues to this were evident in feedback about barriers.

The scores on the ATSPPH-SF and the comments in this section suggested moderately receptive attitudes toward seeking professional help. However, the mean score from this study was significantly lower score than published means from the most comparable samples, a community medical practice and a group of graduate students (Elhai et al., 2009; McCarthy, Bruno & Sherman, 2010), which suggests that teachers may have comparatively less favorable attitudes than some populations.

Role Identity. Although studies have contended that helping professionals (doctors, social workers, nurses psychiatrists, and teachers) may be reluctant to seek professional help for emotional issues, especially those who identify with professional roles as caregivers, (Adams et al., 2010; Putnik et al., 2011; Siebert & Siebert 2007) the fact that more than half of this sample had already received counselling or psychotherapy, suggested that teachers as helping professionals are relatively receptive to mental health treatment. While participants in this sample engaged in less help-seeking than a study of social workers in the US (Siebert & Siebert, 2007), we cannot infer lower rates of help-seeking since Siebert and Siebert (2007) queried help-seeking versus counselling or psychotherapy. A few comments made regarding role expectations, weakness, and stigma were reminiscent of role identity theory, but these were far

less prevalent than comments about other barriers, which suggested that this may not be a focal barrier. However, overexertion is characteristic of professionals with an idealized caregiver identify (Siebert & Siebert, 2007), that was evident in distress scores and associated comments. Therefore, we would need to administer a role identity measure to verify whether professional identify is actually a significant factor in help-seeking.

Unmet Mental Health Needs. Results also indicated that there were barriers impeding access to mental health services, since one-fifth of the sample had not received counselling or psychotherapy, despite an interest in this service. Moreover, there were higher rates of distress among the sample than those who had endorsed accessing counselling or psychotherapy, which suggests possible unmet mental health needs. This is a concern because unresolved mental health issues may require intervention from other systems, such as the legal or health care systems (Cohen & Peachy, 2014), that can be expensive and inappropriate options for addressing mental health issues.

Barriers to Help-Seeking. Statistically, financial restrictions were most frequently endorsed as barriers, followed by privacy concerns, "other" reasons (most commonly time), and unavailability of the service. These barriers were also reiterated in the comments section. However, several other themes also emerged including service delivery limitations with EAP programs, concerns regarding the prospective quality and effectiveness of psychotherapy, ambivalence about symptoms and the need for psychotherapy, stigma, career advancement and job retention repercussions, and the lack of support by family and friends to engage in this service.

These barriers were consistent with several of the obstacles to psychological help-seeking identified in previous studies among helping professionals including concerns regarding work coverage, privacy, career advancement, disappointing clients, embarrassment, and public stigma (Adams et al., 2010; Chew-Graham et al., 2003; Garelick, 2012). However, the barriers in this study also extended beyond the largely demographic and attitudinal barriers mentioned in the helping professionals literature to pragmatic issues such as inability to find time, inaccessibility, and unavailability described in a Canadian study of help-seeking for mental health problems (Afifi, Cox & Sareen, 2005). This finding was consistent with Komiya et al., (2000), who suggested that there were factors beyond gender, stigma, emotional openness, and distress level that accounted for the variance in help-seeking.

The comments regarding barriers were very illuminating and provided valuable insights that could ease access to mental health care as well as improve the effectiveness of these interventions. These included providing clear information about the mental health services available to these professionals and how to access these programs, EAP access to all staff regardless of status, assurance that programs are confidential, improving access to care from remote communities, decreasing wait times, offering services outside of work hours or making it feasible to leave work for appointments, increasing the number of psychotherapy sessions available through EAPs, access to service providers that were not part of one's professional circle, no upfront payment for services, and in one case, allowing a psychotherapist to continue providing therapy, despite a change in the school's EAP provider. Those who had negative experiences with counselling or psychotherapy were seeking competent therapists and good therapeutic alliances. However, since the majority of EAP programs do not solicit feedback form clients (Csiernik, Sharar & Granberry, 2014) it may behoove school boards to require evaluation

of EAP services, while still maintaining the confidentiality of the program. Moreover, school boards may need to prioritize barriers in order to target the most substantial obstacles to treatment.

Another notable finding in this section is that nearly a third of the sample had never wished to go to counselling or psychotherapy. This figure was very consistent with the percentage of people who denied any experience of mental health interference since becoming a teacher and was slightly lower than the percentage of people reporting little to no distress in the last 30 days. Therefore, it is feasible that these statistics may reflect a resilient proportion of the sample and or those with insufficient distress to warrant treatment. Alternatively, this figure may also reflect unfavorable attitudes toward psychotherapy or an endorsement of alternative support strategies, such as the support from friends and family, exercise, and the self-help resources that were proposed in some of the comments in this section. If so, it may be important to have a variety of evidenced based options available, including options that will be perceived as non-stigmatizing.

Sources of Help. The study also investigated these professionals' sources of mental health support. While respondents listed a variety of supports, they primarily accessed counselling or psychotherapy through EAP and benefits programs, medical practices, and private mental health practitioners (social workers, psychologists, counsellors). The fact that only one-third of participants accessed professional support through their EAP and insurance benefits, despite the need indicated by K6 scores, suggests there may be an underutilization of these services. Moreover, the finding that medical practices were one of the primary sources of support is consistent with studies by Adams et al., (2010) and Putnik et al., (2011). However, there is a

question of whether physicians have the qualifications necessary to provide psychotherapy, especially in the case of severe mental health issues (Cohen & Peachy, 2014).

