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Understanding the Lived School Experience of a Young Boy with ODD and Symptoms of Anxiety through Interpretive Phenomenological Analysis: Child, Parent, and Teacher Perspectives

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Understanding the Lived School Experience of a Young Boy with ODD and Symptoms of Anxiety through Interpretive Phenomenological Analysis: Child, Parent, and Teacher Perspectives

by

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Abstract

Oppositional defiant disorder (ODD) and anxiety disorders are among the most common mental health problems affecting children and adolescents today. Youth struggling with externalizing disorders such as ODD or internalizing disorders such as anxiety are at a higher risk of experiencing multiple challenges during their school years and well into adulthood. Despite the array of concerning outcomes frequently associated with each of these disorders there is minimal research that explores the presentation and implications when these disorders co-occur. Furthermore, a clear understanding of the experiential component of children and adolescents with ODD and anxiety is profoundly lacking. Further complicating the matter, some research has shown that even subthreshold anxiety, in which an individual demonstrates fewer symptoms than required for a diagnosis of anxiety, can lead to impairments comparable to those seen among individuals who meet full diagnostic criteria for an anxiety disorder. The lack of understanding of the experience of co-occurring ODD and sub-threshold anxiety in the educational setting and the implications associated with co-occurring ODD and sub-threshold anxiety are concerning because children and adolescents spend the majority of their time in school. My research aims to make a novel and meaningful contribution to the limited research on ODD and anxiety by exploring the lived school experience of a boy with ODD and subthreshold symptoms of anxiety. The participants in this study included an adolescent boy (Joshua), his mother (Jacquie), his grade 4 teacher (Diane), and his school behaviour support teacher (Marlene). Each participant engaged in two virtual interviews of approximately 60 minutes in length. An interpretive phenomenological analysis methodology was employed to authentically capture Joshua's lived experience of school through interviews with Joshua, his mother, and two of his former school teachers. Findings illuminated that despite Joshua's positive attributes, which included being a

smart, funny, and curious boy, he displayed a tremendous amount of anger, along with some anxiety. He experienced ineffective exclusionary discipline measures that remained in place until he met a teacher who changed his trajectory. Joshua's lived experience of school during his elementary years, as described by Joshua, his mother, and two of his former teachers, was tumultuous until two caring educators built a warm, patient, understanding, and supportive relationship with him. Based on findings from this study, possibilities for practice are provided for consideration for school-based teams and school psychologists who may encounter other students like Joshua. Additional areas of research within the greater context of ODD and anxiety in the educational setting are also offered for consideration.

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Lastly, everything I put into this journey is dedicated to my late mother. Thank you for your legacy of grit, stubbornness, passion, compassion and "die before I quit no matter how hard it gets" attitude that lives on through me. I am where I am today because of you.

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Chapter 1: Introduction

My Relationship to My Research Topic

My connection to children with behaviour challenges has been present as long as I have been old enough to care for and work with children. When I was 14, I had my nose cracked by a 5-year-old I was babysitting; he threw a screen door window frame at me because he was upset (I still have a deviated septum due to this incident). When I was 16, I was sworn at and called names by a 7-year-old with ADHD and ODD whom I regularly babysat because he did not want to do his chores. I have several other stories like these from my adolescent years. These are not regular babysitting jobs, yet somehow, they were the ones I got. My early experiences with children who had explosive episodes did not bother or deter me. In hindsight, I have no idea why I could handle these situations so well. Still, due to my comfort with difficult children, I established a reputation as the one who would babysit the children no one else could handle, so those are the kids I got to watch during those years. My adolescent babysitting experiences were the seeds of inspiration for the work I would later embark on in my teaching career and subsequent shift to working as a school psychologist.

During my career as a teacher, I spent six years working in a specialized, segregated elementary school program for students with severe mood and behaviour disorders. The requirements for student placement in the program included a formal diagnosis of a severe mood or disruptive behaviour disorder (e.g., ODD, reactive attachment disorder, conduct disorder) or neurodevelopmental disorder (fetal alcohol spectrum disorder etc.), a propensity for aggressive and violent behaviour, an IQ higher than 75, and an Alberta education special eligibility code 42 (which identifies a student as having a diagnosis of a severe social emotional/behavioural

disability and that the student requires additional supports in their education program; Alberta Education, 2021). I had anywhere between 9 and 13 students in my classroom each year, along with the support of one full-time educational assistant. There was a seclusion room in the classroom for when students became a serious danger to others. The students in my class were in grades 4, 5, or 6, which meant those who came into the program in grade 4 were with me for 3 years.

I learned and experienced a tremendous amount during my time teaching in that classroom. Given the small class size and number of years the students remained in my classroom, I was gifted with a unique opportunity to really get to know my students and their stories on a profoundly personal level. Understanding their histories, learning their passions and strengths, and sharing laughter and moments of joy with these students helped me see who they were beyond their most aggressive and volatile explosions, which for some happened with alarming regularity early on. When my perception of these students shifted from dangerous and dysfunctional to playful, curious, and sensitive, the way I interacted with them changed. The way I ran my classroom changed. And the way I responded to crises changed. I completely flipped the status quo of how behaviour classes were supposed to run in the process. We engaged in class meditation, mindful art, dance party Fridays, hikes in the nearby ravine, gym class, and field trips with other classes in the school among other activities. The dynamic within my classroom and the reputation of my classroom was being rewritten. I started getting asked to present for other professionals working with this population of children (i.e., training for group home staff, professional development or educators working in the inpatient programs etc.). My passion and purpose became helping these students see how amazing they are and helping others see how amazing they are. I realized that if I wanted to make a difference to these students, I

would have to go bigger. My reach would have to extend beyond the four walls of my classroom, so I left my 7-year teaching career to go back to grad school to become a school psychologist.

My experience as a teacher is the driving force behind my topic of choice for my doctoral research. My goal is to provide a study that plants a seed of change to shift the current paradigm among many educators and psychologists regarding students with ODD, ADHD, and other challenging behaviours. In my experience, I have seen a framing effect thinking error (Wilcox & Schroeder, 2015) where students with these kinds of diagnosis are seen as behaviour problems first, and students second. My goal is to inspire mental health and education professionals to understand these students needs on a deeper level than what we may typically understand based solely on their diagnosis.

Introduction to the Literature

Although rates may vary by geographical location, diagnostic processes, sampling procedures, and analysis methods (Polanczynk et al., 2015), between 10% and 20% of children and adolescents worldwide experience some form of mental disorder (Kieling et al., 2011; Polanczynk et al., 2015). In Canada alone, an estimated 12.6% of children and adolescents aged 4-17 are affected by at least one mental disorder (Waddell et al., 2014). As children continue from adolescence into early adulthood, these rates increase. For example, the prevalence of mental disorders in adolescents and young adults between ages 15 and 24 is 30% (Statistics Canada, 2013); this amounts to well over a million adolescents and young adults across Canada suffering from at least one mental health problem. These mental health problems can impact adolescent functioning; approximately 20% of adolescents in the general population experience severe impairments in their ability to function in one or more areas of daily living, such as maintaining friendships, performing well in school, and coping with setbacks, due to mood,

behaviour, anxiety, or substance abuse disorder. (Merikangas et al., 2010). In addition to impairments in daily functioning, youth who have a mental disorder are at higher risk of experiencing a comorbid mental, developmental, or physical condition (Merikangas et al., 2010).

Statement of the Problem

Anxiety disorders and behaviour disorders, such as oppositional defiant disorder (ODD), are some of the most common mental health conditions affecting children and adolescents (Merikangas et al., 2010). However, researchers note that the relationship between anxiety and behaviour disorders has been complicated to ascertain, which they attribute to a lack of research in this area (Bubier & Drabick, 2009; Marmorstein, 2007). Furthermore, the complexity of anxiety and behaviour disorders may dissuade researchers from investigating these phenomena. Of particular interest is the lack of research on the nature of the relationship between ODD and anxiety (Boylan et al., 2007; Cunningham & Ollendick, 2010; Fraire & Ollendick, 2013; Leadbeater et al., 2012; Martin et al., 2014).

The lack of research on the relationship between ODD and anxiety is surprising because understanding the comorbidity of anxiety and ODD is important for psychologists to be able to accurately identify when these two disorders co-occur, recognize how they present when comorbid, and determine which treatments and interventions would be most effective when these conditions are comorbid (Cunningham & Ollendick, 2010; Martin et al., 2014). Empirical evidence regarding symptom presentation and the nature and degree of impairment in functioning when ODD and anxiety symptoms co-occur is sparse and needs further attention (Cunningham & Ollendick, 2010; Martin et al., 2014). Fraire and Ollendick (2013) further explain that additional research is needed, mainly because children with comorbid conditions such as ODD and anxiety are at an even higher risk for adverse life outcomes in multiple areas

such as academics, social interactions, and mental health problems in adulthood than those without comorbid disorders. Understanding the nature of the relationship between these two disorders can help mitigate adverse life outcomes by leading to further research to inform the subsequent implementation of successful treatments and interventions explicitly designed for comorbid ODD and anxiety (Fraire & Ollendick, 2013).

The relationship between ODD and anxiety can also be complicated when the anxiety is subthreshold, meaning the individual does not have all the necessary symptoms present to warrant a formal diagnosis of an anxiety disorder. When an adolescent does not meet full diagnostic criteria for an anxiety disorder, there can still be risks and complications due to subthreshold anxiety symptoms. Adolescents who have subthreshold symptoms of anxiety have an increased risk of death by suicide compared to non-anxious adolescents (Balazs et al., 2013). Additionally, the occurrence of suicidal ideations amongst adolescents with subthreshold anxiety is two times greater than for non-anxious adolescents (Balazs et al., 2013). Adolescents with subthreshold anxiety are at higher risk for social and academic impairments than their non-anxious peers. High levels of anxiety symptoms can be identified in children as young as preschool age; however, few studies explore the impact of subthreshold anxiety in youth (Broeren et al., 2013). Findings such as these illuminate the need for increased understanding of subthreshold anxiety.

Present Study and Research Questions

A common theme among researchers studying ODD and anxiety is that further research is needed to understand the impact that co-occurring ODD and symptoms of anxiety can have on the daily functioning of children and adolescents (Boylan et al., 2007; Cunningham & Ollendick, 2010; Martin et al., 2014). This understanding is an essential aspect of making informed

decisions regarding the appropriate treatment of these comorbid disorders (Boylan et al., 2007; Cunningham & Ollendick, 2010; Martin et al., 2014). Despite the existence of co-occurring ODD and anxiety, few studies have investigated the impact of this comorbidity (see Boylan et al., 2007, Fraire & Ollendick, 2013; Martin et al., 2014). Furthermore, I could not find any research on the impact of subthreshold anxiety on the presentation of ODD. This is noteworthy because anxiety can exacerbate symptoms of other disorders (Haller et al., 2013) and because subthreshold anxiety can be a precursor to the onset of anxiety disorders (Shankman et al., 2009)

Given the lack of research on ODD and comorbid anxiety and subthreshold anxiety, this study aimed to explore the connection between research and practice in this area by capturing the lived school experience of youth with ODD and subthreshold anxiety symptoms. The school setting was chosen because it is an environment in which children and adolescents spend a significant amount of time and, therefore, reflects an essential aspect of their lifeworld. For example, by the time youths graduate from high school, they will have spent more time in the school setting than any other social setting outside their home and neighbourhood (Meece & Eccles, 2009). Given the significant amount of time children and adolescents spend in the school environment, the school setting plays a substantial role in their social and emotional growth. It contributes to the trajectory of their adult lives, such as career choices and lifetime earnings (Meece & Eccles, 2009). In consideration of the lack of understanding about ODD and subthreshold anxiety, and the implications of the presence of these pathologies on a student's experience at school, this study intended to make sense of what school is like when a student has ODD and subthreshold anxiety by answering the following research questions: What is the lived experience of school of an adolescent boy with ODD and symptoms of anxiety? What was his experience? What did it mean for him? How did his mother see his experience? What did it mean

for her? How did his teachers see his experience? What did it mean for each of them? And lastly, what did the experience mean for everyone?

Chapter 2: Literature Review

The following literature review begins with an overview of shared risk and protective factors that influence the development of mental disorders from early childhood through to adulthood. It includes a brief review of adverse outcomes associated with child and adolescent mental health problems. After that, the focus shifts to the two main areas of interest in this study—ODD and anxiety, providing an overview of ODD, anxiety, and subthreshold anxiety. After that, the discussion turns to the paucity of research on the relationship between ODD and anxiety. Nearing the conclusion of the literature review, I assert that, based on extant research, the relationship between ODD and anxiety requires further investigation. Further to this, subthreshold anxiety should also be included in research on ODD and anxiety.

The purpose of the literature review in this study is to introduce readers to research on ODD, anxiety, and related topics relevant to this study such as risk and protective factors, and comorbidity. In IPA, the literature review is designed to contextualize the phenomenon of interest within the research prior to introducing the phenomenon in a real-world context via the lived experiences of the participants (Smith et al., 2009). This literature review is, therefore, not a comprehensive systematic review of the depth and breadth of the entire scope of research on ODD and anxiety. It is an introduction to aspects of the research that relevant to the phenomenon of interest in this study, which is the lived school experience of an adolescent boy with ODD and subthreshold anxiety.

In addition to this, throughout this paper, the terms disruptive behaviour disorders, externalizing disorders, internalizing disorders, and behaviour problems have been used

interchangeably. These terms are applied by the researchers when they have combined individual diagnoses of their participant pool into larger categories due to the challenges with identifying specific diagnoses and comorbidity. For example, internalizing disorders often refers the grouping of anxiety and depressive disorders. Disruptive behaviour disorders and externalizing disorders often refer to the grouping of ODD, ADHD, conduct disorder, and behaviour problems broadly refers to common symptoms associated with disruptive behaviour disorders and externalizing disorders such as aggression, poor self-regulation, impulsivity, peer conflict, and other related problems. As will be later discussed, comorbidity is common among childhood disorders, which can make it challenging for researchers to find participants with a single diagnosis of interest, such as a diagnosis of just ODD. Therefore, when these terms are used in the literature review, it indicates that those researchers collapsed comorbid disorders into a single broad category that they have subsequently labelled broadly, and I have used the labelling language of their particular study when discussing the findings.

Factors Affecting Mental Health

Multiple factors influence mental health from infancy through adolescence and adulthood (Kieling et al., 2011). Some factors increase the risk of mental health problems (risk factors), while others decrease the risk of mental health problems (protective factors). Kraemer and colleagues (2001) explain that the relationship between risk factors, protective factors, and life outcomes can be complicated and multifaceted. Risk and protective factors can overlap, occur independently, moderate, or mediate the relationship between other factors and outcomes (Kraemer et al., 2001). For example, a child may experience bullying and victimization at school (risk factors) but have warm, supportive parents and a safe, supportive community (protective factors). As a result of the complex interactions between risk and protective factors, it can be

difficult for researchers to isolate direct causal relationships between risk and protective factors and specific mental health outcomes (Kieling et al., 2011; Kraemer et al., 2001).

Despite the challenges associated with establishing direct causal evidence, researchers have identified multiple factors that have strong associations with an increased or decreased likelihood of child and adolescent mental health problems, including genetic, environmental, social, and biological factors (Kraemer et al., 2001; Lochman, 2004; Lochman et al., 2009). The following discussion about risk and protective factors aims to illuminate factors common to the development of various mental health problems, including ODD and anxiety.

Risk Factors

Kraemer et al. (1997) explained the term *risk* as the probability of a particular negative outcome within a population of individuals and *factor* as the agent or event identified as a risk (Kraemer et al., 1997) which increases the likelihood of poor adjustment to present and future life circumstances (Martinez-Torteya et al., 2009). Such factors have the potential to disrupt typical development and lead to higher rates of maladaptation (Masten & Matti-Stefandini, 2009). During childhood, the presence of risk factors can lead to adverse outcomes throughout life, including mental health problems (Martinez-Torteya, et al., 2009). In one retrospective US study of over 5,000 adult participants who reported having a mental disorder diagnosis, just over half of respondents reported exposure to at least one risk factor during their childhood (Green et al., 2010).

Research findings indicate that risk factors can impact individuals from infancy on. Circumstances such as maternal post-partum distress and depression are risk factors that can impact the emotional development of a very young child (Bayer et al., 2011; Vanska et al., 2017). Maternal depression is also predictive of later childhood internalizing disorders such as

anxiety and depression (Bayer et al., 2011; Vanska et al., 2017). In addition to environmental factors during early development, specific temperamental characteristics can also be risk factors. One study conducted in Italy by Melegari and colleagues (2015) determined three main temperamental profiles of harm avoidance, novelty seeking, and persistence among children who met criteria for either ODD, ADHD, or anxiety (based on a preschool aged psychiatric assessment, findings from the child behaviour checklist, and Cloningers temperament assessment).Their findings showed that the young children in the ADHD group presented with high novelty seeking and low persistence, meaning these children seek novelty but do not sustain their interest or persevere. The young children in the anxiety group demonstrated high harm avoidance and low novelty seeking. The authors note this group of children presented higher persistence than the ADHD group but lower than the control group. Among the ODD group, the researchers found the children had temperament features comparable to the children in the group with ADHD; however, the children in the ADHD group presented with higher novelty seeking, persistence, and harm avoidance than the children in the ODD group. The researchers conclude that their findings indicate that these diagnoses are characterized by particular profiles of emotional drives that are poorly regulated (Melegari et al., 2015)

Other childhood temperament characteristics such as high reactivity, irritability, and negative affect are risk factors for mental health problems in childhood (Frick & Morris, 2004). This includes exposure to environmental risk factors such as low parental education, living in less supportive neighbourhoods (Bayer et al., 2011; Nguyen et al., 2018; Snedker & Herting, 2013), and harsh parental discipline practices (Bayer et al., 2011).

Likewise, a significant relationship exists between the number of adverse childhood experiences (ACEs) and mental health problems (Danese et al., 2009; Merrick et al., 2017;

Rytila-Manninen et al., 2014). Consequently, ACEs are considered risk factors (Rytila-Manninen et al., 2014). Examples of ACEs include physical abuse, exposure to family violence (Martinez-Torteya et al., 2009; Peltonen et al., 2010), and maltreatment (Dubowitz et al., 2016; Kaplow & Widom, 2007). School bullying, victimization, exposure to criminality, and substance abuse are also considered risk factors for later problems (Rytila-Manninen et al., 2014). Importantly, risk factors and adverse childhood events can have an additive effect; the more ACEs children have, the higher the likelihood that they will experience a psychiatric disorder severe enough to warrant hospitalization for treatment in later life (Rytila-Manninen et al., 2014).

The familial context and lengthy process leading up to divorce also influence children's mental health outcomes in addition to the actual event of divorce; for example, high conflict in parental relations that occur throughout the divorce process can produce negative consequences for children (Strohschein, 2005). Anxiety disorders, substance abuse disorders, and disruptive behaviour disorders are more prevalent among adolescents whose parents are separated or divorced than adolescents whose parents are together (Merikangas et al., 2010). Furthermore, adverse family events may even increase the risk for specific comorbidities. For example, Noordermeer and colleagues (2017) found that children with ADHD who were exposed to adverse family events such as divorce and high family conflict had significantly higher rates of ODD than children who did not have a history of adverse family events. The researchers add that it is unclear how these life events influence the development of ODD (Noordermeer et al., 2017).

Additional environmental circumstances that pose a risk for mental health problems include single parent, stepparent, and low-income households (Bayer et al., 2011; Nguyen et al., 2018) poor parent-child relationships (Bayer et al., 2011; Olives et al., 2012) and affiliation with deviant peers (Noordermeer et al., 2017). For example, Piotrowska and fellow researchers (2015)

found that household income, parental education, and parent employment status are all associated with antisocial behaviours inclusive of symptoms ODD and conduct disorder (i.e., irritable, headstrong, aggressive etc.). Other neighbourhood conditions such as violence, economic strain, local job availability, and unstable family structures can also increase the risk of aggressive behaviour among children and adolescents (Vanfossen et al., 2010).

Protective Factors

Protective factors are broadly defined as factors that promote healthy adjustment to present and future life circumstances (Martinez-Torteya et al., 2009; Masten & Motti-Stefanidi, 2009). These factors include individual characteristics and circumstances that may mitigate the likelihood of adverse outcomes such as mental health problems and may even foster resilience in the face of negative childhood experiences (Buchanon, 2014; Dubowitz et al., 2016; Martinez-Torteya et al., 2009; Masten et al., 2009). For example, research has shown that having one mentally healthy parent when the other parent has a mental disorder can function as a protective factor against the effects that having a parent with a mental disorder may otherwise have (Vanska et al., 2017). Furthermore, warm, positive parenting styles are also associated with a lower risk of child and adolescent mental health problems (Martinez-Torteya et al., 2009). In addition to positive parenting styles, social support can also play a protective role for children and adolescents, particularly against peer victimization and internalizing problems (Burke et al., 2017). Individual protective factors include average to high average cognitive abilities (Ryland et al., 2010), the ability to self-regulate, healthy levels of self-confidence, and appropriate social interactions with peers (Zolkoski & Bullock, 2012). Parental employment (Dubowitz et al., 2016), neighbourhood safety, and community support (Vanderbilt-Adriance et al., 2015) have also been shown to play a protective role.

Functional Impairments

One of the main diagnostic criteria for most mental disorders is the extent to which symptoms interfere with functioning across multiple environments (APA, 2022; Francis et al., 2010). Notably, the presence of mental health problems negatively impacts individuals' short- and long-term functioning in various ways and in a variety of contexts. Individuals with mental health problems are more likely to experience challenges related to social interactions, romantic relationships, coping with occupational demands, and dealing with stress than individuals without mental health problems. Children and adolescents with mental disorders also experience impairments in their social, emotional, and academic functioning. Children with internalizing and externalizing disorders often struggle to regulate emotions and behaviour (Turner et al., 2010). This inability to regulate themselves as effectively as same-age peers can make these children particularly vulnerable to maltreatment and victimization by peers (Turner et al., 2010). They are also at a higher risk of experiencing sexual victimization (Turner et al., 2010). Maltreatment and peer and sexual victimization are most prevalent during preadolescence (Turner et al., 2010). It is hypothesized that children with internalizing and externalizing disorders are more susceptible to certain types of peer victimization because they engage in undesirable or frustrating behaviours that peers and maladapted parents or caregivers may respond to inappropriately (Turner et al., 2010). Children with internalizing and externalizing disorders may also be more likely to engage in intentional or unintentionally bothersome or aggressive behaviours towards peers, which can at times cause their peers to then irritate and provoke them in return (Turner et al., 2010).

Adolescents with mental health problems struggle significantly as well. They tend to display poor academic performance compared to peers without mental health problems (Fonseca

et al., 2010). They are also at a higher risk of becoming a parent during their adolescent years (Copeland et al., 2015). Additionally, adolescents with ODD and CD and anxiety are more likely to be involved in the criminal justice system (Burke et al., 2015). Burke and colleagues (2015) found that three-quarters of first-time adolescent offenders met criteria for at least one mental disorder. Half of those youth with one disorder also met criteria for a second disorder (Burke et al., 2015). Notably, ODD, anxiety, and conduct disorder rates were significantly higher among adolescents involved in the criminal justice system than in the general population (Burke et al., 2015).

As shown in a longitudinal study by Copeland and colleagues (2015), child and adolescent mental health problems can precipitate functional impairments well into adulthood in individuals who meet full diagnostic criteria for a childhood psychiatric disorder and those who present with only some symptoms of a childhood psychiatric disorder. In their analysis of 1,420 child participants, those who met full diagnostic criteria for a childhood psychiatric disorder (26% of participants) were six times more likely to experience adverse outcomes than adults who did not meet full diagnostic criteria for a childhood psychiatric disorder. The adverse adult outcomes they measured included educational failure, criminality, addiction, suicidality, mental and physical health problems, and untimely death (Copeland et al., 2015). It is worth noting that these findings were significant even after controlling for variables associated with ACEs and adult psychopathology. Furthermore, their findings demonstrated that the abovementioned adverse outcomes were not limited solely to those who met full diagnostic criteria for a mental disorder as a child. Participants who presented with only some symptoms of a mental disorder during childhood or early adolescence (31% of participants), which the authors labelled subthreshold, were also at a higher risk of adverse adult outcomes than those who did not meet

their subthreshold symptom criteria (Copeland et al., 2015). The children and adolescents in the Copeland study who presented with a subthreshold mental health problem were three times more likely to have at least one of the adverse adult outcomes than those with no history of mental health problems (Copeland et al., 2015). Other researchers have also shown that childhood mental health problems, such as comorbid internalizing and externalizing disorders, are predictive of economic, social, and psychological difficulties into early adulthood (Ormel et al., 2017).

In addition to social, emotional, and academic impairments in individuals with a disruptive behaviour disorder, there are also staggering societal costs related to disruptive behaviour disorders (Buchanon, 2011; Christenson et al., 2016). These costs include school assessments, involvement in the criminal justice system, increased hospital visits, cost recovery from illegal activity, and court costs (Christenson et al., 2016). Of considerable concern are the expenditures associated with criminal behaviour. In a cost analysis conducted by Cohen and Piquero (2009), high-risk youth incur an estimated $5 million in lifetime societal costs associated with criminal behaviour, approximately $1 million in heavy drug use, and $1 million with dropping out of high school. Specific costs related to criminal behaviour, drug use, and high school dropout include those pertaining to frequent police contact, cost recovery associated with property crimes, theft, victimization, and incarceration costs. The authors note that these three categories of societal costs are not mutually exclusive. For example, an adolescent may have dropped out of school because of drug use, or a drug user may engage in criminal behaviour to support their use. There are also costs associated with drug rehabilitation, premature death, and expenses incurred due to decreased work capacity (Cohen & Piquero, 2009). Meanwhile, the monetary savings of intervening with a high-risk youth is estimated to be between $2 million and

$5 million if intervention occurs right from birth (Cohen & Piquero, 2009). It is important to note that the authors did not address specific aspects of early intervention to reduce lifetime criminality associated costs, only that successful prevention early on can make a significant difference in the financial burden associated with the criminal behaviour trajectory of high-risk youth (Cohen & Piquero, 2009). In addition to this, the authors did not address the mental health status of their population. However, other researchers have shown that mental health problems are significantly high among adolescents involved in the criminal justice system (Burke et al., 2015). Recall that in Burke et al.'s study, researchers showed that 75% of first-time offenders met criteria for at least one mental disorder, and approximately 50% of the youth with one disorder also met criteria for a second disorder (Burke et al., 2015). These findings support Cohen and Piquero (2009) in their advocacy for early intervention as a way of minimizing the likelihood of criminal behaviour among high-risk youth. Findings from Burke and colleagues (2015) suggest that it may be advantageous to prioritize mental health as part of early intervention programming.

Scott and colleagues (2001) provided further evidence for the financial burden associated with childhood behaviour disorders. In their study, the researchers showed that adult males who had been diagnosed with conduct disorder as children imposed societal costs ten times higher than individuals who did not receive a diagnosis of conduct disorders as a child (Scott et al., 2001). These costs included expenses associated with responding to and dealing with criminal behaviours and welfare benefits (Scott et al., 2001). The above studies illuminate the extent to which impairment in functional outcomes resulting from child and adolescent mental health problems have long-term consequences that impact both society and the individual. These

researchers' findings provide evidence for the need for preventive interventions that address the well-being of youth with mental health problems to decrease the implications of these disorders.

Diagnostic Considerations for Oppositional Defiant Disorder and Anxiety

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR; American Psychiatric Association [APA], 2022) indicates that disorders of conduct, disruption, and poor impulse control reflect children's inability to effectively manage their emotions and behaviours. These disorders of conduct, disruption, and poor impulse control are typically more common in males than females (APA, 2022). Disorders that share features of disruption, impulsivity and conduct commonly first present in childhood or adolescence and can result in various functional impairments at school and at home (APA, 2022; Boylan et al., 2007). In addition to functional impairments associated with these disorders, such as conflicted interpersonal relationships and difficulties with learning, these children and adolescents are at a higher risk of comorbid problems such as mood and anxiety disorders as well as substance use disorders (APA, 2022; Bubier & Drabick, 2009; Thompson et al., 2015).

Oppositional Defiant Disorder

Although the DSM-5-TR identifies ten different conditions related to disruptive behaviour, impulse control, and conduct problems, the most prevalent of these is oppositional defiant disorder (ODD; APA, 2022; Boylan et al., 2007). ODD prevalence ranges between 1% and 11%, with a ratio of 1.59 males to 1 female (APA, 2022). Children with ODD are at an increased risk of experiencing additional emotional and behavioural disorders including anxiety, depression, ADHD, and conduct disorder (Ollendick et al., 2009). Interestingly, ODD shares features with anxiety, including irritability, avoidance, and oppositionality (Bubier & Drabick, 2009). Although irritability and oppositionality are not considered symptoms of anxiety in the

DSM, youth with anxiety disorders present as more irritable and angrier than same-age peers without anxiety (Hawkins & Cougle, 2011; Stoddard et al., 2013; Vidal-Ribas, et al., 2016). Additionally, like many other childhood disorders, ODD and anxiety also appear to have shared risk factors such as child temperament, parent-child interactions, and exposure to violence in the community (Bubier & Drabick, 2009; Marmorstein, 2007).

ODD is the most common disruptive behaviour disorder in children (Althoff et al., 2014; Martin et al., 2017). Along with ADHD and conduct disorder, ODD is one of the most frequent reasons for referral to mental health supports for children and adolescents (Althoff et al., 2014; Fonseca et al., 2010; Nock et al., 2007). Individuals with ODD consistently experience conflicts with others, such as their parents, teachers, supervisors, or romantic partners (APA, 2022; Burke et al., 2014). These conflicts are pervasive and can significantly impact their adjustment to various contexts and life circumstances (APA, 2022; Boylan et al., 2014).

Diagnostic criteria. ODD is fundamentally a disorder in which a cluster of developmentally typical child/adolescent behaviours of defiance present more severely and pervasively and are, therefore, considered developmentally atypical (Barry et al., 2013). These behaviours include negativity, disobedience, and argumentativeness predominantly directed towards adult authority figures (Greene et al., 2002).

In the DSM-5-TR, criteria for ODD are organized into three main areas that all must be present for an individual to receive a diagnosis. The first criterion pertains to symptom presentation—individuals must display a minimum of four out of eight symptoms listed under the categories of anger and irritable mood (affective dimension), argumentative and defiant behaviour (behavioural dimension), and vindictiveness for at least six months (APA, 2022). Examples from the affective dimension include frequently losing one's temper and being easily

annoyed. Symptoms from the behavioural dimension include arguing with others, intentionally refusing to reply with requests or rules, deliberately annoying or bothering others, and revengefulness (APA, 2022; Burke et al., 2014). It is important to note that these symptoms must be present in the child's interactions with at least one individual who is not a sibling.

The second criterion concerns the level of distress experienced by individuals due to these symptoms and the negative impact symptom presentation has on their relationships and functioning at school, home, during social outings, and in the workplace, if they are employed (APA, 2022). The third criterion is confirmation that the behaviour is not the result of another disorder or side effect of substance use (APA, 2022). Notably, the number of settings, such as school, home, work, or with peers, in which the symptoms occur determines the severity of ODD; mild occurs in one setting; moderate occurs in two settings; and severe occurs in three or more settings (APA, 2022). The typical age of onset of ODD is mid-childhood (Burke, 2012); although the effects of ODD for some individuals can last a lifetime (Burke et al., 2014).

