MIDDLE SCHOOL TEACHERS' ATTITUDES AND PERCEPTIONS ABOUT THEIR ROLE IN PROMOTING PUPILS' MENTAL HEALTH IN THE STATE OF KUWAIT

Submitted by Dalal Alradaan

PhD

University of Exeter

September 2012

Aknolowledgments

The completion of this thesis has been made possible through the love and support given to me by a number of individuals. Most importantly, I must extend my thanks and appreciation to God, who has given me the blessing and the help needed to progress through this work: patience, perseverance and support. I am ever grateful for His blessings and kindnesses.

This research has been more than just completing a study project. Achievement of this study has been the opportunity to interact with people from different cultural backgrounds, and to test myself in difficult moments. I would like to express my profound gratitude and appreciation to my two supervisors, Dr. Hazel Lawson and Professor Brahm Norwich, both of whom have provided encouragement and advice thereby facilitating the completion of this project. They have motivated and inspired me, and I owe them a great deal of thanks and respect for this, in addition to their time and ever-constructive feedback, which will be never forgotten.

I wish to express a special thanks to His Majesty sheikh Sabah Al-Sabah, the president of Kuwait, for his committed and continuous promotion of educators and education in Kuwait. I also wish to emphasise the role the Kuwaiti government has had to play in my completion of this research; without their sponsorship throughout my study, my thesis would never have been possible. I acknowledge how much I owe my country, and hope to someday repay this favour.

In addition, I send my love and thanks to my family. I am eternally grateful to my father, who has made countless sacrifices for me, not only throughout the course of this thesis but since my birth. I also thank my mother from deep in my heart for her unconditional love and numerous prayers, requesting my safety and success. In addition, I am grateful to and thankful for my husband and children, who have been undergone this challenging journey with me, experiencing my stresses and pressures, the innumerable ups and downs. I also thank my brothers, sisters and their families for their love and faith. Lastly but not least, I would like to express my appreciation and indebtedness to all participants for their willingness to share their views with me and their time they gave to complete the surveys and interviews.

Abstract

The aim of this study was to explore the complexity of teachers' attitudes and perceptions about promoting their pupils' mental health in Kuwait middle schools. Specifically, the study aimed to investigate teachers' understanding of mental health and promoting mental health concepts. Further aims were to discover more about the contextual factors that shaped teachers' attitudes towards promoting pupils' mental health, and teachers' perceptions about barriers that might hinder the implementation of the promotion process. The study also attempted to elicit teachers' perceptions about the changes required to put promoting pupils' mental health into practice in Kuwait educational context.

The study adopted a mixed-methodology approach within a pragmatic context in two stages. Data for the first stage were obtained from participants through a systematic survey conducted with 497 Kuwaiti middle school teachers, chosen randomly. In stage two, twelve teachers were chosen purposely to take part in semi-structured interviews. Data were analysed quantitatively and qualitatively.

The findings from the study suggested that Kuwaiti middle school teachers tend to hold moderately favourable attitudes towards promoting pupils' mental health. However, a variety of personal, interpersonal, socio-cultural, and structural-organizational barriers were perceived by teachers that could undermine their positive attitudes and impact on moving towards the implementation of the promotion process. The results of the study indicated a significant relationship between those barriers and the cognitive, affective and behavioural components of teachers' attitudes. The study also showed that teachers' attitudes and perceptions were markedly embedded within the socio-cultural and religious aspects of the study context. Additionally, the study has theoretical implications for understanding the values underlying the commitment to promoting pupils' mental health in schools and teachers' attitudes in this area. As regards practical implications, the study provides a set of recommendations, relating to policy, curriculum, pedagogy, methodology, and teacher education and training in the area of pupils' mental health. Finally, some areas for further research investigations are suggested.

Table of Contents

Appendices

List of Tables

List of Figures

Chapter 1: Exploring the Gap

1.1 Introduction

The current study aims to explore the complexity of promoting pupils' mental health in mainstream schools in the Kuwaiti context, with a particular focus on middle school teachers' attitudes towards their role as promoters of pupils' mental health and their perceptions about barriers to, and change required for the implementation of the promoting process. This chapter starts by setting out the rationale for and significance of the study. This is followed by an account of the overall aims of the current study and the questions associated with it. Additionally, the research approach adopted will be presented in brief. Finally, the chapter will conclude with an overview of the thesis.

1.2 Background and rationale for the study

In the UK, there is a growing view that teachers in schools are expected to be more keenly involved in the promotion of mental health amongst pupils meaning that there is the need for additional responsibility for the early recognition of mental health issues must be shouldered by teaching staff, as well as referring affected pupils to the appropriate help (World Federation for Mental Health, 2003; Baxter, 2002; Lines, 2002; Capey, 1997). In this way, teachers are now expected to do more than simply educate and adhere to the national curriculum. The current study was developed as a response to the issues surrounding the incidence of mental health problems among pupils in the schools of Kuwait, and the apparent link with long-term negative impacts leading to a surge of interest within the political and the academic areas in the capability of educational institutions to deliver interventions (MOE, 2009). Additionally, the study could be such a step towards a clearer understanding of the schools' role in tackling pupils' mental health promotion depends on the willingness of the teaching staff in each school to be involved in this responsibility.

It has already been established that there is adequate evidence to support the notion that the application of mental health education amongst pupils in middle school possibily affects their emotional, social and mental health, with a similar positive impact on their academic performance (Pinfold *et al*., 2003; Weist *et al*., 2005; Woolfson, Mooney & Bryce, 2007). However, successfully implementing such programmes and curricula ultimately necessitates

the exploration of teachers' attitudes to the role of mental health promoter, with further attention directed towards potential barriers that may be experienced, as well as wider changes and processes requiring implementation. Accordingly, the main goal of the current study is not concerned with teaching staff acting as mental health professionals within the, but rather in facilitating their capacity to act as a valuable resource in supporting the mental health issues of pupils in dealing with and recognising mental health problems.

Education within Kuwait has been prioritised by the decision-makers and policies have commonly been implemented in a top-down way, ignoring teachers' viewpoint in regard to educational change (MOE, 2009). Therefore, this study might direct attention towards the importance of investigating and analysing the views of teachers in a variety of teaching areas, and specifically teachers' attitudes towards promoting the mental health of pupils within the socio-cultural context of Kuwait.

Furthermore, also in the context of Kuwait, pupils have been given information and insight into how to deal with a number of education-related concerns, but pupils' mental health has been completely overlooked, with only the evaluation of counselling initiatives receiving some attention. Therefore, the focus on promoting pupils' mental health in schools has been encouraged through the delivery of counselling by school counsellors in Kuwait. It is understood that the majority of studies carried out in Kuwait in the context of teacher variables have been predominately focused on the strategies and methods of teaching, with emphasis directed toward assessing such teaching approaches so as to facilitate the development of pupils (MOE, 2008). However, no attention has been directed towards the ways in which pupils' mental health issues could be tackled other than through the counselling system. In addition, there have been no studies concerned with investigating and examining teachers' attitudes to promoting pupils' mental health, considering the barriers and the feasibility of such promotion.

The overall aim of this study is to develop better insight and understanding of the aforementioned issues, applicable within Kuwait, in an attempt to provide valuable contributions in the area of promoting pupils' mental health. The study seeks to develop understanding of the views of teachers regarding implementation barriers and their overall views in terms of the required changes to be adopted. It is also hoped that such an understanding will help to contribute to this topic, as it is recognised that the issue of pupils' mental health is complex, especially when considering the support required from teachers.

1.3 Aims of the study

The current study aims to focus on understanding the complexity of promoting pupils' mental health, its concept, theories and practice, barriers to implementation and requirements for change. More specifically, the study is concerned with the promotion of pupils' mental health in public schools in the Kuwaiti context, with a particular focus on teachers' attitudes and perceptions about this process. In this regard, the study aims to:

- Investigate Kuwaiti middle school teachers' attitudes toward their role in promoting pupils' mental health.
- Elicit Kuwaiti middle school teachers' understanding of the mental health concept, and the promotion of pupils' mental health.
- Explore factors influencing Kuwaiti middle school teachers' attitudes towards promoting pupils' mental health.
- Explore Kuwaiti middle school teachers' perceptions about barriers to promoting pupils' mental health.
- Explore Kuwaiti middle school teachers' perceptions about change required to put the implementation of promoting pupils' mental health into practice.

The first and second aims explores the range of beliefs, emotions, and behavioural intention of teachers in order to establish deeper and clearer insight into their views held by teachers about mental health and its promotion. Such beliefs about mental health and promoting pupils' mental health could guide teachers in their day-to-day communications within the school setting. Additionally, teachers' feelings and behavioural intentions about being involved in the promotional process could affect their readiness or willingness in regard to such promotion. The third research aim is concerned with exploring factors that might influence teachers' attitudes and perceptions in this area. The fourth aim investigates barriers that might hinder the application of pupils' mental health promotion. The final aim is concerned with highlighting any elements of change that may be able to facilitate practices of mental health promotion in the schools of Kuwait.

A concluding significant goal is to gain insight into the possibility of promoting pupils' mental health by exploring teachers' attitudes towards the promoting process. This insight,

which could be gained from teachers' responses, would be significant in adjusting the current polices of schools ethos regarding their role in pupils' mental health promotion, and specifically teachers' role in this area, or in creating and formulating new educational policies regarding this promotion process.

1.4 Research questions

Based on the study aims and the mixed-methodological research approach, which will be outlined later in the methodology chapter, the main aims of the current study are divided into two groups of questions, approached by a complementary research design consisting of two research phases:

The first phase of the study's research design (quantitative) involves employing a survey attempting to answer the first group of questions, which are:

- What are Kuwaiti middle school teachers' attitudes towards promoting pupils' mental health?

- Is there any significant statistical correlation between the three components of teachers' attitudes to pupils' mental health (cognitive-affective-behavioural)?

- Are there any significant statistical differences in Kuwaiti middle school teachers' attitudes towards pupils' mental health that can be attributed to teachers' gender, age, years of teaching experience or levels of education?

- What are Kuwaiti middle school teachers' perceptions about barriers to promoting pupils' mental health?

- Is there any significant statistical correlation between the perceived barriers to promoting pupils' mental health and teachers' attitudes?

The second (qualitative) phase of the study's research design involves utilizing semi-structured interviews addressing the second group of research questions, which are:

- What are Kuwaiti middle school teachers' perceptions about promoting their pupils' mental health?

- What are Kuwaiti middle school teachers' perceptions about barriers to promoting pupils' mental health?

- What factors do Kuwaiti middle school teachers perceive as affecting their perceptions in promoting mental health?

-What are Kuwaiti middle school teachers' perceptions about the changes necessary to put promoting pupils' mental health into practice?

1.5 Research approach

In the current study, a mixed-methodological approach related to the pragmatic framework, consisting of two complementary research design stages appropriate to the type of research questions, was utilized. This approach for gathering data draws on both qualitative and quantitative traditions in a way that best considers and helps to answer the study questions. Adoption of this approach is based on the belief that a mixed-methodological approach can profitably amalgamate study approaches, depending on their overall significance in terms of answering specific study questions (Johnson & Onwuegbuzie, 2004). It can be also called a multi-purpose, or a 'what works' approach, thereby enabling researchers to deal with questions that may not be efficiently answered if aligned with a narrower research methodology (Creswell, 2003). The study uses a mixed-methodological research approach in order to garner a clear insight into teachers' perceptions and attitudes towards the promotion of pupils' mental health. This mixed-methodological approach has enabled the researcher to view the phenomena from different angles and helped in improving and enriching the interpretation and discussion of the data.

The first, quantitative stage of the current study consists of conducting a survey aiming to create a wide-ranging illustrative overview of teachers' attitudes, perceptions, and overall understanding of teacher's views of pupils' mental health promotion, for the purpose of generalizing results. During this current stage, a large sample of Kuwaiti teachers — totalling 479 — was chosen randomly for the survey.

The second stage of the study aimed to answer the second group of questions in order to illuminate the complex issues associated with the promotion of pupils' mental health and teachers' views in relation to their role in this area. The implementation of the second qualitative stage afforded the exploration of the views and attitudes of the participants within

the social reality of their authentic context, as highlighted by Eiser (1994). In this regard, attitudes are viewed as being the outcome of communications between social and personal elements, rather than merely personal entities, as highlighted through the survey stage. This was approached by utilizing semi-structured interviews with a purposive sample of 12 teachers, in order to gain a more in-depth understanding of teachers' perceptions and attitudes towards promoting pupils' mental health.

1.6 Significance of the study

This study is designed to be both original and timely, maximising the value of its findings and implications. This is closely linked to the context of the study, since the promotion of pupils' mental health in schools is still a relatively new concept in Kuwait, and will continue to undergo development. Although the concepts of mental health, particularly among young people, have been the subject of global interest in recent decades, the issue has only now become critical in Kuwait, so this study is targeted at a specific moment of decision.

By utilising the unique position that teachers hold in the development of young people, this study will contribute to both the theoretical understanding of attitudes towards pupils' mental health, and provide practical information which may contribute to how teachers approach their pupils in future.

From a theoretical standpoint, the research may be able to provide some valuable understanding of the international discussion surrounding the promotion of pupils' mental health within education, with particular presentation of the complexities of this issue in the Kuwaiti context.

More generally, as an example of multi-dimensional attitude measurement, it sheds light on some of the personal and social aspects of attitudes, opposing a one-dimensional view. By the same process, in insisting on recognition of social complexity and the specifics of the teachers' social settings, greater understanding of the roles of multiple elements in forming attitudes may be attained. A related point is that positive attitudes do not translate into guaranteed success nor vice-versa; changes in policy and practice may not succeed unless teachers become advocates for them, able to integrate them within their own framework of beliefs.

In terms of practice, this study gives a voice to a sample of teachers, and draws out the implications of what they have to say. Providing this space and analysis may assist teachers in articulating and understanding their own attitudes towards their pupils' mental health, particularly within the Kuwaiti context, with its specific barriers, cultural considerations and criteria. If understanding issues around mental health will benefit teachers in structuring and delivering education, this will also assist pupils, through improved support, greater likelihood of receiving earlier appropriate assistance, and developing resilience. This is particularly apt for the middle school stage addressed in this study, when young people are dealing with a wide range of social, emotional and biological changes and pressures.

As Kuwait continues to develop its current policies for the promoting of pupils' mental health, the present study is especially valuable in highlighting the need for reform, and the commitment and understanding teachers demonstrate towards mental health promotion in schools. The potential value and the importance of improved teacher-training it highlighted. However, of equal importance is the evidence that reform need not be whole-sale, but should be incremental and responsive to the culture, values and society of Kuwait.

Finally, alongside the significance of the results of this study to Kuwait's education system, the structure and subject of the project may have positive impacts. The use of a mixed-methodology approach within a complementary research design in this context is quite unusual, and will provide a helpful example for future researchers. The study also raises a number of important questions and areas for future research, which could guide further investigations.

1.7 Overview of the study

In order to best respond to the stated research aims, the thesis is arranged into seven chapters:

Chapter One provides the justification for the study and the research questions, with the considered value of the research and its overall purpose further discussed.

In Chapter Two, a contextual background of the educational system operational in Kuwait is provided, followed by an overview of mental health policies within the country, as well as the present position on pupils' mental health promotion within Kuwait's schooling system.

Chapter Three details the theoretical background for the study, highlighting a number of mental health concept-related definitions, discussing the issues and theories believed to be

pertinent within the area of mental health promotion in schools. Additionally, the chapter highlights the high rate of emerging mental health problems among young people and the importance of promoting their mental health. This is followed by a review of the theoretical models that stem from different ontological positions, and consequently lead into different approaches to promoting mental health, with a particular focus on the appropriate approach to promoting pupils' mental health in schools. Then, the chapter highlights the rationale for promoting young people's mental health. Finally, the chapter concludes with a review of research literature related to the current study in regard to teachers' attitudes and role in promoting pupils' mental health, as well as the various barriers that may have an impact on the promoting process.

Chapter Four provides an overview of the study approach, the methodological concerns that guided the research framework of the current study, the ontological, epistemological and philosophical assumptions, and the justification for the mixed-methodological research approach with a complementary research design. A description of the two stages of the study (quantitative-qualitative) is given, and the data collection methods and analysis approach utilised for the rich data are discussed.

Chapter Five provides a breakdown of the results of the research survey, with attention directed towards the attitudes of teachers and perceptions about the possible barriers facing the implementation of the promotion of pupils' mental health, and perceptions about changes that are required to put this implementation into practice.

Chapter Six presents analysis of the qualitative interviews. It provides rich and detailed description of teachers' perceptions about pupils' mental health, promoting pupils' mental health, barriers that might undermine the promotion process and changes needed to implement these processes.

Chapter Seven incorporates all of the research findings through analytical discussion in direct connection to the literature review. This follows by presenting the limitations faced in the study and consideration of a number of ethical issues. The chapter concludes with the theoretical, practical and methodological implications of the findings, outlining the contribution of the study in the area of promoting pupils' mental health in Kuwait schools and teachers' perceptions and attitudes towards promoting pupils' mental health.

Chapter 2: Context of the study

2.1 Introduction

This chapter sets out the context in which the current study was carried out. The chapter presents a brief profile of the country and the nature of the Kuwaiti education system. Additionally, it sketches the historical development of mental health policy in the State of Kuwait, which will be addressed with an emphasis on the status of promoting pupils' mental health within the education system, and the current policy followed in Kuwaiti schools to promote pupils' mental health.

2.2 Country profile

The State of Kuwait is a small sovereign Arab country located in north-east of the Arabian Peninsula. Lying strategically to the north-western side of the Arabian Gulf, it shares borders with Iraq to the north and the kingdom of Saudi Arabia to the south (see Appendix (I), p. 277 and Appendix (II), p. 278). The capital city of Kuwait is Kuwait City. Kuwait's population was an estimated 3.6 million in 2009, and the land occupies an area of 17,820 square kilometres (Ministry of Education, 2008). The official language in Kuwait is Arabic, and Islam its principal religion. The governance system in Kuwait is monarchical and its constitution involves parliamentarian organization. Administratively, it is divided into six provinces controlled by the Kuwaiti central government. Kuwait is one of the highest-income countries in the world. It is the fifth largest petroleum and oil producer in the world, with exports of oil accounting for approximately half of Kuwait's national revenue and 80% of government income (Ibid.).

2.3 Education system in Kuwait

The State of Kuwait has paid significant attention to education. This attention derives from the important role that education plays in encouraging people to become thoughtful and active individuals within socity (MOE). Further attention is directed by the State towards training, in order to assist individuals to become productive and effective citizens within a human resources team (Ibid.).

With this in mind, it is detailed in Article 40 of the Constitution of the State of Kuwait that 'education is the right of all citizens to be provided and supervised by the state in accordance with the law and in keeping with the general system and ethics. Education is compulsory and

free of charge for citizens from the first grade of primary school (6 years)' (Kuwait Constitution, 2012).

Historically, education in Kuwait was established by a group of scholars and clergymen who were educated in neighbouring countries. Education was connected with the emergence of mosques in Kuwait, where sessions were limited to religious topics, teaching of the Qur'an and reading and writing (Al-Abdulghafoor, 2000). Traditionally, mosques were used simultaneously as places of worship and education. In many cases they were used as 'courts of first instance' for disputes arising between people. Education took place in a small number of Quranic schools known as 'kuttatib' which were funded by wealthy people. The 'kuttatib' is a place for the gathering of scholars who dedicate part of their homes to receive children to educate them; this may be a humble place comprising a group of pupils supervised by one teacher, with another assisting him (Ibid.). The idea of 'kuttatib' came from Egypt, and Arabs knew them from the pre-Islamic era. These 'kuttatib' played a significant role in education until the establishment of the first formal school in Kuwait, 'Al Mubarakiyya School', in 1912. The school started to offer subjects and training in letter–writing skills, commerce, arithmetic and English for their pupils.

Recently, the Kuwaiti education system and its enhancement may be accredited largely to the fact that the country has benefitted from oil and its revenue. The education system within the country is managed by the Ministry of Education. The Ministry of Education has six administrative educational authorities: Al-Jahra, Al-Ahmedi, Mubarak Al-Kabeer, Al-Farwanya, Hawali, and Al-Asema. These administrations hold responsibility for the implementation and supervision of plans and policies drawn up by the Ministry of Education. Accordingly, these plans are in line with the most important objectives assigned to the field of education. These include:

- Establishing a balance between preparing an individual to adapt to changes witnessed at regional and international levels, and protecting and preserving the state's cultural identity;
- Preparing individuals for practical life and meeting technological advancements, as well as delivering fundamental basic skills.

2.4 Structure of the education system in Kuwait

The current structure of the Kuwaiti education system comprises two types of education: public education and private education. Both are comprised of three main levels, namely, Primary, Middle and Secondary. In all of these levels, classes are segregated by sex, starting from grade one. Primary level education is preceded by two kindergarten years, and includes five grades, from age six to ten. At the middle level, pupils go through four levels, from age eleven until they are fourteen. The high secondary stage has three grades, for ages fifteen to seventeen (see Figure 2.1).

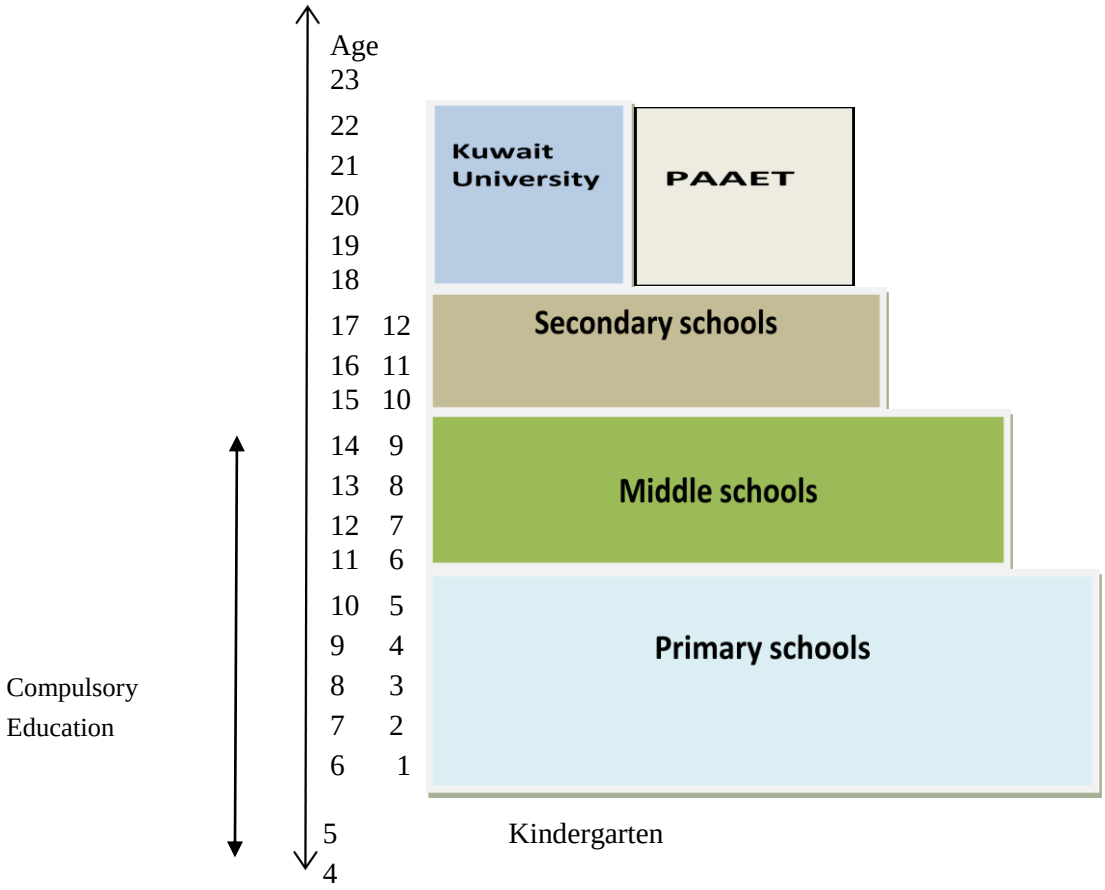


***Figure 2.1*: The structure of Kuwaiti education system**

The Ministry of Education does not encourage the automatic transfer of pupils from one grade to the next, so as to avoid escalating problems for pupils with aspects of weakness. It

prefers to allow them to attain a certain level of achievement that enables them to advance their education to the next grade.

The main subjects taught at primary level are Islamic Studies, Arabic, English, Combined Sciences, Mathematics, Computer Science, Social Studies, Physical Studies, Art, Music, and (for girls) Home Economics. At Middle and Secondary levels, additional subjects are introduced, such as Geology, Biology, Chemistry, Physics, Geography, History, Economics, French and Philosophy. However, no mental health education curriculum or programs to promote pupils' mental health have been implemented in the schools of Kuwait.

The education in the private schools in Kuwait established due to a social and economic renaissance in Kuwait, which witnessed immigrants arriving in large numbers from different Arab and foreign countries, and who now compose a large section of Kuwaiti society (Al-Abdullah, 2003). Hence, this has added to the responsibilities shouldered by the government to open private schools, supplying the education provided in their homelands. Private schools are monitored and assessed through inspection visits by the Ministry of Education. These private schools follow the same systems as public schools regarding goals, exams and administrative issues. Curricula taught in these schools are state-approved, while permitting the use of additional text books. The Ministry of Education in Kuwait further recognises the provision of special education facilities as an important aspect of its role. Hence, it has provided equal educational opportunities for pupils with learning disabilities by opening in excess of 11 schools and educational institutes for them over the last few years.

Higher education includes post-secondary education and technical training, which is supervised and provided by PAAET (The Public Authority for Applied Education and Training) and Kuwait University. PAAET has established institutions and training centres which are more vocational in orientation and offer two-year technician programmes for secondary certificate holders.

At university level, a Bachelor's degree normally requires completion of eight semesters (over four years) for all programs, except for engineering (five years and above) and medicine (seven years of study according to its three introductory level programs).

At postgraduate level, the duration of programs leading to the award of the higher diploma consists of two or three semesters. Master's and Doctoral degrees are not yet available in all

majors. Additionally, the government of Kuwait provides scholarships for students to study abroad in different countries around the world.

2.5 Teacher education in Kuwait

Since the establishment of the Kuwaiti education system, the government has opted to source staff externally. However, considering the rise in the number of schools and pupils, there was a more pressing need for administrators and teachers, and so the government was required to initiate a number of critical steps to ensure the development of a sound teaching force within the country (Al-Abdullah, 2003).

Acknowledging the value and importance of teachers' on-the-job training, the Ministry of Education directed its focus to ensuring teachers were trained to an adequately professional level. Currently, the most widely recognised training institutions include the Faculty of Education at the University of Kuwait, and the College of Basic Education, with the latter providing academic, cultural and pedagogical training. Importantly, the training programmes put the emphasis not only upon general subjects, but also on specialised topics, in addition to delivering vocational training. A number of self-improvement initiatives are also promoted, thus providing teachers and trainers with the capacity to improve their expertise and skills, and to thereby become better acquainted with new developments in their professional field (MOE, 2008).

2.6 Mental health in Kuwait

The focus of this current study is to explore the status of promoting pupils' mental health within the Kuwait education system, with an emphasis on the role of teachers in this area, and their awareness of this responsibility. It is therefore critical to examine not only the teaching of the academic curricula but also the extent of training, if any, in the area of pupils' mental health offered for teachers during their studies in educational institutions and during their working career. This will reveal the extent of teachers' awareness, knowledge and training regarding pupils' mental health issues.

The researcher of this study carried out a review of the syllabuses of all the academic subjects provided for teachers during their education in the College of Education in Kuwait University and the College of Education in the PAAET. The review showed that there was no subject

covering mental health issues and the skills required to recognise and deal with pupils' mental health issues included in the whole course of study for teachers.

Therefore, no effort of any kind has been undertaken to establish a system to provide teachers with knowledge and training to raise their awareness in the area of mental health. Neither is there any mental health education or training course provided for teachers during their academic studying or career. In short, the teachers' role in promoting the mental health of young people in schools remains neglected in the education system in colleges, school curricula, and throughout the whole school ethos.

The question which arises here is how schools in Kuwait are promoting their pupils' mental health. Does promoting pupils' mental well-being constitute a core of these schools' plans and activities? If so, what is the position of this goal within school culture? To shed light on these issues, it is critical to first address the history and policy of mental health in Kuwait, and then examine the way that schools are attempting to promote pupils' mental health.

Until the beginning of the twentieth century, no attention was paid to mental health due to the economic, cultural and social conditions present in most Arabian Gulf countries at that time. During that period, people living in the Gulf area were poor and could barely find their daily sustenance; if they got sick, most could not afford medication and therefore relied on herbal medicine (Taher & Al-Mosawy, 1995).

Mental health problems were basically related to the mainstream regional and social traditions in these regions, and methods applied in treatment were primitive, with superstitions and mascots (totems), myths and idols playing an important role in this field. Eleanor Calverley, the first American doctor in Kuwait in 1955, described the life of the people of Kuwait as very hard and harsh: people suffered from illnesses and pains, and their wounds bled with no one to alleviate their pain or to give them the right treatment, except through traditional medicine based on herbal remedies. She also reported that if mentally ill people were not healed by this traditional medication, the defect was ascribed to genies and hence 'Zaar', a traditional session where anthems and folk songs are played, was the accepted way to treat this illness. Eleanor Calverley also described this 'Zaar' as a traditional treatment that mentally ill people received from traditional and religious healers (sheikhs), which included some holy recitations for the patient, using amulets to drive the 'evil eye' away, and

writing on some bowls with holy water (zaaafran), which the healers then asked the patient to drink and wash some parts of their body (Al-Mosawy, 1992, p.24).

The first hospital, established in 1913, was the American Missionary. Kuwaitis feared attending this hospital due to their distrust of Americans, as they considered them as strangers and conquerors who might do something bad to them. The end of 1949 saw the first specialized centre for nervous and mental diseases where the specialists provided mental health services. That year also saw a facility established for mentally sick women. A hospital for mental and nervous diseases opened in 1956 and later became the hospital of psychiatry. The psychiatric hospital developed in 1985 and its services extended to male/female pupils in all educational phases, and so the services came to encompass pupils experiencing mental health issues under the Ministry of Social Affairs.

The policy to promote mental health in Kuwait was initially formulated in 1983. Mental health care has been incorporated into the primary health care system since 1983 and was centralized in the Kuwait Psychiatric Hospital. There is a consensus that mental health care can be categorised into two levels of provision in Kuwait. The first of these is considered to be part of the Kuwaiti mental health care system, which is delivered through the family doctor at the primary care level and is government-funded. The second is the mental health care offered by a number of counselling and psychiatric clinics through country-wide mental health programmes.

In recent years, significant numbers of the general population have experienced post-traumatic stress disorder (PTSD), as a result of Iraqi aggression against Kuwait in 1990 (Al-Turkait & Ohaeri, 2008). This topic has been afforded much attention of late. Accordingly, the Reggie Centre was established, which is a specialised unit created for the purpose of PTSD-related care and systemic studies, commanding considerable human resources.

With regard to young individuals, they are also provided with mental health care services through the Ministry of Social Affairs, within the Maternity Hospital and Geriatric Department (Taher & Al-Mosawy, 1995). In addition, a number of other centres, including specialised schools and prisons, also offer psychiatric clinics for such people. Nevertheless, it should be acknowledged that, at present, there is a lack of community-oriented mental health facilities.

It is worth pointing out the diverse impact that the Iraqi aggression had on young peoples' mental health. Kuwait, as is well known, was attacked by Iraq in 1990. This aggression inflicted a number of negative conditions on young people, resulting in behavioural, cognitive, emotional, mental health and psychological impacts amongst this population (Al-Rashidi, 1995). For example, young people suffered from fear and anxiety on a daily basis, with a number of individuals developing psychological disorders after witnessing terrible events, including disease, fear, killings and violence (Ibid.). With this in mind, a number of findings, such as those publicised by the Ministry of Education in 1991, have emphasised that cases of aggressive behaviour, suicide attempts, fatigue, fear manifestation, non-compliance with law, poor concentration and sleep disturbance, to name but a few, are all known to have increased amongst the young population of the country.

Following the end of the Gulf War and the liberation of Kuwait, there were a few studies carried out reporting the impact of war-related traumatic experiences and their resulting stress on the Kuwaiti population (e.g. Al-Ansari, 1994; Al-Saraf, 1994). However, young people were not the focus in these studies. Notably, one study carried out by Al-Turkait and Ohaeri (2008) aimed at investigating the severity of specific mental health problems, such as depression or anxiety, among the children of Kuwaiti military men. Findings derived from the study indicated that the war situation and factors such as the father's participation in the war or being held prisoner due to the war, as well as the mother's subsequent stress, could significantly affect a young person's mental health.

Examining the nature of research carried out in the field of young people's mental health in Kuwait, most of the studies have epidemiological paradigm aims, designed to measure the effectiveness of certain counselling programs in reducing cases of mental health disorders among pupils. Unfortunately, no attention was paid to investigating the role of schools or teachers in promoting pupils' mental health or provision for mental health disorders.

2.7 Mental health in the schools of Kuwait

According to the Ministry of Education (2009), the role of schools in Kuwait at the present time is no more than that of a provider of information to the learner in all fields of science and knowledge. Yet, according to the stated aims of education in Kuwait, the school has another important role, in disciplining the behaviour of pupils, whilst simultaneously providing services that facilitate the achievement of practical educational objectives in

building the personality of the pupil, achieving mental and social adjustment and limiting the negative effects of modern life on children and adolescents.

It is from this starting point that the Ministry of Education established the School Mental Health Service Department in 1981, to provide mental health care in the schools of public education and kindergartens. Mental Health counsellors were appointed, qualified both scientifically and professionally in this department, and capable of liaising with all parties in the educational process - the school, the family and society.

The terminology of 'mental health' is commonly used in this department in the Ministry of Education and within the Kuwaiti context to indicate the 'psychiatric health' term, which is used to identify those severe mental health disorders which require intensive psychiatric help (MOE, 2009). It is worth pointing out here that most of the mental health services provided in this education department take the form of counselling. Counselling is described as a process concerned with improving the overall psychological health of an individual, which thus facilitates the client in achieving their full potential through promoting development, personal growth and self-understanding, subsequently inspiring the person to implement more positive and productive behaviours (Rogers, 1961).

2.8 The historical development of counselling in Kuwaiti schools

Soliman (1993) points out that the services of counselling were not available in Kuwaiti schools until 1985, where they were temporarily installed in a few public schools in Kuwait. After 1988, those counsellors became permanent appointments in all schools in Kuwait. Those counsellors had graduated from the Faculty of Social Studies and the Department of Psychology in Kuwait University, where they received internship training courses in schools, provided for them through cooperation with the Ministry of Education. The historical development of counselling in Kuwaiti schools may be divided into three general stages, according to the events happening during each stage (during the period 1960-1987).

The first stage began in 1960, with the establishment of the first counselling service institute. Initially, the counselling service was limited to pupils suffering from mental disorders. The service was further developed when the Administration of Social Work was established. Following this, under the Department of Social Work Services, a department for mental guidance and orientation was established, to take over the provision of mental services for

pupils who were referred for diagnosis and treatment by social workers at the schools (Al-Sahel, 1989). The counselling service in this stage covered only specific cases, such as mental disorders, under-achievement, speech difficulties, emotional problems, and behavioural disorders (MOE, 2009).

In the second stage, which began in 1970, the policymakers in the Ministry of Education paid more attention to counselling services for the developmental needs of pupils. In this stage a counselling project for secondary school pupils was established. School mental services officially started in the state of Kuwait with the establishment of the first institute for educating mentally retarded pupils, in October 1960. In this stage, the need to appoint psychiatrists became urgent, in order to handle the treatment of pupils with mental health difficulties referred from schools. For the purpose of developing special methods of education for these cases, appropriate to their mental levels, an office was established for mental services, attached to the Institute for the Mentally Retarded (special institute). The mental services provided by psychiatrists during this period were sufficient to cope with the problems they faced in schools (Al-Sahel, 1989). Additionally, at this stage, Kuwait University started to develop its role in the field of counselling by making counselling courses available. As a consequence, at the end of this stage, major development came about and resulted in the creation of the Division of Psychological Counselling and Guidance, and counsellors from the Division of Supervision of Psychological Services and Education started to work in secondary schools (Ibid.).

In the third stage and with the increase of the numbers of pupils experiencing mental health problems in different educational levels, officers of the Mental Health Services became convinced of the importance of providing mental health services in schools comparable to other educational services. Hence, in 1984, the Mental Health Services started to develop and gradually to encompass all general educational levels, including kindergarten, primary and middle schools. Decision-makers in the Ministry of Education and Kuwait University became aware of the value of counselling for the development of society (Al-Sahel, 1989). One of the most important events which happened at this stage was the establishment of the School Mental Health Service Department. This department consists of the following three sections: educational psychological counselling, psychological research, and technical vocation for psychological services. The Ministry of Education defines this Mental Health Services Department as ‘a group of specialized technical efforts including the processes of giving the learner the chance to detect their capabilities and abilities and employ them for optimum

performance as a student, and providing him/ her with the atmosphere to adjust him/herself and his/her environment in a way that allows the comprehensive development of the personality on the way to achieving the stated educational targets' (MOE, 2009, p.21). The general objectives of the School Mental Health Services Department include:

1. Helping the learner to develop, grow and adjust within the school, the family and the society in general.
2. Making it possible for learners to be provided with sound emotional development, using all they have in terms of general and personal abilities, especially within their school and environment, in terms of material and human capabilities.
3. Being eager to provide guidance and orientation for learners, both professionally and educationally.
4. Facilitating the learner to achieve positive interaction with others.
5. Helping learners to solve their problems and enabling them to acquire the skills required to reach solutions by sound methods, leading to satisfaction and happiness, personally and socially.
6. Helping to care for gifted and talented pupils in order to enable them to reach high levels of performance in their field and to be appreciated by society (MOE, 2009).

The establishment of this department is a sign of the improvement of counselling in Kuwait and it has meant an increase in the number of professional counselling services. It has also meant that counsellors and psychologists are more independent of other departments in doing their own work, meaning they have the opportunity to develop themselves and their work.

In Kuwaiti schools, pupils who experience mental health problems are referred to the school counsellor, who provides those pupils with the appropriate intervention to deal with their problems. In cases with severe problems and those cases of pupils requiring intensive counselling interventions, pupils are referred to professionals and specialists in the School Mental Health Service Department within the Ministry of Education. However, in many cases, unfortunately, these pupils are in great need and receive help too late. A further referral, to the psychiatric hospital, would be made in the most severe cases.

2.9 Conclusion

This chapter has provided a detailed breakdown of the education system implemented within Kuwait and its overall structure. It has also addressed the policies concerning mental health in

Kuwait, with key attention directed towards how pupils' mental health is promoted in Kuwaiti schools. In particular, the chapter sheds light on the historical development of counselling in Kuwaiti schools, as counselling is the only fundamental method for providing mental health services in Kuwaiti schools. Furthermore, the chapter described briefly the lack of consideration of mental health education and promoting pupils' mental health in teachers' education in the academic curriculum, and the extent of training in the area of pupils' mental health offered for teachers during their studies in educational institutions and during their working career. The following chapter will highlight some perspectives in the field of promoting mental health in schools and the role of schools in this promoting process. It will also outline the problems of defining the mental health concept, with particular focus on the recent positive concept of mental health and the continuum concept of mental health, which will be followed by a review of the theoretical models for promoting mental health, the rationale for promoting young people's mental health, and a review of research literature related to the current study in terms of teachers' attitudes, their role in promoting pupils' mental health, and the various barriers that have an impact on the promoting process.

Chapter 3: Perspectives on promoting mental health and review of the literature

3.1 Introduction

This chapter reviews the literature related to the current study of teachers' perceptions and attitudes towards promoting pupils' mental health, beginning with a theoretical background highlighting a number of definitions of the concept of mental health. This is followed by a review of theoretical models of promoting mental health and their different ontological positions, leading into a discussion of different approaches to promoting mental health, focusing on the model appropriate for implementing the promotion of pupils' mental health in schools. Following a discussion of the rationale for promoting young people's mental health, the chapter concludes with a review of the literature related to teachers' attitudes and perceptions about their role as promoters of pupils' mental health, and the various factors and barriers which might undermine this promoting process.

3.2 Definition issues

3.2.1 The term 'mental health'

The concept of 'mental health' is markedly problematic to define, because the word 'mental' can be difficult to describe and is commonly accompanied by widely negative associated perceptions. Part of the problem lies in the historic use of the word' mental', as the concept is often confused with mental disorders/illnesses. Tudor (1996) argues that such confusion sets everything related to mental health under the mental illness term. He also reports that the concept of mental health has been viewed through as a medical framework, for example, mental health is defined as the absence of diagnosable mental illnesses (1996). This problem of confusion was addressed early by Wilson (2003), who brings a sense of clarity to the discussion: 'Mental health is confused with mental illnesses, and as such quickly passed over to psychiatrists and other specialists to sort out. In fact, mental health is simply what it says it is. It is about the health of the mind-that is, the way we feel, think, perceive and make sense of the world' (p.15).

Such a view sees mental health as a positive quality, and echoes the early attempt of the World Health Organisation to redefine the concept of mental health in positive terms. The WHO provided a positive definition for the 'health' concept, stating that the term relates to 'a complete state of physical, mental and social well-being and not only the absence of infirmity or disease' (WHO, 2001). This definition views mental well-being as a fundamental aspect of general overall health. A further explanation for the term 'mental health' was provided by WHO, as an 'integral component of health, through which each person realises his or her own cognitive, effective and rational capacities to cope with the stresses of normal life and work to participate effectively and productively in his or her community' (WHO, 2001, p.1).

The positive conceptualisation of the concept of mental health has been reflected in a number of other definitions of mental health that have been posited, centred on the ability of a person to adapt to change as a response to their environment and corresponding psychological and social considerations. For example, in the United Kingdom, a positive definition for 'mental health' was introduced during the 1990s, at which time the term was explained in Mosby's Dictionary of Nursing, Medicine and Allied Professions as 'an individual's state of mind dictating the ways in which a person is able to cope with and accordingly adjust to on-going stresses associated with everyday living' (Anderson & Anderson, 1995, p. 450). In UK, Health Education Authority defined the term of mental health concept as a positive sense of well-being alongside resilience - spiritually and emotionally, facilitating a person's ability to endure disappointment, pain and sadness, and enjoy life, and representing the belief of the individual in their own self-respect and importance (Health Education Authority, 1998).

More positive formulations of the cocept of mental health have been provided in, for example, in the Surgeon General's Report (2000) in the USA, which aligns mental health with the ability of an individual to successfully maintain good relationships, to cope and adapt, and to be involved in productive activities. Keyes (2002), in Canada, recognises that mental health can be described as the power of a person to understand, perceive, explain and clarify their environment, adapt to changes, and to be involved in and maintain successful social communications. In Australia, mental health may refer to the utilisation of cognitive and interpersonal skills, as well as the most advantageous development of such with the aim of attaining a number of goals in one's life (Department of Health and Aged Care, 2000). In the same vein, the positive aspects of the definition have been reflected in the field of psychology, particularly in the perspective of 'positive psychology', that holds mental health comprises more than simply not being diagnosed with mental disorders (Kitchener & Jorn,

2002). Within the Arab context, the mental health concept conforms to social and cultural values alongside religious considerations. In the Islamic and Arabic culture, good mental health is concerned with 'conformity', which includes the feelings of being satisfied and secure through creating a balance between one's psychological capability and environmental demands within the socio-cultural context 'including religious principles and cultural values (El-Islam, 2006).

In the context of young people, this positive view of understanding the concept of mental health has been reflected in the way that a mentally healthy young person is viewed, as it links their mental health with their capacity to live a full and rewarding life with confidence and sociability. Two definitions that describe mentally healthy young people in the UK include one from the Mental Health Foundation: 'The mentally healthy young person is the one who is able to develop emotionally, psychologically, spiritually, creatively, and intellectually in ways appropriate for the child's age'(p.5). The other comes from the mental health report of Local Government Information Unit and Children's Services Network (LGIU CSN, 2007), which suggests that mental health, as a term, can be described as not only being concerned with the lack of mental disorder, but a number of other fundamental considerations, including the capacity to establish and maintain relationships, acquiring adaptability to both change and the anticipations of others, the capacity to enjoy life and learn, to understand the difference between right and wrong, and to adequately manage day-to-day obstacles and problems (p. 5). Such a positive understanding of the concept of mental health suggests that young peoples' mental health needs to be understood within a resilience context rather than a pathogenic and medical perspective which assumes that mental health is the absence of mental illness. This suggests that the aim of improving young people' mental health is 'everybody's business', and not merely the job of the counsellors and mental health professionals; this is of particular relevance to those who are in direct contact with young people, such as teachers, who are the focus of the current study.

3.2.2 Mental health problems and mental illness: points on a continuum

In an attempt to gain insight into the acknowledged positive concept of mental health, it is important to understand how a 'mental health problem' or 'mental illness' is perceived and what these terms encompass. It might be supposed that mental health and mental illness are two opposing concepts, though they may also be seen as belonging to one large scale or continuum, as highlighted by Dogra *et al*. (2002). The term 'mental illness' or 'mental

disorder' is usually used within medical and clinical psychiatric institutions to refer to any diagnosed mental disorder. According to the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, individuals are diagnosed with a mental disorder or illness if symptoms depict changes in behaviour, mood or thinking, or an amalgamation of more than one (DSM-IV, 1994). Anderson and Anderson (1995, p. 450) suggest a clearer definition for mental illness: 'any disturbance of emotional stability as manifested in maladaptive behaviour and malfunctioning performance can be caused by genetic, biological, chemical, physical, psychological, or social and cultural factors'.

The term 'mental health problem' may be used to describe symptoms and signs that do not meet the stipulated standards or criteria to be classified as a mental disorder, as they are less severe and alterable and can be treated; nevertheless, it is widely acknowledged that, if left untreated, such problems can cause significant upset and stress in a person's life and might become more severe (Surgeon General Report, 2000). However, the majority of people are known to overcome mental health problems and establish coping mechanisms or ways of managing their issues, subsequently facilitating their capacity to lead normal, active lives; it is suggested that this can be achieved through support group involvement or more formal treatment options (Mental Health Foundation, 1999a).

Importantly, it is recognized that understanding mental health problems is influenced by cultural elements: Rosenhan & Seligman (1989) state that the concept of 'mental problem' can refer to a number of abnormality-related elements, including unconventionality and moral code violation, recognising that such definitions involve a number of social judgements. Similarly, Gross and McIlveen (1996) emphasise that 'bound by culture', 'ideals' and 'value judgements' are all relevant terms when related to mental health problems.

Individuals are believed to be capable of achieving improved levels of mental health if there are no clinical or diagnosable mental health issues (Keyes, 2002). However, it is also emphasised by Keyes that, if an individual is not diagnosed as having a mental health disorder, this does not guarantee that positive mental health will be reclaimed. For instance, mental health levels can be reduced if a person experiences day-to-day tension, work-related pressures or a stressful lifestyle, even if, psychologically, the individual has not reached a low enough level to be described as having a pathological mental illness. Figure 3.1 below illustrates the mental health continuum model, as introduced by Keyes (2002). It is clear from

the figure that all people can be positioned somewhere within the range on the continuum at different points in their lives.

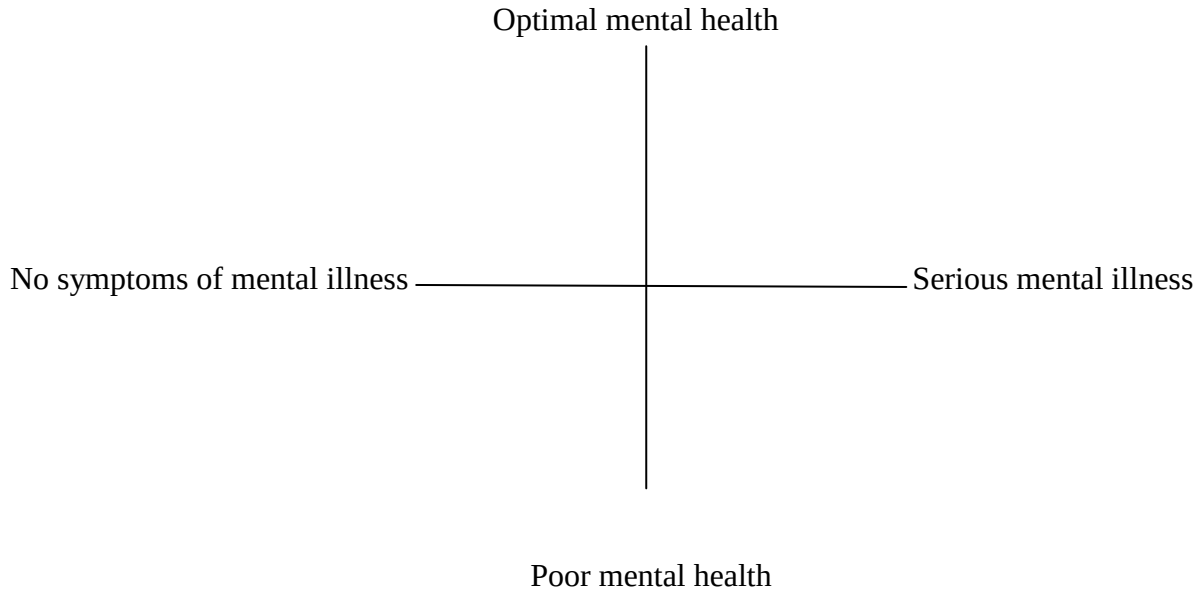


Figure 3.1 **Keyes's continuum model (2002) adapted from Health and Welfare Canada: Striking a Balance (1988)**

According to Keyes's framework, mental health could be enhanced even for those with mental illness; however, this suggests moving beyond the simple categorization of individuals as either mentally ill or mentally healthy. In many cases, symptoms associated with acute mental disorders have an episodic nature, are alterable, and are surrounded by periods of wellness or recovery (2002). In other words, in spite of being diagnosed with mental disorders, a person can experience mental well-being; on the other hand, a person may not be diagnosed with mental illnesses but may still experience poor mental health. The continuum model illustrates four possible positions (quadrants) where people can be situated regarding their mental health:

Quadrant 1: Individuals have good mental health without a diagnosed mental illness.

Quadrant 2: Individuals experience symptoms of mental disorders but still have good mental health: i.e. they have social support, they are coping, they feel empowered, and they are able to participate in social activities and maintain good relationships.

Quadrant 3: Individuals experience poor mental health and show symptoms of mental disorders: examples are people who have poor housing (or are homeless), are unemployed, or have low income and no social support.

Quadrant 4: Individuals have no symptoms of mental illness but experience poor mental health or have difficulty coping with changes in their life.

In his model, Keyes (2002) also refers to the presence of mental health as 'flourishing', a term denoting mentally healthy adults possessing a notable degree of emotional well-being, happiness and satisfaction, recognising purpose in their lives, having a sense of personal growth and evolutionary change as opposed to being victimised by life's events. On the other hand, Keyes goes on to emphasise the concept of 'languishing', used to refer to a person who does not enjoy complete mental health but also is not experiencing any mental illness. This term 'languishing' highlights the potential to improve the mental health of an individual without there being any diagnosis of mental illness (which is essentially recognised as being critical to gaining insight and understanding of the ways in which mental health promotion can be geared towards a particular individual with mental illness). Therefore, it may be emphasised that a person with poor mental health may not have any mental problems, whilst an individual with mental problems may nevertheless be mentally healthy. It may be assumed that good mental health is not only defined by a lack of mental illness, as some individuals have a better level of mental health than others, irrespective of whether or not one individual is described as being mentally ill (WHO, 2001). Thus, it is worth noting that the distinction between being well or 'normal', and experiencing mental illnesses or being 'abnormal', is not clear-cut, thus suggesting that the point at which the state changes from abnormal to normal is indefinable (Dogra *et al.* , 2002; Weare, 2000).

