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DISRUPTING THE CYCLE OF ACES: EXAMINING TEACHERS' EXPERIENCES WITH SUPPORTING STUDENTS

BY

LINDSAY GORDAY

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Lindsay Gorday

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and the oral examination is approved

Supervisors:
Dr. Jeff Chang
Athabasca University

Dr. Simon Nuttgens
Yorkville University

External Examiner:
Dr. Shelley Skelton
Shelley Skelton Psychological Services Inc.

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1 University Drive, Athabasca, AB, T9S 3A3 Canada
Toll-free (CAN/U.S.) 1.800.788.9041 ex. 6821
fgs@athabascau.ca | fgs.athabascau.ca | athabascau.ca

Dedication

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Abstract

Negative impacts to mental health and wellbeing that stem from exposure to adverse childhood experiences (ACEs) can contribute to high risk behaviours and health issues through a person's lifetime. Interventions are necessary to support children and adolescents who are affected by these adversities to mitigate negative consequences and reduce occurrences. Schools are increasingly relied on to provide a multitude of social-emotional supports and services, with teachers holding a significant portion of these responsibilities. This study used interpretative phenomenological analysis (IPA) to explore the lived experiences of teachers who have supported students impacted by ACEs. A homogenous sample of six participants were recruited and individually interviewed. Individual and cross-case analyses of the data revealed six superordinate themes: Intrinsic Motivation, Work Conditions, Collaborative Supports, Systemic Factors, Establishing Relationships, and Conundrums. Connections of these findings to existing literature, study strengths and limitations, and considerations for future practice and policy are also discussed.

Keywords: adverse childhood experiences, trauma, youth mental health, teachers, school

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Chapter 1. Introduction

Mental health issues affect people of all ages and socioeconomic status (Bethell et al., 2017; Crouch et al., 2018; Mental Health Commission of Canada [MHCC], 2013). Despite data that reveals a higher prevalence of mental health problems and illness during early adulthood, it is essential to recognize that the onset of many mental health issues occurs during childhood and adolescence (Das et al., 2016; MHCC, 2013, World Health Organization [WHO], 2018). Ten to 20% of youth experience mental disorders worldwide, with 50% of youth experiencing a diagnosable disorder by age fourteen (National Alliance on Mental Health [NAMH], 2016; WHO, 2018). Suicide is the second leading cause of death for youth aged fifteen to twenty-four and the leading cause of death among Indigenous youth of the same ages (Findlay, 2017; Kumar & Tjepkema, 2019; Statistics Canada, 2022). The cause of mental health problems and trajectory of outcomes varies due to diversity in personal characteristics, experiences, and privilege. Nonetheless, exposure to adverse childhood experiences (ACEs) can have significant negative effects on cognitive, emotional, social, and physical health throughout one's lifetime (Das et al., 2016; Felitti et al., 1998; McEwen & Gregerson, 2019; Sonu et al., 2019).

Identifying early interventions that support the well-being and resilience of children and adolescents is essential to mitigate the negative impact of ACEs (Centers for Disease Control and Prevention [CDC], 2019; Das et al., 2016; McEwen & Gregerson, 2019; Metzler et al., 2016). However, effectively supporting youth impacted by ACEs or other mental health problems is an ongoing challenge due to the prevalence of need relative to the availability of services and reluctance to seek mental health support due to associated stigma (Bowers et al., 2013; MHCC, 2013; Sunderland & Findlay, 2013). Schools are an attractive and cost-effective solution for

addressing many of the unmet social-emotional and mental health needs of children given the wide-reaching scope of schools and pre-existing abilities of educators to support children and adolescents (Hellmuth, 2018; MHCC, 2013; Shoshani & Steinmetz, 2014). While positive outcomes have been found for many school-based mental health programs and initiatives, questions remain as to the practicality of implementing such programs within current systems or whether any such programs are being used (Askell-Williams & Cefai, 2014; Froese-Germain & Riel, 2012; MHCC, 2013). Requiring teachers to fulfill roles for which they may not feel supported or qualified for could also contribute further to the paucity of supports, especially considering the complexity of issues connected to ACEs (Franklin et al., 2012; Froese-Germain & Riel, 2012; Mælan et al., 2018; Reinke et al., 2011; Weare & Nind, 2011). Further research is required to identify how students negatively affected by ACEs are understood and responded to within the school environment.

Study Purpose

The purpose of this research is to examine the lived experiences of teachers who provide academic and non-academic supports to students negatively impacted by adverse childhood experiences. Through this study, I hoped to gain insights into individual and systemic factors that support or impede teachers' ability to support youth mental health and well-being in relation to ACEs. Developing an enhanced understanding of these lived experiences could also provide opportunities to explore current needs within the health and educational systems. I used interpretative phenomenological analysis (IPA) to gain detailed narratives of participants' personal experiences and to highlight the realities of supporting youth mental health and well-being within educational settings.

Research Questions

The following research questions guide this study:

1. How do teachers make sense of their personal agency and ability to support students who have been negatively affected by adverse childhood experiences?
2. Based on their lived experiences, what factors do teachers associate with positive or negative outcomes in their work to support students negatively impacted by ACEs?

In the next chapter, I review the literature that informed the study.

Chapter 2. Literature Review

Through this study, I sought to examine teachers' lived experiences with supporting students who have been negatively impacted by adverse childhood experiences (ACEs). The purpose of this literature review is to synthesize information regarding ACEs and to examine approaches that schools and educators may be using to support student mental health and well-being. To begin, I review the research on ACEs to document prevalence and describe the potential negative outcomes associated with exposure to ACEs. I also examine specific vulnerability factors and potential negative effects of ACEs during childhood and adolescence. Next, I review available school-based mental health (SBMH) supports and interventions, focusing on intended purposes, potential outcomes, and issues. Within this section, I have identified factors connected to teacher roles and responsibilities that influence how educators respond to student mental health needs in schools. I synthesize these findings, highlighting important factors and barriers to supporting student mental health in schools, particularly for students who have experienced ACEs, and emphasize the need for further research in this area.

Understanding Adverse Childhood Experiences

Adverse childhood experiences (ACEs) are typically described as psychosocial factors or potentially traumatic events that can have significant long-term impacts on one's health and well-being (Boullier & Blair, 2018; Petruccelli et al., 2019). The term "adverse childhood experience" is sometimes used interchangeably with terms such as "childhood trauma" or "maltreatment" due to common experiences; however, they are not synonymous. *Trauma*, as defined by the National Child Traumatic Stress Network [NCTSN] (2008), threatens a person's life or physical integrity and overwhelms an individual's capacity to cope. It is a possible outcome of exposure to adversity but is not the event or experience itself. *Maltreatment* is a

component of some but not all ACEs (Bartlett & Sacks, 2019; Boullier & Blair, 2018; NCTSN, 2008; Petruccelli et al., 2019). The original Centers for Disease Control and Prevention (CDC) – Kaiser Permanente ACE Study (Felitti et al., 1998) defined and measured ACEs according to three categories of childhood abuse (psychological, physical, sexual) and four types of household dysfunction including, children who witness violence towards their mother or live with people contending with substance abuse, mental illness, or imprisonment. Subsequent studies, including the second wave of data collection in the original ACE study (Felitti et al., 1998), have generally broadened the definition of ACEs categories to include physical and emotional neglect and household dysfunction due to parental separation or divorce (Petruccelli et al., 2019). The current ACEs scale includes all ten categories; however, researchers have proposed that other common childhood adversities should also be included given evidence that shows detrimental long-term effects related to childhood bullying and peer victimization, isolation and peer rejection, poverty and deprivation, and exposure to community violence (Finkelhor et al., 2015).

The CDC-Kaiser Permanente ACE Study was conducted from 1995 to 1997 and included two separate waves of data collection with over seventeen thousand participants (CDC, n.d., 2016; Felitti et al., 1998). Surveys completed by participants were examined to reveal associations between ACEs and later emerging issues with adult health and well-being. Felitti and colleagues (1998) published many significant findings that highlighted the high prevalence of ACEs, the positive correlation between the number of ACEs a person is exposed to and corresponding levels of risk behaviours or health issues in adulthood, and the numerous connections between exposure to ACEs and several leading causes of death in adults (CDC, n.d.; Felitti et al., 1998). Subsequent research has confirmed and extended many of these findings, thereby highlighting the need to shift attention away from the consequences of ACEs in

adulthood and towards efforts to prevent or reduce their occurrence (CDC, 2019; Merrick et al., 2018).

The original CDC-Kaiser Permanente ACE Study revealed that exposure to ACEs is quite common, with nearly 64% of participants reporting exposure to one or more ACEs (CDC, n.d.; Felitti et al., 1998). Of this number, more than 12% reported exposure to four or more ACEs (CDC, n.d.). Physical abuse (28.3%) and living with family members that abuse substances (25.6%) were the most prevalent experiences, while having an incarcerated household member (4.7%) was the least (CDC, n.d.; Felitti et al., 1998). Merrick and colleagues (2018) revealed similar findings concerning the prevalence of ACEs through their examination of data collected from the 2011-2014 Behavioral Risk Factor Surveillance System (BRFSS), a nationally representative telephone survey regarding health conditions, health-related behaviours, and the use of preventive services in the United States. Twenty-three states included an ACEs specific assessment in their BRFSS, which provided data from 214 157 non-institutionalized adult respondents, whom were included in Merrick and colleagues' sample. Their analysis of participant responses revealed that approximately 61% of respondents reported experiencing at least one ACE. Specifically, 38.45% experienced no ACEs, 23.53% one ACE, 13.38% two ACEs, 8.83% three ACEs, and 15.81% experienced four or more ACEs.

Unlike the original ACEs study, which used a predominantly white, middle-class adult sample, these results were collected from a more diverse sample (Felitti et al., 1998; Merrick et al., 2018). The BRFSS participant sample included individuals who identified as black, Hispanic, or multiracial, as well as participants that held varying levels of education and income. Although ACEs were common across all demographics, some populations appeared to be more vulnerable to exposure and the subsequent impacts of ACEs including respondents who were multiracial,

identified as gay/lesbian, or bisexual, and those who had lower levels of education or income (Merrick et al., 2018).

While comparatively fewer researchers have investigated ACEs in Canada than in the United States, Canadian studies have produced similar findings. McDonald and colleagues (2014, 2015) conducted the Alberta Adverse Childhood Experiences Study, surveying 612 females and 595 males about their exposure to ACEs. The survey included eight questions from the original Kaiser Permanente ACE questionnaire, modified to reflect Albertan and Canadian contexts. The researchers also added living with a household member with a chronic medical condition as a category but removed the question about parent incarceration. Ninety-seven percent of participants responded to all questions. The occurrence of ACEs reported by participants included 44.2% reporting zero ACEs, 35.7% reporting one to two ACEs, and 20.0% reporting three or more ACEs. Nearly half (49.1%) of the participants identified at least one form of household dysfunction and 27.2% reported at least one type of abuse. McDonald and colleagues identified that higher ACEs scores were reported by females, adults with low household incomes, those who were born in Canada, and by individuals with poor psychosocial and physical health ratings.

Felitti and colleagues' (1998) findings contributed to and initiated an extensive body of connected research about the considerable potential impact of ACEs through one's lifetime (Brown et al., 2009; Garrido et al., 2018; McEwen & Gregerson, 2019; Merrick et al., 2018). Findings from the original ACEs study, as well as subsequent research, have revealed a significant relationship between the number of ACEs one is exposed to and subsequent health risk behaviours and diseases experienced in adulthood (Felitti et al., 1998; McDonald & Tough, 2014; McDonald et al., 2015; Sciaraffa et al., 2018). Adults who have been exposed to more

ACEs are more likely to engage in risky and impulsive behaviours (e.g., smoking, heavy alcohol consumption, substance abuse, high-risk sexual practices), and experience a wide range of physical health issues (e.g., ischemic heart disease, severe obesity, cancer, lung disease, stroke, diabetes, chronic headaches, HIV, liver disease, autoimmune disease) and mental health problems (e.g., depression, anxiety, suicidality, hallucinations, intense negative responsivity) (Campbell et al., 2016; Felitti et al., 1998; Petruccelli et al., 2019; Sonu et al., 2019). Limitations of several of these studies, however, is the over-emphasis on adult health and behavioural outcomes and the reliance on the recall of older adults and retrospective data (Boullier & Blair, 2018; McEwen & Gregerson, 2019; Tonmyr et al., 2020). Until recently, less attention has been given to the effects of adversity during childhood and adolescence (Tonmyr et al., 2020).

The National Survey of Children's Health (NSCH) collected parent reports for more than fifty thousand children through 2017-2018, finding that approximately one in three children between the ages of 0-17 had experienced at least one ACE and approximately 14% had experienced two or more ACEs (Health Resources and Services Administration [HRSA], 2019). The NSCH survey mainly examined household challenges or disruption due to parental separation or divorce, mental illness, substance abuse, parent or guardian incarceration, or witnessing household violence. Parental death, receiving or witnessing neighborhood violence, and being discriminated against due to race or ethnicity were also included. The most prevalent ACEs identified were parental divorce or separation (23.4%), followed by living with household substance abuse (8.0%) and having an incarcerated parent or guardian (7.4%). With the inclusion of more ACEs categories and more diverse populations, further details regarding prevalence and vulnerability factors have also begun to emerge (Crouch et al., 2019a; Merrick et al., 2018).

Although ACEs are common across socioeconomic and demographic variables, some populations are at a higher risk of being exposed to ACEs than others (Bethell et al., 2017; Crouch et al., 2019a; Merrick et al., 2018). Sex, age, family structure, race/ethnicity, annual household income, educational attainment, employment status, healthcare needs, sexual orientation, and geographic location all influence the prevalence of ACEs in children (Crouch et al., 2019a; Merrick et al., 2018). The 2016 NSCH (Crouch et al., 2019a) data showed that exposure to parental divorce or separation, which was the most prevalent of the ACEs examined, was more likely for children from ethnic minorities (Non-Hispanic African American children), children with special healthcare needs, children living in poverty, and children living in rural areas. The 2011-2014 BRFSS (Merrick et al., 2018) showed that average ACEs scores were larger for multiracial participants relative to other race/ethnicity categories. Significantly higher rates were also reported by respondents with less than a high school education, those with an income less than $15 000 per year, and those identifying as gay/lesbian or bisexual (Merrick et al., 2018).

Children involved in the child welfare system are more vulnerable to ACEs, (Kerker et al., 2015), as are children who have pre-existing special health care needs (Bethell et al., 2014; Crouch et al., 2019a). On average, children involved in the child welfare system have been exposed to more than three ACEs (Kerker et al., 2015). Although higher prevalence of ACEs is also frequently reported for older children (ages 13-17 years), many researchers recognize that the older the child, the longer they have had to be exposed to ACEs (Crouch et al., 2019a; Garrido et al., 2018). Regardless of age, it is difficult to ascertain the full extent of impact that any given experience of adversity, let alone multiple exposures, may have on a child's development and well-being (Sciaraffa et al., 2018).

The Negative Impacts of ACEs on Children

Exposure to ACEs can directly influence an individual's quality of life by affecting biological, psychological, and social-emotional domains of functioning (Cook et al., 2005; NCTSN, 2008; Perfect et al., 2016; Sciaraffa et al., 2018). While the negative effects of ACEs have been well-documented for adults, short and long-term consequences of ACEs have also been increasingly observed in the health and behaviour of children (Boullier & Blair, 2018; Liming & Grube, 2018; Sciaraffa et al., 2018; Tishelman et al., 2010). Although every child responds differently to adversity, depending on factors such as developmental age and prior experiences, children who have been exposed to ACEs are more likely to exhibit poorer self-regulation, social-emotional skills, interpersonal relationships, and cognitive and executive functioning (Sciaraffa et al., 2018; Tishelman et al, 2010). Early exposure to ACEs can also contribute to a wide range of behavioural issues and mental health problems that negatively impact a child's development, general functioning, and academic success.

Self-Regulation

Trauma associated with ACEs can contribute to reduced emotional or physiological regulation in children, including deficits in emotion identification, hypervigilance to threat, and an impaired ability to modulate arousal (Cook et al., 2005; Liming & Grube, 2018; NCTSN, 2008; Tishelman et al., 2010). These difficulties are often expressed through common physiological symptoms (e.g., headaches, chest pains, stomach aches) and maladaptive behaviours associated with bodily dysregulation (NCTSN, 2008). Bodily dysregulation may include hypersensitivity to sensory stimuli such as sound, smells, physical touch, invasion of personal space, light, and sudden movements. Alternatively, under-reacting and exhibiting a lack

of awareness or response to internal or external physical sensations such as pain or touch can occur (Cook et al., 2005; NCTSN, 2008; Tishelman et al., 2010).

Social-Emotional Functioning and Relationships

The negative repercussions of ACEs on children's social-emotional functioning and behaviours are present in their social relationships (Bethell et al., 2017; NCTSN, 2008; Sciaraffa et al., 2018; Tishelman et al., 2010). Children who have been exposed to two or more ACEs, including those as young as ages 3 to 5, are more likely to exhibit social-emotional deficits that commonly impede social relationships, compared to those with no ACES (Bethell et al., 2017; McKelvey et al., 2018; Sciaraffa et al., 2018). These social-emotional challenges include difficulties with calming down when excited or wound up, playing well with others, and developing or maintaining friendships (Bethell et al., 2017; Sciaraffa et al., 2018). These issues may contribute to social isolation behaviours, difficulties with boundaries, and peer rejection (Tishelman et al., 2010). They can also negatively impact a child's sense of identity and create safety issues due to difficulties with understanding and responding appropriately to social cues (Tishelman et al., 2010).

Cognitive and Executive Functioning

Growing evidence has shown that the developing brain is particularly susceptible to impacts of toxic stress and trauma, such as those caused by ACEs, which can lead to permanent changes to the brain structure that negatively affect different body systems (e.g., immune and endocrine), as well as one's cognitive and executive functioning (Cook et al., 2005; NCTSN, 2008; Sciaraffa et al., 2018, Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Trauma-associated impairments to cognitive functions that may stem from ACEs include issues with information processing, lower IQ scores, reduced verbal and language

abilities, and impairments to visual, verbal, spatial, and working memory (Tishelman et al., 2010; Perfect et al., 2016). ACEs exposure have also been related to attention and memory problems, which is consistent with studies that have found correlations between ACEs and attention deficit hyperactivity disorder (ADHD) (Brown et al., 2016; Hunt et al., 2017; Liming & Grube, 2018).