Workplace Psychological Safety

Moderate scores on the Workplace Health scale corresponded with a response of "somewhat". In the absence of normative data, a "somewhat" endorsement suggests that overall schools are meeting national standard guidelines to some degree. However, these moderate ratings are not a resounding endorsement and some of the comments referring to "toxic" work environments, unsafe working conditions, and "bullying" by administrators, suggests that there is room for improvement in schools' standards and practices for workplace psychological safety. An examination of individual items indicated two areas of lower endorsement that appear to warrant particular attention, 1) "the promotion of a healthy work life balance and the means to attain this balance" and 2) "leadership by someone who is respectful of mental illness and promotes mental health literacy among staff". Correlation analysis also revealed a negative relationship between the severity of distress and workplace psychological safety as well as a positive correlation between fear regarding job retention and workplace psychological safety.

The low endorsement of work-life balance among this sample was also illustrated in participants' comments and consistent with the results of a recent Canadian Teachers' Federation survey (2014) which found that 93% of teachers struggle with this balance, often having insufficient time for their own children, partners, family, friends, or leisure. The implications of excessive workloads have significant consequences for families because research has shown that employees who experience overload at work were twice as likely to allow work to interfere with their family life, than they were to permit family life to impact work (Duxbury & Higgins, 2012).

They (2012) also found that work-life conflict had detrimental impacts on employees sleep, self-care, energy, social life and leisure. In light of educational initiatives, such as school based mental health care, which will only add to teachers' job responsibilities (Manion et al., 2014), it will be important to address the ongoing issue of the evolving and growing workload expectations of teachers. Thus, employers will need to explore the primary causes of excessive workload if they hope to improve employee well-being (Duxbury & Higgins, 2012).

The finding that there was a negative relationship between distress level and workplace psychological infers that an individual's mental well-being may impact their interpretation of how safe their work environment, and therefore, is unsurprising that people who had a lower sense of psychological safety experienced more anxiety about job retention, if they disclosed mental health concerns. Regardless, the findings suggest that both individual and organizational factors may be contributing to issues of workplace psychological safety, and therefore, interventions should be collaborative. In fact, Grayson & Alvarez (2008) suggested it was easier to effect change at the organizational level, by addressing school climate factors, than it would be to intervene at a community or individual level.

While various workplace stress models may explain these findings, Psychosocial Risks and Psychosocial Safety Climate appear most relevant. For example, scale results and work-related comments were consistent with eight of the thirteen psychosocial factors (Samra et al., 2012) which informed Canada's national standard on workplace psychological safety. These included involvement and influence, balance, organizational culture, psychological protection, workload management, psychological support and civility and respect. While this may be expected since the Workplace Health scale was developed based on the guiding principles of this

standard, participants' comments across the survey highlighted these risks. Issues regarding work-life balance were most consistent with the Demands-Control-Support model (Gilbreath, 2012), one of the job stress models underlying the national workplace psychological safety standard, in that teachers are reporting excessive workloads without sufficient supports and resources to manage these workloads.

Since free employer handbooks have already been developed for assist in the implementation of these standards (Gilbert & Bilsker, 2012), some schools are already adopting the recommendations of the national standard (e.g. Bluewater District School Board, 2015), and organizations such as Guarding Minds @ Work (Samra et al., 2012) have already designed surveys that assist workplaces to measure their respective performance on these 13 psychosocial factors, this model may be an imminently viable choice. Moreover, individual assessments of schools or regions may enable more customized intervention.

Psychosocial Safety Climate (PSC), defined as "policies, practices and procedures for the protection of worker psychological health and safety" (Dollard & Bakker, 2010, p. 580) was also a relevant model given its effectiveness in mitigating fatigue from job demands and its capacity to moderate the relationship between recovery and fatigue as well as teacher engagement (Dollard & Bakker, 2010; Garrick et al., 2014). An element of this model that will be important to remember when implementing the workplace psychological safety standard is the collaborative engagement of all stakeholders including management, employees, unions, and health and safety representatives in the development of psychological safety policies and procedures as well as the shared responsibility for job stress prevention. However, this model is similar to the premise and goals of the national standard and may therefore be redundant.

Nonetheless, the promising results from these studies suggests that successful implementation of this national psychological safety standard has the potential to improve teacher well-being.

Strengths

There were notable strengths to this study. First, it explored the actual mental well-being of teachers, adding to the limited research on staff mental health in elementary and high schools. Secondly, the study provided some insight into these professionals' receptivity to mental health treatment and their perception of psychological safety in schools. As previously mentioned, the literature on help-seeking was limited in itself and there was only one small study that even included teachers in the literature on help-seeking in helping professionals. While there has been considerable research regarding workplace models of employee well-being, and even studies investigating the specific factors associated with teacher mental health and safe schools, this study is both timely and valuable in that the Workplace Health scale measures the specific psychosocial factors associated with the recently released Canadian guidelines for workplace psychological safety. This permits the study to compare teachers' perceptions against national standards.

Another strength of this study was the sample; data was collected nationally and the sample size was significant. The sample also appeared to be relatively demographically representative of Ontarian and Canadian teacher statistics. Therefore, there is some level of confidence in generalizing this to teachers across Canada.