3.3 Young people's mental health: a key area of concern

Young people may have mental problems that can go unrecognised (Meltzer, Gatward, Goodman & Ford, 2000); often these are seen as natural and perhaps necessary struggles to adjust to new circumstances. The continuum model seems to fit here, as the key issues revolve around what happens should a young person get stuck and overwhelmed by their feelings, and be unable to function well in their life. Some young people do not always cope well with life events or deal with the strains and stresses of daily life (YoungMinds, 1996).

These young people are not ‘mentally ill’, but they do have significant ‘mental health problems’, though these problems may not match the criteria of mental disorders or mental illnesses. Most of these problems are manageable with help from friends, parents and teachers, and are quite mild, temporary and often reactive to what is going on in families and at schools (Keyes, 2002). However, if mental health problems are not recognized early, they can have significant and costly impacts on education, families, relationships in adulthood, social services, and the health care system (Paternite *et al.*, 2008). Thus, support from others becomes a necessary resource for coping with these problems (Health and Welfare Canada, 1988). This study focuses on the potential support available from teachers, who have direct contact with those young people.

The mental health of young people is a critical area for consideration, thus necessitating focus and attention from policy-makers and professionals (WHO, 2005). Much attention has been directed toward the significance of mental health amongst young people (Belfer, 2005), due to the increasing rates of mental health problems in the context of schools. In the United Kingdom, for example, there has been a rise in pupils demonstrating notable effects in terms of their mental health, with evident negative impact on their academic achievement (Rothì & Leavey, 2006), family relationships, and the capacity to establish and maintain friendships (Rutter & Smith, 1995). There is now a growing concern in the UK regarding the prevalence of mental health problems amongst this young population, with school exclusions as a result of behavioural issues becoming more common, alongside ever-growing waiting lists for professionals in this area, namely counsellors (Capey, 1997; Baxter, 2002; World Federation for Mental Health, 2003; Lines, 2002; Neil & Christensen, 2007).

It has also been highlighted that approximately 20% of all young people will face some type of mental problem, such as behavioural or emotional complications (WHO, 2001). However, only 10%–22% of such mental health issues experienced by young people who visit primary care services are recognized by social workers and other professionals in the field (WHO, 2005). Hardy (2008) also notes that up to three-quarters of all young people who need some form of mental health service are not provided with such.

Young people in middle school (aged 11-15 years old) are progressing through adolescence, during which time a pupil may experience many different instances of confusion relating to growth and biological and psychological development, in addition to pressures from a number of outside sources, namely the community, family, friends, peers, school and teachers

(Erikson, 1971). Puberty can be viewed as a fundamental factor potentially impacting on the mental health of young people, thus posing a number of significant risks for young people, for example low self-esteem, depression, eating disorders, and negative body image (Kaltiala-Heino *et al*., 2003).

A number of changes affect the way in which an individual experiences transition to adulthood, with young people and adolescents in middle school recognised as being at a fundamental stage in forming their own identity, making lifestyle choices, establishing relationships, and making various important decisions which could affect their educational achievement (Morgan, 2008). Compared to adults, young individuals are particularly vulnerable to developing mental health issues following challenges and pressures in their day-to-day lives. For example, financial concerns, limited educational or career opportunities, leaving the family home, or problems with relationships may all contribute to increased levels of stress or pressure, which can cause the emotional, intellectual and social development of young people to deteriorate and induce mental disorders among other consequences, including costs inflicted upon the healthcare system (Suhrcke, Pillas & Selai, 2007).

Additionally, it is widely recognized that mental health problems increase when pupils progress to middle schools (Mental Health Foundation, 2005). Mind (2001) in UK states that, of a middle school with 1,000 pupils, it is likely that 100 may be suffering with significant distress, 50 may be seriously depressed, 10–20 may be suffering from OCD (obsessive-compulsive disorder), whilst 1–5 females may be found to have some form of eating disorder. According to Mind (2001), additional data showed an increase of 47% in self-harming between 1982 and 2001 in UK.middle schools. It has been also noted through recorded data that suicide attempts are witnessed amongst 2%–4% of pupils, with successful suicide observed in 7.6 cases out of every 100,000 individuals aged between 15 and 19. In addition, bulimia or anorexia nervosa is found in as many as 25% of pupils in middle schools. It should however be recognised that the figures detailed refer only to those cases diagnosed and reported; thus, as well as those who have been diagnosed, there may be more individuals with unrecognised and untreated problems. It was reported by Murray and Lopez (1996) that if adequate attention is not paid to young people and their potential mental health problems, such mental health issues will be responsible for most of young people's difficulties.

Issues experienced during adolescence are likely to stem from a number of causes and not only one individual factor (Flay, 2002; Werner & Smith, 1992). It is believed that there is no

sole dominant cause of young people experiencing mental illness, but rather an amalgamation of numerous biological, environmental and psychological risk factors (Werner & Smith, 1992). Accordingly, young people's mental health problems are commonly persistent and are linked with a number of different factors, including chronic illness, childhood adversities, financial difficulties, high alcohol consumption, and a lack of social support (Dogra *et al.,* 2002). Often these problems are interconnected and can lead to difficulties in the psychosocial development of young people. If consideration is given to pupils' thoughts, feelings and behaviour, and the hormones pumping around their bodies, it is hardly surprising that middle schools experience events such as pupils fighting, feeling attraction to others, and exerting power over others, being victimised, and feeling angry and confused. Thus, the young people in the middle stage of education might be at real risk of experiencing emotional and social mental health problems and need to have their mental well-being considered.

Unfortunately, there is an apparent lack of reliable statistics in Kuwait concerning the likelihood of mental health problems among young people. In fact, there is a paucity of documented screening studies for mental problems among young people in Kuwait, and where such screening studies do occur (e.g. Al-Ansari, 1994; Al-Saraf, 1994; Al-Turkait, Ohaeri, 2008; Al-Rashidi, 1995), it is clear that they were directed towards screening a specific mental health disorder. (For examples of these studies, see Chapter Two, Section 2.6).

3.4 Promoting young people's mental health

Interest in promoting public mental health has increased owing to two key factors, as highlighted by WHO (2005). Firstly, physical health and mental health are viewed as going hand-in-hand with life quality and therefore need to be taken into account as fundamental aspects of the way in which overall health can be improved. More specifically, there is a wealth of evidence to support the positive relationship between mental and physical health and well-being with various positive outcomes, including reduced crime rates, educational achievement, the establishment and development of positive personal relationships, and work-related productivity. Additionally, it has been widely recognised that mental illnesses have increased globally, with both developing and developed countries struggling to deliver the required levels of care, and notable burdens experienced in this area, such as the costs associated with treatment. This has led to a keen interest in the potential to promote and

encourage the promotion of positive mental health alongside preventing and treating such ailments (WHO, 2001c).

The promotion of mental health means to enhance and augment the prevention of mental ill-health and promote positive mental health, which would subsequently safeguard people from problems in this area (Jenkins, 2001; Rowling, Martin & Walker, 2008; Secker & Platt, 1996). Promoting mental health directs attention towards reducing risk factors and maximizing the development of the resilience factors (Tudor, 1996; Bartley, 2006). For example, promoting mental health can be enhanced through seeking to address coping and transition skills, and further deliver a sound developmental strategy for mental health (Hodgson, Abbasi & Clarkson, 1996). Essentially, mental health promotion and its associated approaches can be described as any efforts directed towards improving attitudes and levels of knowledge and skills required to facilitate emotional and social development, personal well-being and a healthy lifestyle (Adelman & Taylor, 2006).

3.5 Theoretical conceptualizations of promoting mental health

Although there is currently no universally accepted definition of the term ‘mental health’, the way in which mental health is conceptualised has given rise to various important and essentially distinct strategies of mental health promotion, as witnessed across a number of countries and global populations. There are two perspectives: the pathogenic and the salutogenic.

3.5.1 Deficit model (pathogenic perspective)

Pathogenic theories classify health as a lack of illness, with attention directed toward that which causes individuals to become ill. Here, the overall objective is to establish and accordingly eliminate causes of illness, i.e. to heal the person and thus achieve healthiness. According to the pathogenic approach, historically, the promotion of individuals’ health is based on utilising the deficit model in identifying needs and problems and allocating professional resources in which such issues can be overcome or fixed (Morgan & Ziglio, 2006). Thus, promoting mental health based on this approach focuses on identifying risk factors in terms of disease, illness, disability, and dysfunction (Bartley *et al.*, 2007). However, according to Morgan and Ziglio (2006), there are various risks of taking a solely deficit-based model in promoting mental health. First, such an approach tends to identify individuals and communities in negative terms, regardless of what might work well; additionally, this model could result in disempowering communities such as mental

professionals, who are required to solve mental problems. An additional factor is the danger that people themselves will be blamed for their disorders and societal factors will be ignored; furthermore, the presence of risk factors may not lead automatically to negative outcomes in an individual's life, as each individual has a resilience trend and coping styles (protective factors) which could help them to recover. Bearing in mind these risks, an alternative approach to a pathogenic one to promote mental health is the salutogenic approach.

3.5.2 Asset model (salutogenic perspective)

Asset model strategies have received a great deal of attention and emphasis in the area of mental health promotion, as they consider not only those experiencing difficulties but the mental health of all the members of society (Rappaport, 1977; Tew, 2005; Morgan & Ziglio, 2006). In contrast to the deficit model, an asset-based approach adopts a salutogenic perspective, aiming to investigate and asses the origins of disease rather than curing the disease (Antonovsky, 1979).

MacDonald & O'Hara (1998) claim that the promotion of mental health work can reduce the overall prevalence and gravity of mental issues; thus, lowering costs required to treat mental illnesses. Morgan & Ziglio (2006) similarly emphasise positive competence in establishing issues and implementing solutions, which thus encourages individuals' levels of self-esteem and results in there being a lesser dependence on professional services. Masten & Reed (2005) explain that the salutogenic strategy was first adopted in studies carried out in the context of children, following the interest of numerous developmental psychologists in the 1970s in the ways in which children were seen to behave and succeed despite being recognised as facing significant risk factors. The resulting information was used to guide intervention policies and programmes promoting the overall capability of children experiencing damaging life situations.

Essentially, in terms of the worldwide awareness of mental health and its positive conceptualisation, the common view is that the awareness of the promotion of mental health and the adoption of the asset-based framework have together affected the way in which mental health has been defined with respect to young people. For instance, the Mental Health Foundation's definition of young people's mental health has been adopted by the Department for Education and Skills (2001); this definition highlights the belief that those individuals considered to be mentally healthy are able to establish and maintain good relationships,

succeed in playing and learning, progress through good psychological development, and develop good morals.

In consideration of the young population, it is stated that the essential foundation of any definition regarding mental health in this context is 'resiliency', which refers to young people's ability to cope with and recover from internal and external stresses (O'Grady & Metz, 1987). Werner & Smith (1992) indicate that adolescents should develop a sense of belongingness, thus inducing confidence by establishing affectionate relationships with adults and having a sound support system, whether this is through an educational institution, youth group or church, for example. Such protective factors help to enhance and facilitate the mental health of young people.

Luthar (1991) reported that while risk factors pull a child away from successful pathways, other protective factors can compensate and exert pressure to point a child back towards successful outcomes. He also suggests that pupils' mental health can be enhanced and that a role of support should be adopted in this area by any and all adults involved with young people. For young people in particular, resilience-related studies postulate that educational institutions deliver supportive environments wherein academic, personal and social skills can be enhanced (Davidson, 2008). The following section will address the role of schools as a protective factor in promoting pupils' positive mental health.

3.6 School as a protective factor

Recent attention has been paid in the UK to the fundamental role that educational institutions should have in terms not only of academic development but also in ensuring that mental health problems amongst young people are recognised and handled alongside the facilitation of a healthy and safe environment conducive to mental well-being (Atkinson & Hornby, 2002; MHF, 1999a; Dryfoos, 1994). Pupils' emotional and social well-being should be taken into account and prioritised (Elias *et al*., 1986; Weare, 2000; Rutter & Smith, 1995).

In the context of the UK, YoungMinds (1996) advocates the view that schools should shoulder some degree of responsibility for promoting mental health amongst young people, emphasising that schools are in a unique and valuable position to affect such individuals' mental health, a demand also advocated by Purkey & Aspy (1988). Moreover, the Department for Education and Skills (2004) also states that young people's mental health promotion is beneficial both generally and academically, making the issue central to

government policy. In addition, in 1999, the National Healthy Schools Programme was introduced as a combined proposal between the Department for Education and Employment and the Department of Health. Subsequently, in 2004, a more precise strategy was devised, comprising criteria and national themes, and was successively linked to the agenda of Every Child Matters in four different areas: emotional health and well-being with attention also to bullying; healthy eating; personal, social and health education, including focus on sex and relationships education; and physical activity (Department for education and skills, 2004).

The UK government has highlighted the valuable role played by such schools in the area of promoting mental health and provided schools with guidance to help them to maintain this role. Such guidance was first delivered to schools with the aim of aiding them in meeting pupils' needs through promoting young people's mental health (Department for Education and Employment, 2001). With this in mind, this report seeks to provide a description and rationale for why schools are considered to be in a valuable position to impact on and enhance pupils' mental health, thus facilitating the identification of problems and the delivery of solutions.

The overall value of schools in terms of their ability to promote mental health amongst such individuals has been acknowledged with schools now recognised as having a key role to play and having a notable influence on the emotional and behavioural development of young people (Wells, Barlow & Stewart-Brown, 2003; Rutter & Smith, 1995). Arguably, it is necessary that schools recognise and encourage improvement in pupil's mental health. Moreover, it is expected that educational institutions eradicate any factors which may potentially induce any mental health problems, by having a clear and firm policy on dealing with such problems. Perhaps the primarily vehicle by which schools can function as a protective force is the school climate or ethos, and the psycho-social bonding pupils feel towards the school community.

Many proposed models suggest levels of promoting mental health in schools, emphasising the role of school in recognizing mental health problems early among pupils as part of any approach to promoting pupils' mental health in school. These models also emphasise the collaborative teamwork and multi-agency mental health services models between educational staff and mental health professionals in promoting pupils' mental health. In the UK for example, CAMHS may be seen as a model that includes and contextualises all services working towards promoting young people's mental health in a multiplicity of settings (Child

and Adolescent Mental Health Services, 2008). Some of these services directly deal with young people's mental health, while other services are seen as part of a wider picture interconnected with the education context. This might support the notion that mental health needs to be 'everyone's business' and not only the work of specialists.

CAMHS provides a tiered approach for promoting young people's mental health, where different levels of mental health promotion are defined, capturing opportunities for early recognition and intervention, prevention, and specialist input. This approach includes four tiers: Tier 1 comprises front-line professionals who have little or no specialist mental health knowledge but are often the adults most commonly exposed to young people in difficulty on a daily basis. Tier 2 includes professionals who have some specialist knowledge and experience; they often work collaboratively with other services at this level but do not usually form part of an identified team. Tier 3 includes professionals who are normally working within a coordinated team based in a mental clinic or through child psychiatric outpatient services. They offer support to young people and children and their families where more severe, complex, persistent mental health problems have been identified. Tier 4 offers highly specialised interventions for young people with the most advanced, complex and persistent mental illnesses that require considerable specialist knowledge, skills, experience and resources.

Weare (2000) also offers a three–level model for promoting mental health in schools: the 'primary level', seen as the wellness level, seeking to decrease the numbers of new cases; the 'secondary level', characterised by temporary mental illness or difficulty from which the person will probably recover; and the 'tertiary level', where severe and recognisable mental illness has been diagnosed.

Similarly, the NHS Health Advisory Service (1995) suggests a four tiered approach structuring multi-agency mental health services and the arrangement of such for the promotion of pupils' mental health in schools (see Figure 3.2). The first level is perhaps the most important level which underlines schools'expected role in assuming some responsibility in identifying and recognizing pupils' mental health in schools, and referring affected pupils for appropriate support as required (Rothì, Leavey & Best, 2008).

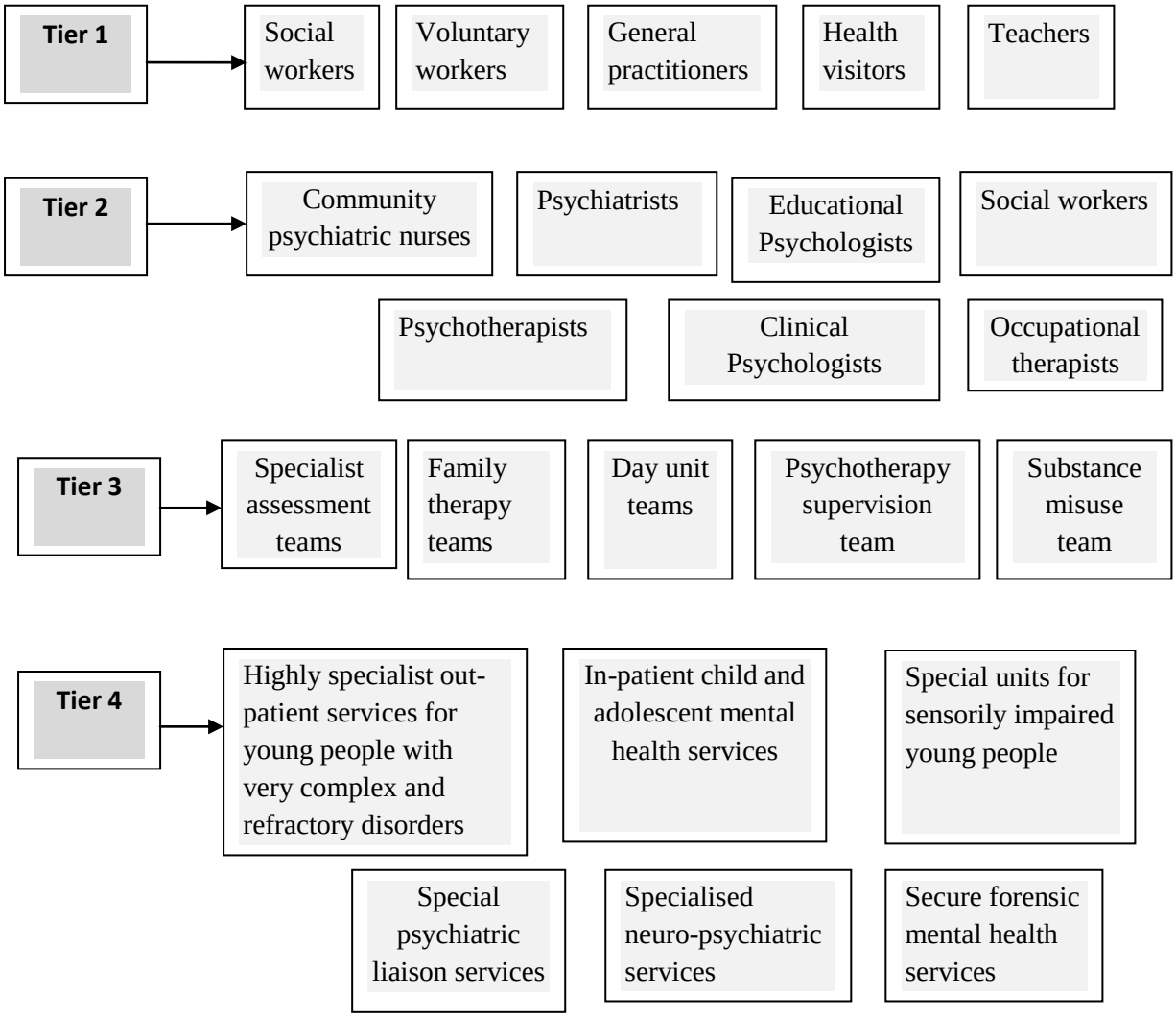


Figure 3.2 **Tiers of promoting mental health (NHS Health Advisory Service, 1995)**

The 'primary level' is associated more with school ethos, which can be described as 'the curricular and organisational features of the school which communicate certain values to the school community and thereby help promote the development of fundamental values in children' (Atkinson & Hornby, 2002). It is about the school's environment and its capacity to promote or underpin mental health among pupils. Encouraging a good school ethos requires capable good leadership and commitment from the management team; high levels of participation from, and good relations between, staff, parents and pupils; a commitment to equal opportunities; valuing diversity; and clear policies on behavioural expectations (Atkinson & Hornby, 2002; MHF, 1999; Weare, 2000).

Curricula have been proposed as another area for making possible changes to promote pupils' mental health in schools in connection with collaboration between educators and mental

health professionals. In the UK, for example, applying mental health education for pupils has been found to be effective in raising pupils' awareness and understanding of mental health issues, providing mental health information, and identifying strategies for coping with problems in order to promote young people's emotional, mental and physical well-being (Department for Children, Schools and Families, 2010). In the UK, it was found that young individuals receiving efficient and well-considered social-emotional learning and mental health programmes are more likely to demonstrate better attitudes to the learning experience, resulting in attaining higher marks in various subjects, investing greater effort into academic work, with fewer instances of absence or exclusion (Weare, 2004). Research conducted by Meldrum, Venn & Kutcher (2009) also demonstrated that the implementation of a mental health curriculum in Canadian schools subsequently facilitated the promotion of pupils' mental health and also decreased stigma around mental health issues.

One of the most significant examples in the field of mental health education internationally is the SEAL (Social and Emotional Aspects of Learning) curriculum in the UK. This curriculum aims to develop the qualities and skills which help to achieve effective learning through promoting positive behaviour in young people. SEAL includes five emotional and social areas of learning: managing feelings, empathy, self-awareness, motivation, and social skills. SEAL in middle schools aims to develop skills such as working in a group, understanding another's point of view, resolving conflict and managing worries, and sticking at things when they get difficult (Hallam, 2009; Department for Children, Schools and Families, 2010).

PATH (Promoting Alternative Thinking Strategies) is another example of educational mental health curriculum, applied in school districts in the US. It is based on the idea that skills learnt in the classroom should be generalised to children's everyday lives. The content of the PATHS curriculum consists of emotional understanding, self-control, relationships, interpersonal problem-solving skills, and positive self-esteem, and has been found to be effective in improving protective factors (social and emotional competencies and social cognitions), as well as reducing behavioural risk (depression and aggression) amongst a broad range of pupils (Kam *et al.,* 2004).

3.7 Rationale for promoting pupils' mental health in schools

There are a number of outcome rationales for promoting pupils' mental health in schools. The following section will highlight the legal, educational-psychological and social-ethical justifications.

3.7.1 The legal-legislative rationale

In the context of the UK, the Department of Health published a National Service Framework (DOH, 2004), focused on the mental and psychological well-being of children and young people, delivering the fundamental foundation of National Service Framework for Children, Young People and Maternity Service. The report suggests that, despite there being various children with mental health problems that can be diagnosed, there remain others with less significant issues but who should nevertheless be given help in order to lead improved lives.

The Fundamental Health Report of LGIU and CSN (2007) seeks to involve everybody in the promotion of young people's mental health, including holding positive views and feelings about themselves, learning confidently, overcoming problems and enjoying relationships. The report is written for one fundamental audience - those directly involved with young people and children - although it is understood that individuals and entities with an indirect influence should also take note of the report and its statements. Additionally, the report carries out a review of policy initiatives in term of legalisation within the UK, utilising this review to establish the main accountabilities of key groups in the support and promotion of mental health amongst children. These groups include children and young people themselves, the government, local authorities, parents and carers, schools, the voluntary sector and youth justice.

In the context of Kuwait, equivalent specific policy is recognised as being merely a 'piece of text'; no steps have so far been taken towards establishing people and groups who have direct contact with young people and children, nor have actions been implemented in the promotion of mental health within this population. This reflects what was generally reported by the WHO, that projects concerned with the promotion of mental health in non-industrialised countries have been built mainly on the support delivered by primary healthcare staff involved in more basic services, and that, regardless of the attempts made to validate mental health legislations, there remains a lack of documentation in this regard (Herrman, Saxena & Moodie, 2005). Accordingly, it is recognised that there is a lack of official policy concerned with promoting the mental health of children and young people in Kuwait. Nevertheless, it

should also be acknowledged that the implementation of legislation and policies is merely one step towards the ultimate objective of promoting pupils' mental health.

3.7.2 The psychological-educational rationale

In the context of the psychological-educational rationale, promoting pupils' mental health is essentially focused on young people's learning. Educational establishments are becoming increasingly concerned with mental health promotion as a result of the volume of studies being carried out in this area, which highlight the importance and significance of emotional and social well-being and mental health for effective learning (Weare, 2000). Furthermore, as highlighted by the Health Education Authority (1998), pupils are more inclined to adopt a 'can do' attitude and have higher levels of self-esteem when they have positive school experiences, with a number of studies stating that the enhancement of young people's emotional and social potential further improves their overall ability to learn and go on to achieve well academically (Greenberg *et al*., 2003). In this same vein, it is noted by Adelman and Taylor (2000) that alongside the growth of mental health problems, there are commonly obstacles in a number of different areas, such as in learning, with young people and children becoming frustrated and experiencing negative impacts associated with poor school performance and academic failure. Mental health problems are likely to go hand-in-hand with undesirable behaviours in the educational setting, increasing the chance of school exclusion following poor achievement (Rothì & Leavey, 2006). Accordingly, it can be seen that the promotion of mental health amongst young people could help to circumvent a number of detrimental situations and negative outcomes through the early recognition of such problems. Paternite *et al.*, (2008) argue that if such issues are not highlighted early enough and solutions are not provided, significant and costly effects may be witnessed, in terms of education, families, relationships and social services.

There is much support for the presence of a positive link between academic success and mental health, as well as the belief that behavioural and emotional health problems pose notable obstacles to learning (Adelman & Taylor, 1999; Waxman, Weist & Benson, 1999). Rones & Hoagwood (2000) further recommend that attention be afforded to young people's mental health issues: that 'children whose emotional, behavioural, mental or social difficulties are not addressed have a diminished capacity to learn and benefit from the school environment' (p. 236).

The implementation of a pupils' mental health promotion policy relies on the fact that a school promoting sound mental health is an ideal setting in which caring, respect and trust of one another are fostered. Positive interactions between both young people and adults are enhanced through schools' mental health promotions. Furthermore, it is also understood that, when people feel confident and have good levels of self-esteem, they are more likely to form and maintain positive relationships, which may ultimately help to establish a learning-conducive environment (Adelman & Taylor, 2000). The promotion of mental health can enable pupils to tackle any obstacles and issues whilst reinforcing and supporting relationships (Wyn *et al*., 2000).

The above discussion suggests that more attention should be paid toward pupils' mental health in the educational context, which can be justified in a number of different ways. Firstly, both young people and children spend a large portion of their time at school, and so this setting is ideal for mental health promotion. Also of chief importance is the impact felt by such individuals following the experience of mental health disorders, with such effects known to be complicated and multi-faceted, thus affecting various educational and social opportunities. Many pupils experience issues known to impact on their capacity to achieve academically and to learn, as has been highlighted by Dryfoos (1994), with pupils recognised as being more at risk when they are in middle-school education. Low educational attainment is believed to reduce employment-related opportunities later on in life (Close-Conoley & Conoley, 1991). Individuals need to be offered useful treatment for such problems; otherwise these disorders may progress and affect their entire lives (MHF, 1999).

3.7.3 The social-ethical rationale

The Convention on the Rights of the Child published by the United Nations (1998) has obligated all the governments around the world to maintain young people's mental, physical, social and spiritual needs. This convention emphasises that various rights need to be taken into consideration and assigned focus, attention and protection, ensuring safeguards from mental and physical abuse, facilitating and respecting the child's views, the right to life and the best interests of the child, and access to healthcare services, whilst also guaranteeing non-discrimination (United Nations, 1998).

Kuwait is a signatory to the United Nation Convention on the rights of children and young people, and the constitution of the State of Kuwait details the general legal framework regarding the provision of care for young people, emphasising that young people should be

cared for by the State and protected from any form of abuse, whether moral, physical or spiritual (Article 10 in Kuwait Constitution, 2012). Thus, Kuwait clearly needs to be concerned with ensuring all young people are afforded their rights in educational, health-related and social aspects. However, the promotion of mental health amongst such individuals is recognised as inadequate, with a lack of policy or planning for the promotion of mental health within the context of educational systems. Put simply, the social-ethical rationale highlights the fact that all young people and children have the right to live healthy lives at all levels. As has been suggested by Roaf & Bines (1989), one way of achieving progress and change is by adopting a strategy considering individual's rights, needs and opportunities. Together, the educational, ethical and legal arguments deliver sound support for the promotion of young people's mental health.

3.8 Overview of studies of teachers' views of pupils' mental health

In the UK, it has been argued that, while professionals are concerned with pupils with mental health problems, teachers have mostly been concerned with developing pupils' intellectual, technical, logical, and sometimes creative powers, but rarely their mental well-being (Weare, 2004). A review of the literature made by the researcher in the current study indicates that, while considerable efforts have been made to enhance mental health services in schools, little attention has been paid to exploring teachers' attitudes and perspectives towards pupils' mental health issues, and their voices in this area have gone relatively unheard. The literature review in the current study will cover studies in three areas: first, teachers' attitudes towards their role to promoting pupils' mental health; second, factors associated with teachers' attitudes towards promoting pupils' mental health; third, barriers to promoting pupils' mental health that could hinder teachers' role in promoting pupils' mental health. With regard to previous studies conducted in this area, the section will start by shedding light on issues regarding the definitions of attitudes, attitudes models and attitudes measures and will also address the rationale for employing the multi-dimensional attitudes model in the current study.

3.8.1Definitions of attitudes

The term 'attitude' is commonly used by individuals, groups and professionals to describe a psychological state prompting or influencing an individual to implement some form of action. It has been utilised in the field of social psychology for a number of years and is considered

to be of pivotal importance, with Allport (1935, p. 798) stating that, 'the concept of attitude is probably the most distinctive and indispensable concept in contemporary American social psychology', with Eagly & Chaiken (1993) further supporting this view. However, regardless of its long-term use in psychology and its history, a number of different definitions have been put forward for the concept.

With the above in mind, it is pertinent to highlight the view of Moliner & Tafani (1997), who, when analysing attitudes and their overall nature, highlight that, regardless of the range of different definitions, there remains consensus regarding three main points: firstly, that the concept depends on a process which cannot be examined directly owing to the fact that it is inherent to the individual; secondly, the attitudinal process comprises an observable aspect in terms of the response and expressed views, which can be evaluated; and thirdly, the response of an individual with regard to an entity, element or object can be examined in terms of beliefs, emotions, feelings and the data comprised thereby to establish behavioural intentions towards such. In this same vein, attitudes are described by Ajzen (2005, p. 3) as being 'a disposition to respond favourably or unfavourably to an object, person, institution or event', although the author goes on to state that the evaluative nature of an attitude is ultimately what underpins attitude and characterises such (p. 4). Furthermore, Ajzen (2005) emphasises that there is much value associated with classifying and labelling attitude-relevant responses, such as those according to feelings, cognition and behaviour, for example, which therefore suggests that attitude may be considered as one of three different types, although all types are fundamentally evaluative in nature.

3.8.2 Models of attitudes

When reviewing attempts to define attitudes, two main approaches can be seen in the literature, namely the single-component model and the three-component model (Stahlberg & Frey, 1996), each of which is discussed in greater detail below.

3.8.2.1 The single component model of attitudes

The framework of the single component model is regarded as one-dimensional, owing to the fact that it focuses solely on one component of attitude, with evaluation being dominant. The model considers the affective component of attitudes to be the only pertinent or applicable indicator regarding attitudes' evaluative nature. Overall, in the context of this particular model, 'evaluation' and 'affect' are used interchangeably in discussing attitudes. Those

advocating the use of this particular framework, such as Ajzen & Fishbein (1980), posit that the model differentiates between beliefs and behavioural intentions, with the former relating to the views held concerning objects or the knowledge, information or thoughts an individual possesses relating to such, which may be either positive or negative, whilst the latter makes reference to a tendency to a number of different attitude-related actions and the willingness to react to a particular attitude-object in a particular way.

3.8.2.2 The multi-dimensional model of attitudes (three-component model)

In contrast, the three-component model involves those elements viewed as being distinguishable responses to a particular object, as emphasised by Eagly & Chaiken (1993). Attitudes are explained as being tendencies to react to various stimuli with certain types of response, as explained by Rosenberg & Havoland (1960, p. 3). Such responses or classes of reaction are recognised as follows: affective, relating to emotions relating to like or dislike; cognitive, relating to beliefs, ideas and views; and behavioural/conative, relating to action tendencies or behavioural intentions.

The definition of attitudes put forward by Triandi *et al. (*1971) recognised these three elements: 'an attitude is an idea charged with emotion which predisposes a class of actions to a particular class of social situations' (p.2). This definition relates the overall notion of attitude to the cognitive element, the affective component, which is linked with emotion, and the tendency to action in regard to the behavioural aspect. Ajzen (2005) argues that attitude is a 'complex' and a 'multi-dimensional construct' consisting of three components, namely, emotional or affective, which represents the positive or the negative feelings about the object; a cognitive component, which comprises ideas and beliefs about it; and a conative component, relating to the tendency to behave in a particular way towards it.

This three-component framework has been further illustrated through the presentation of an exemplar by Eagly & Chaiken (1993, p. 1), who explain the term 'attitudes' as being the psychological propensity communicated through assessing a particular entity with either like or dislike. As this definition suggests, evaluation may refer to various different response assessments, whether affective, behavioural or cognitive, covert or overt. Moreover, this particular description also highlights the fact that an attitude may be established and developed in direct regard to evaluative responding, thus implying that individuals do not

have attitudes until they are recognised as being communicated in an affective, behavioural or cognitive response. The link between the three components is shown in Figure 3.3

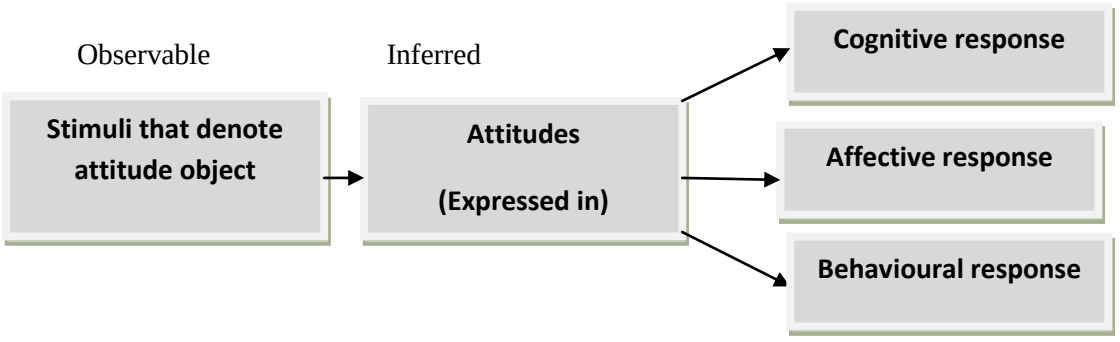


Figure 3.3 **The multi-component model of attitudes (Eagly & Chaiken, 1993)**

- **The cognitive component**

Thoughts concerning the object of the attitude are established through the cognitive component (Eagly & Chaiken, 1993; Ajzen, 2005; Stahlberg & Frey, 1996). Such thoughts are commonly theorised in the form of beliefs, which are the relations and connotations individuals establish between a number of different attributes and the object in question. Such cognitive assessment responses may include covert responses that arise when certain connections are apparent or implied in addition to the overt reactions of those beliefs verbally communicated. Eagly & Chaiken (1993) further highlight that cognitive responses are occasionally referred to by other terms, including cognitions, inferences, information, knowledge and opinions.

Overall, an individual assessing an object in a positive way is likely to provide positive attributes, whilst negative attributes may be used for negative attitudes. Importantly, the attributes linked with the object are recognised as being either favourable or unfavourable assessments, and are therefore recognised by psychologists on an evaluative continuum, ranging from extremely negative through to extremely positive, with the inclusion of a neutral position at the centre of the scale.

- **The affective component**

Within this component there is the inclusion of emotions, feelings, moods and sympathetic nervous system activity experienced by individuals in direct relation to the attitude object (Eagly & Chaiken, 1993; Ajzen, 2005; Albarracian, Johnson, Zanna & Kumkale, 2005). Importantly, in the cognitive component, i.e. the thoughts network, the attitude object is positioned centrally, with each network component recognised as comprising some degree of importance, whether positive or negative. Thus, when conducting an assessment concerning the overall value of learning, it should be noted that, without valuing their direct environment and surroundings, people cannot learn, owing to the fact that environmental aspects assigned to a particular object are undoubtedly imbued with value. Accordingly, it is stated that affective responses may be either extremely positive or extremely negative, positioned according to the dimension of meaning and its perceived value. With this in mind, it is understood that, overall, individuals possessing a positive object attitude have a greater tendency to hold some degree of positive affective reaction, whilst those with a more negative object attitude are instead likely to hold negative affective responses. For instance, some teachers have been seen to be markedly pessimistic concerning the promotion of mental health amongst pupils, whilst other teachers are more positive and optimistic in this regard.

- **The conative/behavioural component**

This particular element represents the way in which an individual reacts to the attitude object, with further consideration to the intentions to act, as articulated in overt behaviour (Eagly & Chaiken, 1993; Ajzen, 2005). Such reactions may be established through the evaluative aspect of meaning, which also runs from extremely negative to extremely positive. For instance, mental health promotion may be viewed by teachers either positively or negatively, with teachers who hold the more optimistic view facilitating and encouraging any changes necessary, whilst more negative opinion-holders will be more inclined to refuse to implement the required actions. It has been suggested that those who assess an object in a positive, constructive way are more likely to partake in supportive actions, whilst those holding more negative views will seek to hinder or obstruct such actions.

As can be seen from the breakdown of these elements, a vital consideration is that reactions are significantly complicated, and are not only attitude-based; for example, they might interconnect with the social situation and background of the relationship between people.

Undoubtedly, there is much that is attractive about the three-component framework, although it should be recognised that an attitude may be established by an individual without the presence of all three elements. In the view of Franzoi (1996), attitudes may actually be found to hold only one of the components; thus, when attitudes are being formed by a person to an object, cognitive information may play a pivotal role in establishing what is valuable; in other instances, affective data may be more relevant, particularly when the situation is especially emotion-arousing. Moreover, it should also be recognised that an individual's attitudes might be influenced by past behaviours or particular situation-relevant information. Finally, it should also be acknowledged that contrasting feelings and views may be held by a person.

3.8.3 Empirical support for the three-component model of attitudes

Various efforts have been directed towards assessing and comparing the one-dimensional and three component attitude models. According to Ajzen (2005), both models find support. The three-component framework has not received empirical support owing to the inability of factor-analytical methods to validate and explain the individual elements; it has been stated by some, e.g. McGuire (1996, cited in Stahlberg & Frey, 1996) that the three could not be conceptually differentiated owing to their being too closely linked. In contrast, however, the framework holds that, whilst the three components are correlated, this link is only moderate, which is necessary so as to ensure that the three are not completely unrelated but are distinguishable. Furthermore, other researchers note some support for the model, with Ostrom (1969) and Kothandpani (1971), for example, stating that affect, behaviour and cognition are all interwoven but nevertheless remain distinct from one another. In addition, a number of other scholars, including Dillon & Kumar (1985) and Bagozzi & Burnkraut (1985), draw similar conclusions following the analysis of the attitude structure.

Moreover, it has been highlighted by Breckler (1984) that there may be some degree of variation witnessed in attitude dimensionality in terms of the object under investigation, which is a view supported by the works of Schlegel (1975) and Schlegel & DiTecco (1982), which make clear that a single affective response may convey attitudinal structures, as has been similarly suggested by Ajzen & Fishbein (1980), in cases where there are simple beliefs relating to an object, with small numbers, and which do not contrast one another. On the other hand, however, it is held that, should there be a number of different complex beliefs which may be considered even partially contrasting; a simple assessment response will be inadequate to accurately signify the structure of the attitude in its entirety.

Throughout the course of numerous studies, those factors believed to strengthen or weaken the relationship between elements have been investigated. For instance, Fazio and Zanna (1981) propose that attitude components, namely affect and behaviour, are more likely to be significant in regard to those attitudes gained or developed through straightforward experience. Another argument, put forward by Breckler (1984), was that tests of the three-component framework are inadequate owing to their dependence on verbal response measures. With this in mind, statistical analyses may actually be considered as providing a representation of three dissimilar elements; however, the links between such factors remain significant. Moreover, it is noted by Stahlberg and Frey (1996) that, in a multi-dimensional context, attitude may depend not only on the object being investigated but also on the individual forming the view.

3.8.4 The link between attitudes and behaviour

A number of researchers have found there to be a lack of correlation between the dimensions of attitude and behaviour, with several studies instead adopting the view that attitudes are more likely to define and forecast behaviours. One of the most important studies is that of LaPiere (1934), who travelled with a Chinese couple across some of the United States, visiting hotels and restaurants. Following this endeavour, LaPiere wrote to all of the establishments the trio had visited and queried whether Chinese guests would be provided with service: despite only one establishment having refused them service during their trip, 92% responded to the letter stating that they would not serve Chinese individuals. As a result, it was concluded by LaPiere that there was a very weak link between actions and attitudes. For instance, following the conclusions of LaPiere, there was a notably cynical view of how attitudes could help to predict behaviours, which can be seen when reviewing the work of Wicker (1969), who found a number of inconsistencies between behaviour and attitude measurement, thus leading to criticism of the lack of results in the area of attitude-related studies. Ajzen & Fishbein (1980) subsequently stated that behaviours may be better predicted if there is insight into or awareness of the intentions of an individual to behave in certain ways. Ajzen & Fishbein (1980) suggested that it is thought that such behaviours can be predicted from attitudes by considering a number of attitudes toward the behaviour, such as through experience, values and behavioural intentions, and subjective norms, such as normative beliefs concerning situation-appropriate behaviours.

However, there is a disadvantage associated with this view, which is that there is no consideration of whether or not the person is able to control or affect their behaviour. This theory was subsequently amended by Ajzen (1991), who incorporated the perceived behavioural control of a person with the framework then becoming known as the Theory of Planned Behaviour. Although this theory is known to have established a number of results in terms of understanding the link between behaviours and attitudes, there has nevertheless been criticism owing to the inability of the theory to establish interconnection between behaviour and attitudes (Eiser, 1994).

3.8.5 Attitudes measures

It has become clear that attitudes cannot be directly measured owing to their construction being covert and unobservable (Stahlberg & Frey, 1996; Krosnick, Judd & Wittenbrink, 2005). A wealth of measurement tools have been adopted in an attempt to predict and calculate the attitudes of individuals, with some concerned with primarily assessing the evaluative character of an attitude (Osgood, Suci & Tannenbaum, 1975), and others more concerned with evaluating the opinions and beliefs of individuals concerning the object at hand (Likert, 1932; Thurstone, 1931). Such tools are commonly referred to as self-report measures, which question an individual on their opinions and attitudes, with the sample thus asked to provide self-descriptions.

There are three distinct methods used in attempting to create and develop a self-report attitude scale: the semantic differential approach, the Likert summated rating strategy, and Thurstone's equal-appearing interval method. In addition, the one-item rating scale may also be used to measure attitudes, although this is considered less appropriate and dependable when compared with more complex, traditional approaches (Stahlberg & Frey, 1996; Hogg & Vaughan, 2005).

With regard to attitude studies, rating scales and self-report tools have been adopted broadly with the aim of measuring direction and intensity of an attitude and views concerning the object under investigation. Such measures commonly comprise a number of questions, posed in terms of the strength of views held by an individual in relation to the object. Those questioned are able to communicate their opinions through an extremely-positive to extremely-negative evaluation continuum (Smith & Mackie, 2007). There are, however, various drawbacks associated with the use of such scales, with the Likert scale, for example,

having come under criticism for not providing equal, adequate intervals between responses; nevertheless, the tool is widely used. Krosnick, Judd & Wittenbrink (2005) argue that this rating scale is very useful despite being demanding on the participants and time-consuming Furthermore, the main drawback of such self-reporting tools is the perceived social desirability bias inherent in their use, with the sample themselves potentially providing inaccurate answers to questions or otherwise providing the answers they feel they should give, i.e. those which are socially desirable. Accordingly, during recent years, efforts have been geared towards eradicating such self-presentational biases, e.g. by disguising the study's aim (Krosnick, Judd & Wittenbrink, 2005; Ajzen, 2005).

In an attempt to circumvent the drawbacks listed above, a number of less direct approaches have been applied in the measurement of attitudes, the most common of which include psychological measures and unobtrusive behavioural observations (Stahlberg & Frey, 1996; Krosnick, Judd & Wittenbrink, 2005). However, such approaches are not as widely utilised owing to the disadvantage that there are a number of interpretation issues regarding ambiguity, as well as ethical difficulties.

3.8.6 Justifying the use of the three-component model

The multi-dimensional framework (three-component model) is to be utilised in this current study, because it is best placed to reveal the difficulty and complication associated with the promotion of mental health amongst pupils. It enables me to conduct evaluations through three different types of response, irrespective of whether these may be separated during analysis. The model is considered appropriate as it delivers an all-inclusive approach for analysing the attitudes of teachers in the area of mental health promotion amongst pupils. The views of teachers are, to some degree, based on affective, behavioural and cognitive data or on such information subsequently shaping the attitudes through intended behaviour, feelings and thoughts. Thus, the researcher hold the opinion that, although responses in the affective area may control and ultimately rule attitude when considering or acting on something, it should also be taken into account that behaviours, intentions and thoughts are also part of attitude-forming and evaluation.

In addition, it is acknowledged that studies carried out previously into the attitudes of teachers have not directed emphasis toward the complexity of such views with regard to mental health promotion; whilst attention has been placed upon the cognitive aspect, there

has been inadequate attention concerning the multi-dimensional nature of attitudes. The three-component model has been supported by the work of Schlegel (1975) and Schlegel & DiTecco (1982), who state that, if there are complicated, numerous beliefs, a simple evaluation will be inadequate in terms of demonstrating the entire attitude structure.

3.8.7 Studies of teachers' role in and attitudes towards the area of the study

When considering the amount of contact a child has with a single entity, schools are in a unique position to deliver care through their teachers. The role of the teachers in terms of the mental health of pupils has been highlighted by a number of a policy documents published in both educational and mental health fields, with teachers highlighted by the National Service Framework for Children, Young People and Maternity Services (DOH, 2004) as being assigned to 'Tier One' of CAMHS in UK. In terms of the promotion of mental health amongst pupils, without question, teachers in Canada were found to have the most direct contact and are therefore in a valuable position to recognise signs of mental health problems and accordingly make a difference (Meldrum, Venn & Kutcher, 2009). Teachers in US schools were also found to be good informants as to which pupils are most likely to need to be supported or provided with mental health services, and significant sources of the initial referral with schools (Appleton, 2000; Adelman & Taylor, 1999). Accordingly, in recognition of problems and their treatment, particularly in situations where there may be a lack of parental help-seeking, teachers have a role to play (Sayal, 2006).

In the UK, although it has also been argued strongly by many educators that it is the role of the school to educate and that pupils' mental health should be left to experienced and trained professionals, there is a recent growing view that teachers in schools are expected to be more keenly involved in the promotion of mental health amongst pupils (Rothi & Leavey, 2006). This suggests that there is a need for additional responsibility in the recognition of mental health issues to be shouldered by teaching staff, as well as the subsequent referral to the appropriate help. In this way, teachers are now expected to do more than simply educate and adhere to the national curriculum.

A review of literature indicates a paucity of studies in the field of teachers' attitudes towards promoting pupils' mental health. Early on, a study by Roeser and Midgley (1997), which aimed to explore the views of 192 teachers regarding their role in promoting their pupils'

mental health, found that teachers felt to some extent burdened by the requirement to meet pupils' mental health problems and recognise pupils' mental health. Moor *et al*. (2006) and Walter, Gouze & Lim (2006) have also found teachers lacking in self- confidence when it comes to managing mental health-related problems in their classroom, having difficulty in identifying mental problems among pupils that might require intervention, and experiencing less comfortable feelings in discussing emotional or mental health with pupils compared to any other topic related to pupils' health. It was also established through a survey carried out by Rothì, Leavey, Chamba & Best (2005) that teachers were frequently confused regarding the terms used by CAMHS, and found handling such mental issues within their class particularly problematic. Another study by Cohall *et al*. (2007) indicates that teaching staff generally seem to be accepting of the important role they play in helping young people to enhance their mental health, but nevertheless usually feel uncomfortable in encountering issues in a mental health context. These less positive feelings among teachers were recognised as being associated with teachers' concerns related to the severity of the mental problems and teachers being ill-equipped in terms of knowledge and training skills. Thus, all of these previous studies linked teachers' feelings of being less comfortable to address pupils' problems in a mental health context with teachers' inadequate training and knowledge in this area.

Results of previous studies also showed that relationships between teachers and pupils are the core step in the path towards teachers' taking part in the shared responsibility of promoting pupils' mental health. Researchers have directed a great deal of attention to gaining insight into the relationships between pupils and teachers, and the subsequent outcomes of such in regard to the child's overall school adjustment and mental health (Lynn, McKay & Atkins, 2003; Murray & Pianta, 2007). A study by Birch & Ladd (1997) explored the perceptions and attitudes of public school teachers towards their role as a promoter of mental health and well-being in the classroom and found that relationships between pupil and teachers are linked to positive behaviours demonstrated by the pupil, including academic competence, classroom participation and liking school. They also argue that opposing relationships between such parties are linked to negative behaviours, including classroom disengagement, poor academic performance, school avoidance and undesirable attitudes. Prior work in this area emphasised the significance of the relationships between pupils and their teachers, as any trust or warmth, in other words, any positive emotional attachments, in addition to positive involvement, instructional support and open interactions, would ultimately facilitate young people in terms

of improving their overall cognitive representations associated with their teacher relationships, which bear similarity to secure caregiver-child connections (Ainsworth *et al.*, 1978; Pianta, 1999; Pianta & Steinberg, 1992). For instance, it is mentioned by Reddy, Rhodes & Mulhall (2003) that, through the monitoring of various pupils' progress, it was established that those pupils experiencing the most significant decline in pupil-teacher relationships were also more likely to suffer from depression; on the other hand, those pupils who maintained good relationships and received a high level of teacher support during this same time-scale were recognised as having comparatively low levels of depression, as well as higher levels of self-esteem and confidence. Thus, it is clear that teachers play a vital role in the mental well-being of their pupils and they can provide a protective environment and enable young people to be resilient and to reach their potential. In Gallichan and Curle's (2008) study, young people described the value of positive relationships with teachers as a significant factor affecting their mental well-being. Young people in the study reported on the failure of some teachers to take their needs into account. They also reported that the judgements made of them by their teachers could result in negative reactions, such as anger and not fulfilling the expectations of others. Similarly, Lynch & Spence (2007) report that absence among teachers led young people to fall behind with school work, and ultimately to leave school.

3.8.8 Factors associated with teachers' attitudes

Studies carried out in this area showed that teachers' unfavourable perceptions of this responsibility were associated with some factors referred to as young person-related variables and teacher-related variables. These factors were found to be interrelated in many ways.