ACEs exposure impairs the ability to regulate attention, which includes problems with sustaining focus, completing tasks, organizing and processing information, reasoning, problem-solving, and difficulty planning for or anticipating future events (Cook et al., 2005; NCTSN, 2008). Brown and colleagues' (2016) found that children with ACEs scores of two or more were significantly more likely to have moderate to severe ADHD. Similar findings were reported by Hunt et al (2017), including that children with three or more ACEs have a significantly higher probability of receiving an ADHD diagnosis compared to children with two or fewer ACEs.

Behavioural Issues

ACEs can impede social-emotional skills, relationships, and learning, which frequently results in undesirable emotional and behavioural problems and/or symptoms of distress (Crossfield & Bourne, 2018; McKelvey et al., 2018). Children with three or more ACEs are more prone to exhibit externalizing behaviour problems (e.g., aggression, attention issues) and overall problem behaviours (e.g., disruptive behaviours, oppositional defiance), compared to those reporting none (Hunt et al., 2017; Liming & Grube, 2018; McKelvey et al., 2018; Perfect et al., 2016). Internalizing behaviours and symptoms are also typical amongst this population, which are often characterized by sadness or depression, anxiety, actions of withdrawal, and low

self-esteem (Crossfield & Bourne, 2018; Perfect et al., 2016).

Garrido et al. (2018) found a correlation between ACEs scores and preadolescents' engagement in health-risk behaviours such as violence, substance use, and delinquency (e.g., shoplifting, property damage, fire-setting, carrying a concealed weapon, or trespassing for theft). Their sample included children aged 9 to 11 who had been placed in foster care due to maltreatment. Garrido et al. found that for each additional ACE there was a 24% increase in the likelihood of engaging in violence, a 54% increase in the probability of engaging in delinquent acts, a 50% increase in the odds of substance abuse, and a 42% increase in the likelihood of any risk behaviour involvement. Although there were no significant sex differences in ACEs exposure, boys had significantly higher likelihoods of engaging in violence and delinquency than girls (Garrido et al., 2018).

Fox et al. (2015) suggested that every additional ACE a child experiences increases their risk of becoming a dangerous and chronic juvenile offender by 35% after controlling for other risk factors for criminal behaviour. Cumulative ACEs scores were also correlated with psychiatric symptoms such as depression, and heightened risks of both non-suicidal self-injury (NSSI) and suicidal behaviours during adolescence (Kaess et al., 2013; Rytilä-Manninen et al., 2018; Serafini et al., 2015). Serafini et al. (2015) and Kaess et al. (2013) reported that experiences of sexual abuse and family dysfunction, including neglect or negative parent-child relationships, are especially predictive of NSSI and suicidal behaviours.

Academic Issues

Studies conducted with school-aged children have found that increased ACEs exposure, by type and count, is strongly associated with academic issues such as poor school attendance, academic failure, decreased school engagement, disciplinary involvement, grade retention, and

high school dropout (Bethell et al., 2014; Blodgett & Lanigan, 2018; Crouch et al., 2019b; Iachini et al., 2016; Morrow & Villodas, 2017; Stempel et al., 2017). Previous analyses have shown that children experiencing two or more ACEs are nearly three times more likely to repeat a grade in school, compared to children without (Bethell et al., 2014). Iachini et al.'s (2016) examination of the effects of different types of adversities on a sample of students repeating ninth grade revealed that household incarceration and parental separation or divorce were the most common adverse experiences. They also reported that students impacted by ACEs typically exhibited disengagement behaviours (e.g., grade reduction, suspensions, attendance issues) that began to occur concurrently with or after the adverse experience(s). Stempel et al., (2017) found that witnessing neighborhood violence, living with family members that abuse substances, or having multiple ACEs was significantly associated with chronic school absenteeism.

Insufficient Supports

Despite the prevalence of mental health issues experienced by youth, including those associated with ACEs, many children and adolescents do not receive the support and services they require. Problematic behaviours and deficits that stem from ACEs exposure affect how professionals and systems support these children and youth, with disproportionate numbers of suspension or expulsions occurring for children exposed to domestic violence, mental illness, substance abuse, living in poverty, parental divorce, and parent incarceration (Bethell et al., 2017; Zeng et al., 2019). Lack of financial means, limited availability of traditional mental healthcare services, and the significant social stigma attached to mental illness contribute to the existing need-to-service gap in youth mental health (Bowers et al., 2013; Hellmuth, 2018; MHCC, 2013; Sunderland & Findlay, 2013). The gap in services has driven the need to explore

the provision of mental health supports available through alternative settings, by looking beyond those available in more traditional clinic or office-based practice (MHCC, 2013; WHO, 2013).

School-Based Mental Health: Supports and Interventions

Schools have been identified as ideal settings for providing mental health supports and interventions to children and adolescents (Durlak et al., 2011; MHCC, 2013; Shoshani & Steinmetz, 2014). Logistically, schools provide cost-effective opportunities for reaching a large number of youths over an extended period, while mandatory school attendance naturally increases the likelihood that students who are negatively impacted by ACEs or other mental health problems will receive ongoing support compared to clinic-referred children (Askell-Williams & Cefai, 2014; Hardcastle et al., 2018; MHCC, 2013). School-based professionals and educational staff are also accustomed to recognizing and responding to student needs, including identifying and intervening with children exposed to ACEs (The Alberta Teachers' Association [ATA], 2018; Askell-Williams & Cefai, 2014; Moon et al., 2017).

Differences in organizational conditions and priorities influence how school mental health is addressed at the provincial, district and community/school level (MHCC, 2012). These conditions include protocols for decision-making and policies on training, implementation, and roles (MHCC, 2012). Policymakers face complicated decisions about the allocation of resources to maximize student mental health and well-being (MHCC, 2013; Taylor et al., 2017), as school jurisdictions also require that school-based mental health (SBMH) programming document enhanced learning and academic outcomes (Durlak et al., 2011; Froese-Germain & Riel, 2012; Moon et al., 2017; Weissberg et al., 2015). Movements to incorporate SBMH practices and policies into schools have become more visible as mounting evidence highlights the strong link between school success and mental health (Alberta Education, 2017; Blodgett & Lanigan, 2018;

MHCC, 2012).

Alberta Education (2017) promotes the use of a comprehensive whole-school approach to supporting mental health in schools. This approach is based on the incorporation of evidence-informed strategies and the development of a strong pathway to service that aims to: "promote positive mental health across environments, provide universal supports within classroom and school settings, identify students in need of additional mental health supports, facilitate referrals to specialized school staff or mental health providers, and support the student's recovery process in the school setting once interventions have been initiated," (p. 26). Standards requiring the full integration of mental health strategies into school-wide policies and practices are complicated, however, by the wide array of available frameworks and factors associated with effective use (Askell-Williams & Cefai, 2014; Froese-Germain & Riel, 2012; MHCC, 2013). Similarly, the foundations for a comprehensive pathway to service are built upon ideal circumstances and a strong understanding of the "roles and responsibilities in pathways to, through and from service" (Alberta Education, 2017, p26; Domitrovich et al., 2008). Quality implementation of SBMH programming, including those described by Alberta Education (2017), is more complex than is typically described in organizational reports, given discrepancies between what is planned and the actual implementation (Domitrovich et al., 2008). Effectively supporting student mental health and well-being requires a broader understanding of the factors involved in the various domains of SBMH, including those offered through professional service providers, focused approaches, and teacher supports.

Roles and Responsibilities of SBMH Professionals

SBMH services are delivered by school-employed and community-employed providers in school buildings, which includes professionals such as social workers, guidance counsellors,

nurses, psychologists, and psychiatrists (Alberta Education, 2017; Doll et al., 2017; Osagiede et al., 2018). These services may also include Indigenous organizations or Elders when supporting Indigenous student needs (Alberta Education, 2017). SBMH service providers typically work under the guidance of larger governing bodies, while providing mental health promotion, prevention, and interventions within the school environment (Alberta Education, 2017; Berzin et al., 2011; Osagiede et al., 2018).

SBMH professionals engage in a variety of roles, from facilitating communication between home, school, and community, to consultation and collaboration with school staff, to targeted student supports and interventions (Berzin et al., 2011; Mælan et al., 2018; Moon et al., 2017). Individual or group counselling are a primary focus of many service providers including school psychologists and social workers (Osagiede et al., 2018; Suldo et al., 2010). SBMH service providers perform crisis intervention, behavioural intervention support, social-emotional behavioural assessments, and consultation with school staff and parents (Berzin et al., 2011; Suldo et al., 2010). Many SBMH professionals also have the capacity to provide school-wide supports such as in-service training and mental health promotion and prevention. However, this typically occurs much less frequently (Berzin et al., 2011; Reinke et al., 2011; Osagiede et al., 2018).

The provision of mental health services (MHS) is influenced by both system-level and personal-level factors, which differs across schools and school districts (Osagiede et al., 2018; Suldo et al., 2010). Factors such as department or district-level administration may affect MHS delivery and access (Domitrovich et al., 2008; Suldo et al., 2010). Skepticism towards SBMH services in schools and reductions to school budgets have contributed to decreased availability of SBMH service providers, as well as difficulties they experience due to overwhelming caseload

requirements (Atkinson et al., 2014; Suldo et al., 2010). Changes to government policies in Alberta led to the elimination of the Regional Collaborative Service Delivery (RSCD) grant on September 1, 2020, for instance, which was typically used to fund and provide access to health care workers and family support workers who were paired with schools (Alberta Education, 2017; United Nurses of Alberta, 2020). As such, school-based professionals are often divided among several schools and carry out administrative responsibilities that crowd out the time needed to provide direct service to students (Hellmuth, 2018; Suldo et al., 2010). The ratio of guidance counsellors to students in Ontario secondary schools, for example, is 396:1, with more than ten percent of these school ratios rising to 826:1 (People for Education [PFE], 2018). Limited access to private spaces, and conflicting views between practitioners and school staff regarding the relative importance of academic accountability and student well-being, can also make it difficult to schedule time to work with students (Suldo et al., 2010). As a result, SBMH professionals may only be able to provide a limited number and type of services.

SBMH service providers require support from and collaboration with school staff, and teachers in particular, to effectively meet the mental health needs of students (Berzin et al., 2011; MHCC, 2013; Suldo et al., 2010; Weare & Nind, 2011). While some teachers work collaboratively with SBMH professionals, others are less willing to be involved or perceive mental health as outside the role of educators (Shelemy et al., 2019; Suldo et al., 2010). Inconsistencies across schools and school boards have also made it challenging for SBMH professionals and educators to implement their complementary roles and responsibilities for student mental health and well-being (Froese-Germain & Riel, 2012; Mælan et al., 2018; Moon et al., 2017; Shelemy et al., 2019).

Focused SBMH Approaches

The integration of focused SBMH approaches in schools could more seamlessly provide information and strategies to prevent ACEs, as well as create opportunities for necessary referrals to be made for children requiring additional services and resources (Holland et al., 2017; Kieling et al., 2011; Meldrum et al., 2009). Existing SMBH approaches target a wide array of outcomes including the development of interpersonal characteristics and social-emotional learning (SEL), response to specific conditions such as internalizing and externalizing problems, and more general objectives aimed to enhance awareness and understanding of mental health (Durlak et al., 2011; MHCC, 2013; Taylor et al., 2017).

Many schools use a multi-tiered intervention process, sometimes referred to as the Response to Intervention (RTI) model, to meet student learning and social-emotional needs (Government of Alberta, 2020). These interventions are provided through a continuum of supports, which begin with universal prevention and instructional programs that all students receive, and sequence through to more targeted assessments or services designed for individual students (Alberta Education, 2017; Dorado et al., 2016; Government of Alberta, 2020; Hellmuth, 2018). Specific areas of focus vary depending on student characteristics such as age, protective and risk factors, and whether interventions are implemented through a whole-school model or within isolated classrooms (Shoshani & Steinmetz, 2014).

Research has increasingly found evidence of the benefits of specific programs, including social-emotional learning approaches, positive psychology interventions, cognitive-behavioural strategies, mental health literacy programs, trauma-informed approaches, and increased attention to school climate (Collaborative for Academic, Social, and Emotional Learning [CASEL], 2018; Durlak et al., 2011; Taylor et al., 2017; Weare & Nind, 2011; Waters, 2011). However, due to

the primary obligation of schools to support student learning and academic success, school administrators and stakeholders must make complicated decisions about priorities when considering mental health and well-being interventions for schools (Durlak et al., 2011; Froese-Germain & Riel, 2012; Moon et al., 2017).

Social-Emotional Learning Interventions

School-based programs focused on social-emotional learning (SEL) are constructed around frameworks that foster social, emotional, and academic competencies (CASEL, 2018; Weissberg et al., 2015). CASEL (2018) promotes the establishment of evidence-based SEL practices for all children in preschool through high school. Specific competencies targeted through SEL approaches include self-awareness, self-management, social awareness, relationship skills, and responsible decision-making (Weissberg et al., 2015). Standard techniques utilized in SEL programs include skills training, role-playing, positive feedback, modelling, and self-reflection (MHCC, 2013).

Durlak and colleagues' (2011) meta-analysis of 213 school-based universal SEL programs implemented across multiple grades and age levels (kindergarten to high school) showed significant positive effects on targeted social-emotional competencies and attitudes about self, others, and school. Improvements were observed in social and emotional skills, attitudes towards self and others, positive social behaviours, conduct problems, emotional distress, and academic performance. Increases in prosocial behaviours, reduced conduct and internalizing problems, as well as improved academic performance, were additional positive outcomes of the implemented program. On average, students enrolled in an SEL program ranked eleven percentage points higher on standardized tests compared to control groups (Durlak et al., 2011). Durlak and colleagues recognized, however, that additional follow-up studies were needed to

confirm the durability of the programming given that only 16% of the studies examined included post-academic information, and other factors or skills could have contributed to academic growth.

Taylor et al. (2017) similarly found both short-term and long-term benefits through their meta-analysis of 82 school-based universal SEL interventions as measured by positive youth development (PYD) indicators and factors of well-being including improvement in self-control, interpersonal skills, problem-solving, the quality of their peer and adult relationships, commitment to schooling, and academic achievement. SEL programs also contributed to protective outcomes against negative behaviours such as decreased substance use, risk-taking behaviours, and problem behaviours (e.g., violence, bullying, classroom disruption, non-compliance) (MHCC, 2013; Taylor et al., 2017). Although SEL approaches to mental health have been identified as a positive universal prevention strategy, they generally are not intended to provide the targeted individualized social and emotional support necessary for students impacted by more complex physical or mental health problems (Hellmuth, 2018).

Positive Psychology Interventions

Positive psychology is the scientific study of positive experiences and positive individual traits, and factors that facilitate their development (Duckworth et al., 2005, p. 630). As such, positive psychology interventions (PPIs) aim to cultivate three domains of happiness including pleasure, engagement, and meaning (Duckworth et al., 2005). Within educational settings, PPIs are used to foster student well-being by enhancing positive emotion skills (e.g., hope, gratitude, and serenity), character strength, positive relationships, and resilience, rather than focusing on the removal or reduction of negative factors (Roth et al., 2017; Shoshani & Steinmetz, 2013; Waters, 2011). Waters' (2011) evaluation of twelve school-based PPIs showed positive effects

on student well-being and academic performance across different grade levels, countries, and ethnic and cultural identities. Although the specific effects varied depending on the skill focus and techniques used (e.g., journaling, meditation, and structured resiliency training), each of the interventions examined were associated with significant improvements in student well-being. A common factor of the programs reviewed, which may have contributed to their success, was that most of the PPIs were implemented by trained teachers rather than requiring delivery by an external expert, which facilitated a whole-school approach to supporting student well-being.

Shoshani and Steinmetz (2014) conducted a one-year intervention and two-year longitudinal repeated measures study evaluating the impact of a whole-school PPI on both instructional staff and Grade 7, 8, and 9 grade students at a large middle school in the center of Israel. Findings showed that both high-risk (i.e., living below the poverty level or being from single-parent families) and low-risk students experienced significant improvements in mental health following the implementation of the PPI. Specifically, measures of self-esteem, self-efficacy, and optimism were strengthened, and interpersonal sensitivity symptoms were reduced. Significant decreases in general distress, anxiety, and depression symptoms were also identified.

Roth et al.'s (2017) evaluation of multi-target and multi-component PPIs provided to seventh-grade students revealed additional evidence for the positive impacts of PPIs on students' mental health and subjective well-being (SWB). Their findings showed positive outcomes for all SWB indicators assessed including life satisfaction, positive affect, and negative affect. Although statistical significance was not met for effects on symptoms of internalizing and externalizing problems, notable declines were evident in scores of the intervention group participants relative to the control group. Roth and colleagues suggested that PPIs may be useful to alleviate symptoms or help to prevent internalizing and externalizing disorders. They also recognized,

however, that clinical interventions may be necessary to target the causal mechanisms of psychopathology.

Mental Health Literacy Programs

Mental health literacy (MHL) interventions provide essential foundations for increasing awareness and understanding of mental health and mental illness during critical stages of life, for children and adolescents (Bowers et al., 2013; McLuckie et al., 2014; Wei et al., 2011). MHL programs help to create a basis for early identification and intervention needs, and support the reduction of the social stigma attached to mental illness and treatment (Bowers et al., 2013; McLuckie et al., 2014; Wei et al., 2011). Although researchers have found mixed evidence for the overall effectiveness of different MHL programs, a majority of the MHL studies reviewed by Wei et al. (2013) showed improvements in knowledge and attitudes related to mental health, and help-seeking behaviours.

A major drawback of many MHL programs is the significant amount of time, expertise and external resources required to implement them effectively (Askell-Williams & Cefai, 2014). *The Guide* is a web-based MHL resource that was specifically designed to be used in conjunction with junior high and high school health curriculums, which requires a relatively shorter period for implementation (Kutcher et al., 2015; McLuckie et al., 2014). To implement *The Guide* program, teachers complete a self-study that provides information about processes for identifying mental health needs and connecting with external supports for students (Kutcher et al., 2015). Teachers receive six structured modules that address the following domains of mental health: (a) stigma, (b) understanding mental health and mental illness, (c) specific mental disorders that onset during adolescence, (d) lived experiences of mental illness, (e) help-seeking and support, and (f) the importance of positive mental health (Kutcher et al.,

2015, McLuckie et al., 2014; Wei et al., 2011). McLuckie et al. (2014) found significant improvements in both knowledge and attitudes towards mental health after implementation of *The Guide*, as well as at two months follow-up.

