

CLASSROOM TEACHERS AND THEIR EXPERIENCES WITH A DIAGNOSED MENTAL
DISORDER IN THE ATLANTA AREA: A HERMENEUTIC PHENOMENOLOGY

by

Becki L. Kelly

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

Liberty University

2017

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APPROVED BY:

Dr. Tamika Hibbert, Ed.D., Committee Chair

Dr. Amy McLemore, Ed.D., Committee Member

Dr. Valerie Mathura, Ph.D., Committee Member

ABSTRACT

The purpose of this hermeneutic phenomenological study is to describe the experiences of nine classroom teachers with clinically diagnosed mental disorders in the southern part of the metro Atlanta area. An ontological philosophical assumption is utilized through a social constructivist view while framed through the modified labeling theory (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989) and the social identity theory (Tajfel, Billig, Bundy, & Flament, 1971). The central research question is: How do classroom teachers diagnosed with a mental disorder describe their experiences in the school environment? Research questions cover (a) their emotions and the prevalence of them, (b) their relationships with their students and peers, (c) their sense of professionalism, and (d) stigma and disclosure. The data collection methods include interviews, a dyadic focus group, and journaling. Data was analyzed by continuous reading of data, memoing and highlighting, reflecting and then categorized, subcategorized, and coded with text segments. The four themes that emerged are (a) Teaching is Very Stressful, (b) Medication is the Key to “Normalcy”, (c) Not Everyone can be Trusted, and (d) Having Mental Disorders is Not All Bad. Other results include problems with sleep, negative emotions, administrator bullying, family issues, feeling the students are not the first priority, and the view that many other colleagues have undiagnosed mental disorders. Final considerations include comments for school systems and governance. Future research is needed in programs and interventions for educators who struggle with diagnosed mental disorders.

Keywords: mental disorders, mental illness in the workplace, stigma, teacher stress, teacher emotions, school relationships, teacher professionalism

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Dedication

This dissertation is dedicated to the nine participants: Alexa, Anne, Jackie, Laura, Lucy, Patty, Susie, Tessa, and Wilma. You know who you are! I feel a deep “sisterhood” for each of you. Susie- We miss you and Rest in Peace.

Acknowledgements

I would like to thank my nine participants who I dedicated this manuscript to because without all of you this dissertation would not be possible. It was brave and courageous to participate in a study such as this that could affect your careers if certain people knew who you were! Thank you to my Committee Members- Chair Dr. Tamika Hibbert, Dr. Amy McLemore, and my local Committee Member, Dr. Valerie Mathura, who is a fantastic editor! Thank you to my Research Consultant, Dr. Fred Milacci, who taught me to “watch my tone” in my writing, yet I still struggle with that and I blame that on my mental disorders!

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List of Abbreviations

American Psychiatric Association (APA)

Americans with Disabilities Act (ADA)

Attention-Deficit/Hyperactivity Disorder (ADHD)

Center for Disease Control (CDC)

Diagnosed Mental Disorder (DMD)

Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)

Generalized Anxiety Disorder (GAD)

Human Resource (HR)

Institutional Review Board (IRB)

Modified Labeling Theory (MLT)

National Board for Professional Teaching Standards (NBPTS)

National Institute of Mental Health (NIMH)

Obsessive-Compulsive Disorder (OCD)

Performance Improvement Plan (PIP)

Social Identity Theory (SIT)

CHAPTER ONE: INTRODUCTION

Overview

This chapter provides a framework for this qualitative study. This is a hermeneutic phenomenological study that describes the experiences of nine classroom teachers with clinically diagnosed mental disorders in the southern part of the metro Atlanta area. Chapter one focuses on the background of mental disorders in teachers, along with a description of the researcher's situation to self. The problem statement addresses the gap in the literature followed by the purpose statement stating the focus and intent of this study. The empirical, theoretical, and practical significance of this study is discussed and the research questions are addressed. Lastly, definitions of acronyms are provided that will aid in understanding the symptoms of mental disorders.

Background

Mental illness of children and young adults has been a focus in the media with high-profile school shootings and the seemingly increase of violence nationwide. School violence garners public attention and generates a renewed interest in school safety (Cornell & Mayer, 2010; Hall & Friedman, 2013). Cornell and Mayer (2010) stated that historically, school violence is not new with documented evidence in clay tables dating back to 2000 B.C. Teachers in Colonial America were faced with student mutinies and in the past four decades legislation such as *The Safe and Drug-Free Schools Act of 1986* to the modified *Gun-Free School Zones Act of 1996* indicated that schools can be dangerous places (Cornell & Mayer, 2010). Former President Barack H. Obama asked for more communication and resources to combat this difficult issue (Compton, 2013; Klein, 2013; Somashekhar, 2013; Szabo, 2013). Research and politicians call on educators to teach children more social skills and strategies for behavior associated with

mental health within schools (Lei, Guo, & Liu, 2012; Trussell, 2008; Tyson, Roberts, & Kane, 2009; Walter et al., 2011) and to identify mental health problems in children who are in need of services (Cornell & Mayer, 2010; Franklin, Kim, Ryan, Kelly, & Montgomery, 2012; Johnson, Eva, Johnson, & Walker, 2011; Klein, 2013; Mundia, 2012; Ralph, 2013).

What is currently missing from the literature is evidence that mental disorders occur across the country in classrooms from the very person who is tasked to be a positive role model and keep our children safe - the classroom teacher. While the majority of teachers with mental disorders are effective and positive role models, poor mental health can create issues in the classroom that could be detrimental to those in the school environment (Jennings & Greenberg, 2009).

Social Context of Mental Illness

In 2004, an estimated 25% of adults in the United States reported having a mental illness in the previous year (Reeves et al., 2011). Kessler, Chiu, Demler, and Walters (2005) found this estimate closer to 30%, with 14% of this population being moderate or severe cases. Former President Obama stated that mental illness affects one in five Americans (Somashekhar, 2013). An assumption could be made that this 20-30% may include classroom teachers. Shipley (1961) wrote, "The mental ailments that afflict teachers are, in substance, the same as press upon the remainder of the population" (p. 1). This study involves the diagnosed mental disorders of classroom teachers and how their mental disorders affect them and others in the school environment. How a classroom teacher with a diagnosed mental disorder copes and manages with the disorder is relevant to education as teachers are role models for children and all stakeholders demand a safe learning environment (Mundia, 2012; Sepulveda, Garza, &

Morrison, 2011). Teachers are also directly responsible for the students' experiences in learning and academic achievement (Brien, Hass, & Savoie, 2012; Brown & Roloff, 2011; Jennings & Greenberg, 2009; Richards, 2012).

A diagnosed mental disorder is not to be confused with mental health. Mental health, as defined by Merriam-Webster on-line (n.d.), refers to:

The condition of being sound mentally and emotionally that is characterized by the absence of mental disorder (as neurosis or psychosis) and by adequate adjustment especially as reflected in feeling comfortable about oneself, positive feelings about others, and ability to meet the demands of life. (Merriam-Webster on-line, n.d.)

Those with good mental health can cope with the normal stresses of life and can work productively in three areas of well-being: (a) emotional, (b) psychological, and (c) social (Center for Disease Control (CDC), 2013).

Mental disorder is defined by the American Psychiatric Association (APA, 2013), authors of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as follows:

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.

Mental disorders are usually associated with significant distress in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily

between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above. (APA, p. 20)

History to Current Literature

Research on mental disorders in teachers is rare and outdated (MacAnespie, 1978; Shipley, 1961). Delp (1963) wrote that an evaluation of former teachers in a mental institution did not attribute teaching to be the cause of the illnesses. Delp (1963) stated, “We may be happy that teaching did not produce the situation, but one always wonders to what extent teaching aggravated the existing problem” (p. 142). How a diagnosed mental disorder affects classroom teachers and their relationships with children and their peers, or how the disorder affects their daily functioning in the school environment is unknown.

There is an ample amount of literature addressing stress and burnout of teachers and the factors contributing to these phenomena. Some of the current literature on educators’ mental health, especially stress and burnout, is focused on teachers in the United States (Ballou, 2012; Brown & Roloff, 2011; Mahan et al., 2010; Richards, 2012; Veenstra, 2010); Australia (Tyson et al., 2009); Borneo (Mundia, 2012); China (Leung, Mak, Chui, Chiang, & Lee, 2009); Canada (Brien et al., 2012); Finland (Ervasti et al., 2012); India (Maheshbabu & Jadhav, 2012; Shukla & Trivedi, 2008); Turkey (Koruklu, Feyzioglu, Ozenoglu-Kiremit, & Aladag, 2012); England (Illingworth, 2010; Paver, 2010); and Jordan (Jaber & Al-Zoubi, 2012). This research in all countries demonstrated that teachers are stressed and burned out (Kipps-Vaughan, 2013) with the stressors tending to be the same.

In the literature on stress and burnout, when researchers refer to depression or anxiety in participants, the findings are based on self-report measures of symptoms from the participants

who completed questionnaires, surveys, and/or scales (Ballou, 2012; Brien et al., 2012; Brown & Roloff, 2011; Ervasti et al., 2012; Illingworth, 2010; Jaber & Al-Zoubi, 2012; Koruklu et al., 2012; Leung et al., 2009; Mahan et al., 2010; Maheshbabu & Jadhav, 2012; Mundia, 2012; Nagai, Tsuchiya, Touloupoulou, & Takei, 2007; Richards, 2012; Shukla & Trivedi, 2008; Tyson et al., 2009; Walter et al., 2011). Current literature does not shed light on whether or not a diagnosed mental disorder precipitates or precludes the symptoms that lead to stress and burnout in teachers. As Delp (1963) stated above, teaching did not cause the mental illness in the participants in that study. This study does not attempt to answer this dilemma, yet by the essence of this study, experiences of classroom teachers with diagnosed mental disorders may offer some insight on this topic.

Other than parents and family members, teachers are with children for a significant portion of the children's lives (Bentz, Edgerton, & Miller, 1969). Therefore, a teacher needs to have good mental health by seeking treatment (if needed) for a diagnosed mental disorder and understand the harmful effects and implications to teaching and learning. Hamre and Pianta (2004) found that caregivers of young children, who experienced self-reported depressive symptoms, also reported being less sensitive, more withdrawn, and had more negative interactions with the children.

Research on children's relationships with parental mental illness (Hamre, Pianta, Downer, & Mashburn, 2008; Kelchtermans, 2005; Mundia, 2012; Rudasill & Rimm-Kaufman, 2009; Spilt, Koomen, & Thijs, 2011) may reveal how children in schools are affected by a teacher who has a mental disorder. Children with mentally ill parents are at increased risks for psychological and social problems (Gladstone, Boydell, Seeman, & McKeever, 2011; Reupert &

Maybery, 2007). There is limited research to indicate whether or not a child exposed to a teacher with a diagnosed mental disorder could experience these same risks found by having a mentally ill parent.

Theoretical Concepts

The researcher could not find any statistics on how many teachers have a diagnosed mental disorder in the classroom and one reason could be due to the stigma attached to this illness (Mundia, 2012; Overton & Medina, 2008; Pescosolido et al., 2010). Stigma is an important factor in deciding whether or not a teacher discloses about their mental disorder. The modified labeling theory (Link et al., 1989) is relevant in this discussion due to the stigma attached to mental illness by society who tends to label mental disorders with prejudices and stereotypes that devalue, reject, and discriminate against those with mental illness. The diagnosed person, in this case the classroom teacher, then has to make a decision whether or not to disclose this information to others due to a possible backlash of negative behaviors towards them (Smith & Hipper, 2010) or damage to their career (Charmaz, 2010).

The social identity theory (Tajfel et al., 1971) establishes a framework for how an individual behaves within the group they identify with. This theory focuses on the interaction of both personal and social identities. The social identity theory looks at how people see and define themselves in relation to others (Ellemers, 2010). Teachers are to act and behave in ways defined by the group, which includes being “professional”. Teachers with a diagnosed mental disorder may possibly struggle with these aspects of professionalism depending on the severity of their disorder. Finding current literature describing teachers’ perceptions of what it means to be a professional in the education field is difficult.

This study extends the knowledge beyond stress and burnout to identify and understand experiences of classroom teachers with a diagnosed mental disorder. Utilizing a phenomenological approach leads to descriptions of experiences that are (a) oriented to the world, (b) strong in interpretation, (c) rich and thick in description, and (d) deep beyond what is immediately experienced (van Manen, 1990). The results of this study assist in promoting an understanding of mental disorders of teachers in the classroom school environment and this new knowledge can then be applied to decision-making for all persons at the administrative and legislative levels.

Situation to Self

This study is relevant to me as I have three mental disorders as diagnosed by the DSM-5 (APA, 2013). These diagnoses are major depression, ADHD, and insomnia. I believe through a social constructivist framework that my experiences with mental disorders define who I am. Creswell (2013) wrote that social constructivism with an ontological philosophical belief involved the construction of multiple realities through lived experiences and interactions with others. These realities, or meanings, are subjective, varied, and complex involving historical and cultural settings. Ontology concerns the nature of reality as seen through many different perspectives.

My parents had undiagnosed depression during my childhood. I experienced first-hand the emotional consequences (emotional distance, downgrading, anger, alcohol abuse, and the effects from spousal physical violence) their mental illness had on each other, on my siblings, and me. During my childhood there were no expressions of love, such as hugs, kisses, term of endearments, or use of the three words, "I love you". I carried all of this into my adult life, making many of the same errors as my parents. I sometimes see my father looking back at me in

the mirror. I have been in education for 12 years, but since I started in this field, I have made a conscious effort to maintain an emotional attachment to my students and colleagues.

Using an ontological philosophy, the multiple perspectives and the different experiences expressed by the participants who have a diagnosed mental disorder, describe the essence of the phenomena in their own voices. I believe this study assists in describing what I experience within the school environment, including relationships with peers and students, the diversity of emotions expressed, my sense of professional identity (lack of) as an educator, and disclosure and stigma associated with the mental illness label. Because of my mental disorders, these experiences have been difficult and sometimes turbulent. The expectation was that the participants would describe similar experiences and this was found to be true.

Link, Cullen, Struening, Shrout, and Dohrenwend's (1989) modified labeling theory proposes that individuals diagnosed with a mental illness will have the following coping strategies in adjusting to the diagnosis and label placed on them by society: (a) keep the illness a secret, (b) withdraw from society, or (c) educate others about mental illness. I choose to educate other adults and children on mental disorders and to convey that not everyone with a mental diagnosis has the label, stereotype, and behavior of being dangerous and crazy. Former President Obama, in his push to bring mental illness to light, stated in a June 2013 White House press conference, "...most mentally ill people are not violent and that many violent people have no diagnosed mental problem" (Somashekhar, 2013, p. 1).

Problem Statement

The problem is there is a lack of research describing the experiences of classroom teachers with diagnosed mental disorders. This study describes the experiences of nine participants who are classroom teachers with diagnosed mental disorders in the school

environment. Based on the literature regarding stress and burnout and the negative outcomes on teachers in the United States (Ballou, 2012; Brown & Roloff, 2011; Fisher, 2011; Mahan et al., 2010; Silva & Fischer, 2012), it was anticipated that classroom teachers with diagnosed mental disorders would experience even more negative outcomes than those with stress and burnout based on self-assessments.

Decades of research on poor mental health, stress, and burnout of teachers use self-reported measures (Ballou, 2012; Brien et al., 2012; Brown & Roloff, 2011; Ervasti et al., 2012; Illingworth, 2010; Jaber & Al-Zoubi, 2012; Koruklu et al., 2012; Leung et al., 2009; Mahan et al., 2010; Maheshbabu & Jadhav, 2012; Mundia, 2012; Nagai et al., 2007; Richards, 2012; Shukla & Trivedi, 2008; Tyson et al., 2009; Walter et al., 2011). Brown and Roloff (2011) found that teachers who experienced burnout were more likely to experience exhaustion, depersonalization, and reduced personal accomplishment, which could result in a decreased commitment to teaching. Richards (2012) suggested that stress buildup over time leads to burnout where teachers no longer believe their efforts are making a difference in the outcomes of their students. A significant correlation between mental health and burnout found teachers' perceptions, thinking, and judgments could be negatively influenced while coping with stress (Jaber & Al-Zoubi, 2012). In a study by Mahan et al. (2010), stressors adversely affected the teachers' psychological health.

Nearly 20-30% of the general population is diagnosed with a mental illness in the United States (Reeves et al., 2011). Research suggests that nearly half of the population experiences some symptoms of mental illness over their lifetime (Glieb & Frank, 2014). Therefore, it is possible that classroom teachers with diagnosed mental disorders are experiencing symptoms

more intense than average stress and burnout. In this study, findings of classroom teachers with diagnosed mental disorders and their experiences within the school environment advances the existing knowledge of stress and burnout and helps to fill the gap in the literature. The problem is that current literature of teachers that addresses stress and burnout is not based on actual diagnoses of mental disorders and how their symptoms authentically impact the school environment.

Purpose Statement

The purpose of this qualitative, hermeneutic phenomenological study is to describe the experiences of classroom teachers with diagnosed mental disorders in the southern part of the Metro Atlanta area. For this study, diagnosed mental disorder is explained by the American Psychiatric Association (APA, 2013), authors of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). By focusing on classroom teachers and their experiences with a diagnosed mental disorder, the researcher believes this study has given the participants a voice in describing this phenomenon for a deeper understanding of how their mental disorders affect relationships, their professionalism, how they perceive the disorders (stigma), and their emotional competence with dealing with the day-to-day stresses in the school environment. This study is not only to inform teachers, but for policy makers and school organizations to be educated on the challenges faced by classroom teachers with diagnosed mental disorders.

Significance of the Study

This study reveals knowledge that will extend beyond the literature found regarding stress and burnout in teachers. The intent is that this study of diagnosed mental disorders in classroom teachers will reach farther than the impact of stress and burnout, as this phenomenon is complex due to the variety of symptoms associated with the different mental disorders (DSM-

5, APA, 2013). This study can be used as a starting point for future studies in this area. Van Manen (1990) stated there might be uncomfortable effects on the participants, such as discomfort, anxiety, false hope, and self-doubt; but there may also be an increased self-awareness, moral stimulation, insight, a sense of liberation, and so forth. This self-awareness could lead to a change in life-style or the changing of priorities.

Jennings and Greenberg (2009) suggested that teachers, who are aware of and control their emotions in the classroom environment, had better student behavior and academic achievement. Teachers who have a diagnosed mental disorder, upon reading this study, may realize the implications for their own lives and become aware of the commonalities among other teachers with the same experiences of having mental disorders in the school environment. Teachers may also realize the effects their actions and behaviors have as role models for children and peers, especially in relationships. Ainsworth (2010) found that race of the role model was not an indicator of educational success in low-income children, but a role model from a higher status neighborhood did have positive effective educational outcomes. Brace-Govan (2013) found that teachers are direct role models and due to their proximity and high interaction with children, are role models whether they believe they are or not. Effective role models are those “who confirm and reinforce the desire to achieve” (p. 119), which is a main goal of teachers. Mulholland (1967) stated that teachers point the way for the next generation, and “What they teach in the way of information, insights, problem solving ability, and similar areas will determine the level and degree of success in these areas of the next generation of adults” (p. 102).

School organizations generally seem unaware of the possibility that classroom teachers can have a diagnosed mental disorder and when confronted with such a prospect due to issues regarding a teacher related to mental illness, rarely know how to handle it (De Lorenzo, 2013). This study yields useful information from the teachers' stories in relation to possible solutions, and especially, a more empathetic response to the teacher with mental disorders. There may be an increased awareness within the institutions (van Manen, 1990) of mental disorders in teachers. Murray and Pianta (2007) asserted that many times structural and administrator resources only focus on academic achievement and outcomes. The classroom teachers, with all of the pressures and demands within the school environment, are tasked to establish positive relationships with students.

Policy makers and community stakeholders are generally unaware of the psychological effects and ramifications of teaching (Raines Evers, 2011). Policy makers continue to expect more from classroom teachers, who claim they are already stressed and burned out. School reform and accountability measures just never seem to end, with new approaches continuously in the works without adequate time to test the effectiveness of the previous reform (Paver, 2010). Add to this pressure the characteristics of mental disorders in teachers, some more severe than mild, and it could be a recipe for disaster. A goal for this study is for policy makers to understand the significance of mental disorders in classroom teachers and the effects on the overall school environment.

This study is framed by the modified labeling theory (Link et al., 1989) and the social identity theory (Tajfel et al., 1971). The modified labeling theory states that those with diagnosed mental disorders are stereotyped with negative images of being crazy, violent, and/or

inept to function in society. This stereotyping, called a stigma, results in prejudices and bias that devalue, reject, and discriminate against those with mental disorders. Smith & Hipper (2010) said that disclosing one's mental disorders could lead to a backlash of negative behaviors towards them. Charmaz (2010) stated that due to the biases and prejudices to those having mental disorders, there could be resulting damage to teachers' careers. This current study reveals that most teachers who have been diagnosed with mental disorders not only consider having mental disorders as a stigma, but also had concerns when diagnosed because of their own perceptions and stigma of "mentally ill" people!

The social identity theory (Tajfel et al., 1971) states that an individual behaves as others in the group they identify with. This theory examines how people see and define themselves in relation to others (Ellemers, 2010). Teachers are to act and behave in ways defined by the group, which includes being "professional." Teachers with a diagnosed mental disorder may possibly struggle with these aspects of professionalism depending on the severity of their disorder. In this study, several teachers did not feel that they were professional in terms that would describe a typical, idealistic teacher.

Research Questions

How a diagnosed mental disorder affects the daily interactions of classroom teachers is unknown as current research only addresses stress and burnout from self-reporting measures of the perceptions of symptoms. This phenomenon is important in understanding the impact of a diagnosed mental disorder on the teachers and others within the school. Finding studies suggesting the importance of studying diagnosed mental disorders in classroom teachers and the effect of this diagnosis in the actual school environment is difficult. The central question this

study poses is: How do classroom teachers diagnosed with a mental disorder describe their experiences in the school environment?

Other research questions include:

RQ1: How do classroom teachers diagnosed with a mental disorder describe their emotions as it relates to feelings, thoughts, and reactions experienced in the school environment?

Hargreaves (2000) stated that the educational system neglects the emotional dimension in educational reform and they cannot be compartmentalized away from action and rational reflection. Jennings and Greenberg (2009) wrote that “socially and emotionally competent teachers set the tone of the classroom...” (p. 492) and are aware of their emotions, their emotional patterns and tendencies, and use their emotions “to motivate learning in themselves and others” (p. 495). There is research which addresses anger in teachers (Dorney, 2010; Farouk, 2010) and symptoms of depression and anxiety (Mahan et al., 2010; Mundia, 2012). However, this literature does not specify if the origins are based on a true diagnosis by a medical or mental health professional. The intent of this question is to reveal a clearer picture of the prominent emotions and the consequences of those emotions as experienced by classroom teachers with diagnosed mental disorders.

RQ2: How do classroom teachers diagnosed with a mental disorder describe their relationships with their students and peers?

Research demonstrates the importance of positive relationships within the school environment, with more literature focusing on teacher-student relationships (Jennings & Greenberg, 2009; Rudasill & Rimm-Kaufman, 2009; Sepulveda et al., 2011; Spilt et al., 2011).

How and to what extent a diagnosed mental disorder affects relationships in a school environment can only be assumed based on studies of relationships on stress and burnout in teachers. The intent of this question is to have a better understanding of these phenomena.

RQ3: How do classroom teachers diagnosed with a mental disorder describe their sense of professionalism in the school environment?

Teachers have a sense of what professionalism means (Darby, 2008; Matulic-Keller, 2011; Tichenor & Tichenor, 2004, 2005), but it is unknown if having a diagnosed mental disorder affects a teacher's self-efficacy or perception of their abilities in maintaining a professional character. This question reveals the perceptions of classroom teachers as professionals with diagnosed mental disorders.

RQ4: What factors do classroom teachers diagnosed with a mental disorder identify as contributing, or influencing, their decision to disclose their mental disorders within the school setting?

The literature found that the label of having a mental disorder and stigma from others can be debilitating; therefore, people tend not to disclose their illness (Overton & Medina, 2008; Pescosolido et al., 2010; Pettit, 2008; Schomerus et al., 2012; Thoits, 2011). How classroom teachers with a diagnosed mental disorder feel about trusting colleagues or others in the school environment enough to disclose their disorders is unknown as based on previous studies. Understanding the thought processes or influences behind a decision to disclose or not could be beneficial. This study indicates how classroom teachers with diagnosed mental disorders chose whether or not to disclose and their thought processes about disclosing.

Definitions

The following key terms regarding diagnosed mental disorders are defined for understanding:

1. *Depression*- Usually diagnosed as Major Depressive Disorder, the state of being extremely sad and/or loss of interest or pleasure for at least a two week period, which may include feeling empty, hopeless, lack of interests in doing activities that used to bring pleasure, a change in body weight of more or less than 5% in a month, insomnia or hypersomnia, restlessness or slowing down in psychomotor ability, fatigue, feelings of worthlessness or inappropriate guilt, diminished ability to think or concentrate, indecisiveness, and/or suicide ideation, a plan or attempts of suicide (American Psychiatric Association (APA), DSM-5, 2013).

2. *Anxiety*- Usually diagnosed as Generalized Anxiety Disorder (GAD), the state of having excessive worry and apprehension that causes significant distress or impairment over events or activities (i.e., social, work, academic) that may include restlessness, feeling on edge, easily fatigued, mind going blank, difficulty concentrating, irritability, muscle tension, and/or sleep disturbance for most days within a six month period (APA, DSM-5, 2013).

3. *Attention-Deficit/Hyperactivity Disorder (ADHD)*- A persistent pattern of inability to focus or concentrate, distractibility, loss of items, poor listening skills, poor organization, avoids activities requiring sustained mental effort, does not always complete tasks, **and/or** a persistent pattern of hyperactivity/impulsivity such as constant movement when and where it is inappropriate, talks excessively, blurts out, lacks patience, intrudes on others; all that occurs for at least six months that negatively impacts or interferes with social, academic, and/or occupational functioning (APA, DSM-5, 2013).

4. *Obsessive-Compulsive Disorder (OCD)*- Obsessions are recurrent and persistent thoughts, urges, or images that are intrusive that cause significant distress and are time-consuming (over one hour a day) that lead to compulsive behaviors (hand-washing, ordering, checking) or mental acts (counting, repeating words) in an effort to stop, ignore, suppress, or neutralize the obsessions (APA, DSM-5, 2013).

5. *Insomnia*- the inability to fall asleep, stay asleep, and/or early awakening without the ability to return to sleep that occurs at least three times a week for three months, resulting in significant distress and impairment in all areas of life (i.e., educational, occupational, social, behavioral (APA, DSM-5, 2013).

6. *Comorbidity*- More than one diagnosed mental disorder that overlaps in symptoms and shared genetic and/or environmental risk factors (APA, DSM-5, 2013).

Summary

This study intends to further our knowledge of classroom teachers who have been diagnosed with a mental disorder and how the disorder affects their behavior, sense of professionalism, and relationships in the school environment. Previous research addressed stress and burnout in teachers; however, this study advances the understanding of the phenomena of mental disorders in a more in-depth description of the classroom teachers' experiences with their diagnosed mental disorders. With statistics suggesting that approximately one-fourth of the adult population in the United States suffers from mental illness, it seems logical that there are classroom teachers who have mental disorders in schools across the United States. These teachers are with children for much of the child's early life and therefore, it is imperative that educators and policy makers understand how mental disorders of teachers affect the safety and learning environments in our schools.

CHAPTER TWO: LITERATURE REVIEW

Overview

This chapter provides a background regarding the literature on mental disorders and teachers in the school environment. The modified labeling theory and the social identity theory frame the theoretical framework for this study. The history of mental disorders in teachers is reviewed. This review examines the related literature regarding teacher stress, emotional competence, relationships in the school environment, and the perception of professionalism in the education field. In addition, the literature discusses reasons for teaching, mental disorders in the workplace along with interventions, bullying, stigma, and disclosure.

Theoretical Framework

Modified Labeling Theory

The main theory framing this study is the modified labeling theory by Link et al. (1989). Link et al. (1989) extended Scheff's classic labeling theory of 1966. Scheff's theory stated that the label "crystallizes" (Link et al., 1989, p. 402) and the individual conforms to the expectations of society; therefore, the labeled person assumes the role of mentally ill. Critics of Scheff's 1966 theory claim it is not the label that is troubling for mentally ill persons, but their behavior (Link et al., 1989). Scheff (1999) revised his original theory and admitted it was insufficient and one-dimensional as the theory excluded emotions and the role of the social bond. Scheff (1999) stated, "The term *labeling* [emphasis added] is itself perhaps unfortunate" (p. xiii) as it implies mere classification. Prior to the term "modified labeling theory", Link (1982) suggested that labeling can create deviant behavior, stabilize and maintain the deviant behavior, as well as consequences in other areas of the person's life such as jobs, friendships, family relationships, and mate selection, "even in the absence of outright discrimination or favoritism" (p. 212).

The modified labeling theory asserts that society labels mental illness with a stigma and stereotypes that devalue, reject, and discriminate against those with mental illness. Once a person is diagnosed and labeled with a type of mental illness, the stigma and stereotypes are internalized thus becoming relevant and threatening (Corrigan & Watson, 2007; Link et al., 1989). The label creates shame, lowers self-esteem/self-efficacy, creates differentness with others, and makes coping efforts difficult. Link et al. (1989) proposed that persons with mental illness resort to a combination of three coping strategies: (a) secrecy (conceal illness), (b) withdrawal (limit social interaction), and/or (c) educating others on the illness to head off criticism and negative attitudes. These coping mechanisms are meant to be self-protecting, however, this could backfire. Link et al. (1989) explained that, “The more strongly the labeled cases feared rejection the more likely they were to (a) feel demoralized, (b) earn less income, and (c) be unemployed” (p. 404). The modified labeling theory states there will be negative consequences of stigma that could cause a person to develop more mental disorders or repeated episodes (Link et al., 1989; Moses, 2009; Thoits, 2011).

The modified labeling theory further predicts that a confidant of the labeled person may also experience these same three coping strategies. Smith and Hipper (2010) found this to be true for the participants in their study as well. The labeled person and the confidant became co-owners of the information. Therefore, if a diagnosed mentally ill teacher confides in another teacher (confidant) about the diagnosis, it is conceivable that the teacher and confidant will be considering the same three coping strategies as proposed by Link et al. (1989). The confidant may have to decide what to do with the newly discovered information, even though they may not

have a diagnosed mental illness. This can put stress on the confidant and a strain on the working relationship.

Thoits (1985) expanded upon the modified labeling theory to include self-labeling. Thoits (2011) described the processes in mental illness and proposed there are other options besides the three coping strategies of Link et al. (1989). There are always those that deny they have a mental illness, those that are unaware of their labeled status, or those that view aspects of their illness as cultural stereotypes. In addition, other strategies include (a) self-stigmatizing where the individual accepts and internalizes societies view, (b) deflecting where the person denies they are like the stereotypical mentally ill person and does not consider the illness a threat, (c) avoidance by keeping the illness a secret or withdrawing from others who may be biased or only socialize with those with mental illness, (d) self-restoring which is used when the person has already been devalued or rejected involving self-esteem restoring strategies, and (e) challenging so that the person confronts the bias, attitudes, and actions of others. Thoits (1985) focused more on self-labeling and the use of a variety of strategies depending on the seriousness of the mental illness.

Thoits (2011) argued that many labeled individuals actually resist the stigma and stereotyping instead of accepting it or adapting to it. This resistance is “an opposition to the imposition of mental illness stereotypes by others” (p.1) which involves both deflecting and challenging behaviors. Thoits (2011) described a challenging strategy that uses compensating or overcompensating as those who work overly hard to excel at skills or tasks thought to be difficult or impossible for persons with a mental illness. Teachers are observed working long hours in a day, working weekends, or taking work home. In this study of classroom teachers with

diagnosed mental disorders, most teachers accepted their diagnosis and were adapting to the symptoms with medication therapy. However, the stigma of having a mental disorder did affect the perceptions of themselves, and if and how disclosure was accomplished. This study promotes the basis of the modified labeling theory.

Social Identity Theory

The social identity theory is also relevant to this study (Tajfel et al., 1971). Hogg (2010) defined the social identity theory as people identifying who they are based on their group affiliations and intergroup behaviors. In research by Tajfel, Billig, Bundy, and Flament (1971), the subjects maintained their social categories and intergroup dynamics in the experiments by making decisions based on the other member's decisions. Individuals are motivated to achieve and maintain a positive personal identity and social identity (Rodriquez, 2010). A personal identity refers to definitions and evaluations of oneself, such as attributes, qualities, and achievements. The social identity is the group affiliation and the theory proposes that people classify themselves and compare their group to other groups. If the group is positive and valuable, then the social identities become part of the subjective self if the group identity promotes high self-esteem (Rodriquez, 2010). Groups adhere to certain standards with similar attitudes and behaviors. Group memberships help people interpret social situations. If a person is non-normative in the group, this invites rejection from others in the group. If a teacher behaves inappropriately in certain situations, this could cause negative responses from other teachers in the group.

The social identity theory has been applied to analyze and understand societal problems, such as stereotyping and stigma (Ellemers, 2010). The stigma and feelings of isolation

associated with mental health can be debilitating to those diagnosed, or even undiagnosed, with mental illness. Ellemers (2010) defined social comparison as a process where people determine their value and standing in a group. An example would be, "...school teachers may be seen as having higher social standing than garbage collectors" (p. 799). Many times people care so much about their group status and value that they sacrifice their interests or positive self-views to help or benefit the group (Ellemers, 2010). A teacher with a diagnosed mental disorder may not disclose in order to save the reputation of not only themselves, but also colleagues and the teaching profession.

Skogen (2012) described her position as a university professor and her decision to disclose that she suffered from bipolar disorder. Skogen (2012) portrayed the majority of university professors as having a public role, having a high-status job, being successful, highly competent, and being an expert in their field. University professors have credentials and knowledge that is disseminated to students in academic journals and conferences, and even think-tanks or policy-making committees. Skogen (2012) asked, "How might professors' hard-earned reputations [sic] be impacted if their peers and the public suddenly became aware that they suffered from a severe mental illness?" (p. 492). Skogen (2012) referred to stigma as the "bogeyman" (p. 493), the fear of mental illness being there and fearing what will happen if the truth were known, and that "mental illness is one of the most undesirable labels one can carry in the academic world" (p. 497). Skogen (2012) eventually decided to face the bogeyman and emancipate herself from the identity of a person diagnosed as severely mentally ill. Skogen (2012) desired to be a model of truth against the stereotype that the mentally ill are not intelligent, not rational, not successful, and not whole.

In this study of classroom teachers with diagnosed mental disorders, several teachers had difficulty seeing themselves as a professional or idealistic teacher. Teachers also found challenges in interpersonal relationships and their ability to trust others, which tends to dispute the original social identity theory that individuals in a group identify with one another as the in-group.

Related Literature

The National Institute of Mental Health (NIMH, n.d.) reported these statistics: “Mental disorders are common in the United States and internationally. An estimated 26.2 percent of Americans ages 18 and older — about one in four adults — suffer from a diagnosable mental disorder in a given year” (para. 1). NIMH (n.d.) added:

Mental disorders are the leading cause of disability in the U.S. and Canada. Many people suffer from more than one mental disorder at a given time. Nearly half (45 percent) of those with any mental disorder meet criteria for 2 or more disorders, with severity strongly related to comorbidity. (para. 2)

The Center for Disease Control (CDC, 2011) stated further that, “...nearly 50% of U.S. adults will develop at least one mental illness during their lifetime” (para 5). Reeves et al. (2011) reported that the “southeastern states generally have the highest prevalence of depression, serious psychological distress, and mean number of mentally unhealthy days” (p. 10). Reeves, Lin, and Nater (2013) surveyed Georgia communities and found anxiety and mood disorders as the most prevalent psychiatric conditions. This study focuses on classroom teachers in the Atlanta area.

History of Mental Disorders in Education

Early writings of educators with mental illness described those who are different and out of the ordinary. History is full of examples of feeble-minded, misfits, weak, lazy, crazy, and

mentally ill educators (Gutek, 2011; Rousmaniere, 2013; Time Weekly Newsmagazine, 1934). Time Weekly Newsmagazine (1934) printed there was an “appalling assertion that no less than 1,500 of New York's public school teachers were actually unbalanced. Many were hopelessly insane, some almost maniacs” (p. 1).

Rousmaniere (2013) wrote of American educators with mental illness throughout history as viewed through disability studies and declared that incompetence and inability of teachers is “represented in the common American idiom, ‘Those who can, do; those who can’t; teach’” (p. 92). Rousmaniere (2013) described the history of mental illness in teachers through a circular argument:

First that schools are themselves broken institutions which attract teachers who are in one way or another inadequate or abnormal. *Second* that schools are so broken that they *cause* teachers to become inadequate or abnormal. The problem is thus a double-edged sword: schools attract weak and disabled educators *and* they make educators weak and disabled. (p. 92)

Gutek (2011) portrayed several historical educators with mental illnesses. Jean-Jacques Rousseau is described as having “a strong sense of being lost in nature” (p. 144), “inconsistent and contradictory” (p. 152), and a “quarrelsome person and an erratic and inconsistent theorist” (p. 153). Gutek (2011) wrote that John Mills Stuart, an educator promoting thought and expression, suffered from “depression, severe self-doubts, and inner anxiety” (p. 297). Charles Darwin had a severe chronic anxiety disorder that prevented him from attending scientific meetings and social gatherings (Carson & Wakely, 2013).

There are a few outdated articles about mental illness in teachers in the literature (Bentz et al., 1969; Delp, 1963; Keavney & Sinclair, 1978; MacAnespie, 1978; Mulholland, 1967). The data in 1963 indicated that a “good share of mentally and emotionally unstable people are in the teaching profession” (Delp, 1963, p. 142). MacAnespie (1978) wrote of 36 teachers with psychiatric conditions. Eleven of those teachers were diagnosed schizophrenic as they heard voices, had hallucinations, inflicted harm to children, and left the classroom or school for long periods of time. Shipley (1961) speculated upon a “little-discussed problem in the field of education: the problem of the mentally disturbed teacher” (p. 1). Teachers cannot completely teach when other problems, especially poor mental health, occupy their efforts and interests (Keavney & Sinclair, 1978; Mulholland, 1967; Shipley, 1961). Both teacher and students are aware, to some degree, of the mental health problems of the classroom teacher (Mulholland, 1967). Bentz, Edgerton, and Miller (1969) recommended that teachers be provided with more information regarding mental health as they were able to identify symptoms of mental illness in colleagues.

There are famous people throughout history, including educators, who have mental illness and have made positive contributions to society. Carson and Wakely (2013) commented that these contributions of mentally ill historical figures provided “positive images for those experiencing mental health problems today” (p. 16) and should help to reduce the stigma of mental illness.

Stigma and Disclosure

Stigma is defined as a set of negative and often unfair beliefs that a society or group holds about something (Stigma, Merriam-Webster online, n.d.). The stigma of having mental

illness is degrading and is perpetuated by others through stereotypes, prejudice, discrimination, and avoidance (Corrigan & Watson, 2007; Overton & Medina, 2008; Pescosolido et al., 2010). The media perpetuates the negative image, such as the reports of violence and uncontrolled behaviors, of those with mental disorders (Corrigan, Markowitz, & Watson, 2004; Overton & Medina, 2008). Corrigan, Markowitz, and Watson (2004) considered this media sensationalism as “institutional stigma” (p. 483) since it is a choice by media personnel to promote mental illness with violence. The large amount of these stories prolongs prejudice and bias towards people with mental illness. Linking the recent gun violence in the United States to mental illness may be counterproductive by increasing stigma towards mental illness (Glieb & Frank, 2014; Hall & Friedman, 2013) and causing loss of civil liberties (Glieb & Frank, 2014). Mental illness is not always the cause of violent crimes as only “3-5% of serious violent acts are directly attributed to mental illness” (Hall & Friedman, 2013, p. 1278). Other researchers suggested that mental illness is not a reliable indicator of future acts of violence (Glieb & Frank, 2014; Shern & Lindstrom, 2013).

Employees often do not reveal their mental health history (Mechanic, Bilder, & McAlpine, 2002) or current problematic mental health issues for fear of being fired (Stewart, 2008) or having damage done to their career (De Lorenzo, 2013). Mental illness is seen as a weakness (LaMontagne et al., 2014) or a character or moral flaw viewed as falling short of society’s ideal expectations (Kenny, 2001; Overton & Medina, 2008). Even educational efforts to attribute much of mental illness to a neurobiological basis discovered that attitudes about people with mental illness have not improved (Pescosolido et al., 2010; Schomerus et al., 2012). Manderscheid et al. (2010) found only 24.6% of the people surveyed believed that people cared

or were sympathetic to their mental illness. Associative stigma is experienced by children who have a parent with a mental illness, as the prevailing perception is that the child will inevitably develop the disorder (Koschade & Lynd-Stevenson, 2011).

Due to this stigma, people with mental illness tend not to disclose their illness or talk about it (De Lorenzo, 2013; Honey, 2004; Kenny, 2001; Pettit, 2008; White, 2007). Mechanic, Bilder, and McAlpine (2002) stated that reporting statistics on the number of mental ill persons is generally underestimated as people “do not know their psychiatric status or are reluctant to report it because of stigma” (p. 245). Whether or not a person discloses their mental illness depends on several factors. These factors include the extent of the illness, cultural and social norms, values, position and status within the organization, opportunities and policies of the organization, and the amount of support from colleagues and administrators (Charmaz, 2010).

Mental illness becomes part of the person’s identity and some people suffer distress from keeping the secret (Charmaz, 2010). Disclosures tend to be partial and selective in terms of revealing the illness, but not the severity. Disclosures are also “personal, identifying, irrevocable, but usually voluntary” (Charmaz, 2010, p. 11). By disclosing, the persons open themselves to intrusive questioning and scrutiny. Disclosure is usually done to explain odd behaviors, to explain difficulties of completing tasks, to gain acceptance, or to educate others on the illness. Rarely is disclosure used to request or demand accommodations at work (Charmaz, 2010). Jones (2011) wrote that disclosure for accommodations is made to improve the worker’s ability to perform their duties at work or their workplace experiences, such as interpersonal support. This need for accommodations is weighed against the possibility of stigmatizing reactions and interpersonal conflict from others. The Americans with Disabilities Act (ADA) of

1990 allows for workers with mental illness to receive accommodations (Charmaz, 2010; De Lorenzo, 2013; Jones, 2011).

Research indicated that even mental health professionals could hold stereotypes and prejudices to those seeking help for their mental health disorders (Kenny, 2001; Overton & Medina, 2008; Pettit, 2008; Skogen, 2012). Those with mental illness who fail to remain on a medication regimen may experience a “double stigma” (Roe, Goldblatt, Baloush-Klienman, Swarbrick, & Davidson, 2009, p. 44). First is the stigma of having a diagnosed mental illness and the second stigma comes from the practitioner’s frustration at the person for being non-compliant for not taking their medication.

Pescosolido et al. (2010) recommended that research focused “on the abilities, competencies, and community integration of persons with mental illness...may offer a promising direction to address public stigma” (p. 1329). A renewed focus on the contributions and effectiveness of teachers could affect how a teacher responds to their mental illness and in their ability to seek medical or mental attention. Corrigan and Watson (2007) recommended targeting young children in an effort to “forestall the prejudice and discrimination of mental illness before young people can begin to act on it” (p. 527). Charmaz (2010) suggested targeting not only the individual who has the illness, but also employers and universities. Managers need training on how to deal with and assist employees with their mental illness, while universities need to consider this issue in educating administrators and educators. Jasko (2012) wrote that “educators have the capacity to turn the tide and to counteract popular stigmas about mental illness” (p. 304). Skogen (2012) agreed that educators who have a diagnosis of mental illness are in a position to “debunk false stereotypes of the mentally ill” (p. 507).

Mental Disorders in the Workplace

Recent reports highlight the increasing incidence of mental health related problems in the workplace (Ashman & Gibson, 2010; Banerjee, Chatterji, & Lahiri, 2014; Dewa, Lesage, Goering, & Caveen, 2004; Dimoff & Kelloway, 2013; Grove, 2006; LaMontagne et al., 2014) and the high costs to industries and organizations (Charbonneau et al., 2005; De Lorenzo, 2013; Dewa, Chau, & Dermer, 2010; Goetzl et al., 2004; Harvard Health Publications, 2010; Hemp, 2004; Kessler et al., 2006). Statistics suggest that mental illness affects 17-20% of the working population in a year and is a problem that is common globally with anxiety disorders and mood disorders (depression and bipolar disorder) having the highest occurrence (Banerjee et al., 2014; De Lorenzo, 2013; LaMontagne et al., 2014). Dimoff and Kelloway (2013) wrote that Canada is struggling with poor employee mental health that is currently a prevalent and costly issue, and that "...no workplace is immune to poor employee mental health..." (p. 209). LaMontagne et al. (2014) stated that mental illness is "a large and complex phenomenon in the workplace" (p. 132), and that 5% of the working population suffers from serious mental disorders while another 15% suffers from moderate mental disorders. Charbonneau et al. (2005) found an estimated 68% of persons suffering from depression are employed. These statistics are believed to be underestimated as most of the research uses self-assessed surveys and questionnaires to gain data on mental illness (Banerjee et al., 2014; Charbonneau et al., 2005; Dewa et al., 2004; Goetzl et al., 2004; Harvard Health Publications, 2010; Jones, 2011; Kessler et al., 2006).

A 1995 National Health Interview Survey (NHIS) found that 12% of persons declaring to be schizophrenic had full-time employment and of all participants indicating some degree of mental illness, those employed tended to have more education, possibly indicating that those

persons were less impaired (Mechanic et al., 2002). In addition, those people with mental disorders who hold high ranking and high paying occupations may have completed most of their higher education before their first onset of mental illness. In the 1995 NHIS, 30% of participants who self-reported a serious mental disorder (schizophrenia, paranoia, depression, psychoses) were teachers, librarians, counselors, and health assessment and treating occupations. The APA (2013) estimated the occurrence of schizophrenia at .3-.7% and the bipolar disorders yield an estimated prevalence rate of 1.8% in all countries that report mental disorders (Mechanic et al., 2002).

Symptoms of mental illness affect employee work ethic in compromised performance, cognitive thinking, absenteeism, co-worker relations, and safety (De Lorenzo, 2013), while reducing the supply of labor (Banerjee et al., 2014). Mental illness is usually not dealt with until the consequences are noticed and deemed unacceptable. The hiding of mental illness due to stigma and shame can result in employees being considered incompetent and lacking in work ethic (De Lorenzo, 2013; Grove, 2006; Harvard Health Publications, 2010). The literature on mental illness in the workplace suggests that the personal toll on employees and the financial costs to companies would be lessened if workers would seek treatment (Grove, 2006; Harvard Health Publications, 2010). Each psychiatric disorder has its own characteristics of symptoms and can overlap disorders (Banerjee et al., 2014). Symptoms may appear differently at work than other settings (Harvard Health Publications, 2010), which makes diagnosis and maintenance of the disorder more difficult. A Canadian study found higher rates of co-morbid disorders among professionals (Dewa et al., 2004).

There are many negative effects of the cost of mental illness in the workplace including absenteeism and the opposite, presenteeism (Ashman & Gibson, 2010; Charbonneau et al., 2005; Charmaz, 2010; De Lorenzo, 2013; Hemp, 2004; Kessler et al., 2006; Palo & Pati, 2013).

Presenteeism is “the problem of workers being on the job but, because of illness or other medical conditions, not fully functioning- can cut individual productivity by one-third or more” (Hemp, 2004, p. 49). Ashman and Gibson (2010) extended the definition of presenteeism to include excessive work and staying beyond work hours in order to be seen as a committed employee valued by the company, although negatively impacting the work-life balance. By not spending more time on other activities known to promote mental well-being, such as exercising, socializing, hobbies, recreational and entertainment activities, a person can lose their sense of self. At times the organization encourages the extra time and dedication, combined with the problem of the person not being able to recognize or react to it, which unethically affects a person’s identity (Ashman & Gibson, 2010). Presenteeism tends to be invisible and not directly noticeable (De Lorenzo, 2013; Hemp, 2004; Palo & Pati, 2013) or intermittently visible (Charmaz, 2010).

Palo and Pati (2013) studied some determinants of sickness presenteeism and found presenteeism to be higher if there were excessive job demands, the individual had high self-efficacy, individuals worked in a team, there was social support at work, there was a concern of job security, concern for irreplaceability, and family issues. Excessive job demands is also termed “role overload” and “high strain job” (Palo & Pati, 2013, p. 258) where the employee is expected to perform more with limited resources and time pressures, which utilizes prolonged physical and psychological effort. Teachers are in a position where the job is demanding and

“might report more presenteeism” (Palo & Pati, 2013, p. 258). There are factors that compel an employee to come to work sick, such as displaying a commitment and good performance to maintain job security, as well as the knowledge that there is no one to do the work if they are absent (irreplaceability). When a person works in a team each individual depends on the other and does not want to let the team down, and having strong relationships with colleagues generally indicates a higher rate of attendance while ill. When a person has high self-efficacy, a positive belief in themselves and their abilities to complete tasks, they tend to go to work when sick. Some personal problems, such as financial problems and the need to be away from family could drive an individual to be at work more than home. In the study by Palo and Pati (2013), over commitment was not found to be a factor; however, over commitment is found in Type A personalities which signifies a high need for recognition and advancement, excessive competitiveness, and a high desire for achievement.

Hemp (2004) wrote, “A central aim of presenteeism research is to identify cost-effective measures a company can take to recover some, if not all, of the on-the-job productivity lost to employee illness (p. 55). In 2003, depression in employees was estimated to cost employers \$35 billion in reduced performance at work (Hemp, 2004). Research contends that presenteeism costs more than absenteeism or disability (Hemp, 2004; Kessler et al., 2006); however, LaMontagne et al. (2014) reported that a study from Australia found the greatest costs from depression was due to turnover rates. Kessler et al. (2006) estimated there are 65.5 lost workdays a year per worker due to bipolar disorder and 27.2 days for a major depressive disorder, which includes both absenteeism and presenteeism estimates. However, presenteeism rates are higher than absenteeism rates. For bipolar disorder, absenteeism accounted for 27.7

days versus 35.3 for presenteeism. For a major depressive disorder, absenteeism accounted for 8.7 days a year versus 18.2 days for presenteeism. In terms of costs, Kessler et al. (2006) estimated \$96.2 million in lost workdays and \$14.1 billion salary-equivalent in lost productivity per year for bipolar disorder in the United States. The amounts for a major depressive disorder are estimated at 225 million workdays lost per year and \$36.6 billion salary-equivalent lost productivity. These figures were highest for professional occupations.

With education being a professional occupation, students could lose a valuable amount of instruction if their classroom teacher has a diagnosed mental disorder and is absent many days due to symptoms of that mental illness; as well as presenteeism, being in the classroom with less than optimal performance. Palo and Pati (2013) wrote, “Members of occupational groups whose everyday tasks are to provide care..., or teach or instruct have a substantial increased risk of being at work when sick” (p. 264). Dewa, Lesage, Goering, and Caveen (2004) added that it is important to understand mental disorders and their patterns between different occupational groups. Dewa et al. (2004) stated, “Indeed, in our knowledge-based economy, where the heavy lifting is done with our minds and not our backs, it is imperative that we find the solutions” (p. 23).

The fact remains that when people do not feel well at their jobs, they cannot do their best work (Hemp, 2004). Depression causes fatigue and irritability (Charbonneau et al., 2005) that hinders people’s ability to get along with others. Other symptoms include appetite disturbances, anxiety, diminished concentration, and in untreated extreme cases, a threat of suicide (Charbonneau et al., 2005). Depression-related illness is one of the costly conditions affecting

employers (Goetzel et al., 2004). Productivity is lessened, or in the case of education, students' success and well-being may be affected emotionally and academically.

