

RECLAIMING STUDENT VOICES ON SCHOOL-BASED, MENTAL HEALTH IMPACTS:
YOUTH REFLECTIONS, LIVED EXPERIENCES AND RECOMMENDATIONS FOR
TRANSFORMING ONTARIO SECONDARY SCHOOLS

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A DISSERTATION SUBMITTED TO
THE FACULTY OF GRADUATE STUDIES
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
DOCTOR OF EDUCATION

GRADUATE PROGRAM IN EDUCATION
YORK UNIVERSITY
TORONTO, ONTARIO

JULY 2020

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ABSTRACT

In recent years, student mental health has gained considerable attention in Ontario's secondary schools. While the voices of students are central to the discussion about school-based mental health impacts, they are often undervalued or missing altogether in academic and policy literature on the topic. This phenomenological study reclaims and thematically analyzes the reflections of 11 youth participants on the cultural features of their Ontario public secondary school that impacted their mental health. The critical and conceptual theories of Michel Foucault (1988), Paulo Freire (2000), and Corey Keyes (2002) inform this dissertation's theoretical framework. Three main findings were revealed in this study: (1) a gendered and stigma-laden culture of silence had a significant mental health impact on the youth in their secondary school; (2) the youth identified a number of supportive and unsupportive educational practices as impactful; and, (3) peer relationships were shown to be supportive and unsupportive mental health features for the youth, with an emphasis on bullying and peer-support groups. The youth recommendations presented in this study have profound implications for how to best support the mental health of secondary-school-aged youth in Ontario moving forward.

DEDICATION

I dedicate this doctoral dissertation to all youth living with a mental health issue or diagnosis. This study's act of experiential reclamation is only one small step in the quest for a more equitable and inclusive public education system in Ontario.

I also dedicate this dissertation to my family and friends, living with or without a mental health issue or diagnosis. You know who you are.

Next, I dedicate this youth-driven study to the soon-to-be youth in my life, my 3-year-old daughter, Logan, and my newborn son, Landen. You are my light and inspiration. Thank you for the cuddles and smiles during my writing breaks.

Last, but certainly not least, I dedicate this work to my wife, Kristi. I am eternally grateful for your unyielding love and support throughout this academic marathon.

ACKNOWLEDGEMENTS

The completion of this doctoral dissertation was made possible by the support and mentorship of many individuals, some whose names may not be included below. I would, however, like to express my most sincere appreciation to the following:

To Dr. Chloë Brushwood Rose, for your ongoing encouragement, guidance, and expertise. Your dedication to your students is inspiring.

To Dr. Jen Gilbert and Dr. Carl James, for your insightful feedback during the revision and defence phase.

To my wife, Kristi, who believed in me every step of this academic journey.

To each of the 11 youth participants. Your willingness to candidly reflect on your mental health experiences throughout secondary school was no simple task. Thank you for your courage, insight, and expertise.

Again, thank you to all of you from the bottom of my heart.

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LIST OF ABBREVIATIONS

CAMH	Centre for Addiction and Mental Health
CMHA	Canadian Mental Health Association
CMHO	Children's Mental Health Ontario
CRT	Critical Race Theory
CSIE	Centre for Studies on Inclusive Education
IEP	Individualized Educational Programs
LGBTQI	Lesbian, Gay, bisexual, transgender, queer, and intersex
MCCSS	Ministry of Children, Community, and Social Services
MHC-SF	Mental Health Continuum-Short Form
MHLTC	Ministry of Health and Long-Term Care
OME	Ontario Ministry of Education
OSDUHS	Ontario Student Drug Use and Health Survey
OYSPP	Ontario Youth Suicide Prevention Plan
PAR	Participatory Action Research
TDSB	Toronto District School Board

Chapter One: Introduction

“I felt like a ghost.” These five, impactful words resonated with me, the qualitative researcher. This is how a former Ontario high-school student, living with a mental health issue, candidly described his day-to-day experience with mental health in secondary school. What does it mean to feel like a ghost? To feel unheard, ignored, passed by, forgotten, excluded, undervalued, cast aside, solitary, invisible, and voiceless? The list of potential synonyms and inferences goes on. In this study, I consider what features of Ontario secondary-school culture contribute to the experiences of marginalization that this youth and others describe. This doctoral dissertation explores the connection between the mental health of secondary-school students and the many social, academic, environmental, and broader cultural features within a given secondary-school climate.

This dissertation draws on the lived experiences of 11 former Ontario secondary-school students who lived with mental health issues during their high-school years. The ultimate goal of this dissertation was to answer the following overarching research question: According to former Ontario secondary-school students with a mental health diagnosis, what features of their secondary-school culture impacted their mental health? Ultimately, I argue that by carefully listening to the mental health reflections of 11 youth on their time in secondary school, we can gain unique insight into the school-level and even systemic gaps in youth mental health prevention and support in the province of Ontario. Furthermore, the themes that emerged in this study can inform how to better support the overall mental health of all secondary-school students in Ontario’s public schools, not only those students living with a mental health issue or mental illness.

The emergent themes in this study suggest that there is a culture of silence on mental health amongst youth in Ontario secondary schools. The findings reveal that youth simply do not talk openly and critically about their experiences with mental health, and those who do speak up are disproportionately young women. The impact of this silence is that youth are not adequately supported, both mentally and emotionally, at an already vulnerable time in their development. Furthermore, the youth in this study identified teachers and peers as impactful mental health supports. Thus, this dissertation provides insight into the interpersonal dynamics, best teaching practices, and peer-support groups that insulate and support youth mental health in secondary school.

Where the Research Begins

In qualitative research, it is important and necessary to begin by explaining where the author's personal experience fits in relation to the research; that is to say: How did I come to ask these research questions? From what sociocultural position did I analyze the data? More importantly, what cultural biases emanate from my positionality? Being upfront and reflexive about my cultural bias and any contextual limitations of the research agenda is integral to the authenticity, transparency, and significance of the findings (Patton, 2015). Furthermore, transparency dispels guess-work about the possibility of ulterior researcher motives. The fewer hidden assumptions the better.

I am currently an intermediate, French immersion teacher in the Kawartha Pine Ridge District School Board. As an intermediate school teacher, I regularly encounter youth experiencing mental health issues in my classroom and clubs, as well as on my sports teams. In my 9-year career, I have lost count of the number of youth I have supported for a mental-health-specific issue. I have carefully and compassionately listened to many students in crisis. I have

initiated and taken part in countless meetings with parents because I was deeply concerned for their child's mental health and emotional well-being. I have contacted the Children's Aid Society more times than I can recall because I was deeply concerned for the well-being of an adolescent. I have also actively utilized my applied-suicide-intervention-skills training within my school on a number of occasions. Not surprisingly, many of the youth I have supported have no professional mental health diagnosis, nor have they ever sought professional help for their mental health issue.

As an intermediate, public school teacher in the province of Ontario, I see the daily burgeoning mental health gaps in my classroom and school. And, sadly, the mental health needs of many youth go underserved and even unmet because our school system lacks the resource capacity and expertise needed to keep up with the demand. Undeniably, there is a youth mental health crisis in our province, and I witness it on a daily basis in my professional life. While I have had my own struggles with mental illness, I also benefit from greater sociocultural privilege than many of my students and study participants. I am a white, Canadian-born, Catholic-born, cis-gendered, educated, middle-class, male, and bilingual researcher in my mid-30s. I have never, in any real sense, encountered systemic discrimination for who I am or perceived to be. Unlike many visible minorities, I have never been limited by systemic barriers to opportunity because of my perceived sociocultural identity. Rather, I have come to recognize my position of sociocultural privilege and often question those cultural norms and institutional practices that reproduce the status quo.

While below I share my own personal journey with mental health, by no means do I claim to speak for all individuals who have experienced, are experiencing, or will experience a mental health issue. In fact, this study takes explicit issue with the tendency for marginalized

populations to be silenced or spoken for by members of dominant sociocultural groups or hierarchical professions. Much of the epistemological value of this study lies in the emancipatory and humanizing act of discursive transformation, which lies at the heart of Freirean problem-posing education. This study aims to listen to and empower marginalized youth to speak about their lived mental health experiences in secondary school. The hope is that by empowering marginalized youth, they will grow into agents of mental health change in Ontario, both systemically and socio-culturally. I share my own story because I feel that it adds context and humanizes the research agenda of this dissertation.

How did I become interested in the area of youth mental health? For many years, I have lived with anxiety and depression, which began when I was still an adolescent. I use the word *live* deliberately and strategically. It has not always been “doom and gloom,” as the common stereotypes of these diagnostic labels often convey. But, sometimes it has been. My experience with mental illness is varied and fluid, dotted with many periods of flourishing and languishing mental health. Although I have experienced moderate levels of anxiety and depression over the years, I cannot say that it has ever entered the realm of severe depression or anxiety. I have, however, experienced longstanding periods of perpetual sadness, anger, self-loathing, and loneliness alongside sentiments of uncontrollable anxiety, panic, and worry.

For many years, I hid my experience from my family and closest friends. I felt ashamed and confused. What was happening to me? Why was I feeling like this? There was nothing in my life that ostensibly justified these feelings, so why couldn't I snap out of it? I longed for my old, joyful, and clear-minded self. This was not me. I was a sharp, charismatic, and outgoing athlete. I was a talented actor and an avid singer and guitarist who enjoyed performing in front of audiences. I was an outgoing socialite with a witty sense of humour. I was a leader in my

secondary school, with unrelenting positivity and an unyielding smile. But somewhere along the way something changed. A lot had changed. And I did not understand why. This was the most frustrating part of coming to terms with my mental illness.

The onset of my depression and anxiety began in early university, although the roots of my experience likely commenced earlier on in childhood. When I was 7 years old, I experienced severe panic attacks and chronic anxiety following a traumatic event in my quiet neighbourhood. I remember the day like it was yesterday. I was riding my bicycle around the block when a blue cargo van abruptly stopped in front of me, and a man demanded that I get into his van. Despite my full-blown panic, I was able to turn my bike around and pedal frantically away from him. The van made an aggressive three-point turn, pursuing me in the opposite direction down a one-way street. Luckily, I was far enough ahead of him that I was able to turn the corner and duck into my back laneway without him seeing me. I vividly recall pounding on the glass of our back sliding door as his van sped by my laneway. Even in the sheer terror of the experience, I was strategic. I consciously took my back laneway, so that my bike could not be seen by my potential abductor as he sped by my house. I was balling my eyes out hysterically. I vividly recall shaking in my mother's arms as I tried to verbalize what had just taken place.

Later that day, my younger brother, my mother, and I walked the streets of our neighbourhood with a police officer as I described the incident, the man, and the vehicle. It was a lot for a 7-year-old to handle. Not long after this incident came the panic attacks and the nightmares revolving around abduction. Loud vehicles terrified me. Blue vehicles and cargo vans especially terrified me. On a number of occasions, I vividly remember sprinting away and hiding from similar vehicles in a full-blown, fight-or-flight response. Sometimes, I was with friends or brothers when my flight response was triggered, and other times I was alone on my paper route.

I never did seek professional help for my near-abduction experience as a young child; although years later, as an adult, it came out with a vengeance in a counselling session. My parents recognized the toll that this terrifying experience had taken on me at such an early age, and they kept a closer eye on me as a result. They were aware of how it impacted my ability to trust others and my overall sense of security in the world. As a result of this trauma, I often preferred staying close to my parents in public settings. When I went away without my parents on school or sports trips, I would often become physically ill. In the early 1990s, children's mental health services were not overly developed and accessible in my area. Furthermore, my parents were certainly not in a socioeconomic bracket that could afford private counselling or support. So, I coped as many who have experienced trauma did. I turned inwards and pushed forward. And, to my detriment, I never really talked about it with anyone, even my parents, until much later in life.

It took me a long time to come to terms with the ways that my near-abduction shaped me. I, generally, had trouble trusting people, especially adults. Nevertheless, a noticeable shift in my sense of trust and security took shape early on in high school. A big part of my newfound sense of security grew out of my physical development. As I matured physically, I felt more and more capable of winning the potential power struggles that haunted me from a young age. As a result of my perceived strength and physical size, my anxiety about child abduction subsided in my teenage years; but I was to face other challenges.

When I went to the University of Ottawa at the age of 17, similar to many other students my age, the transition to post-secondary school was not easy. I moved away from home at a younger age than most and, shockingly, suffered a serious concussion after falling from a two-story balcony at the end of my 1st year of studies. A wooden balcony railing gave out while I

was leaning on it, and I plummeted 15 feet into a state of unconsciousness. Luckily, I survived the fall. I postponed writing my final exams for several months as I healed from my injuries and orthopaedic surgery. Unfortunately, this was not my first concussion either. I had suffered a number of head traumas on the school yard and as a young hockey player. Little did I know, but this concussion would seriously impact my mental health for a number of years. Only in hindsight can I fully understand the effect that this head injury had on my mental and emotional health.

The decade following my concussion was marked by my deepest struggles with depression and anxiety. I kept my pain to myself and hid my mental illness from those I loved most. Occasionally, I would break down in tears when with a family member or a close friend, but I never delved into the full extent of my pain. On many days, getting out of bed to attend class was a struggle. I would sleep for 12 or more hours and still feel heavy, sore, and tired. I wished I could enter social situations and not be awkward or avoid eye contact. I desperately hoped for the pervasive feelings of irritability and anger to dissipate. I wished the unpredictable and debilitating panic attacks would go away for good. The tight chest, the uncontrollable heart-beat, the sweaty palms, the lump in my throat, the tight muscles, and the feeling of butterflies and nausea in my abdomen were only some of the symptoms. Social paranoia paired with unrelenting feelings of inadequacy and hopelessness were especially challenging because they prevented me from talking about my mental health issues with my loved ones for a long time. Finally, binge eating carbohydrates and the inability to have only one alcoholic beverage without it turning into 10 wore on me and led to many mornings of guilt, self-pity, and regret.

I wished the voice inside my head that told me that everyone was judging me or that people did not like me would hush-up. I was afraid to share my struggle with anyone. I genuinely

thought that people would judge me if I told them about my disturbing and unrelenting thoughts. Unaware of how stigma was impacting me, I delayed seeking professional help for decades. Instead, I stubbornly and silently put my head down and struggled to cope as best as I could. I resorted to exercising, meditating, and reading every self-help book on the market. I even prayed regularly that my pain would go away. I tried nutritional approaches and naturopathic remedies. I avoided going to my family doctor for years because I was afraid to talk about my mental health.

The thought of going to a doctor or a counsellor, or taking any kind of medication for my mental health, terrified me. At the same time, there was a small and deeply ashamed part of me that longed for professional help. My denial, however, was thick and layered. There were moments of lucidity when I would commit to the notion of seeking professional help; yet, my impulse was often short-lived, and I changed my mind several hours later. I always seemed to find a reason not to reach out for help. I began intellectualizing my experience, using books and internet resources to better understand my symptoms or to self-diagnose. The combination of denial, stigma, and fear was powerful. It made me numb and prevented me from accessing mental health services for many, many years.

After years of evasion, I started to talk and, most importantly, to listen to others. Through talking and listening, I began to understand that my mental illness was not my fault and that it did not make me a failure. I came to terms with the fact that mental illness was rampant on both sides of my family. I also began to open my heart to friends and peers. I had a close friend who was hospitalized several times as a result of his bipolar disorder, and I stood by his side during trying times. Other friends shared their mental health struggles with me or opened up about the mental health adversity of their family members, and I listened carefully and compassionately. I

found immense strength in the realization that I was not alone in my struggle. And the day I realized that I was not alone was the beginning of my path to healing.

But, what kept me silent for so long? While mental health stigma is the knee-jerk, short answer to this question; it is only a partial answer. There was a toxic layer of hegemonic masculinity embedded in my denial. The tough-guy role that I played for years disguised my most vulnerable and authentic self. I was essentially a struggling actor. I was compelled to act strong and okay all of the time. Performing this façade was arduous because pretending that I was okay when I was not was exhausting. If someone found out that I was struggling or vulnerable, I would be perceived as weak, broken, emotionally fragile, unmanly, or feminine; although, I soon came to the realization that no amount of learned man-ness could alter my mental health reality.

Instead of toughing it out, I would need to take ownership for my mental health, actively seek out and accept professional help. And, this was not an easy step for a middle child from a family of three boys, in which I was taught by my father and my grandfathers to tough-it-out. Although I was never explicitly told not to cry, it was regularly modelled by the men in my life. I never saw my father cry. I never saw my grandfathers cry. I never once heard them speak openly about their emotions or their feelings. The only afflictive emotion that they ever displayed was anger or irritability. From a very young age, my family, in conjunction with the broader culture of masculinity in the west, taught me to exist within a small, performative box. Within this limiting, tough-guy framework, I was supposed to be stoic, strong, and tough.

With support, I was able to question the hegemonic masculinity of my forefathers and the hyper-gendered norms of western culture. I boldly and defiantly pushed back against the intersection of mental health stigma and hegemonic masculinity in relation to my own

experience with mental health. In order to begin my process of healing, I had to face the all-important question: If I open up about my mental illness, what does that make me? I have realized that the very things that make you vulnerable and human do not make you weak. In fact, the opposite is true. Having opened up to my loved ones and having sought professional help, I am stronger today than I have ever been. Talking openly about my mental health experience with my partner, my family, and my closest friends has proven to be immensely helpful in my healing journey.

A steady dose of counselling, running, optimal nutrition, sleep hygiene, and medication have been key pieces in my ongoing recovery. As well, learning to practice mindfulness has provided me with a toolkit to recognize and filter out my affective triggers. Practising gratitude and positivity and focusing on the things that matter and that are within my sphere of control have also been integral philosophical features in my healing journey. Finding balance in a world of excess is an ongoing juggling act, and it is a process that I will continue to embrace throughout my adult life. Being authentic about my own mental health journey has helped me become a better husband, father, brother, son, friend, and teacher. And for that I am forever grateful.

Sharing my story of mental illness and health, particularly in a research paper, feels vulnerable and uncomfortable. Why is my mental health story important? How is the lived mental health experience of a researcher relevant to a dissertation? What does my story have to do with listening to the reflections of youth with lived mental health experiences? My answer to these important questions is three-fold. First, I shared my mental health experiences because, I, like the 11 youth interviewed in this dissertation, have a mental health story to tell. It is both important and fair to ask of myself what I have asked of the research participants. Second, my

mental health experience has inevitably shaped my research questions and conclusions in this dissertation. Thus, at the very least, clearly acknowledging and stating my positionality as a researcher is integral to transparent, qualitative research. Finally, Keyes (2002) is clear about one thing: We all live with mental health.

Regardless of whether or not one lives with a professional mental health diagnosis, we are all susceptible to languishing mental health. Thus, the mental health of someone living with a mental illness could flourish, while the mental health of someone without a mental health diagnosis could languish. Numerous features constantly influence the mental health experience of all humans. Mental health is a fluid concept and experience for everyone. And, mental health diagnoses aside, there are many sociocultural, personal, familial, and professional features that impact the day-to-day fluidity of our mental health. Ultimately, this dissertation exclusively focuses on the school-based features that impacted the mental health of the interviewed youth during secondary school.

Defining the Problem: The Purpose, Rationale, and Significance of the Study

In Canada, poor mental health is the number one cause of disability (Mental Health Commission of Canada [MHCC], 2014); and, on average, it reduces an individual's life expectancy by 10 to 20 years (Chesney, Goodwin and Fazel, 2014, as cited in Centre for Addiction and Mental Health [CAMH], 2019a). Recent research findings indicate that in Canada, 15% to 20% of youth are living with a mental health disorder, and between 6% and 8% of youth meet the diagnostic criteria for depression (Meldrum, Venn, & Kutcher, 2009). According to Pearson, Janz, and Ali (2013 as cited in CAMH, 2019a), youth between the ages of 15 and 24 years are more likely to experience a mental illness or a substance abuse issue than any other demographic. Additionally, 34% of Ontario high-school students indicate moderate to serious

levels of psychological distress, while 14% of youth report serious levels (Boak et al., 2016 as cited in CAMH, 2019a). More shockingly, under 25% of youth access specialized support for their mental illness (Waddell, McEwan, Shepherd, Offord, & Hua, 2005). These statistics, supported by multiple research studies over time, suggest that the current state of youth mental health is a growing social crisis in Ontario.

Estimates from the Mental Health Commission of Canada (MHCC, 2009) indicate that 70% of mental health problems begin in childhood or adolescence. Children and youth spend a significant amount of time at school, thus underlining the central role that schools must play in offering a supportive and preventative venue for early mental health care. More significantly, the fear of stigma or mental health discrimination prevents many individuals from seeking help and support for their mental health issue (MHCC, 2013).

Additionally, in any given year, 7 million Canadians will encounter a mental health issue, and approximately 4,000 Canadians will die of suicide (CAMH, 2019a). More shockingly, 1 in 2 Canadians will have, or have experienced, a mental illness by the age of 40 years (Smetanin et al. 2011, as cited in CAMH, 2019b). In Canada, suicide is the number one cause of non-accidental death among children and youth between the ages of 10–24 years and accounts for 20% of deaths in this age group (Children’s Mental Health Ontario [CMHO], 2013). Every week approximately 10 children and youth die by suicide in Canada, and roughly three of these deaths occur in Ontario (CMHO, 2013). More significantly, suicide rates are, on average, five or six times higher in First Nations, Metis, and Inuit communities throughout Canada. Furthermore, reports suggest that approximately 10% of intermediate and secondary-school students in Ontario have seriously considered suicide, and approximately 3% have attempted suicide at least once (CMHO, 2013). Finally, despite mental health issues accounting for 10% of all hospital visits in Canada,

provincial mental health services only receive 7% of the total health care budget, which amounts to a \$1.5 billion shortcoming (CAMH, 2019a).

The gravity of these statistical figures cannot be overlooked. Given that mental health is a multifaceted and systemic crisis in Canada, it requires the concerted effort and collaboration of many individuals, organizations, and provinces to drive change. This dissertation contributes to the ever-burgeoning conversation on adolescent mental health in Ontario by explicitly focusing on reclaiming the lived mental health experiences of secondary-school students. The aim of this research is to facilitate the development of youth-driven mental health policies and practices in schoolboards, schools, and classrooms in Ontario moving forward.

This doctoral dissertation is a deliberate act of discursive reclamation. When I designed this study, I purposefully set out to recover the voices of marginalized youth on their lived experiences with mental health in secondary school in Ontario. All too often, the views and experiences of youth are discredited because of ageist assumptions and prejudiced perceptions regarding the phenomenological competence of youth. For youth who experience a mental health issue or live with a mental health diagnosis, rampant ableism adds an additional layer of discrimination to the problem.

Youth with perceived disabilities are often silenced in decisions that directly impact their lives. This research takes explicit issue with the widespread tendency for adults to speak for youth on their mental health experiences. The voices of youth living with a mental health diagnosis should not be left out of the mental health conversation or overshadowed by the commentary of adult professionals. The youth interviewed in this study have insights to share; however, in order for us to learn from their experiences, we need to actively listen to them. Thus,

empowering youth as agents of change in mental health is an important first step toward experiential and discursive emancipation.

The participation of youth in research that directly impacts them is integral to the reclamation process. According to Brown and Rodriguez (2009), “participatory action research (PAR) is grounded in the epistemological belief that authentic understandings of social problems require the knowledge of those directly affected by them” (p. 1). Although this dissertation does not explicitly implement co-investigation processes unique to PAR methodology; it is, nevertheless, committed to PAR’s guiding principles for conducting research with marginalized youth. In a similar vein to Brown and Rodriguez (2009), Freire (2000) asserts that

in problem-posing education, people develop their power to perceive critically the way they exist in the world with which and in which they find themselves; they come to see the world not as a static reality, but as a reality in process and transformation (p. 83).

Thus, my role as researcher is two-fold: First, it is to offer a discursive platform for the voices of youth to be heard on mental health; and, second, it is to serve as a pedagogical facilitator, urging the youth to engage in meaningful, problem-posing, and critical-experiential reflection. Thus, in a Freirean sense, a principal aim of this study is to engage youth critically in a process of dialogue and reflection on those features within their secondary school that impact their mental health. The hope is that empowering youth to become problem-posing agents for mental health will make pedagogical and cultural transformation in Ontario public education possible.

This research assumes a postcolonial posture to reclaim the authentic, lived mental health experiences of marginalized individuals who form the sociocultural fabric of the mental health culture in Ontario secondary schools—students living with a mental health diagnosis or experiencing a mental health issue. The central problem underpinning this dissertation grows out of the lack of phenomenological expertise historically afforded to youth on the topic of student mental health in Ontario. The intersection of longstanding asylum-driven hierarchies with the contemporary medicalization and proliferation of mental disorders has endowed psychiatrists and psychologists with discursive mental health dominance (Conrad & Slodden, 2013; Foucault, 1963, 1988; Foucault, Lagrange, Burchell, & Davidson, 2008). The medical model's subsequent epistemological dominance within the educational system shapes adult- and teacher-led mental health practices and interventions within Ontario secondary schools and, more specifically, classrooms.

One major conceptual shortcoming of the medical model of mental health is its tendency to permanently situate an individual's mental health experience within the person, downplaying the many cultural, environmental, and discursive factors that, as Keyes (2002) argues, contribute to mental health challenges. Alternatively, social and critical models of mental health consider an expansive array of factors that impact one's mental health (Beresford, 2002; Coppock & Hopton, 2002). More importantly, critical and social theories of mental health value the unique voices and perspectives of youth, which are at the heart of this dissertation. These inclusive models also offer space and expertise for those living with mental health challenges to speak openly about their mental health and the impact of their life experiences and contexts.

Within critical and social frameworks of mental health, individuals living with a mental health illness, issue, diagnosis, or disability reclaim experiential credibility and competence.

Despite the many supportive merits of the mainstreaming of conversations on mental health and emotional well-being in school boards, schools, and classrooms in recent years, the question remains: Whose voices are included on the topic of mental health in the Ontario public education system? More specifically, what are the features in schools that impact the mental health of youth, as identified and described by the impacted youth?

Current mental health institutions, policies, curriculum, and best practices in education in Ontario overwhelmingly rely on the expertise and perspectives of psychiatric, psychological, medical, and health professionals and researchers and often downplay, or completely negate, the valuable input of youth with lived mental health experience (e.g., Centre for Addiction and Mental Health, 2012a,c; Healthy Minds Canada, n.d.; LivingWorks, 2014a,b; MHCC, 2009, 2012, 2013, 2014; Ministry of Children, Community, and Social Services, 2010–15a,b; Ontario Ministry of Education [OME], 2005, 2013a,b, 2019).

The Ontario Student Drug Use and Health Survey (OSDUHS), which started in 1977, is a province-wide, research-driven exception to my above assertion (See: CAMH, 2012b).

According to CAMH (2012b), OSDUHS “provides current and reliable information about the health risk behaviours, attitudes, and beliefs of Ontario adolescents; and it tracks changes over time” (p. 1). Of noteworthy importance, the OSDUHS surveys thousands of students in more than 200 schools across the province every 2 years, and the sample is said to be representative of all Grade 7–12 students in Ontario public schools (CAMH, 2012b).

Similar to the attitudes, beliefs, and behaviours of high-school-aged students in Ontario, which were accessed through OSDUHS on a wide variety of health topics (e.g., bullying, mental health, and drug use); the in-depth and experiential reflections of the 11 youth in this study, on school-based mental health impacts and their systemic recommendations for change, are also

essential. Both quantitative and qualitative research approaches can inform ministries; school boards; school administrators; and, most importantly, frontline teachers and support staff of the divergent perspectives, complex needs, individualized stories and personal histories underpinning the diversity of student mental health impacts and needs in Ontario's secondary schools. Whereas the guiding research questions of OSDUHS preference sample breadth, focusing on large-scale and long-term epidemiological trends, this qualitative study's research questions prioritize depth, zooming-in on a limited number of individual contexts and school cultures, ultimately, offering potential explanations for some of the province-wide results of the OSDUHS.

By no means does this dissertation argue that the individual student experiences and the emergent qualitative themes in this study be re-situated as mental health *Truths*. Nor, is the aim of this dissertation to erase the supportive value of existing diagnostic models, supports, practices, and educational strategies espoused by the long-established and well-evidenced traditions of psychiatry and psychology. This dissertation does, however, critically assert that the exercise of listening to and including the lived mental health experiences of youth is extremely valuable. The unique, ground-up perspective that this dissertation offers can contribute to a more inclusive and participatory approach to mental health in Ontario; that is to say, metaphorically, that both the microphone and the stage ought to be shared equitably by all stakeholders of youth mental health in Ontario.

Throughout this qualitative study, I adopt a transformative and phenomenological research posture. It is transformative, in a Freirean sense, and sets out to recover the sidelined expertise of an oppressed, minority community: Secondary-school students in Ontario living with a mental health issue or diagnosis. It is phenomenological because the sole methodological

aim of this study is to make sense of individual human experiences through a reflective lens. This dissertation offers a unique epistemic contribution to the existing body of inclusive mental-health research in education, which is detailed in the literature review in Chapter Three. The Ontario Ministry of Education (OME) has launched a macro-level policy shift toward best mental-health practices in classrooms and schools in Ontario over the past decade (2005, 2013a,b, 2019); however, the degree to which this province-wide dissemination of mental health literacy frameworks in education is an inclusive, critical, and effective solution requires further exploration.

The findings from this study have the potential to further inform mental health policy and best practices in Ontario and comparable educational contexts beyond. The experiential reflections of the interviewed youth offer insights for rethinking educational policy, the professional roles of administrators and teachers, and teaching practices. This dissertation problematizes the discursive qualities of the current mental-health literacy discourse in Ontario: Who is speaking? Whose voices are being heard? And, what role does institutional power play in (re)shaping the mainstream mental health conversation in education? While this dissertation calls into question the supremacy of the psychological-psychiatric worldview in education, by no means does it cast aside the validity of this worldview. Rather, it argues for the emergence of other ways of interpreting, understanding, and listening to experiences of mental health.

Conceptual assumptions cannot be avoided and should always be stated candidly and transparently. As such, this dissertation asserts three key epistemological and ontological assumptions about the former secondary-school-student participants living with a mental-health diagnosis. First, it presupposes that there are features within the secondary school climate that adversely impact the mental health of youth. Second, it assumes that the former students need

their voices to be heard. Finally, it assumes that the former students have insightful contributions to the research problem. These assumptions are steeped in the anti-oppressive pedagogy of Freire (2000) and the postmodern critiques of the 18th-century asylum in France by Foucault (1988).

While these conceptual assumptions underpin the rationale of this dissertation, a fourth assumption underlies my understanding of youth mental health: Each and every student has individual and complex mental health needs, regardless of whether they have a professional diagnosis or not. The idea that all students find themselves in motion on a mental health continuum, and many students live with an undiagnosed mental health issue, reflects Keyes' (2002) dual-continuum model of mental health, which informs the conceptualization of mental health in this dissertation. I discuss each of the assumptions and the theoretical frameworks from which they are drawn below.

Situating the Research: Contemporary Mental Health Policy

The contemporary, mental-health policy context underpinning this study is imperative to understanding its significance within the broader sociocultural landscape in Ontario and Canada. In the absence of context, a study's historical positionality and research contribution are at risk of lifelessness, incoherence, and seeming ambiguity. However, in the interest of introductory concision, I have deliberately situated the mental-health policy overview—on the principal governmental and non-governmental mental health directives, frameworks, goals, and policy initiatives in Ontario, Canada, and even globally—in the first section of the literature review in Chapter Two. The discussion funnels-down, moving from a brief snapshot of the federal, to the provincial, and finally to the current educational context in Ontario. As the sub-heading suggests, the policies overviewed are contemporary, reaching back approximately 10 years.

Discussion of the Theories Relevant to the Study

In this study, I draw theoretical and conceptual inspiration from the works of Michel Foucault (1988), Paulo Freire (2000), and Corey Keyes (2002). More specifically, I dovetail Foucault's discourse analysis and Freire's *conscientization* to develop an empowering and historically-informed theoretical lens to frame the experiential reflections of the youth participants. I turn to Corey Keyes' (2002) dual-continuum model of mental health to develop a critical, inclusive, and emancipatory conceptualization of mental health, thus providing terminological clarity to the study.

I begin outlining the theoretical framework by discussing the historical and critical relevance of Michel Foucault's (1988) well-known work, *Madness and Civilization*. In this book, Foucault (1988) introduces readers to the notion of the *medical gaze* and explores how the advent of the psychiatric institution, the white coat, and the doctor-patient relationship reinforced the subjugation of those perceived as mentally ill. In his historical assessment of the institutionalization of the "mad," Foucault (1988) focuses on a discontinuity in the treatment/understanding of those regarded as mad in 18th century France and England.

Foucault (1988) analyzes both Philippe Pinel's and Samuel Tuke's 18th century asylums and notices that their particular modes of treatment marked a noticeable shift from the historical physical oppression of the mad to a particular kind of mental oppression. The shift that Foucault (1988) identifies is also credited as the advent of the institution of psychiatry, since it was at this time that observable disorders became documented and categorized for the first time, particularly in Pinel's asylum in Paris. Both Tuke's and Pinel's asylums espoused a particular moral revolution; that is, mad individuals were no longer physically brutalized in their assumed animality but were instead treated as morally inferior subjects, with the potential for moral

transformation. The subjectification process was not a physical affair but was a psychological process, which led to the overall abasement of the psychiatric patient.

Foucault (1988) focuses a great deal on Pinel's asylum and outlines the three features that define the subjectification of the madman: "1. Silence; 2. Recognition by Mirror; and 3. Perpetual Judgment" (pp. 260–262). In Pinel's asylum, silence was absolute; the "madman" was ignored and made to feel as though he did not exist. However, prior to the 18th century, the madman was given relentless physical attention, in the form of chains, whips, and many other violent acts cast in his direction. Recognition by mirror was used to show the madman that he was no less mad than all of the other patients in the asylum. At first, he was heralded and exalted as the legitimate figure of his delusion, superior to all of the other madmen in the institution; but soon after, he was morally abased and made to perceive himself as objectively mad (Foucault, 1988). According to Foucault (1988), "He is now pitilessly observed by himself. And, in the silence of those who represent reason, and who have done nothing but hold up the perilous mirror, he recognizes himself as objectively mad" (p. 264).

The final stage of the subjectification process was perpetual judgment. The perpetual use of silence and mirrors created a situation whereby the madman was increasingly summoned to judge himself. Whether by "an angry eye, a thundering tone of voice, a group of staff armed with strong chains that they shook noisily", the madman was perpetually judged by others in the institution, and this fear and anxiety led to his own self-regulation and subjectification (Foucault, 1988, p. 265). The madman's alienation was further exaggerated by the introduction of the medical personage, a figure of power who used objective scientific truths to control and abase the patient. According to Foucault (1988),

These powers...took root in the madman's minority status, in the insanity of his person, not of his mind. If the medical personage could isolate madness, it was not because he knew it, but because he mastered it; and what for positivism would be an image of objectivity was only the other side of his domination. (p. 272)

Foucault (1988) further argues that Sigmund Freud abolished this process at the turn of the 20th century but maintained the primacy of the medical personage. While the process used to subjectify the madman in the asylum no longer operates to the same degree within the current mental health education framework, there still exist remnants of this moral conversion. Whereas Foucault identified the shift from physical to mental oppression of the mad in the 18th century, in my view, the 20th century brought forth a subtler shift from mental oppression to a distinctively positivist, bureaucratic, and systemic form of oppression of the mentally ill person.

The observable dominance of institutional psychiatry, as a science devoted to defining, judging, and charting the discourse of mental health education in western culture, must be deconstructed if we value the importance of equality as it relates to mental health. By refusing to question the fundamental assumptions underpinning the practices of psychiatry and psychology; the construction of *Diagnostic Statistical Manuals*; and the dissemination of pathology-centred, uniquely western narratives of health, we continue to consent to the ontology of a system that alienates the mentally ill *other*. My dissertation draws on Foucault's ideas to help facilitate this theoretical interrogation and deconstruction of the mentally ill subject.

The relationship between Foucauldian discourse analysis and Freire's theory of conscientization (2000) is not necessarily an obvious one. Dovetailing these theories provides

historical context, on the one hand, and participatory emancipation, on the other. While Foucault (1988) urges us to remain critically cognizant of the historical debasement of those with mental health disabilities, Freire (2000) encourages the creation of participatory and transformative communities of educational praxis—reflection and action.

The ultimate aim of establishing a Freirian community of dialogue, action, reflection, and transformation is to facilitate the creation of a bottom-up, thematic exchange of ideas and experiences to foster greater critical consciousness and awareness for the members of the oppressed group; in this case, secondary-school students living with a mental health issue or illness. Foucault and Freire fit nicely together for this very reason. Foucault (1963, 1990, 1977, 1988; Foucault, et al., 2008) is committed to the historical and theoretical documentation of dehumanizing realities, while Freire (2000) is concerned with the transformation of dehumanizing realities. For Freire, the experiential emancipation of vulnerable social groups—from historically-promulgated *limit-situations* (i.e., situations that historically restricted freedom) through *praxis* (i.e., the linking of reflection and action)—is the essence and *raison-d'être* of dialogue.

Freire's theory of conscientization, as detailed in the *Pedagogy of the Oppressed* (2000), is central to the aims of this doctoral dissertation. For Freire (2000), it is essential for those who have been denied the right to voice, to reclaim their right to be heard. It is precisely the exercise of dialogue, which empowers individuals or groups in oppressed social situations, that liberates them from, and even beyond, limit-situations. True Freirian dialogue, however, must embody the correct spirit. It must possess a constructive essence of love, humility, and a genuine commitment to the betterment of the dehumanized group or person (p. 91).

Dialogue, for Freire (2000), is not a domineering person or entity speaking for the interests of others; rather, it is a hopeful, creative, critical, trustworthy, collaborative, and, ultimately, a transformative and interactive process. Dialogue is about reclaiming voices, interests, and humanity; specific, unique, and individual people narrating their own truths (Freire, 2000, pp. 96–97). According to Freire, “the investigation of what I have termed the people’s ‘thematic universe’—the complex of their ‘generative themes’—inaugurates the dialogue of education as the practice of freedom.” Reflective dialogue as the practice of freedom is precisely what this dissertation process hopes to accomplish in listening to the lived mental health experiences of secondary-school students in Ontario.

As Freire (2000) contends, human beings operate in a milieu of dialogical interaction, shifting between the awareness of their own limits and the recognition of their potential for liberation and freedom within a given reality (pp. 103, 109, 113). Hope, confidence, and thematic investigation drive Freire’s (2000) critical methodology of *conscientizacao*, or conscientization. The basis of Freire’s generative methodology is to explore people’s thinking about, and action toward, their oppressive reality. Thus, at its root, conscientization is about making a deliberate shift toward both self and situational awareness for the purpose of social and political emancipation.

This dissertation, principally subscribes to the theory of conscientization underpinning Freire’s methodology; however, it does not intend to imitate his well-charted, methodological trajectory, step-by-step. Freire (2000), for example, emphasizes the use of codifications, in the form of photos or sketches, to aid with the facilitation of critical group discussion. Visuals were not a tactic employed in this study; nor was there a focus group component to the research, although a focus group would be interesting to explore in future research. Similar to Freire,

however, a situational issue—the sociocultural features in secondary school impacting youth mental health—were identified and represented in a set of semi-structured interview questions to garner critical reflection and collaborative engagement from the youth participants. A final question sought critical recommendations from the youth on policy and program improvement within schools.

The overall purpose and character of this research was open-ended, exploratory, and participant informed. By drawing on both the critical-historical aspects of Foucault's depiction of the maltreatment of the mentally ill, and the transformative and voice-amplifying aims of Freire's conscientization (2000), this dissertation aims to balance critical reflection and social emancipation.

Conceptualizing mental health.