Prevalence. Prevalence rates from different researchers vary slightly. Nock and colleagues (2007) replicated the national comorbidity study involving retrospective interviews with just over 9,000 English-speaking participants living in the United States. In their study, the estimated lifetime prevalence of ODD was about 10%. Other researchers found that among adolescents, the prevalence is 12.6% (Merikangas et al., 2010). Although numbers were consistently higher among males across all age groups, the prevalence difference between genders was not statistically significant (Nock et al., 2007). Despite some variation, these prevalence rates are consistent with more recent rates noted in the DSM-5-TR of 1% to 11%, with an average rate of approximately 3% (APA, 2022). Age of onset is typically between 7 and 13 years of age (Nock et al., 2007); onset beyond early adolescence is considered rare (APA,

2022). While the age of onset typically occurred in middle childhood, 70% of respondents indicated that they no longer experienced symptoms of ODD by 18 years of age. The average duration of ODD was found to be approximately six years.

Comorbidity. ODD is a predictor of the later emergence of conduct disorder, however, not all children with ODD develop CD (Althoff et al., 2014; APA, 2022; Greene et al., 2002; Loeber & Burke, 2011; Rowe et al., 2010). Despite this, many children diagnosed with ODD do end up with CD (APA, 2022). One study found that children diagnosed with ODD are twelve times more likely to be diagnosed with CD than children without ODD (Nock et al., 2007). Children with ODD are also at a high risk of developing other clinical disorders, such as anxiety or depression (APA, 2022; Dery et al., 2016; Greene et al., 2002; Lavigne et al., 2001; Nock et al., 2007; Stringaris & Goodman, 2009). Nock and colleagues (2007) explain that individuals with a history of ODD in childhood are more vulnerable to developing mental disorders as adults even when symptoms of ODD did not persist beyond childhood or early adolescence (Nock et al., 2007). ADHD is the most common comorbidity; however, ODD also co-occurs with other neurodevelopmental, disruptive, and mood disorders (Calles, 2016).

More recent research points to specific dimensions of ODD to predict specific disorders later in life (Althoff et al., 2014; Leadbeater & Homel, 2015; Mikolajewski et al., 2017; Stringaris & Goodman, 2009). For example, the affective dimensions of ODD (such as irritability) are predictive of internalizing disorders (Althoff et al., 2014; Burke, 2012; Dery et al., 2016; Leadbeater & Homel, 2015; Mikolajewski et al., 2017; Stringaris & Goodman, 2009), while the behavioural dimensions of ODD (such as argumentativeness) can be predictive of externalizing and conduct problems as well as substance abuse (Leadbeater & Homel, 2015; Mikolajewski et al., 2017).

Overall, ODD is a strong predictor of later internalizing disorders (Boylan et al., 2007; Dery et al., 2017; Nock et al., 2007; Rowe et al., 2010). In a prevalence study by Nock and colleagues (2007), 92% of respondents who had ODD also met criteria for at least one other lifetime clinical disorder, with more than half of these being some form of anxiety disorder. Interestingly, they also found that the ODD diagnosis often preceded the symptoms and subsequent internalizing disorders (Nock et al., 2007). The presentation of comorbid ODD and internalizing disorders can also change over time and by gender (Leadbeater et al., 2012). Researchers found that when ODD is comorbid with both anxiety and depression in adolescence, during adulthood, for females, the symptoms of anxiety increased, while in males, the symptoms of depression increased (Leadbeater et al., 2012). For both genders, the symptoms of oppositionality either decreased or stabilized (Leadbeater et al., 2012).

Implications. The presence of ODD has detrimental effects on multiple domains of functioning in various contexts, including school, home, and the community (Burke et al., 2014; Greene et al., 2002). At school, children with ODD often engage in behaviours that impact their learning and adjustment (Da Fonseca et al., 2013). These behaviours can include refusal to complete assignments or participate in classroom discussions and activities and engagement in ongoing conflicts with teachers and peers. They may also have difficulty adhering to classroom rules and instigate arguments with peers and school staff in opposition to those rules. As a result of their poor engagement in learning, strained social interactions, and refusal to comply, children with ODD tend to have significantly lower grades than their typically developing peers (Da Fonseca et al., 2013; Greene et al., 2002). At home, children with ODD argue and refuse to comply with parental requests. In other social settings such as extracurricular activities, sports groups, or playing at the playground, children with ODD more frequently get into conflicts with

their peers or team members, blame others for missing a goal, seek revenge on the playing field, or are intentionally bothersome to others.

Interestingly, specific dimensions of childhood ODD may predict additional social and behavioural problems during adolescence (Aebi et al., 2013; Mikolajewski et al., 2017) and adulthood (Aebi et al., 2013). The headstrong dimension of ODD is predictive of alcohol and cannabis use disorders, antisocial behaviour, attention problems, and overall externalizing problems (Aebi et al., 2013; Mikolajewski et al., 2017). Meanwhile, the irritability dimension is predictive of overall antisocial and externalizing behaviours (Mikolajewski et al., 2017). The hurtful dimension of ODD is a strong predictor of youth delinquency and adult criminality (Aebi et al., 2013). Outcomes from research on dimensions of ODD provide evidence for the predictive nature and developmental progression of ODD. Researchers explain that their findings illuminate the need for early identification of ODD to implement interventions that mitigate the adverse outcomes related to childhood ODD such as alcohol and cannabis use disorders, antisocial behaviour, overall externalizing problems, and criminality (Aebi et al., 2013; Mikolajewski et al., 2017).

Although research on the long-term effects of ODD is limited, studies have shown that the detrimental effects of child and adolescent ODD can carry on into adulthood (Burke et al., 2014). In a longitudinal study, the presence of ODD in school-aged boys predicted poor and limited social relationships and difficulty in romantic relationships during early adulthood (Burke et al., 2014). The authors surmise that the challenges experienced in early adulthood are likely to lead to negative experiences in overall quality of life and impairments in adjusting to mature adult life (Burke et al., 2014). In another longitudinal study on the effects of ODD, findings indicate that the presence of ODD in adolescence predicted lower educational

attainment in males and higher debt in females (Leadbeater & Ames, 2016). For both genders, ODD predicted more significant trouble paying for life necessities and greater perceived workplace stress (Leadbeater & Ames, 2016). It is likely that the trademark symptoms of irritability and defiance inherent in ODD that linger into adulthood also impede individuals' compliance with the rules and responsibilities inherent in educational institutions and their ability to persevere when faced with challenges in the workplace (Leadbeater & Ames, 2016). It is worth noting that, given the relationship between ODD and other problems such as adulthood substance abuse and internalizing disorders, researchers have begun to draw attention to ODD as a way of identifying risk for later psychopathology (Mikolajewski et al., 2017).

Anxiety

Anxiety disorders are among the most common childhood mental health problems (Keeton et al., 2009; Lyneham & Rapee, 2005; Polanczyk et al., 2015); this group of disorders affects 117 million children worldwide (Polanczyk et al., 2015). Additionally, anxiety disorders are one of the earliest to occur among childhood disorders (Merikangas et al., 2010). The average age of onset for the group of anxiety disorders is approximately 8 years of age; half of all child and adolescent cases occur between 6 and 12 years of age (Costello et al., 2011). Despite its ubiquity and early age of onset, child and adolescent anxiety often go undiagnosed and untreated because of the internalizing nature of anxiety, which renders it more difficult to identify (Connolly et al., 2007).

Anxiety occurs when individuals experience excessive fear or anticipation of a future threat that interferes with their daily functioning (APA, 2022). Lyneham and Rapee (2005) highlight four common factors that contribute to presence of anxiety in children. These factors are the extent to which a child avoids fear-provoking situations; how the child processes

information, such as an overly negative perception of events and outcomes; the child's ability to use coping skills in fearful situations; and the dynamic of parent-child interactions such as the degree of warmth from the mother or the amount of autonomy the child is granted. Although further discussion of these four factors common to anxiety in children is beyond the scope of this paper, it is important to note that that these factors are relevant to all anxiety disorders in children (Lyneham & Rapee, 2005).

Risk factors. Many factors associated with an increased risk for anxiety disorders are similar across anxiety disorders (APA, 2022; van Oort et al., 2011). For example, temperament factors such as negative affect, a propensity to worry, and behavioural inhibition are risk factors for several types of anxiety disorders (APA, 2022; van Oort et al., 2011). Environmental factors such as parental overprotectiveness, parental loss and separation, and being a victim of physical or sexual abuse are also risk factors for multiple forms of anxiety (APA, 2022; van Oort et al., 2011). Research has also shown that bully victimization and low self-competence are additional anxiety risk factors (van Oort et al., 2011). Risk factors associated with specific anxiety disorders are noted below in the discussion on each disorder outlined in the DSM-5-TR.

Diagnostic criteria. Eleven forms of anxiety disorder are outlined in the DSM-5-TR (APA, 2022). The DSM-5-TR specifies the anxiety disorders in developmental sequence to correspond with each disorder's typical age of onset (APA, 2022). These disorders, in order of earliest age of onset to the latest age of onset, are separation anxiety, selective mutism, specific phobia, social anxiety, panic disorder, agoraphobia, generalized anxiety, substance or medication-induced anxiety, anxiety due to another medical condition, other specified anxiety, and unspecified anxiety. Notably, the age of onset of anxiety disorders as a group is typically earlier than in other conditions (Patten, 2017). It is important to note that this order does not

suggest that these disorders progress in nature from one to the next. The following is an overview of each anxiety disorder described in the DSM-5-TR.

Children with *separation anxiety* experience excessive fear and distress over being separated from primary attachment figures (APA, 2022; Connolly et al., 2007). This disorder presents the earliest of all anxiety disorders with an average age of onset is approximately 10 years old (Lijster et al., 2017). However, this disorder does occur in children much younger (Costello et al., 2011). Children who suffer from separation anxiety may be unable to be in a room alone and may need to be near their primary attachment figure and exhibit clinging behaviour in the home and in public (APA, 2022). Environmental risks associated with separation anxiety in children include life stressors in which the child experiences a loss, such as the death of a close family member, moving to a new school or neighbourhood, or experiencing a natural disaster (APA, 2022). In young adults, risk factors may include moving from home, entering a romantic relationship, or becoming a parent (APA, 2022).

Children with *selective mutism* refrain from initiating or reciprocating conversation with most individuals (APA, 2022; Connolly et al., 2007). These children often communicate in whispers or through non-verbal signals to individuals outside of their family (Connolly et al., 2007). However, children with selective mutism often speak at home in the presence of immediate family members (APA, 2022). Notably, selective mutism is associated with high levels of social anxiety (APA, 2022). Risk and protective factors associated with selective mutism are not well identified. However, suspected risk factors include temperament, such as high neuroticism, as well as environmental factors such as overprotective or controlling parents (APA, 2022)

When individuals have a *specific phobia*, they experience intense fear and extreme distress regarding a particular object or situation (called the phobic stimulus) to the extent that they go significantly out of their way to avoid the phobic stimulus (APA, 2022; Connolly et al., 2007). The average age of onset for specific phobias is approximately 11 years of age (Lijster et al., 2017). Although this form of anxiety shares risk factors with other anxiety disorders, there is also some evidence that in some situations, upsetting or traumatic experiences involving the feared object or situation precedes the development of a phobia of an object or situation (APA, 2022).

Social anxiety has an average age of onset of this disorder is 13 years of age, 75% of cases occur in youth between ages 8 and 15 (APA, 2022). Individuals with social anxiety experience marked fear or anxiousness about being scrutinized and judged negatively in social situations (APA, 2022). Notably, for children to be diagnosed with social anxiety, the anxiety must occur in social situations with peers, not just with adults (APA, 2022). Children or adolescents with social anxiety may have difficulty participating in class discussions, initiating conversations with unfamiliar people, and avoiding parties and other social events (Connolly et al., 2007). Behavioural inhibition is a risk factor in the development of social anxiety (Broeren et al., 2013).

A *panic disorder* occurs when individuals experience sudden, recurrent, and unexpected onset of a series of physical and cognitive symptoms associated with intense fear (APA, 2022). These symptoms include heart palpitations, sweating, perceived difficulty breathing, nausea, dizziness, fear of losing control, or fear of dying (APA, 2022). The reappearance of subsequent panic attacks after the first one may lead individuals to engage in avoidance behaviours out of fear of re-occurring panic attacks (APA, 2022). Avoidance behaviours may include structuring

their day to ensure help is available in the event of a panic attack, avoiding exercise, or refraining from going out in public (APA, 2022). The average age of onset for this anxiety disorder is approximately 30 years (Lijster et al., 2017). Risk factors such as childhood physical or sexual abuse tend to be more common among individuals with panic disorders than individuals with other forms of anxiety (APA, 2022).

Generalized anxiety disorder (GAD) consists of excessive worry about everyday events, including schoolwork, family, health, social interactions, and even natural disasters (APA, 2022; Connolly et al., 2007; Keeton et al., 2009). Symptoms of GAD commonly seen in youth include seeking high levels of reassurance, responding overly negatively to critical feedback or evaluation, and having somatic complaints (Keeton et al., 2009). The typical age of onset for generalized anxiety disorder (GAD) is mid-thirties (APA, 2022, Lijster et al., 2017); however, when many adults are finally diagnosed with GAD, they report that they have felt anxious all their lives (APA, 2022). The excessive worry typical of GAD is nonspecific, challenging to control, associated with physiological symptoms such as restlessness, muscle tension, and sleep disturbance, and causes significant distress or impairment in one or more areas of functioning (such as school, work, or in social settings; APA, 2022). GAD commonly co-occurs with separation anxiety and social phobia (Keeton et al., 2009). Like most other anxiety disorders, risk factors for GAD include temperamental traits (e.g., behaviour inhibition and neuroticism) and the environmental factors of childhood adversity and an overprotective parenting style (APA, 2022).

It is important to note that although each anxiety disorder is unique, and the age of onset varies considerably, they all share the common features of high levels of fear and apprehension about stimuli or situations (APA, 2022; Craske & Stein, 2016; Swedo & Pine, 2005). These

features lead to behaviours such as hypervigilance, avoidance, and heightened physiological response (Beesdo-Baume & Knappe, 2012; Craske & Stein, 2016; Swedo & Pine, 2005). Children with an anxiety disorder may display somatic symptoms such as headaches and stomach aches; they may be more prone to crying, irritability, and even angry outbursts (Connolly et al., 2007). Notably, while the response to stimuli or situations that individuals with anxiety experience is disproportionate to the actual risk (Craske & Stein, 2016), children tend not to recognize that the fear they are experiencing as unreasonable or disproportionate to the situation (Connolly et al., 2007).

Prevalence. Before reviewing the prevalence rates of anxiety, it is important to note that a significant amount of the research on the prevalence rates and average age of onset of anxiety in children and adolescents collapses all anxiety disorders together as a group (Spence et al., 2017). This makes it difficult for researchers and clinicians to fully comprehend how many children or adolescents suffer from which disorders and beginning at what ages. For example, although the average age of onset for GAD is 34, research has shown that among over 6,000 participants (from the general population), 1.8% of boys and 1.3% of girls between ages 4 and 11 meet criteria for GAD (Spence et al., 2017). Overall, in comparison to mood, behaviour, and substance use disorders, anxiety has the earliest age of onset (Merikangas et al., 2010), with the initial onset of anxiety often occurring during childhood and adolescence (Beesdo-Baume & Knappe, 2012; Craske & Stein, 2016; Kesslet et al., 2009). However, the average age of onset does not reflect the initial age of onset. For example, although the average age of onset of GAD is during adulthood, children as young as 6 years old may also meet criteria for GAD. Therefore, although the following discussion on prevalence rates includes the average age of onset for each

anxiety disorder cited in the literature (which is frequently in adulthood), it is important to consider that anxiety disorders often begin during childhood and adolescence.

When all forms of anxiety disorder are combined, anxiety represents the most prevalent group of disorders (Baume & Knappe, 2012; Kesslet et al., 2009; Lyneham & Rapee, 2005). Furthermore, prevalence rates increase with age (Lyneham & Rapee, 2005), and women are twice as likely to experience anxiety as men (Beesdo-Baume & Knappe, 2012). In Canada, about 700,000 (2.5%) Canadians over the age of 15 reported symptoms consistent with diagnostic criteria for GAD during a 12-month period (Pelletier et al., 2017). Of this Canadian population, 23% of those diagnosed with GAD were between the ages 15 and 29 (Pelletier et al., 2017). In the US, from a sample of over 10,000 adolescents 13-18 years of age, 32% met the criteria for some form of an anxiety disorder (Merikangas et al., 2010). Among adolescent populations, anxiety is more prevalent among females (Essau et al., 2014; Merikangas et al., 2010). Notably, the degree of difference between sexes varies based on the type of anxiety (Hale et al., 2008; Merikangas, 2010; Knappe, 2012).

Comorbidity. Anxiety is highly comorbid with other disorders (Lyneham & Rapee, 2005). Older children with one anxiety disorder are often diagnosed with a second anxiety disorder (Kendall et al., 2010; Manassis, 2000). Additionally, adolescents who experience a primary anxiety disorder in conjunction with a second anxiety disorder, or a depressive disorder, report experiencing significantly higher anxiety, fear, and depression levels than adolescents with a single anxiety diagnosis (Franco et al., 2007). Parents of these adolescents also rate their children as having significantly higher internalizing and externalizing problems than the parents of adolescents with only a single anxiety disorder (Franco et al., 2007). Furthermore, adolescents with comorbid internalizing and externalizing disorders experience psychosocial difficulties that

adolescents with solely anxiety do not (Franco et al., 2007). These researchers hypothesize that the presence of anxiety exacerbates the symptoms and effects of other internalizing and externalizing disorders (Franco et al., 2007; Scaini et al., 2020).).

Implications. Diagnosing childhood anxiety can be challenging. Some researchers argue that part of the diagnostic challenges associated with anxiety are a result of its internal nature (Jolin et al., 2008). Children with anxiety may not overtly display behaviours indicative of a problem (hence the internalizing nature of the phenomena). Children's lack an emotional vocabulary to identify or communicate what they are feeling may contribute to this (Gail & Strain, 2003). Researchers also note a lack of research on childhood anxiety resulting from developmental constraints of the disorder (Jolin et al., 2008; Lyneham & Rapee, 2005). For example, it may be considered developmentally appropriate for a young child to be afraid of the dark or experience some degree of anxiousness at being separated from a primary caregiver (APA, 2022; Jolin et al., 2008). Therefore, the clinician must establish whether a child's fear of the dark or fear of separation from his or her parents is developmentally appropriate or atypical and subsequently suggestive of an anxiety disorder. The severity of the fear and degree of impairment resulting from the fear are key considerations in distinguishing between developmentally typical or atypical levels of fear.

Overall, due to developmental influences, anxiety disorders may present differently depending on which stage children or adolescents are at in their development (Hale et al., 2008; Kendall et al., 2010). Anxiety is not considered pathological unless it significantly impairs the child or adolescent's functioning and does not subside as the child or adolescent develops and matures (Connolly et al., 2007). Children and adolescents with anxiety experience more significant difficulties in their psychosocial functioning, such as social competence, self-esteem,

and academic achievement, than non-anxious peers (Essau et al., 2014; Teubert & Pinquart, 2011). They are also at a higher risk of experiencing anxiety or mood disorders during adulthood than their non-anxious peers (Swedo & Pine, 2005).

Adolescent anxiety is a risk factor for adult alcohol and substance use disorders (Essau et al., 2014). Additionally, adults at the age of 30 who experienced anxiety as adolescents report experiencing poor adjustment and family relationships, lower life satisfaction, minimal coping skills and higher levels of chronic stress (Essau et al., 2014). Essau and colleagues (2014) note that adolescent anxiety is a stronger predictor of later substance abuse and psychosocial problems than childhood anxiety. They hypothesize that the biological changes and social stressors inherent in adolescence may exacerbate the adverse effects of the participant's experience of anxiety. This, in turn, may impair their ability to handle life stressors effectively, leading to impairment in the development of coping skills and, consequently, more lasting adverse outcomes (Essau et al., 2014).

Subthreshold Anxiety

Defining subthreshold anxiety. Subthreshold anxiety is generally understood as the presence of symptoms of anxiety that are mild, atypical, not easily identified, brief but recurrent, and/or do not meet full diagnostic criteria for an anxiety disorder (Haller et al., 2014). Based on this, one could argue that the use of rigid diagnostic criteria such as those outlined in the DSM-5-TR is flawed. If an individual does not meet the complete the list of symptoms for an anxiety disorder, even if they have some symptoms, they will not be diagnosed with an anxiety disorder. This lack of diagnosis could potentially lead to the individuals not getting the help they need to treat their symptoms. This in turn warrants continued work toward an empirically validated definition of subthreshold anxiety so that clinicians and researchers can accurately identify

individuals suffering from subthreshold anxiety symptoms (Clarkin & Kendall, 1992; Shankman et al., 2009).

The need for an empirically validated definition is complicated by the lack of consensus among researchers and clinicians about how to identify subthreshold anxiety (Kanuri et al., 2015). Not surprisingly, various definitions and qualifiers for the term subthreshold can create challenges for researchers attempting to bring attention to this non-diagnostic category (Haller et al., 2014). Lack of consensus regarding subthreshold anxiety criteria between studies can lead to a lack of consistency in recognizing what constitutes subthreshold anxiety and, therefore, impacts the research's validity in enhancing our understanding of this condition. However, when researchers do have unified criteria for what comprises subthreshold, the same constructs may not be measured in each of the studies.

As an illustration, some researchers use scores on criterion-based measures to categorize subthreshold anxiety. In a study conducted by Kanuri and colleagues (2015) on subthreshold anxiety, and subsequent interventions among college students, the researchers used the scores of two different standardized measures. They quantified subthreshold anxiety as being present when an individual obtained a score of 15 or higher on the Depression Anxiety Stress Scale but did not meet full DSM-5 diagnostic criteria for an anxiety disorder (DASS; Lovibond & Lovibond, 1995). Although the DASS is not intended for diagnostic use, researchers note that the DASS is one of the most widely used norm-referenced screening scales of its kind in research in adult populations (Dunstan et al., 2017). They further divided their definition of subthreshold anxiety into subcategories by the severity of the existing symptoms, the level of distress resulting from the symptoms, and the degree of worry associated with the anxiety. More specifically, the subcategories these authors used were subthreshold but considerable symptoms of overall

anxiety (i.e., high autonomic arousal, high-stress levels), subthreshold but high generalized anxiety disorder symptom severity, subthreshold but existing symptoms were distressing, and subthreshold with considerable worry (Kanuri et al., 2015). Despite this study's further organization of subthreshold anxiety into subcategories, each subcategory is still encompassed within their broad definition of subthreshold anxiety. Each subcategory of subthreshold anxiety represents a slightly different manifestation of the condition.

Balazs and colleagues (2013) used a similar quantification approach in their large-scale study on the prevalence of subthreshold depression, subthreshold anxiety, and suicidal thoughts and ideations among European adolescents. However, they used the Zung Self-Rating Anxiety Scale instead (SAS; Zung, 1971). Although these authors did not provide a rationale for using the SAS instead of another more recognized rating scale such as the DASS, it is noted that the developers of the DASS do not recommend it for use with adolescent populations because of the lack of research on its use with this age group as well as the possibility that the language of the test items may be above the comprehension level of most adolescents (Lovibond & Lovibond, 1995). Researchers also explain that the SAS has clinical utility, particularly for screening for anxiety symptoms, because it is more sensitive than the DASS and more economical than more in-depth methods such as a structured clinical interview (Dunstan et al., 2017). The researchers used the four SAS index score ranges (scores range from 25 to 75) from the rating scale to organize the adolescents into one of three categories. Adolescents who obtained an index score of 44 or below were considered non-anxious. In contrast, adolescents who received index scores between 45 and 60 were deemed to be sub-threshold anxious (which is identified on the rating scale as minimal to moderate anxiety). Adolescents with index scores above 60 were considered anxious. It is noted that the researchers collapsed Zung's categories of marked or severe anxiety

(index scores of 60-74) and extreme anxiety (index scores above 70) into the single category of anxious (index scores of 60 and above; Balazs et al., 2013).

Another example of how to ascertain the presence of subthreshold anxiety can be found in a study conducted by Lewinsohn and colleagues (2004). In their comprehensive study on the prevalence of full syndrome and multiple subthreshold disorders among adolescents, the researchers defined subthreshold anxiety as meeting criteria for at least three symptoms from the diagnostic criteria for an anxiety disorder from the DSM-III-R but not the full diagnostic criteria for the disorder (Lewinsohn et al., 2004). This definition was subsequently repeated in a follow-up longitudinal study on the predictive nature of subthreshold conditions conducted a few years later by some of the same authors (Shankman et al., 2009). However, they used the DSM-IV criteria as the measures in their follow-up study because that was the most updated version of the manual at that time. The authors noted that although there were slight changes in diagnostic criteria in the newer DSM that was released in the midst of their longitudinal study, this did not impact their findings because diagnostic criteria still displayed a high level of concordance (Kappa >.98; Shankman et al., 2009).

The approach taken to identify subthreshold anxiety by Lewinsohn and colleagues (2004) and Shankman and colleagues (2009) holds promise for researchers and clinicians. This method of defining subthreshold as present when some but not all diagnostic criteria are met fosters the opportunity for researchers and clinicians to continue to adhere to updated versions of diagnostic criteria outlined in the diagnostic manual put out by the APA. Furthermore, adherence to a specific number of criteria outlined in the DSM enhances fidelity in identifying subthreshold anxiety. The DSM is already a resource many North American clinicians and researchers use when identifying psychiatric disorders.

Prevalence of subthreshold anxiety. Research suggests that subthreshold anxiety may be more prevalent in adolescents than clinical anxiety. In a European study, researchers found significant rates of subthreshold anxiety among adolescents (Balazs et al., 2013). Of the 11,109 adolescent participants aged 11-14 years, 32% had subthreshold levels of anxiety (Balazs et al., 2013). It is worth noting that approximately 6% of adolescents in this participant pool also presented with a clinical anxiety disorder. Notably, these authors, like many others, analyzed anxiety disorders as a group instead of by specific anxiety disorder.

In a longitudinal study of the prevalence and course of subthreshold comorbid conditions among adolescents, almost 20% of 1,505 participants between the ages of 14- and 20 met criteria for subthreshold anxiety (Shankman et al., 2009). Notably, individuals who demonstrated subthreshold anxiety symptoms at the first of the four measures were almost twice as likely to meet the diagnostic criteria for an anxiety disorder before the age of 34 (Shankman et al., 2009). The authors note that their study is the first longitudinal study to illuminate the predictive nature of subthreshold disorders into full-scale disorders (Shankman et al., 2009).

There is slightly more research on the prevalence of subthreshold anxiety by specific diagnosis among adult populations. For example, the prevalence of subthreshold GAD in adults is almost twice as high as clinical GAD (Haller et al., 2013). Older adults show higher rates of subthreshold GAD than middle-aged individuals, and women show higher rates of subthreshold GAD than men (Haller et al., 2013).

Overall, these prevalence rates indicate that despite the lack of research into subthreshold anxiety, the occurrence of this condition warrants further investigation. Although researchers demonstrate that subthreshold anxiety can predict later anxiety-related complications in adults, no studies exist on the prevalence and impact of subthreshold anxiety among youth (Balazs et al.,

2013). Furthermore, literature on the prevalence rates of subthreshold anxiety in adolescents in Canada and the United States appears to be limited. Despite the paucity of research on subthreshold anxiety among adolescent populations in North America, global findings on the prevalence and impact of subthreshold anxiety among adolescent populations powerfully illuminate the need for further understanding.

Impact of subthreshold anxiety. At present, subthreshold depression is the most well-researched subthreshold condition; however, there has been a recent increase in attention to subthreshold anxiety (Shankman et al., 2009; Teubert & Pinquart, 2011). Research on subthreshold anxiety has demonstrated that although it is not a clinical diagnosis, it can negatively impact functioning and increase the likelihood of developing a fully manifested disorder. In the absence of full-scale GAD, individuals may still experience significant distress and psychosocial impairment (Copeland et al., 2015; Haller et al., 2013; Karsten et al., 2013).

Researchers investigating subthreshold anxiety explain that the limited research in this area may lead clinicians to give less attention to subthreshold disorders. However, subthreshold disorders still warrant treatment and interventions because a subthreshold disorder still negatively impacts functioning and is a risk factor for full clinical manifestation of disorders in adulthood. In a systematic review of the current literature on the impact of subthreshold GAD, researchers have shown that subthreshold GAD is a risk factor for developing threshold GAD (Haller et al., 2013). The presence of subthreshold GAD also increases an individual's risk of developing other clinical pathologies such as mood and substance use disorders (Haller et al., 2013). Subthreshold GAD can also exacerbate other mental health and somatic disorders and increased prescribed benzodiazepine use compared to non-anxious populations (Haller et al., 2013).

Comorbidity of Externalizing and Internalizing Disorders

Research interest regarding the connection between internalizing disorders such as anxiety and externalizing disorders also referred to as disruptive behaviour disorders (DBDs) stems back several decades (See Angold et al., 1999, for example). Existing research in this area has illuminated relevant data regarding etiology, diagnosis, treatment, and functional implications. However, much of the research on child and adolescent co-occurring mood and behaviour disorders collapsed anxiety and depression into the category of *internalizing disorders* and collapsed ODD, CD, and ADHD together and referred to them as problems of conduct, *externalizing disorders*, disruptive behaviour disorders or behaviour disorders (Drabick et al., 2010). The behaviour disorders are likely collapsed together in this manner because they share a similar presentation concerning problems with self-control of emotions and behaviours (APA, 2022). While this more generalized approach allows for the inclusion of a significant number of participants and more generalizable findings, it can limit the understanding of the interaction among specific disorders. Even when common childhood disorders are collapsed into two main constructs in this manner, the research is still sparse. However, two older studies are frequently cited in the literature on ODD and anxiety. In one study that looked at the prevalence of disorders co-occurring with anxiety among 173 children between ages 8 and 13 in a clinical setting, 9.2% of the participants had comorbid ODD and anxiety (Kendall et al., 2001). In the other study, researchers found that the comorbidity of anxiety and conduct problems (inclusive of ODD) is three times more likely to occur than expected by chance (Angold et al., 1999). Notably, published studies on the rates of comorbidity among specific anxiety disorders and other psychiatric diagnoses are limited (Costello et al., 2005; Costello et al., 2011).

Research supports a significant relationship between externalizing disorders and internalizing disorders. In a longitudinal study carried out by Knappe and colleagues (2022) they found an increased likelihood of anxiety well into adulthood when externalizing disorders were present during childhood. Interestingly, their findings indicate that when children have a later than typical age of onset of an externalizing disorder, their risk of developing an internalizing disorder later in life is greater than the risk for those who experience early onset externalizing disorders. They note that their findings suggest there may be a heterotypic continuity between childhood externalizing disorders and the development of internalizing disorders in adolescence and adulthood (Knappe et al., 2022).