3.8.8.1 Young person-related variables

A review of the literature shows two main variables related to young people having a significant impact on teachers' views in the area of promoting pupils' mental health: the gender of the young person and the type and severity of the mental health problem. Gender has been highlighted by Gowers, Thomas & Deeley (2004) as the only aspect considered an accurate and independent forecaster of recognition of mental health problems among pupils by teachers, in that more mental health concerns were expressed for girls than boys.

Regarding the impact of the type and severity of the mental health problem on teachers' views of pupils' mental health, studies have found teachers to be good at recognising signs of young people's mental health problems, but teachers' ability to rate severity was affected by the type of symptomatology being displayed (e.g. Loades & Mastroyannopoulou, 2010; Roeser & Midgley, 1997). In addition, help-seeking by teachers is more prevalent for young people recognised as having behavioural problems than those with emotional problems (Meltzer *et al*., 2000). This may be owing to the impact and perceptibility of such problems within the classroom environment, making behaviour-related symptoms more easily recognised whilst emotional problems may not be as visible and burdensome (Farmer *et al*., 2003; Poulou & Norwich, 2000; Rothì & Leavey, 2006; MHF, 1999). The type of mental disorder is fundamental to the teacher's capacity to establish the mental health state of an individual. For instance, young people exhibiting symptoms associated with disruptive behavioural disorders were viewed by teachers as being severe and atypical and thus requiring interventions by professionals (Maniadaki, Sonuga-Barke & Kakouros, 2003). Conversely, 'internalised' mental health problems, such as anxiety and depressive symptoms, are less likely to be recognised by teachers (Loeber, Green & Lahey, 1990). In fact, teaching staff are known to prefer working with those children who illustrate obliging, supportive, thoughtful and dependable behaviours in the classroom environment, as opposed to those children who may be troublesome, insistent and problematic (Wentzel, 1991).

3.8.8.2Teacher-related variables

Teachers' years of experience were recognised as an important factor that could influence teachers' perceptions and attitudes towards promoting pupils' mental health. For example, Rabinow (1960) found that, teachers with a greater number of years' experience were more likely to hold the view that they could effectively deal with pupils' mental health needs, since such teachers would have a greater degree of knowledge in this area. Moreover, the study of Roeser & Midgley (1997) provides evidence that a teacher's years of experience and level of professional education are positively linked with the need to recognise and address mental health problems amongst pupils, thus notably affecting their roles in this regard, although a negative association was found with the view that such needs are burdensome.

In addition to the above studies, research by Lee, Dedrick & Smith (1991) established a link between teachers' sense of personal teaching effectiveness and greater job satisfaction. Midgley, Feldlaufer & Eccles (1989) suggest that teachers who consider themselves to be

more effective in their roles may not feel quite so pressured or burdened by pupils' mental health needs and that the teaching style adopted by teachers has an impact on the attitudes they develop concerning the promotion of pupils' mental health.

A number of other studies, such as those carried out by Ames (1992) and Maehr & Midgley (1996) have also provided support for a relationship between pupils' motivation and performance and the learning-oriented goals of teachers through their instructional practices. It was found that pupils display more adaptive learning patterns when teachers employ practices which highlight the importance of effort, intrinsic enjoyment of work and task mastery than when teachers make use of other practices that place emphasis on competition amongst pupils (such as through directing attention to ability-oriented objectives) and those emphasising relative capacity. Those teachers that are recognised as stressing mastery and individual growth as the overall aims of learning ultimately may be more familiar with pupils' well-being. It has been suggested that the use of task-focused instructional practices by teachers is positively linked with the views held by them that tackling mental health problems is a fundamental aspect of their own role, despite the negative aspect of feeling burdened by pupils' mental health needs (Roeser & Midgley, 1997).

The interactive and supportive practices delivered by teachers have been addressed by previous studies in relation to promoting pupils' mental health. Studies highlighted that such supportive practices, including but not limited to positive praise during teaching, are linked with a greater degree of appropriate task behaviour and pupil achievement (Nowacek, McKinney & Hallahan, 1990). Essentially, the positive impacts derived from teacher-pupil praise are a fundamental factor within the teaching environment, recognised as priming pro-academic and pro-social behaviours. In this regard, studies have emphasised that praise and increases in such are able to achieve desirable classroom behaviours, including fewer disruptions and a greater degree of task engagement (Sutherland, Wehby & Copeland, 2000).

3.9 Barriers to promoting pupils' mental health

A review of previous studies in the area of teachers' perceptions about barriers to implementing the promoting of pupils' mental health in schools indicates that a variety of barriers could undermine teachers' participation in their responsibility in the area of recognising and fostering pupils' mental health in school. A number of these barriers will be presented in the following section.

- **The lack of training, skills and knowledge**

The lack of information about mental health issues and inadequate training have been identified as two of the greatest barrier to teachers alleviating pupils' mental health problems; in a study in the US these two barriers were found to affect the degree of teachers' confidence about their ability to deal with mental health problems in their classrooms (Nelson & While, 2002; Roeser & Midgley, 1997).

In the UK context, owing to the greater degree of importance being placed on school inclusion, teachers are commonly required to handle pupils with special educational needs, including behavioural, emotional or social issues (Rothì, Leavey & Best, 2008). As well as following a curriculum which establishes differences between pupils' capacities, teachers are assigned additional tasks, and so there is the need for training so as to ensure roles are satisfied in regard to behavioural and mental health problems (Department for Education and Employment, 2001; Department for Education and Skills, 2004). However, according to Rothì, Leavey, Chamba & Best (2005) teachers are concerned about the inadequacy or otherwise complete lack of training in this area (As has been established through school inspection reports (Office for Standards in Education, 2005) in the UK, as many as 75% of teaching staff are believed to need training in the area of pupils' mental health, with other studies also recognising that pupils with BESD (behavioural, emotional, social difficulties) are at a greater risk of exclusion at school owing to teachers' incapacity to adequately handle such problems (Balton, 2002).

A study by Repie (2006), who surveyed regular and special education teachers in American secondary schools regarding their views on detecting pupils' mental health, identified the lack of knowledge and training skills as the most significant barrier to identifying and recognizing pupils' mental health. Teachers who participated in the study viewed themselves as insufficiently knowledgeable about pupils' mental health issues, leading them to underestimate the severity of mental health problems among pupils. Teachers frequently feel uneasy and ill-equipped to deal with the mental health problems of pupils, so there is the pressing need for them to undergo additional training as well as having professional support and guidance (Atkinson & Hornby, 2002). It has also been stated by the CAMHS (2008) in the UK that there is disparity in terms of what educational institutions do to encourage and promote mental health, nevertheless, the perception remains that there is an inadequate

number of confident and skilled staff able to tackle the task of the promotion of pupils' mental health.

Additionally, it was also found that, if teachers are provided with greater knowledge, support and understanding, they will then be more able to provide and maintain good levels of mental health amongst their pupils, such as through the identification of problems and referral to the appropriate sources of help (Atkinson & Hornby, 2002). Knowledge and training skills are known to improve the overall competence of teachers and the quality of their teaching, especially in consideration of the application of any underlying processes within an inclusive model (Han & Weiss, 2005). For example, Yager and O'Dea (2005) discussed the significant role of mental health education and training courses in facilitating teachers' tasks in prevention programs for eating disorders among pupils in schools. Another study by Crawford and Caltabiano (2009) investigated North Queensland teachers' knowledge about youth suicide, and showed that only 15% of high-risk situations were correctly recognized by teachers. Nevertheless, despite various plans and programmes devised to assist teaching staff in the UK (Chazan, 1993; Cooper, 1989), the main emphasis is placed on handling disruptive behaviours as opposed to examining and looking into causes of emotional or mental health issues (Bowers, 1996).

Teachers could benefit from education and training in being made aware of the negative consequences of all behaviours, not just those that disrupt the classroom. Teachers in American schools were found to believe that addressing pupils' mental health needs is part of their responsibility and they would be happy to see the implementation of in-service training regarding emotional and mental issues, as this would help them with any health-related problems in the classroom, specifically if their classes include pupils who exhibit severe mental health problems (Walter, Gouze, & Lim, 2006).

Fundamental to ensuring professional competence is the requirement to guarantee understanding and knowledge in the necessary areas so as to ensure teachers feel able and confident to communicate with pupils in a number of different ways (Goldman *et al*., 1997). A study by King, Price, Telljohann & Wahl (1999), conducted on 228 American teachers in order to explore their beliefs about their role in terms of affecting pupils' lives, revealed that teachers are capable of reducing the number of suicides and decisions pupils make in suicidal situations; however, only 9% of the target population believed they had the knowledge and skills necessary to identify pupils suffering in this regard. Such findings are not necessarily

surprising when considering the almost complete absence of teacher training among US teachers in the arena of mental health issues, as emphasised by Cohall *et al*. (2007).

- **The lack of support for teachers**

The literature indicates that promoting the mental health of pupils, as part of the overall health and well-being of their pupils, is central and can be achieved by providing a supportive environment with good learning opportunities; however, it is argued that schools should provide teachers with support in their plans (Wyn *et al*., 2000). This will help teachers to feel confident in implementing changes in their own area, and to rely on their own abilities; it will also act to support the mental health of teachers themselves (Kidger *et al.,* 2010).

An important concept to be considered in this area is the 'burnout' of teachers, highlighted by Maslach and Jackson (1981), referring to those individuals who experience feelings of depersonalisation, emotional exhaustion and/or a reduced feeling of personal achievement. Typically, teachers may experience a number of different periods of stress during their teaching careers (Burke, Greenglass & Schwarzer, 1996). Depersonalisation refers to an adverse, detached perspective towards people in general, with teachers displaying a lack of care and consideration towards pupils (Han & Weiss, 2005). The concept of emotional exhaustion refers to an individual's full and complete depletion of emotional resources, which can mean, from a teacher's perspective, that engagement with pupils is reduced (Han & Weiss, 2005). Finally, reduced feelings of personal achievement relate to the individual's negative self-evaluation in consideration of their overall job performance or life attainment (Maslach & Jackson, 1981), such as when teachers have the sense that they are not providing pupils with any advantages or gains in terms of development and skills enhancement (Ibid.).

Additionally, teachers' feelings of burnout may be related to undesirable behaviours in the classroom, in combination with the teacher's own ability to deal with such actions (Evers, Tomic & Brouwers, 2004). In their study exploring teachers' views of their role as 'tier one mental health professionals' in UK schools, Rothì *et al*. (2008) found that teachers are very concerned about any change in the nature of their responsibilities in the class room, as they feel insufficiently supported. Teachers in their study reported that mental health problems among pupils in the class room could add extra burden in term of managing the classroom, which is a factor also commonly responsible for raising teachers' stress levels, and teachers wanting to change their career path. Hastings & Brown (2002) also found that special

education teachers, who are exposed to more frequent and more severe behaviours, have been shown to be at higher risk of stress, burnout, and mental health problems. Additionally, a number of teachers have been found to lack informal support frameworks, such as those able to provide advice upon coming across mental health problems in young people, or when pupils are diagnosed as having certain problems. In fact, teachers stated that they are very rarely provided with adequate information regarding pupils' mental health problems (Gowers, Thomas & Deeley, 2004).

In the light of the above, it is argued that there is a fundamental need for mental health professionals within educational institutions to work alongside teachers to encourage and ensure positive mental health among teachers, by helping to educate teachers how to overcome any job-related stress (Lynn, McKay & Atkins, 2003; Akin-Little, Little & Delligatti, 2004). This will subsequently enable them to deliver education whilst promoting mental health (Kidger *et al*., 2010).

- **The lack of linkage between mental health professionals and teachers**

There is considerable evidence that teachers can be good informants on certain aspects of their pupils' mental health (Loeber, Green & Lahey, 1990; Sanford *et al*., 1992). Teachers also have many helpful suggestions regarding approaches to ameliorating the mental health of their pupils. For example, findings from Roeser & Midgley (1997) reported that 'too often teachers' expertise is undervalued and underutilized' (p.129). Lusterman (1985) also stated that 'teachers are rarely asked for their insights into or information about, their pupils' mental health problems, by school counsellors and psychologists' (p.30). Similarly, a study by Babcock & Pryzwansky (1983) indicated that school counsellors and psychologists see themselves as experts and therefore do not seek information from teachers.

Importantly, teachers commonly interact with pupils' parents regarding any behavioural or emotional problems (Dwyer *et al*., 2005; Shanley, Reid & Evans, 2007). With regard to mental health, the role of teachers has been emphasised through various policy documents, both within educational and health-related sectors. Appleton (2000, cited in Rothì *et al.* 2005), reported that teachers are increasingly becoming recognised as key sources of referral to mental health counsellors, thereby adopting a position of the first point of contact in regard to pupils' mental health problems. For instance, in the UK, the National Service Framework for Children, Young People and Maternity Services (DOH, 2004) sees teachers as being in

the first tier of CAMHS. The 'tiered' approach offers a model to identify the styles and levels of specialism involved in offering a comprehensive and coordinated service for children and young people. The Mental Health Foundation (1999) reported that this model provides a useful way of conceptualising and planning for the whole range of promotional, preventive, early intervention, and specialist services regarding children and young people's mental health. Such a tiered approach comprises those who are engaged in young people's lives, such as parents, carers, relatives, friends, teachers and neighbours. Accordingly, if there is a lack of parental help-seeking, teachers' awareness is then fundamental in ensuring problems are addressed (Sayal, 2006). Thus, it needs to be recognised that teachers are professionals closely involved with children on a day-to-day basis, but ultimately lacking adequate knowledge, understanding, awareness and training in mental health. In order to ensure problem identification and assistance, this short-coming needs to be addressed.

It was suggested by Paternite and Johnston (2005) that the application of the multiagency models of mental health promotion in schools provides the prospect of forming collaborative relationships between the educators and mental health professionals, with the aim of establishing interdisciplinary teams concerned with devoting more attention to the promotion of mental health.

- **The lack of co-operation between teachers and parents**

Stanger and Lewis (1993, cited in Loades & Mastroyannopoulou, 2010), recognised that whilst adults may experience mental health issues and seek help, it is not common for young people to seek professional help; rather, it is more common that their parents will initiate such actions. Although parents are usually able to identify and acknowledge their children's mental health problems, actions from parents may not be taken to deal with it. This lack of actions might rationalise with by number of different factors, including inadequate understanding, a lack of information, poor access to health services and sources of help, or even parental problems (Rothì & Leavey, 2006). Furthermore, as indicated by Zwaanswijk *et al*. (2003), culture and religion can be factors in this outcome.

Given that teachers are seen to have a critical part to play in terms of recognising mental disorders and facilitating treatment, particularly in instances where parental help-seeking may be lacking (Sayal, 2006), parents should be encouraged to become involved through teachers implementing support groups, applying the shared vision of assisting young people and

children in dealing with mental health issues, which could be achieved by delivering the appropriate information and seeking to develop healthy minds (Keyes, 2002).

Parents' decision-making may be an obstacle in the delivery of school-based mental health services reaching young people. A number of studies carried out in the US and Canada (e.g. Pottick, Lerman & Micchelli, 1992 and Cohen *et al*., 1991, as cited in Rothì *et al.* 2005) have suggested that upon facing mental health problems with their children, parents may choose to seek help and advice from teachers as opposed to more formal experts; on the other hand, when formal services are utilised, it is recognised that external mental health services are approached less commonly than school-based services in combination with medical personnel (Barker & Adelman, 1994).

The effects of the family on the mental well-being of the young person have been highlighted through various studies. For instance, Rones and Hoagwood (2000, cited in Rothì *et al.* 2005) reviewed and analysed 47 different studies of the effects of school-based initiatives in relation to the behavioural and emotional problems of pupils, and they found that intervention success was markedly influenced by the levels of cooperation between parents and teachers. Thus, it is clear that there are a number of additional facilitators who can help to achieve good outcomes with regard to pupils' mental health, including good relationships with and involvement from parents of pupils and teachers, as well as the inclination and preparedness to share data concerning the history of the child, along with any stressful or upsetting circumstances known to arise during the course of their lives.

- ## Institutional barriers

A number of different elements linked with the structure of the school can impact on the views and attitudes of teachers regarding the mental health concerns of pupils, namely class size, lack of time and funding (Nelson & While, 2002).

Research suggests that large class size might be associated with greater feelings of burden by teachers regarding the mental health needs of their pupils (Rothì & Leavey, 2006; Lee, Dedrick, & Smith, 1991). Research also revealed that in classrooms where teachers felt more burdened by the needs of their pupils, the pupils themselves, on average, would report greater levels of distress and lower levels of psychological well-being and academic adjustment (Roeser & Midgley, 1997). The findings also revealed that teachers were found to be less burdened in schools that had programs in place to address pupils' mental health needs.

Moreover, literature has shown that children who demonstrate disruptive behaviours may have a negative impact on the academic and social environment of other pupils. Accordingly, in classroom environments where there is disruption of lessons by pupils, there is a negative impact on learning and teaching (Lewis, 2001), such as when the teacher needs to invest time in dealing with disruptive behaviour. For example, if a teacher was to spend 10 minutes of each academic class period each day handling such behaviours, this would result in more than 60 hours' teaching time being lost in any 9-week period, or 240 hours each academic year (Paternite, 2004). Such a hypothetical example could be representative of the reality, in the sense that behavioural and emotional needs occupy more than 10 minutes of the teacher's time during each class period (Burke, 2002).

Funding is a major barrier to teachers' involvement in enhancing pupils' mental health (Rothì *et al.*, 2008). Although one school may source external funding or otherwise use its budget to employ learning mentors or additional teaching staff in an effort to further support pupils within the classroom environment, another school may instead choose to hire a trained mental health professional, such as a counsellor, or to otherwise provide current staff with additional training (Ibid.) Owing to the fact that, in the past, schools have not been specifically concerned with the mental health of their pupils and teachers, it can be understood why there may be a lack of inclination amongst schools to seek help for problematic pupils. Essentially, this could be owing to schools being over-worked, as emphasised by Marland (2001), as opposed to a lack of care for pupils in other areas, such as mental health.

- **Religious beliefs**

The overall understanding of the public of mental health is markedly influenced by spiritual and religious considerations (Haque, 2005). In parts of India, for example, mental illnesses are seen as a punishment or curse from God as a result of either evil spirit manifestations or past life sins (Mukalel & Jacobs, 2005). In the case of Arab-Islamic countries, spiritual causes are commonly held responsible for mental health problems, with the neglect of religious duties, for example, cited as one of the key reasons for such ailments (El-Islam, 2006). With such beliefs and considerations taken into account, it is therefore important to understand the ways in which the Kuwaiti population consider and perceive mental health; thus, as the country is chiefly Muslim, it is imperative that the Islamic concept of mental health is acknowledged and appreciated. For example, questions about how religion impacts

on mental health perceptions, how mental health is perceived by Muslims and how mental health can be promoted within this specific socio-cultural environment, have to be answered.

Although the Muslim community may ultimately derive from a number of different ethnic and national backgrounds, Muslims are guided by two religious texts (*Sunnah* and *Qur'an)*.in how mental health problems should be handled. The concept of mental health is rooted in the Islamic view that describes individuals as having two main components: body and soul. Whilst the former is fragile and will ultimately perish, the soul is believed to be eternal, with the body essentially only providing transport for the soul (Q38:71–72)[1]. Thus, the soul governs and dictates the behaviours performed by the body, and will be held accountable for any such actions following the death of the physical body. In this regard, it is believed that the soul has three different levels: the '*ruh'* (spirit), the '*qalb'* (heart), and the '*aql'* (intellect), all of which must have their purity, and which must be guided by and seen to conform to the stipulations cited in the *Qur'an*. Interaction and balance between the three main components of the soul will guide you to a happy life (Haque, 2005).

In Islam, good mental health is associated with happiness. This happiness could be achieved both in the current world and the hereafter. It is relevant to stress that, in Islam, people are recognised as simply microcosms within a vast universe, meaning that, alongside the cosmos adhering to God's prescribed nature, people must also adhere to divine injunctions or otherwise be punished. Essentially, if a person is seen to submit to God's will, life conflicts will not be experienced or individuals will be given the moral and psychological tools to deal with challenges (Al-Issa, 2000).

Mental health is considered by Islam as comprising the presence of virtues with the potential to establish well-being as well as the absence of pathology. There is a clear belief detailed within the *Qur'an* that mental health is preserved through virtue. Virtues may be recognised as either external or internal: the former may be considered as the satisfaction of divine commandments, for example, being good to others, following Islamic rules (attire, cleanliness, eating, relationships and worship). On the other hand, internal virtues may stem from analysis of the Qur'anic disclosures, and may concern the desire to improve oneself and gain knowledge. External and internal virtues are recognised as being complementary, with

[1] Quotations in this format indicate a verse from the Qur'an. The numbers between parentheses indicate the location of the verse in the Qur'an. The first number is that of the chapter, and the second number refers to the location of the verse within the chapter.

both needing to be fulfilled in order to achieve happiness and sound mental health (Ali, 1996).

It can be seen that there are numerous considerations and impacts in terms of dealing with and encouraging mental health, stemming from Islamic ways. The focus is directed upon the creation and establishment of positive qualities, ensuring that negative ones are circumvented so as to ensure positive mental health. It has been stated in the *Qur'an* that three factors are fundamental in acquiring a good state of mental health, namely faith, patience and repentance. Faith in God can be encouraged and improved by developing God-consciousness and praying, which will help to provide the individual with protection and security, as well as reluctance to commit any wrongs; the development of patience is recognised as being a reliable and lasting cure for many different ailments, whilst repentance requires that forgiveness is sought from God should any rules broken, thus resulting in self-integration and the relief of psychological turmoil (Haque, 1998). In addition, there are a number of Prophet-given injunctions to overcome anger, which may include leaving the area that arouses a person's anger, making ablution, sitting down or lying down or taking a few sips of water. All of these considerations and more can help to achieve unity with God and peace and happiness, physically and mentally.

In Kuwait, it seems that these religious cognitive frameworks have a significant impact on the way that people perceive the concept of mental health. For example, beliefs about temptation by the devil may be seen as reason for 'schizophrenic delusions', 'obsession ruminations', worries and morbid fears (Al-Ansari *et al.,* 1989). Religious healing is encouraged instead of seeking psychiatric or counselling help. People also believe that there are cognitive schemas giving after-life rewards to those who suffer mental problems and only the sacrilegious could give up the hope of relief by God (El-Islam, 2006). Therefore, faith reinforcement rituals may be recommended for those people experiencing mental health problems.

- **Socio-cultural beliefs**

In some Asian Muslim countries, many individuals hold the belief that mental health problems and their symptoms are attributable to a person losing their soul, thus resulting in confusion and physical weakness. In others, it is believed that such problems are due to the presence of 'wind' in the stomach, with delusions and hallucinations resulting from the effects on blood vessels and nerves. Furthermore, in other cultures, mental health problems

are commonly assigned a label of physical illness in an attempt to avoid the stigma of mental health disorders (Reiko, 2008). For instance, considering one of the fundamental principles of Chinese medicine—that the mental and spiritual processes and the physical body are maintained and regulated through air circulation—it is believed that excessive, unbalanced or undisciplined airs are predominantly responsible for any type of illness, mental or physical. Accordingly, it is believed that a loss of good mental health is attributable to abnormal emotions impacting on air function, thus resulting in blockages or shortages of breath (Haque, 2005).

In Kuwait, many people believe that talking about mental health issues and seeking counselling are related to new Western ideology and less accepted by Kuwaiti people due to its conflict with traditional values and beliefs (Al-Thakeb, 1985). Seeking help with mental health problems is inconsistent with Islamic and Kuwaiti traditions and will often result in resistance. For example, many people believe that mental health problems might be seen as the effect of an 'evil eye' or 'evil spirit' on an individual rather than being understood as mental health problems. Additionally, people believe that the traditional healer, known as 'Shiekh' or 'Mottawaa', is the only one able to drive the 'evil eye' away (Sayed, 2003). The healer treats people who suffer from mental health problems by reciting some ritual words, giving them 'blessed water' to drink and use of incense. Ghubash and Eapen (2009) reported that some cultural beliefs affect peoples' understanding of mental health problems in the Arabian Gulf. They found that the majority of the depressed women who participated in the study did not recognize their depression as a mental health problem but rather considered it a result of 'evil eye' or 'Jinn touch'. These beliefs in turn could be reflected in the way people conceptualise promoting pupils' mental health in Kuwait schools, considering the impact of these beliefs on, for example, teachers and parents.

- ## Stigma towards mental health

A definition of 'stigma' has customarily included discrimination, labelling, separating, status loss and stereotyping in terms of power imbalances (Link & Phelan, 1996). Stigma is also recognised as being a form of disgrace and shame impacting on the ways in which individuals consider someone and how that person considers themselves (Smith, 2002). Essentially, the term 'stigma' is used in relation to discriminating attitudes and negative behaviours towards those suffering from mental health issues.

There are many different stereotypes and stigmas attached to mental health, such as the view that individuals with mental health concerns are dangerous, flawed, socially incompetent or weak, or a combination thereof (Wahl, 1995; 2003). It is recognised that there is a lack of research considering the nature and impacts of stigma in the context of young people experiencing emotional or behavioural issues and those receiving healthcare (Kataoka, Zhang & Wells, 2002). Chandra & Minkovitz (2007) recently carried out a study in USA investigating the link between the attitudes of young people to mental health services and their overall inclination to make use of such services. The results showed that, although pupils stated that peers and parents were both able to affect their views on the utilisation of such services, they were concerned about the reactions they would receive from school staff. Furthermore, another study carried out amongst UK medical students established a link between students' avoidance of mental healthcare and the stigmas they perceived in terms of mental health issues, with the view commonly held that mental health problems were frequently seen as signs of weakness (Chew-Graham *et al*., 2003).

The stigma has its effect on young people's seeking help. Bailey (1999) found that the fears of stigmatisation could affect the early interventions to prevent mental health illness among young people. Importantly, in the classroom setting, stigma linked with mental illness can impact on the way in which pupils suffering with such illnesses are treated by their teachers and peers (Corrigan & Kleinlein, 2005). Meldrum, Venn & Kutcher (2009) suggest that schools need to adopt anti-stigma activities and programs as a significant part of school policy and ethos, with the researchers arguing that school-based anti-stigma actions provide the potential to develop understanding of mental illness and to accordingly enhance the views of people dealing with such ailments. Furthermore, it is acknowledged that such activities are able to affect individuals on all social levels, whether parents, administrators, teachers or community members, in addition to the students themselves.

The impact of stigma derived from culture, society, friends, family or media can be seen not only on pupils, but also on parents in hiding their children's mental problems. In a number of Arab and Muslim countries, many young people are excluded from school due to the fear of stigma and families' feeling of shame that their children suffer from mental problems, or their fear that their children might be physically abused (El-Islam *et al.*, 2000). They may keep them isolated from the community or locked up, limiting the possibilities for teachers to promote pupils' mental health.

Additionally, despite the fact that mental health services are offered for young people in outpatient clinics in all five regional hospitals in Kuwait, the majority of pupils' parents seek mental health services from private agencies. This behaviour may relate to stigmatization issues and fears of information about mental health problems being added to their civil record, resulting in limited options to complete studies and less chance of getting a job. Thus, this impact could be reflected on teachers' and parents attitudes towards promoting pupils' mental health in the schools of Kuwait.

- **Changes in family structure and roles**

In Kuwait, the discovery of oil has had an impact on family structure, and subsequently on the way people deal with and promote their mental health. In Kuwaiti society, family plays a vital support role in individuals' decision-making as it is the most significant source of psychological and emotional support for its members and has a significant role in running people's affairs, e.g. arranging marriages, business and property management, decisions on taking professional advice. After the discovery of oil, nuclear families became more common than traditional extended families. This change may have brought about a variety of mental problems among people, as individuals who live in extended families have fewer mental problems than in nuclear families (El-Islam *et al.,* 1983; 2006). The extended family used to play a vital role in promoting the positive mental health of its members through communication and strong relationships between its members; supporting people with their mental health leading to the early recognition of signs of problems (Al-Rowaie, 2001). However, traditional views and structures also have the capacity to negatively impact on mental health and its promotion. For example, some beliefs emphasise that problems or issues should not be discussed outside of the family owing to a fear of labelling or stigma (Al-Rowaie, 2001).

There is also the fact that Arab culture maintains a degree of gender discrimination, which means that, as well as living in vastly different social worlds on account of their sex, an individual's position in terms of mental health and its treatment may also differ. Women are required to be silent concerning different issues, such as discrimination and domestic violence. This may also be combined with the fact that, in such cultures, women are mainly escorted by family members outside of the house, with outdoor socialisation usually limited only to males (El-Islam, 1994). As a result, it may be difficult for females to disclose or

discuss their emotions or problems they may be experiencing mentally owing to there being little opportunity to do so.

As an additional consideration, Kuwait's vastly increased wealth has led to a number of changes (Khalaf & Hammoud, 1983) in terms of the way in which people now handle transactions and the values they hold; such shifts are recognised as being responsible for the increase in mental health problems amongst young people in the country (El-Islam *et al*., 2000), with such individuals considered less able to adapt to change. It has also been acknowledged that the role of women in modern-day Kuwait has impacted on mental health provision, with their conventional role of a wife and a mother having changed as a result of such socio-economic changes, thus inducing mental health problems (El-Islam, 1994).

- ## The impact of media

Amongst the media, mental health issues have been hot topics, with fear, shame and punishment commonly associated with those suffering with mental health problems, and an apparent link emphasised between those suffering in this regard and crime, danger, evil and violence (Rose, 1998). Those with mental health problems are commonly portrayed in the media as being like a bomb ready to explode (Smart & Wenger, 1999). With such views taken into account, it can be seen that the mass media are a powerful influence on the views of the public, with a large portion of negative attitudes in this area commonly recognised as being associated with those displayed through various forms of media (Wahl, 1995: 2003; Edney, 2004). According to Smith (2002), despite there being much media interest in mental health and psychology areas, providing the opportunity to communicate a non-stigmatised view, the overall effect has been disappointing, with the media serving only to increase negative views concerning mental health.

Undoubtedly, the link between mental illness in the media and public understanding of it is complicated, with McKeown & Clancy (1995, cited in Cutcliffe & Hannigan, 2001) noting that the relationship is circular, since negative images in the media cause negative attitudes, and media coverage subsequently feeds off negative public perceptions. In the mass media, mental illness is generally viewed as being dangerous and deviant, and is further commonly pinpointed as an individual's main characteristic. To facilitate change, it is argued that precise and exact stories and messages concerning mental illness must be publicised (Hiday *et al*., 1999).

In Arab countries, those with mental health problems have been assigned a number of negative images and stereotypes, including being malodorous, having poor hygiene, not dressing well, displaying disorientated movements, having an absent, haunted look, and foaming at the mouth. In addition, mentally ill individuals are commonly viewed as a source of humour or as providing rich material for drama (Al-Maleh, 2009). Al-Maleh also added that these false representations of mental health issues can be seen as the main reasons behind the negative views held and stigmas assigned to sufferers, which explains why such individuals hide their mental problems and continue to suffer without expressing how they feel or seeking help. In his view, this can lead to a number of other problems, including low levels of self-esteem and confidence, hiding away from family, friends and society in general, and subsequently becoming an outcast. Nevertheless, the media continue to provide the public with incorrect and detrimental images of people with mental illness, with such individuals commonly labelled as unpredictable, dangerous and needing to be confined. This, in turn, might be reflected in the existence of fears among teachers' regarding pupils with mental health problems in their classroom, thereby influencing teachers' attitudes and perceptions about promoting pupil's mental health.

3.10 Reflection on the chapter

There is growing global awareness of the shift from defining mental health in narrow quasi-medical terms as the absence of a diagnosable problem, to a positive concept supported through promotion of social and emotional development and prevention from mental health illness. This positive concept could also be understood further through the continuum concept, where the degree of a person's mental health quality is situated on a scale. For young people, this continuum term is more associated with resiliency, a term which describes how young people have (to varying degrees) the ability to resist negative effects of mental stresses that do not match the accepted criteria for mental disorder. Resilience can especially be promoted if young people receive appropriate support at the right time, including early recognition of mental health problems.

In this chapter, a review of the theoretical models of promoting mental health indicated that the 'salutogenic model' is more suitable than the deficit model for promoting pupils' mental health in schools. In relation to young people, the model reflects their capacity for development, learning achievement and well-being by considering young peoples' strengths

and resilience and assessing their deficits and problems, avoiding labelling with problematic behaviour or mental health problems and understanding the factors impacting on a young person's mental health.

This review of the literature sheds light on the significant role of schools in promoting pupils' mental health. Schools are in a unique position to integrate the essential protective factors shown to contribute to mental health development by reorienting their systems, including ethos, culture, policy, curriculum and school environment. Additionally in this chapter, the social-ethical, legal-legislative and psychological-educational rationales for promoting pupils' mental health were highlighted.

Results from previous studies showed the lack of research carried out in the area of teachers' attitudes towards promoting their pupils' mental health. Also, the majority of the studies referred to have adopted conventional quantitative approaches in order to establish the degree to which individuals reject or accept the overall concept of pupils' mental health promotion and positive mental health. Such approaches do not seek to investigate the intricacies surrounding mental health concepts, related attitudes, or the promotion of mental health, and direct less emphasis towards the role adopted by contextual and social elements potentially impacting on attitudes by emphasising particular norms and values.

The literature indicated that teachers show a willingness to accept the promotion of pupils' mental health; however, many of them showed negative attitudes toward the additional responsibility, associated with a variety of barriers. Various of these barriers were highlighted by the literature such as teacher-related variables, young person-related variables, teachers' lack of knowledge and training skills, teachers' need to be supported, the lack of cooperation between teachers and mental health professionals, and between teachers and parents, institutional barriers, social-cultural beliefs, religious beliefs, stigma towards mental issues, changes in family structure and roles, and the media.

Additionally, the literature suggests that there is a difference between the attitudes of teachers in different countries as well as within countries. This may be the result of different stages of development in terms of educational systems, as well as the cultural context. Both contextual and cultural aspects may be important in the shaping of teachers' attitudes and overall understanding concerning the promotion of mental health amongst pupils. With this in mind, it is considered that investigating this phenomenon could prove to be valuable in developing

both theory and practice, particularly in the case of Kuwait, owing to the fact that the literature has mainly neglected to consider the role of contextual factors in learning and teaching processes.

Socio-cultural theory has changed the focus of the promotion of mental health. The focus of the socio-cultural approach on the relationship between an environment and the individual suggests that meaning is created and developed through connections, communications and transactions between people, culture, symbols and the environment (Rogoff, 2003; 1998). With this in mind, the attitudes and understanding of the promotion of pupils' mental health, as held by teachers, should not be considered in any context other than that within which they arise.

Owing to the fact that the school culture and social context together establish an environment playing a key role in the changing and shifting of teachers' attitudes, it is therefore stated that the intricacies involved in promoting all relevant areas, namely mental health issues, teachers' attitudes and beliefs, and pupils' mental health, should be investigated and analysed through a model concerned with gaining insight into the impacts of culture and context. Accordingly, throughout the course of this research, the exploration of such themes will be carried out in direct relation to investigating the attitudes of teachers. Nevertheless, it should be noted that the study will begin by using a more conventional framework for understanding the attitudes of teachers toward the promotion of pupils' mental health, by adopting both quantitative and qualitative research approaches. Subsequently, as the implementation of the research journey develops, social-interpretative lenses will be applied in an attempt to understand the complicated nature of the issues at hand. The research, in its entirety, will change focus in an attempt to gain understanding of the more complicated issues within the socio-cultural approach. The following chapter is dedicated to considering and discussing the methodological framework.

Chapter 4: Methodology and Research Design

4.1 Introduction

This chapter presents the methodological concerns that guided the research framework of the current study. It starts with a brief description of the research paradigm. This is followed by a presentation of the ontological, epistemological and methodological assumptions and justifications of the research approach. Additionally, a description of the two phases of the study (quantitative-qualitative), data collection methods, sampling and analytic approaches are discussed. Then, the reliability, validity and trustworthiness of the study are evaluated. Finally, the chapter concludes with a consideration of a number of ethical issues.

4.2 Research paradigm

The term paradigm stems originally from 'paradigema', a Greek word meaning 'pattern'. Kuhn (1970, cited in Bryman, 1988a) defined paradigm as "an integrated cluster of substantive beliefs, variables and problems attached with corresponding methodological approaches and tools..." (p.4). Paradigm constitutes a standpoint for considering the world, understanding and deciphering what is witnessed, and subsequently establishing which of the observed phenomena are real and valid, to the degree that their documentation is justified (Rubin & Rubin, 2005). The term is considered as the 'world view' that researchers bring to their inquiry and that guides their research action (Guba & Lincoln, 1994). Therefore, how researchers view the world is intimately related to the paradigmatic perspective they adopt.

In the context of behavioural and social sciences, paradigms have commonly been assigned to two traditional groups. A positivist/quantitative paradigm seeks to establish generalisations or scientific laws to explain the phenomenon under investigation, and accordingly focuses on the measurement, reliability, replicability, and transparency of producers (Ernest, 1994). The other paradigm is known as the constructivist/interpretive/qualitative paradigm, and seeks knowledge by interpreting the phenomena of the world and trying to capture shared meanings from the point of view of the people who live and experience the situation under scrutiny (Creswell & Plano Clark, 2007).

There is considerable argument regarding the distinctions between the positions of the two paradigms. 'Paradigm Wars', a term used by Tashakkori & Teddlie (1998) in reference to

debate in this area, were instigated when the overall supremacy of the mono-method was challenged in the 1960s subsequently resulting in the introduction of a combination of approaches. Later on, in the 1990s, a mixed-model approach was recognised. The 'mixed-methodological research' approach combines both qualitative and quantitative aspects, so that design, collection and analysis data encompass both characteristics (Creswell, 2003). During this time of debate, there was a lack of consensus concerning the link between methodologies and paradigms, as highlighted by Tashakkori & Teddlie (2003).

A mixed-methodological represents an approach employs element of both paradigms. According to Tashakkori & Teddlie (1998), it was through the development and progression of the argument concerning paradigms and the link to studies that the positivist philosophy was first questioned, and was accordingly replaced by a constructivism, linked with social reality and its constructed nature. This period of conflict was referred to as the 'mono-method era', and highlighted researchers' application of a solely qualitative or quantitative design method with the utilisation of one of several approaches stemming from either qualitative or quantitative approaches, reflecting the main paradigm beliefs (either constructivist or positivist).

Creswell (2003) highlights a significant link between the design method and the overall paradigm position. A quantitative approach suggests the holding of positivist paradigm beliefs, while a qualitative methodology suggests beliefs related to the constructivist paradigm. A number of methodologists (e.g. Seale, 1999; Ritchie & Lewis, 2003; Tashakkori & Teddlie, 2003; Johnson & Onwuegbuzie, 2004; Creswell, 2009) have supported the expansion of a mixed-methodological strategy, through which qualitative and quantitative frameworks are combined in relation to a pragmatic approach.

Creswell (2009) argues that such a strategy has become more widely accepted and employed in the social sciences. Furthermore, Creswell highlights a number of reasons for this, including the growth, improvement and perceived legitimacy of this study approach, which develops and evolves continuously, and the view that the mixed-methodology may constitute a development in methodology, insofar as it makes use of the advantages and benefits associated with both qualitative and quantitative methods. Creswell also notes that social studies are predominantly concerned with addressing complicated issues, and so the use of a qualitative or quantitative methodology on its own may not be considered adequate. Dependence on a single research approach could be risky as it provides researchers with an

inadequate view of human behaviour and experiences (Creswell, 2003; Cohen, Manion & Morrison, 2007).

The mixed-methodological research approach has been described as one that seeks to amalgamate quantitative and qualitative strategies, directed toward gathering and analysing such data during the course of a single or multi-phase research (Tashakkori & Teddlie 1998; Creswell, 2003). It has been highlighted by Tashakkori & Teddlie (2003) that when considering mixed-model research, there are three key areas to be taken into account. Firstly, it has the capacity to provide answers to research questions that cannot be facilitated through other approaches. Essentially, the mixed-methodological research approach can provide answers to both exploratory and confirmatory questions. Secondly, this approach is able to provide stronger suggestions and conclusions through delivery of rich, in-depth answers to complicated social phenomena. Thirdly, such an approach also delivers the chance to express a number of different perspectives through varying results. With such advantages in mind, it is argued by Tashakkori & Teddlie (1998) and Creswell (2003) that the approach helps to overcome and provide clarification of the opposing and contradictory views of the positivist (quantitative)/interpretivist (qualitative) paradigm debate, and is recognised as being compatible with a pragmatic paradigm — as well as being important in terms of undertaking a real life research. Such a mixed-methodological approach in a single study yields more robust understanding and interpretation of holistic perspectives of the phenomenon under investigation, and as a result better-informed educational policies may be devised (Steckler, Mcleory, Goodman, Bird & McCormick, 1992; Creswell, 2003). Moreover, as highlighted by Bryman (2008), the increasing popularity of mixed-methodological research appears to suggests the ending of the 'paradigm wars', as it is commonly viewed as having opened up the way for a third set of beliefs in the research field, known as the pragmatic paradigm.

The pragmatist paradigm holds that worldviews arise out of actions, situations, and consequences, rather than antecedent conditions. Pragmatists state that there is a close relationship between the choice of approach and the nature and purpose of study questions (Creswell, 2003), with studies within this paradigm being commonly multi-purpose, adopting a 'what works' approach, thereby enabling researchers to deal with questions that may not be efficiently answered if assigned an entirely qualitative or quantitative nature. This view is further supported by Darlington & Scott (2002) who state that, essentially, a large number of choices concerning whether or not a quantitative or qualitative study approach should be adopted are not based on philosophical commitment but rather on the confidence and trust in

a methodology and/or design being most suitable in the context. In this regard, the pragmatic framework, as a set of beliefs was introduced as an individual paradigm response to the discussion surrounding the 'paradigm wars' and the introduction of mixed-methodological and mixed-model strategies. Importantly, this is multi-faceted as a result of the refusal to make a choice between only interpretive or positivist stances (Creswell, 2003).

Tashakkori & Teddlie (1998) and Creswell (2003) argue that the pragmatic framework has intuitive appeal and the capacity to consider research areas of interest whilst welcoming and supporting suitable approaches and utilising results in a positive way in agreement with the value system possessed by the scholar (Creswell, 2003). With this in mind, the pragmatic framework can be adopted in regard to management and social study research, as the model is compatible with the quantitative and qualitative mixed approaches utilised within 'practitioner-based' studies. A mixed-methodology study approach related to the pragmatic framework helps in gathering data stemming from both qualitative and quantitative traditions in a way that best addresses specific study questions.

The main goal of the current study was to investigate a broad understanding of attitudes of middle school teachers in Kuwait towards promoting pupils' mental health. To achieve this goal, the researcher planned to have a large random sample. In this case the scientific paradigm would be the best approach for collecting data, because in this stage, the researcher aimed to capture a broad picture without in-depth understanding. However, the researcher also wanted to explore in depth teachers' perceptions about promoting pupils' mental health and understanding of mental health concept, barriers to promoting pupils' mental health, changes to put this promotional process into practice, and how their perceptions affect their practice regarding their role as pupils' mental health promoters, and the influence of their religious, socio-cultural context in shaping these perceptions. This aim would require more than just the scientific approach, so the researcher decided to construct a combined paradigm approach (positivist and interpretive) in the current study, and implement a mixed-methodological approach within a pragmatic context. The researcher's decision was guided by the study aims enumerated below in addition to study questions which will be followed later in this chapter:

- Investigate Kuwaiti middle school teachers' attitudes toward their role in promoting pupils' mental health.
-

- Elicit Kuwaiti middle school teachers' understanding of mental health concept and promoting pupils' mental health.

- Explore factors affecting Kuwaiti middle school teachers' attitudes towards promoting pupils' mental health.

- Explore Kuwaiti middle school teachers' perceptions about barriers to promoting pupils' mental health.

- Explore Kuwaiti middle school teachers' perceptions about change.required to put the implementation of promoting pupils' mental helath in the schools of Kuwait.

4.3 The ontological and epistemological assumptions underpinning the study

Any research paradigm is largely defined by basic philosophical assumptions. These assumptions are about knowledge, reality and the path that researchers follow to achieve their goals (Crotty, 2003). These basic assumptions can be characterized as the ontological, epistemological, and methodological questions (Guba & Lincoln, 1994).

The ontological assumption can be considered to mean 'the study of being', and predominantly deals with 'what kind of world we are investigating, with the nature of existence, with the structure of reality as such' (Crotty, 2003, p. 10). The term ontology is commonly broken down into two competing sets of assumptions. Realism recognised as the ontological assumption providing the overall foundation for the positivist research approach, posits a reality that exists independently of conscious perception; it insists metaphysically on objective existence (Ernest, 1994). Relativism, the ontological assumption underpinning the interpretive stance, assumes that reality is a human construct (Wellington, 2000), and that access to this reality is only through social constructions, such as language, shared meanings (Crotty, 2003), and the negotiation of meanings (Pring, 2000).

The epistemology assumption can be described as 'a philosophical grounding for deciding what kind of knowledge is possible and how can we ensure that this knowledge is adequate and legitimate' (Crotty, 2003, p. 8). According to Biesta (2005), epistemology takes into account a number of ideas surrounding knowledge and its overall nature. There are two main epistemological stances in education research: objectivism and constructivism. Objectivism emphasises the ways in which the social world can be analysed and assessed as natural

science to explain human behaviour, and to validate the use of experimental research methodologies (Cohen & Manion, 1994). Constructivism adopts the view that individuals create their own situational knowledge, possessing their own individualised understanding of the world and its events (Ernest, 1994).

The current study adopted two different research approaches. The scientific paradigm applied in the case of the quantitatively understood questions, underpins the epistemological perspective that what is investigated and investigator are two distinctive entities. Thus, the researcher is able to study the social phenomenon without being influenced by it or otherwise influencing it; 'inquiry takes place as through a one way mirror' (Guba & Lincoln, 1994, p. 110). Within the scientific paradigm, objectivism (as an epistemological position) veiws meaning as being inherent in the object and there to be discovered; this directly impacts the selection of methods and methodologies, and more specifically, the ways in which these are progressed and advanced, and adopted in accordance with research objectives

The study will also adopt the interpretive paradigm for answering qualitatively focused questions, since this paradigm considers knowledge as being subjective and personal, and therefore necessitates the investigator to be involved with the research. The paradigm emphasises that knowledge is viewed by social actors (subjects) as it lived, felt, experienced and undergone (Schwandt, 2000). Moreover, the research paradigm takes its philosophy from the constructivism view, which is based on constructing and developing thick description surrounding subjective meanings (Ernest, 1994).

The mixed-methodological research approach within its pragmstic context combines the view of the scientific paradigm, where knowledge depends on its purposes and to generalise about causal relationships, with that of the interpretive, to illuminate specific situations (Tashakkori & Teddlie, 1998). In the view of Morgan (2007), pragmatism stands back from ontological questions and considers knowledge in terms of whether it works. Pragmatism is essentially not dedicated to any particular philosophical or reality system, which is the case in mixed-methodological studies in the sense that investigators take into account both qualitative and quantitative assumptions when carrying out such studies. Therefore, the current study does not align itself with any specific philosophical assumptions about reality (Creswell, 2009), as the philosophical assumptions underpinning it, based on the mixed-methodological approach used, are subordinated to what works and how its questions can be answered and its aims achieved. Secondly, the approach used in the current study allows researchers to decide

which study methods best fulfil the purpose and needs of the research. Thirdly, truth is not considered to be subject to a duality between independent reality and the mind; therefore, in the case of mixed-methodological studies, scholars utilise both qualitative and quantitative data as they seek to establish the deepest insight and understanding of the topic at hand (Tashakkori & Teddlie, 1998). In practice, pragmatic orientated research consider what to study and the best ways of doing so in consideration of what it wants to achieve. Mixed-methodological research scholars therefore need to determine a rationale behind the mixing of approaches.

Pragmatists agree that studies are always carried out within historical, political, social and other contexts. Pragmatism avoids questions of reality as being internal or external to the mind, judging this to be philosophical, rather than practical interest (Cherryholmes, 1992). Accordingly, in the context of a mixed-methodological approach study, pragmatism creates an avenue for a number of different assumptions, analyses, methods and worldviews.

4.4 The justification for utilizing a mixed-methodological approach

The aim of methodology in any research is to describe, illustrate and evaluate the reasons behind the use of particular methods (Wellington, 2000). Methodology can be described as the design, plan of action, process and strategy that justifies the selection of certain approaches and links them with the desired outcomes (Crotty, 2003). A researcher's choice of methodology should be compatible with the nature of the investigated phenomenon and the research questions. Robson (2002) also suggests that the general principle is the appropriateness of the research strategy and the employed techniques for the questions needing to be answered.

In the current study, a mixed-methodological approach, implemented through a complementary research design appropriate to the research question types, was utilised. The researcher's own pragmatic beliefs have led to the selection of the mixed-methodology approach, reflecting a conviction that an amalgamation of study approaches is viable, which each establishes its overall significance through the answering of specific study questions and achieving the aims of the study. Accordingly, the researcher adopted a pragmatic view as she was interested in ensuring a suitable 'fit' between the research questions posed and the study methods utilised - more so than in the degree of the philosophical consistency of the epistemological positions commonly linked with various research methods and approaches

(Snape & Spencer, 2003) and how these attitudes relate to teachers' practices in classrooms (Silverman, 2006).

The reason for applying mixed-methodology approach is the researchers' belief that any research questions dealing with human phenomena are complex and cannot be answered by using single approach. Also, using such approach could be connected to researcher's belief that the world is complex, and that no single truth is ever adequate, and that any truth isolated from its complementary truth is considered as a half-truth. This study aims to explore middle school teachers' perceptions and understanding of mental health concepts. These perceptions are complex: there are no single universally agreed definitions regarding these concepts (Mental Health Foundation, 1999; LGIU & CSN, 2007), and there is no assumption that there is a common shared understanding and experience of the same phenomena (concepts) among all participants. Crotty (2003, p. 8) suggests that meaning is not so much discovered as formed, and so it can be stated that individuals may differ in the meaning they assign to one particular event, and objects and subjects may be considered as associated in the generation of meaning.

Adopting a mixed-methodological approach in this current study can be also justified by Silverman's (2006) argument that there are areas of social reality that cannot be measured merely by statistics, including attitudes, experience and interpretations. It has been argued by Kiki & Miller (1986) that 'attitudes' are not necessarily linked with people's minds, and so there is the need to ensure comprehensive and in-depth analytical assumptions when investigating them.

For the reasons outlined above, the concepts of 'mental health' and 'promoting pupils' mental health' in this study cannot have a single interpretation based only on positivist foundation. The inadequacy of employing solely one approach in investigating teachers' attitudes has been debated by many authors (e.g. Merriam, 1998; Bell, 1993). Therefore, a mixed-methodological approach has the ability to provide the researcher with more details which could not be captured by using one approach (Creswell & Plano Clark, 2007).

Additionally, the literature suggests that attitudes cannot be measured through direct observation; rather than they must be inferred; however, they can be deduced by considering the way in which individuals behave, the beliefs they hold, as well as what they feel and say(Ajzen & Fishbein, 1980). Therefore, the utilisation of a mixed-methodological approach

may prove to be valuable for capturing the intricacy of the attitudes held by teachers in regard to mental health promotion amongst pupils, gathering a more in-depth understanding from an internal perspective. Moreover, a review of the literature in the field of mental health education indicated that research related to attitudes has been mostly carried out within the field of epidemiology or psychology, encompassing only positivist approach, using surveys, which may be insufficient to address the complexity of the core attitudes (Norwich, 1998; Brockington, Hall, Levings & Murphy, 1993). Surveys can help researchers to shed light on attitudes; however, they cannot explain how these attitudes are shaped and might influence behaviour (Secker & Platt, 1996). An additional criticism is that this positivist view will take the 'individual self' as starting point and the core of analysis without addressing how social interaction led to these attitudes being the way they are (Eiser, 1994).