The third conceptual framework that unpins this dissertation is Corey Keyes' (2002) conceptualization of mental health as a continuum-based experience. The overall significance of Keyes (2002) work is that he is concerned with building bridges and conversations across theoretical and research traditions. A clear example of this is Keyes' (2002) statement that “mental illness and mental health are highly correlated but belong to separate continua, and therefore the prevention and treatment of mental illnesses will not necessarily result in more mentally healthy individuals” (p. 220).

Keyes is far more concerned with exploring the supportive value of psychological, social, and emotional factors for the whole person, regardless of a diagnosis, in attaining and maintaining a high degree of self-perceived well-being, positive mental health, and everyday functionality. Furthermore, Keyes (2005) argues that mental health is more than simply the absence of psychopathology and introduces measures for individuals to self-report on their

mental health or subjective well-being within clinical settings (p. 539). Keyes' (2002, 2005) ongoing assessment of the life features that promote positive mental health, ultimately, underlines the assumption of fluidity underpinning Keyes' conceptualization of mental health and well-being. Overall, Keyes' short- and long-form questionnaires have been shown to be statistically valid and reliable measurement instruments, internationally, and have contributed to a number of statistically significant correlations across studies and cultural contexts (e.g., Joshanloo, Wissing, Khumalo, & Lamers, 2013; Keyes, Dhingra, & Simoes, 2010; Peter, Roberts, & Dengate, 2011; Petrillo, Capone, Caso, & Keyes, 2015).

Keyes (2002) nuances mental health by making the key conceptual distinction that while someone may be living with a mental health diagnosis, they may also be experiencing positive and flourishing mental health as a result of an appropriate balance of individual, psychological, social, and emotional support factors in their daily lives. Conversely, Keyes (2002) asserts that someone may not be living with a mental health diagnosis but may be experiencing languishing mental health or mental illness due to the presence of unsupportive, individual, psychological, sociocultural, and emotional features in their lives.

The horizontal continuum—low level of mental illness to high level of mental illness—intersects with the vertical continuum—low mental health (languishing) and high mental health (flourishing). There is no fixed end-point to the dual continua Keyes espouses (2002, p. 210); however, his use of the notions “complete” mental health to describe flourishing with a high degree of well-being and “incomplete” mental health as languishing with a low degree of well-being are certainly contentious from a critical disability and postmodern perspective. Nevertheless, Keyes (2002) “introduces and applies an operationalization of mental health as a

syndrome of positive feelings and positive functioning in life. Dimensions and scales of subjective well-being are reviewed and conceived of as mental health symptoms” (p. 207).

So, what are the features in one’s life that may cause “flourishing” or “languishing” mental health or “low” level or “high” levels of mental illness? More specifically, in the context of this dissertation’s central research question: What youth-identified, secondary-school features contributed to languishing or flourishing mental health among the youth participants? Ultimately, all of the youth-identified, mental health impacts throughout secondary school can be explained through the intersecting, Keyes-inspired continua of languishing and flourishing mental health and low and high mental illness.

Just as it was crucial for me to share my researcher positionality and lived experiences with mental health when introducing this study, it is also integral for me to state clearly my conceptualization of mental health. Similar to Keyes (2002), mental health is very much a fluid concept for me. My understanding of mental health has inevitably been informed by the pervasiveness of the psychiatric-psychological model of disorder; however, my own critical leanings, shaped by my personal and familial experiences and educational privilege, have forced me to question the psychiatric-psychological notions of mental health and disability. Inspired by the canonical theorists, Michel Foucault and Paulo Freire, I view mental health/illness as a medical-psychiatric-psychological construct that only exists as a particular set of culturally-specific, socially-constructed, relational truths, which have been historically promulgated by functions of institutional power, wealth, expertise, and bureaucratic mechanisms of social control.

The order/disorder, normal/abnormal, ill/well dichotomies inherent to psychiatric and psychological diagnostic models ignore, or at best underemphasize, the fluid nature of

consciousness and the impermanent nature of being and health. Moreover, I feel that the institutional practices of psychiatry and psychology are especially precarious when one considers their propensity to exist and operate as grand, sovereign narratives governing the falsely dichotomous constructs of sanity and insanity. Psychiatric observation and labelling have oppressive effects when one acknowledges the subsequent treatment of, and the lack of belonging felt by, those who have been systemically othered because of a behavioural deviation from a mental health norm within western culture.

Furthermore, it is simply insufficient to euphemize mental health discrimination in the seemingly blameless and disempowering umbrella category of “stigma.” However, like racism, sexism, homophobia, classism, and ableism and the intersections of these various forms of discrimination, systemic oppression toward individuals who identify with a particular mental health identity—or are perceived to occupy the sociocultural space attributed to a particular socially-reified psychiatric identity stigma—should instead be framed and understood for that which it is, mental health discrimination (Holley, Stromwall, & Bashor, 2012). Thus, the emergence of *mental healthism* as a useful conceptual term to capture oppression or discrimination emanating from one’s mental health identity or experience is long overdue.

In concluding this section, it is important to reiterate that mental health, like disability, is a social and historical construct. Mental health is not conceptually consistent across cultures; it varies considerably across social class, race, ability, age, sexual orientation, and gender identity. Furthermore, the medicalization of the mental health concept within the educational system in Ontario underemphasizes, and even ignores, the voices, stories, and lived experiences of the youth who are directly impacted by educational policy decisions on youth mental health.

Overview of the Chapters

In Chapter Two: Review of the Relevant Literature, a detailed literature review is presented. Four literature themes are explored. By highlighting some of the key research contributions within the literature themes, I clearly carve out this dissertation's unique contribution within the greater educational landscape. The themes are: 1. Contemporary youth mental health policy; 2. Discrimination and sociocultural determinants of mental health, 3. Experiences with bullying: Incidence rates, impacts, and interventions; and, finally, 4. Reclaiming (secondary school) student voices on mental health.

In Chapter Three: Research Methodology, I explain the methodological steps taken in this qualitative study, highlighting the qualitative design and data collection methods, the ethical considerations, and the data interpretation and analysis processes. I also provide a brief biographical and contextual overview of each of the study's 11 participants.

In Chapter Four: A Culture of Silence, I present and discuss the emergent qualitative themes in the data. I discuss the overall impact of mental health stigma on youth within secondary schools in Ontario. This chapter explores the distinctly silent nature of the mental health culture within secondary schools. Although there has been a noticeable shift in mental health dialogue, policy, colloquial chatter, and popular culture in recent years, most of the youth admitted to feeling as though they were limited or constricted in terms of what they could safely disclose about their mental health to peers and teachers in their secondary school. A number of participants described feeling judged or ashamed because of their mental health experience or diagnosis, thus leading to an uncomfortable, isolating, and stigmatizing silence for many of the youth.

A gendered analysis is also presented in the second portion of this chapter, explicitly discussing the differences between male and female participants, most notably the differences in disclosure between them. A key revelation in this chapter is the adoption of mental health acting by many of the youth, particularly the female participants. Participants admitted that it was far easier to act okay than it was to face the potential discriminatory ramifications of disclosing their mental health status or experience. Ultimately, this chapter explores the mental health impacts of witnessing or experiencing, firsthand, the hurtful symptoms of mental health stigma. A key finding in this chapter is that mental health stigma played a role in delaying or preventing the youth from accessing mental health support. The impact of mental health stigma on participant sentiments of trust and safety while at school is also a significant piece in understanding the culture of mental health silence in secondary schools in Ontario.

In Chapter Five: The Mental Health Impacts of Teachers: (Un)Supportive Approaches and Practices, I embark on an analytical discussion of the impact of teacher-student relationships. This chapter provides an overview an overarching divergence in the findings. On the one hand, many of the youth distinguished between supportive and unsupportive educational approaches and teaching and assessment practices. Supportive approaches and practices were typically accommodating academically, emotionally, and mentally. They were flexible and responsive to the emerging needs of their students. So-called “supportive” teachers’ set up their classrooms preventively and adopted inclusive assessment practices and best-teaching practices. They were engaging, understanding, and possessed a number of humanizing qualities. Moreover, their approaches to order and discipline were described as less strict and more laid-back.

On the other hand, unsupportive teachers were far more authoritarian in nature. Their teaching and assessment practices lacked instructional differentiation and their behavioural

approaches lacked planning and understanding and were often reactionary and punitive. Nevertheless, it was very apparent from the youth reflections that merely having one or two understanding and supportive teachers could have made an immensely positive impact on the mental health of youth in secondary school.

In Chapter Six: Peer Mental Health Impacts: Bullying, Friendship, and Peer-Support Groups, the discussion on the value of school-based relationships continues; but, instead, it focuses exclusively on the mental health impacts of peers. While witnessing bullying, or experiencing it firsthand, was identified over and over as having a negative, interpersonal mental health impact on the youth participants, not all of the peer interactions were bleak. In fact, peer support, in the form of friendship or school-based, peer-support groups, proved to be highly supportive and impactful features in the youths' secondary-school environment. Thus, the second portion of this chapter presents a case study of one particular peer-support group in a Hamilton-region high school. The supportive value and transformative impact of school-based, peer-support groups for mental health was repeatedly raised by the three youth participants who attended this secondary school. Further research into which types of peer-support groups work best in which setting is worth pursuing in order to better understand the varied utility of peer-support models for mental health in schools.

Finally, in the conclusion of this dissertation, I provide an overview of the study's most significant findings from Chapters Four, Five, and Six. The research limitations of this study are addressed in this chapter, along with the study's overall niche and contribution to research on youth mental health in Ontario's secondary schools. Finally, several areas for future research directions are presented in the context of this dissertation's novel, qualitative findings.

I now turn to Chapter Two and thematically situate the scope, the aims, and the findings of my study alongside comparable research programs. Contextualizing my study within the broader educational landscape helps me better situate this study's theoretical, empirical, and methodological contributions to the existing field of literature.

Chapter Two: Review of the Relevant Literature

This comprehensive literature review covers a number of interrelated topics that are explored, either directly or indirectly, in this doctoral dissertation. The four literature themes that I have generated are organized into topics most relevant to the study's central research questions. Some of the themes are explicitly related to the research questions, while others are meant to give context and positionality to the research. The four themes that organize this literature review include: 1. Contemporary (youth) mental health policy; 2. Experiences with discrimination and sociocultural determinants of mental health; 3. Bullying and peer relationships; and, finally, 4. Reclaiming (secondary school) student voices on mental health.

Contemporary Youth Mental Health Policy

While there is an overt absence of youth voices within traditional policy doctrines on mental health, I begin with an overview of recent mental health policy changes in Ontario for two main reasons: First, I draw critical attention to the lack of youth voices within public policy literature and governmental decision-making on youth mental health. Second, in the simplest sense, policy provides historical and political context to the study. Therefore, policy serves as both a frame of reference and as a starting point.

Over the past decade in Ontario, there have been a number of noteworthy mental health policy developments, which have directly impacted youth. To begin, in 2011, the Government of Ontario, under the Liberal Party leadership of Dalton McGuinty, ushered in a provincial mental health action plan. The policy initiative, *Open Minds, Healthy Minds: Ontario's Comprehensive Health and Addictions Strategy*, included four long-term aims, which were in-line with the MHCC's strategic aims: First, it sought to improve mental health care and well-being for

everyone in Ontario; second, it vowed to improve Ontario's communities by making them healthier, more resilient, and inclusive; third, it set out to identify mental health and addiction issues for early intervention; and finally, it sought to establish a quality mental-health-care system that is efficient, integrated, and individual-directed (Government of Ontario, 2011).

The aims of the first phase of Ontario's mental health policy platform between 2011 and 2014, specifically targeted mental health care and services for children and youth (Government of Ontario, 2011). The concerted focus on children and youth grew out of recent research in Canada that suggests that approximately one in five children and youth qualify for a mental health diagnosis, while less than a quarter access services for early intervention and treatment (Lemstra, Neudorf, D'Arcy, Kunst, Warren, & Bennett, 2008; MHCC, 2012).

Given the severity of the child and youth mental health context in Ontario, the first phase set out to establish speedier access to services for children and youth; to improve current processes and methods for early identification and support for children and youth; and, finally, to underline the explicit governmental focus on children and youth and, particularly, the need to support the unique needs of vulnerable children and youth (Ministry of Children, Community, and Social Services [MCCSS], 2010–15a). The outcome of the strategic focus on children and youth mental health care was that more than 50,000 children received early intervention and follow-up care for their mental and emotional health needs throughout phase one of the provincial strategy (MCCSS, 2010–15a).

The second, 3-year phase of the *Open Minds, Healthy Minds* policy platform in Ontario was launched by the Government of Ontario in 2014, under the Liberal premiership of Kathleen Wynne. Phase two saw a policy focus shift from children and youth toward the transition of services into adulthood (Ministry of Health and Long-Term Care [MHLTC], 2014). The

principle aims of the second wave of *Ontario's Comprehensive Health and Addictions Strategy* comprised the following: First, the allocation of \$2.75 million to ameliorate the wait times and access issues within several priority mental health facilities throughout Ontario; second, in-line with the provincial poverty-reduction strategy, the allocation of \$16 million for the development of 1,000 more supportive-housing units; third, an increase in institutional capacity for supporting youth with eating disorders through the creation of a 12-bed paediatric treatment wing at Ontario Shores; and, finally, the engineering of a funding model, under the direction of Susan Pigott and the Mental Health and Addictions Advisory Council, in order to improve mental health outcomes, quality, and access issues in Ontario (MHLTC, 2014).

In conjunction with the *Open Minds, Healthy Minds* policy initiative, Ontario launched its first ever, province-wide, youth suicide prevention plan in 2013. *The Ontario Youth Suicide Prevention Plan* (OYSPP), was established based on specific recommendations of Children's Mental Health Ontario (CMHO, 2013; MCCSS, 2010–15b). The comprehensive plan seeks to address the high rates of suicide among children and youth in Ontario, particularly the soaring rates in First Nation and Inuit populations throughout Ontario (MCCSS, 2010–15b).

According to the Canadian Mental Health Association (CMHA; 2013), OYSPP has four overarching goals: First, to mobilize knowledge and capacity across the province by training the most relevant support figures, such as teachers, guidance counsellors, and nurses; second, to support the development of a Community Mobilization Guide to compile the most relevant, evidence-informed practices for youth suicide prevention; third, to increase financial support for best practices to prevent youth suicide; and, finally, to provide better evidence-informed support to aboriginal communities, so that they can develop their own suicide prevention strategies. The success of OYSPP hinges on the collaborative efforts of all relevant stakeholders. It is essential

that governmental organizations, school boards, and community organizations work together to build stronger networks to facilitate province-wide, system-level change.

The provincial mental health policy action plans were mirrored by school boards, community organizations, and professional mental health stakeholders. The Toronto District School Board (TDSB), for example, released its 4-year strategic plan for children and youth mental health and emotional well-being in 2014. The TDSB strategy (2014), entitled, *Healthy Schools, Healthy Relationships: Children and Youth Mental Health and Well-Being* presented five strategic commitments to improve student mental health and bolster academic achievement. First, all staff received specialized training on mental health; second, each and every school established a mental health team composed of students and staff; third, there was a 50% increase in the number of secondary schools participating in anti-stigma initiatives by the end of the 2014 school year; fourth, the TDSB deepened their current mental health partnerships in the community in order to better meet the evolving wellness needs of staff and students; and finally, schools bolstered efforts to engage and communicate more effectively and consistently with parents.

The TDSB is the largest and most diverse public school board in the province and is, thus, an ideal yardstick for measuring school-level changes in mental health policy in Ontario. All other publicly-funded school boards in Ontario have developed similar mental health policy platforms, indicating a recent province-wide, school-level prioritization of child, youth, and educator mental health within frontline, educational venues. The OME has also disseminated two notable policy documents on mental health in recent years.

The key OME policy document in support of inclusion in schools, called *Learning for All: A Guide to Effective Assessment and Instruction for All Students, Kindergarten to Grade 12*,

was released in 2013 and provides practical strategies for Ontario's educators to best implement inclusive and equitable instructional and assessment practices in their classrooms for all students, including students with complex mental health needs (OME, 2013a). By encouraging the implementation of evidence-informed, educational practices, such as universal design and differentiated instruction, the aim and hope is that all students in Ontario can thrive at school. Recognizing that all students have a unique, diverse, and complex set of individualized needs, including mental health needs, is an inclusive and preventive starting point for teachers when designing their classrooms, supporting the mental and emotional health of their students, as well as instructing and assessing students with unique learning styles and cognitive needs.

The second, most important OME policy document issued on student mental health in recent years is entitled, *Supporting Minds: An Educator's Guide to Promoting Mental Health and Well-Being* (2013b). The primary aim of this policy document is to support student mental health in the classroom and school in order to remove or, at the very least, reduce mental-health-driven barriers and gaps in student learning and achievement. This document provides practical strategies for educators to best support the most vulnerable students in their classrooms. *Supporting Minds* (OME, 2013b) was an OME response to the province's *Open Minds, Healthy Minds* (MHLTC, 2014), which urgently called for a province-wide prioritizing of child and youth mental health services across ministries. While the system-wide platform provided educators with classroom-based strategies and interventions to support student mental health, it was also explicit about the professional limitations of teachers. According to *Supporting Minds* (OME, 2013b),

While educators cannot and should not attempt to diagnose mental health problems, they have an important role in promoting positive mental health at school; identifying students who may have mental health problems; and connecting those students with appropriate services (p. 6).

The significance of *Supporting Minds* (OME, 2013b) is that it clearly stipulates that teachers are not to assume any kind of specialized or diagnostic mental health role; but that, nevertheless, they must play a crucial preventive, supportive, and mobilizing role in insulating students with complex mental health needs. This newly defined role for teachers serves to complement and bolster the creation of safe, accepting, and inclusive learning environments for all students, as set out in *Learning For All* (OME, 2013a). Ultimately, the ministry-level, board-level, and school-level policy changes in the area of mental health over the past decade are clear: Supporting student mental health is a primary concern in Ontario's schools. Thus, these ministry-level policy shifts in student mental health signal a clear prioritization of the inextricable link between student mental health and student success.

The discursive mainstreaming of mental health within governmental and educational venues in the past 10 years has undoubtedly signalled a paradigm shift in the policy prioritization of mental health. However, given the adult leadership in the ever-growing child and youth mental health crisis in Ontario, the question remains: Where are the diverse voices of youth in these governmental, ministry, and school board policies and action plans? Furthermore, what are Ontario's youth saying about their mental health, and where are their voices in the youth mental health policy development process?

Experiences With Discrimination and Sociocultural Determinants of Mental Health

While the policies outlined above conceptually stripped mental health of its culturally-specific determinants, influences, and impacts, this section reclaims the sociocultural nuances and experiential analyses missing in the policy overview. To begin, discrimination can manifest in many traditional and non-traditional forms. It can take place in a range of social venues, whether person-to-person or in groups, and in a multiplicity of interactive or virtual settings. Of essence, though, is that discrimination can lead to devastating mental and emotional health consequences for the individuals or groups, directly or indirectly, affected by it. As the literature reviewed below suggests, certain groups are more vulnerable to the effects of discrimination for a number of social, historical, and systemic reasons. The reasons are innumerable, and the effects are far-reaching. Given that discrimination tends to affect certain sociocultural groups more than others, it follows that one's association with a particular demographic identity may loosely serve as a social predictor for the likelihood of developing mental health issues.

Research suggests that mental health and discrimination intersect in a number of demographic groupings, including race, gender, age, sexual orientation, disability, and socioeconomic status. For example, Mays and Cochran (2001) demonstrate that self-identified members of lesbian, gay, and bisexual communities experience higher rates of both lived discrimination and perceived discrimination, placing them at a greater risk of developing stress-rooted psychiatric disorders. In a similar vein, Diaz, Ayala, Bein, Henne, and Marin (2001) delve into the consequences of homophobia among gay and bisexual Latino men in New York, Miami, and Los Angeles. Similar to Mays and Cochran's (2001) study findings, Diaz et al. (2001) reveal that as a result of negative social experiences with homophobia, the participating Latino men had higher rates of mental and emotional distress, alongside a deflated sense of self.

Finally, Newcomb and Mustanski's (2010) review study, on the link between internalized homophobia and the development of mental health issues among lesbian, gay, and bisexual individuals, found that there was a stronger link to depression than anxiety in the studies under review; and the link to developing anxiety and depression was more pronounced with age. Within the US school context, Fisher et al. (2008) discuss the increased risk of academic, social, and emotional difficulties among LGBT students. According to Fisher et al. (2008) schools in the US are simply not doing enough to support the mental health of this minority group and, thus, propose the implementation of a public health framework, with multi-level interventions, to educate about and further prevent LGBT discrimination in schools.

From a critical race theory (CRT) perspective, Williams and Williams-Morris (2000) posit three reasons why exposure to racism by African Americans contributes to poor mental health outcomes among these racialized minorities in the US. To begin, racism toward members of the black community impacts their socioeconomic status in the form of unequal access to resources and sub-standard living conditions, which may compromise their mental health. Second, experiences of racism necessarily impact one's physical and psychological well-being and, thus, makes these individuals more susceptible to mental health issues. Third, the widespread negative stereotypes associated with being a member of the African American community can also lead to negative self-perceptions and, therefore, impact one's self-esteem and mental health.

McGee and Stovall (2015) also use CRT to nuance the discussion on the mental health impacts of racial trauma on African American college students. In particular, McGee and Stovall (2015) draw attention to the tendency for the mental health concerns of black students in college and university campuses to be downplayed or ignored altogether because of the mythical

dominance of racialized concepts, such as grit and resilience. The authors cite Geronimus (1991) and draw attention to the experience of “weathering,” which they describe as “a phenomenon characterized by the long-term physical, mental, emotional, and psychological effects of racism and living in a society characterized by white dominance and privilege” (McGee & Stovall, 2015, p. 491). Furthermore, McGee and Stovall (2015) introduce the readers to Smith’s (2006) “racial battle fatigue” framework, which the authors describe as “the response to trauma and stress symptoms often manifested as anger, escapism, withdrawal, frustration, and avoidance” (p. 500).

McGee and Stovall (2015) argue that the experiences of black students in American college and university campuses are largely defined by perpetual battles against racial stereotypes. Black students’ inevitable and repeated exposure to racism and discrimination, even in its subtlest forms, “can lead to detrimental psychological and physiological stress” (McGee & Stovall, 2015, p. 500). Thus, McGee and Stovall (2015) underline the crucial need to analyze the intersection of race, discrimination, and mental health outcomes within traditionally white institutions (i.e., American colleges and universities) where the existence of racial bias is too often denied. Furthermore, McGee and Stovall (2015) call for more research into how the experience of racism and discrimination contributes to mental fatigue, mental distress, and mental illness among black youth.

Solorzano, Ceja, and Yosso (2000) echo the CRT framework espoused by McGee and Stovall (2015) and define microaggressions as “subtle insults (verbal, non-verbal, and/or visual) directed toward people of colour, often automatically or unconsciously” (p. 60). The mental health impacts of microaggressions on people of colour require more research attention. The subtle nature of microaggressions often prevents them from being challenged. More education on

the various forms of microaggressions is needed in all educational settings moving forward. The University of Minnesota Office of Equity and Diversity (n.d.) created useful table, adapted from the foundational work of Sue et al. (2007), to outline the most common themes underpinning microaggressions toward marginalized populations.

The racialized themes underpinning the most common microaggressions are as follows: Alien in our own land, ascription of intelligence, colour blindness, assumption of criminality, denial of individual racism, myth of meritocracy, pathologizing cultural values or communication styles, second class citizens, environmental microaggressions, and how to offend without really trying. Ultimately, considering the concepts of weathering, racial battle fatigue, and microaggressions, it is clear that people of colour experience a disproportionate amount of social and environmental mental health impacts. Thus, more research into the implications of this disproportion is needed in order to better understand the intersection of one's experience with marginalization and subsequent mental health outcomes.

In addition to sexual orientation and race, one's socioeconomic context can also adversely impact one's mental health outcomes. In Canada, individuals living in low-income households are three to four times more likely to report poor or fair mental health (Mawani & Gilmour, 2006; as cited in CAMH, 2019a). Additionally, between 23% and 67% of the homeless population in Canadian cities report living with a mental illness (Canadian Institute for Health Information, 2007, as cited in CAMH, 2019a). According to McLeod and Shanahan (1996), the mental health and emotional well-being of children in poverty is consistently poorer than children in middle- or upper-income households. These findings correspond with Belle's study (1990) close to three decades ago, underlining the inextricable link between the experience of poverty and the development of sub-par mental health outcomes trending in contemporary

psychological literature. Belle's study, focuses specifically on the issue of poverty among women and children, since demographic data in the US, at the time, revealed that women and children were the two most disadvantaged socioeconomic groups. The disproportionate socioeconomic disadvantage among women and children may be explained by a plethora of deep-seated sociocultural, systemic, and historical trends in the trajectory of inequity within western contexts; however, such explanations offer no reprieve.

To reiterate the links between poverty and mental health, Meltzer, Harrington, Goodman, and Jenkins' (2001) ground-breaking British study shows that a significant number of socioeconomic factors in the lives of children, between the ages of 5 and 10 years, contributed to an increase in self-harm or suicidal attempts among the children and adolescents surveyed. Meltzer et al.'s (2001) nation-wide research indicates that the prevalence of self-harm and suicidal attempts among British children and adolescents is greater in single-parent families than in other family models, in single-child families compared to families with 3 or more children, in lower-income brackets than in higher-income brackets, in families who either rented or were in state-subsidized housing versus families who owned and occupied their homes, and in families who resided in apartments or maisonettes versus families who resided in detached or semi-detached homes. The significance of this research is reflected in the stark outcomes. The complex link between poverty and sub-par mental health across a variety of socioeconomic measures should be a matter of grave concern for governments and policy makers moving forward.

In addition to the disproportionate negative mental health outcomes among non-heterosexual individuals, racialized people, women and children, and people living in poverty, is the glaring over-representation of negative mental health outcomes among members of First

Nations' communities in Canada. As Kirmayer, Brass, and Tait (2000) argue, the significantly higher rates of depression, suicidality, substance abuse, and violence among Canadian First Nations' communities are deeply-rooted in longstanding, oppressive colonial and neo-colonial practices, as well as the assimilation inherent in all forms of cultural genocide. Kirmayer et al. (2000) also argue that the most detrimental mental health outcomes within First Nations' communities are found among youth, which, again, makes the link to adolescent vulnerability found in other literature.

Mignone and O'Neil (2005) chart-out the relationship between social capital and the risk factors for suicide among First Nations' youth and argue that social capital—defined as the quality of meaningful interactions in the form of networks, relationships, resources, and trust—can have a profound effect on the overall mental health outcomes within a First Nations community context. Mignone and O'Neil's research speaks volumes to governments and policymakers alike, calling for a context-sensitive, culturally-informed, and community-based approach to solving the mental health crisis within many of Canada's First Nations' communities.

Wilson (2003) engages in a fascinating discussion on the therapeutic value of land for First Nations peoples in her culturally-nuanced exploration of the healing potential of land for members of an Anishinabek (Ojibway and Odawa) community in northern Ontario. Wilson and Rosenberg (2002) also point toward the importance of culturally-sensitive policy responses to the mental health crisis within First Nations' communities in Canada, calling for further research into the relationship between First Nations peoples attachment to their culture and the determinants of health.

There are also strong links among mental health, addiction, and homelessness. According to Jayatunge (2013), both mental health and addiction have a bidirectional effect on homelessness in Canada. Gaetz, Donaldson, Richter, and Gulliver (2013), contend that while there are many different reasons why people become homeless in Canada, particular groups and individuals are statistically more vulnerable than others. Single adult males, youth between the ages of 16 and 24 years, First Nations people, individuals who identify as LGBT, women, and single-parent families are more likely to become homeless than other sub-populations.

Although less adult women are homeless than adult men, special attention should be paid to the circumstances of female homelessness, since the circumstances in which they become homeless, and their experiences with homelessness, frequently involve backstories of violence or abuse (Gaetz et al., 2013). The significance of discussing the bidirectional links between mental health, addiction, and homelessness is that it draws attention to the social complexities, nuances, and inextricable links between these interrelated sociocultural issues. It is simply unviable to discuss any of these issues in isolation, without, at the very least, addressing the intricate interrelationships among them.

Individuals living with intellectual disabilities have also been shown to be at a greater risk of developing mental health issues. In Cooper, Smiley, Morrison, Williamson, and Allan's (2007) large-scale British study, 40.9% of those living with an intellectual disability were also living with a clinical mental health diagnosis. Echoing Cooper et al.'s (2007) research, in the Canadian context, Lunskey, Garcin, Morin, Cobigo, and Bradley (2007) emphasize the overall lack of mental health supports for children, youth, and adults living with both an intellectual disability and a mental health disability. Unfortunately, the mental health support gaps Lunskey et al. (2007) identify require further attention, since they have not been adequately addressed by the

Canadian government, despite growing awareness of the prevalence of individuals living with both an intellectual and a mental health disability who lack adequate supports.

The age and grade level of students is also a key influence on mental health (Ma, 2007). Ma's (2007) research analysis of a 1998 cross-national survey in Canada on the relationship between middle- and secondary-school students' experiences at school and their personal health outcomes (e.g., physical health, mental health, and self-esteem), revealed significant findings across age and grade levels. Ma (2007) found that the physical health, mental health, and self-esteem of Canadian students consistently declined from Grade 6 to Grade 10. Furthermore, with every grade level, students were more significantly concerned about their body image, particularly females. This supports Pearson, Janz, and Ali's research (cited in CAMH, 2019a), which found that men have disproportionately higher rates of addiction than women, whereas women have disproportionately higher rates of anxiety and mood and eating disorders. That said, what is particularly interesting in Ma's (2007) study is the crucial mental health support role attributed to parents. Ma revealed that the stronger the parent-child relationship and the greater the parents' involvement in the child's school life, the better the child's mental health and self-perceptions.

Conversely, children who experience abuse and neglect are much more likely to develop a mental illness when compared to similar-aged children who grow up in a stable family or non-abusive household (Underwood, 2011). Shockingly, in Ontario, youth in care are 32% more likely to be diagnosed with a mental illness than youth who are not in care or within the child welfare system (Berge, 2007, as cited in Underwood, 2011). Comparatively, Underwood (2011) cites Racusin et al. (2015) to reveal the distressingly disproportionate rates in mental health diagnoses among American children in care: Children in care are 16 times more likely to have a

mental health diagnosis and eight times more likely to be taking psychotropic medication than their peers who are not in care.

Parekh's (2014) recent research on the TDSB reveals disproportionate sentiments of exclusion among students with learning disabilities, students with mild intellectual disabilities, as well as students in individualized educational programs (IEP). Since one's sense of belonging can inevitably impact one's self-esteem, confidence, and organizational citizenship; by extension, sentiments of exclusion will necessarily impact one's overall mental and emotional well-being. Parekh's (2014) study also reveals a significant relationship between students' sentiments of exclusion and their race, sexual orientation, and generational status.

Thompson, Iachen, Overpeck, Ross, and Gross (2006), explore similar issues of belonging and connectedness in schools. Thompson et al. (2006) demonstrate that younger students, female students, students with higher academic performance and extracurricular involvement, students with more friends, students in two-parent families, students who perceived themselves to be physically attractive, and students whose parents were involved in their school lives felt a high degree of connectedness and well-being in their school environment. Parekh's (2014) and Thompson et al.'s (2006) research underlines the significant role that broader sociocultural features play in disproportionately influencing the mental health and success outcomes of particular groups of students.

Shedding light on these research outcomes offers, at the very least, a starting point for concerted critical discussion as to why certain groups are systemically privileged, while others are disadvantaged. Such a discussion is vital to a more complete understanding of how belonging, connectedness, and other social factors impact the mental health and emotional well-being of children and youth in schools. According to Bond et al. (2007), for example, school

belonging and social connectedness are vital determinants of mental health and emotional well-being among students in Australia. Their study revealed that 8th-year students with the greatest self-identified sense of social and school connectedness had the lowest rates of mental health issues, academic underachievement, and substance abuse 2–4 years later, in secondary school.

Keyes' (2002) dual-continuum model of mental health, which was outlined in the introduction, offers tremendous insight into how broader sociocultural and individual factors influence mental health outcomes for all individuals, regardless of whether or not they have a professional diagnosis. Keyes' (2002) dual-continuum model offers insight into the contextual factors that contribute to an individual's flourishing or languishing mental health (vertical axis) or low or high levels of mental illness (horizontal axis), on the perpendicularly intersecting dual continua. Keyes' (2002) psychological research into the features that contribute to languishing and flourishing mental health frames such discussions in a more social, environmental, and holistic way. Keyes' (2002) model of positive psychology, adopted by the CMHA, conceptualizes how mental and emotional well-being can be fostered in social environments by diminishing the sociocultural factors that cause individuals to languish, while simultaneously promoting factors that encourage individuals to flourish.

In the next section, I shift the discussion to focus on the detrimental effects of bullying on the mental health of youth. Similar to discrimination, there is a well-evidenced link between all forms of bullying and languishing mental health outcomes. Although discrimination intersects with bullying, the scope, the diversity, and the frequency of bullying, as well as its relevance for the school-based experiences of youth, necessitates further attention.

Experiences With Bullying: Incidence Rates, Impacts, and Interventions

Statistics on bullying within schools suggest that incidence rates vary significantly from country to country. For example, in Finland 11.3 % of students reported being bullied, compared to 19% in the US and 49.8% in Ireland (Dake, Price, & Telljohann, 2009). Comparatively, in Toronto, Ontario, 49.5 % of middle- and high-school-aged youth admitted to being bullied in online venues (Mishna, Cook, Gadalla, Daciuk, & Solomon, 2010). These differences suggest the importance of considering how and why students report incidences of bullying and what students understand bullying to mean. At the same time, teachers who work with students throughout Canada overwhelmingly identified cyberbullying as the most significant issue youth face today (Canadian Teachers' Federation, 2008; as cited in Canadian Red Cross, n.d.).

The evidence across countries and cultures suggests that youth bullying, whether in a school or an online venue, significantly impacts the mental health and academic success of both elementary- and secondary-school students. The degree to which methodological discrepancies and cultural differences influence statistical incidences of bullying is perhaps worthy of further consideration and discussion. Nevertheless, the experience of bullying, and the subsequent mental health impact, is a theme that transcends state boundaries and is, thus, an important issue.

Implicit in this conversation about bullying is the fundamental belief that social and environmental factors have the real potential to influence the mental and emotional health of individuals, regardless of race, age, gender, sexual orientation, or socioeconomic status, among other demographic indicators. As some of the research below suggests, some demographic groups are, seemingly, more vulnerable to being bullied for a variety of social, systemic, and historical reasons. Nevertheless, bullying can influence and impact anyone, and, subsequently, influence one's mental health and emotional well-being in both the short- and long-term. In

addition, bullying-type behaviours may differ based on gender. Boys are far more likely to engage in physical forms of bullying, such as fighting; while girls are much more likely to engage in less direct forms of bullying, such as online bullying (Wendy & McCuaig Edge, 2008, as cited in Canadian Red Cross, n.d.).

Conversely, as Gristy (2012) argues, healthy peer relationships can have a profound impact on bolstering school attendance and well-being for secondary-school students. Positive peer relationships can provide protection and support, and school leaders often diminish the key role that interpersonal connections play in promoting positive mental health in secondary-school-aged youth (Gristy, 2012). Similarly, in a recent Australian study conducted with over 1,300 secondary-school students, Skrzypiec, Slee, Askell-Williams, and Lawson (2012) demonstrated that the likelihood of students obtaining an abnormal score on a strengths and difficulties questionnaire significantly decreased as the number of good friends increased, especially for victims of bullying. Ultimately, Gristy's (2012) and Skrzypiec's et al. (2012) research is significant because it shifts focus to the positive impacts of healthy peer relationships as opposed to paying attention only to the negative mental and emotional impacts of bullying.

A growing body of research also points toward the role that bullying in childhood and adolescence plays in the development and persistence of mental health disabilities among victims, bullies, and even bystanders (Arseneault, Bowes, and Shakoor, 2010; National Institute of Child Health and Human Development, 2012). For example, in a well-known Finnish study by Kaltiala-Heino, Rimpelä, Rantanen, and Rimpelä (2000), with over 16,000 student participants between the ages of 14 and 16 years, several instrumental findings emerged. First, they determined that both youth who were victims of bullying and youth who bullied others were equally likely to develop depression. More significantly, those who bullied others were more

likely to experience suicidal ideation than those who were bullied. The significance of this large-scale and multi-regional study, is that it underlines the pervasiveness of mental health issues among all youth engaged in or victimized by bullying.

In a related Irish study, Mills, Guerin, Lynch, Daly, and Fitzpatrick (2004) explored the relationship between bullying and the mental health of its victims. The study was conducted with a group of several hundred youth of a similar age range. Mills et al. found that victims of bullying were more likely to develop depression, attempt suicide, and access some form of mental health support services than non-victims. While the former two studies do not explicitly differentiate between the type of bullying experience and the mental health outcomes among the victim and the bully, Hinduja and Patchin (2010) take this conversation one step further by specifically exploring the impact of cyberbullying on 2,000 American middle-school students.

Hinduja and Patchin's (2010) study suggests that both traditional forms of bullying (e.g., physical, verbal, non-verbal, and group bullying) and the more recent technological forms of cyberbullying yield similar detrimental effects on both the bully and the bullied. Their study revealed that suicidal thoughts and attempts were more likely to occur among both self-identified bullies and the bullied when compared to students who did not identify with either experience or identity. Furthermore, contrary to Kaltiala-Heino, et al.'s (2000) study, suicidal thoughts and attempts proved to be more prevalent among youth who were the victims of bullying than in youth who were the bullies.

While there may be a slight variance in the findings on bullying, mental health, and suicidality in youth, factors such as culture, study design and scale, as well as the methods and instruments selected in these studies may offer some explanation for the minor differences. Nevertheless, these studies seem to suggest a shared understanding. Bullying, regardless of one's

role in the power imbalance, impacts the mental health and emotional well-being of youth in a number of serious ways. Finally, as Hinduja and Patchin's (2010) research indicates, the traditional school setting is merely one venue within which bullying may take place. The implications of this research sheds significant light on the expansive nature of cyber venues for youth interaction and, thus, calls for more research on self, peer, and systemic regulation of bullying in non-traditional, online venues.

One well-known way of systemically regulating bullying within the school venue is the widespread implementation of anti-bullying campaigns. Anti-bullying educational practices actively support the mental health and emotional well-being of students and, by extension, teachers. A safe and supportive environment means that all students are included and accepted. In recent years, research into the effectiveness of school-based, anti-bullying interventions has explored the supportive mental health value of implementing various anti-bullying interventions in schools. Ttofi and Farrington (2011), for example, embarked on a systematic review and evaluation of close to 50 anti-bullying interventions in schools. They found that bullying and victimization decreased by an average of 20% following the implementation of most programs. Furthermore, Ttofi and Farrington (2011) show that the most successful anti-bullying programs were more intensive and enduring, involved parents, and were supported by strict consequences and increased supervision.

In a similar review research on the links between anti-bullying interventions and incidences of bullying, Vreeman and Carroll (2007) found comparable results. Vreeman and Carroll (2007) show that seven out of 10 studies that focused on whole-school, anti-bullying interventions revealed a noteworthy decrease in bullying-type behaviours and incidences. Vreeman and Carroll's (2007) review also indicates an overall decrease in bullying by increasing

the number of social workers within schools. Contrary to the findings of Ttofi and Farrington (2011) and Vreeman and Carroll (2007), Ferguson, San Miguel, Kilburn, and Sanchez (2007) found practically no significant reduction in bullying and victimization following anti-bullying interventions in their meta-analytic review study. Ferguson et al. (2007), however, imply that there are modest reductions in bullying when programs specifically target at-risk youth. Along similar lines, Merrell, Gueldner, Ross, and Isava's (2008) meta-analytic review of 16 anti-bullying intervention studies, undertaken between 1980 and 2004, indicates that while some anti-bullying interventions produce modest reductions in bullying behaviours, the interventions may, in fact, have much more impact on increasing student knowledge and perceptions of bullying than on diminishing incidences of bullying.