Among studies that have explored the comorbidity of anxiety and DBDs, a significant association between the two has been illuminated. In addition to a significant association between DBDs and anxiety disorders, children and adolescents with both disorders frequently experience a multitude of challenges in social, emotional, and academic functioning that appear to be different from or more prevalent than the challenges encountered when they only have one disorder or the other (Cunningham & Ollendick, 2010; Drabick et al., 2010; Levey et al., 2007; Martin et al., 2014). For example, among preschool-aged children, those with ODD and anxiety were almost four times as likely to experience functional impairment at school than those with just anxiety (Martin et al., 2014). Examples of functioning in the school environment can include attention levels, coping with school-related stressors such as assignments, tests, or class presentations, navigating the school schedule and schedule changes, working, and interacting with classmates and teachers during structured and unstructured times, and adherence to classroom and school rules and expectations (Reynolds & Kamphaus, 2015). Students who have difficulty with daily functioning in the school environment may have trouble paying attention to

lessons, feel anxious before tests, show up for classes late (or not at all), get into conflicts with teachers and peers, and frequently get in trouble for breaking school rules (Reynolds & Kamphaus, 2015).

Concerning ODD and anxiety disorders specifically, Fraire and Ollendick (2013) state that "understanding the comorbidity between anxiety and ODD is especially important given that children with comorbidity may be at higher risk for negative life outcomes" (p. 230). Children with both anxiety and a DBD such as ODD display poorer outcomes in their social interactions and academic performance than children who have anxiety without a DBD (Franco et al., 2007). Despite the importance of the complex interplay between DBDs and anxiety, and more specifically ODD and anxiety, multiple researchers assert that there is a significant lack of research on the comorbidity of these two pathologies (Bubier & Drabick, 2009; Cunningham & Ollendick, 2010; Marmorstein, 2007).

Marmorstein (2007) conducted a noteworthy study on the relationships between specific behaviour disorders and anxiety disorders and the influence of age and gender among youth ages 9-17. In this study, Marmorstein found that in addition to positive associations between ADHD, ODD, CD and anxiety, these associations tend to be more prevalent among boys than girls (Marmorstein, 2007). When looking at associations by age group, the author found that the strongest associations between ADHD, ODD, and CD and anxiety occurred during pre-adolescence and early adolescence. Findings from this study highlight that the likelihood of ODD occurring in conjunction with specific anxiety disorders is greater than chance. However, it is unclear which disorder appeared first (the behaviour disorder or anxiety) among the sample of participants (Marmorstein, 2007).

Comorbid anxiety and ODD in preschool children is associated with more significant impairments in relationships with other children in the school setting (Martin et al., 2014). Although the comorbidity between ODD and anxiety appears to vary by type of anxiety, there are symptoms among anxiety disorders that may be closely related to ODD, especially in very young children (Martin et al., 2014). For example, children with ODD and children with anxiety both tend to be touchy and easily annoyed by others, which is particularly salient among children with social anxiety; children who are easily annoyed can also come across as oppositional (Connolly et al., 2007; Martin et al., 2014). When ODD and anxiety are comorbid, it is unclear whether irritability is a result of the ODD, or the being touchy and easily annoyed is a result of the anxiety disorder, or some other set of complex interactions not yet identified or understood (Bubier & Drabick, 2009; Martin et al., 2014).

Specific dimensions of ODD may even be predictive of the later development of anxiety. For example, in a longitudinal study conducted by Dery and fellow researchers (2017) with 304 Canadian children under 10 years of age, they found that specific dimensions of ODD could be predictive of the subsequent development of anxiety in some children. More specifically, they found that both boys and girls with pronounced symptoms of irritability associated with ODD were at a greater risk of developing anxiety 2 years later that those with more pronounced defiant or vindictive symptoms. The researchers conclude that their findings provide evidence for the need for targeted early interventions that address the irritability symptoms of ODD (Dery et al., 2017). Further to this, other researchers have found that even among children with comorbid inattentive ADHD and ODD, irritability was still associated with a greater risk of the development of anxiety and/or depression during adolescence (Felix et al., 2022).

Etiology of Comorbid ODD and Anxiety

Various Researchers present differing hypotheses to explain the relationship between ODD and anxiety disorders. In some children, anxiety symptoms include irritability or being easily annoyed, particularly those who experience social anxiety (Boylan et al., 2007; Martin et al., 2014). As a result, some children may be misidentified as having ODD instead of anxiety. Researchers hypothesize that the relationship between anxiety and ODD may stem from similar symptoms such as irritability, being easily bothered by minimal things, and poor affect regulation (Boylan et al., 2007; Martin et al., 2014). Although the DSM-5-TR does not identify irritability in the diagnostic criterion for anxiety disorders, researchers have shown that, as previously mentioned, irritability occurs more frequently among youth with anxiety than youth without anxiety (Boylan et al., 2007; Martin et al., 2014).

ODD and anxiety may co-occur due to shared risk factors (Boylan et al., 2007; Bubier & Drabick, 2009; Drabick et al., 2010). Unfortunately, a lack of research on specific co-occurring DBDs and anxiety has led to minimal understanding concerning the shared risk processes unique to anxiety and specific DBDs (Bubier & Drabick, 2009). Some of the shared risk processes between DBDs and anxiety that researchers have noted include home environment circumstances such as parental rejection (Knappe et al., 2022), exposure to neighbourhood violence, temperament, misattributions during social situations, and low socioeconomic status (Bubier & Drabick, 2009; Drabick et al., 2010; Fraire & Ollendick, 2013).Shared risk factors for ODD and anxiety among preschool aged children in particular include higher levels of emotion dysregulation and low inhibitory control (Martin et al., 2017).

As previously noted, comorbidity refers to the presence of two or more psychiatric disorders occurring simultaneously (Clarkin & Kendall, 1992; Jensen, 2003). Two or more disorders can manifest concurrently, referred to as cross-sectional comorbidity, or one after the

other, referred to as longitudinal comorbidity (Clarkin & Kendall, 1992). An in-depth discussion about the impact of cross-sectional versus longitudinal comorbidity is not germane to this discussion on comorbidity. Despite this, it is important to note that, as Clarkin and Kendall (1992) point out, understanding if comorbid disorders are ordinal or concurrent is an important consideration for treatment decisions. For example, suppose symptoms of an anxiety disorder are present before a disruptive behaviour disorder. In that case, it is possible that treating the anxiety symptoms first may alleviate some symptoms of the DBD, subsequently reducing the need for more intensive treatment for the DBD. Whereas, if both anxiety and a DBD manifest simultaneously, it may be better to address both disorders as separate entities and, therefore, more effectively treat both disorders at the same time (Clarkin & Kendall, 1992). Unfortunately, research regarding comorbidity can be challenging (Jensen, 2003). For example, factors such as how researchers qualify comorbidity, the clinical measures they use to identify the presence of multiple disorders, the cut off scores they use to determine clinical conditions have, and the lack of attention to the potential impact of the order of disorder emergence have all come under scrutiny (Jensen, 2003).

Some researchers posit that multiple disorders reflect more severe pathology than the presentation of a single disorder (Franco et al., 2007; Leadbeater et al., 2012). For example, when a child has ODD and anxiety, the co-occurrence of the anxiety with the ODD may exacerbate the symptoms of ODD (Martin et al., 2017). This, in turn, may make it even more challenging for children who have ODD and anxiety to self-regulate. Other researchers note that the presence of one disorder may lower the threshold of the expression of another (Bubier & Drabick, 2009). Comorbidity is a complex phenomenon. The presence of comorbid disorders leads to more significant impairment than the presence of a single disorder. They have an

additive effect as well, meaning that the symptoms of each comorbid disorder are more severe than the symptoms would be if there was only one disorder present (Becker et al., 2012). Angold and fellow researchers (1999) emphasize that "comorbidity is a real and unavoidable characteristic of common childhood and adolescent psychiatric disorders…" (Angold et al., 1999, p. 67).

A Developmental Model of Anxiety and DBDs

Bubier and Drabick (2009) present a developmental model to explain how shared risk factors may interact and subsequently result in a comorbid DBD and anxiety. The authors propose that risk factors related to temperament, autonomic arousal, and information processing may predispose a child to experience more intensely negative emotional reactions than peers without these predispositions. More specifically, irritability, low frustration tolerance, autonomic hyperarousal, hypervigilance, and negative attribution biases may predispose a child to experience negative emotional reactions more frequently, and in more situations than individuals without these traits (Bubier & Drabick, 2009). Importantly, when negative emotional responses are present during circumstances where the children cannot avoid the emotion-inducing situation, both anxious symptoms and reactive aggression may occur. It is unclear whether these symptoms manifest concomitantly or if one occurs before the other (Bubier & Drabick, 2009; Marmorstein, 2007). Despite which condition precedes the other, once anxious symptoms and reactivity co-occur, the risk of co-occurring clinical anxiety and DBDs increases significantly (Bubier & Drabick, 2009). For example, children with separation anxiety disorder attempt to avoid separation from their primary attachment figure. If there is a threat of separation, these children experience significant anxiety. As a result, a child may become argumentative or defiant in anticipation of the separation or in an attempt to avoid separation (Bubier & Drabick, 2009).

The proposed conceptual model for the development of comorbid anxiety and disruptive behaviour disorders has significant clinical implications because it brings to light the need for clinicians to consider that some of a child's oppositional behaviour could be an attempt to avoid an anxiety-provoking situation, and as such, may not represent true oppositionality or defiance (Bubier & Drabick, 2009). However, it does not account for circumstances in which one disorder fully manifests at a clinical level while the other remains at the subthreshold level. It also does not account for the relationship between specific DBDs such as ODD and anxiety.

It is conceivable that when anxious symptoms and reactive aggression co-occur, only one of the disorder manifests at a clinical level, while the other remains below the threshold of a formal diagnosis. Bubier and Drabick (2009) state that

> anxiety symptoms may precede the onset of disruptive behaviors and in turn exacerbate these disruptive behavior problems. This potential series of events could result in the apparent development of a diagnosable disruptive behavior disorder before the development of a diagnosable anxiety disorder (p. 662).

As such, children may experience both anxiety symptoms and reactive aggression and, therefore, receive a diagnosis of ODD long before receiving a diagnosis of anxiety. Importantly, even though they do not meet diagnostic criteria for anxiety, they may still experience anxious symptoms (referred to as subthreshold anxiety) in conjunction with ODD. Furthermore, the experience of anxiety symptoms may still lead to functional impairments above and beyond what may be expected if the child did not present with any developmentally atypical anxiety levels.

Understanding ODD and Anxiety

Comorbid anxiety and DBDs, such as ODD, can have significant implications for diagnosis, assessment, and treatment (Cunningham & Ollendick, 2010). Diagnosticians would be

remiss not to consider how an internalizing disorder influences the presentation and course of an externalizing disorder such as ODD (Boylan et al., 2007) because anxiety may exacerbate symptoms of other pathologies, including ODD (Martin et al., 2017). One approach to the treatment of anxiety and a comorbid condition may be to treat the anxiety first to mitigate the severity of some of the symptoms of the comorbid condition. Conversely, diagnosticians should also consider how ODD influences the presentation and course of anxiety. The limited existing research indicates that DBD and anxiety, specifically ODD and anxiety, co-occur frequently enough to warrant interventions to address these problems simultaneously (Leadbeater et al., 2012; Levey et al., 2007). However, there is a shortage of empirically validated treatments developed for children and adolescents with comorbid anxiety and ODD (Raishevich et al., 2010). The magnitude of the emotional and financial impact on families and society warrants further efforts such as early intervention to prevent these problems (Grove et al., 2008).

As previously noted, researchers argue that exploration into the co-occurrence of subthreshold and full-syndrome disorders has also been neglected (Boylan et al., 2007; Lewinsohn et al., 2004). Lewinsohn and colleagues (2004) underscore the need for the inclusion of the assessment of subthreshold disorders in conjunction with full-syndrome disorders to better understand the trajectory of pathologies. Assessment of comorbid threshold and subthreshold pathologies among children must be further investigated to obtain clarity about the course of comorbid ODD and anxiety (Boylan et al., 2007; Russo & Beirdel, 1994).

Implications for assessment and treatment. Early identification of subthreshold anxiety disorders accompanied by early treatment may reduce the risk of full-onset disorders and reduce the risk of suicide (Balazs et al., 2013). This is particularly relevant because some research suggests that subthreshold disorders may be precursors to full syndrome disorders (Shankman et

al., 2009) and lead to complex mental health problems in early adulthood (Leadbeater et al., 2012). In addition to reducing anxious symptoms, implementing therapeutic interventions in the subthreshold anxiety population may also be more cost-effective than waiting until individuals meet full diagnostic criteria for an anxiety disorder before implementing treatments (Knuri et al., 2015). Consequently, "subthreshold conditions may therefore represent good targets for preventive interventions." (Shankman et al., 2009, p. 1493). It is worth noting that interventions are best developed and implemented when the population they are designed for is well researched and understood. Unfortunately, research on comorbid ODD and anxiety, both threshold and subthreshold, is scarce, increasing the difficulty of effectively serving this population.

Regarding treatment, implementing general prevention-based intervention programs for mood and behaviour disorders in the education setting shows promise (Kanuri et al., 2015). School-based interventions that focus on anxiety prevention have a measurable positive impact on children identified as at-risk for anxiety disorders (Teubert & Pinquart, 2011) and for children who have ODD (Da Fonseca et al., 2013). For example, findings from intervention research by Levy and colleagues (2007) show that implementing an anxiety-based intervention program that incorporates psychoeducation on symptoms and triggers of anxiety, cognitive restructuring of anxious thoughts, and coping strategies when feeling anxious for children who displayed anxiety and co-occurring aggression and ODD showed marked decreases in both internalizing and externalizing behaviours. Interestingly, some children who met diagnostic criteria for ODD, CD, or ADHD at the outset of the anxiety intervention program no longer met full diagnostic criteria for their disorder upon completion of the program (Levey et al., 2007). The outcomes from their study illuminate that addressing the anxious aspect of childhood pathology in comorbid

conditions can have diffuse positive effects on other clinical problems. This intervention brings further attention to the need for research to clarify the relationship between anxiety and DBDs to better understand why an anxiety intervention can impact ODD the way it did in this study.

Unfortunately, studies such as the one mentioned above that focus on children who have ODD in conjunction with subthreshold and threshold anxiety are scarce. The lack of intervention research in this area likely stems from the current significant gap in understanding how children and adolescents with comorbid clinical and subclinical conditions are affected. It is challenging for researchers to investigate solutions when the literature on the problem is so limited. Therefore, further studies on children and adolescents with ODD and internalizing symptoms such as anxiety are warranted. As the previous discussion highlighted, children and adolescents with these conditions are at a higher risk of developing anxiety and affective disorders well into adulthood. They are also at a higher risk of suffering from various functional impairments affecting their quality of life. Conducting further research on the impact that ODD and varying degrees of comorbid anxiety can have on children and adolescents is pertinent to prevention and treatment research and practice for anxiety and ODD.

Chapter 3: Methodology

Through this study, I aimed to understand the phenomenon of ODD and subthreshold anxiety through the lens of the individuals experiencing the phenomenon. Throughout my analysis I sought the experiential aspect of the phenomenon, not the empirical aspect. Therefore, I did not focus on clinical presentation, functional impairment, or other categorial or empirical data. My study sought essence, not evidence. This means I was not engaged in a discourse analysis for the purposes of positivistic notions of causal inferences. Instead, from a metaphorical perspective, my research focused on listing for the music behinds the words, the

meaning and messages beyond what has been articulated by the participants. My goal was to capture that there is something to the phenomenon from the perspective of my participants, which my interviewees revealed to me through their process of meaning-making and through my process of making sense of their meaning-making. This process of understanding a phenomenon and meaning-making of the experience of the phenomenon is interpretive phenomenology. It is a methodology that involves a rich description of the lived experience of the phenomenon (Schwartz-Shea & Yanow, 2012). Researchers refrain from imposing external frameworks (i.e., theories) on the study, and set aside their judgement about the realness or validity of the phenomenon (Finlay, 2009). Conversely, if a qualitative study that claims to be phenomenological does not present the phenomenon richly as it is lived by the participants (i.e., an abundance of direct quotations from the participants), then it is not phenomenological research (Finlay, 2009).

In interpretive phenomenology, the focus is on the meaning of a significant lived experience of an individual or a group of individuals (Smith et al., 2009). This methodology aims to capture the meaning of an experience through a "systematic examination of the experiential" (Smith et al., 2009, pp. 5). The emphasis in phenomenology is on the essence of the experience, not an explanation or analysis (Finlay, 2009). The essence of a phenomenon is the meaning behind the issue at the very core of the phenomenon (Lin, 2013). Data gathering typically involves interviews with one or more individuals who have experienced the phenomenon that is sought to be understood (Smith et al., 2009). Phenomenological interviews use open-ended questions that allow the researcher to access a richly detailed account of the participant's thoughts, feelings, and experiences related to the phenomenon (Smith et al., 2009). It is a dynamic process of interaction between the researcher and the participant, whereby the

researcher accesses the participants' experience and makes sense of the participants lived experience through interpretive activity that decodes the meaning behind the experience of the phenomenon (Pietkiewicz & Smith, 2012). Interpretive phenomenology is a particularly rich methodology because it accesses what may be perceived as overtly meaningful and what may be unstated but implicitly meaningful to the experience of the phenomenon (Pietkiewicz & Smith, 2012). Therefore, analysis and discussion move beyond descriptive aspects such as what happened and who was there. In interpretive research, the researcher attends to and interprets the emotions and impacts of the phenomenon along with how the participants experienced the phenomenon and what it the experience of the phenomenon meant to them.

Philosophical Framework

Phenomenological research is described as a "philosophical approach to the study of experience" (Smith et al., 2009, p. 11). Put another way, phenomenology is the application of philosophical ideas to an empirical project (Finlay, 2009). Phenomenology is a method with strong philosophical underpinnings that emerged from the works of Husserl, Heidegger, Merleau-Ponty, and Sartre (Smith et al., 2009). Each of these philosophers added to and enhanced the emergence of interpretive work as a methodology. Husserl was interest in how an individual might know their own experience of a phenomenon to identify the core aspects of the experience (Smith et al., 2009). However, unlike later philosophers who took to this form of experiential understanding, Husserl believed that experience could be understood objectively through bracketing oneself from the phenomenon. Heidegger, who was a student of Husserl's, contributed to IPA through his belief that our being-in-the-world is a contextualized and subjective experience in relation to something in the world (Wrathall & Dreyfus, 2006). He posited that the interpretation of meaning-making of a phenomenon in context is paramount to

interpretive endeavours in psychology (Smith et al., 2009). Merleau-Ponty added to IPA by drawing attention to the sensory aspect of being-in-the-world as part of the experiential aspect of a phenomenon (Smith et al., 2009). He emphasized that our experience is an embodied perspective. Sartre's contribution to phenomenology is his views on the developmental aspects of the human experience and the notion that human beings are in a perpetual state of becoming (Smith et al., 2009). He also echoes Heidegger's work on the worldliness of the human experience and how the presence or absence of personal and social relationships contributes to the depth and breadth of our ability to conceive of our experiences (Smith et al., 2009).

IPA is comprised of principles drawn from phenomenology, hermeneutics, and ideography. *Phenomenology* is an eidetic method, meaning that it looks at how the individuals in the experience see the experience, what makes the experience special or unique, and aims to make the invisibility of the experience to outsiders visible and understood (Pietkiewicz & Smith, 2012). Researchers in phenomenology focus on how people perceive an experience; IPA researchers do not adhere to a predetermined categorical or scientific criterion (Pietkiewicz & Smith, 2012). Instead, they are encouraged to be creative and flexible in their thinking.

In IPA, a *hermeneutic* approach means the researcher must attempt to understand what it is like to be in the shoes of the participants and to understand the experience from their perspective (Pietkiewicz & Smith, 2012). The combination of phenomenology and hermeneutics results in "a method which is descriptive because it is concerned with how things appear and letting things speak for themselves, and interpretive because it recognizes there is no such thing as an uninterpreted phenomenon" (Pietkiewicz & Smith, 2012, p. 363). Two layers of meaning-making happen. First, the participants make meaning of their experience through the interview process. Then, the researcher interprets the meaning-making the participant or participants

shared (Pietkiewicz & Smith, 2012). This means IPA is double-hermeneutic because the researcher is making sense of participants making sense of their experiences (Smith et al., 2009). The meaning-making that is occurring is both cognitive and affective (Smith et al., 2009). It is a relational process (Babich, 2018) that is attentive to the phenomenon being explored and the subjective connections and interactions between the researcher and the researched (Finlay, 2009).

Ideography is the process of in-depth analysis of the perspectives of each of the participants (Pietkiewicz & Smith, 2012). Researchers who take an idiographic approach give their full attention to each case during analysis before moving on to the next one. Then, when researchers write up their analysis, they highlight overall themes in the analysis, individually, collectively, or both, and exemplify them with narrative excerpts from the individuals interviewed (Pietkiewicz & Smith, 2012). This process allows for a detailed understanding of each participant in the study.

Ontology and epistemology are philosophical assumptions that influence the researcher, participants, and research process (Creswell, 2013). *Ontology* relates to the nature and characteristics regarding reality and the nature of being (i.e., subjective versus objective; Olafson et al., 2010; Sandberg, 2005). Ontology essentially asks what the nature of reality is. Ontological considerations are often not addressed in either educational or psychological research (Olafson et al., 2010). *Epistemology* considers the origins of how we know what we know, referred to as the known subject (Sandberg, 2005; Vasilachis de Gialdino, 2009). Epistemology asks how knowledge becomes known (Creswell, 2013). Simply put, ontology is our reality, while epistemology refers to the ways we represent that reality (Enosh & Ben-Ari, 2016).

The main purpose of IPA is to understand how individuals make sense of their experience of a phenomenon (Pietkiewicz & Smith, 2012). Wrathall (2006) explains that we can know a phenomenon through how that phenomenon reveals itself to us, which unfolds within the context of our relationship to the phenomenon (Schwartz-Shea & Yanow, 2012). There are several different ways a phenomenon can reveal itself through our direct or indirect experience with the phenomenon (Wrathall, 2006). However, if the phenomenon is not revealed to us, this does not mean it does not exist, only that we are not consciously attending to its existence (Wrathall, 2006). One well-known example that helps explain this notion of how we know what we know through how we know it, is Heidegger's hammer example. A hammer is a thing that is known as it is because of its use as it relates to nails and boards (Wrathall, 2006). If object (the hammer) is found in a different context (such as being used to stir paint) then although it is still physically the same object, its meaning changes because it is now differently constituted (Wrathall, 2006). A phenomenon is considered to be differently constituted as a result of differing contextual factors such as such as time, place, and personal history (Schwartz-Shea & Yanow, 2012).

In IPA, when differing or conflicting perspectives or experiences of a phenomenon exist, it is considered normal; multiple interpretations of a phenomenon can all be true (Schwartz-Shea & Yanow, 2012). Taken further, phenomenology is an approach that extends beyond looking at something to interpretive looking (Schwartz-Shea & Yanow, 2012). Conversely, positivistic perspectives espouse a single truth that must be hypothesized, tested, and observed (Schwartz-Shea & Yanow, 2012). This means that from a positivistic perspective, when differing truths exist, the data is considered suspect, not that there may be multiple truths (Schwartz-Shea & Yanow, 2012). Through an interpretive approach, researchers seek to understand what something is by learning what it does and how it is used by certain people within a particular context

through interpretive understanding, not making and testing hypothesis (Schwartz-Shea & Yanow, 2012).

There is no single starting point to meaning-making, and it may change over time or as contextual factors change (Schwartz-Shea & Yanow, 2012). Wrathall (2006) explains that "we can't deduce the essence of things from the way they show themselves to us when we reflect on them as objects and articulate properties…" (pp. 41). This means that interpretive phenomenology is about more than just what we see before us. It is about the meaning of a phenomenon, which reflects our deeper understanding of it based on our relationship to and experience with the phenomenon. Smith and colleagues (2009) describe experience as tantalizing and elusive. In IPA, interpretation delves deeper than mere description and seeks to bring the researcher closer to knowing the phenomenon as it is, not as it fits into some broad categorical or theoretical structure (Wrathall, 2006).

Study Format

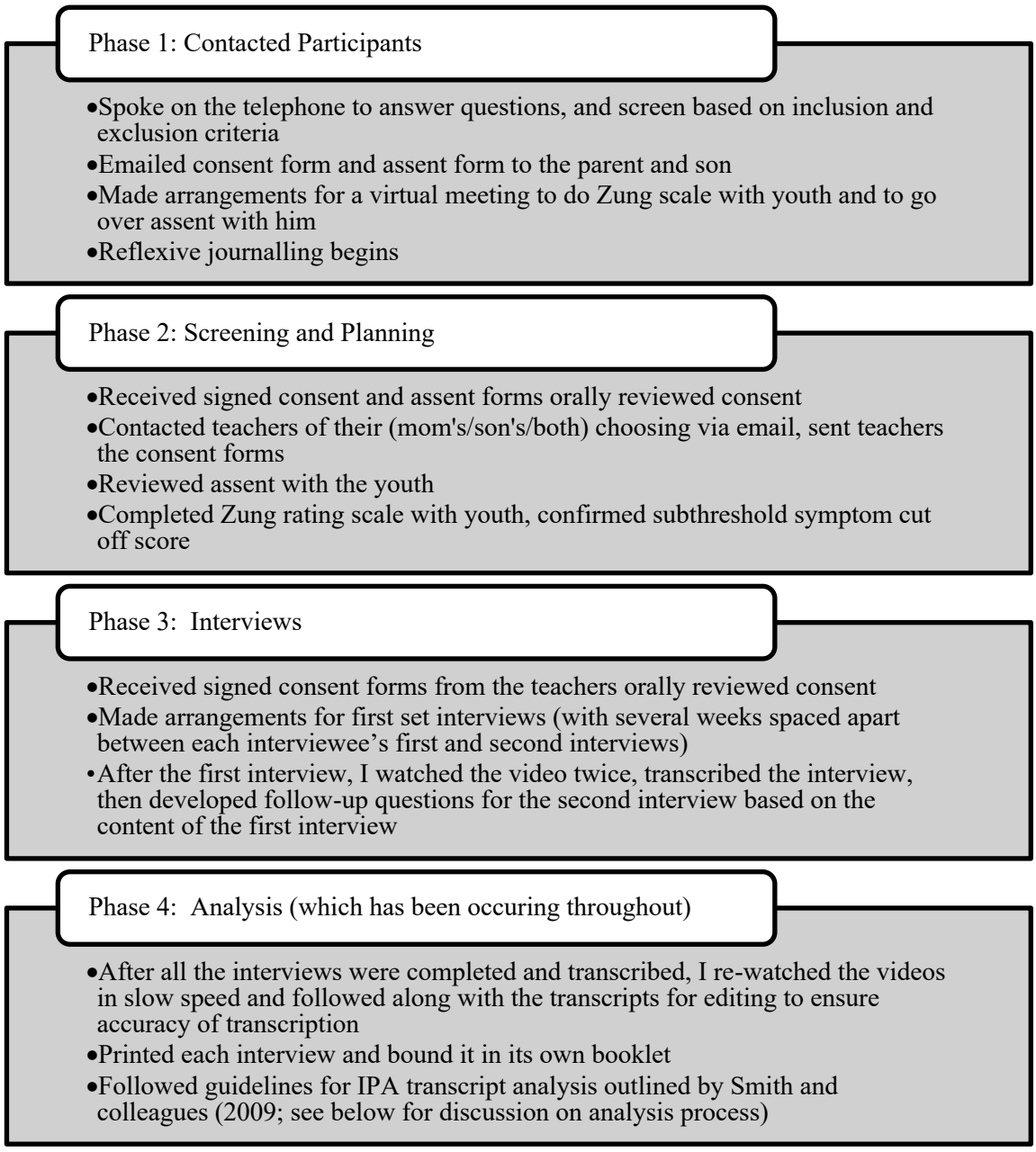
This study adheres to an IPA format, which focuses on a small number of participants, referred to as cases by Smith and colleagues (2009). Each participant has experienced the phenomenon being studied in some significant capacity. The young boy is at the heart of the phenomenon because he has ODD and subthreshold anxiety symptoms, while the three adult participants have an intimate relationship with the phenomenon because of their relationship and shared experience with the youth. Gathering multiple perspectives of the same phenomena aids in developing a more detailed and multifaceted understanding of the phenomena being studied (Smith et al., 2009). In this study, data gathering is in the form of a series of open interviews conducted with each participant in conjunction with my reflexive processes. Information

gathered from the first interviews is used to inform the focus and guiding questions of the second interviews (Smith et al., 2009).

Study Implementation

The figure below lays out the process of implementation of this study. However, it is essential to note that IPA begins the moment the research questions are formulated. This is because IPA is a way of thinking as well as a methodology. Any interaction the researcher has with their research is part of IPA. Furthermore, data analysis in IPA is not reduced to a final step that occurs after all other steps are complete. In IPA, analysis is a cyclical process that occurs any time researchers interpret their research, including during interactions with their participants, engagement in reflexivity, interpretation of their findings, and writing about their findings. As Schwartz-Shea and Yanow, (2012) describe it, in IPA researchers are like the captain of a ship, they must be attuned to the weather and changing tides and be willing to repeatedly veer of course from the original course that was set forth while still on dry land. In the analysis section of this paper, I elaborate on the IPA process that I engaged in throughout this study. Therefore, the purpose of the figure below is to present a simplified visual representation of this study that sets the reader up for the detailed discussion that follows.

Figure 1. Phases of Implementation



Participants

In order to clearly present the activities involved in this study, the discussion on the format of the study has been divided in four phases. However, as previously noted, it is important to keep in mind that IPA research is not linear. Therefore, although research actions

are presented here in a sequential manner, in practice, the research activities occurred in more circular manner. The first step was obtaining participants, which was done through a poster shared via email to colleagues, posted on social media, and printed posters put up at the University of Calgary in the Integrated Services in Education clinic. Upon contacting interested participants, I followed up via telephone to establish if they met the criteria for participation in this study. It should be noted that there were several parents who expressed interest in participating in this study because they firmly believed their son had ODD, even though no formal diagnosis was made (which meant they did not meet participation criteria). During the phone interview, I confirmed English language, established if they met initial inclusion criteria, explained the screening process, and arranged to complete the SAS with the adolescent boy.

Inclusion Criteria. Candidates for participation in this study had to meet preliminary criteria. The adolescent who is the focus of the interviews and study must be a boy between 12 and 14 years of age and have a diagnosis of ODD. A boy was chosen because, as noted in previous chapters, boys are more likely to present with ODD and anxiety than girls. Participants were also considered if they had comorbid DBDs, ADHD, depression, or learning disorders as well because these conditions frequently co-occur with ODD or anxiety. The youth who participated in this study was diagnosed with ODD and ADHD by his psychiatrist. He has been on stimulant medication to treat his ADHD since approximately 7 years of age (grade 2). Symptoms of subthreshold anxiety were determined via the Zung SAS. It is important to note that although some diagnostic criteria were used to determine participant goodness of fit for participant this study, these criteria are solely for the purposes of framing the phenomenon, which in this study is the lived school experience of a young boy with ODD and symptoms of anxiety. Therefore, readers are cautioned against making causal inferences between the

diagnostic profile of the participant and the experiences that are shared. IPA is about understanding the emotions, meaning, and lived experience of the gestalt of the phenomenon, not moderators, mediators, or correlations between diagnoses and described events.