Steps to Intervention

There is a general lack of knowledge about mental illness in the workplace and therefore, few policies and resources to deal with this negative issue (Ashman & Gibson, 2010; Charbonneau et al., 2005; De Lorenzo, 2013; Dewa et al., 2004; Goetzel et al., 2004; Grove, 2006; Harvard Health Publications, 2010; Hemp, 2004; Jones, 2011; Kessler et al., 2006; LaMontagne et al., 2014). The first step is to accept the reality of a diagnosis of a mental illness (Charmaz, 2010; Hemp, 2004) and make sure managers are aware of the condition (Hemp, 2004), assuming the person with mental illness will disclose. Charmaz (2010) added that individuals, along with their physicians, might not be aware of the mental illness symptoms and rationalize symptoms as stress and work-related issues. The barriers to recovery are multiple and individual; likewise, "the remedy will be found within the individual and his/her relationships" (p. 291), including relationships outside of work. Acknowledging a diagnosed mental illness means affirming and accepting its presence so at times, mental illness is seen as abstract. By normalizing illness and symptom routines, persons with a diagnosed mental illness see themselves as normal and not sick enough to need hospitalization (Charmaz, 2010). In this frame of mind, people do not disclose the diagnosis and/or delay seeking medical or mental health treatment. Hemp (2004) wrote that any profession involving women should recognize that women are more likely to suffer from depression and this can affect customer relations. In a study by Banerjee, Chatterji, and Lahiri (2014), symptoms of psychiatric disorders were higher for women than men, with 14% of the women experiencing a depressed mood compared to 9%

of the men. Symptoms of depression, which indicated poor work-related outcomes for both men and women, were insomnia/hypersomnia, indecisiveness, and severe emotional distress. For women, the symptom of fatigue was a large indicator of depression. Managers also need to be aware of physical health issues facing employees that can lead to experiencing depression. Banerjee et al. (2014) also recommended employers provide an educational program to educate employees on their mental illness, whether they are diagnosed or not.

Grove (2006) wrote that symptoms of mental illness can be exasperated by toxic relationships in a working environment, including bullying, or even the person being in the wrong job. Treadway, Shaughnessy, Breland, Yang, and Reeves (2013) stated, “The prevalence of workplace bullying offers an interesting paradox, in that bullying is an anti-social behavior for which companies and employees share disdain, yet bullying behavior appears to be pervasive in the workplace” (p. 274). Mr. H. (2012), an anonymous author, wrote that teacher-on-teacher bullying, or also referred to as workplace harassment, isn’t a new phenomenon. Mr. H. (2012) revealed “...some of the worst examples of bullying I’ve seen in academic settings have occurred between colleagues” (p. 64). Treadway et al. (2013) found that bullies can possess high levels of social ability and competence so that employers rate them high on evaluations. These workplace bullies were able to choose bullying behaviors that were psychologically painful for their victims.

LaMontagne et al. (2014) recommended a comprehensive program regarding mental health intervention that would benefit all stakeholders. This integrated approach includes (a) reduce or modify work-related risk factors, (b) develop the positive aspect of the work environment by addressing the worker’s strengths and capabilities, and (c) address all mental

health problems regardless of the cause. In reducing or modifying work-related risks, LaMontagne et al. (2014) recommended early detection and treatment including teaching employees strategies for coping with the stressors and supporting rehabilitation techniques. The intent is to prevent or control the impact of job stress, which is unique to each work environment. There is a “slow uptake of effective job stress prevention and control strategies in practice” (p. 134) as solutions need to be at the organization and individual level, as well as be context-specific.

Developing a positive aspect of the work environment includes accentuating the organizations and worker’s positive capabilities and skills, along with understanding and preventing mental illness (LaMontagne et al., 2014). Positive interventions include authentic leadership, a supportive workplace culture, more autonomy (job control), and the reward for good quality work. A positive work environment not only provides income and security, but also a purpose and meaning through the building of social networks, adult socialization, self-identity, self-efficacy, self-esteem, a sense of accomplishment, happiness, and better mental health. When a worker has a positive well-being, it is the presence of positive feelings and effective functioning (LaMontagne et al., 2014). Organizations need to address their strengths and weaknesses as well as monitoring their programs, policies, and practices in order to benefit workplace mental health. Palo and Pati (2013) recommended that organizations look at their position on sick leave and if absence due to sickness has negative consequences, consider a more relaxed stance where sick people are encouraged to stay home and rest. There should be no adverse effect for taking sick leave when employees are truly ill.

Lastly is the issue of addressing mental health problems. LaMontagne et al. (2014) stated that organizations and individuals should be taught to develop knowledge and skills in recognizing mental health disorders in addition to the ability to initiate support and reduce stigma until professional help can be obtained. With mental illness, teachers may not disclose due to fear of damage to their career. Managers, leaders, and administrators' attitudes play a role in changing stigma perceptions. Corrigan et al. (2004) argued that the label of mental illness should not define a person in their work environment; what is important is the degree of competence or incompetence they demonstrate. Measuring incompetence is easier on standards of performance within an occupation, but the term mental illness reflects the negative effects of a label and can lead to discrimination. A study by Charbonneau et al. (2005) found that most participants (90%) were able to recognize the symptoms of depression; however, only 29% of participants felt comfortable discussing their depression with a supervisor. At this stage, employees need to understand help-seeking behavior (Charbonneau et al., 2005) and resources within the organization (LaMontagne et al., 2014) to assist with finding professional medical or mental health expertise. The literature emphasized the need for organizations to promote and provide employees with programs educating on mental illness, the symptoms, and where to go for treatment (Ashman & Gibson, 2010; Charbonneau et al., 2005). Hemp (2004) recommended counseling for depression for individual and family, screening and outreach programs, access to low cost medications, and individual case management. Banerjee et al. (2014) supported the use of corporate wellness programs and employee assistance programs. Other considerations in any intervention program are confidentiality and the prevention of discrimination.

De Lorenzo (2013) explained the procedures of how a typical employee who is not able to achieve their normal work performance and/or has attendance issues is usually treated. First, the operations manager may attempt an informal meeting with the employee to find out the reasons or causes of the work reduction or absences. A Human Resource (HR) person will then be brought in and a plan will be developed to improve the employee's performance, called the Performance Improvement Plan (PIP). Some organizations will skip the informal meeting with the employee and move right to the meeting with the operations manager and HR person. If the employee fails to meet the expectations of the PIP, they are terminated. Statistics show that the employee will tend not to disclose they have a mental illness due to the fear of stigma and discrimination from others as well as self-shame (De Lorenzo, 2013).

De Lorenzo (2013) proposed integrating a series of "Buffer Stage policies" (p. 231) prior to the PIP. The intent of the Buffer Stages is to assist organizations from unintentionally placing employees with a hidden mental illness on a PIP that may be difficult or impossible to achieve, perhaps resulting in further damage to the employee's mental and physical health. There are three buffer stages. Buffer Stage #1 occurs with an informal meeting with the operational manager who has kept documentation for two months of unacceptable workplace issues. If the employee does not disclose a causal factor, a member from HR meets with the employee. At Buffer Stage #2, the HR representative gives the employee the opportunity to disclose any health or other issues confidentially to HR. If the employee discloses, medical documentation is required and the employee works with the HR representative confidentially. If the employee does not disclose, the process moves to Buffer Stage #3. Here the HR representative assumes the employee may have a concealed illness. The employee is given three options: (a) reduced hours

for a few months, (b) take a two-to-three month absence from work at no pay, or (c) move into the formal Performance Improvement Plan (PIP). A recognized symptom of mental illness is difficulty in making decisions and deficits in cognitive functioning. The time from Buffer Stage #1 to Buffer Stage #3 allows the employee time for recuperation when they may not have to disclose their mental illness, or they may decide to disclose their mental illness to the HR representative under strict confidential conditions, and not have to go to the PIP. This process allows the mentally ill person to consider their options and work with the HR representative who has skills and resources that the operational managers may not have. The mentally ill person is able to make a less pressured decision about disclosing.

Rather than moving immediately to a PIP, HR policies need to consider that employee's poor performance and/or lack of attendance may not be insubordination or from a lack of work ethic. HR should consider a mental health illness and make the needed accommodations as specified by the 1990 ADA (De Lorenzo, 2013). The ADA of 1990 allows for workers with mental illness to receive accommodations (Charmaz, 2010; Corrigan et al., 2004; De Lorenzo, 2013; Jones, 2011), such as reduced work hours or relocating to a less stressful position in the organization. Corrigan et al. (2004) listed such accommodations as utilizing job coaches to provide support and counseling, job restructuring, workplace modifications (room dividers), and sick time or the use of unpaid leave.

Research has found that many people with mental disorders have difficulty adhering to medication procedures and regular counseling sessions, combined with the symptoms of mental illness being cyclical (McCann, Clark, & Lu, 2008; Reupert & Maybery, 2007; White, 2007). Research shows that an average of half of all people who are prescribed psychiatric medication

will cease to take it (McCann et al., 2008; Roe et al., 2009). Roe, Goldblatt, Baloush-Klienman, Swarbrick, and Davidson (2009) found their participants who stopped the medications did not generally have a good relationship with their physician. These participants felt they were not consulted in shared decision-making, they felt pressured by the doctor to take the medication, and the need or reason for the medication and side effects were not discussed. The participants also felt pressured by family and friends to take medication. The perception of stigma in the mentally ill has been shown to deter individuals from taking their medication (McCann et al., 2008; Roe et al., 2009). Treatments and good maintenance therapy reduces absences, work dysfunction, and prevents subsequent re-occurrences of problematic symptoms (Mechanic et al., 2002). Mental illness and this inconsistency with treatment and therapy could have negative effects in the classroom for both the classroom teacher and students.

Professionalism

Researchers state that there is not a common understanding in the academic world of what is meant by teacher's professional identity and it is a complex phenomenon (Lei et al., 2012; Stone-Johnson, 2014). Research points to the multiple meanings, yet common understandings associated with the term "professionalism" do exist (National Board for Professional Teaching Standards (NBPTS), 2014; Phelps, 2003; Tichenor & Tichenor, 2004, 2005; Weber & Johnsen, 2012). In education, teachers are committed to students and need to have a high knowledge of expertise and possess content knowledge, have the ability to transfer this knowledge to students through effective pedagogy and communication skills, and be life-long learners (Krishnaveni & Anitha, 2008; Lei et al., 2012; NBPTS, 2014; Phelps, 2003; Tichenor & Tichenor, 2004, 2005; Weber & Johnsen, 2012). The NBPTS (2014) noted that

teachers should empower students to continue their quest to be life-long learners. Another characteristic of professionalism involves positive and committed relationships to the stakeholders, such as parents, peers, management, and students (Krishnaveni & Anitha, 2008; Lei et al., 2012; Tichenor & Tichenor, 2004, 2005). Modeling appropriate character traits and upholding the highest ethical standards are important aspects of professionalism (Krishnaveni & Anitha, 2008; Lei et al., 2012; NBPTS, 2014; Phelps, 2003; Tichenor & Tichenor, 2004, 2005). Professionalism involves a concern for the self that consists of empowerment and continuously developing their personal and professional life as an educator (Krishnaveni & Anitha, 2008; Lei et al., 2012). Reflecting on their practice, evaluating goals, exploring new ideas and theories, and filling leadership roles are all keys to being professional teachers (Krishnaveni & Anitha, 2008; Lei et al., 2012; NBPTS, 2014; Tichenor & Tichenor, 2004, 2005; Weber & Johnsen, 2012).

Lei, Guo, and Liu (2012) concluded that the higher a teacher's sense of professionalism, the more effectively they can solve students' problems, ease job burnout, and improve their enthusiasm in education. Self-efficacy and sense of professionalism were related to higher motivation, satisfaction, and commitment of teachers (Gustems-Carnicer & Calderon, 2013). Some teachers believe expressing negative emotions in the classroom, such as anger, is unprofessional (Chang, 2013). Darby (2008) found that when teachers' professional identity and self-understandings were challenged, fear and intimidation set in. The recommendation is that school organizations include teachers in plans regarding school reform. When politics and organizations rally for school reform without teacher input, the added curriculum requirements take away from teacher-student relationships (Darby, 2008; Hargreaves, 2000; Kelchtermans,

2005) while diminishing teachers' contributions and the professional status of teachers (Matulic-Keller, 2011).

Tichenor and Tichenor (2004, 2005) wrote that, "American society does not generally view teachers in the same way as they view other professionals..." (p. 89). Studies suggest that teachers and other stakeholders will not be in agreement as to what is a necessary character trait for professional teachers and believe that not all teachers exhibit the behaviors and characteristics of being a professional (Matulic-Keller, 2011; Tichenor & Tichenor, 2004, 2005). Matulic-Keller (2011) findings suggested the participants (teacher, administrators, parents, union representatives) did not have a common framework on how to define professionalism in education. Stone-Johnson (2014) found a difference between veteran teachers' sense of professionalism and Generation X's sense of professionalism. Veteran teachers tend to become bitter about changes, feeling that their identity is being worn away. Generation X teachers tend to be more flexible and less rule-bound, resulting in considering changes as being just part of the job and not a condition of their identity (Stone-Johnson, 2014).

Stress and Burnout

Stress and burnout is thoroughly addressed in the literature with the causes and factors leading to stress and burnout remaining numerous and varied. Some causes in the United States include lack of support from co-workers, supervisors, or parents (Mahan et al., 2010; Richards, 2012; Silva & Fischer, 2012), expectations from family (Silva & Fischer, 2012), relationships with students (Silva & Fischer, 2012), problematic behavior of students (Chang, 2013; Cornell & Mayer, 2010; Mahan et al., 2010; Richards, 2012; Silva & Fischer, 2012), large class sizes (Richards, 2012; Silva & Fischer, 2012), number and content of tasks assigned (Brown & Roloff,

2011; Richards, 2012; Silva & Fischer, 2012), lack of resources (Silva & Fischer, 2012), lack of participation in decision-making (Richards, 2012; Seyfarth, 2005; Silva & Fischer, 2012), long work hours (Brown & Roloff, 2011; Richards, 2012; Silva & Fischer, 2012), job dissatisfaction (Ballou, 2012; Fisher, 2011; Silva & Fischer, 2012), work in urban schools (Silva & Fischer, 2012), poor school management (Richards, 2012), lack of safety in and around school (Cornell & Mayer, 2010; Mahan et al., 2010), stress of being “accountable” (Richards, 2012), teachers not being allowed to speak freely (Richards, 2012), and a lack of emotional and social competence (Jennings & Greenberg, 2009). Some researchers suggested that the personality of an individual is important in determining if stressors lead to stress (Jepson & Forrest, 2006; Kyriacou, 2001; Tellenback, Brenner, & Lofgren, 1983). Kyriacou (2001) reasoned that while we can investigate the causes of stress in the school environment, what is more important is that stress is unique to each individual teacher depending “on the precise complex interaction between their personality, values, skills, and circumstances” (p. 29). Jepson and Forrest (2006) found the relationship between teachers having a Type A personality and stress was influenced by their occupational commitment and achievement strivings. Of the 88% of the teachers with a Type A personality, those who had a high desire for achievement and those who did not have a high commitment to teaching had higher levels of stress. Type A personality is generally characteristic of more pronounced physiological and emotional reactivity including impatience, irritability, hostility, competitiveness, the tendency to work hard to achieve goals, and to be successful (Jepson & Forrest, 2006). Fisher (2011) added aggressiveness and being a perfectionist to the characteristics of the Type A personality.

Is this stress and burnout normal or are the participants' feelings of anxiety and depression a sign of mental illness? Thoits (1985) explained that people do validate themselves based on another person's deviant reactions (stress, burnout, situational depression, anxiety). Through social support, "Individuals are reassured that their feelings have some objective bases because others have also experienced them and can point to their cause..." (p. 238). Teachers may also compare similar conditions, experiences, and stressors in order to confirm if their own condition was problematic or not. If deemed problematic, they may seek help from a medical or mental health professional.

Stress can lead to feelings of fear, anxiety, depression, and anger (Kipps-Vaughan, 2013). Prolonged stress results in fatigue, not wanting to go to work (absenteeism), withdrawal, sensitivity to criticism, aggression towards others (Seyfarth, 2005), high employee turnover rates, and serious health concerns (Sorenson, 2007). Chang (2013) stated that frequent emotions of anger, frustration, and unhappiness exhibited by teachers could result in burnout. These emotions need to be recognized and cognitively considered by teachers. In Chang's (2013) study, teachers who rated incidents with students as high intensity of emotions also had higher ratings of burnout.

Burnout is defined by Seyfarth (2005) as "a form of alienation characterized by the feeling that one's work is meaningless and that one is powerless to bring about change that would make the work more meaningful" (p. 206). Friedman (2006) maintained that burnout is the result of the teacher's desire to give and help students; however, the students reject or lack the desire to accept this help. This can lead to the teacher feeling like a failure. Teachers experiencing burnout tend to be inflexible, negative, and have less regard for colleagues and

students. When teachers become burned-out, their negative behaviors affect the classroom and learning environment (Jennings & Greenberg, 2009; Kipps-Vaughan, 2013). This can have “harmful effects on students, especially those who are at risk of mental health problems” (Jennings & Greenberg, 2009, p. 492) and “burnout threatens teacher-student relationships, classroom management, and classroom climate” (Jennings & Greenberg, 2009, p. 496). Veenstra (2010) found that teachers, who had high support from colleagues and administrators, were less likely to be depressed on self-report measures. In this study, only 38.6% found their administrator highly supportive. Research indicates that supportive relationships provide for a positive climate and is integral to the day-to-day functioning of the workplace (Charmaz, 2010; Grove, 2006). Morgan, Ludlow, Kitching, O’Leary, and Clarke (2010) discovered the absence of positive experiences rather than the presence of negative events undermined teachers’ commitment, motivation, and efficacy. These positive experiences in making a difference, such as seeing students succeed, enhancing students’ lives, and seeing students engaged in learning, are regarded as reasons educators became teachers in the first place.

Reasons for Teaching

Researchers ask why teachers chose the education field as a career (Decker & Rimm-Kaufman, 2008; Friedman, 2006; Jarvis & Woodrow, 2005; Rinke, 2008; Sinclair, 2008; Younger, Brindley, Pedder, & Hagger, 2004), especially with many teachers experiencing stress and burnout. Research has suggested that teacher education programs teach to the idealistic goals and aims of teaching, while disregarding the reality of the classroom (Cooper & He, 2012; Friedman, 2006), which can contribute to inadequate and uneasy feelings once in the actual teaching environment. Friedman (2006) proposed a theoretical model called “*The Teacher’s Bi-*

polar Professional Self” (TBPS). This model discusses the two poles of teacher needs: on one end of the continuum are the narcissistic needs of the teacher and at the other pole are the altruistic aspirations for the students. In the middle of the continuum is a tension-filled area where teachers attempt “to compromise and merge their narcissistic ambitions and altruistic needs into a balanced mode” (p. 736).

The American Psychiatric Association (APA) defines narcissism as “a pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy...” (DSM-5, 2013, p. 669). Narcissistic persons may exaggerate successes and skills, believe they are superior in power and in control, may be envious of others, and even have an unrealistic sense of entitlement. Friedman (2006) explained a teacher’s narcissistic needs as receiving some type of reward that includes power and influence, getting respect and appreciation from all stakeholders, and positively affecting the students’ future. The focus is on the teacher and the students are seen as a group or “as an audience” (p. 727). The narcissistic needs of the teacher are fulfilled when classroom discipline is maintained by controlling student behavior and the teacher feels respected by all stakeholders while “giving impressive classroom performances” (p. 727).

Altruistic aspirations aim at benefiting the students by the teacher giving of themselves through professional and personal services (Friedman, 2006; Sinclair, 2008). Altruistic aspirations include the passing of knowledge through instructing and “directing children with a view to the future” (Friedman, 2006, p. 726). These aspirations involve friendship and support for each student with warmth and affection, empathy and caring by being sensitive and nurturing to each student’s needs and problems, and supportive teaching to impart knowledge and skills to each individual. The narcissistic needs of the teacher and the altruistic aspirations for the

students are mediated by the following skills: (a) educational and interpersonal, (b) teaching, and (c) classroom management. These skills allow teachers to realize the needs at each end of the continuum and, ideally, a compromise between the two poles. How each teacher behaves personally and professionally depends upon their personality (Decker & Rimm-Kaufman, 2008; Friedman, 2006) as well as their inclination and degree of narcissism and altruism on the continuum (Friedman, 2006). Friedman (2006) suggested that teachers may need to adjust their desires in either direction to fulfill both their needs and the students' needs, or they "may be doomed to burn out" (p. 738). Research demonstrates a natural tendency for future teachers in teacher education programs and teachers in their first few years of teaching to go from thoughts about self to thoughts and reflections about the students (altruism), such as the impact teachers have on students and the effectiveness of their teaching (Cooper & He, 2012; Decker & Rimm-Kaufman, 2008; Younger et al., 2004).

Decker and Rimm-Kaufman's (2008) findings found five personality characteristics where pre-service teachers had high scores on self-assessed measurements. These characteristics are neuroticism, extraversion, conscientiousness, agreeableness, and openness to experience. Neuroticism refers to nervousness and a concern about succeeding in relation to other teachers. Those with high conscientiousness are goal-oriented and strive for excellence, those high in extraversion tended to be warm and sought excitement, openness related to having and exploring new ideas and novel actions, and those high in agreeableness were more sympathetic and altruistic.

Other factors influencing individuals in choosing teaching include a desire to work with children (Jarvis & Woodrow, 2005; Rinke, 2008; Sinclair, 2008); performing a service for

teaching future citizens (Marshall, 2009; Younger et al., 2004); social justice and societal change (Rinke, 2008); high job satisfaction (Jarvis & Woodrow, 2005); an interest in the main subject content they teach and wanting to pass on that knowledge (Jarvis & Woodrow, 2005; Rinke, 2008); teaching would be a challenging (Sinclair, 2008; Younger et al., 2004), rewarding, and a stable career (Jarvis & Woodrow, 2005; Marshall, 2009); future teachers have a self-concept where they believed they have the personality to teach well (Rinke, 2008; Sinclair, 2008); other teachers told them they should pursue the teaching field or they were inspired by teachers they previously had (Marshall, 2009); and they always wanted to teach since they were children (Jarvis & Woodrow, 2005; Marshall, 2009). Marshall (2009) found that her participants expressed “a purpose and a meaning, and that they were ‘called’ to do it...they are helping students and helping the world to be a better place...” (p. 33).

Research with participants who have chosen teaching as a second career has found similar results as above (Bauml & Castro, 2009; Chambers, 2002; Williams & Forgasz, 2009) and that second career teachers see themselves differently from first career teachers as they offer valuable skills (life experiences, workplace skills, personal qualities), new perspectives from the previous career, a willingness to use innovative pedagogies through autonomy and creativity, and a commitment to teaching students to apply their knowledge to real-world activities. Williams and Forgasz’s (2009) participants felt they have higher intrinsic levels of motivation, an established work ethic, more maturity, refined people skills, and professionalism. Chambers (2002) found her participants perceived themselves to be more tolerant of diversity, more compassionate, good problem-solvers, analytical thinkers, and adept at multi-tasking.

Other reasons for venturing into teaching as a second career include the desire to be a teacher for the first career, but they did not follow through (Chambers, 2002); the rejection of the corporate world for its limitations and concern for profit instead of service (Chambers, 2002); the steady employment of teaching with more security and a less constricted work environment (Chambers, 2002); and the availability of resources such as training programs, time flexibility, financial security, and support of friends and family (Bauml & Castro, 2009). Ex-military men transitioning to teaching addressed the above reasons and added that they were flexible, mission-oriented, disciplined, professional, confident, self-motivated, and that the leadership abilities learned in the military were assets in the educational field (Robertson & Brott, 2013). A disadvantage for some ex-military men were the mental health and rehabilitation issues due to war and the military to civilian transition, which for many, resulted in grief and loss of the military lifestyle. Robertson and Brott (2013) stated, “Veterans called their teaching careers wonderful and fulfilling, and they considered themselves ‘blessed’ to work with children” (p. 72).

Relationships and Emotions

Researchers agreed that emotional and instructional support as well as children’s relationships with their teachers can predict social and academic success (Bernstein-Yamashiro & Noam, 2013; Cornell & Mayer, 2010; Gehlbach, Brinkworth, & Harris, 2012; Gustems-Carnicer & Calderon, 2013; Hamre et al., 2008; Jennings & Greenberg, 2009; Jeon, Buettner, & Snyder, 2014; Kavenagh, Freeman, & Ainley, 2012; Kelchtermans, 2005; Kipps-Vaughan, 2013; Mundia, 2012; Ripski, LoCasale-Crouch, & Decker, 2011; Rudasill & Rimm-Kaufman, 2009; Shukla & Trivedi, 2008; Spilt et al., 2011; Trussell, 2008). When the relationship between the

teacher and student is positive and reciprocal, learning occurs. When children are unable to form positive bonds with their classroom teacher, it may lead to diminished academic outcomes and negative school experiences (Hargreaves, 2000), along with poor behavior (Sepulveda et al., 2011). Simbula (2010) suggested that a teacher's work ethic and high work engagement could positively affect student success as students show the same enthusiasm as the teacher. Ripski, LoCasale-Crouch, and Decker (2011) found a link between self-reported depression and poor teacher-student interactions in student teachers and their students. Jeon, Buettner, and Snyder (2014) reported that depression in preschool teachers and in-home child care providers was associated with behavioral problems in children, such as aggression, anger, lack of control (externalizing problems), depression, anxiety, sadness, and withdrawal (internalizing problems).

Jennings and Greenberg (2009) stated that, "Inadequate relations with a teacher may lead to dislike and fear of school and over time may lead to feelings of alienation and disengagement" (p. 501). These students tend to exhibit attendance issues, delinquency, academic failure, and dropping out of school. "Research has demonstrated that many teachers deal with highly stressful emotional situations in ways that compromise their ability to develop and sustain healthy relationships with their students, effectively manage their classrooms, and support student learning" (Jennings & Greenberg, 2009, p. 515). Gehlbach, Brinkworth, and Harris (2012) found teacher-student relations in middle school to be very malleable and the students perceived the relationship with the teacher to decline during the school year. There were two student outcomes that influenced the perception of a positive relationship with the teacher: if they had a high self-efficacy of success in the class and if they had put in effort during the school year. For the teacher, a student completing homework influenced a perception of a positive

relationship with the student. Additionally, students who saw their teachers as similar and having similar perspectives of each other were indicators of positive student-teacher relationships (Gehlbach et al., 2012).

Teachers need to understand the society students are growing up in and the factors children now face (Bernstein-Yamashiro & Noam, 2013), along with the multitude of dynamic systems in these students' lives (Verschueren & Koomen, 2012). Family dynamics are varied with divorce and remarriage, single parents, same sex parents, grandparents raising children, moms and dads who may rarely be home, and foster homes. There are drug and alcohol issues (for adults and adolescents), family and street violence, poverty, homelessness, transience, all forms of abuse, and racism. Many students come to school with these social and psychological burdens (Bernstein-Yamashiro & Noam, 2013) on a daily basis and then teachers are challenged to set high standards and push children through the mandated rigorous curriculums, while each student is expected to leave the high school with diplomas in their hand.

Thijs and Eilbracht (2012) suggested that negative teacher-student relationships could be potentially improved by better teacher-parent relationships. When teachers learn more about a family's ethnicity, socioeconomic status, and education level, they may become more tolerant and understanding. Chang (2013) claimed that teachers should evaluate students' motivations for poor behavior and not automatically assume that students are being disrespectful. Some classroom disruptive behaviors are shaped by the cultural background and home environment of the child, and this explanation should be taken into consideration.

Children need to know that their teacher cares about them (Bernstein-Yamashiro & Noam, 2013; Jennings & Greenberg, 2009; Kavenagh et al., 2012; van Manen, 1990).

Kavenagh, Freeman, and Ainley (2012) found that boys, who evaluated their relationships as strong with their teachers, reported their teacher's understood and cared about their feelings and were available to help them. Hamre, Pianta, Downer, and Mashburn (2008) discovered that "when children are placed in classrooms with teachers who report feeling depressed, feeling that they have little ability to effect the children in their classrooms, and who are observed to offer lower emotional supports, those teachers are more likely to report significant student-teacher conflict, even in the absence of reports of problem behaviors" (p. 134). Hamre and Pianta (2004) concluded that depressive caregivers who did not monitor or positively interact with young children might miss important opportunities to prevent child misbehavior.

Ripski et al. (2011) found that pre-service teachers who self-evaluated themselves with depression in their third year of teacher training still self-evaluated themselves with depression at the conclusion of their training program, following student teaching at the five-year point. These same students tended to show lower quality instruction during their student teaching experience. Ripski et al. (2011) emphasized that teacher educators "should pay attention to possible signs of depression and consider intervention strategies that target individuals who seem to be experiencing this negative mood state" (p. 91).

Students with disabilities need stronger relationships with teachers than most regular education students (Murray & Pianta, 2007). These students are at a "heightened risk of developing social, emotional, and mental health problems" (p. 105). In developing positive relations with students, there are many factors to consider, including the teacher's own characteristics, student's background, home and community environment, and the classroom and school characteristics (Murray & Pianta, 2007; Thijs & Eilbracht, 2012; Verschueren &

Koomen, 2012). Teachers need to reflect on their beliefs and the way they act with their students to ensure they are providing consistent praise, positive feedback, personal involvement, while also maintaining strong classroom management, consistent discipline, and high standards for student expectations (Murray & Pianta, 2007).

The emotions and mental health of the teacher affects the teacher's own well-being (Gustems-Carnicer & Calderon, 2013) and their relationships within the school. Teachers, by nature, are caregivers and tend to ignore or postpone activities directed at self-care (Kipps-Vaughan, 2013). The teacher's ability to recognize and control their emotional health is important as emotions influence cognitive functioning and motivation (Jennings & Greenberg, 2009). This control of emotions affects how teachers interact with students who are emotionally challenged. When a student misbehaves, the outcome of that child's social and emotional well-being depends on the teacher's handling of the situation. A teacher who reacts with support, sensitivity, and uses the event as a teaching moment, will leave that child with a positive and lasting impression. This support and sensitivity also teaches coping strategies to the child through the teacher's modeling of controlling their emotions (Jennings & Greenberg, 2009).

Other research points to the teacher-child relationship and how teachers internalize their emotional experiences with their students, which can render the classroom teacher either mentally well or stressed and burned-out (Jennings & Greenberg, 2009; Spilt et al., 2011). Each teacher has their own unique level of comfort ability with relationships. How a teacher determines a relationship with a child is as much about the child's characteristics as the teacher's characteristics and temperament (Hamre et al., 2008; Jennings & Greenberg, 2009; Kyriacou, 2001; Kyriacou & Sutcliffe, 1977; Murray & Pianta, 2007). Chang (2013) asserted that when a

teacher has a close relationship with a student and that student has poor behavior, the level of negative emotions the teacher experiences is increased.

Kyriacou and Sutcliffe (1977) suggested the high stress levels in teachers in their study might be more about the teacher's personality characteristics than the biographical characteristics (gender, position, age, qualifications, teaching experience). Teaching requires a high level of emotional labor (Naring, Briet, & Brouwers, 2006), which refers to the amount of energy required to express or suppress emotions. Having to show emotions when a teacher does not feel them or having to suppress emotions because it would not be appropriate in the educational setting was related to emotional exhaustion and depersonalization (Naring et al., 2006). Von Kanel, Bellingrath, and Kudielka (2009) found that teachers with high symptoms of depression had higher risk for coronary heart disease based on high levels of an inflammation marker called fibrinogen.

Furthering knowledge about the effects on children from a classroom teacher with mental disorder, the literature addresses research on children who have a parent or parents with mental illness. Verschueren and Koomen (2012) stated there are relevant similarities between parent-child and teacher-child relationships; both can be considered attachment figures by being a "secure base and safe haven" (p. 207). Children are with their classroom teachers for quite a long period of time during school hours. Bentz et al. (1969) wrote, "Teachers are culture carriers...and function as parent surrogates for the better portion of a child's waking day" (p. 400). Delp (1963) suggested that teachers may have more influence on children's emotional development than others, except parents, due to the long close contact. Research suggests that children who are exposed to a parent with mental illness can suffer long-term from social and

psychological effects and poor physical health (Atkins, 1992; Reupert & Maybery, 2007).

Children with a mentally ill parent may also be stigmatized through association (Bee, Berzins, Calam, Prymachuk, & Abel, 2013; Bournnell, 2011; Koschade & Lynd-Stevenson, 2011).

Researchers stress the importance for children who have a mentally ill parent to receive interventions in order to cope with the daily challenges they face (Bee et al., 2013; Bournnell, 2011; Reupert & Maybery, 2007). A nurturing environment has been shown to be a protective factor for those genetically predisposed to a mental illness (Bee et al., 2013; Bournnell, 2011). Teachers are considered support systems and need to be able to help vulnerable children who are at-risk for developing mental illness (Bentz et al., 1969; Koschade & Lynd-Stevenson, 2011; Mundia, 2012), whether or not the teacher knows about the status of parent(s) mental illness. There is a possibility of the mentally ill teacher not being available emotionally for the students or responding in inappropriate ways, such as anger. Spilt, Koomen, and Thijs (2011) wrote that, "...personal, supportive, teacher-student relationships inherently demands emotional involvement from teachers" (p. 458). A person suffering from depression tends to be emotionally distant. If children are confronted with a mentally ill classroom teacher, it is possible there could be adverse consequences for their well-being.

Bee, Berzins, Calam, Prymachuk, and Abel (2013) interviewed children, parents with a mental illness, and professional participants to assess what factors were of most concern for children living with parents with severe mental illness. Children had three priorities of concern, including wanting parent symptoms to subside, needing problem-based coping skills, and increased knowledge about mental health. Children experienced anxiety and depression due to family conflict and lack of parental warmth and responsiveness, isolation from peers (due to

associative stigma), concern about developing mental illness, and wanting to alleviate financial pressures. Parents acknowledged their erratic parenting and negative emotions, and the lack of resources due to financial constraints. Parents were concerned about hospitalization, their children not having friends, and their children developing mental illness. The professional participants state the above concerns and acknowledged the need for services for children's empowerment, resiliency, and advocacy. These professionals understand that many times the children's basic needs are not always satisfied and parents may be emotionally unavailable. Professionals perceive "the presence of a supportive adult as key to emotional resiliency" (Bee et al., 2013, p. 4).

Abraham and Stein (2013) studied emerging adults in college who had a mother with mental illness and found that if the parent and child had a history of reverse roles, the emerging adult had lower levels of psychological well-being. The study also found a pattern of lower levels of affection, reciprocity, and feelings of obligation towards the mentally ill mother. Boursnell (2011) found that parents with a mental illness may attempt to keep their children from knowing about the illness in an attempt to stop the cycle of intergenerational mental illness. This idea suggests that parents with mental illness, even though concerned with biological transmission, are also concerned about their children learning behaviors modeled by the parents: also "labelled as social transference of mental illness" (Boursnell, 2011, p. 32). The danger of having both a mentally ill parent and a mentally ill teacher could be troublesome for a child, especially if the child has maladaptive coping skills. Gladstone, Boydell, and McKeiver (2006) noted that children fear others will find out about the family secret and become invisible; therefore, the effects on their lives are not always seen. Researchers ask that children be heard

and considered in the interventions to better care (Gladstone, Boydell, & McKeiver, 2006; Gladstone et al., 2011; Koschade & Lynd-Stevenson, 2011; Reupert & Maybery, 2007).

Emotions are an integral part of a teacher's practice as teachers use emotion all the time. Many emotions are involved in teaching (Darby, 2008; Hargreaves, 2000; Jennings & Greenberg, 2009; Kelchtermans, 2005). The emotional character of teachers is based on the experiences of interactions through culture, upbringing, and relationships. Education is a field where the teacher must express or suppress their emotions depending on what the profession and the organizational structure expect. Emotions also reflect the teachers' beliefs in what good education is (Kelchtermans, 2005) and emotions are expressed when their voices are challenged or ignored. Sometimes, however, emotions are difficult to control (Jennings & Greenberg, 2009), especially in mental illness. "This use of emotion can be helpful or harmful, raising classroom standards or lowering them; building collegiality and parent partnerships or putting other adults at a distance" (Hargreaves, 2000, p. 824). Anger is an emotion that has as its main function the alleviation of stress (McKay, Fanning, Paleg, & Landis, 1996). As stress levels increase, discomfort increases and anger releases that tension.

Anger affects children in negative ways. Children of angry parents consider anger to be a punishment, and these children tend to be more aggressive, noncompliant, and less emphatic, along with having poor academics, social adjustment issues, delinquency, and depression (McKay et al., 1996). In a study of college students, even though the students acknowledged their behavior was the cause for the teacher's anger, they still most likely blamed the teacher for the emotional outburst (McPherson & Young, 2004). Students hold assumptions of what are

acceptable teacher behaviors and the more extreme the display of anger, the more unacceptable the students rated the teacher and negatively affected the student-teacher relationship.

Recent research has addressed anger in teachers. Some anger is situational, however, angry outbursts resulting in inappropriate behaviors can be a symptom of mental illness (APA, 2013, DSM-5) and detrimental to the school environment. Darby (2008) stated that when teachers get blamed for lack of student success or are made to feel fearful or apprehensive, “some teachers just get angry and dig in their heels while others just give up in frustration” (p. 1171). Dorney (2010) wrote that women teachers indicate that “anger is frequently a barrier in their relationships with colleagues and administrators and, at times, serves to derail the women’s efforts to address problems in their schools” (p. 143). This anger results in the burying of knowledge and the maintaining of the “status quo” (p. 157), ultimately affecting students. Anger directed towards students is usually in the form of pent-up frustration and tends to be short-lived. However, in the school environment, anger towards other adults tends to fester and the on-going cognitive appraisal of the situation tends to make the anger worse (Farouk, 2010).

Not all anger directed towards students is short-lived. A “hidden” problem (Tremlow, Fonagy, Sacco, & Brethour, 2006; Whitted & Dupper, 2008) exists in schools where teachers are the offenders of bullying. Teacher bullying towards students can be an issue that affects student’s psychological, academic, and social well-being (Koenig & Daniels, 2011; McEvoy, 2005; Sylvester, 2011; Tremlow et al., 2006; Whitted & Dupper, 2008; Zerillo & Osterman, 2011). Students who are bullied by teachers may feel humiliated, demoralized, trapped, fearful, and begin to question their academic and social competence (McEvoy, 2005; Sylvester, 2011). Bullying can take many forms and has consequences from mild irritation to distress, anxiety, and

depression to suicide (Cornell & Mayer, 2010; Whitted & Dupper, 2008). Bullying by a teacher exhibits a power imbalance that generally is used to maintain discipline and control (McEvoy, 2005; Sylvester, 2011; Tremlow et al., 2006; Whitted & Dupper, 2008), and used by teachers to teach responsibility or in an attempt to be funny (Sylvester, 2011). Sylvester (2011) commented that with high-stakes testing, students are usually the recipients of the teacher's frustrations, especially those students who are slow learners and cannot keep up with the quick pace of the curriculum. Although it is conceivable that teachers who bully may not know that they are in fact demonstrating bullying behaviors, "teachers who bully leave a blight on the profession that most of us consider a calling" (p. 45).

Zerillo and Osterman (2011) found that teachers who are aware of both physical and verbal bullying towards students by other teachers find physical bullying more detrimental than belittling or other verbal abuse. Some teachers felt belittling behaviors, such as screaming, humiliating, and intimidating students were acceptable in order to maintain classroom behavior and meet instructional goals. In a study by Tremlow, Fonagy, Sacco, and Brethour (2006), 45% of the teachers surveyed admitted to bullying a student and 70% stated they had seen bullying by other teachers. Teachers "realized that bullying is a hazard of teaching, and that all people bully at times and are victims and bystanders at times" (p. 194). Researchers emphasized that the majority of teachers are thoroughly dedicated to teaching (McEvoy, 2005; Tremlow et al., 2006; Whitted & Dupper, 2008). The intent of the Tremlow et al. (2006) study was not to victimize or persecute teachers; however, some teachers (a tiny minority) are not suited for teaching. The education field has yet to "resolve the root of pathological power dynamics in the school" (p. 196).

Whitted and Dupper (2008) found 86% of students at an alternative school declared to being bullied physically and psychologically (88%) by a teacher. The main physical maltreatments reported were not being allowed to use the restroom (70%), being grabbed very hard by the teacher (38%), and being punched by the teacher (32%). Other complaints from the students were being pushed, slapped, shook, and having things thrown at them, all by the teacher. One student wrote that “he was hit by an adult and then was suspended as a result of the altercation” (p. 337). The main psychological maltreatment towards the students by the teacher involved being yelled at (66%), being isolated from others (64%), and being ignored (56%). Other grievances included the teacher calling names (including racial slurs), saying mean things about the student’s family, not being allowed to participate in activities, and the teacher not offering help when asked for by the student. In a study of college students, Chapell et al. (2004) found 19% reported being bullied by a teacher while 44% reported seeing a teacher bully another student, indicating “that bullying graduates to college” (p. 59).

Bullying not only occurs with teachers mistreating students, but also teachers intimidating other teachers. Mr. H. (2012) wrote that workplace harassment, or school-based teacher-on-teacher bullying, does damage to its adult victims and may be on the rise in the current school climate. Mr. H. (2012) concluded that school reform and accountability measures could add to the bullying problem “as irrational pressures on humans increase, irrational human behaviors also increase, bullying between adults being but one of those behaviors” (p. 66). Some teacher-on-teacher bully behaviors observed by Mr. H. (2012) involved spreading false rumors or accusations, criticizing other teachers in conversation with students, intimidating through threats of physical harm, policing colleagues by following their movements and actions, trying to

control the curricular choices of other teachers, and exploiting power relationships within the school environment. Teacher-on-teacher bullying and teacher-on-student bullying often are perpetrated by respected members of the school (Mr. H, 2012; Twemlow et al., 2006). Simbula (2010) found that when there were positive social supports among teachers, this positively influenced teachers' work engagement, well-being, and job satisfaction. Jeon et al. (2014) stated that when there are behavioral problems with children, the typical strategies are to focus on the teacher's classroom management style or teaching them how to deal with children's negative behaviors. Educational systems need to consider the teacher's psychological health and possibly the teacher's lack of resources, such as counseling or other mental health services, time, and/or money to address their psychological difficulties (Jeon et al., 2014).

McEvoy (2005) stated that school policies and responses to reports of teacher bullying are ineffective or do not exist. McEvoy (2005) studied high school and college-aged students and 93% indicated they could identify which teachers were the high rate bully offenders, and 89% of those teachers had been teaching for five or more years. Educators who were in focus groups stated they were disheartened by the unprofessional behavior of colleagues and "feeling powerless to stop the problematic behavior" (p. 9). Generally, in systems such as school cultures, if bullying behavior is not recognized or stopped the behaviors tend to increase and intensify over time (Evans, 2003), especially if the teacher is modeling the bullying behavior.

Aggressive behavior may lead to undesirable results for individuals, schools, and society (Cankaya, 2011; McPherson & Young, 2004). Teacher trainees who demonstrated anxiety, which led to aggression, were also found to have high levels of anger. Cankaya (2011) recommended that changeable personality traits (anger and anxiety) need to be identified to

make schools safer. Hall and Friedman (2013) addressed the question of why schools are targets for violence by mass shooters and wrote:

Schools symbolically hold value as symbols of hope, achievement, and betterment while at the same time being the place where many have their first negative encounters with authority or failure academically or socially. Since communities often cherish schools, they also may be the easiest way to make others suffer the pain, hurt, or anxiety that the mass shooter wants to inflict. (p. 1277)

Summary

The literature acknowledges the importance of good mental health, as this is the basis for positive relationships for students and peers and optimal learning conditions. The literature addresses stress, burnout, teacher emotions and the complexity of emotions within relationships, and teacher bullying. The theories provide the framework for how the stigma of having diagnosed mental disorders may influence a teacher's behavior and the possibility of disclosure, along with views on how professionalism is viewed in the education arena. Due to the lack of research regarding the actual effects of teachers with a diagnosed mental disorder and their effect on children, the researcher chose to address the literature that focused on children who have a mentally ill parent as a possible link to the understanding of teacher-student relationships. Research on the issue of mental disorders in the workplace allows for insight into adults who suffer from mental disorders, the struggles in other occupations with mental disorders, and some recommendations for keeping those with mental disorders employed.

By studying diagnosed mental disorders in teachers, this new knowledge describes a phenomena that extends the literature on stress, relationships, emotions, along with stigma and

disclosure for a more empathetic view and understanding of the daily experiences of classroom teachers with diagnosed mental disorders.

CHAPTER THREE: METHODS

Overview

The purpose of this study is to describe the experiences of classroom teachers who have diagnosed mental disorders and how those disorders affect their day-to-day lives in the school environment. This chapter describes the design utilized in this study, a hermeneutic phenomenological qualitative approach that addresses the central question: How do classroom teachers diagnosed with a mental disorder describe their experiences in the school environment? The chapter continues into a discussion of the setting and participant information. The procedures are thoroughly explained as is the researcher's role. Data collection in the form of interviews, a focus group, and journaling is discussed. The interview questions include an explanation for their purpose and is grounded in the literature. The steps to data analysis is detailed along with the description of the implementation of Creswell's (2013) Data Analysis Spiral. Lastly, this chapter addresses trustworthiness and ethical considerations are outlined for this study.

Design

This study utilized a qualitative design that "goes beyond measurement of figures...to deep down to the root of the subject of investigation" (Olubunmi, 2013, p. 52). Qualitative research is designed to give the classroom teachers with mental disorders a voice of their lived experiences (Creswell, 2013; van Manen, 1990). This qualitative study applies a hermeneutic phenomenological approach. Creswell (2013) defined a phenomenology study that "describes the common meaning for several individuals of their lived experiences of a concept or phenomenon" (p. 76). Van Manen (1990) wrote that hermeneutics "describes how one interprets the 'texts' of life" (p. 4).

A hermeneutic phenomenological approach was conducted to describe the experiences of classroom teachers who have diagnosed mental disorders as the phenomenon. In hermeneutic phenomenology, the emphasis is on being pro-active to self-reflecting, to being reflexive, and to facilitate awareness of the relationship between the researcher, the participant, and the resulting data (van Manen, 1990). This reflexivity of personal experiences and individual understandings results in a fresh view of the phenomenon (Creswell, 2013; LeVasseur, 2003; Shaw, 2010). Shaw (2010) explained that “our goal is to understand the nature of human experience in the many and varied ways in which it is lived” (p. 241). A hermeneutic approach implies interpretation by seeking in-depth information of the participants’ understanding of their world and how this understanding shapes their practice (Chan, Fung, & Chien, 2013). A teacher diagnosed with a mental disorder, upon reflection during this study, may well understand to a greater extent the experiences of being in a school environment and the impact of mental disorders on all aspects of their teaching career.

Van Manen (1990) wrote that phenomenology is the study of the “essence” of experiences. Essence is defined as:

A good description that constitutes the essence of something is construed so that the structure of the lived experience is revealed to us in such a fashion that we are now able to grasp the nature and significance of this experience in a hitherto unseen way. (van Manen, 1990, p. 39)

Gillam (2014) wrote that phenomenology in the study of mental illness can generate “rich findings in areas such as early intervention...and it can easily be seen how such research can influence policy and practice in mental health more generally” (p. 13). Donohue-Smith (2011)

expressed the need for qualitative research in mental illness to understand both the nature of the illness “and of ‘what works’ to promote healing” (p. 138). Dwyer (2000) conducted a phenomenological approach in which she interviewed women university students who had an Attention-Deficit/Hyperactivity Disorder (ADHD) diagnosis and the challenges in their studies. Dwyer (2000) reported that her design allowed for “descriptions of their ‘symptoms’ and some of the consequences of these characteristics” (p. 143), “to provide a venue for these women’s voices because it is from their voices that we can learn”, and gives us a better “understanding of this ‘invisible’ disability” (p. 144). Dorney (2010) discussed the phenomena of anger and women teachers. This phenomenology allowed the teachers to “tell their stories” about “cultures [schools] that clearly discourage the exercise of voices that question or challenge the status quo” (p. 145). Therefore, studying the experiences of diagnosed mental disorders of classroom teachers describes a certain way of being in the world and the nature of mental disorders as meaningfully experienced in the school environment (van Manen, 1990).

Research Questions

The Central Question (CQ) this study posed is: How do classroom teachers diagnosed with a mental disorder describe their experiences in the school environment? Other research questions include:

RQ1: How do classroom teachers diagnosed with a mental disorder describe their emotions as it relates to feelings, thoughts, and reactions experienced in the school environment?

RQ2: How do classroom teachers diagnosed with a mental disorder describe their relationships with their students and peers?

RQ3: *How do classroom teachers diagnosed with a mental disorder describe their sense of professionalism in the school environment?*

RQ4: *What factors do classroom teachers diagnosed with a mental disorder describe as contributing, or influencing, their decision to disclose their mental disorder within the school setting?*

Setting

This study found nine classroom teachers diagnosed with mental disorders from the southern part of the Atlanta metro area. The researcher knew seven participants while two were located by the snowball effect. The initial interviews were conducted face-to-face, at a location specified by each participant so they felt as comfortable as possible. Seven of the nine teachers agreed to be interviewed at the researcher's home, one teacher chose to interview at a local restaurant, and one teacher interviewed at her place of employment. The focus group interviewed at a local restaurant with two classroom teachers. Three classroom teachers participated in writing journal entries.

Participants

The participants were acquired from a purposeful sample and snowballing. Gall, Gall, and Borg (2007) described the goal of a purposeful sample as, "select cases that are likely to be 'information-rich' with respect to the purpose of the study" (p. 178). The snowball or chain-sampling strategy "involves asking well-situated people" (Gall et al., 2007, p. 185) to refer participants for the study. Creswell (2013) wrote concerning the sampling strategy for phenomenological studies, "It is essential that all participants have experience with the phenomenon being studied" (p. 155). For this study, participants needed to have a diagnosed mental disorder and teach fulltime in the classroom setting. To gain participants, the researcher

first contacted potential participants (classroom teachers known to have diagnosed mental disorders) by a private Facebook message informing them of the study and asking for their participation. They were informed of an informational website (beckistudy.com) to access if they needed further details about the study. This strategy did not produce any participants. The researcher then approached colleagues and close friends individually, either face-to-face or by telephone, to ask for their participation and seven teachers agreed to participate. The other two participants were gained by the snowball effect. Other colleagues who chose not to participate in this study gave the researcher names of other possible contacts, and one individual was gained this way. The final participant had attended a class at Liberty University and the professor told her about this study. She contacted the researcher by email and accepted the invitation to participate after the researcher explained the study by telephone. All participants were gained by verbal contact.

A total of nine participants completed the study and demographics can be found in Table 1. Seven of the nine participants are Caucasian, one is Hispanic, and one is African American. All participants are female and range in age from 35 to 55. The nine teachers were employed in five different schools. Participants have from 9 to 28 years of teaching experience. Two have bachelor degrees, five have master's degrees, and two have education specialist degrees. Seven teach at the elementary level and two teach at the high school level. Prior to the study, the researcher knew seven participants and two participants were gained by the snowball effect. Of interest, six participants disclosed that they had children with one or more diagnosed mental disorders. The remaining three teachers did not volunteer that information.

Table 1

Summary of Participant Characteristics and Mental Disorders

Participant	Age	Years Teaching	Ethnicity/Race	Grade Level	Highest Degree	Diagnosed Disorder(s)
Alexa	48	28	Caucasian	Elementary	Masters	Depression, Anxiety, ADHD
Anne	51	21	Caucasian	Elementary	Masters	Anxiety, ADHD, OCD
Jackie	36	12	Caucasian	Elementary	Masters	Anxiety
Laura	43	16	Caucasian	Elementary	Bachelors	Anxiety, Depression
Lucy	49	25	Caucasian	Elementary	EDS	ADHD
Patty	35	12	Caucasian	Elementary	Bachelors	Depression, Anxiety
Susie	35	13	Caucasian	Elementary	Masters	Depression, Anxiety, Insomnia
Tessa	42	13	African American	High School	EDS	Anxiety, Depression
Wilma	55	9	Hispanic	High School	Masters	ADHD

Five different mental disorders are represented in this study. They are ADHD, insomnia, depression, anxiety, and OCD. Six of the nine participants have comorbidity by having more than one diagnosed mental disorder. Three teachers have two diagnosed disorders and three teachers have three diagnosed disorders. Comorbidity is explained by the American Psychiatric Association (APA) in the DSM-5 as “the boundaries between many disorder categories are more fluid over the life course; many symptoms assigned to a single disorder may occur, at varying levels of severity, in many other disorders” (p. 5).

Procedures

This study acquired participants from purposeful sampling and the snowball method. In the planning stages, it was determined that the researcher would contact medical and mental health professionals in the southern part of the Atlanta area who treat adults (who are teachers) with mental disorders. These professionals would contact their patients known to be classroom teachers who have a diagnosed mental disorder (as designated by the DSM-5, APA, 2013), and send an invitation from the researcher to participate in this study. If the teachers were interested in participating, they would contact the researcher directly through email or telephone. These participants would also be asked if they have colleagues who meet the criterion and who might be interested in participating in the study. All medical and mental health professionals would be anonymous and all participants would be provided pseudonyms.