Despite discrepancies in the findings of various systematic review studies, there remains an implicit hope within much of the literature that anti-bullying programs have the potential to transform schools and classrooms into safe, positive, and supportive environments for students; thereby, enhancing the learning, social interaction, and well-being of all students. Fekkes, Pijpers, and Verloove-Vanhorick's (2005) study in the Netherlands underlines the key role that maintaining multiple lines of communication between parents, teachers, students, and health professionals plays in facilitating, supporting, and reinforcing an anti-bullying culture within classrooms and schools. Furthermore, Fekkes et al. (2005) reiterate the central role that teachers must play in a whole-school approach to anti-bullying by disseminating whole-school/classroom programs, presenting anti-bullying lessons, and playing an active communicative role on the consequences of bullying-type behaviour.

Swearer, Espelage, Vaillancourt, and Hymel (2010) also echo the importance of a three-pronged, whole-school approach to anti-bullying education, underlining individual, peer, and

whole class/school considerations when thinking about the various types and levels of intervention. In a similar vein, Dake et al. (2009) summarize the key factors that underpin a multifaceted, whole-school, anti-bullying approach, including, but not limited to, bullying risk assessments; bullying awareness conferences and training for students and teachers; student-led bullying prevention teams; increased staff supervision; regular parent-teacher conferences; consistent school/classroom rules; school/classroom education on bullying types, impacts, prevention strategies, and resources; as well as meetings to debrief with bullies, victims, and their parents.

Crothers, Kolbert, and Barker (2006) have been instrumental in capturing the voices of middle-school students on various anti-bullying interventions. Their study shows that students preferred proactive anti-bullying strategies that were teacher-led, namely effective classroom management and immediate support in response to bullying reports. Among the least popular anti-bullying strategies for students were programs or supports implemented by non-teaching personnel (Crothers et al., 2006). Student reflections on anti-bullying interventions are valuable to the discussion of best anti-bullying practices, since listening closely to youth voices is integral to improving classroom programming and interventions.

Ananiadou, Schneider, Smith, and Smith (2004) also discuss how carefully monitoring anti-bullying programs in schools leads to better anti-bullying practices. Ananiadou et al. (2004), found that anti-bullying programs that were regularly evaluated were more likely to contribute to a reduction in bullying behaviours. In a slightly different vein, Olweus and Limber (2010) and Stevens, De Bourdeaudhuij, and Van Oost (2001) discuss the merits of international collaboration and comparative programming for improving and disseminating anti-bullying initiatives. For example, the overarching success of the Olweus bullying prevention program in

Norway (Olweus & Limber, 2010; Stevens et al., 2001) inspired the creation of similar programs in other national contexts, such as the DFE Sheffield anti-bullying project, the anti-bullying intervention in Toronto schools, and the Flemish anti-bullying project. Ultimately, listening to student voices, implementing effective program evaluation, and encouraging comparative programming are all useful pedagogical strategies to ensure that the best possible anti-bullying practices are being implemented within classrooms and schools across countries and cultures.

As for how teachers in Ontario can ensure that they meet the anti-bullying needs of their students, the curricular and equality guidelines established by the OME offer a suitable place to start. The OME provides a clear-cut mandate for teaching about anti-bullying and promoting positive mental health within the recently updated Ontario health and physical education curriculum document (OME, 2019). Anti-bullying, wellness, and mental health education are touched upon at specific grade levels, in an age-appropriate manner. For example, in Grade 3 students are introduced to the brain's stress response, and they discuss external factors that cause stress. Students are also introduced to the features that underpin healthy and supportive relationships and the concept of bullying (OME, 2019). By Grade 7, however, students begin to discuss specific types and impacts of bullying and harassment. They also explore mental health, mental illness, substance abuse, and body image (OME, 2019).

The 2019 version of the Ontario health curriculum is the most up-to-date (OME, 2019). Ford's Progressive Conservative government recently finalized the changes to the previous 2015 version developed under Kathleen Wynn's Liberal government (OME, 2015). Ford's contentious review of the Ontario health curriculum drew a lot of media attention and public criticism over the proposed additions and omissions. For example, Sarah Flicker reflected on the finalized health curriculum revisions under the Ford government stating, "I must say, I'm quite relieved.

Its way better than I thought it was going to be. To me, it doesn't look like a tremendous departure from the 2015 curriculum" (Vomiero, 2019). Conversely, Jen Gilbert expressed her disapproval of the most notable change to the 2019 revised health curriculum in Ontario: The new process in place for parents to withdraw their children from select health lessons and topics (Vomiero, 2019).

Curricular revisions aside, teachers are expected to continue delivering classroom programming that promotes an anti-bullying culture within schools. The fact that anti-bullying and mental health education are enshrined in the Ontario curriculum provides consistency across school, teaching, and regional contexts. Additionally, inclusive policies remain in place outside of the curriculum documents. For example, the OME (2013a) suggests in *Learning for All* that teachers take a leadership role in facilitating groups, such as the Gay-Straight Alliance and other equality and diversity-type clubs. Supportive groups of this kind actively promote initiatives for discrimination-free classrooms and schools.

The final section of this literature review examines the prevalence of student voice in educational research, specifically in relation to experiences with mental health issues, mental illness, mental health disability, and languishing mental health. While this study explores the lived experiences of former secondary-school students in Ontario living with a mental health issue or diagnosis, some of the literature that I survey on student voice and mental health is from schools and youth outside of the Ontario context.

Reclaiming (Secondary School) Student Voices on Mental Health

In surveying the research on student voice, a number of gaps become evident in the literature. Identifying gaps in the literature is essential to carving out the original research contribution of this study. Accessing the lived experiences of secondary-school students living

with an existing mental health issue or illness is the phenomenological gap that this research attempts to address. As highlighted in the theoretical framework in the introductory chapter, this dissertation adopts a clear position on the importance of listening, firsthand, to the school-based, mental health experiences of secondary-school students. For reasons which may include assumptions of participant incompetence, gatekeeping barriers, or assumed expertise in second-hand accounts, students with mental health “disabilities” are too often spoken for by adults in professional and authoritative positions.

The problem with third-person accounts of student experiences is that they misrepresent the individual experience by filtering it through an adult lens, which is removed from, and even disconnected from, the lived experience of youth. Even if a lived experience is carefully observed by teachers, social workers, educational assistants, parents, or administrators, it necessarily involves a second-hand perception, thus distorting the account of the individual with the lived experience. Building on recent patient-centred and client-centred approaches in health and social work settings, my dissertation aims to shed further light on the first-person, school-based experiences of secondary-school students; in particular, the features within the current secondary-school environment in Ontario that impact the day-to-day, mental health of youth.

This section offers a review of the research in three areas: First, it highlights examples of research on student voice in education; second, it provides an overview of existing research on student voice and mental health in secondary schools; and, finally, it focuses specifically on recent research that is closely related to the focus of this doctoral study: The experiential reflections of secondary-school students, living with a mental health issue or diagnosis.

Research on student voice in education is an area that has gained considerable momentum in the past several decades. Lincoln (1995), Giroux (1986), and Orner (1992)

highlight the emergence of literature focused on bringing about school-based changes through liberatory research on student voice in education in North America, Latin America, England, Australia, and France. Giroux (1986), in particular, adopts a critical approach to reanalyzing the absence of student voices in educational reform and practice literature, underlining the role that power and institutional politics play in silencing the bottom-up accounts of students. Conversely, Orner (1992) adopts a feminist, post-structuralist critique of research into student voice in education and argues that the liberating trends within research discourse on student voice need to carefully reconsider the role that researcher positionality, purpose and meaning, and power relationships play in further othering students in research agendas that claim to focus on student voice.

More than a decade later, Fielding (2004) echoes the post-structural critiques of Giroux (1986) and Orner (1992) in drawing further attention to some of the broader methodological issues in conducting voice-giving research with students. Fielding (2004) reignites the issue of speaking of and for others, underlining the need for researchers to speak with and for students within a supportive research dynamic. Furthermore, Fielding (2004) underscores the importance of making students co-researchers in the quest for educational reform and school improvement. Soohoo (1993), provides an early template for students as co-researchers in her work on middle-school students' obstacles in classroom learning.

Cook-Sather (2006) presents a comparable argument when re-centring the discussion of “student voice research” and “students as co-researchers” around three integral concepts: rights, respect, and listening practices. Similarly, Pekrul and Levin (2007) emphasize the importance of listening to the voices of students for the greater purpose of school improvement in the Manitoba school improvement program. Mitra (2006), however, adopts a slightly different approach by

repositioning the emphasis from simply listening to students toward actively facilitating student leadership and engagement in reclaiming student voices. In fact, Mitra (2004) argues that engaging student voices is crucial to youth development because it fosters growth in agency, belonging, and competence in youth.

Finally, Lodge (2005) critiques the longstanding, knee-jerk assumption that listening to the voices of students in school improvement processes is unreflexively valuable, irrespective of context or agenda. Lodge (2005) is by no means anti-student voice; however, similar to Giroux (1986) and Orner (1992), Lodge (2005) calls for a more nuanced approach in researching student voice, emphasizing the value of engaging in dialogue with students in school improvement research as opposed to the notion of simply passively listening to student voices.

What is important to take from the discussion of literature on student voice is that there has been a significant bottom-up emphasis in recent years by scholars and educators. Whether emphasizing student voices on the experience of learning or student voices on broader school improvement or climate issues, the significance of the above research is that it demonstrates that students across cultures have relevant things to say about decisions that affect their learning and well-being in schools; and it is, indeed, important to listen to them, engage with them, and initiate dialogue with them, as well as encourage student leadership to foster student voices. The next portion of this section looks, specifically, at some of the recent literature on student voice and mental health in secondary schools.

In recent years, much has been written on elementary- and secondary-school student voices and mental health. However, a disproportionate amount of the research on student voice focuses on the second-hand voices and perspectives and interpretations of non-students. For example, many voice-oriented studies seeking to better support child and youth mental health in

schools in Canada, the US, the UK, and Australia have been written exclusively from a teacher perspective, largely ignoring the firsthand voices of students (Froese-Germain & Riel, 2012; Graham, Phelps, Maddison, & Fitzgerald, 2011; Reinke, Stormont, Herman, Puri, & Goel, 2011; Roeser, & Midgley, 1997; Rothi, Leavey, & Best, 2008; Walter, Gouze, & Lim, 2006). Other authors, like Sherman (2008), highlight the voices of school administrators and superintendents on child and youth mental health issues in schools; while other authors, such as Rustemier and Shaw (2001), bring in the voices of learning supporters and para-professionals on building a more inclusive, mainstream classroom environment for students with a wide range of intellectual, learning, and mental health disabilities.

Conversely, some research has not disregarded student voice outright but, rather, has blended together the voices of students and teachers. Kidger, Gunnell, Biddle, Campbell, and Donovan (2009) published a mixed-methods study exploring student and staff views of emotional health and well-being in UK schools. Although, this dissertation deals strictly with the reflections of students with a mental health diagnosis; Kidger et al.'s study (2009), nevertheless, provides insight into how to approach school-based conversations about mental with students and staff. Significantly, Kidger et al.'s (2009) findings suggest that both students and staff felt that much more needed to be done at the school and educational policy levels to determine which programs are working in schools so that they can be applied more consistently (Kidger et al., 2009). Smith, Gaffney, and Nairn (2004) undertook a similar study on student and staff perspectives on health rights in secondary schools in New Zealand. Although the focus was not exclusive to mental health, Smith et al.'s (2004) findings underline the need to close the research gap on student voice, particularly listening to and engaging with the perspectives of students with a mental health issue or diagnosis.

In addition to the plethora of research on teacher, administrator, staff and student, and para-professional voices on mental health in schools, there is an emerging and substantial body of literature that seeks to reclaim exclusively the voices of children and youth on mental health at the whole-school level (Coombes, Appleton, Allen, & Yerrell, 2013; Hall, 2010). On the methodological front, authors, such as Awartani, Whitman, and Gordon (2008), are concerned with the development of instruments to capture the voices and perceptions of young people on student mental health, particularly the relationship between various learning contexts and self-reported mental health. Awartani et al. (2008) developed the Voice of Children methodological tool to better capture the data emerging from youth focus groups on mental health.

From a slightly different perspective, authors like Kalafat (2003) and MacLean, Sweeting, and Hunt (2010) access the voices of young people to determine the factors that influence help-seeking for mental health issues, since school-based personnel have been identified as one of the last groups that youth would approach for mental health support. Furthermore, Kalafat (2003) emphasizes the inextricable link between academic achievement and positive student mental health: Students experiencing mental health issues have significantly lower academic outcomes than students without mental health issues. Kalafat's (2003) study in the US focuses exclusively on adolescents; whereas, MacLean et al. (2010) focus more broadly on children and adolescents in Scotland, offering a gender and age analysis of help-seeking trends in mental health. According to MacLean et al. (2010), boys and young adolescents were less likely to seek help for their mental health for a variety of gendered, stereotyped, and normalizing beliefs that cause misinformation about mental health.

From a critical discipline perspective, Michail (2012) and Scelso (2013) afford voice to students who have been suspended in Australia and the US, respectively, making the point that

zero-tolerance and out-of-school suspensions for school-based misconduct did little to correct and rehabilitate negative behaviour and, instead, led to further exclusion, academic underachievement, and a streamlined gateway into the youth criminal justice system. While mental health was not dealt with explicitly in these studies, there is an assumed link between student mental health and suspension-type misconduct. Finally, Mandel and Qazilbash (2005) sought to access the voices of secondary-school students on school-based health centres in Boston. Mandel and Qazilbash's (2005) development of a youth advisory board afforded student representatives with an opportunity for input on school-based health centres that service youth, signalling a decisive move away from the medical model of care toward a collaborative and participatory model of school-based health, which emphasizes patient and student voices.

As for contemporary research on the voices of secondary-school students living with a mental health issue or diagnosis, there is substantial research across various national and cultural contexts. It is important to note, however, that the specific nature, scope, and terminology of the studies vary considerably. More importantly, the research spans multiple academic disciplines and research methodologies, and the most recent efforts are geared toward designing collaborative projects across disciplines.

To begin, similar to this study's approach, Irwin, Evans, and Andrews (2007), Jamieson (2006), and Arnold (2007) employ narrative inquiry to better understand the lived experience of a single youth living with bipolar disorder, an eating disorder, and social anxiety disorder, respectively. While the single-story method comes with a host of methodological critiques, stemming primarily from the phenomenological dangers of ascribing additional meaning to a single story; it, nevertheless, provides a venue for youth to voice their experiences with mental health disabilities in school and beyond.

Other studies, such as Giallo, Gavidia-Payne, Minett, and Kapoor (2012), underline the value of including the voices of the siblings of youth with disabilities on mental health. In a slightly different light, Palmer, Heyne, Montie, and Abery (2011) emphasize the importance of including the voices of friends and families of young people with disabilities. While neither of these studies focuses explicitly on a particular disability, nor are they conducted within a school context, they reiterate the point that young people with disabilities are often spoken for by support and professional figures in their lives. While there remains value in second-hand accounts, the voices of caregivers should not overshadow the first-person accounts of lived experiences in schools.

On the intersection of race and disability, Bacon, Jackson, and Young (2005) address the issue of race in reclaiming the voices of African American boys with behavioural disorders in elementary and middle schools in the US. Bacon et al.'s (2005) focus groups reveal that the boys felt judged by students and staff because of their mental health, race, and behavioural reputation. Additionally, the boys emphasized the important role caring teachers played in supporting and preventing them from stepping out of line. In a similar intersectional light, Clarke, Boorman, and Nind (2011) address the issue of reclaiming gender in educational research on student voices and mental health, thus making a strong case for participatory research projects.

Similar to Bacon et al.'s (2005) repositioning of race, Clarke et al. (2011) confront the issue of gender and underrepresentation in student voice research by accessing the voices of teenage girls with social, behavioural, and emotional issues in English secondary schools. Several of the themes that emerged from Clarke et al.'s (2011) interviews underline widespread sentiments of disenfranchisement. Bacon et al.'s (2005) and Clarke et al.'s (2011) repositioning of race and gender at the forefront of mental health discussions is at the core of a more culturally

responsive approach to mental health support in schools. Clauss-Ehlers, Serpell, and Weist (2013) have spearheaded recent research on the importance of developing culturally-responsive schools to deal with burgeoning mental health needs.

A number of studies are more closely connected to the research trajectory of this doctoral dissertation. Although none of the current research explicitly deals with the unique focus of this doctoral study, several studies touch on various aspects of this dissertation's purpose and design. For example, Zigmond (2006) conducted interviews with secondary-school students with emotional and behavioural disorders, 3, 6, 12, 18, and 24 months after exiting alternative high schools. This doctoral dissertation performs a similar, reflective exercise with students living with a mental health issue or diagnosis; however, it focuses on students from mainstream schools. As well, this doctoral study is not exclusive to emotional and behavioural disorders.

Other authors, such as Byrnes and Rickards (2011) and Keefe, Moore, and Duff (2006), reiterate the value of listening to the voices of students with disabilities to inform educational practice. Keefe et al.'s (2006) comprehensive book repositions young men and women with disabilities as the experts of their own educational experiences, shedding light on a wide range of youth experiences with special education classes, teacher strategies and interactions, components of positive and inclusive classrooms, peer relationships, and personal challenges and successes. This dissertation adopts a similar approach to Keefe et al.'s (2006); but, it focuses exclusively on the school-based, mental health reflections of youth living with a mental health issue or diagnosis.

Employing a more collaborative-type design, Lind (2007) conducted research with adolescents as co-researchers, together with teachers and nurses, in order to promote mental health in an alternative Canadian secondary school. Drawing special attention to the value of all

student voices for improving learning in schools is at the core of DeFur and Korinek's (2010) research. What is significant in DeFur and Korinek (2010), however, is their deliberate attempt to access both rural and suburban student perspectives, an approach to accessibility that is deliberately embedded in the design of this doctoral dissertation. Finally, an emancipatory review study, conducted by Cefai and Cooper (2010) in Malta, analyzed the findings of five studies, which gave voice to secondary-school students with emotional, social and behavioural issues about their experiences in the classroom and at school. Two major themes emerged from Cefai and Cooper's (2010) study: First, the secondary-school students frequently alluded to negative rapport with teachers; and, second, the secondary-school students felt victimized, oppressed, powerless, excluded, disconnected, and stigmatized in their schools.

This section has shown that a substantial amount of research has been conducted around the niche of this study, but not explicitly within it. Unfortunately, very little has been done to access the reflections of former students with a diversity of mental health issues or diagnoses on their lived experiences in mainstream, public secondary schools in Ontario. As this literature review demonstrates, the studies surveyed above differ in a number of ways: First, they sample a broader or narrower demographic, either focusing explicitly on emotional and behavioural disorders, for example, or more broadly on all types of disabilities; second, they were conducted in different national, cultural, or school contexts; and, finally, most were conducted with adolescent, school-based participants as opposed to recently-graduated/exited youth participants.

This dissertation's decision to access recently-graduated/exited secondary-school students through a community organization, instead of current secondary-school students, is based on the assumption that it affords the participants with a greater sense of reflective autonomy and security when crafting their responses. By having the students reflect on their

experiences beyond the institutional, ethical, and gatekeeping influences of public school boards; it can be argued that their answers are, potentially, more authentic.

Recent studies in Ontario have emphasized closely related, but far from identical, research questions to the one's posed in this study. For example, Faulkner, Adlaf, Irving, Allison, and Dwyer (2009) draw on data from the Ontario Student Drug Use and Health Survey to explore the degree to which student experiences with school connectedness impacted the mental health of over 2,000 Ontario youth analyzed in the research. Similar to this doctoral dissertation, the authors explore questions about which sociocultural features impact the mental health of secondary-school aged youth in an Ontario context, although they focus exclusively on one's sense of school connectedness and experience of belonging. Dissimilar to this dissertation, this study looks at the experience of all youth, regardless of a mental health diagnosis, since all youth live with fluid and socioculturally-informed mental health. The findings of Faulkner et al. (2009) underline divergent experiences of social belonging and well-being across gender, self-perceptions of academic and health status, extra-curricular involvement and frequency of physical activity. Specifically, Faulkner et al. (2009) found that females who reported low grades, poor health, insufficient daily physical activity, and low extra-curricular involvement were disconnected from their school environment and most at-risk of sub-par mental health outcomes. While this dissertation also noted school-based differences in mental health impacts across gender, it dissimilarly broadened the analysis of school-based mental health impacts to include features other than school connectedness and belonging and tentatively presented gendered differences in school-based stigma, which should be explored further in a larger sample.

Whitley, Smith and Vaillancourt (2012) explore similar research questions concerning those school-based features impacting the mental health of youth in Ontario. While this dissertation takes an explicitly youth-centered focus, Whitley et al. (2012) also include the impacts of teacher-identified mental health literacy gaps, in addition to youth-identified, school-based mental health impacts. Similar to the youth-driven findings of this dissertation, Whitley et al. (2012) argue that professional gaps in teacher training significantly impact the mental health of youth in schools. Since Ontario teachers feel largely ill-equipped to competently and confidently support the mental health of their students, Whitley et al. (2012) argue for more specialized mental health literacy training for teachers and a more concerted focus on anti-bullying interventions. Furthermore, Whitley et al. (2012) contend that school-based bullying, in particular non-physical forms of relational bullying, has devastating mental health impacts on school-aged youth in Ontario. Whitley's et al. (2012) findings echo the qualitative accounts of the youth participants in this dissertation on the importance of more seriously addressing the mental health impacts of bullying in schools. The authors also underline the insulating value of supportive, school-based, peer relationships. Whitley's et al. (2012) recent call for more concerted mental health literacy and anti-bullying training for teachers, extends the traditional role of the teacher beyond purely academic concerns to include the importance of buffering the psychosocial impacts on youth. Interestingly, the recommendations of the Ottawa-based authors reflect the four-pronged, youth recommendations espoused in further detail in this dissertation's conclusion: 1. Building Capacity, 2. Building Literacy; 3. Building Awareness; and 4. Building Connections.

In a slightly different way, Duncan, Boyle, Abelson, and Waddell (2018) explore the drastic mental health service gaps for youth in Ontario and recommend developing more

effective measurement systems to predict and support the mental health of school-aged youth. While this dissertation explores different sociocultural questions, it, nevertheless, argues that the methodological decision to interview youth with a mental health diagnosis about their mental health experiences in high school is a potentially small-scale, qualitative measurement tool for filling the school-based, informational and service void that Duncan et al. (2018) identify. I argue that the benefits of the in-depth, phenomenological case analyses presented in this dissertation are many, especially when one considers the youth-driven nature of the sociocultural findings and the professional recommendations for Ontario schools.

Finally, the closest Canadian study to the aims of this dissertation is the recent ethnographic work of Jenkins, Johnson, Bungay, Kothari, and Saewyc (2015) in the community of Lakeview, British Columbia. Similar to the primary question of this dissertation, the author's focus on those sociocultural factors contributing to emotional distress in youth in the small, northern community of Lakeview. Twenty-seven youth participants between the ages of thirteen and eighteen were interviewed from the local secondary school and alternative school to explore community-based mental health impacts. The sample was diverse and included the perspectives of First Nations and non-First Nations youth. It also reported a proportionate gender split. The main findings of Jenkins et al. (2015) highlight an overwhelming experience of community, interpersonal, and individual disconnection for the interviewed youth. The authors noted that the experience of racialization amongst First Nations youth, the prevalence of fractured families, as well as the broader community impacts of ageism, economic segregation, and substance abuse issues contributed to overwhelming sentiments of emotional distress for many of the youth.

While Jenkins et al. (2015) explore almost identical questions to this dissertation, there are a number of subtle differences between the two studies. First, this dissertation focuses

explicitly on sociocultural factors impacting the mental health of youth *within* the school context, and does not consider the broader community context in the same way as Jenkins et al. (2015); although, it would be interesting to employ a community-based approach in future Ontario research with similar questions. Secondly, this dissertation interviews Ontario youth who have recently exited secondary school, emphasizing experiential reflection-type research as opposed to interviewing northern British Columbia youth *currently in* secondary school. Third, dissimilar to this dissertation, Jenkins et al. (2015) include the voices of youth with or without a mental health diagnosis, arguing that the term emotional distress is inclusive of all youth, since one's experience with mental health is both fluid and significantly informed by community and broader cultural factors. Fourth, Jenkin's et al. (2015) adoption of the term *emotional distress* was not employed in this dissertation, but it is, nevertheless, a fascinating terminological choice. Rather, this dissertation uses the broader concept of *mental health impacts*, since it accounts for both supportive and non-supportive cultural features impacting the mental health of youth, as opposed to only focusing on those emotionally distressing factors. Despite the slight differences in design and approach, Jenkins et al. (2015) and this dissertation are recent Canadian studies that are well-paired, since they both take a unique, emancipatory, critical and qualitative approach to understanding the broader sociocultural factors contributing to emotional distress or languishing mental health outcomes in Canadian youth at school and within the broader community context.

In concluding this literature review, this dissertation builds on existing research on the related topics of youth voice, and mental health voice in education to contribute to the current body of knowledge in the field of inclusive mental health education. This qualitative research platform is bottom-up, collaborative, transformative, emancipatory, and youth-centred. The

study's design and findings are unique in the province of Ontario and within Canada, more broadly. Furthermore, province-wide accessibility and urban-rural and regional accessibility considerations make this study's contribution even more novel.

I now turn to Chapter Three: Research Methodology to detail the research design, the data collection and analysis methods employed, as well as the ethical considerations addressed in this study.

Chapter Three: Research Methodology

This chapter clearly outlines the methodological theory, the data collection methods, the ethical considerations, and the data analysis techniques in the overall design and implementation of this doctoral study. I have divided this chapter into five sequential sections: First, I explore the methodological theories that underpin my research agenda; second, I explain the data collection methods employed and the rationale for selecting them; third, I present several practical and ethical considerations addressed in the implementation of the study; fourth, I explain and justify my approach to the data analysis; and, finally, I conclude the chapter with a brief demographic summary of the 11 youth research participants.

Before delving into the five sections of this chapter, I feel it is necessary to re-state the two central research questions I explore in this study. First, according to former secondary-school students with a mental health diagnosis in Ontario, what features of their secondary-school culture impacted their mental health? Second, as experts of their own experience, in what ways can youth reflections inform best educational practices and policy around mental health in Ontario secondary schools moving forward? The remainder of this chapter is dedicated to explaining the theories and methodological techniques employed in the design, data collection, and data analysis to address the study's central research questions.

Methodological Theory

This qualitative study draws from a range of methodological theories and paradigms to formulate its research approach and overall design. In particular, I rely on three primary frameworks: critical, phenomenological, and narrative theories. This study is also transformative in a Freirean sense because it is participatory. It gives voice to a marginalized social group, i.e.,

former secondary-school students in Ontario living with a mental health diagnosis. According to Freire (2000), “humans...exist in a dialectical relationship between the determination of limits and their own freedom” (p. 99). Thus, when adopting a critical attitude toward what Freire refers to as “limit-situations,” “conscientizacao” or critical consciousness “begins to introduce women and men to a critical form of thinking about their world” (p. 104). Listening to the experiences of youth is not simply about facilitating a personal change for the youth; rather, Freire’s approach emphasizes the potential for ground-up social change. Thus, empowering youth to reflect on their lived experiences opens the possibility for not only personal transformation, but meaningful systemic change.

My aim as a researcher to listen to the in-depth stories of a marginalized and often silenced group in semi-structured interviews makes this research political, social, and change-driven. Finally, the potential for this research to assist a historically oppressed group to transcend the top-down and historically-limiting enterprises of mental health identity (re)construction—in psychiatry and psychology—opens the space for youth living with a mental health issue or a mental illness to speak, firsthand, about their lived experiences in secondary school. Thus, presenting the youth reflections in educational literature and policy spaces provides a platform and venue for their voices to be heard, and even taken seriously, by key decision-makers in the fields of youth mental health and public education in Ontario.

According to phenomenologist Clark Moustakas (1995, as cited in Patton, 2002), researchers typically engage in three common relationships with the researched, “being-in, being-for, or being-with” (p. 8). In the case of this purposive sample, I feel that my relationship with the research participants is best explicated as a “being-for” relationship. According to Moustakas (1995, as cited in Patton, 2002), in this position,

I am listening. I am also offering a position, and that position has an element of being on that person's side, against all others who would minimize, deprecate, or deny this person's right to be and to grow.... I become an advocate of the person with reference to his or her frustrations in dealing with others (p. 8).

“Being-in and being-with” are also key relational positions when undertaking any qualitative inquiry. Being-in and being-with are closely tied to Patton's (2002) discussion of the importance of adopting a position of empathic neutrality as a researcher.

Empathic neutrality urges the researcher to remain open, judgment free, and caring when interacting with the research participants (Patton, 2002, p. 53). It also calls upon the researcher to be reflective, reflexive, and critically aware of one's own social position in order to embrace any discrepancies in feelings, understanding, worldviews, and sociocultural contexts between the researcher and the participants. Being explicit about my sociocultural identity, philosophical orientation, and bias at the outset of this study was essential to ensuring that the data collection and analysis were self-reflexive, and I was open to what the participants had to offer. The uniquely human character of empathic neutrality, as Patton (2002) espouses, is at the ethical core of qualitative research with human participants and is the guiding philosophical principle of this study. For Patton (2015), the practice of empathic neutrality is further connected to the practice of mindfulness:

in qualitative inquiry, when interviewing, mindfulness means that you are completely focused on the interaction with the person or people being

interviewed. Likewise, in observation, your mind becomes immersed in the setting, the situation, and what is happening so that you can be present to see what is unfolding (p. 60).

Researcher reflectivity and reflexivity are also key features of this qualitative inquiry. They are the reason I shared both my positionality and my personal experience with mental health in the introductory chapter. If the reader lacks an understanding of the researcher's cultural context, personal conception of mental health, and individual motivations for embarking on this research project, this dissertation is at risk of a false objectivity that problematically distances the researcher from the phenomena of study. A lack of discursive reflectiveness and researcher reflexivity can have very oppressive consequences in qualitative research, especially when conducting research with marginalized groups.

Now that I have adequately explicated my conceptual position as it relates to mental health, I further detail the methodological orientation of my research. In this research project, I adopt a phenomenological perspective and mode of inquiry. According to Van Manen (2007), "Phenomenology is a project of sober reflection on the lived experience of human existence—sober, in the sense that reflecting on experience must be thoughtful and, as much as possible, free from theoretical, prejudicial, and suppositional intoxications" (p. 11). Thematically sifting through the lived, mental health experiences of the Ontario youth that I interviewed was a highly interpretive and, therefore, subjective exercise for me, the researcher. By employing a phenomenological perspective, I relied heavily on the concept of empathic neutrality when interviewing the participants and interpreting the qualitative, participant accounts.

Throughout this research project, I reflexively and carefully uncover the *how* and *why* behind the youth participants' lived secondary-school experiences with mental health. As well, I explore the overarching questions of *what?* and *so what?* in order to address the broader cultural and mental health implications of the youth participants' school-based experiences. Ultimately, I echo the approach that Patton (2015) espouses, by focusing my attention on "the essence of shared experiences" (p. 117). The phenomenological perspective and method that I employ brings meaning and understanding to the lived experiences of the group under study and to the student mental health culture within Ontario secondary schools.

My "fascination with meaning," as Van Manen (2007) eloquently explains, is the *raison-d'être* of the study's phenomenological qualitative design (p. 12). The cultural picture that I paint in this study's conclusion emerged by combing through hundreds of pages of interview transcripts, which capture hours of in-depth, raw, human conversations. As Van Manen describes:

Not unlike the poet, the phenomenologist directs the gaze toward the regions where meaning originates, wells up, percolates through the porous membranes of past sedimentations—and then infuses us, permeates us, infects us, touches us, stirs us, exercises a formative affect (p. 12).

The thematic conclusions drawn in this dissertation and the meaning made from the commonalities and divergences in participant experiences organically emerged from employing an approach that privileges meaning-making based on the participants' descriptions of their experience. To clarify, this dissertation does not focus on dissecting the structure of the

participants' narratives; rather, it takes the descriptive youth accounts of their secondary-school experience at face value and applies a thematic analysis approach across the 11 participant reflections.

By design, this study's phenomenological analysis privileges depth over breadth. I thematically analyzed, in-depth, a compilation of student reflections before proposing transformative recommendations for improving the youth mental health climate in Ontario's secondary schools. In no way does this thematic analysis claim to have all of the answers to the youth mental health crisis in Ontario secondary schools. This study, nevertheless, offers a refreshing perspective on the broader problem, and it reclaims some of the voices that are absent in the policy decisions implemented by educational institutions. The very act of empowering youth to speak about their lived experiences with mental health is inherently valuable. Furthermore, in Chapter Six, which details the transformative potential of school-based, peer-support groups for mental health, I present a powerful case study analysis of a unique and trail-blazing secondary school in the Hamilton region, especially as it relates to the peer-support groups for mental health.

I now turn to the next section of this chapter to discuss the data collection methods employed in this study and the steps taken to implement these methods in the field.

Data Collection Methods

Throughout this study, I used purposeful sampling techniques when recruiting participants for my qualitative interviews. I networked with the provincial branch of the Canadian Mental Health Association (CMHA) in order to access youth clients living with mental illness. Accessing my participants through a well-established, national organization for the promotion and support of mental health proved to be a less difficult route when considering the

broader ethical and bureaucratic factors that impacted my study's overall feasibility. The red tape surrounding researcher access to students with disabilities within public school boards in Ontario deterred me from attempting to gain access directly through the drawn-out and highly restrictive research approval processes within regional school boards. Instead, I was able to access more efficiently and interview the same youth demographic, outside of their secondary-school environment, about their school-based experiences. The participants were selected because they were "information rich" individuals with regards to the questions being asked (Patton, 2015, p. 46). Thus, my participant selection had nothing to do with where I would interview them; but, rather, what I would interview them about.

Once CMHA Ontario granted me access, I reached out to the 31 regional branches across the province. My hope was that I would be able to access students in various regions throughout the province. The goal of pitching my research to a plethora of branches was not to make regional generalizations from the study data; but, rather, so I could make my research accessible across the province. I thought that it would be worthwhile to provide the same opportunities regardless of where one lives, be it urban/rural, or northern/southern, eastern/central/western. In the end, not all branches responded to my invitation nor approved my research. However, four CMHA branches seemed very interested in the rationale and voice-affording merits of my research. I, then, went through an internal ethics approval process at each of the four CMHA branches: CMHA Hamilton, CMHA Parry Sound-Muskoka, CMHA Peterborough, and CMHA Toronto. Interestingly, through these branches, I was able to access a diverse cross-section of the Ontario population with a northern, a south-western, a Toronto, and a central eastern sample.

Following ethics approval from the various branches, I circulated a recruitment poster across peer support and youth program settings of the participating CMHA branches. In various

cases, internal social workers assisted with the recruitment process and directly connected me to potential interview candidates. The poster briefly explained the study and provided a Survey Monkey link to the initial participant survey. It also detailed the compensation/incentive for participation in the study. I offered each participant a \$50 compensation/incentive for their time—a gift card for a local establishment of their choice. In some cases, it was a gift card for their preferred, local shopping centre, so that they could spend the money at a store of their choice.

In total, I received 13 survey responses from potential participants at the four CMHA branches. I had decided that I would interview all of the respondents, insofar as they met the study's selection criteria. In the end, 11 participants were interviewed. One potential participant did not show up to the scheduled interview, and the 13th potential participant unfortunately responded to the survey after all of the data had been collected and analysis was underway. It was not feasible for me to travel to Peterborough for that interview. A copy of the brief, 15-question survey that I used to recruit the participants through Survey Monkey appears in Appendix A.

All of the youth participants in this study had already successfully graduated from secondary school when the semi-structured, qualitative interviews were conducted. A copy of the semi-structured, qualitative interview guide appears in Appendix B. None of the participants had been out of secondary school for more than 5 years at the time of the interviews, and most participants had been out of secondary school for less than 3 years. A 5-year limit was chosen in order to ensure that participants' experiential recall was relatively recent. As well, it was determined that with a ceiling of 5 years, enough individuals would qualify to participate in the study. Although experiential reflection involves at least some degree of memory distortion or

disconnect between the lived experience and its recall, 5 years was determined to be a reasonable limit of elapsed time for this study. Seven of the 11 participants were enrolled in a post-secondary education institution at the time of the interviews.

Of the 11 interview participants, one participant was from the Toronto region, four participants were from the Peterborough region, four participants were from the Hamilton region, and two participants from were from the Parry Sound-Muskoka region. Eight of 11 the participants identified as female; three identified as male. Three of the participants selectively identified themselves as lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI); and one participant identified himself as “a child of someone who suffers from alcoholism.” None of the participants identified as a member of a visible minority group. Two participants were diagnosed with a mental illness prior to secondary school; six participants were diagnosed during secondary school; and three participants were professionally diagnosed after secondary school, although they had dealt with their mental illness throughout secondary school. One participant began accessing mental health support through CMHA prior to secondary school, six participants accessed CMHA support during secondary school, and four participants accessed support after high school.

This study did not control for any particular mental health diagnosis. There was a diverse representation of diagnoses within the study. Participant diagnoses include, but are not limited to: drug-induced psychosis, generalized anxiety disorder, social anxiety disorder, major depressive disorder, borderline personality disorder, bipolar disorder, post-traumatic stress disorder, obsessive-compulsive disorder, trichotillomania, eating disorder, anorexia nervosa, panic disorder, conversion disorder, addiction/substance abuse, and oppositional defiance

disorder. In the fourth section of this chapter, I provide a more detailed overview of each of the study participants' demographic and mental health-specific information.

Once I had received 12 survey responses and determined that the respondents met my initial inclusion criteria, I began contacting them to set up interviews. For eight of the 11 participants, I travelled to their local CMHA branch to conduct the semi-structured, qualitative interviews face-to-face in a conference room at the branch. Four face-to-face interviews were conducted in Peterborough and four face-to-face interviews were conducted in Hamilton. I was willing and prepared to travel to all localities; however, I made mental health accommodations for the remaining three participants. The two participants from Parry Sound-Muskoka and the participant from Toronto preferred to be interviewed via a telephone. The reason for this accommodation was consistent across all three cases: to reduce interview anxiety. These three participants simply felt more comfortable answering the questions over the telephone. Although I perhaps lost some elements of non-verbal communication in the telephone interviews, such as facial expressions, gestures, and overall body language; I focused on the printed interview transcripts when analyzing all of the interviews, rendering the medium of the interview less relevant.

Each of the 11 interviews varied substantially in length. Some interviews lasted as little as 40 minutes, while other interviews were slightly more than an hour and a half long. It would be incorrect to generalize that the longer interviews were better interviews. In fact, some of the shorter interviews provided more concise and data rich. Regardless of the interview length, I covered the same semi-structured interview guide with each of the participants (See Appendix B). I applied what Patton (2015) refers to as “emergent design flexibility” to probe areas of interest throughout the various interviews. According to Patton (2015), emergent design

flexibility means remaining “open to adapting inquiry as understanding deepens/or situations change. [It also] avoids getting locked into rigid designs that eliminate responsiveness, [and] pursues new paths of discovery as they emerge” (p.46).

The flexibility inherent in a semi-structured interview approach was essential to the research agenda. I wanted to provide opportunities for the youth to influence the direction of the inquiry as opposed to a rigid, inflexible, researcher-driven study. Since I—the adult, privileged, researcher—had developed the semi-structured interview guide, the very least that I could do to offer voice and control over the data collection instrument was to provide built-in, interview flexibility. I soon realized the immense benefits of the casual structure and open-ended questions of my interview guide. It permitted participant-driven topics and areas that I had not necessarily envisioned to emerge naturally. Ultimately it helped me to get much closer to what Seidman (2006) describes as “the root” of in-depth, qualitative interviewing: “an interest in understanding the lived experience of other people and the meaning they make of that experience” (p. 9).