Lastly, the scales in this study, the K6 and ATSPPH-SF were selected because they are brief and well known measures of non-specific mental health symptoms and receptivity towards professional treatment (Prochaska et al., 2012; Elhai et al., 2008) which enabled us to make

comparisons with published data in the US and Canada. The K6, ATSPPH-SF and Workplace Health scales also exhibited good to excellent reliability with alpha co-efficients of .84, .82, and .94.

Limitations

However, there were also some limitations of this study that may have influenced the interpretation of findings and the degree of exploration. First participants were self-selected. Consequently, those who were distressed may have been compelled to participate or conversely felt they had insufficient time, motivation, and or energy to participate in the study. Secondly, the study recruited teachers that were current members of teacher's federations, either actively employed in the sector or on a work leave. Therefore, the results may reflect those who have exhibited some level of resilience in remaining in the field. Thirdly, the use of secondary data limited specific exploration within these fields and impacted the capacity to make direct comparisons to studies using alternate research designs. Lastly, there were some possible weaknesses in two of the scales utilized in this study. The Workplace Health scale was designed specifically for this study, and although it demonstrated reliability, it has yet to be validated. Therefore, findings regarding this scale must be interpreted with caution. In addition, there was no normative data for Workplace Health scale or the ATSPPH-SF which made if challenging to interpret the actual degree of workplace psychological safety and receptivity to professional psychological support.

Future Research

This study elicited several possible areas for future research. The fact that 37% of the sample was experiencing no to low distress suggested some mental health resiliency. From a

preventative perspective, a future study may want to interview teachers from low, moderate and high distress groups to identify individual and organizational differences that act as protective factors such as emotional intelligence, coping mechanisms, resources, and supports. Since this study has demonstrated a need for intervention, some preliminary investigation of interventions are warranted. Moreover, since research has recommended that employee involvement is imperative to the success of intervention designs (Grawitch et al., 2007), future research should engage teachers, as well as educational support staff and administrators in open-ended discussions about the types of individual and or organizational interventions that would ease their distress levels. However, research suggests that a one size model does not fit all (Grawitch et al., 2007), and similar to a national study of help-seeking practices among the general population (Afifi, Cox & Sareen, 2005), needs may vary provincially or even locally. This research could also be used to inform priorities for EAP programs, benefits programs, and school based initiatives. In the next phase of this research, it would also be beneficial to perform a discriminant function analysis or logistic regression to identify which factors are most predictive of help-seeking, which could also be used to inform interventions. Though outside of the scope of this study, a gender analysis of help-seeking in teachers may prove useful since the majority of teachers are female and studies have typically found lower ATSPPH-SF scores in males (Komiya et al., 2000).

Implications for Counselling and Practice

The sub-clinical and clinical levels of mental distress reported in this study suggest a significant and immediate need for access to interventions such as psychotherapy. However, since the cost of psychotherapy was identified as the most significant barrier to accessing

therapy, or sufficient levels of therapy, the expense of psychotherapy needs to be considered. Moreover, the brief counselling approach of EAP programs is likely to be insufficient for those who meet the criteria for serious mental illness. This is also complicated by the disparities in the availability and funding for psychotherapy due to a diverse range of EAP and work benefits insurance providers and under-resourced locations. Given the relatively pervasive level of distress among these teachers, there should be a minimum level of psychological service provided to these professionals, ensuring remote areas having adequate options to access. Additional funding will likely be necessary to address the needs of teachers who require lengthier treatment. However, as one teacher suggested a solution may involve allowing teachers to customize their benefits packages, giving them the choice to prioritize counselling versus other paramedical services. Having access to external psychotherapy options is particularly important given the reluctance teachers expressed to access internal services due to perceived stigma and potential career consequences. Regardless, the additional costs may outweigh the more extensive costs of leaves, medications, and long-term disability. In addition to financial considerations, the individual, organizational and societal benefits to teachers, their families, students and workplace seem well worth the investment.

Psychoeducation may be required to enhance mental health literacy, building awareness about healthy coping mechanisms as well as an understanding of typical, detrimental coping patterns such as isolation, increased substance use, and poor self-care. Moreover, the literature suggests that this may be important to identify the non-specific symptoms of job stress (Putnik et al., 2012) and when they warrant treatment. Given the turnover rate in the early years of teaching (Karsenti & Collin, 2013) it may be beneficial to make this a mandatory component of all teaching certificate programs as well as an ongoing focus of professional development programs.

The stigma of mental illness also has to be addressed within the school system such that teachers feel safe to access treatment or disclose mental health concerns without the fear of reprisal. This will also model respectful attitudes toward mental health to students.

In integrating the feedback of teachers and the literature on help-seeking and workplace stress, models would suggest that school boards, administrators, and unions need to work collaboratively with teachers to help them manage the stressors and demands of teaching including new educational initiatives. For example, if teachers are assuming additional responsibilities such as mental health prevention with initiatives such as school based mental health care, then the funding that is attached to services elsewhere needs to follow the service. Within a collaborative model of workplace health, leadership in the educational sector would contemplate how they could provide the additional resources necessary for teachers to accomplish this task. For example, they may advocate for this funding, thereby enabling schools to hire additional staff to support teachers with their expanding roles versus teachers assuming the responsibility for absorbing these additional demands. Most importantly, workplace research (Grawitch et al., 2006; Grawitch et al., 2007) suggests that teachers need to be involved in designing and evaluating these initiatives, and that initiatives and how to access them need to be clearly communicated to be effective.