As it turned out, the Institutional Review Board (IRB) correctly assessed that while this strategy of getting participants was not illegal for the medical and mental health professionals, it was borderline unethical and the researcher agreed. The researcher then contacted a teacher organization in Georgia in an attempt to access their List serve and put the study out to teachers in this manner. This organization denied the researcher's request due to the requirement of maintaining confidentiality of their members. The researcher contacted a major Atlanta newspaper with the idea of running a weekend online ad to gain participants. This was not cost-effective as a 5x3 inch advertisement would cost \$4,900 to print for three days. More importantly, there was no guarantee if, or how many participants could be acquired. As a last resort, the researcher emailed the school system and asked if she could send a blanket email to school system employees regarding the study. Again, that request was denied due to the issue of confidentiality. Therefore, the researcher decided to contact teaching colleagues that are known

to have diagnosed mental disorders. Camp, Finlay, and Lyons (2002) found this strategy of “pre-existing rapport” (p. 826) to assist in facilitating deeper exploration of this sensitive issue of mental disorders, and “to provide a supportive role” (p. 826).

The researcher gained Institutional Review Board (IRB) approval (see Appendix A) prior to contacting participants and conducting any research. The IRB application ensured the researcher had an ethical study and would be taking all necessary and precautionary steps to maintain the participants’ confidentiality, their identity, their emotional safety, and guaranteeing there would be no deception to the participants, including making certain there is no more than a minimal risk to each participant. Minimal risk is defined as “no more emotional or physical stress than might be anticipated in daily life” (Liberty University, n.d., IRB Frequently Asked Questions section, para. 8), including a financial or legal risk.

This study involved recruiting participants known to the researcher as having a diagnosed mental disorder and by the snowball effect. A total of 20 prospective participants were contacted by private Facebook messaging (see Appendix B) to invite them to participate in this study and provide them with the researcher’s website address. An informational website was established (beckistudy.com) in the event potential participants wanted to obtain more information regarding the study (See Appendix C). There were no responses. The researcher then contacted each potential participant individually, either face-to-face or by telephone, to ask for their participation. Seven participants were gained with this method and the other two participants were gained by the snowball method. Nine classroom teachers agreed to participate in the study when contact was verbally made. No participants were recruited or contacted before, during, or after the study through any school system communication means. This was due to the sensitivity

of this study and the possibility that classroom teachers would not be comfortable discussing their mental disorders within the school environment for fear the organization would find out their involvement and the potential for negative consequences.

Upon meeting with the teachers for the individual interviews, participants signed consent forms (see Appendix D) and asked questions about the study prior to commencing with the research questions (see Appendix E). This phenomenological approach lends itself to interviews as teachers described the conscious reality of their experiences. Participants were given pseudonyms for names to protect their true identity. The initial interviews lasted from 60-120 minutes in duration and were face-to-face. A dyadic focus group was conducted with two classroom teachers through face-to-face contact. This interview was held during a one-week break and the other seven participants were on trips or had previous engagements and could not participate. The focus group lasted 90 minutes in duration. All participants were asked to keep a journal for two weeks and were reminded to refer to the research questions. Three participants chose to complete journals with four journal entries submitted to the researcher.

The researcher transcribed all data gathered through audio recordings. Stuckey (2014) wrote that transcripts are important in data analysis and nonverbal behaviors should be added to establish reliability, dependability, and trustworthiness. Tone and inflection can be added to transcripts, such as capitalizing words or putting in parenthesis how words were spoken (softly, angrily), as inflection and emphasis by the participant impacts data analysis (Green et al., 2007; Stuckey, 2014). Stuckey (2014) added that the “transcriptionist’s contribution is the first step in the interpretation of data” (p. 8). For this reason, the researcher preferred to transcribe all of the data so the interpretation is hers and not the transcriptionist’s. Participants were asked to review

the portion of the study where they participated (individual interview, journal, and/or focus group) for member checking and validity. Creswell's (2013) Data Analysis Spiral was used to analyze the data.

Researcher's Role

My name is Becki L. Kelly and I am a school counselor at the elementary level. I have been in education for thirteen years. Besides being a Type A personality, I have three diagnosed mental health disorders: depression (Depressive Disorder), ADHD impulsivity (Neurodevelopmental Disorder), and insomnia (Sleep-Wake Disorder) as outlined in the DSM-5, APA (2013). Although this may sound overwhelming, I do take medications for the three diagnoses, which help to moderate my moods and emotions so I am able to live a fairly productive, happy life. I also have a Type A personality, that is reflected in my perfectionist and overachieving tendencies, desire for recognition and advancement, competitiveness, and emotional reactivity.

As a proponent of Link et al.'s (1989) modified labeling theory, I believe that a societal label is assigned to those with mental illness. The labeled person has several coping options including concealing the illness and keeping it a secret from others, withdrawing or limiting themselves from social interaction, or as I have chosen to do, educating others on the mental illness. I chose this topic for my dissertation because it is important to me as a person and professional. Link et al. (1989) referred to educating as preventive telling, "in hopes of enlightening them so as to ward off negative attitudes" (p. 403). Further, the modified theory states that the individual's need to educate suggests that the labeled person considers stigmatization likely, and "this risks direct discrimination" (Link et al., 1989, p.403). The stigma associated with mental health can be debilitating to those diagnosed, or even undiagnosed, with

mental illness. Much of the issue with disclosure has to do with self-identity and realizing that mental illness exists and accepting it as part of your being.

I have been under a doctor's care for 27 years starting with the depression diagnosis and have been medicated for depression since that time. I, like other medicated people, would go on and off my medication with poor results until I finally realized that I could not take breaks from the anti-depressants. White (2007) described this experience of not following the medicine regimen as a failure to acknowledge the illness. Most people with depression typically struggle with finding a medication that works (Keith, 2013). In the beginning years of taking anti-depressants, I felt like a mouse in an experimental laboratory as my body would get used to the medication and I would have to change medications. Each new medication was a battle with finding the correct dosage that worked effectively. Without anti-depressants, I am moodier and more prone to bouts of anger, which is why I researched the literature on anger and emotions in teachers. Shortly after the depression diagnosis, I was diagnosed with insomnia and regularly take medication for sleep on evenings where I have to work the next day or attend a function where I need a restful night of sleep. Since starting the doctorate program, my impulsivity and lack of focus was making it difficult to achieve my responsibilities as a school counselor and complete my work in my classes for Liberty University. I went to a Neuropsychologist in June 2013, where I received the last diagnosis and the needed ADHD medication. I have seen mental health counselors sporadically in the past 20 years, but currently I am not seeing a therapist due to lack of time. I am past the point of denial and realize that counseling is a required option for treatment and good mental health.

I do not like to refer to mental illness as a disability, although it is commonly referred to in that respect, as the word disability has negative connotations. For many people, mental illness can be a disability without interventions and support. I do tend to struggle with my mental disorders, even on medications, and I believe other teachers experience these same problems on a regular basis without any kind of support from the school or district. Some teachers may not have other social network systems (family, non-educator friends) to assist them with everyday school tasks, especially the stress and commitment of being a classroom teacher. Social network systems are crucial to coping with mental disorders.

This is a hermeneutic phenomenological study so my experiences with mental health and my personal biases were bracketed (Chan et al., 2013; Creswell, 2013; LeVasseur, 2003; van Manen, 1990) to the best of my ability from the experiences of the classroom teachers. After much thought and consultation with my professors and colleagues at Liberty University, I decided to reveal my mental disorders up front to the participants who did not know me. Many of the participants in this study already knew of my mental disorders. Previous literature recommended this approach of disclosing at the onset, as disclosure assists in placing the participants on a more even playing field, assigning the researcher a less powerful position which helps to demonstrate respect for the participants, and establishing a quick, authentic, and more trusting relationship with the participants (Dickson-Swift, James, Kippen, & Liamputtong, 2007; Morrison & Stomski, 2014; Pyrczak, 2013). Pyrczak (2013) stated:

Sometimes, qualitative researchers disclose their own background characteristics as they relate to the variables under investigation....This is done in an effort to 'clear the

air' regarding any personal points of view and biases that might impact the researcher's analysis of the data. (p. 116)

Chan, Fung, and Chien (2013) recommended that after disclosing to participants, the researcher should emphasize that there are "different and unique lived experiences and perceptions in different people that the researchers cannot know entirely prior to the interview" (p. 6). This statement allow for the participants to feel free in telling their stories and sense that they are contributing to the study and the new knowledge that will hopefully be gained by studying diagnosed mental disorders in classroom teachers.

I have been reflecting and applying reflexivity to my own experiences with mental disorders to identify any bias or prejudices that I have. I have read literature on being reflexive (Chan et al., 2013; Creswell, 2013; Guillemin & Heggen, 2009; Pyczak, 2013; Shaw, 2010) and in doing so I realized I do have certain biases. As Shaw (2010) reflected about an experience of bias that interjected itself during an interview, she stated, "To be reflexive, we need to reveal our presuppositions in order to not be surprised by them (or what they do) anymore; these presuppositions remained latent and still potent when faced with a powerful enough emotive trigger" (p. 238). When a researcher is not reflexive and presuppositions are encountered, biases could damage the relationship between researcher and participant, as well as hinder the information seeking process.

I have two biases. The first bias is in regards to medication. Medication has been a life-saver for me and quality of life is more important than the quantity; meaning that I would prefer to be happy and successful even if it means a shorter life due to the side effects of the drugs on my body. I realized in being reflexive and reflective, that I do believe that individuals who do

not medicate may not be aware of the negative effects of mental illness and the detriments caused to others. Mental disorders can cause mood swings, emotional outbursts, inconsistencies in behavior, and so forth. The literature suggested that uncontrolled mental disorders could negatively affect students. A teacher with a diagnosed mental disorder should be under the care of a medical physician and a mental health professional so when things are not going well, they can seek assistance. By being aware of this medication bias, I am aware not to interject my bias into the interview process in the event a teacher is not taking medication for their symptoms. The second bias is that I believe I am treated unfairly in my school environment, and it is important that I do not disclose this information to any participants.

Guillemin and Heggen (2009) noted that being reflexive also involves considering research ethics by being aware of the researcher's role and of the ethical dimension in the researcher-participant relationship. In thinking about the ethics of this study, I needed to be constantly aware of not doing harm to the participants, scrutinizing what I say and do, while reflecting on the interpretations and consequences of my behavior as seen by the participants. Guillemin and Heggen (2009) emphasized that the researcher recognize when a situation could cross an ethical boundary and then be prepared to retreat, if necessary. For example, if a participant were to become emotional and unsettled during an interview, I planned to stop the interview if the participant was not able to continue and recommend they see their therapist or offer them a list of counselors in the area. This strategy was not needed during the interviews. Winkler (1995) suggested that participants may try to put the researcher into the therapist role and added it may be appropriate to say, "Have you ever had professional help in dealing with this problem? You might find it helpful" (p. 20).

I frequently discuss my mental health disorders with others to break that barrier of stigma and to educate others about the importance of bringing this issue to the forefront by communicating about it. Through this process of discussing my mental disorders, others have disclosed to me about their diagnosed mental disorders, including teaching colleagues. Keith (2013) found that her female participants who disclosed about their mental illness in the workplace eventually felt that “coming out of the closet about having a mental illness also allowed many of them to find relief in the honesty and self-acceptance surrounding their identity as a mental health consumer” (p. vii). I have disclosed my diagnoses with colleagues and with my elementary students in classroom guidance sessions. I agree with Dr. Ruth White (2007) that:

Disclosure to students makes it easier for them to understand that the mentally ill are all around us, that we are not to be feared, that treatment can work, and that career and success in life are indeed possible. Disclosure “normalizes” mental illness. (p. 141)

Dr. White (2007) teaches at the university level, but I think education about mental health should begin at a young age. I believe I have an obligation to teach about mental disorders to my students, some who have observed symptoms of a mental disorder in peers, teachers, and/or family members. I have found that children are receptive to my disclosure and many children will disclose that they have a diagnosed mental disorder (usually ADHD). For some children who may not be diagnosed but suspect they have symptoms of a particular mental disorder, knowing there is a reason for their actions and misbehavior is a benefit to their self-esteem instead of always thinking they “are bad”. When we start teaching our students that teachers are human and err, students learn they can still be successful in their careers and lives even though a

person has a mental disorder. In this study, my intent is to educate others by adding to the research that is lacking and outdated in this area on the struggles of classroom teachers with a diagnosed mental disorder. The literature focused on stress and burn-out of teachers without considering that there could be underlying diagnosed mental disorders as a relevant precipitating factor for the inability to handle the stress and everyday conflict of being a classroom teacher.

Van Manen (1990) suggested that researchers ask themselves to describe a lived experience with the phenomenon under study. My overall research question is for classroom teachers to describe experiences with diagnosed mental disorders in a school environment. Describing my own difficulties with mental disorders is problematic due to the sensitive nature of this study, not only for the participants, but for me as well. I am not anonymous in this study! I do have experiences that have affected me negatively, for long periods of time, in regards to how others have perceived my behaviors and actions. Keith (2013) wrote that she is able to “forgive myself for my behavior and accept myself for who and what I am” (p. 87). I believe that “It is what it is and I cannot change it.” However, I am not so self-forgiving about my inappropriate behavior. I, too, have to cope and deal with the mental disorders throughout my lifetime.

Data Collection

Data collection involves the use of data triangulation. Kimchi, Polivka, and Stevenson (1991) defined data triangulation as “the use of multiple data sources with similar foci to obtain diverse views about a topic for the purpose of validation” (p. 384). Thurmond (2001) stated, “The intent of using triangulation is to decrease, negate, or counterbalance the deficiency of a single strategy, thereby increasing the ability to interpret the findings” (p. 253). Simply, the more data that can be obtained from different sources, the more interpretation is available to

enhance the completeness and confirmation of data” (Thurmond, 2001) in qualitative research. Denzin (2012) added that triangulation is a strategy that adds “rigor, breadth complexity, richness, and depth to an inquiry” (p. 82). Flick (2017) furthered Denzin’s original concept from 1970 by adding that Denzin sees triangulation as a step to knowledge and less toward objectivity or validity. Triangulation aims at deeper, broader, more comprehensive understandings that often include “discrepancies and contradictions in the findings” (p. 53).

The researcher used three types of data collection for data triangulation: (a) individual interviews, (b) a dyadic focus group, and (c) journaling. Interviews are the most widely used technique for collecting data in qualitative research and the most useful in uncovering the story behind the participant’s experiences (Creswell, 2013; Doody & Noonan, 2013). Interview questions are open-ended with participants responding in their own words. The researcher engaged in establishing rapport, used active listening skills, and reduced researcher bias. Interviews lasted from approximately 60-120 minutes. The purpose of the focus group was to assess if the participants had any reflections to share. The researcher served as the moderator, not participant, in the focus group (Acocella, 2012). The focus group lasted approximately 90 minutes. The journal writings allowed for participants to reflect and provide valuable descriptions of experiences in the school environment. All collected data is stored in the researcher’s password protected computer and written data is maintained in a locked safe until all data can be destroyed three years following completion of the project (Protection of Human Subjects, 2005).

Individual Interviews

The researcher's desire and intent was, first and foremost, to conduct the initial interviews face-to-face. Observing a person's non-verbal communication, such as gestures and facial expressions, often tells more than the words themselves. In any interview, the recommendation is that the researcher establishes rapport and trust with the participant (Doody & Noonan, 2013; Mealer & Jones, 2014; Shaw, 2010; Shenton, 2004; Winkler, 1995). For the initial interviews, the researcher met in a face-to-face meeting and each participant chose where they wanted to meet based on their comfort level. The interviews were audiotaped and transcribed by the researcher within a few days.

The researcher had considered utilizing SKYPE, which allows for synchronous interaction and the capability to record both the visual and audio interaction (Hanna, 2012). Olubunmi (2013) wrote that the use of social media is imperative for research. SKYPE is a close alternative to the face-to-face interviews by allowing the researcher and participant the ability to read face and body language (Hay-Gibson, 2009). Bertrand and Bourdeau (2010) pointed out that the results in a recorded interview from SKYPE "is a mirror of what it was in reality" (p. 73). However, since all of the participants lived fairly close to the researcher and were comfortable with interviewing face-to-face, SKYPE was not needed.

Online communication was initially considered in this study as it offers anonymity and accounts can be set up with pseudonyms for identification. Email is a form of asynchronous communication and can involve multiple email exchanges over an extended period of time (Meho, 2006). Although email is more time-consuming and there may be misinterpretation, emailing can be advantageous if participants are geographically far away, do not want to meet

face-to-face, and prefer to communicate through writing. Email offers flexibility in time scheduling and eliminates transcription errors. Email was utilized in this study to send several participants the research questions in advance of the initial interview and occasional short messages. The researcher originally used Facebook to contact prospective participants employing on-line messaging (synchronous), which engages in real-time conversation. Jowett, Peel, and Shaw (2011) considered this form of communication more difficult without visual cues such as facial expressions and tone of voice. Facebook messaging was not utilized for interviewing.

Telephone interviews were also considered for the initial interviews, but were not needed. Telephone interviews are useful if the participants are asked to disclose information that is deemed sensitive (Mealer & Jones, 2014; Winkler, 1995). Sensitive research includes issues that could damage a person's reputation, financial standing, or employability (Mealer & Jones, 2014). This information could also lead to stigmatization or discrimination. Sensitive topics include psychological well-being and mental health problems. By using a telephone interview, the participant's emotional distress may be alleviated or reduced. Although this method lacks visual cues, Mealer and Jones (2014) asserted that the telephone allows for an emotional distance, which the participant may perceive as less judgmental and allows for "an environment to engage with their reality" (p. 35). The researcher should take notes to serve as a reminder of non-verbal communication when utilizing the telephone for interviews.

In summary, the participants preferred face-to-face interviews and the journaling results were hand-delivered to the researcher. The research questions were given to the participants ahead of time, either by hand-delivering the questions to the teachers or using the teacher's

personal email address. The researcher allowed the participants to have the questions prior to the individual interviews as some participants seemed uncomfortable and nervous about the topic and were concerned what the interview questions entailed. By reviewing the interview questions ahead of time, the teachers were able to reflect and consider their responses in more detail and at a more comfortable level during the interview. Three journal entries were submitted within three weeks prior to the focus group and one journal entry was submitted two days after the focus group.

Interviews utilized the open-ended questions below:

1. (Preliminary Questions) What is your gender, age, number of years in teaching, highest degree attained, and current school level you are teaching?
2. What mental health disorders do you suffer from (based on medical diagnosis) and explain the symptoms you exhibit for each diagnosis?
3. Explain the origin of your mental disorder(s) (i.e., biological, socially constructed, or combination).
4. When was your mental disorder(s) diagnosis? Explain the circumstances leading up to the diagnosis.
5. If medicated, what do you currently take? Explain any side effects associated with them.
6. What would happen if you stopped the medication(s)?
7. (Central Question) How do classroom teachers diagnosed with mental disorders describe their experiences in the school environment?
8. What are your reasons for becoming a teacher?

9. What is your favorite part of being a teacher?
10. What challenges do you have and how do you cope with them?
11. What are your strengths from these mental disorder(s) in performing daily functions in the school environment?
12. What are your weaknesses from these mental disorder(s) in performing daily functions in the school environment?
13. (Research Question One) How do classroom teachers diagnosed with mental disorders describe their emotions as it relates to feelings, thoughts, and reactions experienced in the school environment?
14. Describe situations where you could not control or self-regulate your mental disorder(s) (decision-making, emotion regulation).
15. What were the consequences of these situations?
16. What factors attribute to the increase of mental disorder symptoms?
17. (Research Question Two) How do classroom teachers diagnosed with mental disorders describe their relationships with their students and peers?
18. How do your mental disorder symptoms affect your relationships with students, colleagues, and superiors?
19. How does your mental disorder prevent or promote your ability and effectiveness to be a role model in the school environment?
20. (Research Question Three) How do classroom teachers diagnosed with mental disorders describe their sense of professionalism in the school environment?
21. How would you define professionalism in teaching?

22. How does your mental disorder change your image of yourself as a teacher and as a professional?
23. (Research Question Four) What factors do classroom teachers diagnosed with mental disorders identify as contributing, or influencing, their decision to disclose their mental disorders within the school setting?
24. Do you perceive mental disorders as a “stigma” and does this affect your desire to disclose or share your experiences?
25. After your diagnosis, how did you perceive yourself differently? How did it change your perception of yourself?
26. Who in the school environment have you confided in regarding your diagnosed mental disorders?
27. What were your thoughts and feelings prior to and after disclosure?
28. (Final considerations are to assess if the participants have thoughts, opinions, or suggestions on ways the educational system could assist classroom teachers with a diagnosed mental disorder in reaching self-efficacy and job-satisfaction in the school environment.) What solutions or programs can be taken by the school or district to ease your symptoms or behaviors associated with your mental disorders?
29. What would you like administrators and local governance to know about mental disorders in the classroom teacher?
30. Please share any parting thoughts or ideas you may have regarding your mental disorders that you have thought about but have not shared.

Question one is an informational gathering question where the data is used for biographical purposes. This enquiry was used as an icebreaker in learning about each other as the researcher and participant establish a rapport in casual conversation since these questions are non-threatening (Mealer & Jones, 2014; Winkler, 1995). Question two is the identification of the mental disorders of each participant, which is the basis and the major criteria for this study. Qualitative research is designed to give the classroom teachers with mental disorders a voice of their lived experiences (Creswell, 2013; van Manen, 1990). Teachers must also be in the classroom full-time so their experiences with the phenomena are relevant and current. Questions three and four obtain background and history of each participant. Gender is relevant as research indicated that females are more likely to suffer from depression than men (Hemp, 2004) and Banerjee et al. (2014) found that psychiatric disorders were higher for women than men, with 14% of the women experiencing a depressed mood compared to 9% of the men. How many years a teacher has taught is relevant as the more years the teachers have taught, the higher likelihood the teachers will have more experiences with mental disorders in the school environment. Knowing the other biographical data gives the readers a sense of who the participants are and an avenue to getting to know them better. Questions five and six are relative to medication to understand how dependent each participant is on the medication and to determine if they follow a regular medication regime. No research could be found in regards to medications and educators. Studies in the private sector report that only about 50% of persons with prescriptions for psychiatric medications actually take those medications or do not take them regularly (McCann et al., 2008; Reupert & Maybery, 2007; Roe et al., 2009).

Question seven is the central question giving the participants the reason for the purpose of the study. Questions eight and nine assess why the participants decided to pursue the education field and their favorite part of teaching. These questions helped to determine how invested each participant was in their teaching career. Friedman (2006) discussed the difference between the narcissistic needs of the teacher and the altruistic aspirations for the students. Ideally there should be a compromise in the middle. Friedman (2006) suggested that teachers may need to adjust their desires to fulfill both their needs and the students' needs, or they "may be doomed to burn out" (p. 738). For some teachers, teaching is steady employment with more security (Chambers, 2002) and a desire to work with children (Jarvis & Woodrow, 2005; Rinke, 2008; Sinclair, 2008). Questions 10 to 12 assess what the participants consider to be their strengths and weaknesses in the school environment by discussing their challenges as a teacher with mental disorders and the coping skills they utilize. Research discussed challenges in education, but it is unknown how classroom teachers with mental disorders will describe their strengths and weakness in the school environment.

Question 13 is research question one and serves as a starting point for the participants to know that they are answering questions about their emotions in the school environment. This question does not require an answer, but requires reflection. Questions 14 and 15 ask the participants to describe actual occurrences where they may have had difficulty with emotions due to their mental disorders, and what happened as a result of the emotional display. Naring, Briet, and Brouwers (2006) found that teaching requires a high level of emotional labor, and having to show emotions when a teacher does not feel them or having to suppress emotions because it would not be appropriate, was related to emotional exhaustion and depersonalization.

Also relevant is if issues with controlling emotions affect teacher bullying towards students, which research has shown to be detrimental to the student's psychological, academic, and social well-being (Koenig & Daniels, 2011; McEvoy, 2005; Sylvester, 2011; Tremlow et al., 2006; Whitted & Dupper, 2008; Zerillo & Osterman, 2011). Question 16 targets what factors in the school environment initiate and trigger the mental disorder symptoms in the school environment. This question assesses how well the classroom teachers can handle each school day and what specifically can cause problems for the teachers. Individuals should know what their triggers are in the environment and plan in advance how to handle those triggers. Such triggers may stem from problematic behavior of students (Chang, 2013; Silva & Fischer, 2012), an overload of tasks assigned (Brown & Roloff, 2011; Silva & Fischer, 2012), little or no participation in decision-making (Seyfarth, 2005; Silva & Fischer, 2012), teachers not being allowed to speak freely (Richards, 2012), and/or lack of support from co-workers, supervisors, or parents (Mahan et al., 2010; Richards, 2012; Silva & Fischer, 2012).

Question 17 is research question two which directs the interview to the topic of relationships with all persons within the school environment. Research indicated that positive relationships are crucial for students in their academic learning and success in the school environment (Bernstein-Yamashiro & Noam, 2013; Gustems-Carnicer & Calderon, 2013; Kipps-Vaughan, 2013; Richards, 2012). Question 18 asks the participants to assess their relationships in the school environment with students, administrators, other teachers and adults, and parents. Are some relationships different and if so, what could be the reasoning behind that (Jeon et al., 2014; Ripski et al., 2011; Simbula, 2010)? Ripski et al. (2011) found a link between self-reported depression and poor teacher-student interactions in student teachers and their students.

Jeon et al. (2014) reported that depression in preschool teachers and childcare providers was associated with behavioral problems in children, along with depression, anxiety, and withdrawal. Question 19 asks the participants about being a role model. Previous research indicated that role models are the most influential in students' educational success (Ainsworth, 2010; Brace-Govan, 2013; Brien et al., 2012; Brown & Roloff, 2011; Jennings & Greenberg, 2009). Ainsworth (2010) found that role models from higher status neighborhoods had positive outcomes on student success. Brace-Govan (2013) explains that teachers are direct role models whether they believe they are or not. Therefore, it is imperative that classroom teachers understand the role they play and if a person with a diagnosed mental disorder is a negative role model, how it could affect the entire school year of learning and achievement for students.

Question 20 is research question three which cues the participants to discuss professionalism. This question does not require an answer, but requires reflection. Questions 21 and 22 ask participants to define professionalism and how the symptoms of their mental disorders affect their idea of being a professional. Professionalism should involve following the teaching standards (National Board for Professional Teaching Standards, NBPTS, 2014) as a guideline, having positive and committed relationships to all of those in the school environment (Krishnaveni & Anitha, 2008; Lei et al., 2012), and being a positive role model with high ethical standards (Krishnaveni & Anitha, 2008; Lei et al., 2012; NBPTS, 2014). The NBPTS (2014) noted that teachers should empower students to continue their quest to be life-long learners and continue to obtain knowledge in their personal and professional life (Krishnaveni & Anitha, 2008; Lei et al., 2012). This data can be assessed through the biographical data of teachers and what level of degrees they have earned.

Question 23 is research question number four that directed the participants to answer questions regarding stigma and disclosure. This question does not require an answer, but reflection is necessary. Questions 24-27 ask the participants if they believe their mental disorder has a stigma associated with it, if they felt the stigma when they were diagnosed and how it affected them, and if and to whom they disclosed, as well as the factors involving those disclosures. Once a person is diagnosed and labeled with a mental disorder, the label may create shame, lowers self-esteem/self-efficacy, and makes coping efforts difficult. The label can be internalized and may become relevant and threatening (Corrigan & Watson, 2007; Link et al., 1989). Thoits (2011) argued that many labeled individuals actually resist the stigma and stereotyping, while others diagnosed with a mental disorder may accept or adapt to the label. Question 28 asks the participants if there is anything that governance at all levels can do to help alleviate the symptoms regarding their diagnosed mental disorders in the classroom. Teachers need to have input into decision-making and their careers. When politics and organizations rally for school reform without teacher input, the added curriculum requirements take away from teacher-student relationships (Darby, 2008; Hargreaves, 2000; Kelchtermans, 2005) while diminishing teachers' contributions and the professional status of teachers (Matulic-Keller, 2011).

Question 29 asks for specific comments teachers would like school systems and lawmakers to know regarding having diagnosed mental disorders in the classroom. Question 30 is for hindsight moments where the participants may have thought about, but not yet stated their experiences with mental disorders in the classroom, leaving the door open for further data gathering opportunities.

Focus Group

A focus group was conducted with two willing classroom teachers during a school break. All participants were invited to participate in this focus group, but most participants had travel plans and could not attend. This focus group followed the initial interviews and three journal writings. The focus group was conducted face-to-face, data was audio recorded, and the researcher transcribed the data. Hudson (2003) recommended recording not only participant's responses, but also their interactions with other participants. Focus groups are essential to help clarify, extend, or complement (triangulate) data collected by the individual interviews (Hudson, 2003). Focus groups are important for an individual's deeper understanding to help clarify their own interpretations (Acocella, 2012; Deggs, Grover, & Kacirek, 2010) and offer participants an opportunity to share and express themselves that they might not have done in individual face-to-face encounters (Stancanelli, 2010). Focus groups are also a way for participants to become aware of unthought-of interpretations in their previous views, which triggers a snowball effect that adds to the richness of the responses (Hudson, 2003). However, the presence of others could inhibit a participant, leading to more socially desirable and stereotypical answers (Acocella, 2012). The researcher intended to use a round-robin format (one person at a time in a circular pattern); however, with only two participants the round-robin format was not needed.

Dyadic interviewing is a tool that can be effective for a focus group even though it is a relatively new method of interviewing (Morgan, Eliot, Lowe, & Gorman, 2016). Morgan, Eliot, Lowe, and Gorman (2016) described that dyadic interviews can provide the participants more time to delve into their experiences on the topic. Morgan et al. (2016) stated, "Dyadic interviews can encourage an especially lively dialogue when participants share a common interest in a topic

that can lead them to enjoy discussing the topic with each other” (p. 110) and are easier to schedule. Having a two-person conversation is easier for the researcher to moderate than a larger group. Although the focus group was not originally intended to be dyadic, the end result was an effective format with the two participants.

Focus groups have the advantage of being flexible in the questioning and discussion as the researcher can react and direct the conversation to more useful, relevant data and to stay on-task (Hudson, 2003). Shenton (2004) suggested asking participants to offer reasons or explanations as to why particular patterns emerged from the data. Only one question was used to initiate the group interview: What have you learned about yourself from this experience of telling your story? Participants discussed other topics as the interview progressed.

Journaling

The third type of data collection was journaling where participants typed journal entries and delivered them to the researcher. Journaling offers a medium for freely expressing emotions, feelings, and experiences of daily events (Hayman, Wilkes, & Jackson, 2012) in the school environment, which could shed light on experiences that may not emerge through the interview or focus group process. Janesick (1999) wrote that journaling offers the participants the opportunity to refine their responses and is used for “reflection, catharsis, remembrance, creation, exploration, problem solving, problem posing, and personal growth” (p. 511). Van Manen (1990) stated that writing responses forces the participants into being reflective, sometimes due to the linguistic demands from the process of writing, which then places constraints on the freedom to speak about the lived experiences. Other challenges to journaling include poor participation, feeling exposed, and staying on track (Hayman et al., 2012).

Journaling takes additional time that the participant may not have (Janesick, 1999), and this was found to be true in this study. Only three participants chose to journal and reflect on this study although all participants were invited to participate.

Data Analysis

Thorne (2000) described data analysis as the “most complex and mysterious of all of the phases of a qualitative project, and the one that receives the least thoughtful discussion in the literature” (p. 68). Literature regarding the mechanics of data analysis is limited. A major technique of data analysis is in the phenomenological design of bracketing personal experiences and biases (van Manen, 1990), yet how bracketing is achieved and why it is appropriate is rarely explicit in the literature (Chan et al., 2013; LeVasseur, 2003). The definition of “bracketing” is dependent on what phenomenological approach is adhered to. LeVasseur (2003) wrote, “...bracketing as described by Husserl (1931) implied that prior knowledge could be suspended and set aside so that fresh impressions could be formed about phenomena without the interference of these interpretive influences” (p. 409) and “that essences can be understood without our necessarily inferring their concrete existence in the world” (p. 412). This explanation of bracketing by Husserl in 1931 (LeVasseur, 2003) has been criticized and redefined by philosophers throughout time, with recognition from some phenomenologists that our experiences and prior knowledge is embedded in historical context and cannot be set aside. LeVasseur (2003) expanded the understanding of bracketing and added “...the project of bracketing attempts to get beyond the ordinary assumptions of understanding and stay persistently curious about new phenomena” (p. 419). Bracketing allows for fresh experiences and the possibility of new meanings.

Van Manen (1990) discussed the importance of bracketing and stated that “the problem of phenomenological inquiry is not always that we know too little about the phenomenon..., but that we know too much” (p. 46). The researcher’s perception of the phenomenon leads to certain assumptions, presuppositions, and pre-understanding that predispose the investigator to interpret the nature of the phenomenon before analyzing and interpreting the data (van Manen, 1990).

Van Manen (1990) recommended “turning the knowledge against itself” (p. 47) in order to get to the deeper meaning. In this study, the researcher attempted to bracket her experiences from the participants’ experiences.

This study utilized parts of The Data Analysis Spiral (Creswell, 2013, p. 183) technique for manual analysis. Originally the researcher planned to use computer software (ATLAS.ti 7) and applied for an account. The use of computer software assists in improving the rigor of data analysis and facilitates the work of the researcher (Jacelon & O’Dell, 2005), however, the researcher felt comfortable using self-made charting techniques based on personal skills and comfort level. The bottom of Creswell’s (2013) spiral involves reading and re-reading the texts multiple times, while memoing (by annotating in ink and highlighter) in the margins of all transcripts for concepts and ideas. The intent of memoing is to see the whole part before breaking down the data. Note writing in the margins is used to “isolate the most striking and relevant aspects of the data” (Robertson & Brott, 2013, p. 71). The researcher needs to continuously read between the new data collected and the data that was previously analyzed (Ayres, 2007; Jacelon & O’Dell, 2005; Thorne, 2000) to assist in identifying “emergent themes without losing the connections between concepts and their context” (Bradley, Curry, & Devers, 2007, p. 3).

The next spiral of Creswell's (2013) model is describing, classifying, and interpreting the data into categories by coding and labeling. Coding is the process of assigning names from individual words to meaningful segments on what the findings of the experiences may suggest, such as the index of a book (Glaser & Laudel, 2013). Coding has the advantage of separating relevant and irrelevant information. Bradley, Curry, and Devers (2007) defined coding as a technique to "catalogue key concepts while preserving the context in which these concepts occur" (p. 3). Coding is refined to fit the data, which results in an inductive approach based on the experiences of the participants (Theron, 2015). Since there are limited and outdated research articles regarding the experiences of classroom teachers with diagnosed mental disorders, a deductive approach with established codes was not appropriate. The final coding structure was composed after saturation occurred. Saturation is the point where no new concepts emerge (Bradley et al., 2007; Jacelon & O'Dell, 2005). Codes are ultimately based on the perceptions and knowledge of the researcher (Bradley et al., 2007; Jacelon & O'Dell, 2005), which is why it was imperative for the researcher to bracket her experiences and reflect on biases.

Creswell (2013) recommended aggregating data into smaller clusters of information (25-30) and then combining them into five to six themes "for most publications" (p. 185). Themes, or categories, are broad units of data consisting of several codes to form a common idea (Creswell, 2013) or construct (Gall et al., 2007). Gall et al. (2007) emphasized the importance of clarifying the meaning of each category, creating sharp distinctions between each category, and deciding which categories are the most important to the study. Bradley et al. (2007) pointed out that themes not only identify conceptual domains, but also suggest a relationship among the concepts. Categories reduce the amount of data by combining text into more manageable

patterns for comparing data types between the data sets (interviews, focus group, journals) and within each data set (Ayres, 2007). Ayres (2007) referred to this step as “resynthesis” (p. 491), the process of re-contextualizing themes and categories into an account that makes sense of the entire data set. Jacelon and O’Dell (2005) wrote of the importance for the researcher to be creative in the data analysis phase and move from stating the obvious to exploring the hidden meanings of the data. The intent is to be able to adequately answer the research questions (Ayres, 2007; Glaser & Laudel, 2013; Jacelon & O’Dell, 2005; Pyrczak, 2013). The top of Creswell’s (2013) Data Analysis Spiral is to represent and visualize the data by presenting the information by visual means and a final composition of lessons learned.

This study utilized a data analysis technique used by Creswell (2013) called “lean coding” (p. 184). Creswell (2013) stated that beginning researchers tend to “develop elaborate lists of codes” (p. 184), but in “lean coding,” Creswell (2013) develops a short list (five to six categories), and then expands the categories as data is obtained and reviewed. From the categories, the themes emerge. Creswell (2013) stated that counting codes for frequency of occurrence is not particularly relevant in qualitative studies. Creswell (2013) explained that “counting conveys a quantitative orientation of magnitude and frequency contrary to qualitative research” (p. 185). Creswell (2013) elaborated, “In addition, a count conveys that all codes should be given equal emphasis, and it disregards that the passages coded may actually represent contradictory views” (p. 185). Based on Creswell’s (2013) technique of lean coding, the researcher in this study focused on analyzing data based on categories derived from the research questions. Data was analyzed using categories, subcategories, and coding was in text segments. Tables were generated with the research questions and the data from the interviews, focus group,

and journal writings were coded into the categories and subcategories until all of the data had been placed in a category.

Trustworthiness

Trustworthiness involves the amount of rigor in a qualitative study that can be assessed by the following criteria: credibility, dependability, confirmability, and transferability (Connelly, 2016; Cope, 2014; Lincoln & Guba, 1985; Morrow, 2005). Shenton (2004) acknowledged that a researcher in qualitative research must ensure that the findings from their study must emerge from the data and not the researcher's predispositions. There are five strategies that are utilized for trustworthiness in this study. These strategies include (a) member checks, (b) audit trail, (c) reflexivity or memoing, (d) peer review, and (e) triangulation (Creswell, 2013; Gall et al., 2007; McBrien, 2008; Shenton, 2004).

Creditability

Creditability refers to the truth and reality of the data as understood by the researcher and expressed to the readers (Cope, 2014; Thomas & Magilvy, 2011). For the data to be creditable, the data needs to be rich, plus plausible and persuasive (Tracy, 2010). Thomas and Magilvy (2011) state that member checks help to establish credibility. Participants need to be given the opportunity to check, review, and respond to the written product to validate the findings "were faithful" (Pyrczak, 2013, p. 114), authentic, accurate, with completeness of the experiences shared, and to clarify any misconceptions made by the researcher (Chan et al., 2013; McBrien, 2008; Rowley, 2012; Shenton, 2004). This process of member checking increases the reliability of the study by verifying the data is accurate and complete. Shenton (2004) stressed the need to review audiotapes and ensure the articulations expressed by each participant are accurately captured.

Another strategy to ensure creditability is peer review. This strategy utilizes others who have a fresh perspective and can ask questions regarding all aspects of the study to ensure accurate representations are from the participants (Thomas & Magilvy, 2011). Peers may be able to challenge assumptions made by the researcher, whose closeness to the study could inhibit their ability to view results objectively (Shenton, 2004). Peer review has the potential to safeguard against researcher bias, inaccurate subjectivity, and/or the attempt to fit interpretations that cannot be substantiated by the data (McBrien, 2008).

Triangulation is a method that involves utilizing multiple data sources and methods in “an attempt to gain an articulate, comprehensive view of the phenomenon” (Cope, 2014, p. 90). By utilizing various methods of data collection and comparing individual participant’s viewpoints and experiences with the other participants, creditability and confirmability is ensured (McBrien, 2008; Pyrczak, 2013; Shenton, 2004). Triangulation is also achieved by utilizing different participants (Shenton, 2004) from different types of schools, classrooms, and various mental disorders.

Dependability and Confirmability

Dependability refers to the consistency of the data and this data could be repeated with additional studies over similar conditions (Cope, 2014; Thomas & Magilvy, 2011).

Confirmability requires bracketing by the researcher as the results must be from the participants and not the researcher’s biases, viewpoints, or motivations (Cope, 2014; Thomas & Magilvy, 2011). The benefactors of the research need to have a sense of trust in the findings of the study. The audit trail is the common strategy for ensuring dependability. This audit trail is a running log that documents contact with the participants, such as interviews, phone calls, focus group,

electronic communication, recording length of time in the activity, and minor notes of the activity. The audit trail verifies the study is being completed and allows for other researchers to replicate the study (Guest, MacGueen, & Namey, 2011; Shenton, 2004). The audit trail is a record of why decisions and interpretations are made (Ayres, 2007; Chan et al., 2013; McBrien, 2008; Stuckey, 2015). The audit trail for this study may be found in Appendix F.

A strategy ensuring confirmability is called reflexivity where the researcher becomes aware and open to their biases and motivations regarding the phenomena under study. The researcher makes explicit their experiences and biases with the phenomenon (Cope, 2014; Shaw, 2010; Thomas & Magilvy, 2011; Tracy, 2010). McBrien (2008) emphasized that reflexivity is an on-going, continuous process, as researchers tend not to know what their biases and prejudices are prior to a study. Chan et al. (2013) stated that prior to starting a research project; the researcher must acknowledge their values, interests, perceptions, and thoughts. Readers gain trust that the researcher is credible and accountable, including possessing a grasp on the reality and intuitive findings of the study (Shenton, 2004). Shaw (2010) explained that the importance of reflexivity is to facilitate awareness of the dynamic relationship between the researcher and participants to bring forth “a fresh understanding of the phenomenon we are investigating” (p. 241).

Transferability

Transferability refers to the findings being applicable in similar settings (Cope, 2014; Creswell, 2013; Thomas & Magilvy, 2011; Tracy, 2010). Cope (2014) stated, “A qualitative study has met this criterion if the results have meaning to individuals not involved in the study and readers can associate the results with their own experiences” (p. 89). Thomas and Magilvy

(2011) added that the findings can help “to build interventions and understandings” (p. 153) to apply the research into practice. Creswell (2013) advised that to ensure transferability the results from the participants must be “rich, thick descriptions” (p. 252) by using quotes.

Ethical Considerations

This study was approved by the IRB (see Appendix A) before any research was conducted. The most important consideration in this study involves maintaining confidentiality. Pseudonyms were assigned to each participant at the time the consent forms were signed. Participants were informed that the study was voluntary and they could withdraw from the study at any time and that the data would be in a secured location with only researcher access. Participants were made aware there would not be any type of compensation for their participation.

Each teacher chose to meet face-to-face for all interviews. A list of local therapists and counselors from the southern part of the Atlanta area was provided prior to the individual interviews, although the classroom teachers did not feel compelled to take the list as they had their own medical or mental health professional. Guillemin and Heggen (2009) emphasized “being aware of the delicate negotiations involved when probing participants to be insightful and reflective, while at the same time understanding the effects of doing this in terms of potentially harming the participant” (p. 298). If there were emotional problems for the participant during the interviews, the interviews would be postponed until the teacher was able to resume, however this was not the case as the classroom teachers in this study were able to complete all interviews without emotional incident.

McBrien (2008) wrote that “the quality of the research study is dependent on honest and forthright investigation” (p. 1289). In this study, the findings are honest and from the

participant's stories. There was no deception of any kind involved. The data is safely secured in a password-protected computer and a locked file cabinet, while the names of the participants assigned to the pseudonyms are secured separately in a locked safe from all other data.

Summary

Chapter Three examines the hermeneutic phenomenological method utilized in this qualitative study, along with the research questions framing the study. The nine participants are introduced with biographical data, including their diagnosed mental disorders. The settings and procedures are discussed. The researcher discusses her role in this study and the need for bracketing. Data triangulation is explained and the three data collection methods are clarified, along with the procedures utilized for analyzing the data from the interviews, focus group, and journaling. Strategies to ensure trustworthiness are described, including credibility, dependability, confirmability, and transferability. Lastly, ethical considerations are explored with confidentiality being the top priority due to the sensitivity of the phenomena.

CHAPTER FOUR: FINDINGS

Overview

This chapter presents the results from the data analysis. The purpose of this hermeneutic phenomenological study is to describe and understand the experiences of classroom teachers who have diagnosed mental disorders in the school environment. A detailed description of nine participants in the southern part of the greater Atlanta area is included. The results are explained in the development of four themes and the research questions are answered in the voices of the classroom teachers in both narrative and table formats.

Participants

Nine female classroom teachers participated in this study and were assigned or chose their pseudonym (see Table 2). Each participant met the criterion of being a full-time classroom teacher and having one or more diagnosed mental disorders. There are seven Caucasians, one Hispanic, and one African American. The ages ranged from 35 to 55 years old and they had nine to 28 years of teaching experience. Seven teachers teach at the elementary level and two teachers teach at the high school level. Two teachers have their bachelor degrees, five teachers have their master's degrees, and two teachers have their education specialist degrees. The researcher worked with or had worked with six participants, one participant was a friend, and the other two participants were obtained through the snowball effect.

Three teachers are diagnosed with one mental disorder, three teachers are diagnosed with two mental disorders, and three teachers are diagnosed with three mental disorders. In other words, six teachers experience co-morbid disorders. Seven teachers have an anxiety diagnosis, five teachers are diagnosed with depression, four teachers are diagnosed with ADHD, one teacher is diagnosed with insomnia, and one teacher is diagnosed with obsessive-compulsive

disorder (OCD). In addition to the diagnosed mental disorders, five participants self-diagnosed themselves with other disorders; two were positive they were OCD, two suffered from insomnia, and one felt like she had depression.

Biographies

Table 2

Biographies of Participants Mental Disorders and Medication Usage

Participant	Diagnosed	Not/Self-Diagnosed	Origin of	Medication(s)
Alexa	Depression, Anxiety, ADHD	-	Biological and socially constructed	Yes
Anne	Anxiety, ADHD, OCD	Insomnia	Biological and socially constructed	Yes
Jackie	Anxiety	Depression	Biological and socially constructed	Yes
Laura	Anxiety, Depression	-	Biological	Yes
Lucy	ADHD	OCD	Biological	No*
Patty	Depression, Anxiety	OCD	Biological	Yes
Susie	Depression, Anxiety, Insomnia	-	Biological and socially constructed	Yes
Tessa	Depression, Anxiety	-	Biological and socially constructed	Yes
Wilma	ADHD	Insomnia	Biological and socially constructed	No

Note. OCD= Obsessive-Compulsive Disorder; ADHD= Attention-Deficit/Hyperactivity Disorder
 *Lucy had to stop her ADHD medicine due to a diagnosis of a heart problem.

Alexa

Alexa is a Caucasian female who is 48 years old and has been teaching elementary school for 28 years. She has a Master's Degree. Alexa was diagnosed in her 30s with anxiety, depression, and ADHD. Alexa suffered from post-partum depression after the birth of her only child when she was 25 years old. She was having thoughts like "God I don't want this kid" and was embarrassed that she felt that way. The post-partum depression ended after six weeks. Six years later her husband had an affair and according to Alexa, this triggered both the anxiety and the depression. Alexa stated, "I just lost it and so it wasn't very long after that that I started medication." Alexa jokingly told her doctor, "If you don't put me on meds I'm going to kill somebody!" Fortunately, Alexa and her husband did save their marriage. The ADHD was also diagnosed in Alexa's adult years, and her doctor told her he would not medicate her for the ADHD as she had already developed strategies to cope with it and that she did not need to become "dependent on" that medication. Alexa has two prescriptions for the depression and one prescription for the anxiety to take when it is needed. She also suffers from Crohn's Disease and hypothyroidism.

Alexa stated that her main symptoms for ADHD are impulse control and organizational problems. Alexa claimed that the lack of impulse control gets her "in a lot of trouble" as she speaks her mind without thinking. She said, "If it comes up, it comes out!" Alexa vows that every year she will improve her organization skills, "but it never works out!" She described her classroom as "organized chaos" because she can find things in her "piles and piles" of stuff. The students are amused when they frequently help her find her lost eye-glasses located on top of her head. Alexa likes "normal days" when they are structured and everything falls into place. By

normal she means “no field trips, no assemblies, no picture days.” She continued, “That helps me just keep my sanity...if it’s not a normal day then it throws me for a loop.”

Alexa stated that her symptoms for depression are under control with her current regimen of anti-depressant medications. Prior to the medication and when she was having the personal issues, she suffered from having a short temper, being aggravated, lack of patience, and some tears. Alexa said, “I usually don’t lose my cool with the kids” but she found herself snapping her fingers and “everything got on my nerves.” She admitted, “I was like I need to go to the doctor and get some meds because I’m going to kill somebody and lose my job!” When the anxiety occurs Alexa feels panicky and her heart races. She explained, “I just have to calm down and talk to myself.” Alexa stated she takes her anxiety medication sometimes to help her sleep, when she feels the anxiety coming on, and “if I have a full-fledge panic attack then I take one.” She said:

I don’t have anxiety usually in the summer so I know it’s job-related. I know I get stressed and get overwhelmed and that’s when it starts coming out, and it is rare that I have a panic attack when I’m not working.

In regards to the Crohn’s Disease, Alexa observed, “Whenever I started a flare, it’s been when I’m working. So it is stress, its stress.”

Alexa attributed her mental disorders to being both biological and socially constructed. She stated that “depression runs in the family” as most of her relatives, including her mother, are on medication. She has a grandmother who “was institutionalized and went through shock therapy” and her father “lives up on the mountain by himself.” Alexa said that her father does not like taking medication so “he deals with his [disorder] by getting outside and being a part of

nature, he's like a modern day hippie." Alexa added "alcoholism runs rampant on both sides." She stated that she does not have an addictive personality, but confessed, "Well, I binge watch TV. I like Netflix!" Alexa stated that "as a teenager I had tricho [trichotillomania] where I plucked my hair out. I just had a little bald spot! I would hide it!"

Several years ago Alexa thought she could deal with the mental disorders on her own without the medications and decided she did not "want to be dependent" on them anymore. She stopped taking the medications and said it was the lowest she had ever been. Alexa said, "It was horrible" and she "cried a lot." Alexa stated she had "dizzy spells...like something in the matrix" and added:

I went into the fight or flight mode, if I had not had my son, I'd have been gone. I'd have run! Because that's what I wanted to do, run from everything, go to the Bahamas and disappear on an island, so it was bad.

Alexa went to the doctor to start her medications again. She explained, "I started thinking about it like diabetes, a diabetic has to have their insulin. If I have to have my meds, then I have to take them to the day I die. Oh well" (Alexa, personal communication, July 19, 2015).

Anne

Anne is a 51-year-old Caucasian female who had been teaching for 20 years in all school levels and was currently teaching at the elementary level with a Master's Degree. She is diagnosed with anxiety, ADHD, and OCD. About 14 years ago, Anne suffered from post-partum depression after her second child and more problems surfaced after going back to work. She described this time in her life as having "too many balls in the air when I dropped my basket

finally.” Anne stated that prior to these events she had developed compensating behaviors so she “had been as functional as I could be for a really long time.”

Anne stated that her symptoms of anxiety and OCD tend to overlap and are hypervigilance, irritability, anger, getting migraines, feeling panicky, not being able to sleep, desire to be in control, and eventually crying and not being able to stop. The main symptom of OCD is intrusive thoughts and ruminations related to safety issues involving herself, her children, and her students at school. At home she would be “locking things that were locked, checking and double checking and triple checking, forever checking my children, over and over and over, even though I knew they were fine.” Anne added, “And I still occasionally do it with other people’s children at school.” At school she claimed, “I’m hypervigilant on the playground” and added that “other teachers are a little too lax.” The ADHD symptoms include being very active, lacking impulse control, and being productive to becoming overwhelmed to shutting down. Anne described her hyperactivity as, “I can go on little sleep and little food, but I have become aware that I don’t go very well!” Anne has a prescription for her ADHD, one prescription for insomnia when needed, and one for the anxiety as needed. She has a thyroid issue that caused fatigue until she started that medication.

Anne attributed her mental disorders to being both biological in nature and socially constructed. She had a grandfather with an anxiety disorder. Anne stated, “My mother is borderline personality disorder...she also cycles and I think there’s some bi-polar features...she’s also very narcissistic.” She described her mother as being loving at times, but “has very antagonistic relationships” and “when she doesn’t love you, she drops you like a hot rock on your head.” Anne explained the socially constructed component of her diagnosed

mental disorders, “It’s living in that cycle and that uneven emotional footing all the time that contributed to what was an already biological factor.”

Anne said that if she were to stop taking her medications “It would not be good...I would be very dysfunctional.” She stated, “I know I would cry a lot and I would not get anything done,” and “I would be much more irritable and I would have more of the migraines.” Anne added, “I would miss more work, have poor, very poor interpersonal relationships, and I would be really unhappy.” Anne suggested that if she had had the option of medication from an earlier age, she may have taken a different path in life and that she had really wanted to go to law school. She said, “I wonder who I would have been, I don’t think I would have been a teacher” (Anne, personal communication, June 11, 2015).

Jackie

Jackie is a Caucasian female who is 36 years old and has been teaching elementary school for 12 years. She has a Master’s Degree. Jackie is diagnosed with anxiety and unofficially- depression. She takes an anti-depressant to control the anxiety. Jackie described her anxiety symptoms as having a fast heart rate, shortness of breath, kind-of panicky, and she can feel the blood pumping through her arms.