Furthermore, whereas quantitative studies have the ability to compare scores across populations and settings, qualitative studies have been viewed as providing a sense of the meaning of a phenomenon. An integration of both approaches may provide a new sense of the concept under investigation. In this respect, the current study aims to investigate teachers' attitudes and perceptions about their role in promoting pupils' mental health, while at the same time seeking to explore the social reality of teachers' understanding of these terms. Teachers may work in similar conditions or have similar experiences, but this does not necessarily mean that their views and perceptions relating to promoting mental health, barriers and changes to implementation to the promoting process are identical; thus, individuals could consider and understand meanings differently through their own experiences and viewpoints within the same socio-cultural context (Maxwell, 1996).

4.5 Sampling of the study

Matching the two phases of the study, there were two phases of sampling. The questionnaire sample was selected randomly and the qualitative sample was chosen purposively. The two types of sample are discussed below.

4.5.1 Phase one: quantitative sample

A random cluster sample was selected for the survey (first phase of the study), covering teachers of a variety of ages, gender, levels of education and teaching experience, from four of Kuwait's six provinces (Hawali, Al Farwanya, Mobarak AlKabeer, Al Jahra), as each province has one administrative educational authority.

The survey was administered to middle school regular education teachers employed by the Kuwait Ministry of Education. All shared the same ethnic background, being Kuwaiti. In February 2011, 600 copies of the survey were distributed and there were 479 returns, representing 82.2% of the intended sample.

4.5.2 Phase two: qualitative sample

Purposive sampling provided the researcher with the capacity to target an 'information-rich' population, which is recognised as comprising individuals who can provide large amounts of data in relation to the study aim (Patton, 2000, p. 169). Erlandson *et al*. (1993) reported that being more aligned to the aims and views of the system overall increases the chances of someone being happy to take part, so one is likely to get quite a narrow demographic applying.

The survey ended with a postscript seeking participants willing to participate in the research interviews. The researcher received 30 agreements, which is a satisfactory number if one considers the rarity of the interview-based approach within the Kuwaiti education system. However, more than 15 teachers withdrew from the interview sample either on the basis of cultural sensitivity related to female/male face-to-face interview, or because of administrative obstacles. In the end, twelve were selected purposively, targeting maximum variety of levels of education, teaching experiences and varied teaching and educational qualifications.

4.6 Research design and data collection methods

The current study adopts a mixed-methodological research approach within mixed-method complementary research design. The complementary design is one type of approach to combine qualitative and quantitative research in mixed-methodological research, as it is recognised that a more in-depth and comprehensive answer to a research question may be garnered through complementary approaches (Bryman, 2008). This suggests that any gaps inherent in the use of one method can be filled by another (Bryman, 2008). The general aims were broken down into two groups of questions which can be approached through a research design consisting of two phases (Figure 4.1).

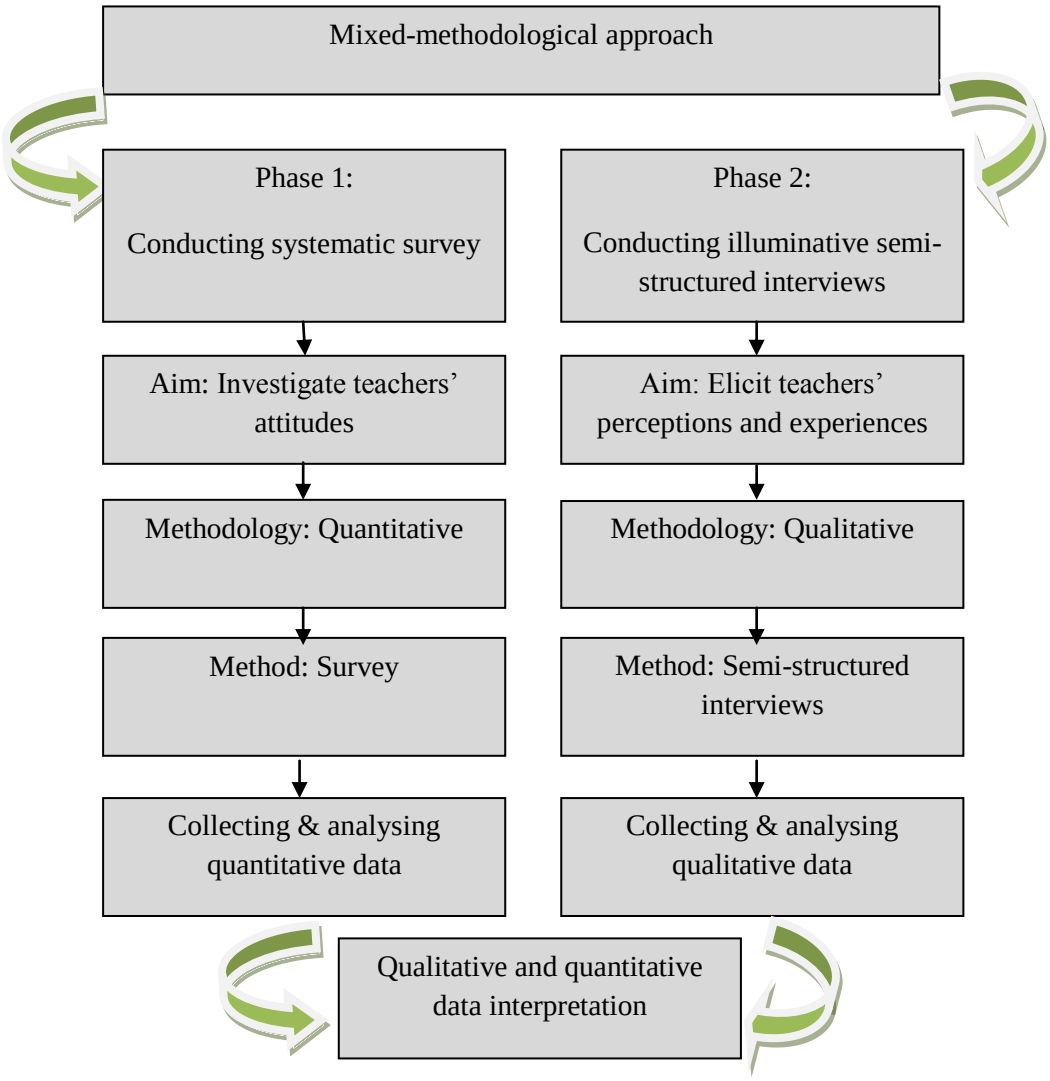


***Figure 4.1*: Research design of the study**

However, this does not mean that the two phases are separated; rather they are linked in order to give a clearer picture and to gain rich information about teachers' attitudes towards promoting pupils' mental health, and perceptions about barriers and changes needed to put this promotion into practice.

The idea behind using mixed-methods research design when investigating a social phenomenon is that combining quantitative and qualitative sources of data yields more robust understanding and interpretation of holistic perspectives of the phenomenon under investigation, and as a result better-informed educational policies may be devised (Steckler, Mcleory, Goodman, Bird & McCormick, 1992; Creswell, 2003). Additionally, there is practical value in seeking a convergence of the findings between two or more methods

utilised in the research design (Tashakkori & Teddlie, 2003). Mixed methods provide researcher with a greater reliability in the interpretation of the data, demonstrated by the agreement of different data sources. Generally mixed-method approaches are used when seeking more validity for the data, needing to compare, contrast or validate quantitative statistical results with qualitative findings (Tashakkori & Creswell, 2007). Furthermore, each method of research has its strengths and weakness, which a combination of methods seeks to overcome (Ritchie & Lewis, 2003). In the following sections research design including the quantitative and the qualitative phases will be discussed.

4.6.1 Phase one: Quantitative phase (survey)

The first phase of the research design is aimed at answering the first group of research questions:

- What are Kuwaiti middle school teachers' attitudes towards promoting pupils' mental health?
- Is there any significant statistical correlation between the three components of teachers' attitudes to pupils' mental health (cognitive-affective-behavioural)?
- Are there any significant statistical differences in Kuwaiti middle school teachers' attitudes towards pupils' mental health that can be attributed to teachers' gender, age, years of teaching experiences or levels of education?
- What are Kuwaiti middle school teachers' perceptions about barriers to promoting pupils' mental health?
- Is there any significant statistical correlation between the perceived barriers to promoting pupils' mental health and teachers' attitudes?

This first phase of the research design consisted of a survey strategy. Bryman (1988a) defines the survey as a 'study approach involving the gathering of data on a number of units and commonly at one point in time with the aim of systematically gathering a volume of data that can be quantified in regard to numerous variables, which are subsequently analysed with the aim of establishing association patterns and behaviours' (p. 104). Using surveys could help to provide the investigator with the views of a large number of participants, who perhaps could not be interviewed owing to various reasons, such as location. Surveys are valuable for gathering factual data, such as on attitudes, behaviours, beliefs, experiences and predictions about mental health promotion, for example, as has been emphasised by Weisberg *et al.* (1989).

Among the greatest advantages of employing surveys in research are that it requires less time to collect the data and the questions are always exactly the same for all respondents. Surveys are an attractive method owing to the capacity to generalise within certain parameters, as well as the capacity of the tool to make statements supported by a large volume of data, and the potential to determine the level of confidence assigned to the findings subsequently garnered; however, a survey cannot explain why a situation occurred or why people behave in a particular way in a situation (Cohen, Manion & Morrison, 2007). It has been noted by Pring (2000, p. 54) that the use of surveys may be problematic as it could mean that similar answers to a particular question may not give accurate depictions of the way in which certain individuals feel about a specific situation.

4.6.1.1The sections of the survey

The survey is divided into three main sections; these will be described in the following paragraphs (see Appendix (III), p. 279, for the final version of the survey).

- Section one: Background information

This part of the survey informs the participants of the main aim of the survey and how they should answer the questions. Teachers are asked to provide general information relevant to their age, gender, educational level and years of teaching experience.

- Section two: Teachers' attitudes scale

This part focuses on teachers' attitudes towards promoting pupils' mental health and is organised as follows:

- A Likert scale (seventeen items) measures the 'cognitive component' of teachers' attitudes towards promoting pupils' mental health, which is heavily influenced by the extent of teachers' knowledge and beliefs. These items were formulated based on the definitions of mental health concepts in the publications by the WHO (2001), the Mental Health Foundation (1990), LGIU & CSN (2007), and the Surgeon General's report on Mental Health (2000). This cognitive scale (A) was divided into three thematic units or domains. The first domain is intended to reflect teachers' beliefs about mental health problems as alterable problems. The second domain focuses on teachers' beliefs about promoting pupils' mental health in schools. The third domain focuses on teachers' beliefs regarding the requirements and outcomes of the promotion process.

- The second component of teachers' attitudes towards promoting pupils' mental health is the 'affective component' (B) (five items). This measures teachers' general feelings towards promoting pupils' mental health, teachers' feelings towards including pupils with mental health problems, teachers' feelings towards recognizing pupils' mental health problems, teachers' feelings towards dealing with pupils' mental health problems in their classroom, and teachers' feelings towards managing a class that includes pupils with mental health problems. In this part, a semantic differential scale encompassing bipolar adjectives (Osgood, Suci & Tannenbaum, 1975) such as 'comfortable-uncomfortable', pessimistic-optimistic', negative-positive', 'interested-uninterested', and 'happy-unhappy' was employed to explore teachers' affective and emotional responses to promoting pupils' mental health. Throughout the course of this section, the participants were required to indicate which adjective most closely explained their perspective, through a corresponding number on the scale from 1 to 5. The total of these items was used to generate a compound score for the affective component; a higher score indicates positive attitudes.
- A Likert scale was employed to measure teachers' 'behavioural component' attitudes (C) including ten items which measure behavioural responses towards promoting pupils' mental health among teachers. Teachers were asked to indicate their degree of agreement in respect of general statement provided at the beginning of this section *"*If I have or recognize a pupil with mental health problems in my class, I will..... *"*.

- Section three: Teachers' perceptions of barriers scale

This part focused on teachers' perceptions about barriers to promoting pupils' mental health. Teachers were asked to indicate their responses to the question 'To what degree does each item represent a barrier to your participation in promoting pupils' mental health?' The participants were asked to respond to 16 Likert type items, representing four barrier dimensions - personal barriers, interpersonal barriers, structural-organizational barriers, and social-cultural barriers.

In all the Likert scales, teachers were asked to provide the response which indicated their degree of agreement with each statement. The Likert scale is one of the most common statistical techniques for investigating attitudes. It is essentially a multiple-indicator of set attitudes; the goal here is to measure intensity of agreement with certain themes or issues,

namely cognitive, affective and behavioural intentions. The level of agreement was indicated by a format consisting of a 5 point scale: *strongly agree*, *agree*, *undecided*, *disagree*, *strongly disagree*. Scoring 5 is the highest and 1 the lowest for positive statements. Negative statements are scored in opposite order: 1 for the highest positive response and 5 for the lowest response (see Appendix (III), p. 279).

4.6.1.2 Construction of the survey

In the construction and development stage of the survey, many criteria were followed. Firstly, a review was carried out of the literature related to mental health in schools, promoting pupils' mental health, teachers' views and perceptions regarding their role in identifying and recognizing pupils' mental health problems, barriers which could undermine teachers' role in this area, and the changes required in order to put promoting pupils' mental health into practice (see Chapter 3). As highlighted by Bryman (2008), literature reviews provide the investigator with knowledge of what is already known in the area in question, as well as the various theories, methodologies and methods that have been utilised, and concepts considered relevant to the area.

Secondly, reviews of previous studies gave insight into possible tools and approaches that might be appropriate to this area of research. Very few useful instruments were evident in this review. The researcher therefore constructed a new survey to use in the study. The researcher based the design of the survey on the theories, definitions and assumptions found in education text books, and in the literature review related to the areas of the current research, including mental health terminologies, specifically, the positive concept of mental health, the alterability of mental problems, the causations of mental health problems among young people, the core principles of prompting pupils' mental health, teachers' role in this area, and barriers to prompting pupils' mental health and putting it into practice. Additionally, the researcher benefited from the multi dimensional model (three components model) of attitudes in forming the survey items, adopting three components, namely, cognitive, affective, and behavioural (Eagly & Chaiken, 1993; Ajzen, 2005) (see Chapter 3).

4.6.1.3 Translation of the survey

As the first language of most Kuwaitis is Arabic, the English version of the survey was first translated into Arabic for use. The main concern of the translation was to provide an accurate

parallel meaning (with less emphasis placed on a word-for-word match). In order to check the validity of the translation, assistance was sought from an English language lecturer in Kuwait University, in the department of translation. As an initial step, the researcher translated the survey into Arabic (see Appendix (XI), p. 378, for a copy of the survey in Arabic), and then asked the lecturer to translate it back into English. A comparison between the two versions of the translation was undertaken, before the final survey was approved.

The survey items were written in everyday language, free of any kind of scientific abstract terms for some definitions, such as mental health, mental health problems, and promoting mental health. Additionally, in order to check the content validity of the survey (that survey statements cover the range of features under study), the researcher contacted her supervisors and other specialists in mental health in the UK for assistance and suggestions regarding the appropriateness and wording of the survey items. Then, the revised survey was piloted on 60 teachers before being distributed to a large number of participants.

4.6.1.4 Administration of the survey

The survey was conducted by the researcher. 600 copies of the surveys were distributed, of which 520 were returned, though as some forms were incomplete, the final number of surveys employed in the study was 479, representing a response of 82.2%. Ten schools (five boys' school and five girls' school) were chosen randomly from four of the six provinces in Kuwait. First, the researcher requested recent statistical numbers of the middle schools and teachers working there from the Kuwait Ministry of Education. The researcher chose to administer the survey to 10 schools in four provinces, with 600 male and female teachers, contacting 60 teachers in each school. Official permission was sought from the Kuwaiti Ministry to gain access to the schools, to administer the survey and conduct the interviews.

4.6.2 Phase two: Qualitative phase (semi-structured interviews)

The second phase of the study research design aimed to answer the second group of the research questions:

- What are Kuwaiti middle school teachers' perceptions about their pupils' mental health and promoting mental health?

- What are Kuwaiti middle school teachers' perceptions about barriers to promoting pupils' mental health?

- What are Kuwaiti middle school teachers' perceptions about the changes necessary to put promoting pupils' mental health into practice?

- What factors do Kuwaiti middle school teachers perceive as affecting their perceptions of promoting mental health?

The second phase of the study involved employing qualitative methods through interviews. The interview is a tool for encouraging individuals to discuss their views, perceptions and interpretations in response to a particular situation or phenomena. Interview lies at the heart of social research (Esterberg, 2002, p. 83). It allows the researcher to gain access to the individual's perceptions, intentions, experiences and wishes in participant's words, rather than investigator's (Rubin & Rubin, 2005). Interviews also provide further insight into the claims made by the respondents to the surveys, thus enriching the findings revealed.

There are several types of interviews: structured, unstructured and semi- structured (Robson, 2002; Flick, 2006). It is emphasised by Snape & Spencer (2003) that qualitative research methods, such as interviews, deliver all-inclusive, general understanding of the actions and views of participants in the context of their overall lives. In the current study, the researcher utilised semi-structured interviews for many reasons. Firstly, semi-structured interviews would give study participants a voice, and provide invaluable data and feedback that could be critical for developing a variety of elements related to the learning and education infrastructure, such as the content of the curriculum, teacher training, or learning materials (Giannakaki, 2005). Additionally, semi-structured interviews are considered a powerful method for collecting data, due to their ability to provide a chance to access participants' perceptions, definitions of constructions of reality and situations and meanings, as there are no specific questions or limited required responses (Punch, 2005; Tashakkori & Teddlie, 1998). Furthermore, semi-structured interviews have the potential to elicit rich data, as they can provide unique access to the way in which participants view their activities and experiences, and their opinions of such, and further help to explore the way in which individuals perceive and comprehend their surrounding world (Kvale, 2007). This type of in-depth interview offers the participants the chance to highlight the contextual factors impacting on teachers' attitudes and perceptions about promoting pupils' mental health. Bryman (2008) argues for semi-structured interviews as follows: 'What is crucial is that the questioning allows interviewers to get a sight of the ways in which interviewees view their social world' (p. 442).

The topic and the questions of the interviews were mostly based on an analysis of pilot interview questions submitted to three teachers, where a list of topics was set to cover the study questions (see protocol of semi-structured interview, Appendix (IV), p. 287). The pilot study helped me to address the appropriateness and the quality of questions and enable me to refine the interview items through testing them within a real-life context (Yin, 2003). In order to ensure that interviewees understood the meaning of the questions, some questions were added as the interviews unfolded, and wording and ordering modified. The interviews were piloted on three Kuwaiti middle schools teachers. Amendments were then carried out as a result of the pilot interviews and feedback.

4.6.2.1 Conducting the interviews

The researcher contacted the twelve teachers who agreed to be interviewed. The researcher contacted them by telephone to arrange a convenient appointment. The researcher was keen to leave the choice of setting to the interviewee to ensure an appropriate, favourably quiet interview environment. All the interviewees chose to meet me in their schools, specifically in the library of the school, where they reported that they felt free, relaxed and encouraged to expand on their views. However, religious and cultural considerations did not allow the researcher (as a female) to be alone in a closed place with a male teacher. The researcher was therefore obliged to keep the door of the room open or to ask the head teacher to attend the session, which may at times have influenced interviewees' expressions of their opinions and views.

At the beginning of the interview, the researcher introduced herself and briefed the participant about the purpose and significance of the study. The participants were assured of the security and confidentiality of the collected data before permission to audio tape the interview was requested. Each interview lasted for approximately 40–50 minutes, with an emphasis being placed on listening to the interviewees, putting them at their ease and ensuring that their contribution felt valued. Achieving rapport with the respondents is important (Bryman, 2008), and throughout the interviews the researcher managed to establish a good rapport with them; however, this engagement did not involve fully identifying with the subjects (Cohen, Manion, & Morrison, 2007).

4.7 Data analysis

Data analysis can be described as the way in which meaning, order and structure can be assigned to large volumes of data (Marshall & Rossman, 1995, p. 111). In this current study, there were different ways to analyse data based on the types of data obtained.

4.7.1 Quantitative data analysis

The quantitative data from the survey were fed into SPSS software (Statistical Package for Social Science; version16.0 for Windows XP). Two kind of statistical analysis were performed: descriptive and inferential. The descriptive statistics applied to means, frequency counts, percentages, and standard deviation of the variables, while the inferential statics included one-way analysis of variance [ANOVA], independent samples t-test, one-way and correlation analysis, used to determine the differences between age, years of experience, gender and level of education in relation to teachers' attitudes, perceptions and scale dimensions. In addition, factor analysis was employed in order to reduce the number of scale items to a lower number of variables.

4.7.2 Qualitative data analysis

Data collection in qualitative research is not easily separated from data analysis (Miles & Huberman, 1994). Therefore, the researcher began to do data analysis from the first contact with participants during interviews. Different techniques were used to achieve this ongoing data analysis, such as initial reading of transcripts post-interview analysis notes, and writing memos (Maxwell, 1996). This early analysis of the data reduced the risk of problems that can be faced when dealing with a huge amount of data gathered from multiple interviews, by enabling the identification of important themes for future interviews (Cohen, Manion & Morrison, 2007).

After the researcher finished the field study in Kuwait and returned to the UK, she started to 'manage' the qualitative data using general guidelines that many researchers propose. The researcher used an interpretive analytic framework to analyze the data obtained from interviews. For example, Miles & Huberman (1994) suggest that raw data in qualitative research could be analysed using three main analytical stages: data management, data reduction and data display. Data management involved transcribing, translating, editing and typing up notes, then, formatting, paginating and indexing the data using computers or notebooks.

The recorded interviews were transcribed and translated, with the text then subjected to coding. According to Delamont (1992), coding is recognised as categorising and classifying data into concepts, issues, themes and topics. Furthermore, as highlighted by Coffey & Atkinson (1996, p. 27), coding has the capacity to reflect analytical ideas, and may be further utilised with the aim of dividing and categorising data into more general and simplistic groups. This means that the researcher is required to progress through the data systematically, word by word, phrase by phrase, line by line, and provide a descriptive code corresponding to each item (Cohen, Manion & Morrison, 2000).

It was considered that noting down the data in this way helped to reduce the data size, thus facilitating the analysis of the patterns and relationships found to have emerged during the course of the study (Strauss & Corbin, 1990). The researcher made the decision to analyse the data manually as opposed to employing a software package. This was because of a concern that computer-based analysis directs more attention to reducing the data through linguistic patterning, which subsequently means the information may be less valuable than that which is ascertained through manual analysis, which can draw on data-researcher interaction. Moreover, it should be recognised that some qualitative data, namely feelings, knowledge and views, as provided through participants' quotations (Patton, 2000), are often unclear and imperceptible to computer programs. Following the management of the data, the researcher sought to identify any common themes found to have emerged during the course of the study which might provide answers to the study questions.

Initially, the researcher went through the transcripts used an interpretive analytic framework to analyze the data obtained from interviews. This was made through data reduction and management after interviews' translation and transcription. Starting with highlighting the significant items, providing descriptive code corresponding to each item, categorising items into more general and simplistic groups of concepts, and classifying them into themes and topics. The coding aims to break down the interviews into chunks. Subsequently, organisation was carried out, which involved the various sections of information being categorised so that segments could be quickly located and clustered before being assigned to their relevant construct, theme or question. Coding was focused on 'breaking down, examining, comparing, conceptualizing and categorizing data…..[which] yields concepts, which are later to be grounded and turned into categories' (Strauss & Corbin, 1990, p. 61). On a secondary level, the chunks of information were summarised into fewer constructs, categories and sets through pattern-coding. Strauss & Corbin (1990, p. 116) suggest that this

third level involves the selection of the main category, systematically linked with other groups, supporting links and filling in groups requiring subsequent enhancement and modification. In this particular phase, codes were assigned with names and operational definitions considered to be most fitting to the ideas and models they describe (see Appendix (IX), p. 320, for the samples of analysis and coding the emerged themes in interviews data).

4.8 The reliability and validity of the quantitative phase

For the quantitative phase, reliability was achieved by piloting the survey and measuring its reliability. In December 2010, the survey was piloted with a sample of 60 teachers. In order to determine the reliability and factorability of the 'Inter-correlation Matrix', the researcher employed Cronbach Alpha (α), one of the commonly used tests of internal reliability, based on the rationale that items measuring the same dimension will highly correlate (Bryman, 2008). The Cronbach Alpha reliability coefficient was used to test the reliability of the two scales, attitudes (0.87) and perceptions of barriers scale (0.87) - which revealed a statistically satisfactory level of reliability (Ibid.) (see Appendix (V), p. 290). Additionally, a factor analysis approach (the principal component using Varimax rotation) was employed to reduce the number of attitude scale items to a few interpretable factors that determine whether groups of attitudes scale items tend to bunch together to form distinct clusters, referred to as factors (dimensions) (Bryman & Cramer, 2001). The factor method was also used to explore the possibility of finding patterns between questions based on the correlation matrix between these questions. With the aim of removing data redundancy and accordingly highlighting any basic or fundamental link between variables, factor analysis was applied. As a result, scales factor loading was explored, which is an indicator of the degree of association between a factor and its items.

4.9 The trustworthiness of the qualitative phase

With regard to the qualitative phase in this current study, it is recognised that quality could be achieved by ensuring the trustworthiness of the findings through directing careful consideration to the ways in which the data was gathered, analysed and interpreted, and how the research study was conceptualized (Lincoln & Guba, 1985; Silverman, 2000; Miles & Huberman, 1994). Trustworthiness can be broken down into four different criteria: conformability, credibility, dependability and transferability (Lincoln & Guba, 1985; Tashakkori & Teddile, 1998).

Conformability is related to the principle that complete objectivity in social research is impossible, but that it can be shown that research is conducted in good faith; briefly, it should be clear that the researcher did not overtly control the conduct of the study and the derived findings (Lincoln & Guba, 1985). The researcher attempted to ensure conformability by employing two main strategies to ensure the credibility and dependability of the study namely peer and member checks.

In addition, Conformability demands were met by adopting a mixed-methodological research approach in form of a complementary research design consisting of a combination of quantitative and qualitative phases and involving several and different methods to collect data not only minimized the likelihood of misinterpretation but also provided the study with richness of data to facilitate sorting and examining data from various aspects. The triangulation applied in this study supported the transferring insights to a wider population (Erlandson *et al*., 1993). Stake (1995) suggests that triangulation is a crucial means of validating research and ensuring accuracy.

In order to ensure credibility and dependability (validity), the researchers used peer examination, also known as auditing. Lincoln & Guba (1985) claim that dependability is concerned with identifying the overall credibility and worth of the study, with researchers recommended to implement an auditing approach, which involves the maintenance and storing of all data analysis decisions, fieldwork notes, interview transcripts, etc. In this way, peers may adopt the role of auditors, most notably at the end of the study. Auditing has grown in popularity because it increases the overall dependability and soundness associated with qualitative research (Bryman, 2008). Auditing requires that manuscript drafts and entire data are communicated to at least three peers, with their role being to highlight important points for analysis, and subsequently critique the data and study, which will help in drawing conclusions. During the study, the researcher used peer examination to evaluate the data and enhance its credibility (Mertens, 2005). The researcher asked two peers at the Graduate School of Education at the University of Exeter to go through the interview transcripts with the aim of establishing whether the same codes would be assigned to corresponding data segments. The overall aim here was to question whether it was possible that any themes had been overlooked that would notably change the interpretation of the findings and the conclusions subsequently drawn. The researcher also attempted to use a member check strategy throughout the study for two reasons: firstly to ensure that interpretations were

presented accurately, and secondly to make sure that data obtained really reflect participants' beliefs.

Finally, in the current study, the criterion of transferability was met by providing a thick description of the data and context. According to Merriam (1998), if rich, in-depth, descriptive information is produced, transferability is then possible. Merriam goes on to state that description enables an audience to see the degree of resemblance between their own situation and that of the research context, and to subsequently establish whether the results can be transferred (p. 211). In the current research, the researcher have delivered in-depth descriptions of the research itself, as well as the target sample, information-gathering techniques, and data analysis methods. Moreover, the researcher has included various sample quotations in a bid to facilitate readers' understanding and provide them with access to some of the original data. Nevertheless, it is fundamental to recall that adopting a mixed-methodological approach not only aims to make generalisable findings, but also seeks to provide context-relevant insights. In this regard, the potential that findings derived from the current study might be transferred and utilised by other researches carrying out studies in other contexts is considerable.

In addition, employing a purposive sampling method in the qualitative phase of the current study could be considered as a method of ensuring trustworthiness. Purposive sampling provides me with the capacity to target an 'information-rich' population, i.e. individuals who can provide large amounts of data in relation to the study aim (Patton, 2000, p. 169). Similarly, piloting the interviews enabled me to address the validity and the quality of questions (Yin, 2003), and offered another way to ensure the trustworthiness of the qualitative phase in this current study.

4.10 Ethical considerations

A number of different ethical considerations require attention during the course of any research study (Pring, 2000). Importantly, when researchers gather data relating to certain individuals, attention must also be directed towards the responsibilities and right of all involved - not only the sample itself but also the researcher (Cohen & Manion, 1994). This research study was affected by a number of ethical considerations, which are discussed further below.

4.10.1 Gaining informed consent

Ethical considerations are various and wide-ranging, though the predominant concerns include gaining informed consent from individual participants, providing the sample target with the opportunity to withdraw from the study whenever desired, and safeguarding the sample in terms of confidentiality and identity (Cohen, Manion & Morrison, 2007; Pring, 2000). 'Informed consent and respondent validation represent a way to ethically ensure participant understanding' (Silverman, 2006, p.324). The BERA Revised Ethical Guideline 11 (BERA, 2004) stresses that researchers should ensure that all participants understand the aims and processes of the research, what kind of participation is required from them, the sources of the funding, how the data will be used, how and to whom it will be reported, if there is any risk or any expected detriment to taking part in the process, and whether they wish to be participants.

Before conducting this study, it was necessary for the researcher to pass through two different types of gatekeeper: formal (i.e. institution-related authorities) and informal gatekeepers, who may not have institutional power but who nevertheless are influential within the context of the study. At the outset of the research, the researcher was provided with ethical approval from the Ethics Committee of Exeter University to conduct my research, signed by her supervisors (see Appendix (VII), p. 317). Additionally, an official letter was sent by the investigator to the Kuwaiti Cultural Office in London - addressed to my academic supervisor in the Kuwaiti Embassy in London - requesting permission from the Kuwait Ministry of Education to carry out the research in Kuwait. The letter contained a number of important research-related details, including the target sample number required, the methods of data-collection, a letter noting the permission of my supervisors to carry out the work, and my guarantee that the sample would remain anonymous and the confidentiality of the data maintained. Subsequently, a letter was sent to various Kuwaiti middle schools by the Kuwait Ministry of Education.

Upon arrival in Kuwait, the researcher established communication with the head teachers of each of the schools, to request and arrange access. Although personal contact can prove to be valuable in terms of building rapport and may ultimately result in a simple and easy way of acquiring access, it is nevertheless emphasised that formal procedures need to be adhered to (Celnick, 2002). The introduction that the researcher provided for the teachers was facilitated

by the head teachers of the respective schools. Notably, such introduction did not necessarily mean that the sample of teachers would want to be involved in the study; first, ethical issues needed to be overcome and informed consent needed to be gained. Accordingly, all phases of the research were explained, and the potential participants were advised that they had the right to participate or withdraw (Cohen, Manion & Morrison, 2007), and that they were also able to seek further clarification from me if this was deemed necessary.

Regarding the BERA Revised Ethical Guidelines 10 and 11 (BERA, 2004) which stress the need for 'Voluntary Informed Consent', the researcher informed the participants that they were volunteers and should not feel under pressure from school administrators or head teachers to engage. As was mentioned before, only teachers who volunteered participated in the study.

4.10.2 Anonymity and confidentiality

A further ethical issue to be raised relates to the confidentiality and anonymity of the participants. So as to provide the target sample - both the teachers and the schools - with suitable levels of anonymity, the researcher created a 'data ownership' contract, using the Informed Consent Form which was distributed amongst the sample of teachers (see Appendix (VIII), p. 318).

The concept of anonymity refers to ensuring the identity of all involved in the study is not disclosed or identifiable through the data and information detailed in the study (Cohen, Manion & Morrison, 2007). To facilitate this, direct references were not made, with the individuals instead being assigned pseudonyms, namely alphabetical letters: H.M, S.S, H, K, M, U, T, Z, F, L, M.S, R. The consideration of anonymity is intrinsically linked with confidentiality, which emphasises the notion that any references made throughout the research paper - whether in terms of reports, representations or other comments - should ensure the source of the data is not identified.

Importantly, it is highlighted by Radnor (1994) that researcher must seek to build trust and ensure participants have been assured of confidentiality and privacy and have been provided with the opportunity to be listened to without prejudice, prejudgment or bias. With this in mind, during the process of this study (4 months), the researcher provided the participants with information relating to the overall purpose of the study, as well as the fact that any data gathered would be utilised only for the purpose of the study. Permission from each

participant was acquired– not only for this study but also for reference in future studies and publications.

4.10.3 Protection from harm

Another ethical issue that can be raised is protection from harm. This involved ensuring that the research would be conducted in a safe environment, which the researcher believes that she was able to do in the current study, through administering the survey and conducting the interviews in the schools. The researcher also attempted to reduce the stress or discomfort of the participants by interviewing them in the library, where they mentioned that they felt more comfortable.

4.11 Conclusion

This chapter has provided a breakdown of the methodological approach employed throughout the course of the research, and further discusses those tools which have been implemented. The ontological and epistemological philosophical assumptions underpinning the study were discussed. Furthermore, the sampling approaches, the research design and procedures, and data collection and subsequent analysis tools were presented and explained. The relevant ethical considerations were also outlined.

However, despite the in-depth consideration and analysis of the ways in which this study was designed and ultimately carried out, the researcher does not claim that this study is perfect or that it necessarily employed the optimum combination of approaches and tools. As has been stated by various scholars in the past, including Modood (1999), no methodology can ever be claimed to be best or the most appropriate. This study is much the same: although the researcher emphasises that every effort has been made to carry out a comprehensive study and to gain good understanding, limitations and problems are nevertheless apparent, and these should be taken into account during the analysis and discussion of findings, which will be provided in the following chapters.

Chapter 5: Findings of the survey

5.1 Introduction

This chapter is based on the analysis of quantitative and qualitative data from the survey. This survey consisted of two scales: a scale of teachers' attitudes towards their role in promoting pupils' mental health and a scale of barriers measuring teachers' perceptions about barriers to the implementation of programmes related to pupils' mental health. In order to analyse the closed-ended questions of the survey, the data was entered into a computer and an SPSS software programme (v.16) was employed. The open-ended questions were analysed qualitatively.

The chapter begins by presenting descriptive data of the survey variables followed by teachers' general attitudes towards their role in promoting pupils' mental health. This is followed by detailed results from factor analysis regarding the dimensions of the three components of attitudes, namely cognitive, affective and behavioural. Additionally, data pertaining to teachers' attitudes towards promoting pupils' mental health in relation to the demographic variables, namely gender, years of experience, age, and the level of education, is presented. Also, teachers' general perceptions about the barriers to the implementation of promoting pupils' mental health and the detailed results from factor analysis regarding the dimensions of these barriers in relation to teachers' demographic variables are presented. Finally, the chapter concludes with a qualitative analysis of the open-ended questions.

5.2 Descriptive data

The survey of the current study was conducted on regular teachers in Kuwait governmental middle schools in February 2011. Out of 600 copies of the survey, 520 were returned, a number of which were incomplete. As a result, the final number of surveys employed in the study was 479, a response rate of 82.2%. The sample, therefore, comprised 479 female and male middle school regular education teachers employed by the Kuwait Ministry of Education, all sharing the same Kuwaiti ethnic background. In accordance with cultural norms, male teachers teach male pupils and female pupils are taught by female teachers. In the first phase of the research, the survey was conducted in four of the six Kuwaiti provinces (Al-Jahra, Hawali, Mubarak Al-kabeer, Al-Farwanya), as each province has one administrative educational authority. Ten schools (five boys' schools and five girls' schools)

were chosen randomly from across the provinces. In each school, 60 Kuwaiti teachers were asked to complete the survey. The descriptive data of teachers' demographic information will be illustrated below. SPSS software was employed to analyse the findings of the survey, with descriptive statistics used to determine the frequency counts, means, percentages, and standard deviation of the variables. Factor analysis was utilized in order to reduce the number of scale items to a lesser number of variables (dimensions). Independent samples T-test, and one-way analysis of variance (ANOVA) were used to determine the differences between gender, age, years of experience and level of education in relation to teachers' attitudes and scale dimensions.

5.2.1 Gender

Table (5.1) and Figure (5.1) below show the frequencies and percentages of females and males participating in the study.

Gender	Frequency	Percentage
Male	211	44.1%
Female	268	55.9%
Total	479	100.0%

Table 5.1 **Frequencies and percentages of participants' gender**

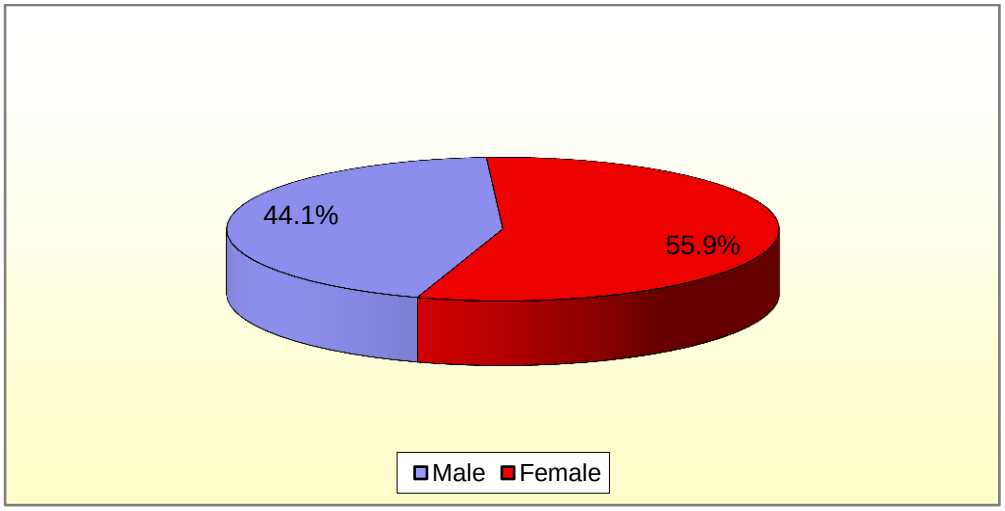


Figure 5.1 **Percentage distribution of gender**

5.2.2 Age

Table 5.2 and Figure 5.2 below show that that majority of teachers participating in the current study were between 31 and 35 years old. The smallest age group represented was 46 to 50. This could be seen as a normal result, in that the compulsory retirement age of Kuwaiti teachers is 50.

Age group	Frequency	Percent
From 21 To 25 Years	44	9.2%
From 26 To 30 Years	103	21.5%
From 31 To 35 Years	151	31.5%
From 36 To 40 Years	89	18.6%
From 41 To 45 Years	50	10.4%
From 46 To 50 Years	42	8.8%
Total	479	100.0%

Table 5.2 **Frequencies and percentages of participants' age**

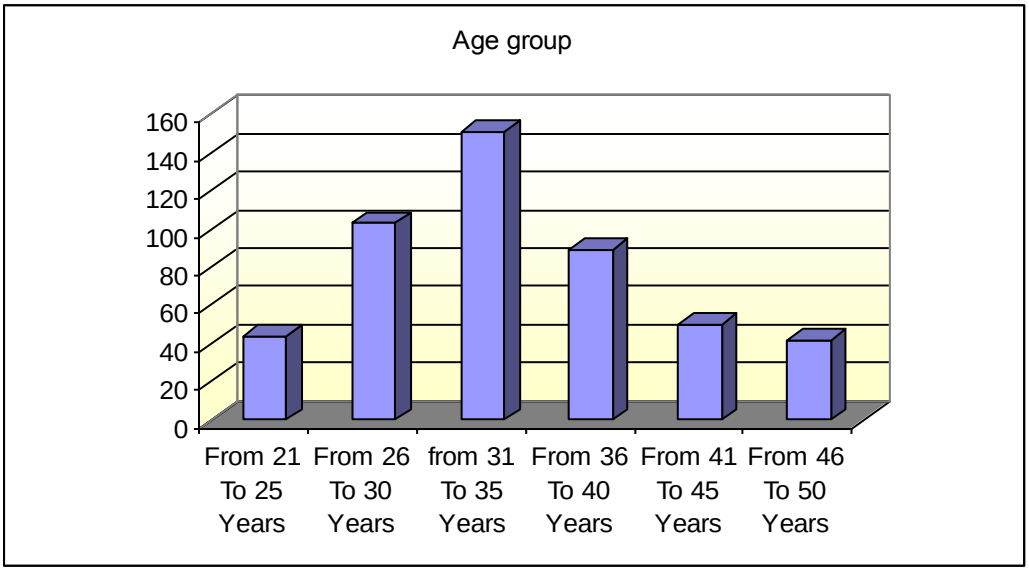


Figure 5.2 **Frequency distribution of participants' age**

5.2.3 Years of teaching experience

Table 5.3 shows that teachers who had between 1 and 5 years of teaching experience formed the majority, which indicates that most of the middle school Kuwaiti teachers participating in this study are recent graduates**.**

Experience	Frequency	Percent
From 1 To 5 Years	194	40.5%
From 6 To 10 Years	92	19.2%
From 11 To 15 Years	95	19.8%
From 16 To 21 Years	62	12.9%
Above 20 years	36	7.6%
Total	479	100.0%

Table 5.3 **Frequencies and percentages of years of teaching experience**

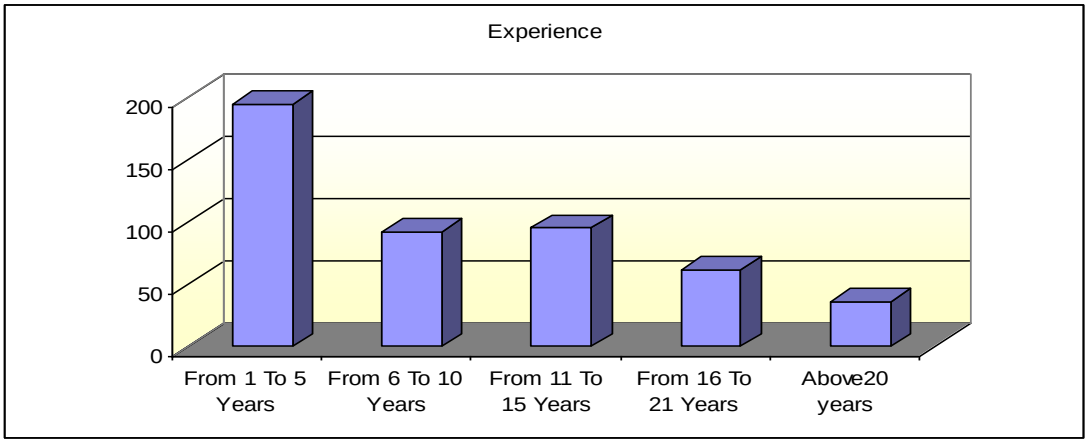


Figure 5.3 **Frequency distribution of participants' years of teaching experience**

5.2.4 Level of education

From Table 5.4 and Figure 5.4 it appears that 90.2% of the teachers hold a Bachelors degree. It is worth pointing out that one of the recent graduation plans set by the College of Education in Kuwait University is to equip new teachers with a Bachelors degree in education.

Level of Education	Frequency	Percent
Diploma	16	3.3%
Bachelor	432	90.2%
Master's Degree	20	4.2%
PhD	11	2.3%
Total	479	100.0%

Table 5.4 **Frequencies and percentages of participants' level of education**

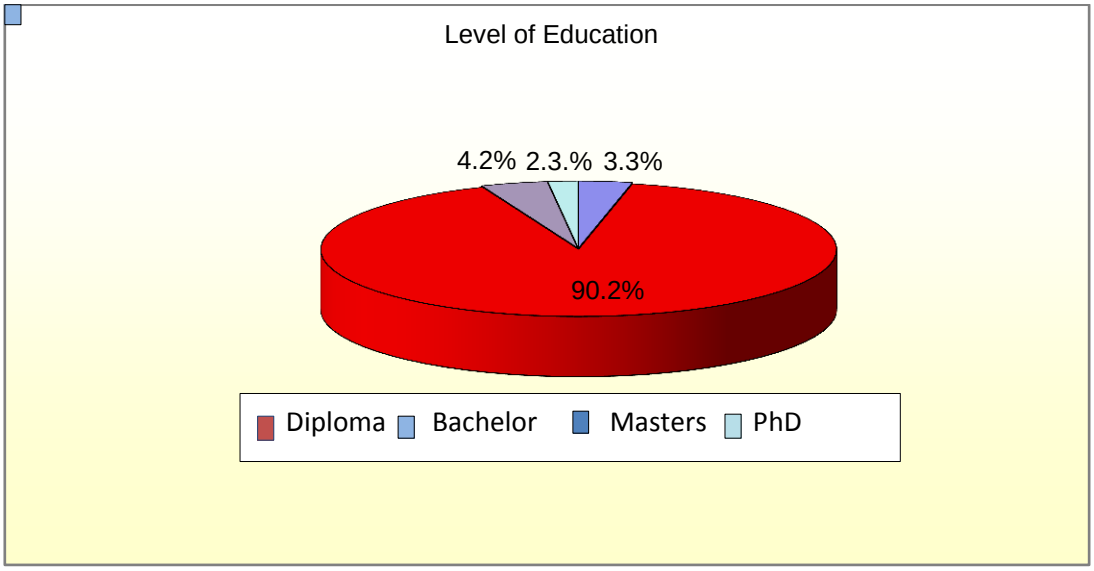


Figure 5.4 **Percentage distribution of level of education**

5.3 Factor analysis for data deduction

A factor analysis statistical method (principal component using Varimax rotation) was employed in a pilot study of 60 participants, in order to reduce the numbers of scale items to a few interpretable factors that determine whether groups of attitudes scale items tend to bunch together to form distinct clusters, referred to as factors (dimensions) (Bryman & Cramer, 2001).

5.3.1 Reliability analysis

In order to determine the factorability of the "Inter-correlation Matrix", the researcher has employed Cronbach Alpha (α) which is one of the commonly used tests of internal reliability, and is based on the rationale that items measuring the same dimension will correlate to a high degree (Bryman, 2008). In this study, the reliability (i.e. Cronbach Alpha) of all 32 items of attitudes scale was 0.86, reflecting a satisfactory and reliable internal reliability of scales, indicating that the questions were correlated and related to each other.

5.3.2 Exploratory factor analysis

Factor analysis was employed to remove redundancy in data and reveal the underlying correlation that may exist between the variables. It explored the factor loading, which is an indicator of the degree of association between a factor and its items. After factor analysis, the 35 statements (items) given in the attitudes scale yielded 5 factors (dimensions) including 32 items. Therefore, there were items in the original factors of the attitudes scale that are not included, as shown in Table 5.5.

Item No.(as it appears on attitude scale)	Factors/Dimensions	Factor Loadings	Explained Variance	Cronbach's α
Cognitive component	**(1) Beliefs about mental health problems as alterable problems**		4.862	0.65
C1	A mentally healthy person is someone who can cope with, adjust to life's stressors, and adapt to changes.	.379		
C2	Somebody with a mental health problem which is temporary would not be said to have a mental illness.	.379		
C3	The majority of people who experience mental health problems can recover if they get help early on.	.592		
C4	Mental health problems that are not recognized early can become more severe.	.588		

C5	Young people have the right and the need to be mentally healthy.	.568		
	(2) Beliefs about promoting pupils' mental health in schools		5.593	0.75
C6	Schools hold a unique position in positively affecting the mental health of pupils.	.584		
C7	Teachers play an influential role in recognizing pupils with mental health problems.	.745		
C8	It is not the teachers' job to promote pupils' mental health in the class.	.551		
C9	Promoting pupils' mental health means supporting pupils to strengthen their positive mental health.	.419		
C10	Promoting pupils' mental health means enhancing individual knowledge and skills to foster their mental health.	.303		
C11	Teachers are expected to assume some responsibility in the early recognition of pupils' mental health problems.	.321		
C12	Professionals other than teachers should take primary responsibility for promoting pupils' mental health.	Excluded item		
	(3)Beliefs about requirements and outcomes of promoting pupils' mental health		6.727	0.74
C13	Promoting pupils' mental health requires teachers to have specific training skills.	.565		
C14	Promoting pupils' mental health requires teachers to have adequate knowledge of mental health issues.	.679		
C15	Promoting pupils' mental health has a positive impact on their social and emotional well-being.	.611		
C16	Referring pupils with mental health problems for appropriate early support reduces the risk of their developing severe mental health problems.	.412		

C17	Having pupils with mental health problems in my class impedes the learning of other pupils.	.397		
C18	Promoting pupils' mental health has a positive impact on their academic achievement.	.555		
Affective component	**(4)Affective response towards promoting pupils' mental health**		8.861	0.88
A1	Including pupils with mental health problems in your class.	.628		
A2	Recognizing pupils' mental health problems.	.823		
A3	Dealing with pupils' mental health problems in my classroom.	.837		
A4	Managing a class which includes pupils with mental health problems.	.737		
A5	Promoting pupils' mental health.	.747		
Behavioural component	**(5) Behavioural response towards promoting pupils' mental health**		9.652	0.83
B1	Accept responsibility for promoting pupils' mental health in my class.	.681		
B2	Increase my knowledge about mental health issues and how they affect pupils.	.643		
B3	Hope his/her problems will go away.	.348		
B4	Be willing to implement a positive mental health curriculum.	.592		
B7	Engage in developing training in the appropriate skills to recognize and deal with pupils' with mental health issues.	.594		
B8	Co-operate with the school administration in decision- making concerning pupils' mental health.	.586		
B9	Be willing to work with mental health professionals in order to address emotional/ behavioural issues in my classroom.	.540		

B10	Co-operate with the parents of pupils with mental health problems.	.545		
B11	Suggest to the head teacher to move pupils with mental health issues to another class.	.341		
B12	Be aware of the mental health services available for my pupils in the school.	.533		
B5	Refer pupils directly to a school counsellor or social worker.	Excluded		
B6	Treat him/her just like the other pupils regardless of his/her problems.	Excluded		

Table 5.5 **Attitudes scale factor loadings**

In addition, Table 5.5 on factor loading shows the latent constructs of attitudes besides the items of each factor. It also shows the factors (dimensions) of the three attitude components and the 'Explained Variance' of each factor and Cronbach Alpha results that determined the factorability of the "Inter-correlation Matrix". As a result, the attitudes scale consists of three components, and each component has its dimensions: the cognitive component (beliefs about mental health problems as alterable problems, beliefs about promoting pupils' mental health in schools, beliefs about requirements and outcomes), the affective component, and the behavioural component, as shown in Table 5.6 and Figure 5.5.