Conclusions

In conclusion, this sample of teachers experienced levels of distress that far exceeded the typical rates in the general population. This is important in that these levels of distress are typically associated with impaired social, family, and occupational functioning and normally warrant treatment, and in the case of severe distress, intensive treatments beyond the 3-4

treatments typically offered in EAP programs (Csiernik et al., 2014). The finding that almost 40% of participants experienced little to no distress suggests some resiliency that would be valuable to investigate. Attitudes toward help-seeking were generally favorable. However, they were less favorable than comparable samples and there were gaps in service suggesting some barriers to help-seeking. Based on the respondents feedback there were several measures that could be taken to imminently improve access to treatment, including access to existing resources. However, barriers such as cost, time, availability and stigma may need to be addressed to enhance access. Lastly, it was found that there were some sense of psychological safety in schools, but scale items and comments suggested areas for change, in particular a focus on work-life balance and leadership that was more supportive of mental health concerns. It is essential to remember that schools are workplaces and teachers require the resources and supports necessary to manage their workloads and mental well-being, for the sake of themselves, their families, students, and the school climate.

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Appendix A

Western Research

Research Ethics

Western University Non-Medical Research Ethics Board
NMREB Amendment Approval Notice

Principal Investigator: Dr. Susan Rodger
Department & Institution: Education\Faculty of Education,Western University

NMREB File Number: 105571
Study Title: An Examination of Teachers' and Education Professionals' Mental Health and Wellness
Sponsor:

NMREB Revision Approval Date: October 30, 2014
NMREB Expiry Date: February 28, 2015

Documents Approved and/or Received for Information:

Document Name	Comments	Version Date
Instruments	revised questionnaire	2014/10/09

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

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

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

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

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

[redacted]

Ethics Officer to Contact for Further Information

Erika Basile [redacted]	Grace Kelly [redacted]	Mina Mekhail [redacted]	Vikki Tran [redacted]

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

Appendix B

An Examination of Teachers' and Education Professionals' Mental Health & Wellness

LETTER OF INFORMATION

Introduction
My name is Kirsten Marko and I am a graduate student at the Faculty of Education at Western University. I am conducting research into the experiences of stress, burnout and mental health in the lives of teachers and other education professionals.

Purpose of the Study
The aim of the study is to explore mental health and wellness, stress and the experience of seeking help, balancing work life and home life, and burnout among teachers and education professionals. We hope to, through this project, develop an understanding of the needs, strengths and challenges faced by people who work in the education system.

Participation
If you agree to participate in this study you will be asked to complete a survey that asks questions about stress, mental health, burnout, and your quality of life. The survey is completed electronically. Using the link provided here and in the email to which this letter is attached, you can access the survey. The survey will take about 20 minutes to complete.

Confidentiality
The information collected will be used for research purposes only, and neither your name nor information which could identify you will be used in any publication or presentation of the study results. Otherwise, all information collected for the study will be kept confidential.

Risks & Benefits
While there are no known risks to participating in this study, you might find that responding to questions about these topics is upsetting. You will also find, attached to the email where you found this letter, a list of mental health resources organized by geographical area and school board, which you may find useful.

Voluntary Participation
Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your employment or connections with your professional affiliations.

Publication
The results of this study are intended for publication. If you choose to complete any of the free response items, we may quote you. Your name will not be used.

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

Thank you,

Susan Rodger, PhD., C. Psych
Associate Professor,
(Removed email information)

Kirsten Marko, BA Psychology (Hons)
Master of Arts Candidate
(Removed email information)

Faculty of Education, Western University,
1137 Western Road, London, ON N6G 1G7

Appendix C

Teacher Mental Health and Wellness Survey

Demographic Section

Please note that the survey cannot be returned to once the browser has been closed - only the responses completed before the survey was closed will be recorded.

Please complete the following items. If you would prefer not to answer any item, you are permitted to skip it.

Q1 Gender:
- ❍ Male (1)
- ❍ Female (2)
- ❍ Transgender (3)

Q2 Please indicate your age.
_____ Age (1)

Q3 Level(s) currently teaching:
- ❑ Primary (1)
- ❑ Junior (2)
- ❑ Intermediate (3)
- ❑ Senior (4)
- ❑ Alternative (5)
- ❑ Other (6)

Q4 How long have you been teaching (including this year)?
_____ Years (1)

Q5 How many different schools have you taught in?
_____ # of schools (1)

Q6 What is your current role in the school? Is this role full time or part-time?

Occasional Teacher (1)	❑ Full Time (1)	❑ Part Time (2)
Long-term Occasional Teacher (2)	❑ Full Time (1)	❑ Part Time (2)
Classroom Teacher (3)	❑ Full Time (1)	❑ Part Time (2)
Learning Support Teacher (4)	❑ Full Time (1)	❑ Part Time (2)
Guidance Counsellor/School Support Teacher (5)	❑ Full Time (1)	❑ Part Time (2)
Chaplain (6)	❑ Full Time (1)	❑ Part Time (2)
Psychology Staff (7)	❑ Full Time (1)	❑ Part Time (2)
Social Worker (8)	❑ Full Time (1)	❑ Part Time (2)
Educational Assistant (9)	❑ Full Time (1)	❑ Part Time (2)
Child and Youth Worker (10)	❑ Full Time (1)	❑ Part Time (2)
Principal (11)	❑ Full Time (1)	❑ Part Time (2)
Vice Principal (12)	❑ Full Time (1)	❑ Part Time (2)
Other (please specify) (13)	❑ Full Time (1)	❑ Part Time (2)