Jackie believes her mental disorders are biological and socially constructed, but mostly biological. She stated that her mother’s entire side of the family has “total symptoms all the way down. I worry about my kids.” Her mother is diagnosed with schizophrenia and has been institutionalized several times. Two years ago Jackie had to obtain medical guardianship of her mother. She stated:

I got her permanently on injections and they [clinic] are supposed to legally let me know if she ever comes off the injections...she knows I am not messing around, that I will call the po-po one more time and I will call the doctors and she'll be back in there.

Jackie stated that this is a very hard, stressful time when she has to deal with her mother. She was diagnosed with anxiety about the time "with the craziness with mom." Jackie explained that her mother was having a hard time realizing that Jackie was moving on with her married life and trying to have a child. Jackie said, "She freaked out which caused me to freak out!" She added, "I was a mom pleaser, but I'm not now!"

During summer break, Jackie lowered her dosage of medicine and was feeling good. She thinks if she were to go off the medication completely, "I would clam up or kind-of panic." Jackie also believes that once school resumes, she would have a difficult time without any medication. Jackie has a conflict with an administrator and just seeing this person puts Jackie on edge. She explained, "I tense the freak up!" (Jackie, personal communication, June 12, 2015).

Laura

Laura is a Caucasian female who is 43 years old and has been teaching for 16 years at the elementary level. She has a Bachelor's Degree. Laura was diagnosed with depression and anxiety "officially" about "four years ago" and both are controlled by one medication. Laura stated about the medication, "Whatever chemically is wrong with my brain, it fixes it. Because I feel like a completely different person." Laura added, "For the depression, it isn't as bad as the anxiety and it's all under control right now. I'm not heavily medicated." Prior to the diagnosis, Laura said, "I thought I was perfectly normal." However, she knows now that she self-

medicated with food. She explained, “I used to weigh over 300 pounds, I didn’t drink or do drugs. I just ate a lot.”

Laura stated her symptoms for the anxiety and depression, “I get real stressed, real tense pretty fast. Like people will cry when they get stressed, but I don’t do that. I just get really mad.” Prior to seeking help for her anger, Laura had a particularly difficult student and she “almost had a nervous breakdown that year.” She stated that the pressure “was driving me insane.” Laura said, “I push everything down and I hide things really well. And then, then I just snapped and I get really mad. And kind-of out-of-control.” However, her family would take the brunt of her anger and frustrations. Laura’s husband would tell her “it’s not normal to feel this way,” so one morning she woke up and said, “This is not normal...and I just can’t keep doing this.” She didn’t want her young son “to grow up thinking that his mom’s crazy” and she was tired “of being miserable,” so she decided to seek professional help.

Laura stated that she feels like a completely different [better] person after her doctor increased her medication. She would never stop the medication because, “It wouldn’t be good, it wouldn’t be good. I wouldn’t commit suicide, but I think I’d be raged, raged all the time. It wouldn’t be pleasant for anybody, I’d become a bitch.”

Laura believes the origins of her mental disorders are biological. She thinks that her father may be “autistic.” Her father lost his mother when he was 12 and he had been on his own since he was 14 years old. Laura believes her father is “depressed and he has some anxiety too from what happened in the war.” Her father had “pulled some guys out of a burning helicopter” in the Vietnam War. Laura described her father as “a brave guy, he just never speaks, he’s very

silent.” Laura said she has a very close relationship with her mother (Laura, personal communication, April 8, 2015).

Lucy

Lucy is a Caucasian female who is 49 years old and she has been teaching for 25 years at the elementary level. She has an Education Specialist Degree. Lucy is diagnosed with ADHD but is quick to say that she doesn't think of ADHD as a mental disorder, but “as a gift.” She described her symptoms with ADHD as being impulsive, blurting out before thinking, finding it hard to complete tasks, lack of focus, irritability, and high activity. Lucy stated that when she was a child “I got more spankings when I was growing up that did no good!” Lucy was diagnosed three years ago after she realized that her disorder was affecting her family. She elaborated:

It got to where my family couldn't stand me, my boys were gone all the time, my husband was going to leave...I was making their life miserable because it had to be my way or no way. It was bad, I couldn't even stand myself.

Lucy also realized that she had some undiagnosed OCD tendencies as she likes things to be kept in a certain way, organized, and in a specific location in her home. She confessed, “I'd organize our pantry and everything had a place and in containers and then I'd get up and it'd be all messed up and I'd be like ‘Whoever messed this up you'd better get back in here!’”

Lucy had tried to take different medications for the ADHD but there were negative side effects. One medication had a rare side-effect where “the last three fingers would go numb and I didn't sleep.” Another medication “dropped my blood pressure so low that all I did was sleep!” This led to the doctors finding out that she had a heart abnormality and she needed to keep her

blood pressure under control and therefore, had to stop taking ADHD medication. At this time there are no medications for ADHD that are compatible with her heart problem.

When Lucy went off the ADHD medications, she found her symptoms came back and stated, “I was irritated with myself, I couldn’t talk, especially to adults. I could not tolerate adults. I was like what went through my brain came out my mouth.” Lucy has “adjusted to it so can control it better.” She admits that “it’s hard, it’s hard.” She said she is still impulsive and finds it hard to complete tasks due to the difficulties in maintaining focus. Lucy pointed to a pile of folders on the table and said, “I can’t get anything done. Those folders- I’ve been working on them for two weeks and last year I had them finished in an hour!” Lucy said, “I’ve even thought about taking half of the medication that they had me on, just to see, as long as it doesn’t increase my blood pressure.” Lucy said the origin of her ADHD is “definitely biological” (Lucy, personal communication, March 12, 2015).

Patty

Patty is a 35-year-old Caucasian female and she has been teaching elementary school for 12 years. She has her Bachelor’s Degree. Patty is diagnosed with depression and anxiety. She described her depression symptoms as having “mood swings, extreme lethargic moments,” and her anxiety symptoms include heart “palpitations” and difficulty ‘breathing.” When she had her first panic attack about seven years ago, Patty stated, “I thought I was having a heart attack,” and she was taken to the hospital. This incident occurred about six months after the birth of her only child. Patty had been diagnosed with the depression about 10 years ago. Patty spoke about being OCD, but she is not diagnosed with it. Patty also suffers from poor sleep and stated, “I just

don't sleep very well, I wake up more tired than I was when I went to bed." Patty recently found out she has sleep apnea. She also has high blood pressure.

Patty takes a prescription for the depression and a prescription for the anxiety. She does not need the anxiety medication very often "unless it comes the beginning of school and I take it a lot!" She also said she has problems with "the beginning of school nightmares." Prior to being diagnosed with depression, Patty said "my moods were becoming so high and so low and I had seen it with my mom." Patty spoke with her mother who recommended a visit to the doctor. Her doctor suggested medication. Patty said:

I'm not one of those people that doesn't want to take medication, the more you give me the better I am. I'm not trying to be a hero, don't sit there and try natural things, no, give it to me and be done with it!

When asked about the origin of her mental disorders she said, "I think all of mine came from my mom because she has the same thing." Patty stated that her mother, a retired teacher, has depression. She also realized that some of her issues are related to the death of her father. Patty added, "It also started right after my dad passed away and that was a huge thing...I mean I was standing right there with him when he passed away. He just dropped dead right in front of me." Patty stated that anger presented itself right after her dad died.

Patty said that if she were to stop taking the medications "I'd be very irritable, very jumpy, um, just all emotions like I would be like a rollercoaster." If she misses a day of medication, she can tell a difference right away. Patty said she will cry and get "very angry, like at stupid things" (Patty, personal communication, July 20, 2015).

Susie

Susie is a 35-year-old Caucasian female who has a Master's Degree and has taught for 13 years at the elementary level. She is diagnosed with anxiety, depression, and insomnia. Susie stated, "I never had any problems until college, in college I started having panic attacks." She also had insomnia in college and tried different medications to alleviate those symptoms. She described "full-blown anxiety" as "I can't get up out of bed, I mean like I cannot function. Like I sweat, I can't sleep." Susie takes medication "every day" for anxiety. Susie said that her main symptom for depression is "I just want to sleep. Which is totally contradictory to the insomnia." Susie was diagnosed with depression after her first child was born around 13 years ago as she "had post-partum depression that was bad, like really bad." She has been on anti-depressants since that time. Susie said that other symptoms of her depression included "my temper is very short and I get very agitated," and she has issues with impulsivity due to not being able to control what she says. Susie confessed:

I mean it just pops out, it comes right out, and I'm just like "Oh, why did I say that?" I don't mean to say things and I don't know what that is attributed to besides me just being a blunt person, but I guess it all ties in. I don't know, I don't really think that I'm bipolar.

Susie stated about her mental disorders, "I definitely think it is genetic biological, but I think that it's environmental too," and elaborated, "It's coming from a long line of crazy people." There have been several family members on the maternal side that had "killed themselves." Her mother was in and out of mental hospitals and was "bi-polar manic depressive with schizophrenic tendencies" and Susie was raised mostly by her father and grandmother. Susie stated that her dad had told her most of her life that "there is nothing wrong with you, there's

nothing wrong with you,” and Susie believes that her father “didn’t want me to be like my mom.” Susie said her current medication regimen involves one medication every day to avoid panic attacks, two prescription medications to help her sleep, and one anti-depressant.

Susie reported that there have been times when she did not have some of her medications because the nurse would say, “I’d been too long without seeing the doctor and that he couldn’t prescribe my medicine.” Susie would be frustrated with the doctor because stopping a few of the medications could also cause “a stroke or something like that because it is so addictive.” She knew she would not be able to sleep or go to work without them and described those moments as being panicky, having cold sweats, and “everything is just very magnified” (Susie, personal communication, March 7, 2015).

Tessa

Tessa is an African American female who is 42 years old. She has been teaching for 13 years at the high school level and has her Education Specialist Degree. Tessa is diagnosed with anxiety and depression. Tessa had her first panic attack in college but “didn’t realize what it was.” She described the panic attack:

It was just like this impending doom, like I was just going to die, it was awful and I was trembling and nervous and I just didn’t know why and it was like, “Okay, what is going on here? Am I about to die, is God telling me I am about to die?” It went on for about a week. Then it just went away.

After her only child was born Tessa had post-partum depression. She stated, “It was really bad,” so she headed to the doctor for help. Tessa described her depression symptoms as

having bad mood swings, irritability, lacking patience, and “no joy in anything, wanting to stay home all the time, I didn’t want to do anything.”

Tessa takes one medication for both conditions but discovered that the generic of the medication did not help to control her symptoms. She said, “I found myself getting irritable and all that stuff again and I can’t have short patience in the classroom!” Tessa added, “The least little thing would set me off and I said I can’t do this, I can’t be in the classroom and not be medicated!” After she started taking the brand of the medication, her symptoms became under control and she does not have panic attacks.

Tessa believes the origin of her mental disorders may be a combination of biological and socially constructed events. Tessa was the oldest of four children when her father was killed in a tragic accident. Life became more difficult after that and her mother suffered from depression after the accident. Tessa said all of the siblings have some type of mental health issues.

Tessa stated that she tried to wean off the medication one time in the summer under the care of her doctor, but she couldn’t do it. Now she knows she needs it and is afraid to stop taking the medication. Tessa said that if she misses a dose, she can tell. Tessa stated that her husband is supportive and he told her, “I’d rather you feel good and be yourself.” She added, “If I’m not on my meds, nobody in the house is happy!” (Tessa, personal communication, July 22, 2015).

Wilma

Wilma is 55 years old and a Hispanic female. She has been teaching for nine years at the high school level and has her Master’s Degree. Wilma struggles with undiagnosed “Insomnia, but it can also be triggered by my thyroid issue.” Wilma was diagnosed with ADHD about seven

years previously when she took one of her sons to the doctor to be evaluated for ADHD. The doctor told her that she noticed that Wilma moved a lot and could not “sit still,” so she decided to test Wilma too. The doctor told her that “90% of the time it comes from a parent.” Wilma did test as having ADHD, however, the doctor told her she had “managed so far” and she did not need to do anything for the ADHD, including no need to take any medication for the disorder. Up until the time of this diagnosis, Wilma did not know she had ADHD. Wilma described her symptoms as being “hyperactive,” having some focusing problems, and “easily distracted by little noises in the background.” She stated that she gets distracted but she “can manage to focus but it takes me a little work to bring it back.”

Wilma believes the origin of her ADHD is both biological and socially constructed. She said, “When I think back to my family, our family dynamics, half of us were just like *jumping* [emphasis added], including my mother and grandmother, they were always like a bunch of little ants.” Wilma added, “We just thought it was cultural!” Looking back on it now, Wilma said her brothers were very active and “always in trouble.” She confessed, “I always thought ‘I’m scatter-brained’, but I never thought it was because I had a condition.” Wilma recalled being forgetful as a kid and said, “I remember losing my lunch boxes, my umbrellas, and my thermos, and I used to go through those in a year like there was no tomorrow.” After losing a few lunch boxes she decided to “get a brown bag and then I’d forget my lunch somewhere.” Eventually Wilma said she learned to be “super organized” and added, “I would put my bag at the front door and make sure I got ready the night before.” She walked to school so if anything was forgotten, there was no going back (Wilma, personal interview, June 6, 2015).

Results

Theme Development

Morse (2008) stated that qualitative researchers tend to confuse categories and themes. Themes are the meaning, or essence, of the data whereas categories are a list of similar data that defines the characteristics of that data. Morse (2008) suggested that the researcher read each paragraph of the interview and ask, “What is this about?” Connelly and Peltzer (2016) stated that categories are used to answer the research questions. Themes explore the relationships between the categories to answer what the data is about, how the data is perceived, explained, and experienced by the participants.

In this study, there are two main categories: (a) challenges from having a diagnosed mental disorder, and (b) advantages of having a diagnosed mental disorder. Under challenges are six sub-categories including administrator issues, classroom/student issues, relationship issues, personal issues, emotional issues, and family issues. Each sub-category included examples of the issues (coded as text segments) as related from the experiences of the classroom teachers with their diagnosed mental disorders. There are four themes that stand out regarding the experiences of classroom teachers who have diagnosed mental disorders. Three of the four themes came from the challenges category. The fourth theme is a compilation from the advantages of having a diagnosed mental disorder as described by participant’s shared strengths and positive experiences from their diagnosed mental disorders.

The overall theme is that “Teaching is very stressful!” The main reason for this stress is teaching has many demands. The second theme is that “Medication is the key to ‘normalcy.’” The participants who are medicated would never go off their medication as this would result in negative, unacceptable behaviors that could jeopardize their career. The third theme is “Not

everyone can be trusted.” This theme resonated throughout the interviews. The final theme is that “Having mental disorders is not all bad.” There are some strengths and positive viewpoints that teachers expressed regarding having diagnosed mental disorders in the teaching profession.

Teaching is very stressful!

Teachers had several examples for reasons why they get stressed out in the school environment. These include issues with colleagues and administrators, teacher observations and evaluations, being called into a superior’s office, and having too many tasks and demands in the work environment. Teachers described the many demands that are required of them which produces stress. These demands include having to teach to the wide range of abilities of the children, dealing with difficult children and behavior issues, a lack of motivation in students, a lot of testing, and the pressure of meeting curriculum deadlines. Added to these demands are personal issues, such as the lack of time management and organization skills, being too impulsive, and having too many tasks going at one time.

Alexa stated that being evaluated “hasn’t helped me one bit.” She added, “All it has done is make me a more stressed out teacher.” She elaborated by saying she doesn’t feel like she is “treated like a professional” and “I don’t feel like I can make my own decisions.” She continued, “It would make my life less stressful if I didn’t feel like I was under constant scrutiny.” Alexa also feels stressed “when a lots going on” and during teacher planning days teachers do not get much time to set-up their rooms. She said, “We have meetings” and then the teachers get on a bus to “take a drive through the neighborhoods to see where our kids live.” She added, “We’re from this town, we know where our kids live.” Alexa said that meetings are difficult as the administrator always tells the teachers to get their children’s test scores up. She

said, “I’m going to do my best. I’ve come out of there angry, stressed, and pressured.” Alexa has experienced flare-ups of her Crohn’s Disease when she is working. Alexa summarized how she felt, “Some of us have mental disorders because of the school system, because of the stress of being a teacher.”

Anne believes that stress is inherent in the teaching profession. She stated:

Our profession has come to the point where there are too many things to do, and because I have a high need to be doing it right, I suffer, the stress of knowing that it’s an unreachable goal now for me.

She explained, “I can’t, no matter how many balls I put in the air, it’s never going to be enough.”

Anne would like to transfer out of elementary school and said:

There are so many different subject areas, and now we have to differentiate and within each subject there are three or four different levels of what you’re doing, plus the response to intervention for the kids who are lagging, plus enriching the gifted, and so elementary really doesn’t fit with my brain function.

Anne elaborated, “I want to transfer out because it actually creates more stress and it’s become an endless job, I can never accomplish it and that triggers my anxiety, so it’s really not the best fit for me psychologically or emotionally.”

Anne struggles with meeting all of the needs of her students. She stressed, “It tortures me to have to look at certain kids and say there’s probably something else I could or should be doing for you but I can’t add it to the list of the stuff I’m already doing.” Anne explained, “I don’t like being in this position where I have to make choices like that, because these are people’s lives.”

Anne finds teacher evaluations stressful and had to speak with the administrators about not scheduling planned visits. They compromised and said, “Okay, let’s do a planned one and then let’s do a surprise one.” Anne stated, “I did obsess over the planned one. I totally tortured myself over that one...I just over-planned and over-planned and worried and worried and worried.” Anne dislikes faculty meetings as “my medication is gone and so I over-participate.” As a coping mechanism she sat with her team, hoping they would stop her, but she found that they “enjoyed the show.”

Jackie stated she was getting panic attacks from “any type of stress from school.” The biggest reason for stress is confrontation. She has experienced parents not believing their child could misbehave at school and Jackie said, “Before I explain and get it across about the kid’s behavior, they’re [parent] freaking out on me, they’re freaking out on me, so I freak out entirely.” Jackie believes that teaching is “probably the most stressful job...we’re the most stressful because we have to deal with everyone from all different levels in the classroom.”

Laura believes that her disorders cause her to get “down on myself” and to get “stressed out so easy.” She believes that teaching is “an impossible job to do effectively.” Laura stated, “For someone with a generalized anxiety disorder, teaching is probably the worst profession I could have chosen.” She added, “People don’t realize how stressful teaching is.” Laura gets stressed out when her perception of the student work to be completed “doesn’t match the students’ final product, even if the final product is correct.” Laura explained that so many students come to school with so many issues beyond their control and beyond the teacher’s control. She said she needs to connect with them and manage their problems, and “somehow getting them to perform.” She stressed, “My job depends on their test score.”

Lucy is teaching gifted children and stated that the gifted children are “the ones who want to learn and they’re a lot like me.” Prior to teaching this more homogenous group she was teaching in a regular education classroom and Lucy said, “I was at that point where I was like I can’t do this anymore.” The many differences in the students’ abilities was beginning to cause stress for Lucy.

Patty finds that her anxiety peaks prior to school because of the unknown. She will have the “beginning of school nightmares.” With her obsessive and compulsive symptoms, Patty finds change really difficult. She stated, “If I can prepare myself, I’m okay.” Patty would stress with getting a new student if she didn’t know about them ahead of time. She elaborated, “It throws me for the rest of the whole day.” Patty said she gets stressed if she’s called to the principal’s office even though it is not for anything negative.

Susie stated “that her weaknesses from my mental disorder are magnified like, by so much because of the stress that I feel.” She added, “I always feels like I’m hanging on by a thread. Like with the principal, I feel like I would be so less stressed without her.” Susie stated that her principal was aware of her anxiety because of a doctor’s note stating Susie was absent due to GAD [Generalized Anxiety Disorder]. She continued, “Anytime that I’m absent, it upsets me and makes me very worried, because like this year like my absences, any time I’m absent I feel panicky and I feel like it's being held against me.” Susie said her mental disorder symptoms are aggravated when “I’m under the gun from the principal.” Susie also becomes stressed when administrators want to observe her teaching. Susie was due for an observation and she said, “That morning I woke up and I had the biggest migraine...by the time I got to school it was coming through my eye, I was like nauseated.” The administrator told Susie she could not get to

the scheduled observation and Susie said the migraine went away. Susie said, “I fear every day that I’ve done something wrong, and that I’m going to get an email that says you need to come see me.”

Tessa’s husband is a coach and certain times of the year he spends less time at home. Tessa said, “Its extra stress then and I know I can’t miss a dose of medicine.” She added, “I have to make sure that things are organized and in order...so it will not get me to that point of being flustered or where I can’t deal with it.”

Wilma said that in those days and weeks where there is a lot going on like testing and meetings, and “the students are not working as hard as they should,” she stated, “I feel edgy.”

Wilma said that sometimes:

The ADHD kicks in with your lack of sleep and your brain is in a fog and those are the weeks that I cannot wait until Friday so I can regroup, and if I have papers ungraded and it comes to staying organized, because when I’m like that I’m overwhelmed and literally like close to tears midweek.

Near the end of the school year, Wilma feels like “I am ready for this to be over you know, you do get burned out, and you’re ready for a break.”

Medication is the key to “normalcy”.

One recurring theme is that medication is overwhelmingly necessary to maintain as much professionalism as possible. In the biographies, teachers explained that they would not go off their medication because they had previously seen undesirable personality traits that were not positive or acceptable to themselves or others. Many participants admitted that they would struggle with emotions and organizational problems if they were not medicated. Examples of

adverse emotions and behaviors were low self-esteem, lack of patience, frustrations, anger, being abrasive, crying, shouting, not sleeping, and ruminations. Many teachers admitted to these same problems even when medicated, but to a lesser degree because they had better self-control.

Alexa stated, “I need to go to the doctor and get some meds because I’m going to kill somebody and lose my job!” She had tried to go off her medication and Alexa stated she went into the “fight or flight mode” and wanted to run away “and disappear on an island.” She added that when she went off her medication it was “the lowest I’ve ever been.” Alexa stated her doctor did not want to medicate her for the ADHD as she had already “developed strategies to cope with it,” although Alexa disagreed with that assessment and had told the doctor she needed ADHD medication to “help control my mouth so I think before I blurt out!” Alexa acknowledged that having diagnosed mental disorders is like having diabetes as both require medication to survive. Alexa stated that she would have to take a Xanax for anxiety after grade level curriculum meetings. She said the teachers got tired of hearing “you’re not doing this well enough and you need to be doing this,” so the Xanax helped with the stress.

Anne stated that without medication she “would be very dysfunctional” and would cry, not complete projects, be irritable, have more migraines, and “would miss more work and have very, very poor interpersonal relationships.” Before Anne was diagnosed with mental disorders, she blamed difficulties in life on her family environment and trauma she had experienced. Anne used to believe that she was “broken” and wished to “be normal.” After her diagnoses, Anne said, “I had to look in the mirror and say, ‘Haha, guess what? It is you too!’” Anne knows that her medication creates a harmonious balance in her work life. She explained:

I have to balance not just with the children in the classroom meeting their needs, but you know in modern teaching you *have* [emphasis added] to collaborate and if you're not a successful collaborator, you are not doing your job.

Interestingly, Anne admitted this, "Before I got diagnosed with ADHD, I used to have fender benders all the time, all the time and car accidents and now that I'm medicated, that does not happen to me."

Jackie said she lowered her medication when she went on summer break, but suspected that when school started she "would clam-up or kind-of panic" without her full dose of anti-depressant medication. When Jackie had an issue with her administrator, she had to call her doctor to get a prescription for the anxiety she was experiencing. Laura knows that medication keeps her from being "raged" or very angry. She stated, "I'd be a bitch" and "it wouldn't be pleasant for anybody." At one point in Laura's career she had a very difficult student and she added, "I had to take Xanax daily," which helped her to remember that she "was the adult." Laura said, "I was never on any kind of anxiety medication until I became a teacher."

Patty needs her medication or her emotions "would be like a rollercoaster" and she would be "very irritable, very jumpy." She stated, "I'm not one of those people that doesn't want to take medication, the more you give me the better I am." Susie stated that if she were to forget to refill her medications, "I'm probably not in school the next day." She told of instances where she had not seen her doctor in a while, so "he couldn't prescribe my medicine." Susie said, "I guess my mental disorder has led to my not being professional, according to her [principal] because I've missed days because of my mental disorder that led me not to have sick days."

Tessa said she and the doctor tried to wean her off her medication, but she said, “I couldn’t do it.” Tessa stated that if she were to “miss a dose,” she can feel her mental disorder symptoms coming back. Tessa said that before medication “the least little thing would set me off” and she told herself, “I can’t do this, I can’t be in the classroom and not be medicated!” Tessa also mentioned that without medication “I would *not* [emphasis] have the patience to deal with teenagers.”

Participants understand that medication is not an option; that it is necessary for a healthy attitude, disposition, and happy state. Two participants who cannot take the stimulant medication for ADHD have expressed the need to be extra vigilant along with having to be aware of their behaviors in order to be appropriate and professional in the school environment. Lucy had to go off her ADHD medication because she was diagnosed with a heart disorder. She said she sees negative behaviors returning, “I’m blurting out whatever, interrupting people’s conversations to say something that has nothing to do with what they are talking about.” Lucy added, “There’s many times I just have to cover my mouth.” Lucy said she struggles with “staying focused, getting things done” and “mouth overload, saying things I didn’t intend to say!”

Wilma has never taken medication for her ADHD as her doctor had told her, “You don’t need to do anything, you’ve managed so far no problem.” However, Wilma admits to having problems with organization and time management. Wilma said, “I need to stay focused” which she learned after her diagnosis.

Not everyone can be trusted.

The participants expressed a general distrust of administrators, other staff members, and parents. Teachers described having to be careful about what they said and to whom for fear their comments would be misconstrued or told to others. Some teachers saw unethical practices by colleagues regarding student's abilities, such as not completing data or doing interventions to avoid the extra work and paperwork so students do not get the extra accommodations they may need.

Alexa had a personality conflict with a previous superintendent and had several meetings with him. She stated that she "had caught him so many times in lies that I didn't trust him and didn't have respect for him." Before one meeting, she thought, "he would twist your words and say other things" so she told the superintendent, "I'm not talking to you until my husband gets here!" Alexa described her current administrator as "being very controlling" and "has run off some very good teachers." Alexa was talking to a parent about opting out of testing when another teacher came in on the conversation in disagreement. Alexa said, "She went and tattled on me [to the administrator] and I got in trouble for promoting opting out." In another incident, Alexa voiced her frustrations about a testing program her administrator was purchasing. She voiced her objections to a group of teachers and said, "I knew the minute it came out of my mouth that I would be tattled on to the principal, and sure enough the next day there I sat in her office!"

Anne believes that people "either love me or you hate me" in regards to her interpersonal relationships with colleagues, which she finds difficult at times and said "people tolerate me" and "sometimes I intimidate them." She also believes people think "she's really being a bitch"

when it's really anxiety creeping in and said, "I think other people who are different from me mostly focus on my weaknesses." Anne stated that she is careful about sharing too much about her life as people like to gossip and "there's people I don't trust to keep my business secret."

Anne found out a colleague she trusted was lying about the abilities of a student, and took that student out of SST (Student Support Team). Anne was upset and said, "Like you dismissed that kid from SST who can't read, for your own needs. I just can't get past it." Anne elaborated, "Then what happens is maybe it's just one person in the grade level and then people realize the one person is doing it and getting away with it and then it becomes the whole grade level." Anne overheard another colleague say, "Oh I just faked that, don't worry about it." Anne said, "I just can't get over it. I still can't get over it."

Anne found it difficult to trust her principal. She would discuss her mental disorders with her administrator in order for the administrator to understand what Anne was feeling and thinking. Anne stated that her administrator "was inconsistent" as she would understand what Anne was saying one day, but then she would "be angry" with Anne at other times. This lack of support forced Anne to stop discussing her mental disorders and the symptoms with the administrator.

Jackie feels that her administrator had been dishonest with her on several occasions and as if talking with her administrator, she asked, "What satisfaction do you get from this?" Jackie said, "I've learned you cannot trust many people where I'm at" and "I don't have friends I can rely on there." Jackie stated she is honest with her principal, but that her principal does not believe her. Jackie also discussed seeing her colleagues "fudging numbers" for student's records

and said to her colleagues, “That’s not a true representation of the kid, so how are you going to be able to give him the correct diagnosis?”

Laura has seen several special education teachers “warehouse children and ‘tweak’ their data to show ‘improvements’ on specific goals, but the improvement in reality doesn’t even exist.” With this distrust of the regular school system and its inherent workings in regards to special education students, she chose to send her child to a private school.

Lucy finds that she is honest with people and “basically it gets misconstrued and it always ends up being what you didn’t say.” She does not trust a lot of people to say things to them so she said, “I just quit talking to people.” She added, “I just learned that if it doesn’t need to be repeated I don’t tell anybody.”

Susie stated, “I am very lonely at work. I mean even with my two friends there, there’s things I don’t tell them, because I can’t trust them.” She elaborated, “I feel like if I do say too much, then it gets turned around and then somebody else is saying something...I just feel like I am by myself. And I don’t have a support system at school.” Susie was told by a friend, “It’s like being stuck in hell. She said if you can get out, you need to get out, it does your mind that good.” Susie continued, “She [principal] pretends like she’s not listening and she’s really what’s stirring it up. She creates the environment.” Susie asks herself, “Am I being paranoid? Or, is this really happening? I just totally feel paranoid all the time, all the time.”

Tessa said her administrator ran the school like a business and described him as “hands off.” She said, “I don’t think he’s a people person; he hasn’t formed relationships with kids or staff and was not friendly.” She did not want him to find out about her depression and said, “I would never want him to know because I don’t want him to have anything that he could possibly

use against me, I guess because I don't trust him.”

Having mental disorders is not all bad.

Classroom teachers discussed how having diagnosed mental disorders is a strength and how their experiences with the disorders can be advantageous. Teachers stated that because of their own mental disorders, they were better able to identify symptoms of mental disorders in their students, which assisted them in being more understanding and compassionate. They also felt more knowledgeable and competent to discuss the child's symptoms with parents. Of interest, five teachers had behavior or academic problems as children and felt those experiences helped them in teaching their students strategies for learning and coping strategies for better conduct.

Alexa stated that her strength was in dealing “with the awkward children, like the ones that don't fit in or the ADHD bouncing-off-the wall kids.” She added, “If you have ADHD you can kind-of understand the issue.” Alexa's son has ADHD so she could have that conversation with parents whose children were exhibiting the ADHD symptoms at school. She said this “makes it easier to approach the parent and say I know what you're going through, I know what you're dealing with.” Alexa admitted that “I've had kids that have anxiety disorders,” and if she knew the parents really well, she could tell them about her anxiety symptoms.

Anne believes that having ADHD helps her to do more than a few tasks at a time “and do them fairly well.” However, she admitted there is a fine line to how many tasks can be achieved before it becomes too stressful. Anne also sees the ADHD as being a positive factor to having “great creativity.” Anne believes her OCD, and her awareness of the OCD to keep it in check, helps to keep her students safe, especially on the playground when there are visitors there.

Anne's disorders lends itself to "accepting of differences" in children. She said that teachers who are not aware of these symptoms in kids "just see the child as being mean, or the child is lazy, the child is being disruptive." Anne elaborated, "You don't see it as the child is struggling to function to expectations, that it's not necessarily a choice, and it may be situational, it might be social-emotional, it might be a brain difference...." Anne stated that "because I have those things, I have more choices of how to work with children."

Jackie stated that she believes her anxiety puts the kids "first" and she makes sure she is "doing everything that I can to get a true representation of the behavior and academics." Jackie said "my morals kick in" and she will do the right thing. Laura believes her disorders help her to "have your little ducks in a row" and she said, "I'm always prepared for class." She added she is "very ordered and organized" and that teaches the students to be "real structured" and organized. Laura believes she works "ten times harder" to get the special education kids "where they need to be."

Lucy sees her ADHD as being conducive to being "very outgoing" and she will "even talk to strangers." She likes to initiate conversations and have fun with people. She added, "That helps in the classroom too because I can be silly with the kids." Lucy sees her high activity as a positive trait. She believes that her ADHD helps to "spontaneously teach" and "we don't have to have that structure," and she added, "I teach better that way." Lucy feels that by having ADHD she is able to explain to parents what it is and that "it's not a bad thing." She also said that administrators tend to go to the ADHD teachers "when they want something done."

Patty finds that her "extremely obsessive-compulsive" characteristics help with "my classroom management and my discipline." She also believes that understanding her disorders

and her daughter's ADHD can assist in teaching parents about their child's symptoms. Patty stated she tells parents, "As a mom this is what I am seeing in your child...I know because I've dealt with this."

Wilma finds her ADHD a benefit in her "ability to relate to the students" and she will tell them "I'm also a little ADHD so I do understand that you can't sit still." She stated that she is in-tune to her students and said, "I see they are just too antsy so I say 'you need a timeout...go to the bathroom, go drink water.'"

Research Question Responses

This section addresses the research questions. All of the teachers' comments are presented in Table format and several quotes from teachers are presented in narrative format to illustrate the teachers' voices with the phenomena of having diagnosed mental disorders in the school environment.

Central question results.

There are five preliminary questions and the responses are represented in Tables 3-5. The first two preliminary questions are: (a) What are your reasons for becoming a teacher and (b) What is your favorite part of being a teacher? The teachers' responses to these two questions are in Table 3. These answers are not part of the four themes that emerged.

Table 3

Answers to the Questions Regarding Reasons for Becoming a Classroom Teacher and Favorite Part of Teaching

Comments	Participant(s)
Reasons for becoming a teacher	
Always wanted to be a teacher	Alexa, Laura, Patty, Susie, Tessa
Teaching is a second career	Anne, Jackie, Tessa, Wilma

Table 3 (continued)

Comments	Participant(s)
Reasons for becoming a teacher	
Changed career path in college from Physician	Lucy
Thought she would be good at it	Laura
Struggled as a student herself and could help kids	Susie
Favorite part of being a teacher	
Enjoy seeing their students learn	Anne, Jackie, Laura, Susie, Wilma
Building relationships with students	Alexa, Patty, Tessa
Having summers off/being with own kids	Jackie, Laura
Having previous students say how much you taught them and they remember you years later	Patty, Tessa
Gets personal needs met	Anne, Patty
Teaching gifted students	Lucy
Teaching is kinesthetic, can move around	Wilma

Alexa

Alexa stated that she decided in second grade that teaching would be her profession. She said, “I just adored my second grade teacher and I wanted to be just like her!” Alexa added, “I just never even thought about anything else.” She stated the best part of teaching was “getting to know my children, my kids” and building relationships with her students. Alexa admitted, “If you ask me if I like kids outside of my class, I’d say no, not really. But when they are *mine* [emphasis added] in my classroom, it is so different.” Alexa continued, “I love getting to know their individual stories, their little quirks” (Alexa, personal communication, July 19, 2015).

Anne

For Anne, teaching is a second career. Anne had not considered teaching because as a child she “didn’t enjoy school” and her mother saw the underachievement “as lazy and as a choice.” She stated that report card comments included “too gregarious, I was focused on the

wrong things, and never meeting expectations.” Anne added, “But I would have never thought I’d be a teacher because I didn’t even like or respect most of my teachers, I thought some of them were fools.” Anne had gone to graduate school to study to be a college professor but decided that having to “publish or perish” would cause her too much stress, so she left the program. After a few years of marriage and then divorce, her mother persuaded her to return to graduate school to “finish something because you need to be employable,” so Anne chose education.

Anne stated the best part of teaching is when the students learn. Anne enjoys “taking them from not knowing and understanding something to knowing and understanding something” and added, “I really get off on that. It’s like wow, look what I did. It gives me a sense of accomplishment.” Anne admitted that students learning is “for their own good, but I am getting my needs met.” Anne explained, “As I’ve come to look at it, it is the only career where I can, when I get bored because I lose interest in things, that I can change my daily work as needed.” She elaborated that she “can come up with a new plan...because I need new, I need novelty, that’s part of who I am” (Anne, personal communication, June 11, 2015).

Jackie

For Jackie, teaching is a second career. She considered changing to the education field while in college but the change would have delayed her graduation by a couple of years. Jackie was in the business field for a few years and was laid-off. She figured that was the time to make the change so she went into education. Jackie stated, “I’m thankful I did it, I can be at home with my kids in the summertime and not put them in daycare and all that stuff.”

Jackie's favorite part of teaching is when the students learn. Jackie likes "seeing it click with the kids and actually knowing that if I bust my tail, it's going to click. And seeing them realize that all I have to do is try a little bit and then I got it." She also enjoys having her children in her school and being with them in the summer (Jackie, personal communication, June 12, 2015).

Laura

Laura knew she wanted to be a teacher. She stated, "I really wanted to help kids...I'm pretty organized and I'm pretty structured so I thought I could do some good. And honestly, I wanted to have summers off too!" When asked if she has considered going back to school to get her Master's Degree, Laura said, "Nope...I just don't have the energy, my husband is gone all the time, I work all the time, and taking care of my son is a full-time job." Laura answered that her favorite part of teaching is, "Having summers off! I know that's not a very good correct reason, but that's what it is." Laura said she enjoys "watching the progress that all students make throughout the academic school year" (Laura, personal communication, April 8, 2015).

Laura reflected after the initial interview about being a teacher and wrote, "For someone with a generalized anxiety disorder, teaching is probably the worst profession I could have chosen. It's made me angry, bitter, and disgusted, and I feel the need to up my medication" (Laura, personal communication, February 20, 2016).

Lucy

Lucy had gone to college in pre-med but decided halfway through that the medical career path was not what she wanted, so she changed to education. She stated, "I hated hearing people complain, everybody's supposed to be healthy and happy or goofy." Lucy gets pleasure from

being around her gifted students. When Lucy was in the regular classroom, however, she says that she was at the point of saying “I can’t do this anymore.” She added about her gifted students, “They are the ones that want to learn and they’re a lot like me, so we get along really well and I like the hours...you know what you teach them they are going to get it” (Lucy, personal communication, March 12, 2015).

Patty

Patty’s mother was a teacher and Patty added, “It was ingrained in my blood!” When she was a child she remembers “playing teacher” and “going to school with mom.” Patty stated, “There really was nothing else I could think of myself doing.” Patty spoke about the best part of teaching as getting to know the kids and building relationships with her students. She stated she enjoys, “Having my older kids [previous students] come back and seeing them [years later].” Patty had a parent tell her that her son, who Patty had as a student nine years previously, said, “You’re the one person he remembers.” Patty was flattered and said, “So that to me makes it worth it.” She wants her previous students to “have a lasting memory of me. I want that.” Patty added, “I want to be that person that they say ‘you know what, she was a hard-ass but I loved her because *she* [emphasis added] loved me no matter what’...that to me is the whole reason” (Patty, personal communication, July 20, 2015).

Susie

Susie stated that she had always wanted to be a teacher as she was a struggling student and “had problems reading and I was behind.” When Susie was in third grade, “my mom, she had her first breakdown and that’s when my grades went down.” Susie stated that when she was in sixth grade, a teacher became her mentor and worked with her all the time, even through

college. Susie said this mentor teacher “made me want to be a teacher.” Susie explained, “She is that person that believed in me, and she didn’t care what it took to get me there.” Susie likes when the students learn. Susie stated she likes “seeing their growth every year and seeing them change and become independent” (Susie, personal communication, March 7, 2015).

Tessa

For Tessa, teaching is a second career. Tessa was laid off in her first career when the company she worked for had downsized. She recalled her childhood:

I used to have my siblings on the porch in the back of my grandmother’s house playing school and using the TV Guide as worksheets. I think it’s always been in me, but then I didn’t want to get into teaching because there’s no money!

Tessa stated the best part of teaching is getting to know the kids and building relationships with her students. Tessa shared that she is “momma away from home.” The students tend to seek her out in the mornings, between class changes, and after school. Tessa said, “It’s like the kids are attracted to me, during class changes my room is full of kids! It’s the same thing all the time.” She emphasized, “It’s constant and those relationships are priceless.” She recalls a time when a former student wrote her on Mother’s Day, “He sent me the sweetest little text and I almost cried, and I mean he has a mom and a step-mom and he still appreciates what I did for him” (Tessa, personal communication, July 22, 2015).

Wilma

For Wilma, teaching is a second career. Wilma had several jobs before deciding to pursue the education field. She stated:

I've always been big on volunteerism and the satisfaction that brings and also in conjunction with the fact that I can't sit still, this job kind of suits me because I don't have to be behind a desk all the time just minding my business, it allows me to move around, there's a lot of kinesthetic and I'm definitely kinesthetic, it allows me to get rid of that pent-up energy, and aside from that, I do like teaching.

Wilma enjoys when the students learn. Wilma stated, "I think we all live for that 'ah ha moment' when your students finally get it and they come and tell me, 'Oh my gosh, it finally makes sense', so I like that" (Wilma, personal communication, June 6, 2015).

Central question results.

The next three preliminary questions include: (a) What challenges do you have and how do you cope with them, (b) What are your strengths from having a diagnosed mental disorder in performing daily functions in the school environment, and (c) What are your weaknesses from having a diagnosed mental disorder in performing daily functions in the school environment? There was an overlap in responses to the challenges and weakness questions so the responses were combined. The challenges and weaknesses of teachers with diagnosed mental disorders are paramount in the emergence of the theme "Teaching is very stressful." Other themes that emerged from these responses are "Medication is the key to 'normalcy'" and "Not everyone can be trusted." Table 4 lists the answers to challenges and weaknesses along with the coping strategies as stated by the teachers, followed by quotes in the narrative section highlighting the teachers' difficult experiences in the school environment.

Table 4

Answers to the Questions Regarding Challenges, Weaknesses, and Coping Strategies

Comments	Participant(s)
Challenges and weaknesses	
Issues with colleagues and/or parents	Alexa, Anne, Jackie, Laura, Lucy, Patty, Susie
Bad behavior or difficult child/personality conflict	Alexa, Jackie, Laura, Lucy, Susie, Wilma
Questions effectiveness to meet all students' needs	Anne, Jackie, Laura, Susie, Tessa, Wilma
Stress/dislike teacher evaluations and observations	Alexa, Anne, Jackie, Laura, Susie, Wilma
Ruminating about choices made, actions, intrusive thoughts, self-doubt of abilities	Alexa, Anne, Jackie, Susie, Wilma
Lacks organization skills and/or time management	Alexa, Anne, Lucy, Tessa, Wilma
Issues with and/or distrust of administrators	Alexa, Anne, Jackie, Susie, Tessa
Too impulsive/not in control of what one says	Alexa, Lucy, Susie
Worries about how others perceive her	Anne, Lucy, Susie
Being too honest with others	Anne, Jackie, Lucy
Frustration with faculty meetings	Alexa, Anne, Wilma
Getting behind on paperwork/grading/lesson plans	Lucy, Wilma
Difficult to stay focused/high activity level	Lucy, Wilma
Lack of administration help with behavior issues	Laura, Lucy
People-pleaser, dislikes confrontation	Jackie, Patty
Having too many tasks to do in a short time/difficulty completing or initiating tasks	Anne, Lucy
Stress when students do not complete work to teacher's expectations	Laura, Wilma
Administrators know about mental disorders, negative perception	Anne, Susie
High/Excessive absences	Anne, Susie
Frustration with low achieving students	Susie
Not having connections with transient families	Tessa
Getting kids motivated with subject area	Tessa
Sacrificed principles	Jackie
Difficulty controlling frustrations/anger	Laura
Having to/thoughts about making changes	Patty
Judges other people	Anne

Table 4 (continued)

Comments	Participant(s)
Coping strategies	
Self-talk	Anne, Laura, Lucy
Gets advice from administrator/colleagues	Patty, Wilma
Thinks about her own children	Anne
Forces self to be real structured	Alexa
Frequent exercising	Laura
Chews gum, hand over mouth to resist blurting out	Lucy
Use of technology as reminders	Anne
Got a refill of medication	Jackie
Went to the source to attempt to resolve issue	Jackie
Keeps quiet and stays “under the radar”	Susie
Lots of family connections, good communication	Tessa
Sets goals to have grading completed	Wilma

Note. Challenges and weaknesses combined (instead of separate) due to overlapping answers.

Alexa

Alexa described her main weakness as being able to control what she says. She admitted, “I have no filter” and “I have been in trouble *so* [emphasis added] many times, even all the way up to the superintendent.” Alexa even told her doctor that she wanted to go on ADHD medication and said to the doctor, “Maybe it will help control my mouth so I think before I blurt out and he’s like ‘I don’t think so!’” Alexa gets upset during faculty meetings and stated, “No matter how many times you tell me what my test scores have to be, that is not going to change as I’m doing my best, no matter what! I’ve come out of there angry, stressed, and pressured.” Many times she blurts out things and knows she will be in the principal’s office the next day so she has time to ruminate overnight about the upcoming conversation.

Alexa stated she has a few challenges in teaching and the biggest one is “keeping myself organized.” In coping with organization, Alexa confessed that she is “absolutely forced to be

real structured.” Another challenge is dealing with difficult students. She said it is “rare,” but “sometimes you’ll have that kid that just drives you insane...we just have a personality conflict.” Alexa has problems with the administrators and described her principal as “very controlling and has run off some very good teachers.” She continued, “If you just leave me alone, I promise I’ll get the job done. Just leave me alone. Let me do it my way.” Having this type of principal is difficult for Alexa. Alexa revealed that she does not “like change” and does not “want to go to a new school.” She expounded on this by saying, “I’m thinking I’m like survivor, I will outwit, outsmart, outlast. I feel like if I leave, she wins!”

Alexa stated that the teacher evaluation system puts “more pressure on me” and causes her to be “a more stressed teacher” and not “a better teacher.” She added:

If you are a good teacher, you are going to do your best no matter what kind of kids you have, no matter what kind of principal you have; you’re going to do your best because that’s what you do! (Alexa, personal communication, July 19, 2015)

Anne

For Anne, many of her strengths become weaknesses. Anne stated that she struggles with seeing the positive aspects of her teaching because she will then focus on how *she thinks* [emphasis added] others perceive her, which is a weakness. She can do many tasks at one time, until suddenly there are too many tasks going on and the stress can become overwhelming, which then triggers the anxiety. Anne said that “task initiation and task completion” are her weaknesses. If she doesn’t like what she needs to do, she has “trouble getting started.” Anne knows that every job requires “hoops to jump through,” but said, “I just like to pick the hoops I jump through.” Anne stated:

I think our profession has come to the point where there are too many things to do and because I have a high need to be doing it right, I suffer, the stress of knowing that it's an unreachable goal now for me. I can't do it no matter how many balls I put in the air, it's never going to be enough.

Anne stated she is an honest person, but then that will offend someone because "I'm a little too focused on telling it like it is." Anne admitted that her medication wears off at the end of the day so faculty meetings are difficult as she "over-participates." She believes colleagues find this annoying yet they "enjoy the show." She added, "It takes a while for me to realize they are actually enjoying it or triggering it, not even on purpose, I'd like to think people are not cruel."

Anne admitted that one of her biggest challenges is replaying occurrences in her mind over and over again until she understands what had happened. She stated, "With the children I'll replay something with one of the students and I'll be like, now that I take a step back I see that it was really this and I should of, could of done that." Anne added:

I think I take what we're doing so seriously and I guess I feel burdened by it more teaching the younger children which is another reason why I think I would be less stressed going to high school, a lot of teenagers, not all of them, they have adult coping skills.

When she has a bad interaction with someone, Anne acknowledged:

I beat myself up over it and I feel bad about myself over it, or I blame myself or I replay it, which is a little of the OCD, it just spins around and it's the part people don't see but it's playing in my head at the same time I'm doing six other things.

For Anne, differentiating for every child in her classroom is difficult and explained, “It tortures me to have to look at certain kids and say there’s probably something else I could or should be doing for you but I can’t add it to the list of the stuff I’m already doing.” She added, “It’s hard. I don’t like being in this position where I have to make choices like that because these are people’s lives.”

Anne is very perceptive about her mental disorders and she explained that she’s had many years in therapy to analyze her issues. However, being perceptive can be a challenge.

Anne stated:

But that’s also a blessing and the curse though because if you’re that self-aware it also drives the engine of all that self-doubt, those intrusive thoughts that I, every move I make, was that the right thing, what else could I have done...and under stress, it gets worse. And then too much of that anxiety triggers so I have to monitor and I hate to say it, but the fact it impacts other people makes me do better about it, especially when they depend on me.

Anne acknowledged that she is a perfectionist and another challenge is that it “makes me judgmental of others.” She added, “I do judge other people, I’m judging myself a lot, I judge other people, it’s not nice, but I can’t stop it.” Anne also dislikes teacher evaluations and finds the areas she gets lower marks on are the areas she believes she excels in.

Another challenge Anne discussed is inherent in being at the elementary school level and involves time management. She stated, “There are so many transitions and if you’re not on-time you affect other people and so I have a lot of these timers going off, they all have different sounds and I know what they mean.” She keeps her cell phone on her desk and sometimes

when an alarm goes off, “the kids want to jump up and swipe it before me, and if that happens, it might not register.” Anne explained, “I have to physically go and be the person who turns it off and then that triggers the next set of behaviors which is wrap it up, it’s about time to transition.”

Anne utilizes several strategies for coping with the challenges. She uses a lot of “self-talk” when intrusive thoughts occur and finds technology very useful in accomplishing everyday tasks. Besides the alarms for assistance with transitioning in school, Anne uses an app on her cell phone called ‘*Simple*’ that “meets my OCD need because it asks me to pick what symptoms I have and I rate them and it meets my need to feel in control of it.” Anne elaborated, “I think self-awareness is one of the things that helps me with it.” Anne said that she also keeps pictures of her children (when they were in elementary school) in her desk. When she comes up empty-handed in strategies for helping some students and things are not working, Anne stated, “I look at my pictures and I look at that kid and try to plaster my kid’s face on theirs [her student] and say, ‘I’m now their teacher, what do I want her or him to do?’” (Anne, personal communication, June 11, 2015).

Jackie

Jackie stated that her challenge is that she is “a people-pleaser” and added, “I don’t like to tick people off.” Jackie has a difficult time with her administrator and has had a few issues. She continued, “When I had that issue with the administration, I was like what the hell, I’ve never had anything like this happen, no complaints, no nothing, and I kept thinking ‘What am I doing wrong?’” Jackie described “not getting sleep” and “second guessing myself as a teacher” following the incident. Jackie felt she needed to re-address the problem and went directly to the

administrator. She elaborated, “If I’m not doing something right, I’ll solve it. I’ll try to fix it or find out how to fix it.” Jackie stated that during this time she “did call [doctor] and actually got another refill.” Jackie stated that the issue with the administrator never resolved itself.

Jackie had a student who was a teacher’s child. She said the teacher/parent was always complaining when she took conduct cuts from the child. Jackie stated:

She was bitching at me because I took two conduct cuts, one day and the other another day, and I said, “I’m done, and that’s the first year in 13 years that I threw my arms up.” It is not worth it.

Jackie ended up giving the kid an “A” in conduct and sacrificing her principles in a moment of weakness. She shared, “That’s against everything I believe in” (Jackie, personal communication, June 12, 2015).

Laura

Laura stated her biggest challenge is “stress” due to a few difficult students she has had and the administration seems unwilling to assist with them. She elaborated, “A lot of stress as far as classroom behavior, when the kids are acting up and they’re out of control and there’s really no help, there’s really nobody that will back you up.” Laura stated her weakness is her “difficulty controlling my anger,” but added, “Well not really anger. It’s more like frustration. Frustration is a better word because I’m not sitting there screaming at the kids.” Laura said her colleagues do not realize she feels like this and she admitted, “Believe me, inside it’s a storm” (Laura, personal communication, April 8, 2015). Laura later wrote:

As a control freak, I have certain expectations as to how I perceive lessons should go and how they should be completed. If my perception doesn’t match the students’ final

product then I tend to get stressed, even if the final product is correct. (Laura, personal communication, February 12, 2016)

Laura also discussed that teaching is a really difficult job and she struggles with meeting the needs of all of her students. Laura uses self-talk to help with her frustrations. When she had a disruptive special education student, she would have to remind herself that “he’s just a child” and “I was the adult.” Laura frequently exercises as a coping mechanism and said, “I’m taking a self-defense class so I got me a Bob, which is one of those punching guys and I just get out there and just start going to town on him!” (Laura, personal communication, April 8, 2015).

Lucy

Lucy stated her challenges with ADHD include, “staying focus, getting things done, and also not being able to control my activity level. I can’t be still, very hyper, probably mouth overload, saying things I didn’t intend to say.” Lucy admitted, “You could ask a lot of people and they think I’m a bitch.” Lucy’s weakness is her lack of focus and inability to concentrate and clarified, “I try to do way too many things at one time because I want to get it done and go on to something else.” She finds difficulty with time management and getting things done.