Thus, the semi-structured interview guide permitted the flexibility required to report on the lived experience of the youth participants, while remaining cautious and very much cognizant of my own researcher motivation, bias, and privileged distortions. According to Thompson and Chambers (2012),

research does not occur in a vacuum but is typically driven by an agenda, which may actively seek to guide or change mental health policy. Clearly, in such a situation [...] researchers should be reflexive in relation to considering the role their own ambitions may have on the research process (p. 32).

During the interviews, I was particularly careful of my researcher agenda, motivations, and set of assumptions. Thus, echoing Patton (2015) and Thompson and Chambers (2012), remaining mindful, empathically neutral, and reflexive was especially important when conducting research with a mental health scope.

I addressed additional considerations when I conducted the interviews. I ensured that the interview room was tidy and comfortable, and that the participants knew where the bathroom was. I offered the participants water upon arrival. I also made sure that I was dressed in a relaxed manner. I wore the same clothing to all of my interviews: jeans and a golf shirt and sandals. I did not want the youth to receive the impression that I was an outsider who came to interrogate them with invasive and judgment-laden questions about their experience with mental health.

I spent the first 15 to 20 minutes of each interview reviewing the study ethics protocol and building rapport with the youth. I made sure that they fully understood the nature and goal of the study and the reasons for their qualitative participation. I also underlined the vital importance of their informed and ongoing consent, making sure that they understood that they could withdraw their consent to participate in this research at any point, up until the time of publication. I also wanted the participants to feel comfortable to stop the interview at any point, if they required clarification of a question or the research again. Furthermore, if they felt uncomfortable with any of the questions, they were not required to answer them.

To build a common ground and a positive rapport with the youth, I spent several minutes opening up to the participants about my own positionality as an intermediate teacher within a Grade 7–12 context, a doctoral researcher, a young adult who is not far-removed from secondary school, and an individual with lived mental health experience. Finally, depending on the participant, I engaged in several minutes of casual, non-research related talk to break the ice and

to get to know the participants on a more relaxed and conversational level. This rapport-building time worked wonders to diminish interview anxiety and was integral to the success of all of the interviews.

Next, due to the sensitivity of the mental health topics discussed and the potential for triggering the participants with the emergent personal, familial, and mental health content of the interview, I made sure to go over a crisis plan with each of the participants prior to commencing the interview. I ensured that they had someone to speak with onsite at their CMHA branch, if the need arose. As well, I provided participants with local crisis-line information, in the event that they needed to speak to someone in the days or even weeks following our interview.

Additionally, I was very cognizant that some individuals would find recording devices anxiety-provoking. As such, I made sure that participants were aware that they were being recorded; however, the principal recording device that I used was an old iPhone 6. A back-up recording device was on the chair beside me, and it looked more like an official interview tool. I chose to keep the iPhone on the table because, after all, smart phones are an everyday accessory for the participants' generation. By using a smart phone as the primary recording device, I felt that I diminished some of the interview anxiety for the youth.

Once all of the interviews were complete, I (re)listened to the interview recordings twice and made some informal, thematic notes on emergent trends in the data. I then sent the audio recordings to a transcriber for several months. Upon receiving the transcripts of the 11 interviews, I purchased a large binder and printed out the 15-plus hours of interview data. I organized the binder by participant and, at this point, gave each participant a pseudonym for anonymity and research confidentiality purposes.

Before turning to the data analysis portion of the study, I briefly detail some of the specific ethical considerations that emerged in the study design and data collection phases.

Ethical Considerations

There are a number of ethical considerations that all researchers have to address when conducting qualitative research with human participants, including research with participants living with a mental health issue, illness, or diagnosis. However, Thompson and Chambers (2013) outline a number of specific considerations that should be addressed when conducting qualitative research in mental health fields. The themes covered in their co-authored chapter on ethical issues in qualitative mental health research include: “informed consent and respect for autonomy, confidentiality and privacy, avoiding harm, multiple roles and dual relationships, power, and politics” (pp. 23–24). This work was central to my understanding of how to conduct qualitative research on mental health.

Thompson and Chambers (2013) begin their chapter by making an important point about perceptions of vulnerability and incompetence when working with individuals with “disabilities.” They argue that there are longstanding assumptions on conducting research with individuals with disabilities, that there is an increased risk of vulnerability and incompetence. These sorts of discriminatory assumptions have long barred individuals with disabilities from participating in research programs and decision-making processes, which affect their lives. This research aims to further debunk the commonplace assumptions of incompetence and vulnerability by repositioning students living with a mental health issue, illness, or diagnosis as the experts on their own experiences.

Thompson and Chambers (2013) offer a very important discussion on how to avoid harm in qualitative research. They assert that harm, in the form of emotional distress, is not exclusive

to populations with disabilities. There is a risk of triggering emotional distress in all research with human participants, and it should not always be perceived as a negative experience. I followed this advice and worked hard to build rapport with the participants at the outset of the interviews, as well as to offer opportunities for post-interview support or reflection when necessary. Finally, researchers must use their judgment in determining if an interview should be put on hold or not pursued further (Thompson & Chambers, 2013). In this study, I made various accommodations so that participants were as comfortable as possible during the data collection phase of the research; for example, by offering telephone interviews as opposed to traditional, face-to-face interviews.

Thompson and Chambers (2013) also address the issue of researcher boundaries and the potential of becoming over-involved. Sometimes this occurs if the researcher has a professional or personal role within or is closely affiliated with the research group. Reflecting on my multiple roles, I was particularly careful when considering my insider/outsider location in the study. Insider connections, whether professional or personal, inevitably influence the collection and analysis of data; since prior knowledge, personal opinions, relationships, and power dynamics cannot simply be forgotten or ignored.

I found it particularly useful to reflect on my own positionality within the research agenda and to state openly and honestly who I am personally, professionally, and educationally at the outset of each interview. I made sure that the participants knew that I was an intermediate school teacher, with lived mental health experience, with transformative research aspirations based on my own empirical observations and memories as both a former secondary-school student and a current intermediate teacher and researcher. Ultimately, transparency, communication, reflection,

and informed consent within the research process proved to be ethical and practical safeguards against potential tensions that my diverse relationships with the research agenda posed.

Outsider-ness typically manifests in poor questioning or insensitivity to the needs, views, reflections, and experiences of the participants. While an insider may have access to too much knowledge and context, the outsider is at risk of not having enough. In this study, I straddled both insider and outsider dynamics. I am an outsider to the organization and the participants, since I am not an employee of the community organization, nor am I an affiliate member or community volunteer. My father, however, has worked in one of the provinces' 30-plus CMHA branches for approximately 25 years. Growing up with exposure to various CMHA awareness and fundraising events has afforded me with an appreciation for the work that my father does within the CMHA. Thus, given my lifelong, familial exposure to the organization as a child, teenager, and young adult, the goals and work of at least one CMHA branch are not entirely foreign to me.

I am also, in part, an insider because I bring a teacher's perspective on the secondary-school classroom to the study. I am currently an intermediate school teacher within a secondary-school setting in the Kawartha Pine Ridge District School Board. I have taught a variety of grades and levels and at different schools throughout my 5 years in the profession; therefore, I bring a teacher's perspective and understanding to the study. While my teaching experience provided immense contextual benefit, I was also very careful not to taint the interview context with my teacher assumptions and biases. The ultimate goal of the interviews was the open-ended questioning of former students, which meant allowing them to tell *their* unique stories. The data analysis phase of the study inevitably involved my own thematic organizing, filtering, and

connecting of the data; however, that is very much an unavoidable part of qualitative data analysis.

As for the structure of the questions in the interview guide, I strategically devised open-ended questions to avoid leading the participants to any particular response. Patton (2015) emphasizes the importance of posing open-ended questions, arguing that such questions and skilled interviewing can and do affect the quality and the meaningfulness of participant responses (p. 427). Patton (2015) warns of “the horns of a dichotomy,” arguing that “dichotomous questions can turn an interview into an interrogation or quiz rather than an in-depth conversation” (p. 447). Furthermore, closed, fixed-response, and dichotomous-type interviews are dangerous because, according to Patton, “respondents must fit their experiences and feelings into the researcher’s categories. [As well], the interview may be perceived as impersonal, irrelevant, and mechanistic and can distort what respondents really meant or experienced by [...] limiting their response choice” (p. 438).

There are times, however, when dichotomous questions and detail-oriented probes are appropriate. For example, when checking to see if someone has specific knowledge or experience, or in order to access contextual details of who, where, why, what, how. According to Patton (2015),

skilled interviewing requires distinguishing different kinds of questions—
descriptive questions versus questions that ask for interpretations or judgments.
It means distinguishing both questions and answers that are behavioural,
attitudinal, or knowledge focused. And skilled interviewing involves the art of
listening and really hearing (p. 427).

In carefully reflecting on Patton's (2015) insights, I seldom employed dichotomous questions in the open-ended interviews, other than for content verification. Conversely, I was deliberate in posing authentic, exploratory, and open-ended questions. Ultimately, I favoured two types of qualitative questions throughout the interviews: role-playing/simulation questions and presupposition questions. Role-playing "questions provide a context for what would otherwise be quite difficult questions" (Patton, 2015, p. 459). For example, the final transformative question in the semi-structured interview guide is structured in an open-ended and imaginative fashion: "Imagine you were in a professional leadership position in a school or school board".

Additionally, "presupposition questions communicate that the respondent has something to say, thereby increasing the likelihood that the person being interviewed will, indeed, have something to say" (Patton, 2015, p. 459). For example, when asking the youth about the school-based features that impacted their mental health during secondary school, the question begins with "what." This presupposes that the participants have relevant knowledge on this topic and encourages them to answer freely without feeling limited or restricted. As well, I asked the students to suppose that I was at their school with them and to describe what I would see, hear, and experience that may impact their day-to-day mental health. Ultimately, while all open-ended questions have the potential to generate rich and deep reflections, Patton (2015) makes the crucial point that none of these lines of questioning should be overused.

Finally, in pacing the interviews, I was careful not to drag any of the interviews on for too long. Interviews that are drawn out risk losing sight of the research focus. As Patton (2015) argues, it is important for researchers to provide participants with ongoing feedback in the form of verbal and non-verbal cues so that the interview stays on track. This is not a matter of leading the interviewee, it is simply done in order to keep the participant focused. Thus, I made a habit of

linking any emergent questions or themes back to the study's central purpose throughout the interviews. Finally, I was also mindful of affording all of the participants with the opportunity to add anything at the end of the interview. Ignoring this final, open-ended opportunity is a disservice to the research agenda, as rich insights can still emerge at the end of an interview.

At the end of each of the interviews, I carefully reviewed my interview notes and (re)listened to the recorded data over the next couple of days. According to Patton (2015), "the period after an interview or observation is a critical time for reflection and elaboration. It is a time of quality control to determine whether the data obtained will be useful" (p. 473). As Patton (2015) asserts, post-interview reflection is integral to the data analysis phase of the study.

Having described the data collection methods, as well various ethical and practical considerations addressed throughout the design and data collection phases of the study, I now summarize the steps that I took in thematically analyzing the qualitative interview data.

Data Analysis

This study applies Peel's (2020) six-stage data collection and thematic analysis process. According to Peel (2020), the basic function of the thematic data analysis approach "is to organize and simplify the complexity of the data into meaningful and manageable codes, categories, and themes" (p. 7). Peel's (2020) six stages are:

- (1) collect the data;
- (2) engage with the data;
- (3) code the extracts from the data;
- (4) generate the code categories from the codes;
- (5) conceptualize the themes from the categorized coded extracts; and
- (6) contextualize and represent the findings (pp. 7–8).

To be clear, the six-stage data collection and thematic analysis process followed in this study was far from one-directional; rather, I moved “back and forth as needed, throughout the phases” (Braun & Clarke, 2006, p. 16, as cited in Peel, 2020). Creswell’s (2013, p. 182, as cited in Peel, 2020) non-linear or spiral approach, which is defined by “moving in analytical circles,” allowed me to continually (re)analyze the raw data from the first interview until the final dissertation draft. Ultimately, the thematic analysis was multi-directional, comparative, and ongoing.

Drawing on Patton (2015), I also used other qualitative data analysis strategies, including unique case orientation, inductive case analysis and creative synthesis, and context sensitivity (p. 47). According to Patton (2015), unique case orientation “assumes that each case is special and unique” (p. 47). Each case is analyzed individually before engaging in a meaningful cross-case analysis. Inductive analysis “begins with immersion in the details and specifics of the inquiry to discover important patterns, themes, and interrelationships; exploration and attention to what emerges is followed by confirmatory inquiry” (p. 47). This type of analysis always concludes with a creative synthesis. Finally, context sensitivity “emphasizes thoughtful, comparative case analyses and extrapolating patterns for possible transferability and adaptation in new settings” (p. 47).

Following Patton’s (2015) advice, I began data analysis by, first and foremost, acknowledging that each case in this research project is authentic and unique. Next, I applied an inductive analysis approach to each individual story, moving from the specific details within each of the interviews toward general, emergent, qualitative themes. Finally, I compared the general themes across all cases to find similarities, intersections, and disjunctions in the thematic findings. Once the cross-comparison analysis was complete, I creatively synthesized the bulk of the themes in three consecutive chapters, in which I present the interpretation of the findings.

My qualitative analytic journey began by carefully (re)listening to the audio recordings of each of the 11 semi-structured interviews. At this stage of the analytics process, I “engaged with the data” (Peel, 2020, p. 8) by actively listening to the recordings and jotting down any words, ideas, or overarching themes that jumped out at me. Once I completed this initial coding activity, I re-read each interview transcript twice and began “generating the code categories from the codes” (Peel, 2020, p. 8). Following the first analysis of the transcripts, I identified seven generic code categories that were present, to some degree, in all of the interviews:

- 1.) Silenced identities, distrust, and stigma culture;
- 2.) Bullying and harassment in youth;
- 3.) (Un)supportive teachers and learning spaces;
- 4.) The game changer: peer support;
- 5.) (Un)supportive adults;
- 6) Beyond the school doors; and
- 7.) Youth vision and recommendations for change.

I then returned to each interview transcript to develop the codes further with data-rich quotes and anecdotes, generating 70 pages of rich, narrative, and thematically-organized interview data.

Taking a step back from the seven codes that originally emerged, I soon realized that I could group a number of them into themes based on similarities. I then worked on “contextualiz[ing] the themes from the categorized coded extracts” (Peel, 2020, p. 8). I prioritized themes that were explicitly related to the dissertation’s central research questions and then “contextualize[d] and represent[ed] the findings in three thematically-inspired data chapters” (Peel, 2020, p. 8). The first theme, “silenced identities, distrust, and stigma culture,” contains a plethora of rich information closely connected to the central research question.

Chapter Four, on the culture of mental health silence in Ontario secondary schools emerged from this coded data. More specifically, the revelatory gendered findings within the chapter emerged when I compared the youth narratives within this theme across the participants' selective disclosure of their gender in the demographic component of the initial SurveyMonkey questionnaire.

Next, I noticed that many of my conversations with the youth revolved around the role that adults played in supporting or not supporting them and the subsequent mental health impacts. The categorized codes of “(un)supportive teachers and learning spaces” and “(un)supportive adults” emerged from this key insight. Since the central research question focuses explicitly on the features within the secondary-school environment that impacted the mental health of the youth participants, I decided to eliminate the categorized code of “beyond the school doors.” Instead, I focused exclusively on the participants reflections within the school environment, rather than the effects of (un)supportive adults, such as parents, beyond the school context. This analytical sifting helped me thematically formulate Chapter Five on the mental health impacts of teachers and their (un)supportive approaches and practices.

Finally, the categorized codes of “bullying and harassment amongst youth” and “game changer: peer-support groups for mental health” emerged as highly interrelated. Both codes thematically tackle the impacts of interpersonal dynamics from two opposing perspectives and address the impact of peers on the mental health of the participants, whether positive or negative. From this overlapping dynamic, I created Chapter Six on the mental health impacts of bullying, friendship, and peer-support groups. I then explored the final categorized code, “youth vision and recommendation for change,” in the conclusion chapter. The recommendations within this code provide unique insight into what the youth participants would do differently within secondary

schools to better support student mental health; that is, if they were in a position to do so. The significance of these recommendations is noteworthy. They provide a marginalized population with a critical voice and open up areas for further discussion and research.

A Summary of the Study's Youth Participants

Before concluding this chapter, I present a brief description of each interview participant in this study. Following the descriptions, I present the participant descriptions and demographic information in a concise table for reference throughout the dissertation (See: Table 1). I begin by introducing Brandon.

Brandon lives in a small, rural community outside Parry Sound. He enjoys everything to do with fishing and spends any free time he has outdoors. He attended high school in Parry Sound and graduated in 2013. Brandon was diagnosed with a learning disability and was enrolled in a number of alternative and special education classes throughout secondary school. He felt alienated because of his academic limitations. He admitted to experiencing bullying based on his special-education status, especially during his elementary school years.

Throughout secondary school, Brandon struggled with major depression, but he did not seek professional help through the CMHA until after he graduated. He eventually reached out to a co-worker about his suicidal thoughts. Brandon identified himself as the child of someone with alcoholism. During his childhood and adolescent years, he lived in multiple homes, even living with his grandparents for an extended period of time. In his senior secondary-school years, Brandon was mainly enrolled in the co-op and served as a teaching assistant in a special education class. Following high school, Brandon directly entered the workforce and has not completed any post-secondary education since graduation in 2013.

Kristin also went to secondary school in Parry Sound; however, she graduated in 2011. Kristin is an avid runner and regularly uses cardiovascular exercise as a proactive outlet for her anxiety and depression. Early on in secondary school, Kristin developed severe anxiety and depression, which started to impact her academic and extracurricular life. She was professionally diagnosed in her Grade 12 year and soon after began receiving professional support through the CMHA.

Kristin's parents divorced when she was 5 years old, and she lived in multiple homes throughout elementary and secondary school. During high school, Kristin opened up to her father about her languishing mental health. Her father, a paramedic, had also experienced mental health challenges throughout his life; so, the father-daughter support network was vital to Kristin's accessing professional help. At the time of the interview, Kristin was enrolled in a post-secondary institution and was studying to become a social worker. She believes whole-heartedly in the power of peer-support models in the mental health field. Throughout secondary school, Kristin used cannabis multiple times a day to manage her debilitating anxiety. Today, Kristin is recovering and relies on exercise, medication, and a strong support network to maintain her mental health.

Cheyenne attended secondary school in the North York region of Toronto. Throughout high school, Cheyenne struggled with low moods and paranoid thoughts. She relied heavily on in-school supports for her languishing mental health, namely child and youth workers. Although Cheyenne was not professionally diagnosed with a major depressive disorder until the end of her Grade 12 year, she admitted that it had been going on for years prior to her accessing support through the CMHA.

Cheyenne identified as an LGBTQI female and as a student with an IEP. She successfully graduated from secondary school in 2016 and is not currently attending a post-secondary institution. Cheyenne admitted that familial and personal impacts beyond the school doors negatively influenced her mental health during high school; however, she did not feel comfortable divulging any details to me. Cheyenne alluded that her relationship with her parents was shaky, and that her aunt was the primary, familial source of her mental health support.

Greg split his secondary-school years between Ajax and Peterborough. Early on in secondary school, Greg began using drugs and alcohol while at school, during the evenings, and on weekends. Although Greg admitted that his friendships were lacklustre, he hung around his particular social group because they all used drugs together. Admittedly, Greg had turned to drugs in order to self-medicate for his underlying anxiety and depression. Unfortunately, Greg developed drug-induced psychosis following a multi-day drug binge in Ajax during his Grade 11 year. Greg was hospitalized and diagnosed with anxiety, depression, and drug-induced psychosis following his psychotic episode; however, he did not receive regular support through the CMHA until after high school.

Greg eventually graduated from high school in Peterborough in 2016, but his path to convocation was delayed several years following the onset of his mental illness. His home life throughout secondary school was not free from turmoil. Greg, along with his mother and sister, decided to leave his father because he was emotionally abusive. Greg is not currently attending a post-secondary institution and lives in Peterborough.

Holly also graduated from high school in Peterborough. Holly's childhood was characterized by trauma. She was repeatedly sexually abused by a landlord in her early childhood. Holly had never met her father, and she recalled frequently moving around the

province with her mother as a child, attending five different schools in various localities across Ontario—Saint Thomas, Kingston, Sydenham, Trenton, and Peterborough.

It took years for Holly to come to terms with the mental health impacts of her sexual trauma. It was not until after high school that she was diagnosed with post-traumatic stress disorder and she began accessing support through the local CMHA. Holly successfully graduated from high school in 2013, and is not currently enrolled in a post-secondary institution. She is expecting her first child and was delighted to share the news with me in the interview.

Mike also graduated from high school in Peterborough in 2013. Mike struggled with anxiety throughout his childhood and secondary school. Mike often had long sleepless stretches of time and would not eat in front of people while he was at school. As a result, Mike spent most of his high school years hungry and overtired. He noted that he barely slept at all during his entire Grade 10 year. Although Mike was an academically capable student and was enrolled in all academic courses in Grade 12, his severe anxiety often inhibited him from achieving his full potential.

Mike was never particularly close to his family members, including his mother, step-mother, father, and brother. His parents worked long hours, and he never had a positive relationship with his older brother. He was diagnosed with generalized anxiety disorder during high school, although he did not access support through the CMHA until after he graduated from high school. Mike identifies as LGBTQI. He is currently studying electrical engineering and social work at a college and is excelling academically. He loves to play video games during his free time.

Keira attended secondary school just outside Peterborough, in the small town of Lakefield. Keira was involved in many extracurricular activities, including rugby, volleyball, and

soccer. She began using cannabis at the age of 15, and that same year she moved out of her parents' house to live with one of her friends. At the beginning of Grade 10, Keira was hospitalized for drug-induced psychosis. Upon her return to school, Keira frequently found herself in interpersonal conflicts with peers and described herself as the victim of mental health bullying.

Keira's home life was just as trying as her peer relationships. In her Grade 11 year, her father was arrested on Family Day for assault, and her mother was about to give birth to her 7th child. Keira dropped out of high school for a period of time and eventually finished her secondary-school credits in an alternative school setting. Keira is not currently attending a post-secondary institution. She skipped many of the demographic questions on the initial survey, so her date of graduation is missing, as well as when she began accessing professional support for her mental illness. However, it is likely that Keira was diagnosed with depression and psychosis during her hospitalization in Grade 10.

Mary graduated from an inner-city Hamilton secondary school in 2015. Mary identifies as LGBTQI. She enjoys the company of the few friends that she still has but genuinely longs for more meaningful peer connections. Mary spent her early childhood years living on a farm in Pembroke. When she was 6 years old, her parents divorced, and she consequently moved to Hamilton. Mary's home environment was not stable. She described how her brother, who also lived with mental illness (attention deficit hyperactivity disorder [ADHD] and Tourette's) was physically abused by their father on a regular basis. Similar to the second-hand violence at home, Mary was regularly exposed to firsthand violence in her secondary school. Mary recalled being bullied for her sexual orientation after she came out in Grade 9. She also admitted being physically and emotionally abused by one of her previous male partners.

Mary was first hospitalized during her Grade 10 year and was diagnosed with borderline personality disorder, post-traumatic stress disorder, obsessive-compulsive disorder, trichotillomania, eating disorder, conversion disorder, and depression. Upon returning to high school from her first hospitalization, Mary began receiving support through the CMHA. She is currently attending a post-secondary institution in Hamilton.

Nicola graduated from secondary school in Hamilton in 2015. Tragically, Nicola lost her mother to cancer in Grade 5, and she struggled with depression following her passing. Nicola described her father as the prototype tough guy who never talks about his feelings and, instead, would go on vacation and drink alcohol to escape the pain of losing his wife. Nicola's two older brothers were similar to their father in this regard. Nicola was surrounded by men who thought that talking about their feelings was not acceptable. In fact, when Nicola began self-harming, abstaining from eating, and binge exercising, her brothers responded in the only way they knew: "Stop doing this. Why are you doing this? You are hurting people."

Nicola is a self-proclaimed perfectionist. In her Grade 9 year, she was diagnosed with anorexia nervosa and major depressive disorder. Sadly, Nicola best friend's mother, with whom she was quite close, died of cancer when she was in Grade 11. Nicola began accessing school-based and CMHA supports in Grade 9, the same year she was diagnosed with anorexia nervosa and major depressive disorder. She currently attends a university in central Ontario.

Sara also graduated in 2015 from the same Hamilton secondary school as Nicola. Sara also began accessing supports for her mental health during high school. She was diagnosed with anxiety during late high school, and her obsessive-compulsive disorder and trichotillomania were diagnosed in her 1st year of university, when she moved away from home. Sara's father is a police officer who struggled with post-traumatic stress disorder while Sara was in high school.

Her father would regularly have mood swings and fits of rage at home. Sara's mother, who lived with an anxiety disorder, had difficulty coping with the impact of her husband's mental illness. Her parents eventually sought counselling for their respective mental health issues and marriage difficulties.

Sara was an academically capable, popular, and social adolescent with a supportive group of friends. She abstained from drugs and alcohol during high school because she saw, firsthand, the impact that it had on her father. Although, Sara had experienced severe anxiety since Grade 5, she was diagnosed with generalized anxiety disorder with severe panic attacks, obsessive-compulsive disorder, and trichotillomania during late high school and early university. She is currently attending a university in Ontario.

The final participant, **Talia**, also graduated from the same Hamilton high school as Nicola and Sara in 2015. Talia is an inspiring and award-winning leader in the area of youth mental health in the Hamilton region. She is safeTALK-trained and was an instrumental leader in a school-based mental health group, which took shape in her Grade 11 and 12 years. According to the Ontario Association for Suicide Prevention (2013), "safeTALK is a 3-hour training program that prepares helpers to identify persons with thoughts of suicide and connect them to suicide first aid resources." Talia actively worked, and continues to work, on a number of peer-support initiatives within her community.

Talia was diagnosed with a generalized anxiety disorder, social anxiety disorder, panic disorder, and depression before she started high school; but she did not start accessing CMHA and in-school supports for her mental health until secondary school. In her Grade 7 year, her father, uncle, and grandfather were all diagnosed with cancer in the same month. This particular group of events significantly impacted Talia's mental health. As well, in early high school, Talia

began experiencing severe suicidal ideation. Her thoughts of suicide were so strong at the beginning of Grade 11 that, fortunately, Talia admitted herself to the McMaster hospital for psychiatric treatment. Talia is currently enrolled in a social work program at a local college. She has a passion for holistic nutrition and firmly believes in the importance of nurturing the mind-body connection for mental health optimization.

Table 1

Demographic Summary of the Youth Participants

Participant pseudonym	Secondary school location(s)	Self-disclosed, professional mental health diagnosis/es	Self-identified gender	Self-identified membership in a marginalized group
Brandon	Parry Sound	Depression	Male	“Child of someone who suffers from alcoholism”
Cheyenne	Toronto (North York)	Depression	Female	LGBTQI
Greg	Ajax, Peterborough	Depression, anxiety, and drug-induced psychosis	Male	N/A
Holly	St. Thomas, Peterborough, Kington, Sydenham, Trenton	Post-traumatic stress disorder	Female	N/A
Keira	Lakefield	Drug-induced psychosis	Female	N/A
Kristin	Parry Sound	Depression, anxiety addiction	Female	N/A
Mary	Hamilton	Borderline personality disorder, post-traumatic stress disorder, obsessive-compulsive disorder, trichotillomania, eating disorders,	Female	LGBTQI community (lesbian)

		conversion disorder, and depression		
Mike	Peterborough	Generalized anxiety disorder	Male	LGBTQI
Nicola	Hamilton (Stoney Creek)	Anorexia nervosa, major depressive disorder	Female	N/A
Sara	Hamilton (Stoney Creek)	Generalized anxiety disorder, obsessive- compulsive disorder, trichotillomania	Female	N/A
Talia	Hamilton (Stoney Creek)	Generalized anxiety disorder, social anxiety disorder, panic disorder, depression	Female	N/A

This concludes the brief contextual and demographic summary of the 11 interview participants in this study. More details about each of youth participants are presented in the next three chapters. Chapters Four through Six creatively interpret the interview data and present the thematic findings of this study. Chapter Four describes the culture of silence amongst youth on their lived experiences with mental health in Ontario secondary schools. Interestingly, this chapter also highlights gendered trends within the mental health silence, distinguishing between the lived experiences of the male and female participants.

Chapter Four: A Culture of Silence

In this chapter, I explore what I call the *culture of silence* around student mental health in Ontario secondary schools. In using this phrase and the word *silence*, I aim to describe my participants' experiences in secondary-school culture as characterized by a lack of social interaction, a lack of access, a lack of support, and a lack of being heard and understood. What does a culture of silence in the context of secondary-school student mental health in Ontario look like? More specifically, how is this culture of silence around mental health in select Ontario secondary schools experienced and described by the youth participants? This chapter explores these two questions in the context of the principal research question of this dissertation: What features in the participants' secondary schools impacted their mental health? I argue that the culture of mental health silence has a significant impact on the mental health and emotional well-being of students in Ontario secondary schools. I explore the culture of silence detailed by the participants through two sub-themes:

1. Acting okay: "I would rather avoid stigma"
2. Traditional masculinity and help seeking: "Tough guys don't ask for help"

Situating and weaving the stories of the 11 youth within the two sub-themes provides readers with an understanding of how the conditions for silence around student mental health are fostered. In this chapter, I argue that the culture of silence around student mental health is far less uniform, consistent, and homogenous than the term *silence* might initially convey. I argue that the participants' experiences of silence around their mental health are divergent; highly individual; and, most significantly, gender-informed. While remaining discerningly silent about their mental health to avoid stigma was a major point of commonality amongst the youth participants, the specific reasons for their silence and the ways in which they performed mental

health silence varied from case to case and, most notably, across gender. Unfortunately, the limited sociocultural diversity of the interview participants prevented further analyses on issues, such as race and social class.

Nevertheless, the qualitative analysis revealed two noteworthy and highly-gendered trends around the youths' mental health silence. The first sub-theme, "Acting okay: 'I would rather avoid stigma,'" presents the firsthand accounts of several female students who adopted an acting role in hiding their mental health issues from their teachers and peers at school. Despite the variety of mental health difficulties the female adolescents experienced, "acting okay" meant facing less stigma, real or perceived, in their high schools. In interviews with a number of female participants, the façade of "acting well" at school seemed to be the path of least social resistance; that is, it was easier for them to act mentally and emotionally "okay" for their peers and teachers than to face the emotional impacts of mental health stigma (i.e., guilt, judgment or shame). As the analysis below reveals, many of the female participants explicitly spoke about "acting" to avoid the social and emotional consequences of stigma that may accompany the disclosure of one's mental health status or identity.

The second sub-theme in this chapter, "Traditional masculinity and help-seeking: Tough guys don't ask for help," further explores the seeming gender differences within the proposed culture of silence. The experiential reflections of the three male participants presented in this sub-section portray a small group of young men who seemed to unconsciously suppress their emotional, mental, and affective difficulties throughout secondary school and even beyond. Unlike several of the female participants who protectively assumed a façade of "acting okay," I was surprised how a number of the young men unknowingly performed the traditional, masculine, gender role of "acting tough." In so doing, these "tough guys" suppressed their mental

health issues, turned emotionally inwards, and remained rigidly silent. Since socio-culturally and stereotypically, that is how men are “supposed” to cope with physical and emotional hardship, I was not overly surprised to witness what I sensed was masculine posturing. Ultimately, the hyper-masculine construct of acting tough was quite apparent throughout the male participants’ experiential reflections.

While remaining silent about one’s mental health was a common theme across genders, the way that each participant performed their mental health silence was equally gender-informed and individually-informed. This chapter focuses on the experiences of most of the 11 participants, demonstrating the salience of this theme for students struggling with mental health issues. The narrative feel of the analysis offers a firsthand flavour that highlights the value of listening to the unique perspectives of often marginalized students.

What Is Mental Health Stigma? Who Does It Impact and How?

Before delving into the case data, it is useful to begin with a clear definition of mental health stigma. Mental health stigma is an internalized mark of shame or guilt felt by those living with a mental health issue or illness. The discriminatory origins of mental health stigma in the west are as much sociocultural as they are institutional. How discriminatory caricatures of the mentally-ill person have been historically (re)produced and disseminated for several hundreds of years is an important area to explore.

Michel Foucault’s (1988) renowned work, *Madness and Civilization*, provides a useful starting point for contextualizing the historical stigmatization of the mentally ill person. In his seminal work, Foucault describes how, for centuries, the mentally ill person of the modern psychiatric asylum was socially-constructed to be feared and controlled by the “normal” or “non-mentally ill” population. According to Foucault,

In the reduction to animality, madness finds both its truth and its cure; when the madman has become a beast, this presence of the animal in man, a presence, which constituted the scandal of madness, is eliminated: Not that the animal is silenced, but man himself is abolished (p. 78).

The historical debasement of the “insane” has fuelled an array of pejorative caricatures to portray the “animality” of the mentally ill person: crazy, mad, ill, sick, violent, confused, unstable, disabled, insane, disorderly, perverted, ungodly, irrational, and impulsive. And, surely, modern media representations of mental illness (e.g., in popular films or the daily news) have done little to debunk these stigma-laden portrayals of mental illness. The social consequences of longstanding cultural stereotypes of the “mad” are of particular contextual relevance to this research. The recent work of Haller et al. (2012), for example, which adopts Joseph Gusfield’s theory of societal “ownership” of a public problem, analyzes and presents the discriminatory depiction of disability in Canadian newspapers between 2009 and 2010.

Employing a critical approach, such as Haller et al.’s (2012), to debunk the common stereotypes, misconceptions, and discriminatory portrayals of the “mentally ill” person within Canadian media venues would be a useful starting point for the critical reframing of mental health, especially in the age of social media. This begs the following questions: How has the historical proliferation and perpetuation of pejorative caricatures of the “mentally ill” person impacted everyday attitudes and beliefs about those living with a mental illness? Furthermore, how have these stereotypes impacted the social lives and overall sense of belonging of those living with a mental illness? In what ways do negative attitudes about mental illness shape how those with a mental illness are treated within their respective cultures or communities? And, finally, how do these internalized feelings of shame, guilt, or judgment, which emanate from

mental health stigma, impact an individual's decision to seek support, to open up, or to speak out about their mental health issues or difficulties? Sadly, the answer to the final question is clear and well-evidenced in this study: Stigma is a barrier to inclusion; it perpetuates a shameful silence; and, finally, it delays and prevents people from seeking professional support and care.

According to the MHCC (2013), stigma or prejudice is defined as “a negative and unfavourable attitude,” which “causes those living with a mental illness to be labelled, stereotyped, and feared”. Sadly, stigma remains the most significant barrier to accessing mental health services in Canada. While 7 million Canadians will experience a mental illness this year, many will not access help because of mental health stigma. Stigma keeps many individuals hidden and silent; specifically, the fear of being judged or perceived differently for having a mental health issue prevents over half a million Canadians from going to work every single day (MHCC, 2013).

In addition to the implications of avoiding specialized treatment, remaining hidden or silent about one's mental health may also impact one's day-to-day emotional well-being and sense of social belonging. For example, Rüsçh, Angermeyer, and Corrigan (2005) argue that the impact of mental illness stigma is three-pronged: First, the symptoms of mental illness can be difficult to cope with; second, being publicly forthcoming about one's mental health status may impact one's employability or contribute to workplace discrimination; and, finally, the internalization of mental health stigma can lead to the experience of, what is now commonly referred to in psychological literature as, self-stigma. According to Rüsçh et al. (2005), self-stigma causes individuals to “accept the common prejudices about mental illness, turn them against themselves, and lose self-confidence” (p. 529). The concept of self-stigma is an important one, and it is a driving force behind the culture of mental health silence explored in

this chapter. Ultimately, mental health stigma is devastating for Canadians on a number of economic fronts; however, the sociocultural, subjective well-being and the qualitative implications of stigma in the day-to-day school experience of the youth interviewed in this study are similarly significant.

Mental health status is not a permanent, sick/well dichotomy, nor should it be. Identities are far more fluid than common binary notions suggest. Furthermore, who knows about one's mental health experience and what they know are highly personal and socially strategic calculations. Surely, there are individuals who would much prefer keeping their mental health status private. And that is certainly okay. Physical and mental health information are personal and rights-based matters; therefore, the choice to share one's mental health experience selectively should be an individual decision that is free from the discriminatory influence of stigma. Unfortunately, as the youth participants describe below, this is seldom the case. Nevertheless, the individual right to mental health privacy is fundamental; and it is central to this dissertation's position.

So, given the above-mentioned importance of the right to self-disclose, what are the benefits of being selectively open about one's mental health status? Recent research suggests that the selective disclosure of one's mental health diagnosis can positively impact one's sense of social belonging while limiting one's internalization of stigma (Bos, Kanner, Muris, Janssen, & Mayer, 2009). Unfortunately, the seeming culture of silence around mental health in the secondary schools described in this study prevented many of the participant youth from selectively disclosing their mental health issue or diagnosis to their teachers and peers. What sociological forces permitted and sustained this culture of mental health silence in the secondary schools in this study?

Of major significance is the well-documented culture of stigma and discrimination in Canada. According to a statistical report by the MHCC (2015), 37.9% of individuals living with a mental health diagnosis reported experiencing discrimination based on their mental health status (p. 5). The statistical prevalence of mental health discrimination in Canada does little to prevent a culture of mental health silence; and it is, quite plausibly, the driving force behind it. Since the disclosure of one's mental health status often leads to negative social or economic consequences (Tillery, Varjas, Roach, Kuperminc, & Meyers, 2013); many individuals choose to keep their mental health private to avoid discrimination. The interpersonal distrust and low self-esteem that grows out of mental health stigma are symptoms of what Rüsçh et al. (2005) refers to as self-stigma; these sentiments were also prevalent across many of the cases in this study.

In the next section, I explore the relationship between stigma and the culture of silence around student mental health in select Ontario secondary schools through the narratives of the students themselves. The role that mental health stigma played in producing and sustaining a culture of silence in the participants' secondary schools in Ontario is discussed. Additionally, the individual and gendered performances of mental health silence are also analyzed.

Acting Okay: "I Would Rather Avoid Stigma"

The first of the two sub-themes in this chapter provides an in-depth look at the stories of four female youth from various secondary schools across Ontario. A number of similarities are found across cases, in the participants' reflections on how and why they performed mental health silence within their secondary-school environment. Interestingly, the four female youth felt more comfortable hiding their emergent mental health issue or professional diagnosis from peers and students in their schools. In fact, for most participants in this study, fear of coming out about their mental health issue outweighed the perceived benefits of seeking help, thus delaying them

in accessing the mental health supports and resources available in their high school and community. More importantly, even after seeking professional support for their mental health issue, many participants were hesitant to share their lived mental health experience or psychiatric diagnosis for fear of being judged or ostracized by their peers. While all of the participants expressed varying degrees of concern surrounding how their peers perceived them in secondary school, a number of youth articulated similar concerns about their teachers.

Overall, a seeming desire of the four young women to be perceived as “normal”—that is, not to be stigmatized for their mental health issue or diagnosis—is at the heart of this emergent theme. The four female students discussed below described themselves as skillful actors throughout secondary school. Masking one’s mental health issue was a relentless theatrical gig, which was perceived as preferable to the stigma associated with their mental health issue, diagnosis, or identity status. The experience of eventually coming out about one’s mental health varied substantially from youth to youth.