Q7 Please indicate the features of the community where you work (check all that apply):
- ❑ Remote (1)
- ❑ Rural (2)
- ❑ Urban (3)
- ❑ (4)
- ❑ 5001-15,000 people (5)
- ❑ 15001 – 50,000 people (6)
- ❑ 50,001 – 100,000 people (7)
- ❑ 100,001 – 200,000 people (8)
- ❑ 200,001-500,000 people (9)
- ❑ 500,001-1,000,000 people (10)
- ❑ Over 1,000,000 people (11)

Q8 Marital Status:
- ❍ Married (1)
- ❍ Common-law (2)
- ❍ Divorced (3)
- ❍ Separated (4)
- ❍ Single (5)
- ❍ Widowed (6)

Q9 Do you have children?
❍ Yes (1)
❍ No (2)
If No Is Selected, Then Skip To Do you currently care for ageing pare...

Q10 How many children do you have in each of these age groups?

	# of children in age group (1)
Age 0-2 (1)	
Age 3-6 (2)	
Age 7-11 (3)	
Age 12-18 (4)	
Age 19-25 (5)	
26 and older (6)	

Q11 Please estimate the number of hours per month you spend caring for your child/children.

Q12 Do you currently care for ageing parents or adult siblings?
❍ Yes (1)
❍ No (2)
If No Is Selected, Then Skip To Do you do any volunteer work outside …

Q13 What type of support do you provide for your ageing parents or adult siblings? Please check all that apply.
❑ They live with me (1)
❑ They live on their own and I visit them on a regular basis to check on them (2)
❑ They live in a supported care facility (3)
❑ I advocate for their health and well-being needs with healthcare providers (4)
❑ Other (please explain) (5) _____

Q14 Please estimate the number of hours per month you spend caring for your ageing parent or sibling.

Q15 Do you do any volunteer work outside of your school?
❍ Yes (1)
❍ No (2)
If No Is Selected, Then Skip To Do you do any volunteer work at your ...

Q16 Please estimate the number of hours per month you spend doing volunteer work outside of your school.

Q17 Do you do any volunteer work at your school?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To Since becoming a teacher or education...

Q18 Please estimate the number of hours per month you spend doing volunteer work at your school.

Q19 Since becoming a teacher or education professional, have you ever experienced mental health distress that interfered with your ability to engage in the activities of everyday life (i.e. work, relationships, health-promoting behaviours, etc.)?
- ❍ Yes (1)
- ❍ No (2)

Q20 Have you ever received psychotherapy or counselling?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip To If you have never gone for counselling...

Q21 Where did you go for help? Check all that apply.
- ❑ Privately paid therapy (psychologist, social worker, counsellor) (1)
- ❑ Family Doctor (2)
- ❑ Clergy member (3)
- ❑ Psychiatrist (4)
- ❑ EAP (Employee Assistance Provider) (5)
- ❑ Mental Health Distress Crisis Line (telephone) (6)
- ❑ Walk-in Clinic (7)
- ❑ Other (8) _____

Q22 Please briefly explain the reason(s) why you received psychotherapy or counselling.

Q23 Was the psychotherapy/counselling helpful?
- ❍ Yes (1)
- ❍ No (2)
- ❍ I'm not sure (3)

Q24 If you have never gone for counselling or psychotherapy, but you wished you could, what prevented you? Check all that apply.
- ❑ Financial restrictions (1)
- ❑ It was not available in my community (2)
- ❑ Privacy issues (3)
- ❑ Other (4) _____
- ❑ I have never wished to go to counselling or psychotherapy. (5)

If I have never wished to go t... Is Selected, Then Skip To End of Block

Q25 Please briefly describe your situation with regards to your reason for not receiving counselling or psychotherapy when you wished you could have.

Please note that the survey cannot be returned to once the browser has been closed - only the responses completed before the survey was closed will be recorded. Please complete the following items. If you would prefer not to answer any item, you are permitted to skip it. The following questions ask about how you have been feeling during the past 30 days. For each question, please select the number that best describes how often you had this feeling.

Q26 During the past 30 days, about how often did you feel...

	All of the time (1)	Most of the time (2)	Some of the time (3)	A little of the time (4)	None of the time (5)
...nervous? (1)	❍	❍	❍	❍	❍
...hopeless? (2)	❍	❍	❍	❍	❍
...restless or fidgety? (3)	❍	❍	❍	❍	❍
...so depressed that nothing could cheer you up? (4)	❍	❍	❍	❍	❍
...that everything was an effort? (5)	❍	❍	❍	❍	❍
...worthless? (6)	❍	❍	❍	❍	❍

Q27 The last 6 questions asked about feelings that might have occurred during the past 30 days. Taking them altogether, did these feelings occur more often in the past 30 days than is usual for you, about the same as usual, or less often than usual? (If you never have any of these feelings, select the associated option.)

	A little more often than usual (1)	A bit more often than usual (2)	A lot more often than usual (3)	About the same as usual (4)	A little less often than usual (5)	A bit less often than usual (6)	A lot less often than usual (7)	None of the time (8)
These feelings have occurred... (1)	❍	❍	❍	❍	❍	❍	❍	❍

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

Q28 During the past 30 days, how many days out of 30 were you totally unable to work or carry out your normal activities because of these feelings? (Insert # of days)

Q29 Not counting the days you reported in response to the previous question, how many days in the past 30 were you able to do only half or less of what you would normally have been able to do, because of these feelings? (Insert # of days)

Q30 During the past 30 days, how many times did you see a doctor or other health professional about these feelings? (Insert # of times)

Q31

During the past 30 days, how often have physical health problems been the main cause of these feelings? (1)	All of the time (1) ❍	Most of the time (2) ❍	Some of the time (3) ❍	A little of the time (4) ❍	None of the time (5) ❍

Q32 Please insert any additional comments about these questions and/or this topic below.