Additionally, a Pearson's product-moment correlation coefficient was used to investigate the relationship between the excluded items (C12, B5, B6) from the attitudes scale and the dimensions of the attitudes components scale. Table 5.7 revealed no and poor correlation between the five dimensions of the attitudes components scale and the excluded items, based on Cohen's (1988) guidelines for correlation values interpretation. There was no correlation between the excluded item C12 and the three dimensions of the cognitive component of attitudes (Dim1, Dim2, Dim3), the affective component dimension (Dim4), and the behaviour component dimension (Dim5) and the excluded items ($p<.01$). In addition, there was a poor correlation ($p<.01$) between all the dimensions and the other two excluded items (B5, B6.) In conclusion, the results of this correlational analysis agreed with the results of the factor analysis which excluded the three items from the total items in the attitudes scale.

N	Factors/Dimensions	Mean	Std. Deviation
(1)Cognitive component	Dim1: Beliefs about mental health problems as alterable problems	4.33	.45
	Dim2: Beliefs about promoting pupils' mental health in schools	4.27	.48
	Dim3: Requirements and outcomes of promoting pupils' mental health	4.31	.51
(2)Affective component	Dim4: Affective response towards promoting pupils' mental health	3.47	.97
(3)Behavioural component	Dim5: Behavioural response towards promoting pupils' mental health	4.14	.49

Table 5.6 **Means and SD of the three components of attitudes**

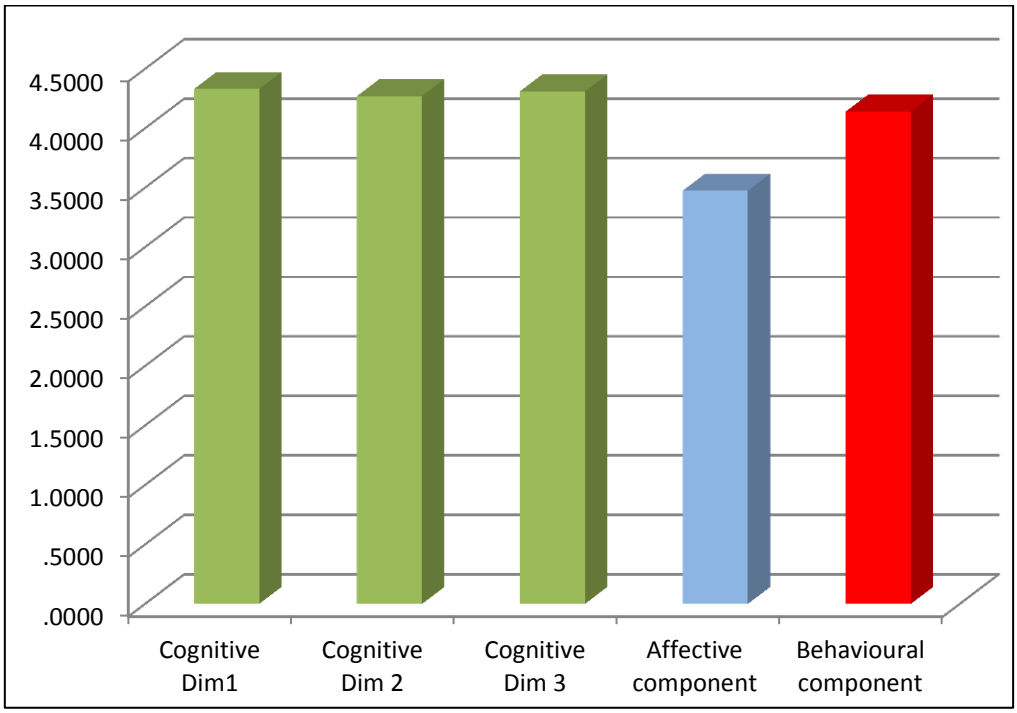


Figure 5.5 **Descriptive statistics for the three components of attitudes**

Item	Dim1	Dim2	Dim3	Dim4	Dim5
C12	.054	.087	.137**	.047	.034
B5	.216**	.269**	.291**	.127**	.348**
B6	.170**	.139**	.150**	.130**	.273**

** Correlation is significant at the 0.01 level (2-tailed)

Table 5.7 **Correlation between mean scores of the three components of attitudes scale and the excluded items**

5.4 Analysis of teachers' attitudes towards promoting pupils' mental health

The attitudes part of the survey (attitudes scale) was conducted and the data obtained was fed into SPSS software (Statistical Package for Social Science; version16.0 for Windows XP). The following section shows the analysis of teachers' attitudes towards promoting pupils' mental health. The purpose of this section of the chapter is to illuminate the first question of the first stage of the study: What are the attitudes of Kuwaiti teachers in middle schools towards promoting pupils' mental health?

In this section, the analysis of attitudes aims to gain a clear and detailed picture of teachers' attitudes towards promoting pupils' mental health, focusing on the three components of the attitudes scale, namely cognitive, affective and behavioural intentions. In the following section, teachers' general attitudes towards promoting pupils' mental health will be presented, to be followed by a detailed analysis of the relationship between the three components of attitudes.

5.4.1 Teachers general attitudes towards promoting pupils' mental health

The results of the attitude scale suggested that Kuwaiti teachers in middle schools tend to hold mildly positive attitudes towards promoting pupils' mental health. Examination of the above Table 5.6 and Figure 5.5 show that the majority of Kuwaiti teachers in middle schools tend to hold strong beliefs about the three dimensions of the cognitive component of attitudes: teachers' beliefs about mental health problems as alterable problems (M=4.33, SD=.45), teachers' beliefs about promoting pupils' mental health in schools (M=4.27, SD=.48), and teachers' beliefs about the requirements and outcomes of promoting pupils' mental health (M=4.31, SD=.51). In addition, teachers hold slightly positive feelings towards

pupils' mental health issues (affective component) (M=3.47, SD=.97). Moreover, teachers have fairly positive intentions towards the implementation of promoting pupils' mental health (behavioural component) (M=4.14, SD=.49) (see also Figure 5.5). In the following section, the relationship between the three components of attitudes will be presented before going on to analyse them in detail.

5.4.1.1 Cognitive component of attitudes

The cognitive component of attitudes is mainly integrated with participants' beliefs and knowledge aspects. In this study, the cognitive component is measured by three dimensions or thematic units: teachers' beliefs about mental health problems as alterable problems, teachers' beliefs about promoting pupils' mental health in schools, and teachers' beliefs about requirements and outcomes (psychological, social and academic) of promoting pupils' mental health. Teachers were asked to indicate the degree of their agreement with the statements representing the previous three dimensions. The level of agreement was indicated by a format consisting of a 5 point scale with the range: *strongly agree (SA), agree (A), undecided (U), disagree (DA), strongly disagree (SD).* Scoring 5 is the highest and 1 the lowest for positive statements. Negative statements were scored in opposite order: 1 for the highest positive response and 5 for the lowest response (the responses of participants to these statements were re-coded). Additionally, throughout the analysis of the data, the statements of the dimension were put in descending order of mean score, starting with highest mean at the top.

- **Beliefs about mental health problems as alterable problems**

The main aim of this dimension (beliefs about mental health problems as alterable problems) of the cognitive component of attitudes was to investigate Kuwaiti middle school teachers' beliefs about the mental health concept and their perceptions of a mentally healthy person, mental health problems and young people's right to be mentally healthy. The results showed that Kuwaiti teachers participating in this survey tend to have a high level of agreement with beliefs about mental health problems as alterable problems. They had a mean overall agreement score of 4.33 out of 5.00 for their beliefs about this area, and the associated standard deviation of .45 shows relatively low variation in scores.

Specifically, Table 5.8 shows that most teachers (94%) have supported pupils' right and need to be mentally healthy. Also, teachers hold positive beliefs in terms of understanding mental health problems. 90.5% of teachers also agreed strongly with the statement that temporary

mental health problem would not be said to constitute a mental illness, 89.5% agreed with the statement that people who experience mental health problems can recover if they get help early on, and 87.9 % showed their agreement to the beliefs about the idea that mental health problems that are not recognized early can become more severe. In addition, 90.3% of them believe that being mentally healthy means being able to cope with and adjust to life's stressors, and adapt to changes.

N	Items	SA	A	N	D	SD	Mean	Std. D
C5	Young people have the right and the need to be mentally healthy.	283 59.1%	167 34.9%	21 4.4%	5 1.0%	3 0.6%	4.50	.69
C4	Mental health problems that are not recognized early can become more severe.	221 46.1%	200 41.8%	50 10.4%	7 1.5%	1 0.2%	4.32	.73
C1	A mentally healthy person is someone who can cope with and adjust to life's stressors, and adapt to changes.	228 47.6%	206 43.0%	32 6.6%	7 1.5%	6 1.3%	4.29	.76
C3	The majority of people who experience mental health problems can recover if they get help early on.	189 39.5%	241 50.3%	47 9.8%	1 0.2%	1 0.2%	4.28	.66
C2	Somebody with a mental health problem which is temporary would not be said to have a mental illness.	181 37.7%	253 52.8%	39 8.3%	5 1.0%	1 0.2%	4.26	.66

Table 5.8 **Frequencies and percentages of beliefs about mental health problems**

- **Beliefs about promoting pupils' mental health in schools**

This section aims to investigate how Kuwaiti middle school teachers understand the concept of promoting pupils' mental health in terms of the school's unique position in this area, and

teachers' responsibility for pupils' mental health. The results showed that Kuwaiti teachers participating in this survey tend to have a high level of agreement with beliefs about promoting pupils' mental health in schools. They had a mean overall agreement score of 4.27 out of 5.00 for their beliefs about this area, and the associated standard deviation of .45 shows relatively low variation in scores.

Examination of Table 5.9 indicates that most teachers have strong fairly beliefs that stress the school's unique position in positively affecting the mental health of pupils (79.9%). Additionally, most teachers (85.4%) agreed with the statement given about teachers' expected and assumed responsibility in the early recognition of pupils' mental health problems. Consistently, teachers (87.9%) showed their agreement about their influential role in recognizing pupils with mental health problems. In addition, most teachers strongly agreed that promoting pupils' mental health means supporting pupils to strengthen their positive mental health (90.2%) and enhancing individual knowledge and skills to foster their mental health (88.2%). 91.7% of teachers, however, hold the conflicting belief that promoting pupils' mental health in the class is not their job.

Such results give rise to many questions: why do the majority of teachers (94%) support pupils' right to be mentally healthy and that they agree that they have an influential role and responsibility in recognizing pupils with mental health problems, and at the same time believe that promoting pupils' mental health is not their job? This could reflect, in a sense, their lack of knowledge and skills in terms of promoting pupils' mental health. In addition, this may reflect the insufficient time teachers have to recognize pupils' mental health issues in the class, due to excessive teaching demands. Also, teachers' responses to this item might refer explicitly to their role in class: perhaps the teachers see that they have a role but not specifically in class teaching. Therefore, this is a key finding which can be explored in semi-structured interviews.

N	Items	SA	A	N	D	SD	Mean	Std. D
C6	Schools hold a unique position in positively affecting the mental health of pupils.	176 36.7%	207 43.2%	69 14.4 %	9 1.9%	18 3.8%	4.40	.70
C7	Teachers play an influential role in recognizing pupils with mental health problems.	193 40.3%	228 47.6%	45 9.4%	9 1.9%	4 0.8%	4.34	.68
C10	Promoting pupils' mental health means enhancing individual knowledge and skills to foster their mental health.	208 43.4%	220 45.9%	47 9.8%	4 0.8%	0 0.0%	4.31	.68
C9	Promoting pupils' mental health means supporting pupils to strengthen their positive mental health.	186 38.9%	246 51.3%	36 7.5%	6 1.3%	5 1.0%	4.25	.69
C11	Teachers are expected to assume some responsibility in the early recognition of pupils' mental health problems.	169 35.3%	240 50.1%	57 11.9 %	5 1.0%	8 1.7%	4.16	.79
C8	It is not teachers' job to promote pupils' mental health in the class *	211 44.1%	228 47.6%	34 7.1%	4 0.8%	2 0.4%	4.12	.77

Table 5.9 **Frequencies and percentages of beliefs about promoting pupils' mental health in schools**

- **Beliefs about requirements and outcomes of promoting mental health**

This section aims to explore teachers' views regarding the requirements for promoting pupils' mental health and outcomes. Teachers tended to agree or agree strongly with the statements given about the essential requirements for promoting pupils' mental health and outcomes. They had a mean overall agreement score of 4.31 out of 5.00 for their beliefs about this area, and the associated standard deviation of .51 shows relatively low variation in scores.

	Items	SA	A	N	D	SD	Mean	Std. D
C18	Promoting pupils' mental health has a positive impact on their academic achievement.	275 57.4%	171 35.7%	24 5.0%	8 1.7%	1 0.2%	4.48	.69
C16	Promoting pupils' mental health reduces the risk of developing severe mental health problems.	234 48.9%	204 42.6%	38 7.9%	3 0.6%	0 0.0%	4.39	.66
C15	Promoting pupils' mental health has a positive impact on their social and emotional well-being.	236 49.3%	201 42.0%	35 7.3%	3 0.6%	4 0.8%	4.38	.72
C14	Promoting pupils' mental health requires teachers to have adequate knowledge of mental health issues.	211 44.1%	219 45.7%	33 6.9%	2 0.4%	14 2.9%	4.27	.84
C13	Promoting pupils' mental health requires teachers to have specific training skills.	201 41.9%	216 45.1%	52 10.9%	2 0.4%	8 1.7%	4.21	.85
C17	Having pupils with mental health problems in my class impedes the learning of other pupils.*	195 40.7%	200 41.8%	60 12.5%	17 3.5%	7 1.5%	4.16	.88

Table 5.10 **Frequencies and percentages of beliefs about requirements and outcomes of promoting pupils' mental health**

As can be seen in Table 5.10, most teachers (87.0%) agreed that promoting pupils' mental health requires them to have specific training skills. Furthermore, 89.8% of teachers showed their agreement with the statement given about the belief that promoting pupils' mental health requires them to have adequate knowledge of mental health issues. Additionally, the results indicated that most teachers agree on the psychological outcomes of promoting pupils' mental health. Specifically, results indicated that most teachers (91.3%) hold strong beliefs that promoting pupils' mental health has a positive impact on pupils' social well-being.

Moreover, most of the teachers (91.5%) agreed with the statement that promoting pupils' mental health is important in reducing the risk of developing severe mental health problems. Although teachers agreed strongly with the statement about the positive academic benefits of promoting pupils' mental health, they were not as strong in the responses to the statements about the psychological and social benefits. 93.1% of the teachers agreed with the positive impact of promoting mental health on pupils' academic achievement. However, 82.5% were concerned about the negative effect of having pupils with mental health problems in their class, as they believe that this could affect other pupils' learning negatively. In order to investigate the relationship between the three dimensions of the cognitive component of attitudes, Pearson product-moment correlation coefficient was used. Table 5.11 indicates that the three dimensions representing the cognitive component of attitudes had low-to-medium significant correlations with each other.

Cognitive dimensions		Dim1	Dim2	Dim3
Dim1	Pearson Correlation	1	.415**	.334**
	Sig. (2-tailed)		.000	.000
	N	479	479	479
Dim2	Pearson Correlation	.415**	1	.462**
	Sig. (2-tailed)	.000		.000
	N	479	479	479
Dim3	Pearson Correlation	.334**	.462**	1
	Sig. (2-tailed)	.000	.000	
	N	479	479	479

**. Correlation is significant at the 0.01 level (2-tailed).

***Table 5.11*Correlation between mean scores of the three dimensions of the cognitive component of attitudes**

5.4.1.2 Affective component of attitudes

The purpose of this section is to investigate teachers' emotional responses and feelings towards promoting pupils' mental health. Teachers were asked to indicate their feelings towards such a promotion process. Generally, examination of Table 5.12 shows that teachers tended to agree slightly to positive feelings towards promoting pupils' mental health. They

had a mean overall agreement score of 3.47 out of 5.00 for their beliefs about this area, and the associated standard deviation of .97 shows relatively high variation in scores. Teachers slightly agreed with the statements given about helping pupils to foster their mental health, recognizing mental health problems among their pupils, dealing with pupils' mental health in class, managing a class which includes those pupils, and including pupils with mental health problems in their classes. This means that teachers feel predominantly less comfortable towards promoting pupils' mental health. The table shows the degree of teachers' feelings, rated from 5 to 1, with 5 being the highest and 1 being the lowest for positive feelings ('comfortable-uncomfortable', 'interested-uninterested', 'pessimistic-optimistic', 'negative-positive', and 'happy-unhappy'). The 5 feeling ratings were averaged by the researcher for each participant, to give an average feeling rating for each teacher.

N	Items	Mean	Std. D
A5	Helping pupils with mental health problems.	3.92	1.02
A4	Managing a class which includes pupils with mental health problems.	3.54	1.25
A3	Dealing with pupils' mental health problems in my classroom.	3.52	1.23
A2	Recognizing pupils' mental health problems.	3.46	1.14
A1	Including pupils with mental health problems in my class.	3.92	1.02

Table 5.12 **Means and SD of the affective component of attitudes**

Such results give rise to a question: Are these less positive feelings because of their lack of knowledge in the area of pupils' mental health, and the required skills to recognize and deal with mental health problems among pupils, impacting negatively on their self-confidence in this area, and in turn on their attitudes to the implementation of promoting pupils' mental health? All those issues could be possible explanations for such results, but they cannot be

captured through the analysis of the surveys, and need further investigation in the qualitative stage.

5.4.1.3 Behavioural component of attitudes

This section aims to explore teachers' intentions towards their role as pupils' mental health promoters and their willingness to change their behaviour to implement promoting pupils' mental health in school. Teachers were asked to indicate the degree of their willingness to show positive behavioural intension towards promoting pupils' mental health. The findings showed that teachers tend to hold fairly strong positive beliefs about behavioural intension towards promoting pupils' mental health. They had a mean overall agreement score of 4.14 out of 5.00 for their beliefs in this area, and the associated standard deviation of .49 shows relatively low variation in scores. Examination of Table 5.13 indicates that there is a tendency among most teachers (87.9%) to accept their responsibility for promoting pupils' mental health. This positive tendency could be seen in many facets: increasing their own knowledge regarding pupils' mental health issues (88.1%), engaging in developing training skills (83.1%), being willing to implement a positive mental health curriculum (79.8%), co-operating with the school administration in decision making concerning pupils' mental health (88.5%), being aware of the mental health services provided (83.7%), readiness to work with mental health professionals (80.4%), and willingness to co-operate with parents (87.9%). Finally, most of the teachers agreed fairly strongly with the negative statements which represent the potential negative behavioural intentions towards promoting pupils' mental health: being willing to hope a pupil's mental health problems will go away (77.6%) and suggesting to the head teacher to move pupils with mental health issues to another class (89.8%).

N	Items	SA	A	N	D	SD	Mean	Std. D
B12	Be aware of the mental health services available for my pupils.	158 33.0%	243 50.7%	61 12.8%	13 2.7%	4 0.8%	4.26	.74
B10	Co-operate with the parents of pupils with mental health problems.	177 37.0%	244 50.9%	45 9.4%	10 2.1%	3 0.6%	4.25	73

B1	Accept responsibility for promoting pupils' mental health in my class.	193 40.3%	228 47.6%	45 9.4%	9 1.9%	4 0.8%	4.24	.76
B9	Be willing to work with mental health professionals.	157 32.7`%	228 47.7%	60 12.5%	26 5.4%	8 1.7%	4.21	.74
B2	Increase my knowledge about pupils' mental health issues.	160 33.4%	262 54.7%	30 6.3%	22 4.6%	5 1.0%	4.16	.79
B8	Co-operate with the school administration.	204 42.6%	220 45.9%	49 10.3%	3 0.6%	3 0.6%	4.12	.79
B3	Hope his/her problems will go away.*	164 34.2%	208 43.4%	72 15.0%	27 5.7%	8 1.7%	4.12	.79
B4	Be willing to implement a positive mental health curriculum.	135 28.2%	247 51.6%	78 16.3%	14 2.9%	5 1.0%	4.11	.89
B11	Suggest to the head teacher moving pupils with mental health issues to another class.*	193 40.3%	237 49.5%	34 7.1%	13 2.7%	2 0.4%	4.02	.93
B7	Engage in developing training in the appropriate skills.	189 39.5%	209 43.6%	60 12.5%	16 3.4%	5 1.0%	3.98	.89

Table 5.13 **Frequencies and percentages of the behavioural component of attitudes**

5.4.2 Correlation between the components of attitudes

The purpose of this section of the chapter is to illuminate the second question of the first stage of the study: Is there any significant statistical correlation between the three components of teachers' attitudes to pupils' mental health (cognitive-affective-behavioural)? In order to investigate the relationship between the three components of attitudes, Pearson product-moment correlation coefficient was used. Table 5.14 indicates that the three components of attitudes (the cognitive component includes its three dimensions: beliefs about mental health problems as alterable problems, beliefs about promoting pupils' mental health in schools,

beliefs about the requirements and outcomes of the promotion process), were slightly correlated with each other. However, all these correlations were low to medium and shows that the factors were only loosely inter-related. This corresponds with the initial analysis that there were three distinct components of attitudes and that the three component model of attitudes is relevant to this study.

Dimensions of attitudes' components		Cognitive Dim1	Cognitive Dim2	Cognitive Dim3	Affective	Behavioural
Cognitive Dim1	Pearson Correlation	1	.415**	.334**	.149**	.264**
	Sig. (2-tailed)		.000	.000	.001	.000
	N	479	479	479	479	479
Cognitive Dim2	Pearson Correlation	.415**	1	.462**	.197**	.418**
	Sig. (2-tailed)	.000		.000	.000	.000
	N	479	479	479	479	479
Cognitive Dim3	Pearson Correlation	.334**	.462**	1	.163**	.364**
	Sig. (2-tailed)	.000	.000		.000	.000
	N	479	479	479	479	479
Affective	Pearson Correlation	.149**	.197**	.163**	1	.413**
	Sig. (2-tailed)	.001	.000	.000		.000
	N	479	479	479	479	479
Behavioural	Pearson Correlation	.264**	.418**	.364**	.413**	1
	Sig. (2-tailed)	.000	.000	.000	.000	
	N	479	479	479	479	479

**. Correlation is significant at the 0.01 level (2-tailed).

Table 5.14 **Correlation between mean scores of the three components of attitudes**

5.5 Factors influencing teachers' attitudes

This section of the analysis attempts to answer the third research question of the quantitative stage of the study: Are there any significant statistical differences in Kuwaiti middle school teachers' attitudes towards pupils' mental health that can be attributed to teachers' gender, age, years of teaching experience or level of education? A T-test and one-way ANOVA were carried out in order to examine the relationships between the three attitude components

(cognitive, affective, and behavioural), using gender, age, years of teaching and educational level as independent variables, and the scores of attitude components as dependent variables.

5.5.1 Gender

An independent sample T-test was conducted (see Table 5.15). The T-test did not reveal statistically reliable differences between male and female Kuwaiti teachers in the three dimensions of the cognitive components of the attitudes scale: Dim1 (beliefs about mental health problems as alterable problems), Dim2 (beliefs about promoting pupils' mental health in schools), and Dim3 (beliefs about requirements and outcomes of promoting pupils' mental health).

Cognitive component										
Variable		**Dim1: Beliefs about mental health problems as alterable problems**			**Dim2: Beliefs about promoting pupils' mental health in schools**			**Dim3: Beliefs about requirements and outcomes of promoting pupils 'mental health**		
Gender	N	M	SD	Sig	M	SD	Sig	M	SD	Sig
Male	210	4.34	.45	.631 (NS)	4.28	.47	.654 (NS)	4.09	.58	.335 (NS)
Female	268	4.32	.45		4.26	.50		4.17	.45	

Affective component Dim4: Affective response				**Behavioural component Dim5:Behavioural response**		
	M	SD	Sig	M	SD	Sig
Male	3.29	1.00	.000*	4.09	.53	.088 (NS)
Female	3.61	.92		4.17	.49	

Table 5.15 **Means, SD, and Significant difference values for the dimensions of attitude components and gender factor**

Moreover, there were no statistically reliable differences between male and female Kuwaiti teachers in the dimension of the behavioural component of attitudes scale (Dim5) (behavioural response towards promoting pupils' mental health). However, there was a statistical difference between male and female Kuwaiti teachers in the dimension of the affective component, as the descriptive statistics showed that the mean scores of female

teachers in the affective component (M=3.61, 3.29; SD=.92, 1.00; respectively) were higher than those of male teachers. This means that female teachers tend to hold more positive feelings towards promoting pupils' mental health.

5.5.2 Age

A one way ANOVA test was utilised to explore the effect of teachers' age on the five dimensions of components in the attitudes scale.

Cognitive component										
Variable		**Dim1: Beliefs about mental health problems as alterable problems**			**Dim2: Beliefs about promoting pupils' mental health in schools**			**Dim3: Beliefs about requirements and outcomes of promoting pupils 'mental health**		
Age group	N	M	SD	Sig	M	SD	Sig	M	SD	Sig
From 21 to 25 years	44	4.23	.42	.039**	4.20	.50	.536 (NS)	4.22	.38	.212 (NS)
From 26 to 30 years	103	4.16	.45		4.33	.35		4.27	.43	
From 31 to 35 years	151	4.34	.50		4.36	.53		4.30	.63	
From 36 to 40 years	89	4.29	.51		4.35	.41		4.44	.47	
From 41 to 45 years	50	4.33	.55		4.34	.47		4.32	.54	
From 46 to 50 years	42	4.16	.38		4.33	.38		4.31	.38	

Affective component **Dim4: Affective response**				**Behavioural component** **Dim5: Behavioural response**		
	M	SD	Sig	M	SD	Sig
From 21 to 25 years	3.39	.87	.004*	3.98	.50	.031**
From 26 to 30 years	3.49	.89		4.23	.43	
From 31 to 35 years	3.62	.90		4.10	.53	
From 36 to 40 years	3.55	.99		4.32	.54	
From 41 to 45 years	3.30	1.13		4.16	.51	

Table 5.16 **Means, SD, and Significant difference values for the dimensions of attitudes components and the age group factor**

It is evident from the results in Table 5.16 above that there were statistically significant differences between all the age groups of Kuwaiti teachers in Dim1 of the cognitive

component (F=2.36, df=5,479, p=0.039, p< 0.05). Additionally, there were statistically significant differences between all the age groups of Kuwaiti teachers in Dim4 (effective component of the attitude scale) (F=3.47, df=5,479, p=.004, p< 0.05), and in Dim5 (the behavioural intentions of attitude scale) (F=2.48, df=5,479 p=.031, p< 0.05). However, there were no significant differences between all the age groups of teachers in Dim2 and Dim3 of the cognitive component of the attitude scale. Post Hoc comparisons using the Bonferroni test indicated that teachers aged 31 to35 years old held more positive beliefs regarding their understanding the alterability of mental health problems (M=4.34, SD=.50) than teachers in the other age groups. Also, the same age group held more positive feelings (Dim4) (M= 3.62, SD= .90) towards promoting pupils' mental health. Additionally, the results revealed more positive behavioural intentions (Dim5) (M= 4.32, SD=.54) towards promoting pupils' mental health among teachers aged 36 to 40 years old than teachers in the other age groups.

5.5.3 Level of education

A one way ANOVA test was also conducted to explore the impact of teachers' level of education on their attitudes. The results of Table 5.17 reveal statistically significant differences between teachers' different levels of education in the three cognitive component dimensions, Dim1 (F=2.35, df=4, 479, p=.053), Dim2 (F=2.26, df=4,479, p=.012, p< 0.05), and Dim3 (F=3.54, df=4,479, p=.007, p< 0.05). However, the results revealed no statistically significant differences in the affective component dimension (Dim4) (F=.249, df=4, 479, p=.910, p0.05), and the behavioural component dimension (Dim5) (F=.658, df=4,479, p=.621, p> 0.05) between teachers' different levels of educations.

Post Hoc comparisons using the Bonferroni test indicated that teachers who had their Masters degree held more positive cognitive attitudes towards promoting pupils' mental health. Particularly, they had more positive beliefs in all three dimensions or thematic units of the cognitive component, which includes teachers' beliefs about mental health (Dim1) (M=4.42, SD=.43), promoting pupils' mental health in schools (Dim2) (M=4.46, SD=.43) and requirements and outcomes (psychological, social and academic) of promoting pupils' mental health (Dim3) (M=4.40, SD=.54), than other teachers in the other education groups.

Affective component Dim4: Affective response				Behavioural component Dim5: Behavioural response		
	M	SD	Sig	M	SD	Sig
Diploma	3.46	1.00	.910 (NS)	4.03	.46	.621 (NS)
Bachelor	3.46	.97		4.14	.52	
Masters	3.45	1.07		4.32	.45	
PhD	3.98	.60		4.33	.44	

Cognitive component									
Variable		Dim1: Beliefs about mental health as alterable problems			Dim2:Beliefs about promoting pupils' mental health in schools			Dim3: Beliefs about requirements and outcomes of promoting pupils 'mental health		
Level of education	N	M	SD	Sig	M	SD	Sig	M	SD	Sig
Diploma	16	3.98	.60	.053**	3.97	.40	.012**	3.91	.69	.007**
Bachelor	432	4.34	.44		4.27	.49		4.32	.50	
Masters	20	4.42	.43		4.46	.43		4.40	.54	
PhD	9	4.24	.34		4.33	.44		4.37	.36	

Table 5.17 **Means, SD, and Significant difference values for the dimensions of attitude components and education level factor**

5.5.4 Years of teaching experience

A one way ANOVA was also utilised in order to explore the significant differences between teachers' years of experience and the five dimensions of attitudes components. The results of ANOVA in Table 5.18 show that there were significant differences between teachers according to their years of teaching experience. For example, in the affective component dimension (Dim4)(F=3.21, df=4,479, p=.013, p< 0.05), and in the behavioural component dimension (Dim5)(F=3.42, df=4,479, p=.009, p< 0.05) of their attitudes towards pupils' mental health, but not in the three cognitive component dimensions: Dim1 (F=1.69, df=4,479, p=.150), Dim2 (F=1.013, df=4,479, p=.400, p> 0.05), and Dim3 (F=1.43, df=4,479,p=.222, p> 0.05). Post Hoc comparisons using the Bonferroni test indicated that teachers who had

above 20 years teaching experience have more positive feelings towards promoting pupils' mental health (Dim4) (M=4.40, SD= 53) than teachers in the other experience groups, and more positive behavioural intentions towards promoting pupils' mental health (Dim5) (M=4.29, SD=.45) than teachers in the other experience groups.

Cognitive component										
Variable		**Dim1: Beliefs about mental health as alterable problems**			**Dim2: Beliefs about promoting pupils' mental health in schools**			**Dim3: Beliefs about requirements and outcomes of promoting pupils 'mental health**		
Years of Teaching experience	N	M	SD	Sig	M	SD	Sig	M	SD	Sig
From 1 to 5 years	194	4.36	.45	.150 (NS)	4.26	.49	.400 (NS)	4.26	.54	.222 (NS)
From 6 to 10 years	92	4.32	.44		4.25	.49		4.37	.49	
From 11 to 15 years	95	4.33	.48		4.32	.52		4.40	.53	
From 16 to 21 years	62	4.37	.42		4.28	.46		4.31	.45	
Above 20 years	36	4.15	.47		4.12	.36		4.28	.42	

Affective component Dim4: Affective response				**Behavioural component Dim5: Behavioural response**		
	M	SD	Sig	M	SD	Sig
From 1 to 5 years	3.56	.92	.013**	4.12	.51	.009**
From 6 to 10 years	3.47	.97		4.14	.47	
From 11 to 15 years	3.53	1.01		4.14	.62	
From 16 to 21 years	3.41	1.05		4.07	.62	
Above 20 years	4.40	.53		4.29	.45	

Table 5.18 **Means, SD, and Significant difference values for the dimensions of attitude components and years of teaching experience factor**

In considering the results highlighted above, it is fascinating to note that the majority of the results associated with the effects of demographic variables, i.e. age, gender, level of education, and years of teaching experience, in relation to the three individual components of the attitude survey, i.e. affective, behavioural and cognitive, were generally found to be in line with the results garnered through the analysis of the effects of demographic variables on

the dimensions of the components attitudes survey, i.e. Dim1, Dim2, Dim3, Dim4 and Dim5. Regarding testing the normality of the data that subjected to ANOVA according to the age groups factor, using Shapiro test shows p values are less than 0.05 so the data are not normally distributed. The tests for the normality of the dependent variable for the different years of experience are shown in the table of testing normaliyt (see Appendix (VI), p. 294, an example of how normality was tested of the data that was subjected to ANOVA according to the groups of teaching years of experience). For smaller samples, the Shapiro Wilks test is preferred. This shows p values below 0.05, so the data is not normally distributed. However ANOVA is considered to be robust even for non-normally distributed data. So ANOVA can still be used for this analysis.

Significantly, such results need to be carefully understood and translated owing to the fact that small differences may be extremely statistically significant when a large sample is taken (N=479). Furthermore, the results also highlighted that there was a major likelihood that the findings could be merely coincidental, which thus emphasises the belief that both the personal and social factors examined are not recognised as strong attitude predictors. Although it was understood that statistical findings do provide some degree of direction or otherwise a generalised overview of the topic at hand, it is nevertheless understood, as highlighted by Pallant (2005, p. 219), that there should not be too much emphasis placed on statistical significance; rather, there must also be consideration of other factors.

5.6 Analysis of teachers' perceptions about barriers to promoting pupils' mental health

This section of the chapter aims to illuminate the fourth research question of the quantitative stage: What are Kuwaiti middle school teachers' perceptions about barriers to promoting pupils' mental health? In order to answer this question, a scale of barriers measuring teachers' perceptions about barriers to the implementation of programmes related to pupils' mental health was employed.

5.6.1 Factor analysis for data deduction

A factor analysis statistical method (principal component using Varimax rotation) was employed in the pilot study, to determine whether groups of barriers scale items tend to

bunch together to form distinct clusters, referred to as factors (dimensions) (Bryman & Cramer, 2001).

5.6.2 Reliability analysis

In order to determine the factorability of the "Inter-correlation Matrix", the researcher employed Cronbach Alpha (α) which is one of the commonly used tests of internal reliability, which is based on the rationale that items measuring the same dimension will highly correlate (Bryman, 2008). In this study, the reliability (i.e. Cronbach Alpha) of all 16-items of the barriers scale was 0.83, which indicates a satisfactory and acceptable level of internal reliability, and reflects that the items of the barriers scale were correlated to each other (see Appendix (V), p. 290).

5.6.3 Exploratory factor analysis

After employing factor analysis, the 18 statements (items) given in the barriers scale yielded 4 factors (dimensions) including 16 items. Therefore, there were items in the original factors of the barriers scale that are not included, as shown in Table 5.19.

Item No.(as appearing on attitude scale)	Factors/Dimensions	Factor Loadings	Explained Variance	Cronbach's α
	(1) Personal barriers		16.005	0.85
Ba1	Lack of awareness about my role and responsibility.	.766		
Ba2	Inadequate knowledge and personal education about pupils' mental health issues.	.852		
Ba3	Inadequate training to recognize the early signs of pupils' mental health problems.	.838		
Ba4	Teachers' negative attitudes.	.717		
	(6) Interpersonal barriers		11.907	0.75
Ba12	Lack of partnership between parents and teachers.	.605		
Ba13	Resistance among administrators and inspectors.	.730		

Ba14	Lack of partnership between specialists (e.g. counsellors, educational Psychologists) and teachers.	.789		
	(3) Structural-organizational barriers		13.284	0.73
Ba7	Lack of information resources related to pupils' mental health.	.606		
Ba8	Concerns over workload and time limits.	.722		
Ba9	Absence of an educational policy which expects teachers to be responsible in promoting pupils' mental health.	.665		
Ba10	Inadequate funding.	.612		
Ba11	Curriculum, pedagogy and the examination system.	.563		
	(4) Socio-cultural barriers		11.885	0.70
Ba15	Social stigma towards talking about mental health problems and labelling.	.574		
Ba16	Alternative cultural and religious beliefs about dealing with mental health problems.	.745		
Ba17	Schools' culture and ethos (social view of school and schooling).	.736		
Ba18	Inappropriate media representations of mental health problems.	.624		
Ba5	Teachers' interests in teaching.	Excluded		
Ba6	Absence of change in educational vision.	Excluded		

***Table 5.19*: Barriers scale factor loadings**

Table 5.19 shows the factors (dimensions) of the barriers scale and the 'Explained Variance' of each factor and Cronbach Alpha results that determined the factorability of the "Inter-correlation Matrix". As a result of using factor analysis, the barriers scale sis composed of four dimensions and each dimension has its items: the personal barriers dimension, the structural-organizational barriers dimension, the interpersonal barriers dimension, and the socio-cultural barriers dimension. Additionally, a Pearson's product-moment correlation

coefficient was used to investigate the relationship between the excluded items (Ba5, Ba6) and the dimensions in the barriers scale. Table 5.20 reveals no and poor correlation between the four dimensions of the barriers scale and the excluded items. There was no correlation between Dim4 of barriers (social-cultural barriers) and the excluded item (Ba5) (r=.028, p>01), and poor correlation between Dim4 and the excluded item (Ba6) (r= .130, p>01). In addition, there was a poor correlation between the other three dimensions (Dim1, Dim2 and Dim3) of barriers and excluded items (Ba5, Ba6) (r=.205, .175; .175, .139; .135, .150). In conclusion, the results of this correlational analysis confirm the results of the factor analysis, which excluded the two items from the total items of the barriers survey.

Item(N)	Dim(1)	Dim (2)	Dim(3)	Dim (4)
Ba5	.205**	.175**	.135**	.028
Ba6	.170**	.139**	.150**	.130**

**. Correlation is significant at the 0.01 level (2-tailed).

Table 5.20 **Correlation between mean scores of the dimensions of barriers and the excluded items**

5.6.4 Analysis of teachers' perceptions about barriers to promoting pupils' mental health

In this study, teachers' perceptions about barriers to promoting pupils' mental health encompass four main dimensions: personal, interpersonal, structural-organizational, and socio-cultural barriers. The results of the survey suggested that Kuwaiti middle school teachers generally perceived barriers to promoting pupils' mental health mildly positively (M=3.93, SD=.73). Teachers were asked to indicate their agreement with the statements representing barriers that might undermine the movement to put promoting pupils' mental health into practice.

Examination of Table 5.21 and Figure 5.6 shows that Kuwaiti teachers in the middle schools tend to hold fairly strong beliefs about personal barriers (M=4.06, SD=.76) and interpersonal barriers (M=4.12, SD=.56). In addition, teachers showed moderately strong beliefs about structural-organizational barriers (M=3.78, SD=.80) and social–cultural barriers (M=3.79,

SD=.80) to promoting pupils' mental health (see also Figure 5.6). In the following section, the relationship between the four dimensions of barriers will be presented before a more detailed analysis is provided.

Barriers dimensions	Mean	Std. Deviation
(1) Personal barriers	4.06	.76
(2) Interpersonal barriers	4.12	.56
(3) Structural-organizational barriers	3.78	.80
(4)Social-cultural barriers	3.79	.80

Table 5.21 **Means and SD of the barriers dimensions**

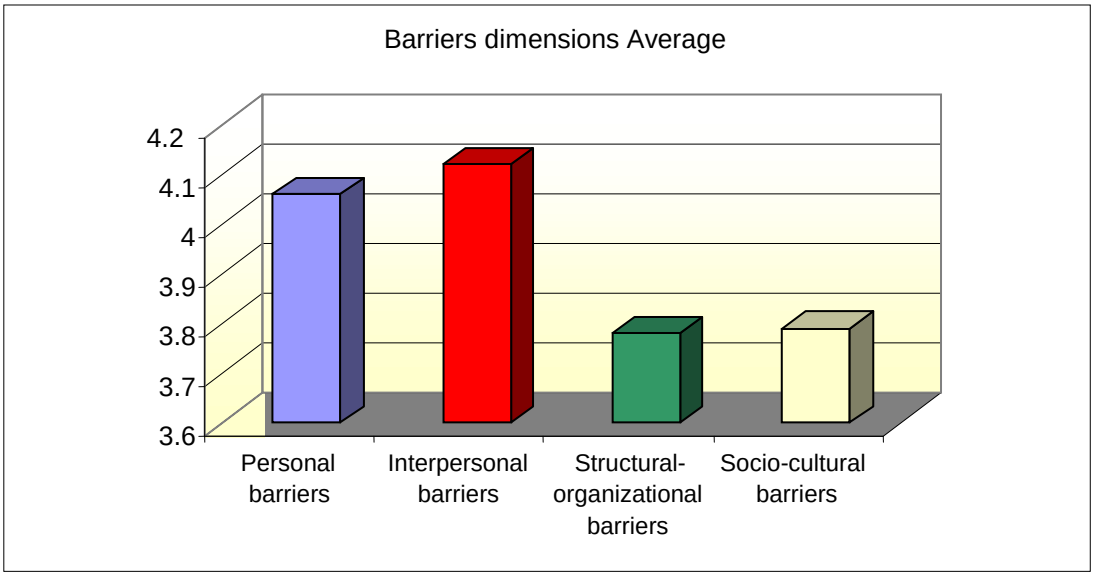


Figure 5.6 **Descriptive statistics for the four dimensions of barriers scale**

In order to investigate the relationship between the four groups of barriers, Pearson product-moment correlation coefficient was used. Table 5.22 indicates that all the perceived types of barriers are significantly inter-correlated, though most are at a low level. This is consistent with the factor analysis which identified four distinct factors covering the range of perceived individual barriers.

Barriers		Personal	Inter-personal	Socio-cultural	Structural-organizational
Personal	Pearson Correlation	1	.305**	.252**	.383**
	Sig. (2-tailed)		.000	.000	.000
	N	479	479	479	479
Inter-Personal	Pearson Correlation	.305**	1	.114*	.136**
	Sig. (2-tailed)	.000		.013	.003
	N	479	479	479	479
Structural-Organizational	Pearson Correlation	.252**	.114*	1	.383**
	Sig. (2-tailed)	.000	.013		.000
	N	479	479	479	479
Socio-cultural	Pearson Correlation	.383**	.136**	.383**	1
	Sig. (2-tailed)	.000	.003	.000	
	N	479	479	479	479

**. Correlation is significant at the 0.01 level (2-tailed).

Table 5.22 **Correlation between mean scores of the four groups of barriers**

5.6.4.1 Personal barriers

Personal barriers refer to factors related to the teachers themselves, such as lack of knowledge, lack of training, lack of awareness of responsibility and the teachers' attitudes. Generally, the data derived from the survey indicate that middle school teachers in Kuwait tend to hold tend to have a high level of agreement with beliefs about the existence of the personal barriers to promoting pupils' mental health. They had a mean overall agreement score of 4.06 out of 5.00 for their beliefs about this area and associated standard deviation of .76 shows relatively low variation in scores.

Examination of Table 5.23 indicates that 81.6% of the teachers perceived their negative attitudes to issues related to pupils' mental health as the most significant personal barrier (M=4.10, SD=.86). Similarly, the next personal barrier identifies two barriers: a lack of awareness about the teacher's role and responsibility regarding pupils' mental health (M=4.09, SD=.89) was perceived by 81.8% of teachers, and inadequate training to recognize the early signs of pupils' mental health problems (M=4.09, SD=.89) was perceived by 83.7% of teachers. Inadequate knowledge regarding pupils' mental health issues was perceived by

85.0% as the lowest rating of personal barriers to promoting pupils' mental health (M=4.07, SD=.85).

N	Items	SA	A	N	D	SD	Mean	Std. D
Ba4	Teachers' negative attitudes towards pupils' mental health issues.	165 34.4%	226 47.2%	69 14.4%	9 1.9%	10 2.1%	4.10	.86
Ba1	Lack of awareness about the teacher's role and responsibility regarding pupils' mental health.	185 38.6%	207 43.2%	52 10.9%	16 3.3%	19 4.0%	4.09	.89
Ba3	Inadequate training to recognize the early signs of pupils' mental health problems.	161 33.6%	240 50.1%	55 11.5%	7 1.5%	16 3.3%	4.09	.89
Ba2	Inadequate knowledge and personal education about pupils' mental health issues.	143 29.9%	264 55.1%	48 10.0%	11 2.3%	13 2.7%	4.07	.85

Table 5.23 **Frequencies and percentages of personal barriers**

5.6.4.2 Interpersonal barriers

Interpersonal barriers refer to the influence of people with whom teachers deal during the educational process, such as the school administration and inspectors, parents and professionals. Table 5.24 shows that the majority of Kuwaiti teachers in middle schools tend to have a high level of agreement with the existence of the interpersonal barriers to promoting pupils' mental health. They had a mean overall agreement score of 4.12 out of 5.00 for their beliefs about this area, and the associated standard deviation of .56 shows relatively low variation in scores.

Examination of Table 5.24 indicates that 83.9% of the teachers perceived a lack of partnership between themselves and parents as the most significant interpersonal barrier (M=4.21, SD=.85). Similarly, the next interpersonal barrier identifies two barriers: school administration and inspectors' resistance to change (M=4.10, SD=.84) was perceived as a barrier by 81.8% of teachers and a lack of partnership between themselves and specialists such as counsellors and educational psychologists (M=4.10, SD=.86) was perceived as a barrier by 76.6% of the teachers.

N	Items	SA	A	N	D	SD	Mean	Std. D
Ba12	Lack of partnership between parents and teachers.	206 43.0%	196 40.9%	59 12.3%	11 2.3%	7 1.5%	4.21	.85
Ba13	Resistance among administrators and inspectors.	163 34.0%	229 47.8%	69 14.4%	9 1.9%	9 1.9%	4.10	.84
Ba14	Lack of partnership between specialists (e.g. counsellors, educational psychologists) and teachers .	128 26.7%	239 49.9%	90 18.8%	8 1.7%	14 2.9%	4.10	.86

Table 5.24 **Frequencies and percentages of interpersonal barriers**

5.6.4.3 Structural-organizational barriers

Structural-organizational barriers refer to factors related to the educational system, school context and daily practices, such as workload and lack of time, lack of information resources, inadequate funding, curriculum, pedagogy and the examination system, and absence of an educational policy for promoting pupils' mental health. Generally, teachers tend to have a moderate level of agreement with the existence of the structural-organizational barriers. They had a mean overall agreement score of 3.78 out of 5.00 for their beliefs about this area and associated standard deviation of .80.

Examination of Table 5.25 indicates that 88.1% of the teachers perceived workload and limited time as the most significant structural-organizational barrier (M=4.07, SD=.85). Next, 79.3% of the teachers agreed that the lack of information resources related to mental health in school is an important structural-organizational barrier to promoting pupils' mental health (M=4.01, SD=.94). Similarly, the third structural-organizational barrier identifies two aspects: the absence of an educational policy which expects teachers to be responsible for promoting pupils' mental health (M=4.00, SD=.94) was perceived as a barrier by 74.1% and inadequate funding (M= 4.01, SD= .94) was perceived as a barrier by 79.2% of teachers. Finally, curriculum, pedagogy and the examination system, perceived by 81.2% of the teachers as a barrier, received the lowest rating of the structural-organizational barriers (M=3.95, SD=.85).

N	Items	SA	A	N	D	SD	Mean	Std. D
Ba7	Concerns over workload and time limits.	202 42.2%	220 45.9%	45 9.4%	7 1.5%	5 1.0%	4.07	.85
Ba9	Absence of an educational policy which expects teachers to be responsible for promoting pupils' mental health.	153 31.9%	215 44.9%	87 18.2%	12 2.5%	12 2.5%	4.01	.94
Ba8	Lack of information resources related to pupils' mental health	149 31.1%	231 48.2%	64 13.4%	21 4.4%	14 2.9%	4.00	.94
Ba10	Inadequate funding.	145 30.3%	210 43.8%	78 16.4%	20 4.1%	26 5.4%	3.95	.85
Ba11	Curriculum, pedagogy and the examination system.	160 33.4%	229 47.8%	57 11.9%	19 4.0%	14 2.9%	4.00	.94

Table 5.25 **Frequencies and percentages of structural-organizational barriers**

5.6.4.4 Socio-cultural barriers

Socio-cultural barriers encompass those related to social context. They include factors related to the social view of mental health and promoting mental health, such as cultural and religious beliefs, media representations of mental health and social stigma around talking about mental health problems and labelling. Generally, the data derived from the survey indicates that middle school teachers in Kuwait tend to hold moderate levels of agreement with the existence of the social–cultural barriers to promoting pupils' mental health. They had a mean overall agreement score of 3.79 out of 5.00 for their beliefs about this area, and an associated standard deviation of .80.

Examination of Table 5.26 reveals that 74.7% of teachers perceive school culture and ethos regarding promoting pupils' mental health as the most significant social-cultural barrier (M=3.90, SD= 87). Next, 83.5% of the teachers agreed that social stigma towards talking about mental health problems and labelling is an important socio-cultural barrier to promoting pupils' mental health (M=3.84, SD=.86). Similarly, the third socio-cultural barrier identifies two aspects: inappropriate media representations of mental health problems (M=3.70, SD=.86) were

perceived as a barrier by 82.4% and alternative cultural and religious beliefs about dealing with mental health problems were perceived by 83.1% of teachers as a barrier.

N	Items	SA	A	N	D	SD	Mean	Std. D
Ba17	School culture and ethos (social view of school and schooling).	152 31.7%	206 43.0%	77 16.1%	13 2.7%	31 6.5%	3.90	.87
Ba15	Social stigma towards talking about mental health problems and labelling.	140 29.2%	260 54.3%	30 6.3%	21 4.4%	28 5.8%	3.84	.86
Ba18	Inappropriate media representations of mental health problems.	127 26.5%	268 56.9%	43 8.9%	20 4.2%	21 4.4%	3.70	.86
Ba16	Alternative cultural and religious beliefs about the ways of dealing with mental health problems.	168 35.1%	230 48.0%	44 9.2%	26 5.4%	11 2.3%	3.70	.86

Table 5.26 **Frequencies and percentages of socio-cultural barriers**

5.6.5 Correlation between barriers and attitudes

This section of the chapter aims to illuminate the fifth research question of the quantitative stage: Is there any significant statistical correlation between teachers' perceived barriers to promoting pupils' mental health and teachers' attitudes? In order to investigate the correlation between the three components of teachers' attitudes (cognitive, affective, and behavioural) and groups of barriers to promoting pupils' mental health (personal, interpersonal, structural-organizational, social-cultural), a Pearson product-moment correlation coefficient was employed. Table 5.27 below indicates that most of the barriers were correlated negatively with the teachers' attitudes towards promoting pupils' mental health, as would be expected. However, teachers' readiness to show behavioural intentions towards promoting pupils' mental health was more strongly correlated with three of the four barriers: personal, social-cultural and structural-organizational. This means that teachers who perceived higher personal, interpersonal, social-cultural barriers and structural-organisational barriers have lower behavioural intentions towards promoting pupils' mental health.

Barriers		Cognitive Di1	Cognitive Di2	Cognitive Di3	Affective	Behavioral
Personal	Pearson Correlation	-.166**	-.168**	-.331**	-.215**	-.716**
	Sig. (2-tailed)	.000	.000	.000	.000	.000
	N	479	479	479	479	479
Inter-personal	Pearson Correlation	-.088	-.099*	-.104*	-.389**	-.270**
	Sig. (2-tailed)	.053	.030	.023	.000	.000
	N	479	479	479	479	479
Socio-cultural	Pearson Correlation	-.021	-.028	-.124**	-.007	-.699**
	Sig. (2-tailed)	.054	.537	.006	.000	.000
	N	479	479	479	479	479
Structural-organizational	Pearson Correlation	-.146**	-.057	-.090	-.076	-.704**
	Sig. (2-tailed)	.001	.211	.050	.098	.000
	N	479	479	479	479	479

Table 5.27 **Correlation between teachers' attitude components and the four dimensions of barriers to promoting pupils' mental health**

5.7 Analysis of the content of the open-ended questions

The participants were asked two questions following the conclusion of the survey. These questions queried whether or not they considered there to be any additional barriers concerning the implementation of mental health promotion amongst pupils, as well as what changes needed to be made in order to facilitate the implementation of such a process within a Kuwaiti context. Although the sample did not highlight any new barriers, they did provide a number of suggestions for changes.