Lucy said that “little bitty things annoy the crap out of me,” like someone walking into the classroom and interrupting things. In spite of interruptions that annoy her, Lucy confessed that she does the same thing:

You know how you just kind of barge in because you know if you don’t say it right then you’re going to forget it. And I know that bothers people, it’s not that I think I’m more important it’s just that I know if I don’t say it, it’s gone!

Lucy stated that she will just keep students who misbehave and not send them to the office because “I knew nothing was going to happen.” She also finds colleagues challenging and gets annoyed when they misconstrue something she has said. Parents can be challenging too and one day she had to go “right back at her [parent] like a bulldog” when the parent accused her of something she did not say. Lucy confessed that sometimes she just has “to cover my mouth” and she will “chew gum” so “there’s something in my mouth” so she doesn’t talk. Lucy talks to herself and has to really “think before I speak” and “not just blurt it out.” She asks herself, “Do I really need to say this just because that’s what I’m thinking?” (Lucy, personal communication, March 12, 2015).

Patty

Patty stated her challenges involve “parents.” She added, “I do my best to keep everybody happy.” Patty was going to have a parent the next school year that she had previously had, and she had had an issue as the previous son (student) would lie. She questioned the intent of the administration, “Why would they let her have me, if I’ve already had issues? It’s one of those things, there’s always one person or student that I have to pray about the summer before.” Patty does not have any problems with administrators and said, “I’ve always felt they had my back no matter what.”

Patty said her weakness is “change!” She emphasized that making a change does not include curriculum and teaching. Patty did say that getting a new student in her classroom without prior notice “is very difficult” and “throws me off for the rest of the whole day.” Patty said that if she knew ahead of time, she could “prepare myself,” and then she would be fine. Patty wanted to “redecorate my classroom” before school started but realized that her obsessive-

compulsive behavior of keeping everything the same and in order would prevent her from changing her room. She initially thought “it’s a mess so why not change it” to “no, no, then it will be different” and settled on “I want it all back the right way where it has to go!” Even in Patty’s “own personal world” where she has the power to change things she admitted, “I don’t want to change anything if I don’t have to.” She indicated that she was content with her bachelor’s degree and did not want to pursue another degree. Patty believes she copes with difficult parents by communicating with administrators over problems that occur (Patty, personal communication, July 20, 2015).

Susie

Susie stated her principal has a personality conflict with her, which has resulted in the principal giving unfair, negative evaluations. Susie said her biggest challenge is “not having a boss who likes me.” Susie elaborated:

It’s all these people and they’re all talking about each other, and everybody is talking about everybody, and what they’ve done and who has done what, and she [principal] pretends like she’s not listening and she’s really what’s stirring it up. She creates the environment, it’s easy for people to run in there and they tell her everything.

Susie said that her weakness was that the principal “knows that I have it. And she can use it against me.” She stated she had been absent from work “because I was having panic attacks,” and her doctor’s note stated the reason for the absences was “GAD” [Generalized Anxiety Disorder]. Susie believes the administrators “would not have known it” had the doctor not written it.

Susie told of an incident with the principal and assistant principal where she had a panic attack. She said, “They were both on me. I had to have my inhaler because I couldn’t breathe.” She emphasized, “I think that my weaknesses from my mental disorders are magnified like, by so much because of the stress that I feel because she [principal] doesn’t like me.” Susie worries whenever she is out of school. She stated, “Anytime I’m absent I feel panicky and I feel like its being held against me...it upsets me and makes me very worried.” She continued, “I stress about it all the time.” She also believes colleagues gossip about her all the time.

Susie discussed a time when she was supposed to be evaluated in the classroom. She was so nervous about the evaluation and she stated, “That morning I woke up and I had the biggest migraine...but by the time I got to school it was coming through my eye. I was like nauseated.” When Susie found out the administrator could not do the evaluation that day, she stated, “I was fine,” and the migraine went away.

Another challenge for Susie is difficult children and her impulsivity. She explained, “My mouth- that is a challenge for me. To keep my mouth shut...when some students pop off at me and I want to pop back. And I don’t know if that’s everybody, or it’s me.” Susie confessed that she will antagonize them:

I’ve caught myself in the past where I feel like I’m pushing them, pushing ‘em, just to see. And I’ll be like “don’t do that.” I’m just being honest! I try not to be ugly, just straight up ugly. I worry about the perception of me...from everybody. It always feels like I’m hanging on by a thread.

Another challenge for Susie is teaching the lower academic-achieving students. She added, “Most of the time the children I work with are at the lower end of the spectrum and they

are harder to deal with. I think our socio-economic group lends itself strongly to us having that problem.” Susie copes by “keeping my mouth shut and doing what I’m supposed to be doing, and staying under the radar” (Susie, personal communication, March 7, 2015).

Tessa

Tessa said she does not trust her principal and sometimes this can be a challenge as the principal runs the school like a business and the school culture is not as friendly as it once was. Another weakness for Tessa is time management and she has found herself at school late at night to finish up everything. Tessa explained her dilemma:

My goal is to leave it at school as I don’t want to take away time from my daughter....But when you have 150 papers to grade, 150 lab reports to grade, you can’t do that in an hour, plus grading interactive notebooks. Plus I have kids come in to talk...when the kids are there I can’t get anything done, and I’m not going to tell the kids I have things to do because for some kids it’s the only attention they get from an adult.

Tessa stated that when she is crunched for time she starts to have trouble with her anxiety.

Tessa explained that many students have “this block” about the sciences and that the challenge is to get “the kids to realize that science is not hard” and that “they can do it.” She finds students who dislike the sciences and “have the wall up” generally do not take the extra time and effort to learn it. Tessa noted that another challenge is that some parents are not involved and the student is not motivated. She observed that cell phone numbers seem to “change every month” and email addresses “come back undeliverable.” She continued, “It’s those situations where I have trouble with the kid, he’s not doing what he’s supposed to be doing, he’s not producing, and I can’t get in touch with the parent, or the parent is not

concerned.” Tessa added, “There’s nothing else to do.” Tessa stated that they do have transient students in her school and this can be a challenge in getting parent involvement. She elaborated:

I still have those that come in that I am not familiar with and no way to contact a parent and I don’t have that connection....I have learned that if you don’t pay your rent this month and you don’t pay your rent next month, and then you get evicted the third month and they’ll go live somewhere else.

Tessa utilizes a convenient coping strategy for most of the students who have issues with motivation. She explained:

I was raised in the county I teach in, so I know the parents and I can make that connection. I have a large family and have a lot of cousins come through my class, so I am able to call the parent and they [students] get in line! (Tessa, personal communication, July 22, 2015)

Wilma

Wilma said that “keeping up with the paperwork” has always “been a challenge for me.” She added, “When I was a secretary filing for me was always a pitfall.” As far as teaching, Wilma shared, “I know how important it is for the grades to be posted on time, for the students to get feedback.” She explained, “The job in itself has helped me maybe to stay focused because if you don’t post grades, someone will be yelling and the parents will be complaining, and the kids want to know.” To cope with getting behind, Wilma noted, “I have to have a goal and to hold myself responsible. I tell the students ‘you will have this graded by Tuesday,’ and I know they’re going to complain if I don’t have it done.” She added, “That helps me stay focused and get it done.”

Wilma stated that sometimes she questions her effectiveness with a student who just isn't learning and understanding the Spanish language. She said, "I know it's not my fault but I question myself, what did I miss, what could I have done differently, maybe I wasn't forceful enough, maybe I didn't explain it, I don't know." Wilma would ask her colleagues if there was something she could have done and they would respond that she did "everything possible." She concluded by saying, "I still feel like a little bit of a failure, I'm disappointed in myself...I feel like I'm losing my mojo" (Wilma, personal communication, June 6, 2015).

Wilma admitted her weakness with ADHD is in "keeping up with the grading" of assignments and tests. She has to set deadlines for having things done as her students will say, "You're slacking off!" Wilma said it is the students "that helps me stay focused and get it done...I need to stay focused as I want to stick to the promises." She stated her colleagues tell her, "Don't stay at work so late when you can do it at home." Wilma observed that "I'm not as focused at home...its fatigue and once you get home you're kind of like turned off." She explained:

If I am home and if I have grading to do, I cannot work there which is why I stay at work because at home in the back of my mind I'm like "I could be doing laundry or I could be folding or something", there's a part of me that just wants to get up and do it, and I find it distracting. (Wilma, personal communication, June 6, 2015)

Central question results.

The last preliminary question addressed what strengths the teachers with diagnosed mental disorders have in the school environment. The results from this question emerged as the theme "Having mental disorders is not all bad." There are some strengths and positive

viewpoints that teachers expressed regarding having diagnosed mental disorders in the teaching profession and it is important that a theme reflect these experiences. Table 5 lists the responses teachers had regarding strengths and a narrative follows with the teachers' descriptions of those positive experiences.

Table 5

Answers to the Question Regarding Strengths

Comments	Participant(s)
Strengths	
Identifies, understands, compassionate, and assists the students with mental disorder symptoms	Alexa, Anne, Jackie, Patty, Wilma
Recognizes/accepts/self-aware of own mental disorders	Alexa, Anne, Jackie, Patty, Wilma
Experienced academic/behavior struggles as a kid	Anne, Jackie, Lucy, Susie, Wilma
Can communicate to parents about children who exhibit mental disorder symptoms	Alexa, Anne, Lucy, Patty
The priority is the kids	Anne, Jackie, Lucy, Patty
Being honest with others	Alexa, Anne, Laura, Lucy
Good classroom management/few discipline issues	Laura, Patty, Wilma
Works harder, makes best choices for the students	Anne, Jackie, Laura
Ability to form close relationships with students, role of "mom"	Alexa, Tessa
Can do several tasks at a time/multi-task	Anne, Lucy
High energy, outgoing, is fun with the students	Lucy, Wilma
Teaches character education along with the subject area	Anne, Wilma
Strong need to be professional, follow rules	Anne, Patty
Organized, overly prepared, teaches students to be the same	Laura
Lots of family connections, good communication	Tessa
Desire to mentor and assist other teachers with mental disorders	Anne
Evaluations say good rapport with students	Wilma
Classroom decorated like "home"	Tessa
Wants to be the "stable" factor in students' lives	Patty
Has no strengths	Susie

Alexa

Alexa believes her greatest strength in teaching is being able to “deal with the awkward children, like the ones that don’t fit in or the ADHD bouncing-off-the-wall kids.” Alexa admitted, “I understand where they’re coming from because I was a bouncing-off-the-wall kid, so that is one of the best things so if you have ADHD you can kind-of understand the issue.” Alexa stated that when she has students who are ADHD, it’s “easier to approach the parent and say I know what you’re going through” because of experiencing it with her son. If she knows the parents very well, she has told them about her anxiety and how she can relate to their child’s problems with anxiety (Alexa, personal communication, July 19, 2015).

Anne

Anne is very aware of her mental disorders and believes a strength is her ability to help parents understand the symptoms of mental disorders, especially ADHD. She can also relate to those students in her class. As a child, Anne disliked school and did not succeed to the expectations of her family and teachers. She was even surprised when she decided to change her career to education. Anne described how her childhood experiences and knowledge of ADHD helps her to accept students who have ADHD:

Like if you’re a teacher and you’re not aware of any of these things, you just see the child as being mean, or the child is being lazy, or the child is being disruptive. You don’t see it as the child is struggling to function to expectations and that it’s not necessarily a choice. It may be situational, it might be socio-emotional, it might be a brain difference because I have those things [disorders] so I have more choices on how to work with the children.

Anne knows that her biggest strength is that she is a good teacher as she works very hard to give her students the best education possible and incorporates a character education program into her curriculum. She believes in being very professional and is accepting of her mistakes. Anne quietly mentors other teachers who have challenges with mental disorders.

Anne lists her strengths, but then she will focus on how her strengths become weaknesses. Anne believes that being able to complete several tasks at a time and “do them fairly well” is a strength, but there is a fine line on when several tasks become too many. Anne described herself as being very direct, tactful, and she tries to take the other person’s perspective in mind. She feels a strength is her ability to be honest. She believes that if someone asks her a question, she assumes they want the truth. Anne believes her honesty is then a weakness because it can cause problems with relationships (Anne, personal communication, June 11, 2015).

Jackie

Jackie believes her strength from her diagnosed mental disorder comes from the ability to identify she has the disorder and deals with it. Jackie stated her strength is “Admitting that I’ve got an issue and not trying to hide it, not trying to say ‘oh I’ll be fine, I don’t need medication’. I’ve seen where it’s gotten my mom!” She is able to admit when she is irritable and to apologize, especially to her husband. Jackie will say to her husband, “I know I’m being a bitch, but this is how I got to cope with it, are you okay with it? I’m just admitting that I’m wrong.” Jackie said another strength is “communication and doing what I can to help the kids.” Jackie had problems as a child in reading and is able to help struggling students in both academics and with mental health issues, and she is honest in her appraisal of the students and puts them “first over politics.” She claimed that she does not fudge data as she has seen some colleagues do.

Jackie even approached another teacher, “I’m like dude, that’s not a true representation of the kid, so how are you going to be able to give him the correct diagnosis?” Jackie noted, “I make sure that I’m doing everything that I can to get a true representation of the behavior and academics” (Jackie, personal communication, June 12, 2015).

Laura

Laura’s strength is in her organization skills and having “everything just so” with her “little ducks in a row” before she walks out the door for the day. She added, “I’ve never been in a situation where I am not prepared, I’m always prepared for class.” Laura stated, “I make sure I’m overly prepared, very ordered, and organized.” Laura added, “Because of my anxiety, I have a tendency to over-prepare and over-plan. This leaves the children with very little time to get into some mischief” (Laura, personal communication, February 12, 2016). Laura described a colleague, “She can come in in the morning and nothings done, no copies or anything.” She added, “It would drive me insane. But it doesn’t faze her, I wish I were more like her.”

Lucy

Lucy stated that her strength is in being “very outgoing” and she admitted, “I’ll even talk to strangers!” She finds this helpful in the classroom as she can be “silly with the kids” and laughs with them. Lucy added that her high energy is a strength and said, “Once I get up I’m ready to go. I don’t need coffee or caffeine, when I hit the floor, I am ready to go.” She admitted that, “I don’t think other people take it as strengths.”

Lucy also understands ADHD in her students as she struggled when she was a kid and “got more spankings when I was growing up that did no good.” She has had “several parents talk to me about ADHD in their child” (Lucy, personal communication, March 12, 2015).

Patty

Patty said that her strength involves an undiagnosed mental disorder. She stated, “I am extremely obsessive-compulsive [OCD], and that goes with my classroom management and discipline. I have to have it a certain way and if I don’t, it’s wrong.” Patty follows directives and procedures as asked by the school system, state, and federal government. She stated, “Whatever I’m told I’m going to do it and second of all, there’s a reason we have to do it that way.” Patty added that you can still “twist it to make it your own” and still follow the rules.

Patty knows she is a stable person in the lives of her students and believes the students come first. She is aware of her mental disorders and recognizes mental disorder symptoms in her students and she will assist parents by educating them of ADHD symptoms so they can identify the ADHD in their child (Patty, personal communication, July 20, 2015).

Susie

When Susie was asked about her strengths as a classroom teacher with mental disorders, she thought about the question and stated flatly, “I guess I have no strengths, I think I am at a total disadvantage. And I think that if someone has never had a panic attack, they cannot relate or understand. Because it’s not something that just everyone has” (Susie, personal communication, March 7, 2015).

Tessa

Tessa has a strong family connection to the community and has good communication with all stakeholders. She stated that her strength is in her “ability to form relationships” with her high school students. She has her classroom decorated like a home and she feels like she is mom to the kids. Tessa believes, “When they have a relationship with you, they will go to the

ends of the Earth to try to please you. They will do whatever needs to be done to please you.” Tessa admitted that prior to medication she learned that “being ugly, being nasty and snippy, kids don’t do well with that.” She acknowledged that for the students to get to know her, she has to be “calm and collected” (Tessa, personal communication, July 22, 2015).

Wilma

Wilma stated that her strength is her “ability to relate to the students” who have ADHD. Wilma finds her students “feel comfortable” and are “at ease and makes them want to work” when she tells them about being ADHD herself. She will tell them “I’m also a little ADHD so I do understand that you can’t sit still.” Wilma had problems with her ADHD as a child by forgetting or losing her lunch boxes, umbrellas, and thermos and would “go through those in a year like there was no tomorrow.” Wilma teaches at the high school where 90-minute classes are the norm. She stated, “I try to work the classroom dynamics to where they get to get up, where everyone gets a potty break, if you want to stand, if you need to stand just to stand, you go ahead and do that.” Wilma acknowledged, “I don’t find that disruptive because I myself cannot sit for an hour, not even for 30 minutes without moving, so let alone 90 minutes!” She also tells the students that ADHD is not a handicap and added, “I want to make them understand that they too can be successful if they put their mind to it.”

Wilma likes to make learning Spanish fun and will sing and dance, although her students will say, “Please don’t hurt yourself!” Wilma teaches character education in her classroom. She tells her students, “I realize that we don’t like everyone we meet, sometimes the chemistry is not there,” but she expects them all to be respectful to each other and her (Wilma, personal communication, June 6, 2015).

Research question one results.

Research question one asks the following questions: (a) Describe situations where you could not control or self-regulate your mental disorder (decision-making, emotion regulation), (b) What were the consequences of these situations, and (c) What factors attribute to the increase of the mental disorder symptoms? In Table 6, the teachers describe what problems, or with whom issues had occurred, and then what types of consequences resulted. Table 6 also lists factors that increase teachers' mental disorder symptoms in the school environment. The teachers' responses illuminate the themes that "Teaching is very stressful," "Not everyone can be trusted," and "Medication is the key to 'normalcy.'" The narrative reflects the issues of teachers in their struggle with controlling emotions due to having mental disorders.

Table 6

Answers to the Questions Regarding Situations of Inability to Control Emotions, Consequence of that Action, and What Factors Increase Mental Disorder Symptoms

Comments	Participant(s)
Situations that caused problems with regulating emotions	
Issues with difficult student(s)	Jackie, Laura, Lucy, Susie, Wilma
Issues, lack of support with administrators/ superintendent	Alexa, Jackie, Laura, Susie
Issues with parents	Jackie, Laura, Lucy, Patty
Problem with colleague(s)	Alexa, Anne, Jackie, Lucy
Personal issues outside of school	Anne
Reactions from others for being honest with them	Lucy
Students not behaving, fighting	Wilma
Not being medicated caused negative emotions	Tessa
Teachers not being involved in decision-making about expenditures	Alexa
Consequences	
Called to superior's office for meeting	Alexa, Anne, Jackie, Lucy, Patty, Susie
Questions self and actions	Alexa, Anne, Jackie, Lucy, Susie

Table 6 (*continued*)

Comments	Participant(s)
Consequences	
Caused dissention/problems in family life	Alexa, Anne, Jackie, Laura
Lack of control/impulsivity	Alexa, Lucy, Susie
Absent from school	Anne, Susie
Lower evaluations/write-ups	Jackie
Feelings of humiliation and embarrassment	Anne
Increased medication because of school issues	Jackie
Students say she is too tolerant of bad behaviors	Wilma
Factors increasing mental disorder symptoms	
Disrespect/lack of motivation in students	Jackie, Laura, Lucy, Susie, Tessa, Wilma
Demands on teachers	Alexa, Anne, Laura, Tessa, Wilma
Not being in control of a situation	Alexa, Anne, Laura, Lucy
Self-doubt about teaching abilities	Anne, Jackie
Working environment/grade level	Anne, Jackie
Confrontation from others	Jackie, Lucy
Being pressured for a deadline	Susie, Wilma
Start of school/uncertainty	Patty
Being called in to superior's office	Patty
Balancing family life with work demands	Tessa

Alexa

Alexa has had a couple instances where she lost control and said things that got her in trouble. In one school the superintendent had told a group of teachers that they could not wear jeans during a work day as the school board believed it to be unprofessional. Alexa asked out loud, "What the hell?" She exclaimed, "And it just came out!" Alexa continued with her comment, "Oh my God, are you kidding me, who would say that, the school board a bunch of uneducated people, with high school diplomas? I went off!" The superintendent took offense to Alexa's comment and called her into his office. Alexa did not trust the superintendent as "he

would twist your words and say other things,” so she told him, “I’m not talking to you until my husband gets here.” She called her husband and told him, “The shit’s hit the fan, I’m fixin to get fired!” Alexa did not get written up, but it was a stressful meeting. Following the meeting, a school board member called Alexa to tell her that the school board “never said you couldn’t wear blue jeans on a planning day” and that this comment was made by the superintendent himself.

In another instance, there was a change in the lunchroom about the lines and the taking of trays. Alexa disagreed with the change as it caused a traffic jam in the cafeteria. She said, “I thought it was stupid and I didn’t like the way it was being done.” She added, “I just *went off* [emphasis added] on the person that was running it,” and another staff member tried to calm her down and Alexa lost it on her, “Who do you think you are, you’re just a parapro, don’t tell me what to do!” Alexa stated that she “was not medicated at the time of these incidents.” Alexa admitted that the lack of control “is an absolute impulse, it is my mouth that gets me in trouble.” She used to question herself and her actions, such as “I should have did this, I shouldn’t have said that or I should have said this or I shouldn’t have done that.” She said these incidents occurred years ago when her attitude was “I am who I am, you take me or leave me.” Alexa admitted that when she was younger she would even say about herself, “I’m not a good person because I can’t even control myself.”

Recently, Alexa got upset at a faculty meeting about a program her administrators purchased that involved more testing of her students. Alexa wrote in her journal that she voiced her opinion at the meeting and immediately thought, “My impulsiveness from my ADHD is to blame for my inability to keep my big mouth shut.” She continued:

I knew the minute it came out of my mouth that I would be tattled on to the principal, and sure enough the next day there I sat in her office. I basically had a little tantrum about being tattled on....However, the bottom line is, “How professional is it for us just to sit quietly by while our students suffer for decisions that are useless and we do not have any input into?” (Alexa, personal communication, January 30, 2016)

Alexa said the factors that increase her symptoms of her disorders are all of the demands put on teachers, especially in pre-planning and on planning days. She described the demands:

When a lots going on and you’ve got to get this done and then get that done, and oh, report cards are due but we want you to get this, this, and this done, oh, we’re not going to give you any time to get it done, oh, you’ve got a planning day, no we’re going to have meetings all day; um our preplanning this year, we did not get one single full day to work in our rooms.

Alexa said when there’s a lot going on and the administrators want even more from the teachers, she said her symptoms of her disorders increase and “that’s when it comes out when I feel stressed and overwhelmed” (Alexa, personal communication, July 19, 2015).

Anne

Anne described an incident where she got angry at a teacher and yelled at a different teacher in the hallway. She actually yelled at the teacher she is friends with and not the teacher who the issue was really about. She was “so humiliated” and embarrassed about the incident. Fortunately, this incident blew over without much backlash or hurt feelings. In another incident, Anne had a family event that triggered memories from her childhood and she had to leave school the next day due to an anxiety attack. She was out for several days. Anne does not like being

absent from school but she also understands the impact of her being in school and not feeling well and how it affects the children. Anne elaborated:

I'm kind-of hard on myself about my symptoms because I want to make sure I'm modeling the right thing and that I'm interacting appropriately and that I'm meeting the mission. I can't be my best self every day...I have to look at myself in the mirror, especially with migraines, and ask can I go in and give good service, or has it progressed to the point where I could make it through the day but actually the children are going to get nothing out of me being there? It would be better for me to stop, take care of myself, having a substitute is going to be equal to me being there today. And I have to make those kinds-of choices regularly.

Anne admitted:

I do battle with myself a lot because I hate to miss work and I think so much of my self-esteem and how I keep balanced is feeling successful in my profession. So when I might have to miss I have to manage those feelings, those worries, those intrusive thoughts of "well you just suck, you can't even get there."

Anne stated that working at the elementary level triggers her mental disorder symptoms. She previously has taught at the middle school and high school levels and prefers the schedules and work environment more than the elementary level. Anne explained:

I didn't enjoy working with middle school students as much, the phase of life they are in it's just so unpleasant for me to be around, but the schedule being every 45 minutes would work fine for me, it's still the same subject matter and you just repeat, repeat, repeat.

Anne elaborated about the elementary level:

There are so many different subject areas, and now we have to differentiate, and within each subject area there are three or four different levels of what you're doing, plus the Response to Intervention for the kids who are lagging plus enriching the gifted, and so elementary really doesn't fit with my brain function.

Anne wants to go back to teaching high school because the elementary level "actually creates more stress and it's become an endless job. I can never accomplish it and that triggers my anxiety, so it's really not the best fit for me psychologically or emotionally" (Anne, personal communication, June 11, 2015).

Jackie

Jackie had a student whose parent was a teacher on her team. The student would "turn in his work without completing it" and he got "a low grade," which made the mother/teacher angry. Jackie described the teacher/parent and the child, "She's disrespectful and her son is disrespectful." As time went on, Jackie said, "He will talk back to me, he'll roll his eyes at me, throw things at me." This student had "pushed my [Jackie's] daughter up against the fence" and "threw wood chips at her." One day on the playground Jackie said to this student, "I think you're trying to push my buttons." The student replied, "I'm trying to see how much I can get away with from you without getting into trouble." Jackie described what happened:

So I went to the principal just to see how to handle it and she told me to address it with the parent of the child, so one, I feel like she set me up to begin with, and so I addressed it with the mom and the next thing I know the mom is screaming at me down the hallway,

kids are there, during school hours...I'm crying, I have to get coverage, and from then on, that principal was on me like white on rice.

This entire incident caused Jackie to question her abilities as a teacher. She said, "I had blood-shot eyes, just tired, exhausted, waking up at 3:00 in the morning, my husband is like 'what is wrong with you,' and I said, 'I keep thinking about this stuff and I cannot stop', that's my passion!"

Jackie explained the outcome, "I did get a write-up in my evaluation and it said I was unprofessional and I should not have dealt with it in the manner that I did." The principal told Jackie she "was very unprofessional and you should do it after hours." Jackie told the principal, "In 13 years I've never had this...I care what's in my record and this is not a true reflection of *me* [emphasis added]."

In a later incident, the principal came in to evaluate Jackie and wrote in her evaluation "you were texting during school hours" while at her desk and "why were you smiling?" Jackie explained:

I had just finished up an hour lesson standing up the entire time for my math lesson, she came in and I had just sat down. I had taken a picture of one of my kids...I was sending the mom the picture, I was smiling about this picture because I was like this is a stride for this kid...I was proud of the kid. Do you fault me for that?

The principal gave her low marks on the evaluation along with her observations of what she felt Jackie did inappropriately.

For Jackie, any type of confrontation increases her anxiety symptoms, especially with superiors. Another factor is disrespect from students, especially when a parent does not accept

that their child was disrespectful. In dealing with the difficult child whose mother was a teacher, Jackie said:

I have never felt, and probably because this kid did it to me this year, so much anxiety, as far as every time he'd come in the classroom my shoulders would tense up and I'd say "this is not me," he purposely does things to get to you.

Jackie has had parents "freaking out on me" without waiting to hear what their child had done or believing her as the teacher. She stated, "They're freaking out on me, so I freak out entirely. But they would never know it." Another factor that increases her anxiety is when a child says they can't do the work without even trying. Jackie said:

If they won't do it and they won't try, then I'm like "why the frick should I try with you." So it makes me unmotivated, but then once they actually see their successes then I'm motivated more to do it, but if they're going to cop out and not even try and be like their parents sometimes, yeah, it ticks me off...If they're not motivated at home and they don't see that motivation at home, they're not going to do it. They give up. (Jackie, personal communication, June 12, 2015)

Laura

Laura has had a difficult student (with a diagnosed mental disorder) in her teaching career that caused her to rethink being a teacher, and it was also a time when her psychiatrist had to increase her medication. The child would have meltdowns daily and Laura felt like she was not getting support from administrators. The parents were also not supportive and coddled the 7-year-old like he was a toddler. Laura wrote an example of his behavior:

To avoid work, he would make up excuses that would give him an excuse to start screaming. It could be something as simple as “I lost my favorite blue pencil!” and he would immediately start the *loud* [emphasis added] crocodile tears and incessant chanting about how he lost his favorite blue pencil. When I would produce another blue pencil to shut him up, he would say, “That’s not mine!” and continue his all-day tirade. (Laura, personal communication, February 12, 2016)

Laura described how she felt about that student:

That was one student that I could see myself hurting and when he was really out-of-control and I had to bring him out of the classroom, I really had to stop myself and say “okay, he’s just a child,” and when I put my hand on him I said “do it very lightly.” Sometimes I really wanted to hurt him because he was horrible. But I thought to myself, he can’t defend himself against someone your size, he can’t, that’s not fair....That kid was so manipulative you just couldn’t get through to him! He was so manipulative and wily. There was not one likeable thing about that child. Not one thing. Usually you can find something about a kid...I felt like out-of-control with him. Inside I felt like I could literally beat him to an inch of his life. I wouldn’t but I felt I wanted to, you know what I mean? I felt like I could snap at any moment.

Laura added:

When I got home I would snap as I had to keep it together at school as I knew I had to, but I would snap at home, that was a horrible year for me and my family...yeah, that ruined my whole life that year, it was a really bad year for my family.

Laura said that if she ever had another student like this, “I would probably resign.” Even though Georgia allows a teacher to refuse to teach a student, Laura said she would never ask that. She stated, “The school system will make your life a living hell. There’re going to transfer you, there’re going to keep pushing you out.” Laura stated that “not being in control of a situation” increases her mental disorder symptoms. She added, “If I feel like I am not in control, it upsets me, it upsets me” (Laura, personal communication, April 8, 2015).

Lucy

Lucy said that “a lot of times I would say and smart off to kids that were being like total butts” and she got away with it because she “had that relationship with the parents.” She added, “You know how you express your thoughts and opinions, I would just say it.” People, especially colleagues, would get offended by the answers that Lucy would give. She admitted:

Don’t ask me if you don’t want to know because I’m going to tell you the truth. And that does come across as being a bitch. I think a lot of people that don’t know me avoid me for that reason.

Lucy had a student tell his mother he was going to be “taken out of REACH [gifted]” and originally the student said that Lucy told him that. The mother “came up here all hot and heavy” and a meeting in the principal’s office ensued. Lucy had not said what the student accused her of so when the mother started yelling at Lucy, she fought back:

I went right back at her like a bulldog...I said you’re not going to come in here and yell at me about something I didn’t say and do, and she backed down. I guess that’s a good thing because they don’t understand what we do here. That really ticks me off.

According to Lucy the principal just said, “Whoa whoa whoa” in an effort to control the situation, but nothing was said to Lucy after that.

The factors that increase Lucy’s symptoms of her ADHD are, “I think disrespect, the back-talking, and especially the laziness.” She tells students she will not argue with them during school hours, she tells them, “I argue at 3:30 [dismissal] and they can come back.” The students that bother her the most are the ones with the attitude or say, “I’m here because my mama made me, and then they disrupt the whole thing. So that would set me off.” Lucy added:

You know they know how to do it [academics] and then they refuse to do it because they’re just lazy and then they say “my mama said” and I say “your mama didn’t say that because I know your mama” and I would tell them, “I’ll call your mama right now!”

(Lucy, personal communication, March 12, 2015)

Patty

Patty had a parent bypass the school and call directly to central office to complain that Patty had “yelled at her son.” A representative from central office came to the school and Patty was called into the principal’s office. Patty was annoyed that the mother had gone to central office about something that could have been handled at the school level. She was also bothered by the fact that this student was prone to not telling the truth and the mother believed him over her. Patty stated that the kid was brought in to the meeting and when the student was asked if the teacher yelled at him, “He says no.” Patty was asked, “Do you have a problem with this kid and I said, ‘No, he is great for me. He’s making good grades.’” It was determined that there was not a problem between this student and Patty, and Patty had not yelled at him.

Patty stated that her mental disorder symptoms are aggravated at the beginning of the school year due to the unknown and on those scarce occasions when she does get called to the principal's office. She stated:

It rarely happens but when it does I'm like "oh crap" and you start thinking what did I do, what have I done, what have I said to a kid, what have I done to a kid, what has someone said to me, what have I not done? (Patty, personal communication, July 20, 2015)

Susie

Susie has had a few emotional battles within herself that involved administrators and students. She discussed a situation that occurred where she was accused of yelling at the principal, and she said:

I don't remember screaming at her. I wouldn't scream at anybody, not in a professional way, you know? But that year so many people were talking about me, and like she had to be feeding it because it was only stuff that she knew, and so it was very hard for me to keep my emotions in check because there's nothing that I could do that year that would help her fix anything.

Susie stated that some kids really do annoy her. She added, "Now I can lose it with a quickness" and they "can make that sarcasm come out in me." Susie confessed that certain kids "can push my buttons." Susie begins to question herself and said, "I ask myself, and I don't know if you ask yourself, but I say 'is this because I have this or am I like this mentally or is every teacher like this?'" Susie continued, "Some teachers can say what they want and get away with it...if I had said those things, I'd have been fired!"

Susie stated her mental disorder symptoms can be triggered when “I’m under the gun from her [principal].” She had gone to her administrator about completing a report as she needed guidance due to some changes in procedures. She was told to “do it the way it’s always been done, and I said ‘okay’. And then I got in trouble for the way I did it.” Susie was later confronted by this administrator as the report was incorrect and she said, “She [principal] got upset, she got upset with me and told me to do it again!” (Susie, personal communication, March 7, 2015).

Tessa

Tessa stated that her difficulties with emotions were before she started her medication regimen. She clarified:

I would have times when I would cry, like for an hour and I just didn’t know why I was sad. There was no reason, it was just sadness...I did have times when I would be angry and I felt like I was losing control...that’s why I don’t want to stop taking meds because I don’t want to go back to that.

Tessa explained that the medication “takes away a lot of my emotions, my normal emotions...it levels you out, it takes away the extremes.”

Tessa acknowledged that balancing her family time and workload does increase her mental disorder symptoms. She shared:

I can’t miss a dose of medicine and I have to make sure that things are organized and in order, as much as possible, so it will not get me to that point of being flustered, you know, where I can’t deal with it. (Tessa, personal communication, July 22, 2015)

Wilma

Wilma stated that sometimes she will get frustrated or annoyed with her students and then she will tell them, “Okay guys let’s just take a break, go drink water, check your texts, call your mother!” She allows them to use their cell phone on breaks because she knows it helps them to avoid using their phones during class. Wilma shared, “It gives me a break also so I can run and get coffee.” Overall Wilma stated that she “is very tolerant” but doesn’t accept situations where the high school kids “are fighting and pushing each other.” She admitted that sometimes students cross the line and she has to discipline and added, “Our job doesn’t allow us to be consistent all the time. There are certain things you have to be flexible, other times not, life is not fair.”

Wilma stated that there are times when her ADHD symptoms are increased. She explained:

Those days we have testing and meetings and makeups and it’s all happening at the same time in the same day and I feel like aww...we have milestones [state testing] and my tutoring and students making up tests, I feel edgy. And I do tell my students “look guys, today I am feeling like you, a little too much going on so bear with me if I seem a little mad or something.” You know what they ask me? “Do you need some coffee?!”

Wilma said that she likes her job and the students, however, she admitted, “As much as I love it, some months, weeks, some days, I am ready for this to be over you know, you do get burned out and you’re ready for a break.” She can get frustrated with students who lose motivation and complain about her class. Wilma noted, “And you know you have weeks where the students are not working as hard as they should, it’s frustrating because you are out there

giving your all, you are giving 200% and they're giving you 10%" (Wilma, personal communication, June 6, 2015).

Research question two results.

Research question two had the following questions: (a) How do the symptoms of your diagnosed mental disorder affect your relationships with students, colleagues, and superiors, and (b) How does your mental disorder prevent or promote your ability and effectiveness to be a role model in the school environment? Table 7 lists teachers' responses on how their mental disorders affected their relationships and being a role model, followed by the narrative that focuses on quotes from teachers describing their relationships and how they see themselves as role models. The theme "Not everyone can be trusted" is evident in the teachers' lack of satisfactory relationships with colleagues and administrators, along with the themes "Teaching is very stressful," "Medication is the key to 'normalcy,'" and "Having mental disorders is not all bad."

Table 7

Answer to Questions Regarding Mental Disorders Affecting Relationships and if Mental Disorders Affect Abilities as a Role Model

Comments	Participant(s)
How mental disorders affect relationships	
Able to understand symptoms of specific disorders, more compassionate to those kids	Alexa, Anne, Jackie, Patty, Wilma
Distrust of other adults in the school	Alexa, Anne, Jackie, Lucy, Susie
Can communicate to parents about child who exhibits mental disorder symptoms	Alexa, Anne, Lucy, Patty
Stress from too many levels of children's abilities	Anne, Jackie, Laura
Stress from work environment/curriculum demands	Anne, Laura, Lucy
Honest with colleagues, sometimes hurts feelings	Anne, Jackie, Lucy
Teaches character education along with subject area	Anne, Wilma
Doesn't listen to student's personal issues	Laura

Table 7 (continued)

Comments	Participant(s)
How mental disorders affect relationships	
Likes to be in control and not controlled by administrator	Alexa
Perfectionism/curriculum not appreciated by colleagues	Anne
Feels alone, no support system	Susie
Good rapport with students	Wilma
Can affect relationship with administrator when school is run like a business	Tessa
Are you a role model?	
Yes	Anne, Laura, Patty, Tessa, Wilma
No	Alexa, Jackie, Lucy
Sometimes, to certain students	Susie
How mental disorders affect abilities as a role model	
May get discouraged, think you're not making a difference	Anne, Jackie, Tessa, Wilma
"I'm just me" or "I'm mom"	Alexa, Jackie, Tessa
More self-aware of behaviors	Anne, Wilma
Need to be professional, accept mistakes	Anne
Sees teaching as co-parenting, can be a burden	Anne
Teach students to be very organized/structured	Laura
Needs better relationships with students	Laura
Need to be the "stable" factor in student's lives	Patty
Lack of patience with students	Susie
Desire to mentor and assist other teachers with mental disorders	Anne

Alexa

Alexa stated she does not have a problem with the relationships with "her kids." She said, "I will warn them if I'm having a bad day" and say something like, "I'm having a bad day, don't push me!" Alexa said the kids understand her and "usually they're all right." Alexa will joke with her students and say, "I'm going to beat you over the head with a stick, and they know

that I'm not serious." Alexa said, "I don't have any problems with parents, my parents love me...I guess it's because I'm real with them...you can text me on my cell phone number or whatever." Alexa does not like her principal and does have problems with that relationship. She stated:

I have issues with the control. I don't like to be controlled, I don't like to be told what to do. If you ask me, oh my gosh, I will do this. But if you tell me what to do, I'm going to rebel against it and do just the opposite. I don't know why I'm like that but I am. I have problems with authority, if a cop pulls me over, I'm mad at the cop not at myself, I'm like "How dare you pull me over!"

When asked about being a role model, Alexa confessed, "Gosh I don't see myself as being a role model," and added, "I'm just me!" Alexa explained:

I just think I'm their mom at school and that's the way I look at it. We're a family and I'm your mom at school, I'm no more a role model than mom is. I mean yes, I want you to have good morals, I want you to be a good person, be a productive member of society, and it certainly hasn't affected me being a role model. I just am who I am and I think I'm a good person. (Alexa, personal communication, July 19, 2015)

Anne

Anne believes she has good relationships with students. She had recently changed to a lower grade level and said, "I think there was a disconnect between my expectations and what I knew to do and moving down a grade level." Anne added:

The students were so young and I wasn't prepared for it. I think they love me, they draw me pictures and they want to please and they know I love and care about them, but

they're a little bit afraid sometimes, not ask me questions, but some they think I'm too firm for them.

Anne explained about her class:

When they walked in the door, I was at a loss. Plus somehow, even though it's supposed to be random, I end up with push-out from special ed., self-contained, I get all of them. If they're early intervention program, I get the majority, if they're special ed., I got all but one for the whole grade level.

Colleagues told her "it's a compliment," but Anne does not see it the same way. She added:

If we shared a little bit more, if everybody did what they are supposed to do when they have them, then I would have a better quality of life and the children I was serving who had those needs would get more from me and the kids who don't have those needs would get more from me. It disadvantages everyone when you do that.

Anne's relationships with colleagues can be troublesome. She explained that she models to students on how to be a good person and her co-workers respond negatively:

A lot of people still make fun of me because my social skills curriculum is not hidden, it's right up front and I do it all the time with students I don't even teach. But I do it globally to everybody's students and teachers don't like that necessarily, they make fun of it basically. There's nothing more important to teach people than how to get along with others, accept and understand yourself and solve problems. The content, the curriculum to me is secondary to that, which sounds like to other teachers, they think I have it backwards.

Anne summed up her relationships by saying:

I think you either love me or you hate me, and there's little in-between. You know, people tolerate me, but this has been my whole life, there's really strong feelings about me one way or the other. There's very few people in the middle. But it could be that I look at it that way because I tend to be black or white. Sometimes it's either yes or no or this or that; whether that's real or just my perception.

Anne definitely believes she is a role model and stated, "They learn more from who you are and what you do than anything else." She added that elementary school teachers "are co-parenting" and "it's a burden to me." She emphasized, "To me that's a *huge* [emphasis added] responsibility and sometimes it burdens me because I just can't live up to it." Anne believes being a role model comes with both the good and the bad. She stated, "When I mess up I try to accept the fact that when I mess up I'm still a role model of how you handle that as human beings make mistakes all the time."

Anne also believes educators need to be role models for other teachers. She stated, "I think we miss the boat because sometimes we need to be more careful about who we pick to mentor whom." Anne added, "If a new teacher reaches out to me, then I will afford them anything that I have, anything I can do to support them I will." She said, "As a veteran teacher, especially as hard as the job is now, I have to be a good role model for those new teachers...I can't just be a one-off, I can't be the only one."

Anne has taken another teacher who has similar mental disorders and history, and has offered "support and services" as she believes that is part of her responsibility as a professional. She said, "I don't distance myself because it's kind of a sisterhood or brotherhood, we share certain things, but I also see myself as a role model." Anne elaborated, "I pride myself when that

person does better and I actually feel like I've contributed and been a positive role model because I believe she knows I am not judging her." However, Anne is honest with that colleague she is helping and stated:

When her disorder influences the children that we are both working with, I do say, "I'm not about to send my kids who are struggling to you. If you can't do it, we've got to come up with another plan." (Anne, personal communication, June 11, 2015)

Jackie

Jackie said she has a good relationship with her students and does whatever is necessary for them. However, she distrusts her administrators and most of her colleagues and does not have a relationship with them. Jackie explained that she is "more reserved as far as the teachers at school." Jackie especially does not want other people in her school to know about her mother's mental disorder. She clarified, "I don't want them [her children] to have that label that their grandmother is a nut case basically so I keep that hidden." Jackie has a tenuous relationship with her principal. She expounded:

I'm done moving schools, I will suck it up, and someone said why don't you put in for a transfer, and I said no, 1) I'm not going to let her bully me out of this school and 2) this is where my kids go here and these are their friends.

When Jackie was asked if she was a role model she stated, "I don't know. I don't know." When her students have difficulties with academics, she says, "I will tell my kids 'hey I struggled with this and I'll show you exactly what I struggled with and why', but you just got to move on from it and learn from it, and keep on moving!" She stated that her colleagues tell her, "Oh my God, it's the way you handle things and the way your classroom management is, they've

come and commended me for that, for the organization, the communication.” Jackie said, “I don’t take pride in it, I’m just like, that’s me and I just move on. I really don’t think of myself as a role model.” After a pause she stated, “That’s kind of bad isn’t it?” (Jackie, personal communication, June 12, 2015).

Laura

Laura stated she does not believe her mental disorders affect her relationships with colleagues and superiors. However, she admitted that with students, “I probably snap at them more than I should, I feel bad sometimes. I’m not screaming at them, but I snap at them and say ‘Didn’t I just tell you that? I just told you that five seconds ago.’” Laura knows that one of her deficits is in “building a relationship with my kids.” She added:

I definitely push my kids and that’s important because some teachers don’t care and I care about their academics. I probably should care more about their personal life and listen to them, but I guess that’s the pros and cons...I’m more concerned about getting these sight words learned and getting these math facts learned, let’s go.

Laura confessed:

I could have a better relationship with my kids. I get embarrassed saying this but the kids will try and tell me something and I say that I just don’t have time to hear this right now, I just don’t have time. Just go sit down, we’ll talk later, we’ll talk at recess.

Laura contemplated this comment and replied:

I don’t have a relationship with my kids where they feel they can come to me. I don’t have that and it is definitely part of my problem. I’m like okay, let’s move on, we’ve got to go to the next thing. I love my kids, don’t get me wrong, every kid I love but I just

don't want to hear it or listen to it right now. So that's definitely a big regret of mine.

I'm going to have to work on that I guess because I don't want my kids to grow up and hate me. I don't want them to say I was a good teacher, but man "she was a bitch! Yeah, I learned a lot from her that year but she was a bitch. Don't ask her to repeat herself because she'll take your head off!"

Laura stated, "I really should put more of an effort in [on relationships]. I just don't know how to do it, I don't know how to balance it." Laura said she has seen teachers who are overly friendly to the students being taken advantage of and added:

I feel like the kids respect me, but they don't feel warm and fuzzy with me...I feel like if you give an inch, they're going to take a mile, and that's why I am very careful about being warm and fuzzy. Of course if a kid is crying, I'm going to hug them.

Laura believes she is a role model in teaching academics. She stated that the students "are going to come out of my class knowing a lot more than when they showed up." Laura pushes kids "to be more organized, you know, put this here, put that there, and every day you'll do the same thing over and over- real structured" (Laura, personal communication, April 8, 2015).

Lucy

Lucy stated she has positive relationships with the administrators, students, and most colleagues. She said she observes the principal first and has "learned how to read if she was in a good mood or a bad mood and I knew when to stay away." She felt like "I got along with them but if the bad mood was there, I stayed away!"

In discussing relationships with colleagues she said she is apprehensive sometimes about talking with them. She stated, “Most people don’t like to hear the truth, they want you to tell them what *they* [emphasis added] want to hear.” Lucy said that a colleague had asked her, in a text message, how Lucy perceived her. Lucy replied, “If you don’t want to know the reality don’t ask me.” She said:

That makes me come across as the wicked witch I guess, but I’m not here for them I’m here for the kids. If you like me that’s fine, if you don’t that’s fine...they’ll come to me because they know I’m going to tell them whether I hurt their feelings or not.

Lucy further explained:

Most days I’m in the mood to socialize and then I hate not being able to say things to certain people because I know it’s going to get turned all around and sometimes it’s hard to work like that. I have to bite my tongue. Sometimes I feel like I’m in high school!

When Lucy is asked if she considers herself a role model, she replied, “I guess I don’t look at myself as being a role model here” (Lucy, personal communication, March 12, 2015).

Patty

Patty believes her disorders do not affect her relationships with students, colleagues, or superiors. As far as administrators, she stated, “I’ve never had a problem with anybody. I’ve never had an issue.” Patty said that her mental disorders “help me to understand them [students] more, like the crazy one [emotional-behavioral disorder] I had this past year, I understand completely.” Patty believes all teachers are role models “because we’re the one stable thing they have in their life for 180 days.” Patty explained:

They know I'm not going to be out, I'm not going to be the one who takes off once a week or whatever, whose always gone, whose always sick, um, I want to be that one stable thing and for the kids, a lot of them, that is the only stable thing they have.

Patty said that another part of being a role model is her ability to discuss with parents about mental disorders that she has experienced with her child. She will see symptoms in her students that are the same symptoms that her child experiences. Patty will say to a parent, "I know because I've dealt with this...I'll tell them that as a mom this is what I am seeing in your child" (Patty, personal communication, July 20, 2015).

Susie

Susie believes that her mental disorders do not really "affect my relationships with my students." She feels that she has a good relationship with most of her students. However, with colleagues and administrators, relationships are difficult. Susie stated:

I totally feel like I'm totally alone all the time. Um, I feel like I'm just by myself, I try not to say anything to anybody, um, and I feel like if I do say too much, then it gets turned around and then somebody else is saying something...I don't have a support system at school and I think it's really important when you have a job, that you feel like you have a support system. I think that is what your boss is there for. People that I'm friends with, I don't trust them.

Susie gets tears in her eyes and she stated, "I guess you could call it paranoia, is that paranoia? I just feel totally paranoid all the time, all the time. I mean that's the only place I get paranoid." She confides about her family, "In my other daily life, I don't feel like there's anyone out to get

me. I don't have family problems, I don't fuss with my siblings, or my cousins. We don't talk about each other behind their back."

Susie said that she is a role model for most kids but not for others. She added, "I guess it just depends on the kids...there are some that I try to have a relationship with, but I just can't...I'm supposed to be the adult and not act like a middle schooler, but it's hard." However, for some students she has "a lack of patience." She further added:

I feel like I set certain ones off and I don't mean to, but they're the ones that can be set off...when you catch yourself going "I really don't like that kid," that kind of makes you feel bad because you're like I should give every kid a chance. (Susie, personal communication, March 7, 2015)

Tessa

Tessa believes her mental disorders do not affect her relationships with her students, parents, and colleagues. She is very close with her students and is "momma away from home." Tessa does not have a close relationship with her new principal and shared:

He's kind-of hands-off. I don't think he's a people person, he hasn't formed any relationships with kids or staff. With our previous principal we were like a family and someone was describing this to him and he said, "Well my family is at home." So he sees it as this is work. But as I said earlier, if you don't form those relationships, you're not going to do well.

Tessa can't help but speak about the beloved previous administrator, "With the previous principal he would have gatherings for no reason. We felt appreciated, we felt needed, and we felt wanted. Now it's totally different, the school is being run like a business." She elaborated,

“People have said ‘it feels cold’ coming into the building...and they [students] say ‘we just don’t feel like we’re wanted.’”

Tessa believes she is a role model in spite of her mental disorders. She stated:

The kids see you more than they see their parents. I’ve had kids tell me they want to go to the University because that’s where I went, they want to major in biochemistry because I did, I’m in a sorority so they want to be in my sorority. I don’t see why someone wouldn’t think they are a role model.

Tessa said when you get “those discouraged moments” and you think “you’re not making a difference,” you just need to “look back and think, well I know I’ve touched at least one” (Tessa, personal communication, July 22, 2015).

Wilma

Wilma does not think her ADHD affects her relationships in the school. She stated, “I would like to believe that everybody likes me and if they don’t like me, the message is that you should always be respectful.” She tells her high school students:

I realize that we don’t like everyone we meet, for whatever reason, sometimes the chemistry is not there, you’ve all been there, and you will meet a person that you don’t like them and you don’t even know anything about them. So if you can be respectful I can live with the fact that you don’t like me or that you don’t like my class. Just do your job, and no problems.

Wilma also said that sometimes the students say “I am expecting too much from them.” She said she explains the curriculum and that “you want them to learn in a short time and it is important” and “it’s not that I’m trying to be difficult, it’s just something we have to do in

foreign languages.” Wilma mentioned that in her evaluations, the administrators always comment that “I have good rapport with my students.”

When asked if she is a role model for her high school students, she said, “I try to be.” Wilma teaches not only Spanish, but character education, specifically tolerance and culture. She tells her students, “My goal is that you learn Spanish, but in the end you know, the big goal is that we need to learn to be tolerant...we are not here to judge.” Wilma explained that when a student is disrespectful, she will “treat them with respect even though they are not as respectful because it’s important that we behave in a way that we want them to behave also, even though deep down inside we don’t want to” (Wilma, personal communication, June 6, 2015).

Research question three results.

Research question three addresses the following: (a) How would you define professionalism in teaching, and (b) How does a mental disorder change your image of yourself as a teacher and as a professional? In Table 8, teachers defined what they believed professionalism was, and how they saw themselves in terms of their image as a professional because of their diagnosed mental disorders. The narrative follows with quotes from the teachers. The theme “Teaching is very stressful” emerges from this research question as teachers describe how their image of themselves as professionals is sometimes tainted because of the many demands in teaching and lowered self-efficacy from not meeting self-expectations. Other themes that emerged included “Medication is the key to ‘normalcy,’” “Not everyone can be trusted,” and “Having mental disorders is not all bad.”