Please note that the survey cannot be returned to once the browser has been closed - only the responses completed before the survey was closed will be recorded. Please complete the following items. If you would prefer not to answer any item, you are permitted to skip it. This measure is designed to determine how you currently feel about your job and its related aspects. There are no right or wrong answers. Work quickly and choose your first impression. Please indicate the degree to which each statement applies to you by marking whether you:

Q33

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

I am bored with my job. (1)	❍	❍	❍	❍	❍
I am tired of my students. (2)	❍	❍	❍	❍	❍
I am weary with all of my job responsibilities. (3)	❍	❍	❍	❍	❍
My job doesn't excite me anymore. (4)	❍	❍	❍	❍	❍
I dislike going to my job. (5)	❍	❍	❍	❍	❍
I feel alienated at work. (6)	❍	❍	❍	❍	❍
I feel frustrated at work. (7)	❍	❍	❍	❍	❍
I avoid communication with students. (8)	❍	❍	❍	❍	❍
I avoid communication with my colleagues. (9)	❍	❍	❍	❍	❍
I communicate in a hostile manner at work. (10)	❍	❍	❍	❍	❍
I feel ill at work. (11)	❍	❍	❍	❍	❍
I think about calling my students ugly names. (12)	❍	❍	❍	❍	❍
I avoid looking at my students. (13)	❍	❍	❍	❍	❍

My students make me sick. (14)	❍	❍	❍	❍	❍
I feel sick to my stomach when I think about work. (15)	❍	❍	❍	❍	❍
I wish people would leave me alone at work. (16)	❍	❍	❍	❍	❍
I dread going to school. (17)	❍	❍	❍	❍	❍
I am apathetic about my job. (18)	❍	❍	❍	❍	❍
I feel stressed at work. (19)	❍	❍	❍	❍	❍
I have problems concentrating at work. (20)	❍	❍	❍	❍	❍

Q34 Please insert any additional comments about these questions and/or this topic below.

Please note that the survey cannot be returned to once the browser has been closed - only the responses completed before the survey was closed will be recorded. Please complete the following items. If you would prefer not to answer any item, you are permitted to skip it. This questionnaire asks how you feel about your quality of life, health, or other areas of your life. If you are unsure about which response to give to a question, please choose the one that appears most appropriate. This can often be your first choice. Please keep in mind your standards, hopes, pleasures and concerns. We ask you think about your life in the last two weeks.

Q35 Please read each question, assess your feelings, and select the option on the scale that gives the best answer for you for each question.

	Very poor (1)	Poor (2)	Neither poor nor good (3)	Good (4)	Very good (5)
How would you rate your quality of life? (1)	❍	❍	❍	❍	❍

How would you rate your health? (2)	❍	❍	❍	❍	❍

Q36 The following questions ask about how much you have experienced certain things in the last two weeks.

	Not at all (1)	A little (2)	A moderate amount (3)	Very much (4)	An extreme amount (5)
To what extent do you feel that physical pain prevents you from doing what you need to do? (1)	❍	❍	❍	❍	❍
How much do you need any medical treatment to function in your daily life? (2)	❍	❍	❍	❍	❍
How much do you enjoy life? (3)	❍	❍	❍	❍	❍
To what extent do you feel your life to be meaningful? (4)	❍	❍	❍	❍	❍
How well are you able to concentrate? (5)	❍	❍	❍	❍	❍
How safe do you feel in	❍	❍	❍	❍	❍

your daily life? (6)					
How healthy is your physical environment? (7)	❍	❍	❍	❍	❍

Q37 The following questions ask about how completely you experienced or were able to do certain things in the last two weeks.

	Not at all (1)	A little (2)	Moderately (3)	Mostly (4)	Completely (5)
Do you have enough energy for everyday life? (1)	❍	❍	❍	❍	❍
Are you able to accept your bodily appearance? (2)	❍	❍	❍	❍	❍
Have you enough money to meet your needs? (3)	❍	❍	❍	❍	❍
How available to you is the information that you need in your day-to-day life? (4)	❍	❍	❍	❍	❍
To what extent do you have the opportunity for leisure activities? (5)	❍	❍	❍	❍	❍
How well are you able to get around? (6)	❍	❍	❍	❍	❍

Q38 The following questions ask you to say how good or satisfied you have felt about various aspects of your life over the last two weeks.

	Very dissatisfied (1)	Dissatisfied (2)	Neither satisfied nor dissatisfied (3)	Satisfied (4)	Very satisfied (5)
How satisfied are you with your sleep? (1)	❍	❍	❍	❍	❍
How satisfied are you with your ability to perform your daily living activities? (2)	❍	❍	❍	❍	❍
How satisfied are you with your capacity for work? (3)	❍	❍	❍	❍	❍
How satisfied are you with yourself? (4)	❍	❍	❍	❍	❍
How satisfied are you with your personal relationships? (5)	❍	❍	❍	❍	❍
How satisfied are you with your sex life? (6)	❍	❍	❍	❍	❍
How satisfied are you with the support you get from your friends? (7)	❍	❍	❍	❍	❍
How satisfied are you with the conditions	❍	❍	❍	❍	❍

of your living place? (8)					
How satisfied are you with your access to health services? (9)	❍	❍	❍	❍	❍
How satisfied are you with your mode of transportation? (10)	❍	❍	❍	❍	❍

Q39 The following question refers to how often you have felt or experienced certain things in the last two weeks.