Some youth found it easier to confide in a close friend or family member, while others opted to confide in a teacher, counsellor, social worker, extended family member, or physician. Whether through a clearly communicated psychiatric label or the discussion of symptoms, sharing one’s experience with family, friends, and educators proved consistently difficult for the youth, particularly in the earlier stages of onset. However, of utmost importance to this dissertation’s central research question are the similarities found in the day-to-day mental health experiences that the female youth describe below, especially through the lens of mental health stigma and the proposed culture of silence.

Actor one: Holly.

Holly, who was diagnosed with post-traumatic stress disorder after graduating, candidly reflected on how her high school experience was marked by loneliness and hiding. Holly was exposed to poverty and familial instability early on in childhood. She painfully recounted the sexual abuse that she experienced at the hands of an apartment landlord in early childhood. Sadly, Holly did not disclose her history of sexual abuse to anyone until adulthood because she feared that the Children's Aid Society would remove her from her mother and twin sister. As a result, Holly explained, her childhood and adolescence were characterized by incessant avoidance and hiding. According to Holly,

[S]o, for me when I get super depressed, I just want to go in a closet and hide...like I don't have any energy to do anything. I don't want to be around anybody. That's when I get to, like, my dark spots.

Holly was terrified of sharing her struggle with anxiety and depression because it meant telling someone about her past trauma. Holly was guilt-ridden, isolated, hopeless, and silent; a complex condition that is typical among survivors of childhood sexual abuse (Gorey, Richter, & Snider, 2001). It took many years for Holly to realize that what she had experienced in childhood was not her fault.

How Holly's severe depression remained unnoticed by her peers and teachers throughout secondary school was of particular interest to me. How could someone experience such intense emotional pain, yet remain stoic in their performance of wellness at school and in their wider community? Holly explained it in this manner: "I hid it very well. I took acting class...like

nobody could tell, I was such a great actor.” Despite describing her day-to-day high school experience as consistently overwhelming, Holly was determined to hide her mental health from everyone except for a close friend and her general practitioner.

Holly’s disclosure to a health professional is very much in line with current research on the processes that lead to help-seeking behavior following childhood trauma. While the rationale for seeking help from a general practitioner varies, many individuals first disclose their somatic symptoms of trauma to their family physician (Stige, Træen, & Rosenvinge, 2013). More significantly, those with post-traumatic stress disorder are disproportionately represented in non-help-seeking or delayed-help-seeking behaviour (Stige et al., 2013). The evasive nature of help-seeking trends among individuals with post-traumatic stress disorder provides some explanation as to why Holly avoided seeking help for her mental health issue. The fear of being found out was also an incentive for Holly to “act well.”

But Holly admitted that the perpetual acting role also came with a hefty emotional price: First, she admitted that putting on the daily public façade that everything was okay, even though it was not, was psychologically exhausting; additionally, it delayed Holly in accessing professional mental health support through her general practitioner until after her high school graduation. Holly’s experience of trauma in early childhood significantly damaged her ability to trust others, a well-evidenced barrier among those living with post-traumatic stress disorder (Stige et al, 2013). The significance of Holly’s acting was that it produced additional mental health impacts for her: mental and physical burnout and social isolation. It also delayed professional treatment and support.

Holly’s silence was strategic. It was apparent that Holly was profoundly ashamed of divulging her sexual trauma to anyone in high school. She explained that she was not ready to

come forward; she was terrified of how disclosing her victimization might impact her family and social life. Silence, however, was not comfortable for Holly; her reflections on hiding her traumas were charged with anxiety and pain. At the same time, Holly explained that, at the time, enduring the pain was a seemingly worthwhile and necessary. Holly chose to self-manage her somatic and emotional symptoms for years because she felt alone and ill-prepared to confront the horrors of her sexual trauma. Consistent with the literature on help-seeking behavior among individuals with post-traumatic stress disorder (Stige et al., 2013), reaching out was a last resort for Holly. Holly's silence was inextricably linked to her traumatic past, and it was compounded by the depressive and anxious symptoms of her experience with post-traumatic stress disorder.

Actor two: Nicola.

Similar to Holly, Nicola was silent about her mental health. However, Nicola's reason for hiding her mental health issue in secondary school was different from Holly's. Nicola's hiding was overwhelmingly stigma-driven. Despite divergent rationales for silence, the performative aspect and the isolation that came with mental health silence were consistent in both Holly's and Nicola's cases. Nicola, who experienced the onset of anorexia nervosa and major depressive disorder throughout secondary school, also described her experience of perpetually hiding her mental health issue at school. It was not until the middle of her Grade-12 year that Nicola became more comfortable with sharing pieces of her ongoing experience with anorexia nervosa through a school-based, peer-support initiative. According to Nicola, aside from the peer-support group in Grade 12, "everyone else, I kind of hid away from it. I would tell them, I'm fine. I'm fine. I'm fine."

Nicola explained how she continually maintained the public façade of "I'm fine." When I asked her why she felt as though she could not express her true emotions to her peers and

teachers, Nicola's response was cutting and to the point. Our discussion quickly turned into a reflection on her school-based experience with mental health stigma. She explained how, beyond the physical symptoms of her anorexia nervosa diagnosis, the most stressful component of secondary school was navigating mental health stigma post-treatment. Following several bouts of intensive, in-patient treatment, Nicola returned to school physically well; however, although her weight was restored, the mental-emotional component of her anorexia nervosa diagnosis was ongoing. Unfortunately, many of her peers failed to understand the recurrent component of the illness.

Nicola explained how, frustratingly, several of her peers falsely assumed that she had permanently resolved the eating disorder. Some even equated her ongoing emotional difficulties with attention-seeking. Of significance is that her peers failed to comprehend the ongoing treatment and maintenance plan of those diagnosed with anorexia nervosa. The apparent lack of understanding by select peers impacted Nicola's mental health in secondary school. As a result, she buried her eating disorder to avoid the overwhelming feelings of shame. Faced with negative peer reactions, Nicola fixated on making her peers think that she was better even though she was struggling daily. According to Nicola, this meant "I have to watch what I say. I have to like make sure everyone knows that I'm fine. I have to hide how I'm feeling."

Nicola's commentary on the difference between her peers' reactions to her mental illness when she was visibly underweight prior to her hospitalization, and when she returned to school with her weight restored is particularly noteworthy. Nicola's experience with negative peer reactions post-treatment speaks to the well-supported reality that visible and physical health issues remain more socially acceptable than invisible or mental health issues (Rössler, 2016). The false dichotomy that separates physical and mental health into two distinct categories is a

stigma-fuelled fallacy. The social implications of this fallacy for those, like Nicola, who straddle both the visible and invisible symptomology of mental health, offer a nuanced glimpse at the discriminatory workings and colloquial impacts of mental health stigma.

Similar to Holly, Nicola also became a polished actor throughout her day-to-day secondary-school experiences. Nicola described how she felt misunderstood by her peers and overly suspicious of their perceptions and judgments. Given these relentless interpersonal sentiments, Nicola worked tirelessly to escape the negative peer reactions that accompanied her experience with anorexia nervosa. For Nicola, this meant hiding from stigma and “acting well.” Nicola played an exhausting part in a production of self-preservation. She loathed the perceived and real judgments of her peers. Similar to Holly’s exhaustion from acting, Nicola worked tirelessly to insulate herself from her school community’s seeming lack of school-based education on the topic of anorexia nervosa.

Although a tireless endeavour at the outset, Nicola’s façade eventually took an emotional toll. Physically coping with the symptoms of her mental illness, paired with the experience of perpetually playing the part of an unyieldingly healthy character, impacted Nicola’s day-to-day mental health and emotional well-being in secondary school. In addition to the mental health impacts of stigma and the culture of silence, Nicola admitted that her unofficial acting career also significantly impacted her attendance record, academic record, and overall learning experience.

Actor three: Sara.

Sara shared a number of similarities with Holly and Nicola. Sara also outlined her acting prowess in the hallways and classrooms of her secondary school. Although her reasons for hiding her generalized anxiety disorder, obsessive-compulsive disorder, and trichotillomania were different from Holly’s and Nicola’s, she similarly described how her relentless acting role

consumed her everyday high school existence until her eventual hospitalization in 1st year of university. When I initially questioned Sara, she framed her experience of hiding her mental health from teachers and peers as a selfless endeavour that was not fuelled by stigma. According to Sara,

I used to do, like, musicals and plays and acting classes.... The only reason I hid it is because, I just didn't, like it sounds sad, I just didn't think my problem was as important as everyone else's. So, I thought, why am I going to share mine, 'cause no one's going to care. They'd be like, who cares?

Although I was fascinated by Sarah's decision to keep her mental health to herself, I could not help but wonder about her propensity to downplay her mental health. Was her inward tendency a symptom of diagnostic denial, guilt, or shame or, potentially, a patchwork of all three emotions? Sara further explained that she was uncertain about the physical and emotional symptoms of living with concurrent anxiety disorders. Although she had an inkling that her symptoms may be connected to an emergent mental health issue, she was unable to pinpoint that it was an anxiety-based disorder until her diagnosis post-high school.

By Grade 12, however, Sara admitted that her acting role had entirely collapsed. She could no longer feasibly hide her anxious thoughts and feelings from her family and broke down emotionally at home on a regular basis. As a result, Sara's parents referred her to a local counsellor in Stoney Creek. This proved to be a crucial first step in Sara's therapeutic journey. Sara would later find ongoing community support from an outstanding university counsellor in

Ottawa. Notably, it was not until Sara moved away to university that she began to fully make sense of her debilitating and longstanding struggle with anxiety.

Sara candidly explained how her day-to-day experience in secondary school was marked by perpetual anxiety. For Sara, stigma, paired with her lack of mental health awareness, compounded her mental health silence. Sara revealed that she had refused to reach out to peers and teachers about her mental health issues after observing the negative peer reactions that followed the public mental health disclosure of several students in her secondary school. Bearing witness to the unfair treatment of several of her peers, who had shared their mental health journeys, deterred Sara from speaking up. Instead, Sara chose to remain hidden. Being branded by her peers as “crazy” or an “attention-seeker,” as her classmates had been dubbed, was equated with utter social failure for Sara. In her mind, speaking out about her mental health meant conceding her “normal” reputation. The thought of publicly identifying as having a mental health issue or diagnosis meant conceding to the worst kind of social othering. Thus, for Sara, quietly struggling was preferable to the perceived, and perhaps real, alternative.

The harsh reality of mental health gossip in Sara’s high school impacted her ability to trust her peers and teachers. It was precisely this distrust, fuelled by stigma, which caused Sara to hide her mental health throughout her entire high school tenure. Consequently, the fear of peer judgments (an overt social symptom of stigma) considerably delayed Sara’s coming out to her friends and teachers about her mental health. The impact of distrust on Sara’s mental health is seemingly obvious: loneliness, fear, panic, and dread. The emotional isolation that defined Sara’s acting role was desolate. Stigma, ultimately, delayed Sara in accessing the plethora of mental health resources available at her high school. Stigma was the driving force behind her admitted mental health illiteracy and selfless denial.

Actor four: Kristin.

Kristin expressed similar reasons to Holly, Nicola, and Sara for keeping her mental health issues under the surface. However, unlike the previous three actors, Kristin never explicitly described her experience as acting. Nonetheless, Kristin's word choice in the interview does not make her acting role any less significant. Kristin's interview was dotted with examples of her prominent acting role during high school. Her role was tireless and multifaceted. She lived this acting role in a number of ways: She diminished her emotions, hid her symptoms, disguised her apathy, maintained her silence, and refused to access professional help.

Kristin carefully reflected on how hiding her depression and anxiety delayed her in accessing professional mental health support during her secondary-school years. In the interview, I sensed that hiding was an expression of acting and a function of social preservation for Kristin. The reasons for hiding her mental health were complex but, nevertheless, calculated. Kristin was more explicit and forthcoming than the previous cases about the ways that both mental health stigma and her own denial further impacted her well-being in secondary school. According to Kristin,

Well I was, I mean, it was something I didn't really express; but it would be dismissed in a way. But I also didn't really know what was going on at the time, so I would just play it off as "I'm sick."

Faking illnesses became a common practice for Kristin in trying to cope with and hide her depression. For Kristin, it was easier to cry sick than it was to face the perceived embarrassment that would accompany reaching out about her relentless and debilitating sadness.

Kristin mentioned that one teacher was more observant than others and, informally, provided mental health accommodations for her in the form of assignment extensions. However, Kristin was quick to explain that she did not look for sympathy or attention from her teachers and peers. She saw her depression and anxiety as a character flaw or weakness. What Kristin referred to as embarrassment was actually a euphemism; she was more than embarrassed. I was convinced that Kristin was deeply ashamed of her mental health issues; and, this stigma-driven shame kept her overwhelmingly silent throughout high school.

In spite of Kristin's deep-seated shame, she approached a few select teachers with her emotional issues. What she discussed with them, however, was highly selective. She carefully chose who she told, what she told, and how she framed her emotional issues. Kristin candidly explained the rationale for her selective approach: "I would go to [the teachers] but I wouldn't tell them certain things because I was embarrassed. And you know what if they tell my parents." Not only was Kristin ashamed of her peers and teachers finding out about her anxiety and depression, but she was equally concerned about what her parents would think if they found out. The shame that Kristin internalized was all-encompassing; and she spent a great deal of time suppressing her sentiments.

In my dialogue with Kristin, I could not help but wonder whether her stigmatized understanding of depression and anxiety was a by-product of the pervasive culture that equates mental illness with a character flaw or an inherent weakness. In reflecting on an accommodation Kristin's observant and compassionate teacher provided, she stated "I didn't want that, you know. I didn't want the sympathy.... And, I'm tough and that kind of thing. So, I had my own self-pride in a way." The mark of shame, in her case being perceived as weak or broken, significantly delayed her in seeking help for her depression and anxiety. Acting tough meant that

Kristin hid from potentially supportive relationships. Kristin was so preoccupied with how she would be perceived by her teachers and peers that she suppressed her mental health needs. Kristin was the only female participant who alluded to being “tough.” Other participants who connected their mental health to weakness or toughness were male, and their insights are explored in the next section of this chapter on the seemingly gendered trends in help-seeking behaviour among high school adolescents.

Finally, Kristin nuanced her mental health experience by discussing the lack of curricular education on the topic of mental health. According to Kristin, the health and physical education focus in her high school pertained almost exclusively to matters of sex, drugs, and pregnancy. She recounted how, frustratingly, in her classroom experience, mental health was a seeming footnote or curricular omission. Kristin explained how she struggled to make sense of her symptoms because she did not receive adequate educational information on the topic of mental health.

Similar to Nicola’s account of the lack of education on anorexia nervosa in her high school, curricular silence on matters pertaining to mental health was also identified as a problematic feature in Kristin’s secondary school. This situation begs the question: If educators were not sufficiently covering mental health topics at Nicola’s and Kristin’s secondary schools, how could youth access this crucial, even life-saving, information? And, more importantly, if this omission stemmed from a lack of specialized knowledge on mental health, where else can the professional and educational capacity to disseminate critical, mental health information to youth be found in society?

Although Talia’s experience was not introduced above, her reflection on how health was taught, yet taught incorrectly, in her school echoes Kristin’s experience. Talia portrayed an

educational culture and broader stigma culture that falsely extricates the head from the body. According to Talia, “I expected going into high school to learn something about what was going on in my head, right? Because it seems like the school system teaches you everything, but from the neck down.” The frustration that Talia, Nicola, and Kristin expressed on the lack of mental health literacy in their high schools tells the story of two school cultures, at opposite poles of the province, which share a common deficit: The insufficient dissemination of mental health information to students. And, the mental health impacts were clear and consistent for all three youth: uncertainty, confusion, isolation, hiding, silence, and delayed treatment.

If we seriously consider what Nicola, Kristin, and Talia are saying beneath the surface, it is that most educators in their schools failed to discuss topics that may have shattered the seeming culture of mental health silence. Unfortunately, silence thrives in the taboo. And mental health topics were very much taboo at their secondary schools. This meant that mental health was downplayed, ignored, or strategically avoided altogether. This was Kristin’s experience throughout her high school years. For Nicola and Talia, however, the latter half of their secondary-school tenure saw a remarkable cultural shift on mental health in their secondary school. The paradigm shift in their high school came in the form of an organic, peer-support group for mental health. The inclusive and supportive nature of this game-changing initiative is discussed in detail in the latter portion of Chapter Six.

It is important to conclude this section by resituating the discussion. Participants in this study seemingly identified the issue of mental health education, or the lack thereof, as strongly linked to their experiences of acting and stigma in school. How is mental health illiteracy tied to acting and stigma culture? First, the lack of basic mental health education that several participants described fails to provide youth with a mental health yardstick to gauge and regulate

their well-being. Second, the expressed lack of open and critical discussion on mental health by educators excluded precious opportunities to debunk widespread stigma narratives circulating in the participants' schools. And, finally, an expressed school culture predicated on mental health illiteracy is worrisome because it offers limited education on the many pathways to accessing help, help-seeking roadmaps which are potentially life-saving. Ultimately, mental health illiteracy, paired with a pervasive culture of stigma, kept a number of the participants silent about their mental health issues in secondary school. And, remaining silent involved a degree of exhaustive role-playing, be it acting tough, acting well, or acting silent.

In the next section, I pay special analytical attention to the gendered elements within the proposed culture of silence. Kristin's performance of toughing-out is a timely segue. While each of the study's participants hid from the negative influence of stigma, the flavour of their so-called "acting" was seemingly informed by gender. With the exception of Kristin's tough guise, all of the female participants in this study were interpersonally strategic about maintaining a façade of wellness. Their decision to "act okay" was not only deliberate, it was also deceptive. They feared the alternative to hiding: The social repercussions of stigma. Therefore, hiding their mental health issue was deeply connected to the survival of their reputation.

The three male participants discussed in the next section, "Traditional masculinity and help-seeking: 'Tough guys don't ask for help,'" were far less deliberate about and even aware of their mental health silence. For these young men, silence proved to be an unconscious and oddly gendered norm. In the three male cases, their hiding behaviour lacked the strategy and intentionality observed among the female participants. Interestingly, none of the male participants were explicit about acting okay, acting well, or hiding their languishing mental health symptoms. This made me wonder about the degree to which the social construct of

masculinity informed the behaviour of the young men interviewed. Was how they performed their mental health issues related to their gender? If so, how closely and in what ways?

Traditional Masculinity and Help-Seeking: “Tough Guys Don’t Ask for Help”

With the exception of one female participant—Kristin, the experience of “toughing it out” was unique to and consistent across the experiences of the three male participants in this study. While the qualitative cases in this study are limited, the gendered trends within the small participant sample are compelling and suggest that gender intersects in complex ways with experiences of mental health. Significantly, some of the young men were explicit in their expressions of traditional masculinity; while others were subtle in their expressions, and it was more implicit and embedded in their reflections. Interestingly, the male participant who offered the most insightful and reflective responses also identified as LGBTQI, a group that typically exists in greater opposition to traditional and hegemonic understandings and portrayals of masculinity.

Contextualizing traditional/hegemonic masculinity.

Before highlighting the tough guises below, I first briefly explain what I mean when I use the term *traditional masculinity*. Australian sociologist, Raewyn Connell’s theory of hegemonic masculinity (1995) serves as a useful starting point for a discussion of historically-specific constructs of masculinity. Masculinity is a fluid and culturally-specific construct. Nevertheless, some particular masculine traits have been sustained over the long-term. This means that men are responsible for continually acting out and perpetuating a restrictive set of masculine traits in their day-to-day, non-verbal performances, speech choices, and sociocultural interactions. In Connell’s infamous and fiercely debated work, *Masculinities* (1995), his concept of hegemonic

masculinity outlines a historically (re)constructed performance of what the ideal and dominant man entails. Connell (1995) explains that the dominant and narrow narrative of masculinity is very much sustained by an anti-gay and anti-feminine behavioural hegemony within western culture. This means that men who do not conform to the dominant version of masculinity are relegated to a lesser-than societal position, sharing a common ground with women and other non-men types.

According to Jewkes et al. (2015), Connell's concept of hegemonic masculinity is a useful "analytical instrument to identify those attitudes and practices among men that perpetuate gender inequality, involving both men's domination over women and the power of some men over other (often minority groups of) men" (p. 113). Thus, the application of the concept of hegemonic masculinity, in the context of this dissertation, is useful in order to better understand how the dominant and inequitable variants of traditionally masculine behaviour (e.g., "toughing it out" or "sucking it up") directly impact the attitudes and practices of men around their mental health. Jewkes et al.'s (2015) insight into Connell's theory suggests that men who openly disclose or discuss their mental health are less masculine, less heterosexual, and more feminine than their silent and tough male counterparts. Ultimately, the implications of Connell's theory may explain the increased prevalence of male suicide in western culture and in Ontario, specifically.

How does hegemonic masculinity produce particular masculine behaviours around mental health, and in what ways were these behaviours present in the micro-cultures of the participants' schools in this study? In this dissertation, I focus on a western construct of masculinity; and although this construct may vary across individual and secondary school contexts, masculinity is played out in a rather coherent and consistent fashion across a diversity

of Canadian cultures. Here are some of the most common traits or adjectives associated with traditional, hegemonic masculinity throughout the province of Ontario, which I have encountered: strong, emotionless, authoritative, assertive, fearless, distrustful, hyper-rational, aggressive, territorial, possessive, defensive, selfish, competitive, calculative, physical, tough, militant, straight, muscular, powerful, and many other words considered to be masculine or anti-feminine.

The young men who were interviewed in this study seemed to conform unknowingly to some of these narrow gender roles. For example, the average interview time for the three male participants was shorter than the average interview time for the eight female participants. Additionally, I felt that the male participants required more prompting to motivate in-depth sharing of their mental health experiences. Finally, only 27% of all study participants were male. In a study where participants were included insofar as they met the study's inclusion criteria and time requirements, male participants accounted for only one quarter of the survey respondents. The disproportionality in participation is noteworthy. The ratio signals a disproportionate response rate on the gender front.

A mere surface-level analysis of this disproportionality leads me to wonder how traditional masculine roles influenced the gendered participation rates in this study. It seems that tough guys are less likely to share; and, as the data suggests, they are also less likely to ask for help. The lack of male participants in this study is a participatory reality that needs to be brought to the forefront of mental health discussions on gender. The participatory ratio in this study of three male respondents versus eight female respondents should be noted. As a researcher, it would be an interpretive disservice to brush aside the *why* behind gender disproportionality.

My research observations potentially offer a glimpse into the gendered trends of expressive behaviour, especially as they relate to reflecting on and sharing personal experiences and feelings. The act of sharing one's feelings is a vulnerable undertaking and is seemingly the antithesis of traditional masculine performance. In the same way that sharing experiences and feelings threatens traditional masculinity, asking for help for a perceived mental health issue can be similarly viewed as anti-tough and anti-man. Thus, this section sheds light on the intersection of stigma with the performative construct of traditional masculinity. The addition of a gendered lens to the analysis of the culture of silence in this chapter reveals that the young men in this study seemed to live with a different kind of shame from their female counterparts. For the male participants, shame was complicated by the comparative pressures associated with measuring up to a hyper-masculine yardstick.

Ultimately, the intersection of mental health stigma and gendered helping-seeking trends that I propose fits well with Kimberle Crenshaw's (1989) theory of intersectionality, which posits that various forms of oppression, such as racism, sexism, ableism, homophobia, and classism, rarely occur in isolation. Instead, many individuals encounter compounded marginalization by identifying with more than one of these sociocultural categories. For example, a black woman with a physical disability will likely encounter different barriers to inclusion from a white man with a lower socioeconomic background.

Sociocultural identities are complex, which means that one's experience with discrimination is often layered and overlapping. In the context of mental health oppression and the sharing of discriminatory experiences, oppression is much more complex than an oversimplified, stigma/stigma-free dichotomy. It is important to consider how individuals

experience stigma in relation to their gender and culture, when thinking about the forces that sustain a culture of silence, forces that inhibit help-seeking and experience-sharing.

Tough guy one: Brandon.

Brandon, who lived with depression throughout the 4 years of his high school tenure, admitted that he never even considered the idea of reaching out for mental health support while in school. In fact, it was not until 3 years after high school that Brandon finally opened up to a colleague and friend about his languishing mental health. When I further prompted Brandon to clarify why he chose to open up to his colleague, he highlighted the important role that acquired and sustained trust played in his decision. According to Brandon,

I was doing stuff that I shouldn't be doing, and I opened up to him about it, and he gave me the most support, and I could trust him. And, I guess that was a major thing with me throughout the last few years—trust.

Brandon painfully admitted that he had never felt that he could share his difficulties with anyone in his high school community, be it teacher, peer, family, or support worker. As such, Brandon struggled silently throughout high school because he was afraid to share his feelings with anyone.

In my interactions with Brandon it was apparent that he had difficulty talking about his feelings. Brandon's responses were short; and he required much support, encouragement, and prompting to share anything in detail. Could some of Brandon's brevity have stemmed from his cognitive disability? Yes, quite possibly. However, when Brandon spoke about his feelings, he was harsh, explicit, and to the point. Special educational needs aside, Brandon was a competent

expert on his own mental health experience. I sensed that Brandon's awkward reflections stemmed from a discomfort in sharing and opening up. Talking about his feelings was a very raw and vulnerable experience for Brandon. It pushed him beyond the conventional expectations of how men are supposed to deal with their struggles. It was brave for him to meet with me and share. Incentives aside, Brandon took a risk in trusting me as a researcher, while he had admittedly struggled with trust throughout secondary school. I was proud of him. He stepped beyond the narrow confines of traditional masculinity in the hope that sharing his story could positively impact others.

The extreme interpersonal distrust that Brandon lived with throughout secondary school paints a stark picture of social isolation. Surely, part of his heightened distrust was a psychosocial manifestation, that is, a social symptom of his mental illness. Since depression can distort one's perceptions, it necessarily impacted the way he viewed his social surroundings. The degree to which his depression distorted his perceptions cannot be fully ascertained; however, how he felt and coped on an average day in high school can be accessed. For example, when I asked Brandon about his experience of a typical high school day, he said, "I felt like I was nothing, I was just a typical kid there, you know trying to get an education."

Brandon expressed feeling invisible to his old friends who had "ditched" him for reasons that are still unclear to him. "I felt like a ghost, pretty much except my last semester of high school. They walked right over top of you, you know, just didn't even acknowledge that you're there." Brandon identified as a student who lacked a peer group; and he admitted that it was much easier "to ignore [his depression] and move forward" than to ask for help. He had considered approaching his mother about it during high school; however, at the time, she was dealing with her own alcohol addiction issues.

Brandon had also never met his father. Although I did not pursue, in any depth, how the lack a father figure may have impacted Brandon's relationships and mental health, I was certain that his father's absence had shaped him. The very admission that Brandon had thought about going to his mother for support suggests that he was likely looking for someone to speak to. The silence that Brandon experienced was seemingly painful. And it was not until it became unbearable in post-secondary school that he finally asked for help.

Brandon's way of dealing with his depression throughout secondary school was, what I would describe as, quintessentially masculine. His only coping strategy was to ignore his symptoms and to move forward. Brandon's coping strategies sounded a lot like the colloquial saying, "toughing it out"—if you ignore something long enough it will go away. Unfortunately, Brandon's silent-avoidance approach to managing his mental health and well-being was equally hyper-masculine and stigma-laden. Ultimately, Brandon's refusal to seek help for his mental health issue closely aligns with research that argues that there is a gendered disproportionality in mental health help-seeking behaviour; this research was reviewed in the literature review in Chapter Four.

Tough guy two: Mike.

Interestingly, Mike, the male participant who offered the most insightful and in-depth responses, identified as LGBTQ; an identity that, arguably, threatens the traditional masculine hegemony. The interview with Mike required far less prompting than the interviews with the other male participants. He was much more forthcoming and unyieldingly candid in his reflections. Although Mike's tough guise was far less explicit than the other two male participants, traditional masculinity, mental health stigma, and the psychosocial symptoms of his

anxiety led to his silence. Mike's insight into his own experience and his critical affiliations were refreshing.

Mike discussed the significance of school culture in his choice to hide his generalized anxiety disorder from his peers and high school faculty, albeit from a different perspective. Similar to Brandon, Mike did not share details about his mental health issues with anyone throughout high school because he was, admittedly, afraid of approaching teachers and administration. I was particularly interested in why Mike was afraid to share his struggles with adults and prompted him to explain the reasons he hid his issues for so long. Mike excitedly jumped at the opportunity to critique the disciplinary culture of his secondary school and insightfully questioned the impact that the traditional student-teacher hierarchy and disciplinary approach had on the trust dynamic between students and faculty. Mike expanded for several minutes on what he identified as an institutional culture in schools that prides discipline and punishment.

As I listened to Mike's account, I could not help but think of the overt connection between his experience of distrust and his performance of mental health silence. Mike made insightful connections to some of the most foundational critical theories in education, such as, Foucault's perspective on discipline, Bentham's panopticon prison, and Freire's banking model of education. As Mike put it:

I feel like there needs to be a system where a student can speak with the faculty and not be afraid of repercussions. Like, just tell them what your problem is without knowing them as a disciplinary centre. Like, my only relation to the head office is that they'll detail you, or they'll tell you and

they'll suspend you, or they'll go through your stuff. Like there's not really a supportive association anywhere.

The perceived lack of trust and school-based support that Mike described, once again underlines the important role that trust plays in bolstering access to mental health support and countering stigma culture in schools. Without nurtured trust and understanding, high school students will not feel comfortable to step forward and share their mental health difficulties. Ultimately, Mike's detailed critique of the impact of authoritarian discipline structures is discussed in more depth in Chapter Five, which reports on the mental health impacts of educational approaches to order and discipline in schools.

So, while Mike seemed to take issue with approaching school-based faculty about his mental health concern, I was curious whether he had similar feelings about seeking support from his family members or his peers. On the family side, Mike refused to share anything about his mental health with his parents or his brother. He was clear that he was not close with any of his immediate family members. But what about his peers? Did Mike trust his peers or his closest friends with his mental health issues? I wondered whether Mike's silence was specific to his family dynamics, so I inquired further.

It turns out that Mike shared surface details of his experience with anxiety with select peers, and that he felt a sense of consolation in knowing that other students were experiencing similar issues. However, when I further pursued how much information about his anxiety he shared with his "good friends," and whether it was a frequent or supportive mechanism, Mike laughingly admitted that his friends did not really understand what was going on with him. As a researcher and a teacher, I identified Mike's awkward laughter as an analytic signpost. It

suggested that he thought that there was a certain shame or taboo in volunteering information about his mental health issues to his peers. Mike's laughter signified the unspoken; and, I could not help but wonder what was driving the unspoken, mental health silence.

Mike, rather unintentionally, provided a glimpse of how stigma, traditional masculinity, authoritarian school structures, and the symptoms of his illness collided to create his mental health silence. When I asked Mike where one could access mental health help in his secondary school, he framed mental health help-seeking as something that was beyond his control.

According to Mike, school staff

would have to tell you. You would have to have a problem first and you would have to go through the disciplinary process before they tried to help you....

And, I think a lot of my mental health issues were based in fear, so I really wasn't looking to ask a lot of people.

Mike's passive approach to help-seeking paints the picture of an individual who was unwilling to disclose his mental health issue. His fear about asking for support, although a symptom of his anxiety disorder, also seemed to be a symptom of mental health stigma and hegemonic masculinity. Even though Mike's friends had a vague idea about his anxiety disorder, peer support for his mental health issue was limited. Mike, however, felt as though he belonged socially, which, in the overall well-being equation, is a good starting point for any adolescent.

Admittedly, simply knowing that some of his peers were going through similar things, made him feel less alone in his struggle. According to Mike, "so I guess I could say [...] it was often a good experience just having known other people my age were going through similar

things.” Mike’s mental health silence was not absolute like it was for Greg and Brandon. Mike admitted that his peers casually spoke about mental health and the stressful things in their lives, but that they never really delved into them. Having good friends was a supportive experience for Mike, but silence, although not absolute, was still the norm in his peer group when it came to understanding, discussing, and supporting each other’s mental health issues.

Mike’s day-to-day experience at school was one of perpetual (perceived) judgment. Mike did not like bringing his own food to school for fear of eating in front of others; and, as a result, he often skipped meals. The intense feelings of judgment that accompanied the disordered eating component of his anxiety disorder significantly impacted his ability to learn at school. Mike often went without food for long stretches throughout the day, and he admitted that this impacted his cognitive performance and overall energy. Following high school, Mike eventually accessed support through his family doctor; but, generally, he kept his struggles with anxiety to himself.

Mike explained how he sought help on his own without the assistance of friends, siblings, or parents. Mike hid his mental health issue from the school-based supports due to the lack of institutional trust and understanding that he identified. The culture of discipline that Mike reflected on, ultimately, deterred him from seeking help much earlier. He felt uncomfortable approaching the supportive adults in his school. Mike, generally, perceived the faculty as unsupportive, unapproachable, and anything but trustworthy. And while his peers were supportive, it was not an explicit or specific mental health support. Instead, it came in the form of friendship and the accompanying sense of belonging. Mental health was not talked about in-depth. Sharing feelings and expressing the specifics of his struggles was not the norm; pervasive silence was the seemingly hyper-masculine norm for Mike.

Tough guy 3: Greg.

Similar to Mike and Brandon's portrayals of an unconscious and gendered silence, Greg's story also contains a gendered tone of embedded, masculine toughness. In Greg's first 2 years of secondary school, he dealt with ongoing bouts of undiagnosed anxiety and depression. For the most part, Greg kept his mental health difficulties to himself. He did, however, share some minor details with his mother. He was quite close to her, especially after they, along with his sister, left his abusive father in Ajax. So, at the beginning of Grade 11, Greg found himself in a new high school in Peterborough, without an authentic peer group and with languishing mental health. Greg spent much of his time feeling alone, silent, and paranoid.

Not long after moving to Peterborough, Greg began abusing drugs with a new peer group. Greg acknowledged that this new peer group was far from authentic, since their "friendships" revolved entirely around drugs. His spiralling substance abuse eventually culminated in a forced hospitalization for drug-induced psychosis during the summer prior to Grade 12. Greg went on a 1-week binge of marijuana, alcohol, and ecstasy use; while his mother was away in British Columbia dropping his sister off at university. Admittedly, Greg had invited his peer group over to his mother's house for a party, and it ended up evolving into a week-long drug binge. This drug binge caused extreme paranoia in Greg; and the events of that week, ultimately, culminated in his arrest and long-term hospitalization under the Mental Health Act.

Overall, Greg described his mental health journey throughout high school as one of isolation, abuse, and avoidance. The silence underpinning his mental health symptoms and tough guise significantly impacted his day-to-day well-being throughout secondary school, both prior to and following his hospitalization. Greg's anxiety, depression, and drug-induced psychosis largely defined his existence in secondary school. Greg talked about how he missed half of the

school days because he was always “pretty much anxious and paranoid mixed together.” His alarming attendance record made me wonder if friends, teachers, or guidance counsellors worried about, or even noticed, his chronic absences. So, I probed Greg for further information on this. Greg responded by stating that sometimes his friends would ask, “but it didn’t really seem like they were interested in getting to the bottom of why I would be skipping school.”

Interestingly, Greg was also not keen on sharing his mental health issues with anyone—be it peers or teachers. Although part of Greg’s inwardness was linked to the psychosocial symptoms of his mental illness, his introverted personality, and his desire to avoid stigma; I still wondered about the role that traditional masculinity played in his mental health silence. While Greg was not explicit about being tough or stereotypically masculine, I sensed that Greg’s knee-jerk performance of hegemonic masculinity played a key role in his rigid silence.

Greg was not one to share his feelings or struggles with others, and this was quite apparent during the interview. When I interviewed Greg, he required a lot more prompting than the other participants. His reflections were vague and, at times, obscure. He was also noticeably guarded when it came to sharing his feelings and emotions. I really got the sense that Greg wanted to share more with me, but that he was constrained by the rigid confines of his masculine performance.

Admittedly, Greg had never shared his mental health struggles with anyone aside from his mother. His school guidance counsellor and special education teacher were also notified about his mental health following his hospitalization. Greg candidly alluded that there was just no connection with any of his teachers; and that, because of this, he never bothered to talk to them about what he was experiencing. From Greg’s point of view, his teachers most likely

thought that he was “shy” or “lazy,” because, when he did attend class, he avoided any kind of attention or participation. According to Greg,

[P]retty much only my guidance counselor knew [about my mental health].

And then that special teacher for that small classroom. She kind of knew. But she didn't really understand it. And then she eventually kicked me out of the program since I skipped too many classes.

Greg had been placed into this alternative classroom because of his attendance record, and not explicitly because of his languishing mental health. Notably, Greg could not recall his mental health ever being openly discussed in the alternative classroom. And I was just as perplexed as Greg when he shared that he was kicked out of this specialized classroom for the precise reason that he was placed into the classroom in the first place—his attendance issues.

Aside from the school guidance counsellor, who else knew about Greg's mental health? While some of his peers were aware of his arrest and hospitalization, I was curious whether these peers actually understood what he had gone through. Did they check in with him or ask him how he was doing when he returned to school? It turns out that they did not really discuss it. Greg flatly admitted that he had no close friends. While he did talk about the small group that he would drink, smoke pot, and do other drugs with, none of his “closest” peers knew about his mental health issues.

The friendships that he maintained in secondary school were entirely based on utility. These so-called “friends” used Greg to enable their addictions because his house was often vacant. It was a place where they could go and get drunk and stoned. None of these friends were

genuinely concerned about Greg's mental health, neither before nor after his drug-induced psychosis. The friendships that he built in Peterborough were convenient and fake. He did, however, reflect fondly on one close friend that he had in Grade 9. Sadly, he grew apart from this particular friend when the friend became heavily involved with a new girlfriend. As such, Greg kept his debilitating anxiety and depression entirely to himself.

He avoided large groups in the hallways and in the cafeteria. He would leave for home before lunch to avoid the crowds, and he would even leave class early and plan alternate routes throughout the school to avoid noise and potentially uncomfortable social situations. Greg described his experience as one of extreme paranoia. He frequently thought that his peers were talking about him and using code words in front of him. For example, at one point his paranoia was so severe that he believed that various friends were using the "she" pronoun to secretly talk about him. Greg's lack of a trustworthy peer group impacted the quality of his mental health and played a significant role in delaying his access to professional mental health support.

Overall, Greg was a man of few words. A big part of Greg's silence can be explained by his introverted personality, the psychosocial symptoms of his mental illness, and his desire to fly under the stigma radar. But the elephant in the room was seemingly gender. Greg never explicitly said that he needed to "act tough" or to "behave as a man ought to"; but Greg expressed the deep-seated, assumed, and very much sociocultural norms of hegemonic masculinity. Unbeknownst to himself, he conformed to the standards of one narrow variant of masculinity: the emotionless, the inward, and the silent. As a result of his closed-off demeanour, Greg received minimal help and support from peers and teachers for his mental health issues throughout secondary school. And the impacts of his social isolation and loneliness were clear:

languishing day-to-day mental health and a less-than-satisfactory learning experience in secondary school.

Conclusions on the Culture of Mental Health Silence

A number of significant findings emerged from the qualitative data in this chapter. The culture of silence that exists around student mental health in the Ontario secondary schools implicated in this study is diverse. While the interview data suggests that the culture around student mental health was consistently silent, the precise nature of that mental health silence, and the participants' performance of that silence, varied significantly across cases. In the interest of generalizability, below, I present the two most significant, inductive findings that emerged from the data analysis in this chapter.

First, mental health silence was the secondary school norm for the majority of the youth interviewed. This means that the youth were, generally, not comfortable opening up about, discussing, or seeking help for their mental health issues from peers and teachers in their secondary school. Second, instead of opening up, discussing, and seeking peer and teacher support for their mental health issue within their secondary-school climate, hiding from mental health stigma was the most commonly-observed behavioural motive and standard across the participant pool. Many participants expressed concerns about the potentially discriminatory and social implications of mental health stigma. There was a widespread and overwhelming fear of deviating from the mental health "normal" because it necessarily implied sacrificing one's reputation. Ultimately, this fear of mental health stigma was especially pronounced in the experiential reflections of the female participants in this study.