- **Training skills**

The majority (82.6%, N=396 teachers) of the sample suggested that teachers be provided with adequate training in order to ensure they have the necessary skills to facilitate mental health promotion amongst their pupils. Furthermore, it was also stated that such training should be an on-going process so as to ensure teachers are continuously provided with up-to-date information. Moreover, some of the sample also noted that training should teach how to identify pupils with mental health issues.

- **Mental health education for teachers**

Three hundred and forty seven teachers (72.4%) suggested providing teachers with the appropriate knowledge and increasing their awareness, which could reinforce their role as teachers in promoting pupils' mental health. Some teachers suggested that these mental health education courses should be offered as continuous workshops in order to be more effective. Some teachers also suggested that pupils themselves need to be educated in mental health issues in order to raise their awareness in this area.

- **The quality of the teacher-pupil relationship**

Fifty nine teachers (12.3%) mentioned that the teacher-pupil relationship has a great impact on pupils' mental health. Some teachers mentioned that warmth, security and trust resulting from this relationship have an effect on pupil's cognitive, emotional, behavioural and academic development.

- **Collaboration between specialists and teachers**

More than half of the participants (54.6%; N=262 teachers) stated that there should be some degree of partnership between educational psychologists, mental health professionals, psychological counsellors and the Ministry of Education in Kuwait, and teachers.

- **Educational curricula**

Furthermore, it was argued by 36.3% of the sample (174 teachers) that changes and amendments need to be made to the school curriculum in order to ensure mental health promotion is successful. They suggested reducing the content of the extensive and demanding educational curriculum in order to leave a space in which pupils' mental health issues could be recognized and discussed.

- **Mental health services for teachers**

A common response, from 281 teachers (58.6%), was the consideration of teachers' mental health. Teachers mentioned that mental health services or self-care courses should be provided under the supervision of mental health professionals and school psychologists, for any teacher and at any time and in close proximity to their schools.

- **Workload and time**

Two hundred and twelve teachers (44.3%) requested a decrease in teachers' workload, as currently there is insufficient time for teachers to recognize pupils' mental health issues in the class. They mentioned that excessive teaching demands and some additional activities make the idea of promoting mental health issues currently unworkable.

- **Class size**

Slightly less than half of the sample (47.2%; N=226 teachers) complained that the large number of pupils in each classroom makes it very difficult, if not completely impossible, for teachers to make use of cooperative activities, including pair work and group tasks, or to otherwise find time to assign attention to mental health issues amongst pupils. With this in mind, it is pertinent to highlight that, on average, middle school classes comprise between 45 and 50 pupils.

- **Partnership with parents**

Sixty two teachers (13.0%) argued that more effective partnerships with parents need to be established. For example, they mentioned that parental opposition to teachers' involvement in their children's mental health problems could be an essential factor in teachers avoiding discussion of these issues.

- **Socio-cultural and religious beliefs about mental health**

A minority of the teachers (10.4%; N=50 teachers) stated that there are a number of cultural, religious and social beliefs common amongst individuals, such as parents, in regard to pupils' mental health issues; these need to be amended to assist successful implementation of change regarding the promotion of mental health amongst pupils. In this regard, it has been emphasised by teachers that mental health problems, and the patterns and recognition of such within the context of Kuwait, are impacted upon by the socio-cultural heritage of attitudes, beliefs and traditions.

- **Challenging the bureaucratic and competitive education system**

Although it has been noted by a number of teachers that the promotion of mental health amongst pupils is fundamental, as it can lead to a number of positive results, psychologically

and academically, it was nevertheless highlighted by 13.2% of the sample (N=63 teachers) that such promotion is not currently realistic. For instance, one teacher highlighted that this would not be possible unless the educational framework undergoes significant change. Moreover, other teachers stated that education policies need to be amended with consideration to pupils' mental health.

Importantly, although the open-ended question analysis suggested that teachers accept their own role in terms of promoting pupils' mental health, there remains a lack of consensus concerning how time limits and workload changes would ultimately affect teachers' attitudes. In this same vein, it is difficult to determine what type of training and courses teachers should be provided with in order to succeed in mental health promotion, as the survey did not shed light on such issues. Furthermore, the responses to the open-ended questions and the teachers' views on the perceived barriers provide a rationale for the inconsistency apparent in their responses. Additionally, during the process of responding to the attitude scale statements, it was clear that teachers considered such statements from a practical perspective.

5.8 Conclusion

The results of the survey stage of the current study indicated that attitudes in general are multifaceted and complex. It was noted that a single score cannot be sufficient to capture these attitudes. Therefore, the multi-dimensional model of attitudes, rather than the single-component model, and factor analysis were utilised in investigating teachers' attitudes towards promoting pupils' mental health in this study. The findings revealed three core components of attitudes – the cognitive component (which includes beliefs about mental health problems as alterable problems, beliefs about promoting pupils' mental health in schools, and beliefs about requirements and outcomes of promoting pupils' mental health), the affective component, and the behavioural intentions component.

Generally, the findings of the survey stage of the study indicated that Kuwaiti middle school teachers participating in this study tend to hold mildly positive attitudes towards promoting pupils' mental health. At the level of the cognitive component of teachers' attitudes, the results show that the majority of Kuwaiti teachers in middle schools tend to hold strong beliefs regarding the three dimensional area of the cognitive component of teachers' attitudes. Additionally, those teachers predominantly hold fairly strong beliefs about their behavioural intentions towards promoting pupils' mental health. On the other hand, they predominantly

hold slightly favourable positive feelings about promoting process. Such results give rise to many questions: Why do teachers predominantly hold less comfortable feelings towards their role as promoters of their pupils' mental health? Is it because of the way they perceive and understand the term 'mental health'? Does it reflect their lack of self-confidence in promoting pupils' mental health? Does it reflect their lack of appropriate skills and adequate knowledge about promoting pupils' mental health? Does it reflect the effects of socio-cultural and religious beliefs associated with the term 'mental health' and the promotion of mental health in Kuwai society? With these issues in mind, the subsequent qualitative phase might provide reasonable explanations for the teachers' responses.

Moreover, the findings from the survey revealed that statistically significant differences can be attributed to the effects of demographic factors- namely, teachers' gender, age, level of education, and years of experience-on teachers' attitudes towards promoting pupils' mental health. The findings showed that the most significant difference was in terms of the affective or behavioural dimensions.

In addition, the results of the survey suggest that Kuwaiti middle school teachers generally perceived barriers to promoting pupils' mental health mildly positive. Additionally, the results of the study indicated that teachers' perceptions about barriers to promoting pupils' mental health encompass four main dimensions: personal, structural-organizational, interpersonal and socio-cultural barriers. The results indicate that most of the barriers were correlated negatively with the teachers' attitudes towards promoting pupils' mental health, as would be expected. However, three of the four barriers, personal, social-cultural and structural-organizational, were found to have large, negative correlation with teachers' readiness to show behavioural intentions towards promoting pupils' mental health.

Finally, it needs to be considered that the effort made through the survey to provide teachers with the opportunity to disclose their views and opinions is not adequate in terms of gaining insight into their more subtle conceptions concerning the promotion of mental health practices amongst pupils. Although the adoption of the survey did deliver a quantitative approach, making it possible to analyse varied beliefs concerning mental health and the promotion of such amongst pupils, such an approach was not adequate in terms of comprehensively examining the complexity of attitudes. Essentially, the survey provided an avenue through which teachers' lives could be viewed and their attitudes garnered about the topic at hand.

Chapter Six details the second stage of this research, with attention directed towards conducting a comprehensive inquiry into teachers' attitudes towards and perceptions about promoting mental health amongst pupils. The chapter will also seek to provide some degree of insight and understanding of the issues and questions highlighted during the course of the survey. Importantly, a number of questions will be taken into account: How do teachers understand the promotion of pupils' mental health in schools, and the necessities and outcomes associated with such processes, within the context of Kuwait? Why are they generally less positive when it comes to what they feel about this promotion? What are their fears and concerns that might impact on the intention to promote mental health amongst pupils? To what degree can age, gender, level of education and teaching experience impact on the views of teachers in terms of promoting pupils' mental health? What other contextual factors may affect the attitudes of teachers in regard to the promotion of pupils' mental health? Is there a link between the attitudes and views of teachers about the barriers associated with promoting pupils' mental health? How do teachers view the necessary changes associated with promoting the mental health of pupils? In view of these questions, the main results will be examined in depth and discussed accordingly, in addition to those garnered in regard to promoting pupils' mental health.

Chapter 6: Findings from the Qualitative Stage

6.1 Introduction

This chapter presents the results obtained from the qualitative phase of the study (the second stage). These findings include data collected from conducting interviews with a sample of 12 teachers who had completed the survey in the first stage of the study. This chapter addresses the following study questions:

1. What are Kuwaiti middle school teachers' perceptions about their pupils' mental health?

2. What are Kuwaiti middle school teachers' perceptions about barriers to promoting pupils' mental health?

3. What factors do Kuwaiti middle school teachers perceive as influencing their perceptions of promoting mental health and the barriers they experience?

4. What are Kuwaiti middle school teachers' perceptions about the changes necessary to put promoting pupils' mental health into practice?

In this chapter, teachers' perceptions are described and analysed through the data derived from the semi-structured interviews. The interviews were fully transcribed and analysed in relation to the research questions and the emergent themes.

Participants	Gender	Level of education	Years of teaching experience	Age
H/M	Female	BA	5	30
S/S	Female	BA	4	28
H	Male	Masters	11	45
K	Female	BA	7	32
M	Female	BA	15	37
U	Male	Diploma	20	40
T	Female	BA	5	26
Z	Female	Masters	12	36
F	Male	BA	15	39
L	Male	PhD	8	33
M/S	Female	BA	4	25
R	Female	BA	5	29

Table 6.1 **Teachers interviewed in the second phase of the study**

Subsequent to the analysis, the data was categorised into four distinctive groups, according to topic:

- Teachers' perceptions about promoting pupils' mental health and factors affecting these perceptions.
- The socio-cultural context.
- Teachers' perceptions about barriers to promoting pupils' mental health.
- Teachers' perceptions about changes needed for the promotion of pupils' mental health.

In order to adhere to ethical considerations and the preservation of anonymity, the sample individuals were referred to through the use of alphabetical letters. As can be seen from Table 6.1, the sample of middle school teachers was diverse in terms of gender, age, levels of education, and years of experience in middle-school teaching in Kuwait. A number of categories were simplified through the assignment of a theme, with each category comprising a number of subcategories. Although the majority of these groups and subcategories were recognised as being interlinked, there was occasional disagreement. The categorisation and themes are presented with the addition of participants' quotations in this chapter. The key themes will be described through in-depth analysis, provided for each of the theme-related categories in the following sections.

6.2 Teachers' perceptions about promoting pupils' mental health

The themes of teachers' perceptions about promoting pupils' mental health derived from the interviews covered two major categories. The first category relates to teachers' perceptions about mental health, and includes teachers' understanding of the mental health concept, mental health problems and mental illnesses, and the causes of mental health problems. The second category was about teachers' perceptions of the philosophy of promoting pupils' mental health, which includes teachers' perceptions about the meaning of promoting pupils' mental health, the school's role, the teacher's role in promoting pupils' mental health, and the requirements and the outcomes of promoting pupils' mental health.

6.2.1 Perceptions of mental health (terminological issues)

The analysis of the data derived from the interviews indicated that teachers hold a variety of conceptions about mental health. These perceptions can be broadly divided into four main

categories: teachers' understanding of the terminological issues related to mental health (the meaning of the mental health concept, understanding mental health problems, understanding mental illness), causes of mental health problems, and young people's right to live in a mentally healthy way (see Figure 6.1).

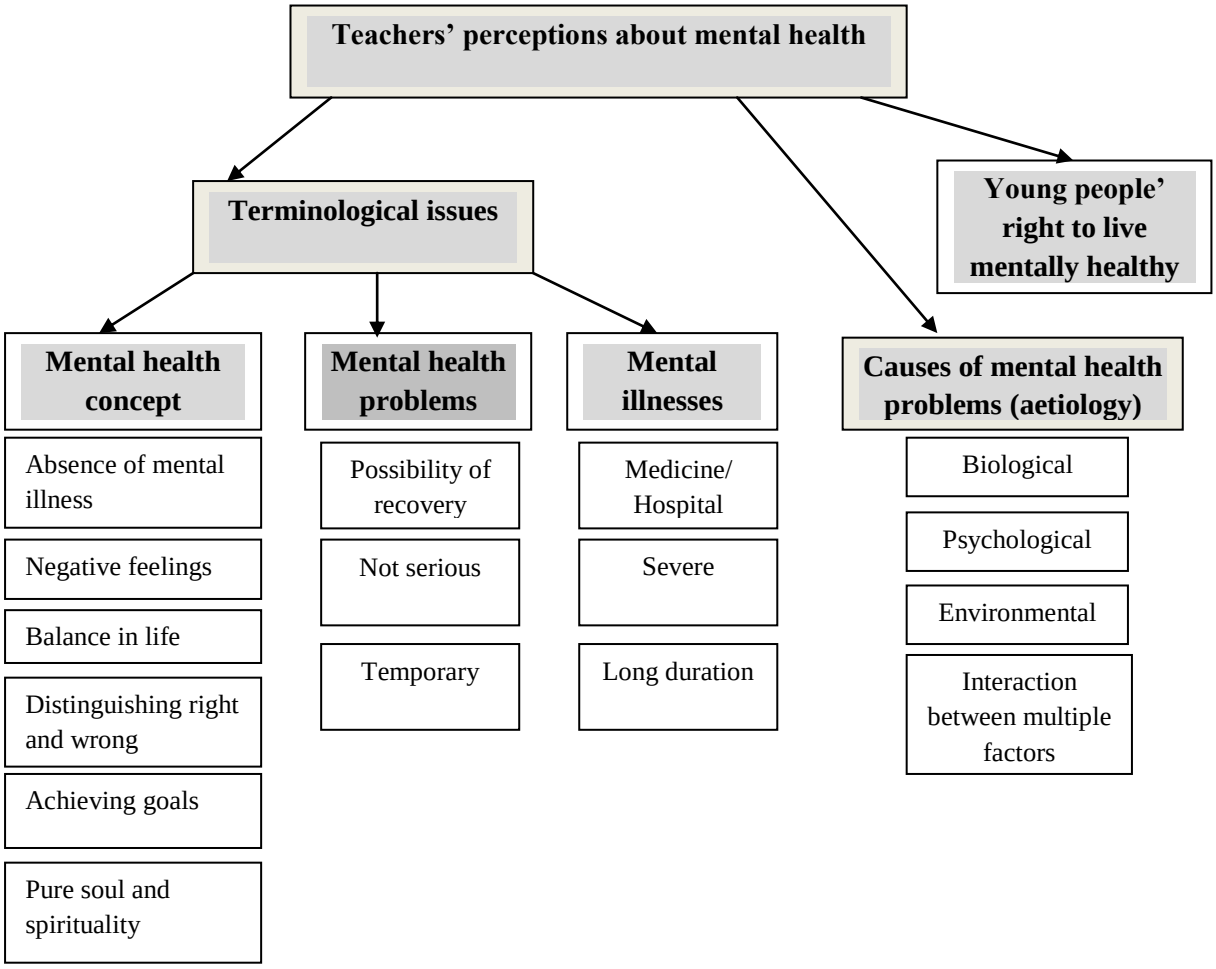


Figure 6.1 **Teachers' perceptions about mental health concept**

- ## Perceptions about understanding mental health concept

Teachers' responses about the way they perceive and understand the mental health concept did not vary widely. Most of teachers' perceptions (eight teachers) were strongly associated with the concept of mental illness, with the most frequently mentioned view about the concept of mental health being the absence of mental illness. This view was exemplified by the following response:

"Personally, I think that mental health means not suffering from any kind of mental disorder. It means to behave appropriately and normally" (H/M).

It seems that teachers found it easier to define poor mental health and negative feelings associated with poor mental health than defying the mental health concept itself. Such views are clearly represented by the following responses:

"Mental ill-health is feeling unhappy and feeling depressed'' (K).

"Mental health is not to be being anxious and stressed" (R).

"Mental health is not having low self-confidence, feeling unwanted and feeling lonely" (T).

On the other hand, some interviewees (six teachers) used positive feelings to express their view of the mental health concept; as one teacher said:

"Mental health is the inner happiness feeling and the feeling of satisfaction about your life and relations, so that you can focus on your work and achieve the tasks required of you" (H).

Interestingly, two teachers responded with a more positive understanding regarding the meaning of the mental health concept.

"Once a person has achieved at least some of his goals in life, he will feel satisfied, happy and relieved, and will be encouraged to do his best to face life's pressures and uphold his responsibilities in life" (M).

"To have good mental health is to be happy, not bored with your life. It entails focusing on your life and your work, and doing your best to achieve your goals" (M).

"Mental health is one's ability to distinguish between the right and the wrong. It is what leads a person to develop himself in spite of pressures around him. It has the meaning of creating a balance" (S/S).

Some teachers' perceptions regarding the meaning of mental health appeared to be rooted in participants' religious beliefs, as one interviewee mentioned that mental health is *"....to have a good spirituality. Since the soul is functioning in many levels and comprised of spirit, heart and intellect, all of these should be kept pure and guarded by God, so that no harm can come to the soul and people can have clear minds" (L).*

In terms of teachers' perceptions of the way they can recognise that pupils have mental health concerns, teachers' responses tended to avoid reference to mental health-related terminology, due to their fears of labelling the pupils, and their feeling less confidence in doing so, because of their lack of skills and knowledge in this area. This view was emphasised by some teachers' responses:

"When considering the needs and behaviours of pupils, terms would be concerned more with learning-related difficulties or behavioural problems, with 'mental health' labels avoided.....there is sometimes the feeling amongst teachers that a certain pupil may be experiencing a mental health issue, which can come as a result of strange behaviours or comments, but that this is more of a gut feeling" (M).

"I personally don't use the term mental health. We feel ourselves in an inadequate position to make judgements in this regard. We are not experts in the mental health area to provide a clinical diagnosis" (F).

"Although some pupils can sometimes exhibit strange behaviours, teachers are not given any form of criteria or checklist from which to establish whether or not a mental health issue is present, and so their role, in the context of mental health, essentially rests on establishing whether or not the individual is distressed in some way" (L).

"If something is wrong with the child in school, it generally shows up by their work standard dropping" (M).

Regarding teachers' recognition of mental health problems among pupils, five teachers mentioned some signs that show that pupils might have mental health concerns. Such views are clearly represented by the following responses:

"We can say that something is wrong when the pupil behaves abnormally and if he is not following the rules in the school and classroom" (M).

"There is a pupil demonstrating strange actions and behaviours, who may also sometimes make odd comments. This causes you to consider whether the child has mental health issues, although this can be just a feeling" (F).

"Some pupils exhibit other difficulties besides being academically challenged; there may be issues in relationships, such as with other children or adults; there may be confidence and self-esteem issues; there could be unusual behavioural patterns that may cause them to stand out amongst other pupils. Essentially, some children experience troubles in relating" (M).

"We might be of the view that some behaviours are unusual; although a teacher cannot generally use a checklist to determine whether or not a mental health problem exists, we do strive to establish any areas of distress shown by the pupil" (K).

"Should a pupil demonstrate problems in school, this is commonly seen in deteriorating academic work. It's a type of red light; it can indicate that something might be wrong, that they have reduced capacity to concentrate" (T).

Additionally, when teachers were asked to describe a mentally healthy person and how this related to their perspectives on mentally healthy pupils, one teacher stated that *"...we can say that a person is mentally healthy when we feel that he is happy and has no problems. A mentally healthy person is one who can adjust to life's stresses, have the ability to adapt to changes rather than just give up, letting their problems become worse" (S/S).*

One teacher also said that a *"mentally unhealthy person is one who behaves sometimes violently with no control on his/her behaviour" (L).*

Another teacher mentioned that "*to be mentally healthy you need to have some control over your own emotions and choices" (Z).*

A further teacher responded *"I think that a mentally healthy person is one who is not suffering from any mental health issues. A mentally healthy person needs to be completely mentally healthy to be and be able to live happily and normally" (H/M).*

- **Perceptions about mental health problems and mental illnesses**

Most of the interviewed teachers (eight) shared basic perspectives regarding mental health problems and mental illness. Severity, duration and the possibility of recovery from mental health problems were the main criteria used by teachers to distinguish between mental illness and mental health problems. One teacher illustrated this common view saying that:

"It is experiencing mental issues that require asking for psychiatric help and medicine. Briefly, mental illness is being sad and lost. It is an illness which could lead others to lose control of their behaviour and they might behave aggressively. Mental illness is a serious problem and it might not be treatable" (H/M).

Another teacher said: *"People who experience mental health problems might be hospitalised. It is not a simple matter; it is something wrong with one's mind. If we lose our minds, how can we live normally in this stressful life? " (S/S).*

Additionally, five interviewees used a variety of behavioural and emotional expressions to describe the term mental illness. One teacher said: *"Mental health illness is to feel lacking in energy and experience extreme tiredness with no ability to overcome your stresses. It is like functioning unusually...sometimes stupidly and crazy'' (U).*

Another teacher said: *"Mental illness can lead you to be antisocial and isolate yourself from others, because you feel that you are different. This could lead you to feel sad and lack hope" (F).*

Other teacher reported *"Sometimes, a mentally ill person can lose his desire to live, and attempt suicide. I heard lots of stories about people who killed themselves because they were experiencing mental health disorders - especially famous people. Once they became old and felt that people were no longer interested in watching their work, they felt sad and lonely" (S/S).*

Teachers' responses to the question 'Do you think that people who experience mental health problems can overcome these problems and how?' showed that few teachers understand that mental health problems are alterable. One teacher illustrated this common view saying that: *"Sometimes mental health problems are less serious and if person can evaluate the situation and think more logically, they might recover from mental health problems especially if they get support and guidance" (H/M).*

Another teacher stated*: "I know one person who was diagnosed with depression, but he still functions normally in his life. If these people were supported and provided with sympathy and help early, I think that they might be able to cope effectively, because their problems are temporary and might be treated" (S/S).*

- **Perceptions about the causes of mental health problems**

It appears that there were different aspects concerning the perceptions teachers commonly have about mental health, regarding the overall causes of such issues amongst young people. Some teachers illustrated this view in saying:

"Mental health problems could be inherited from parents, as parents' genes not only transfer physical illness, but also mental illnesses'' (F).

"It could be the consequences of some bad environmental issues surrounding those pupils, related to their family, friends for example" (H/M).

"It could be something related to their personal traits....as some young people are shy, antisocial....this might lead them to isolate themselves from society and consequently have no friends. Thus, this would make them unhappy" (R).

"Sometimes, mental illness itself occurs if young people's readiness to experience such problems trigger with inherited reasons. So both genes and environment could cause such problems" (R).

"Some circumstances related to family feuds; divorce, drug and alcohol addiction among parents could result in pupils experiencing some mental health problems" (S/S).

- **Perceptions about young people's right to live mentally healthy**

Teachers reported that all young people have an equal right and need to be mentally healthy. These equal opportunities may be based on teachers' religious beliefs. As one teacher reported *"I believe that all people are equal, so all young people are equal and have the right to be respected and valued. Their right to be mentally healthy is equal to their right to be physically healthy or their right to education "(H/M).*

Another teacher also stated that *"I think that being mentally healthy is the right of all people around the world. Just like any adult in society, I think that young people have the right to live normally. Even if they have mental health problems, they have the right to live without any stigma. I think that this is their right, and accords with the demands of our religion, which emphasizes that all human beings are equal" (S/S).*

To sum up, the overall understanding of teachers in relation to mental health is centred on five areas: views of the mental health concept, views on the alterability of mental health problems (understanding mental health problems and mental illnesses), views on what constitutes a healthy or mentally ill individual, views of the right of young people to enjoy a mentally healthy life, and perspectives regarding mental health problems and their sources.

Accordingly, teachers showed a lack of familiarity regarding the positive concept of mental health. Additionally, teachers' distinguishing between mental health problems and mental illness based on severity, duration and the possibility of recovery. Moreover, teachers described academic difficulties and unusual behavioural patterns among pupils as important signs that could show that pupils are experiencing problems. Furthermore, the interviewees attributed mental health problems to biological, environmental and psychological elements, and to the interaction of these elements. In respect of the equal rights of pupils to be well in terms of mental health, teachers hold religiously influenced ideals, which could be referred to their particular belief system. Such an analysis leads to a question concerning whether or not the ideological beliefs held by teachers are consistent with their more practical beliefs, and further, whether or not teachers consider their understanding surrounding mental health to be linked with an apparent absence of mental illness.

6.2.2 Perceptions of the philosophy of promoting pupils' mental health

The section teachers' perceptions of the philosophy of promoting pupils' mental health includes their perceptions of the meaning of promoting pupils' mental health, their role and responsibility in promoting pupils' mental health, the school's role in this area, and the requirements and outcomes of the promotional process.

- **Perceptions about the meaning of promoting pupils' mental health**

Some teachers (seven) showed a positive understanding of the meaning of promoting pupils' mental health. Some teachers illustrated this common view as follows:

"It means supporting pupils and providing them with chances to acquire skills to deal with their problems" (H).

"It means understanding pupils, knowing their problems and difficulties" (M/S).

On the other hand, some other teachers (five) viewed the meaning of promoting pupils' mental health only through the lens of identifying deficits, or the medical model. They reported that the promotion of pupils' mental health already exists in schools, as it is the counsellors' job:

"School already provides mental health intervention for pupils with diagnosed disorders, through counsellors. Counsellors follow up on those pupils...It is the job of the professional" (H/M).

- **Perceptions about the school's role**

Teachers' responses to the question 'How can schools promote pupils' mental health?' indicated that most of the interviewed teachers (eight) believe that schools occupy a crucial position in promoting pupils' mental health. However, few teachers showed that they believe that schools are currently prepared for this task. As one teacher responded: *"Personally, I believe that schools are not ready yet" (F).*

One teacher also stated that: *"Promoting pupils' mental health demands a change in the school's beliefs and ethos" (M).*

Another teacher said: *"Promoting pupils' mental health in schools is not to do with regulations or adding an extra curriculum project; it is about doing something with awareness" (T).*

Some teachers (eight) viewed school promotion of mental health as a matter of participation all school staff, as one teacher said: *"A whole range of teamwork is needed, and each member of school staff should participate" (S/S).*

Another stated that: *"If you ask me to support these pupils, I need you to provide and update me with everything related to those pupils. This requires co-operation between all members of school staff" (M).*

Additionally, other teachers offered examples of how schools can take part in promoting pupils' mental health, based on their unique position in young people's learning and future life:

"Personally, I think that promoting pupils' mental health is supporting pupils not only when they need support in difficult times, but also before they experience problems. Building a

strong relationship with teachers is important, so that in times when they feel that they need help, they can receive it from their teachers" (S/S).

Another teacher said: *"Schools need to set new policies and regulations for school staff regarding their role in promoting pupils' mental health and providing training courses for teachers, besides conducting intervention counselling programmes. I think that all members of school staff should work collaboratively. Schools need to support teachers to reach this goal as they are doing the hardest job in this educational system, 'teaching' " (H/M).*

- **Perceptions about teacher's role**

Although most of the teachers (eight) held strong beliefs concerning their responsibility and the influential role they play in recognizing pupils with mental health problems, their responses also indicated contradictory beliefs that promoting pupils' mental health in the class is not their job and that professionals other than them, such as school counsellors and social workers, should take primary responsibility for promoting pupils' mental health. For example, one teacher reasoned that: *"Perhaps many teachers believe that promoting pupils' mental health is not their responsibility... Maybe they are right. Personally, I think that it should rest with mental health counsellors in schools. However, I also believe that teachers have some role in this" (S/S).*

Another teacher said: *"It is important to keep in mind that the teacher's primary job is to teach, not to become a psychologist or a social worker as well. A teacher's job becomes more difficult if given the additional tasks the new educational system demands, meeting the required standards that pupils need to achieve. Yes, it could be a part of my job and responsibility, yet it is not my job. I think that school counsellors and professional have the adequate skills and experience to do that better than us" (H/M).*

Despite the previous contradiction in teachers' perceptions, a few teachers (two) viewed promoting pupils' mental health as a part of their role and responsibility, and they suggested ways they could show this responsibility, as one teacher said:

"Honestly, I believe that there is a lack of awareness among individuals in the community regarding these mental health issues and promoting mental health. Sometimes we feel that we want to support these people, but we do not know how to do that or I can say feel scared to help them" (M).

Other teachers provided some suggestions by which teachers can reinforce their responsibility in promoting pupils' mental health. One teacher said: *"Close relationships with pupils could provide teachers with a clear picture of a pupil's needs and any mental health problems he/she might have. Such close relationships could help pupils to build their confidence, give them a chance to talk about their feelings to their teachers; especially, if teachers offer praise and encouragement" (F).*

One teacher illustrated this theme by saying: *"Teachers need to be careful in this relationship as the judgments made by them about their pupils could result in negative outcomes, and an absence of support from teachers could lead to young people falling behind with school work'' (H).*

One teacher also said: *"Some teachers become angry because a pupil did not do his homework or did not meet his teachers' expectations. This is not the type of relation required. Teachers should support them even if they show some weakness or difficulties'' (M).*

- **Perceptions about the requirements of promoting pupils' mental health**

Running alongside the perceptions of teachers regarding schools and the mental health of pupils, teachers were asked in the interview to give their opinions in regard to what is required to implement the promotion of pupils' mental health, with consideration of the most likely results associated with promotional process.

There is enough evidence through the data derived from the interviews to show teachers' perceptions of the way and the time in which promoting pupils' mental health in schools should be implemented. They reported that these promotional processes need to be comprehensive, as one teacher argued *"I think that promoting pupils' mental health should be a comprehensive and gradual process. I mean by comprehensive that it should involve all the members of schools, parents and community in this business. We need united teamwork" (S/S).*

It could also be suggested from the data that teachers reported that promoting pupils' mental health is a matter of process, not merely a state. In this vein, teachers believe that the promotional processes should be gradual. By 'gradual implementation process', one teacher

ment that *"Once the process has been evaluated and proved to be successful, we can move towards applying these promoting processes in all schools" (M).*

Another teacher recommend to: *".... start practically, by focusing on the main staff members who have the most contact with pupils – teachers - and providing ongoing support once they have been equipped with the necessary knowledge and skills to promote pupils' mental health in their classroom, first" (S/S).*

Several teachers (seven) viewed the requirements to put the promotion of pupils' mental health into practice mainly in terms of providing them with education courses in mental health and specifically in the area of pupils' mental health, whether in their teaching career or previously in their studies at college. One teacher said: *"there is a need for educating teachers on mental health issues, preferably incorporated within the college curriculum" (H).*

Another teacher emphasized raising teachers' awareness as a main requirement for promoting pupils' mental health in schools: *"You need first to start with programs to raise teachers' awareness of their role in this area" (H/M).*

One teacher viewed the requirements mainly in terms of attending training courses: "*Training is necessary. Many teachers are able to recognize that some kinds of misbehaviour could be a sign of serious mental health problems, but equally could not. However, teachers are not yet equipped with all the skills and knowledge necessary for all the demands of such a task" (S/S).*

- **Perceptions about the outcomes of promoting pupils' mental health**

In specific consideration of the views of teachers regarding the outcomes of mental health promotion amongst pupils, the data suggest that these views can be divided into two different categories, namely academic outcomes and social and psychological outcomes (see Figure 6.2).

The findings from the interviews revealed that most of the interviewed sample (ten) held similar views concerning the social and psychological advantages associated with promoting the mental health of pupils, and further maintained that pupils will achieve a greater degree of development in psychological and social aspects.

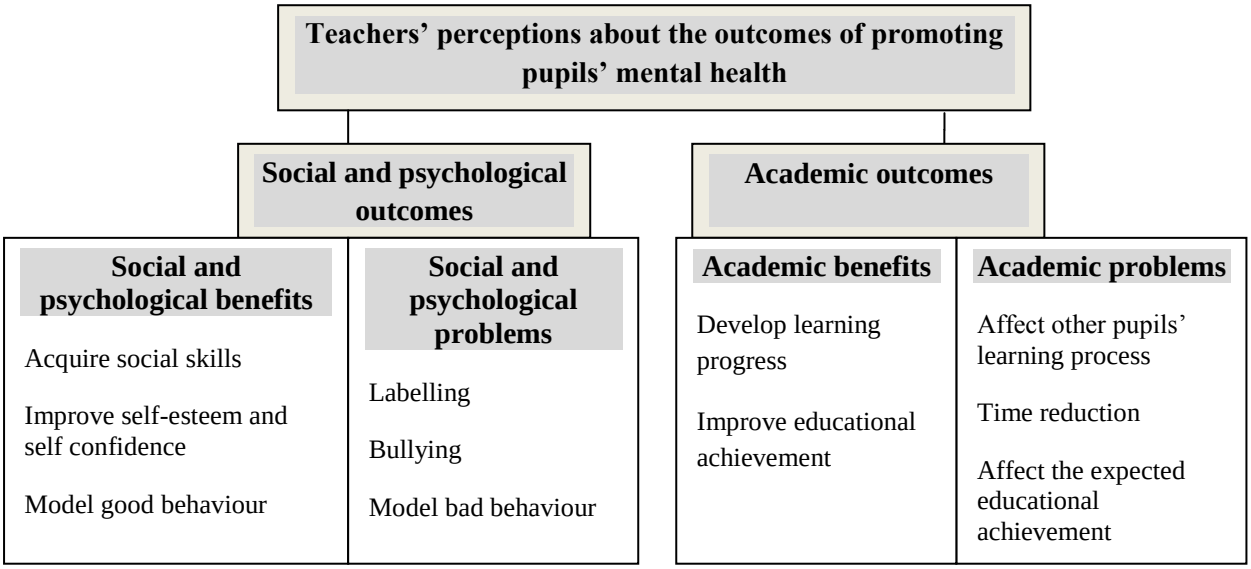


Figure 6.2 **Teachers' perceptions about the outcomes of promoting pupils' mental health**

"When pupils feel valued and supported, they will be able to acquire good skills and experience that could benefit them in their future" (L).

"This in turn might reflect in their feelings towards others, so that they will show empathy towards their peers who are experiencing mental health problems" (S/S).

In contrast to such recognized psychological and social benefits of promoting pupils' mental health, some teachers (six) reported that the promotion process may cause some psychological and social problems. Such disadvantages may include bullying, modelling bad behaviour, and labelling. For example, one teacher said: *"It is possible that if peers recognize that teachers are paying particular attention to some pupils, they will label them as having mental health problems and may bully them" (H/M).*

The academic benefits of promoting pupils' mental health were found to be debatable through the data. Teachers' beliefs about the academic benefits varied widely. Most of them (ten) reported that promoting pupils' mental health will help pupils to achieve better educational progress and but that experiencing mental health problems could be a significant barrier for other pupils' academic achievement. As one teacher put it, *"Pupils will be able to manage academically because they will emphasize their academic achievement more. Therefore, if they are psychologically well, I think they will learn more" (L).* Another teacher

stated that: *"Their academic achievement will be improved because they will not feel that they are different from their peers or behind them" (F).*

Considering the over-emphasis placed on academic achievement within the educational context in Kuwait, particularly in regards to Kuwait's highly demanding education system, many of the interviewed teachers (seven) considered some degree of negative academic effects would be experienced by pupils as a result of the promotion process. They highlighted a number of potentially detrimental effects associated with promoting mental health amongst their pupils. One teacher put it this way:

"We are required by administrators and inspectors to cover all this extensive curriculum content in a limited time. How can we find time to consider pupils' mental health?" (M).

One teacher also reported that *"Although promoting pupils' mental health could lead pupils to get better support, it might lead teachers to be busier than they already are and affect the other children, especially the talented pupils; these gifted pupils may feel frustrated" (H/M).*

Another teacher stated that the effect of promoting pupils' mental health will be the impeding or slowing down of the learning process and academic achievement of other pupils: *"For some educational stages, like middle school, the teaching process requires that teachers conduct a variety of activities in order to allow pupils to acquire the necessary learning skills. This in turn will demand time and might slow down their learning" (M).*

With regards to the views of teachers of enhancing mental health, it may be stated that there was much debate surrounding the academic results associated with promoting pupils' mental health, which thus emphasises the mixed views of teachers in this regard. Furthermore, there was the view that pupils with good mental health are more likely to achieve promising academic results; however, it was held by teachers that time spent on promoting this area means teaching could be affected, impacting negatively upon the learning progress.

Furthermore, it was highlighted by teachers that the more years of teaching experience, the greater the potential positives for the way in which teachers can recognise and interpret mental health issues amongst their pupils. As one teacher put it: *"Teaching experience can show when there is a problem. Experience can give an indication of the norm" (T).*

Another said: *"When teachers have more years of experience, this might give them good experience of mental health issues. It might be the case that young teachers, with less experience, might feel more concerned by pupils' mental health issues, as they might be less experienced in dealing with such situations" (L).*

Teachers' level of education was also found to repharse as influencing teachers' perceptions of promoting pupils' mental health. One teacher suggested: *"I think that teachers' level of education is important here. Better educated teachers are more aware about pupils' mental health issues, because when they study more, they will be more open-minded and will have read in different areas" (S/S).*

6.3 Teachers' feelings about promoting pupils' mental health

The findings from the interviews revealed a range of mixed affective responses and emotions in relation to the promotion of mental health among interviewed teachers. For example, most of the teachers (ten) showed positive feelings towards promoting pupils' mental health. Teachers' responses indicated that teachers feel optimistic about promoting pupils' mental health and they think that it is a good idea. One teacher said: *"Promoting pupils' mental health is an excellent idea and I strongly support it. I believe that it will help pupils to maintain their life at all levels; academically, socially and emotionally" (K).* In contrast, some teachers expressed some fearful feelings and worries that outcomes may not be desirable, owing to the concern that they may be unable to recognise mental health problems in their pupils.

One teacher's fears were justified by saying: *"Personally, I would like to participate in recognizing pupils' mental health problems; however, I feel scared of these mental health issues. I don't think that I will feel comfortable if I have pupils with mental health issues in my classroom. In addition, teachers will spend extra time on these issues, which could lead them to feel stressed and uncomfortable" (H/M).*

Another teacher said*: "We feel comfortable and enthusiastic about the idea. However, we feel worried about the outcomes. The promotion process might affect the learning processes for the whole class" (M).*

Additionally, teachers also voiced concerns regarding the roles adopted by administrators, head teachers, inspectors and policy makers, with such school staff commonly described as

being unaware and uneducated concerning the requirements necessitated by the process, particularly in a practical sense. As one teacher said:

"Administrators and head teachers may be less informed about the daily practices of promoting pupils' mental health, and the processes that teachers need to follow in their classroom. So they need to be involved in these processes" (H/M).

In addition, the data derived from the interviews suggested that the degree (severity) and the type of pupils' mental health problems could be a source of these fears. One teacher mentioned that: *"Teachers might not be able to support these pupils in their classes. Especially, if a pupil's problems are less serious and do not threaten the teacher's safety, we might be able to support them" (S/S).*

6.4 Teachers' intentional behaviours

Despite the contradiction of perceptions about their feelings and beliefs, teachers' perceptions about their behavioural intentions towards promoting pupils' mental health were generally positive. Such intentions were not always explicitly stated, though can be comprehended from teachers' responses to many issues related to the practice of promoting pupils' mental health. Although some other perceptions that emerged from participants' responses were brief, they were fundamental in impact, and can be categorised under the term 'conditions'. Teachers' concerns represented the conditions that should be in place to put promotion into practice. These conditions relate to other themes of the study, and they will be mentioned in more detail in this chapter.

Teachers showed readiness to accept the undertaking of the promotional process. Such views are clearly represented in the following response:

"I am happy to accept my responsibility regarding promoting pupils' mental health, but I do need support from the school's head teacher and administrators. Also, I need information sources regarding pupils' mental health issues" (S/S).

Teachers also emphasised their inclination to alter and adapt their styles of teaching with the aim of ensuring their responsibility was managed properly and the approach implemented as required. As one teacher said: *"Promoting processes could be actually and easily implemented if teachers used more developed teaching strategies. By focusing on the necessary information, space for pupils' mental health issues will be offered '' (T).*

In fact, a number of the teachers (six) were very enthusiastic about the prospect of changing teaching styles and incorporating mental health considerations within their usual educational plans. However, a lack of understanding of the ways in which this can be achieved persiststed, with plans involving mental health issues still not implemented. As one teacher said:

"We have not taught or delivered such mental health topics before, or planned any lessons including this content. Personally, I normally try to change my mode during teaching so that I can wake pupils who are not paying attention, or slow down to allow pupils to catch up with me. Sometimes, I do my best to recognise all pupils' attention. However, I have never discussed pupils' mental health issues in my class" (H/M).

One important point is that teachers' readiness to promote of pupils' mental health was conditional upon a co-operative school environment or community. As one teacher stated: *"All the institutions in the community need to participate in this promotion, as this will provide a co-operative and supportive school environment that leads teachers to feel encouraged to implement these promoting processes" (L).*

Additionally, some teachers (seven) viewed co-operation between teachers and parents as a condition for the implementation of promoting pupils' mental health. As one teacher mentioned: *"Co-operation and support from parents for teachers is important to ease the task of considering pupils' mental health issues" (M).*

Moreover, most teachers (eight) reported that the level of awareness of everyone's responsibility in promoting pupils' mental health needs to be raised. As one teacher said: *"All people, including parents, school staff, researchers, social workers, and all members of society, need to know that they have a responsibility in this area" (K).*

The need for training emerged again as a condition and requirement demanded by teachers in order to promote pupils' mental health; as one teacher reported: *"We need more training in mental health issues before we are asked to show our responsibility" (H/M).*

To put it briefly, the data derived from the interviews suggests that most of teachers voiced generally positive views in regard to their responsibility for promoting pupils' mental health.

However, responses of other teachers indicated teachers' negative views about this role, which were justified by either personal or administrative concerns. In general, teachers' perceptions were concerned with the provision of personnel and environments that support them. The data indicated that these conditions encompass providing regular teachers with mental health information resources, mental health training and educational courses, and creating collaborative partnerships between teachers and parents, social workers and mental health counsellors.

The responses provided by teachers and the discussion of these indicate their understanding in regard to the promotion of pupils' mental health, as well as emphasising the complexity associated with their perspectives; nevertheless, there is a lack of rationale for why teachers choose to respond in this way, and why they show positive behavioural intentions towards some points of the promotion processes, and negative ones to others. Why did they understand the mental health concept differently? Although teachers showed positive beliefs towards pupils' right to live mentally healthy lives, they were predominantly less than comfortable about the promoting process, especially the inclusion of pupils with mental health problems in their classes, and their perceptions of the academically negative outcomes of the promotion process. Is it just that there is insufficient time to recognize and support pupils' mental health issues in the class, due to excessive teaching demands, or is it reflective of their general attitudes towards mental health issues? Alternatively, one may ask whether these responses reveal that teachers feel they are not equipped with the knowledge and skills needed to promote pupils' mental health. How can this inconsistency be explained? These questions need more in-depth analysis of teachers' responses and this will be offered in the discussion and implications chapter (Chapter 7), which aims to look beyond the text and establish the context of the given responses.

6.5 Perceptions of the impact of the socio-cultural context

Following analysis, it was established that there are various socio-cultural contexts understood as influencing teachers' perceptions of promoting pupils' mental health, and consequently affecting the movement towards the implementation of promoting pupils' mental health in Kuwait. This theme reflects many factors related to the socio-cultural context in which the study was carried out, such as the common religious beliefs about the causes of mental health problems and the approaches to dealing with such problems, the

cultural beliefs associated with mental health issues, and the nature of the educational system in Kuwait. In fact, this point was not explicit in teachers' responses; rather it was implicit in their shared way of thinking. This theme is represented in Figure 6.3.

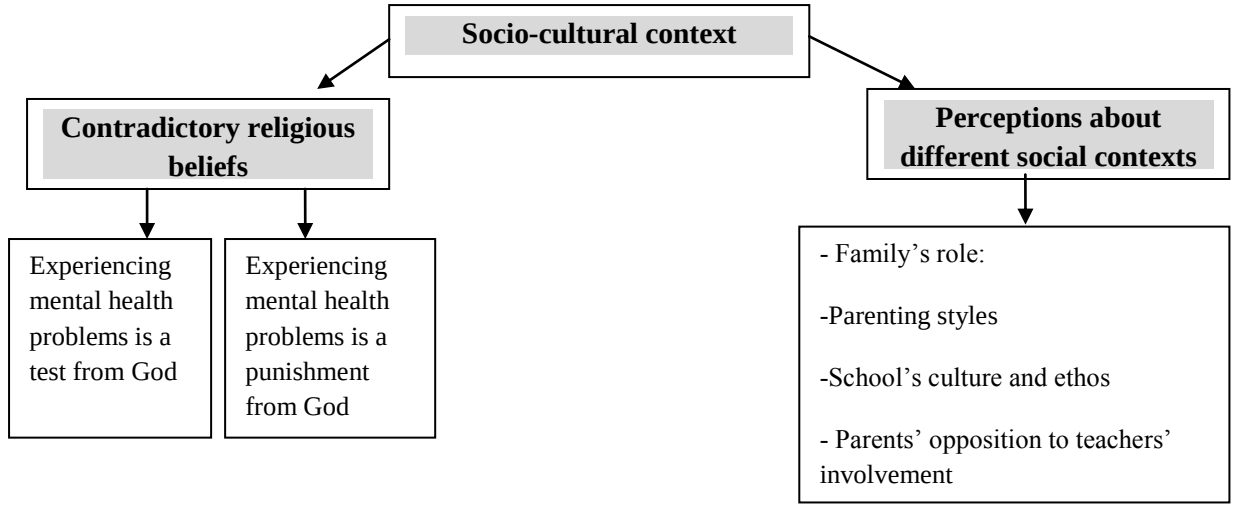


Figure 6.3 **Different socio-cultural contexts**

6.5.1 Contradictory religious beliefs

Teachers' responses indicated that there are two main common conceptions linking their religious beliefs to beliefs about mental health and promoting mental health. First, most of the teachers (ten) highlighted those beliefs regarding mental health as being a matter of the soul, since the achievement of the inner happiness which guides one to mental health can be attained through fulfilling religious duties towards God, *'*Allah*'*. These beliefs also stressed that experiencing mental health problems is a test from *'*Allah*'*. Teachers reported that promoting mental health, according to these beliefs, needs to be accomplished through religious duties, strengthening of faith and believing in God. One teacher illustrated this view clearly by the following response:

"These beliefs are linked to Arabic and Islamic culture. For example, people in the past, and even now, have considered mental health problems to be the result of the 'evil eye' or 'touch of jinn', and have held that a traditional healer is able to drive the 'evil eye' away. Many people here in Kuwait believe that experiencing mental health problems is a test from God, given to certain people to understand their level of belief in God" (S/S).

She added: *"If their children have mental health problems, this means that God is testing them through their children. They think that God, "Allah", is testing people's level of religiosity, patience and confidence in Allah; those who succeed in this test will get a very great reward in the hereafter" (S/S).*

She concluded*: "As a result, people need to face their problems without complaining, increase their prayers and strengthen their deep relationship with 'Allah', as this is the only way to heal their problems. I believe that people are still affected by these cultural and religious beliefs in dealing with children and their mental health problems" (S/S).*

Another teacher stated that *"The right way to promote pupils' mental health is through teaching pupils their religious duties and how to strengthen their relationship with God, 'Allah'" (L).*

On the other hand, six teachers expressed the opinion that mental health-related problems are occasionally considered to be punishment from God, and that this view is held by some parents, who prefer to hide their children due to their fears of stigma. One teacher explained:

"Parents for example might be affected by these beliefs and take their children who have mental health problems to those healers. Then, they will not communicate with and inform their children's teachers, counsellors and social workers about their children's problems, because parents are hiding their children's suffering even from family and cousins" (H/M).

He continued: *"Some parents could avoid seeking help from a school counsellor because they don't want their children to feel stigmatized and ashamed before their teachers and peers. They are scared of acquiring social stigma; they are concerned that others will know about their children's mental problems" (H/M).*

Some teachers (ten) reported that these beliefs could lead teachers to feel more sympathetic and supportive of those pupils. One teacher said *"they might avoid pupils with mental health problems because they are scared that 'evil touch' will be transferred to them, as they believe. Thus, this will be reflected in the amount of support teachers will provide to pupils. Nevertheless, these beliefs might be reflected in more sympathy and support from teachers to pupils" (M).*

To conclude, the two main common contradictory religious beliefs about mental health issues in the Kuwaiti context could either support or undermine the movement towards promoting pupils' mental health. Regarding mental health problems as a test from Allah may be expected to support the promotion of pupils' mental health, while viewing mental health problems as a punishment from Allah, may undermine the promotion process. The implication here is that these religious beliefs about mental health problems, either positive or negative, could affect teachers' perception and attitudes towards promoting pupils' mental health.

6.5.2 Perceptions about different social contexts

Teachers' responses indicated that there are a number of social contexts which impact on teachers' perceptions and attitudes towards promoting pupils' mental health in Kuwaiti schools, consequently either facilitating or discouraging such a promotional process. Regarding social contexts, the opinions of teachers are predominantly centred on parents' expectations of teachers, based on their parenting styles, and teachers' perceptions about the family's role in promoting pupils' mental health.

Parents who consider their children to be experiencing mental health issues may be reluctant to voice such concerns owing to the stigmatisation and shame associated with such a problem. In relation to the family context, which is recognised as being the intermediary between school and society, it was highlighted by some of the sample (eight teachers) that parental styles may also negatively impact on the way in which pupils experiencing mental health issues may be dealt with, which may be the case amongst parents who are overly protective or sympathetic. As one teacher said: *"We still have some parents who try to hide their children's problems and have not allowed them to go to the school. Many parents insist on hiding their children's mental problems from the beginning until the problems become serious.... how can we work toward promoting pupils' mental health with such beliefs in parents' minds?"(L).*

Some parents oppose the involvement of professionals or even teachers in issues related to their children's mental health in school. This view might discourage teachers and professionals from supporting pupils experiencing mental health, pupils who are at risk, or even other pupils.