	Never (1)	Seldom (2)	Quite often (3)	Very often (4)	Always (5)
How often do you have negative feelings, such as blue mood, despair, anxiety, depression? (1)	❍	❍	❍	❍	❍

Q40 Please insert any additional comments about these questions and/or this topic below:

Q41 Please note that the survey cannot be returned to once the browser has been closed - only the responses completed before the survey was closed will be recorded. Please complete the following items. If you would prefer not to answer any item, you are permitted to skip it. Read each statement carefully and indicate whether you agree or disagree, using the scale below. Please express your frank opinion in responding to each statement, answering as you honestly feel or believe.

	Disagree (1)	Probably disagree (2)	Probably agree (3)	Agree (4)
I would obtain professional help	❍	❍	❍	❍

if I was having a breakdown. (1)				
Talking about psychological problems is a poor way to solve emotional problems. (2)	❍	❍	❍	❍
I would find relief in psychotherapy if I was in an emotional crisis. (3)	❍	❍	❍	❍
A person coping without professional help is admirable. (4)	❍	❍	❍	❍
I would obtain psychological help if I was upset for a long time. (5)	❍	❍	❍	❍
I might want counselling in the future. (6)	❍	❍	❍	❍
A person with an emotional problem is likely to solve it with professional help. (7)	❍	❍	❍	❍
Psychotherapy would not have value for me. (8)	❍	❍	❍	❍
A person should work out his/her problems without counselling. (9)	❍	❍	❍	❍
Emotional problems resolve by themselves. (10)	❍	❍	❍	❍

Q42 Please insert any additional comments about these questions and/or this topic below:

Q43 Please note that the survey cannot be returned to once the browser has been closed - only the responses completed before the survey was closed will be recorded. Please complete the following items. If you would prefer not to answer any item, you are permitted to skip it. Read each statement carefully and indicate whether you agree or disagree, using the scale below. Please express your frank opinion in responding to each statement, answering as you honestly feel or believe.

	Disagree (1)	Probably disagree (2)	Probably agree (3)	Agree (4)
Seeing a psychologist for emotional or interpersonal problems carries social stigma. (1)	❍	❍	❍	❍
It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems. (2)	❍	❍	❍	❍
People will see a person in a less favourable way if they knew he/she was seeing a psychologist. (3)	❍	❍	❍	❍
It is advisable for a person to hide from others that he/she has been seeing a psychologist. (4)	❍	❍	❍	❍
People tend to like less, those who are receiving professional psychological help. (5)	❍	❍	❍	❍

I would be worried about keeping my job, or getting another job with my employer, if an administrator knew I was receiving professional psychological help. (6)	❍	❍	❍	❍

Q44 Please insert any additional comments about these questions and/or this topic below:

Please note that the survey cannot be returned to once the browser has been closed - only the responses completed before the survey was closed will be recorded. Please complete the following items. If you would prefer not to answer any item, you are permitted to skip it. The following questions ask information about mental health in your work environment. Please choose the appropriate response to each question to indicate how true you believe it is for your work environment.

Q45 Do you feel that your workplace...

	No (1)	Not Really (2)	Somewhat (3)	Quite a bit (4)	Definitely (5)
...meets and adheres to the legal requirements of a psychologically safe and respectful workplace? (1)	❍	❍	❍	❍	❍
...promotes, encourages and enforces respectful language, attitudes and behaviours towards mental health	❍	❍	❍	❍	❍

and mental illness? (2)					
...provides its employees with the appropriate knowledge and means of protecting and supporting one's mental health? (3)	❍	❍	❍	❍	❍
...provides and facilitates a supportive, safe and respectful atmosphere, where you could turn to a colleague if you felt you were experiencing psychological distress? (4)	❍	❍	❍	❍	❍
...is overseen and led by an individual who is respectful towards mental illness and seeks to promote & implement mental health literacy amongst your faculty? (6)	❍	❍	❍	❍	❍
...promotes, encourages and provides the means for its employees to maintain a	❍	❍	❍	❍	❍

healthy work-life balance? (7)					
...would provide appropriate and adequate assistance if you came forward with a mental health issue or while in psychological distress? (9)	❍	❍	❍	❍	❍

Please note that the survey cannot be returned to once the browser has been closed - only the responses completed before the survey was closed will be recorded. Please complete the following items. If you would prefer not to answer any item, you are permitted to skip it.

Q46 Below you will find a list of some parts of life that can contribute to stress, and under each type of stress there are some specific examples. Please rate the extent to which each part of your life may be stressful overall, then rate each specific example as well.