It is important, however, to further nuance the above-mentioned findings about the culture of mental health silence in Ontario secondary schools. First, while mental health silence

was the norm across cases, the diverse performance of mental health silence can be explained by a multiplicity of impact factors, which include, but are not limited to, the following: The participant's personality; the psychosocial symptoms of the participant's mental illness; the participant's family circumstance; the participant's history of trauma; the participant's secondary-school culture; and a number of other socioeconomic, peer, and broader sociocultural considerations.

Given the many influences at play, it is not surprising that mental health silence was not identically performed across the participant cases. This is not a qualitative revelation. Many individual, sociocultural, and environmental factors collide and overlap to impact a given individual's behaviour and performance of their lived mental health experience. Moreover, there are innumerable reasons and ways that one may understand, cope with, and discuss mental health. The influences are many, and they are equally individual and cultural. However, one very significant and overarching trend emerged from an in-depth analysis of the participants' performance of mental health silence in this chapter: The way youth participants performed mental health silence in their secondary schools trended across gender.

Given that the most significant sociocultural factor to emerge in this study pertains to the intersection of the participants' gender and the performance of their mental health silence, the principal question remains: How did the participants' performance of their chosen gender impact the performance of their mental health silence? The female participants were far more likely to take on an acting role explicitly in order to protect their social reputation and to hide from mental health stigma. Conversely, the male participants were far less deliberate and strategic about their mental health silence. While the male participants were aware that mental health stigma exists,

they were not preoccupied with strategically avoiding stigma or “acting well”; nor were they concerned with preserving their social reputation within their high school.

The male participants appeared to be performing, quite unknowingly, the norms associated with the traditional and hegemonic construct of masculinity. For all three male participants reaching out for mental health support was a last resort. In all three cases, professional support for their mental illness was significantly delayed; and, in one instance, it was legally enforced. Furthermore, the three male participants were generally uncomfortable when it came to sharing details about their mental health issues with their peers or their teachers.

While the mental health introversion of the male participants can be explained by a variety of individual and contextual factors, it can also be explained by what I interpreted as an unconscious and automatic performance of hyper-masculine norms and expectations. Sharing information about one’s mental health issue is a vulnerable and emotional undertaking, which stands in stark opposition to the pervasive tough, rational, and hyper-masculine ideal of “tough guys don’t ask for help” in western culture. Asking for help means admitting that things are not okay. Through a lens of fear, it conveys weakness. And in the most hyper-gendered sense possible, it means opening up and conceding a perceived defeat. Ultimately, for the male participants, breaking the silence was perhaps unknowingly anti-man, in the narrowest possible sense of what masculinity entails; whereas, for the female participants it was more about preserving a social reputation and avoiding the shame of being found out.

To conclude this chapter, it is imperative that I bring attention back to the central research question of this dissertation: What features of the participants’ secondary-school culture impacted their mental health? The answer to this is clear and intuitive. The pervasive culture of mental health silence within the select Ontario secondary schools in this study was devastating

for the youth participants. The anticipation of encountering mental health stigma was stressful for many of the participants. It did not have a positive effect on their day-to-day experience in secondary school. It worsened their sense of self-worth, their sense of belonging, and their emotional well-being during their secondary-school years. It also significantly delayed treatment for their mental illness in a number of instances. In those cases where professional mental health treatment was sought, the culture of silence further contributed to feelings of isolation and shame upon returning from hospitalization. A number of the youth contemplated breaking the culture of silence, but the overwhelming majority feared the discriminatory impacts of widening the scope of their mental health disclosure. However, there was one notable and silence-breaking outlier: Talia. Talia's exceptional story of mental health leadership, which is an extraordinary experience, is detailed in Chapter Six: Peer Support and Mental Health Transformations.

Protecting or restoring one's mental health reputation seemed to be a day-to-day initiative for many of the female participants. The façade of acting well was exhausting and deceptive. Conversely, the male participants struggled emotionally in their stoic silence. They were isolated and disconnected from the social supports, peer or teacher, required to thrive emotionally and academically in secondary school. They were drowning in their seemingly knee-jerk performance of traditional masculine constructs. Ultimately, the impact of the culture of mental health silence on the day-to-day mental health of the interviewed youth was detrimental. The culture of silence was a significant and all-encompassing barrier to the promotion of flourishing mental health for the youth participants. By extension, the culture of silence detailed in this chapter most likely impacted the mental health of all students in the secondary schools implicated, regardless of whether or not a student was experiencing a mental health issue or illness.

The next two chapters uncover the exceptions to the culture of silence: the influential relationships, peer and teacher; the educational approaches to order and discipline; and the teaching assessment practices that impacted the lives of the youth participants. Chapter Five highlights how unsupportive educational approaches upheld the culture of mental health silence; while, other, more supportive teaching and assessment practices insulated students and caused cracks in the silence. Chapter Six provides further nuance to the culture of silence argument by focusing on social disruptions, supportive peer spaces, and transformational pockets in the culture of silence. Drawing attention to interruptions, discontinuities, and exceptions is important to nuance seemingly homogenous arguments.

Chapter Five: The Mental Health Impacts of Teachers: (Un)supportive Approaches and Practices

In this chapter, I explore the mental health impacts of various school-based relationships identified by the youth participants. In Chapter Five, I focus exclusively on the mental health impacts of student-teacher dynamics. In Chapter Six, I then shift the focus to analyze the detrimental effects of school-based bullying, as well as the supportive mental health potential of supportive friendships and peer-support groups. Special attention is given to the transformational potential of peer-support groups, which emerged from a small case sample in a Hamilton-region secondary school.

In the two subsections below—1. Varied pathways to order and discipline; and, 2. Teaching and assessment practices—I analyze the features of the teacher-student dynamic, namely school-based discipline structures and teaching practices, which the youth identified as having a negative impact on their mental health. I also explore the inverse: Youth-identified discipline, teaching, and assessment practices that best supported the mental health of the youth participants.

Contextualizing the Value of Teachers

What is most relevant to this dissertation's research question—What features of secondary school impacted the mental health of the interviewed youth?—is that the participants repeatedly identified teaching philosophies, approaches, and assessment practices as a key feature impacting their day-to-day mental health in secondary school. Interestingly, no specific questions about teachers were included in the initial interview guide; yet, the youth reflections on

the significance of their interactions with teachers continually emerged. In this section I use the term “teachers” or “educators” interchangeably. Guidance counsellors and special education teachers, for example, are included in these categories. There are even a number of instances where the participants discuss principals and support staff (i.e., educational assistants and child and youth workers). As such, I treat all of the adult professionals as educators. Teachers, guidance counsellors, administrators, child and youth workers, educational assistants, librarians, all share one common thread: They are potentially supportive adults within their secondary-school community. And, although the types of impacts varied substantially based on each educator’s interpersonal strengths, professional roles, best teaching and assessment practices, and mental health knowledge base, the supportive and transformative mental health potential of teachers was nevertheless consistent.

Supportive and positively impactful teachers did not necessarily practise teaching in a manner that was pedagogically remarkable or unprecedented; in other words, they did not zealously supersede the professional standard of practice expected of teachers in Ontario. Rather, what shone through was their humanizing quality, their propensity to focus on building meaningful, adaptable, accommodating, and supportive relationships with students. The educational philosophy and practices of these supportive educators are in line with Freire’s (2000) humanizing purpose of education, that of being personable, relatable, and very much in touch with the emerging needs and issues their students face.

Participants also viewed supportive educators as having an authentic sense of humour and a discipline style that was far less authoritarian and “banking model”-esque than their less-progressive and engaging colleagues. As well, the youth described their teaching styles as highly interactive and accommodating, and their assessment practices as student-driven, fervently

embracing choice and flexibility. Case examples of this Freirean variant of transformational teaching are explored below. What is particularly noteworthy, however, is that the student reflections were highly critical of what Freire (2000) refers to as “narrative education”; whereby “the teacher refers to a reality as if it were motionless, static, compartmentalized, and predictable” (p. 71). Instead, the teachers who the youth identified as supportive were described as dialogical, flexible, fluid, and understanding of the diverse cognitive, mental health, and social needs of their individual students. More importantly, learning was not a one-directional, depository activity; instead, it was highly interactive, social, and context-specific.

According to Freire, the humanist educator’s efforts

must coincide with those of the students to engage in critical thinking and the quest for mutual humanization. His [sic] efforts must be imbued with a profound trust in people and their creative power. To achieve this, they must be partners of the students in their relations with them (2000, p. 75).

This kind of teaching, argues Freire, empowers students to develop a critical consciousness that moves away from passive listening into the realm of co-investigation, dialogue, and problem-posing learning (p. 81). The emancipation of the learner relies on this reciprocal, supportive relationship between teachers and students. Thus, in the context of this dissertation, all students, especially those with complex mental health needs, are far better off in a supportive secondary-school context that is dialogical and humanizing. I explore this potential here through the student participants’ insights into the supportive and unsupportive features of teacher-student relationships.

The supportive and unsupportive teaching practices identified in this chapter offer keen insights into the role that positive and meaningful teacher-student relationships play in supporting youth mental health in secondary schools in Ontario. It is important to underline that this chapter's central theme emerged from in-depth interviews with youth from close to a dozen secondary schools around the province. Therefore, this chapter's analysis offers a starting point for engaging in discussions with teachers and school administrators around the inextricable link between supportive teaching and assessment practices and positive student mental health outcomes.

Educators can learn a great deal from the youth reflections offered below if they ask, for example, where their school context fits in with these stories and what observable thematic intersections exist in their classroom or school community. These types of questions are useful because they encourage meaningful reflection and professional growth on teacher-student relationships and interactions that best support youth mental health within Ontario secondary-school settings.

Divergent Educational Philosophies: Varied Approaches to Order and Discipline

School and classroom management techniques, such as determining which rules are enforced and how they are enforced, are the main focus of this section. Below, I present a number of supportive and unsupportive approaches to classroom and school-wide order and discipline that the youth participants discussed. Both supportive and unsupportive cases had a significant impact on the day-to-day mental health of the former high school student participants. Thus, much can be learned from a nuanced discussion about the noteworthy mental health impacts of teachers' approaches to order, structure, and discipline.

The following cases detail the ways that varied teacher pathways to order, discipline, and support, at both the classroom and whole-school level, impacted the mental health of the interviewed youth. I begin this section by first, exploring the strict teaching and disciplinary approaches that the youth identified as unsupportive. The mental health impacts on students of teachers' quest for order and discipline are assessed. Finally, I conclude the section by juxtaposing examples of strict teaching and disciplinary practices with a much more supportive and humanizing philosophy of education espoused by select, approachable educators.

Unsupportive educational approaches and the quest for order and discipline.

A number of the students identified strict teachers and punitive school structures as having a significant impact on their mental health. For Mike, who lives with generalized anxiety disorder, the freedom to enter and exit the classroom without being questioned or called out was a supportive mental health feature for him. In a number of classes, however, Mike found it stressful to ask teachers to leave the classroom to use the washroom or to get a drink from the water fountain. He recounted how several of his teachers were very strict about students remaining in the classroom, even if they needed to use the washroom. According to Mike,

[A] student would want to go pee and they do it every day so they'd [the teacher] be like, "Oh that's too much. You can't go every day. You can't go today." And that's really not okay. You can't do that to someone.

Mike felt strongly that these types of strict bathroom policies signalled a complete lack of respect for the autonomy of students. Mike's indignation critiques those traditional school rules and structures whose sole purpose was to maintain classroom order. Mike, however, was

adamant that these strict, unsupportive, and inherently distrustful bathroom policies were outdated and, therefore, had no place in Ontario schools. Seeking permission to use the toilet was, ultimately, dehumanizing for Mike: “it’s just, you’re not given that much respect, and they feel you’re suspicious or something.” Mike was passionate about the detrimental impacts of what he described as an authoritarian approach to bathroom usage. From this conversation, I sensed that Mike’s experience with anxiety at school was aggravated by teachers who implemented hyper-regulated washroom policies.

In addition to Mike’s commentary on the authoritarian nature of some teachers’ bathroom policies, Mike was highly critical of certain school attendance practices. For example, Mike was perplexed as to why in secondary school, if he was feeling ill, he needed an adult to validate his feelings. In Mike’s words,

[I]f you’re having an awful day and you feel sick, you have to go to the office and explain it to them. But no one can validate that for you. It’s as if I do not have enough value to say that I’m feeling sick? Like, I need someone to confirm that? Like, I need to call my parents to tell you that I’m feeling sick?

Interestingly, Mike was supportive of attendance consequences if someone was electively skipping class for leisurely purposes; however, in Mike’s case, he often missed class due to his anxiety symptoms, and his mental health symptoms were not always visible or obvious to others. As a result, Mike felt very uncomfortable justifying his illness to the office in order for his absence to be approved. Overall, Mike’s critique of the rigid attendance practices in his school

should be carefully considered when moving toward a more supportive and less authoritarian model of schooling. As Mike shared:

I feel like there needs to be a system where a student can speak with the faculty and not be afraid of repercussions. Like, just tell them what your problem is without knowing them as a disciplinary centre. My only relation to the head office is that they'll detail you, or they'll tell you off and they'll suspend you, or they'll go through your stuff. Like, there's not really a supportive association anywhere there.

Mike's use of the term "disciplinary centre" to describe his high school is perhaps a typical remark when speaking to adolescent youth about their high school experiences; yet, his description can, nevertheless, tell us a lot about the way that he viewed the authoritarian and unsupportive roles of the educators in his school. Mike's negative experiences with heavily regulated bathroom policies, along with the scrutinizing attendance procedures surrounding his mental health absences, soured the way that he perceived his school and the staff.

More concerning is the notion that Mike could not identify a single supportive association anywhere in his school, which is the very antithesis of what schools strive to be. Given the lack of supportive connections and discipline techniques that Mike described, what can I infer about the supportive mental health gaps at Mike's school? The answer is several things. First, I can infer that Mike did not trust the educators in his school. As well, he did not feel safe or supported within the punitive culture he

described. Finally, Mike felt largely afraid and unsupported from a mental health perspective, and these sentiments did not bode well for Mike's mental health or academic experience in high school.

If Mike's case was the only example of this in the study, it would have been much easier to disregard his cutting commentary as perhaps a qualitative outlier. However, the accounts of Kristin and Sara also suggest a similar hyper-disciplinary culture within their high schools. More significantly, their overlapping reflections indicate the mental health impacts of hyper-disciplinary measures on their lived experiences in their high schools.

Similar to Mike, Kristin also encountered strict teacher responses to her mental-health-related absences. Kristin recalled that some teachers would question her absences because the symptoms of her anxiety, depression, and addiction were not evident or visible to others. She explained how when she felt sick at school, it was often dismissed or questioned. Although Kristin was not entirely aware of the link between her physical and mental health at the time, neither were the adults in her life. According to Kristin, she would say,

I'm just going to stay home sick, so I would get a lot of frustration from my teacher and my parents too because they'd be like "What do you mean you're sick? You're fine." And, I'd be like no, I'm sick.

Kristin's experience with unsupportive teachers and parents did nothing to insulate her from her depressive symptoms; instead, their lack of awareness and understanding of her mental health symptoms further isolated her.

Sarah was highly critical of the authoritarian nature of the principal-student relationship in her school. According to Sara,

I was happy that Ms. Preston, the new guidance counsellor, came at the same time as the new principals, because they were just so rule enforcing all the time that they never paid attention to students. They paid attention to what they were doing and how they could just, like, punish them.

Sara's principals were so preoccupied with enforcing uniform policy and attendance, that they completely missed the student mental health piece. Although the participants seldom discussed the role of principals, the leadership role that administrators play in establishing and enforcing the pathways to order and the subsequent disciplinary processes in secondary schools is, nevertheless, a significant point to consider.

For Talia, the punitive response of one particular math teacher upon learning of her mental health status was devastating to her. In Talia's words, "I remember my math teacher... wanted to separate me from my whole classroom and just kind of stick me off to the side.... I was like the one closest to the door, away from my friends." Talia admitted that she often felt that her teachers thought that she was lazy, procrastinating, or did not care academically; even though it was her anxiety, panic attacks, and depression, which led to sleepless nights, missed classes, and late assignments. According to Talia, "unfortunately, a lot

of teachers didn't care. A lot of stigma shined through certain teachers. Especially core subjects. Math, science, English. Very strict and honestly no empathy at all." The math teacher's seating arrangement reflects a strict and controlling spatial response to Talia's mental health: A punitive response, which did nothing to support Talia's mental health in the classroom and, in fact, further alienated her from her peers.

Similar to Talia, Holly spoke of how her strict teachers contributed to a constant feeling of being overwhelmed at school. According to Holly, "the bus ride home, I'll tell you right now, was the best part of my day." I sensed that, for Holly, school was not a safe and supportive place; and it seemed that her overly-strict and punitive teachers were a significant reason for this experience. Holly described most of her teachers as pushy when it came to her underperformance in class. In Holly's words, "they were just always pushing me, you know, work and stuff. But they didn't understand, you know, how I couldn't get.... I really didn't have any support."

Although Holly's post-traumatic stress disorder was not diagnosed until she completed high school, her needs throughout high school, although not communicated directly to teachers, were no less significant. The strict academic approach many of Holly's teachers used to make her more accountable are outdated practices for all students, regardless of one's mental health diagnoses. As Holly suggests,

[W]hen they were yelling, like nagging me about my stuff, they should have been supporting me, rather than just harassing me about stuff because I didn't have anybody to support me. So, I'd go home and sit there and cry because I didn't know what to do.

The strict communication of various teachers and their narrow preoccupation with academic matters suggests that most of Holly's teachers were completely unaware of the social-emotional piece of her well-being; and, more importantly, the well-evidenced bidirectional relationship between student mental health and emotional well-being and academic performance (Suldo, Gormley, DuPaul, & Anderson-Butcher, 2014).

Similar to Talia and Holly, Greg felt that he could not approach any of his teachers. In Greg's words, "some teachers were kind of bad like, 'Oh you're going to be falling, falling through the cracks.'" Greg admitted that his teachers simply thought that he was lazy because of his struggling attendance record and missed assignments. Greg wished that his teachers had not perceived him as lazy; but that they, instead, had understood that it was his anxiety, depression, and psychosis, which prevented him from asking questions in class and caused him to miss a lot of school.

When I asked Greg if he had ever tried to explain his mental health issues to his teachers, he candidly explained that since he did not know anything about their life situations, he did not feel comfortable sharing his mental health experience with them. Ultimately, Greg felt as though his teachers were only interested in giving him a hard time about his attendance and missed school work. This strict approach of teachers to Greg's academic difficulties suggests that Greg's complex mental health and academic needs were largely misunderstood by the bulk of the educators in his school community.

Overall, the unsupportive traits of teachers, in their quest for academic order, structure, and discipline, impacted the mental health of the youth participants. In the experience of Mike, Kristin, Sara, Talia, Holly, and Greg, many of their educators were overly concerned with order, discipline, and structural matters. Words, such as strict, punitive, pushy, intense, demanding, or

authoritarian, accurately convey their approach to discipline and order. Whether it was the educators' strict preoccupation with bathroom, uniform, or attendance policies; their intense verbal pressure to fix academic underperformance; their alienating classroom seating arrangements; or their unapproachability and inflexibility on academic matters, the mental health and academic success of all students, not only those living with a mental health issue, was compromised.

Supportive approaches to order: Toward a humanizing teaching philosophy.

In contrast to the, above-described, strict, rule-obsessed, unapproachable, and unsupportive teaching approaches and structures, a number of the youth participants cited examples of teachers whose humanizing philosophy, softer approach to order, and overall flexibility made them understanding; easy-going; and, ultimately, supportive of their mental health. For example, Cheyenne eloquently described supportive approaches to order in the following way: “well, some teachers have a kind and soft trait. Like, they're nice, they're fun, they teach very well. They're not strict in any way. They don't yell at the students for no reason.”

Holly also described a select few teachers in a similar way, stating that: “Some teachers were nicer to me than others, like, more supportive. My biology teacher would let me come in at recess and stuff.” Likewise, Holly's drama teacher possessed a similar approachability and kindness. Holly, excitedly described her “really amazing drama teacher” in the following way:

He was so interactive. We played games, the whole class. I learned a lot. He got me out of my comfort bubble.... He was loud and fun. Very kind. Never yelled

at you for a mean reason. His voice always had like a perk in it. It was never aggressive, mean, or bossy.

Similar to Cheyenne and Holly, Kristin, explained how some teachers were more approachable and supportive than others. According to Kristin, some teachers “were just personable” and “made school fun, cracked a joke, and they’d laugh with you; not ‘we’re in school, just be serious.’” She specifically reflected on an art teacher who was very “helpful.” She vividly recounted how this teacher made her “feel proud of [her]self” and of her art. I could not help but wonder if her fondness for this particular teacher was mainly due to her self-proclaimed love of art and hands-on activities. Nevertheless, this art teacher’s educational approach—her positivity, encouraging demeanour, and helpfulness—is most certainly relevant to the discussion on the mental health impacts of supportive teaching philosophies.

In comparison to Holly and Cheyenne, Kristin had a positive view of most of the teachers in her high school. Kristin felt that her mental health was well-supported by the educational approaches that the school personnel used. In Kristin’s words,

[T]he teachers were great. They were great with my mental health, in my opinion, in my high school. The student services was amazing; if you had a problem, they would take it first hand to deal with it, you know, have you with open arms, anytime.

Kristin’s description of her approachable teachers, along with the accessible and flexible mental health supports in her school, show how a combination of approachable teaching philosophy,

paired with access to effective youth mental health services, can have a huge impact in supporting the mental health of youth in schools.

Mary's reflection further nuances the analysis on supportive educational approaches, when she makes the key distinction between quality and quantity in supportive teaching philosophies. According to the youth participants, it was not necessary or realistic for every single teacher to be approachable and supportive. Rather, for most of the interviewed youth, simply having a select few approachable teachers, who they could genuinely count on, was meaningful and sufficient. Mary's experience confirmed this crucial point about the mental health value of quality over quantity, when she stated:

I found that having those few support systems, my guidance counsellor, my teacher, my friend; that is what kept me going. So, having something to look forward to, it's like a stake in the ground with a little flag, and you go toward the flag.

Similar to the participants above, Mike was also keen to point out the value of the less-strict and approachable teachers in his high school. For Mike, it was the humanizing and down-to-earth philosophy of select teachers that made them approachable, and, unknowingly, supportive. When I asked Mike what it was about certain teachers that made them more in-touch with and receptive to students' needs, he insightfully responded:

When teachers would actually talk to me outside of class. Some of them would try to ignore you, if they could. Just like, "Hey, how's it going?" That

can be nice, you know. Like, if I'm just sitting in the library, you can talk to me; you're my teacher. It's nice to see that they have more than one facet, that isn't just like, discipline and teaching.

Similar to Mike's point about humanizing teachers who went out of their way to have a non-academic conversation with him, Sara spoke about what it meant to her when teachers showed that they cared about her. She spoke powerfully about how the simplest gesture, such as "if someone was having a rough day, [a teacher saying], 'Go and take a 10-minute walk' kind of thing," meant a lot to her. It only took a few approachable teachers, whose educational *raison-d'être* extended beyond academics, for her to feel that: "Oh, so, there actually are nice teachers in this school." This, again, supports the point that less-strict and humanizing educational approaches helped Sara to feel supported. Overall, the positive impact that these select few teachers, and their approachable and supportive philosophies, had on Sara's mental health was remarkable and noteworthy.

For Talia, too, it only took one teacher. Talia's guidance counsellor was the most approachable, influential, and supportive figure in her secondary-school experience. According to Talia,

It was this female guidance counselor that really stepped up to the plate, helped me to believe in myself when I couldn't believe in myself. And really got me on track for Grade 12 [...] She promised me that she would talk to every teacher, help them understand what I was going through. And it was at that point that I finally found someone that understood me.

Talia's go-to guidance counsellor vouched for her, listened to her, understood her, and encouraged her whenever she needed an emotional boost. Her guidance counsellor's educational approach meant the world to Talia. Her philosophy of kindness and compassion was a foundational support for Talia's mental health throughout her time in high school.

Since Talia was so eloquent, I was curious how she would describe the qualities that underpin an approachable and supportive teaching philosophy. Talia responded powerfully, stating that: "I think, at that moment, it was for them not to be a teacher. It was for them to be human and just have a normal, honestly in a way, unprofessional conversation. Just engage in conversations as humans." As an intermediate teacher, I was taken aback by Talia's use of the word "human" to describe the supportive, adult interactions that she had longed for. More starkly, Talia's assertion that "it was for them not to be a teacher" suggests that, in her mind, "teacher" and "human" were mutually exclusive concepts.

Talia's insight is cutting, since the implication that teachers possess non-human characteristics is significant and far-reaching. I could not help but wonder what, for Talia, bestowed teachers with non-human traits. The eerily foreign, authoritarian, and disciplinary tone that Talia's critique conveyed, not only stripped teachers of their supportive, academic, and emotional value, but of their very humanity. Talia viewed unsupportive teachers as powerful, socially-distant, and even robotic figures, whose job was to merely deposit knowledge in the hierarchical and machine-like, banking system espoused by Freire (2000). Thus, the unsupportive, non-human teacher was devoid of rapport and connection-like qualities, and the subsequent social-emotional impact on students' sense of belonging and well-being was clear.

Talia further explained that her supportive teacher prototype closely corresponds with a given teacher's approach to classroom management. In contrast to the strict approaches to order and discipline highlighted in the previous sub-section, Talia described the classroom management philosophy of supportive teachers, stating that: "even when teaching, they were just their own bubbly self. They didn't have to have that professional, strict manner.... They made their classroom environment safe, welcoming, and then some." Beyond the humanizing qualities of the laid-back, conversationalist-type teacher, the teachers who were available to listen, without judgment, when students were in crisis or in need of a supportive adult, were also vital allies in supporting student mental health. Ultimately, Talia's overall point that emotionally-available teachers were approachable and supportive teachers underlines the crucial role that adopting an approachable and supportive teaching philosophy can play in positively shaping and supporting the mental health of students.

Each of the above-cited participants revealed how supportive approaches to order had a positive impact on the day-to-day mental health of students throughout secondary school. In listening to the accounts of the students, we can gain a better understanding of the supportive and humanizing teaching approaches that can make a difference in the lives of secondary-school students in Ontario. At the heart of an approachable and supportive teaching philosophy was a transparent, emotionally-receptive, and community-oriented educator. Furthermore, educators who subscribed to a supportive teaching philosophy were not afraid to be vulnerable or genuine; they were not afraid to show their humanity; and, they were not afraid to make it known that they were available to listen to students in times of need.

The findings in this section suggest that a supportive educational philosophy is the antithesis of a strict and order-driven approach to education. A supportive educational

philosophy is neither a mean nor an aggressive approach to order, as several participants noted. It embodies the practical necessity of rules and structure but also recognizes the primary importance of being adaptable and understanding of individual students' cognitive and mental health needs. Furthermore, a supportive educational philosophy prioritizes the importance of building and nurturing teacher-student relationships.

The participants described the teachers who embodied a supportive philosophy as authentic, approachable, and multi-dimensional; that is, they were concerned with much more than teaching and assessing the given curriculum. Supportive and approachable educators valued relationships, and they valued community. A supportive and approachable educational philosophy translated into teachers who were kind, caring, and compassionate of the social, emotional, and mental health needs of their students. Finally, something as simple as initiating a friendly and non-academic conversation with a student outside of class went a long way in building positive teacher-student relationships.

Overall, what is most noteworthy about the findings in this sub-section is that the supportive and approachable quality of the teacher-student relationship proved to be much more important than the quantity of positive teacher-student relationships. Seriously considering the above-data, one can see that when teachers adopt a supportive and approachable educational philosophy, there are real, measurable, and positive mental impacts in the lives of secondary-school students.

Teaching and Assessment Practices

In this section, I shift the discussion from educational approaches to order and discipline to consider the student mental health impacts of specific teaching and assessment practices. Similar to the previous section, I begin by detailing the youth-identified, unsupportive teaching

and assessment practices and their impacts. I then conclude by, again, shifting the focus away from those less-than-satisfactory and unsupportive teaching and assessment practices to the best and most-supportive teaching and assessment practices for supporting student mental health. This second sub-section will, thus, pave the way for the emergence of the best mental health practices for educators moving forward.

Unsupportive teaching and assessment practices.

Whole-group presentations.

Greg poignantly reflected on how one particular teaching and assessment practice—the whole-group presentation—impacted his mental health in the classroom. For many students with anxiety, performance-based tasks, such as whole-group presentations, can be daunting; and, in Greg’s case, daunting was an understatement. Greg explained how his social and performance anxiety was an everyday reality for him throughout secondary school. Greg regularly endured extreme paranoia in the presence of large classroom groups or crowds. As such, Greg routinely spent his class time planning his exit routes in order to avoid large groups of people. If the hallways were crowded, Greg would immediately seek out the nearest exit sign. Through the assistance of his guidance counsellor, Greg eventually received an accommodation to leave all of his classes 10 minutes early, so that he could avoid groups of people. Unfortunately, Greg’s teachers in his academic classes were far less accommodating and inclusive when it came time to formal assessment.

Greg spoke in detail about how his teachers in the academic stream would heavily rely on whole-group presentations as an assessment method. In Greg’s words, “in academics we had more stand-ups in front of the class, and I just felt pretty anxious in front of the class where everybody’s watching you.” It was, therefore, not a coincidence that Greg’s attendance record

started to slip when he switched into academic classes. The severity of Greg's social and presentation anxiety, paired with a lack of differentiated and inclusive assessment, impacted Greg's attendance and overall learning. When I further questioned Greg about why whole-group presentations impacted his mental health in the classroom, he candidly explained that there were "just so many people in the classroom. And then feeling anxious, watched, and maybe people talking about me." I wondered, however, whether his teachers knew about the extent to which these sorts of presentations caused him distress, and whether or not he was offered alternative assessment types. Greg admitted that his teachers probably thought that "he was shy and stuff"; and, consistent with the data in the first section of this chapter, Greg never felt that he could approach his teachers about his mental health.

The prevalence of whole-group presentations in academic classes made it difficult for Greg to achieve academic credits throughout secondary school. That said, all classes were challenging for Greg because of his mental health symptoms, yet some classes were less stressful than others. For example, Greg noted that he was less anxious and more successful in the applied stream. He even found brief success in an alternative classroom, where small class sizes were the norm. As for the time he spent in academic classrooms, Greg candidly divulged that, initially, he tried to push through whole-group presentations, but he eventually resorted to lying to avoid presenting. For example, Greg explained that he would frequently tell his teachers that he did not do the work, that he was not ready, or that he lost it. Avoiding presenting was far easier than exposing himself to the dread and panic of what he perceived to be public humiliation for a credit. Ultimately, the prevalence of the whole-group presentation method and the perceived unapproachability of teachers significantly impacted Greg's day-to-day mental health in secondary school.

Similar to Greg, Sara also identified an awful experience with whole-group presentations in secondary school as a feature that impacted her mental health:

I had a really bad panic attack that day, still not knowing what it was; and I was in the bathroom by myself. So, I went up to [my teacher], and I was teary-eyed and was like “I can’t present today.” And, she made me do it, so I failed that presentation. She was like “suck it up” kind of thing.

This unsupportive approach to Sara’s mental health needs during a panic attack proved to be a traumatic assessment experience for her. In contrast to this scenario, Sara also reflected on a teacher who approached her presentation anxiety in a much more supportive manner. Instead of forcing her to present when she was experiencing an anxiety attack, the second teacher, instead, encouraged Sara to focus on her breathing and offered her an alternative space to sit and relax. More significantly, this teacher moved her presentation to another date. The second teacher’s approach proved significantly more supportive of Sara’s anxiety around presentations.

Nevertheless, whole-group presentations proved to be a noteworthy assessment stressor for Sara.

Traditional tests and exams.

Aside from the impact of whole-group presentations on student mental health, the youth participants repeatedly raised traditional testing, namely traditional tests and exams, as a teaching and assessment practice that led to increased stress in their day-to-day lives. For example, Talia reflected on how major tests impacted her, stating that: “I would panic so much that studying for it would be almost impossible, and I’d fail the test. And my teacher would have no idea what happened and didn’t even care to ask.” Talia’s emotional commentary on the impact of

traditional sit-down tests on her mental health calls into question the widespread use of high-stakes testing in our current educational context. Surely, there are multiple ways to capture what one has learned or to demonstrate a specific competency in an area. The traditional, closed-book test is simply one narrow way to assess student learning. More importantly, this overused, knee-jerk assessment practice is impractical and unnecessary in our current educational context, when one considers the significant impact that test anxiety and overall academic stress has on the everyday mental health of secondary-school students.

Similar to Talia, Mary spoke about how difficult exam season was for her and her peers. In her words, “I guess coming up to exam time, obviously was stressful for everyone. And, I could feel the stress of everyone around me and that kind of made me more stressed out.” I questioned Mary further, because I was really interested in what it was about traditional academic testing that had such negative impact on her mental health. Mary beautifully summed up why traditional tests and exams were so stressful for her and many of her peers, when she described her feelings in the lead-up to exams:

[A]nd then, all of a sudden, you’re piled on all of this work, and you have to memorize all this stuff, and I have really bad concentration, poor memory and stuff; trying to remember all this stuff and going through it was extremely hard.

As Mary’s case shows, the added pressure of high-stakes tests and exams contributed to undue academic stress for her. Perhaps there were other, more accommodating and supportive methods to measure what Mary knew, while supporting her mental health in the process?

Keira also reflected openly about how exams and tests were just one more stressor in her already-overwhelming life. She admitted that the academic workload in the lead-up to exams stressed her so much that she would not even study for them. For Keira, exams proved to be one more worry impacting her fragile mental health. In speaking about her worries, Keira genuinely explained that she was worried about “family life at home. I was worried about my friends. I was worried not only about my grades, but my future.” Exam period was just one more overwhelming feature in Keira’s life; and, sadly, she admitted that she did not have the resources, the support, or the desire to cope with added assessment stress in a healthy way.

Homework and workload stress.

In addition to whole-group presentations and traditional testing, general academic workload also impacted the mental health of many of the youth participants. Brandon reflected on how school workload was an ongoing and nagging stressor in his secondary-school years. When I asked Brandon to share what it was about the school work that was so stressful, he plainly stated that, “just being hard I guess. Not being able to accomplish it on time.” For Brandon, the volume of school work and the degree of difficulty wore on him. And although he felt that his teachers genuinely wanted him to graduate, he admitted to me that “there was never that extra pep talk from them.” As a result, Brandon’s mental health languished because of the perpetual pressure of a never-ending pile of school work. More significantly, in Brandon’s case, the challenges that he encountered with his learning disability were brushed aside.

Similar to Brandon, Cheyenne was straightforward in her description of how the volume of school work and homework impacted her mental health throughout secondary school. In Cheyenne’s words, “some teachers give out work, assignment after assignment.... Some teachers are just really strict when it comes to their assignments.” Interestingly, Cheyenne admitted that it

was not only her mental health that was impacted by the tendency of some teachers to unnecessarily pile on homework and assignments. Cheyenne explained that “a lot of students complained about how the teachers would give them too much homework.” In listening to Cheyenne’s account of academic stress, it is evident that overall workload impacted student mental health in her school and created feelings of general malaise for Cheyenne and her peers. Cheyenne was not a very talkative nor descriptive participant, so her mention of teaching and assessment impacts, although brief, suggests its significance in her experience of secondary school.

Holly also spoke about the impact of school workload and teaching style on her mental health in secondary school. Holly was frank about her constant feeling of being overwhelmed at school. The volume of assessments in the form of homework, assignments, and traditional tests and quizzes was unbearable for her. According to Holly, “school was always overwhelming for me because I had to be on all of the time.” When I asked what she found overwhelming, Holly responded, “it was mostly the teachers and the work...the homework. It was the homework that I had to bring home.” Holly’s point about the endless stream of work and take-home assignments outside of the classroom calls into question the link between student stress and the still-very-much-vibrant homework culture in secondary schools in Ontario.

Transmission and transaction teaching styles.

In addition to the workload, Holly made an interesting comment on the impact of lecture-copy-memorize-replicate teaching styles. Holly explained that, in certain classes, such as history and social studies, she encountered several teachers who were entirely anti-interactive and anti-engaging. In Holly’s words, “I didn’t like teachers who put papers up and made us write them down and didn’t talk.” And while everyone is entitled to their own teaching style preference,

what is significant about her reflection is that these “boring” teachers were the same teachers who were not interested in the social or emotional experiences of their students. Not surprisingly, they were also the same teachers who piled on the student workload. The boring teachers were there to transmit the subject matter one-directionally, over-assess the content, and check-out at the bell. Ultimately, these sorts of educators were charged with the narrow responsibility of transmitting and transacting knowledge from teacher to student in a hierarchical, one-directional, procedural, and hyper-curricular manner.

In the final portion of this section, I contrast the depictions of Greg, Mary, Cheyenne, Sara, Talia, and Holly of unsupportive teaching and assessment methods with a number of supportive and accommodating teaching and assessment practices that the youth participants outlined. In so doing, I argue that these inclusive teaching and assessment practices offer a mentally- and emotionally-insulating template for all students to feel safe and supported at school. Within such a supportive environment, students cannot only learn in a safe and inclusive manner, but they can also flourish.

Supportive and accommodating teaching and assessment practices.

In turning to several firsthand accounts of inclusive and accommodating teaching and assessment practices, this section also offers several insights into how teachers can best set up their classrooms to support the mental health of students. The findings below show that teachers who were open-minded enough to grant students with mental health accommodations proved to be more flexible and understanding of the individual contexts and needs of their students. As well, teachers who valued student voice and student choice in their programs were much more successful at supporting the mental health of their students. Moreover, teachers who implemented differentiated instructional and assessment strategies in their teaching practice were

far more supportive to students than teachers who opted for the traditional methods of transmission teaching and assessment that heavily rely on lecture-style learning with an emphasis on silent reading of textbooks, copying notes, memorizing, and restating information on tests, quizzes, written assignments, exams, and whole-group presentations. To clarify, I do not argue that these types of assessment methods have no place in the modern classroom, but that they should not be the primary means of assessing learning, especially in the absence of student choice. The mere inclusion of choice provided the participants with a sense of ownership over what they learned and how they showed it. I now turn to the data and review some of the findings in detail.

Mental health accommodations.

The former students identified teachers' implementation of mental health accommodations as having a supportive impact on their mental health. Only a couple of the participants had a formal IEP to support their learning. Thus, the bulk of the assessment accommodations outlined below were teacher-driven and in-the-moment pragmatic ways to support student learning and mental health. In some cases, the teachers were not formally aware of the mental health history of the youth; however, in other cases they were. Regardless, one thing is clear: Teachers' willingness to embrace flexibility in their assessment practices was a refreshing, supportive, and impactful feature in supporting the mental health of the youth participants.

One supportive example was presented in the first part of this section, in the discussion of the importance of implementing presentation accommodations. The student participants mentioned several other examples of supportive teaching and assessment practices—namely,

deadline extensions, walk breaks, and alternative exits—to reinforce the importance of supportive teaching and assessment practices.

Flexible workload and extensions.

Teachers who were generally more sensitive to student workload and flexible with their deadlines proved to be much more supportive in the view of the youth participants. For example, Kristin recounted how one teacher’s sensitivity to her mental health context made a big difference to her during a time of need: “Actually one teacher, my English teacher, he was very aware. And gave me 2 weeks extra to write my final essay. Because he knew I was going through rough things.” Without formal knowledge about Kristin’s experience of depression, this teacher provided Kristin with an extension during a time of crisis. This simple assessment accommodation, an assignment extension, proved to be incredibly supportive of Kristin’s mental health.