Trauma-Informed Approaches

The four key assumptions of trauma-informed approaches, as identified by the Substance Abuse and Mental Health Services Administration's (SAMHSA, 2014), include realization of the widespread prevalence and impact of trauma, recognition of the signs of traumatic exposure, response grounded in evidence-based practices, and efforts to resist re-traumatization of individuals (p. 9). Such approaches are also grounded in six key principles including (a) safety, (b) trustworthiness and transparency, (c) peer support, collaboration and mutuality, (d) empowerment, voice, and choice, and (e) cultural, historical, and gender issues (SAMHSA, 2014, p.10). For programs, organizations, or systems to effectively apply the principles of a trauma-informed approach, "staff training, a budget that supports ongoing training, and leadership that realizes the role of trauma in the lives of their staff and the people they serve," are also necessary (SAMHSA, 2014, p. 10).

Growing awareness of the prevalence and significant impacts of trauma among youth has spurred calls for schools to develop an understanding of trauma-informed care and to provide access to trauma-specific treatments (Chafouleas et al., 2019; National School Boards Association [NSBA], 2019; Overstreet & Chafouleas, 2016; Pataky et al., 2019; Perfect et al., 2016). School is not only recognized as a place where the consequences of traumatic exposure may be manifested, but also an essential potential contributor to a child's healing and coping (Tishelman et al., 2010). Professional development focused on trauma-informed care typically aims to convey understanding of the impacts of trauma on student learning and behaviours at

school, with attention to guiding protocols for implementation and assessment (Chafouleas et al., 2019; Ko et al., 2008; Overstreet et al., 2016).

Shifting educators' understanding and response to students impacted by ACEs involves shifting perspectives away from identification of student deficits and towards understanding what has happened to a student (NSBA, 2019). Although educators are cautioned against assuming that difficult child behaviours or learning challenges are connected to adverse experiences, there are benefits to considering social-emotional influences and a child's surrounding setting when working to understand all students' behaviours, performance, and needs (Tishelman et al., 2010). The mnemonic CAPPD is sometimes used within school-based training to create more trauma-responsive systems, which includes the following behaviour guidelines for working with trauma: *Calm, Attuned, Present, Predictable,* and *Don't let children's emotions escalate your own* (Walkley & Cox, 2013, p.122).

The University of California, San Francisco's (UCSF) Healthy Environments and Response to Trauma in Schools (HEARTS) program is one example of a trauma-informed approach, which utilizes an RTI framework (Dorado et al., 2016). The mission of HEARTS is to collaborate with school systems to promote success through the development of "more trauma-informed, safe, and supportive environments that foster resilience and wellness for all (children/youth and adults alike) in the school community," (Dorado et al., 2016, p.164). Dorado et al. (2016) evaluated the effectiveness HEARTS delivered in four different schools. School personnel reported significant increases in their understanding of trauma and the use of trauma-sensitive practices. Dorado and colleagues also found improvements in students' ability to learn, time on task, and school attendance.

Despite mounting evidence supporting the integration of trauma-informed approaches in schools, determining how to integrate these practices into the current school landscape and assess the relative impacts on mental health and academic outcomes remains the main challenge (Chafouleas et al., 2019; Perfect et al., 2016). Although schools prioritize educational outcomes, many students need help dealing with traumatic stressors such as ACEs to effectively engage with learning (Ko et al., 2008). Dombo and Sabatino (2019) argue that "for schools, or any environment that serves children to be trauma-informed, they must address three crucial areas: safety, connection, and emotional and behavioral regulation" (p.18). Increased focus needs to be placed on how the school environment influences and supports the needs of youth impacted by ACEs (Aldridge & McChesney, 2018; Masko, 2018).

Attending to School Climate

Attending to a school's psychosocial climate has the potential to safeguard against negative outcomes for children exposed to ACEs, as well as to teach resilience (Aldridge & McChesney, 2018; Evans et al., 2013; McEwen & Gregerson, 2019; Sciaraffa et al., 2018). *School climate* or *school environment* has been defined within the literature as the "encompassing norms, expectations, and beliefs that contribute to creating a psychosocial environment that determines the extent to which people feel physically, emotionally, and socially safe" (Aldridge & McChesney, 2018, p. 122), whereas *resilience* is typically defined through an individual's ability to manage stressful circumstances and overcome challenges (Pataky et al., 2019, p. 649). As an alternative to characterizing resilience as an individual trait, opportunities to support the development of resilience and positive well-being within school settings should be examined (McEwen & Gregerson, 2019; Sciaraffa et al., 2018). Factors associated with a positive school climate and favorable student outcomes, across all developmental levels,

typically include feelings of safety, connection, and support (Aldridge & McChesney, 2018; CDC, 2009; Crossfield & Bourne, 2018; Sege et al., 2017).

School Safety. Student perceptions of school safety, related to both structural and relational factors, are associated with improved psychosocial well-being and prosocial behaviours, while reducing the prevalence of mental health issues and risk behaviours (Aldridge & McChesney, 2018; Crossfield & Bourne, 2018). Students typically feel safest in classrooms that have clear expectations and consistent routines, calm and receptive teachers, and opportunities for student choice (Aldridge & McChesney, 2018; Dombo & Sabatino, 2019; Ruzek et al., 2016). Their sense of belonging and connection with others also impact their feelings of safety (CDC, 2009; Dombo & Sabatino, 2019). Perceptions of safety and connection contribute to resilience by enhancing a child's ability to recognize, understand, and regulate their emotions and behaviours (Dombo & Sabatino, 2019; Jennings, 2019). Helping students to feel safe at school and to develop alternative models of relationships with teachers and peers, compared to those constructed through trauma and adversity, is a critical element of supporting children and adolescents affected by ACEs and other traumas (Aldridge & McChesney, 2018; CDC, 2009; Jennings, 2019; Sege et al., 2017).

School Connectedness. Perceptions of *school connectedness* are associated with students' sense of belonging and the belief that adults in the school care about their learning, as well as about them as individuals (Aldridge & McChesney, 2018; CDC, 2009). These perceptions have been positively associated with psychosocial well-being and pro-social behaviours in adolescents, as well as decreased prevalence of mental health issues and risk behaviours (Aldridge & McChesney, 2018; Crossfield & Bourne, 2018). The CDC (2009) identified the following factors as contributors to increased school connectedness: (a) adult

support, (b) belonging to a positive peer group or stable network of peers, (c) commitment to education (i.e., believing school is important to their future), and (d) school climate. Stable relationships with caring and supportive adults also serve as strong protective factors against the negative effects of trauma and adversity in youth (Crossfield & Bourne, 2018; McEwen & Gregerson, 2019; Murphey & Sacks, 2019; Rudasill et al., 2010; Sege et al., 2017).

Resnick et al.'s (1997) analysis of the 1995-1996 National Longitudinal Study of Adolescent Health data, which included two separate waves of data collected from a cohort study of more than 200 000 adolescents in grades 7-12 (aged 12-19) in the United States, found school connectedness to be the strongest protective factor for both boys and girls to decrease substance use, school absenteeism, early sexual initiation, violence, and risk of unintentional injury (e.g., drinking and driving). School connectedness also ranked second, after family connectedness, as a protective factor against emotional distress, disordered eating, suicidal ideation and suicidal attempts. As such, schools and educators have an important role to play in promoting increased focus on enhancing the internal factors that contribute to school connectedness (CDC, 2009; Murphey & Sacks, 2019). Since teachers serve as prominent role models and play such a central role in the lives of children and adolescents, it makes sense that much of school connectedness is mediated through teacher-student relationships (ATA, 2018; Bellis et al., 2018; Jennings, 2019).

Teacher-Student Relationships. Research consistently finds the powerful influence that positive teacher-student relationships have on the well-being, resilience, and success of students impacted by adversity (Crossfield & Bourne, 2018; Jennings, 2019; Masko, 2018; Post et al., 2019; Rudasill et al., 2010). Specifically, Masko (2018) found that care was a central factor in positive teacher-student relationships, identifying four main aspects of care: having a warm demeanor, showing understanding to students' lived experiences, teacher-as-parent, and honest

and clear communication. Jennings' (2019) literature review differentiated between age groups as to what students identified as important to positive teacher-student relationships. Elementary students identified that levels of closeness (positive emotion and warmth expressed between teacher and student), conflict (negative emotion and perceived lack of support), and dependency impacted teacher-student relationships and the associated academic and behavioural outcomes. Students in higher grades (i.e., ages 11-17) identified perceived support (teacher sensitivity to student needs), utilization (willingness to access teacher help), and relatability (sense of belonging and acceptance) as crucial elements of positive teacher-student relationships (Jennings, 2019; Ruzek et al., 2016).

Through positive teacher-student relationships, trauma-exposed students have opportunities to "develop new models of relationships and new models of self in relation to others," (Jennings, 2019, p. 12) which may help to reduce risky behaviours and to increase positive student outcomes (Forster et al., 2017; Rudasill et al., 2010). Positive student-teacher relationships are associated with reduced probability of substance use by adolescents who have been exposed to ACEs, with those exposed to more ACEs appearing to benefit more (Forster et al., 2017). Students who feel safe, connected, and supported through secure teacher and peer relationships are also better able to develop healthy social-emotional skills and to engage in learning (Jennings, 2019).

Challenges with Implementation

Despite strong evidence of the benefits of focused SBMH approaches, challenges with implementation and sustainability in schools impede effectiveness (Chafouleas et al., 2019; Durlak et al., 2011). Implementing SBMH interventions in schools is far more complex than the manualized controlled studies that have been used to examine existing initiatives, especially in

regards to access of resources and expertise (Askell-Williams & Cefai, 2014). System-level gaps occur because of differences among decision-makers on choice and delivery of programs, lack of clear protocols and resources, and competing system priorities (Askell-Williams & Cefai, 2014; Froes-Germain & Riel, 2012; MHCC, 2013). Other barriers are limited access to funding and resources, time constraints, and the responsibility being placed primarily on teachers without adequate support (Askell-Williams & Cefai, 2014; Froese-Germain & Riel, 2012; MHCC, 2013; Shelemy et al., 2019). The willingness and capacity of educators to adequately implement mental health strategies is an essential component of improving the current conditions of youth mental health for students negatively impacted by ACEs (Froese-Germain & Riel, 2012; McLuckie et al., 2014; Moon et al., 2017; Shelemy et al., 2019). It is also necessary to enhance teachers' experience, knowledge, and skills if they are expected to successfully implement SBMH programming with their students (Askell-Williams & Cefai, 2014; Domitrovich et al., 2008; Moon et al., 2017; Reinke et al., 2011; SAMHSA, 2014).

Teacher Roles and Responsibilities in SBMH

Teachers fulfill numerous roles and responsibilities to ensure that all students are provided with optimal learning environments and opportunities to be successful (Alberta Education, 2018). While most teachers believe their primary role is to focus on the academic needs of students (Shelemy et al., 2019), guiding frameworks such as Alberta Education's (2018) *Teaching Quality Standard* reflect the complexity of demands on teachers to effectively support students. Planning, instruction, and assessment of academic learning, for instance, requires teachers to consider multiple individual and system-level factors that influence learning. These considerations include program criteria, instructional strategies, and student characteristics such as socioeconomic factors, diversity and culture, and health and wellbeing (Alberta Education,

2018, p. 5; Reinke et al., 2011). The *Teaching Quality Standard* also requires teachers to demonstrate competence at establishing inclusive learning environments and fostering effective relationships. These standards include "being aware of and facilitating responses to the emotional and mental health needs of students" (Alberta Education, 2018, p. 6) and "collaborating with community service professionals, including mental health, social services, justice, health and law enforcement" (Alberta Education, 2018, p. 4). Teachers' ability to make sense of and respond to competing demands has led to differences in how they perceive their roles and responsibilities related to student well-being (Ekornes, 2017).

Generally, teachers provide SBMH supports through universal (Tier 1) and targeted (Tier 2) interventions, based in frameworks such as the RTI model, for academic and social-emotional needs that impact learning (Alberta Education, 2018; Franklin et al., 2012). Teachers typically also advocate for children to receive additional support through collaboration or referrals to SBMH professionals or other community specialists who are competent to provide more intensive interventions (Alberta Education, 2017; Froese-Germain & Riel, 2012; Shelemy et al., 2019). While most teachers agree that they should be involved in supporting student mental health, there are different views on teachers' roles and how capable teachers feel to take them on (Franklin et al., 2012; Froese-Germain & Riel, 2012; Reinke et al., 2011; Shelemy et al., 2019; Weare & Nind, 2011).

A lack of organizational, parent, and professional supports contribute to the pressures on teachers from school administrators, parents, and students to provide more direct psychosocial supports to students (Ekornes, 2017; Phillippo & Kelly, 2014; Powers et al., 2011). As responsibilities that are traditionally reserved for trained professionals are being increasingly placed on teachers, several issues have emerged (Froese-Germain & Riel, 2012; Mælan et al.,

2018; Moon et al., 2017; Shelemy et al., 2019). Issues with teachers' perceived competence, experience of stress, and dilemmas with ethical decision-making are some the difficulties that are arising.

Teacher Competence

Teachers require adequate training and support to effectively implement the various SBMH approaches and interventions required of them including identifying student needs, delivering classroom-based strategies, collaborating with other school staff or mental health professionals, and making referrals (Ball et al., 2016; Ekornes, 2017; Reinke et al., 2011; Osagiede et al., 2018). Reinke et al. (2011) found that while 89% of surveyed teachers agreed that schools should address the mental health needs of children, fewer teachers felt they had the necessary skills (34%) or knowledge (28%) required to do so. This is consistent with other researchers' findings that teachers feel ill-equipped to manage and respond to student mental health needs (Ekornes, 2017; Mælan et al., 2018; Osagiede et al., 2018; Rothi et al., 2008).

Teachers' knowledge and capacity to provide SBMH supports is largely influenced by the availability of learning opportunities (Ekornes, 2017; MHCC, 2013; Phillippo & Kelly, 2014). Ekornes (2017) argued that while, "one cannot expect teachers to have detailed knowledge about the full range of mental health problems and diagnoses, … competency demands for teachers include both knowledge about effective mental health interventions and awareness of warning signs for emerging problems," (p. 334). Although standardized pre-service training addresses some SBMH competencies, such as provision of social-emotional and behavioural supports, these competencies are generally more focused towards academic domains than social-emotional development or mental health (Ball et al., 2016). Additional mental health

training programs can positively affect teachers' perceived competence, but such opportunities are often not readily available (Ekornes, 2017; MHCC, 2013; Rothi et al., 2008).

Many teachers recognize and support the need for further training to adequately understand and support mental health (Froese-Germain & Riel, 2012; Osagiede et al., 2018; Rothi et al., 2008). Such training should be provided by qualified mental health professionals and tailored towards specific competencies and needs that teachers identify (Ekornes, 2017; Osagiede et al., 2018; Rothi et al., 2008). Rothi et al. (2008) found that teachers were most interested in receiving training that would support their ability to identify student mental health issues, provide them with information about available supports and resources, and provide practical strategies to support student mental health needs in the classroom. Concerns regarding teacher capacity with SMBH remain, however, as teachers continue to receive limited preparation and support for their expanding roles with student mental health (Ball, 2011; Reinke et al., 2011; Shelemy et al., 2019). Consequently, teachers' feelings of incompetence and inadequacy have been associated with increases to teacher stress and attrition (Ball & Anderson-Butcher, 2014; Ekornes, 2017; Prilleltensky et al., 2016).

Teacher Stress

Teaching is a highly stressful profession, with 30% to 50% of new teachers leaving the profession within their first five years (Ball & Anderson-Butcher, 2014; Herman et al., 2018; Prilleltensky et al., 2016). Teacher stress affects teachers' job satisfaction, work performance, physical health and well-being, and personal relationships (Prilleltensky et al., 2016; Shernoff et al., 2011). It can also directly affect student outcomes, as well as reduce teachers' ability and willingness to engage with student mental health issues (Ball, 2011; Ball & Anderson-Butcher, 2014; Ekornes, 2017; Herman et al., 2018). Although many factors influence teacher stress,

teachers' expanding roles and responsibilities have largely increased teachers stress (Ball & Anderson-Butcher, 2014; Ekornes, 2017; Prilleltensky et al., 2016). Teachers' perceived responsibilities overwhelm their ability to help students experiencing mental health problems, which compromises teachers' ability to cope with the demands placed on them (Ekornes, 2017).

Teachers seldom receive what they require from school systems to feel competent or supported in their responsibilities for student mental health (Ball & Anderson-Butcher, 2014; Osagiede et al., 2018; Shernoff et al., 2011). As a result, many teachers feel conflicted between their responsibilities and experience heightened stress due to increased workloads and time constraint issues (Ekornes, 2017; Shernoff et al., 2011). Despite teachers' recognition of benefits associated with mental health promotion in schools, teachers have difficulty prioritizing academic over non-academic tasks due to significant pressures to demonstrate system-based measures of academic success (Ekornes, 2017; Shernoff et al., 2011). Secondary school teacher participants interviewed by Shelemy and colleagues' (2019) described feelings of frustration and helplessness when describing issues (e.g., lack of training, role uncertainty) that interfered with their capacity to adequately support the mental health of their students. These stress-related issues were also compounded by a lack of parental involvement (Shelemy et al., 2019).

Ekornes (2017) suggests, "Teacher stress emerges chiefly from a mismatch between feeling responsible for and being able to help students with mental health problems" (p. 333), as teachers feel both a professional obligation and a personal duty of care for their students. The pressures teachers place on themselves to help students, in addition to those placed on them by school administrators and parents, can lead teachers to feel overwhelmed by the mental health needs of students and to feel intense negative emotions including guilt, worry, and a sense of helplessness (Ball, 2011; Ekornes, 2017; Prilleltensky et al., 2016). Shelemy et al. (2019)

captured the complexity and emotional challenge experienced by educators trying to support student well-being through the following participant quote:

> I came into teaching to help young people to be more successful to change their lives for the positive and generally I've been successful in doing that but when you can't and when […] that support is either not there or they can't do it, then that's a horrible feeling (p. 377).