	Never (1)	Seldom (2)	Quite often (3)	Very often (4)	Always (5)
My work-life overall (1)	❍	❍	❍	❍	❍
My students (2)	❍	❍	❍	❍	❍
My leadership team (3)	❍	❍	❍	❍	❍
My co-workers (4)	❍	❍	❍	❍	❍
Policies (5)	❍	❍	❍	❍	❍
Lack of resources (6)	❍	❍	❍	❍	❍
Other (please specify) (7)	❍	❍	❍	❍	❍
My personal life overall (8)	❍	❍	❍	❍	❍

My relationship with my spouse or partner (9)	❍	❍	❍	❍	❍
My relationship with my children (10)	❍	❍	❍	❍	❍
Caring for children (11)	❍	❍	❍	❍	❍
Caring for other family members (12)	❍	❍	❍	❍	❍
Financial difficulties (13)	❍	❍	❍	❍	❍
Other (please specify) (14)	❍	❍	❍	❍	❍
Work-Life Balance (15)	❍	❍	❍	❍	❍
My responsibilities at work (16)	❍	❍	❍	❍	❍
My responsibilities at home (17)	❍	❍	❍	❍	❍
Other (please specify) (18)	❍	❍	❍	❍	❍

Q47 Please insert any additional comments about these questions and/or this topic below:

Please note that the survey cannot be returned to once the browser has been closed - only the responses completed before the survey was closed will be recorded. Please answer each statement below by putting a circle around the number that best reflects your degree of agreement or disagreement with that statement. Do not think too long about the exact meaning of the statements. Work quickly and try to answer as accurately as possible. There are no right or wrong answers. There are seven possible responses to each statement ranging from "Completely Disagree (#1) to Completely Agree (#7).

Q48

	1 Completely Disagree (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 Completely Agree (7)
Expressing my emotions with words is not a problem for me. (1)	❍	❍	❍	❍	❍	❍	❍
I often find it difficult to see things from another person's viewpoint. (2)	❍	❍	❍	❍	❍	❍	❍
On the whole, I'm a highly motivated person. (3)	❍	❍	❍	❍	❍	❍	❍
I usually find it difficult to regulate my emotions. (4)	❍	❍	❍	❍	❍	❍	❍
I generally don't find life enjoyable. (5)	❍	❍	❍	❍	❍	❍	❍
I can deal effectively with people. (6)	❍	❍	❍	❍	❍	❍	❍
I tend to change my mind frequently. (7)	❍	❍	❍	❍	❍	❍	❍
Many times, I can't figure out what emotion I'm feeling. (8)	❍	❍	❍	❍	❍	❍	❍
I feel that I have a number of	❍	❍	❍	❍	❍	❍	❍

good qualities. (9)							
I often find it difficult to stand up for my rights. (10)	❍	❍	❍	❍	❍	❍	❍
I'm usually able to influence the way other people feel. (11)	❍	❍	❍	❍	❍	❍	❍
On the whole, I have a gloomy perspective on most things. (12)	❍	❍	❍	❍	❍	❍	❍
Those close to me often complain that I don't treat them right. (13)	❍	❍	❍	❍	❍	❍	❍
I often find it difficult to adjust my life according to the circumstances. (14)	❍	❍	❍	❍	❍	❍	❍
On the whole, I'm able to deal with stress. (15)	❍	❍	❍	❍	❍	❍	❍
I often find it difficult to show my affection to those close to me. (16)	❍	❍	❍	❍	❍	❍	❍
I'm normally able to "get into	❍	❍	❍	❍	❍	❍	❍

someone's shoes" and experience their emotions. (17)							
I normally find it difficult to keep myself motivated. (18)	❍	❍	❍	❍	❍	❍	❍
I'm usually able to find ways to control my emotions when I want to. (19)	❍	❍	❍	❍	❍	❍	❍
On the whole, I'm pleased with life. (20)	❍	❍	❍	❍	❍	❍	❍
I would describe myself as a good negotiator. (21)	❍	❍	❍	❍	❍	❍	❍
I tend to get involved in things I later wish I could get out of. (22)	❍	❍	❍	❍	❍	❍	❍
I often pause and think about my feelings. (23)	❍	❍	❍	❍	❍	❍	❍
I believe I'm full of personal strengths. (24)	❍	❍	❍	❍	❍	❍	❍
I tend to "back down" even if I know I'm right. (25)	❍	❍	❍	❍	❍	❍	❍

I don't seem to have any power at all over other people's feelings. (26)	❍	❍	❍	❍	❍	❍	❍
I generally believe that things will work out fine in my life. (27)	❍	❍	❍	❍	❍	❍	❍
I find it difficult to bond well even with those close to me. (28)	❍	❍	❍	❍	❍	❍	❍
Generally, I'm able to adapt to new environments. (29)	❍	❍	❍	❍	❍	❍	❍
Others admire me for being relaxed. (30)	❍	❍	❍	❍	❍	❍	❍

While there are no known risks to participating in this study, you may have found that responding to questions about these topics was upsetting. Below you will find, as well as attached to the email where you found the link to this survey, a list of mental health resources organized by geographical areas in Ontario, which you may find useful (contact information removed).

Curriculum Vitae

Name: **Sheila Linseman**

Post-Secondary Education:

Western University
London, Ontario
Master of Arts, Counselling Psychology
2013 – Present

Wilfrid Laurier University
Waterloo, Ontario
Honours Bachelor of Arts, Psychology
Graduated with Distinction
1989-1993

Related Work Experience:

St. Joseph's Health Care London
Parkwood Institute
Psychometrist
2009 – Present

Wilfrid Laurier University
Waterloo, Ontario
Teaching Assistant (Social Psychology)
1992-1993

Awards:

SSHRC Canadian Graduate Scholarship-Master's Program
Western University
2015

Internship Award-All Disciplines
Wilfrid Laurier University
1992

Internship Award-Psychology
Wilfrid Laurier University
1992