Given that the primary data gathering method was through in-depth verbal interviews, all participants in this study had to fluently speak, read, and write in the English language. This was established through a brief informal telephone interview during first contact with the participants. Adolescents were also considered for this study if they lived with one or both biological parents or had been in the same foster family or with their adoptive parents from birth.

Chosen Participants. Throughout the rest of this paper, I will be referring to my participants by their pseudonyms. Identifying information, including name, professional title, and geographical location, have been removed and/or significantly altered to protect the identity of the individuals involved in or referred to in this study. Joshua is the adolescent boy whose experience is the heart of this study. Joshua, Joshua's mother Jacquie; Joshua's behaviour support teacher in grades 4 and 5, Diane; and Joshua's former behaviour support teacher from kindergarten to grade 4, Marlene, all participated in the interviews. These characters are introduced in more detail at the beginning of chapter 4.

Screening and Planning

After Jacquie provided consent and Joshua provided assent, I completed the SAS with Joshua to determine the presence of subthreshold anxiety symptoms. Joshua's score on the SAS was 46 (subthreshold anxiety score range is 45 -74). Then Jacquie and Joshua chose two teachers they both believe know him well and may be willing to participate in the study. They contacted the two teachers they chose via email; once both teachers confirmed with mother and son that they were interested, mom sent me an email, copying teachers to introduce me to them. I then

sent the teachers the consent forms. After I had written consent from all participants, I scheduled the first round of interviews. The first interview I completed was with Joshua; then I interviewed Jacquie, then Diane, then Marlene. I kept this sequence for both rounds of interviews. As a token of appreciation for their time and participation, each participant received a $20 gift card to Tim Hortons.

Ethical Considerations. Some ethical considerations had to be addressed at the onset of this project. Given that this project involved work with an adolescent boy, and because it explored personal experiences that may have been uncomfortable to remember, I had to ensure any risks of harm were minimized. I had several methods of minimizing risk prepared if necessary. For example, taking a break from or stopping the interview and booking a second interview for a later date, reminding them that they do have the right to rescind their assent or consent at the interview phase of the study were all options for addressing any potential but minimal harm that could have arisen. I also reminded my participants that they did not have to answer any interview questions they did not want to.

Although no harm is known to have resulted from this study, for a couple of participants, there were moments when they became visibly distressed while sharing something they thought or felt regarding the phenomenon. I showed warm, empathic listening and remained calm and supportive when this occurred. During my first interview with the youth, there was a moment when he became red-faced, would not look directly at the screen, and appeared to be welling up with tears. Given the impact the content at that moment was having on him, I took a moment to ask if he was ok and if he would like to change the subject or stop the interview, which he did not. When the interview was over, I checked in with him again to ensure he was okay. Then, at

the beginning of my second interview, I checked in with him again regarding how he felt after our last interview to make sure he was still okay and ready to continue.

Confidentiality. Respecting the confidentiality of all individuals participating in the study has been and will continue to be of the utmost importance. Aside from the consent forms, all written documents, including the SAS, interview guides, transcripts, and data analysis documents, were de-identified, and pseudonyms of my choosing were used. Interviews were conducted via a password-protected Zoom video chat room, and recorded videos were downloaded onto a password-protected personal computer. Videos will be deleted upon successful completion and approval of this paper. Notably, digital records have been saved according to procedures outlined by Conjoint Faculties Research Ethics Board obtained during the ethics (REB19-0130_MOD4) approval process.

Interviews

The interview format for this study adhered to guidelines recommended by Smith and his colleagues (2009). They explain that in IPA research, interviews are an opportunity for the participants to speak freely, reflect on their experiences, and tell their stories. During interviews, participants might feel like it is a one-sided conversation with a purpose where the participant does the majority of the talking, and the researcher listens openly and intently.

The interview schedule in IPA is meant to be a guide comprised of a small number of open-ended interview questions designed to elicit participants' perspectives on their experience; it is not intended to be a lengthy script that the researcher must not veer from. This makes IPA interviewing different from other qualitative interview methods (see Creswell, 2012, or Yin, 2014, for examples of typical qualitative interview formats). Smith and colleagues (2009) emphasize that in an IPA interview, part of the researcher's role as an active listener is to be

flexible, which includes formulating questions in the moment that further access something the interviewee is sharing at that time, and in some cases abandoning the interview guide altogether because the interview must instead follow a course set out by participants through what they share in the interview.

Good interview techniques vary but should include highly engaged listening and well-timed, thoughtful questions (Smith et al., 2009). A good interview encourages rich data through the thoughts, feelings, and stories that the participants share. A poor interview is typically rapid paced and includes closed questions and leading or judgmental questions or comments from the interviewer (Smith et al., 2009). The authors state that "good research interviewing requires us to accept, and indeed relish, the fact that the course and content of an interview cannot be laid down in advance." (Smith et al., 2009, p. 65). In IPA, more experienced researchers may only have a single question they plan to ask in their interview. They treat the remainder of the interview as an organic process that unfolds based on how the participant answers the researcher's primary question (Smith et al., 2009).

I prepared an interview guide for the first interview with each participant for this study. For the first interview with each participant, my interview guides consisted of a few main questions and a series of prompts to seek more detail or understanding about what the interviewee was sharing (see Appendices D to F). After I completed each interview, I watched the recording, made reflexivity notes (which will be addressed in more detail after the analysis section), and transcribed the interview. I then prepared the interview guide for the second interview based on my observations and reflexivity notes. For all my second interviews with each participant, I asked questions to pursue an even deeper understanding based on what was shared with me during the first interview. I formulated questions to clarify what I did not understand, what I was

curious about, and what I wanted to know more about to capture the lived experience of a boy with ODD and anxiety in the educational setting. This circular process provided me with further opportunities to immerse myself in the lifeworld of my participants.

Analysis

For this study, I adhered to analysis procedures for IPA research recommended by Smith and colleagues (2009) in their seminal book on the theory and method of IPA. In IPA research, analysis is a process of "reduction, expansion, revision, creativity and innovation." (Smith et al., 2009, p. 81). This means that the research ebbs and flows between the particular and the general from a place of curiosity and a desire for deeper understanding. This intellectual dance facilitates the process of making sense of participants making sense of their experiences, which is the core of IPA.

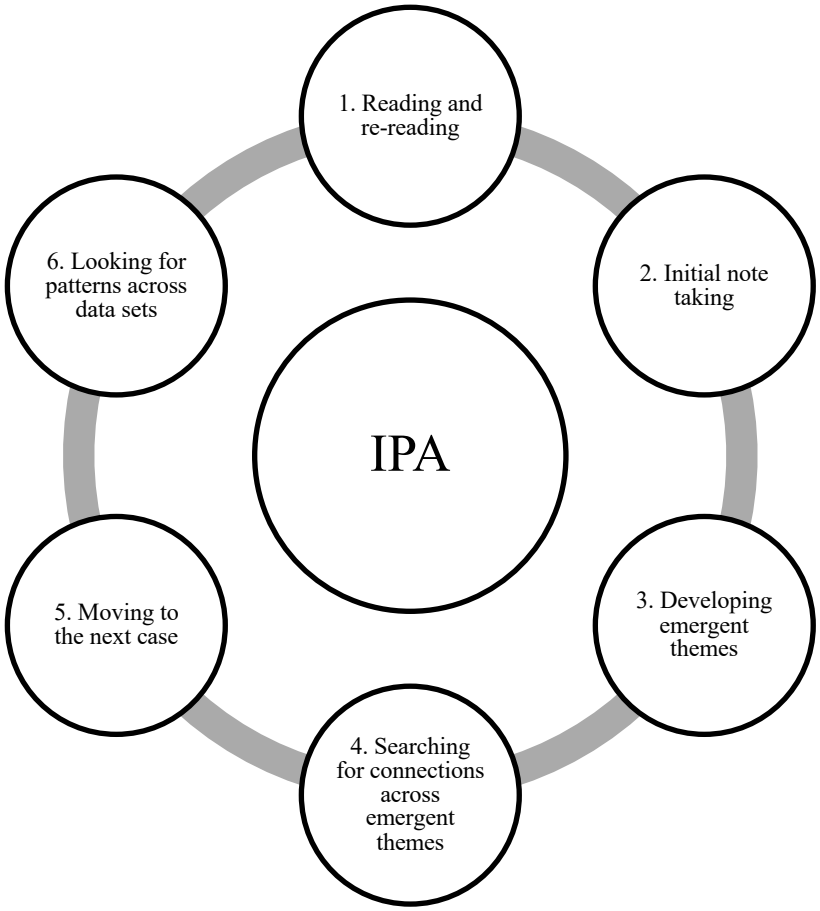
The layout of the following discussion regarding my analysis might imply that I followed a compartmentalized step-by-step process that began after all of the interviews were completed and transcribed. However, this is not the case. In qualitative research, data analysis begins when researchers begin to formulate their research questions and continues throughout the process and writing the findings data collection (Baxter & Jac, 2008; Smith et al., 2009). For example, Smith and colleagues state, "transcription itself is a form of interpretive activity." (p. 75) because during transcription, researchers become immersed in the data, which leads to reflection on the data as they go through it and note taking about thoughts and ideas that come up as transcription is completed. This initial analysis consisted of formal reflexive writing, regularly scheduled reflexive meetings with my supervisor, and even a few mad scrambles out of the shower or out of bed to write down some spontaneous insight I had during informal musings about my research. The sequential layout of the analysis section of this study is solely for the organization

of the structure of this paper. Therefore, it is important to keep in mind throughout the following section that I began reflexive practice and analysis in advance of the following discussed steps.

In Smiths' and colleagues' (2009) seminal book on theory and method in IPA research, they recommend six main steps to guide the analysis process (discussed in detail below). Their recommendations mirror steps outlined by Braun's and Clarke's paper on thematic analysis (2006). However, Smith and his colleagues (2009) provide a much more detailed account of the process, provide examples, promote autonomy and flexibility in approach, and speak to the process through the IPA lens. The authors emphasize that as IPA researchers become more skilled and experienced, the analysis becomes less about the steps and more about what is included in each of those steps. Given that I am still in the novice stage of my research skills, I adhered closely to the recommendations in their IPA book, and I engaged in a more traditional approach to analyzing my data. I analyzed by hand instead of using computer software to organize interview content and subsequent analysis. The interview data I analyzed includes 5 hours and 34 minutes of recorded interview content (Jacquie – 87.34 minutes, Joshua 83.20 minutes, Diane – 72.55 minutes, Marlene – 77.53 minutes). This interview content was then transcribed into 156 pages of text (Jacquie – 43 pages, Joshua – 40 pages, Diane – 32 pages, Marlene – 41 pages). In preparation for the IPA approach to analysis, I adjusted my transcript document layout to correspond with my IPA methods book recommendations, with one tiny adjustment. In the book, the researchers recommend a blank column on the left for writing emergent themes, the interview transcript in the middle column, then another empty column on the right for noting exploratory comments. In my documents, I put the interview transcript in the left column, the exploratory comments column in the middle, and the emergent themes column on the right. I used this layout because it aligns with the sequences of steps described in the

book. Then I printed and bound each of the 4 interviews into booklets. This was done merely for organizational purposes. Once this was carried out, I was ready to pursue further understanding of my data.

Figure 2. Analysis Process



Step 1: Reading and Re-reading. At this stage of the process, I immersed myself further into my data. After I edited my transcribed data for accuracy, I re-watched to the videos while reading along with the transcription. This time though, the goal was just to listen to and see what my participants were saying entirely. By doing this, I was beginning to enter the world of my participants. I also commented in my reflexivity journal about things that stood out for me. This included statements that moved me, connections I noticed between interviewees' perspectives,

challenges I was experiencing, and how some of what they were saying connected to my own experience (particularly the teachers).

Step 2: Initial noting. This next stage is considered the most detailed and time-consuming. The purpose is to "produce a comprehensive and detailed set of notes and comments on the data" (Smith et al., 2009, p. 83). Throughout this process, the researcher interactively reads the data instead of superficially reading over it. There are three types of exploratory comments: descriptive, linguistic, and conceptual comments. *Descriptive* comments focus on the subject matter of the dialogue (e.g., talking about a typical school day). *Linguistic* comments focus on the functional aspect of language (e.g., laughter, pauses, etc.). *Conceptual* comments focus on the deeper level of what is being said (e.g., shame and regret about his anger at school). As per Smith's and colleagues' (2009) recommendations, I colour-coded my exploratory notes. I wrote descriptive exploratory notes in pink, linguistic exploratory notes in blue, and conceptual exploratory comments in purple.

During this stage, I also carried out other aspects of engaging with the data. After I read through the transcripts and made exploratory notes on the interview from beginning to end, I decontextualized my relationship with the interview sequence by reading the interview transcript from end to beginning. I made additional notes from this perspective. I also underlined sections I thought were important, particularly those that seemed to answer my research questions explicitly and directly through what the interviewee was saying. I also wrote in my reflexivity journal after working on my analysis.

Step 3: Developing emergent themes. At this stage, the process shifts to making mapping connections and patterns throughout my exploratory notes.(Smith et al., 2009). This process is considered the hermeneutic circle, which means I shifted back and forth between

looking at the parts of the interview data and the gestalt of the data. When articulating a theme, a balance must be established between "enough particularity to be grounded and enough abstraction to be conceptual." (Smith et al., 2009, p. 92). There should be a symbiosis between what the participants say and what the researchers interpret from what the participant has said. During this analysis phase, I read and reread through my exploratory notes and noted the emergent themes from those notes (in green) in the "themes" column in the transcript booklet. I also worked through the interview data from beginning to end, then took a decontextualized approach by reading and noting themes from the end back to the beginning again.

Step 4: Searching for connections across emergent themes. Smith and colleagues (2009) note that this analysis stage, like the others, is not prescriptive, so researchers are encouraged to explore innovative ways of organizing the content. The purpose is to look for patterns and connections between emergent themes in the interview data. For my research, once I went through the interview, completed my exploratory commenting, and noted emergent themes, I then created a document where I cut and pasted each of the emergent themes along with some of my exploratory comments to support the theme. Once I spent some time looking at and thinking through each of the themes, I reorganized them so that related themes became clustered together into overarching themes (a process referred to as subsumption). The table below is an excerpt from the emergent themes document from the interview with the grade 4 teacher. The theme at the top in bold is the overarching theme that I developed by subsuming the themes of "smart/love of learning, funny, good character." The middle column is the page number where evidence supporting that theme is found. The column on the right is the sample of interview quotes and words I noted during my exploratory analysis as a reminder to myself of the specific interview content that supports that theme.

Table 1

Organizing Themes

Gifts and Strengths		
Smart/love of learning	1	Incredibly bright, incredibly insightful
	8	He clearly understood the subject matter so he would go around helping other students happily
	18	Academically inclined, good student
	20	University level reading
	21	We don't do enough to tease out that giftedness, I think he's gifted in some areas, I think he's definitely gifted
	22	He could challenge the teacher cause he was very bright
	23	He was very bright so he could challenge what [a teacher] was saying, and he did
	29	Really smart
Funny	1	Really great sense of humour
	2	Hilarious, gregarious
	15	Humour was a huge strength for him, he could draw people in
	21	Quirky sense of humour…
	25	hilarious
	29	Really funny
Good Character	10	Chivalrous
	15	Verbal child in touch with what's going on, in touch with his teacher, compassion, a really good friend, engaging,
	25	Great personality
	29	Unique view of the world
	32	He was a really good group leader; I don't think anyone ever realized that about him

Step 5: Moving on to the next case. Once the above-noted steps were completed with one interview data set I moved on to the next one. It is important to note that even though the process is repeated for interviews from each participant, the researcher must attempt to treat each data set as entirely new and minimize being influenced by the findings from the previous data set (Smith et al., 2009). Based on recommendations in the book, I took a couple of steps to avoid allowing my thinking to be influenced by my earlier analyses' findings. I wrote in my reflexivity journal, engaged in a dialogue with my research supervisor about my thoughts and conclusions,

and took a short break for a few days before diving into the analysis of the following interview so that I could look at the content with a clear mind.

Step 6: Looking for patterns across data sets. During this stage of analysis, researchers ask themselves key questions about their interview data to direct their thinking and reasoning, including "what connections are there across cases? How does a theme in one case help illuminate a different case? Which themes are most potent?" (Smith et al., 2009, p. 101). Although the researchers recommend laying the tables of each data set out next to each other on a large surface next to each other and looking across all of them, I chose to do this process by creating a digital document. First, I colour-coded each of the interviewee's data sets. Then I began cutting, pasting, and organizing themes, similar to the process noted above in step 4. Table 2 below is a sample from this document. The dusty rose colour is the youth, the lavender colour is the mother, the orange colour is the grade 4 teacher, and the green is the behaviour support teacher. Please note that in the interest of brevity I have removed a number of the exploratory comments and left only three from each participant for the purposes of providing a sample of the data.

After I finished organizing the data into core themes that reflected the phenomenon from everyone's perspective, I wrote out a list of possible themes until I came up with titles for the themes that I believed most accurately and eloquently expressed the sentiment and lived experience of the phenomenon. Then I wrote these down in my discussion section outline that I had put together for my research committee. I also further refined how I stated the core themes as I wrote the findings section of this paper.

Table 2

Organization of Core Themes

There are consequences to consequences		
Punishment triggers feelings	13	I'm not having to do everything in the little room in the office (resentful tone)
	21	I can't change what happened in the past (shame)
	22	I worry what would happen if it happened again (fear of further isolation)
The past is painful	13	(Observable emotions/tears talking about his past), it's hard to talk about
	14	Sadness, guilt, regret, angry with myself, I don't like remembering that
	15	I don't like talking about it (visibly emotional – red face, voice quivering
There are consequences to consequences		
Consequences of his anger	4	he spent almost a whole grade in the office,
	6	Put in a little quiet room
	8	Gr 1, 2, 3, spent a lot of time in the office
Consequences were/are painful	8	…he really hated that, looking back I probably should have advocated a little bit better for him because they used it almost as a threat
	10	I don't any kid should be stuck in the office like that, he hated it…it was not good for him, he was missing out on the social aspect of school
	12	He hated being along…it was very much I feel like it was a punishment for sure, he felt like he was bad, to have reiterated…being reminded how bad you were all the time, he just hated it, he does not like being left alone
You don't know what you don't know	8	The teacher wasn't in a position to deal with [him]
	10	We didn't know what was going on and we didn't know how to deal with it properly
	38	Really tough and we had no idea what was going on
School was a negative place	9	He hated school, he hated reading, he didn't have buddies, the buddies he had were troublemakers as well
	14	I think some it he's blocked it out honestly
	17	So much interaction with the school, it was generally not positive…it was mostly not positive honestly
School sucks		
Reputation preceded him	10	I was waiting for this child that I had heard all this.
	24	I heard a lot of stuff before, so there was a lot of word of mouth, which is really unfortunate
	25	Terrible (re: his reputation), it was self-fulfilling prophecy, when you spend your first whole year in the office, you never make it to a class, what kind of self-confidence and self-esteem would you ever have…his early experiences were awful for him, I think they were defeating (this is an amazing quote that could fit in a few different places)
School sucks		

His experience	3	It was very hard for him, it was really hard on him (re: how often he was sent out of the classroom)
	4	He was disconnected I guess from the experience of being at school, wasn't enjoying being at school, *vicious cycle of him trying in the classroom, getting sent back out…*, just seemed very subdued
	5	…he probably felt like he as being punished…seeing the whole school experience as a negative thing at that point, he didn't really care to do the work that was placed in front of him

Quality and Trustworthiness

Qualitative research differs from quantitative research in that standards of credibility are less established (Yardley, 2000). Yardley (2000) explains that this lack of perceived credibility regarding qualitative methods results from an imbalance in research methodology courses in psychology programs; there are far more quantitative research methods courses than qualitative research methods courses. Interestingly, in both my master's and doctoral program in school and child psychology, a quantitative methods course is a requirement. In order to take a course in qualitative research methods, I would have had to take/audit an additional course in one of the other areas of psychology in the department, such as the counselling psychology program. Yardley (2000) also notes that the credibility of qualitative research methods in psychological research is still in its infancy because qualitative research, in general, is still a new research tool for researchers in the field of psychology. As a result, Yardley (2000) recommends four broad approaches that can be applied in a number of ways to increase the trust in qualitative research methods in a study in psychology. They are sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance (Yardley, 2000). Smith and colleagues (2009) provide a guideline of Yardley's recommendations to apply more specifically to IPA research, which I then adhered to in my research.

Sensitivity to context refers to researchers' awareness of the socio-cultural implications of their study and sensitivity to the data (Smith et al., 2009; Yardley, 2000). It is noted that my

interviews were conducted during the COVID-19 global pandemic, so the interviews were conducted via Zoom instead of in person. Before the pandemic, conducting an interview virtually may have served as a barrier to my participants trusting me and feeling comfortable with sharing their stories. However, we were well over a year and a half into the pandemic, so virtually interacting with others became the norm. Sensitivity to the data, which is part of sensitivity to context, is demonstrated by respecting the raw material of the interviews. This means that instead of just summarizing interviews, the researcher provides a considerable number of excerpts from the participant interviews. This approach also demonstrates sensitivity to the voice of the participant. As will be seen in the finding sections below, I have honoured the voice of my participants by weaving several quotes from their interviews throughout the discussion.

Commitment and rigour reflect researchers' adherence to maintaining a thorough study (Smith et al., 2009; Yardley, 2000). It includes a prolonged commitment to the research topic and competent application of analysis methods. In my study, I maintained a commitment to my research by engaging with it almost daily (despite working full time as a registered psychologist). On some days, this meant several hours of analysis, and on some days, this meant re-reading a chapter from the IPA book by Smith and colleagues (2009) or writing in my reflexivity journal. Rigour was maintained by adhering closely to the process recommended by Smith and colleagues (2009). As part of this, I organized and documented my work and provided a detailed description of the process in this paper so that someone could carry out an independent audit by following the "chain of evidence" to my conclusions (Smith et al., 2009, p. 183). It is worth noting that an independent audit does not need to, and may not, lead the auditor to the same conclusions as the researcher. However, it should show how that researcher came to those conclusions.

Transparency and coherence include how clearly the researcher describes elements of the analytic process, how apparent it is that IPA was implemented (and not some other form of qualitative research), and how clearly the description of the findings is presented (Smith et al., 2009; Yardley, 2000). Transparency in IPA can include tables, diagrams, and examples. It also consists of the ongoing acknowledgement that the study is an interpretive process whereby a researcher is making sense of the participant making sense of their experience. I demonstrated transparency and coherence by providing excerpts of documents of various steps of my analysis and through excerpts from my reflexivity journal (see below). I also acknowledged the interpretive nature of my study by refraining from claims of generalizability of my findings to a larger population.

Impact and importance address how influential researchers' ideas are (Smith et al., 2009; Yardley, 2000). In qualitative research, although findings are not generalizable, the thoughts and ideas should still influence the beliefs or actions of the reader (Yardley, 2000). Implications of findings should be made clear. They should also expand a reader's understanding of the topic. Smith and colleagues (2009) explain that in IPA "a test of its real validity lies in whether it tells the reader something interesting, important, or useful." (Smith et al., 2009, p. 183). I have done my best to be sensitive in my approach, rigorous in my methods, transparent in my process and findings, and comprehensive in my perspective on the implications of my findings. However, it would be both presumptuous and biased of me to make claims about the extent to which readers may find my research interesting, important, or useful. That conclusion I leave to the reader to determine for themselves.

Reflexivity

Being a reflexive researcher involves a researcher's self-appraisal of how personal history and experiences influence the entire research process including focus, questions, design, data collection methods, findings, and how findings will be presented (Attia & Edge, 2017; Berger, 2015; Gough, 2003). Reflexivity is influenced by how the researcher is part of the research and shares the participant's experiences (Berger, 2015). The purpose of reflexivity is for the researcher to attend to and acknowledge their thinking about their research, how their pre-existing relationship to their research focus shapes it, and how that influences their claims (Whitaker & Atkinson, 2019). However, it is more than mere self-reflection (Whitaker & Atkinson, 2019). A reflexive researcher engages in a cyclical process of being immersed in the phenomena they are studying and stepping outside of it (Berger, 2015; Enosh & Ben-Ari, 2016). It may include a confessional account of the methodological process along with self-examination of a researcher's reactions to their research throughout their study (Enosh & Ben-Ari, 2016; Finlay, 2003). Reflexivity is a process of discovery and construction through deliberate awareness and intentional activity (Enosh & Ben-Ari, 2016; Finlay, 2003).

Reflexivity in qualitative research is a method that facilitates the process of the researcher examining their relationship to their research that provides rich insight as a result of self-inquiry and reflection of interpersonal dynamics between the researcher and participants (Berger, 2015; Finlay, 2003). Reflexivity can illuminate unconscious motivations and biases and help the researcher evaluate the entirety of the research process as it is occurring (Berger, 2015; Finlay, 2003). Importantly, bias is an inherent part of being human. As my supervisor stated in one of our reflexivity meetings, "Saying you're unbiased is just saying you're ignoring your biases" (from reflexivity journal entry on December 3, 2021). She was referring to blind spot bias, which is when individuals do not see the bias they have (Wilcox & Schroeder, 2015).

Reflexive practice is a dynamic process in which the researcher must continually ask themselves where they are at personally, cognitively, and emotionally in relation to their participants and their research, along with what the implications might be based on where they are aware they are at in that moment (Berger, 2015). Whitaker and Atkinson (2019) posit that reflexive practice is a fundamental process that is paramount to all research, particularly in the social sciences. This is because the researcher's observations and descriptions play an inherent role in constructing the phenomena they are investigating. Therefore, a neutral position when observing and describing phenomena is not possible (Whitaker & Atkinson, 2019).

Before engaging in reflexive practice, researchers must first reflect on their personal experiences that influence the process and outcomes (See Berger 2015 for examples). With this in mind, researchers must acknowledge that personal experiences impact the process and outcomes of their study by stating their position in relation to their research (Whitaker & Atkinson, 2019). Reflexive practice is influential throughout the research process (Berger, 2015). For example, when researchers are reflexive during the formulation of research and interview questions, they can identify content that they are drawn to or shy away from and become aware of their thoughts, reactions, and triggers related to their phenomena of interest (Berger, 2015). During analysis and writing, reflexive practice can be a doorway to biases in editing and interpretation (Berger, 2015). Another way of understanding reflexivity is to consider it a practice of self-supervision by the researcher (Berger, 2015). To be reflexive, a researcher should consistently engage in three main practices throughout the entirety of a study—keeping a reflection log about their experiences with the participants, repeating the review of the interview after a few weeks, and consulting with colleagues throughout the process (Berger, 2015). Current reflexive practices focus predominantly on the narrative of the self in relation to the research,

which begins from the moment the original research questions are formulated (Finlay, 2003). Qualitative researchers acknowledge that their work amalgamates the participants, the researcher, and the relationship between the two contexts (Finlay, 2003).

There are different approaches to being a reflexive researcher (Finlay, 2003; Gough, 2003). Finlay (2003) identifies five variations of reflexive practice: introspection, intersubjective reflection, mutual collaboration, social critique, and ironic deconstruction. In *introspective reflexivity,* researchers engage in ongoing self-reflection that guides their understanding and interpretation of their research (Finlay, 2003). This form of reflexive practice helps researchers further access their participants' social and emotional world and is meant to be a "springboard for interpretations and general insight" (Finlay, 2003, p. 8). In introspective reflexivity, the researcher acknowledges the link between the researcher, the participant, and the knowledge claims that the researcher makes about their findings.

Through *intersubjective reflexivity***,** researchers address the mutual meanings in the research relationship (Finlay, 2003). Researchers attend to the "self-in-relation-to-others" (Finlay, 2003, p. 9), which includes examining the emotional investment they have in their research and participants. This approach is challenging for researchers because it requires them to take a psychodynamic approach to access their personal and even unconscious motivations (Finlay, 2003).

Researchers who engage in *mutually collaborative reflexivity* engage the participants in reflexive dialogue during analysis or evaluation, which may occur as a single event or through cycles for mutual reflection between the researcher and participants. In this approach, researchers play a dual role of researcher and participant in their study. Practitioners of this form of reflexive practice explain that a collaborative, reflective dialogue between researcher and participants

allows for the representation of multiple voices in a study instead of just the subjective voice of the researcher.

Social critique reflexivity attends to the power imbalance between researcher and participant (Finlay, 2003). Finlay (2003) provides an example of the potential power imbalance and subsequent tension that may arise if a feminist researcher is researching men. Through reflection on experiential accounts and the lens of theoretical frameworks regarding the social construction of power, the researcher deconstructs the source of their conscious or unconscious position of authority in relation to their participant or research.

Lastly, researchers engaging in reflexivity as *ironic deconstruction* challenge the voice of authority and advocate instead for multiple voices to be heard. These researchers attend to the ambiguity of language and how the multiple meanings of language influence societal and individual understanding (Finlay, 2003). They acknowledge and may even celebrate paradoxes and ambiguities in their research journey.

Another example of an approach to reflexive practice is provided by Whitaker and Atkinson (2019). They elaborate on *epistemic reflexivity*, which is essentially the researcher's reflexive practice of their ways of knowing. These authors define research as being inherently reflexive. However, it is up to the researcher to be transparent about their thinking about their research. They explain that epistemic reflexivity captures the influence that contexts such as the researchers' discipline (i.e., psychology, sociology, anthropology, etc.) and general intellectual orientation have on their research process. Whitaker and Atkinson (2019) elaborate on the multiple levels of epistemological reflexivity: disciplinary, methodological, textual, and positional. The authors note that each level of reflexivity interacts with the others in complex

ways, and they emphasize that reflexivity, much like IPA, is not an isolated, linear, or sequential process but is instead fluid and circular (Gough, 2003; Whitaker & Atkinson, 2019).

In *disciplinary reflexivity,* researchers acknowledge that the intellectual tradition they adhere to influences the nature of their research and the phenomena they study (Whitaker & Atkinson, 2019). Reflexivity of disciplinary knowledge and tradition considers the key ideas, accepted methods, leading researchers, and classic studies that permeate that discipline.

Methodological reflexivity aids in illuminating how the research method frames the phenomena to be studied (Whitaker & Atkinson, 2019). This becomes particularly relevant with methodologies that include direct researcher-participant interactions such as field research or interviews because human interactions can be highly variable encounters. Methodological reflexivity is also important in qualitative research because there is an interdependence between the chosen methodology and the conclusion made about their findings due to the methods they chose (Whitaker & Atkinson, 2019).

Textual reflexivity addresses the role of language in representing social worlds, scenes, and actors. In textual reflexivity, the researcher's accounts of their research aid in the construction of the phenomena through their descriptions (Whitaker & Atkinson, 2019). How a researcher accounts their research reflects their style of thinking and their paradigms.

In *positional reflexivity,* researchers overtly acknowledge that their identity and personal history have implications for their research. Positionality influences factors such as the phenomena the researcher is studying, their perspectives on their participants and findings, and their chosen orientation. It is important to note that the researcher's positionality is not deterministic. Instead, it is interactional; it is the researcher's position in relation to their research interactions with their participants and all phases of their study.