Professional Conduct

While teachers are encouraged to develop healthy and caring relationships with students, and many children and adolescents seek connection and guidance from trusted adults, educators are cautioned against taking on the role of a therapist or trying to support complex student needs in isolation (Venet, 2019). However, the prevalence of ACEs and mental health problems experienced by children and adolescents, and the barriers to obtaining the necessary supports and services, contribute to conflicting emotions teachers feel as they respond to students' non-academic needs (Felitti et al., 1998; Mælan et al., 2018; Merrick et al., 2018; Reinke et al., 2011; Shelemy et al., 2019). Mælan et al. (2018) examined different perspectives regarding overlapping roles, for example, quoting one of their participants, a ninth-grade teacher:

> There is a clear boundary between being a teacher and being a therapist, because I'm not a therapist. I do not have the background and expertise, and I do not think I should aim to be one either … but I can naturally be compassionate and I tell my pupils that they can come to me at any time and talk if they need to, I will always listen to them…. (p. 21)

Teachers who take on responsibilities to support student mental health often work to provide a stable environment and to convey empathy, caring, trust, and positive regard for students (Shelemy et al., 2019). Since students affected by ACEs or other trauma may struggle to

identify and maintain boundaries, teachers are also responsible for clarifying their roles to minimize confusion and to maintain appropriate relationship boundaries (Shelemy et al., 2019, Venet, 2019). Role conflict between a disciplinary role and a caring supporter can compromise the well-being of students and teachers (Venet, 2019).

Although professional codes of conduct guide teachers' behaviour and decisions in their work with students, these codes are neither exhaustive nor fully defined (ATA, 2018). Teachers must interpret these standards in accordance with their own professional understanding and contexts of practice; however, teachers may experience frustration due to conflicting intrapersonal values and their own *ethical intuitions* about what is in the best interests of a child, given their unique circumstances (Maxwell et al., 2018, p. 5). These dilemmas are particularly common in situations where teachers are faced with decisions relating to student privacy, fairness, and protection from harm (Maxwell et al., 2018).

Synthesis

The prevalence and negative impacts of ACEs found in the literature conveys the importance of early interventions in the lives of children and adolescents exposed to ACEs. Leaning on schools to provide effective responses to the complex and diverse needs of students requires a comprehensive approach and strong foundation for effective and sustainable outcomes (Alberta Education, 2017; MHCC, 2013). While many studies highlight the positive outcomes associated with SBMH approaches and interventions, the extent to which any specific approach or service is available and implemented is not clear in the literature. There is also a lack of understanding of the depth of understanding of teachers and their competence to respond

effectively to the specific needs of students impacted by ACEs.

Teachers have complex roles within education. In addition to addressing academic priorities, they are responsible for advocating for students and supporting diverse social-emotional needs. Exploring teachers' experiences with working to support students who are negatively impacted by ACEs provides an important lens through which to view complex student needs and current applications of SBMH supports and interventions in schools. It also addresses gaps in the literature regarding the extent to which schools, and teachers specifically, are equipped to understand and effectively respond to the complexities of student mental health and well-being associated with ACEs exposure. The main questions guiding my research include:

(1) How do teachers make sense of their personal agency and ability to support students who have been negatively affected by ACEs?

(2) Based on their lived experiences, what factors do teachers associate with positive or negative outcomes in their work to support students negatively impacted by ACEs?

The next chapter describes the method I used to address these questions.

Chapter 3. Methodology

In this chapter, I explain the method used to answer the research questions I have just described. First, I share key ideas of interpretative phenomenological analysis (IPA) and my rationale for using it. Next, I outline the methods that I employed in this study to sample, collect, and analyze my data. Finally, I discuss factors that may influence the validity and quality of this research and share important ethical considerations.

Interpretative Phenomenological Analysis

Interpretative phenomenological analysis (IPA) is a qualitative research approach centered on developing an in-depth understanding of personal lived experience (Smith, 2011; Smith et al., 2009). IPA researchers examine and interpret how individuals make sense of and derive meaning from their experience of a specific phenomenon within the unique contexts of their experience (Eatough & Smith, 2017; Smith, 2011). IPA operates through a two-stage interpretation process or *double hermeneutic* where, "the researcher is trying to make sense of the participant trying to make sense of what is happening to them" (Smith et al., 2009, p. 3). While Jonathan Smith is primarily credited with the origination of IPA as a distinct qualitative approach for experiential-based research in psychology, the theoretical foundations of IPA are rooted in three dominant areas of philosophy: phenomenology, hermeneutics, and idiography (Eatough & Smith, 2017; Smith, 2017, 2018; Smith et al., 2009).

Phenomenology

Phenomenology is a philosophical approach concerned with the study of lived experience (Smith et al., 2009; Oxley, 2016). According to Smith et al. (2009, p. 11), "The founding principle of phenomenological inquiry is that experience should be examined in the way that it occurs, and in its own terms." The phenomenological base of IPA is drawn from the work of four

major phenomenological thinkers including Husserl (1927), Heidegger (1962/1927), Merleau-Ponty (1962), and Sartre (1956/1943). These philosophers shared a common interest in deciphering the underlying meaning and essence of human experience (Eatough & Smith, 2017; Smith, 2011; Smith et al., 2009).

Husserl's (1927) phenomenology, as described by Smith et al (2009, p. 14), aimed to examine the *content* of conscious experience through the focus on specific and essential features of the experience itself. Accordingly, Husserl required a *phenomenological attitude*, which involved being reflective of everyday experiences and applying an internal examination of our perceptions of objects in the world (e.g., specific things, thoughts, values, decisions, physical experiences, etc.) rather than of the objects themselves (Smith et al., 2009, p. 12). Methods suggested by Husserl to achieve this phenomenological attitude, including *bracketing* and *eidetic reductions*, have been influential to the development of important reflective processes used in IPA (Smith et al., 2009, p. 14). Phenomenologists used eidetic reductions, or processes to identify the elements of phenomena or experiences that make them unique, by focusing on how things appear to individuals in experience and attending to how people make sense of and talk about objects and events, rather than categorizing information according to pre-determined criteria or pre-existing perspectives (Pietkiewicz & Smith, 2014). Bracketing requires phenomenologists to recognize and withhold their preconceptions from interpretations and descriptions of the phenomena (Pietkiewicz & Smith, 2014).

In comparison to Husserl's first-person approach, Smith et al. (2009) described the perspectives of Heidegger (1962/1927), Merleau-Ponty (1962), and Sartre (1956/1943) as more contextual and relational in nature. In essence, these philosophers perceived people in relation to how they make sense of their experiences based on specific variables that exist within the world

they live in and contextual elements of their interactions within that world. Considering how factors such as environment, culture, or time may influence how people derive, interpret and share meaning about their experiences provides outside observers with a richer understanding of those lived experiences (Smith et al., 2009). As such, IPA's examination of human lived experience and the meanings people attribute to their experiences requires researchers to "consider the person as embodied and embedded in the world, in a particular historical, social and cultural context" (Eatough & Smith, 2017; Shinebourne, 2011, p. 18).

Hermeneutics

Hermeneutics is a theory of interpretation that has strongly influenced the analytic processes and objectives of IPA (Smith et al., 2009). Hermeneutics extends understanding of a phenomenon beyond description by instead, emphasizing the contextual meaning of participants' words and sense-making processes (Smith, 2007; Oxley, 2016). Although Heidegger (1962/1927) is most strongly associated with IPA's hermeneutic grounding, Schleiermacher (1998) and Gadamer (1990/1960) have also been noted as influential theorists (Smith, 2007; Smith et al., 2009).

According to Smith et al., (2009), Schleiermacher (1998) viewed interpretation as a holistic process concerned with both a *grammatical interpretation* of the examined text and *psychological interpretation* of the author. While Schleiermacher's ideas were initially formulated around literary texts, they provide a contextual lens for how to analyze texts developed from participant accounts in human science research (Smith, 2007). Analysis of a transcript provides opportunities to draw meaning from the words and language used, and to make sense of the intention and qualities of the person who shared them (Smith, 2007).

Researchers derive these meanings through relational and shared understandings that exist from being part of a larger, collective whole (Smith, 2007).

Unlike Schleiermacher, Gadamer (1990/1960) is understood as having an absolute focus on the text itself (Smith, 2017; Smith et al., 2009). Gadamer's attention to the influences of a reader's historical context highlighted how a person's preconceptions can affect how they make sense of a phenomenon and emphasized the necessity of critical thinking during engagement with the data (Eatough & Smith, 2017; Smith, 2007; Smith et al., 2009). Like Gadamer, Heidegger (1962/1927) was also concerned with the role of presuppositions in interpretations (Smith, 2007; Smith et al., 2009). Heidegger's ideas convey the inevitable influence of *fore-ceptions* (prior experiences, assumptions, preconceptions) on researcher's examination of any new stimulus, which can create obstacles to adequate interpretation (Smith et al., 2019, p. 25). As such, IPA researchers are required to acknowledge their biases and assumptions, and to prioritize new revelations over one's preconceptions (Eatough & Smith, 2017; Smith et al., 2009). While earlier philosophical conceptions of bracketing align with these requirements, Smith and colleagues (2009) recognize that such bracketing processes can only be partially achieved and thus encourage researchers to integrate ongoing reflexive practice throughout their interpretative processes.

The hermeneutic circle is a central concept held by most hermeneutic thinkers that offers conceptual frameworks for how to examine and understand a phenomenon by illuminating the balanced relationship between the whole and its parts (Smith et al., 2009). "To understand any given part, you look to the whole; to understand the whole, you look to the parts" (Smith et al., 2009, p. 27). Methods employed in IPA are also guided by the iterative processes of the

hermeneutic circle, which work to elicit discovery of meaning within different layers and entry points into the data rather than through fixed, sequential steps (Smith et al., 2009).

Idiography

IPA is based on a commitment to focus on the detail and depth of the particular, as well as to examine phenomenon and meaning as individually perceived (Smith, 2017; Smith et al., 2009). In contrast to nomothetic approaches, which are focused on analysis of a group and condense individual participant data into general claims, IPA's idiographic approach features and maintains each individual case within context, using this as a foundation for an analysis across cases in the study sample (Pietkiewicz & Smith, 2014; Smith, 2011, 2017; Smith et al., 2009).

Rationale for Using IPA

Effectively supporting youth mental health in schools, particularly for students impacted by ACEs, requires a detailed examination of teachers' experiences given their integral roles in coordinating and delivering SBMH supports (Ball et al., 2016; Oxley, 2016). Although accumulating research related to ACEs and student mental health supports exists, a specific focus on teachers' experiences with supporting students impacted by ACEs is lacking. IPA is a suitable methodology for this research because it "recognizes that there is not a direct route to experience and that research is really about trying to be *experience close* rather than *experience far*" (Smith, 2011, p.10). Teachers are primary advocates for students and are often responsible for implementing and accessing interventions to support students' academic and social-emotional needs. I designed my research questions to gather and examine rich, detailed information about how teachers make sense of and experience ACEs and SBMH, as well as to gain important insights into specific variables that influence outcomes for children affected by ACEs

(Pietkiewicz & Smith, 2014; Smith et al., 2009).

My decision to use IPA over other qualitative approaches was based on the specific aims of my research and factors such as time, cost, and personal interests. Unlike grounded theory, for instance, I wanted my research to increase understanding and awareness of complex situations (i.e., interactions with ACEs and SBMH) rather than generate a theoretical explanation or process for them (Corbin & Strauss, 1990; Creswell & Poth, 2018). The use of an ethnographic approach, which requires ongoing direct observations of a group (Creswell & Poth, 2018), would not have been feasible due to personal constraints that I had with time and finances, as well as potential issues that could arise due to my dual-role as a researcher and Alberta educator. An ethnographic focus would also not be appropriate given my intention to examine conditions of experiences rather than group variables (Creswell & Poth, 2019). While narrative approaches and case studies can provide similar opportunities as IPA, to collect detailed stories from individuals about their lived experiences or to construct research according to a social justice framework, the descriptions are typically based in specific places or timeframes and used to relay information about one or few individuals' stories or cases (Creswell & Poth, 2018). IPA research focuses on and supports understanding of experiences or phenomena, rather than of a specific case or individual's account, which I believed was necessary to describe the essence of teachers' lived experiences with working to support students who are negatively impacted by ACEs.

Recruitment and Sampling

In accordance with IPA sampling strategies, I recruited a small number of participants through purposive sampling (Smith et al., 2009), using pre-defined criteria to increase the relative homogeneity of the group and the likelihood that information supporting the goals of this research could be obtained (Larkin et al., 2018; Pietkiewicz & Smith, 2014; Smith, 2017). In this

study, the inclusion criteria required that eligible participants: (a) worked at a public school in Alberta, Canada, (b) had a minimum of three years full-time teaching experience, (c) were currently working with or had worked with students in middle school or junior high (i.e., grades 6-9) within the past two years, and (d) had specific, identifiable experiences working with students impacted by ACEs, as defined by the Centers for Disease Control and Prevention (n.d.).

Data Collection

I collected data through semi-structured interviews that were conducted with individual participants via video-conference software (Pietkiewicz & Smith, 2014; Smith, 2011; 2017). Semi-structured interviews provided flexibility to adapt questions, topics, and sequences in response to the unique perspectives and experiences of each participant (Pietkiewicz & Smith, 2014; Smith et al., 2009). The interview schedule (see Appendix B) was developed with five overarching questions that were directly related to the main research questions of this study, to promote depth in responses and support the collection of rich data (Smith et al., 2009).

I allotted 45-to-90 minutes for each interview. I provided participants with the list of interview questions ahead of time, and a brief description of the interview process (Smith et al., 2009). The interview questions were open-ended to encourage detailed responses from participants and were stated in a way that did not portray assumptions or lead participants in any particular direction (Smith et al., 2009). All interviews were video-recorded and transcribed verbatim (Smith, 2011).

Data Analysis

A guiding assumption of IPA, based in its phenomenological and hermeneutic roots, is that "experiences dealt with in research are always interpreted" (Rettie & Emiliussen, 2018, p. 2). The processes of interpretation within IPA are adjusted around two main objectives. First,

researchers seek to gain understanding and insights from their participants' world to provide descriptive accounts of their experiences and how they make sense of them, with a goal to be aligned with the participant's views as closely as possible (Larkin et al., 2006). To this end, I was aware that a double hermeneutic or dual interpretation process was needed, in which I first considered each participant's perspective and how they made sense of their experience during my initial readings and note-taking, as well as the contexts of their work. I then worked to interpret participants' experiences and meaning-making based on what stood out from the participants' descriptions, as well as details that related to my guiding research questions, while also remaining aware of how my own pre-conceptions and contexts of experience could bias my interpretation (Pietkiewicz & Smith, 2014; Smith, 2018). A second aim is to examine the initial description through the lens of the *person-in-context,* which includes a more critical analysis and interpretation of meanings available relative to wider socio-cultural or theoretical domains (Larkin et al., 2006). In accordance with IPA's idiographic underpinnings, I completed a detailed analysis and investigation of themes within each individual case, with attention to relevant contextual variables shared, prior to examining and identifying patterns or themes emerging across cases (Miller et al., 2018; Smith, 2017; Smith et al., 2009).

IPA does not follow a single prescriptive method nor linear process of analysis (Smith et al., 2009). While iterative and inductive cycles are common to IPA, researchers are encouraged to be creative and flexible in their examination and interpretations of the data (Smith et al., 2009). To support my work as a novice researcher, however, my process for data analysis closely followed Smith and colleagues' (2009) six-step framework, which includes (1) data immersion, (2) initial note-taking, (3) documenting emergent themes, (4) connecting themes, (5) repeating the process for each new case, and (6) finding patterns across cases.

Data Immersion/Active Engagement

The first stage of analysis requires immersion with the data, which I began by re-watching and carefully listening to the video-file while reading along with the first written transcript. This step supported my recall of the interview and my ability to keep the participant's account and interpretation as the central focus (Pietkiewicz & Smith, 2014; Smith et al., 2009). From this point, I conducted multiple additional readings of the transcript to facilitate a more thorough analysis of the content and a stronger understanding of the what occurred during the interview (Smith et al., 2009).

Note-taking

While reading the transcript, I highlighted sections of the transcript that stood out to me and created hand-written notes in the margins to document potentially significant observations and reflections made regarding specific interview content, interesting language use (e.g., implied meanings), emotional responses, context, and other noteworthy facets (Pietkiewicz & Smith, 2014; Smith et al., 2009). I also made notes about personal considerations and questions that I would later work through in my reflexive journal. Once I had reviewed the transcript multiple times, I reviewed my initial notes and developed a table to support more interpretative noting based on different conceptual levels of understanding and interrogative reflection (Smith et al., 2009).

I began by creating a column to record specific transcript sections that I had previously highlighted according to what stood out on its own accord or how they related to the full context of the transcript (Smith et al., 2009). Next, I created a column to include my initial comments and to further develop my exploratory notes in relation to the transcript sections chosen. I analyzed noteworthy sections of the original transcript and initial comments to identify what

concrete and conceptual areas of focus stood out. I examined linguistic-based details (e.g., features of the participant's language use: intonation, repetitions, laughter), and conceptual-based notes to document thoughts or questions about seemingly less visible features such as implied meanings (Pietkiewicz & Smith, 2014; Smith et al., 2009). I worked to keep an open mind during this exploratory note-taking to support a more comprehensive understanding of how each participant made and shared meaning about their experiences. I included specific details from the transcript in my notes, when necessary, to support the next steps in my analysis, which relied on my notes rather than transcript data (Smith et al., 2009).

Emergent Themes

My next goal was to develop a set of initial understandings, written as concise phrases, that reflected the experiences of the individual, as well as those derived through analytic interpretations and reflexive thinking (Larkin et al., 2006; Pietkiewicz & Smith, 2014; Smith et al., 2009). To do this, I constructed a third column in my table entitled *Experiential Statements* (*Emergent Themes*), which aligned with co-occurring frameworks described by Smith (2009, 2021) in previous publications, as well as during an introductory workshop that I attended. I then examined each section of my explanatory comments and considered how the information fit together or could be summarized into a statement that effectively captured key details and participants' intended meaning. While these statements served as my emergent themes, there were many of them and they did not exist within a clear chronological order or pattern sequence. As such, I copied the statements onto a new page so that I could view them cohesively.

Connecting Themes

At this stage, I examined patterns and connections across experiential statements/ emergent themes to cluster them according to conceptual similarities or differences (Pietkiewicz

& Smith, 2014; Smith et al., 2009). I began by examining the experiential statements that I had grouped together and then used different coloured highlighters to identify which statements seemed to fit together. After I had completed multiple iterations of this process, sometimes adding or removing one of my coloured dots, I developed overarching statements that reflected the main theme(s) of each colour category. (Pietkiewicz & Smith, 2014). I had numerous themes that emerged through this process with each participant, which required me to analyze further similarities and differences amongst them. As a result, I was able to identify overarching, superordinate themes and connected sub-themes that more clearly depicted the most significant facets of the participant's account (Pietkiewicz & Smith, 2014; Smith et al., 2009). I created a new page to provide a more linear account of these details, which included a descriptive label for each superordinate theme, followed by the connected sub-themes and related experiential statements. Some of the initial themes were removed through these processes if they no longer fit with the developing structure.