Table 8

Define Professionalism and How Mental Disorders Affect Professionalism or Image

Comment	Participant(s)
Definition of professionalism	
Doing the job to the best of your ability	Jackie, Laura, Lucy, Patty, Susie, Tessa
Being respectful and showing respect	Alexa, Lucy, Tessa, Wilma
Being at work, being present	Laura, Lucy, Patty
Following the rules and ethical standards	Anne, Patty, Wilma
Dressing in a professional manner	Anne, Wilma
Staying out of other people's business	Lucy, Susie
Communicating with all stakeholders	Jackie
Having pride in your work	Laura
Not repeating gossip	Lucy
Not complaining about the job	Patty
Not on Facebook/social media with parents	Patty
Staying quiet and 'under the radar'	Susie
Conducting self in a manner pleasing to God	Tessa
Students look up to you in respect	Tessa
How mental disorder(s) affects professionalism/image	
Can talk with parents about mental disorder symptoms in their children	Alexa, Anne, Jackie, Lucy, Patty
Afraid of failure as an educator	Anne, Jackie, Susie, Wilma
Accepts disorder(s) as who they are	Alexa, Anne, Jackie, Patty
Works harder, best choices for the students	Anne, Jackie, Laura
Understands and experienced behavior struggles as kids	Anne, Lucy, Wilma
Has 'fun' with the students	Lucy, Wilma
Keeps more to self to avoid miscommunication	Lucy, Susie
Understands and experienced academic struggles as kids	Jackie, Susie
Hard time accepting choices made by administrators that negatively affect students	Alexa, Anne
Harder on themselves than others are	Anne, Laura
Extra conscientious about being professional	Anne
Not listening to the children	Laura
Has too many tasks going at once, frustrates kids	Lucy
Explains to students she understands and has ADHD	Wilma
Others focus on her weaknesses, causes self-doubt	Anne
If not medicated, no patience for high school kids	Tessa

Alexa

Alexa had a difficult time defining professionalism and stated, “I don’t think I am extremely professional.” She said that professionalism is about “being respectful to your students, to your parents, to everyone that’s involved in that student’s education, and that’s the best I can say.” Alexa wrote in her journal, “I feel like maybe I struggle with acting completely professional when I disagree with things being done with or to my students” (Alexa, personal communication, January 29, 2016).

Alexa said, “I got called into the office to read standard 10 on professionalism.” Alexa tells the story:

I was talking to a parent who I’ve known for several years and we were talking about ‘opting out’ [from the state test] and I hate the whole testing thing, I think it’s ridiculous, and so I was telling her that when my child was young and if it were like it is now, heck yeah I’d opt him out. I wouldn’t make him go through all this.

A colleague overheard the conversation and approached Alexa on the merits of testing, so Alexa continued, “The constitutional amendment, the 14th amendment will allow you to be in charge of your child’s education. So don’t tell me you can’t opt out because you most certainly can.” The colleague got annoyed with Alexa, “So she went and tattled on me and I got in trouble for promoting opting out.”

Alexa does not think that having mental disorders has an effect on her image as a teacher or a professional. She stated:

I’m not one who’s ashamed of my disorders, I’m just like “I am what I am.” And you know, yes I have anxiety, yes I have depression, and I look at it the same as if you have

diabetes...it is what it is. It's a chemical imbalance, a chemical imbalance and I can't help it any more than you can help whatever's going on with you. (Alexa, personal communication, July 19, 2015)

Anne

Anne is very conscientious about her work and stated that she holds herself to the "professional ethics standards" and "to a higher degree than most people." Anne dresses up more than most teachers and believes that "if you want to be taken seriously and if you wanted to be treated as a professional," dressing up is part of the career. She acknowledged that her colleagues make fun of her because "I wear high heel shoes and skirts all the time." She said that when she worked at the high school level she would be teased with comments such as "you dress like you work in a bank." Anne stated, "Sometimes I think I go too far with the professionalism that I intimidate people." She explained further, "In the education field it's like we constantly have to *prove* [emphasis added] our value all the time and it's gotten way out of hand." In other words, although Anne loves dressing up and she feels professional when she does, she believes that wearing skirts and heels is part of an image you have to portray to your superiors in order for them to see you as a professional.

Anne discussed the notion of moving into an administrative position, but stated, "I think that the stigma of having a mental disorder would follow me there." She emphasized, "I think other people who are different from me mostly focus on my weaknesses." Anne also believes in making "choices based on what I truly believe is right for children" and feels that administrators are "a little hamstrung there." She added, "Sometimes I wonder, or maybe I buck the system and

I think this one way that I'm doing it the right way and that's part of my disorder...and that creates self-doubt and I try not to focus on it" (Anne, personal communication, June 11, 2015).

Jackie

Jackie defined professionalism as, "Doing the best that you can, giving the best that you have, best academics, providing the best materials that you can, communicating back and forth with the parents, with the administration about the kids." She also believes that when there are problems with student's academics, part of being professional is "letting them know [administrators] 'hey I tried this, I've tried this, but still not doing right' ...I've got some that won't come to me and learn...SST is up to par, it is perfect." Jackie elaborated about the Student Support Team (SST), "I've taken every type of academic model to try to figure out their strengths and weaknesses and then provided that with their documentation."

Jackie stated that she did have some problems with her image as a teacher and professional when she was diagnosed with anxiety. She explained:

I kind-of felt like I was failing, I couldn't be the person that I wanted, only because of thinking what my mom had been through and how she didn't last very long [in teaching] and I thought maybe I would follow that same path...I was not perfect, I know I'm not perfect but I'm thinking "Oh my God could this keep me from doing what I always wanted to do," and be successful in what I am doing.

Jackie joked about what she tells her husband, "If I ever show any symptoms of that [schizophrenia] you'd better file nine and send me to Ridgeview" [mental hospital in Atlanta] (Jackie, personal communication, June 12, 2015).

Laura

Laura sees professionalism as “showing up to work every day, doing your job, having pride in your work.” She added that having special education students was more demanding and stated:

Don't just write them off as being special ed. and say I don't have to do anything with them. That just means I have to work ten times harder to get them where they need to be. If you have a kid whose home life is not good, which I had a child this year whose come and gone, come and gone, and some teachers would say well it's environmental, I don't have to worry about him. No, you're going to have to work ten times harder with that child.

Laura stated, “This is one thing I can say about myself, I know I can have a negative attitude and get stressed out, but they are going to come out of my class knowing a lot more than when they showed up.” Laura also defined professionalism as “doing your best.” She continued:

But my thing is, if I'm doing my best, they're going to be doing their best. If I'm showing up every day, you'd better be here at 8:00, eyes wide open, leaning forward and paying attention. Because if you're not, I'm going to get you for it. “Get you” meaning I'm going to hold you accountable.

Laura feels her anxiety and depression affect her image of herself and said, “I think it's just getting down on myself and getting stressed out so easily. And not listening to the kids, I know I can be abrasive sometimes...I'm a lot harder on myself than anyone else” (Laura, personal communication, April 8, 2015).

Lucy

Lucy sees professionalism as “showing respect to coworkers, students, and parents, being at work and doing your job, staying out of other people’s business because if they want you to know they’ll come tell you.” She has had colleagues accuse her of saying things she did not say, or what she did say “it basically gets misconstrued and it always ends up being what you didn’t say.” Lucy elaborated, “To some people you have to say ‘Don’t repeat this,’ but I just learned that if it doesn’t need to be repeated I don’t tell anybody.”

Lucy’s image of herself as a professional is generally “positive.” She continued, “I think people with ADHD are just like big kids who never really grew up, it’s fun for us, you know?”

On the downside, Lucy thinks:

It’s also frustrating because it seems like I have ten things going at once, especially in the classroom, and I want the kids to hurry up and finish it because my mind is ready to move on to something else so I think it’s frustrating for them, but not for me because I’m ready to move on and they should be thinking about that too! (Lucy, personal communication, March 12, 2015)

Patty

Patty believes that how you handle things on a daily basis speaks volumes to others. She defined professionalism as:

Doing your job without complaining, without it being someone else’s fault all the time, sucking it up, putting your big girl panties on and deal with it, everybody is in the same boat and the way you handle it will show whether you are professional or not.

Patty also feels adamant that teachers should not get on Facebook or other social media with a parent who has a child in their classroom. She stated, “I just think there’s a personal line, a boundary that you don’t cross, nor do I give my personal cell phone number out.” She added, “I don’t want them thinking they can call me at 9:00 at night. I don’t want them to feel comfortable enough with me to be texting me.” Patty does not feel that your clothing is too important as “we’re expected to do so much and be active with the kids, we can’t be in suits with our kids, it’s impossible.” She added, “I want to be relaxed and to be able to get on the floor with my kids” (Patty, personal communication, July 20, 2015).

Susie

Susie had a difficult time defining professionalism. Susie believes “my professionalism is questioned” by her administrators. She stated, “I guess my idea of professionalism for me, right this minute, is keeping my mouth shut and doing what I’m supposed to be doing, and staying under the radar.” Susie added, “I want to be professional, but I want to be backed up, and I want to know that I have that backup but I know I don’t have it.” Susie observed that her lack of feeling professional may not have anything to do with her mental disorders, but with “our school culture.”

As far as her image as a professional, Susie said, “I feel like I make an effort to be [professional], but I’m like, sometimes stuff just comes out, and then after it comes out, I’m like ‘why did I just say that? Why? I shouldn’t have said that.’” She admitted, “I try not to say anything to the kids, kids make up something that’s not really there. It really upsets me that I can be upset that quickly.” Susie concluded by saying, “I guess I am more emotional than

anybody. I fear every day that I've done something wrong, and that I'm going to get an email that says you need to come see me [principal]" (Susie, personal communication, March 7, 2015).

Tessa

Tessa defined professionalism as "doing what you're supposed to do, the way you're supposed to do it. Being respectful to everyone, parents, students, administrators. Conducting yourself in a manner that would be pleasing to God." She added that professionalism includes "being one of those adults that kids can look up to" and "being the kind of person I want to be."

Tessa believes that dressing up is "a give and take." She explained, "I think the kids relate better to you on a personal level when we are dressed down, but as far as academics, I think they do better when you dress up." Tessa notices that when she wears jeans, the classroom atmosphere is more casual. She added, "I don't know if it's because of me, because I am dressed down, or the perception of the kids...so I tend to schedule labs for those days where we are not in the classroom." Tessa observed that when her high school students have dress-down days, they tend to perform worse academically and she shared, "We don't get anything done!" She explained, "If I try to give a quiz, they will not do well even though I know they know the stuff!"

Tessa stated that if she was not medicated, she would have a lower image of herself as a professional. She admitted, "I would not have the patience to deal with high school kids, because you know they can get snippy and get a little attitude!" (Tessa, personal communication, July 22, 2015).

Wilma

Wilma considers professionalism in education to be the same as in all career fields. She defined professionalism as:

Your ability to behave that is appropriate to your work environment, you follow the rules that are posted before you and make sure you follow them and have other people follow them. It has to do with mannerism, it carries on with the way you dress, make sure that is appropriate also, so it's not just behavioral but also physical and visual.

Being respectful is also important and she added, "In this field it's very difficult to be respectful in spite of the fact that this kid is telling you to 'take a hike!'" Wilma will reply, "Thanks and you know what, you need a time-out and so do I, so let me send you to the office!"

Although Wilma said her ADHD does not affect her teaching, she explained a daily ritual that occurs in her class from day one of the semester:

In the mornings I say look guys, when someone says good morning or good afternoon, you should say something back and I sit there every day and every class and say "good morning, good morning, good morning," and if two people say good morning, I say "that's not enough, I have 30 people in here and I want to hear at least, I don't know, 28!"

Wilma shared that the students will look at her like she's crazy and she added, "By week two they say 'Everybody say good morning so she will shut up!'" Wilma said she does the same thing when it is time to dismiss class and she will "hold them by the door" until they respond goodbye in Spanish and she will say, "Be courteous people, it doesn't cost anything." Wilma stated that during class the conversation goes like this:

They say "I don't want to be here" and I say "I get it because I feel the same way, but here we are, I have my coffee, buenas dias, let's get through this." They laugh and say, "You gonna sing a song?" and I'm like "Yes we are!" One thing I like about my job is

that I can do anything, if you feel like singing, you sing. If you feel like clapping, you clap. And I just love I can do that and get away with it.

Wilma said she tries to have fun with them and “they’re like ‘please don’t hurt yourself!’”

Wilma does not believe her image changed too much after her diagnosis. She acknowledged:

It has helped me to understand why I do some of the things I do, and it has helped me to focus. With my students, it’s important to me that they know that I can relate to some of the things they are going through. I need for them to know that, “I get it, ADHD, you can’t keep up with your work.” (Wilma, personal communication, June 6, 2015)

Research question four results.

Research question four asks: (a) Do you perceive having a mental disorder as a “stigma” and how does this affect your desire to disclose or share your experiences, (b) After your diagnosis, how did you perceive yourself differently? How did it change your perception of yourself, (c) Who in the school environment have you confided in regarding your diagnosed mental disorder, and (d) What were your thoughts and feelings prior to and after disclosure? Table 9 lists how the teachers view stigma in regards to having a diagnosed mental disorder. Also, teachers’ state who they disclosed to (if they did) in the school environment, followed by the narrative with teachers’ quotes. The themes “Not everyone can be trusted” and “Medication is the key to ‘normalcy’” emerged from the teachers’ responses.

Table 9

Answers to the Questions Regarding Stigma with Mental Disorders and Disclosure

Comments	Participant(s)
Is there a stigma to you for having a mental disorder? Yes	Anne, Jackie, Laura, Susie, Tessa, Wilma
Is there a stigma to you for having a mental disorder? No	Alexa, Lucy, Patty
How did your perception of yourself change after diagnosis? Didn't change, glad to get meds Lowered self-esteem at first Not much, anger was gone Relief, on medication feels great Teased about being ADHD, wasn't a shock Glad not to be "crazy," was a medical reason Hypersensitive to labels like 'crazy' Realized why her behavior was the way it was Went through a process of believing she was "broken" to acceptance	Alexa, Tessa Anne, Jackie Laura, Tessa Lucy Lucy Patty Susie Wilma Anne
Who have you disclosed to in school? Close colleagues and administrators Close colleagues only Colleagues and parents Colleagues, administrators, students Colleagues, administrators, parents No one	Anne, Patty, Susie Laura Lucy Wilma Alexa Jackie, Tessa
Thoughts and feelings about disclosure Prior to disclosure- knew they needed help to cope Talking about mental health is taboo/cultural Did not disclose/did not trust others to know Nobody's business Disclosure comes with a conversation Hope others don't think she is using disorder as an excuse for an issue/problem Tell administrators about symptoms when it is professional to do so	Alexa, Anne, Laura, Lucy Susie, Tessa Jackie Laura Patty Wilma Anne

Alexa

Alexa stated she does not see her disorders as a stigma, but she wishes that others did not either. She added, “It’s just a label, just a label. Labels don’t bother me. I don’t care.” Alexa affirmed, “I am not ashamed of my diagnosis but I don’t necessarily share it just openly to anybody because I know it is perceived by others as uh, you know, she’s gonna go home and slit her wrists or something!” She added, “It’s not a hidden secret...but I’m not out there parading it either.” Alexa has disclosed to administrators, and she included “coworkers that I am close to” and “every once in a while if I feel it will help a situation, I will tell a parent if it helps their child.”

Alexa did not see herself differently when she was diagnosed with mental disorders. She stated, “I kind of already knew it before I was even diagnosed and I was just glad to get some meds...it was almost a relief in a sense, okay, I’ll get some meds and get myself together.” Alexa said the diagnosis “didn’t make me have lower self-esteem, it just made me happy to get some meds so I wouldn’t be so angry, or short-tempered, and I knew it wasn’t who I wanted to be.” Alexa revealed she “grew up with very low self-esteem” until she was in her 40s. She thinks it might be “something about age” as she “didn’t care what anybody thought” prior to her 40s when she “learned to like herself.” Prior to seeing the doctor, Alexa thought, “If I don’t get some help something bad is really going to happen. I’m going to say something that I don’t need to say or slap a kid, you know?” Alexa added, “I was snappy with my kids but I was *ugly* [emphasis added] to my family” (Alexa, personal communication, July 19, 2015).

Anne

Anne does see her disorders as having a stigma attached to them. She stated she does “share when it’s appropriate but only to people I have a rapport with” and that she has told “certain principals I’ve worked with I alerted them when I was having symptoms to let them know because it seemed to me to be professional...if I share, I do it for professional reasons.” Anne said that part of the stigma is “I get grouped in with lower functioning people who have this disorder.”

When Anne received her diagnosis for her mental disorders, she was emotional. She stated:

I wanted always to think that something was not wrong with me, that it was environmental, that it was my home life, that it was the trauma that I had had. When I was diagnosed at first I was embarrassed and disappointed in myself, I felt let-down and I always thought it was the other and not me and then I had to look in the mirror and say “Ha ha, guess what? It is you too...I have to own it now.”

Anne added, “For such a long time I knew things weren’t right with me and I did seek a lot of help, but it was never my fault and never within my control.” She said the diagnosis does “feed my negative self-image.” Anne continued:

You know, it’s a process and then you come to terms with it and I also think I realized I had always had compensating behaviors. By the time I was diagnosed I already had my Master’s Degree and was already successful in my career. I couldn’t have done all of those things if I was such a horribly broken person, but I did go through a period of time when I thought I just want to be normal and I’m never going to be, I’m broken.

Anne further elaborated about what “normal” is and said, “I have to believe in the fiction that it exists” and “I always have a standard that I hold myself to that I can’t meet” (Anne, personal communication, June 11, 2015).

Jackie

Jackie stated there is a stigma attached when diagnosed with a mental disorder. She added, “I’m afraid they will think that I’m not 100% capable of doing my job, or that having their kids with me is a problem so that’s why I try to keep it under wraps.” Jackie has not confided to anyone in her school and stated, “My administrators don’t know about me...my team doesn’t know.” She added, “I’ve learned that you cannot trust many people where I’m at” and “I don’t have friends I can rely on there.” Jackie said, “I’m doing it for the kids, I love being there, I feel appreciated with the kids and the parents.” For Jackie, having friends outside of school and not in school is “perfectly fine with me.”

Jackie said the diagnosis did affect her. She stated, “I kind-of felt like I was failing, I couldn’t be the person that I wanted, only because of thinking what my mom had been through and how she didn’t last very long (in teaching) and I thought that maybe I would follow that same path.” Jackie said, “I know I’m not perfect but I’m thinking, oh my God, could this keep me from doing what I always wanted to do and be successful in what I am doing?” Jackie communicates with her husband about her symptoms and he monitors her and lets her know if he observes anything that might signal a relapse (Jackie, personal communication, June 12, 2015).

Laura

Laura stated, “Absolutely, having a mental disorder has a stigma attached!” When her husband had asked her to get help for her anger and inability to handle stress she thought:

No way, I didn't want to face the fact that there's a problem because of the stigma attached to it. Because you know back in the day, if you were crazy they just put you in a home or in a facility.

Laura shared that she has confided in a few close colleagues who she has known for a long time and that was all. Laura believes that the school does not have a need to know about her diagnosed mental disorders. She affirmed, "It's none of their business and I didn't tell them. It goes against the privacy act and I don't get how they could legally even ask that." Laura continued in her journal, "I get that I teach children and parents want their children to be taught in a safe environment. However, I am not a danger to my students and I'll do whatever it takes to maintain a safe learning environment" (Laura, personal communication, February 12, 2016).

Laura believes her image of herself and as a professional has not really changed and said, "I think I'm a lot better, the anger is gone." When she went to the psychiatrist, the doctor had asked her what was going on in her life that was causing so much stress. She confided, "I have a son that has special needs and I teach lower elementary grades," and she told him her husband is away from home for his career and "he's gone a lot, I feel like a full-time mom and a full-time dad." The doctor told her "no wonder you are stressed out, you have the weight of New Jersey on your shoulders!" She said the doctor made her "feel kind-of normal, like I wasn't stupid for feeling so stressed."

Laura noted that prior to finding out her diagnoses, she had "a lot of stress and feeling like I was nuts." After the diagnosis, she felt "relief." She recalled, "I realized that there was a reason for the anger and that whole stigma like it's your fault, and then you realize when

someone tells you ‘it’s not your fault’ there is something wrong and you need some help”

(Laura, personal communication, April 8, 2015).

Lucy

Lucy does not see her ADHD as a mental disorder so she does not believe there is a stigma attached to it. However, she believes others see it as an issue and emphasized, “I think that if the word got out to parents that ADHD is a mental disorder that they would be very uncomfortable with their child being in the classroom.” She explained, “Because, you know, they’re going to see mental disorders as crazy or retarded, they don’t understand that whole umbrella thing.” Lucy thinks parents might “go to the principal or go to the board” about a teacher having a mental disorder even if diagnosed with “just” ADHD.

Lucy has told colleagues and parents about her ADHD. She stated, “There have been several parents talk to me about ADHD in their child and I related to them that it’s not a bad thing, I have it myself.” Lucy summed it up by saying, “You probably don’t want me teaching your child while not on medication because I’ll be bouncing-off-the-wall!” Lucy suspected she had ADHD as “I was always teased about being ADHD” and so her diagnosis “wasn’t a big shocker.” The doctors determined, “I’d probably had it my whole life and I just learned to channel it because I was able to graduate from college and keep a job.” Lucy felt that the diagnosis “was just a relief to know at that point because it was getting bad.” Lucy said she felt better after starting the medication. She stated, “I just felt different about life in general, I mean I was happy-go-lucky on medication, people didn’t bother me.” Lucy added, “It made me able to deal with those things that irritated me, I could focus, I could get things done, so that made me feel better.” However, prior to starting medication she shared:

I mean I'd be driving down the road and I'd just cuss somebody out just because I didn't like the way they were driving. If I'd had a loud speaker I'd probably get on it...I was getting on my own nerves before medication and I'm thinking if I'm on my nerves, and I've been this way my whole life, I can imagine how others feel." (Lucy, personal communication, March 12, 2015)

Patty

Patty does not feel there's a stigma attached to having a mental disorder as a teacher because "we're professionals and I don't think they [stakeholders] think it affects us." She explained, "I think, like if you think of a policeman who has a mental disorder...that's a bigger stigma attached to it, but with us, I don't think it's that bad with us." Patty elaborated, "If anything we've become more caring and we understand the kids better."

Patty said she has disclosed to close colleagues and the administration, but whether she chooses to disclose or share depends on "my own personal, my own privacy." After Patty was diagnosed, she said she felt "better because I knew there was something, I felt like I wasn't crazy, that there was actually something wrong...just something simple." She also stated that disclosing does not bother her but "I'm not gonna just share that without a conversation" (Patty, personal communication, July 20, 2015).

Susie

Susie stated "definitely there is a stigma" associated with having mental disorders and that only a few people in the school should know about them, including "the principal, the assistant principal, and my friends." Susie is concerned that others know about her disorders and said, "I think everyone in the front office thinks I'm crazy and that's why I don't go up there."

Susie shared, “Sometimes I’m impulsive and I’m emotional, and sometimes I think I am over-impulsive and over-emotional from my disorders, but I wouldn’t think I am certifiable or anything.” She elaborated:

I have to think more than the average person about what I say, how I say it, how it’s going to be perceived. I catch myself and say “Why did you say that?”, and then I worry about it all night long...I worry about it forever. And then I’m like “do other people do this?” I’m certainly not going to ask them.

Susie said she has confided in a few close colleagues, but “there’s things I don’t tell them because I can’t trust them.” The administrators found out about Susie’s anxiety when she had been absent and the doctor stated on the form that the reason for her absence was generalized anxiety. She also noted that she does not disclose to others as “I’ve always been taught that its taboo. You know, you just don’t tell people.” When she confided to her close friends, she said, “I didn’t feel judged.”

Susie said after her diagnosis it “makes me like hyper-sensitive to words like crazy.” When Susie was asked if she believed she was crazy, she said, “No, I don’t think I’m crazy, I’ve seen crazy!” When someone calls her crazy, she says, “I’m like I will show you crazy! Or do you want to come meet my mom?” Susie asks herself, “Is my threshold of craziness too high, because I know what crazy is, like crazy, crazy. I mean like I think everyone is a little crazy, they just keep it in check” (Susie, personal communication, March 7, 2015).

Tessa

Tessa also believes having a mental disorder has a stigma attached. She stated, “I don’t want anybody to judge my teaching ability based on the fact that I take medication...It’s not that

I'm ashamed of taking meds, I don't want any negative perceptions to cloud the kind of teacher that I am."

Tessa has not disclosed to anyone in the school environment. She explained about cultural differences:

Especially in the African American community, we're not supposed to have those things, we're not supposed to go see a psychiatrist, you just go to church and pray about it and everything is going to be okay. That's why, other than my family, nobody knows that I take meds.

Tessa said her diagnosis was a relief. She stated, "I just wanted to feel better. I was to the point where I just can't continue to go on like this" (Tessa, personal communication, July 22, 2015).

Wilma

Wilma believes there is a stigma associated with having a mental disorder, however, she stated, "I don't see it [ADHD] as a mental disorder," and asked, "How can it be mental?" Wilma explained that people with mental disorders may not tell anyone because, "It doesn't get disclosed for the fear they will treat you differently or they may not understand." Wilma said that some people might use ADHD as an "excuse for faltering or not measuring up to their standards." However, months later in a journal writing (Wilma, Journal, January 23, 2016), Wilma wrote, "Having ADHD/ADD is no longer a stigma. Many are very well educated about this condition and make all the necessary accommodations for their students."

Wilma has disclosed to colleagues, administrators, and some high school students, but added that she does not "want it to come across as an excuse." She stated that when she does

disclose, “I mention it in passing if something big happens and I feel the need to explain.”

Wilma feels that when she discloses she thinks:

I don’t know if they believe me or not because you know some people will say “oh my ADHD brain” but they’re not really ADHD. It’s almost become another excuse for being scatter-brained, because not every scatter brain is ADHD.

After the ADHD diagnosis, Wilma said, “Yeah that makes a lot of sense.” She elaborated:

It hasn’t really changed my self-image but it helps me to understand why I do some of the things I do, and it has helped me focus...I’m more aware of my behavior so things like why I am so scatter-brained sometimes and what do I need to do. I always thought, okay I’m scatter-brained, I get it. But I never thought it was because I had a condition.”

Wilma continued, “It has helped me focus even more because before I was like “Why am I all over the place? This is ridiculous!” (Wilma, personal communication, June 6, 2015).

Final consideration results.

For the Implications Section in Chapter 5, teachers were asked what solutions or types of programs school systems and governance could implement to ease their symptoms from their mental disorders, and what they wanted all levels of governance to know about having diagnosed mental disorders in the school environment. Three of the four themes emerged: (a) Teaching is very stressful, (b) Medication is the key to ‘normalcy,’ and (c) Not everyone can be trusted.

Table 10 illustrates that teachers would like assistance in dealing with their mental disorders, but there does not seem to be much hope that governance at any level will acknowledge or offer assistance with the struggles of diagnosed mental disorders in classroom teachers.

Table 10

*Answers to the Questions Regarding Possible Solutions or Programs for Local School Systems/
Governance and What Participants Would Like for Them to Know About Mental Disorders*

Comments	Participant(s)
Solutions or programs for the field of education/systems	
Back off and trust me	Alexa, Laura
Treat us like the professionals we are	Alexa, Laura
They will not touch the issue/embarrassing for them/stigma	Anne, Jackie
Would not participate as being identified/labeled and be pushed out of education	Lucy, Tessa
Back off on evaluations of successful teachers	Anne, Laura
Administrators need to keep information confidential	Susie
Ask teachers what can be done to help them	Wilma
Better training for autistic/special needs students	Laura
Give us more help for disorders, relieve stress	Patty
Need to understand symptoms of mental disorders	Wilma
Don't know of any solutions	Susie
Get disruptive kids out of the general classroom	Laura
What education needs to know about mental disorders?	
Teaching is a very stressful career	Alexa, Jackie, Laura
Some teachers have mental disorders because of the career	Alexa, Laura
Need medication because of the career	Alexa, Laura
We are not psychotic or crazy	Lucy, Susie
Losing people in the field, take better care of teachers	Laura, Patty
We are not bad people, not bad teachers, not hurting kids	Laura
We are not psychologists, can't fix kids issues	Laura
Be more aware of symptoms/mood changes in teachers	Tessa
Some administrators come to us for help as we are problem-solvers, think at higher level, higher work ethic	Lucy
Everyone needs to be treated fairly, with or without mental disorders	Susie

Alexa

Alexa believes that school systems are not responsible for their employees' diagnosed mental disorders. She stated her opinion on the field of education:

If education as a whole would just place more trust in their teachers, and back off a little, I think that would help, not just for those that have a mental disorder, but anybody, everybody. Because I don't feel respected as a teacher at all. If I'm supposed to be a professional, I don't feel like I'm treated as a professional. I don't feel like I'm allowed to make my own decisions, I feel like everything is just all laid out for you and you're supposed to do it.

Alexa admitted, "Yes, there are some teachers that need reprimanding...instead of giving it a blanket, why don't you deal with individual cases? It would make my life less stressful if I didn't feel like I was under constant scrutiny."

Alexa would like governance to know that "some of us have mental disorders because of the school system, because of the stress of being a teacher, that's why we need medication." She added that her need for medication, especially for anxiety, "*hugely* [emphasis added] drops during the summer months than during the school year" (Alexa, personal communication, July 19, 2015).

Anne

Anne believes any type of program to help those with mental disorders would not be funded. She stated:

They're not going to want it like out in the public because of the stigma of mental disorder or disease or illness, they're not going to welcome this idea that there are people in the classroom who are anything other than normal, perfect role models, even though those actually may or may not truly exist, because of the political nature of the funding, that's never going to fly.

Anne added that a school system has to offer services and treatment programs for alcohol, “but if you stepped up for that, I don’t know what would happen to your career...I think you get marginalized.”

Anne believes that school systems “need to stop focusing so much on evaluation of successful teachers.” She added:

New teachers who are not functioning very well, the system needs to spend the time in resources investing in new teacher’s development as some teachers are not self-aware enough to realize it is them and not the students. They need to invest more in targeted professional development for people who are struggling. (Anne, personal communication, June 11, 2015)

Jackie

Jackie does not believe a school system can do anything for educators with mental disorders. She stated:

If people are actually being 100% truthful and if they go ahead and disclose too much, then is that school gonna go ahead and provide any type of backing for risk of getting it in the public eye, so that’s why I’m thinking you know the school probably won’t cause God forbid, if it gets out on local television that they have a program going on for teachers, what does that say for our system? I would say that, nope, mental health, we are not dealing with that for our employees.

In speaking about stressful careers, Jackie concluded, “I think we’re the most stressful because we have to deal with everyone from all different levels in the classroom” (Jackie, personal communication, June 12, 2015).

Laura

Laura thinks that school systems “need to do their part and get the kids that are crazy help and not put everything on the teachers. It’s just getting worse and worse.” She believes that systems need to “stop putting everything on the teachers to solve all of the problems without providing any training.” Laura’s comments are in relation to autistic and other difficult special needs students. She stated, “I can’t teach 20 kids and a special needs kid and God help you if you ask for an aide.” Laura had asked for an aide for an Asperger student who had frequent melt-downs and the negative response she received from the special education department had this response from Laura, “Oh, you would have thought I said that I worshipped Satan! Honestly the whole world came crashing down. It’s all about saving money.” Laura added, “I feel like its [teaching] an impossible job to do effectively.” Laura would like governance to know that “just because we have an issue doesn’t make us bad people or bad teachers or a danger to our children.” She further stated, “You know we didn’t get into this business to hurt kids.”

In her journal (February 20, 2016), Laura wrote, “I’m a teacher, I’m not a psychologist. I haven’t been trained to manage out-of-control students. I *cannot* [emphasis added] fix all of the problems that children bring with them from home.” Laura continued, “Like our students, all teachers are different and have different strengths and weaknesses. Just because I have anxiety doesn’t mean you have to watch me closely.” Laura wrote that administrators need to “leave me alone and let me teach.” She continued:

My anxiety and need for control will *not* [emphasis added] allow me to slack off and let the students’ academics slide. With me, my students’ progress is a matter of pride. You

couldn't possibly be harder on me than I am already on myself. Leave me alone and trust that I am a professional. (Laura, personal communication, February 12, 2016)

Lucy

Lucy does not think that school systems should know about employee's mental health disorders. She said, "I don't want them to know, it's none of their business if I'm taking whatever pill because I think at this time that's seen as negative and I feel like they would find a way to push us out." Lucy added that even if school systems had programs to help people with mental health disorders, "I probably wouldn't go. I figure I've gotten this far with it and I haven't hurt anybody." She continued, "It's not going to be anonymous...I wouldn't go...I would not be comfortable, I would not feel like I could trust them."

Lucy would like governance in the education field to know that just because you have ADHD, "you're not psychotic!" She continued:

Just because we do things differently than other people, that we're not a bad person. I think we are usually the teachers who relate better to the students, we're good at problem-solving, we think out of the box, and I've noticed in the past couple years, we're the ones our administrators go to when they want something done, or maybe a different answer.

Lucy feels that we as educators, should not push the educational establishment to know more about mental disorders in teachers. She claimed, "I don't think that needs to be pushed on them because I think that in a round-about way, I feel they would slowly push us on out the door"

(Lucy, personal communication, March 12, 2015).

Patty

Patty thinks diagnosed mental disorders in classroom teachers “is so widespread they [systems] need to do something.” She added:

Maybe they need to be more understanding instead of making us train and train and train...I think there could be some support, just talking about it, making more people available for discussion, like counselors for the teachers. They have them for the kids.

Patty would like for governance to know that teachers having mental disorders is more common than the education field knows or believes exists. She added, “They need to give more help to those who need it...I don’t really feel like they do anything to help relieve stress.” Patty continued:

I understand we have things [regulations] from the state, but you also need to take care of your teachers. I think they’re losing a lot and a lot of people don’t want to get into the field. I understand we’re concerned about the kids, but you’ve got to take care of the people who take care of the kids. (Patty, personal communication, July 20, 2015)

Susie

Susie doesn’t know of any specific programs that could help teachers with diagnosed mental disorders. She believes that her administration does not support her and even gossips about her problematic mental health. Susie said, “I think what I tell my principal should be confidential under all circumstances.” She continued, “I just think that crazy or not, if you have an issue you should be treated the same way as other teachers, and we’re not” (Susie, personal communication, March 7, 2015).

Tessa

Tessa does not know how school systems could help those teachers with diagnosed mental disorders but has an opinion about her administrator, “I would never want him to know because I don’t want him to have anything that he could possibly use against me because I don’t trust him.” Tessa said that governance should “be more aware of mood changes and things that happen. Now we are so compartmentalized we don’t even know each other anymore” (Tessa, personal communication, July 22, 2015).

Wilma

Wilma feels that if the system does not know about your mental disorders, they can’t help you. However, “there is a stigma attached to the disclaimer of having a mental disability.” She also believes that the administration “may not understand because sometimes they are aware of certain illnesses but they don’t understand how it affects the person.” In a previous occupation, Wilma mentioned to her supervisor about the ADHD and the supervisor said, “Well I just feel that you can get organized” to which Wilma replied, “I am trying.” Wilma felt the stigma attached to the ADHD left her supervisor unsympathetic.

Wilma would like governance to know that new teachers do usually struggle and administrators should ask the new teacher if they need help. Wilma’s first principal did ask her and Wilma had said, “Honestly I feel like I am all over the place.” Wilma was sent to a “consortium on getting organized” and on “time management,” however, she admits she still struggles with these issues but it has gotten much better with experience. An administrator recently told her, “When others who may not know you come to your classroom, you don’t want

to get in a position where they may evaluate you and think you don't know what you're doing” (Wilma, personal communication, June 6, 2015).

Summary

This chapter has focused on the shared experiences of nine classroom teachers who have diagnosed mental disorders. Biographies were presented in their voices. From the data analysis, the research questions are answered followed by four themes that emerged from the classroom teachers shared experiences in this phenomenology study. Triangulation included individual interviews, a dyadic focus group, and participant journals. Repeated readings of all transcripts and annotations in the transcripts led to categories based on the research questions and sub-categories, followed by codes in text segments. Four themes emerged: (a) Teaching is very stressful, (b) Medication is the key to ‘normalcy’, (c) Not everyone can be trusted, and (d) Having mental disorders is not all bad. Multiple quotes have been included to demonstrate the thick rich voices of the experiences of the classroom teachers.

CHAPTER FIVE: CONCLUSION

Overview

The purpose of this hermeneutic phenomenological study is to describe and understand the experiences of classroom teachers who have diagnosed mental disorders and how their disorders affect them in the school environment. In this chapter, the researcher will offer the readers a summary of the findings of this study, a discussion of the findings in relation to the literature in Chapter Two and the theoretical framework, implications for the education field, the study's delimitations and limitations, and recommendations for future research. The results from Chapter Four will frame the discussions drawn from this study.

Summary of Findings

The central research question of this study searched for answers as to how teachers diagnosed with mental disorders describe their experiences in the school environment. Through the process of coding, categorizing, and annotating transcripts of interviews along with multiple re-readings of these interviews, I asked the question stated in Morse (2008), "What is this about?" Data analysis revealed answers to the research questions and four themes emerged after exploring the categories and sub-categories that were developed from the data of the shared experiences of classroom teachers with diagnosed mental disorders.

The research questions providing the framework for this study include:

Central Question: How do classroom teachers diagnosed with a mental disorder describe their experiences in the school environment?

1. How do classroom teachers diagnosed with a mental disorder describe their emotions as it relates to feelings, thoughts, and reactions experienced in the school environment?

2. How do classroom teachers diagnosed with a mental disorder describe their relationships with their students and peers?
3. How do classroom teachers diagnosed with a mental disorder describe their sense of professionalism in the school environment?
4. What factors do classroom teachers diagnosed with a mental disorder identify as contributing, or influencing, their decision to disclose their mental disorder within the school setting?

In addition, participants were asked what solutions or programs can be taken by the school or district to ease symptoms or behaviors associated with mental health disorders and what they would like administrators and local governance to know about diagnosed mental disorders in the classroom teacher.

Research Questions

Central research question.

The Central Research Question focused on the experiences of classroom teachers with diagnosed mental disorders. Precursor questions explored reasons for becoming a teacher, the favorite part of being a teacher, challenges, strengths, weaknesses, and coping strategies from having a diagnosed mental disorder. Five of the nine teachers had always wanted to become a teacher and four participants said that teaching was a second career. The participant's reasons for wanting to become a teacher mirrors previous literature, such as teaching would be rewarding and a stable career (Jarvis & Woodrow, 2005; Marshall, 2009), they were inspired by teachers they previously had (Marshall, 2009); they always wanted to teach since they were children

(Jarvis & Woodrow, 2005; Marshall, 2009), and they had a desire to work with children (Jarvis & Woodrow, 2005; Rinke, 2008; Sinclair, 2008).

As to their favorite part of teaching, five teachers stated they enjoyed seeing their students learn throughout the school year and to see the growth and progress (see Table 3). Three teachers loved building relationships with students. A few teachers had self-serving reasons as to what they liked most about teaching, which seemed familiar to Friedman's (2006) proposed theoretical model called "*The Teacher's Bi-polar Professional Self*" (TBPS). This theory speculates that there is a continuum where the narcissistic needs of the teacher are on one end and on the other end are the altruistic aspirations for the students. In the middle of the continuum is a tension-filled area where teachers attempt to compromise both their needs and the students' needs. A teacher's narcissistic needs are seen as receiving some type of reward that includes power and influence, getting respect and appreciation from all stakeholders, and positively affecting the students' future. For Anne, it seemed that the gratification came from the process of teaching rather than the end result. Anne stated honestly, "I like taking them from not knowing and understanding something to knowing and understanding something, I really get off on that. It's like wow, look what I did." Anne continued, "It gives me a sense of accomplishment. It's for their own good, but I am getting my needs met." For Patty, having her students remember her by having "a lasting memory of me" is important and she said, "I want that." Susie said her favorite part is seeing "the students grow and not need me as much." Laura and Jackie enjoy "having summers off."

Challenge and weakness responses were combined and the data indicated there were relationship issues, classroom/student issues, personal issues, emotional issues, and for some,

family issues. All nine teachers expressed they had relationship issues with administrators, colleagues, parents, and students. The issues regarding administrators included they abused their power; teachers not being involved in decision-making; a lack of support in areas, especially student discipline; lack of independence with the curriculum; too many observations and evaluations; and too much testing of the students. Issues with colleagues stemmed from not trusting other adults in the school environment due to the lack of support, conflicts with team members, gossiping, and dishonest people. Several teachers mentioned they did not really have many friends and they preferred to keep to themselves. Issues with parents generally involved the parents not supporting the teacher when the children misbehaved and/or interrupted academics. All of the teachers had issues with students ranging from discipline issues, personality conflicts, a lack of student motivation, frustration over low achieving students, and the work involved with differentiating the many different levels of abilities in the classroom. Six teachers felt they were inept at meeting all of the needs of the various students in their classroom. For a more complete list, please see Table 4. The teachers used various coping strategies. Three teachers said they used self-talk and two participants said they would get advice from other colleagues or an administrator. The remaining coping strategies were unique to each participant (see Table 4).

All of the nine teachers had some type of personal issues such as having a lack of organizational skills, lack of time management, difficulty in staying focused, being too impulsive, having too many tasks going at once, and/or being too honest with colleagues. Five participants had difficulty with staying organized and a lack of time management. Three participants expressed their impulsivity and lack of control in blurting out before thinking, being

too honest with others, and disliking faculty meetings. Two participants had attendance issues directly related to their mental disorders. Six teachers mentioned issues they had at home, but most of the teachers correlated those issues with the stress from school.

All nine participants had some type of emotional issues regarding stress, feeling a lack of control over their environment, feeling like a failure, feeling discouraged, low self-efficacy, lack of patience, feeling pressured to meet deadlines, worried about how others perceived them, feeling discouraged, and difficulties with frustration and anger. Five teachers described their difficulties with not being able to let things go and ruminating excessively over choices, actions, and events. Teachers described not being able to sleep, crying, going over and over events in their mind, and self-doubts. Four teachers believed they were harder on themselves than others were and four teachers feared failure.

The teachers had several different answers as to what their strengths were in the school environment. Five participants believed they had a good understanding and acceptance of their symptoms of mental disorders, which led to being more self-aware. Five teachers believed that their diagnosed mental disorders were an advantage in their ability to identify, understand, and assist students who exhibited symptoms of mental disorders. They also felt they were more compassionate with those students. Five teachers felt they were able to communicate those symptoms with parents and students (if appropriate). Interestingly, five teachers mentioned that they had academic or behavioral problems when they were children and this now leads to a better understanding in teaching students in those difficult areas. Other popular answers included that the children come first, they were honest in their character, they had good classroom management, and they work hard for their students. For a more complete list, see Table 5.

Research question one.

Research question one focused on experiences each participant had where they could not control or self-regulate their emotions, what the consequences were, and what factors increased their mental disorder symptoms. The majority of the situations that led to problems with controlling emotions involved administrators, colleagues, parents, and/or students; however, the majority of these circumstances were not in isolation. For example, for Jackie the problem started out with a difficult child whose mother was a teacher on her team. The mother supported her child and the administrator did not support Jackie or assist Jackie with either the student or the other teacher (mom). This situation left Jackie very emotional for a few weeks and she questioned her abilities as a teacher. Jackie admitted she had sleepless nights and conversations with her husband and other colleagues over this situation. The resulting anger still lingered months later as evident in the interview with Jackie. Of interest, many teachers who commented on negative emotions explained that those events happened with other adults and mostly occurred outside of the classroom and not in view of the students. Stressful emotions tended to occur during faculty meetings, in the hallway, the administrator's office, after school hours, and even at home. It is not uncommon for medication to diminish by the end of the school day and this could explain why these moments were more difficult in regulating emotions.

One emotion emerged as a frequent and underlying explanation for the other emotions that teachers experienced, and that emotion is fear. For most of the teachers, they did not know that was the hidden emotion, and for most, the fear was irrational as they feared future events that probably would never occur! The emotions elicited during the daily experiences of teachers included frustration, anger, raising one's voice, crying, anxiety, and several participants had

problems with ruminations for days, weeks, and sometimes months about the confrontations. These continuous re-enactments of the events in the mind led to self-doubt, unhappiness, and for some, a visit to their medical or mental health professional. Teachers listed the top factors increasing their mental disorder symptoms are the constant demands on teachers in the school setting and the disrespect from students, the students' lack of motivation and poor work ethic, and not being in control of a situation.

Six teachers admitted to being called into an administrator's office over these instances of not being able to control or regulate their emotions. The emotions from the consequences included embarrassment and humiliation, along with absences from school, lower evaluations, and questioning of their self and actions, which included ruminations. See Table 6 for a more complete list.

Research question two.

Research question two focused on how teacher's diagnosed mental disorders affected the relationships in the school environment and their ability to be a role model. Most participants felt their relationships with the students were very good. Three participants stated the best part of teaching was getting to know the kids and building relationships with their students. Many participants noted that relationships with adults (administrators, colleagues, and parents) were difficult at times with teachers feeling they were not supported. Three participants explicitly responded that they did not trust their administrators and/or colleagues, although this lack of trust was expressed by three other teachers in answering different research questions. Only five of the nine participants felt they were role models for their students. One participant said she was a role model to certain students, and the other three participants did not see themselves as a role

model. Alexa and Tessa stated they were “mom at school,” and both Alexa and Jackie said, “I’m just me.” See Table 7 for a more complete list.

Research question three.

Research question three focused on how teachers with mental disorders described professionalism and if having a mental disorder changed their image of themselves as being a professional. All nine of the participants defined professionalism as doing the job to the best of your ability and/or being respectful and showing respect. Other popular responses were being present at work and following the rules and ethical standards. Krishnaveni and Anitha (2008) and Lei et al. (2012) stated that teachers show professionalism by empowering themselves and continuously developing their personal and professional life through continuous learning opportunities. Seven of the teachers in this study do have advanced degrees.

Most participants did feel that they worked hard at being professional, although a few participants had difficulty with seeing themselves as a professional. When teachers answered they lacked professionalism, they listed they had difficulties listening to the children, they had too many tasks going and it frustrated the children, they had a hard time accepting choices made by the administrators, and they would avoid others to avoid miscommunication with colleagues (see Table 8).

Research question four.

Research question four focused on whether or not teachers with diagnosed mental disorders disclosed to anyone in the school setting, who they disclosed to, how they felt about disclosing, and if they perceived their mental disorders as being a “stigma.” Six of the nine classroom teachers did consider it a stigma to have mental disorders, although that did not

prevent most of them from disclosing to others at school. The seven teachers who did disclose about having a diagnosed mental disorder generally told close colleagues, or administrators if they felt it was professional to disclose. Charmaz (2010) found that disclosure is usually done to explain odd behaviors, to explain difficulties of completing tasks, to gain acceptance, or to educate others on the illness. Some participants would confide in parents in order to help the students who displayed symptoms of a mental disorder, and a high school teacher stated she would discuss her ADHD with students having or displaying symptoms of ADHD.

Only two teachers admitted to not disclosing to anyone in the school setting. One participant did not trust anyone to keep the information confidential and for the other participant, Tessa, an African American, she said it was part of their culture not to talk about mental health issues and “you just go to church and pray about it” (see Table 9).

Final considerations.

Teachers were asked how school systems and governance could assist those with diagnosed mental disorders and if they knew of any programs intended to ease stress within the school environment. Most teachers felt that school systems do not want to know about mental disorders in teachers and if a teacher were to confide about their diagnosis, their career could be jeopardized. There were many different thoughts and comments and many of the responses did not elicit much hope or promise for interventions or strategies to assist the classroom teacher diagnosed with mental disorders. See Table 10 for the responses from the teachers.

Themes

Van Manen (1990) describes phenomenology as a systematic attempt to “develop a certain narrative that explicates themes while remaining true to the universal quality or essence

of a certain type of experience” (p. 97). There are four themes that emerged from multiple readings of the data regarding the experiences of classroom teachers who have diagnosed mental disorders. Themes identify links between categories and concepts (Connelly & Peltzer, 2016). First, the sub-themes from Tables 3-10 were combined into categories (see Appendix G). Next, four themes were identified by examining the common experiences of the classroom teachers across all of the categories. The overall theme is that “Teaching is very stressful!” The second theme is that “Medication is the key to ‘normalcy.’” The third theme is “Not everyone can be trusted,” and the fourth theme is that “Having mental disorders is not all bad.”

Teaching is very stressful!

This study examined the experiences of classroom teachers with diagnosed mental disorders. This study parallels findings from previous studies that suggested that teaching is a stressful career (Cai-feng, 2010; Lopez & Sidhu, 2013; McCarthy, Lambert, & Reiser, 2014; MetLife, 2013; Richards, 2012; Robert Wood Johnson Foundation, 2016; Skaalvik & Skaalvik, 2016). Lopez and Sidhu (2013) found that 47% of teachers say they experience high levels of stress daily. Additionally, out of 14 occupations surveyed, teachers ranked last in saying “their supervisor always creates an environment that is trusting and open” (p. 3). Seven in 10 teachers stated they are “emotionally disconnected from their work environment” (p. 3). This lack of workplace engagement is considered to negatively affect students’ lack of academic success. The Robert Wood Johnson Foundation (2016) found “46% of teachers report high daily stress during the school year” (p. 2). This stress came from four sources: (a) the school organization (weak principal leadership, lack of a healthy school climate or supportive environment), (b) job demands (high-stakes testing, student behavior problems, difficult parents), (c) work resources

(limited teacher autonomy and decision-making power), and (d) teacher social and emotional competence (lack ability to manage and nurture a healthy classroom). The nine classroom teachers in this study report the same findings as in The Robert Wood Johnson Foundation (2016) study, including poor administrative leadership, a lack of support in the school environment, high job demands, lack of autonomy and decision-making abilities, a lack of quality colleague relationships, and their personal issues with negative and impulsive emotions and behaviors.

McCarthy, Lambert, and Reiser (2014) found that the high demands of the classroom resulted in lowered teacher satisfaction. The MetLife (2013) survey uncovered that teacher satisfaction has declined to the lowest level in 25 years, with only 39% reporting being very satisfied. Stress among teachers has increased since 1985 as “half (51%) of teachers feel under great stress at least several days a week” (p. 45). The MetLife Survey (2013) also found that teachers with lower job satisfaction are “more likely to be mid-career teachers” (p. 46). The classroom teachers in this study were more mid-career teachers and had from nine to 28 years of teaching experience, with the median being 13 years of teaching. The ages of the participants ranged from 35-55 with the median age being 43 years of age.

Berliner (2013) wrote that government agencies still “cling to the belief that if only we get the assessment program right, we will fix what ails America’s schools” (p. 4). Berliner (2013) continued, “They will not give up the belief in what is now acknowledged by the vast majority of educators and parents to be a failed policy” (p. 4). The achievement gaps between the rich and the poor have not decreased because of the No Child Left Behind (NCLB) Act and any reforms are just “wasted effort if the major causes of school problems stems from social

conditions beyond the control of the schools” (Berliner, 2013, p. 5). In this study of classroom teachers, many would agree that all of the testing is not the answer. Alexa shared that she had tears running down her face when the principal told the staff they would be buying a program to test the writing skills of the students. Alexa stated, “I got upset because here is just another test to assess my students to see if they are ready for the test!” (personal communication, January 26, 2016; personal communication, February 18, 2016). Laura wrote about the negative home environments of her students that affect their academic success and she stated, “My job depends on their test scores” (personal communication, February 20, 2016).

Participants in this study of classroom teachers felt that the many demands on teachers are very stressful. The demands discussed included difficult behaviors in students, the evaluations from administrators, having too many responsibilities required from them, and the various academic levels of the students and the amount of differentiation needed. With the push for inclusion of special needs students, some teachers find it difficult to meet all of the student’s academic needs. Laura expressed her opinion that although “most special ed. teachers do their best, but they TOO [emphasis added] are overwhelmed with a lack of resources, too many demands, and too little time.” Laura has seen “some special ed. teachers WAREHOUSE [emphasis added] children and ‘tweak’ their data to show ‘improvement’ on specific goals, but the improvement, in reality, doesn’t even exist” (personal communication, January 20, 2016). Anne would get low academic students, such as “push-out from special ed., self-contained” and in addition to her regular education students, the children from the “early intervention program, I get the majority,” and she stated:

If we [team of teachers] shared it a little bit more, if everybody did what they are supposed to do when they have them, then I would have a better quality of life and the children I was serving who had those needs would get more from me and the kids who don't have those needs would get more from me. It disadvantages everyone when you do that.

Several teachers discussed the pressure added by having frequent observations and evaluations by administrators. Alexa believes she is a good teacher and stated, "All it has done is make me a more stressed teacher." Anne also considers herself to be a good effective teacher and after one of her evaluations, she said to the principal, "I said look, I can tell you the things I'm not good at, I know what my weaknesses are, but things that you gave me a '3' on the first go around are actually what I am good at!" Jackie was upset about her evaluation and said, "I had '2s' in that [evaluation], I've never had '2s' in differentiation...and then on professionalism!"