Limitations of Reflexivity

Reflexive practice has the benefit of revealing meanings and interpretations. However, it also has the potential to obscure meanings and interpretations (Berger, 2013). A researcher's familiarity with the participants' experience with the phenomena is present in all phases of the research process, including participant recruitment, data collection, analysis, meaning making, and conclusions (Berger, 2013). Although researcher familiarity with the phenomena can allow for a deeper understanding of the participants' lived experience, researchers must remain vigilant in the face of possibly projecting their own experience onto their participants and subsequently losing sight of the participant's voice altogether (Berger, 2013; Finlay, 2009). Some researchers may confuse reflexive practice with reflection and subsequently end up with a personal confessional without making the connections between their thinking and the relationship their thinking has to their research (Whitaker & Atkinson, 2019). The difference between reflection and reflexivity is that reflection is typically a solitary process of considering the outcome events or situations outside of the individual while reflexivity is a process of considering and question a persons' own thinking, beliefs, and assumptions throughout (Bolton, 2014). In addition to ambiguity regarding the distinction between reflection and reflexivity, there is also a lack of consensus regarding the conception and application of reflexive practice (Gough, 2003). Understanding what reflexivity is and how to carry it out may be challenging for new researchers to navigate.

As the above discussion implies, reflexivity is a thoughtful, intentional, and complex process that is influenced and guided by many factors. Researchers' personal history, discipline, philosophies, methodology, and relationship to the phenomena they are studying are all elements that can and should be addressed by reflexivity. Reflexive practice does not just parallel a study;

it is an inherent part of the research process (Whitaker & Atkinson, 2019). Reflexivity includes personal reflection as it relates to the research and a professional reflection that acknowledges how theories, methods, and text frame the research process and findings (Gough, 2003; Whitaker & Atkinson, 2019). It is a dynamic process that promotes transparency and trustworthiness in research (Gough, 2003). Although reflexivity is most prevalent in qualitative research, Whitaker and Atkinson (2019) argue that reflexivity should be a fundamental component in all research so that researchers are forthright about their autobiographical origins and predispositions and how those components interact with and influence their research.

My Reflexive Journey

I engaged in reflexive practice by writing regularly about my thinking, engaging in regular reflexive meetings with my supervisor, and moving in and out of my research (i.e., taking time away from the work to clear my mind and then coming back to it). I primarily took an introspective approach in my reflexivity. I used reflection on my own previous experiences and my experience with my research to aid in my understanding of my research and access the lifeworld of my participants. This was my primary approach because I am a new researcher and this approach was most accessible to me. There were also some elements of intersubjectivity as well because I attended to the emotional investment I have in my research and participants. I engaged in the disciplinary, methodological, and textual components of reflexivity primarily through my regular meetings with my supervisor. We discussed biases in psychology, my own biases in my research, my experience with my methodology, and the messages and themes that stood out to me along the way. My positionality in relation to my research was attended to throughout my writings, meetings, and this paper.

My personal history. As a reflexive researcher, I must acknowledge that my personal history influences my perspective. I am conscious of how some of my experiences influence my thinking while other experiential influences linger below my conscious awareness. I grew up in what I consider to be a typical English-speaking urban Alberta blue-collar Caucasian family. My father was, and still is, a master carpenter, and my mother was an artist working in the printing industry designing and creating logos for business cards and company letterhead documents (long before computers came along and made this role obsolete). I have a younger brother; we are close in age and have always been incredibly close as siblings. Our family does not identify with any particular culture, and although we were baptized Roman Catholic, we rarely went to church. My brother and I were well-behaved children who did well enough in school. He maintained that trajectory into junior high and high school; however, I did not. I was a rebellious and impulsive adolescent. I spent what felt like at the time to be the entirety of my adolescence getting grounded for something egregious. I made some questionable friendship choices and decisions and witnessed some disconcerting events during my youth. My mother always believed the crowd I was part of as an adolescent gave me the insight to connect so authentically with troubled children as a teacher and psychologist. I understood their lifeworld because I was a part of it for a snapshot in time during my youth.

I chose to become a teacher in my early twenties after hearing that my favourite elementary school teacher had died. He was my favourite teacher because he was funny and exciting, and he was always there for me when my classmates picked on me because of my braces and headgear. He was my teacher in grade 4 and then again in grade 6. I am sure that all the other students from his class for those two grades would still cite him as their favourite teacher. I remember the school gymnasium being packed for the memorial they held for him at

the school. I felt compelled to carry on his legacy of being a positive, playful, and authentic influence for children. I loved teaching. My students were amazing. Challenging to be sure. But also genuine, honest, and in need of someone who saw them as more than violent and difficult children. I did not see my students as behaviour disordered students (others colloquially referred to my classroom in our school as the "BD class"). I chose to see them as passionate; they felt big feelings and did not know what to do with those feelings, so I was there to help them. Many of them had heart-wrenching trauma experiences that they had to carry with them every day. As I learned from my students about what they needed from me and the other adults in their lives, I became their advocate in return. I spoke at teachers' convention, provided professional development for teachers and group home staff, and my classroom became a pilot classroom for what my principal referred to as "new age" classroom management methods. She called my approach new age because I brought meditation, mindfulness, yoga, and dance parties into my classroom, which was unheard of in a program like ours at that time.

After six years of teaching in the program, it became apparent that if I wanted to make a positive difference for my students and others like them, I needed to do more. That is why I chose to become a school psychologist. I thought that if I obtained the education and degree requirements that would open new doorways of opportunity for me—I could continue to be an agent of change for these students on a larger scale. To this day, and as is apparent by the topic of choice for this study, my purpose remains being a voice for students who struggle with their emotions and behaviour at school.

As a teacher and as a psychologist, my purpose has been to make a positive difference for students who struggle. I believe that a comprehensive understanding of a student's history, functional presentation, and character, coupled with the right people and the right support, will

facilitate a more positive school experience for everyone. To put it plainly, I believe that these students need to feel cared for and to feel understood.

In addition to my experience with the students, I also developed very close relationships with the parents and caregivers of my students. I spoke to some of them on a weekly (and sometimes daily) basis throughout the school year over the course of the one to three years their child was in my classroom. My background as a teacher enhanced my ability to genuinely connect with the parents of students who struggle. During my research interviews, I was able to genuinely understand and appreciate many of the anecdotes my participants shared. I had a doorway into their lifeworld that other researchers may not have had. However, I also had to be mindful that my personal experiences lead to biases. I have done my best to identify and take ownership of the biases I am aware of or was made aware of by my supervisor during our reflexivity meetings. I engaged in reflexive practice to monitor my thinking, so my analysis was more than just imposing the meaning of my own lived experience of the phenomenon onto their meanings and experiences. What follows is an overview of how I engaged in reflexivity in my writings throughout my study. I have provided examples that correspond with each stage of the research process, from contact with participants to writing up my findings to bring the reader along with me on my journey and show how my thinking and understanding expanded along the way.

Reflexivity in practice. I began my reflexivity journal in September 2021, shortly before I was to start interacting with my participants. It began primarily with comments and wonders written haphazardly on the pages after I had somehow interacted with my research (i.e., meetings with my supervisor and committee, emailing with my participants, preparing my interviews etc.). Once I began the interviews, my reflexivity notes expanded and became more organized. I made

note of biases, triggers, and things that occurred during the interview. Below is the entry I wrote on September 9, 2021, after I completed my first interview with the youth. The entry is written in point form with comments and shorthand as it was written in my journal.

> So hard not to get invested emotionally. Tricky to listen without labelling or analysing (clinical brain). He was visibly uncomfortable when talking about his past. Looked a little like he was going to cry so I backed off a bit. Was that the right thing to do? He reminds me so much of [former student], so sweet but w/a big angry streak. Amped up easily. Comments about others annoying him and thinking they're so cool are interesting. He seems to understand his ADHD better than his ODD.

As can be seen above, I acknowledged how my own experience was present in how I viewed this boy. On the one hand, it illuminated the familiar, which meant understanding his experience would be more accessible to me than to others unfamiliar with this type of experience. However, it also meant I had to be disciplined in my thinking to be sure I saw his experience, not remembering a former student's experience. I also wondered about my approach during the interview. This was helpful later when I prepared for the second interview. It was good that I noticed his discomfort. Although I felt uncertain about how I handled it at the time, upon later reflection, I came to understand it was the right thing to do because of the potential impact it could have had if I had chosen to push for more information while he was in that state.

My reflexivity notes also included considerations for the following interview. After that first interview, in which Joshua repeatedly referred to himself as a jerk, I wrote, "next time get more about being a jerk. More about his past when he was more volatile. More about what changed. More about what school used to be like before he loved it." Notes helped to inform the direction of my next interview with him.

After my first two interviews, on October 8, 2021, I had a reflexivity meeting with my supervisor. During this meeting, I shared my initial thoughts and the emerging biases that I was navigating and documenting. She pointed out that I am experiencing what could be considered a visceral bias. A *visceral bias* is when something stirs an individual emotionally. This was most certainly happening with me. At one point, during one of the interviews with the mother, she became very emotional. What she was sharing and the feeling she expressed was so powerful I found myself wanting to cry with her. Although I maintained a warm and supportive affect while she emoted, after the interview was over, I cried as well. Whenever I felt stirred emotionally while I was working with my data, I chose to take breaks to allow myself the time to process what I was feeling before I went back to the work.

I also wrote in my reflexivity journal after every transcription session. Sometimes my notes were narrative, and sometimes they were brief but poignant. For example, on October 25, 2021, I wrote, “transcription is interesting in that you get to know your data really well, but also it’s easy to get lost in the minutiae and lose sight of the gestalt.” This was an experience I would continue to encounter throughout transcription and analysis. It was also something I would come to understand is the hermeneutic circle of phenomenological research, the process of going back and forth between understanding the data's cyclical part-whole-part relationship (Smith et al., 2009).

An interesting bias came up while transcribing one of the teacher interviews. This also occurred at a stage in my reflexivity journey where I became more thoughtful about my relationship with my research. On November 15, 2021, I wrote:

> Finally started transcribing teacher interview. She has so much to say, it’s going to be a major process transcribing this one. The bias I already have is just how much I like this

> teacher and how high my opinion is of her level of competence. It's hard not to put too much merit into her perspective. I will have to be very mindful of that, especially when it comes to the analysis portion of the process.

As will be seen in the findings section below, I managed this positive bias by being sure to provide ample evidence to support her perspectives. This is one of the inherent advantages of IPA. The discussion of the findings in IPA includes copious verbatim examples from the participant interview, more so than may be seen in other qualitative methods (Smith et al., 2009). This level of transparency holds researchers more accountable to their conclusion because they cannot just summarize what they found; they have to support it with evidence.

As patterns began to emerge throughout my interviews and analysis, I reflected on my own relationship with my students. I wondered, "Did they feel this way in my class? Was I the teacher that changed things?" (excerpt from reflexivity journal entry on December 20, 2021). I felt compelled to reach out to some of my former students whom I still hear from a couple of times a year. I worried though that this could further complicate my relationship with my research, so I chose not to.

During deeper components of analysis, my reflections included my thoughts and feelings regarding the analysis process instead of my interactions with my participants. On January 17, 2022, I wrote:

> I have finished mostly doing the exploratory comments portion of the youth interview transcript. I'm thinking I may also read the notes in reverse to do a decontextualized analysis. I find it difficult to do analysis for extended periods of time. There is a certain level of presence required to go beyond discourse analysis to the experiential.

In the above entry, I then go on to say that it might be time to reach out to my committee member who is an IPA expert, to ensure I am on the right track before diving deeper into my research.

When it came time to shift from analyzing individual interviews to looking for core themes, my insights came to me during times of quiet reflection, and my entries took on a more philosophical tone. My entry on January 21, 2022, is result of thoughts that came to me as I sat on my couch enjoying my morning coffee.

> I ran into an interesting hurdle yesterday that I've come to understand through an unbridled theme of thoughts during my morning coffee. Yesterday I was really struggling to wrap my head around these superordinate themes. I felt like the themes I have thus far are big and I wasn't sure how I could find a greater gestalt. Here's what I've realized though. I've sort of been going about the process in reverse. I've jumped straight from exploratory to superordinate, so my process has become one in which I'm not building up to the big theme but instead looking at the big theme and then asking myself "ok, how did I get there? What did I see that makes me think this way?" I had an initial knee-jerk reaction of "oh no I'm doing it wrong" but quickly reminded myself that the beauty of IPA is that you are not trapped in a linear sequential process. It's far more organic than that. I wonder if this is the hermeneutic cycle happening naturally as I continue to become more intimate with my data.

In addition to this increasing depth of thought, my reflexive focus shifted from biases related to my interactions with my participants to questioning my thinking, the quality of my work, and the existential purpose of my research. On February 28, 2022, while deep in the throes of writing the findings section of the paper I observed:

> The more I dive into the writing of my research, the more I seem to be re-ordering and refining some things. I find myself continually asking myself "does this help capture my audience into seeing how much his story matters?" and "Am I really showing what the experience was like for him?". What I struggle to capture well in my narrative right now is the pain this boy and his mother went through. Words on paper don't show the tears and the choked back voice. But also, how do I tell this story without the emotional investment? I need clarity. I can't do that if I go too deep. Is the emotion true to the experience or am I seeing it as more than it is because I've allowed myself to be too pulled in? I have two strategies I have been using when I get stuck in this place. One is to just walk away. Take a break from the work. Take Flower for a walk. Do a load of laundry. Something. Anything to pull my mind out of it. The other thing I do is read Smith and Flowers or other IPA research, something that brings me back to the work. It's a tricky balance to motivated by heart but have to still be able to lead with mind. This is a little human beings' very real experience, not numbers on a page. There is an intimacy to this work that, if not reined in and released when appropriate, poses a risk to the authenticity of the story being told. Too much heart and it's biased, too much mind and I miss their truth.

As the above entry shows, my visceral bias emerged repeatedly throughout my evolving relationship with my research. I established some effective strategies for working through my visceral bias. However, I did not want it to go away completely. In some ways, my visceral bias is also the driving force for this work. Reflexivity allows me to work with my biases, challenges, and insecurities through awareness, understanding, and transparency. This process has held me

accountable to my research process and has made me a more thoughtful researcher along the way.

Chapter Summary

In this chapter, I described and explained the methodology of this study. The design chosen for this project is IPA. The stages of implementation of the study, steps of analysis, and trustworthiness methods were also explained in detail. This chapter then concluded with a comprehensive discussion of reflexivity. In the concluding chapter of this study. I present my findings and then discuss them in further detail. After that I address the implications of my findings, present limitations, and provide some final thoughts in my conclusion.

Chapter 4: Findings and Discussion

Introduction to the Participants

Joshua is a 13-year-old boy who lives in rural Alberta with his mother, stepfather, and three siblings. He loves playing video games, going swimming, and building forts. Joshua participated in the school wrestling team for three years until wrestling was cancelled due to the COVID-19 pandemic. He plans on joining wrestling again when it is available again. At school, Joshua's favourite subject is mathematics. He loves math because he likes solving problems and doing equations. He said that he is good at it and enjoys the recognition he receives for being so good at math. Joshua would like to be a marine biologist when he grows up. He plans on finding a new species of shark so that he can name it after himself.

Joshua's mother, Jacquie, has grown up her whole life in rural communities. She works full-time in the medical field. However, she worked part-time when her children were young so that she could be at home with them more. Jacquie separated from Joshua's father when Joshua

was a toddler. She remarried when Joshua was approximately five years old. Joshua has regular alternating weekend visits with his biological father.

Marlene has been teaching for over a decade. She initially did not want to be a teacher; she wanted to be a psychologist. She decided that path was not for her and left the program she was in. Marlene knew she wanted to be in the field of education when one day, during a shift at her part-time job, she met a young student who had complex needs who was doing her high school practicum at the site and had her EA with her. Seeing the meaningful way the EA was interacting with the student left a lasting impression on her. At that moment, Marlene was inspired to work in education. She started as an educational assistant and worked her way up from there. Marlene has specialized in supporting students with complex needs for almost 20 years. To her, the best part of her job is the relationships she gets to build with her students, their parents, and her colleagues when she is working with all of them to meet the needs of the students she works with.

Diane has been a teacher for over three decades. She has always worked in elementary schools in rural school divisions. She decided to become a teacher when she heard some teachers from the university come to talk to her high school class about a career in education. Their love of students and the opportunity for creativity and autonomy inspired her pursuit of a teaching career. Diane believes that school should be an excellent place for children to come, a place that they want to go to, and it is her job to make it a place that children want to be. For Diane, the best part of her job is the children, laughing with them and sharing experiences with them.

Their Journey Together

Joshua's school experience began tumultuously and included anger, aggression, and physical outbursts. There were several consequences to Joshua's anger at school. His physical

outbursts, peer conflicts, defiance, and disrespect towards teachers led to Joshua having a negative reputation that lingered for several years. Teachers were guarded in their interactions with him; students and teachers avoided him in the halls; parents did not allow their children to play with him during after-school hours; he was not invited to birthday parties; and up until grade 4, he did not have anyone he could call a friend. Joshua's negative reputation impacted his mother as well. In the community, she was seen as the mother of the "problem child." People in the community made disparaging comments to her and to others about her and Joshua.

The primary mode of dealing with Joshua's anger and outbursts during those early years was to keep him alone in the office with the school administrator in close proximity. Depending on which school year it was and what the offence was, Joshua would spend anywhere from hours to days, weeks, or even a couple of months in the school office with no interaction with his same-age peers or classmates. The primary motivation for keeping Joshua in the office for such extensive time is unclear. It could have been intended as a consequence, as a safe space for him, as a way of keeping others safe from him, or for some other reason not apparent through what interviewees shared. The lack of clarity regarding the purpose of this approach suggests that it may have been a reactive response and not part of a behaviour support plan or proactive intervention strategies. Regardless of the motivation for the extensive time he spent alone in the office during his early elementary years, it had a profoundly negative impact on how he experienced school during that time and how he looks back on himself now.

Joshua hated school early on. He hated it because he felt like he was constantly getting into trouble; he felt his teachers disliked him; and he was frequently isolated from others, including his peers. This created a vicious cycle in which he would get angry and frustrated at school because he hated being there, then he would get in trouble for the way he behaved when

he was angry and frustrated, then he would be angry and frustrated because he was in trouble again. What Joshua's mother knew about her son, but the school had yet to understand, was that her son hated to be alone. He would do his best to avoid being physically alone at home. Even if a school office staff was in an adjacent room, this was too far away for Joshua's comfort. This means that while the time in the office was likely not implemented with malicious intent, it had a lasting negative impact on Joshua, to the extent that even now, the idea of having to spend a lengthy amount of time in the office is anxiety-provoking for him.

According to Joshua and Jacquie, the catalyst for change came in the form of two exceptional educators. One was Marlene, the school behaviour support teacher who worked with and spent time with Joshua whenever she could. Marlene cared deeply for Joshua. Right from the start, she saw him as being brighter than other children his age and that he was a very special boy who struggled to express his emotions safely and was misunderstood by others. She thought that he was self-aware and that he managed his feelings and behaviour more effectively with patience, understanding, and the opportunity for him to feel heard.

Joshua’s grade 4 teacher, Diane, worked with Marlene to prepare for Joshua. Diane looked forward to the opportunity to be his teacher. Over the course of that school year, the connection that grew between Diane, and this changed Joshua’s entire school experience for the better. He no longer displayed angry outbursts, and there was less peer conflict. He completed his schoolwork. He spent most of his time in the classroom with his classmates, and time in the office was not an option under Diane’s tutelage. Joshua began to enjoy school, make friends, and discover his gifts. This subsequently led to a shift in how others saw him too. Teachers and other children interacted with him in the halls, he went on field trips, got invited to birthday parties, and began to love school, not just like it, but sincerely love it.

Themes from their Lived Experience

Transcript notations include ellipses (…) to indicate content omitted, square brackets [content] to indicate content added or changed for clarity and curved brackets (commentary) to indicate a comment I have added as part of the analytic commentary.

Theme 1: A bright and capable little boy. "I think he's gifted in some areas. I think he's definitely gifted." (Diane). This first theme was emphasized by all four participants—Joshua has tremendous potential. He is described as a boy with many great qualities, gifts, and talents. All four participants (Joshua included) explained that Joshua has always had a great sense of humour. He also loves to read and spends hours reading whenever he can. Joshua has a keen interest in science and wants to be a marine biologist when he grows up. Diane described him as "hilarious" and "gregarious"; she saw him as a charismatic boy with an infectious and entertaining personality that could "draw people in." Whenever Joshua had a story to tell his grade 4 classmates about something he learned, or something he did on the weekend, he would captivate his audience with his animated approach to sharing his stories. From grade 4 on, Joshua was seen as a strong leader and a good friend to his classmates and peers.

Marlene, Joshua's behaviour support teacher, thoroughly enjoyed her time with Joshua whenever she interacted with him. She spoke highly of his character and saw that he was unlike other children:

> I feel he's a lot more mature in a lot of ways than a lot of kids his age. And he understands even more. Like I'm sure even in your conversations with him, like you just have to sometimes smile because he's like a little adult.

Diane saw the same qualities in Joshua as well when he came into her grade 4 class, “I realized right away that he was incredibly bright. Incredibly insightful. He saw the world through a different lens than most 9-year-olds.”

Both Diane and Marlene believe that Joshua is gifted in several areas. Marlene felt so strongly that Joshua was gifted early on that she did a standardized academic assessment with him only to discover he was above grade level in almost every area measured, with scores in as high as the 99% percentile. She found this perplexing:

> It was funny because, not haha funny, but, in grade 1 and 2 that was always the complaint that I got is that he was so low with his reading level…it wasn’t the fact that he couldn’t read, it was just in the classroom he was bored. And he chose not to at that point. I think. I feel. Because he was just not challenged enough.

Diane noted that by grade 4, Joshua was reading at a university level. His academic skills were so strong that whenever Joshua finished his schoolwork before his peers, he would then go around and help his classmates because, as Diane observed, he “clearly understood the subject matter.”

Joshua’s reported above-average intelligence presentation may not always have necessarily served him as well as other children his age. For him, being as bright as he was also meant that he had the intellectual capacity to argue skillfully with adults and authority figures, “he could challenge what [they] said, and he did.” Diane added that Joshua preferred to err on the side of playful humour when challenging someone he had a close relationship with, such as herself. She felt it was because he was attempting to avoid offending her when he was trying to share his perspective on the matter.

Marlene believed that Joshua's outbursts and other behavioural issues partially stemmed from his lack of engagement with his classroom learning during his first few years of school. For example, when he was upset, he would go to see her in her support classroom. She explained that after an outburst:

> He was able to communicate his thoughts and feelings quite easily and so then…he would just tell me that he got frustrated and that he didn't feel like doing what they were doing…he would tell me he was bored, he just didn't feel like doing like doing the work. It was boring. And then he would get angry and frustrated.

Theme 2: An angry little boy: "It was like everything was just anger … any feeling that he had was expressed as anger…it was just anger" (Jacquie). This theme captures the extent to which Joshua's anger was relevant to his early school experience and was identified via interview content analysis from all four interviewees. Although Joshua no longer inappropriately expresses anger or aggression in the educational setting, Joshua's anger and oppositionality were chronic, pervasive, and explosive during his early elementary school years, from kindergarten to grade 3. Marlene said that she saw Joshua as a "sad, angry little boy" right from the time he started school. He would often get upset, hit his classmates and adults, and run away from his classroom. Kindergarten was an especially difficult year for Joshua because he went through 5 different teachers that school year (it was explicitly noted that this did not have anything to do with Joshua's behaviour). By grade 3, a shift was beginning to occur, but there was still some anger, aggression, and oppositional behaviour. However, grade 4 was an incredibly successful year with no incidents of anger or aggression. In contrast, during grade 5, there was some slight regression, but the positive progress continued and has remained to this day as he navigates his middle school years.

Joshua explained that during his early elementary school years, he had “severe anger issues.” He described himself as “constantly not happy,” “disrespectful,” and “hard to deal with.” He saw himself as a “mean kid,” a "bully," and a “jerk.” Although the data analysis for this study did not include quantification of themes, it should be noted that Joshua referred to himself as a “jerk” 12 times throughout the two interviews when talking about himself in the past. Joshua’s mother explained that “[he] literally had no respect for authority figures, like at all…he would punch, hit, kick, hurt teachers, um, students, sisters, myself. Without discrimination. It didn’t matter. If something triggered him, he would react…” Even a police officer visiting the school became a recipient of Joshua’s verbal aggression. Jacquie explained that Joshua did not distinguish between a person in a position of authority such as law enforcement, school administration, and peers such as classmates and siblings. To him, there was no status or social hierarchy. They were all on the same level, which was either at or below his level.

Joshua's angry outbursts and oppositional disposition remained frequent and prevalent from kindergarten to the end of grade 2. He still presented with many of the same challenges in grade 3; however, they occurred with somewhat less frequency. Throughout those early to mid-elementary years Joshua's anger looked like yelling, screaming, swearing, hitting, throwing chairs, and running away. There was also a couple of occasions in which he became so angry while in the “quiet room” where he was sent (or taken) to calm down, that he intentionally urinated on the floor in the corner of the room.

Joshua recalls times when he would be "dragged" out of the classroom because of his behaviour. There were also times when his aggressive behaviour was so severe that his teachers would respond by evacuating the classroom. Then the administration would come in to deal with the situation, which meant that Joshua would be spending time in the office. Marlene pointed out

that despite Joshua's aggression towards so many others in the school during that time, he was never aggressive towards her, which is likely because of the special relationship she had with him.

Theme 3: A socially driven and anxious boy. "…he's a very, very social kid, whether he knows how to act in social situations or not, which as a youngster he absolutely did not" (Jacquie). The core message from Joshua and his mother that this theme captures is the unspoken conflict Joshua experiences, and experienced historically, between his desire to be seen and feel connected to others, his aversion to being alone, his anxiousness regarding how others perceive him in social situations, and his history of poor social behaviour.

Despite Joshua's history of difficult, oppositional, and aggressive behaviour, he is motivated by, and even thrives, in social interactions. His mom explained that

> Joshua loves people. He is very much a people person. He does not like being alone. He does not like being left alone when he's home. He doesn't like being alone when there's a group of people around. He can't.

She further explained that Joshua cares about what other people think of him, even when he acts like he doesn't care about it. He does not want to appear nervous in front of others and so he tends to engage in silly behaviours, which she sees as an expression of his nervousness in social situations. Joshua experiences anxiety in social situations because he does not want to be embarrassed or disliked so he attempts to make others laugh instead. It upsets Joshua when others do not like him, and he feels happy when they do like him. She described him as quite sensitive in this regard. Joshua takes how others perceive him to heart.

While Joshua was describing what school is like for him now, he stated with a big smile that he is "very funny," which results in him being publicly addressed for disruptiveness by his

classroom teacher. He shared that when he gets sent out of the classroom into the hallway for being funny during inappropriate times, he finds it “really embarrassing.” He explained that “everyone like all of a sudden has their eyes on you, and you kinda start freaking out inside a bit…and you gotta leave…it’s kinda like the walk of shame.” Joshua added that he feels “self-conscious,” “guilty,” and like an “idiot” because everyone is laughing at him as a result of being asked to leave the classroom to go sit in the hallway. Joshua stated that “[he] likes people having a nice image of [him].” He sees being sent out of the classroom is harmful to the perception he would like people to have of him.

Joshua wants the people around him to regard him positively. He likes to be seen as smart and funny. Jacquie, too echoed Joshua's desire for social acceptance, “he likes having people and attention. He really soaks that in.” She also explained that “he really just wants everyone to like him. He really, he doesn't like being thought of in a negative way. And so, if he sees that, then it just really upsets him. It bothers him a lot.”

Theme 4: Consequences have consequences. Joshua’s anger, and the outcomes of his anger resulted in a number of consequences including how he felt about himself and the situation. “Kinda sad that I was there all the time. It doesn’t make me feel good about myself” (Joshua). This theme illuminates a significant portion of Joshua’s lived experience of school during those years that he was violent, aggressive, and yet to be fully understood by others, which was recognized through interview content analysis from all four interviewees.

During those few early years, Joshua spent a tremendous amount of time in the office. From kindergarten to the beginning of grade 4 he would sometimes be in the office to do all of his learning for months at a time. To ameliorate the lack of classroom instruction that Joshua had as a result of his time in the office, Marlene came in to do work with him whenever she could.

The consequence of time in the office had larger consequences for Joshua than anyone likely intended or may have been aware of at the time.

Joshua's mother recognized that "the [administrator] wasn't in a position to deal with him" because, at that point, they did not know why he was behaving the way he was or how to stop it. At that time, the most accessible solution seemed to be to remove him from the classroom and have him spend the majority of his school days in the office with the school administrator nearby. The time that Joshua spent in the office was impactful,

> [He] hated being alone. Um, [administrator] was always very kind to him, but she was the teacher, not a student. And he had no friends around him. And it was very much, I feel like it was treated like a punishment for sure, which I, you know, absolutely it was. Um, but he hated being talked to like that as well. So, it's like, "oh well, you did this to yourself, or this is because you did this." And I understand the explaining it…but he was already in the office away from everything, so he already hated it and then to have it reiterated and reiterated and reiterated…being reminded how bad you are all the time.

Joshua's mother saw his extensive time in the office as a negative experience for everyone, not just Joshua. "It sucked. It sucked for him. It sucked for me. It sucked for the teachers." She explained that he missed out on the social aspect of schooling in those early years, had no friends, and he felt like he was "the bad kid."

One of the main reasons Jacquie saw the experience as so awful for Joshua is that it capitalized on one of Joshua's major fears, the experience of being physically alone. Social isolation was anxiety-provoking for Joshua. It was hard for her not to believe that his early grade-school teachers and school administrator sensed this about Joshua and attempted to use it as leverage whenever they were attempting to discipline him for his anger and aggression.

Joshua also felt that school "sucked" because of all the time he spent in the office. "I didn't like that. I hated it there. I couldn't talk to people. I would just sit there and do absolutely nothing."

Joshua identified a cycle of anger and anxiety as part of what he named as a punitive experience. "I was constantly doing bad things, so I was constantly worrying that I was going to be punished for doing those things." This cycle of doing bad things led Joshua to feel "really angry and really scared."

Marlene saw this "…vicious cycle of him trying in the classroom, getting sent back out, put into the principal's office [and] having me pop in throughout the day whenever I possibly could." She saw the whole experience as "really hard on him":

> He was so anxious to have to go to the principal's office cause he saw that as such a negative thing. And, I still look back on that whole situation as being such a negative, having such a negative impact on him. Um, looking back on it, like I wish I would have been able to do more for him in that, at that point in time, because I think it really made him hate coming to school, and like, I think it was hate. He despised coming to school.

Marlene often saw Joshua in tears even at the notion of going to the principal's office. Some days he wouldn't even make it to his classroom; he would be in the office as soon as he started his day in the building. Marlene tried to go in to see Joshua in the office to do some one-on-one teaching with him whenever she could, and she felt guilty that she couldn't do more with him and for him at that time. Jacquie echoed a similar sentiment of guilt because she felt she "really didn't stand up for him enough" at the time because she was at a loss of what to do. Being removed from social situations caused Joshua "a good deal of upset," but, as she saw it, at that time

> for myself, I just think it was a lot of not knowing what was going on, not understanding how to better advocate for him, and how to deal with him as well as having…other kids going through the school system.

Although Joshua has since grown to love school, at that time, he perceived it negatively. When Joshua was asked, “What was school like before you loved it?” “It sucked," was his reply. Upon being prompted to elaborate, he explained

> I was constantly getting into trouble, and I was always being sent to the office, like 24/7. So, it made it really hard for me to enjoy it. And it was only around grade 4 when I started to, when I started to like change, then it started becoming funner for me because I wasn’t constantly in the office or constantly in trouble.