One teacher stated that *"Some parents refuse any kind of talk regarding their children's mental health; they are very sensitive about these issues. They believe that we are here only to educate" (M).*

Another teacher said: "*Some parents show their frustration about their children's mental health and ask others to support them; then, if support is made available, they do nothing at all. They think that it is only our responsibility, not a shred of responsibility lies with them or school staff" (H).*

Some parents also ignore the mental health issues of their children and emphasise only educational issues. They show no co-operation in this area; as one teacher said, *"They don't care for their children's mental well–being, they just come to discuss their grades, and if you express your concerns, they show carelessness in their responses" (F).*

Additionally, many teachers (eight) stressed the impact of the family on pupils' mental health and the development of mental health problems. They emphasised the vital role of the family in supporting pupils with mental health issues and protecting pupils from developing mental health problems. One teacher said: *"I believe that families have a critical role in promoting their children's mental health. Family is an important information resource for teachers....It depends on how much the family pay attention to their children; if they support them, devote time to discussing their concerns, they will bring up mentally healthy pupils who are able to deal with their stresses, or at least talk about them and ask for help" (S/S).*

She added: *"Other families consider their children's mental health issues as a private matter and teachers are not thought to be qualified or allowed to deal with them. So, teachers will refuse to deal with these children's mental health problems. As a result, teachers will feel more restricted in addressing pupils' mental health issues" (S/S).*

It appears that the school educational context, including schooling system and ethos, is one concern mentioned by eight teachers as another social context that could affect teachers' perceptions and attitudes towards promoting pupils' mental health. Those teachers reported that schools need to adopt a mental health approach at the core of their ethos, by setting policies and regulations and expecting all school staff to be responsible for promoting pupils' mental health. As one teacher stated: *"It should be a whole school context, not only related to teachers: it must be relevant to the school system. Everyone should believe and work under the theme that mental health is a vital component of a young person's overall health. There*

should be a policy that obliges teachers to participate in this responsibility" (L). Another teacher said: *"Teachers are not adequately equipped with a reasonable mental health background. So if you need them to participate effectively in this domain, all who are working in school need to collaborate with them and support them, including counsellors, head teachers, social workers...etc. It is a team task" (F).*

To sum up, the data indicated that there is an interconnection between teachers' perceptions of promoting pupils' mental health and the different socio-cultural contexts with the wider context of Kuwait. The analysis of this interconnection has revealed many features of these themes, related to the requirements of promoting pupils' mental health (highlighted previously), the barriers to, and changes required for, putting the promotion of pupils' mental health into practice, which will be highlighted in the following section.

6.6 Teachers' perceptions about barriers to promoting pupils' mental health

This section focuses on the second question of the second stage of the research: What are Kuwaiti teachers' perceptions in relation to the barriers to promoting pupils' mental health? The data identified that a number of barriers were perceived by teachers in the context of this study that have an impact on teachers' perceptions of promoting pupils' mental health. These barriers have been broken down into four main groups: personal, interpersonal, structural-organizational, and socio-cultural barriers. Each of these groupings comprises categories and sub-categories.

Firstly, personal barriers relate to the teachers themselves. Secondly, interpersonal barriers refer to the impact of various individuals with whom the teacher comes into contact throughout the educational process. Thirdly, structural-organizational barriers are associated with the education system, school context and daily practices. Fourthly, the socio-cultural barriers relate to the social context. All the groups and categories were linked and interact, which affects the way in which teachers perceive mental health promotion amongst pupils, the attitudes of teachers concerning pupils' mental health promotion, and the application of the promotion process.

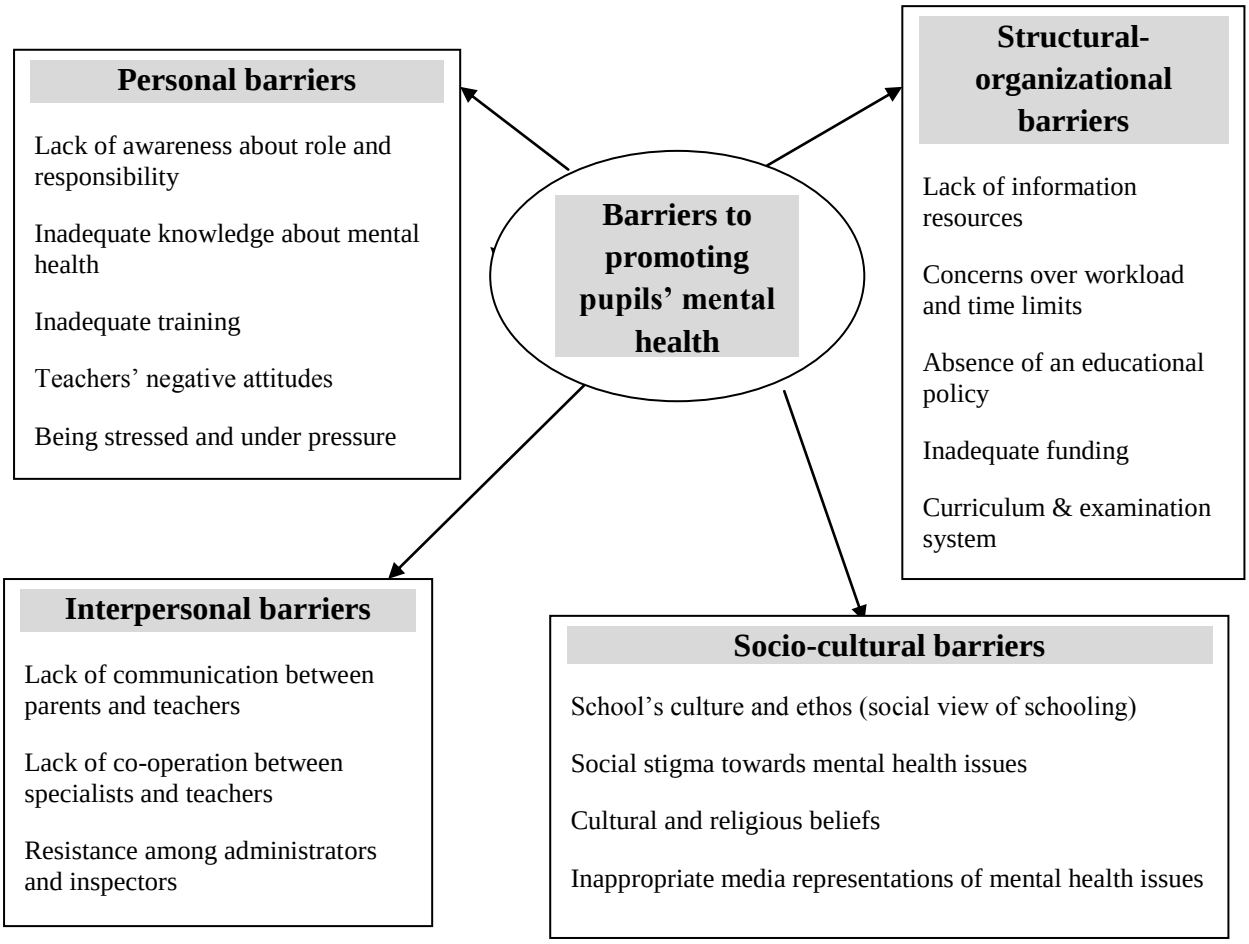


Figure 6.4 **Barriers to promoting pupils' mental health**

6.6.1 Personal barriers

These barriers include different personal levels related to areas of teachers' awareness of responsibility for promoting pupils' mental health, teachers' attitudes, their knowledge, their training skills regarding promoting pupils' mental health and teachers' feelings of being stressed and pressured. The following section will present a description of how teachers participating in the study perceived these personal barriers.

- **Teachers' negative attitudes**

The data derived from the interviews revealed that most respondents (ten) perceived teachers' negative attitudes towards pupils' mental health issues as an important barrier that could undermine the promotion of pupils' mental health. One teacher said:

"Yes, promoting pupils' mental health will be great for most pupils. But I do not think that the task will be easy for teachers" (H).

Another teacher said: *"How teachers feel about pupils' mental health issues correlates with what they believe. Personally, what I normally know about mentally disturbed people is that they can be violent and dangerous. Sometimes, I feel scared when I hear that some pupil has shown signs of these mental difficulties in other teachers' classes. I don't like to talk about it. I hope I will not face it in my class" (S/S).*

- **Inadequate awareness about teachers' role and responsibility**

The data suggested that the viewpoints of teachers regarding their responsibility were perceived by them as an important barrier to promoting pupils' mental health. Teachers believe that they might have some responsibility but not all the responsibility in this promotional approach. The following response is indicative of many teachers' views:

> *"Perhaps many teachers believe that promoting pupils' mental health is not their responsibility... Maybe they are right. Personally, I think that it should rest with mental health counsellors in schools. However, I also believe that teachers' significant position requires them to participate in this responsibility, since pupils' mental health is crucial and affects academic achievement" (S/S).*

However, many teachers considered that part of their responsibility and role is to identify barriers to educational progress, rather than to recognise mental health issues: *"An individual can be taught a subject provided there is receptiveness and the willingness to learn. Accordingly, barriers to learning need to be identified and managed" (M).*

- **Lack of knowledge about mental health issues**

Ten out of twelve participants indicated that they lacked knowledge about issues related to pupils' mental health. They perceived this lack as a barrier that could hinder the movement towards promoting pupils' mental health. One teacher said: *"The area of pupils' mental health issues is wide, and we need to know more about it before any promoting processes are undertaken. Knowledge will assist us to understand pupils' mental health issues more. Also, we will feel more confident in discussing and sharing their concerns and asking for advice if they recognise our knowledge in this area" (H/M).*

- **Inadequate training skills**

It is also clear from the data that most teachers (ten) perceived their inadequate training skills as the main barrier to pupils' mental health promotion. Thus, this training could reinforce teachers' capacity to help pupils to deal with stress and to solve mental problems, and teachers' capacity to identify such problems. It was further emphasised that training is critical in the arena of mental health issues, not only in terms of enhancing their overall capacity to promote mental health but also in changing their attitudes, as is highlighted below:

"Being equipped with the appropriate skills can be useful in allowing us to be reassured and confident that pupils with mental health problems can be helped" (H).

"I think that teachers need to learn more to adapt their teaching approaches to help pupils in the area of their mental health" (M).

One teacher reported that teachers might resist these training programmes: *"We might find it hard when we start training, but by the time we get more training, we will begin to be more able to deal with these issues" (F).*

The data suggested that inadequate training in the promotion of pupils' mental health is predominantly owing to the shortage of mental health courses delivered through the MOE. One teacher said: *"The ministry do not provide us with mental health training workshops. I could not remember having been involved in such programmes'' (M).*

Some teachers (eight) expressed their views on what such courses should comprise, and the ways in which they could be delivered:

"I think that training needs to be approached in two ways: mental health issues in general, and training specialized in a certain area of mental health'' (S/S).

"If training was provided through a trained educational and mental health professional, this would be useful in increasing and maintaining awareness amongst teachers. In this situation, training could be carried out in an educational context…looking at the mental health problems that could be experienced by pupils in an educational environment'' (M).

"Once we have the appropriate training and knowledge courses relevant to what can help us to be able to recognize mental health problems among our pupils in the classroom, and support them, we will be more self-confident and able to participate in the promoting

processes. If they are serious about their training and educational courses, they should plan and organize them carefully, and they should be continuous" (S/S).

"Training could prove to be invaluable if there was someone able to teach the skills and knowledge needed to identify mental health issues and the actions to be taken'' (F).

"Training should comprise techniques on how to deal with someone in a classroom environment" (L).

"Personally, I have not enrolled on any training course concerning mental health, although if this was needed, it should be taken. It should be on-going and not sporadic or short-term'' (H).

- **Being under pressure**

Generally, most of the sample (eight teachers) held the view that the educational policy currently implemented within Kuwait places too much emphasis on academic attainment, which creates a significant issue in the promotion of pupils' mental health. The teachers further voiced their opinion that this policy causes a great deal of stress in various areas, including accountability, administration and inspection issues, examination, parents' expectations, and responsibility, as illustrated in the following responses:

"The extra demands that we are required to do to participate in the task of promoting pupils' mental health and recognizsng their mental health issues could lead us to feel more stressed and overwhelmed than we already are" (S/S).

"Teachers need to be taught how to overcome our stresses before being asked to help our pupils to do that'' (H/M).

6.6.2 Interpersonal barriers

Interpersonal barriers include parents, school administrators, inspectors and peers. These barriers could include lack of communication between parents and teachers, lack of co-operation between specialists (e.g. counsellors, educational psychologists) and teachers, and resistance from administrators and inspectors.

- **Lack of communication between parents and teachers**

Although it was highlighted by many teachers (eight) that a number of parents are involved and co-operative in discussing children's mental health issues with teachers, it was noted that parents could be reluctant to do so. One teacher comented on that*: "Some parents have fears of talking about their children's mental health. They believe that teachers should not be involved, because they don't have the right or the experience to do so" (H/M).*

Most teachers (ten) referred to parents' limited participation for other reasons, related to parents' lack of confidence and trust in some teachers. One teacher said: *"I know that some parents do not show the expected participation with us regarding their children's mental health issues, because they consider us as non-expert and perhaps not trustworthy" (K).* Another teacher said*: "They are afraid that their children's mental health issues will become the chief topic in the teachers' room" (M).*

Another reason reported by teachers that could make parents tend to not talk to teachers in schools about their children's mental health issues is their fear about labelling and social stigma. Teachers mentioned that parents may feel that this stigma would follow their children for the whole of their lifetime. One teacher said: *"They believe that they will be labelled with these mental disorders, and will subsequently not have the opportunity to get a good job in the future, or choose a certain faculty, or even a specific major at university, as their medical history will be recorded in their Civil ID. As a result, they might prefer to discuss their pupils' mental health issues with private specialists in outside clinics, and refuse to allow school counsellors or teachers to take part, and they might remain silent regarding their children's mental problems" (H/M).*

- **Lack of collaboration between specialists and teachers**

Nine teachers mentioned that the lack of collaboration between mental health specialists in schools and out of school is a critical interpersonal barrier to promoting pupils' mental health: *"Counsellors and teachers need to work as a team to maintain pupils' mental health" (L).*

Another teacher claimed*: "We often need to get help from specialists if we feel that something is wrong. Having a good connection with them will benefit pupils effectively. We need to work as a team. I mean all people who work at school need to work together to support pupils' mental health" (M).*

- **Resistance among school administrators and inspectors**

Several responses (eight teachers) emphasised the views held about school administrators that difficulties and issues could potentially worsen if mental health promotion was implemented, as indicated by the following response of one teacher:

"As a teacher, it is common to feel irritated by the school administrators and the way in which they handle staff; it decreases motivation and willingness to teach. We end up holding the belief that inspectors and head teachers may not be capable enough to control the process. Such people may not be prepared enough to deal with such issues and may be unaware of what is happening. Some issues and conflicts may subsequently arise between all involved" (M).

The role of administrators and inspectors was highlighted by another teacher, who stated that: *"Teachers' preparation notebooks are the main concern of inspectors and head teachers alike. There is no flexibility regarding the preparation of lessons and teaching plans. There is uncertainty concerning how permission will be given to discuss mental health issues" (H/M).*

One of the most important points raised by the sample in this regard is that they are worried about their professional career, owing to the fact that administration could impact on teachers' annual reports by giving formal reports to higher bodies. One participant claimed that: *"The annual reports of pupils essentially depend on memorisation and academic attainment. Accordingly, any additional plans or activities might not correspond with teachers' reports. Any subsequent plans of promotion would need to be viewed by teachers as additional to their curriculum tasks" (H).*

The data suggested that the lack of collective educational leadership, as was clear through school staff partnerships, was a possible issue with regard to the adoption of a programme aimed at enhancing pupils' mental health. All of the staff involved in education within a school environment need to work together so as to establish a school culture that facilitates pupils' mental health, subsequently affecting educational achievement.

6.6.3 Structural-organizational barriers

Structural-organizational barriers relate to workload and lack of time, lack of information and resources, lack of funding, absence of an educational policy for promoting pupils' mental health and the restrictions imposed by the curriculum and examination system.

- **Workload and lack of time**

Most of the sample (ten teachers) hold the view that they will be forced to shoulder additional responsibilities and work if pupils' mental health promotional initiatives are adopted, claiming that there will not be enough time to prepare and plan lessons and educational materials as well as to manage in-classroom behaviours.

One teacher said: *"Most of the time I don't have the chance to prepare different materials for my pupils within the regular daily lesson plans; how can you ask me to plan to teach my pupils about mental health issues, or even think about recognizing signs of mental health problems among those pupils?" (M).*

According to teachers' perceptions, a further concern interrelated with workload and time was a lack of teachers, in addition to teachers' hectic schedules. This is seen through the following comment of one teacher: *"As you know, teachers' schedules are often changeable because of the shortage of teaching staff or the absence of some teachers. Also, our schedules are very crowded" (L).*

Moreover, many teachers (eight) thought that they would sacrifice other pupils if they spend more time in dealing with, recognising or managing ways to assist pupils with their mental health concerns. As one teacher said: *"Paying extra attention to pupils who are experiencing mental health problems, or recognizing their mental health issues in my class will require me to take attention away from other pupils, and waste time that should be spent in teaching the class" (H).*

Moreover, the majority of teachers (ten) were worried that they would be exploited and over-worked through having to adopt a number of roles, with one of the sample claiming that the instructional routine would be interrupted with the promotion of pupils' mental health. One said:

"If I am to think about promoting the mental health of pupils, I immediately think I will need to take on additional roles to the usual teaching routine. We will be required to carry out extra activities and tasks, which is likely to result in a lack of time being directed towards pupils' academic attainment. How can mental health issues be afforded attention when there are other tasks to be carried out?" (H/M).

- **Lack of information resources**

It has been ascertained through the data that all of the participants felt, to some degree, that they were not ready to address pupils' mental health issues, with a lack of information sources commonly cited as being responsible for their perceived inadequacy to deal with such an area. One teacher said:

"Unfortunately, there is a lack of information sources, like booklets, brochures or books for teachers to acquire more information related to pupils' mental health. I know that we have counsellors; however, their role is not effective in schools. We noticed that the only thing they usually do was to refer those pupils to specialists if the situation got worse. I think that schools are not adequately equipped yet. Sometimes, if we recognize that any pupil has mental health problems, we feel that we need to know more about his problem, but sources are poor or sometimes not available at all"(S/S).

- **Lack of funding**

Lack of funding to finance the promoting process was not perceived by all teachers as a major barrier, though one teacher expressed her concern regarding the funding barrier saying the following:

"Head teachers and administrators of schools usually receive an annual budget for their schools from the Ministry of Education in Kuwait and they always report that this budget barely satisfies the financial needs of schools. Personally, I don't think that they will spend a major part of this budget on mental health issues. Their excuse will be that psychological counsellors are already appointed in schools. I think that we need more funding to be able to provide what teachers need to take part in this promoting task. Kuwait is a rich country and it should be a priority to finance projects and school approaches related to promoting pupils' mental health" (S/S).

Another issue which is closely related to funding is the salaries of teachers. It emerged as a concern, with most interviewees (eight teachers) complaining about their low salary compared to the salaries of other jobs. The comment of one teacher reflects this view: *"I think that any new policy implemented would need financial support. Teachers need to be rewarded also. Their job is hard and salaries they receive are low. Why do they not raise our salaries if they are asking us for extra tasks?" (H/M).*

Nevertheless, most teachers (ten) indicated a somewhat more humanitarian belief that involvement in promoting mental health amongst pupils concerns not only fiscal factors but also moral responsibility and commitment: *"Even if we have limited support, poor resources, and low salaries, I think that our responsibility is a sense of humanity" (M).*

- **Absence of an educational policy for promoting pupils' mental health**

It was acknowledged by a few teachers that considerations regarding pupils' mental health should be shouldered by the School Mental Health Service Department; however, an educational policy geared towards teachers' involvement in promotion is currently lacking, as several teachers (seven) commented. One said: *"Unfortunately there is no policy set within the education system in Kuwait that would oblige them to take up this responsibility" (L).*

Another teacher reported*: "The only thing I know in this area is that if anything serious emerges we are required to refer pupils to the school counsellor. I know that there are policies for teaching pupils with special needs or retardation" (S/S).*

- **Curriculum and examination system**

According to the data, participants maintain that the examination system and curriculum raised a number of issues in regard to mental health promotion, with a strong link recognised between the two. However, the teachers did not voice any concern regarding the objectives of the curriculum; as one teacher said: *"I do not think that we need to change the aims and goals of the curriculum; what we need to change is the content and the examination system" (S/S).*

From the teachers' perspective, the examination system is fundamentally responsible for the lack of progress in mental health promotion amongst pupils. Ten teachers stated that there is a conflict between the examination system and the teaching curriculum, with the latter emphasising that pupils should be assessed in terms of their capacity to memorize textbook content. Accordingly, pupils' evaluations are based on achieving good levels in this regard, although this ultimately fails to address other factors, including difficulties associated with family, physical or mental health. One teacher stated that, *"In exams, only one format is used, and this can only demonstrate the level of memorization of the text. Thus, we need to think about alternative forms of evaluation and assessment, considering other areas of pupils' lives when evaluating their academic achievement" (S/S).*

6.6.4 Socio-cultural barriers

Teachers' perceptions of socio-cultural barriers included the school culture and ethos (i.e. the social view of schooling), cultural and religious beliefs about ways of dealing with mental health problems, inappropriate media representations of mental health, and the social stigma attached to mental health issues, which have their impact on teachers' attitudes towards promoting pupils' mental health.

- **Social view of schooling**

Many of teachers (nine) have a strong belief that the lack of a school ethos that considers pupils' mental health to be at the core of school could be a potential barrier to promoting pupils' mental health. Teachers reported that the culture of school needs to go beyond the traditional culture which assumes that schools are not a place for socialization, but a place for providing learning and meeting academic needs. Despite the fact that most of teachers (eleven) reported that such promotion needs to be the central role of schools, they were concerned that this description does not represent reality at the current time. Almost all the teachers argued that the current Kuwaiti system has no social role, and this could be considered a significant barrier to the implementation of promoting pupils' mental health. One teacher said: *"The majority of pupils are enrolled in education to fulfil parents' and teachers' expectations, satisfy attendance requirements, and achieve promising grades. Practically, such needs mean that pupils are usually not able to spend much time becoming involved in social roles" (M/S).*

Furthermore, a number of the teachers (eight) also recognied the apparent inconsistency between the teaching and learning reality within schools and educational policymakers' objectives. This was noted by one teacher in the following comment:

"'It is necessary for us to adhere to specified teaching plans and subjects, and diverting away from this could mean the teacher into trouble"(R).

In the view of some of the sample (nine teachers), school failure in implementing pupil's mental health could be due to the overall nature of the curriculum, which is very comprehensive, demanding and informative, and this ultimately means there is no room left for additional activities that could help promote pupils' mental health. This is highlighted by one of the participants, who claimed the following:

"The curriculum adopted by schools is somewhat unproductive. The key role, as a teacher, is to ensure pupils are provided with knowledge and information, and so there is little time left for additional activities" (M).

Another teacher made reference to the ethos and overall position of the social perspective within the school's system, stating the following:

"In reality, teaching is very different from the theory taught at university. Essentially, it is a competition to fill pupils' minds with the most knowledge and information in preparation for tests and examinations, and attendance levels. There is no additional time or space for emotional and social considerations. Ultimately, high grades and academic attainment are most important, but this results in poorly prepared citizens" (H/M).

- **Cultural and religious beliefs and social stigma**

The data suggested that the overall understanding of the public in terms of mental health and the promotion of such is significantly influenced by a number of key factors, such as culture, religion, and spiritual background. This understanding is seen as particularly strongly influenced within societies such as Kuwait.

The effects of religious beliefs on the way that people deal with mental health issues, and the encouragement given to seek religious healing rather than counselling, were highlighted by nine teachers; as one teacher said, *"Many people believe that mental health problems could be a result of ignoring religious duties and signs of weakness of faith" (F).*

Another teacher stated that *"They believe that mental problems are the results of a lost soul and attraction to the devil. People can cope with these mental health problems through a deep relationship with their God and seeking help from religious healers, which could give hope of relief through God, 'Allah'" (H/M).*

A teacher also emphasised the priority placed on seeking religious help to promote one's own mental health and assist other to do so: *"Our religion encourages people to help individuals facing mental problems and guide them to the right way through the Holy Book" (M).*

Seven teachers reported that these cultural and religious beliefs could be reflected in how parents deal with their children's mental health. One teacher related the following:
"Some parents might seek help from religious and traditional healers instead of seeking help from professionals. Then, parents also might continue treating their children through those

healers in spite of the fact that many of them believe that their children need to go to mental health specialists" (S/S).

She continued: *"One explanation could be the healers' desire to secure parents' endowments, as they convince parents that their child has a "jinn touch"or "evil eye", and that they should keep coming to them or their child may die. What normally happens is that these religious healers provide some blessed water and recite from the Holy Book, the "Qur'an". Traditional healers provide incense and medicines based on herbs to treat people with mental health problems" (S/S).*

She also mentioned this story: *"I still remember a story from one of my cousins, whose daughter was suffering from a mental health problem. The teachers informed her father that his daughter was not participating in the class activities, not interacting with her peers and teachers, and spent most of her time alone in the school. Thereafter, her father prevented her from going to school, and hid her in the house. He did not allow her to sit with us when we visited. Sometimes I could hear her hysterical screaming. He sought the help of some of the healers, and they told him that his daughter was a demoniac or had a "touch of jinn". The healer hit her and used his traditional tools to treat her. Her case got worse until she lost her appetite and ability to sleep. Then finally she died" (S/S).*

Society's view of mental health issues, and the negative attitudes towards the subject of mental health and those who have experienced mental health problems, were mentioned as important barriers in the area of promoting pupils' mental health. The two following responses are indicative of this view:

"The misconceptions and stereotypes they hold about mental health issues derive from the stories they heard from their family and cousins when they were children. These stereotypes could strengthen the stigma around mental health issues. As a result, if they experience any mental health issue, they will feel embarrassed to talk about it with anyone because they are scared of being labelled" (H/M).

Such views are consistent with what teachers say about the negative attitudes towards mental health issues and mentally ill persons. This point was also highlighted in the personal barriers section (6.6.4); it also seems that the moral code of Islam is contradictory in terms of dealing with those people in need. Less than half of the participants (five teachers) hold the view that

religious and social contexts associated with mental health understanding are a key barrier to the promotion of such. For instance, the following was stated: *"The negative view of these mental health issues puts blame on our departure from the Islamic religion. People need to follow the manners of their prophet, who dealt with those persons gently and respectfully, as our religion encourages us to do" (U).*

The interviewed teachers viewed attitudes and social views concerning mental health issues in a negative light, arguing that Islamic morals and such views are not complementary, and further recognising that social behaviours are a key concern. Furthermore, they indicated that social behaviours and beliefs have been affected by non-spiritual practices, with one teacher stating:

"The key problem is individuals' social behaviour. In my opinion, religion is not to be blamed for this social stigma. There is no difference between people in our religion. Our religion encourages us to be careful to not label anyone for his flaws" (F).

The data suggested that the social attitudes towards individuals with mental health issues may be viewed as a possible barrier to the application of pupils' mental health promotion, with such perspectives essentially influenced by socio-cultural beliefs. An interesting theme which may result from this is the inconsistency between mental health issues and their social construction, and the religious ideals held by people in relation to such issues. People may be seen to treat people suffering from mental health issues well, but obstructive behaviours also continue to be witnessed; thus, when considering the attitudes of people towards mental health issues, particularly teachers, some degree of attention must be directed towards the broader social context, the educational context, and the religious context.

- **Inappropriate media representations of mental health issues**

The data provided a great deal of evidence to support the view that public perceptions of mental health issues are significantly affected by the media, such as through the inappropriate representation of those suffering from mental health illnesses. One teacher stated that, *"I think it is the impact of the media. The way that the media presents mental health issues negatively gives people incorrect assumptions about mental health issues. The image of mentally ill people represents danger, crime and violence. In fact, the media feeds these images of the mentally ill. Maybe these are realistic images, maybe not. However, it is*

scary... a threat to our lives if we so much as talk to them. They sometimes represent them in a way that leads others to laugh at them" (S/S).

Another teacher said*: "Mental health issues bring to my mind those crazy, dangerous people with messed-up hair, smelling bad and having an ugly appearance, being dressed inappropriately and homeless.....I hope that I do not face anything like this in my class" (M).*

"How can we ask teachers to recognise pupils' mental health issues, when many teachers feel scared about even discussing issues about mental health? Before you ask teachers to participate in the responsibility of promoting pupils' mental health, the media need to change their representation of these mental health issues and act to raise public awareness of them" (S/S).

"Though there might be an inner desire among teachers to help pupils with mental health concerns, such inappropriate representations make them hesitate. I was in such a situation with one of my pupils" (F).

The teachers recognized a number of different elements as potentially impacting on the adoption of pupils' mental health promotion. It is clear that such elements are linked and work together to affect attitudes towards, and understanding of, the approaches and processes involved in enhancing mental health amongst pupils. Furthermore, it should be acknowledged that such barriers and their categorisation are not well-defined; essentially, the boundaries between such categories are hypothetical owing to the fact that something may be viewed as structural-organizational at one point but as interpersonal at another. However, regardless of such interconnectedness, it is evident that there are various clashes between the various barriers and their individual aspects.

6.7 Teachers' perceptions about changes

Throughout the course of the interviews, there was discussion surrounding the factors able to support the implementation of mental health promotion amongst pupils. Four key factors were highlighted, each related to a key category and recognised as potentially contributing to changes in terms of pupils' mental health promotion. The four factors are developing educational policies, organizational and structural changes within schools, societal awareness, and teachers' commitment (see Figure 6.5).

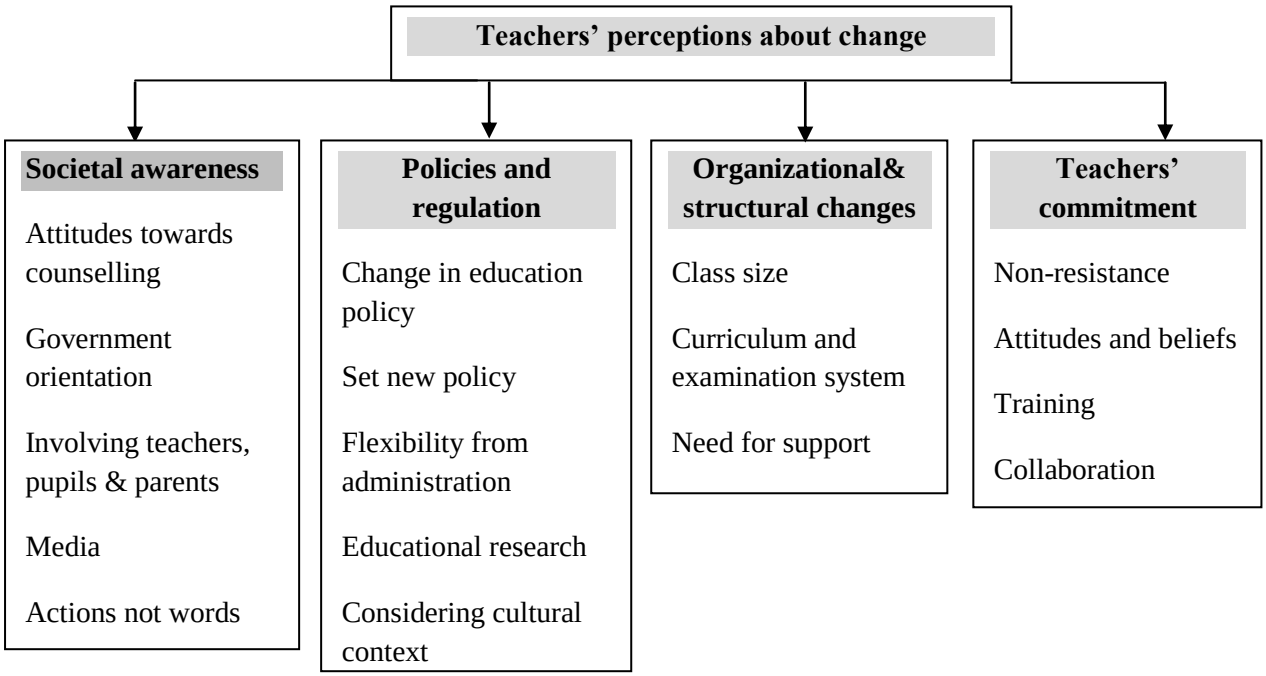


Figure 6.5 **Teachers' perceptions about change**

These categories appeared to be able to interact with and subsequently affect the ways in which teachers' attitudes, the promotional process, and the adoption of pupils' mental health promotion are understood, as shown from the data.

In an attempt to deliver understanding and insight, each of the aforementioned categories is presented separately. Furthermore, as can be seen from the data, in which teachers commonly questioned how barriers to change can be overcome, it is necessary to highlight that the theme of change is significantly linked with barriers.

"I believe life's nature is centred on change; this cannot be argued. Nevertheless, so as to progress, there is the need to ensure that all staff within an educational institution, including teachers, recognise the value of this process, and then work to overcome any obstacles potentially restricting the adoption of promotional strategies "(M).

6.7.1 Societal awareness

Most of the teachers interviewed (ten) believe that the social view held by the public in regard to mental health issues and individuals suffering with such should be amended and that enhanced public awareness is needed. The teachers placed considerable emphasis on the

ways in which pupils' mental health promotion could be achieved in schools, with the sample recognising numerous key areas able to facilitate such change, namely attitudes towards counselling, governmental orientation, local communities, media, and parents.

Teachers suggested increasing awareness among teachers, pupils, parents and the school staff towards seeking counselling, to facilitate dealing with and reducing the negative impacts of these problems. As one teacher said, *"School staff need to be fully aware of the importance assigned to the mental health of pupils. The Ministry should have a department dedicated to this area. This department needs to be responsible for arranging activities and lectures to raise awareness about promoting mental health" (H).*

It was suggested by nine teachers that the government, institutions and organisations all have a role to play in facilitating change. The need for further cooperation to achieve this goal, such as from local communities, was also noted:

"The government and social institutions are responsible for dealing with the mental health issues of pupils, not only schools or professional entities. Accordingly, there is the need to encourage the participation of local communities, businessmen, parents, etc" (H/M).

The Media was also another significant theme needing to be considered as part of the broad social context in this domain; as one teacher said: *"There is the need to change the societal view of mental health issues if teachers are to feel more comfortable with dealing with this aspect. It should be recognised that the media is fundamental in changing such views and increasing awareness, which could help teachers to address mental health" (L).*

Another teacher also stated that, *"The media are very powerful in terms of enhancing mental health issues awareness, which can be achieved through campaigns seeking to provide people with knowledge of the problems and the ways in which help can be received. Traditional and religious solutions only worsen the problem" (M).*

Furthermore, it was highlighted by nine of the participants that the involvement and support of teachers is fundamental and directly related to local community involvement when seeking to promote pupils' mental health in the context of Kuwait. Teachers hold the view that parents are an essential means to achieving this change as they are able to deliver different material and moral support, not only for the change itself but also for the school and its teachers. This belief is highlighted by one teacher as follows:

"Parents have some degree of responsibility to promote mental health amongst their children, and they should actively teach and consider the ways in which such problems can be overcome through communication, both with their children and teaching staff " (M).

This suggests that the involvement of parents should extend not only to education in the classroom environment but also to teachers' concerns with the mental health issues of pupils and taking part in educating their own children, as proposed below:

"I think that parents also can share the responsibility and give a hand in promoting their children's mental health. It is assumed that they should teach them some skills to overcome and solve their troubles; at least they should be required to support us by telling them to talk about their concerns with teachers in schools" (H/M).

Most of the sample (ten teachers) stated that social awareness can be achieved through ensuring that actions take the place of words; as one teacher put it:

"Speeches are of limited value and only a short-term method; processes need to be practical and consider the design and implementation of clear plans and rules, with the necessary facilities and resources provided to facilitate change" (H/M).

6.7.2 Policies and regulations

According to the data, most of the participants (ten) hold different opinions regarding the importance of legislative systems and educational policies in implementing promotional processes. All of the teachers were in favour of a top-down approach. As one teacher commented: *"Establishing policies supporting pupils' mental health promotion should be viewed as obligatory, and so there is the need for the Ministry of Education to establish policy and legislation to ensure promotion and awareness" (S/S).*

In contrast, the data suggested that teachers were also concerned with establishing more efficient and positive ways through which parents, teachers and pupils could play a role in terms of policy-making:

"Enhancing the mental health of pupils should not depend on educational or government policy or regulations; teachers should be creative and inventive to facilitate processes and their success" (F).

Although such teachers did give some consideration to their own role in supporting change in educational policy, there was a call for consideration of the views and opinions of parents, teachers and pupils prior to any change.

"Parents', pupils' and teachers' voices need to be listened to and taken on board prior to implementing change. However, realistically, it is recognised that a number of professionals fail to do so and instead adopt plans without considering the practicalities within the educational environment'' (L).

Furthermore, it was also generally held by the teachers (nine of the sample) that the perspectives of professionals, in combination with study findings, need to be considered by policymakers, rather than simply taking into account the views of Education Ministers, etc., who may not have direct experience with the practical aspects of education. As one teacher said:

"Professionals, researchers and universities should be utilised as much as possible to make use of their skills and knowledge, with programmes and policies concerned with enhancing the mental health of pupils taking into account moral and cultural considerations" (H/M).

The views of policymakers in relation to education overall and the specific consideration of pupils' mental health received much criticism from the respondents, who requested that such views be changed, as can be seen from the following responses:

"The thoughts and views of policymakers affect the decisions ultimately made in regard to pupils' mental health issues and promotion in this arena " (M).

"There is the need to change policy makers' thoughts and beliefs if the right approach is to be selected and adopted, as such individuals are able to make decisions concerning teaching staff, schools and pupils" (S/S).

The beliefs held by teachers as to the role of policymakers has resulted in them feeling frustrated concerning any changes to be implemented within the Kuwait education system and the status of the system itself. This is seen through the following comment:

"Memorisation seems to be prioritised within the educational system, meaning individuals are forced to neglect their interests and instead follow labour choices" (S/S).

Furthermore, nine teachers reported that setting a new education policy to implement the promotion of pupils' mental health is crucial. As one teacher said: *"Pupils' mental health policies should be implemented as early as possible, such as from nursery age, as doing so at a stage of advanced education may be problematic" (S/S).*

Finally, as highlighted earlier, teachers feel there is an urgent need for schools' educational systems to be changed, with head teachers and administrators needing to be more flexible. Administrators need to be more concerned with leading and setting examples as opposed to addressing only traditional issues and adopting a more rigid, authoritarian stance, as this is recognised as hindering the development of pupils. Such individuals need to be actively involved in promoting processes so that there is a greater chance of success. As one teacher said: *"Head teachers need to show more flexibility and more interest in learners' social and emotional, as well as academic, development" (H/M).*

It can be seen through the data that change needs to be two-way, with the needs, views and roles of parents, teachers and pupils all taken into account alongside the school context and supported throughout the policy-making process. Furthermore, it was recognised that there is a great deal of value associated with considering the cultural ethos of Kuwait during the process of reforming the education system, as opposed to simply implementing policies from other cultures: *"It is known that society holds a number of views and resources, and so the country's individual context should be taken into account before applying changes witnessed in other countries, owing to the differences amongst societies. Importantly, experiments should not be carried out in the area of education" (M).*

6.7.3 Organizational and structural changes in schools

The teachers interviewed emphasised that a number of structural and organizational barriers are apparent and need to be overcome before pupils' mental health can be promoted. A detailed description of these suggestions follows.

- **Class size**

A number of teachers (nine) stated that smaller classes are needed in order to ensure such a promotional process could be implemented effectively, with one of them stating: *"If the process of promotion is to be successful, class size need to be reduced"* (F).

Many teachers (eight) stated that too many pupils in one classroom would cause issues conflicting with the overall purpose of mental health promotion, and so there should be only a certain number of pupils in one classroom: As one teacher said:

"Overcrowding in classrooms means the identification of pupils' mental health issues is near-impossible. Around 20 or fewer pupils is an ideal number, meaning that mental health status can be recognised by teachers and issues handled and overcome effectively" (H/M).

- **Curriculum and examination system**

The data revealed that participants were concerned about the curriculum in respect of its aims, content, the examination system, overall goals, and pedagogy in general. In this regard, the participants took into account the content of textbooks and claimed that the curriculum is far too detailed and that time does not permit the implementation of the process of pupils' mental health promotion. It was found that, overall, the teachers are dissatisfied with the curriculum and there is the need to ensure that any surplus or otherwise unnecessary content is removed. Moreover, it was recommended that the examination system undergo change. The teachers highlighted that such amendments would ensure adequate time to address the mental health needs of pupils; as these teachers commented:

"The curricula are full of useless information. They need to be updated and focus on the important themes required for effective learning. The curriculum should be condensed and freed from unnecessary information, and made less boring. It should include flexible and supportive activities. When you ask teachers to recognize pupils' mental health problems, you are asking them to take time from their original teaching time which is required to cover this curriculum. This will make the task hard for teachers" (S/S).

"There is a pressing need to establish new evaluation criteria, with movement away from memorisation, which may help in passing tests but not in long-term success for future citizens. Evaluation should consider group work and activities emphasising learning effectiveness and flexibility, and ensuring there is the time to recognise the health issues of pupils" (H/M).

"Owing to the examination system currently utilised, traditional teaching styles are used by staff; this needs to be updated so as to be more technological and creative, and ensure

teaching staff do not become overburdened with additional tasks, e.g. the promotion and recognition of mental health issues amongst pupils" (S/S).

Furthermore, most of the teachers (ten) hold a strong belief that styles and approaches to teaching are critical, with the view held that the responsibility for adapting, changing and varying teaching methods falls to the teachers, and so these need to be aligned with pupils' requirements, delivering opportunities to understand and acknowledge the mental health issues of pupils. As one teacher commented:

"In the arena of teaching, flexibility is fundamental, although this means that pupils and teaching staff will not be forced to strictly adhere to extensive curriculum information. Essentially, this would mean that tasks are eased in terms of pressure, thus facilitating the time and space for enhancing awareness of pupils' mental health" (M).

On the other hand:

"The most realistic and suitable approach for implementing mental health awareness is to adapt the current curriculum, which will help to ensure this field receives attention without inflicting additional pressures and stresses upon teaching staff" (L).

The third view of this concern about change relates to providing emotional and social educational curricula (mental health education) for teachers and their pupils, as a step towards supporting teachers in the task of promoting their pupils' mental health; as one teacher stated: *"Teachers must receive a curriculum providing adequate data and information so as to increase their levels of awareness regarding mental health issues and the ways in which such problems can be managed and overcome. Such documentation will help to ease job-related stress" (K).*

Although some teachers (seven) showed interest in delivering this type of mental health education curriculum for pupils, they reported that such ambitions could be hard to achieve if we consider the aims of the policymakers, which are achievement based and do not provide room for such a curriculum. One teacher said: *"I'm ready to deliver this sort of curriculum. However, the curriculum in our schools is so extensive and we have to cover it within a certain time. I think it will be too difficult to specify time to teach such a curriculum. I think that the administration of school will refuse to apply this curriculum" (S/S).*

It can be seen from the above that there is a lack of consensus amongst teachers in terms of the curriculum, and that changes need to be implemented to ensure pupils' mental health promotion can be facilitated. Such changes need to be introduced to address the content, assessments system and teaching strategies of the curriculum. In addition, it seems that the objectives of policymakers restrict teachers in terms of the promotion of mental health amongst pupils, simply because more conventional teaching approaches are utilised with an emphasis on the delivery of the curriculum alongside the management of the classroom. Importantly, it is considered that there is very little flexibility in terms of acknowledging and addressing the mental health issues of pupils in the classroom environment.

- **Teachers need support**

Generally, the sample involved in the research can be seen to have very sound and well-defined beliefs in terms of the promotion of pupils' mental health, which centre on the fact that teachers need to support such a process if this is to be successful. It was emphasised by the teachers that education policy within Kuwait places too much importance on academic achievement, so that academic results are stressed to a significant degree. Furthermore, such excessive academic demands also mean that teachers are so stressed that there is no room to address mental health concerns amongst their pupils. In this regards, one teacher said: *"If we want to consider issues relating to pupils' mental health, we need someone to consider our mental health. Sometimes we feel stressed and overwhelmed, and we need support, but we can't find it. People within education need to consider our mental health and provide us with suitable services" (F).*

Additionally, ten teachers reported that they need support to implement a successful promotion process of pupils' mental health. It was reiterated amongst the sample that support in all of these areas is lacking and is therefore unsatisfactory. Moreover, they reported that such support would help teachers to feel less pressured, as one teacher said: *"In my opinion, what teachers can get from support will be these agents' participation in saving teachers' time and effort, which in turn could lead to them accomplishing good progress in terms of promoting their pupils' mental health" (L).*

Such support must come mainly from human sources, with professionals, parents, school administration and communities involved. One teacher said: *"Co-operation between us and mental health professionals will make it easier to refer pupils to the appropriate and timely*

mental health services. At least, we will find them if we need help with how to deal with mental issues" (L).

Another teacher said: *"We need the support of administrators, head teachers and inspectors. In particular, head teachers' support may be considered among the most important, as they need to be flexible and open-minded in decreasing the amount of demanding work required from us. Thereby, we can gain enough time to address pupils' mental health" (M).*

Another teacher stated: *"Co-operation and support from parents for teachers is important to ease the task of considering pupils' mental health issues" (M).*

One teacher reported that there should be support for teachers emotionally, as they experience considerable stress due to their difficult job and extensive associated demands. One teacher said: *"We need our mental health to be considered first before we consider our pupils' mental health. As you know, healthy minds bring up healthy minds" (M).* One teacher suggested a way to support teachers emotionally: *"There should be specific mental health courses and workshops provided by the government for teachers. This might help them to learn how to overcome their stresses. At least we need the school counsellors to arrange special programs or advice in this area"* (K).

Furthermore, nine teachers asked for support in the form of material: *"There is a lack of information sources in the schools that could tell us if the pupil has mental health problems, how to deal with these problems, how we can support them" (H/M).*

As one teacher mentioned, *"These materials should not be limited to written information sources. There should be practical information sources provided for teachers, for example, training programs" (S/S).*

6.7.4 The commitment of teachers

Teachers are commonly directed through their attitudes, beliefs and values in regard to change; thus, teachers need to be convinced of the rationale and justification behind such change. According to the data, most teachers (eleven) reported that mental health promotion amongst pupils will not be successful unless there is commitment to change by those who are in a position to support the teaching establishment. One teacher said:

"There should be a change in order to implement promoting pupils' mental health and we are looking forward to this change. However, this change is the responsibility of the Ministry of Education; we cannot do the change ourselves" (H/M).

Another teacher reported: *"Promoting pupils' mental health should be a gradual process because it is not easy to ask people to change suddenly. You have to convince them that there are worthwhile reasons for change. Administrators in schools and inspectors need to be convinced of the importance of these processes and their demands so that they can assist teachers to overcome any difficulties they will face in order to achieve this goal. They need to be more flexible with teachers, especially with those who have pupils with mental health concerns in their classes" (S/S).*

Most of the participants (ten teachers) further hold the belief that change will only be supported by the teachers if their own needs are fulfilled, such as in terms of ensuring they are able to enjoy a good standard of living through wages and rewards, which will subsequently help to increase commitment. One teacher said: *"If we ask teachers to work effectively in the area of pupils' mental health, we need to support them financially so that they will not look for extra work which affects their performance in their class. For example, if you want to train teachers in this area, you need to give them rewards" (M).*

Another teacher stated that, *"Policymakers need to consider the teachers' role very seriously when they make decisions relating to pupils, because this will be instrumental in increasing teachers' feelings of responsibility and commitment. Applying any policy or programmes to promote pupils' mental health needs to suit our society culture and morals" (H/M).*

In addition, the teachers also emphasised the view that they need to be actively involved in the promotional process, including training in this area, which would ultimately help to improve and enhance their levels of commitment.

The conclusion may be drawn that change, together with teachers' commitment to such, is not simple, but is rather complicated and requires a great deal of support - both internal and external - and from a number of sources, both material and human. Teachers are of the opinion that they require in-depth and systematic training so as to ensure confidence and competence in identifying and dealing with mental health issues amongst their pupils, which should include the most appropriate and suitable practices for implementation, as identified through research. Furthermore, in relation to such strategies, there is also a pressing need to

ensure teachers' roles are taken into account by policymakers. Teachers need to feel secure and that they are adequately rewarded for their contributions, and also that their stress and pressures are taken into account; this is believed to help facilitate good performance. The teachers' responses have provided important insight concerning the various aspects, i.e. financial support, intrinsic motivation, psychological and emotional rewards, and religious commitment, which can support the adoption of mental health promotion amongst pupils.

6.8 Reflection on the findings, and conclusion of the chapter

Thus far, this chapter has provided a general overview concerning the perceptions of teachers in the context of pupils' mental health promotion. These perceptions were subcategorized through the analysis of the data into three main categories: perceptions of promoting pupils' mental health, which includes teachers' perceptions about the mental health concept and promoting pupils' mental health; feelings towards pupils' mental health issues; and behavioural intentions towards (readiness to participate in) promoting pupils' mental health. Additionally, the subsequent analysis has also highlighted the heterogeneous perceptions commonly held by teachers, spanning a large range of various aspects and areas including cultural and social context, perceptions of barriers to, and the change required for, mental health promotion, and requirements and outcomes of promotion.

Furthermore, through the analysis of the data, it can be seen that teachers' conceptualisations of mental health and the promotion of mental health amongst their pupils are considerably influenced by their cultural perspective. The perceptions of teachers are formed and shaped by their Islamic religious beliefs in relation to equal rights, the necessity to provide sympathy and support to those experiencing difficulties, and equality amongst human beings; accordingly, the majority of responses depict a socio-ethical discourse.

In relation to implementation barriers in the context of pupils' mental health promotion, the qualitative data analysis revealed the role of contextual factors, subsequently supporting the view that promotion-related barriers are not solely attributable to resources; in actual fact, this is a very complex issue comprising a number of contextual and intercorrelated factors, all of which need to be taken into careful consideration so as to ensure successful and effective promotional process. Moreover, consideration of the impacts of various factors in relation to daily routines should also be taken into account in the implementation of promoting pupils' mental health.

When reviewing the findings from this study, there is the need to ensure all of the issues are addressed in a comprehensive and in-depth manner. The fact is that teachers are working within environments and contexts which notably restrain them; accordingly, change must be implemented which takes into account the education system context, the broader social context, and school and classroom contexts. The perceptions and understanding of teachers in relation to this issue must be assigned an adequate degree of value and attention. With this in mind, the emergent issues highlighted previously necessitate a comprehensive review, with teachers' responses taken into account, together with the adoption of a holistic view of the data. This will be carried out in the discussion chapter (chapter 7) which will consider the wider context.

Chapter 7: Discussion the findings and implications of the study

7.1 Introduction

This chapter aims to present a thorough discussion of the key findings obtained from the quantitative and qualitative data. This discussion takes into account responses to the research questions and the interpreting of these findings in relation to the relevant perspectives of the existing literature on teachers' attitudes to and perceptions of promoting pupils' mental health in school. In this chapter, the findings from the survey will be discussed first and then the findings from the interviews. Additionally, the chapter provides a discussion of the limitations faced in the study. It concludes with a discussion of the project's practical, theoretical and methodological research implications, mapping out the contribution of the current study to the promotion of pupils' mental health and teachers' attitudes to that process. As also a number of recommendations for future studies will also be provided.

7.2 Discussion of survey findings

The findings derived from the survey highlight three main themes, which will be discussed in detail in the following sections. These themes are:

1. Teachers' attitudes towards promoting pupils' mental health.
2. Factors influencing teachers' attitudes towards promoting pupils' mental health.
3. Barriers to promoting pupils' mental health and making changes.

7.2.1 Teachers' attitudes towards promoting pupils' mental health

The analysis of teachers' attitudes towards promoting pupils' mental health aims to illuminate the first question of the first stage of the study: What are the attitudes of Kuwaiti teachers in middle schools towards promoting pupils' mental health?