Susie discussed that because her administration dislikes her, it "has resulted in the principal giving unfair, negative evaluations." In one of Wilma's observations, she did not have a lesson plan prepared and she said to the administrator, "Well my ADHD brain." The administrator told her "you're not a new teacher so I get it...it is important you always have them" and Wilma replied, "Will do." Wilma said, "I would get so nervous because I knew I would struggle reading through my own lesson plan, not because I didn't know it, but in trying to follow it."

In the current trend of assessing a teacher based on student's achievements and successes, teachers with diagnosed mental disorders find this unfair because the child's home environment

and the students' mental health is not taken into consideration. Of interest, in Georgia, students take a survey to evaluate their teachers and it is not uncommon for some students who dislike their teacher to want to sabotage them.

In previous research (Richards, 2012; Skaalvik & Skaalvik, 2016), teachers noted they were *not given* the time needed to complete everything they needed to do for their job satisfactorily. In this study, Alexa and Wilma stated that they did not get enough time on pre-planning days due to meetings and other tasks required by their administrators. However, six of the nine teachers (including Alexa and Wilma) stated that their personal struggles were from their lack of time management ability, a lack of organizational skills, their impulsiveness, and their difficulties with staying focused. Could this "lack of time given" concern be due, in part, to mental disorders that were not considered as factors for the lack of time reported; that the teachers' own personal struggles with mental disorders could be a factor in the lack of time needed to complete the requirements in the school environment?

In a study by Cai-feng (2010), the research found that poor mental health had a negative effect on work performance in university teachers. Carlotto and Camara (2015) report that psychosocial variables such as role ambiguity, overload, low level of social support, and low level of perceived self-efficacy were significantly associated with the increase of common mental disorders. Carlotto and Camara (2015) defined overload as it "happens when there is too much work to be developed in a short period of time and the individual has scarce resources to do it" (p. 205). Teachers with diagnosed mental disorders in this current study discussed the heavy workload, high expectations, and the lack of social support as challenges and weaknesses in their school environments.

Medication is the key to ‘normalcy’.

Sirey et al. (2001) found that a “patient’s perceptions of the severity of illness was a more powerful predictor of [medication] adherence than was the actual severity of symptoms” (p. 1619). This requires that a person accept their illness. Sirey et al. (2001) also found that even though the participants accepted their diagnosis, there was still “the fear that others may be critical and rejecting” (p. 1619). They further uncovered that when their participants stopped taking medication, “it may be to counter the notion that they are now part of the devalued group of ‘mentally ill’ individuals” (p. 1619). In this study, Laura admitted, “I didn’t want to face the fact that there’s a problem because of the stigma attached to it. Because you know back in the day, if you were crazy they just put you in a home or in a facility.”

Seven of the nine teachers in this study were on a medication regime and understood that medication was the only way to help survive the daily stresses in the school environment. However, they still reported that they were stressed in the school environment, even on medication or having increased their medication dosage. Alexa had attempted to stop her medications as she thought she could “deal with it on my own.” She admitted, “It was horrible” and “I cried a lot. I went into the fight or flight mode.” Alexa stated she wanted to “go to the Bahamas and disappear on an island.” She summed it up by saying, “that’s the lowest I’ve ever been when I quit taking them. That was lower than when I first started taking them.” Without medication, Anne stated, “It would not be good. I would be very dysfunctional.” She added, “I would cry a lot and I would not get anything done...I would be much more irritable and I would have more of the migraines” and “I would miss more work, have poor, very poor interpersonal relationships, and I would be really unhappy.” Patty said, “I’d be very irritable, very jumpy, um,

just all emotions like I would be like a rollercoaster.” Jackie said she would “panic” and “clam up.” Laura flatly admitted, “I couldn’t do the job without medication.” Susie expressed, “I’m probably not in school the next day,” and added that she would be “panicking because I can’t go to sleep,” and “I would have cold sweats, um, everything is just very magnified.”

Tessa is African American and said that mental illness is not discussed in her culture. Ward, Clark, and Heidrich (2009) found that African American women tend not to rely on medication for their mental disorders. Their participants “endorsed a range of coping behaviors, including seeking professional help, using informal support networks, prayers, and avoidance” (p. 1598). There is a cultural perception in the African American community that “you can handle it on your own,” there is a “strong woman syndrome,” and “what happens in the family stays in the family” (p. 1597). Tessa stated she needs her medication and said, “I’m afraid to stop. We [with the doctor] tried to wean one-time and I couldn’t do it.” She added that she “would have short patience in the classroom. And that was more so my issue, the least little thing would set me off and I said I can’t do this, I can’t be in the classroom and not be medicated!”

Two teachers (Lucy and Wilma) in this study were diagnosed with ADHD and both of them said they did not consider ADHD to be a mental disorder. Research indicated that adult ADHD has substantial negative outcomes social, academic, and personal wellness (Combs, Canu, Broman-Fulks, Rocheleau, & Nieman, 2015; Kooij et al., 2012; McIntosh et al., 2009; Newark, Elsaaser, & Stieglitz, 2016; Ramos-Quiroga et al., 2015; Rostain, 2016). Several studies (Instanes, Haavik, & Halmoe, 2016; Kessler et al., 2006; Kooij et al., 2012; McIntosh et al., 2009) discuss the comorbidity that ADHD has with other mental disorders, and the lack of

diagnosis of other mental disorders can worsen the comorbidity of both the diagnosed and undiagnosed disorders because of treatments prescribed. Ramos-Quiroga et al. (2016) stated that 75% of people develop a comorbid disorder across the life span. Newark, Elsaaser, and Stieglitz (2016) found that adults with ADHD have lower levels of self-esteem and self-efficacy. Combs, Canu, Broman-Fulks, Rocheleau, and Nieman (2015) found that individuals with ADHD, particularly those with inattention and slow cognitive speed, led to higher levels of stress.

Both Lucy and Wilma were not on medication for their ADHD and did report difficulties in time management, organization skills, impulsivity, and lack of focus. Lucy had to stop taking her medication as she was diagnosed with a heart condition. When she stopped the medication she said, “In a few weeks all those symptoms came back, I was irritated with myself, I couldn’t talk, especially to adults. I could not tolerate adults. I was like what went through my brain came out my mouth.” She added, “Now I’ve kind of adjusted to it so I can control it better, but it’s hard, it’s hard. And I can’t get anything done.” Lucy admitted, “I’ve even thought about just taking half of the medication that they had me on, just to see, as long as it doesn’t increase my blood pressure taking half of the medicine.” Wilma shared that her doctor said, “You know what, you don’t need to do anything you’ve managed so far no problem.” Wilma will not consider medication even if the doctor had suggested it. Wilma described her biggest challenge as “keeping up with the grading” and when there’s a lot going on, she said, “I feel edgy” and “I am ready for this to be over you know, you do get burned out, and you’re ready for a break.” Wilma admitted to asking herself this question, “Why am I so scatter-brained sometimes and what do I need to do?”

Not everyone can be trusted.

Research has found that teachers who had positive relationships with colleagues and administrators were less stressed and had better mental health (Corr, Davis, Cook, Waters, & LaMontagne, 2014; Margolis & Nagel, 2006; Richards, 2012). All of the nine teachers in this current study did discuss negative or untrusting relationships in the school environment. Jackie said she is “more reserved as far as the teachers at school, I’m reserved with them anyway because I don’t trust them there.” She does not trust her administrators either. Lucy doesn’t trust colleagues because what she says “basically gets misconstrued and it always ends up being what you didn’t say,” and she added, “I lost a good friend a couple years ago because of that...so I just quite talking to people.” Anne said, “There’s people I don’t trust to keep my business secret.” Anne added, “A lot of people still make fun of me because my social skills curriculum is not hidden, it’s right up front.” Anne talked about a colleague, “I over-participated in meetings and then they didn’t like it and she would shame me in front of the group.” Susie said, “People that I’m friends with, I don’t trust them.” Alexa discussed a previous administrator, “I had caught him so many times in lies that I didn’t trust him and didn’t have respect for him.” Alexa stated that a few of her colleagues “went and tattled on me and I got in trouble.” Tessa did not want her principal to know about her mental disorders and stated, “I don’t want him to have anything that he could possibly use against me, I guess because I don’t trust him.” Wilma has found some of her students to be disrespectful and described a student who would “cuss people out, act like an idiot, talk excessively.”

Another area of trust involves decision-making, which involves the administration making all of the decisions without input from teachers. Stone-Johnson (2014) found that

veteran teachers tend to become bitter about changes and feeling that their identity has been worn away. Alexa stated that her principal wants total control and “cannot stand anybody that has an opinion that’s different from hers. She wants them butt-kissing robots.” Alexa, Laura, and Lucy discussed that not having “control” over their environment causes stress.

Other classroom teachers felt a lack of support from administrators or colleagues. Susie stated that the principal gossips about her and “she’s really what’s stirring it up.” Laura was a bit dismayed when her administrator “transferred [a student] out of my room because the grandmother and mother said I was racist.” Tessa also “had an administrator take a white student out of my classroom because the parent felt her child would do better with the white teacher. This was a parent who threatens law suits.” Some classroom teachers did not feel supported when they had students misbehaving and disrupting academics. Lucy and Laura stopped sending disruptive students to the office because the kids would come right back after having been sent to see the administrator. Lucy stated, “I’d just deal with them myself because I knew that taking them down there nothing was going to happen.” Laura said, “A lot of stress as far as classroom behavior, when the kids are acting up and they’re out of control and there’s really no help, there’s really nobody that will back you up.” Skaalvik and Skaalvik (2016) found that a lack of support from supervisors led to high levels of stress and thoughts of leaving the profession. Laura had a difficult special education student and lacked administrator support. She said that if she ever got another student like that, “I think I would probably resign as I can’t do that again.”

Having mental disorders is not all bad.

Classroom teachers in this study felt they had strengths because of their mental disorders. Alexa stated, "I can deal with the awkward children, like the ones that don't fit in or the ADHD bouncing-off-the-wall kids, I understand where they're coming from because I was a bouncing-off-the-wall kid." Anne said, "We can do two and three tasks or things at once, and do them fairly well." Jackie stated she was efficient at assisting students who needed extra interventions by making "sure that I'm dotted my I's, and crossing my t's...I will make sure that I'm following everything that I can for that to make sure I have the correct documentation." Laura said, "I have energy from the ADHD" and "I make sure I'm overly prepared, very ordered, and organized." Lucy shared, "I am very outgoing...I'm very active." Patty stated she is a rule follower and "I'm extremely obsessive-compulsive, and that goes with my classroom management and my discipline." She added, "If anything we've become more caring and we understand the kids better." Tessa and Wilma said their strengths are their ability to form and relate with their high school students. Other strengths discussed included the ability to assist parents of students who showed symptoms of mental disorders, being more compassionate towards those students, being honest, putting the kids' needs first, and working hard for the kids. Teachers stated that having academic and behavioral issues as children made them more self-aware and able to help their students. Susie is the only participant who felt she did not have any strengths in the school environment.

Discussion

The purpose of this study is to describe the experiences of classroom teachers with diagnosed mental disorders using a hermeneutic phenomenological approach. The findings of this study of classroom teachers with diagnosed mental disorders and their experiences fill a gap

in the literature. Previous studies tend to rely on self-assessment scales given to participants by the researcher and not actual diagnoses from medical and mental health professionals. This study of teachers with diagnosed mental disorders advances the literature from previous studies that found that teachers are stressed and many suffer from burn-out. In this study, all participants stated their mental disorders were biological, which means their disorders were inherited. There is a social component to their disorders also, as other family members (usually one or both parents) had diagnosed mental disorders so that the symptoms and behaviors exhibited by other family members were learned by the participants in this study. Therefore, due to the intense stress of teaching experienced by the participants in this study, it can be assumed that this stress occurs, in part, to the symptoms of their diagnosed mental disorders and not just the daily environment of teaching.

The findings of this study corroborate previous findings in regards to having mental disorders in the workplace (not teaching) and having parents with mental disorders, as participants with depression and anxiety in previous studies had many of the same challenges as the teachers in this study: mood swings, trouble with emotions, difficult relationships, low self-efficacy, negative feelings from the stigma/label attached, and fatigue from poor sleep patterns. As far as the literature on the bullying of children, only one participant admitted to leaning in that direction. The remaining eight participants described the relationships with their students as very good and described how the children's needs take priority. In this study of classroom teachers, administrators who exhibited full control over the school environment typically did the bullying. This study of classroom teachers also corroborates the literature on the reasons for teaching, such as loving children, always wanting to be a teacher, and wanting to impart their

knowledge on students. In this study of classroom teachers, four of the nine teachers stated that teaching is a second career. Previous research stated that people went into teaching due to steady employment of teaching with more security, they had valuable skills to offer, they did not like the corporate world, or they were let go as the company down-sized. In this study, two of the four teachers had been let go due to downsizing of the company they worked for. However, all of the second career teachers in this study considered the work schedule (holidays, weekends, and summers off) and being able to be with their own children as most important in choosing the teaching profession.

This study found a connection between the modified labeling theory and in part, the social identity theory. For the modified labeling theory, six teachers believed there was a stigma attached to their disorders and two of those six teachers chose not to disclose to anyone in the school environment. For the three teachers who felt there was not a stigma attached to having a mental disorder, at times statements in their interviews indicated the opposite. There is speculation that they may view their disorders as a stigma; however, they chose not to accept their disorder as being negative. The results of this study corroborates previous research on the modified labeling theory that stigma does, at least initially, impact how people feel about their diagnosis/label in regards to prejudice and biases they perceive others may have. Most of the teachers believe they need to educate others on mental disorders in order to accentuate the positive aspects, such as you can have a mental disorder and still perform in a stressful teaching environment. This study of classroom teachers adds to the study of Willetts and Clarke (2014) who utilized the social identity theory to bring light to the two levels of professionalism that can exist in a working environment. Willetts and Clarke (2014) advocate for different standards

depending on the reality of the job at the base level. In this study, teachers felt others judged their professionalism more negatively at the school level, which made them question their professionalism in general. Maybe the definition of professionalism in teaching should be more realistic to actual job demands and the stresses associated with those many demands.

This study of classroom teachers uncovered some unexpected and interesting results: (a) administrator bullying, (b) the lack of trust in adults in the school environment, (c) the absolute need for medication to alleviate the symptoms of the diagnosed mental disorders, (d) sleep difficulties and the seemingly endless ruminations over negative events, (e) problems at home because of the school environment, and (f) teachers being aware of other educators with mental issues who are not diagnosed, or if diagnosed, are not getting the support needed from medical or mental health professionals. A thought is, if so many teachers are believed to have mental disorders in the classroom, are people with mental disorders more attracted to the teaching field? Overall, this study extends the literature in education to include classroom teachers who have diagnosed mental disorders and how their experiences impact all stakeholders in the school environment.

Theoretical Framework

The main theories framing this study are the modified labeling theory by Link et al. (1989) that extended Scheff's classic labeling theory of 1966, and the social identity theory (Tajfel et al., 1971).

Modified labeling theory.

The modified labeling theory contends that society, and sometimes the individual who has the mental disorder, will stereotype individuals or themselves through stigma, "a set of

negative and often unfair beliefs that a society or group of people have about something” (Stigma, Merriam-Webster Dictionary online, n.d.). The modified labeling theory states there may be negative consequences of stigma that could cause a person to develop more mental disorders or repeated episodes (Link et al., 1989; Moses, 2009; Thoits, 2011). Thoits (1985) expanded upon the modified labeling theory to include self-labeling and focused more on the use of strategies to deny, deflect, isolate themselves, accept the diagnosis, and challenge others’ stereotypes of mental illness.

Pasman (2011) stated that “stigma can be internalized and create self-stigma” (p. 122). She elaborated, “A label could function as a justification of socially unacceptable behavior, making it possible for an individual to blame his disorder, rather than his character flaws, for his behavior” (p. 125). Pasman (2011) affirmed that labeling can also have a positive effect by encouraging the person “to get the right treatment” (p. 125), “to rehabilitate or empower themselves against prejudice” (p. 125), and can “foster interpersonal understanding” (p. 122).

Szeto, Luong, and Dobson (2013) found that the use of the specific label “depression” was perceived more negatively than general labels, such as mental illness or mental disorders. Although stigma exists towards those with mental disorders regardless of the label, “the term ‘depression’ was rated as more unfriendly, more unpleasant, and generally more negative” (p. 667).

Classroom teachers in this study discussed stigma, being labeled, and whether or not they disclosed to anyone in the school environment. Several participants discussed that mental disorders come with a “label.” Alexa admitted that diagnosed mental disorders are “just a label,” but stated, “Labels don’t bother me.” Anne said, “I get grouped in with lower functioning people

who have this disorder and as soon as that label comes into play, I get lumped in to them.”

Jackie doesn't want her kids to know about her mother's schizophrenia and stated, “I don't want them to have that label that their grandmother is a nutcase.” Susie said that because of her mother's mental illness, talking about it “was taboo” and Tessa said that the stigma of mental disorders was “cultural” for her. She continued, “In the African American community, because we're not supposed to have those things, we're not supposed to go see a psychiatrist, you know, you just go to church and pray about it and everything is going to be okay.” Ward et al. (2009) found there was a stigmatizing attitude and discrimination in the African American community regarding mental disorders. Wilma was concerned when she told her administrator about her ADHD, as she “didn't want it to come across as an excuse.”

Because of current stigma regarding mental disorders, participants revealed their diagnoses to close colleagues they trusted, administrators when they had to, and sometimes to parents and students, as appropriate. Seven out of nine participants had disclosed to someone in the school environment about their mental disorders. Participants seemed guarded as to whom they told, but once a relationship was established, they were more freeing with the disclosure. Jackie and Tessa have not disclosed to anyone at school. Jackie stated she has not disclosed because “you cannot trust many people where I'm at” and she did not want the parents thinking “I'm not 100% capable of doing my job or I am incompetent as a classroom teacher.” Tessa said, “I don't want any negative perceptions to cloud the kind of teacher that I am.”

Gough (2011) found there are no guarantees that disclosure of mental disorders will facilitate changes in attitudes and thinking of others. However, Gough (2011) discussed some benefits that may occur by disclosing: (a) to facilitate learning to improve understanding and

challenge assumptions, (b) to facilitate social change in negative beliefs, stereotypes, and discrimination, and (c) to trigger disclosures from others who may be mentally unhealthy from the burden of keeping the secret of their mental status.

The results of this study builds on previous studies that support the modified label theory of Link et al. (1989) that suggests that labels, in this case diagnosis, do impact those with mental disorders. Most teachers did believe there is a stigma attached to having a mental disorder and were cautious of whom to disclose to, if they did, in their school environments. Some teachers avoided getting the diagnosis of a mental disorder because of the fear of the stigma and after the diagnosis, they did self-stigmatize until they accepted the disorder. “Labels” still have a strong predominance affecting status, prejudice, and discrimination among groups of people in our society.

Social identity theory.

The social identity theory (Tajfel et al., 1971) states that people identify with those who are based in their group affiliations and intergroup behaviors. This becomes the “us” group (in-group) or the “them” group (out-group). People adopt the identity of the group (i.e., teachers). Individuals are motivated to achieve and maintain a positive personal identity and a positive group identity (Rodriquez, 2010). The social identity theory states that when groups compete for resources and identity, differences, prejudices, and discrimination can form. Groups adhere to certain standards with similar attitudes and behaviors. The teaching profession has standards that educators must follow and educators are expected to be professional at all times.

The participants in this study of classroom teachers defined professionalism in education in many different ways. The most common definitions included doing the job to the best of your

ability, being respectful and showing respect, following the rules and ethical standards, and being present at work. Some participants felt they were not respected or treated as professionals.

Jackie said her administrator did not believe her when there were issues with a colleague and the administrator thought the worst of her. Alexa admitted, “I have a hard time with this question, because I don't think I am extremely professional.” She was called into the administrator’s office to read standard 10 on professionalism. The principal asked if she read it and Alexa replied, “Yes,” and thought to herself “so leave me alone.” When asked by the researcher what the standard said, Alexa laughed and said, “I don’t know!” Alexa also disagrees with decisions administrators make that she feels are not in the best interests of the children. Alexa asked, “How professional is it for us just to sit quietly by while our students suffer for decisions that are useless and we do not have any input into?”

Three classroom teachers defined professionalism as being present for work. Sado et al. (2014) found that for depression and anxiety disorders, more than half of productivity loss occurs in the workplace. They report that age (younger rather than older) and the number of previous sick days were significant predictors of repeated sick leave. In this study of classroom teachers with diagnosed mental disorders, two participants said they missed work due to symptoms of their disorders. Anne said there are times when she would wake up with bad migraines. She would ask herself, “Can I still give good service, or has it progressed to the point where I could make it through the day but actually the children are going to get nothing out of me being there?” Anne added, “I do battle with myself a lot because I hate to miss work and I think so much of my self-esteem and how I keep myself balanced is feeling successful in my profession.” Anne said that when she misses work “I have to manage those feelings, those worries, those intrusive

thoughts of ‘well you just suck, you can’t even get there.’” Although Anne did not know the term “presenteeism” from the literature in Chapter Two (Ashman & Gibson, 2010; Charbonneau et al., 2005; Charmaz, 2010; De Lorenzo, 2013; Hemp, 2004; Kessler et al., 2006; Palo & Pati, 2013), she was aware that being at work meant more than just a physical presence. Susie struggles with migraines too and admitted to missing work because of them. Susie said her administrator questions her professionalism and she stated, “I guess my mental disorder has led to my not being professional, according to her [principal] because I’ve missed days because of my mental disorder that led me not to have sick days.”

The results of this study indicate that the latest literature on social identity theory is the most relevant and not the tenets of the original theory. Many participants expressed they were professional and followed the standards. However, some participants seemed to have difficulty in their image as a professional, or their administrators had difficulty in the professionalism exhibited by some of these teachers. For the classroom teachers in this study who struggled with being professional, it may be that they have not adopted the identity of the teacher group or it may be that their mental disorders prevent them from fully assimilating into the teacher group of professionals. Walker and Lynn (2013) found in their study that a person’s role identity was actually based on the roles of other individuals and not the group. This aspect of the social identity theory supports how the teachers with diagnosed mental disorders approached the identity of the group- as individuals. Teaching is generally an individual activity and therefore, it is conceivable that in the social identity theory, the “group” may not exist.

Principal and Teacher Bullying

Research has found that bullying is detrimental in psychological, physical, social, and costs to organizations and individuals (Samnani, 2013), including educational environments (Ariza-Montes, Muniz, Leal-Rodriguez, & Leal-Millan, 2016; Blase & Blase, 2002; de Wet, 2010; Fahie & Devine, 2014; Malahy, 2015; Venzor, 2011). Research suggests that power, control, and rule-orientated bureaucratic structures lend itself to bullying in the school environment (Ariza-Montes et al., 2016; Blase & Blase, 2002; de Wet, 2010; Samnani, 2013). De Wet (2010) found that principal-on-teacher bullying can be attributed to a lack of monitoring that governs the behavior and actions of principals. In other words, who is supervising administrators to make sure they are professional and fair? The author defined principal-on-teacher bullying as “the principal’s persistent abuse of power that may impact negatively on the victims (teachers)” (p. 1451). Blase and Blase (2002) believe that principal-on-teacher bullying needs to be addressed and not ignored. They further stated that collaboration “is successful when school principals build trust in their schools” (p. 721) which serves as the foundation for professional dialogue, problem solving, innovative initiatives, and successful learners. Blase and Blase (2002) acknowledged that school districts would be reluctant to allow for studies of “general administrator abuse” (p. 720). Malahy (2015) stated, “Teachers must feel safe in the workplace and be assured that bullying will no longer be treated like a silent epidemic (p. 143).

In de Wet (2010), the researcher found that teachers have a “right to a workplace experience in which they feel valued and respected” (p. 1451), however, the reality is “that schools are toxic workplaces” (p. 1451). At the individual level, teachers expect autonomy, recognition, power, influence, and participation opportunities. However, many teachers “face a

different reality” (Ariza-Montes et al., 2016, p. 819) including rigid hierarchies, excessive bureaucracy, and excessive work demands that interfere with their private lives. This causes “feelings of frustration, disappointment or injustice” (p. 819) that “may result in a greater sense of bullying among teachers” (p. 819). Further, the concern is that what is delivered to students can be compromised by the teacher’s well-being. Ariza-Montes, Muniz, Leal-Rodriguez, and Leal-Millan (2016) stated, “It is easy to imagine how complicated it must be to teach and transmit values when one feels harassed at its own workplace” (p. 820).

In a study in Europe, 48.7% of the teachers have “experienced workplace bullying” (Ariza-Montes et al., 2016, p. 818). Ariza-Montes et al. (2016) stated that research in the area of bullying experienced by teachers is “not sufficiently developed” (p. 819), and that teaching is very susceptible to the issue of bullying by principals and among teachers. Ariza-Montes et al. (2016) believe bullying occurs at two different levels: (a) the organizational level, and (b) the individual level. They stated that teaching has lost its prestige, its traditional social status, credit, and reputation. There is now more competitiveness and hidden agendas among staff members. Inherent in teaching is the ambiguous and subjectivity of evaluations, but “quality and quantity are difficult to measure” (p. 819) in teacher output and “superiors have greater opportunities to make decisions in an arbitrary manner that negatively influence their subordinates’ lives” (p. 819). Ariza-Montes et al. (2016) further added that although administrators may have good intentions in the evaluation system, to teachers it “can generate a sense of injustice, real or imagined” (p. 819).

Fahie and Devine (2014) found their teacher participants struggled with psychological problems (stress, feelings of inadequacy, hypervigilism), physical problems (sleeplessness,

stomach complaints, skin issues, weight loss/gain), social problems (exclusion, isolation), and economic problems (did not seek promotions, resigning, exiting the workplace). Fahie and Devine (2014) reported that once the teachers saw themselves as victims of bullying, they could not see themselves as anything else. This resulted in the “ultimate form of control” and the bully “successfully manipulates the school culture” (p. 247). Malahy (2015) discovered that teachers with higher graduate degrees reported being bullied more than teachers with bachelor degrees. The teachers with higher degrees encountered “negative acts related to having your opinion ignored, or being ignored or excluded” (Abstract, p.2). Malahy (2015) found teachers with doctoral degrees had the highest frequency of bullying encounters.

In this study of classroom teachers with diagnosed mental disorders, participants expressed their lack of control, lack of decision-making, a lack of support and distrust from administrators and colleagues, and a demanding environment that causes them to be stressed, many times with negative consequences. Classroom teachers in this study experienced bullying at times from administrators and colleagues. Alexa stated she had a problem with her administrator who micro-managed and wanted to control everything. Alexa declared, “I don’t feel like I’m allowed to make my own decisions.” She said, “I have issues with the control. I don’t like to be controlled, I don’t like to be told what to do.” Alexa elaborated, “If you tell me what to do, I’m going to rebel against it and do just the opposite. I don’t know why I’m like that but I am. I have problems with authority.” Alexa explained that her principal “cannot stand anybody that has an opinion that’s different from hers. She wants them butt-kissing robots.” Anne, Laura, and Patty discussed that they needed control in their school environment. Laura stated she is “a control freak.”

Jackie stated that her principal did not believe her when there were issues concerning Jackie's integrity and Jackie wonders what her principal's motivation is for being dishonest. Susie knew that colleagues were going to the principal about her so she went to discuss it with her principal. The principal responded by saying that she "doesn't listen to gossip." Susie said, "Whatever!" as she knew her principal did gossip about her. She said, "I think what I tell the principal should be confidential under all circumstances." Susie believes that the gossiping is part of "the school culture" which starts from the top down. Tessa described her principal as "kind-of hands off," he is not "a people person," and "he hasn't formed relationships with kids or staff." She continued, "If you don't form those relationships, you're not going to do well." Tessa noted that the principal ran their school "like a business."

Anne knows that her colleagues "make fun of her" and do not support her. Alexa discussed that her colleagues "tattle" on her to get her "in trouble." Jackie does not trust any of her colleagues in her school due to conflicts within her grade level. Patty and Lucy have experienced conflicts with parents and have not been satisfied with the administrator's level of support. Laura and Lucy discussed their lack of support from administrators with difficult students.

Previous research addressed teachers who bully students (Venzor, 2011; Zerillo & Osterman, 2011). Venzor (2011) found that students bullied by teachers had lowered academic motivation, self-efficacy, and academic performance. In this study, only one teacher, Susie, mentioned she borders on bullying. Susie said, "I've caught myself in the past where I feel like I'm pushing them, just to see. And I'll be like 'don't do that'. I'm just being honest. I try not to ever be ugly, just straight up ugly." Susie elaborated on this:

I think sometimes that it's harder for me, sometimes I'm just like, my mouth- that is a challenge for me. To keep my mouth shut, with some students they pop off at me and I want to pop back. And I don't know if that's everybody, or if it's me. There are some students that can make that sarcasm come out in me. But I ask myself, and I don't know if you ask yourself, but I say "is this because I have this, or am I like this mentally or is every teacher like this?" Some teachers can say what they want and get away with it, like another teacher can talk to her class anyway they want and get away with it, if I had said those things, I'd have been *fired* [emphasis added].

Ruminations and Sleep

Five classroom teachers discussed that they had difficulties sleeping due to the internal ruminations from negative events that happened at school. This was an unexpected finding in the data in this study. Research has uncovered a correlation between stress, rumination, and sleep disturbances (Akerstedt, 2006; Berset, Elfering, Luthy, Luthi, & Semmer, 2011; Cropley, Dijk, & Stanley, 2007; Kosir, Tement, Licardo, & Habe, 2015; Mullan, 2014; Van Laethem, Beckers, Kompier, Dijksterhuis, & Geurts, 2013; Van Laethem et al., 2015).

Cropley, Dijk, and Stanley (2007) found that teachers who have high stress in their job tend to demonstrate a greater chance of ruminative thinking. They also found that "ruminating about work issues in the hour before bed raises cognitive and physiological arousal of the central nervous system, and being highly aroused delays sleep onset and leads to poorer sleep" (p. 190). Van Laethem et al. (2015) discovered that work-related stress, ruminating (also called perseverative cognition), and sleep quality become a "vicious cycle" that "mutually influence each other over time" (p. 391). Akerstedt (2006) reported that "shortened or disturbed sleep" (p.

493) exacerbates the effects of stress. Van Laethem, Beckers, Kompier, Dijksterhuis, and Geurts (2013) concluded that “high job demands and low job control are associated with poor sleep quality” (p. 546). Berset, Elfering, Luthy, Luthi, and Semmer (2011) found that “rumination is the central agent transmitting negative effects of work stress into the sleep phase” (p. 81).

Anne discussed how “not sleeping actually compounds my symptoms.” Anne monitors her sleep each night to make sure she is getting enough. She said, “If I let the insomnia pattern go, then that’s when I drop my basket and everything just starts coming apart, migraines, and my anxiety.” Anne explained, “Part of the anxiety and the OCD for me is also intrusive thoughts and even though I have to do a lot of positive self-talk because of the ruminations, I’ll keep back something all the time, it’s annoying.” Anne shared more, “But my *inner truth* [emphasis added] is, I’m always failing in some way. It’s those obsessive thoughts, it intrudes.” Anne described how she feels:

On the inside are the intrusive thoughts, you know like you feel like sometimes you’ve got on a skirt and you’ve tucked it into your underwear or pantyhose in the back and like everyone can see your underwear and you don’t know it...oh my gosh, my symptoms are showing! I’m on the verge of tears a lot and then at some point if I don’t resolve it, I just start crying and can’t stop.

Anne said, “With the children, I’ll replay something with one of the students and I’ll be like, now that I take a step back I see that it was really this and I should of, could of, done that.” Anne stated, “Yeah I do that a lot.” Susie said, “I think that I have to think more than the average person, about what I say, how I say it, how it’s going to be perceived.” She will catch herself after she blurts out and will ask herself, “Why did you say that? And then I worry about

it all night long. I worry about it forever.” Susie wonders if other people ruminate about negative events and said, “I’m like ‘do other people do this?’” Friends will tell her not to worry so much and Susie replies, “That’s easy for you to say, because you’re not [solely responsible for] making your mortgage!”

Jackie had a problem with her administrator and said, “I wasn’t getting sleep the entire Spring Break and I kept second-guessing myself as a teacher.” Jackie continued, “I had blood-shot eyes, just tired, exhausted, waking up crying at 3:00 in the morning and my husband is like ‘what’s wrong with you?’ and I said, ‘I keep thinking about this stuff and I cannot stop.’” Wilma ruminates over not being able to reach certain students academically and said, “I question myself, what did I miss, what could I have done differently, maybe I wasn’t forceful enough, maybe I didn’t explain it.” Wilma talked about her undiagnosed insomnia and said, “I’m overwhelmed and literally like close to tears because I feel like I’m not sleeping.” She further added, “The ADHD kicks in with your lack of sleep and your brain is in a fog.” Alexa said when she was younger she thought, “I’m not a good person because I can’t even control myself.” When she ruminates she continuously thinks, “I should have did this, I shouldn’t have said that or I should have said this or I shouldn’t have done that.”

Mullan (2014) concluded that interventions to improve sleep are needed due to the “relationships between sleep, stress, and health” (p. 433). Kosir, Tement, Licardo, and Habe (2015) stated that “people who are ruminating remain fixated on the problems and on their feelings without taking action” (p. 140) and suggested that interventions that focused on combating rumination could help alleviate stress in teachers.

We Are Not Crazy

The classroom teachers in this study expressed their concern that just because they have a diagnosed mental disorder, it does not make them crazy. They do not want to be seen as unstable, incompetent, or unsafe around children. Alexa said, "It's a chemical imbalance, and I can't help it any more than you can help whatever's going on with you." Anne stated that she already had her Master's Degree and was already successful in my career when she was diagnosed. She continued, "I couldn't have done all of those things if I was such a horribly broken person." Laura stated, "Just because you have an issue doesn't mean you're a bad person or you're going to hurt somebody's kid. You know we didn't get in the business to hurt kids." Lucy said, "Just because you have ADHD, you're not psychotic!" and she is "not a bad person." Lucy added, "I figure I've gotten this far with it and I haven't hurt anybody...I'd probably had it my whole life and I just learned to channel it because I was able to graduate from college and keep a job." Patty said that after her diagnosis, "I felt like I wasn't crazy, that there was actually something wrong" and it was "something simple." Susie emphasized, "I don't think I'm crazy, I've seen crazy! I think that sometimes I am over-emotional and I'm over-impulsive from my disorders, but I wouldn't think I am certifiable or anything, it makes me like hypersensitive to words like 'crazy.'"

It is necessary to note that not one teacher stated that other people call them crazy, incompetent, psychotic, broken, or a bad person. However, they still *believed* that if people knew about their mental disorder(s), those people would feel this way because of the stigma, label, and negative stereotyping that occurs with having a mental disorder (Link et al., 1989; Thoits, 2011).

The Non-Diagnosed Teacher

Most of the classroom teachers in this study were perceptive about their mental disorders and how their disorders affected themselves and others. Several teachers in this study brought attention to a more important issue, and it is not in regards to teachers who have diagnosed mental disorders in the classroom, but those teachers in the classroom who do *not* have *diagnosed* mental disorders! Administrators should be included in this concern as some participants felt superiors had issues with mental disorders. Anne believed her principal behaved like her mother who suffered from borderline personality disorder. Anne said of her administrator, “It created a dynamic that was more like in my childhood, but once I became aware that she had this [speculation], I would just kind of accept that.” Alexa, Laura, and Lucy shared that they knew of colleagues who struggled with mental health and who were undiagnosed.

Several participants expressed they were aware of colleagues who suffer from mental disorders, diagnosed or not diagnosed. Patty said mental disorders in teachers are “so widespread they [school districts] need to do something.” Laura wrote, “I must say that almost *all* [emphasis added] of my colleagues are on some type of medication that helps calm their nerves. It’s the nature of the business!” Susie spoke of colleagues who she thinks have mental disorders and she exclaimed, “I just know that these people who think they have the perfect life, they don’t.” In the focus group, Alexa stated, “I’m not sure if they had it before teaching or if teaching caused it! But there is a lot of mental illness in other adults in my school! It seems like many are not even diagnosed.” Laura agreed, “I said the same thing! About everyone I work with takes meds plus I know the others just aren’t diagnosed!”

Parcesepe and Cabassa (2013) stated that public stigma towards mental disorders is a barrier that prevents people from seeking mental health care. Szabo (2014) reported that mental health is not considered important by the federal government or insurance companies. Even if people want to get help for their mental problems, usually there is no place to go for that help.

Denial

There will always be people who are in denial about any disorder, whether physical or mental (Thoits, 2011). O'Mahony (1982) found that denial can come from defense mechanisms where the individual cannot self-identify or they have deceptions within their ego about integrating that role of being mentally ill. Yet, the patients do "view themselves as being much more like the mentally ill than usual" (p.109). Livneh (2009) wrote that "denial is an elusive concept" (p. 225) even though it has been studied for more than 100 years. What is known about denial is that there are many different forms, patterns, states, and levels of consciousness that involve cognitive, affective, and behavioral components that manifest in complex ways. Whether a defense mechanism, a coping strategy, or distorted reality, denial can be dangerous. Thoits (2011) discussed a coping strategy called deflecting, where the person denies they are like the stereotypical mentally ill person and does not consider the illness a threat. Bernstein (2010) stated there could be a physiological component where there is impairment to the frontal lobe of the brain that governs self-awareness. This leaves the person with an inability to understand they have a mental disorder.

Wilma is one participant who does not accept or understand how much her ADHD affects her in the school environment. In her interview, she admits to being "hyperactive," "easily distracted," "scatter-brained," "can't sit still," and "my ADHD brain is all over the place"

(personal communication, June 6, 2015). Wilma also stated that her biggest challenges were “keeping up with the paperwork” and “keeping up with the grading.” Her students will tell her “You’re slacking off,” when she doesn’t return their papers graded. Wilma stated she has issues “with time management.” In a previous occupation her boss would get angry with her and say, “I just feel that you can get organized.” Wilma said she would be having “so much fun” teaching that she would miss scheduled activities and she would say, “Ah, I forgot, darn it.” Her teaching mentor advised her to “use a timer” to keep her on-schedule. Wilma said that if she doesn’t get grades posted on time, and she has missed deadlines, “someone will be yelling and the parents will be complaining and the kids want to know.” She also stated that for a scheduled observation, she forgot to write up her 10-page lesson plan, so the administrator asked her “if she could get a lesson plan by the end of the day.” When Wilma was asked about stigma, she claimed, “You know...I don’t see it as a mental disorder and it struck me...I have a mental disorder?! How can it be mental?” Wilma wrote in her journal (seven months later), “ADHD has neither hindered my performance at work nor has it negatively affected my relationship with students. It has been all the contrary.” She concluded by writing, “Having ADHD/ADD is no longer a stigma. Many are very well educated about this condition and make all the necessary accommodations for their students” (personal communication, January 23, 2016). There is a “disconnection” between what is occurring in the reality of the classroom and in Wilma’s perception on the impact of her mental disorder.

ADHD is erroneously considered to be a minor mental disorder and some people do not consider ADHD to be a mental disorder at all. ADHD has some very disruptive symptoms in the teachers in this study, including lack of time management, a lack of focus, losing things,

irritability, and especially impulsivity. Teachers stated they have difficulty controlling what they say, and after words come out of their mouths, they think “oh why did I say that?” Teachers also expressed that they have difficulties completing tasks because they cannot focus or are easily distracted. In short, ADHD “interferes with functioning or development” (DSM-5, APA, 2013).

Kids Come First

The classroom teachers in this study say they love their students and the kids come first and need to be the priority. Teachers expressed their desire to ensure the safety of the children, establish relationships so children will have a good school experience, and pave the way for all students to be successful. Alexa stated that in her classroom, the kids are “mine and I just love them.” She added that she enjoyed the relationships with her students and “getting to know them.” Lucy said some teachers do not care for her. She added, “I’m not here for them [teachers], I’m here for the kids, if you like me that’s fine, if you don’t that’s fine.”

Some teachers discussed how they love their students and even how they will sacrifice their time with family for those kids. Tessa knows that in her extra time she should be grading and planning, but the students come in her room to talk. She said, “After school I can’t get out of my classroom and in the morning they ask where I’ve been.” She continued, “When the kids are there I can’t get anything done, and I’m not going to tell the kids I have things to do because for some kids it’s the only attention they get from an adult.” Tessa concluded, “Those relationships are priceless.” Patty observed, “I want to be that one stable thing and for our kids, a lot of them that is the only stable thing they have.”

All of the classroom teachers described having difficult children in their classrooms, yet most of them seem to put in extra effort on student’s behavior and academics even when

colleagues may not put in the extra work. Jackie said, “Kids are first,” and she will work extra hard to try different strategies and have accurate data to get a “true representation” of the student, even though she has seen others “fudging” data. Laura believes children come to school at a serious disadvantage due to the issues in the family and “the downfall of society” due to the loss of the traditional nuclear family. She explained, “In the worst situations, we have students raising themselves because their parents are addicted to drugs, alcohol, or quite simply, don’t give a shit.” Wilma stated she relates well with her high school students who have ADHD and said, “A lot of times when they come with these issues themselves and they feel like no one understands, and then when I tell them, look, I’m also a little ADHD so I do understand,” she finds the kids are “at ease and makes them want to work.” Anne works hard on helping her students that have behavior problems. She said, “I try to reject the behavior and not the child” and “I try to de-personalize the behavior and have a social contract with each child.” Anne further discussed how she would not be an effective administrator because of the emphasis on governance and how administrators bestow the guidelines for programs and funding regarding what benefits students. She stated, “If I don’t think that is in the best interest of this particular child, I’m going to do this on a case-by-case basis, not as a program, but that would not make me an effective principal,” and in the end, hurt the evaluation of the school as seen by the state or federal government.

Family Stressors

Research finds that balancing work and family roles can create conflicts at home (Depolo & Bruni, 2015; Erdamar & Demirel, 2014; Saravanan & Dharani, 2014). Saravanan and Dharani (2014) find that in today’s families, women are still “playing a dual role” (p. 10) of being both

the breadwinner and homemaker. For women teachers, this presents conflicts at home. Depolo and Bruni (2015) stated, “Teachers’ work extends beyond the job site and requires a lot of extra effort when they are at home” (p. 891). Erdamar and Demirel (2014) found that teachers continued to think about their work problems at home, sacrificed their sleep to complete household chores, and “teachers feel stressed and nervy at home” (p. 4923).

In this study, seven of the nine classroom teachers are married. They made comments about the effect of the stress of the school environment and the symptoms of their disorders resulting in conflicts at home. Several spouses pushed the participants to go to the doctor to get help or else! Alexa, Laura, and Lucy stated that their husbands were a factor in them getting medical help for their disorders and in getting on medication. Lucy said that “her husband was ready to leave.” Alexa admitted that her husband went with her to the doctor and he said, “You need to put her on something or we're gonna get divorced.” Laura shared, “My husband would say you really need to get some help with this anger and the inability to handle the stress, not in the workplace, but at home.” She added, “I thought no way, I didn’t want to face the fact that there’s a problem because of the stigma attached to it.”

Jackie depends on her husband to alert her to signs that her negative symptoms are increasing. Jackie told her husband, “If you ever see any symptoms of that [mother’s schizophrenia],” to institutionalize her! Anne described how her lack of impulse control affects her marriage:

I can’t rein it in with my husband. I’ll rage sometimes and when I have an episode and we know what it is and that’s a good thing about having a successful marriage, which I just can’t imagine how I got where I am, I really can’t.

Fahie and Devine (2014) found their teacher participants would sometimes discuss these issues with family members who could provide assurance and support. However, most of the teachers would “edit” (p. 247) their stories “fearing that their husbands would become upset or angry should the full truth be revealed” (p. 247).

Implications

This study is intended to fill the gaps in existing literature of the experiences of classroom teachers who have diagnosed mental disorders and who struggle with stress and negative occurrences in the school environment. By selecting a purposeful sample of classroom teachers who have mental disorders, as diagnosed by medical or mental health professionals, teachers are able to express their stories of life in the classroom with mental disorders. By hearing their stories, it is the hope that governance will take heed of the plight of all teachers, not just those with mental disorders, and understand the reality in the classrooms and understand the effect this can have on our children in their journey of learning.

Finding previous literature on teachers with diagnosed mental disorders is difficult as the research is limited and outdated. This study extends the past research as the teachers in this study do have mental disorders that have been diagnosed by medical/mental health professionals. Please see Appendix H for a list of topics presented in this study and the theoretical, empirical, and practical implications for the future.

Theoretical

Modified labeling theory.

This study has implications for the modified labeling theory that states that those with mental disorders may feel stigmatized which leads to negative perceptions of the self. In a study of women with chronic mental health problems, Camp et al. (2002) found that their participants

did not internalize the stigma of their disorders as they did not accept the mental disorder representations as valid or legitimate, and rejected them as not applicable to themselves. The Camp et al. (2002) participants noted that many times in social situations they felt different from others and that of an outsider, so they accepted the difference and avoided interaction with those groups, and sought comfort by others with similar experiences. Interestingly, the participants believed the stigma “was due to the flaws of those who stigmatize” (Camp, Finlay, & Lyons, 2002, p. 830). Camp et al. (2002) summarized from their study that “membership of a stigmatized group does not lead to any predictable long-term damage to an individual’s self-concept” (p. 832).

In the current study of classroom teachers with diagnosed mental disorders, many teachers did initially self-internalize the stigma, but they eventually accepted the diagnosis. One teacher even adamantly expressed that she knew “crazy” [her mother], and she was not crazy! There is evidence that some of the teachers did not have trustworthy friendships, they felt alone, and they would keep to themselves to avoid confrontations or un-pleasantries from others. The challenges involved with maintaining adult relationships in the school environment were problematic. These findings extend the literature on the modified labeling theory.

Social identity theory.

The social identity theory states that individuals identify with the groups behaviors and affiliations. For teachers, there are professional standards and certain expectations of those standards, even though previous research has found the term professionalism to be a complex phenomenon (Lei et al., 2012; Stone-Johnson, 2014). Willetts and Clarke (2014) discussed the social identity theory in relationship to the nursing profession, which also “struggles with

defining and clarify its professional identity” (p. 164). There are two levels to social identity- the higher order identity and the lower order identity. The higher order identity (formal identity) is that of governance, the sanctioning bodies, and the code of ethics that has an indirect or delayed impact on individuals. The lower order identity (informal identity) lies at the building or staff level that directly and immediately affects the individual. According to Willetts and Clark (2014), the prominence of these social identities is dependent on the group context and therefore, “social identity salience is seen as significant in influencing identification and performance” (p. 167). For an individual, these salient identities will depend on the level of relevance and subjective importance to that person.

Willetts and Clark (2014) further stated, “Equally important are the context in which professional groups engage in the daily activities characteristic of their profession and their workplace” (p. 168) and there needs to be more research at this level. There needs to be a specific focus on workplace settings and the actions and behaviors of individuals as they perform their daily tasks. As evident in this current study, teaching is no doubt demanding and stressful, and there can be a disconnection between the expectations from the higher order of professionalism and the reality of what occurs at the lower level of the identity. Being professional can be challenging in and of itself, and maybe even more when confronted with the symptoms from diagnosed mental disorders.

Another perspective of the social identity theory is that of leadership. Cummins and O’Boyle (2014) stated that leadership “is still often manifested through force and power” (p. 27) and leaders are “centered on the ‘self’” (p. 28) instead of the “we.” The social identity theory provides the framework for effective leadership through the power of the group (Cummins &

O'Boyle, 2014; Hogg, 2001). Hogg (2001) defines the leader as having influence, "they act as the attitudinal and behavioral focus of the group due to self-categorization" (p. 196). When the group members see the influence and there is a social attraction that enhances the leader's standing, the rest of the group cognitively and behaviorally conforms. By defining the leadership process as a shared group membership, the social identity theory suggests a shared sense of purpose and direction within the school environment. Cummins and O'Boyle (2014) stated that trust is a critical component of this shared group process.

In this current study of teachers with mental disorders, several teachers described the lack of trust and support in their school leadership and colleagues as a challenge in dealing with their mental disorders in the school environment. Some teachers did not see themselves as professional and some were told they did not behave as professionals. Teachers, due to the inherent nature of the job, tend to work more in isolation so it seems that teachers see themselves more as individuals and not as a group. Identifying with the group has many complex factors, including emotional competence, attendance, self-efficacy, image of own professionalism, and high job demand. These findings diverge and extend the current literature of the social identity theory.

Empirical

This study extends the literature from chapter two to include teachers who have diagnosed mental disorders, as diagnosed by medical or mental health professionals. Due to these diagnoses, the descriptions of teacher's experiences are authentically expressed as opposed to the teachers in previous studies that self-assess on questionnaires or surveys based on their feelings or thoughts at the moment. By reflecting on their diagnosed mental disorders, most of

the teachers in this study were self-aware of how the mental disorder symptoms affect them in the school environment, thus helping to fill the gap in the literature. This ability to describe their strengths, weakness, and challenges has facilitated a deeper understanding and knowledge of diagnosed mental disorders in teachers, and how their symptoms affect them in the areas of professionalism, emotions, relationships, thoughts about stigma, and disclosure. See Appendix H for a list of the topics presented in this study and the implications for past and future studies.

Practical

Participant's recommendations.

The classroom teachers in this study with diagnosed mental disorders were asked how school systems and governance could help them in the school environment and what they wanted governance to know about mental disorders. The teachers varied in their responses about how school systems could help teachers with diagnosed mental disorders. Anne stated that school systems would not acknowledge mental disorders in teachers due to the stigma of “crazy” being attached. Anne stated, “Because of the political nature of the funding, that’s never going to fly” and “they’re not going to welcome this idea that there are people in the classroom who are anything other than normal, perfect role models.” Anne elaborated, “It’s just every year we have to watch that thing if you have a problem with alcohol, blah, blah, blah, they have to, it’s perfunctory they have to offer services, they have to offer treatment programs, but if you stepped up for that, I don’t know what would happen to your career.”

Jackie said, “God forbid if it gets out on local television that they [school system] have a program going on for teachers [diagnosed with mental disorders], what does that say for our system?” Several teachers felt that would be the end of their career if people outside of the

school knew about their mental disorders. Tessa felt she would not tell her current administrator as she did not “trust him” with her career. Lucy said, “I feel that they would slowly just push us on out the door.” Lucy added, “I don’t want them to know, it’s none of their business if I’m taking whatever pill because I think at this time that’s seen as negative and I feel like they would find a way to push us out” and “if they had any programs, I probably wouldn’t go.”

Other classroom teachers felt that school systems should learn about common mental disorders and the symptoms associated with them. Wilma felt that because of the stigma attached, most teachers will not disclose. She added, “It doesn’t get disclosed for the fear they will treat you differently or they may not understand because sometimes they are aware of certain illnesses but they don’t understand how it affects the person, so because we don’t tell, there’s not much the administration can do.” Patty said, “I think that its way more widespread than they think and they need to be more understanding” and they “need to give more help to those who need it.” Patty added, “I don’t really feel like they do anything to help relieve that stress.” Patty offered a suggestion; “I think there could be some support, just talking about it, making more people available for discussion, like more counselors for the teachers.” Tessa believes school systems need to be more aware of mood changes and things that happen. She said, “It might be something that could escalate into something, you know, different, you don’t want the kids coming in seeing the teacher whose hung himself.” She stated this happened recently and was reported in the media. Laura stated, “Just because we have an issue doesn’t make us bad people or bad teachers or a danger to our children.” She added, “Would you rather have a teacher who has an undiagnosed disorder who drinks and comes to school drunk, like I’ve heard in the news lately?”

Alexa wanted school systems to leave teachers alone and trust in their abilities as professionals. She emphasized, “Back off a little bit and trust your teachers.” Alexa stated, “I don't feel like I'm treated like a professional. I don't feel like I'm allowed to make my own decisions.” Laura stated she wanted to tell administrators to “leave me alone and let me teach.” She added, “My need for control will *not* [emphasis added] allow me to slack off and let the students' academics slide.” Anne stated, “I think they need to stop focusing so much on evaluation of successful teachers.” She added, “Systems need to spend the time in resources investing in new teacher's development as some teachers are not self-aware enough to realize it is them and not the students.” Laura included that teachers “need better training about special needs students” as these children frequently cause teacher's stress and require extra effort. Susie was so discouraged with education and feeling that she was being treated unfairly and stated, “I don't know of any specific programs that could help us.”

Berliner (2013) stated that our educational system is “burdening teachers with demands for success that are beyond their capabilities” (p. 3). Mental illness is higher in poor neighborhoods and “can easily overburden the faculty of schools that serve poor youth, making it harder to teach and to learn in such institutions” (Berliner, 2013, p. 11). Teachers in this study felt that those in governance of education should realize all the demands on teachers and the enormous amount of stress they feel.

Teachers would like governance to know the following:

Jackie: “Teaching is ‘the most stressful job...we have to deal with everyone from all different levels in the classroom.’”