Repeating the Process

Once a thorough analysis of the first participant's transcript had been completed, I conducted separate analyses that employed the same processes for each of the following participants' accounts. As per IPA's idiographic commitment, I treated each subsequent transcript as its own unique case (Smith et al., 2009). During individual case analyses, I was cautious to bracket out understandings or ideas gained from any previous analyses of other participant accounts but did keep notes for connected thoughts and ideas that I could refer to when later conducting my cross-case analysis (Smith et al., 2009).

Cross-Case Analysis

Once all cases had been individually analyzed, I employed cross-case analyses to expand theoretical and conceptual understandings of the phenomena being examined, teachers' experiences with supporting students who have been negatively impacted by ACEs (Smith et al., 2009). I looked for patterns and connections across cases by examining shared qualities amongst the themes and participant accounts, and by exploring the potential relevance of unique characteristics that differed between cases (Smith et al., 2009). I then identified final superordinate themes and subthemes based on re-occurring areas of focus and converging ideas or experiences. I also made efforts to recognize and bring attention to any significant outliers.

Reflexive Journaling

I utilized a reflexive journaling process to document potentially significant observations or ideas about the interview experience (Pietkiewicz & Smith, 2014), thoughts and decisions made during the analytic process, as well as questions that I had during different stages of the data collection and analysis (Smith et al., 2009, Yardley, 2000). I recorded some of these thoughts and reflections in a structured word document, but also wrote comments in the margins of my digital or printed word documents when I wanted to flag or work through something more immediately. During these processes, I intentionally documented personal assumptions or preconceptions that arose during analysis that could influence my interpretations (Larkin et al., 2006). Emerging reflections and interpretations that were tied to specific content or descriptive notes were also identified to allow the sequence of themes and coding to be tracked (Pietkiewicz & Smith, 2014; Smith et al., 2009).

Attention to Validity and Quality

Yardley (2000) developed an outline for assessing the quality and validity of qualitative research, which can be applied regardless of the specific theoretical orientation of the study. Yardley specified four main characteristics of good research including sensitivity to context, commitment and rigour, transparency and coherence, as well as impact and importance. These guiding factors were incorporated into my research design and methods with attention to how they corresponded with IPA methodologies.

I conveyed sensitivity to context through my empathic engagement with participants and commitment to understanding their individual experiences (Shinebourne, 2011; Smith et al., 2009). During the interviews, I remained attentive to participant needs and contexts that could influence how and what information was shared by participants, including attention to perceived power differentials or other participant concerns (Shinebourne, 2011; Smith et al., 2009; Yardley, 2017). To accomplish this, I used active listening to provide space and time for participants to communicate without concern of unnecessary interruptions, verbalized and conveyed (e.g., nodding, facial expressions) supportive reactions to emotionally-connected aspects of their experiences, and asked follow-up questions about their experiences or feelings in relation to content shared.

I demonstrated commitment and rigour through my attention to detail in all phases of data collection and analysis for this study. I remained attentive to participants during interviews and took notes after the completion of interviews to enhance the collection and completeness of the data I collected. I used interview questions flexibly and adapted them to fit the specific contexts and focus of each individual participant, integrating them into the interview at times that best fit the direction the participant was going in (Smith et al., 2009). I also used iterative processes

including multiple readings of the transcripts, additions to notes, and use of reflections to guide my thinking with each participant transcript, which supported my idiographic commitment and thoroughness of analysis (Shinebourne, 2011).

I conveyed transparency and coherence through detailed descriptions of the research methods including participant selection, construction of the interview schedule, conducting the interview, and steps used in the data analysis. (Shinebourne, 2011; Smith et al., 2009; Yardley, 2000). I documented analytic decisions and interpretations in margins of the transcript, notes within the different stages of analysis, and my reflexive journal. These notes allow for tracking to original sources of the transcript, as well as provide evidence of my reflections and processes.

Lastly, I have demonstrated impact and importance by developing a study that provides information that can enhance readers' understanding of meaningful experiences and could initiate actions towards positive changes (Eatough & Smith, 2017; Yardley, 2017). More specifically, my study aims to acknowledge and provide a greater understanding of how teachers engage in and make meaning of their work to support students who are negatively impacted by ACEs, which is an area that carries important benefits and consequences for all individuals involved in mental health supports for children and adolescents (Turner & Thielking 2019). It also focuses on identifying larger systemic factors that positively or negatively contribute to outcomes for students exposed to ACEs, as a result of factors associated with educational and teacher-based supports, to highlight transformative changes that may be required.

Reflexive Statement

I am both a teacher and counsellor-in-training with multiple experiences relating to the focus of this study. Like many practitioner-researchers, my research stems from a transformative lens and is motivated by a goal to help and empower others (Bordeau, 2000). Although the

purpose of this qualitative research extends beyond my own experiences and aims to "explore interactions and processes within organizations and environments," the social construction of the emerging knowledge cannot be entirely separated from my own perspectives (Canadian Institutes of Health Research et al., 2018, p. 133). My researcher status, as both an insider and outsider, positively contributed to insights gained through a shared understanding of field-based language and background knowledge; however, it also created potential biases stemming from my own perceptions, experiences, and personal vulnerabilities (Bordeau, 2000; Råheim et al., 2016). As with other phenomenological research, considerable attention needed to be paid to how my experiences could shape my interpretation of the phenomenon (Creswell & Poth, 2018). I used ongoing consultation with my supervisors, as well as reflexive journaling, to evaluate my objectivity and potential biases arising from my own experiences, beliefs, and values that could have skewed or interfered with my data analysis and thematic interpretations (Canadian Psychological Association [CPA], 2017; Fleet et al., 2016).

Ethical Considerations

This study was guided by the ethical principles, articles, and applications outlined by Canadian Institutes of Health Research, Natural Sciences and Engineering Council of Canada, and Social Sciences and Humanities Research Council (2018) in the revised version of the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS2). Review of the core principles of this Policy – Respect for Persons, Concern for Welfare, and Justice – supported my identification of potential ethical issues in my study design and actions that I took to balance the potential risks and benefits of this research. I used these principles to guide and monitor my decision-making processes during my data collection, analysis, and writing through attention to informed consent, fairness and equity, and privacy and confidentiality.

Informed Consent

All participants voluntarily gave written consent to participate in this study prior to engaging in any data collection. Eligible participants were informed of the purpose and goals of the study, potential benefits and risks involved, as well as their right to withdraw at any point during data collection or prior to cross-data analysis. I was forthcoming during communications with participants about my dual researcher-teacher role, given the potential influence that it could have had in the recruitment of participants, and emphasized the importance that consent to participate is given voluntarily and should not be provided under the premise of any undue influences including pre-existing relationships or perceptions of power differentials (Canadian Institutes of Health Research et al., 2018). I took adequate time and effort to promote participants' understanding of essential information, as well as to clarify any participant questions or concerns prior to any data collection. Participants were made aware, for example, of potential psychological harm that could result from a participant's disclosure of information that was knowingly or unknowingly connected to sensitive or traumatic experiences (CPA, 2017; Smith et al., 2009). My informed consent form is found at Appendix A.

Fairness and Equity

I justified inclusion criteria for this study through the structure of my research questions and chosen methodology. To mitigate potential conflicts of interest or issues stemming from my dual researcher-teacher role, I excluded anyone with a previous or current direct working relationship with me (i.e., employer, administration, colleague, friend or mentor). I did not exclude those whom I have had indirect pre-existing relationships (i.e., acquaintances). However, I was cautious to ensure I was not unduly influencing any participant's consent or responses

during interviews by providing participants with a thorough description of the study purpose and my roles ahead of time.

Privacy and Confidentiality

Although I informed participants recruited for this study of potential risks, the potential consequences of a reader inferring their identity are further-reaching than themselves (TCPS2, 2018, p. 57). Without being properly safeguarded, information provided by participants could potentially jeopardize jobs or relationships. Teachers' disclosure of information about vulnerable youth also has the potential to negatively affect the welfare of those students and student groups. As such, I implemented processes to safeguard information through all stages of this research study to reduce potential harms to participants, as well as the individuals and groups that they represented. During recruitment and consent, I only collected identifiable information for the purpose of obtaining contact details and requirements for informed consent. I limited this information to the participant's legal name and their preferred method of contact (i.e., email address). I kept documents that contained or could be connected to this personal information in a separate file within a locked area and/or password protected computer. I used pseudonyms and codes to provide participants with anonymity and to uphold confidentiality through all components of data collection, analysis, and written reports, as well as within any presentations or publications of this research.

Summary

IPA is a qualitative research approach that is concerned with understanding personal, lived experiences by attending to factors that influence how individuals make sense of their experiences, as well influences to researchers' interpretations of those shared experiences. I chose IPA for my study as it values and maintains the integrity of each participant's shared

experience but also provides opportunities to examine and highlight key elements that exist across cases. IPA allowed me to interview and gather detailed information about a complex topic from individuals who are directly connected to the areas of focus in my study. As a result, I was able to honour the voices of each of my participants in relation to meaningful aspects of their lives and work, and bring light to the essence of these experiences as reflected by their shared experiences. In the next chapter, I report the results of this study.

Chapter 4. Results

In this chapter, I provide an overview of each participant and summarize important details they shared regarding specific lived experiences supporting students who were negatively impacted by ACEs. These details highlight important elements of each participant's experiences, in keeping with IPA's idiographic approach, that contributed to my identification of individualized superordinate themes (Pietkiewicz & Smith, 2014; Smith, 2017; Smith et al., 2009). I then identified the overarching superordinate themes that emerged from my cross-case analyses and provided supporting evidence for the inclusion of these themes through the addition of direct quotes extracted from individual participant transcripts (Smith et al, 2009). The superordinate themes include: Intrinsic Motivation, Work Conditions, Collaborative Supports, Systemic Factors, Establishing Relationships, and Conundrums**.**

Participant Overview

Data was collected and analyzed through individual semi-structured interviews with six participants, who communicated having 13 to 28 years of teaching experience (see Table 1). The interviews were conducted through online video software (i.e., Microsoft Teams) that took 60 to 90 minutes. I referred to the interview schedule (Appendix B) to guide the interview process and the main questions that I posed but was flexible with question order, depending on the direction of participants' responses. I used follow-up questions to clarify and deepen the information provided by participants. These interviews took place during June to August of 2021, which is important to note due to the considerable changes in the education system in the 2020-2021 school years because of the Coronavirus pandemic. Although factors connected to the pandemic contributed to some of the results, such the identification of further reduced accessibility to

supports and resources, teach participant had a multitude of meaningful experiences to share in response to the main areas of focus for this study that extended beyond this time frame.

Given the diversity of teaching roles and opportunities within Alberta's education system, each participant had a wide range of experiences and roles that distinguished them from other participants. The homogeneity of the group was maintained through the inclusion criteria described in the previous chapter. In this section, I describe relevant background information for each participant, as well as details they shared about students and situations when asked, during the interview, to describe one or more specific experiences they had with supporting students who had been negatively impacted by ACEs. I included information about students to provide broader context to the experiences described by participants about different presentations of and responses to ACEs in a classroom setting. I also wanted to represent difficulties experienced by students and families who may not have the opportunity to share those details themselves. Pseudonyms have been utilized to protect the identity and confidentiality of the participants, as well as students they described through their experiential accounts.

Table 1

Participant Demographic Information

Participant Name	Gender	Years of Experience
Kelly	Female	18
Denise	Female	13
Sarah	Female	25
Dawn	Female	18
Jennifer	Female	28
Leanne	Female	15

Kelly

At the time of the interview, Kelly had been a teacher for approximately eighteen years, working in both specialized programs and public community school programs. While most of her teaching experience was in early childhood and special needs education, Kelly spent the last few years teaching grade six students. During her interview, Kelly identified that being a parent, having previous work experience with families within the foster system, and completing her master's in educational research were also important contributors to her understanding and abilities to support students with ACEs.

Grayson

Grayson was an eleven-year-old student who had significant challenges with focus, attention, and regulation. Kelly described him as highly distractible, impulsive, or emotionally dysregulated (i.e., crying all day). According to Kelly, Grayson's mother was an alcoholic and his father was rarely involved. He and his mother had moved to his grandparents' home after child protection authorities became involved with his family. Kelly worked hard to build a good rapport with both Grayson and his mother, focusing on positive feedback. Grayson also received counselling that was facilitated by child protection staff. Kelly supported this work by helping Grayson to incorporate self-regulation strategies he was learning from his counsellor. Grayson required regular support for learning difficulties and problems with peers. Kelly stated that it would have been nearly impossible to support Grayson effectively without an education assistant who also helped in the class part-time, especially given the large class size and other student needs.

Denise

At the time of the interview, Denise had been a teacher for approximately thirteen years, including six years in an early childhood intervention program followed by her current teaching role in an alternative school program, supporting medically complex students ages 9 to 19 years. Denise has primarily worked as a classroom teacher with students who are predominantly non-verbal, but has also served as acting administrator when the regular administrators were away, allowing her to support other teachers during day-to-day challenges.

During the analysis phase, I contemplated whether to include data collected from Denise because her students required significantly more support than those of the other participants. Upon reflection, I concluded that it is important to include Denise's experiences as they provide a unique lens into how students with medically complex needs may present with ACEs, and factors that facilitate teachers' support of students. Including Denise's experiences also provides a voice to individuals who are typically unable to communicate their own experiences or effectively advocate for their needs.

Ethan

Ethan was a ten-year-old boy diagnosed with fetal alcohol spectrum disorder (FASD). He lived with his adoptive parents. Denise shared that his parents had not realized the extent of his needs when he was adopted, and their negative reactions to him seemed to contribute to his trauma and behaviour problems. Ethan could be fun and friendly, but also had extreme reactions when he became upset--much more intense than Denise's other students, including significant self-injury. During one of his outbursts, Ethan banged his head so hard that he cut open his forehead. He would also threaten staff and run home, which created issues since his mother did not want him to be at home. Denise worked closely with educational assistants and additional

support personnel to support Ethan and his parents. Ethan was later moved to a different school placement.

Sarah

At the time of the interview, Sarah had worked in multiple different roles through the previous twenty-five years including classroom teacher, support teacher, specialist mentor teacher, and school counsellor. She had taught almost every grade level with some years teaching special education and most of her teaching experience in grades 7 to 9. Most recently, Sarah had been a high school counsellor but had transitioned to teaching grade 7 during the school year I interviewed her. During the interview, Sarah identified that her experiences parenting her three children, who are now all high-school graduates, also strongly influenced her understanding and ability to work with students, families, and other educators.

Joseph

Joseph was a grade seven student who required frequent supports and interventions due to increasingly disruptive behaviour over the year, despite a positive start to the year and few issues in earlier grades. Joseph was the middle child in his family, who lived with his father and siblings after his parents' divorce. His father had informed the teachers that Joseph's older brother, who was in grade 9, had also exhibited behavioural problems in recent years. Sarah described Joseph as knowledgeable and charismatic, with a strong ability to talk to adults. Joseph began to fail courses in which he had previously done well, had occasional panic attacks, and increasingly exhibited behavioural issues that led to frequent office visits and disciplinary actions. For example, Joseph made sexualized comments or actions towards others and referred to gang involvement. He was highly distractible and struggled to sit in class. However, he was not permitted to take breaks like taking a walk because he could not manage his behaviour

adequately to be in the hallway alone. Joseph had begun spending time with a new group of friends with whom he often got into trouble, including being involved with the police outside of school. Sarah provided individual academic support, but opportunities to do this were limited and his short attention span interfered with progress. COVID restrictions interfered with previously available services.

Dawn

At the time of the interview**,** Dawn had worked as an educator for approximately eighteen years, first as a tutor and college teacher before becoming a teacher in her current school district. Dawn started with a multi-grade class of students with autism but then transitioned to teaching in a specialized classroom that supports students who exhibit problematic behaviours, with experience teaching grades 1 to 6. Dawn identified that her mother's work as a community support worker contributed to her high level of empathy. She has taken opportunities to extend her learning through professional development for trauma-informed teaching, non-violent intervention training, and other related skills necessary to work with diverse student needs. Dawn had also connected with other students in her community school, which has a large refugee population, through her role as a soccer coach.

Matthew

Matthew was a grade three student who was enrolled in a small-class behaviour program for students with conduct disorders and severe behavioural needs. School staff became concerned about Matthew's behaviour after he physically assaulted a classmate who had accidentally touched his buttocks. Through his mother and other sources, Dawn and her team learned that Matthew's father was imprisoned, his mother had substance abuse problems, and that his mother used corporal punishment. Mathew's mother was also unemployed and

apparently experienced mental health problems, such that she apparently neglected to supervise her children adequately. During this time, Matthew and one of his brothers were harmed by a child predator (specific details about types of harm were not shared). Dawn reported that it was challenging to support Matthew due to the family situation and the blame professionals directed toward Matthew's mother for her children's issues.

Tyrell

Tyrell was a grade five student who was placed in the behaviour program. He exhibited severe aggression, including throwing hole-punchers, flipping over large objects such as an exercise bike, almost breaking a sensory room window, and biting other children. Tyrell's behaviours were so severe that Dawn and her colleagues had to alternate caring for him until his parents could pick him up. Supporting Tyrell was difficult since his parents believed he would simply grow out of his behaviours, and they rejected suggestions to consider medicinal intervention.

Jennifer

Jennifer is an elementary teacher who had been teaching for approximately twenty-eight years at the time of the interview. She has a master's degree in elementary education. Jennifer taught in regular educational settings for two-thirds of her career. Over the last ten years, she had taught students enrolled in mental health treatment programs. Her most recent teaching assignment included grade 4-6 students in an intensive outpatient program. In the program, Jennifer has worked closely with a team of professionals, including a psychiatrist, occupational therapist, and a speech-language pathologist. Each student is assigned a nurse at intake and is overseen by a social worker who liaises with parents or coordinates additional external supports, as needed.

James

James was a grade six student in a regular classroom. He had a Métis background and lived in poverty with his single mom, who had experienced domestic abuse. James often came to school with dirty clothes, unwashed hair, poor lunches, and incomplete homework. He struggled academically, was quick to anger, and easily entered into conflict with other kids or adults. Jennifer recognized a lot of potential in James and worked hard to create a good working relationship with him to try to set him up for success, which included creating opportunities for him to be active. She would take him and another boy out for a run during lunchtime and tried to get them involved in soccer as a constructive avenue for their energy. Towards the end of the year, Jennifer spoke to James' mother and offered to take him, along with her own daughter, to events and outings during the summer to provide some breaks and to maintain the positive momentum that had been established. Jennifer later received an angry email from James' aunt informing her that she had stepped on toes and that the family was unhappy with her involvement. Jennifer was instructed to apologize to James and to have no further communication with him or the family would pursue professional conduct charges. Jennifer identified that this experience helped her to better recognize what was and was not within her role as a teacher when supporting students and their families. She also explained that more targeted support services were not accessible through the school, nor would James have met the criteria to receive any if they had been.