Marlene expressed empathy regarding how hard the whole experience was for Joshua, noting that even as an adult with the capacity for calm and understanding, she would still have found the frequency and duration of isolation as almost incomprehensible,

> I mean, I can’t even imagine myself, who can regulate myself as an adult, to be stuck in a room like that all day, and not being able to be with my friends and, you know, carry out those experiences of what a 6- or 7-year-old child should do.

Theme 5: The ripple of effect of an angry boy. “…his reputation had to be changed” (Diane). This theme addresses an unexpected but relevant aspect of Joshua's school experience. A lingering reputation resulted from his anger and aggression at school, which arose from interview content with Joshua’s mother, his classroom teacher, and his behaviour support teacher. Joshua’s reputation impacted his daily life at school, his reputation in the community, and how his mother felt when interacting with the school and the broader community. For example, even though it has been about 3 to 4 years since there has been a major incident at

school that included an angry outburst or physical aggression, Jacquie still experiences an "anxiety reaction" when she sees the school calling. She cannot help but think, "ah shit, what did he do now" because "for 3 years solid, every phone call that I got from the school was Joshua is in the office, or Joshua has done this…".

All the teachers in the building knew who Joshua was, which, as Diane explained, caused teachers to be guarded with him whenever they interacted with him. She had "heard a lot of stuff" and there was "a lot of word of mouth" about Joshua in the school before he came to her class. She saw this word of mouth as facilitating an incredibly negative experience for Joshua at school. So when she was asked, "…that reputation and that word-of-mouth piece, how do you think, like what do you think that meant for his experience at school?" Diane explained

> I think it was terrible. I think it was terrible for him up until it changed a bit. It was, you know, that self-fulfilling prophecy. When you spend your first whole year in the office, you never make it into class. I mean, what kind of self-esteem and self-confidence would you ever have? You have that feeling of, well I can't even make it into the classroom…I think his early experiences were awful for him. I think they were defeating…they were pretty defeating for him those first few years.

Marlene also saw how negatively her colleagues viewed Joshua due to what they heard about him and everything they saw in the school halls and office. She explained

> They were nervous. They were nervous about working with him because if they didn't know him, they would normally just see him doing the yelling and the screaming and the running down the hallway. Or "oh, look, that kid is in the principal's office again." Or he would have to come in from recess cause he punched out another kid or something like

> that. So they were just seeing all of that. The negativity. Negativity. And, none of the positive getting to know [Joshua] underneath all of that.

In addition to Joshua's negative reputation in the school, Jacquie and Joshua also dealt with judgment in the community due to his reputation. Jacquie felt she was seen as “Joshua's mom, and not in a nice way,” even though she had other children in the school system. Other parents at the school would say, “oh god, your Joshua's mom eh,” with a tone that conveyed both shock and judgment (as demonstrated by Jacquie when she mimicked this statement as it was said to her). Joshua was not invited to birthday parties, and “there were moms that wouldn't let their kids play with him because of who he was.” Joshua’s mom believed his reputation had a negative impact on him for quite some time. “It sucked for him, being the bad kid for, you know, 3 [or] 4 years in a row where he’s the bad kid in the class.”

When Diane was asked if and how Joshua’s diagnoses of ODD played a role in the negative reputation he had among many of the teachers in the school; she felt that it did. She also saw the special education eligibility code 42 as part of the problem.

> That code 42 really irritates me. It irritates me because having kids come in code 42, everyone’s backs, everyone’s shoulders go up…I think his diagnosis, especially when people hear oppositional, they expect it…I think it was very harmful for him, very harmful for his, his um, mental well-being in his first 4 years of school. No, 5 [years]…”

Diane explained that teachers would be guarded during their interactions with him. She saw that how others viewed Joshua influenced how he viewed himself. She believed he perceived himself in a negative and defeatist manner. She described his sense of self at school as

> [t]he problem child…the child who is going to get in trouble for talking. The child who is going to get in trouble for not doing his work. The child who was, you know, couldn't work in a group cause he would disturb. You know, real negative, negative, negative.

Theme 6: A different perspective. "I remember the [Marlene] saying to me 'there's a good kid in there, there's a really good kid in there, I'm glad you're gonna be teaching him'…and right away I was like 'oh there really is'…". (Diane). This theme, which was gleaned solely from the content of the interview conducted with Diane, captures a perspective that appears to have facilitated a tremendous shift in Joshua's presentation and subsequent experience at school. Despite Joshua's alarming reputation throughout the school in the years leading up to grade 4, she chose to see him differently. Diane described Joshua as "incredibly insightful" and that,

> [h]e saw the world through a different lens than most 9-year-olds. He saw the world through a different lens. So, he, when he did things that might antagonize other children, it wasn't because he was trying to antagonize other children; it was because he was looking at it from a different point of view.

Joshua's sense of humour, which she identified as "dry like [her] own," was another aspect of his character that she felt other adults in the school misunderstood. "I think sometimes adults saw his humour as disrespectful. But I didn't take it as that. I thought he was funny. Cause humour is a sign of intelligence." Not only did Diane perceive Joshua's behaviour differently, but she also "loved" how "tough" he was. She felt that his tough presentation, which included his propensity to challenge adults, meant that he was a "thinker" and she enjoyed the way she was challenged by Joshua because he was such a "thinker."

Diane shared that Joshua seemed to feel accepted in her classroom and that his gifts were appreciated by her and by his peers. In her classroom, was in a “warm environment where he could relax” and subsequently “use his frontal lobes.” And that Joshua was no longer “in that survival state…he wasn’t in fight or flight” anymore. Diane pointed out that there were no incidents of violence or aggression towards her during that school year with him as her student. On the very rare occasion that he was in the office because of an incident, it was because it occurred under someone else's supervision during an unstructured time such as recess. Whenever Joshua was brought to the office while under the supervision on another adult at school, she always brought him back to class instead of leaving him in the office. Sending him to the office or leaving him there because someone else put him there was not an option in her mind as an effective strategy for addressing Joshua's challenges. Instead, she dealt with situations herself, and engaged in conversation with him about events instead of punishing him. Diane seemed to have a thoughtful understanding of Joshua's needs in order to help him be successful. She explained that in previous years

> I don’t think there were conversations around it. Or coaching. It was just more black and white. It was very black and white. And for a child that lives in the grey most of his life, he needed coaching along the side, and he appreciated the coaching along the side.

The changes in Joshua’s behaviour during his grade 4 year were so pronounced that the special education eligibility code 42 was removed from Joshua’s programming and changed to a code 53, which was used to identify his silly and disruptive behaviours associated with his diagnosis of ADHD. Diane’s perspective of Joshua and her relationship with Joshua that year paved the way for what his mother believes was the key school year that changed the entirety of her son’s trajectory at school.

Theme 7: The power of authentic relationships. "Whatever they did was awesome, because it made a world of difference for us…specifically those two women are awesome…because (paused here) thank god" (Jacquie). When Joshua's mother made this statement, she was referring to Diane and Marlene. She spoke with emotion, needing to pause as she choked back tears of gratitude for the two women's profound role in her son's life. This theme is a powerful one for what it means as it pertains to Joshua's lived experience of school, and because it is the theme that is most prevalent throughout all of the interview content. All other themes in some way either directly or indirectly lead back to this theme, which emphasizes the importance of sincere relationships developed through genuinely positive intentions. Interview data from all four interviewees contributed to the unveiling of this theme.

Joshua felt all of his teachers were "nice" but that most of his teachers did not like him because of how "hard to deal with" he was. However, the dynamic between himself and both Diane and Marlene was different. He spoke highly of them. Joshua "loved" them both, and described them as nice and funny, adding that Diane is "one of his favourite teachers ever."

When asked what it was about both ladies that made them different from all the others, Joshua explained that "they kinda knew how to deal with me" and that they had "a lot more patience." He felt that they understood what he was "going through," and they "figured out how he worked." Joshua knew he could count on both of them to be there for him, "when I started freaking out, they knew how to help me."

Joshua's mother expressed a similar warmth towards these two educators. Jacquie said Diane was "amazing" with her son. She believes that Joshua's troubles were minimized greatly that school year, specifically because of her. Jacquie shared that Joshua has "really, really good relationships with the teachers who took the time to get down on his level and actually spend

time with him as opposed to just banishing him from the classroom" (referring to Diane and Marlene) and that "up until that point [teachers] were just somebody at the front of the room that he had to listen to for 6 hours a day." Jacquie observed that with Diane, Joshua no longer had to endure the "punishments that he was used to." Diane took the time to get to know and connect with Joshua. She said Diane "didn't put up with any crap," but she did provide non-punitive alternatives and "just handled it differently than the other teachers."

Diane knew she had to be thoughtful in how she interacted with Joshua. She could not just approach him in an alpha manner and expect that he would just automatically comply. "I mean, if you come [in] there that you're going to be the heavy, wow. Wow. That's, that's what an ODD, an ODD child will absolutely, they will up you every step…that relationship building was so key." Instead, she met him where he was at and found other non-threatening and positive ways to interact with him. They teased, joked, and engaged in an ongoing playful rivalry between their favourite hockey teams. Diane was a Calgary Flames fan while Joshua rooted for the Montreal Canadiens. Diane would put funny anecdotes on the board in the morning about a game that happened the night before so that his day started with a playful tone. Sometimes during little breaks, she would play videos for the class of the flames winning games. She showed and shared personal interests with Joshua and the other students in the class, which meant he felt included with his classmates as well.

Diane recognized that Joshua was generous in how he interacted with others in situations where he felt that warmth and generosity being extended towards him. She emphasized that "…he's a very, he, he gives back. He's very reciprocal when it comes to relationships. And, if you accepted Joshua and loved who he was, he reciprocated tremendously. He gave back

tremendously." She added that if this giving approach was not part of the dynamic between Joshua and a teacher then, "he kinda just existed in the class."

Diane saw Joshua's relationship with Marlene as paramount to his success as well. She noted that Marlene "was a real proponent of him when other people weren't," adding that, "you have to have someone in your corner, right. You have to have someone." From Diane's perspective, prior to Joshua joining her class, Marlene was the only person truly in Joshua's corner during those early elementary years. As Marlene explained regarding the impact of the significant amount of time that Joshua spent in the office in grades 1 and 2,

> I think that was really, really hard on him. And, I think he may have struggled a bit as to who his, who his personal connections were…and it might have made him question a few things while he was at school as to who his closest allies were.

Although there was likely no explicitly malicious intent, Joshua's experience during all that time he spent in the office was the primary reason he questioned who his allies were. Marlene explained

> I don't know if they had as much time as I did to sit down and, you know, have that empathy stuff with him. And I always found with him that he needed to be heard. And so, if he wasn't heard by administrators and they would just come, and they would keep him in their office or something, that's when he might start to act out and be a little bit more physical.

Marlene shared that she wished she could have been more available for Joshua so that he did not have to spend so much in the office. She felt, however, that her "hands were tied." Despite the guilt she expressed for not being able to be available for him every single time there was an issue, she identified her relationship with Joshua as a "special bond," which extended into

the relationship Marlene had with Jacquie as well. Marlene's role with Joshua was diverse. In addition to doing the academic assessment reading and learning in the office with Joshua in his early years, she also made her room available to him whenever he needed a safe space to go to, intervened to support him when he was escalated whenever she could, and connected with him in the mornings on days that she anticipated he might struggle more than usual. However, the year Joshua spent in Diane's class Marlene saw him minimally because of how well he was doing in her class. Marlene saw that Joshua "was really driven by relationship." She believed that his most positive and meaningful relationships were "the big key to helping him be successful and to where he's at right now."

Theme 8: Growth is possible. "…I realized I can't go through life like that…I can't just be angry all the time…" (Joshua). This theme sheds light on the other side of Joshua's lived experience of anger and anxiousness at school. It explores what happens once the heightened emotions, angry outbursts, and aggression have settled. This inspiring theme is drawn from all four interviewees.

Joshua is self-aware of his diagnosis and subsequent challenges. For example, regarding his ADHD, he said it makes it harder for him to "focus on stuff" and makes him "kinda hyperactive all the time," while his ODD diagnosis means that "I really don't like authority figures…I have trouble with teachers…I don't like being bossed around a lot…[and] I used to have a problem disrespecting teachers."

Joshua saw the implications his challenges had on his future. When he was prompted to elaborate further on what he meant when he said he realized that he couldn't "go through life like that" anymore, he spoke with conviction when he explained,

> Well, being a jerk all the way up until I'm like older, I don't wanna do that. I don't wanna be a, be mean to everyone I see…I don't wanna constantly be…in the office or being punished. That would suck. I wouldn't be happy. I wouldn't make others happy. No one would want to hang out with me. No one would wanna be around me. No one around me would be happy so I wouldn't be happy. Besides, I'd be affecting others and myself.

Joshua "didn't like being in the office all the time" and "would rather be happy at school making friends and having fun than sitting in the office all alone doing work."

Joshua attributed a few key circumstances to the major shift he experienced primarily in grade 4. First was his self-proclaimed realization that he just could not continue in the same manner because of its implications for his future quality of life. Second, was that he just "kinda learned to get through it all." Third, were the teachers who were nice to him, patient with him, and helped him out by talking to him a lot. Prior to his epiphany, Joshua saw his school experience as "not nice times" that he "did not enjoy it in any way, shape, or form."

Joshua still sometimes worries about what would happen if it happened again but then quickly added that he is not willing "to go back to that." His school experience is much more positive now, "I'm enjoying myself. I'm having fun. I've got friends. I'm hanging out with them. I'm learning fun stuff, and I'm not having to do everything in the little room in the office." Joshua did not refer to himself as a jerk or identify any issues with anger when speaking about his present school experience. Instead, he expressed optimism about all of the learning he gets to do in middle school and has future plans to be a marine biologist when he grows up (and according to his mother, he has the grades and abilities to do so). He is already looking into options for summer whale camps in British Columbia.

Jacquie reiterated Joshua's optimism regarding his present school experience. She stated that there are "no problems" at school and that the last "major incident" was over a few years ago (by major, she meant "kicking, screaming, crying…freak out, blow out…" etcetera at school). Jacquie identified Joshua's connection with Diane and Marlene as the primary factor that enabled Joshua's success. However, she also sees some of his success as a result of that fact that he seems to have grown out of his most challenging behaviours, which is what the pediatrician explained to her may happen when he was first diagnosed with ODD.

Diane recalls that when she began teaching grade 4, she was prepared for all of these things that she had heard about Joshua, but she "never saw it." During his time in her classroom, he developed "really good friendships" and seemed more connected to his classmates and school. Even administration saw the change, saying to Diane that "he's just such a different kid this year." Diane knew that Joshua was having a "better school experience," which she saw as positively impactful for Joshua's mother too, "the more wonderful things she [Jacquie] heard about Joshua, the more wonderful she thought he could be too." From there, she began to see her son as a "regular kid." Diane added that it "broke [her] heart" when Joshua's mother told her that grade 4 was the first year that Joshua had ever had friends at school. Other parents began permitting their children to play with Joshua. He was invited to birthday parties, could come on all the class field trips, and was allowed to, and was capable of, participating in various school-based extracurricular activities, including wrestling, with success.

Diane explained, "there was a real shift in how the school saw him" and "teachers really started to appreciate who he was." He started to "realize he was good at things, and other people were realizing he was good at things." She believes that Joshua started to feel a sense of

belonging, “I think his reputation changed, and people all spoke to Joshua in the hallways again instead of avoiding him.”

Marlene saw a significant shift as well. She felt it began with Joshua’s grade 3 teacher, who was more open to a “push-in” instead of a “pull out” support model, meaning that although Joshua still spent some time in the office, it was much less than in kindergarten, grade 1, and grade 2. Marlene noted a “drastic change between grade 2 and 3, then an even more drastic change in grade 4.” From her perspective, Joshua had a “different outlook on what his school days would be.” She emphasized the change in him was “like night and day…it was unbelievable.” Marlene explained that Joshua “was coming into school feeling safe and cared for and heard and was actually enjoying the daily activities and the challenges.”

Theme 9: Lessons learned. “…please just get to know my kid…if we had figured some things out along the way sooner…some of the incidents could have been prevented…” (Jacquie). At the end of the interview series, participants were asked what advice they would give others who work with students like Joshua. This theme represents the culmination of advice that Joshua, Jacquie, Diane, and Marlene all provided due to their connection to Joshua’s lived experience of school. One common message they all shared was the importance of relationship-building as part of everything else they recommended. For educators, Joshua advised

> you have to be patient with a kid like me. You can’t try and force stuff on them. You have to like, you gotta help them, and like, it doesn't just happen overnight. You can't just say “be better,” and it be better. There’s a lot of stuff that you have to do…it’s a big process.

Joshua recognized that change was something that took time, effort, and actionable steps. Supporting him required a thoughtful time and energy investment from the adults in his school life.

Joshua's advice was not limited just to educators. For youth like himself, Joshua, he had even more to say. "I'd tell them be more respectful and that there are ways that you can cope with these things. You can go for walks. Have, like, fidgets. I'd tell them to get to know the teachers a lot more and just try and be better and be nicer…" Joshua explained that teachers can understand what a student is going through if the student communicates to the teacher what is going. He noted that trust is an important part of opening up to a teacher because "they can, and they will help you.". Joshua sees kindness and good listening as actions indicative of a trustworthy teacher. Joshua suggested that students going through what he went through "not to, like, try and block out their emotions. To, like, let people know that's what you're feeling because other people want to try to help you. Teachers, not a lot of other people."

Jacquie noted the importance of options that do not include time spent alone in the office and the need to "spend more time trying to find out what works for that kid." To spend time

> sussing out those little things for these kiddos so that the alternative isn't something that's, like, a punishment but still allows the teacher, or whomever, to get on with it, but the kid doesn't feel like this horrible, you know, distraction, but that's not the right word…the bad kid in the class.

Jacquie observed that while Joshua's medication was somewhat helpful for treating his ADHD, she does not see it as "the piece in the puzzle as to why he's doing better now in [middle school] than in grade 3." When Jacquie was asked what the "biggest piece of the puzzle" is, she shared

> I think it's the people. I really do. I think it's honestly the people that take the time, to have the patience to come up with solutions rather than just kicking a kid's butt outta class. And I really do think that that's made the biggest difference.

Diane highlighted the importance of transparent expectations to avoid putting students in a position to guess what the teacher wants from them. "I think that's hugely important for someone like Joshua cause if he's trying to guess what you're expecting, he may make the wrong guess." Wrong guesses could lead to misunderstandings and challenges. For her, there was also an emphasis on the importance of recognizing the gifts and "passions" of each individual student and learning "what makes them tick." She explained,

> I think appreciating the gifts of a child regardless of the behaviour. The behaviour is just behaviour. It's just behaviour. Each child brings a gift, and appreciating that gift, and then letting everyone around them know how much you appreciate that gift.

She also pointed to "a lot of coaching" alongside the student to help them learn to make better choices. "It doesn't have to be discipline, discipline, discipline. It can be coach, coach, coach, coach." As part of the coaching, also "catching" those moments of success. She summarized her advice by stating, "these kids have gifts, they do…just relax. They want to be included as anyone else does."

Marlene shared the same message of relationship-building but also added the importance of the relationship with the parents. With the inclusion of the parents in the prioritization of relationships, "that home and school connection becomes so much stronger…and you can work a lot more with the parents in making that a positive experience for the child."

When Marlene was asked to share any final remarks regarding advice for others or anything else she wanted to share that had not been addressed in either of the two interviews, she stated, “segregation is not the answer.” She elaborated further,

> I can't see many kids benefitting from that…sometimes kids need a quiet place to work right. But when it was seen as, like, punitive, I just don't think it was, it was the right way to go. And I think that that took some work getting him, bouncing him back from that.

Summary

Table 3

Summary of Themes

Theme	Exemplar Participant Quote
A bright and capable little boy	“I think he’s gifted in some areas. I think he’s definitely gifted.” (Diane).
An angry little boy	“…it was like everything was just anger…any feeling that he had was expressed as anger…it was just anger” (Jacquie).
A socially driven and anxious boy	“…he’s a very, very social kid, whether he knows how to act in social situations or not, which as a youngster he absolutely did not” (Jacquie).
Consequences have consequences	“Kinda sad that I was there all the time. It doesn’t make me feel good about myself” (Joshua).
The ripple effect of an angry boy	“…his reputation had to be changed” (Diane).
A different perspective	“I remember the [behaviour support teacher] saying to me ‘there’s a good kid in there, there’s a really good kid in there, I’m glad you’re gonna be teaching him…and right away I was like ‘oh there really is’…”. (Diane).
The power of authentic relationships	“Whatever they did was awesome, because it made a world of difference for us…specifically those two women are awesome…because, thank god” (Jacquie).
Growth is possible	“…I realized I can’t go through life like that…I can’t just be angry all the time…” (Joshua).

Lessons learned	"…please just get to know my kid…if we had figured some things out along the way sooner…some of the incidents could have been prevented…" (Jacquie)

As the themes summarized in the table above highlight, Joshua's lived experience of school has been complex. The participants implicitly and explicitly expressed shame and guilt related to Joshua's experience. Joshua felt shame and guilt over who he was and how he behaved during his early elementary years. His mother Jacquie expressed shame and guilt for not advocating for him the way she now thinks she should have then. Joshua's behaviour support teacher Marlene expressed shame and guilt for not being more available for him during those early years. Although Diane did not express any shame or guilt herself, she did express a great deal of sadness regarding the negative experience, negative reputation, and lack of friendships that Joshua had prior to coming to her class. Interestingly, shame, guilt, and sadness were predominantly related to Joshua's experience of being in the office so frequently at such a young age and the implications that form of discipline had on his friendships and overall lived experience of school.

Discussion

This case study used an interpretive phenomenological approach to understand the lived experience at school of a youth with ODD and subthreshold anxiety. Although it was not a primary focus of this particular study, it should be noted that Joshua also has a diagnosis of ADHD, which does commonly co-occur with ODD. Irrespective of diagnostic labels, the themes that emerged from this research illuminate the school journey of a young boy with a great deal of potential, whose lived experience of school shifted from anger and isolation to success and growth, which seemed to be primarily a result of meaningful and authentic connections.

Emergent themes identified via content from interviews with Joshua, his mother, his grade 4 teacher, and his behaviour support teacher were organized into 9 core themes that capture the essence of his experience. These themes are deeply personalized to Joshua's individual experience, making it challenging to make connections to existing literature. Despite this, some aspects of the themes reflective of Joshua's lived experienced can be corroborated by existing scientific literature on gifted students, anger and anxiety, student discipline, and student-teacher relationships. The table below outlines the layout of the discussion that follows. As shown below, the themes have been organized into 4 topic headings in order to facilitate an organized discussion.

Table 4

Themes nested by discussion heading

Discussion Heading	Themes
Positive Attributes	A bright and capable little boy Growth is possible
Anger and Anxiety	An angry little boy A socially driven and anxious boy
Disciplinary Measures	Consequences have consequences The ripple effect of an angry boy
Teacher Student Relationship	A different perspective The power of authentic relationships Lessons learned

Positive Attributes

Joshua saw himself as a smart and capable student. His mother, behaviour support teacher, and grade 4 teacher all echoed the same perspective. Joshua's grade 4 teacher and behaviour support teacher believe that Joshua is gifted based on his high reading abilities, the ease with which he acquired various concepts in core subjects, his insightful nature, and his communication skills with adults. He has never been assessed for giftedness though. Despite the

challenges during Joshua's early elementary school experience, which included a significant amount of time away from the classroom over multiple grades, his academic abilities were not adversely affected. By the time Joshua attended grade 4, he did not appear to have any gaps in his learning. He even took on a leadership role in the classroom that included helping other classmates when he finished his work early.

During the interview portion of this study, Joshua was the first participant to be interviewed so I knew nothing of his skills or abilities. The first time I interviewed him, he presented with age-appropriate communication skills, insight into some aspects of his experience, and moments of self-awareness and clarity. He was also quite personable. In my reflexivity journal after transcribing Joshua's first interview, I noted that I found him "surprisingly insightful" relative to what one might expect given all that he had been through at school. Whether or not Joshua is gifted is impossible to ascertain through a series of interviews and is not germane to this study. However, it is important that Diane, Marlene, and Jacquie, all saw him that way.

Research is conflicted in the area of giftedness and behaviour problems. For example, some research shows that gifted students present with comparable behaviour problems or less behaviour problems than their neurotypical peers (Bracken & Brown, 2006; Richards et al., 2010). Other research shows that some gifted children may experience an array of internalizing and externalizing social, emotional, and behavioural problems (Guenole et al., 2013). Boredom at school and being either over-challenged or under-challenged can increase disruptive behaviours in the classroom among gifted students (Stambaugh, 2017). Diane and Marlene both believe that some of the challenges Joshua experienced early on partially resulted from his early teacher's lack of awareness of the high abilities Diane and Marlene saw in him, which they felt

led to Joshua feeling bored and uninterested in the grade-level learning he was expected to engage in. Instead, he refused to do his work or comply with adult requests, or he engaged in disruptive behaviours such as shouting out, making odd noises, or running away from the classroom. These are behaviours that could be explained by the presence of a DBD such as ODD or even possibly anxiety. However, given the range of social, emotional, and behavioural problems that are sometimes present among gifted students, giftedness may also be misdiagnosed as other childhood psychopathologies such as OCD, depression, and bipolar disorder (Webb, 2000).

Further to this, giftedness could be misdiagnosed as ADHD because some students who are gifted present with emotional dysregulation and impulsivity symptoms that present similarly to symptoms of ADHD (Hartnett et al., 2010; Mullet & Rinn, 2015; Webb, 2000). Giftedness could also be misdiagnosed as ODD because gifted children can come across as intense, sensitive, and prone to power struggles with adults when they receive critical feedback (Webb, 2000). These features may be misinterpreted as irritable, angry, and argumentative, leading to an ODD diagnosis (Webb, 2000). Joshua never received a cognitive assessment to evaluate if he does indeed have a higher-than-average cognitive profile, so it is unclear what role his cognitive abilities played in his elementary school experience. As a researcher, I wonder how Joshua's trajectory may have been different if he had not been able to continue to learn at a level comparable to and, in some cases, above his same-age peers despite the amount of time he spent outside the classroom. I postulate that Joshua's cognitive abilities may have served as a protective factor for him academically; although this is difficult to state with authority due to the lack of data to support this supposition.

Another consideration associated with Joshua's cognitive abilities is the extent to which his cognitive abilities may serve as a protective factor for him in spite of his diagnostic profile and early childhood experiences at school. Although I do not know what Joshua's cognitive score is, given his average to above average academic performance measured by his early academic assessment, in conjunction with his mother's reports regarding his continued academic success, it likely that Joshua presents with at least average cognitive abilities. Research has shown that individuals with higher cognitive scores are less likely to experience lasting impacts associated with early childhood stress and trauma (Nyarko et al., 2020; Ryland et al., 2010; Wingo et al., 2011). However, it is important to note that Joshua is still in his early adolescent years so it is unclear if he will continue on the positive trajectory that it appears that he is currently on. As noted in the literature, researchers have found that the transition from late adolescence to early adulthood may be particularly challenging for individuals with externalizing disorders such as ODD and ADHD. Of additional relevance though is that Joshua appears to have other protective factors in his life such as a positive home, school, and community environment. Therefore, his cognitive abilities may only represent one aspect of the protector factors currently in place that may sustain his continued growth and success despite his diagnostic profile.

Anger and Anxiety

Joshua's anger was described by everyone in a manner that suggested his anger was chronic, pervasive, and impaired his functioning and ability to have a positive school experience. Joshua's anger was expressed verbally through screaming and swearing and physically through hitting, kicking, flipping desks and chairs, and running away, which Joshua identified as him being a "jerk." The anger, irritability, and temper outbursts described by the participants are

consistent with some of the symptoms required for a diagnosis of ODD according to the DSM-5-TR (APA, 2022).

Joshua does not have an anxiety disorder diagnosis. However, during screening for participation in this study, he did meet the cut-off criteria for subthreshold anxiety outlined by Balazs and fellow researchers (2013) through the use of the Zung anxiety rating scale (Zung, 1971). During the interviews, Jacquie and Joshua both identified that Joshua experienced (and still experiences) anxiety in social situations. Joshua worries about what others think about him, and he puts a high level of importance on the impression he makes on others. Joshua shared that he has difficulty falling asleep at night because he lies in bed thinking and "worrying" about all the interactions that occurred that day. Marlene and Diane observed some anxiousness in Joshua when he was younger too. One example Diane shared is that Joshua consistently became quite anxious when the school counsellor came in to do classroom lessons with the students on emotion regulation. It was unclear why he became this way when she walked into the room. Diane suspected that it could be because of the subject matter of the lessons she was coming to teach (social-emotional learning curriculum) or because he occasionally spent time with her after an angry outburst. Marlene reflected that Joshua was likely far more anxious than she realized at the time and that he may have expressed his anxious feelings through his angry outbursts.

Anger and aggression are seen as "broad and complex" (Hendriks et al., 2018). Students with ADHD and problems with anger tend to have a more hostile outlook towards schooling and have poor coping skills for dealing with anger, such as removing themselves from the situation (Ghanizadeh & Haghighi, 2010). Further to this, some researchers argue that for some individuals, anger could be an overt expression of an internalizing disorder such as anxiety (Scaini et al., 2020). Conversely, anxiety can exacerbate symptoms of oppositionality and non-

compliance (Bubier & Drabick, 2009; Franco et al., 2007; Scaini et al., 2020). However, research into understanding the functional implications of the relationship between anger and anxiety among children and adolescents is limited (Bubier & Drabick, 2009; Cunningham & Ollendick, 2010; Marmorstein, 2007; Scaini et al., 2020;). Research into understanding the functional implications of ODD/anger and anxiety in the education setting is in its infancy. What little research is available on the interaction between ODD and anxiety has shown that the co-existence of these two disorders may lead to significant impairment in school functioning that is above and beyond what may be seen from each of these disorders on their own (Martin et al., 2014).

Research indicates that students with comorbid disruptive behaviour disorders and internalizing disorders experience academic challenges in addition to social and emotional challenges. (Cunningham & Ollendick, 2010; Drabick et al., 2010; Levey et al., 2007; Martin et al., 2014). Based on what interviewees shared, Joshua appeared to experience a great deal of impairment in his social and behavioural functioning at school. However, Joshua's experience contradicts the researchers' findings regarding academic implications. As was previously noted, Joshua's teachers reported that he continued to maintain good grades despite his early experiences. Presently, Joshua has plans to pursue post-secondary education and graduate studies in marine biology. Perhaps Joshua's experience is unique to him. Alternatively, it may also be possible that there is a small yet to be researched population of young boys with ODD, subthreshold anxiety (and ADHD) who, despite their clinical profile, may be equipped with cognitive abilities and other attributes that allow them to continue to succeed despite lack of engagement with learning and reduced exposure to classroom instruction during their most challenging behaviours.

Disciplinary Measures

Joshua's school experience was heavily influenced by the amount of time he spent in the office during his first few grades of schooling. During the interviews, he expressed shame, guilt, and self-deprecation as he reflected on that time in his school journey. Joshua's mother, behaviour support teacher, and grade 4 teacher expressed concern over the impact the repeated rejection and isolation had on Joshua at that time. As Diane stated, those early years are "so formative." Joshua missed out on early learning opportunities in the classroom and opportunities to interact with his same-age peers and other children in the school. His mother and behaviour support teacher also expressed feelings of guilt for not doing more to help Joshua so that he did not have to spend so much time alone in the school office.