Keira also identified assignment extensions as a supportive mental health accommodation. In general, Keira felt that she could not approach most of her teachers. However, she spoke in detail about one particular teacher, Mr. Adams, who was at least willing to provide extra time for students. According to Keira, Mr. Adams understood that there were many other factors going on in the lives of youth aside from completing homework and classroom assessments. As a result, he was more than fair when it came to granting extensions to students. According to Keira,

One teacher, Mr. Adams, if I felt like I couldn’t keep up with the time limits of something, I felt like I could go to him and ask him for extra time at least. I

didn't feel like I could get much support from him, but I felt like I could at least ask for extra time.

Walk breaks and alternative schedules.

In addition to assignment extensions, some students identified walk breaks and alternative schedules as a school feature that positively impacted their mental health. For example, Greg commented about how the implementation of a modified schedule served as a supportive, mental health accommodation. In my lengthy interview with Greg, I asked him how he felt at school most days, and he responded by saying,

I [felt] okay because once I had the [mental health] problem, I got to talk to my guidance counselor and my teacher about a special program. And, I was able to come to school 10 minutes after people would regularly start class; and I would get to leave 10 minutes before everybody else got out of class.

Greg's description of how a simple scheduling accommodation bolstered his attendance record speaks volumes of the significant impact that inclusive teaching practices can have on students experiencing mental health issues.

Similar to Greg's experience, Cheyenne expressed how a walk break accommodation served to bolster her attendance and, ultimately, made her feel more comfortable at school. Cheyenne held nothing back when she explained how her experience with depression, particularly in her Grade 12 year, caused her to feel almost perpetually uncomfortable and, at times, paranoid while at school. Cheyenne recounted how she often felt in the classroom:

Well, the classroom environment made me uncomfortable, some of the students did, like at times I felt really unsafe. Like something bad was going to happen in the classroom. Sometimes I would stay home from school because I didn't want to go to school.

Fortunately, the accommodative freedom that Cheyenne was given to leave and re-enter class as needed, usually with a support staff, ultimately bolstered her attendance record and made her feel more relaxed at school. Cheyenne explained how these mental health walks varied depending on the day. Some days she would be out for a walk for 10 minutes of the class; while other days, she would leave class several times throughout the period. The main point, however, is that Cheyenne felt more comfortable socially, emotionally, and cognitively upon returning from her walk break. In Cheyenne's words, "So, I would get out of class and just kind of walk around until I felt comfortable to come back in."

Interactive teaching practices and hands-on courses.

Finally, in addition to extensions and scheduling accommodations, many participants spoke of how the instructional practices of some teachers were less regimented, more creative, interactive, and fun. I repeatedly heard various participants talk about how much they enjoyed music, art, drama, or shop class. It seemed that the creative and innovative subjects offered a calming space for the youth. As well, these subjects tended to be more hands-on and project-based, rather than transmission oriented. Many of the youth also critiqued the core subjects (i.e., math, science, English, and history) as being less accommodating and differentiated in their approaches to teaching.

It is possible that the participants had an innate preference for particular subjects; however, I do not think that their opinions were only reflective of their interests. I strongly suspect that the positive experiences they described in these creative, interactive, and hands-on courses had something to do with the teaching and assessment practices built into these subject areas. Were these sorts of classes more in touch with how students learn best? Were they less stress-inducing? Were they more creative, hands-on, and open-ended and less theoretical, rote, proscriptive, and strict than the traditional faculties (reading, writing, and arithmetic)?

Although, I cannot definitively state that the teaching and assessment practices made these classes more supportive and even therapeutic for the youth, the student participants reflected on the supportive merits of the non-core subjects. Holly, for example, reflected on how in art class, her teacher was very “hands-on, and I’m very artistic and very good at art, and she made me feel proud of myself” In a similar way, Mike reflected on the perks of his guitar class: “it was pretty fun. You got a lot of liberty.... Yeah, I was definitely more comfortable, and I was definitely happier; but I don’t think I learned more.”

Although Mike felt happier and more supported in his guitar class in comparison to, say, a math class, he candidly admitted that it was perhaps not the best class for his overall learning. Mike went on to make a very insightful observation about the teaching approaches used and the learning outcomes across class genres: “I feel like the courses where I had freedom were all very practical. Whereas the other more abstract courses were a lot of sitting, looking, and listening.” Ultimately, Mike’s insightful distinction between the practical and theoretical courses suggests that the practical classes were more in line with what he needed mental health-wise; and the more abstract, core course involved more content-driven learning to the detriment of certain learners, learning styles, and potentially even the mental health of some students. Ultimately, the

creative arts and trades programs provide a type of learning and assessment experience that is comfortable, supportive, and more enjoyable for students.

Interestingly, the supportive and inclusive merits of the arts and the trades' courses, as the youth outline, is even more relevant today. Given the current political-educational climate in Ontario surrounding the Ford government's increase in secondary-school class sizes, many critics have speculated that the larger class sizes will, inevitably, impact course offerings across the arts and trades. This is especially true in rural areas where student numbers are needed to support non-core subject programs, which has been a longstanding issue even prior to the Ford government's recent class size announcement. The stories the student participants shared suggest that the current cuts to public education in Ontario by the Ford government may have overarching mental health implications when considering that certain types of courses will be eliminated before others.

The analysis of the impacts of teaching and assessment practices on student mental health offers a number of very interesting findings: Whole-group presentations; tests and exams; academic workload (i.e., homework and traditional assignments); as well as lecture-copy-memorize-replicate teaching styles negatively impacted the mental health of the youth participants. The firsthand accounts of the student participants call into question the inclusive merits of traditional teaching and assessment practices, such as tests, exams, and homework. There is a large body of critical educational research that calls into question the overall benefits of these longstanding approaches to learning and assessment in education. The reflections of these youth on the link between teaching and assessment practices and mental health force us to ask a number of tough questions: Are formal tests and examinations outdated? In what ways

does homework and assignment volume impact student mental health? Furthermore, how can mental health accommodations better support all students in Ontario?

Seriously considering the youth-identified mental health impacts of presentations, exams, homework, and transmission teaching styles in the section above, alongside the supportive value of the normalized implementation of mental health accommodations, we open up possibilities for differentiated instruction and assessment to flourish. The implications of asking such questions are potentially far-reaching and transformative; that is to say, they impact all students, not simply those living with a mental health diagnosis. As Talia put it,

Even with people that did not have any mental health problems, it was terrifying for them to experience three tests in one day...and if that's the school system trying to teach us how to handle adult life, they're totally screwing up.

Ultimately, the findings in this chapter are very much in line with some of the colloquial arguments that underpin the ongoing anti-test and anti-homework movement in public education throughout North America.

Chapter Conclusions: The Varied Mental Health Impacts of Teachers

The findings presented in this chapter demonstrate that secondary-school teachers' educational philosophies and approaches, and their teaching and assessment practices, significantly impacted the day-to-day mental health experience of the former student participants. The findings also show that teacher-student relationships are, indeed, impactful relationships in the lives of youth. Whether these relationships are a positive or a negative

experience for youth depends on a number of supportive/unsupportive approaches to order, discipline, and teaching and assessment practices outlined throughout the chapter.

The negative mental health impact that certain teachers had on the youth participants appeared in a number of different forms. A strict teaching approach and disciplinary style, paired with an authoritarian and hyper-punitive school structure, proved unsupportive to the mental health of the youth participants. As well, various traditional, teaching and assessment practices, such as whole-group presentations, formal tests and exams, homework volume, and overall workload, significantly impacted the learning, stress levels, and mental health of the former student participants and their peers.

In contrast, various examples of mental health accommodations highlighted the transformative power of supportive teaching and assessment practices. The mere presence of one or two influential educators served as a supportive buffer for insulating a given student's mental health. Accommodating, flexible, and humanizing teachers were the most effective in supporting students with a variety of mental health needs. Ultimately, teachers are powerful role models for youth. Their propensity to impact student mental health on a daily basis should not be overlooked or taken lightly.

A closer look into the mental health impacts of implementing supportive teaching and assessment practices and school-wide mental health accommodations should be an ongoing policy focus in Ontario moving forward. The mental health benefits of approachable and flexible teachers, mentally-supportive teaching and assessment practices, and the normalized implementation of mental health accommodations and differentiated instruction methods by educators are invaluable approaches to supporting secondary-school student mental health. As Talia highlighted, special attention should also be paid to ensuring that teacher mental health is

prioritized, since caregivers with overlapping professional responsibilities are at a higher risk of burning out than those in non-caregiving professions. Thus, teacher stress management, self-care, and personal mental health management must underpin any transformational plan to build more mentally healthy and supportive schools.

The next chapter shifts the focus to the impactful influence of peer relationships on the youth participants. Again, I draw on the qualitative accounts of the youth to reinforce the well-evidenced link between experiences with bullying and sub-optimal mental health outcomes among youth. More significantly, the chapter discusses the mental health value of supportive friendships. Finally, the chapter concludes with a three-participant case study in a Hamilton-region secondary school and presents the implications of this study's most unprecedented and organic finding: The transformational power of school-based peer-support groups for mental health.

Chapter Six: Peer Mental Health Impacts: Bullying, Friendship, and Peer Support Groups

This chapter shifts the focus from the mental health value of supportive teaching philosophies and practices to the value of supportive peer relationships. In a similar vein to the previous chapter, a number of the youth identified how unsupportive peers had a negative impact on their mental health and on the mental health of their schoolmates. Although only five participants explicitly spoke about their experience of being directly bullied in secondary school; all but one participant cited examples of peer-to-peer bullying in their secondary schools, and they explained in detail how these experiences impacted the mental health of all those involved, be it victim, bully, or bystander. The mental health impacts of bullying on all parties involved is well-evidenced in educational literature (Vanderbilt & Augustyn, 2010); and they are a noteworthy and consistent finding in this study. Ultimately, the first section of this chapter explores a number of the youth participants' reflections on the impact that bullying had on their mental health in secondary school.

Following the negative peer impacts presented in section one, section two of this chapter draws attention to positive peer relationships. The supportive merits of healthy, peer relationships overshadows the negative mental health impacts of peer-to-peer bullying. Notably, the majority of the youth participants in this study identified at least one peer, and as many as three peers, as a key source of friendship and support for their mental health throughout secondary school. Similar to the previous chapter on (un)supportive teaching approaches and assessment practices, the second section of this chapter further nuances the discussion on the quantity versus quality dynamic of supportive relationships; however, this time the discussion focuses exclusively on the supportive potential of valuable peer relationships.

Consistent with the findings in Chapter Five on supportive teachers, the mental health value of supportive peer relationships was not related to *how many* supportive peer relationships existed for the youth; but, rather, it had everything to do with the *nature and quality* of the supportive friendship. Thus, the final portion of this chapter explores what it was, specifically, about these powerful peer friendships that positively impacted the mental health of the youth participants. Finally, I conclude the chapter by analyzing the most significant finding of this study: School-based mental health groups played a transformative role in supporting the youth participants.

Although school-based peer-support groups vary in size, dynamics, and style across secondary schools, the mere development of these opportune spaces for peer support in mental health is the most impactful feature that the youth participants identified. The potential for further research into the widespread influence of school-based, peer-support groups on youth mental health is important to explore moving forward.

The Mental Health Impacts of Bullying

Research on the varied impacts of bullying on the mental health of youth is not new in educational literature. As the section on bullying in the literature review in Chapter Two demonstrates, bullying has been studied in innumerable ways, across academic fields, cultures and educational contexts. Nevertheless, it remains a significant finding of this study. Consistent with educational research, this section provides an overview of the detrimental mental health impacts of experiences with peer-to-peer bullying at the secondary-school level. The discussion is not limited to the four participants who admitted to having been the direct target of bullying. Special attention is also given to several other youth reflections on the widespread and longstanding mental impact of simply witnessing bullying in their secondary school.

Bullying: Victim impact statements.

Brandon's experience with relentless bullying throughout elementary school, middle school, and secondary school was detrimental to his mental health. In fact, for Brandon, bullying was the only mental health feature of his secondary school that he repeatedly highlighted in our conversation. Brandon spoke in a numb and expressionless tone when he described his experiences of being the perpetual target of verbal harassment from his peers. Unfortunately, the daily peer taunting that he experienced eventually pushed Brandon to a breaking point, motivating him to leave the regular classroom stream for a special education program in another middle-school setting. Although changing schools was partially driven by an academic need, the negative peer interactions that Brandon experienced were also an influential marker in his decision to transfer.

As the interview progressed, I could not help but wonder why Brandon was targeted by various schoolmates. So, I boldly asked him why he thought he was picked on by select peers. Brandon painfully recalled that it was largely due to his learning disability and his appearance. In Brandon's words,

[A]t the time it was like, I'm not the smartest guy out there, so that was one.

The style I had going. I used to have long hair at the back and all, so they made fun of that.

Consistent with the most current bullying research, Brandon reported that most of the degradation he experienced took place beyond the purview of teachers and trusted adults. The teachers who did witness it were, in Brandon's view, "supportive of him and wanted the bullying

to stop.” Not surprisingly, Brandon was not the only youth in his school being targeted by peers. He recalled witnessing other peers being regularly harassed, verbally and physically, for their differences. When I asked Brandon to describe the sorts of negative peer interactions that I would see happening in the hallways of his school, he succinctly summarized the bullying landscape. According to Brandon, “you would have seen a lot of kids being better than other kids and, you know, making the other ones feel bad.” Brandon was a man of few words, yet the words he used were carefully selected and quite deliberate. Although brief, the significance of his firsthand account is no less relevant.

I still could not help but wonder about the greater impact that Brandon’s experiences had on his mental health and overall school experience. So, I questioned Brandon further to see what I could find out. It turns out that Brandon’s experiences with bullying in school significantly impacted his day-to-day decisions. He, upsettingly, admitted that his experience of always being picked on prevented him from integrating socially. It even prevented him from joining clubs and trying-out for sports teams. The mental health impact of these negative peer interactions placed Brandon in a heightened state of distrust that fuelled his depression. Although, as Brandon reported, the bullying subsided in Grades 11 and 12, he could not overcome the feeling of “people judging me.” Consequently, the mental health impacts of being a victim of and witness to bullying over the course of a decade deteriorated Brandon’s sense of self-worth at school and belonging amongst his peers. Long-term bullying led Brandon down a road of fear, isolation, and ongoing depression. Thus, the mental health impacts of bullying on Brandon are obvious and severe.

Keira, similarly, reflected on her traumatic experiences with peer bullying during her secondary-school years. Unlike, Brandon, Keira was outspoken, irritable, and indignant, as she

recounted how, frustratingly, the verbal and even physical harassment of her peers detrimentally impacted her already-fragile mental health. Throughout the interview with Keira, I sensed that her peers were never really a positive or supportive feature throughout her high school tenure. Keira shared how she painfully lost all of her friends, one after another, to what she called “passive-aggressive bullying.” According to Keira, they bullied her “not to my face. It was always behind my back, and then people would turn on me. They wouldn’t say hi.” These passive-aggressive attacks wore on Keira, causing her to feel perpetually judged by her peers in the school hallways. Over time, Keira began to avoid spaces where she felt judged or bullied. Walking down the hallways of her school became a stressful undertaking, and, eventually, this impacted her overall school attendance.

Initially, I wondered the degree to which Keira’s substance abuse issues contributed to her social anxiety and paranoia. However, once Keira explained, in detail, how her group of friends slowly unravelled and turned on her, I was convinced that the stress associated with these negative peer interactions also played an impactful role in her deteriorating mental health and, potentially, played a role in triggering her drug-induced psychosis. Keira, described the upsetting experience of her friends turning on her:

I had two friends I hung around with; we were a group of three. It was me, and two other girls. And then one day, they just all of a sudden stopped talking to me. And then every one of my other girlfriends came up to me and were like, “Why are you saying this, why are you saying that?”.

Keira was confused by the accusatory tone of her peers, since she could not recall saying any of the things they accused her of saying. The “passive-aggressive bullying” ultimately led to the demise of all of her secondary-school friendships.

In addition to the reflection on her experience with social bullying, Keira also recalled one very impactful incident of physical bullying that shaped her mental health in high school. Keira described how one of the social bullies initiated a physical altercation with her. Fortunately, Keira was not suspended for the fight because she did not initiate the attack. Instead, the school administration determined that she had attempted to defend herself. The fact that Keira was not suspended may have been positive for her student record; however, she explained how, frustratingly, it contributed to even further taunting from her peers. She recalled how, disturbingly, a number of the bullies verbally ridiculed her after the fight, claiming “you shouldn’t be getting special treatment.” Keira was left feeling physically and emotionally defiled by her peers. Sadly, Keira could not identify a single supportive peer relationship in the latter half of her time in secondary school. Tragically, she lost the ability to trust her schoolmates and felt alone, alienated, and paranoid at her own school.

It is impossible to isolate the degree to which the bullying contributed to the development of Keira’s psychosis; nevertheless, her ongoing exposure to social bullying did very little to support and insulate her during a very vulnerable time in her life. Keira felt alone and anxious at her school, and she was certain that peer-related issues detrimentally impacted her mental health on a daily basis. Keira’s experience with bullying in secondary school resulted in a lack of belonging, a lack of safety, and a lack of inclusion. Unfortunately, Keira’s experience demonstrates how the hurtful actions of a small number of peers can have a devastating impact on the mental health of youth.

Mary also reflected on the traumatic impact of physical and verbal bullying throughout her time in secondary school. Mary, who was nicknamed the “fainting goat” by her peers, struggled with a conversion disorder, which seriously impacted her nervous system and sometimes even caused her to pass out unexpectedly. These experiences were humiliating for Mary. However, many of her peers disturbingly found humour in her fainting episodes, and this tore Mary apart inside. Mary struggled to understand her peers’ lack of compassion for her physical and mental health.

Unfortunately, Mary’s experiences with bullying at her secondary school were not limited to her physical and mental health issues. Mary distressfully explained how she was regularly taunted by her peers after coming out about her sexual orientation. Mary sharply reflected on her awful experience with homophobia:

[E]veryone says that my school was a good place, not a lot of bullying happens there but I found that with me it did. I opened up about my sexual orientation, and I would get death threats, notes in my locker.

Mary further explained that the homophobic jeers seemed to worsen when she began openly dating a girl during her Grade 10 year. Mary’s traumatic experience with homophobia significantly impacted her daily mental health, fuelling the multiplicity of diagnoses that she lived with.

Verbal harassment and homophobia were not the only forms of bullying that impacted Mary during secondary school. Prior to coming out about her sexual orientation, she was in a physically abusive relationship with a boy throughout Grade 9 and the beginning of Grade 10.

She described the horrific details of this toxic relationship: “I had an abusive boyfriend when I was there that would hit me, choke me, punch me and stuff.” Fortunately for Mary, a close friend convinced her to seek support in the guidance office for the abuse that she was experiencing. Mary admitted that guidance helped her immensely to cope with her mental health and her experiences with bullying and harassment. According to Mary, “I was [in guidance] all the time. All the time. But they became such a huge impact and positive in my life.”

Ultimately, out of the horrors of Mary’s experiences with physical abuse, verbal taunting, and homophobic slurs, emerged a supportive beacon of hope and safety—the guidance department in her secondary school. Nevertheless, it is apparent that Mary’s ongoing experiences with bullying during her secondary-school years significantly impacted her mental health. Thus, Mary identified bullying as one of the main features of secondary school that negatively affected her during secondary school.

The final two participants who identified bullying as a central feature impacting their mental health throughout secondary school specifically spoke of their oppressive experiences with mental health bullying. Nicola, for example, was bullied by her peers following her in-patient treatment for an eating disorder. I was perplexed as to why anyone would ever make fun of her for being admitted to a hospital; however, it seems that some of Nicola’s female acquaintances were skeptical of the validity of Nicola’s illness.

Nicola explained that a significant number of her peers felt that she was seeking attention for a devastating and even life-threatening illness, anorexia nervosa. The stress associated with the negative peer judgments fuelled Nicola’s experience with major depressive disorder. Nicola recalled that a number of her peers misunderstood her mental illness post-treatment and made hurtful comments like, “Oh, there she goes not eating again.” For the most part, as Nicola

explained, the comments were made behind her back or just out of ear shot while glancing at her. These verbal and non-verbal attacks significantly impacted Nicola's overall well-being throughout secondary school. She felt judged, alienated, and as though she did not belong.

Similar to Nicola, Talia was targeted by a number of judgmental peers who claimed that, "well she's sharing her story because she just wants attention." Despite their callous judgments, Talia continued to share her experiences with anxiety and depression publicly in her high school. She explained that most of the bullying was non-verbal because, in her words, "there were a lot of people that just recognized me as just weird or crazy or attention-seeking." However, the bullying that Talia faced was a necessary adversity for an eventual, award-winning mental health leader. Instead of allowing peer judgments to bring her down, Talia relentlessly persevered, silencing the voices of her bullies. Talia spoke passionately about how her mental health mindset overshadowed the negative judgments of various peers. Talia's resilience propelled her; she had a burning and unyielding desire to bring positive changes to the mental health culture and support systems within her school and beyond. Her leadership in supporting various peers in mental health crisis is commendable.

Throughout the interview with Talia, I developed a growing curiosity as to how Talia was able to overcome her experience with bullying, silencing the negative peer judgments with such confidence. She responded powerfully to my query and proclaimed:

It was more so, just one person, that's all that matters. That's my goal at the end of the day. I don't care if 10 people think I'm being an attention-seeker; if one person benefited from what I said, even through school or class presentations, if anything has to do with health, I would share my story.

Ultimately, Talia and Nicola's experiences with mental health bullying were identified as key features that impacted their mental health. In Talia's case, however, her refreshing and determined leadership approach to extinguishing the negative attacks of her bullies was fascinating and noteworthy.

Bullying: Witness impact statements.

Before concluding this sub-section on the mental health impacts of peer-to-peer bullying, it is important to, at the very least, acknowledge the participants who were not directly bullied. The youth participants who regularly witnessed their peers being bullied in their school environments were also impacted in various ways. Mike, for example, admitted to regularly witnessing violence, and cited examples of sexual harassment and aggressive shouting in his secondary school. Mike was adamant that, contrary to what is often portrayed in mainstream films and television, bullying at his school was rarely physical but mainly verbal and non-verbal. Although, Mike was not himself the direct target of peer harassment, regularly witnessing school-based, peer violence impacted how he felt within his school environment. Overall, Mike's sense of safety in his school was eroded by regularly observing the mistreatment of his peers.

Kristin and Holly also noted that they repeatedly witnessed bullying in their school environment. They both used the word *judgment* to describe how petty and hurtful their peers would often be to one another. Kristin, for example, noted that students in her school who came from a lower socioeconomic background were often called "dirts." According to Kristin, she regularly heard things like, "you're retarded," "wear nicer clothes," or "go take a shower." Kristin also mentioned how hurtful rumours were a common trend within her high school. As Kristin explained, "there would be people that would come to school and be like, 'Okay, I don't

like this person, so I'm going to make up this horrible rumour that everybody is going to believe, just to ruin their dignity". In a similar vein to Kristin and Holly, Talia regularly witnessed what she referred to as "toxic friendships," which were in her words, "drama-based." However, the unfortunate and most significant takeaway message for Talia was that negative peer influences simply added one more stressor to already-overburdened students. According to Talia, the main issue in secondary school was that "there [was] a lot of peer stress, academic stress, family stress, and it [was] all at once. It's not like each of them take a break one week." Thus, the peer stress that Talia spoke of was an undeniable feature impacting the overall well-being of students.

Sara and Kristin also spoke of the school-wide impacts of a number of online bullying schemes in their secondary schools. Kristin cited examples of fake accounts that were created to humiliate select peers in their school. Similarly, Sara described a city-wide "ugly girls" website that was created and disseminated throughout her high school, presenting images of a number of female peers in her school without their consent. The social and mental health impacts of online bullying were, more than likely, devastating for the victims. However, a particularly fascinating findings of this study is that the impact of school-based bullying extended well beyond the mental health of those directly being bullied. Surprisingly, sentiments of trust, safety, belonging, and inclusion were compromised for all students in their respective schools, including those who merely witnessed the bullying and harassment.

Ultimately, this section demonstrates that the mental health impacts of bullying on youth in secondary school are severe and varied. The data in this study overwhelmingly demonstrate that the youth participants repeatedly identified negative peer interactions as a significant feature impacting their day-to-day mental health in secondary school. Not surprisingly, the five participants who were directly bullied suffered more profound and long-lasting social and mental

health impacts. That said, most of participant interviewed, with the exception of one youth, acknowledged that bullying was a serious and common problem at their school. The fact that those who were not directly bullied were able to recount vividly incidents of their peers being bullied is a significant finding to note.

The vivid nature of their witness reflections suggest that the youth participants internalized the distress of their mistreated peers. Although it is difficult to determine the degree to which the youth witnesses felt guilty about not intervening to stop the bullying, it is evident that they were concerned for their well-being. Even more difficult, though, was ascertaining the degree to which the youth could relate to or empathize with the victims. Nevertheless, the impactful link between bullying and the mental health of youth in secondary school is inextricable.

Supportive Friendships and Transformative Peer Support Groups

In contrast to the previous section, this portion of the chapter explores how supportive, school-based friendships and transformational mental health groups positively impacted the mental health of the interviewed youth during secondary school. The discussion is broken into two distinct yet related discussions. The first portion deals with the supportive power of friendships. The firsthand accounts of several participants portray the significance of having even one good friend in their life throughout secondary school. The value and nature of these supportive friendships is explored in order to gauge the overall mental health impacts of these intimate, social connections on the youth. The second portion of this final section then analyzes the transformative potential of peer-support groups. In a handful of secondary-school contexts, various participants detailed the crucial role of peer networks in supporting, maintaining, and even bolstering their overall mental health and sense of belonging at school.

The mental health value of supportive friendships.

Similar to the impactful role that certain teachers played in supporting the mental health of the youth participants, a number of participants reflected on the noteworthy influence of close friendships. In carefully listening to the youth reflections, I was particularly struck by the supportive qualities that underpin these impactful friendships. These valuable friends listened and understood each other; they found resources in times of crisis; and, they even shared their own, relatable, lived experiences with mental health. Let us briefly turn to a few case examples that demonstrate the social, emotional, and mental health power of supportive friendships.

Mike, who referred to himself as “sort of popular,” spoke of the special role that friends, unknowingly, played in supporting him throughout secondary school. According to Mike,

I had good friends, which was a big help; and I never really felt singled out. So, I guess I could say positively, as in, it was often a good experience just having known other people my age who were going through similar things.

The relatability point that Mike made is an important one to consider. Mike was adamant that simply knowing that some of his friends were struggling with similar things helped to shatter parts of the culture of silence within his peer group. Mike admitted, however, that none of his friends knew the extent of his mental health difficulties and his specific diagnosis. Nevertheless, he spoke powerfully about how his friends validated how he was feeling by making connections to his experiences, even if it was not the most profound and intellectually sound advice. For example, “I would say, ‘school is really hard or whatever is going on in my life’; and they would say, ‘I know my school is really hard, my life sucks,’ which is really great and validating.”

Comparable to Mike, Kristin, who referred to herself as a “go to my friends’ type of person,” spoke about her few very close girlfriends on whom she could lean no matter what. Kristin admitted that these friends were very young and immature and in her words, “didn’t have that great of advice.” However, despite their naivety, she insisted that her closest friends were invaluable to her because “they listened, completely.” Unfortunately, supportive friendships were not the norm for all students at Kristin’s high school. Kristin also sadly reflected on a number of peers at her school who lacked a “friend support system.” Without prompting, Kristin elaborated about how the students who lacked a friend circle for support typically visited the guidance department if they were in need of mental health support or imminent crisis counselling. Kristin shared that, tragically, several students died by suicide during her time in high school because they were “not getting the help that they needed.”

In an almost identical fashion, Talia also spoke solemnly and candidly about the youth in her secondary school who, unlike her, unluckily lacked supportive, peer relationships. Talia was humble and exceptionally grateful for her supportive friendships throughout her mental health journey in middle school and secondary school. Talia admiringly recalled, “In Grade 11, I had one person that really touched base with me. Now she’s my best friend. But, unfortunately, that’s not the case for many people.” Talia also found immense support in her award-winning peer-support group, which is discussed in part two of this section. Ultimately, Talia’s reflection, yet again, suggests that supportive, peer friendships have powerful mental health impacts on high school-aged youth.

Echoing Mike and Kristin, Mary depicted her close friends as lifelines in times of crisis. Mary explained that when she was struggling with depression in middle school, she would cry almost all of the time. Fortunately, however, as Mary explained:

I had a couple of friends that would hang on to me, take me to the classroom, make up excuses for me, take me for a walk, and this continued into Grade 9. I had the same friend help me since Grade 6, and she's still around. So, she helped me the most.

I was moved by the passion in Mary's voice when she spoke about the supportive value of those caring friends who supported her throughout her depression. Her vivid recollection of the kindness and compassion of various friends points again to the powerful impact of meaningful and supportive friendships on youth mental health during secondary school.

In a slightly different fashion, Nicola, Greg, and Holly spoke in various ways about the value of one really close friend to support them through adverse times. Nicola spoke fondly of one long-term friend that she had known since kindergarten, who was always a reassuring outlet. According to Nicola, "she stuck with me. She understood me." While several other longstanding friends ditched her when she began openly struggling with her eating disorder in Grade 9 and 10, this particular friend remained, unwaveringly, by her side. The supportive commitment of one friend profoundly impacted Nicola's mental health throughout secondary school.

Unlike Nicola, Holly's one close friend knew absolutely nothing about her ongoing mental health issues. Nevertheless, Holly identified this "close" peer as a supportive mental health feature for her throughout secondary school. In Holly's words, "I had one friend. It was easier to be close to one person rather than a lot of people, and she never knew anything." The traumatic nature of Holly's childhood abuse was likely the main reason she kept it from her closest friend. As discussed in Chapter Four, Holly never sought professional support for her

post-traumatic stress disorder until after high school; and, although her friend knew nothing of her painful and tragic past, she, nevertheless, remained a valuable and impactful peer outlet for Holly.

Greg also spoke fondly of one, valuable friend that he had early on in high school. Sadly, Greg explained to me that their friendship dissolved amicably because his friend began spending all of his time with his new girlfriend. Greg did not seem bitter about their parting of ways; rather, he was reflective about, and cognizant of, the important role that his “good” friend had in keeping him out of trouble. After their falling-out, Greg, hesitantly, attempted to branch out socially. However, Greg’s newfound peer group were far less genuine than his previous friend, and unsupportive of his, soon-to-be declining, mental health.

Greg described how his new peer group was founded purely out of convenience. From our conversation, I sensed that, aside from his one close friend, all of Greg’s high school relationships lacked substance; that is, they were void of the commonsensical, supportive qualities that we all tend to look for in close friends. Instead, his new peer group’s *raison-d’être* revolved entirely around substance abuse. They would hang out together to drink, smoke pot, and smoke cigarettes. Thus, Greg embarked on a self-inflicted and abusive lifestyle with his newfound peer group and, as a result, his mental health began to unravel.

Unfortunately, his best friend was no longer around to support him through his hospitalization and ongoing treatment for drug-induced psychosis. Nevertheless, what is significant in Greg’s recollection of his one very “good” friend is that friendships were indeed valuable and impactful for Greg. More significantly, one friend could make an impact. Similar to the findings concerning supportive teachers in Chapter Five, it was the quality of friendship that mattered and not the quantity.

Ultimately, strong friendships played varying roles in supporting a number of the youth participants in this study. Whether it was lending an ear, relating to common experiences, directing them toward appropriate mental health resources, or simply being there through all the ups and downs, these friends proved to be powerful mental health game-changers for the youth in this study. Conversely, the participants who lacked a genuine friend or supportive peer network alluded to feelings of loneliness, isolation, and disconnection. The positive mental health impacts of having one supportive peer or a small network of caring friends is an important and impactful finding of this section and of this study.

Transforming youth mental health: The value of school-based, peer support groups.

The overall merits of peer-support groups are explored in this final section. The findings detailed are presented in a two-pronged fashion. First, I weave in the student reflections to show how effective these groups were at supporting student mental health. Particular emphasis is placed on the participants' sentiments of belonging found within school-based, peer-support groups for mental health. Second, I present Sara, Nicola, and Talia's reflections on their participation in the same peer-support and mental health awareness group in a Hamilton-region high school as a mini-case study. Their outstanding case is significant because it emphasizes the school-wide, transformative leadership potential of youth-driven mental health groups. Furthermore, the findings in the peer-support group section connect nicely with the well-evidenced efficacy of existing peer-support models in overlapping mental health fields and research disciplines.

Building a sense of belonging and understanding through peer support.

The passionate youth reflections below show, tentatively, that student-driven mental health groups were identified as a very impactful feature for the former student participants.

Before commencing the analysis, it is important to note that some of the peer-support groups in the case examples solely comprised youth with mental health issues or diagnoses, whereas others were inclusive of all students. Indeed, both group models have their respective places and strengths. Cheyenne and Mary, for example, spoke passionately about their experiences of being a part of a group whose membership was exclusive to those who were living with a mental health issue or diagnosis. Now that sufficient context has been established for these peer support groups for mental health, I assess, in detail, the supportive dynamic of these school-based, peer-support groups.

Cheyenne was one of the least vocal of my interview participants. It took much prompting and teasing out for her to elaborate on anything in detail. Our discussion on peer-support groups was an exception. According to Cheyenne, in mental health groups,

at least you have people who all come together who have a mental health issue, and they actually want help and support because that's what people want.

People want to be in a group where they're heard. They don't want to be somewhere where they're alone. Let's just say that out of five friends, only one friend experiences a mental health issue, like how is that friend supposed to talk to other people? They could go to a different group with other people who have the same issues and talk about or hang out with those people.

Cheyenne's reflection was surprisingly assertive. It was definitely the most detailed response she gave throughout the interview. She was passionate about the overall effectiveness of her mental health group. This peer network made Cheyenne feel as though she belonged in her

secondary school. She felt supported because she found like-minded peers who could personally relate to and connect with her lived experiences. Notably, Cheyenne commented several times that she would have loved it if there was a similar after-school group. As well, Cheyenne proudly reported that all of the members in her school-based, peer-support group were recognized for their outstanding mental health leadership by two community organizations—Stop the Stigma and Youth in Control. Cheyenne proudly spoke about her group's role in planning speakers and informational activities for mental health week. This proved to be a wholly cathartic experience for Cheyenne. Ultimately, I sensed that Cheyenne's participation in this mental health support group was the most meaningful experience throughout her time in secondary school. Thus, the group's impact on her mental health speaks for itself.

Similar to Cheyenne's school-based peer-support group, Mary also described the impact that her peer mental health group had on her throughout secondary school. Mary was very open about how her mental illnesses caused her considerable social dysfunction. She, matter-of-factly, explained how the symptoms of her mental illnesses, in conjunction with the impacts of being bullied, caused her to withdraw socially. Fortunately, however, Mary found hope and belonging in her peer-support group. Mary vividly described how this school-based, peer-support group for students struggling with mental health issues helped her immensely. According to Mary,

[B]ecause I kind of withdrew from everything, I didn't see a whole lot of what was going on; but I did connect with people in the building that were also struggling with mental health and kind of heard their side of it, to where they also lost friends and had people talking bad about them.

Mary felt relieved to know that she was not alone in her experience of social isolation. This empowering group offered her the space to connect with others. In this supportive, peer-centred venue, she found strength in relating to the experiences of her peers. For the first time in a while, she felt that she belonged at her school. Mary described this mental health group as welcoming, “anyone could come in and join”. While the public health nurse was the caring professional at the helm of this peer-support group, the students themselves drove the therapeutic discussions and the compassionate culture.

Case study: Nicola, Sara, and Talia’s mental health group.

Nicola, Sara, and Talia spoke of the profound impact of their membership in an award-winning mental health group in their secondary school. Unlike, Cheyenne and Mary’s school-based, peer-support group, Nicola, Sara, and Talia’s group was open to all students, regardless of whether or not they were experiencing mental health issues or living with a mental health diagnosis. The inclusive spin on the more traditional, mental health support group shifted the student culture around mental health within their secondary school. This marked shift set the stage for open dialogue about student mental health. Furthermore, their mental health group carved out a welcoming space for all students to meet, nixing the notion of us and them. Since all students live with mental health, all students were welcome to join the group. Nicola, Sara, and Talia all spoke fondly of the group’s overseer—their guidance counsellor, Ms. Preston. Although it was largely a peer-driven and peer-led group, Ms. Preston was instrumental in laying the initial foundation for the mental health leadership group in their secondary school.

Nicola reflected on the therapeutic value of belonging to a mental health leadership group whose goal was to inform, support, and reach out to students in need. Nicola excitedly shared how inspiring and empowering it was for her to take on a mental health leadership role in her

secondary school. Nicola emotionally compared her high school experience in Grade 9 with that of Grade 12:

[M]e joining this group, we presented to Grade 9s and brought them information and awareness and different resources, so it was kind of cool to be able to help those Grade 9s. Because that was like me in Grade 9. Really struggling.

The mental health leadership piece that Nicola described is especially relevant to the study's findings. The therapeutic impact of peer leadership on mental health at the school level is not only noteworthy, it is potentially transformative.

Sara, similarly, described the cathartic value of the very same mental health group. Sara was genuinely excited when speaking about the cultural shift and leadership movement that accompanied her school mental health group's unrelenting expansion and school-wide popularity. I sensed that this group was doing something very special in their secondary school. In my conversations with both Nicola and Sara, I felt emotionally connected and inspired by their powerful descriptions of the group's exceptional peer-support framework.

As an intermediate teacher with lived mental health experience, their depictions sent shivers through me. I was awe-struck by the transformative impact of this mental health group within their high school. Sara passionately recalled how the group "started out small and then got huge! It's still ongoing. We won awards and stuff. We were at Bell Let's Talk ceremonies. And we won a youth award for our group!" Sara described all of the things that the group was involved with. She explained how they led multiple mental health weeks; participated in suicide

awareness training, namely safeTALK; and infused mental health awareness and resources into the Grade 9 orientation week. She attributed the bulk of her group's success to their teacher mentor and exceptional guidance counsellor, Ms. P. Ultimately, Sara and Nicola shed considerable light on the overall potential of school-based peer-support models for supporting youth mental health.

Award-winning Talia's transformative reflection.

The final portion of this section focuses on Talia's empowering account of the mental health leadership group in her secondary school. I deliberately present Talia in her own subsection for two reasons: First, her personal impact at her school was remarkable in terms of what she did to support other peers in crisis. Second, Talia's insightful and even critical reflections on her school-based peer-support group for mental health stood out as extraordinary. It is important to note that Talia was not a typical high school student; most high-school-aged youth are not emotionally capable or professionally equipped to take on a Talia-type, mental health leadership approach within their high school. Despite the exceptionality of Talia's case, there is much to learn from her experiences, perspectives, and successes.

It is important to note that when I interviewed Talia, Nicola, and Sara in Hamilton, I learned that they all attended the same secondary school. While they each shared fantastic insights, Talia's detailed analysis of the merits of peer-support frameworks, and the importance of self-care in peer-support settings, stood out from the others. Talia was a relentless social worker in her school, especially throughout Grades 11 and 12. She powerfully reflected on the mental health ambassador role that she willingly, yet quite unintentionally, adopted in her school. Her dedication to peer crisis support and youth mental health awareness initiatives was truly astounding. In my passion-infused conversation with Talia, I became increasingly curious about

the reasons underpinning Talia's school-wide, mental health popularity. So, I probed her trail-blazing mental health fame a bit further. Talia modestly and casually explained: "[my peers] knew I was school-wide recognized because of announcements or assemblies or simple announcements of, you know, 'Talia won this city-wide award for mental health or whatever.'" Surely, not everyone wins city-wide awards for mental health. Therefore, I was convinced that there was much more to Talia's story than mental health assemblies and promotional announcements, so I continued to explore her peer support role in-depth.