Taylor

Taylor attended the mental health program where Jennifer taught. Despite having information about Taylor's family history, including stressors that may have contributed to her problems, the support team had difficulty developing an effective intervention plan. This was

exacerbated by the inconsistency between their assessments and her demeanour. Taylor disclosed a significant historical trauma to Jennifer. While this information helped Jennifer understand Taylor's behaviour, Taylor did not want the information shared with others because she thought this would cause her family difficulty. Jennifer felt conflicted knowing that the information would likely be helpful to people on the team, but felt unable to share it without Taylor's consent.

Leanne

At the time of the interview**,** Leanne had taught for approximately fifteen years with most of her experiences in either grade three or grade six classrooms. Most of her teaching experience had been in Alberta schools, with the exception of two years at an international school in Japan. At the time of the interview, Leanne was completing a year of online teaching to grade six students from various schools. Leanne identified that becoming a parent and participating in professional development on the brain and trauma helped her to better support students exposed to ACEs.

Avery

Avery was a twelve-year-old student who had been removed from her home in the middle of the night and placed in foster care. Her older brother had called the police because he observed their mother being beaten up by their mother's boyfriend. Reportedly, Avery's mother also had a drinking problem and tended more to the needs of her boys, which was evident when she only packed a "go-bag" for the boys and Avery arrived at her foster home with nothing. Leanne described Avery as a nice girl who excelled both academically and socially, in spite of her home environment. Avery and her younger brother had been placed with a foster mother with whom she became very close. Leanne has conversations with Avery when Avery needed to.

Leanne also participated in transition meetings between the foster mother, biological mother, and social worker.

Leanne advocated with child and family services after Avery had shared that she was scared to have visits or live with her mother because she knew her mother was drinking again. Shortly thereafter, the children were returned to their mother's care. The next school year, Avery's younger brother was taught by Leanne's teaching partner who informed her that child and family services were involved again as the mother was no longer working, there was no power in the home, and the boy had stopped coming to school. Leanne expressed the view that the system had failed Avery. Leanne described feeling upset because she "felt that [Avery] had confided in me and trusted me and I was absolutely powerless to help her."

Kai

Kai was a twelve-year-old boy who was living with his father and stepmother after his biological mother had suffered a brain aneurism that compromised her ability to care for him. Leanne reported her concerns about the care provided by his father and stepmother because she noticed bruising on him. She was also concerned by "little things" that came out in conversation with Kai, such as sharing that his dad did not get home until 2:00 am the night prior, leaving him and his brother alone during that time. However, she could not elicit further information "because you could tell that secrecy had been drilled into him." Kai's older brother's junior high school also expressed concern, which led them to call the police after their father had picked him up from school. The school later learned that the father had been arrested and both children were placed in foster care because Kai's father had allegedly been planning to kill the children and himself. Leanne worked hard to support Kai, but could not prevent him from following a negative trajectory. Kai reportedly hated his foster family and closed himself off to any supports.

The principal had checked in on Kai after his transition to grade seven in a new school and learned that Kai was already at risk of expulsion despite it only being mid-September.

Superordinate Themes

Six superordinate themes emerged from my cross-case analyses: *Intrinsic Motivation, Work Conditions, Collaborative Supports, Systemic Factors, Establishing Relationships, Conundrums*. Each superordinate theme includes sub-themes depicting specific factors that participants described as influencing their perception of personal agency or student outcomes.

Intrinsic Motivation

Participants largely attributed their personal agency and ability to support students who were negatively impacted by ACEs to intrinsic factors and personal experiences. Personal values, beliefs, and experiences motivated participants to pursue related career opportunities, to further their knowledge and skills through professional development, and to become involved with supporting students in matters beyond academics. These factors contributed to their sense of personal agency. On the other hand, participants described their pre-service teacher education as inadequate to properly equip them or enhance their personal agency in the wide array of roles that are expected.

Personal Beliefs and Values

Participants actively decided to support and engage with students in need, attributing this to a core part of their identity and the moral values that guide them in their personal and professional lives. Many participants also identified that differences in personal beliefs and values amongst educators contributed to whether positive or negative outcomes emerged through their work with students. For example, Denise stated

> I feel like, if I'm able to help support, I will help support that student … but I feel, I couldn't be like that's not my role, that's not my job …. Morally, I'd feel like I'd have to support her. It's part of my teacher code of conduct that I need to make sure that she is safe and being taken care of.

Dawn attributed the inaction of other teachers to their beliefs, "Sometimes teachers think that some kids are just bad. They just, they can't be helped, they're going to stay in the gutters and only have to deal with them for nine months and they're going to be off to another teacher."

Personal Experiences

Many participants attributed their motivation and capacity to support students exposed to ACEs to their personal experiences, which provided them with sensitivity to complex situations and the ability to consider different perspectives in their work with students and families. For example, Sarah credited her parenting experiences for her enhanced perspective-taking abilities that contributed to her personal agency to work with students and families. She acknowledged that, "As you experience teenage years and you have all those experiences, you can side with the parents in understanding what they're going through in their life, to a degree. You never know exactly, but to a degree." Whereas, Dawn shared how her own difficulties during youth triggered her motivation to support students with similar problems.

> Nobody asked what I was going through or inquired – it was just that I was a rebellious kid who had started drinking because I was coping with, oh my God, what had happened. And so, for me, I have my tactics to deal, that I use to handle situations and I know that I can give another student those skills. I can give them those strategies so they don't have to take as long as I did to overcome and understand that it's not your fault, that this is a byproduct of what you've experienced.

Professional Development (PD)

While some participants acknowledged training provided through their workplace, they largely credited their own motivation to go beyond what their employer offered. Their pursuit of additional professional development and formal education was largely motivated by individual passions, interests, and philosophies. The extent to which different learning opportunities and resources provided enrichment largely depended on factors such as accessibility, time, costs, and purpose. For example, Jennifer expressed the benefits to herself and her students that extended from her pursuit of professional learning such as her master's degree.

> I think it's more self-driven passion to understand kids and what I can do to help them, and to help myself too. It's a win-win. When kids are successful, I feel more successful as a teacher … I want this job to be doable for me and I want to walk away feeling like I'm making a difference.

Work Conditions

Participants identified that their personal agency and abilities to support students were directly influenced by their work conditions including the effectiveness of leadership, the complexity and demands of their work, and limitations stemming from inadequate training or professional development opportunities.

Effective Leadership

Multiple participants noted that the positive supports provided by their school's administration contributed to their effectiveness in being able to support students. They identified accessibility of administration and administrators' philosophies or expectations, as key supportive factors. Kelly praised the trauma-informed philosophies shared by her administration team, for instance, but also described difficulties she has experienced with changing availability.

She reported that, "It's not a punishment but the thing is, that with cutbacks, admin isn't always available … If I do call admin it's because I need them. It's not just because I'm tired or I need a break." Dawn emphasized the need for administration to prioritize student well-being before academics to enable teachers to adequately support students and to feel successful as an educator. She explained,

> I need that space and support from my admin to know that first we have to regulate, then we can educate. Because, if the pressure is mounting for the kids to get ready for their PATs [Provincial Achievement Tests] or anything like that, it's going to make me feel like I'm failing because I'm failing at the curriculum level but really, they need to know that we're safe first.

Complexity and Demands

While participants' sense of personal agency was largely influenced by internal factors and motivation, the complexity and demands of their work significantly influenced their self-efficacy. They described pressure mounting from increasing demands, which included navigating large class sizes, balancing the needs of a few students with the needs of the whole, and dealing with lack of funding and resources along with wide-ranging teacher expectations. Participants also noted the difference in support and resources in regular programs as opposed to specialized programs. They shared that these challenges threaten educators' mental health and well-being, especially if they cannot recognize their limitations and set boundaries around taking on extra duties.

Participants made multiple comparisons between the dynamics of regular school programs and specialized programs, commonly identifying greater issues in situations where large class sizes exist, academic focus is prioritized before student well-being, and limited

additional supports exist to help teachers when needed. For example, Sarah identified that her capacity is significantly limited by class size issues in regular settings, despite abilities she has developed from extensive training and experience. In reference to her most current class, Sarah stated,

> I could have handled any one of those students. However, when you give me 30 students in a classroom and you give me Covid and you give me so many restrictions, I'm not equipped at all. I'm – not – equipped – at – all (*Repeated slowly, word by word*).

Jennifer similarly acknowledged that contributors to student success that exist within her specialized program are typically not accessible in traditional settings, which can be an issue for students that transition back into regular programs.

> It's really hard for a regular classroom teacher to simulate what we do when we have six kids in a nice open space versus thirty kids in a crowded classroom with multiple needs and multiple stressors … So, if we can't find ways to mitigate pressures, that's going to be an ongoing issue with inclusion. You have classes loaded up with kids that have more needs than a teacher can meet.

The complexity of teaching demands contributed to participants' realizations and reflections regarding their capacity to effectively meet the needs of all students, as well as themselves. Leanne shared her struggles to balance the significant needs of some students with other student needs, for example, which had her questioning, "At what point does this child's right to an education trump the other kids' rights to an education because the other kids are suffering in terms of their education because I'm spending so much time out in the hallway?" Kelly described similar issues, which have pushed her to be more honest about her capacity and

limits during difficult situations, and have contributed to her ability to set boundaries. She explained,

> At the beginning of my career, I'd be like oh, I can handle it, and then … Even a superhero couldn't do this, it's too much. You need to know when you need extra support. You're not some kind of bionic teacher. And being able to advocate for yourself too, not just looking at it as whining or trying, just advocating for yourself, which also advocates for the kids in your class too.

Inadequate Training

Issues with pre-service education were commonly shared by participants. They cited a lack of focus on knowledge and skills necessary for teachers to be successful, especially to meet the social-emotional needs of students. Participants also reported being frustrated that employer-provided professional development was targeted to the needs of new and inexperienced teachers, largely ignoring the needs of experienced teachers, especially with respect to working with students exposed to ACEs. Multiple participants reported they were previously unaware of ACEs, for instance, only learning after personal pursuits of knowledge. Leanne shared frustrations she had with her own pre-service training, for example, stating

> I don't know what they're doing to be honest, but they're not giving us any kind of training in psychology or anything like that and we almost need it … The only reason I know what ACEs is, is because I did the *Brain Story* certification … This fairly established thing in psychology is not something that most teachers would know or think about. So, I think that speaks to the lack of training.

Jennifer also discussed barriers to meeting her own professional development needs due to ongoing issues that occur with beginning teachers who lack the training to understand and

support complex student needs.

> I'm used to going to PD that's really focused on beginning teachers and so I don't feel challenged as a practitioner … young teachers are just, they're treading water as fast as they can to keep one nostril above water. So, you end up with a lot of reflexive thoughts and teaching behaviours in the moment that probably aren't the best.

Collaborative Supports

Regardless of how they evaluated their self-efficacy, most participants identified their collaborations with others as important contributors to positive outcomes when supporting students negatively impacted by ACEs. Working as part of a comprehensive team, with access to extra supports such as educational assistants (EAs) and allied professionals like school counsellors provided a greater range of supports to meet each student's unique needs. The availability of such supports and time to collaborate enhanced participants' sense of agency to make a positive difference in the lives of the students and families they work to support.

Denise frequently spoke to the importance of being able to support the family, in addition to the students, which required access to external supports that can work beyond the school. She noted positive feedback about the program's family service wellness worker, who "works with the parents to kind of break down those barriers and get the kind of help or support that the family may need." Denise related these services to difficulties she has experienced with trying to support some complex needs, explaining

> There's obviously more going on than what I can do to help support and I think it needs to be a whole, encompassing thing. Like I can't, if I'm doing something at school but then she goes home and is able to cut or whatever or however she's doing it, that's not helping her.

Leanne, on the other hand, described typical problems that she has encountered with accessibility to such supports despite her efforts to refer students that require them.

> Supports in the school are really lacking. I mean, our school counsellor comes once a week and has, if she makes it (she often doesn't), 30 kids to see on that one day a week. So, she can't see them every time, so my kids are getting, I don't know, 15 minutes every two weeks. It's not enough, so a lot of it is just me dealing with it on my own.

Systemic Factors

Participants frequently acknowledged that their capacity to provide or access supports that contribute to positive outcomes largely depends on systemic factors and higher-level decisions about funding, enrolment criteria, and eligibility for additional supports and services. In most cases, there has been cumulative funding cuts that decrease the number of opportunities, services, and resources that are made available to support students and their families.

Funding

Participants argued that availability of funding greatly influences teachers' capacity and willingness to provide supports to students with complex needs. With neither adequate system-based funding for training teachers, nor adequate access to professional service providers, the onus falls to teachers to take on roles for which they are not adequately trained, but may feel obligated to take on. In many situations, participants reported that decision-makers at all levels do not typically prioritize allocating funds to provide students with access to counselling or related supports. When funding is provided, there is a lack of transparency regarding how it is

dispersed, inequities in how it is allocated, and the criteria to receive it. For example, Kelly identified decreases she has observed with availability of extra supports as students get older.

> As they go into junior high, kids get less supports and I think that's unfortunate because it doesn't necessarily have anything to do with any change in their life that they have … we often think of independence and that sort of thing but I think those kids need parents and families and communities just as much as little kids.

Jennifer described how system barriers connected to budgets can create obstacles to accessing beneficial supports because decisions begin to revolve around prioritizing the needs of some students over others. She explained, for example, that

> In a regular setting when kids are struggling and you want to get them tested and you get the response [from administrators], "Well, there's no point in testing them because they're not going to qualify for a special program. They're not going to get any funding and we don't have any money in the budget."

Inequitable Access

Participants highlighted the positive impact that specific school programs and services can have for students who require more focused interventions and supports. They also brought to light disparities that exist between the types of supports available and the criteria for students to access them. Participants valued the benefits of specialized programs for students who benefit from them but also recognize barriers that prevent other students, who have just as great a need, from accessing them. Jennifer described, for example, that teachers frequently identify other students that would benefit from their specialized program more than the student that is transitioning. She noted uncertainty regarding placement decisions and processes, stating

> Some kids never make it into our programs and I don't know if that's a lack of parent advocacy, I don't know if people just aren't informed about the pathways or if they don't have a psychiatrist and haven't been able to connect with a psychiatrist (for a referral). It's kind of a mystery to me too, why the lucky ones are the lucky ones.

The level of student needs also seems to determine the types and immediacy of supports provided. Sarah identified, for instance, "that when you are dealing with suicide, the supports are there, but everything else is difficult" (p. 11). Sarah explained that extensive waitlists and limited availability with supports are a regular problem when working to access supports for students deemed as lower risk. She shared that, "Our community supports, our government, Alberta Health Services (AHS) who would provide counselling for the schools on an outreach basis for family counselling – couldn't get it for six to nine months."

Establishing Relationships

The most significant factor identified by participants as contributing to positive outcomes was prioritizing students' safety and well-being by establishing positive relationships with students and their families. Participants stated that positive relationships provide a sense of community, development of trust in supporting adults, and opportunities to engage with families regarding students' challenges and potential supports.

Community-building

Participants described intentional building of relationships with students as necessary for recognizing students' specific needs and personalizing approaches to meet them. Participants reported use of a variety of strategies to build connections and a positive classroom community to enhance students' feelings of safety and belonging, support the reduction of student vulnerabilities, and promote students' experiences of success. Dawn described the importance of

meeting students where they are at, for example, when supporting them to build understanding and coping strategies for what they have experienced. She explained,

> So many kids believe that what happened to them is their fault. They internalize events … they can't connect their downstairs brain with their upstairs brain to rationalize what happened to them. So, we have to give them strategies to cope and one, we have to know those strategies. Two, we have to understand that when their lid is flipped and they can't regulate, the can't even actually hear you anyways. So, you need to just sit and be with that child and connect with them in a way that the child needs.

Jennifer explained the importance of creating a safe space that values all students by working to recognize, understand, and mitigate students' vulnerabilities. She noted that, "it may be a combination of teaching and boosting a kid with vulnerability but also teaching and boosting the other kids about having some compassion for that and ways they can contribute to keep the vulnerable ones in the class safe." Jennifer also identified issues with focusing on academics before relationships, noting increased difficulties that subject-focused teachers often experience. She reported,

> I've met teachers that are super committed to teaching subjects and they have a lot of great subject knowledge or they have great learning projects but they're not as successful with their learners because it all has to start with relationship … Like you can give all of the requisite training about ACEs and social-emotional development but if you're not starting from that framework of first of all creating a relationship and second of all, creating a safe class climate, it's kind of useless.

Developing Trust

A number of participants emphasized that positive student relationships created a context

for students to develop trust in them, which in turn enabled students to confide in or seek support from them or other positive adults. Participants also highlighted the value of providing reassurance and a sense of belonging to students by exhibiting genuine care and unfaltering support during challenging situations. For example, Leanne described strategies that she has used in class to enhance connections with students, such as question of the day during attendance, which provided opportunities for students to share and for her to identify students potentially at risk to harm. Leanne stated that,

> Once they trust you and you have that relationship, not only will they tell you things but you're in a much better place to support them because you can at least give them somebody in their life they trust … They need to know that somebody's in their corner.

While acknowledging that supports do not remove ACEs, Dawn articulated the importance of showing up for students despite difficulties that arise, to support positive change and increased resiliency. She reasoned,

> They need to know that someone isn't going to give up on them. Someone's going to take everything they have to throw at them and still going to be there … We're like, go ahead, give me your worst. We're still going to be here afterwards. We're not going to get rid of you. We're not going to give up on you. We're here to help you and make you feel successful and we want you to be successful.

Family Involvement

Many participants described the importance of building rapport with students' families to effectively address the needs of their students. While participants identified that families were frequently thankful for supports offered, they also noted that involvement and willingness of parents or guardians to accept interventions and supports varied, and that obstacles related to

household dysfunction, family values, and individual family circumstances could create challenges with accessing or providing available supports.

Household Dysfunction

Participants explained how ACEs facilitated by household dysfunction can contribute to ongoing obstacles experienced by students and difficulties with obtaining supports. Sometimes parents' unwillingness to acknowledge problems or consent to supports was the obstacle. Leanne explained, for example, how issues like divorce create obstacles to addressing student needs even when supports are available. She explained,

> My really affluent families, if they want to, they can access supports. They sometimes don't want to, especially if it's coming out of a divorce because they are feeling guilty and they don't want to acknowledge that there's a problem … Actually, that's not just with divorce, that's with a lot of things.