Consequences for students who express their anger through verbal and/or physical aggression at school often include exclusionary practices such as the student being removed from the classroom or school temporarily or permanently (Ghanizadeh & Haghighi, 2010). Students who behave aggressively during early schooling that receive exclusionary discipline are more likely to continue to receive this form of discipline throughout the remainder of their elementary and junior high school years (Hanno et al., 2011; Novak, 2021). Exclusionary discipline practices like suspension can impair a students' ability to build positive relationships with others in the school (Bear et al., 2016). The use of in-school suspension over out-of-school suspension does not appear to mitigate the impact that suspension has on that student's relationships with others in the school (Bear et al., 2016). One possible reason for relational consequences during an in-school suspension is that even though the student is in the building, there is still a social exclusion component to the discipline. Despite being at school, they are still kept away from their peers (Jacobsen, 2019). Further to this, exclusionary discipline does not address the cause

of the behaviour. An angry outburst could be a result of a student feeling hungry, tired, confused, anxious, etcetera. If educators do not take the time to understand why a behaviour is occurring and instead just focus on punishing the behaviour, they run the risk of giving a consequence to students for attempting to communicate a need through their behaviour.

Despite the continued use of such practices, research does not support their efficacy in improving student behaviour (Greene & Haynes, 2021; Zhang et al., 2004). In some cases, exclusion can further exacerbate the risk of negative outcomes associated with disruptive behaviour disorders and is associated with an increase in poor academic achievement, poor school attendance, delinquent behaviours, arrest during adolescence, increased likelihood of students associating with other students who experience similar problems and (Greene & Haynes, 2021; Jacobsen, 2019; Novak, 2021; Zhang et al., 2004). Students with emotional disturbances, learning disabilities, cognitive impairments, and minority backgrounds are more likely to receive exclusionary discipline than other students (Zhang et al., 2004). Furthermore, compared to all other students with disabilities, students with disruptive behaviour disorders such as ODD are twice as likely to receive exclusion as a form of discipline for their misbehaviour (Sullivan et al., 2014; Zhang et al., 2004). Exclusionary discipline is used less frequently in elementary school in response to aggressive student behaviour (Jacobsen et al., 2018). However, when exclusionary discipline does occur during the elementary school years, it has been associated with an increase in physically aggressive student behaviour (Jacobsen et al., 2018).

Ross Greene (2018) estimates that over 100,000 students in the United States alone experience “archaic interventions” (p. 23) such as restraints, locked door, or blocked door seclusions every year. He argues that if a student repeatedly receives such forms of discipline at school, then it serves as evidence that the school discipline program is not providing the student

with the help that they need (Greene, 2018). Instead, these kinds of responses marginalize and alienate students (Greene, 2018). Another criticism of disciplining students with DBDs is that these students are essentially being punished for symptoms associated with their disability, which they may not be able to control (Katsiyannis & Maag, 1998; Mihalis et al., 2009; Zhang et al., 2004). Mihalis and colleagues (2009) state that "the educational system operates in ways contrary to these student's needs" and that "it is apparent that a lack of caring for students with EBD exists" (p. 110).

Although the research on exclusionary discipline practices unanimously points out the increased risk of several negative outcomes associated with this form of discipline, based on findings from this study, this does not appear to be the case with Joshua. The outcomes he experienced seem to be limited to occurring during the experience, not in the aftermath. Although, this study has revealed some lingering emotional impacts of the experience for Joshua and his mother. At present, Joshua experiences academic success, has positive friendships at school and in the community, loves school and attends regularly, and has not engaged in any delinquent behaviours so far during his middle school years. I suspect two factors that came about in the interviews may have served as protective factors for Joshua against the risks associated with the exclusionary discipline. The first factor is that he had, and has, the ability to be successful academically despite the amount of learning time and social interaction he missed out on at school. The second factor is the relationship that existed between Joshua and a few of the teachers in his school.

Teacher-Student Relationships

Joshua, his mother, his grade 4 teacher, and his behaviour support teacher all spoke at length about the importance of the relationship Joshua had with Diane and Marlene. Joshua felt

that Diane and Marlene understood him in a way other adults did not and that they were more kind and more patient with him than other teachers had been towards him. Joshua's mother was emotional while she shared that she believes that Diane and Marlene changed her son's life because of the time they took to get to know him, understand him, and build a genuine connection with him. All the participants emphasized just how important and life-altering those relationships were as part of Joshua's experience.

Research on the effects of teacher-student relationships has been present for several decades (see Reed, 1961, for an early example). A positive relationship with a caring adult is one of the most important factors in fostering student resilience for students at risk (Doll et al., 2009). Teachers are a "central figure in the possibility of restoring these students" (Morse, 1994, p. 132). Not surprisingly, teachers are the individuals most often identified as the caring adult who made the difference in a person's life (Doll & Lyons, 1998; Doll et al., 2009). The nature of a teacher-student relationship can be protective from negative student outcomes or predictive of negative student outcomes, depending on whether or not the relationship is positive and supportive or rife with conflict (Doll et al., 2009; Lin et al., 2021; McGrath & Van Bergen, 2014). Even one strong bond between a teacher and a student throughout the school years may be enough to profoundly change the trajectory of a student at risk of negative outcomes (McGrath & Van Bergen, 2014). In addition, strong bonds between teachers and students are associated with higher academic achievement and lower disciplinary problems (Crosnoe et al., 2004).

The relationship between a teacher and student can serve as a mechanism for promoting a student's well-being (Lin et al., 2021), prosocial behaviour (Longobardi et al., 2020), emotional development, and academic growth (Mihalas et al., 2009). For example, a supportive teacher can

increase student confidence in their abilities that could therefore shift their experience from overwhelming to challenging in a positive way; essentially, positive student-teacher relationships give students a sense of hope that increases feelings of happiness and well-being at school (Lin et al., 2021).

Some students are at a greater risk of having negative relationships with their teachers, such as those who display aggression, antisocial behaviour, disruptive behaviour, and those who have internalizing or externalizing disorders (McGrath & Van Bergen, 2014). This is likely because students with DBDs tend to display behaviours that may be considered offensive, uncomfortable, and inappropriate, leading to rejection by peers and school staff (Mihalas et al., 2009). However, this group of students also appears to benefit the most when the teacher-student relationship is positive (McGrath & Van Bergen, 2014). Unfortunately, despite the potentially profound impact that a positive teacher-student relationship can have for students with DBDs such as ODD, research on the teacher-student relationship with this population of students is very limited (Cook et al., 2003; Mihalas et al., 2009).

Various researchers recognize that when teachers treat students with warmth and responsiveness (Mclean et al., 2020), get to know the lives of their students, engage in active listening with their students, show genuine care (Morse, 1994) and celebrate successes (Mihalas et al., 2009), they create conditions conducive to building positive teacher-student relationships. Morse (1994) goes into further detail, explaining that caring teachers know their students personally and show empathy for the various difficulties their students may be facing. Caring teachers also respond to problem behaviours calmly, without being permissive or dismissive, and prioritize the relationship with the student over control of the students' behaviour (Morse, 1994).

Joshua had a positive relationship with Diane and Marlene; however, there was more to it than the positive relationship they had with him. Both educators focused on his positive qualities and strengths and believed that he was more than the behaviours he displayed. Although it is unclear if their beliefs were different from his other early educators, Marlene's pursuit of Joshua's inclusion in the classroom setting along with Diane's insistence on keeping Joshua in her classroom instead of sending him to the office suggests that they were optimistic that with the right supports in the right environment, he would be able to succeed. The supports they provided that reflected the right environment included allowing him to work with his peers on projects, being given leadership opportunities, spending time connecting with his teacher, and being included in off-site learning opportunities, as well as having problem-solving discussions instead of sending him to the office and providing him with breaks throughout the day where he could sit in the hall to read.

Teacher beliefs about student success are an integral part of the teacher-student relationship; the kind of relationship a teacher has with a student can influence what that teacher believes the student may be capable of in multiple areas of functioning at school. Unfortunately, there does not appear to be any research at this time on the relationship between a teacher's beliefs about students with DBDs such as ODD and student success. However, research on teacher beliefs regarding students, in general, has shown that teacher beliefs influence student achievement, student efficacy, and general success (Rubie-Davies, 2017; Truebridge, 2016). When teachers have positive beliefs about a student's abilities at the outset, they tend to interact with students differently even when they do not realize it (Rubie-Davies, 2017). This creates a self-fulfilling prophecy (Rubie-Davies, 2017). When teachers believe a student is going to be

successful, they unconsciously behave in ways that enhance the likelihood of that students' success (Rubie-Davies, 2017).

Possibilities for Practice

Findings from this type of study can be beneficial to professionals who support students with anger and anxiety symptoms similar to Joshua. This study is the first of its kind to explore the lived school experience of a boy with ODD, subthreshold anxiety symptoms, and ADHD through the eyes of the boy, his mother, and two of his former teachers. Understanding the lived experience of boys with this kind of diagnostic profile is important. Regardless of whether their lived experience is similar to Joshua's or entirely different, this study can provide professionals with a personalized and contextualized understanding of what school life is like and inform a more thoughtful and individualized approach as a result of their intimate knowing of the boys' experience. This depth of understanding can enrich individualized supports and influence assessment and clinical decision-making.

The following discussion presents possibilities for consideration based on findings from this study. Joshua is just one child. It would not be valid to make generalizable recommendations based on findings from a single case. Additionally, there are several variables such as context and feasibility, that school-based teams, school psychologists, and researchers must consider in their roles and their work. Therefore, what follows is a presentation of ideas for consideration. Where it applies, I have also included examples from my work as a teacher and as a school psychologist to provide further anecdotal real-world context to the discussion.

Possibilities for School-Based Teams

The lessons learned from Joshua's lived experience of school illuminate opportunities for consideration for administrators, teachers, support teachers, and educational assistants to refine

and, in some circumstances, completely rethink their approach to working with students who present with similar challenges to Joshua. Based on findings from this study, two key areas of possibility for school teams to explore in their word with behaviourally challenging students the relationships school staff have with a complex student like Joshua and to what extent discipline is an effective approach for a student like Joshua.

Researchers, educators, and clinicians can all agree on the importance of teacher-student relationships, especially for students at-risk. In Joshua's experience, the relationship he had with one classroom teacher in particular, along with the relationship he had with his behaviour support teacher, completely changed his school experience according to Joshua and his mother. Research identifies warmth, caring, and responsiveness as approaches to building relationships with students in general. However, there were additional things that Marlene and Diane did that went above and beyond what can be found in the research. Diane showed genuine interest in areas that Joshua was interested in. She was playful and joked with him. She took risks with him that some of other teachers would not take, such as allowing him to work with peers and in groups, and she took him on field trips. She also chose to keep him in the classroom. If Joshua needed to be addressed for a problem, she dealt with it herself. She never sent him away. If he needed some personal time, it was on the reading bench outside the classroom door where he could relax, read, reset, and return to his classroom. He was not isolated, instead he was kept close by, with a caring adult in proximity.

Marlene also prioritized her relationship with Joshua. She was available to him as much as she could be so that he could talk through why he was upset or what happened during a recess incident. She went out of her way to have morning visits with him whenever she could so his day would start on a positive note. Marlene also spent a great deal of one-on-one time with Joshua

doing positive things such as having lunch together, reading together, and just enjoying friendly impromptu visits whenever the opportunity was available to do so.

Both teachers genuinely liked Joshua, chose to focus on his gifts and strengths, and believed in his potential. They also both advocated for him so that others in the school would see more of his positives. Diane and Marlene saw that Joshua needed more, and needed differently, so they gave more, and gave differently.

In my own teaching experience, I have been blessed with affirmation from a few of my students about how cared for and valued my students felt in my classroom. One student in my class from grade 4 to 6 invited me to his high school graduation ceremony. It was such an honour to see him on stage, performing with the school band and achieving such a fantastic accomplishment. Another student I had for grade 4 and part of grade 5 also invited me to his graduation celebration with his family. It was a BBQ held in his family's backyard. His mother gifted me with a framed graduation photo of him and a quote about the difference teachers make in a child's life. In addition to being blessed with attending the graduation of two of my former students, several years ago I also received a beautiful thank you letter from a student I had in my class from grade 4 to 6. One of the things he wrote in the letter that stands out to me is that he understands now in a way that he did not before just how much of a difference I made in his life. These stories are just a few personal anecdotes to illuminate just how powerful the teacher-student relationship can be on a personal level for the student and the teacher.

Research has shown that exclusionary practices do little to shift behaviour and teach students appropriate conduct at school. In Joshua's case, exclusion from his classroom resulted in feelings of guilt and shame from him, his mother, and his behaviour support teacher. It also did not teach him how to get his needs met at school in more appropriate ways. There were social

implications to him being in the office as well. Joshua's experience of exclusion seems to have been particularly detrimental because he is so socially motivated and socially sensitive. Joshua experienced exclusion from the classroom as a rejection of who he was as a little person, not as a consequence of his behaviour. This points to the potential unintended harm that could result from this type of disciplinary practice, especially if it becomes the default response to any form of disruptive or problem behaviour.

For some teachers, sending a disruptive student out of the room or to the office may be common practice. However, there are alternatives to exclusionary discipline. One alternative to exclusionary discipline that can be used in the classroom or school-wide is the positive behaviour support model. This method is a universal proactive approach to supporting students by focusing on several areas such as relationship building, clear expectations, positive feedback, and a supportive classroom environment (for example, see Oliver et al., 2019; Quigley, 2014; Reinke et al., 2013).

Another alternative to exclusionary discipline is a collaborative problem-solving [CPS] approach (see Greene, 2011; Greene, 2018; Greene & Winkler, 2019). This individualized approach is effective specifically for students with challenging behaviours. CPS takes a cognitive behavioural approach and encourages educators (and parents) to understand the challenging behaviours, enhance communication with challenging students, and work with them to solve problems instead of taking disciplinary action.

Regardless of evidence-based intervention that educators choose to implement, it would be beneficial for them to address the reason for the behaviour. This can be done through a functional behaviour assessment (FBA). An FBA is a structured method used to establish if there is a relationship between a students' behaviour and their environment (Scott & Cooper, 2017).

An FBA helps educators identify the conditions that the behaviours occur such as time of day, location, individuals involved, and the outcomes associated with the behaviour (Scott & Cooper, 2017). This information might have helped the school team better understand the contributions of anxiety to Joshua's behavioural presentation and help to identify the skills Joshua needed to develop so he could express his needs and feelings more appropriately and have his needs met. Information can then be used to develop a positive behaviour support plan (PBSP) to make data-informed decisions about how to best support students and meet their needs in a proactive manner instead of after a behavioural incident has occurred. PBSPs provide a plan for how to teach students skills they are missing, focus on modifying antecedents to reduce the likelihood of the negative behaviours and focus on reinforcing positive behaviours before addressing potential consequences for the negative behaviours.

If there is a need for a student to spend time away from the classroom, educators should consider choosing a location in the school that the student perceives as safe, child friendly, and conducive to a sense of calm. This is different for everyone student, so if this is part of a support plan for a student, student voice in where they feel safe in the school would be helpful. In my work as both a teacher and a school psychologist, school offices are often high-traffic areas with phones ringing, guests signing in, children coming to get band-aids, and teachers coming to have an impromptu conversation with administration, which sometimes includes venting about difficult students. This is not an ideal setting for a student who may be struggling and easily triggered by this type of environment. If students are out of the classroom for a calming break, perhaps give them something pleasurable to do so that it is not perceived as punitive. For example, Joshua was given worksheets in the office, which often further exacerbated his heightened emotional state. Which is understandable. Sitting alone in the school office, with the

school principal nearby, missing out on fun activities such as recess and gym, and having to complete worksheets would likely be an aversive experience for most children. This time could have been used more effectively by working consistently with Joshua to develop the skills he needed in order to manage his anger more effectively and safely. However, Diane knew that Joshua loved to read, so he had a space in the school hall where he could take a break to relax and enjoy a good book when he needed to.

When I was hired as a teacher, exclusionary discipline was common practice. There were three secure seclusion rooms for when students become physical. There was also a tiered time-out system based on the severity of the offence, systematized loss of privilege based on the number of behavioural infractions in a given day or block of the day, and even a script that students were expected to copy out that was related to the offensive behaviour (i.e., if they misbehaved on the bus, they had to copy out a paragraph on appropriate bus behaviour). There was a token economy set up so that students received fake money that they could use to buy prizes from the class store at the end of the week. Rewards were given both spontaneously and at certain points of the day based on how few infractions a student had at that point in the day. I struggled with these practices. They went against my philosophy as a teacher, and they did not seem effective in facilitating lasting behaviour change. However, this approach was a systemic expectation we were required to adhere to. It took me three years and a change in leadership before I removed these punitive practices from our classroom. It can be challenging for teachers when their teaching philosophies conflict with the policies and procedures of their school. I share this anecdote to normalize the difficult journey that it can sometimes be when beliefs regarding disciplinary practices are not aligned.

All the interviewees were asked what advice they would give to educators working with students like Joshua. Joshua said that teachers need to be patient with students like him because change can take a long time. Jacquie recommended that teachers take the time to get to know the student on a personal level and to see the student as more than just a problem child. Diane advised that teachers focus on helping students learn appropriate behaviours instead of consequencing their misbehaviours. She also suggested that teachers relax and have fun with their students. Marlene recommended that teachers check in with students on a regular basis, such as greeting them outside the classroom in the morning. In addition to these pieces of advice, all the interviewees unanimously advocated for prioritizing the relationship a teacher has with a student. I would further argue that even with the most efficacious intervention available, if the student does not feel safe, cared for, valued, or understood, then the success of that intervention will likely be limited and short-lived.

Possibilities for School Psychologists

Understanding Joshua's lived experience of school has the potential to enhance the work that school psychologists carry out in two areas of practice: assessment and consultation. Joshua's diagnosis came from a medical professional, not a psychologist. There are certain circumstances where a diagnosis from a medical professional is sufficient. However, in Joshua's case, it may not have been sufficient. Joshua's mother, grade 4 teacher, and behaviour support teacher emphasized how bright Joshua is. When the behaviour support teacher completed a standardized academic assessment with Joshua in grade 1, many of his scores were several grades above his grade level at that time. Notably, that assessment was completed with Joshua during the peak of Joshua's challenges at school and subsequent time out of the classroom. Marlene saw Joshua as bored and lacking academic challenge, which she believed was one of the

triggers for Joshua's oppositional behaviour. Given that his diagnosis came from a medical professional, understanding the extent to which his cognitive and learning abilities may have played a role in the challenges he experienced was not addressed.

A psychoeducational assessment by a school psychologist could have ameliorated this problem and provided further insight into his social, emotional, and behavioural functioning. In addition, although it is unclear whether or not a psychoeducational assessment may have changed Joshua's diagnostic profile, an assessment would have provided a more comprehensive understanding of his abilities, functioning, and needs, as well as provided individualized recommendations to help him be and feel successful. Therefore, in situations where a medical professional has diagnosed a student with a disorder that has the potential to significantly impact a student's functioning at school, I would recommend a follow up psychoeducational assessment be completed with the student to obtain further diagnostic clarity and a comprehensive picture of the student's functioning and profile.

Psychologists do their best to make evidence-based decisions regarding diagnosis. Their clinical decisions are based on information gathered via several sources, including interviews with multiple individuals, standardized test scores, rating scale scores, and classroom observations. Despite a clinician's efforts to be as unbiased as possible in their conclusions, there is still a risk of various thinking errors, including cognitive biases and misapplied heuristics (Wilcox & Schroeder, 2014). One example of a thinking error is diagnostic overshadowing. Diagnostic overshadowing occurs when other clinical disorders are not identified because one disorder overshadows other symptoms (Wood & Tracey, 2009). Diagnostic overshadowing could be a result of multiple biases such as confirmation bias or a bind spot bias, which essentially means the clinician looks specifically for ODD if there are symptoms of a disorder, without

considering other possible explanations, and clinicians do not see that they are being biased in their approach to assessment and diagnosis. In Joshua's situation, it is possible that because his ODD symptoms were so pronounced, other diagnostic explanations such as anxiety (clinical or subclinical) and lack of learning engagement were not considered as part of his presenting problems.

Biases can be challenging to mitigate, especially when clinicians are unaware that their biases exist. Therefore, researchers recommend that mental health training programs include explicit feedback on factors associated with a risk of diagnostic overshadowing when students are working with patients and clients (Wood & Tracey, 2009) along with direct instruction on inductive and deductive reasoning processes (Wilcox & Schroeder, 2014). They also suggest that experienced clinicians engage in reflective practice, consult with colleagues, and do hypothesis testing to confirm or disconfirm their diagnostic conclusions (Wilcox & Schroeder, 2014).

In the school division I currently work in, for students who have been diagnosed with an externalizing disorder and ADHD by a medical professional and receiving a psychopharmacological intervention but still struggling significantly at school, we may complete a psychoeducational assessment with the student. During previous work experience, I completed an assessment with an elementary school student who received a diagnosis of ADHD and ODD from a psychiatrist. The diagnosis came in the form of a letter that stated in a single sentence "[student] has ADHD and ODD, please program accordingly." The student was engaging in violent outbursts at school daily, sometimes multiple times a day. As a result of the data obtained from the assessment, this student received an additional diagnosis of a specific learning disorder in writing (severe). The diagnosis of ODD was also replaced with a diagnosis of disruptive mood dysregulation disorder, which more accurately explained his consistently irritable temperament

in conjunction with the extreme physical aggression above and beyond the temper outbursts typically seen among students with ODD. Through a thorough diagnostic interview, parents revealed that this student had a significant trauma history. This information was not previously known to school personnel; therefore, they were not able to sensitively consider the impact of trauma on the student's behaviour. To be clear, I am not aiming to challenge the diagnostic skills of mental health professionals, nor am I saying that every time a student receives a diagnosis from a mental health professional, a psychoeducational assessment should be completed. However, I share this example to show that there may be times when there is more to a student's problems that need to be investigated through a comprehensive psychoeducational assessment.

In the area of school-based consultation, Joshua's lived experience of school emphasizes the valuable role that the school psychologist can play in supporting school-based teams. It is unclear if, at any point in time, a school psychologist was involved in providing consultative support for the school team to help best meet Joshua's needs. Through consultation work, school psychologists can provide educators with psychoeducation regarding co-occurring DBDs and anxiety to help them further understand the needs and functional implications of students with this kind of clinical profile. School psychologists can also support school-based teams with carrying out FBA's, implementing evidence-based interventions, the use of alternatives to exclusionary discipline practices, monitoring the effectiveness of the PBSP plan and leading problem-solving efforts when modifications to that plan are required, and help develop a positive working relationship between the school and home. The involvement of a school psychologist when supporting students with complex behavioural needs can help bridge the gap between research and practice. In my own experience working with teachers, I find that teachers know what to do and why to do it but sometimes get stuck on how to actualize what they know into

their classroom environment—this is where support from a school psychologist might be beneficial.

I once had an early elementary-aged student on my caseload who was quite dysregulated. When he was elevated, he would climb on a high freestanding bookshelf in the classroom, which was a significant safety concern, dump the open school material bins all over the floor, and rip class artwork off the display wall. This teacher was feeling entirely burnt out by the demands of attempting to manage this student and the rest of the class. After documenting patterns of the behaviour, we realized that these behaviours often happen during transitions from gym and recess and during writing tasks. Once we identified the patterns, we could target our interventions to address the antecedents to his dysregulated behaviours. I stayed after school with this teacher to help her make some changes to her classroom. Together, we reorganized almost everything in her classroom, which included removing the high freestanding bookshelf and putting snap lids on the materials bins so that the bins would not open if they were thrown on the floor, and we placed student artwork higher up on the wall out of reach. Once the classroom environment was addressed, we focused on programming changes that included a structured transition system for going to and from highly stimulating, less structured activities, scheduled structured movement breaks throughout the day, scheduled one-on-one time to do some school work in the resource room with the resource teacher, gave him a second desk so that he could have a change of scenery that was still within his classroom, gave him tasks one at a time, and gave him alternative tasks when writing was not main learning goal of the activity. We also set him up with the school counsellor so that she could work with him to develop regulation skills.

This kind of consultation work makes up most of the work that I do as a school psychologist. It is rewarding because it benefits the student and the teacher. It is also an example

of the kind of role a school psychologist can play in a school as a consultant. I could not help but wonder if Joshua's school experience may have been different if a school psychologist had been part of his school-based team from early on.

Possibilities for Researchers

It is hoped that this study will inspire more research in this area. One of the main messages that came out of the findings from this research is that for several years, Joshua experienced school quite negatively. Is this negative school experience unique to Joshua? Or are there other boys with a similar clinical profile who also had similar school experiences? More generally, what if this kind of school experience is common among boys with ODD? How could a pattern of negative school experiences among this population of youth inform assessment, consultation, and school-based interventions? Further to this, are there other interventions out there previously not considered that may now warrant investigation based on what has been found from this study? How impactful would some form of anxiety-based intervention be for students with ODD and subthreshold anxiety? Also, do the answers to these questions differ by gender identity, age, or educational setting (urban versus rural)?

This study is the first of its kind to examine the lived school experience of a boy with ODD and subthreshold anxiety. The existing literature on ODD, coupled with findings from this study, can inspire additional questions that could further our understanding of the trajectory of ODD and anxiety and protective factors that may mitigate the risks associated with ODD and anxiety. The research on ODD and anxiety, whether clinical or subclinical, is extremely limited. This study shows the presence of ODD and subthreshold anxiety is an existing problem; however, at this time, researchers do not have any clarity regarding the prevalence of ODD with

symptoms of anxiety. This could be a rare phenomenon or something far more prevalent than is currently realized.

In addition to the lack of understanding regarding the prevalence and outcomes of cooccurring ODD and anxiety, there is also a lack of clarity regarding the presentation of these two disorders. As discussed earlier in this paper, the few researchers who have focused on ODD and anxiety hypothesize that, in some circumstances, the angry and oppositional behavioural, which they refer to as reactive aggression, may be a suggestive of the presence of social anxiety or separation anxiety, rather than ODD (Bubier & Drabick, 2009). However, reactive aggression could also be suggestive of the co-occurrence of ODD and anxiety, with symptoms of anxiety exacerbating symptoms of ODD (Bubier & Drabick, 2009). Aggression and anxiety share similar biases in information processing, hypervigilance to threats, social misattribution biases, and negative attributions, which could make it challenging to distinguish between the two (Marmorstein, 2007; Reid et al., 2006). The researchers explain that the reactive aggression often seen in children with ODD could instead be the child's attempt to avoid an anxiety-provoking situation (Bubier & Drabick, 2009). This type of anxious presentation could lead to misdiagnosis of a disruptive behaviour disorder such as ODD, and subsequent implementation of interventions and medications used for the treatment of DBDs, not anxiety.

Some researchers advocate for further investigation into factors associated with the development and progression of ODD and anxiety when they co-occur (Cunningham & Ollendick, 2010; Leadbeater et al., 2012). These researchers assert that studies aimed at the identification of risk factors and protective factors of comorbid ODD and anxiety have significant implications for understanding the etiology and subsequent identification and treatment of the disorders (Cunningham & Ollendick, 2010; Leadbeater et al., 2012). For

example, could targeted interventions that prioritize relationships help mitigate some of the mental health risks and negative life outcomes associated with co-occurring ODD and anxiety?

There is also limited up-to-date peer-reviewed published research that addresses the presentation of the affective and behavioural components of ODD that typically occur specifically in the educational setting. This is perplexing, considering this is the setting where these youth spend most of their time. Nevertheless, the existing research provides clinicians with an understanding of the presentation and functional implications of ODD and anxiety in the education setting can help clinicians make more informed diagnostic decisions and recommendations for individualized interventions.

Another research opportunity is investigating differential diagnosis between ODD, intermittent explosive disorder (IED), and disruptive mood dysregulation disorder (DMDD). In the DSM-5-TR (APA, 2022), the ODD diagnostic criteria category anger/irritable mood includes the symptoms often loses temper and is often angry and resentful. In the diagnostic features section of the DSM-5-TR on ODD, there is reference to temper outbursts (APA, 2022, p. 465). However, it is also noted in the DSM-5-TR that these temper outbursts do not include destruction and aggression towards others. In those cases, the DSM-5-TR recommends looking at a diagnosis of IED. Further to this, if a child meets diagnostic criteria for both ODD and IED, then a diagnosis of DMDD must be diagnosed instead; ODD and IED cannot be diagnosed together (APA, 2022). Aside from broad categorical labels to identify a pattern of behaviours, there is no explanation of frequency, severity, duration, or specific features of the temper outbursts or how to distinguish them from the outbursts associated with IED or DMDD. Therefore, research that explores how to differentiate between these disorders may be valuable in order to further inform diagnostic conclusions.

The last area of further research worth consideration based on findings from this study is the impact that a student's cognitive abilities have on the effectiveness of interventions for students with ODD and anxiety and the long-term trajectory of students with ODD and anxiety. For example, do students who have cognitive abilities in the average range or higher and ODD show greater growth as a result of school-based interventions? Do students with average or higher cognitive abilities and ODD have a greater chance of academic success, school completion, post-secondary school, and life success? To what extent, if at all, do average or higher cognitive abilities act as a protective factor against the various implications and negative outcomes associated with disruptive behaviour disorders such as ODD (regardless of whether or not anxiety is present)?

This study is small, unique, and may only be transferable to other individual situations akin to Joshua's. Further research could clarify whether Joshua is idiosyncratic, or if Joshua's experience is one that is more prevalent than educators, psychologists, and researchers are aware of at this time. There are still many unknowns regarding ODD and anxiety that should be addressed to inform our understanding and treatment approaches for students with these two primary presenting issues.

Limitations

There are limitations to this study that must be acknowledged. The first limitation is that this study represents the lived experience of one boy with ODD, symptoms of anxiety, and ADHD. At this time, it is unclear to what extent these findings apply to our understanding of the lived experience of all young boys with ODD, symptoms of anxiety, and ADHD, or if it is reflective solely of Joshua's individual experience. Therefore, findings cannot be generalized from this single study to all students of the same gender and diagnostic profile. The findings

from Joshua's lived experience of school may reflect a culmination of who Joshua is as an individual, what his cognitive abilities might be, what he has been through in his life outside of school, the role various adults have played in is life, and the community he has grown up in. These variables could potentially be relevant factors that have influenced his unique experience. It is for this reason that the findings from this study can only bring forth possibilities for consideration for educators, school psychologists and researchers, not recommendations that would be applicable to the greater population of students with ODD, anxiety symptoms, and ADHD. Findings from this study may fit with one student but not with another. Accordingly, implementation of any of the above noted possibilities for practice should be done thoughtfully and include data on and understanding of that specific student to support those decisions and approaches. More research on the lived experience of school among a greater participant population of boys with the same diagnostic profile as Joshua would shed further light on whether or not his experience is unique as well as provide more evidence in order to make more generalizable findings and recommendations for practice and research.