Laura: “We are freaking stressed out. It's not an excuse, it's just the way it is.”

Lucy: “Just because you have ADHD, you’re not psychotic!”

Alexa: “Some of us have mental disorders because of the system, because of the stress of being a teacher, that’s why we need medicine.”

Patty: “You also need to take care of your teachers. I think they’re losing a lot and a lot of people don’t want to get into the field. I understand we’re concerned about the kids, but you’ve got to take care of the people who take care of the kids. And if you don’t, you’re going to lose them. It’s just, I don’t think you take care of the people you need to take care of.” Malahy (2015) stated, “School districts cannot afford a high turnover rate of teachers, or worse yet, teachers who turn to alcohol, medication, or recreational drugs” (p. 140).

Wilma: “I’m not a southern belle, I’ve always been like this [ADHD] and I’m sorry when people get the impression that I don’t know what I’m doing.”

Anne: “They need to invest more in targeted professional development for people who are struggling.”

Susie: “I don’t know of any programs...everyone needs to be treated fairly, with or without mental disorders.”

Other teachers want governance to know that those teachers with mental disorders are not bad people, are not bad teachers, they are not hurting kids, and they are not psychotic or crazy. Lucy stated, “We just do things differently.”

Interventions.

Research indicates that programs and interventions aiming to reduce stigma can be effective (O’Reilly, Bell, & Chen, 2012; Yap, Reavley, & Jorm, 2015), especially in schools and

in the workplace (Griffiths, Carron-Arthur, Parsons, & Reid, 2014). O'Reilly, Bell, and Chen (2012) found that providing students going into the mental health field the opportunity to have contact with persons who were mentally ill in a safe educational environment decreased their levels of stigma towards those with mental disorders. They also found that the "sharing of personal stories about mental illness is a powerful tool to decrease mental health stigma" (p. 607). Yap, Reavley, and Jorm (2015) reported that peers who knew and understood a friend's actual diagnosis were able to provide help in a crisis or until assistance could arrive. This is referred to as "mental health first aid" (p. 54).

Kosir et al. (2015) had two recommendations to help alleviate ruminating. One strategy is to use "self-focused attention" (p. 140) by learning to detach from work by engaging in transitional rituals or actively devote attention to non-work tasks. The second recommendation was to set up collaborative problem-solving teams aimed at helping teachers with classroom management and intervention with problem students. These teams could have an added benefit of improving the quality of colleague support.

There is a push for classroom teachers to learn about mental disorders in an attempt to help identify students in an effort to positively affect the student's life academically (Andrews, McCabe, & Wideman-Johnston, 2014). While this may be a noble endeavor for the benefit of the students, the literature indicated that teachers have enough on their plates. Andrews, McCabe, and Wideman-Johnston (2014) found that secondary teachers lacked the knowledge and ability to assist students who may be suffering from mental disorders. Sixty-two percent of the teachers surveyed believed it was not their responsibility to assist students with mental health problems. Andrews et al. (2014) advocated that the schools, especially the teachers, learn about

the relationship between mental disorders and learning and “play a significant role!” (p. 271). However, Andrews et al. (2014) stressed the importance of understanding the strengths, experiences, and the needs of teachers before developing strategies for the students.

Malahy (2015) recommended that school boards implement better anti-bullying workplace policies and provide professional development training. Carlotto and Camara (2015) suggested interventions for increasing teacher’s self-efficacy and social support while reducing the workload, which may help to alleviate the risk factors of mental disorders. Maj (2011) stated that those with mental disorders should “be active participants in service planning and delivery” (p. 1535). Corr, Davis, Cook, Waters, and LaMontagne (2014) stated that making policies and relationships between educators and governments more collaborative and fairer “would contribute strongly to the protection and promotion of educator mental health and wellbeing, and in turn contribute to workforce stability and care quality” (p. 1). What should not be forgotten is that the educators needed in these relationships and policy-making ventures must be those who are directly involved with children, preferably those who struggle with mental health and wellbeing. The findings in this study diverge from previous studies regarding programs and interventions as school systems do not have programs for educators to assist with their diagnosed mental disorders. Please see Appendix H for a list of topics and implications for research.

Delimitations and Limitations

This study focused on the experiences of classroom teachers with diagnosed mental disorders. One focus of this study is to add to the literature on stress and burnout, which does not specifically address whether or not a diagnosed mental disorder is the precipitous or antecedent behavior in the stressed or burned-out teacher in the school environment or classroom. This study is limited to classroom teachers (teachers who are with students most of

the day) who have a diagnosed mental disorder as defined by the DSM-5 (APA, 2013).

Classroom teachers must also be employed full-time so their experiences with the phenomena are relevant and current. The researcher had decided to include all types of diagnoses instead of limiting to just depression and anxiety, although the expectation was that classroom teachers with more severe types of mental disorders such as bipolar or schizophrenia may not have a desire to participate. Classroom teachers with more serious mental disorders such as bipolar and schizophrenia could provide a rich, complex picture of the experiences within the school environment.

Due to the inherent nature of qualitative research, there are expected limitations. Two limitations are the small sample size and the make-up of the purposeful sample. The researcher discovered the difficulty of obtaining participants due to confidentiality concerns, the apprehension of teachers with mental disorders, along with the reluctance to disclose and share their experiences. All participants in this study are female. Gender can have an influence on mental disorders (Hemp, 2004). The DSM-5 (APA, 2013) states, “Women are more likely to recognize a depressive, bipolar, or anxiety disorder and endorse a more comprehensive list of symptoms than men” (p. 15). This study was also limited to two minorities. According to the DSM-5 (APA, 2013), “Thresholds of tolerance for specific symptoms or behaviors differ across cultures, social settings, and families” (p. 14). Therefore, culture can affect stigma or social support, diagnosis, treatments, coping strategies, and recovery.

Another limitation of this study is the geographic location of the participants and the inability to apply the same results and experiences to classroom teachers in other regions across the United States (Gall, Gall, & Borg, 2007; Pyrczak, 2013). Participants are limited to the

southern area of the metro Atlanta area, which is not representative of classroom teachers who have diagnosed mental disorders throughout the United States. Reeves et al. (2013) reported that the prevalence of mental disorders in Georgia “mirrored national findings” (p. 1). This study was completed in several locations based on where and when the participants wanted to conduct the interviews. Seven of the nine individual interviews were conducted at the researcher’s home. The other two individual interviews were held at a local restaurant and at the school of the participant; both of which were more convenient for those participants. The focus group was held at a restaurant. A possible limitation could be that all interviews were not conducted in the same location, although this is unlikely since the participants chose the location based on their comfort levels and time preferences. Although age can be a limiting factor, it is not considered a limitation in this study. Younger teachers with mental disorders may not fully understand the connection between the school environment and their disorders, plus they will not have had many experiences in the school environment in which to assess that connection.

Due to the nature of studying mental disorders, which are very complex, there are other inherent limitations. Self-reporting is considered a limitation due to the comorbidity of most of the participant’s mental disorders and the complexity of the many symptoms interacting within each individual. Between the nine teachers, there are five diagnosed mental disorders: ADHD, insomnia, depression, anxiety, and OCD. Each of these disorders have varying symptoms associated with them. Three of the participants had three diagnosed mental disorders, three of the participants had two diagnosed mental disorders, and three of the participants had a single diagnosed mental disorder. When there is more than one diagnosed mental disorder in a participant, symptoms may appear different or other symptoms may be added to existing

symptoms. This is referred to as comorbidity (APA, 2013; Kroska & Harkness, 2008). The DSM-5 (APA, 2013) defined comorbidity as “the boundaries between many disorder categories are more fluid over the life course; many symptoms assigned to a single disorder may occur, at varying levels of severity, in many other disorders” (p.5). The DSM-5 (APA, 2013) stated that “the most common co-occurring mental disorders are ADHD, depression, and anxiety disorders” (p.5). The National Institute on Drug Abuse (2010) stated that “comorbidity also implies interactions between the illnesses that affect the course and prognosis of both” (para.1). The comorbidity of the mental disorders can also be problematic if attempting to make generalizations about a particular type of mental disorder when there is more than one disorder. Some teachers also discussed non-diagnosed mental disorders they believed they had and did discuss the relevance of the symptoms of those disorders in the experiences in the school environment.

Another limitation may be a lack of self-awareness in some teachers regarding the understanding and impact of the full extent of their symptoms of their diagnosed mental disorders in the school environment. This lack of self-awareness may dilute the data as participants may not fully understand the relevance and connection of their disorders on their experiences. Some teachers may have decided to downplay their disorders and the impact of those disorders in the school environment, while other participants may have exaggerated their experiences. A limitation could be that only five mental disorders (insomnia, ADHD, OCD, depression, anxiety) were a part of this study, although it would be unlikely to find a classroom teacher with more severe disorders, such as bipolar, schizophrenia, borderline personality, or psychopathology.

The classroom teachers in this study found it difficult to find time to attend the focus group or complete the journaling, even though they were individually called by cell phone to remind them of the tasks. There would have been more data if participants had participated in all three of the asked requirements. Lastly, researcher bias could be a limitation, although it is understood that bias in qualitative research can happen. The literature acknowledges that the researcher has the final interpretation (Ayres, 2007; Chan, Fung, & Chien, 2013; McBrien, 2008; van Manen, 1990).

Recommendations for Future Research

This study helped to fill a gap of the literature in regards to classroom teachers having diagnosed mental disorders and their descriptions of their experiences in the school environment. More qualitative studies of this type are needed as teacher behavior, especially compounded by daily stress and mental disorders, is so complex and intricate. Deeper studies exploring specific topics described by teachers as being problematic should be pursued and empirically studied. Life experiences are “multi-dimensional and multi-layered” (van Manen, 1990, p. 78).

This topic would be a good quantitative study worth pursuing. Quantitative research would be valuable for statistics shedding light on the numbers of classroom teachers who have diagnosed mental disorders. A national study to explore the statistics (how many teachers, what disorders, comorbidity rate) of teachers with diagnosed mental disorders should be considered. A longitudinal study could focus on teachers with disorders and how their experiences change throughout their career. A study exploring the correlation between teachers with diagnosed mental disorders and teachers without mental disorders in a certain setting (elementary, middle, or high) would be beneficial. However, it does not mean that those not diagnosed do NOT have a mental disorder.

Whether quantitative or qualitative, future studies should be narrowed to a few areas of research, such as sense of professionalism, interpersonal relationships, emotional aptitude, stigma and disclosure, or specific strengths and weaknesses. Studies should extend to other areas of the United States. Future studies could evaluate teachers with just one diagnosed mental disorder. Another consideration for future research could compare teachers with diagnosed mental disorders on medication or not on medication. A study comparing the experiences of teachers with diagnosed mental disorders and exploring the similarities or differences in experiences of others (administrator, colleagues, parents, students) regarding the same teacher could reveal interesting, yet subjective results. A mixed methods study could have the teachers with diagnosed mental disorders also rate their level or degree of intensity in feelings or beliefs for the areas under study (i.e., professionalism, relationships, regulating emotions, stigma, or disclosure). These ratings could be analyzed with their described experiences to determine how they compare or how they are similar. Another possible study would be to conduct a qualitative study of administrators who have a diagnosed mental disorder and compare their experiences from when they were classroom teachers and their current experiences as an administrator, and how their experiences are the same or different regarding their diagnosed mental disorder in the school environment.

Further research is needed as to what programs and recommendations can be offered to assist classroom teachers with diagnosed mental disorders to have more positive experiences and a higher quality of life within the school environment. Also vital are studies providing strategies and recommendations for assistance for teachers who are being bullied in the school environment by someone in authority.

No matter what type of study is undertaken in regards to diagnosed mental disorders in educators, it will be met with resistance, uncertainty, opposition, and battles over “turf” about conducting such research and the determination of bureaucracy and governance not to bring this topic to light. The assumption is that school systems across the country do not even acknowledge there are teachers in the classroom with mental disorders who are so stressed and need interventions. This study requests that governance consider this group of educators and offer programs and interventions to help reduce stigma, reduce the high demands of teaching, reconsider what professionalism really means “in the trenches” at the lowest level, offer trainings on mental disorders and the accompanying symptoms, and lastly, include these teachers in investigative and decision-making processes at the governance levels.

Summary

The objective of this study is to bring awareness to this issue of classroom teachers having diagnosed mental disorders and their experiences in the school environment. The intent was not to answer a question such as “What comes first, the mental disorder before teaching or that teaching leads to the mental disorder?” Several participants felt that they did not need medication until they started in the teaching profession and that during summer breaks, they can reduce their medication levels as there is less stress in their lives. This study is a starting point for research in the area of educators and diagnosed mental disorders in classroom teachers. Each teacher is as different as each student in their classroom and behaviors are on a continuum as their mental disorders range from minor to moderately severe. Therefore, their challenges and coping skills vary greatly, and for some participants, the stronger the difficulties with mental disorders, the more problematic the issues with handling emotions, relationships, weaknesses, and professionalism.

Governance is not knowledgeable or empathetic to the struggles and needs of teachers with diagnosed mental disorders. For some educators who have diagnosed mental disorders, there is little, if any, understanding from superiors regarding knowledge of mental disorders and the struggles and challenges that teachers face because of the stress from the daily tasks associated with teaching, let alone the challenges of dealing with the symptoms of one or more diagnosed mental disorders. Some examples of daily stresses include teaching the curriculum to the many different ability levels of children in the classroom while continuously testing, probing, and re-teaching; staying on schedule with the curriculum demands of the school; teaching character education to students who have not had this taught in the home; utilizing effective classroom management while dealing with discipline and difficult students who may have mental disorders; communication issues with other staff members and the interpersonal problems that occur; dealing with parents who do not understand the school environment; being evaluated by administrators and hoping the students are on their best behavior and engaged in the content; and/or having to attend the required meetings and professional developments that take required time from planning and all of the paperwork and documentation educators need to complete. This is just a quick snapshot of issues teachers are generally confronted with on a daily basis and they have not even left the school building yet to deal with the home environment. Governance at the local, state, and federal levels continuously change policies and standards without regard for teachers who are already under tremendous stress due to the many demands in the school environment, let alone those educators who additionally suffer from the symptoms of diagnosed mental disorders. Also important is the resulting impact on students' academic success and the education of future generations.

The teachers in this study diagnosed with mental disorders, upon reflection during this study, I believe, understand to a greater extent the experiences of being in a school environment and the impact (both positive and negative) of mental disorders on all aspects of their teaching career. I also believe they understand that they are not alone in their struggles with mental disorders in the school environment, even when *they feel alone*.

Berliner (2013) wrote that all of the school reforms aimed at fixing education and blaming teachers is not going to solve the problems in the educational system. Berliner (2013) stated, “The sources of America’s educational problems are outside school, primarily as a result of income inequality” (p. 1). Berliner (2013) added, “Most children born into the lower social classes will not make it out of that class, even when exposed to heroic educators” (p. 2). There is a tendency to expect individuals who are poor to overcome their obstacles and “teachers to save the poor from stressful lives” (p. 3) because “we design social policies that are sure to fail since they are not based in reality” (Berliner, 2013, p. 3).

I will leave you with a final thought as written in Laura’s journal (personal communication, February 20, 2016). Even though these are Laura’s words, this is the reality for many teachers and students in our country today:

Many times I’ve had students walk into my classroom on the first day of school dirty, not having eaten dinner the night before MUCH LESS breakfast that morning, with ZERO school supplies, smelly clothes, and holes in their shoes. They walk into the classroom defeated before the school day even starts. These kids are generally irritable because they’ve gotten little to no sleep the night before because they were caring for the baby through the night just because momma was in bed and wouldn’t get up to give it milk.

I've had kids who slept on urine-saturated mattresses who smelled so bad nobody would want to sit next to them. I've had students who walked in exhausted because momma and her drunken boyfriend fought all night and boyfriend started to beat momma. The students walk in thinking, "So after a long night of no sleep...the teacher STILL expects me to do work?" And yet, teachers are still expected to get an optimal performance from students who come from troubled circumstances. How do we do it? By spending extra time with the student- encouraging, compromising, and yes, sometimes even bribing the kid (finish this assignment and you'll get 10 minutes on the computer). What does that mean for the other 20 or more kids? THEY will get less time with the teacher. That's just how it is. There's only so much of me to go around. I must connect with and manage those students that come from hell as a home life, and somehow getting them to perform. After all, *my job* depends on their test scores.

EPILOGUE

This dissertation has been a long journey and I have struggled with my mental illness. Recently I was diagnosed with Bipolar Disorder. In addition, a month before my dissertation defense I was let go from my job because I was not “professional” enough. Then I read an article the morning of my defense, and I started to feel more vindicated about how I feel, plus the teachers in my study are expressing the same thing.

An article from Michigan State University (Dunn & Henion, 2017) stated a very telling picture of the educational problem in the United States and how the system is broken. Teachers have been posting their resignation letters online and researchers are determining that teachers are not leaving for the typical reasons, such as low pay or student behavior. Dunn explained, “Rather, teachers are leaving largely because oppressive policies and practices are affecting their working conditions and beliefs about themselves and education” (para 4). Another similar study from MSU concluded, “All of the teachers resignation letters and their later interviews [with researchers] attested to the lack of voice and agency that teachers felt in policymaking and implementation” (para 10).

Please policy makers, start listening to the educators in this country and fix our educational system. I am awaiting your phone call!

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APPENDICES

Appendix A: IRB Approval Letter

Appendix B: Post to Individual Educators on Facebook

Appendix C: Website Snapshot

Appendix D: IRB Approved Consent Form

Appendix E: Interview and Focus Group Questions

Appendix F: Audit Trail

Appendix G: Combined Categories before Themes

Appendix H: Implications for Research

Appendix A: IRB Approval Letter

From: "IRB, IRB" <IRB@liberty.edu>

Date: 02/25/2015 11:48 AM (GMT-05:00)

To: Kelly, Becki Lynn <bkelly41@liberty.edu>

Cc: "Hibbert, Tamika S (School of Education)" <tshibbert@liberty.edu> "IRB, IRB" Subject: IRB Approval 2006.022515: Diagnosed Mental Disorders in Classroom Teachers in the Atlanta Area: A Phenomenological Study

Dear Becki,

We are pleased to inform you that your above study has been approved by the Liberty IRB. This approval is extended to you for one year from the date provided above with your protocol number. If data collection proceeds past one year, or if you make changes in the methodology as it pertains to human subjects, you must submit an appropriate update form to the IRB. The forms for these cases are attached to your approval email.

Your IRB-approved, stamped consent form is also attached. This form should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document should be made available without alteration.

Please retain this letter for your records. Also, if you are conducting research as part of the requirements for a master's thesis or doctoral dissertation, this approval letter should be included as an appendix to your completed thesis or dissertation.

Thank you for your cooperation with the IRB, and we wish you well with your research project.

Sincerely,

Professor, IRB Chair
Counseling

Appendix B: Post to Individual Educators on Facebook

My name is Becki L. Kelly and I am a doctoral student at Liberty University. I am searching for participants for my dissertation study. I am looking for classroom teachers in the Atlanta Metro area who have been diagnosed with a mental disorder per the DSM-5 of the American Psychiatric Association (APA, 2013). Examples of mental disorders include depression, attention-deficit hyperactivity disorder, anxiety, bipolar, and insomnia. This post in *no* way indicates that you, as a classroom teacher, fit the criteria of having a mental disorder. The intent is for this post to be shared with other classroom teachers in the Metro Atlanta Area, who may have a diagnosed mental disorder and who might like to participate *confidentially* in this study.

This is a qualitative study that will require several tasks. For full details of the study, please go to www.beckistudy.com. This website is informational only; to inform you of all the details needed to make a decision on whether or not you meet the criteria and the full requirements essential for the study.

If you meet the criteria, please contact me at [REDACTED] or via email at [REDACTED]. Please consider being a part of a study that will be included in the literature on education and mental disorders in educators; a topic that is rarely discussed or researched. Hope to hear from you soon!

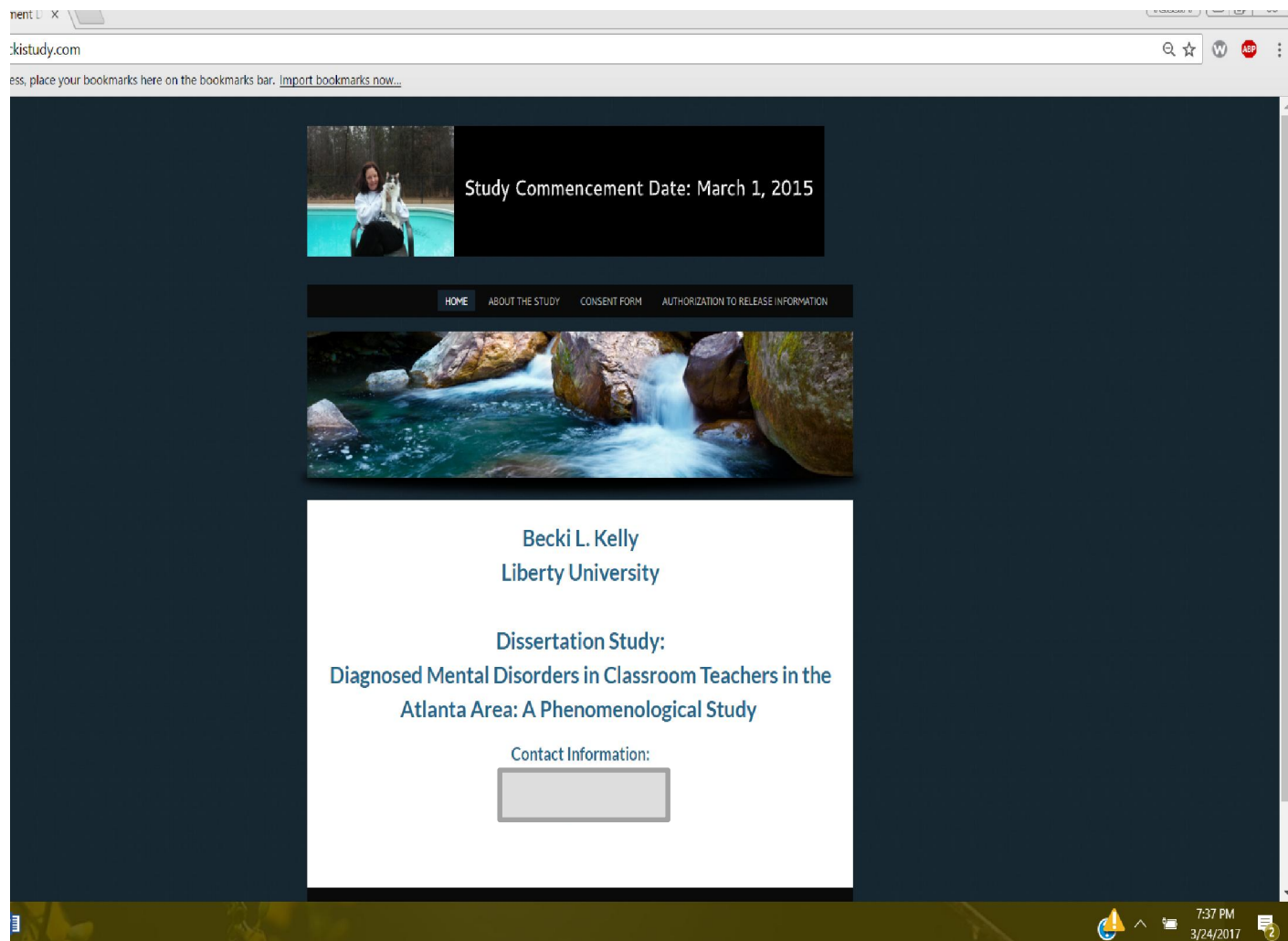
If you know of another classroom teacher who may have a diagnosed mental disorder in the Metro Atlanta Area, feel free to share this post by:

1) Email them this post

2) Resend this post

- a. Please re-send this post to individual persons and not to multiple recipients. Send this post on Facebook by copying the entire post into a new "What's on your mind?" Be sure to type in the person's name *in* the post in order for the post to reach them. Do NOT click on the blue "Post" tab yet!
- b. Click on the "Friends" tab to the left of the "Post" tab and a screen will pop up asking "Who should see this?" Click on "More Options" and then click on "Custom". You will see a screen titled "Custom Privacy". Under "Share this with", type in the individual's name that you would like to send this study to. Click on "Save Changes". Now it is safe to click on "Post".

Appendix C: Website Snapshot



Appendix D: IRB Approved Consent Form

The Liberty University Institutional
Review Board has approved
this document for use from
2/25/15 to 2/24/16
Protocol # 2006.022515

CONSENT FORM

Classroom Teachers and Their Experiences with a Diagnosed Mental Disorder in the Atlanta
Area: A Hermeneutic Phenomenology

Becki L. Kelly, Doctoral Student

Liberty University
School of Education

You are invited to participate in a research study regarding the experiences of having a diagnosed mental disorder in the school environment as a classroom teacher. You were selected as a possible participant because you are a classroom teacher and possibly have a diagnosed mental disorder as designated by the DSM-5 (2013) from the American Psychiatric Association (APA). I ask that you please read this in its entirety and ask any questions you may have before agreeing to be in this study.

This study is being conducted by me, Becki L. Kelly, a doctoral student in the School of Education at Liberty University.

Background Information:

The purpose of this study is to describe the experiences of classroom teachers within the school environment from the perspective of having a diagnosed mental disorder by exploring emotions, relationships, sense of professionalism, and decisions on whether or not to disclose your diagnosed mental disorder. This study is intended to advance the literature on mental disorders in adults in the educational field, which is an area where mental disorders is generally not discussed or researched.

Procedures:

If you agree to be in this study, I would ask you to do the following tasks:

- 1) Read and sign an authorization to release information form for your medical/mental health professional in order for them to verify your diagnosed mental disorder. Read and sign the consent form.

- 2) Participate in an individual interview, preferably face-to-face, which will last approximately 60-90 minutes. It should be a quiet location as the interview will be audio recorded. If any follow-up questions are necessary for further clarification of the data, this can be accomplished by telephone or online and these additional interviews will be brief and audio recorded.

- 3) Participate in maintaining a journal for approximately three to four weeks. This journal will document your relevant experiences in your school setting based on the research questions. The journal may be submitted online or handwritten, and I will collect the journal in person or have the journal mailed at my expense.

- 4) Participate in a focus group with five or six participants either online utilizing SKYPE or via a telephone conference. This focus group will take approximately 60-90 minutes and will be audio recorded.

- 5) Following participation, you will be given the opportunity to read the results of this study in order to check the accuracy and completeness of your experiences and to clarify any misinterpretations made by me.

Risks and Benefits of Being in the Study:

The study has minimal risk as the risks are no more than the participant would encounter in everyday life. It may be possible that discussing your mental illness in the classroom environment may result in uncomfortable feelings and thoughts. All participants will receive a list of area counselors, upon request, in the event a therapist may be needed and you do not have one. Second, if you feel you cannot complete your participation in a particular task, such as an interview, we can postpone it until you are able to complete it. In the event you or I find your participation in this study to be detrimental, you or I may terminate your participation at any time.

For the focus group, confidentiality cannot be guaranteed if another participant were to recognize you in any way. Although not anticipated, in the event I become privy to information that triggers the mandatory reporting requirements for child abuse, child neglect, elder abuse or intent to harm self or others, I will be required to report this and terminate your participation in the study.

Participants are not expected to receive a direct benefit, although the expectation is that your participation in this study may yield valuable data for both you and the literature. It is conceivable that your participation will open up new understandings and insights about yourself and the teaching profession. It is hoped that the knowledge gained will be valuable to school organizations and policy makers and that mental disorders in educators will be an area where further research will be conducted.

Compensation:

There will not be any compensation for this study. I will make every attempt to accommodate you to lessen any expenses (travel, cost of journal, etc.) this study may incur.

Confidentiality:

First and foremost, all efforts will be made to ensure confidentiality! The records of this study will be kept private. Research records will be stored securely and only the researcher will have access to the records. All participants will be assigned a pseudonym and real names will not be used. When the Consent Form is signed, a pseudonym (false name) will be written next to the participant's signature. From this point forward, all future interactions with each participant will be with the pseudonym. This Consent Form and the Authorization to Release Information Form will be kept locked in a personal safe in my home apart from all other data. I will be the only person with this knowledge. The remaining data (using your pseudonym), including audio-recordings, will be maintained in a locked file cabinet in my home. In any published report or conference, I will not include any information that will identify you as the subject. All data will be destroyed after three (3) years of the completion of this study by erasing electronic files and shredding paper documents.

Voluntary Nature of the Study:

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

How to Withdraw from the Study:

A participant may at any time leave the study without explanation and without any type of penalty. Please notify me in writing by email or mail with your desire to leave the study. Any audio recordings will be erased and written forms will be destroyed when your intent is acknowledged by me. No additional information will be needed.

Contacts and Questions:

The researcher conducting this study is Becki L. Kelly. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [REDACTED]. My committee chair is Dr. Tamika Hibbert, and you may contact her, if needed, by email at [REDACTED].

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd, Suite 1837, Lynchburg, VA 24515 or email at irb@liberty.edu.

If you are aware of other classroom teachers who have a diagnosed mental disorder and who you think may be interested in participating in this study, feel free to pass along this letter and contact information or send them to the study's website at www.beckistudy.com.

You will be given a copy of this information to keep for your records.

Statement of Consent:

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

I understand this study involves audio-recording and I give my consent to participate in this documentation.

Signature: _____

Date: _____

Signature of Investigator: _____

Date: _____

Appendix E: Interview and Focus Group Questions

Individual Interview Questions

Interviews will be conducted using open-ended questions below:

Preliminary Questions:

- a. What is your gender, age, number of years in teaching, highest degree attained, past school level(s) taught, and current school level you are teaching?
- b. What diagnosed mental health disorders do you suffer from (based on medical/mental health professionals)? Explain the symptoms you exhibit for each diagnosis.
- c. Explain the origin of your mental disorder (i.e., biological, socially constructed, or combination).
- d. When was your mental disorder diagnosis? Explain the circumstances leading up to the diagnosis.
- e. If medicated, what do you currently take? Explain any side effects associated with the medications.
- f. What would happen if you stopped, or recently stopped the medication(s)?

CQ: How do classroom teachers diagnosed with a mental disorder describe their experiences in the school environment?

- a. What are your reasons for becoming a teacher?
- b. What is your favorite part of being a teacher?
- c. What challenges do you have and how do you cope with them?
- d. What are your strengths from having a diagnosed mental disorder in performing daily functions in the school environment?
- e. What are your weaknesses from having a diagnosed mental disorder in performing daily functions in the school environment?

RQ1: How do classroom teachers diagnosed with a mental disorder describe their emotions as it relates to feelings, thoughts, and reactions experienced in the school environment?

- a. Describe situations where you could not control or self-regulate your mental disorder (decision-making, emotion regulation)?
- b. What were the consequences of these situations?
- c. What factors attribute to the increase of the mental disorder symptoms?

RQ2: How do classroom teachers diagnosed with a mental disorder describe their relationships with their students and peers?

- a. How do the symptoms of your diagnosed mental disorder affect your relationships with students, colleagues, and superiors?
- b. How does your mental disorder prevent or promote your ability and effectiveness to be a role model in the school environment?

RQ3: How do classroom teachers diagnosed with a mental disorder describe their sense of professionalism in the school environment?

- a. How would you define professionalism in teaching?

- b. How does a mental disorder change your image of yourself as a teacher and as a professional?

RQ4: What factors do classroom teachers diagnosed with a mental disorder identify as contributing, or influencing, their decision to disclose their mental disorder within the school setting?

- a. Do you perceive having a mental disorder as a “stigma” and how does this affect your desire to disclose or share your experiences?
- b. After your diagnosis, how did you perceive yourself differently? How did it change your perception of yourself?
- c. Who in the school environment have you confided in regarding your diagnosed mental disorder?
- d. What were your thoughts and feelings prior to and after disclosure?

A final consideration is to assess if the participants have thoughts, opinions, or suggestions on ways the educational system could assist classroom teachers with a diagnosed mental disorder in reaching self-efficacy and job-satisfaction in the school environment.

What solutions or programs can be taken by the school or district to ease your symptoms or behaviors associated with your mental health disorder?

What would you like administrators and local governance to know about diagnosed mental disorders in the classroom teacher?

Please share any parting thoughts or ideas you may have regarding your diagnosed mental disorder that you have thought about but have not shared.

Focus Group Questions

The first question for all focus group participants is: What have you learned about yourself from this experience of telling your story? This will be a “round robin” format with each participant answering this question. A second round robin will be available and each participant will be asked: Now that you have heard the other participants’ answers to the first question, what other comments or thoughts can you add to your previous answer? In the third and final round robin format, the final question will be: Lastly, please add any parting thoughts, feelings, comments, and opinions.

Note: All Interview and Focus Group Questions were created by the author of this study.

Appendix F: Audit Trail

2014	Activity/Comment	
6/9	Applied for Atlas ti license to practice & learn program	
11/24	IRB sent back recommendations for revisions. Trying to find method to gain participants, IRB felt using medical/mental health professionals would be unethical.	
12/8 to 12/15	Dr. Hibbert said use snowball method, Contacted PAGE about utilizing their ListServe, denied. Contacted AJC about ad, 3x5, \$1500, not yet approved by IRB, after Jan 1, rate goes up \$3900. Not financially feasible. Contacted school system about sending mass email about study, denied for confidentiality reasons.	
2015		
1/3	Obtained Fatcow account on website for beckistudy.com	
2/25	IRB approved study for 1 year.	
2/28	Facebook private message to 20 people to find participants, no responses	
3/2	Started contacted participants face-to-face until mid-July, 9 accepted to participate, 7 participants I know, 2 through snowball	
3/7	Susie Interview- 2 hours, Transcribed 3/7 to 3/9- 11 hours	Reading and annotating transcripts multiple times in-between interviews and transcriptions. Made a chart with participants, notes with simple annotations, quotes, answers to RQs on where to find page numbers in transcripts for RQs. Compiled chart until mid-November 2015.
4/8	Laura Interview- 1.5 hours, Transcribed 4/9 to 4/11- 9 hours	
5/29	Lucy Interview- 1.5 hours, Transcribed 5/30 to 6/1- 9 hours	
6/6	Wilma Interview- 1.25 hours, Transcribed 6/7 to 6/8- 8.5 hours	
6/11	Anne Interview- 2 hours, Transcribed 6/11 to 6/13- 10 hours	
6/12	Jackie Interview- 1 hour, Transcribed 6/14 to 6/15- 8 hours	
7/19	Alexa Interview- 1.25 hours, Transcribed 7/19 to 7/21- 8.5 hours	
7/20	Patty Interview- 1 hour, Transcribed 7/23 to 7/25- 8 hours	
7/22	Tessa Interview- 1.25 hours, Transcribed 7/25 to 7/26- 8.5 hours	
6/22	Decided not to not use Atlas ti. Spent about 4 hours to learn it since I purchased the subscription and still not comfortable with the program, have decided it will take me too long to learn it and I can organize my thoughts better just by using the word program.	

2016	Activity/Comment
1/2	Started writing CH 4 while rereading transcripts; CH 4 about 35 hours in January.
1/20	Send Facebook private messages and face-to-face contact to remind participants to journal and attempt to schedule focus group. Not much interest in either.
1/23 1/29 2/12	Wilma Journal Done Alexa Journal Done Laura Journal Done
2/18	Focus Group Interview- 1.5 hours, Transcribed 8.25 hours
2/20	Laura Journal #2 Done; Retyped Laura's two journals as I did not have the program she used at her home- 2 hours; Retyped Alexa's Journal- 15 minutes, (was hand-delivered); Wilma typed her Journal at my house.
2/25	Study ends per IRB
March	Reread all data & notes sporadically, did miscellaneous research for updated articles.
April	Reread all data & notes sporadically, did miscellaneous research for updated articles.
5/2	Met with participants (Anne, Alexa, Laura, Lucy, Wilma) over the next two weeks to member check. Participants Jackie, Lucy, & Tessa decided to forgo the member check. Susie was deceased at this time. Edits were made on my laptop when we met.
6/4	Started writing and editing CH 4 and work on Tables; began notes for CH 5 until 6/22; about 28 hours writing plus 4 hours rereading data.
9/4	Rereading all data, written work, research and identify themes, finished Tables until the end of September; 30 hours writing, 5 hours reading research. Reread data through October sporadically.
11/21	Rereading all data, write themes, more research until 11/27; 32 hours writing, 5 hours reading research
12/19	Decided to change a few themes, wrote new ones and wrote more on CH 5 until 12/29, 28 hours
2017	
1/2	Made up my mind to get serious and finish this manuscript! Started rereading completed writing and transcripts to refresh memory. Started writing on CH 5 again, research articles for literature in CH 5; all until 1/29; 94 hours
1/29	Emailed CH 4 & 5 to Dr. Hibbert, returned 2/11.
1/30	Added resources to reference list, Reviewed APA, found more & read research, edited CH's 1-3 to past tense until 2/14; 31 hours
2/14	Read Handbook 16-17, needed to make major changes to CH 3 (Research Question section & Trustworthiness section), research for those areas and write until February 17, 12 hours

2/18	Do appendices, crosscheck references with manuscript, format tables all by viewing YouTube videos and APA until February 22; 39 hours
2/23	Reworked Tables, type up Audit Trail, decided to consolidate challenges and weaknesses in Ch 4 and Tables due to the overlap through February 24; formatting is a struggle; 20 hours
2/25	Add participant data and revised CH 5, 11 hours
2/26	Last minute edits, work on Table of Contents, 4 hours; Emailed complete manuscript to Dr. Hibbert.
3/11-12	Edits completed from committee, 8 hours
3/20-25	More editing based on checklist and templates, 30 hours
3/26	Edited manuscript to Dr. Mathura (editing), Dr. Hibbert & Dr. Milacci
4/1-5	Working on final edit after Dr. Milacci and Dr. Mathura's input, 26 hours
4/6-7	Work on Defense PPT, 12 hours
4/8-9	Work on Implications, Defense PPT, sent PPT to Dr. Hibbert 4:44, 15 hours
4/9	Edited manuscript emailed to Dr. Hibbert
4/11	Defended dissertation, 1 hr.
4/16-17	Added two areas requested by committee, 2 hours Manuscript sent to Dr. Hibbert for Final Approval: FINAL Approval: 4/18/17

Appendix G: Combined Categories before Themes

Types of Challenges	Participant(s)
1) Relationship Issues	
A) Issues with administrators	
Issues with and/or distrust of administrators	Alexa, Anne, Jackie, Susie, Tessa
Lack of support from administrators/superintendent	Alexa, Jackie, Laura, Susie, Wilma
Lack of administration help with behavior issues	Laura, Lucy
Administrators know about participant's mental disorders, negative perception of participant, lack of confidentiality	Anne, Susie
Administrator very controlling, micro-manages, teachers not involved in decision-making	Alexa
Administrator runs school like a business, not friendly	Tessa
Believes administrator lowered evaluation unfairly	Jackie
B) Issues with staff and parents	
Distrust of adults in the school/problems with others	Alexa, Anne, Jackie, Lucy, Susie
Parents not supportive	Jackie, Lucy, Patty, Susie
Honest to adults and hurts feelings, negative reactions	Anne, Jackie, Lucy
Perfectionism/curriculum not appreciated by colleagues, others focus on her weaknesses	Anne, Lucy
Parents of opposite color said I was racist	Laura, Tessa
People-pleaser/dislikes confrontation	Jackie, Patty
Working environment/grade level discord	Anne, Jackie
Keeps more to self to avoid miscommunication	Lucy, Susie
Feels alone, no support system	Susie
Not having connections with transient families	Tessa
Sacrificed principles	Jackie
C) Issues with students	
Bad behavior/difficult children/personality conflicts	Alexa, Jackie, Laura, Lucy, Susie, Wilma
Questions effectiveness to meet all students' needs	Anne, Jackie, Laura, Susie, Tessa, Wilma
Lack of motivation in students	Jackie, Lucy, Tessa, Wilma
Sarcastic, abrasive to kids	Laura, Lucy, Susie
Too many levels of children's abilities	Anne, Laura
Not listening to the children's stories, lack relationship	Laura
If not medicated, no patience for high school kids	Tessa
Students say she is too tolerant of disruptive students	Wilma
Frustration with low achieving students	Susie
Needs better relationships with students	Laura

2) Personal Issues

Lacks organization skills or time management	Alexa, Anne, Lucy, Tessa, Wilma
Needed to increase meds due to stress at school	Alexa, Jackie, Laura, Susie
Too impulsive/not in control of what one says	Alexa, Lucy, Susie
Being too honest with others	Anne, Jackie, Lucy
Dislike faculty meetings	Alexa, Anne, Wilma
Absent from school or excessive absences	Anne, Susie
Difficult to stay focused/high activity level	Lucy, Wilma
Getting behind on paperwork, grading, lesson plans	Lucy, Wilma
Having too many tasks to do in a short time/difficulty completing or initiating tasks	Anne, Lucy
Doesn't feel like a professional	Alexa, Susie
Hard time accepting decisions made by administrators that negatively affect students	Alexa, Anne
Has too many tasks going, frustrates kids	Lucy
Start of school/uncertainty causes anxiety	Patty
Not being politically correct in spoken responses	Lucy
Judges other people	Anne

3) Emotional Issues

Ruminating about choices made, actions, intrusive thoughts, self-doubts, sleep problems	Alexa, Anne, Jackie, Susie, Wilma
Fear of failure as an educator	Anne, Jackie, Susie, Wilma
Harder on themselves than others are	Anne, Jackie, Laura, Wilma
Gets discouraged, thinks not making a difference	Anne, Jackie, Tessa, Wilma
Not being in <i>control</i> of a situation	Alexa, Anne, Laura, Lucy
Negative emotions (when not medicated)	Laura, Lucy, Tessa
Worries about how others perceive them	Anne, Lucy, Susie
Difficulty controlling frustrations/lacks patience	Laura, Susie
Little things/adults annoy her	Lucy
Feels humiliated/embarrassed when makes mistakes	Anne
Believes she has no strengths	Susie
Feels alone, has no support system	Susie
Stressed Over:	
Teacher observations and evaluations	Alexa, Anne, Jackie, Laura, Susie, Wilma
Being called in to superior's office	Alexa, Anne, Jackie, Lucy, Patty, Susie
Work environment/too many demands	Alexa, Anne, Laura, Lucy, Tessa, Wilma
Too many levels of children's abilities	Anne, Jackie, Laura
When students do not complete work to expectations	Laura, Wilma

Being pressured for a deadline	Susie, Wilma
Confrontation from others	Jackie, Lucy
Having to, or thoughts of making changes	Patty
Sees teaching as co-parenting, can be a burden	Anne
4) Family Issues	
School issues caused dissention in family life	Alexa, Anne, Jackie, Laura
Personal issues outside of school	Anne, Lucy
Balancing family life with work demands	Tessa
5) Positive Aspects of having Mental Disorders	
Identifies, understands, compassionate, and assists the students with mental disorder symptoms	Alexa, Anne, Jackie, Patty, Wilma
Recognizes/accepts/self-aware of own mental disorders	Alexa, Anne, Jackie, Patty, Wilma
Experienced academic/behavior struggles as a kid	Anne, Jackie, Lucy, Susie, Wilma
Can communicate to parents about children who exhibit mental disorder symptoms	Alexa, Anne, Jackie, Lucy, Patty
The priority is the kids	Anne, Jackie, Lucy, Patty
Being honest with others	Alexa, Anne, Laura, Lucy
Good classroom management/few discipline issues	Laura, Patty, Wilma
Works harder, makes best choices for the students	Anne, Jackie, Laura
Ability to form close relationships with students, role of "mom"	Alexa, Jackie, Tessa
Can do several tasks at a time/multi-task	Anne, Lucy
High energy, outgoing, is fun with the students	Lucy, Wilma
Teaches character education along with the subject area	Anne, Wilma
Strong need to be professional, follows rules	Anne, Patty
Organized, overly prepared, teaches students to be the same	Laura
Lots of family connections, good communication	Tessa
Desire to mentor and assist other teachers with mental disorders	Anne
Evaluations say good rapport with students	Wilma
Classroom decorated like "home"	Tessa
Wants to be the "stable" factor in students' lives	Patty
Has no strengths	Susie

Appendix H: Implications for Research

*Starting point for more research on educators with mental disorders in ALL areas.

*Starting point for more research and discussions about support and intervention programs for educators with mental disorders.

Area of Study	Empirical	Theoretical	Practical
Reasons for Teaching	<p>Confirms: Teachers in this study have same reasons for teaching.</p> <p>Extends: Teachers are diagnosed with mental disorders (DMD), not self-assessed. Another reason for teaching is school schedules (summer breaks, weekends, & holidays off). Teaching is stressful and these breaks are very much needed.</p>	<p>MLT- Corroborates & Extends: Some teacher's with DMD chose teaching despite their disorders and despite the stigma attached to mental illness.</p> <p>SIT- Corroborates & Extends: Teacher's w/DMD who always wanted to be a teacher were encouraged by their teachers or had a parent who was a teacher.</p>	<p>Confirms: Teachers with DMD have most of the same reasons for teaching as teachers without mental disorders.</p>
Professionalism	<p>Corroborates: Teachers find defining professionalism difficult as it is a vague concept.</p> <p>Extends: Teachers with DMD struggle with being professional, yet strive harder to excel and meet high expectations, many teachers had advanced degrees.</p>	<p>MLT- Extends: Most teachers with DMD work very hard in their job to excel (challenging strategy) to lower the stigma attached to their disorders.</p> <p>SIT- Extends: Some teachers with DMD do not see themselves professionally and have been told by a superior they are not professional. Colleagues may see teachers with DMD as not part of the teacher group because of actions and behaviors not considered "professional".</p>	<p>Extends: Governance should be tasked with finding solutions for teachers with DMD in order to review and revise current standards of professionalism at the school level (lower level) to accommodate the reality of teaching in the classroom.</p>

Area of Study	Empirical	Theoretical	Practical
Stress & Burnout	<p>Confirms: Teachers in this study have the same causes of stress.</p> <p>Extends: Teachers in this study have DMD by medical/mental health professionals, rather than self-assessments.</p>	<p>MLT- Extends: Teachers with DMD had concerns about the stigma and stress about the negative label.</p> <p>SIT- Extends: Teachers with DMD identify with each other in regards to the rigorous demands of teaching and the other causes of stress/burnout.</p>	<p>Extends: Teachers with DMD need programs & interventions to cope in the stress of the school environment.</p>
Emotional Control	<p>Corroborates: Teachers in this study have difficulty with controlling emotions, such as frustration & anger, fear is a factor.</p> <p>Extends: Teachers with DMD struggle with emotions, especially with adults in the school environment.</p>	<p>MLT- Extends: Teachers with DMD do self-stigmatize at first, and they have worries and other troublesome emotions about being stigmatized by others. They also have concerns for their family members and have a need to protect them from the negative biases from others.</p> <p>SIT- May diverge: Teachers with DMD struggle with controlling negative emotions that can keep them from being accepted into the group.</p>	<p>Extends: Teachers with DMD need programs (anger management) and interventions to handle other negative emotions, plus current coping strategies may need more effective techniques.</p>

Area of Study	Empirical	Theoretical	Practical
Relationships: Adults	<p>Corroborates: As in other work environments, teachers have problems with co-workers and supervisors.</p> <p>Extends: Few and outdated studies of educators with DMD working together in the school environment. This study found relationships with adults problematic, especially in trusting others.</p>	<p>MLT- Extends: Teachers with DMD found relationships with colleagues untrusting and therefore would not discuss their mental health issues.</p> <p>SIT- Extends: Teachers with DMD have difficult relationships with adults and may prevent the teacher group from being cohesive. Some teachers with DMD had a difficult time identifying with individuals also.</p>	<p>Extends: All educators need educational awareness in regards to mental disorders that may result in empathy, more support, more effective communications, and less stigma and bias.</p>
Relationships: Students & Kids are the Priority	<p>Corroborates: Teachers understand the importance of a good positive teacher-student relationship and are committed to the students' needs.</p> <p>Extends: Teachers have DMD in this study and do struggle with difficult children and kids with behavior issues. Overall, relationships with children are treasured. They put kids first over politics and are in education to prepare the next generations to be moral and productive adults. These teachers tend to excel to prove their worth.</p>	<p>MLT- Extends: Teachers with DMD are self-aware enough to understand the challenges of having mental disorders, and are in education for the kids, and empathize with struggling students who have symptoms of mental health issues and advocate for them.</p> <p>SIT: Extends- Most teachers bond within the group of teachers due to the priority of doing their best for the children in all aspects. If there are issues, teachers with DMD will put them on the back-burner for the benefit of the students.</p>	<p>Extends: All educators need educational awareness in regards to mental disorders in both adults <i>and children</i> in order to be more empathetic, more supportive, have more effective communications, and have less stigma towards others and the self.</p>

Area of Study	Empirical	Theoretical	Practical
Stigma & Disclosure	<p>Corroborates: Teachers do know and feel the stigma attached to having mental illness and it does impact disclosure.</p> <p>Extends: Teachers with DMD delayed seeking treatment, other teachers may have mental illness but have not dealt with the issue.</p>	<p>MLT- Extends: Teachers with DMD had concerns about the stigma, some internalized at first until they accepted the disorder(s). Teachers with DMD have concern for keeping careers if it were known about their mental disorders.</p> <p>SIT- Extends: Some teachers did not disclose due to reputation of self/family and culture. Theory states that if the group is positive and valuable, then the social identities become part of the subjective self; however, this study indicates groups are not positive thus identity of group is not always incorporated.</p>	<p>Extends: Teaching is a profession that requires compassion, patience, empathy, and love. Negative biases about mental disorders negate those requirements needed in teaching. Therefore, more education about mental disorders is highly necessary for all stakeholders.</p>
Medication Regimen	<p>Corroborates: Teachers in this study indicate the need for medication to control the symptoms from their mental disorders.</p> <p>Extends: Teachers with DMD had to increase dosages during the school year due to the stress of the teaching environment.</p>	<p>MLT- Extends: A person's perception of the degree of their mental disorder can influence if they will proceed with medication(s). Teachers with DMD understand their illness is not much different than a physical ailment that requires medication so they do adhere to the medication regime.</p> <p>SIT- Extends: Teachers with DMD understand the need for medications to stabilize their emotions and thought processes. This regimen of medication does not always ensure identity with the group.</p>	<p>Extends: Medication is a necessity in the school environment to assist with alleviating the negative aspects of mental disorders.</p>

Area of Study	Empirical	Theoretical	Practical
Denial of Mental Illness	Extends: Had not researched denial of mental illness; this study illustrates that denial of teachers regarding their mental health is a problem in the school setting.	MLT- Extends: It is theorized that people may deny their symptoms of the mental disorders to avoid integrating the role or self-identify as having a mental illness. Teachers with DMD believe there are other teachers who deny or avoid the reality of having a mental disorder. SIT- Extends: Teachers who deny mental illness may do so because they fear the group will not accept them.	Extends: More education is required regarding mental disorders and the symptoms. The more society understands that mental illness is not to be feared and mocked, the more able they will be to lower the prejudices and biases towards those with mental disorders.
Mental Illness in the Workplace	Corroborates: Teachers with DMD describe the same problems with co-workers, excessive job demands, bullying, low self-esteem, and some attendance issues. Extends: This study extends the findings to teachers with DMD and how their mental disorders affect the school environment.	MLT- Extends: Adults with mental disorders in the workplace can struggle if others in the work environment are biased and prejudiced towards mental illness, especially if the person's behaviors seem out of the ordinary. Like professionalism, most teachers with DMD work very hard in their job to excel (challenging strategy) to lower the stigma attached to their disorders. SIT- Extends: Teachers with DMD found relationships to be difficult with other adults and have not identified with the entire group, however, there are many other factors in the school environment that can lead to teacher's difficulty in the workplace. Identifying with the group has many complex factors, including emotional competence, attendance, self-efficacy, image of own professionalism, and high job demand.	Extends: Need more understanding of mental disorders and the negative results from stigma so those teachers with DMD can hope for better working conditions to assist in alleviating the negative aspects of having mental disorders.

Area of Study	Empirical	Theoretical	Practical
Programs & Interventions	Diverges & Extends: This study inquired into what programs are available for teachers with DMD and there are not any available nor is it anticipated there will be in the near future. Recommend support groups, counseling, & more input from teachers with DMD.	MLT- Extends: Programs and interventions are not available and teachers with DMD stated they probably would not take advantage of the programs if they were. The concern is for maintaining their teaching career. SIT- Extends: Programs and interventions are not available and teachers with DMD stated they would like to be able to discuss their experiences with others who have DMD and not to feel alone with the disorders.	Extends: Highly needed and research required to find solutions that will alleviate the challenges in the school environment for teachers with DMD.

DMD= diagnosed mental disorder

MLT= modified labeling theory

SIT- social identity theory