Talia explained that she was the go-to peer for mental health in her secondary school for students in crisis. But, what did this crisis support role entail? I was curious, so I questioned her further. Talia explained: "I had to physically answer texts in class. Someone would say, I'm in the washroom crying, and I want to kill myself." Talia admitted that she supported youth in crisis on a monthly basis. It sounded like very serious matter to deal with as a secondary-school student, with a safeTALK certificate, while coping with her own mental health needs. What about Talia's mental health as the caregiver? I could not help but wonder about the emotional toll that this crisis role had on her own health. My suspicions were, at last, confirmed when Talia shared the following insightful revelation: "Unfortunately, I was emotionally and physically exhausted too during Grades 11 and 12 because I was helping too many people." The critically reflective nature of Talia's candid assertion speaks volumes to the importance of caregiver support within peer-support settings.

Talia further underlined the value of self-care for the supporting peer, insightfully stating:

[I]t's that peer support, but then it's.... I love the concept of peer-support groups and stuff, but then where does the peer leading go? We need to make

sure the peer that is leading and listening to everyone has their own person to go to. Do they have a peer? Do they have an adult? Do they have proper family?

I was astounded by Talia's raw honesty. Talia's reflection elevates the mental health needs of the youth caregiver to the same plateau as the peer in crisis. The inclusive spirit of her reflection seriously considers the value of mental health for all. Ultimately, the importance of self-care for youth caregivers is integral to promoting a more effective and sustainable model of school-based peer support in Ontario.

Talia was a highly inspirational interviewee. She was humble and perceptive. She was a fearless leader and a tireless social-justice advocate at her secondary school. In fact, Talia's dedication to supporting youth continued well beyond secondary school. Currently, she is enrolled in a social work program at a local college, with the hope of one day joining the social work profession. Talia's career choice was significantly influenced by the overwhelming success of the peer-support group, which flourished in the latter half of her time in secondary school.

Talia was steadfast in her belief that peer support was an invaluable piece in reshaping the student mental health culture in her secondary school. Talia powerfully conveyed the transformative potential of implementing peer-support networks in all secondary schools across the province when she stated:

In high school, the only thing that truly shined was that peer-support group. Nothing else really. It was us running school-wide events and school-wide assemblies that really helped [our school] engage as just one community or as

a family for just even a 2-hour assembly. At that moment, it was just the realization that we're all in this together, no matter if there's drama aligned or stigma aligned, we're still in this.

Seriously considering Talia's commentary, we recognize the emotionally-insulating power of peer relationships. More importantly, we validate the movement to combat the harmful impacts of mental health stigma, while promoting a culture of belonging within schools across the province. Whether the prospective, province-wide mental health support groups are inclusive of all students, or solely comprise students with mental health issues, is contingent on the specific needs of the students in a given school context.

Although the ideal premise of school-based, peer mental health support networks is to include all students; a smaller, needs-based faction may be an appropriate and even necessary accommodation to support diverse populations, since not all students feel the same way about large group settings where students with or without mental health issues congregate. Nevertheless, there remains a time and place for an inclusive model and a needs-specific model.

Chapter Conclusions: The Mental Health Impacts of (Un)supportive Peers

This chapter has touched on three main findings. First, the impacts of bullying presented in this chapter were well-evidenced in the reflections of the youth participants. The mental health impacts of peer bullying were diverse and depended on specific circumstances; that is, who was involved, the nature and type of the bullying, and the role the youth assumed. Nevertheless, both victims and observers of bullying were negatively impacted to varying degrees. Second, participants accounts demonstrated that peer-support groups for mental health were positively impactful networks in supporting the mental health of specific, needs-based student groups in

various Ontario secondary schools. Third, inclusive, school-wide mental health groups, made available to all students, played a significant role in reshaping the mental health landscape and overall culture of various secondary schools in the study. While the implementation of both needs-specific and inclusive models proved effective and impactful across several secondary-school contexts in Ontario, the supportive outcomes of these groups were largely determined by student composition and the authenticity of participation. Although Talia's peer-support role was shown to be a lifeline for many students in crisis, the emotional impact on Talia suggests that special attention is required to support the mental health of the peer caregiver. Even with safeTALK training, youth in a supportive crisis roles are particularly vulnerable to emotional depletion. However, caregiver burnout is not exclusive to youth; it also impacts adults a wide array of caregiving professions. Whether or not youth are more susceptible to caregiver burnout in crisis support settings should be explored further.

In concluding this chapter, it is important to note that, in recent years, the fields of social work and mental health care have effectively implemented peer-support workers and models across a variety of programs and services within a diversity of contexts and communities, and their overall effectiveness is well-evidenced (Mahlke, Kramer, Becker and Bock, 2014; Repper & Carter, 2011). Thus, the potential value of integrating a peer-support paradigm into the Ontario secondary-school system is as epistemic as it is pragmatic. Underlining the importance of peer relationships elevates the importance of listening to youth voices on mental health in schools. Since youth are the experts on their own lived experiences, drawing attention to peer connections and relatability is both theoretically and practically valuable. The notion that youth establish genuine and relatable connections with similar-aged peers in their secondary-school

context is not only colloquially observable and commonsensical, it is well-supported the, above-cited, youth accounts in this chapter.

Chapter Seven: Conclusion

The concluding chapter highlights the tentative findings of the three results chapters, Chapters Four through Six. It also addresses the limitations of the research, potential future research directions, and the youth recommendations for improving mental health supports for secondary-school students. This dissertation set out to answer the following central research question: According to former secondary-school students with a mental health diagnosis in Ontario, what features of their secondary-school culture impacted their mental health?

Intersecting Experiences

I began this dissertation by sharing my own experience with mental illness. The purpose of sharing my own story was to humanize the research agenda. Having analyzed the experiences of the 11 youth participants, I feel that it is important to briefly intersect my own experience with the youth-driven findings. Thus, the question remains: Where do my experiences fit with the emergent themes of this study? Although my experience with mental illness was more pronounced throughout my post-secondary-school years; there is, nevertheless, one significant point of thematic intersection with the youth accounts: The gendered culture of silence.

Youth descriptions of what I have called the culture of silence in schools resonated with me. For years, I remained silent and delayed accessing support for my languishing mental health. Some of my mental health denial can be partially explained by the psychosocial symptoms of my experience with anxiety, depression, and post-concussion syndrome. However, the other two major factors which drove me to mental health silence were, undeniably, the impacts of stigma and hegemonic masculinity. To my detriment, I silently internalized this stigma and refused to share my mental health struggles with anyone for years.

As the middle child in a family of three boys, who participated in a variety of competitive sport cultures, I was repeatedly presented with hyper-masculine caricatures and cultural anecdotes of the quintessential “man.” The ideal “man” that I was introduced to from a young age was certainly not encouraged to share feelings, tears, and struggles. Rather, emotional challenges were to be conquered via avoidance, aggression, or suppression. Within this restrictive masculine construct, there was virtually no space for vulnerable conversation. Within the limiting confines of this gendered hegemony, I subconsciously perceived reaching out to others about my mental health as weak; shameful; and, worst of all, feminine. It took years of sociocultural privilege and access to critical education for me to meaningfully unpack how I internalize(d) and conform(ed) to the cultural requisites of hegemonic masculinity, and this self-reflection is ongoing.

Overall Research Contribution and Discussion of the Findings

Reflecting on my own experiences and drawing on the experiences that the participants shared with me, this study offers four major findings, which have both theoretical and practical significance. Theoretical because they help us to better understand the complex challenges youth face in secondary schools in Ontario today, and practical because they can help ministries, school boards, teachers, mental health workers, and caregivers to develop more effective, youth-driven and research-based strategies for supporting student mental health within public schools and communities across Ontario.

Finding 1: Gendered performances in the culture of silence.

The first major finding of this study was revealed in Chapter Four. The findings that emerged from the youth reflections revealed that a culture of mental health silence was the norm

within the participants' public secondary schools in Ontario. There were, of course, disruptions and interruptions to this culture of silence. Most of the participants found immense emotional support in one or two very close friends; while others found connection, understanding, and belonging in a school-based peer-support group or mental health group. These noteworthy exceptions to the culture of mental health silence are further detailed in findings three and four on supportive peers and school-based mental health groups.

Exceptions aside, the culture of mental health silence was characterized by participants' lack of ability to engage in open, authentic, and supportive conversations about mental health with both peers and teachers. Many of the youth felt that they would be negatively judged or mistreated for openly discussing their experiences with mental health within their secondary schools. Stigma was the driving force behind the culture of mental health silence across the cases.

The participants described a secondary-school culture that was rampant with interpersonal distrust on mental health matters. The students feared for their social reputation; and, instead of speaking out, many chose to remain discerningly silent about their day-to-day mental health challenges. For many students, the culture of silence delayed, and even prevented them, from seeking professional mental health support for their mental illness until well beyond secondary school. That said, the way that stigma was internalized and performed was unique to each individual context. However, there proved to be very significant differences in how mental health silence was performed across gender.

The gendered nature of the culture of mental health silence was the most significant finding to emerge from Chapter Four. Although, generally, both male and female participants assumed an acting role when hiding or disguising their mental health within their given

secondary-school contexts, the pathways to the same outcome and the level of performative awareness differed significantly across gender. Although both male and female participants were mental health actors, there were gendered-informed differences in how they adopted their acting roles. Generally speaking, the female participants were deliberate actors, electively hiding their mental health status in order to preserve their social reputation. In fact, several of the participants explicitly referred to themselves as “actors” or “as acting.” A number of the female participants were, admittedly, hiding from stigma, which meant that they were strategic about who they chose to disclose their mental health experience and status to. Ultimately, various female participants were keenly aware of the oppressive social consequences of mental health stigma and their strategic decision to remain silent was a matter of social preservation.

Conversely, the male participants were ostensibly unaware that they were acting. Rather, their acting performance was seemingly ingrained in a sociocultural hegemony of traditional masculinity. The male youth were unconsciously “sucking it up” and “toughing it out” because, according to the commonplace and toxic norms of hegemonic masculinity, that is simply what tough guys do. Thus, for the male participants, remaining silent was less about preserving one’s mental health reputation, and more about unconsciously preserving their perceived masculinity, which was inextricably tied to their social reputation.

Ultimately, acting and hiding was a common experience for both male and female participants, yet the reasons behind the hiding and acting differed across gender. The female participants were conscious, deliberate, and strategic in the quest to protect and preserve their social reputation, whereas the male participants were seemingly unaware of the motives that underpin their hiding, in particular their unconscious, hyper-masculine production.

Finding 2: Teacher impacts—(Un)supportive approaches and practices.

The second major finding of this study pertains to the youth-identified impacts of various educational approaches to order and discipline and select teaching and assessment practices. The findings demonstrate that teacher-student interactions have profound mental health impacts on youth in secondary school, both positive and negative. Similar to the varied experiences and youth performances of mental health silence, the mental health impacts of teachers were also varied, context-specific, and highly individual. There were, however, a few noteworthy trends in the teacher impacts across the 11 cases.

Unsupportive educational approaches to order and discipline and authoritarian-type school structures were repeatedly identified as having a detrimental effect on the mental health experience of the youth participants. When teachers carried out a strict and authoritarian approach to bathroom, attendance, and uniform policies, which remain typical approaches in many secondary schools, this contributed to overwhelming academic and social stress among the youth in this study. Furthermore, strict, inflexible, and structure-obsessed teachers missed out on building authentic human connections and supportive relationships with the youth. These were, ultimately, the connections and relationships that the youth valued and sought at school from supportive adults.

On the teaching and assessment front, unsupportive practices were also found to have a significant impact on the mental health of the youth. The teachers who embraced traditional, transmission-based teaching formats proved to be unaware and unsupportive of the mental health needs of their students. According to the youth, hands-on and interactive teaching styles, which were the identified norm in technology and art-based classes, were refreshingly supportive exceptions to the transmission-obsessed teaching and assessments norms found in the more

traditional, lecture-style classes of the various “core” subjects, such as English and math. Furthermore, traditional high-stakes tests and formal examinations were repeatedly identified assessment methods that contributed to a significant source of stress in the youth reflections. As well, the practice of assigning an excessive workload to students, particularly in the form of homework, was shown to be a significantly detrimental practice through the lens of youth mental health. Whole-group presentations were also identified, by many of the participants with anxiety-based symptoms, as assessment practices that created an inordinate amount of mental health distress. Finally, the teaching practices that espoused inflexible deadlines and afforded no extensions, in conjunction with a lack of understanding of the individual needs and mental-emotional-social contexts of the students, were shown to be highly detrimental features to the mental health of the youth participants.

Refreshingly, the teachers who regularly implemented mental health accommodations in their everyday classroom were identified as espousing supportive educational approaches and teaching and assessment practices. Remarkably, for most of the youth participants, all it took was one or two supportive teachers to make a mental health difference. A more flexible, “laid-back” and “less-strict” approach to order, discipline, and structure within secondary schools was deemed a supportive mental health feature by the youth. Additionally, those “human” teachers, who took the time to get to know the specific learning and emotional needs of their students, proved to be valuable supports for several youth participants. Secondary-school teachers who genuinely listened, understood, and cared about more than simply the academic piece of schooling—that is, the emotional, social, and mental health needs of their students—proved to be invaluable role models and adult supports for many of the youth participants.

Interestingly, teachers who were described as “funny” or as having “a sense of humour” tended to model mentally-supportive teaching and assessment practices. The insulating value of assignment extensions, alternative assessments to traditional testing and small group presentation formats, and interactive and hands-on approaches to teaching were frequently identified by the youth as supportive mental health features within their secondary-school contexts. Thus, normalizing the implementation of mental health accommodations for all students, based on the above-mentioned supportive approaches and practices, would serve to bolster support for student mental health in secondary schools in Ontario. Such accommodating and supportive educational approaches and practices should be consistent for all students, regardless of whether or not a student has an IEP. This would also ensure the students’ and the parents’ right to non-disclosure of their mental health status.

Before I conclude the discussion on this finding, it is helpful to briefly refer back to the theoretical framework of this dissertation. In the stories the youth participants shared, many of the negatively impactful teaching and assessment practices are in line with what Freire (2000) calls the “banking model” of education. Freire’s (2000) critique of the banking model of education sheds light on the overtly dehumanizing nature of this model, since, through this lens, the sole purpose of education is to transmit and transact information.

Within the Freirean banking model there is no space for supportive teacher-student relationships, no space for dialogue, creativity, critical thinking, interactive or bidirectional learning, or the possibility of social transformation. Learning is, therefore, reduced to a machine-like and automated process, which excludes human interaction and social relationships, including teacher-student ones. Such a dehumanizing model of education largely ignores or, at the very

least, downplays the place of student mental health and emotional well-being in the education of youth.

Finding 3: Peer impacts—Bullying and the value of friendship.

Similar to the nuanced character of the previous finding, the mental health impacts of peers were also varied. Consistent with the literature on bullying across cultures and national contexts, detailed in the dissertation's literature review in Chapter Two, the youth identified bullying as a significant school-based feature impacting their mental health. This finding was not surprising, given the overwhelming body of research to support this. Participant accounts showed that negative peer relationships, specifically in the form of bullying, profoundly and negatively impacted their day-to-day well-being. Not all of the participants admitted to experiencing bullying directly; yet, fascinatingly, those who witnessed bullying were also significantly impacted. Thus, the findings suggest that both victims and witnesses identified school-based bullying as a serious feature negatively impacting their mental health. None of the participants admitted to being bullies, yet the literature on this also demonstrates negative mental health outcomes for bullies, nevertheless.

Conversely, healthy peer relationship served as a buffer against the negative impacts of youth bullying. The supportive value of friendship, particularly the propensity to positively influence the mental health of the youth participants, was well-documented across all cases. Although the nature, quality, and quantity of peer friendships varied from participant to participant; what was, nonetheless, consistent is that the presence of as few as one close friend significantly improved the daily mental health experience of the youth. Supportive friendships served to insulate the mental health of the youth while at school by offering them an interactive and even therapeutic outlet for assistance in times of emotional difficulty. Furthermore, the sense

of belonging, inclusion, and understanding that grew out of their meaningful connections with similar-aged peers bolstered their overall sense of emotional and social stability. The interpersonal equilibrium that emanated from positive peer relationships is a very noteworthy finding because it underlines the supportive value of genuine human connections. It seems intuitive and plausible that these findings could be extended across age groups and cultures, since authentic friendships are universally observable and meaningful in human societies.

Finding 4: The transformative potential of peer support groups

The most significant and transformative finding in this study was revealed in the final section of Chapter Six. This section demonstrated that various mental health groups and peer-support models within a number of the participants' secondary schools were pedagogically remarkable, school-based features that supported the mental health of the youth participants and of their peers. This chapter underlined the most significant exception or interruption to the assumed coherence of the culture of mental health silence presented in Chapter Four. In zooming in on the experiences of youth in school-based peer-support settings for mental health, one can see how various secondary schools in Ontario are beginning to disrupt the culture of mental health silence through a community-based response. The propensity for peer-support models and inclusive mental health groups to transform the stigma-laden landscape of many secondary schools in Ontario is a hopeful prospect.

A three-participant case study in a Hamilton secondary-school context underlined the leadership approach and cultural-resistance potential of the development of inclusive, school-based, mental health groups. The mental health group, outlined in the case study, bolstered support for education on and awareness of mental health within the youths' secondary school. The formation of such a culturally transformative group was a bold and deliberate act of mental

health reclamation within an educational space that was largely defined by the culture of silence described in Chapter Four. The development of this peer mental health group was novel and ground-breaking within the given secondary-school context. The qualitative findings on this particular mental health group serve as an educational model to disrupt the oppressive currents of mental health stigma in secondary schools. Through the creation of a meaningful and supportive community of youth, stigma-laden school contexts can be transformed into educational sites of social change. Furthermore, membership within such a group significantly impacted the mental health and emotional well-being of the youth involved in a supportive, empowering, and life-altering fashion.

The inclusive, positive, and safe community forged by the mental health group in the case study, bolstered the youths' sentiments of social belonging, inclusion, and overall mental health understanding amongst the members and non-members in the school community. More significantly, members took part in the group regardless of whether or not one had a formal mental health diagnosis, since all students and individuals live with and experience the fluidity of mental health. Ultimately, the award-winning group's cultural contributions led to greater understanding and support for the needs of all students, including mental health needs, within their given secondary-school context and beyond.

Limitations of the Research

All studies have theoretical, methodological, and practical limitations, and it important to state them clearly and transparently. This study's limitations will be addressed in this section. I will begin by discussing the limitations of the small sample size and the selection of participants. The findings in this study emerged from a limited sample: 11 cases of former Ontario secondary-school students living with a mental health issue or diagnosis during secondary school. A small

sample size is not necessarily a bad thing when one considers the detailed responses accessed through the in-depth interactions with youth. In fact, in-depth interviews can be just as easily framed as a strength, privileging the value of depth over breadth. That said, since this study's small sample size did not control for diversity, there are invariably methodological limitations to the generalizability of the findings. Nevertheless, reporting on the general thematic trends of the data and the implications for Ontario secondary schools remains an invaluable contribution of the research. Furthermore, the themes which emerged provide key discussion points for policy makers and educators alike, and they also provide a launching pad for the development of future research and educational agendas in the area of secondary-school student mental health impacts in Ontario.

Another potential limitation to the study grew out of my participant selection process. I included every youth participant that met the inclusion criteria of the study, even though that was not my original intention when I designed the study. My response rate was much lower than I had anticipated, so, unfortunately, I could not strategically select participants to ensure representation from a diversity of sociocultural backgrounds. The sociocultural identities of the participants were what they were because those just happened to be the individuals who responded to the surveys within the participating CMHA branches. Had I received more survey responses, I could have potentially controlled for cultural diversity. For example, no one in the study identified as being a member of a visible minority group, which suggests limitations in the cultural representation facet of the participant pool. Although this study has regional representation, boasting access in both urban and rural settings, as well as in northern, southern, central, and western regions of the province, this study's findings did not control for the one's location, so it is merely a symbolic gesture of regional representation and accessibility.

Only four of 31 CMHA branches across the province agreed to circulate and advertise my study within youth program spaces. Speculatively, the reasons for such a low branch participation rate had to do with the unionized workload of the employees. While I compensated the youth participants for interview participations, I did not compensate the CMHA staff for assisting with recruitment and for making themselves available for crisis support following an interview. Thus, only having four branches advertise my study limited my overall response rate, which, by extension, limited my ability to screen prospective participants for fair and equitable representation of a variety of sociocultural groups. That said, there was an overwhelming response rate by those participants identifying as LGBTQI—three out of the 11 participants—and, thus, this study boasts excellent representation from this historically marginalized group.

In addition to some of the sociocultural limitations, this study did not control for specific mental health diagnoses. Instead, youth participants were chosen based on whether or not they were living with a professionally diagnosed mental illness or mental health issue during secondary school. Future research could further explore the youth-identified, school-based mental health impacts within each diagnostic category, since each mental illness has a different set of diagnostic symptoms, which, through a medicalized lens, could influence one's lived experience in a comparative way. That said, through a critical disability lens, to assume that one individual with depression, for example, experiences school-based mental health impacts in the same way as another individual with depression, simply because they have the same professional diagnosis, is a fallacious argument.

All youth experience their mental health issue or illness in a highly individual and varied fashion; thus, controlling the study for a particular diagnosis, although seemingly logical, neat, and calculated, would actually limit the scope and breadth of the youth accounts and, thus, have

serious implications for the findings. By opening up the study to all students living with a mental illness or issue throughout secondary school, the point is made that mental health impacts are a universal experience for all students. Mental health impacts all students: students living with a professionally diagnosed mental illness; students identifying as living with a mental health issue; and student who do not experience a mental health issue at all but who are still shifting on Keyes' (2002) fluid, horizontal mental health continuum.

The final limitation to this study relates to its retrospective nature. Although the decision to access the voices of youth 2 to 5 years after secondary school can be met with skepticism about the reflective accuracy of the youth accounts; there, nonetheless, remain several merits to choosing former secondary-school students as the study's participants. First, it was more feasible to access participants with an existing mental health diagnosis through a community organizational setting. The gatekeeping which takes place within public school board contexts can often prevent researchers from accessing student participants, especially when the focus is on youth with mental health "disabilities."

Second, there is also the possibility that current secondary-school students would hesitate to divulge all of the impactful details, since they still exist within the school context and might fear repercussions for their honesty. Even with the guarantee of confidentiality, the participants would have been less likely to be open and transparent in their responses. Finally, when dealing with recently exited secondary-school students, the participant demographic makes a notable shift from interviewing teenagers to interviewing young adults. The potential benefits of this age shift are developmental, since young adults may perhaps offer a more mature perspective than their younger self. As well, time away from secondary school may contribute to greater

memorial insight into their experiences, even though critics of reflective research would focus exclusively on the overall reliability of the memories.

Ultimately, this study does not claim to answer anything beyond the central research questions posed. It is a narrative and phenomenological exploration because it sets out to thematically analyze the school-based mental health impacts of former secondary-school students. Thus, the overall value of this study is found in listening to and reclaiming the youth voices. The researcher interpretation and analysis, and the subsequent thematic findings, creatively weave the stories together. In no way does this study proclaim to get everything about secondary-school student mental health impacts right. There is no positivist truth embedded in these findings. The only truth in these reflections is found in the authenticity and honesty with which the youth participants described their experiences. The findings of this study are tentative at best, since the sample is small and the inclusion criteria did not strictly control for diversity. Nonetheless, my job as the researcher was to find a creative and analytically-coherent way to thematically report on the data; and that is what I have done. Despite the limitations and tentative nature of this study's findings, they can, nevertheless, serve as a discursive starting point for future research agendas exploring similar questions.

Future Research Directions

In reflecting on the findings and limitations of this study, and then situating them alongside the youth policy recommendations, a number of opportunities for future research directions emerged. First, it would be interesting to conduct a similar study with youth focus groups as opposed to one-on-one interviews. The community and participatory dynamic may lead to new insights about the central research questions, since group interaction can bolster creativity. The collaborative merits of focus groups may be especially beneficial in addressing

the second research question when considering mental health policy recommendations moving forward.

Second, cognizant of the study sample's limited diversity, it would be interesting to explore whether or not a more diverse sample yields similar or dissimilar findings. Additionally, while there was substantial representation of LGBTQI youth in this study, greater representation of non-white participants would be beneficial. It would be fascinating to approach and compare the same research question across a variety of marginalized groups to better understand how youths' experiences with specific forms of marginalization may exacerbate their school-based mental health impacts. For example, how does the experience of racialization or poverty further impact youth mental health in secondary schools?

Third, in addition to comparing qualitative responses across a diversity of sociocultural groups, it would also be interesting to explore the same research questions with secondary-school teachers. Since the youth identified teachers as potentially supportive figures within secondary schools, I am curious to explore whether or not a sample of secondary-school teacher reflections in Ontario would reveal comparable results to the youth sample. Furthermore, to what degree are teachers aware of their potentially supportive mental health role? Are they cognizant of the impact that various educational approaches and teaching and assessment practices have on the mental health of their students?

Fourth, the outstanding leadership role that Talia played in the formation and growth of her secondary school's inclusive and supportive mental health group sheds light on the power of a community and peer approach to mental health. Nevertheless, research on the nature, uses, and transformative potential of school-based mental health groups is limited and requires further inquiry. In particular, the crisis-support model that Talia presented raises significant questions

regarding school-based, peer-support models. Since Talia's crisis-support role was an exceptional case and emotionally taxing for her, the question of caregiver support within school-based, peer-support frameworks is an important area to consider further, individually, socially, and legally.

As well, determining which type of mental health group can best support a given school community and mental health context is an important issue to consider. Based on the findings in this study, inclusive, peer-driven mental health groups have the potential to promote belonging, social change, and anti-oppressive education throughout the entire school community; however, there are, perhaps, school contexts and specific circumstances where diagnoses-specific, peer-support groups are more appropriate and effective solutions. Further research into which model best suits a given secondary school context and youth culture is needed, especially when considering the legal implications of peer leadership in mental health crisis support, with or without safeTALK-trained students and alongside a professionally-accredited social worker.

Fifth, in addition to the caregiving conversation surrounding peer support, a similar conversation needs to take place around the subsequent well-being and training of teachers. Despite the recent province-wide push to better train teachers to support student mental health, the role of teachers cannot and should not evolve into that of a full-blown mental health professional. There are very real legal and practical limitations to such an evolution in professional roles.

Inevitably, teachers should be trained to better support the mental health of students; however, in the Ontario context where there is a shortage of mental health professionals, the solution to the burgeoning mental health problem and addressing the social-emotional needs of students in Ontario schools should not be offloaded onto the shoulders of teachers. Instead, more

mental health investment is required in Ontario public schools. This investment should be in the form of more on-the-ground mental health professionals within schools (i.e., social workers, educational counsellors, child and youth workers, mental health nurses, and educational assistants); in conjunction with more knowledge, awareness, and training for teachers on how to set up their classrooms preventively to best support the needs of all students, including mental health needs.

Finally, many of the stories that the student participants shared call into question the level of mental health knowledge, understanding, and awareness of their teachers and indicate that teachers' mental health literacy undoubtedly impacts student mental health. Not surprisingly, it is well-evidenced across educational literature that teachers play a key role in supporting students well beyond their academic needs; in fact, teachers can play a vital role in instilling an overall sense of purpose in their students, which can lead to positive social, emotional, and mental health outcomes for youth (Bundick & Tirri, 2014; Mazzer & Rickwood, 2015).

But, are teachers equipped to deal with the ever-increasing mental health needs of their students? What if teachers lack the mental health literacy and awareness to support the complex mental health needs of their students? More specifically, what if they lack the specialized training, professional resources, lived personal experience, or family experience to properly understand and support students with a wide array of mental health needs? What impact does a lack of teacher support for, and understanding of, mental health have on secondary-school youth? Further research into the impacts of teachers' mental health literacy on secondary-school student mental health is required.

Youth Mental Health Recommendations

Before I present the four-pronged, youth-driven platform for change below, it is essential to note that a number of the youth critiques and recommendations in this study are already reflected in recent, inclusive OME documents, namely *Learning for All* (OME, 2013a) and *Supporting Minds* (OME, 2013b). However, the fact that the Ontario youth in this study are calling for more concerted implementation and dissemination of a number of existing supportive mental health practices suggests that there is a gap between ministry mental health policies in education and the school-based implementation of them. Thus, despite recent advances in the mental health policy discourse in education in Ontario, the youth recommendations below offer critical feedback to educational policymakers, school leaders, and educators, alike, if they hope to better bridge the crucial gap between mental health policy and practice in Ontario's public secondary schools.

Now let us briefly turn our attention to the existing, ministry-endorsed, best mental health practices in Ontario's schools as of late. In *Supporting Minds* (2013b), for example, the first section of the document presents four evidence-informed ways to best support the mental health of Ontario students in the classroom and school: 1. Creating a positive classroom environment; 2. Reducing stigma—talking in the classroom about mental health; 3. Knowing your students; 4. Talking about mental health with parents and students (OME, 2013b, pp. 16-23). The second major portion of the document is devoted entirely to providing specialized diagnostic information in order to recognize and respond to student mental health problems in the classroom and school (OME, 2013b, pp. 27-137.) Perhaps the next version of *Supporting Minds* (OME, 2013b) might also take into consideration the instructional and assessment accommodations, as well as the critical mental health literacy recommendations, espoused by the youth in this study. Since the bulk of *Supporting Minds* (2013b) focuses on disseminating a diagnostic template for

educators to identify and respond to the mental health needs of youth, the next edition of this ministry document may wish to consider, and perhaps even include, the firsthand experiences and recommendations of youth with school-based mental health experience. Ultimately, this dissertation's findings may serve as a useful starting point if considering how to include the perspectives and recommendations of youth with lived mental health experience to shape educational policy and practice in Ontario.

In addition to *Supporting Minds* (OME, 2013b), *Learning for All* (OME, 2013a) offers three explicit strategies for understanding and closing student achievement gaps in Ontario's public education system. Although mental health is not directly referenced in *Learning for All* as a barrier to student achievement, special educational needs are cited (OME, 2013b, p. 11). *Learning for All* presents three, effective and inclusive, teacher-implemented instructional strategies which overlap with some of the youth-driven mental health recommendations cited in this dissertation: 1. Universal design for learning; 2. Differentiated instruction; and 3. The tiered approach to prevention and intervention (OME, 2013b, p.12). Each of the three ministry-endorsed instructional strategies in *Learning for All* (OME, 2013a) provide, at the very least, a starting point for educators and school administrators to preventively set-up their classrooms and schools in a mentally-supportive fashion. The advice to educators in *Learning for All* (OME, 2013a) is meant to be proactive and practical, balancing both the importance of considering the individual needs of all students, including mental health needs, with the realities of teaching in a culturally- diverse learning environment within Ontario's public education system.

I will now conclude this dissertation with the several important recommendations for improving mental health supports that the youth participants suggested. When I first designed this study, I set out to answer two principle research questions. The second research question

was, as experts of their own experience, in what ways can the youth reflections inform best educational practices and policy around mental health in Ontario secondary schools moving forward? While this question was not, in the end, the focus of this study, the youth participants shared insightful recommendations about improving mental health supports in schools.

Building capacity: Mental health professionals in schools.

The majority of the youth participants highlighted the need for a substantial increase in school-based mental health professionals. While opinions on the specific type of mental health professionals required varied from participant to participant (e.g., social workers, child and youth workers, educational assistants, guidance counsellors, and mental health nurses); one thing was clear: Almost all of the youth called for a drastic increase in the presence of mental health professionals in their former schools.

In carefully listening to the participants' reflections, it became clear to me that the professional mental health capacity was generally inadequate in the secondary-school cultures discussed in this study. Thus, the youth participants were emphatic about the need for more specialized and professionally-accredited mental health support staff within secondary schools moving forward. A substantial increase in ministry funding for specialized mental health staff is needed. Ultimately, political will and fiscal support are necessary for this on-the-ground shift to occur in Ontario secondary schools.

Building literacy: Mental health education and training.

In addition to an increase in professional mental health capacity, the youth participants were also adamant about the need for more specialized mental health literacy among students and teachers. The youth participants discussed an array of mental health education and training topics. For example, some participants critiqued the insufficient focus on mental health in the

Ontario health curriculum, arguing that there is simply not enough mental health content in comparison to the other health-related topics, such as sex, drugs, and bullying. Despite the inclusion of mental health in the secondary-school, health education curriculum, the youth argued that simply not enough mental health content was being covered in secondary-school courses.

The youth proposed a multitude of approaches to bolster mental health literacy, ranging from changes to the provincial secondary-school curriculum to shifting priorities in faculties of education. All in all, the youth were certain about one thing: Building greater mental health literacy capacity is a multifaceted and systemic issue that requires the collaboration of the ministry of education, faculties of education, and school boards across the province, as well as the day-to-day implementation within individual secondary schools.

Building awareness: Whole-school mental health campaigns.

Along with the curricular and specialized training recommendations above, the youth identified whole-school mental health campaigns as a crucial area of focus moving forward. In particular, a number of participants identified the importance of “mental health weeks” within secondary schools. However, one participant was highly critical of this idea, arguing that mental health should be continuously promoted within schools; and we should not rely on a special day, week, or month to focus on it.

A number of participants also spoke about the supportive potential of holding regular, school-wide assemblies to create a more positive mental health culture in secondary schools. The idea of hiring engaging youth speakers with lived mental health experience was highlighted as an effective intervention strategy. Posters and anti-stress kits were also identified as an effective means of building school-wide literacy and awareness around mental health in schools. The

practical implications of implementing these youth-identified awareness strategies more regularly should be seriously considered in both policy and secondary school improvement programs moving forward.

Building connections: Peer support and mental health groups.

Perhaps not surprisingly, the majority of participants recommended province-wide implementation of school-based peer-support and mental health groups as a practical policy solution. The youth recommended widespread implementation of needs-based and inclusive student mental health groups within secondary-school environments. The term “needs-based groups,” refers to groups specifically designed to support students with a mental health issue or diagnosis; and the term “inclusive groups” refers to school-based mental health groups, which are open to all students, regardless of a diagnosis.

Introducing a comprehensive peer-support framework into Ontario secondary schools necessitates a closer look at the potential legal ramifications of this practice. It is likely that the formal implementation of a peer-support framework for youth mental health would require an overwhelming increase in school-based, professional mental health capacity. Peer-support groups would invariably require the supervision of specialized mental health workers. Thus, the implementation of a peer-support framework as a viable school-based approach would need to occur under the direct supervision of professionally-accredited mental health workers.

Concluding Remarks

This study empowered youth living with a mental health issue or illness to speak for themselves and about themselves. The Freirean- and Foucauldian-inspired theoretical framework called for a critical, inclusive, and youth-driven approach to mental health. While all individuals,

regardless of a diagnosis, find themselves on a culturally-informed and symptomatically-fluid mental health journey, it is my view that some voices will always be heard louder than others. The reasons for this are complex; but the intersection of dominant institutional discourses with the medicalized power and expertise of mental health experts, at least partially explains the historical eclipsing of youth-driven accounts of mental health. To mitigate this exclusion, this study meaningfully engaged 11 youth participants to speak about the unique mental health impacts of their secondary-school experience. Ultimately, this dissertation is equally a pedagogical and symbolic act of reclamation and a research endeavour.

The overarching hope, however, is that this study does not merely remain a symbolic gesture; but, rather, that it plays a small part in promoting an eventual discursive shift in the area of mental health education in Ontario secondary schools. Whose voice counts and who is genuinely listening to youth are key questions underpinning the epistemic tensions and power struggles among youth and adults and professionals and non-professionals. The inability of youth to speak for themselves, and to be taken seriously by decision-making adults, must be overcome for youth-driven change in mental health to take shape in educational policy and practice moving forward.

Since I started this dissertation with a powerful excerpt from my interview with Brandon, it is only fitting that I leave the reader with a final insight from him, as well. When I asked Brandon what he recommended to facilitate mental health change in secondary schools moving forward, he was concise yet decisive in his response. “Research,” he said. “Like what you are doing.” For a moment, I was taken aback by his blunt statement, since my academic absorption in my dissertation was somewhat distorting. However, Brandon provided me with a powerful perspective and a reminder that stuck with me throughout my research and writing process over

the past several years. Brandon was right; there is immense value in conducting research. Particularly, research that reclaims the secondary-school experiences of youth living with a mental health issue or illness in Ontario. This study is only the beginning of the research quest that Brandon identified, since there remain many more related questions to answer.

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Appendix A: Preliminary Questionnaire

- 1 Please indicate your gender identity (e.g., male).
- 2 Please indicate your preferred first language (e.g., French).
- 3 Please indicate your mental health diagnosis/es (e.g., bipolar disorder). If you have more than one diagnosis, please list all of them.
- 4 When were you diagnosed by a mental health professional (i.e., general practitioner, family physician, psychologist, or psychiatrist)?
 - Before Grade 9
 - During High School (Grades 9–12)
 - After Grade 12
- 5 When did you begin accessing organizational support for your mental health diagnosis (e.g., CMHA services)?
 - Before Grade 9
 - During High School (Grades 9–12)
 - After Grade 12
- 6 Are you currently in high school? Yes/No
- 7 Did you successfully graduate from high school? Yes/No
- 8 Did you graduate or stop attending high school within the past 5 years? Yes/No
- 9 In what year did you graduate from or exit high school?
- 10 Did you attend a public or Catholic high school in Ontario? Yes/No
- 11 Where did you attend high school in Ontario (i.e., city or town)? If you attended high school in more than one location, please list all of the locations.

12 Are you currently enrolled in a post-secondary school (e.g., college, career college, or university)? Yes/No

13 Diversity and inclusion is integral to this study. We value the participation of self-identified members of all minority groups and their allies (e.g. First Nation, Metis, and Inuit; LGBTQI; individuals living with disabilities; and those identifying as members of a visible or invisible cultural group). If you wish to self-identify as being a member of one or more minority groups, please feel free to do so below.

14 Please indicate the CMHA branch where you found out about this study.

15 Personal Contact Information

First Name:

City/Town:

Email Address:

Telephone (Optional):

Thank you for taking the time to complete the preliminary questionnaire. You will be contacted if you are selected for a follow-up interview.

Appendix B: Semi-structured Interview Guide

1.) **Background** (i.e., context, positionality, rapport-building, and ease-in)

Why don't we start by having you tell me a little bit about yourself? (Probes: age, interests, hobbies, education, work, etc.)

2.) **Sensory** (i.e., what is seen, heard, touched, or felt)

Take me back to your high school. What sorts of things would I see/hear going on that impacted the mental health of students? (Probes: What are students/staff doing? What are students/staff saying?)

3.) **Experience** (i.e., what did the student do to elicit behaviours, experiences?)

If I had followed you around during a typical high-school day, what sorts of things would I have seen you doing/experiencing at school? How did these experiences impact your mental health?

4.) **Feelings/Emotions** (i.e., the affective dimension of experience)

On a typical high-school day, how did you usually feel? What were the things at school that made you feel this way?

5.) **Opinions, Judgments, Values** (i.e., cognitive and interpretive features)

In your opinion, what features of/things in your high school impacted the mental health of students? (Probes: Why do you think they had that impact?)

6.) **Knowledge** (i.e., what they know about existing mental health programs, practices, and supports in their secondary school)

If a student was experiencing a mental health issue in your high school, where did they go or who did they go to for support/help? (Probes: Tell me a little bit more about the programs that were in place in your high school to support student mental health. What are your thoughts on some of the programs, practices, or supports that you mentioned?)

7.) **Transformative** (i.e., imagine you are a professional educational leader with the institutional power to drive systemic change...)

If you were a professional educational leader in a school or school board, such as a principal, superintendent, or director, what sorts of things would you focus on or change to better support the mental health of all students in Ontario's secondary schools?