The second limitation to this study is that it is historical in nature. The details of various events dialogues, and feelings associated with those events and conversations primarily represent Joshua's lived school experience during his elementary school years, even though he is now in middle school. One of the reasons for this is that the teachers chosen to participate in the study by Joshua and his mother were both educators that were part of his school experience during his elementary years. The other reason for the historical context is that it became apparent through interviews with participants that that stage of Joshua's life is most relevant to the research questions within this study. Joshua and his mother indicated that Joshua experienced the most pronounced challenges and eventual significant growth in elementary school. His mother shared

that for the past couple of years, anger and aggression have not been of concern in the educational setting for Joshua. More recently, the things Joshua gets in trouble for at school appear to be related to his ADHD and include callouts during class discussions and silliness when he should be doing his work. Importantly, in IPA research, a historical account is common. When doing IPA research, the focus is on the meaning of the lived experience of the phenomena, not the detail or accuracy of the account. However, it is still relevant to keep in mind that there may be inaccuracies of various accounts due to the length of time between the peak of the experience and the sharing of the experience.

The third limitation of this study has to do with the context. This research is focused solely on the school experience, and the perspective of the school experience was gleaned through the child, mother, and two most beloved teachers. It is possible that some of themes may have been different had other teachers who had Joshua in their class during his early and most violent years may have seen his experience differently. There is also the possibility that the themes may have been different if the entirety of his lifeworld including his lived experience at home was explored.

The fourth limitation to consider is the lack of clarity regarding Joshua's clinical presentation. Joshua's diagnosis of ODD (and ADHD) came from a medical professional, which was based on reports from his mother, the school, and observations made by a mental health professional who did some classroom observations of Joshua during his grade 2 year; he did not receive a comprehensive psychoeducational assessment. Based on my professional experience in multiple rural school divisions, it is a usual occurrence in rural communities for the local pediatrician to provide a diagnosis without including a psychoeducational assessment. At times,

there is limited access to resources such as private or school-based psychologists, especially in rural and remote communities.

As a practicing registered school psychologist, I tend to be reticent when I have a student whose diagnoses come from a medical professional when a full psychoeducational assessment has not been completed. In my observations, general medical practitioners and pediatricians do not seem to make use of norm-referenced rating scales from multiple raters in order to evaluate a variety of possible reasons for a child's difficulties (i.e., anxiety, executive functioning, or adaptive scales etc.) or use standardized measures to evaluate the cognitive abilities of a child as part the diagnostic process. This could lead to misunderstandings about a child's abilities and functioning and/or misdiagnosis. Notably, misdiagnosis of ADHD by medical professionals tends to happen more for boys than girls, although the research is inconsistent and limited regarding how often this occurs (Lilienfeld & Arkowitz, 2017).

Through my lens as a clinician, not a researcher, after I heard Joshua's story, I could not help but wonder what his cognitive abilities actually are and to what extent his cognitive abilities may or may not have contributed to his behaviour challenges. I also wonder about other diagnostic considerations such as those noted in the DSM-5-TR (APA, 2022) that should be ruled out when exploring an ODD diagnosis such as social anxiety disorder, intermittent explosive disorder, or disruptive mood dysregulation disorder. Although this is seen as a limitation, it also gives rise to why this study has relevance for practitioners, especially those in rural settings. Perhaps when diagnoses come from a medical professional, especially one whose primary area of practice is general medical care, not mental health, and there may be other variables not addressed via the medical model, such as cognitive abilities or differential diagnosis considerations, it should become best practice to do a follow up psychoeducational

assessment with a registered psychologist to ensure a child's profile and needs are evaluated and understood in their entirety.

Additionally, Joshua's score on the Zung SAS does not indicate the severity or impact that his subthreshold anxiety symptoms have on his daily functioning. His score was a 46, which is one point above the minimum cut off for subthreshold anxiety. However, as research points out, clarity around what constitutes subthreshold anxiety and how to best identify, qualify, and quantify subthreshold anxiety is lacking. As such, clinical conclusions about the severity and impact of Joshua's subthreshold anxiety symptoms cannot be made based on the findings from this study. Taken further, although Joshua's mother, and both teachers, used the term anxiety when they described some of his early and current feelings and behaviours, it is unclear to what extent his anxiety symptoms were present during his early elementary years. It is possible that Joshua did not have any symptoms of anxiety during those years. However, it is also possible that he had comparable or even more pronounced symptoms of anxiety at that time.

A final noteworthy limitation is me. I am a novice IPA researcher. Smith and colleagues (2009) note that becoming a skilled researcher using IPA takes time and a great deal of practice and experience. They note that as IPA researchers become more skilled and confident in the process, they are able to ask more thoughtful questions during interviews, are able go deeper into the meaning of their participants' experiences as they engage with their research and may even establish their own analytic process and write up format to present their findings. Given that this is my first experience with IPA research, it is likely that I may not have asked questions that experts may have asked. Therefore, some of the specific details of the experience may be lacking. Additionally, the findings I presented may lack the depth and breadth that someone with more experience with this methodology would be able to have presented. Despite this, I am

grateful for the thorough guidance I received through my adherence to the IPA procedures recommended by Smith and his fellow researchers (2009).

Conclusions

Joshua's lived experience of school while dealing with ODD, subthreshold anxiety, and ADHD has provided a window into what life has been like for him at school. His experience has illuminated how difficult it can be and how much of a difference the right relationship with the right teacher(s) can make for a student. Joshua's experience may be unique to him. However, Joshua's experience may also be the first to give voice to an experience that is prevalent among other youth with similar challenges. Only future research will be able to suss that out. In the meantime, it is hoped that whoever does read this study is inspired to expand the lens through which they view students like Joshua, reconsider the impact that discipline has on students like Joshua, recognize the importance of having a comprehensive understanding of the clinical profile of students like Joshua, and become the voice for these students who may otherwise not be heard.

For me, the motivation for this study is reminiscent of the starfish parable**:**

> Once upon a time, there was an old man who used to go to the ocean for exercise. One day, the old man was walking along a beach that was littered with thousands of starfish that had been washed ashore by the high tide. As he walked, he came upon a young boy who was eagerly throwing the starfish back into the ocean, one by one. Puzzled, the man looked at the boy and asked what he was doing. The young boy paused, looked up, and replied, “Throwing starfish into the ocean. The tide has washed them up onto the beach and they can't return to the sea by themselves,” the boy replied. “When the sun gets high, they will die, unless I throw them back into the water.” The old man replied, “But there

> must be tens of thousands of starfish on this beach. I'm afraid you won't really be able to make much of a difference." The boy bent down, picked up yet another starfish and threw it as far as he could into the ocean. Then he turned, smiled and said, "It made a difference to that one!" (Modern adaption of the essay The Star Thrower by Loren Eisley, original author(s) of modern version unknown; The Starfish Fund)

This study may be small, but it has the potential to be mighty even if it changes the life of one student because of what Joshua shared through his participation in this research.

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APPENDIX A – Parent Consent Form

Name of Researcher, Faculty, Department, Telephone & Email:
Alethea Heudes M.Ed.,
Doctoral Candidate
Registered Psychologist
School and Applied Child Psychology
Werklund School of Education
alethea.heudes@ucalgary.ca

Supervisor:
Gabrielle Wilcox, PsyD, NCSP, RPsych,
School and Applied Child Psychology
Werklund School of Education
gwilcox@ucalgary.ca

Title of Project:
Angry and Anxious: Understanding the School Experience of an Adolescent Boy with ODD and Symptoms of Anxiety through Interpretive Phenomenological Analysis.

This consent form, a copy of which has been given to you, is only part of the process of informed consent. If you want more details about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The University of Calgary Conjoint Faculties Research Ethics Board has approved this research study.
Participation is completely voluntary and confidential. During the data gathering process unless you disclose to others, only you, your child, and the two teachers you have chosen will know that you are participating in this study. None of the documents, other than consent form to participate in this study, will contain any identifying information. Importantly, no identifying information about any of the participants will be in the final paper about the findings from this study.

Purpose of the Study

The purpose of this study is to understand the schooling experience of an adolescent boy who has a combination of oppositional defiant disorder (ODD) and symptoms of anxiety. This study will include a very limited number of participants (parent, child, and two teachers) and involves a commitment to two virtual one-on-one interviews of approximately 45-60 minutes each.

What Will I Be Asked To Do?

As part of your participation in this study you will be asked to participate in and provide consent for the aspect of the study noted below. Your son will be also asked to give assent to participate, which means he agrees to be a part of the study as well. Please note that if your son does not

agree to participate in the study, then, even if you consent to him participating, I will not be able to include you or your son in the study.

1) With your consent, and your son's assent, your son will fill out a short anxiety questionnaire. The questionnaire includes items such as *"I get upset easily or I feel panicky"* or *"I am bothered by stomach aches or indigestion".* These questions are designed to help confirm that your son is experiencing symptoms of anxiety. I will complete this form with your son either virtually via MS Teams/Zoom link, or via telephone to complete the form. It should take no more than 15 minutes to complete. You will be contacted after your son completes the form to let you know if he meets the criteria to participate.
2) Participate in two online interviews via Microsoft Teams or Zoom where I ask you questions such as *"How would you describe your child overall*?", *"What are your child's strengths?'*, and *"How are your child's problems affecting him at school*?". The interviews will take approximately 45-60 minutes each and may be about 2 weeks apart. The Zoom/MS Teams interviews will be accessed through a password-protected university account, which has high level security precautions built-in so your confidentiality is protected.
3) Your son will also participate two online interviews via Microsoft Teams or Zoom that will also be approximately 2 weeks apart. The Zoom/MS Teams interview will be accessed through a password-protected university account, which has high level security precautions built in, so your son's confidentiality is protected. I will ask him similar questions such as *"How would you describe yourself*?", *"What are your strengths?'*, and *"How do your problems affect you at school*?". Each interview may also take approximately 45-60 minutes.
4) You will identify to teachers that you feel know your son best and help me get in touch with them to carry out two 45-60 minute virtual interviews about two weeks apart with them as well.

*Please note that all interviews will need to be recorded so that I can write them out word for word later. The reason I have to do this so that I can review all of the information from the interviews very carefully to look for important bits of information or themes that are important to this study. To record the interviews, I will use the Zoom/Microsoft Teams recording feature. As soon as the interview is over, I will upload and store the recording on a password protected computer without any personal identifiers.

Please note that your participation in this study is completely voluntary. You may refuse to participate altogether or withdraw from the study without penalty.

What Type of Personal Information Will Be Collected?

Should you agree to participate in this study, some personal information will be collected to determine eligibility criteria for this study, for the purposes of making arrangements for the interviews. You will be asked to provide your name, your child's name, your child's teachers names and emails, your email address, and your phone number. Additionally, although I will be recording the interviews, no one else will have access to, or be able to watch the recordings of the interviews for this study. Once all of the study data has been gathered and analyzed it will be

described in a research paper that will be presented at my final defense and may also later be published in a peer reviewed journal.

Are there Risks or Benefits if I Participate?

There are no significant risks to participating in this study. However, there may be a couple of things that you may (or may not) find inconvenient. First, I will be contacting you on a handful of occasions through phone calls or emails to set up the interviews and follow up calls. Second, the interviews may take up to 60 minutes from your regular daily activities. Third, it is also possible that you or your child may find the interviews unpleasant or boring to participate in, or you may be bothered by the nature of some of the questions. Please note that you and your son do not have to answer any questions you do not feel comfortable answering. Fourth, this study has a very small sample size so even though the data will be deidentified and merged, it is still possible that, if I decide to publish my findings in a peer reviewed journal and you, your son , or his teachers read the published findings, you may recognize a detail as it relates to you. However, I will be sure to avoid publishing any information that may lead to you or anyone else connecting the study findings to any of the participants in this study.

One of the main benefits of your participation in this study is that the information gathered through your participation will help researchers, clinicians, and educators further understand the school experience of adolescent boys who have ODD and symptoms of anxiety. This is an area with minimal research at this time, so it is hoped that this study's findings will motivate other researchers to look more closely at this phenomenon on a much larger scale than this study provides. It is also hoped that this study will inspire clinicians and teachers to consider the role comorbid ODD and anxiety symptoms might play for their students plan interventions accordingly.

As a token of appreciation for your participation in the study, you and your son (and the teachers) will each be given a $20 gift card to Tim Hortons.

What Happens to the Information I Provide?

Personal information you provide will only be available for my use in carrying out this research, no one else will have access to your personal information. In all data gathering documents and in the final paper, pseudonyms will be used to protect the identity of you, your child, and the two teachers. During discussions with my research supervisor, and in consultation with peers, pseudonyms will be also be used. Paper copies of study documents including consent forms will be in a sealed envelope and kept in a locked cabinet only accessible by the researcher and my supervisor. Anonymous study data will be stored for five years on an encrypted USB, at which time, it will be permanently erased. Importantly, a limit to confidentiality will be if you, your child, or either of the two teachers choose to tell anyone about participation in this study.

Participants are free to withdraw up to 2 months from the date of the last piece of data collected; I will let you know in writing via email when this occurs and what the last day to withdraw from the study will be. After this time some of the data will be deidentified, merged together into a single data set, analysis will begin. Once the data is deidentified and merged I will not be able to identify who is who, which is why withdrawal will no longer be possible. However, if you

choose to withdraw your consent prior to the deadline any and all information you provide will be destroyed without consequence.

Signatures

Your signature on this form indicates that 1) you understand to your satisfaction the information provided to you about your participation in this research project, 2) you agree to participate in the research project, and 3) you agree to your son's participation in this project 4) you agree to the participation of teacher two teachers of your choosing
In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You should feel free to ask for clarification or new information throughout your participation.
I wish to be contacted via email to receive the final results of this study when it is completed **(check one) Yes ____ No ____**

Parent Participant's Name: (please print) _____
Son's Name: (please print) _____
Participant's Phone number: _____
Participant's Email: _____
Participant's Signature: _____ Date: _____
Researcher's Name: (please print) _____
Researcher's Signature: _____ Date: _____

Please sign this consent form, scan it, and email it directly to me at alethea.heudes@ucalgary.ca.

Questions/Concerns

If you have any further questions or want clarification regarding this research and/or your participation, please contact:

Alethea Heudes M.Ed.,
Doctoral Candidate
Registered Psychologist
School and Applied Child Psychology
Werklund School of Education
alethea.heudes@ucalgary.ca

Research Supervisor:
Dr. Gabrielle Wilcox, PsyD, NCSP, RPsych,
School and Applied Child Psychology
Werklund School of Education
gwilcox@ucalgary.ca

If you have any concerns about the way you've been treated as a participant, please contact the Research Ethics Analyst, Research Services Office, University of Calgary at (403) 220-

6289/220-4283; email cfreb@ucalgary.ca. A copy of this consent form has been given to you to keep for your records and reference. The investigator has kept a copy of the consent form.

The University of Calgary Conjoint Faculties Research Ethics Board has approved this research study (REB19-0130_MOD4-001). A signed copy of this form will be given to you to keep.

APPENDIX B – Teacher Consent Form

Name of Researcher, Faculty, Department, Telephone & Email:
Alethea Heudes M.Ed.,
Doctoral Candidate
Registered Psychologist
School and Applied Child Psychology
Werklund School of Education
alethea.heudes@ucalgary.ca

Supervisor:
Gabrielle Wilcox, PsyD, NCSP, RPsych,
School and Applied Child Psychology
Werklund School of Education
gwilcox@ucalgary.ca

Title of Project:
Angry and Anxious: Understanding the School Experience of an Adolescent Boy with ODD and Symptoms of Anxiety through Interpretive Phenomenological Analysis.

This consent form, a copy of which has been given to you, is only part of the process of informed consent. If you want more details about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Participation is completely voluntary and confidential. During the data gathering process unless you disclose to others, only you, your student, your student's parent(s) will know that you are participating in this study. None of the documents, other than consent form to participate in this study, will contain any identifying information. Importantly, no identifying information about any of the participants will be in the paper about the findings from this study.

Purpose of the Study

The purpose of this study is to understand the schooling experience of an adolescent boy who has a combination of oppositional defiant disorder (ODD) and symptoms of anxiety. This study will include a very limited number of participants (parent, child, and two teachers) and involves a commitment to two virtual one-on-one interviews of approximately 45-60 minutes each.

What Will I Be Asked to Do?

As part of your participation in this study you will be asked to participate in and provide consent for the following:

1) Participate in two online interviews via Microsoft Teams or Zoom where I ask you questions such as *"How would you describe your student overall*?", *"What are your*

student's strengths?', and *"How are your student's problems affecting him in the classroom*?". The interview will take approximately 45-60 minutes. The Zoom/MS Teams interview will be accessed through a password-protected university account, which has high level security precautions built in, so your confidentiality is protected.

*Please note that the interviews will need to be recorded so that I can write them out word for word later. The reason I have to do this so that I can review all of the information from the interviews very carefully to look for important bits of information or themes that are important to this study. To record the interviews, I will use the Zoom/Microsoft Teams recording feature. As soon as the interview is over, I will upload and store the recording on a password protected computer without any personal identifiers. No one else has access to this computer.

Please note that your participation in this study is completely voluntary. You may refuse to participate altogether or withdraw from the study at any time without penalty.

What Type of Personal Information Will Be Collected?

Should you agree to participate in this study, some personal information will be collected for the purposes of making arrangements for the interviews. You will be asked to provide your name, your email address, and your phone number. Additionally, although I will be recording the interviews, no one else will have access to the recordings of the interviews. Once all of the study data has been gathered and analyzed it will be described in a research paper that will be presented at my final defense and may also later be published in a peer reviewed journal.

Are there Risks or Benefits if I Participate?

There are no significant risks to participating in this study. However, there may be a couple of things that you may (or may not) find inconvenient. First, I will be contacting you on a handful of occasions through phone calls or emails to set up the interviews and follow up calls. Second, the interviews may take up to 60 minutes from your regular daily activities. Third, it is also possible that you may find the interview unpleasant or boring to participate in, or you may be bothered by the nature of some of the questions. Please note that you do not have to answer any questions you do not feel comfortable answering. Fourth, this study has a very small sample size so even though the data will be deidentified and merged, it is still possible that, if I decide to publish my findings in a peer reviewed journal and you, your student, or your student's parents read the published findings, you may recognize a detail as it relates to you. However, I will be sure to avoid publishing any information that may lead to you or anyone else connecting the study findings to any of the participants in this study.

One of the main benefits of your participation in this study is that the information gathered through your participation will help researchers, clinicians, and educators further understand the school experiences of adolescent boys who have ODD and symptoms of anxiety This is an area with minimal research at this time, so it is hoped that this study's findings will motivate other researchers to look more closely at the phenomenon of ODD and symptoms of anxiety on a much larger scale than this study provides. It is also hoped that this study will inspire clinicians and teachers to consider the role comorbid ODD and symptoms of anxiety might play for their students plan interventions accordingly.

As a token of appreciation for your participation in the study, you will be given a $10 gift card to Tim Hortons.

What Happens to the Information I Provide?

Personal information you provide will only be available for my use in carrying out the research, no one else will have access to your personal information. The student, and student's parent(s) are the only other people who will know you are participating in the study. In all data gathering documents and in the final paper, pseudonyms will be used to protect the identity of you, your student, and your student's parent(s). During discussions with my research supervisor, and in consultation with peers, pseudonyms will be also be used. Paper copies of study documents including consent forms will be kept in a locked cabinet only accessible by the researcher and her supervisor. Anonymous study data will be stored for five years on an encrypted USB, at which time, it will be permanently erased. Importantly, a limit to confidentiality will be if you, your student, or your student's parent(s) choose to tell anyone about participation in this study, or if your student chooses to interact with me during the school observations.

Participants are free to withdraw up to 2 months from the date of the last piece of data collected; I will let you know in writing via email when this occurs and what the last day to withdraw from the study will be. Once the data is deidentified and merged I will not be able to identify who is who, which is why withdrawal will no longer be possible. However, if you choose to withdraw your consent prior to the deadline any and all information you provide will be destroyed without consequence.

Signatures

Your signature on this form indicates that 1) you understand to your satisfaction the information provided to you about your participation in this research project, and, 2) you agree to participate in the research project.
In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You should feel free to ask for clarification or new information throughout your participation.
I wish to be contacted via email to receive a copy of the final dissertation paper upon successful completion the researchers' doctoral defense when it is completed. **(check one) Yes ____ No ____**

Teacher Participant's Name: (please print) _____
Participant's Phone number: _____
Participant's Email: _____
Participant's Signature: _____ Date: _____
Researcher's Name: (please print) _____
Researcher's Signature: _____Date: _____

Please place this form in the enclosed envelope, seal it, and return it to the school contact. I will contact you shortly after. If the consent form is not signed and returned within 7 days of being sent to you, I will assume that you do not wish to participate in this study at this time.

Questions/Concerns

If you have any further questions or want clarification regarding this research and/or your participation, please contact:

Alethea Heudes M.Ed.,
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The University of Calgary Conjoint Faculties Research Ethics Board and Foothills School Division have approved this research study (REB19-0130_MOD4-004). If you have any concerns about the way you've been treated as a participant, please contact the Research Ethics Analyst, Research Services Office, University of Calgary at (403) 220-6289/220-4283; email cfreb@ucalgary.ca. A copy of this consent form will be given to you to keep for your records and reference. The investigator will keep a copy of the consent form.

APPENDIX C – Youth Assent Form

TITLE: Angry and Anxious: Understanding the School Experience of an Adolescent Boy with ODD and Symptoms of Anxiety through Interpretive Phenomenological Analysis.

RESEARCHERS:

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What is a research study?

A research study is a way to find out new information about something. Children and teens don't need to participate in a research study if they don't want to participate.

Why are you being asked to be part of this research study?

You are being asked to take part in this research study because we are trying to learn more about your experience at school with having oppositional defiance disorder and symptoms of anxiety. I am asking you to be in the study because you experience on or both of these problems and I want to know more about how these problems affect you at school.

If you join the study what will I ask you to do?

- You will fill out a checklist that asks you some questions about your things you feel in your body when you worry
- You will meet me online in Microsoft Teams or Zoom twice. I will ask you some questions about how things are going for you at school. Both times we meet will take about 45 minutes.
- Don't worry though, the Microsoft teams or Zoom meeting we have will be password protected so only you and I can sign into the meeting.
- I will also be doing similar interviews with your parent(s), and two of your teachers that you and your parent(s) chose for me because they know you really well

Will any part of the study be uncomfortable?

- You might find some of the questions I ask you a bit weird, boring, or personal. You don’t have to answer er anything you don’t want to.

Will the study help others?

This study might find out things that will help teachers, psychologists, and other researchers better understand boys like you so that they can do a good job of being supportive and understanding when teenage boys need help if they are struggling or feel misunderstood.

Who knows about this study?

You parent(s) have said it is okay for you to participate in this study, but only if you want to as well. You can talk it over with them before you decide if you want to be in this study.

Who will see the information collected about you?

The information about you during this study will be kept safely locked up. I take your name off of everything except this form. This means that unless you tell anybody, no one will know you are in this study except for your parent(s). Because I won't be able to remember everything you share with me, I do have to video record the interview so I can go back later. But again, not to worry, I will upload the video right away onto a password protected computer that only I have access to. I will make sure nothing on the file identifies you when I save it.

What do you get for being in the study?

You will get a $10 gift card to Tim Hortons for being in this study.

Do you have to be in the study?

You don't have to be in the study. No one will be upset if you don't want to do this study. If you don't want to be in this study, you just have to tell us. It's up to you. You can also take more time to think about being in the study.

What if you have any questions?

You can ask any questions that you may have about the study. If you have a question later that you didn't think of now, you or you parents can call or email me or my supervisor (our emails are at the top of the first page). You can also take more time to think about being in the study and also talk some more with your parents about being in the study.

What choices do you have if you say no to this study?

If you don't want to be in this study that is okay. If you say yes but then change your mind that is okay too. If you do change your mind it will have to be early on. Once I take your name off everything, I won't be able to remove you from the study because I won't know which information is about you (I take your name off everything remember). I will be sure to let you

the date of the absolute last day you can change your mind about being in the study. If you do change your mind about being in the study, I will also delete all of the information I have from your parents and teacher as well.

If you decide to be in the study, then please write your name below. You can change your mind and stop being part of the study at any time. All you have to do is tell the person in charge or tell your parents to tell the person in charge. It's okay. The researchers and your parents won't be upset with you.

You will be given a copy of this paper to keep.

Would you like to take part in this study?

_____ Yes, I will be in this research study. _____ No, I don't want to do this.

_____	_____	_____
Child's name	Signature of the child	Date

_____	_____	_____
Person who received assent	Signature	Date

The University of Calgary Conjoint Health Research Ethics Board and Foothills School Division have approved this research study **(**REB19-0130_MOD4). A signed copy of this assent form will be given to you to keep.

APPENDIX D - Interview Guide for Parent

Primary Research Question/Phenomena I want to know more about:

What is school life like for a boy with comorbid ODD (Anger), and symptoms of anxiety?

Secondary Questions

a) How does an adolescent boy with ODD, and symptoms of anxiety view his experience of life at school?

b) How do the adults in the life of an adolescent boy with ODD, ADHD and symptoms of anxiety view his experience of life at school?

c) What similarities or differences exist, if any, between how he views his own experiences and how the adults in his life view his experiences? What similarities or differences exist, if any, between how his mother views his experiences and how his two former teachers/school learning coaches view his experiences?

Before conducting interviews with each participant explain the following:

1) Purpose of the study:
    a. The purpose of this study is to gain a deep understanding about how adolescent boys with comorbid conditions and symptoms of anxiety experience life at school.
2) How long the interview will take:
    a. This interview should take 45-60 minutes. We will also have a second interview in a few weeks that will take about the same amount of time
3) Process of recording:
    a. As noted in the consent form, this interview will be recorded via a MS Teams or Zoom. The recording will be kept on a password protected computer. Only the interviewer has access to the recordings. As soon as data analysis is completed the recordings will be deleted.
4) How confidentiality and anonymity of participants will be protected:
    a. I will take all necessary steps to ensure your identity is protected. I will code all documents and remove all identifying information. A pseudonym will be used in all documents as well.
5) Ask if there are any questions or concerns

Parent Interview Guiding Questions and Probes – Interview 1

1. Tell me about your son, how would you describe him?
2. What is your experience of his experience at school?
   Possible Probes:
    a. Strengths? Friends? Learning? Challenges?
    b. What gives you that impression?
    c. Tell me about that?

d. *What does that mean for you?
e. What do you think that means for your son?
f. How might that compare to others his age?

Parent Interview Guiding Questions and Probes – Interview 2

1. What did his teachers mean to him over the years?
2. How do you think his teachers saw him before they knew him?
3. How do you think they saw him after they knew him?
4. How do you think they perceived his diagnoses?
5. Anxiousness? When, over what, what does that look like?
6. Has that changed over time? How?
7. What did that all mean for him and his experience at school?
8. What has been most helpful to him? Why was it helpful?
9. If you could give advice to the helpers of the world who work with children like your son, what would you tell them?

APPENDIX E - Interview Guide for Teachers

Primary Research Question/Phenomena I want to know more about:

What is school life like for a boy with comorbid ODD, and symptoms of anxiety?

Secondary Questions

d) How does an adolescent boy with ODD, and symptoms of anxiety view his experience of life at school?

e) How do the adults in the life of an adolescent boy with ODD, ADHD and symptoms of anxiety view his experience of life at school?

f) What similarities or differences exist, if any, between how he views his own experiences and how the adults in his life view his experiences? What similarities or differences exist, if any, between how his mother views his experiences and how his two former teachers/school learning coaches view his experiences?

Before conducting interviews with each participant explain the following:

6) Purpose of the study:
    a. The purpose of this study is to gain a deep understanding about how adolescent boys with comorbid conditions and symptoms of anxiety experience life at school.
7) How long the interview will take:
    a. This interview should take 45-60 minutes. We will also have a second interview in a few weeks that will take about the same amount of time
8) Process of recording:
    a. As noted in the consent form, this interview will be recorded via a MS Teams or Zoom. The recording will be kept on a password protected computer. Only the interviewer has access to the recordings. As soon as data analysis is completed the recordings will be deleted.
9) How confidentiality and anonymity of participants will be protected:
    a. I will take all necessary steps to ensure your identity is protected. I will code all documents and remove all identifying information. A pseudonym will be used in all documents as well.
10) Ask if there are any questions or concerns

Teacher Interview Guiding Questions and Probes – Interview 1

1. Tell me about ___ , how would you describe him?
2. What is your experience of his experience at school?
   Possible Probes:
    a. Strengths? Friends? Learning? Challenges?

b. What gives you that impression?
c. Tell me about that?
d. *What does that mean for you?
e. What do you think that means for your student?
f. How might that compare to others his age?

Teacher Interview Guiding Questions and Probes – Interview 2

1. What did his teachers mean to him over the years?
2. How do you think teachers saw him before they knew him?
3. How do you think they saw him after they knew him?
4. How do you think they perceived his diagnoses?
5. What did that all mean for him and his experience at school?
6. Was there any impact of his school experience on his life outside of the school?
7. What has been most helpful to him? Why was it helpful?
8. If you could give advice to the educators of the world who work with children like your student, what would you tell them?

APPENDIX F - Interview Guide for Youth

Primary Research Question/Phenomena I want to know more about:

What is school life like for a boy with comorbid ODD, and symptoms of anxiety?

Secondary Questions

g) How does an adolescent boy with ODD, and symptoms of anxiety view his experience of life at school?

h) How do the adults in the life of an adolescent boy with ODD, ADHD and symptoms of anxiety view his experience of life at school?

i) What similarities or differences exist, if any, between how he views his own experiences and how the adults in his life view his experiences? What similarities or differences exist, if any, between how his mother views his experiences and how his two former teachers/school learning coaches view his experiences?

Before conducting interviews with each participant explain the following:

11) Purpose of the study:
    a. The purpose of this study is to gain a deep understanding about how adolescent boys with comorbid conditions and symptoms of anxiety experience life at school.
12) How long the interview will take:
    a. This interview should take 45-60 minutes. We will also have a second interview in a few weeks that will take about the same amount of time
13) Process of recording:
    a. As noted in the consent form, this interview will be recorded via a MS Teams or Zoom. The recording will be kept on a password protected computer. Only the interviewer has access to the recordings. As soon as data analysis is completed the recordings will be deleted.
14) How confidentiality and anonymity of participants will be protected:
    a. I will take all necessary steps to ensure your identity is protected. I will code all documents and remove all identifying information. A pseudonym will be used in all documents as well.
15) Ask if there are any questions or concerns

Youth Interview Guiding Questions and Probes – Interview 1

1. Tell me about how school is for you.
2. How do you feel about school?
3. What gives you that impression?
4. Tell me about what a typical day might look like for you at school
   Possible Probes:
    a. Strengths? Friends? Learning? Challenges?

b. What gives you that impression?
c. Tell me about that?
d. *What does that mean for you?

Youth Interview Guiding Questions and Probes – Interview 2

1. Tell me about your self-esteem?
2. Do you worry ever?
3. What is your experience at school of what others think about you?
4. What does your experience of school in the past mean for you now?
5. What has been most helpful for you going through all of that? Is there anything that seemed to make it all harder for you?
6. What was school like before you loved it?
7. You mentioned ODD and ADHD in our previous interview? What are your thoughts on both of those diagnoses? What do you think your teachers thought/think about those?

Possible Probes:

a. What gives you that impression?
b. Tell me about that?
c. *What does that mean for you?
d. What's different now compared to then?
e. How has that changed over time/since your early elementary days?