Denise described how household dysfunction problems related to mental illness have contributed to difficulties she has experienced with obtaining supports for students. She recalled,

> The one that really sticks out is probably more of the household dysfunction, like mom has a mental illness, hasn't dealt with it, and then kind of spirals down to the child having the same kind of things, not knowing how to deal with stuff ... She doesn't think her daughter needs anything but her daughter is cutting and has bulimia and anorexia, like all of those things and it all kind of stems back to how mom is.

Family Values

The importance of engaging families in conversations and decisions regarding their children was consistently emphasized by participants. However, they also described barriers to supports that stemmed from issues such as stigma, negative family experiences, and different

perspectives regarding types of supports or teachers' roles. Leanne described the barriers that fear, stemming from social stigma or negative parent experiences, can create to providing supports for students in need, which she shared was especially noticeable during her experiences in Tokyo. Based on her observations and experiences, Leanne explained,

> Being diagnosed with a learning disability in Japan, that would be like a death sentence. They would rather have a kid stumble through without a diagnosis or any support than get that diagnosis. But even here … there's also a very strong resistance to any medication and … kids that do need medications sometimes aren't getting the help … You're dealing with parental resistance. You're dealing with safety concerns. You're dealing with lack of support from both within and outside the school system.

Jennifer spoke to the importance of valuing parents as experts of their children but also acknowledged her experience that time is sometimes needed before families are in a place of acceptance regarding their children's needs. She noted,

> The grief cycle for parents in terms of accepting kids that have difficulties can sometimes take a very long time and multiple conversations for them to recognize, yep, my kid is not managing at school or, sometimes the conflict with parents or the demands of parents can really interfere with your ability … you need to talk to the parents as the experts and caregivers of their children.

Family Circumstances

Participants identified that there are difficult family situations that likely contribute to challenges with supporting children that aren't necessarily those identified within the ACEs categories. As such, they articulated the importance of building cultural awareness to better understand situations that may impact students and their families, as well as how they

communicate and respond to different situations. Denise explained, for example, how the supports she provides or accesses frequently look different due to the exceptional needs of her students, compared to neurotypical children. She explained,

> Parents are overwhelmed because their kids are so emotionally – like, they're sixteen years old but they're still in diapers and everything and I think the parents are seeing their kids differently, right? Whereas they aren't either grieving the process properly or they're just having a really hard time … For me, it's been working with my families to get them support, not so much the student necessarily.

Dawn described how her experiences working with refugee students made her more considerate of cultural factors that impact student needs and supports. She acknowledged that, "You have to understand someone's worldview before you're going to be able to talk to parents … Like so many students that are in trauma, the whole family is on the first level, just trying to survive."

Conundrums

Participants were asked to consider their own experiences and their personal views about the extent to which teachers should be involved with supports for students who have been negatively impacted by ACEs. Their shared responses illuminate the tensions between reasonable expectations of teachers, compared to the current realities in which they are required to assume many more responsibilities. These lived experiences also contributed to participants' recall of personal dilemmas and the negative affects to their mental health and well-being.

Assumed Roles

Although most participants shared a belief that teachers should be involved with student supports, they expressed different perspectives about the extent of such involvement and types of roles they should assume. Many participants argued that teachers should have some involvement

in supports because of the knowledge and opportunities they have to engage with students, which increases their ability to recognize and respond to needs, and advocate for additional supports when needed. They described barriers such as lack of training and limits to their professional capacity and knowledge, and communicated their need to maintain boundaries between teachers' roles and those of other professionals such as counsellors.

Kelly and Jennifer both articulated the need for teachers to keep supports focused on identified learning concerns and to avoid communicating information to parents that they are not qualified to provide, such as possible ADHD diagnoses. Kelly identified limitations to teacher involvement supporting complex social-emotional needs, stating that, "We're not trained to do that. We're not. We don't have the one-on-one time with kids. We don't have the counselling ability or even the long-term relationship with them that someone else could have, like a counsellor." Jennifer described similar issues that can occur with parents when advocating for student supports. She cautioned that, "if parents disclose too much or look at you to take your involvement outside of your role … it's important to know how you can refer them to supports also and not try to be that kind of counsellor role to parents."

Multiple participants expressed difficulty understanding other teachers' seemingly removed stances regarding involvement with complex student needs. At the same time, current realities contributed to many participants' perceptions that they had little choice but to become involved, sometimes to their own detriment. Dawn shared her reaction to experiences, for example, reporting that,

> Lots of teachers in regular programs look at me saying like, "How can you do what you do? How can you put up with this?" And so, I'm always baffled when they say that because

> anyone can get hurt and anyone can have a reaction. No one is immune to it. There's no income gap. It's not based on where you came from. It's absolutely an open playing field.

Leanne spoke to pressures placed on teachers due to limited options to access additional supports but also described teachers' tendencies to help students as a result of their caring demeanour and the positive relationships that are developed. She argued, for instance, that

> Whether or not we should [be involved] is irrelevant because quite often we are the only person that child can trust. So, if you are in that role, you are in that role. I mean, no it's not my job to be a counsellor … in the absence of those supports, a lot of it does fall on the teachers. And I don't know many teachers who would refuse to take on that role because we care about those kids.

Dilemmas

Participants experienced difficult ethical decisions as they wrestled with how to maximize students' well-being. Leanne outlined a couple of practices, for instance, that serve to protect the privacy and safety of students but also occasionally create additional barriers to support. She described situations where kids become isolated from other students due to regulation difficulties, for example, noting that, "Other kids don't want anything to do with that child … It's hard because you can't reveal the child's background. I think people would have more empathy if they knew." Leanne also shared reservations that she has experienced with confidentiality and requirements to communicate student disclosures, including an instance when a student divulged self-harm in the form of cutting.

> The first thing she said to me was, "Please don't tell." … So, that's always a big one, is when kids want you to keep something a secret and you can't. And there's also that fear

> that, what if I tell this kid's parents and they respond negatively and I have placed this child in a dangerous situation.

Many participants shared teaching philosophies that value inclusion. However, they also described complex situations that have occurred when trying to balance the needs of one or a few students against those of the larger group. For example, Kelly identified struggles she has experienced with maintaining inclusive-based perspectives and strategies during behavioural outbursts, despite core values that guide her practice.

> If you have a kid that is distracting your whole class or just doing such unique things that the other kids can can't concentrate, that can be really undermining ... I'm built at the core of me as inclusive but I do find some kids are harder to be included than others. If they are threatening other kids like, "I'm going to blow the school up," or if they're saying something like they hate the teacher and swearing … I have no answer for that. I just know, I'm still trying to figure that out.

Personal Impacts

Participants' recall of various situations and events brought to light some of the personal impacts and emotional difficulties they have experienced through their roles as a teacher and work to support complex student needs. On some occasions, these experiences contributed to personal reflections and opportunities for growth. In other situations, participants identified experiencing difficult emotions and negative impacts to their own wellbeing. Denise identified that her experience with Ethan, for example, was personally quite difficult for her due to the intensity of his reactions and the rapport that she had developed with him. She stated that,

> It really threw me in a tail-spin because I'd never seen anything quite like that … It was hard to see him when he was so upset because I've also seen him when he's in his really

> good frame of mind … it just tugs on your heartstrings. But he also taught me a lot about what things I can do better or what things I can improve on down the road to help assist if somebody else came in a lot like him.

Dawn shared strong feelings that she had towards system-based protocols and realities of teaching within specialized programs with aggressive students. She noted, for instance, that she finds the documentation sheet for tracking incidents such as physical injuries as, "One of the most offensive things that I would love to see changed." Dawn also described dilemmas that she has experienced as a result of situations that occur when someone does get hurt. She explained,

> It's just like an assumption that it comes with the territory of the job and we're expected to figure out how to not have that happen, which of course, we do and we are through gesture dictionaries, through understanding the students, and through understanding our job and how to protect ourselves … but you can't take a day off, otherwise people will think that you're weak or that you're not a team player or that you're costing the school money by bringing in a sub. So, that's my biggest frustration.

In the next chapter, I synthesize key findings and discuss implications of my study.

Chapter 5. Discussion

I applied IPA methodologies to examine teachers' experiences with supporting students who were negatively impacted by ACEs to illuminate factors that influence teachers' perceived agency in support processes, as well as factors that contribute positively or negatively to associated student outcomes. In this chapter, I have summarized key findings and made connections to current literature regarding ACEs and educators' roles relating to student mental health and well-being needs. I have identified specific strengths and limitations of my study and highlighted important insights, questions, and areas for further consideration including potential implications for educational practices and policies. I culminated this chapter with reflections about my personal journey with this study, followed by concluding statements regarding the focus of this research.

Summary of Findings

Individual and cross-case analyses of participant data revealed six superordinate themes (Intrinsic Motivation, Work Conditions, Collaborative Supports, Systemic Factors, Establishing Relationships, and Conundrums), in respect to the main research questions of this study: (1) How do teachers make sense of their personal agency and ability to support students who have been negatively affected by ACEs, and (2) Based on their lived experiences, what factors do teachers associate with positive or negative outcomes in their work to support students who have been negatively affected by ACEs. Although aspects of some themes speak predominantly to either personal agency factors or outcome-based factors, there were many areas of overlap that occurred across them

Both internal and external factors were identified by participants as contributors to their sense of personal agency and abilities to provide supports to students who have been negatively

impacted by ACEs. Many participants reported, for instance, that an enhanced sense of agency stemmed from intrinsic characteristics and connected experiences. Guiding values and beliefs held by participants served as motivations for why they should act and contributed to areas of personal passion, leading them to pursue further education and skill development. Participants identified how meaningful experiences in their lives enhanced their empathy for and sensitivity to individuals experiencing difficulties, which improved their ability to recognize and support complex student needs. Participants that identified having opportunities for collaboration with others and access to additional supports shared a greater sense of agency, as part of a cohesive group, compared to individuals who reported more individual role requirements and limited access to additional supports within their work environments.

Inadequate training opportunities and overwhelming work conditions were typically associated with a reduced sense of agency as participants identified greater limits to their capacities to support the complex needs of students, especially when juggling multiple demands or working in non-ideal circumstances such as large class sizes or insufficient access to additional support services and resources. Participants also referenced the negative impact that difficult emotions and challenging experiences, such as continual barriers to accessing additional supports, had on their perceived self-efficacy and associated feelings of defeat, helplessness, and frustration. Regardless of how participants made sense of their personal agency, many reported that their decisions to engage with additional student supports were not always related to their perceived ability but instead to feelings of obligation resulting from limited options to choose otherwise, especially for those working in regular learning programs.

Interventions provided to students exposed to ACEs aim to mitigate negative impacts and prevent further potential harm through additional ACEs exposure. Analysis of participant data

was based on my conception that positive outcomes referred to types of support or situations that helped to reduce negative impacts or exposure; whereas, negative outcomes were connected to no change or potentially worsened circumstances. Participants typically associated negative outcomes with external factors or situations outside of their control including factors related to work conditions, systemic issues, and family-based barriers.

Providing inclusive learning environments and effectively meeting all student needs was identified as particularly challenging in regular classrooms with minimal access to additional supports such as education assistants. Many participants criticized systemic issues, such as funding cuts, for challenges with accessing supports and services necessary to adequately meet the complex needs of students exposed to ACEs. Financial limitations and governing criteria that affected opportunities for assessments or specialized program-availability also limited the potential reach of positive interventions and outcomes as participants continued to retain most of those responsibilities. Additional barriers that prevented access to available supports, as described by participants, included factors related to household dysfunction, stigma, family grief, and cultural values.

Participants frequently associated positive outcomes with opportunities to either further their own capacity or to connect with additional support-personnel and resources. Having a supportive teaching community and effective leadership enhanced participants' perceived capacity to meet student needs and to access help for both students and themselves, when necessary. The positive aspects of working with team-based supports were especially voiced by participants who worked in specialized program settings. Having professional development opportunities and rich learning experiences contributed to participants' understanding and ability to respond to students who may have been exposed to ACEs. Participants also identified the

development of positive relationships with students and families as a critical factor of supports and positive outcomes. Evidence of care between educators, students, and families contributed to foundations of trust and opportunities to begin providing targeted supports where needed.

Connections to Existing Literature

Literature surrounding adverse childhood experiences has tended to emphasize the long-term negative implications related to mental and physical health problems in adulthood. Studies directed at understanding the impacts of ACEs during childhood and adolescence have often relied on parent-reports, adult recall, or retrospective data (McEwen & Gregerson, 2019; HRSA, 2019; Tonmyr et al., 2020). Investigating teachers' lived experiences with supporting students who have been exposed to ACEs provides an additional lens to examine the types of adversities, signs of exposure, and challenges exhibited by children and adolescents.

Identifying Adversities

The most common ACEs identified by participants were those related to household dysfunction, which parallels findings revealed by Crouch and colleagues' (2019a) examination of the 2016 NSCH data. Participants' recall of specific experiences with students also closely resembled findings regarding ACEs amongst higher-risk populations including children from ethnic minorities, with special healthcare needs, involved in the child welfare system, and/or living in poverty (Bethell et al., 2014; Crouch et al., 2019a; Kerker et al., 2015). Consistent with studies that have expanded the definition of ACEs to include other negative or traumatic experiences, participants' responses also highlighted the need to consider expanding the definition of ACEs to include adversities such as witnessing community violence (i.e., refugee or gang-related situations), living with a family member with a critical illness or long-term complex needs, and death or loss of an immediate family member/parent (Crouch et al., 2019; HRSA,

2019; Merrick et al., 2018).

Teachers are rarely provided with sufficient information to understand certain student behaviours. However, they are often required to observe and respond to potential issues and student needs (Askell-Williams & Cefai, 2014; ATA, 2018; MHCC, 2013). Participants working in specialized programs identified greater access to students' backgrounds than teachers in regular programs. Teachers in regular programs commonly learned about potential ACEs from student disclosures, conversations between colleagues, or information that surfaced after participants witnessed students' problematic behaviour and raised 'red flags' about their students. These 'red flags' are consistent with existing literature describing common indicators of trauma in childhood and adolescents including problems in emotional and physiological regulation, poor social skills, cognitive and executive functioning impairments including difficulties with attention and memory, internalizing behaviour problems, or externalizing behaviour problems (Brown et al., 2016; Cook et al., 2005; NCTSN, 2008; Sciaraffa et al., 2018; Tishelman et al., 2010). Participants' responses to these situations largely depended on their own personal attributes, experiences, and access to supports.

Supportive Approaches

Participants echoed previous study findings, stating that pre-service training inadequately addressed their need to understand and respond to student mental health and well-being as part of their teaching practice (Ball et al., 2016; Ekornes, 2017; Froese-Germain & Riel, 2012; Osagiede et al, 2018). They credited professional learning opportunities for enhancing their sense of agency and capacity, while identifying limitations from time, money, and availability of useful PD as barriers (Askell-Williams & Cefai, 2014; Ekornes, 2017).

Participants' described limited involvement in SBMH approaches compared to the

numerous options detailed in my literature review. Some participants described more widely known tiered intervention responses in traditional settings and more targeted social-emotional learning approaches within specialized program. Otherwise, tiered responses and trauma-informed interventions were the most specific SBMH approach described. Participants identified integration of approaches because of specialized program training or participants' personal pursuits of professional development. Participants did not cite pre-service training or whole-school initiatives as significant (Ekornes, 2017; MHCC, 2013; Phillippo & Kelly, 2014). Some participants explained that poor awareness of ACEs and strategies to support students resulted from a lack of time for PD, costs of training (individually or system-based), and the lack of prioritization of PD on this topic for new teachers. These barriers are consistent with current findings on the challenges to, and recommendations for implementation (Askell-Williams & Cefai, 2014; Moon et al., 2017; Reinke et al., 2011; SAMHSA, 2014).

Regardless of their setting, all participants strongly emphasized the need to focus on school climate and teacher-student relationships. This originated from their experiences and personal values, rather than specific SBMH modalities or PD. They acknowledged the importance of developing a sense of safety through both structural and relational factors. Participants described variables such classroom physical arrangement, student seating, or supporting classmates to be compassionate as important to reducing student vulnerabilities and enhancing feelings of safety. Participants also identified intentional efforts to develop teacher-student relationships as necessary to foster students' sense of belonging and to establish trust in a supportive adult. These perspectives intertwine with multiple studies that have described the significant influence of positive teacher-student relationships on student well-being, especially

for students who have been negatively impacted by ACEs (Forster et al., 2017; Jennings, 2019; Masko, 2018; Rudasill et al., 2010).

Increased Responsibilities

Participants acknowledged the important roles that professional service providers like counsellors have in supporting student mental health and well-being. While some schools had a strong network of service providers working alongside the teacher to provide holistic supports, this most frequently occurred in specialized programs. In regular school settings, participants' success with accessing additional supports or services depended on whether the student met specific eligibility criteria, teachers understood the processes required to access those services, or any service providers were accessible. Participants reported positively on situations where students had access to SBMH services. However, participants commonly reported limited availability of such programs as a major barrier to accessing necessary services, especially as students got older. These findings align with data describing factors contributing to the decline in availability of services: reduced funding, few available service providers, and rising counsellor-student ratios (Atkinson et al., 2014; PFE, 2018; Suldo et al., 2010). Participants also linked declining services with increased pressure on educators to support struggling students in addition to the numerous roles they already fulfill, despite frequently feeling unprepared by qualifications and training (Ekornes, 2017; Froese-Germaine & Riel, 2012; Phillippo & Kelly, 2014).

Educators' roles extend beyond their classroom responsibilities, which participants identified as a complicating factor in their willingness and ability to support students beyond academics, especially when their effectiveness as educators is evaluated via standardized testing. They described their experience as *stressful* and *overwhelming* when describing their many roles. Some participants also cited vague but exhaustive descriptions of the expectations placed upon

them, making it difficult for them to understand the scope of their professional responsibility. Despite enhancing their competence by undertaking their own career development, participants' perceptions of teachers' capacities in general corresponded with existing findings that most teachers are not receiving what they need to competently support their responsibilities for student mental health (Ball & Anderson-Butcher, 2014; Osagiede et al., 2018; Shernoff et al., 2011).

Participants also shared their frustrations and dilemmas in their work with students who have been negatively impacted by ACEs, which aligns with current findings on teachers' experience of overlapping roles in educational settings. Role confusion issues, such as those described by Shelemy et al. (2019) and Venet (2019), were identified by Sarah, who as a classroom teacher, was required to maintain a disciplinary role rather than use the skills she had exercised in her previous role as a school counsellor. Ethical dilemmas and values conflicts like those described by Maxwell et al. (2018), were similarly reported by Kelly and Leanne. All participants identified a desire to be involved with supports for students exposed to ACEs where possible, but recognized limitations in both their and their colleagues' abilities to effectively meet those needs as effectively as trained professionals who have appropriate training and time.

Strengths and Limitations

Although all participants recruited for this study met the minimum inclusion criteria, most participants had mainly taught elementary students. I had hoped to recruit participants who worked with students from grades 6-9 to obtain a broader perspective on how students who have experienced ACEs are supported as they get older, including potential differences in types of supports available. While I still see value in collecting data relating more to adolescent years, I had not anticipated the wide-spread experiences and wealth of information that I would receive from participants that had also worked with lower grades. I had also designed my study with

regular learning settings in mind without considering the possibility and value of data related to teachers' work with students in specialized programs.

Interviewing the participants exposed me to a range of experiences and perspectives beyond what I had initially considered, especially since my own experiences had not included many specialized program settings at the time. Their shared experiences provided insights into different ways that teachers understand and work to support students who are negatively impacted by ACEs. This information also provided opportunities to compare experiences in regular and specialized program settings. From an ethics standpoint, I did not collect demographic information about my participants as I wanted to reduce collection of unnecessary or identifying information. In hindsight, explorations of the relationship between participants' cultural identity and their teaching philosophies and practice may have provided a further lens to interpret their experiences. An additional limitation is that reliance on teachers to share their views on the effectiveness of supports does not provide actual outcome data.

Implications for Practice & Policy

This study is consistent with the existing literature in finding that supportive factors such as relationship-building and collaborative supports can contribute to more positive outcomes for students exposed to ACEs. However, participants' accounts expose issues such as inequitable access and inadequate training, which illustrate the need for changes to current practices and policies.

First, I recommend a close examination of educational frameworks to ensure adequate training programs and professional development opportunities are available to pre-service and contracted teachers. Enhanced pre-service and in-service training would enhance educators' understanding and abilities to respond to the complex needs of students, including those exposed

to ACEs. Next, system and school-based decision makers should review how funding is allocated within school systems to support both academic and social-emotional needs of students, including class size, eligibility of students to access support services, and the availability of SBMH service providers, resources, and specialized programs. Finally, educator roles and assignments should be reviewed to clarify professional expectations and responsibilities to better meet the diverse needs of students, especially if schools maintain significant responsibility for meeting student mental health and well-being needs.

Personal Implications and Changes

This study has been more than a culmination of sequential steps to uncover and share important research findings. It has been a personal journey that has included my own lived experiences, learning, and development during some of the most challenging times that I have had in my roles as a parent, teacher, and counsellor-in-training. My motivation behind this study stemmed from the same place that spurred my pursuit of a Master in Counselling degree. I was a teacher who was regularly surrounded with students whom I tried to support the best that I could, but whose needs were beyond what I was capable of or qualified to support on my own. I frequently encountered barriers to accessing additional supports, and I regularly went home feeling heartbroken and worried for them. I so badly wanted more for students than what I believed was available, especially given the multitude of adversities that were disclosed or became visible through their behaviours.

Over the course of this study, there has been a global pandemic, I have persevered through extremely challenging roles, and I have found increased confidence and courage to push myself towards personal growth and opportunities to create change. Engagement with my participants, and analysis of their related but individual experiences, helped me to pause and

reflect on my own practices and work with students exposed to ACEs, but also supported my own learning and understanding of educators' roles and routes to support student well-being. Individually, I have shifted from my role as classroom teacher to a position that allows me to better advocate for students and families, as well as to support students and educators more directly. There have still been many days that I leave my place of work feeling discouraged and frustrated by both my own limitations and those of the system, but engaging in this study continues to motivate me to learn and fight for change in our schools and in our society. It is my hope that this study will also provide opportunities that extend beyond myself to promote positive changes in how children and adolescents that have been negatively impacted by ACEs are understood and supported.

Directions for Future Research

The specific areas of this study unveiled important insights and understandings related to teachers' experiences with students exposed to ACEs, as well as connected support systems, within Alberta educational settings. All participants had multiple years of experience teaching and working with students at different grade levels and within regular or specialized program settings. Further expansion of these areas of focus would benefit from research that also included newer teachers in the field, to identify more recent experiences of pre-service training and competencies. It would also be beneficial to interview additional teachers that work primarily in regular settings and with older adolescent students to expand on the findings from this study. Additional factors to consider would be the inclusion of teacher demographics and perhaps comparisons of urban versus rural learning settings.

While the scope of this project was limited due to time and complex ethical factors, a closer examination of the perspectives and experiences of children and adolescents who have

been impacted would provide a more comprehensive understanding of positive and negative components of supports currently available. Methodologies that could engage more closely with students and educational staff, over an extended period, could also provide valuable information to improve preventative initiatives and supportive interventions used within school environments to protect and enhance the well-being of students.

Conclusion

Further actions are needed to disrupt the negative cycle that ACEs have on the long-term health and well-being of children and adolescents. It makes sense to facilitate some of these changes in schools given the opportunities that teachers and school-based personnel have to establish safe environments and positive relationships through their regular interactions with students. However, findings from this study, as well as others, show that the current educational system and connected support networks often do not have the necessary structures and resources to meet the complex needs of those students effectively. The consequence of these inadequacies has been an increased onus of care being placed on teachers to provide both academic and social-emotional supports, regardless of how complex the needs of students.

While some educators have expanded their knowledge and skills through professional development, better equipping them to respond and advocate for student needs, evidence shows that many teachers feel ill-prepared to provide extended levels of support that exceeds their trained abilities. Students placed in specialized programs typically have access to more extensive support systems compared to students in regular school programs, where service ability has noticeably declined and is frequently reserved for students that meet specific pre-defined criteria. Without changes to practices and policies related to structures of support and school systems, there will continue to be more barriers than opportunities to facilitate positive interventions. As a

result, the negative cycle of ACEs will continue, creating not only ongoing difficulties for the children and adolescents affected but also a continuous strain on societal resources needed to support them and their families over their lifetimes.

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Appendix A: Participant Informed Consent Form

LETTER OF INFORMATION / INFORMED CONSENT FORM

Disrupting the Cycle of ACEs: An interpretative phenomenological analysis of teachers' experiences with supporting students impacted by adverse childhood experiences

March 5, 2021

Principal Investigator (Researcher):
Lindsay Gorday: lgorday1@athabasca.edu

Supervisors:
Dr. Jeff Chang: jeffc@athabasca.ca
Dr. Simon Nuttgens: simonn@athabasca.ca

You are invited to take part in a research project entitled '*Disrupting the Cycle of ACEs: An interpretative phenomenological analysis of teachers' experiences with supporting students impacted by adverse childhood experiences*.

This form is part of the process of informed consent. The information provided should give you the basic idea of what this research is about and what your participation will involve, should you choose to participate. It also describes your right to withdraw from the project. In order to decide whether you wish to participate in this research project, you should understand enough about its risks, benefits and what it requires of you to be able to make an informed decision. Take time to read this carefully as it is important that you understand the information given to you. Please contact me, Lindsay Gorday if you have any questions about the project or would like more information before you consent to participate.

It is entirely up to you whether or not you take part in this research. If you choose not to take part, or if you decide to withdraw from the research once it has started, there will be no negative consequences for you now, or in the future.

Introduction
My name is Lindsay Gorday and I am a Master of Counselling student at Athabasca University. As a requirement for my degree, I am conducting a research project about teachers' lived experiences of working with students impacted by various adverse childhood experiences (ACEs). I am conducting this project under the supervision of Dr. Jeff Chang and Dr. Simon Nuttgens.

Why are you being asked to take part in this research project?
You are being invited to participate in this project because you identified yourself as a teacher who has had a meaningful experience(s) working directly with one or more students impacted by ACEs, during your time employed as a full-time teacher.

What is the purpose of this research project?
This research will identify factors that best contribute to positive student outcomes in terms of mental health and academic success, and potential barriers or limits to support. We hope that this

research will contribute to initiatives for disrupting the typical negative long-term impacts of ACEs on children and adolescents, support preventative interventions, and enhance youth mental health.

What will you be asked to do?
I request that you participate in a 60-90-minute interview with me through a secure online interface. I will record and transcribe the interview without identifying you, and I may print a hard copy to analyze. I will ask you to describe a specific instance(s) where you experienced either success or challenges with supporting a student impacted by adverse childhood experiences. I will ask a set of standard questions, as well as clarifying or follow-up questions when needed.

We will arrange our interview for a time and date that is convenient to your schedule. If I need clarification or further information, I may request a follow-up meeting. Upon completion of your individual transcript, you will have the opportunity to review the transcript document and to alter or clarify your comments.

What are the risks and benefits?
Some participants may find it upsetting to discuss their experiences of working with students affected by adverse childhood experiences. I will be sensitive to your needs and provide information regarding available counselling resources and services, if needed.

All interview participants will be emailed an eGift card of $20, which can be selected from any of the following establishments: Tim Hortons, Starbucks, Amazon, Michaels, or Indigo.

Do you have to take part in this project?
Your involvement in this project is entirely voluntary. You have the right to stop or withdraw your participation during any part of the data collection process. If you withdraw prior to the analysis stage, data collected from you will only be used with your permission. If you would prefer not to share this data, it will be destroyed through a secure process. I cannot guarantee that your individual data can be removed from the study after analysis processes have taken place, however, due to the nature of anonymity assigned to transcripts and later coding stages. If you choose to end your participation during or after the interview, you will not be penalized and will still be eligible to receive the incentive opportunities offered.

How will your privacy and confidentiality be protected?
The ethical duty of confidentiality includes safeguarding participants' identities, personal information, and data from unauthorized access, use or disclosure.

- Each participant's privacy and confidentiality will be maintained by me separating and securing your identifying information, such as that obtained for the purposes of consent, from the interview data collected. Transcripts of the interviews will be re-labelled with non-identifying codes (e.g., A07) and pseudonyms will replace any names or identifiers (i.e., employment organization) that might connect the data to the original participant.

- The small sample size of this study, pre-existing connections amongst teachers, and use of social media for recruitment may increase the likelihood of participants knowing one another. If this risk concerns you, please decline consent to this study.
- All information will be held confidential, except when legislation or a professional code of conduct requires that it be reported, including identifiable risks of child neglect and/or abuse.

How will the data collected be stored?
Data will be collected through an online audio-video interview. The recording of your interview and transcripts will then be stored on a password protected and encrypted laptop. Any paper documents used in the process of data collection or analysis will be secured behind locked doors.

Who will receive the results of the research project?
The existence of the research will be listed in an abstract posted online at the Athabasca University Library's Digital Thesis and Project Room, and the final research thesis will be publicly available. I may present the results of this study at one or more professional conference, or publish it in summarized form in a professional journal. Although direct quotations may be integrated within the final report, they will be attributed to your pseudonym. Upon completion of this research project, all participants will be provided with a summary report.

Who can you contact for more information or to indicate your interest in participating in the research project?
Please contact me, Lindsay Gorday, or my supervisors if you have any questions about this study or require further information.

Ready to Participate?
If you are ready to participate in this project, please complete and sign the attached Consent Form and return a digital copy via email to lgorday1@athabasca.edu

This study has been reviewed by the Athabasca University Research Ethics Board. Should you have any comments or concerns regarding your treatment as a participant in this study, please contact the Office of Research Ethics at 1-800-788-9041, ext. 6718 or by e-mail to rebsec@athabascau.ca.

Thank you for your assistance in this project.

Lindsay Gorday

CONSENT:
I have read the Letter of Information regarding this research study, and all of my questions have been answered to my satisfaction. I will keep a copy of this letter for my records.

Your signature on this form means that:

- You have read the information about the research project.
- You have been able to ask questions about this project.
- You are satisfied with the answers to any questions you may have had.
- You understand what the research project is about and what you will be asked to do.
- You understand that you are free to withdraw your participation in the research project without having to give a reason, and that doing so will not affect you now, or in the future.
- You understand that if you choose to end your participation **during** data collection, any data collected from you up to that point will be retained by the researcher, unless you indicate otherwise.
- You understand that if you choose to withdraw **after** data collection has ended, your data can be removed from the project at your request, up to two weeks after completion of the interview.
- You understand that your data is being collected anonymously, and therefore cannot be removed once the data collection has ended.

	YES	**NO**
I agree to be video-recorded	◯	◯
I agree to the use of direct quotations, with the understanding that my name will not be attached to any statements used	◯	◯
I am willing to be contacted following the interview to verify that my comments are accurately reflected in the transcript.	◯	◯

Your signature confirms:

- You have read what this research project is about and understood the risks and benefits. You have had time to think about participating in the project and had the opportunity to ask questions and have those questions answered to your satisfaction
- You understand that participating in the project is entirely voluntary and that you may end your participation at any time without any penalty or negative consequences.
- You have been given a copy of this Informed Consent form for your records; and
- You agree to participate in this research project.

_____ _____
Signature of Participant Date

In any presentations or publications, I would like to be known by the pseudonym: _____

Principal Investigator's Signature:

- I have explained this project to the best of my ability. I invited questions and responded to any that were asked. I believe that the participant fully understands what is involved in participating in the research project, any potential risks and that he or she has freely chosen to participate.

_____ _____

Signature of Principal Investigator Date

Appendix B: Interview Schedule

Participants were provided with the following information prior to their scheduled interviews to support their understanding of the research focus, questions that would be asked, and the intended goal or purpose of the questions:

My Overarching Research Questions:

- How do teachers make sense of their personal agency and ability to support students who have been affected by adverse childhood events?
- Based on their lived experiences, what factors do teachers attribute to the positive and/or negative outcomes they associate with students impacted by ACEs?

Adverse Childhood Experiences:

- ACEs are typically categorized by adverse childhood experiences related to abuse (physical, emotional, sexual), neglect (physical, emotional), and household dysfunction (mother treated violently, mental illness, imprisonment, substance abuse, divorce or separation).

Interview Questions:

1. Goal: Understanding teachers' perspectives about ACES

    a) **From your teaching experiences, what types of ACEs seem to have the greatest impact on student mental health and/or academic needs?**
        - What type of ACEs have been the most common in your experiences?
        - What type of ACEs seem to create the most needs for support?

    b) **How do you typically become aware that a student has been exposed to one or more ACE(s)?**

2. Goal: Understanding a teacher's specific experience(s)

    a) **Describe, with as much detail as possible, a situation where you were involved in supporting a student affected either academically or social-emotionally by one or more ACEs.**
        - If possible, think about one or two specific examples of working with/supporting a student impacted by ACEs; Describe: student age/grade level, how issue presented, reason for/type of involvement, positive or negative outcomes for student, positive or negative impacts on teacher, what did supports include, were others involved ….

3. Goal: Understanding factors that enhance supports

   a) **What factors, if any, enhanced your ability to provide or access necessary supports for the student(s) you described?**

   b) **What do you think are necessary elements/factors to recognize and effectively support the needs of students affected by ACEs? (e.g., relationships, access to resources**

4. Goal: Understanding challenges or dilemmas

   a) **What, if any, dilemmas or challenges did you face during your efforts to support the student(s) that you described?**

   b) **What other factors or barriers do you think create challenges with effectively supporting and meeting the needs of students affected by ACEs?**

5. Goal: What are teachers' roles in providing such supports? How equipped/willing do teachers feel to provide supports?

   a) **How equipped did you feel to be involved with supporting the student(s) you described? (What factors provided you with this ability/knowledge or what do you think you would need to feel more equipped?)**

   b) **What other supports, if any, are accessible/available to meet the needs of the student(s) that you described? (e.g., training, programs, internal supports & resources, external supports & resources)**

   c) **What is your opinion regarding the extent to which teachers (and schools) should be involved with student social-emotional and mental health needs, such as those that may arise with children exposed to ACEs?**

Appendix C: Certificate of Ethics Approval

Athabasca University
RESEARCH CENTRE

CERTIFICATION OF ETHICAL APPROVAL

The Athabasca University Research Ethics Board (REB) has reviewed and approved the research project noted below. The REB is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2) and Athabasca University Policy and Procedures.

Ethics File No.: **24302**

Principal Investigator:
Mrs. Lindsay Gorday, Graduate Student
Faculty of Health Disciplines\Graduate Centre for Applied Psychology

Supervisor:
Dr. Jeff Chang (Supervisor)

Project Title:
Disrupting the Cycle of ACEs: An IPA Study Examining Teachers' Experiences of Supporting Students Impacted by Adverse Childhood Experiences

Effective Date: May 11, 2021 **Expiry Date**: May 10, 2022

Restrictions:

Any modification or amendment to the approved research must be submitted to the AUREB for approval.

Ethical approval is valid *for a period of one year.* An annual request for renewal must be submitted and approved by the above expiry date if a project is ongoing beyond one year.

A Project Completion (Final) Report must be submitted when the research is complete *(i.e. all participant contact and data collection is concluded, no follow-up with participants is anticipated and findings have been made available/provided to participants (if applicable))* or the research is terminated.

Approved by: **Date: May 11, 2021**

Emily Doyle, Chair
Faculty of Health Disciplines, Departmental Ethics Review Committee

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Athabasca University Research Ethics Board
University Research Services, Research Centre
1 University Drive, Athabasca AB Canada T9S 3A3
E-mail rebsec@athabascau.ca
Telephone: 780.213.2033

Appendix D: Certificate of Ethics Approval Renewal

Athabasca University
RESEARCH CENTRE

CERTIFICATION OF ETHICAL APPROVAL - RENEWAL

The Athabasca University Research Ethics Board (REB) has reviewed and approved the research project noted below. The REB is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2) and Athabasca University Policy and Procedures.

Ethics File No.: **24302**

Principal Investigator:
Mrs. Lindsay Gorday, Graduate Student
Faculty of Health Disciplines\Graduate Centre for Applied Psychology

Supervisor:
Dr. Jeff Chang (Supervisor)

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A Project Completion (Final) Report must be submitted when the research is complete *(i.e. all participant contact and data collection is concluded, no follow-up with participants is anticipated and findings have been made available/provided to participants (if applicable))* or the research is terminated.

Approved by: **Date: April 26, 2022**

Carolyn Greene, Chair
Athabasca University Research Ethics Board

Athabasca University Research Ethics Board
University Research Services, Research Centre
1 University Drive, Athabasca AB Canada T9S 3A3
E-mail rebsec@athabascau.ca
Telephone: 780.213.2033