Generally, the findings of the survey suggest that the majority of Kuwaiti middle school teachers tend to hold moderately positive attitudes towards promoting pupils' mental health. Accordingly, the mean of teachers' responses to the three components of teachers' attitudes - the cognitive, the affective and the behavioural - ranged from a minimum of 3.47 to a maximum of 4.33 on the Likert scale, which ranges from 1-5, with a mid-point of 3. The

findings reveal three main components of teachers' attitudes, namely cognitive, affective and behavioural. Factor analysis shows the multi-dimensional nature of teachers' attitudes towards promoting pupils' mental health in the survey, identifying five core dimensions. The first of these is the cognitive dimension, measured by teachers' beliefs about mental health problems as alterable, teachers' beliefs about promoting pupils' mental health in schools, and teachers' beliefs about requirements and outcomes (psychological, social and academic) of promoting pupils' mental health. The second, affective dimension measures teachers' emotional responses and feelings towards promoting pupils' mental health. The third, behavioural dimension aims to explore teachers' intentions towards their role as pupils' mental health promoters and their willingness to change their behaviour to implement promoting pupils' mental health in school. Additionally, in terms of the second question of the first stage of the study, which aims to investigate any significant correlation between the three dimensions of teachers attitudes towards promoting pupils' mental health, the findings indicate that the three components of attitudes, including their dimensions, are slightly correlated with each other. This corresponds with the initial analysis that there are three distinct components of attitudes and that the three-component model of attitude is relevant to this study.

These findings stand in contrast to the single component model which emphasises a one-dimensional conception of attitude, considering the term 'attitudes' to pinpoint a psychological tendency communicated through the measurement of individuals' feelings (of liking/disliking; equivalent to the affective component alone). This study follows Stevens (1975) in treating attitude as a multi-dimensional construct, which should be regarded as an 'abstraction' rather than a single, identifiable quality (cited in Ajzen, 2005: p. 17). In the following section, the findings related to the three components of attitudes will be discussed.

7.2.1.1 Teachers' beliefs (Cognitive component)

The survey findings reveal three core factors related to the cognitive component of attitudes: teachers' beliefs about mental health problems as alterable problems, teachers' beliefs about promoting pupils' mental health in schools, and teachers' beliefs about requirements and outcomes (psychological, social and academic) of promoting pupils' mental health.

The first dimension of the cognitive component of teachers' attitudes towards promoting pupils' mental health concerns teachers' beliefs about mental health problems as alterable

problems, and aims to investigate Kuwaiti middle school teachers' beliefs about the nature of the mental health concept, the mentally healthy person, mental health problems, mental illness, the importance of early recognition of mental health problems among pupils in preventing these problems to become severe problems, the possibility of recovering from mental health problems, and young people's right to be mentally healthy. The survey findings indicate that the majority of teachers show strong positive beliefs towards promoting pupils' mental health on the Likert scale (M=4.33, SD=.45). The findings show that teachers believe in the right of young people to live mentally healthy, a principle that accords with the Convention on the Rights of the Child (United Nations, 1989). In addition, the findings reveal that the majority of teachers believe in the positive concept of mental health, such that young people can cope with and adjust to life's stressors, and adapt to changes positively, as well as it being possible to prevent temporary mental health problems becoming long-term and severe, and young people being able to recover from mental health problems through early recognition of, and support for such problems. This corroborates the view of 'positive psychology', which declares that the term 'mental health' needs to be viewed in a positive light, and can be defined beyond the narrow definition which views good mental health as merely the absence of mental illness (Seligman & Csikszentmihalyi, 2000; Kitchener & Jorn, 2002; WHO, 2001; Surgeon General's Report, 2000). In this vein, it has also been argued by Keyes, through his continuum model, that one's mental health can be enhanced regardless of a mental illness diagnosis. Keyes argues that this positive view has been proven to have an impact on gaining insight and understanding of the ways in which mental health promotion can be geared towards a particular individual with mental health concerns, if support exists to assist this person in overcoming their problems (2002, p. 208). Linking this view with the context of the current study, this means that teachers' early recognizing of pupils' mental health problems is helpful in preventing these problems becoming severe, even if pupils are not experiencing a diagnosed mental illnesses.

The second dimension of the cognitive component of teachers' attitudes concerned teachers' beliefs about promoting pupils' mental health in schools. In this section, the study explores how Kuwaiti middle school teachers understand the concept of promoting pupils' mental health in terms of the school's unique position in this area, teachers' understanding of promoting pupils' mental health, and teachers' responsibility for pupils' mental health. The results of the survey show that almost all teachers strongly believe in these aspects (M=4.27, SD=.45). Essentially, the majority of teachers believe that schools are in a unique position to

promote and affect pupils' mental health. This finding is supported by the recent view that, alongside delivering academic curriculums, schools have an influential role in young people's emotional and behavioural development (Wells, Barlow & Stewart-Brown, 2003; Rutter & Smith, 1995). The findings also indicate that most of teachers believe that they are responsible for, and play an essential role in recognizing pupils with mental health problems; however, they also held the contrary belief that promoting pupils' mental health in the classroom is not their job. Additionally, the findings show that most teachers strongly believe that promoting pupils' mental health is about learning skills and enhancing individual pupils' knowledge, to support their mental health. This finding supports the argument of many authors in the field of mental health promotion (e.g. Rowling, Martin & Walker, 2008; Hodgson, Abbasi & Clarkson, 1996; Adelman & Taylor, 2006), that the promotion of mental health should direct attention towards reducing risk factors, improving attitudes and levels of knowledge and the skills required to facilitate mental well-being.

The third dimension of the cognitive component of teachers' attitudes towards promoting pupils' mental health aims to investigate teachers' views regarding the requirements for promoting pupils' mental health and its outcomes. The results of the survey show that almost all teachers strongly believe in this aspect (M=4.31, SD=.51). The findings indicate that teachers strongly believe that promoting pupils' mental health requires teachers to be educated, and well-equipped with knowledge and training in the area of pupils' mental health. This echoes Atkinson & Hornby (2002), who argue that providing knowledge and support for teachers can help them to function effectively in identifying mental health problems among pupils and referring them to professionals. Additionally, the survey indicates that the majority of teachers believe that such a promotion process impacts positively on pupils' social and emotional well-being, as it could reduce the development of severe mental health problems. Teachers also agree strongly that promoting pupils' mental health has positive impacts. This finding is in line with Adelman & Taylor (2000), Wyn *et al.*, (2000) and Mental Health Foundation (1999), which provide evidence of overall positive outcomes in regard to academic achievement and the adoption of processes geared towards mental health promotion. However, the findings from the survey in this study also indicate that teachers perceive negative outcomes to the promotion process, in terms of impeding the learning of other pupils.

7.2.1.2 Teachers' feelings (Affective component)

Analysis of the findings about how teachers feel towards promoting pupils' mental health (affective component) indicated that teachers' feeling level are slightly positive (M=3.47, SD=.97). However, the standard deviation of almost 1 shows wider variation about the mean than for the cognitive factors, on the Likert scale (SD=.45, SD=.45, SD=.51). This suggests that the scores of teachers' responses in this area are widely distributed. Some of the teachers had affective scores below the neutral midpoint in the negative range. Such a discrepancy has also been noted by Cohall *et al*. (2007), who found that teachers accept the idea that they have an important role to play in promoting pupils' mental health; however, they feel less comfortable when discussing pupils' mental health problems, as they feel insufficient prepared and supported to be involved in this responsibility of promotion. Similarly, Rothì *et al.* (2008) found that teachers felt that promoting pupils' mental health could be an extra burden, in terms of managing the classroom, which is a factor also commonly responsible for teachers' stress levels, and teachers wanting to change their career path.

7.2.1.3 Teachers' behavioural intentions (Behavioural component)

Although teachers show their agreement with both the positive and negative statements representing their willingness to show positive behavioural intension towards promoting pupils' mental health, overall, the majority of teachers show fairly strong beliefs in this category (M=4.14, SD=.49).

In other words, what teachers saying is that they hold positive beliefs about the ideology of promoting pupils' mental health, and that they are willing to fulfil their responsibility in recognising pupils' mental health issues. However, they feel uncertain and lack confidence about the promotion process. They feel that they will go along with the implementations of all the processes of promotion within Kuwait's education system, despite the barriers they perceive (which will be highlighted in the barriers section later in this chapter).

7.2.2 Factors influencing teachers' attitudes and perceptions

The analysis of the findings in this section attempts to answer the third research question of the quantitative stage of the study: Are there any significant statistical differences in Kuwaiti middle school teachers' attitudes towards pupils' mental health that can be attributed to teachers' gender, age, years of teaching experience or level of education?

The survey findings establish that several factors are associated with the attitudes and perceptions held by teachers towards promoting the mental health of pupils. Gender, age, years of teaching experience, and level of education were found to be the most significant of teachers' demographical characteristics in this respect. Specifically, female teachers tend to hold more positive feelings towards promoting pupils' mental health than male teachers. This finding could in part be explained by the role of women in Kuwaiti society and the division of labour undertaken in Kuwait, as well as large parts of the rest of the world, based on the perceived roles appropriate to women. In Kuwait society women do not commonly work. Most dedicate themselves to looking after their children and attending to domestic matters, while men spend most of their time at work and out of the house. Even when women do have a job, they are usually allocated to 'emotional' employment areas, such as teaching and care-giving, rather than the traditional male sectors. However, surprisingly, when reviewing the literature, it became clear that the effect of gender on teachers' attitudes towards promoting pupils' mental health has not been investigated by any other research.

Additionally, the survey shows that teachers who had Masters degrees held stronger positive beliefs about promoting pupils' mental health. This accords with Roeser and Midgley (1997) who provide evidence that a teacher's level of professional education is positively linked with the need to recognise mental health problems amongst pupils. This might be explained by the notion that teachers who have had further education in the area of pupils' mental health could be more idealistic, fresher and have perhaps not yet been 'ground down' by the demands of the education system. However, although these teachers with Masters degrees might have more knowledge and coherent beliefs in the area of promoting pupils' mental health, when it comes to how these teachers feel and what they plan to do to implement the promotion process, it makes little difference, because they do not show a greater degree in practice of promoting pupils' mental health. In fact, they do not feel any more comfortable or more willing to involve themselves in the promotional process.

Moreover, the survey shows that teachers' attitudes towards promoting pupils' mental health are influenced by their age. The survey results indicate that teachers aged 31 to35 years old held more positive beliefs regarding their understanding the alterability of mental health problems than teachers in the other age groups. This could be explained in that most of teachers in this age group to some degree are mostly new graduated and they still have a fresh mind for their information or they are interested in learning more about mental health. The findings also show that the same age group tend to hold more positive feelings towards

promoting their pupils' mental health. Additionally, the results revealed more positive behavioural intentions towards promoting pupils' mental health among teachers aged 36 to 40 years old than teachers in the other age groups. This could be explained with the fact that the more years teachers spend in teaching, the more experience they can get in the appropriate dealing with pupil's mental health. Unfortunately, the literature review showed a lack of previous studies carried out into the effect of teachers' age on their attitudes towards pupils' mental health. Thus, further research should be carried out to investigate any differences in the attitudes held by teachers regarding their age.

Furthermore, the survey shows that teachers' attitudes towards promoting pupils' mental health are influenced by their years of teaching experience. Teachers who have more than 20 years of teaching experience held more positive feelings and behavioural intentions towards promoting pupils' mental health. This could be due to the fact that those holding teaching roles for a longer period of time develop a greater depth of experience in recognizing and dealing with pupils' mental health. This finding is in line with previous studies that proclaim that the number of years of teaching experience held by teachers is associated with their capability in dealing with the mental health needs of pupils, whereby staff felt more comfortable in tackling such problems when they had a greater amount of teaching experience (Roeser & Midgley, 1997; Rabinow, 1960).

7.2.3 Barriers to promoting pupils' mental health and making changes

The analysis of data in this section aims to illuminate the fourth research question of the quantitative stage: What are Kuwaiti middle school teachers' perceptions of barriers to promoting pupils' mental health?

The survey analysis shows that barriers hindering the promotion of pupils' mental health can be categorised into four types: personal, interpersonal, structural-organisational and socio-cultural. The decision to apply this categorising system is based on an appreciation of the complexity and context-dependent nature of the barriers that are relevant to teachers. Highlighting the need to consider so many aspects reaffirms this study's commitment to take seriously the specific, lived experience of teaching, and reflects the choice of methodology employed. The findings show that the majority of teachers agree with the existence of the above barriers to promoting pupils' mental health. In fact, teachers perceive these barriers as significant factors undermining their readiness to involve themselves in the process of

promoting pupils' mental health. The findings indicate that teachers agree strongly with the existence of interpersonal and personal barriers, on the Likert scale, which ranges from 1-5 points, where 3 is the midpoint (M= 4.06, SD=.76; M=4.12, SD=.56); however, the overall mean score of their beliefs about the existence of structural-organizational and socio-cultural barriers were more neutral (M=3.78, SD=.80; M=3.79; SD= .80).

The findings of the survey also illuminate the fifth research question of the second stage: Is there any significant statistical correlation between the perceived barriers to promoting pupils' mental health and teachers' attitudes? The findings indicate that most of the barriers related negatively to the teachers' attitudes towards promoting pupils' mental health, as would be expected (see Table 5.27). On the behavioural level, the findings indicate that the teachers' readiness to show behavioural intentions towards promoting pupils' mental health correlated more strongly with three of the four barriers - personal, social-cultural and structural-organisational. Based on these findings, it seems that behavioural intentions among teachers to promote pupils' mental health are the most predictable component of teachers' attitudes when it comes to how these teachers perceive these different types of barriers. Perhaps, the importance of this behavioural intention component of teachers' attitudes lies in the idea that when teachers talk about barriers or planning to promote pupils' mental health in practice, they are talking about what can stop them from getting involved in the promotion process and what barriers they come up against in the implementations of these process.

Overall these analyses indicate that it is not only what teachers know, but also about how they feel and intend to behave that ultimately counts. Also, those teachers who have lower mental health promotion behaviour intentions tend to be those who see more barriers to promoting pupils' mental health. This means that knowledge about mental health might be important in relation to promoting pupils' mental health, but not in itself sufficient to induce positive mental health promotion behaviours among teachers. Therefore, findings regarding barriers could hold two main explinations for perceiving these barriers. Firstly, these barriers could reflect actual and real 'perceieved' reasons for not implementing pupils' mental health promotion, though whether these are valid reasons. Secondly, it seems from the findings that teachers were using what psychologists called' the psychological defensive mechanisim', in building rationalisations or excuses, cannot be determined from this kind of study, to justify reasons of not being able to ptomote pupils' mental health sufficiently.

7.3 Discussion of the findings from the interviews

The analysis of data in this section aims to illuminate the first research question of the qualitative stage: What are Kuwaiti middle school teachers' perceptions about promoting their pupils' mental health?

Findings from the interviews reveal a variety of perceptions among middle school teachers in Kuwait about promoting pupils' mental health. The results show that teachers hold positive perceptions about promoting pupils' mental health, and the requirements and outcomes thereof. However, the data derived from the interviews indicates a contradiction in teachers' perceptions about their role and responsibility in promoting pupils' mental health; the findings from the interviews show that some teachers believe that they have responsibility and an influential role in recognizing pupils with mental health issues in the class. However, the findings also indicate that other interviewed teachers viewed promoting pupils' mental health as not being their job that professionals such as school counsellors and social workers, should take primary responsibility for promoting pupils' mental health.

In this vein, a numbers of themes arose from the interview analysis that could rationalise and help to explain such contradictions in teachers' perceptions about their role in promoting pupils' mental health. These themes are interrelated with teachers' beliefs and rooted in two forms of context, namely, the socio-cultural and educational. These themes also provided answers to the second, third and fourth questions of the qualitative stage of the study: What are Kuwaiti middle school teachers' perceptions about barriers to promoting pupils' mental health? What factors do Kuwaiti middle school teachers perceive as affecting their perceptions in promoting mental health? What are Kuwaiti middle school teachers' perceptions about the changes necessary to put promoting pupils' mental health into practice?

7.3.1 Themes within the socio-cultural context

Several themes emerged from the interview analysis that related to the socio-cultural context of Kuwait, which could explain the contradiction within teachers' perceptions about their role in promoting pupils' mental health. These themes include parents' expectations of teachers, religious beliefs about mental health, social stigma, and media representation of mental health issues. These themes will be addressed in the following sections.

- **Parents' expectations of teachers**

Interviewed teachers' perceptions about their role in this area might be influenced and formed by the expectations of other adults in the school and the community, and how teachers respond to these expectations. Parents form one group of adults who frequently expect teachers to work with children to ensure that achievement and mental health are the consequences of learning. Some teachers highlight that most parents would accept the idea that mental health is an asset to children as they learn and that mental health is essential to effective learning. However, teachers occasionally meet parents whose desire for their children to learn the subject matter is so strong that they forget the child's mental or physical health. In such cases, the idea that mental health is conducive to effective learning is relegated to an afterthought, especially when parents place their children's achievement of good grades in the exams above the promotion of their mental health. Therefore, some interviewed teachers perceive a lack of partnership between themselves and parents, which could hinder teachers' role in the mental health promotion process. This finding aligns with Rones & Hoagwood (2000) who assert that successful prevention of mental health problems is influenced markedly by the levels of cooperation between parents of children and teachers. According to Keyes (2002), parents should be encouraged to share their views and concerns with teachers, which could be achieved by delivering the sufficient information to assist pupils to deal with their mental health issues.

- **Religious beliefs about mental health**

Teachers' perceptions about their role and responsibility in promoting pupils' mental health show that religion and culture within the context of Kuwait have an influence on their views and their encouraging of sound mental health among pupils. Teachers reported that parents are affected by some religious and cultural beliefs associated with the causes of their children's mental health problems, and the way that they deal with them. Additionally, the interviewees reported that parents perceive mental health problems as God punishing people for neglecting their religious duties and God testing a person's piety and patience. In fact, some interviewed teachers also relate that the impact of these beliefs can be seen clearly through parents' tendency to ignore the possibility of counselling for their children's mental health, and rather to seek help from traditional and religious healing, where they are treated by recitation of some ritual words, drinking 'blessed water', and the use of incense.

This finding is supported by Mukalel & Jacobs (2005), Funk (2005), El-Islam (2006) and Al-Ansari *et al.* (1989), which report that some cultural and religious beliefs profoundly affect peoples' understanding and the way that they deal with their children and their mental health problems in Islamic countries. Thus, what some teachers suggest is that there is no point in them becoming involved in promoting pupils' mental health while such beliefs still exist within the socio-cultural and religious heritage of people in Kuwaiti society. This could undermine the teachers' role in assisting pupils to enhance their mental health, in that communication and co-operation between teachers, counsellors, and parents is undervalued, and counselling by professionals in schools is distrusted by parents.

- **Social stigma surrounding mental health issues**

One of the issues raised most frequently by some interviewed teachers that could hinder the teachers' role in promoting pupils' mental health is the social stigma surrounding mental health issues and negative attitudes towards mentally ill people. Some interviewed teachers may view themselves as unable to participate in reducing the impact of these problems on pupils due to the extent of this stigma. In fact, some interviewed teachers reported that the stigma affects the parents of pupils and can lead them to hide, exclude or isolate their children from society, including not permitting their children with mental health issues to attend school. The findings show that teachers believe that this stigma not only has a significant impact on the co-operation between teachers, parents and counsellors, but also hinders teachers in promoting pupils' mental health.

The effect of such social stigma could affect the degree of parents' partnership in the promotion of their children mental health, as some interviewed teachers connect the lack of co-operation between themselves and parents, which could impact on the teachers' role in discussing pupils' mental health issues, with parents' lack of confidence and trust in teachers' skills and experience in the area of mental health. The way in which pupils are treated by their teachers was found to be affected by the stigma the teachers perceive and believe in, and that parents show towards their children's mental problems (Corrigan & Kleinlein, 2005). In addition, interviewed teachers believe that the impact of parents' belief in stigma can be seen clearly through the preferences of parents for private clinics when dealing with their children's mental health problems, due to their fear of anything that could be added to their children's ID, and affect their opportunities for working and studying in the future.

- **Media representation of mental health issues**

Media representation of mental health issues and mentally ill people might explain teachers' contradictory perceptions about their role in promoting pupils' mental health, as the interviews reveal fears among teachers about dealing with pupils' mental health problems that correlate with such depictions. This finding agrees with the argument that the media play a crucial role in the way that people perceive mentally ill people and understand mental health problems around the globe (Edney, 2004; Wahl, 1995, 2003; Hottentot, 2000; Smith, 2002) and in the Arabic and Islamic world, forming the context of the current study (Al-Maleh, 2009). Kuwaiti teachers, as a part of this society, are no exception.

7.3.2 Themes within the educational context

A number of themes were found within the educational context in Kuwait that could be related to and explain the contradictions within teachers' perceptions about their role in promoting pupils' mental health. These themes were found to be related to teachers themselves and the education system. These themes will be addressed in the following sections.

7.3.2.1 Teachers

Teachers and their inadequate knowledge and training, the lack of support available for teachers' own mental health, their teaching style, teachers' lack of understanding of the terminology of mental health, and teachers-pupils relationship, are important themes that can be used to explain the contradictions within teachers' perceptions about their role in promoting pupils' mental health.

- **Teachers' inadequate knowledge and training skills**

The contradictions within teachers' perceptions about their role in promoting pupils' mental health could be explained by teachers' belief that they have insufficient knowledge in the area of pupils' mental health. This suggestion supports the findings of previous researches (e.g. Walter, Gouze & Lim, 2006; Rothì, Leavey & Best, 2008; Repie, 2006), which assert that teachers' lack knowledge about mental health affects their views of, and ability to deal with mental health problems among pupils in their classrooms.

In addition, some teachers reported feeling uncomfortable due to a lack of training skills, a resolution of which would be reflected in appropriately dealing with pupils' mental health, and further result in more confident and skilled staff, able to recognise issues and capable of making appropriate referrals to psychiatric and mental health professional services; teachers need a sense of confidence in their own ability to act. Accordingly, the findings show that some teachers have become aware that a number of new skills need to be added to their portfolio of traditional pedagogic skills, so that pupils' mental health is not left to chance. The effectiveness of such training for teachers has been reported by several previous studies - specifically for teachers who teach in middle school - in increasing teachers' ability to identify and recognize early signs of mental health problems, e.g. in preventing suicide (Crawford & Caltabiano, 2009) and reducing instances of eating disorders (Yager & O'Dea, 2005). Some interviewed teachers stated that promoting pupils' mental health requires them to be equipped with knowledge and awareness of mental health issues, and to have appropriate training skills to facilitate the task of promoting pupils' mental health in the school setting. The interviews address more detailed views of teachers' suggestions for these requirements, in terms of the 'quality' and the 'nature' of the training and educational courses that should be provided for them. Teachers suggest a need for training plans to be well-outlined and planned, beginning with general information and skills, before progressing to more specific and targeted sessions. The interviewed teachers also propose that administrators and inspectors need to be involved in mental health education and training, which would result in a greater degree of flexibility in promotion strategies, as the nature and challenges associated with such promotion, would be understood among all administration staff.

- **Support for teachers' mental health**

The findings raise a number of concerns about the lack of support given to teachers, and the consequences for their own mental health. Such shortcomings in the education system in Kuwait may result in teaching staff feeling so stressed due to excessive academic demands, that they do not feel that there is any room to address mental health concerns amongst their pupils. Some interviewed teachers ask for support in order to be able to take on responsibilities, and highlight two different forms of support as fundamental: material support concerned with delivering practical and written documentation, providing mental health education courses and training workshops, as well as reconsideration of rewards and salaries, and human support from parents, professionals and the school administration, with teachers

requiring greater flexibility and open-mindedness in terms of promotional implementation. In fact, based on my personal experience as both a teacher and school counsellor, combined with discussions with counsellors and teacher, it is clear that most teachers are not equipped to deal with the necessary information resources, such as written or specialist individual sources.

Moreover, some interviewed teachers highlight the need to ensure that school teachers are supported emotionally, owing to the high levels of stress and pressure associated with their job. More specifically, most of the teachers voiced their belief that they would be unable to promote mental health amongst their pupils if they themselves were not provided with support. These results are in line with the concept of 'burnout', which is apparent in numerous studies and considered to be a direct result of challenging classroom behaviour, together with stress levels and teachers' class management skills, as many teachers are inclined to change careers due to this factor (Evers, Tomic & Brouwers, 2004; Lynn, McKay & Atkins, 2003). This finding does raise the question of why some teachers ask for their mental health to be considered by education leaders, yet at fail to regard promoting pupils' mental health as being part of their job.

- **Teaching style**

One other important theme that could explain teachers' feeling of being less positive about participating in their role in promoting pupils' mental health is the traditional pedagogic style they adopt in teaching. Owing to the examination system currently utilised, traditional teaching styles are utilised by staff. The findings suggest that teachers desire to alter and adapt their styles of teaching with the aim of ensuring their responsibility in promoting pupils' mental health is met. Teachers' attitudes concerning the promotion of pupils' mental health were found to be influenced by the teaching style adopted (Midgley, Feldlaufer & Eccles; 1989). This suggests the need to change teaching styles in Kuwaiti schools from the traditional ways, which conceive of teachers as senders and pupils' as receivers of information, rather than collaborators in learning, to more creative ways of presenting information, through appropriate technology and techniques.This required shift in teaching style could assist in leaving room and offer time for teachers to recognize pupils' mental health in the class.

- **Teachers' understanding of the terminology of mental health**

The findings from the interviews indicate that some participants view the promotion of pupils' mental health as a medical and professional area. This understanding may arise from how teachers understand the concept of mental health. The findings reveal less familiarity amongst some interviewed teachers with the positive conception of mental health; teachers tend to perceive mental health as the absence of mental disorder. These findings relate to Rothì, Leavey, Chamba & Best (2008), which showed that teachers often felt confused by the terminology used by mental health professionals. This lack of understanding of the positive concept of mental health could further affect the way they are able to identify and recognize these problems among pupils (Rogers & Pilgrim, 2005).

Responses in the interviews made it clear that this difficulty in understanding the positive conception of mental health led teachers to avoid the use of terms surrounding mental health. This avoidance could also be explained by the teaching boundaries, ethos and tradition, and the common perceptions that using this mental health language could be both harmful and stigmatising. The teachers assert that they are not mental health experts who understand the clinical terminology of mental health issues and they do not possess in-depth understanding of clinical diagnostic criteria for mental health disorders. Thus, teachers appear to be more comfortable using language that is grounded in education, using terms such as 'emotional and behavioural difficulties' (EBD) or special educational needs. EBD is a term widely accepted by the educational community as covering a wide range of inappropriate behaviours including mental health problems (Fox & Avramidis, 2003; Clare & Maitland, 2004). This might explain teachers' preference for this to using less familiar mental terms in their classroom.

Another theme relating to the difference in teachers' understanding of the mental health concept is teachers' concerns about the fact that it could be perceived differently in the light of cultural and social considerations: most terms used in the field of mental health were constructed in Western cultures and carried over into the Kuwaiti context. Teachers are also of the opinion that they might not use these terms because they believe that what is seen as 'mentally healthy' may differ from one culture to another. This view is supported by Rosenhan and Seligman (1989), who argue that the concept of mental health can refer to moral code violation and social judgements, as the concept could be seen as a bound by culture (Gross & McIlveen, 1996). Moreover, in my view, the teachers' decision to avoid

using mental health language may have a practical purpose, in that it suggests an intention to keep the responsibility of such promotion on the shoulders of the mental health professionals, thus freeing them, as teachers, of their responsibility towards pupils' mental health.

It is clear from the findings derived from the interviews that teachers' views of the concept of mental health are affected by their cultural and religious beliefs, as the term 'mental health' is conceptualised as conformity of individuals' behaviours to religious values and cultural morals, where such behaviours are judged by others (El-Islam, 2006). Additionally, the influence of cultural and religious beliefs appears clearly in how teachers define the concept of mental health, as they linked good mental health with the idea of a pure soul - happy and protected from harm by God. Good mental health can be enhanced only through the continuous fulfilment of religious duties and being closer to the God, where person can feel more secure and achieve a pure soul. This means that culture and religion have an impact on the way that people within Arabic and Islamic countries conceptualise mental health and the way it should be promoted. Therefore, any change or strategy for promoting mental health in general or that of pupils in particular, as in this study, should consider the cultural and religious context within which the promotion process is to be applied.

Teachers' understanding of the mental health concept is reflected clearly in their responses regarding their views of the mentally healthy person and how they can know if their pupils have mental health issues. Their views are mainly based on explicit signs of pupils' externalised problems, considering such pupils to be troublemakers. Importantly, when questioned about the ways in which pupils with mental health issues are identified, the respondents indicated a number of factors, including academic achievement, undesirable behaviour, social integration and rule-following. Such conceptions suggest a 'deviancy' model for the identification of issues, with teachers emphasising that they commonly evaluate pupils' problems in terms of 'deviation from the norm'.

These findings are not surprising and are supported by previous research (e.g. Bowers, 1996; Meltzer *et al.*, 2000; Farmer *et al.*, 2003; Poulou & Norwich, 2000) which found that teachers are more likely to express their concerns about the behaviour of disruptive pupils than their mental health or emotional problems. Therefore, this difference in understanding of the positive concept of mental health could undermine teachers' role and responsibility, and might affect their attitudes towards pupils' mental health (Repie, 2006), as teachers will

perceive promoting' pupils' mental health as a professional medical concern, in which they do not have a role.

- **Teacher-pupil relationship**

The findings of the present study suggest that teachers feel that the relationship between them and their pupils is a matter of delivering the curriculum and evaluating academic performance. Interviewed teachers suggested that this relationship need to be shifted from the need to satisfy teachers' expectations and doing homework to another type of support relation, emphasise close relationship provide teachers with a clear picture of all pupil's needs. Interviewed teachers rationalised the significant of such close relationship with the secure feelings that pupils might get and the freedom they will show in expressing their feelings and problems, which in turn could facilitate the task of teacher in recognising pupils' mental health. This finding seems to be in line with Birch and Ladd (1997), who report that relationships between pupil and teacher are linked to positive behaviours illustrated by the pupil, including academic competence, classroom participation and liking school. It is also known that confrontational relationships between such parties are linked to negative behaviours, including classroom disengagement, poor academic performance, school avoidance and undesirable attitudes.

7.3.2.2 The education system

The analysis of the interviews data show a number of themes connected to the education system in Kuwait that could rationalise teachers' contradictory perceptions of their role in promoting pupils' mental health such as education policy, curriculum, examination system, workload, limited time and class size, academic outcomes of promoting pupils' mental health, resistance among administrators and inspectors to change,school counsellers' job, and young people's right to the promotion of their mental health.

- **Education policy, curriculum and examination system**

It has been ascertained from the interview findings that teachers have mixed views concerning the value of educational policies and legislative systems in fulfilling promotional approaches, highlighting the need for new and more detailed legislative frameworks and educational policies, so as to ensure pupils' mental health promotion is both assisted and supported. Interviewed teachers emphasise that the change needs to function in two ways -

top-down and bottom-up - where teachers' voices are listened to, respected and taken into account during the policy-making. Nevertheless, although teachers may consider promoting pupils' mental health in a positive light, as a vital part of the learning process, and call for new policies to ensure that pupils' mental health is supported, when it comes to practice, they mention various excuses that inhibit their involvement in such a promotion process From the researcher's point of view this indicates that the teachers are adopting a 'Yes...but...' stance, which might be recognised as a self-contradictory ideology that needs to be examined at a deeper level.

The examination system is another part of the education system that could be considered a major factor in teachers' perception of their role in promoting pupils' mental health. Some interviewed teachers suggest that pupils in the class are likely to demonstrate lower academic performance if there are adjustments made during the promotional process, providing a rationale for their doubts. This may be a result of teachers' interest in achieving what is outlined in the curriculum, in terms of outcomes and the time needed to achieve them. With this in mind, it was recognised through the findings that teachers feel pressured by academic outcome targets, which are known to shape the Kuwaiti education system.

In this context, the findings of the current study highlight that the issue lies in the way education is conceptualised rather than in the promotion of pupils' mental health. Without question, the educational system implemented within the country of Kuwait is competitive and very exam-focused. Accordingly, teachers are required to satisfy policymakers' educational aims, which are essentially concerned with academic attainment. Some interviewed teachers reported that they will be required to focus only on promoting academic achievement as long as the Kuwaiti education system is concerned with exam outcomes and places less value on social outcomes than the academic. Judging from the interview findings, such practice could ultimately result in the promotion process being undermined.

Additionally, based on some interviewed teachers' perceptions, school failure to implement pupil's mental health promotion could be due to the overall nature of the curriculum, which is very comprehensive, demanding and information-heavy, and this ultimately means there is no room left for additional activities that could help promote pupils' mental health. Teachers suggest changes to the curriculum, specifically to its content: they complain that the curriculum is far too detailed, and that time does not permit proper contextualisation of textbook content. They are also in general agreement that any surplus or otherwise

unnecessary information should be removed. Such amendments would ensure adequate time to address the mental health issues of their pupils.

The interviewed teachers also refer to the examination system as fundamentally responsible for the lack of progress in mental health promotion amongst pupils. They claim that there is a conflict between the examination system and the teaching curriculum, with the latter emphasising that pupils should be assessed in terms of their capacity to memorise textbook content. As a result, pupils' evaluations ultimately fail to address other areas, including difficulties associated with family, physical or mental health issues.

Hargreaves *et al*. (1998) argue that examinations are regarded as fundamental, and a critical component of the socio-cultural context within the educational systems of the majority of developing countries, particularly in the Middle East. The authors add that, 'while examinations serve an important certificatory and selective role for pupils, parents and teachers, submission of their results has an accountability purpose for government along with reports from inspections, which put government in a powerful position over individual in schools' (p. 256). They further argue that a competitive atmosphere is achieved through the examination system, meaning schooling establishments, as well as individual teachers, are held accountable for grades and that examinations have one critical aim, which is to develop individual learning in an academic context (1998). However, these findings relating to the impact of the extensive school curricula and examination system raise another question: Is promoting pupils' mental health about having particular content within the curriculum, or is it about the ethical and moral values that teachers believe in, and that guide teachers in their work, or the quality of the human relationships between them and their pupils?

- **Workload, limited time and class size**

Workload and limited time emerged from the findings of the interviews as an important theme that could colour teachers' perceptions about their role in promoting pupils' mental health. Teachers hold the view that they will be forced to shoulder additional responsibilities and work if pupils' mental health promotional initiatives are adopted, claiming that there will not be enough time to prepare and plan lessons and educational materials, or to manage in-class behaviour.

This finding concords with the suggestion by Nelson and While (2002) that lack of time could lead teachers to feel stressed, considering the pressures they could experience due to

the curriculum's content and demands. It is also in agreement with Lewis (2001), Burke (2002) and Paternite (2004), that teachers are already spending extra time in each academic class period each day handling such behaviours, and this means that they will need more time to be able to recognise pupils' mental health issues if promotional process are implemented. Furthermore, the findings of the interviews show that class size (over 50 pupils in one class) could be one of the structural environment barriers that might hinder teachers in promoting pupils' mental health. Interviewed teachers stated that smaller classes are needed in order to ensure such a promotional process could be implemented effectively.

- **Academic outcomes of promoting pupils' mental health**

Teachers' views about the expected outcomes of promoting processes constitute one of the results which most support the overall positive attitudes towards promoting pupils' mental health. The interviewed teachers stated that promoting pupils' mental health is psychologically and socially beneficial to all pupils in assisting pupils to acquire more self-confidence to face stresses in life, establish and maintain positive relationships. Additionally, other pupils may show empathy and support towards their peers experiencing mental health problems.

Despite their largely positive view of the psychological and social outcomes of the promotion process, it was nevertheless found that teachers were concerned about their lack of instructional skills relating to the academic outcomes associated with mental health promotion amongst pupils. The results of the interviews show that teachers hold mixed views about the academic outcomes of the processes of promoting pupils' mental health: although they view it as a supportive process for pupils to achieve better educational progress, they simultaneously consider it a significant barrier to other pupils' academic achievement, with a danger that their learning might be impeded. Teachers seem to be worried that they would be exploited and over-worked through having to adopt a number of roles, with one of the sample claiming that the instructional routine would be interrupted by the promotion of pupils' mental health.

Another area of inconsistency in teachers' perceptions about the academic outcomes of promoting pupils' mental health could be seen clearly through what I term 'mental health-related attention'. The findings show that teachers believe that promoting pupils' mental health could impact on gifted pupils in their classes by reducing the amount of time available

to cover the academic demands. This may indicate teachers' lack of awareness and knowledge regarding pupils' mental health issues, as implicitly assumes that gifted pupils are exempt from experiencing mental health problems. This does not concur with the findings of other studies, which have argued that gifted pupils might be more at risk - due to the adjustment problems they may face - than non-gifted pupils, and that giftedness could increases vulnerability to adjustment problems, related to gifted pupils' often higher sensitivity to interpersonal conflicts and the greater degrees of stress and alienation they might experience than their peers, as a result of being 'different' and their higher cognitive capacities (Janos, Fung & Robinson, 1985; Freeman, 1994).

This finding also highlight a conflict in teachers' perceptions about the equal rights of all pupils to have their mental health taken into consideration and to live mentally healthy lives, and their beliefs that the implementation of mental health promotion will affect the academic achievement of the talented pupils in the class negatively. This is also not in line with those aspects of educational policy in Kuwait which demand equal opportunities for all pupils to reach their full potential, by meeting their individual emotional, educational and physical requirements (MOE, 2008). Therefore, there is a contradiction between, on the one hand, teachers' beliefs that all pupils have the right to enjoy mental health and to be supported emotionally and socially, and on the other hand, teachers' perceptions about the negative outcomes of promoting pupils' mental health.

Teachers seem to perceive that paying more attention to mental health issues (or pupils facing such issues) is a 'wrong use of time' in class, as there is an underlying assumption that time should be used appropriately and only for fulfilling educational demands, in order to meet academic standards. This raises important questions about what education is for: Is education for helping learners to achieve academic standards set by policymakers, while marginalising the social role of schools in fostering pupils' social and mental development? Is promoting pupils' mental health not a part of education? Is promoting pupils' mental health considered a less productive use of time than supposedly separate academic classroom activities? If teachers believe that all pupils have the right to be educated and live mentally healthy lives, why do they think that they sacrifice other pupils if they spend more time dealing with, recognizing or managing ways to assist pupils with their mental health concerns?

- **Resistance among administrators and inspectors to change**

Another factor can potentially help to explain the contradictory perceptions among teachers about their role based on their view of administrators and inspectors in school. Some interviewed teachers report difficulties and express their frustration with the school administration; they reported that there is resistance on the part of the school administration to teachers becoming actively involved in the promotion process. The policy adopted by the school administration in the education system in Kuwait situates teachers in the field of education as educating pupils and following specific teaching plans to achieve the required academic standards within a specific time-frame, leaving no room for flexibility. In fact, within the education system in Kuwait, administrators and inspectors are the only people who have the power to authorise teachers' teaching plans and teachers' annual reports.

The interviews show a clear concern on the part of some teachers that, should mental health promotion be implemented, this would then affect teachers' annual reports, which could result in that teacher's record being tarnished, potentially affecting their professional career in the future. This suggests that some interviewed teachers believe administrators to be inflexible in terms of their teaching plans and lesson preparation, with teachers dictated to through guidelines. It appears that some interviewed teachers worry that there is insufficient time in their schedules to incorporate mental health and that the administrators provide very little flexibility to acknowledge and address the mental health issues of pupils in the classroom. Additionally, some interviewed teachers suggest that making such a change in the education system could deliver a greater degree of flexibility as well as more opportunities for staff to conduct activities concerned with addressing mental health problems and ensuring the promotion of mental health.

Hargreaves *et al*. (1998) describes how the education system implemented within a number of non-industrialised countries is an absolute, undeniable system, which has made a number of entities — the education system, as well as administrators, teaching staff and pupils — unable to act and behave in a free manner. In consideration of this view, it could be emphasised that such an environment has the potential to weaken mental health promotion, should such implementation take place. In fact, teachers reported that administrators within the education system are in a position to compound the feelings of teachers, i.e. pressures and stresses, or to otherwise facilitate in easing their burdens, and that the majority of stress and similar concerns can be traced back to administrative issues.

- **School counsellors' job**

Another theme related to teachers' contradictory views regarding their role as pupils' mental health promoters is their belief that the promotion of pupils' mental health already exists in schools, since this is the counsellors' job. This relates to the conflict between the education policy discourse and the practice discourse of promotion, within the context of the Kuwaiti education system. According to the Constitution of the State of Kuwait, education is the right of all citizens, and the main goal of education is to prepare individuals with knowledge and training skills to become active citizens in academic, physical, technological, social, and psychological terms (MOE, 2008). The goal of education suggests that schools need to consider the 'whole person' of each pupil; schools therefore have a fundamental role in not only delivering academic development but also in ensuring mental health problems amongst young people are recognised and treated, alongside the provision of a healthy and safe environment conducive to mental well-being, promoting pupils' mental health. Accordingly, it is assumed that teachers will be more involved in promoting pupils' mental health, as they are expected to take some responsibility in the early identification of pupils' mental health problems and to refer these young people for appropriate support as required (Meldrum, Venn & Kutcher, 2009). In fact, the education policy in Kuwait encompasses all aspects of pupils' lives - academically, socially, psychologically, and physically – but does not reflect the actual practice of schools in Kuwait. In fact, although some interviewed teachers reported that they have responsibility in this area, they believe that promoting pupils' mental health should be the responsibility of the School Mental Health Services Department in the Ministry of Education in Kuwait, who assign counsellors to schools.

This finding might also reflect that teachers perceive a lack of partnership between themselves and specialist such as counsellors and educational psychologists as a significant interpersonal barrier, which could hinder teachers' role in the pupils' mental health promotional process. Teachers' views and opinions were found to be helpful and supportive in the area of promoting pupils' mental health (Loeber, Green & Lahey, 1990; Sanford *et al.*, 1992), but their expertise is undervalued, underutilized and rarely taken into account by mental health professionals (Roeser & Midgley, 1997; Nelson & While, 2002). Therefore, school counsellors need to think out of the 'professional boundaries' box, and allow teachers the chance to participate in promoting pupils' mental health effectively, through creating more co-operation and communication with them.

- **Young people's right to the promotion of their mental health**

The findings show that some interviewed teachers believe strongly that young people have the universal right to live mentally healthy. Teachers' perceptions of pupils' right to enjoy mental health could be seen clearly through the findings relating to the socio-cultural-religious discourse that teachers adopt when speaking of their overall awareness of young people's right to live mentally healthy lives and the promotion of such, with discussion of this recognised as being driven not only by political correctness but also by religious principles and values. In line with Islamic religious beliefs, which emphasises equality of all individuals, teachers are guided by their beliefs in this respect, as became clear in the ethical discourse emphasised in the views of the sample: This could be rationalised by the impact of the broader social context, moulding and influencing the way in which people understand social phenomena.

The findings from the interviews indicate that most teachers are oriented morally towards what I call a 'value discourse' founded on their religious beliefs, relating to the equality of rights amongst human beings, and the necessity to provide sympathy and support to those experiencing difficulties, which are key and valued aspects of Islam. Thus, in this regard, social connectedness is viewed as having high value, with all individuals willing to both offer and accept help and assistance from one another. However, it should be considered that equal treatment and ensuring justice are not necessarily the same. The abilities, needs and strengths of individuals need to be taken into account, rather than simply implementing one generic standard, which may not be suitable for all. Absolute equality is not a state advocated by Islam, since this could potentially result in neglect of individual differences and the intrinsic differences between people. Enforced uniformity could result in insufferable complications. Teachers' conceptualisations of mental health and the promotion of mental health amongst their pupils are considerably influenced by their cultural perspective, especially in an Arabic and Islamic society like Kuwait, where values and morals are significant components of people's ethical heritage. Long (2000) notes that education is, to a significant degree, impacted by general cultural influences, since both staff and pupils bring into the school environment their own values and beliefs.

This view has perhaps been reflected in the way some teachers illustrated a somewhat more humanitarian strategy, holding the belief that involvement in promoting mental health amongst pupils is not only a concern in terms of fiscal factors but also concerns moral

responsibility and commitment: *"Even if we have limited support, poor resources, and low salaries, I think that our responsibility is based in a sense of humanity" (M).* It is the demand of morality that all pupils should be treated with respect and valued equally, and thus provided with opportunities to progress within the school environment. However, there is a contradiction between teachers' perceptions in every pupil's right to be mentally healthy, and that they as teachers have an influential role and responsibility in recognising pupils with mental health problems, and on the other hand, their objection in practice that promoting pupils' mental health is not their job, and that it is primarily the responsibility of school counsellors and mental health professionals. According to some interviewed teachers, the negative, stigmatised social view of mental health issues runs counter to the moral codes of Islam, in terms of dealing with people in need, which emphasises providing further support for them. The reason behind this contradictory belief may relate to individual personal behavioural and non-spiritual practices for dealing with this type of person, and not to Islamic morals and values. This contradictory view could be seen clearly in teachers' perceptions of the academic outcomes of promoting pupils' mental health, as teachers believe that such a promotional process could slow the learning of other pupils, especially gifted ones. This is in conflict with teachers' beliefs that all pupils have an equal right to mental health.

7.4 The overall discussion of the findings

The mixed-methodological approach utilised in the current study allowed the researcher to reflect and contrast results. While the quantitative results do provide some important general indicators and patterns, the more in-depth interviews allow nuanced analysis and a greater representation of the specific context of the study (Tashakkori & Teddlie, 2003; Creswell & Plano Clark, 2007). In this way, the mixed-methodological approach has proven valuable in drawing out similarities and contrasts within the research tools employed, and ensured a broad view of the context in results (Johnson & Onwuegbuzie, 2004). Although the survey offered some insights into teachers' attitudes towards promoting pupils' mental health, the inconsistencies in teachers' responses in this survey could not be fully understood without conducting the semi-structured interviews.

Employing interviews in addition to the survey allowed gaps inherent through the use of one method to be filled by another (Bryman, 2008). For instance, the data derived from the interviews give a clearer picture and richer information about themes that might underlie the

divergence between teachers' positive beliefs about their role and responsibility in promoting pupils' mental health and their behavioural intentions. This provides evidence for the practical value of the mixed-methodological research approach in seeking a convergence of the findings between multiple methods utilised in the research design; the two research approach are complementary (Tashakkori & Teddlie, 2003).

A mixed-methodological approach also has the ability to offer the opportunity to answers research questions that cannot be answered using a single approach, and deliver rich, in-depth responses to complicated social phenomena (Tashakkori & Teddlie, 2003). It has also been argued by Creswell (2003) that the approach helps to provide explanations for the contradictory views of the positivist (quantitative) and interpretivist (qualitative) paradigms.

In light of the three core findings above, revealed by this study's survey, firstly, while the majority of teachers reported fairly high cognitive and behavioural attitudes towards promoting pupils' mental health, teachers' affective attitudes were lower. This discrepancy was clarified by the fears that teachers expressed in the interviews, of being ill-equipped to recognise mental health problems among their pupils and their lack of familiarity and understanding of the positive terminology of mental health concept, consequently viewing the term as belonging to a medical and professional context. Also, teachers' fears might be explained by parents' expectations and attitudes towards teachers, as parents consider them as neither expert, trustworthy, qualified or allowed to deal with their children's mental health issues. Inappropriate representation in the media of mentally ill people could lead teachers to feel uncomfortable and even scared of dealing with or talking about mental health issues. Thus, such worries and fears could lead teachers to feel less confident and comfortable in tackling the task of the promoting pupils' mental health.

Secondly, the survey findings show a number of factors associated with attitudes held by teachers towards promoting the mental health of pupils. They indicate gender differences in teachers' feelings about promoting pupils' mental health, as female teachers tended to hold more positive feelings in this area than male teachers. In addition, teachers with more years of teaching experience held more positive feelings and behavioural intentions towards promoting pupils' mental health than teachers with less experience. Level of education was also found to have a significant impact on shaping teachers' attitudes as promoters of pupils' mental health, as teachers with further education tended to hold more positive beliefs about

promoting pupils' mental health. Also, age was found throught the data as an important factor attributed with teachers' attitudes towards promoting pupils' mental health, as younger teachers tend to hold more cognitive and effective attitudes, while older people high attitudes were more associated with behavioural intention to deal and participate in the responsibility of promotion process. Analysis of the interviews also highlight gender, age, level of education and years of teaching experience as important demographical factors that impact on teachers' perceptions of promoting pupils' mental health; however, further factors were also highlighted. For example, young person-related variables such as the severity and type of mental health problems was reported by interviewed teachers as important factors that could influence their attitudes and perceptions in this area. This finding agrees with Loades & Mastroyannopoulou (2010) and Rothì & Leavey (2006), who suggest a direct link with teachers' views about recognising pupils' mental health needs and problems. The findings derived from the interviews show that this factor may be interconnected with teachers' fears of dealing with serious degrees of mental problems. Teachers appear to be influenced by the misconceptions and stereotypes they have about mentally ill people. These misconceptions seem to derive from the way that media represent such people as violent, evil, criminal, and sometimes portrayed as being like a bomb ready to explode (Smart & Wenger, 1999). In fact, on this point, teachers care about their safety.

Thirdly, the findings from the survey reveal four groups of barriers perceived by teachers that were negatively related to teachers' attitudes and perceptions about the promotion of pupils' mental, namely personal, interpersonal, socio-cultural, and structural-organisational barriers. Teachers' readiness to show behavioural intentions towards promoting pupils' mental health was stronger when they perceive lower personal, socio-cultural and structural-organisational barriers. The study suggest that behavioural intent among teachers to promote pupils' mental health is the most predictable component of teachers' attitudes when it comes to the effect of these different types of barriers on the practical implementation of such a promotion process. However, the qualitative data derived from the interviews show that those teachers who show lower behavioural intentions attitudes towards promoting pupils' mental health identify more barriers to the promotional process in two ways. One is that the barriers they perceive are real for them and so they are discouraged from intending to promote pupils' mental health, while those teachers who have higher behavioural intention attitudes regard the perceived barriers as not affecting them, perhaps because of their commitment to mental health promotion. Secondly, and alternatively, teachers with low behavioural intention attitudes may be

justifying their low behaviour intentions by using external barriers as 'reasons' for not intending to promote mental health - a kind of rationalisation. Thus, this study draws attention to the likely and practical repercussions of removing or reducing the impact of these barriers in order to promote pupils' mental health effectively.

Additionally, the qualitative data obtained from the interviews draws a sophisticated picture of how these barriers impact on teachers' attitudes to and perceptions of promoting pupils' mental health, and how these barriers interconnect with the wider socio-cultural and the state-wide education contexts. This accords with Karl and Gordon (1992), that individuals' perceptions are formed through personal knowledge, which is sourced in a social setting through social interactions. For example, the findings from the current study show that interpersonal barriers include parents failing to appropriately promote their children's mental health, reflected in a lack of collaboration between teachers and parents and a lack of communication between teachers and school counsellors.

These were found to be interrelated with the socio-cultural, religious context, since teachers' responses in the interview suggest that religious cultural beliefs affect views of causes and appropriate treatment for mental health problems; parents may prefer religious and traditional healing over counselling in dealing with their children's mental health problems, because they believe that mental health problems are test or punishment from Allah. In addition, teachers mentioned worries about the impact of social stigma on parents, who may feel ashamed about their children's mental problems, making it harder and less comfortable for teachers to address pupils' mental health issues**.** This in turn was found through the current study to affect teachers' attitudes towards taking on responsibility for promoting pupils' mental health, as they avoid participating in this task and their readiness to show positive behavioural intentions towards promoting pupils' mental health might be reduced, due to their beliefs that such socio-cultural, religious beliefs exist in parents' minds. Figure (7.1) highlights the core findings of the current study in relation to the qualitative findings that allow a more detailed picture of each to emerge.

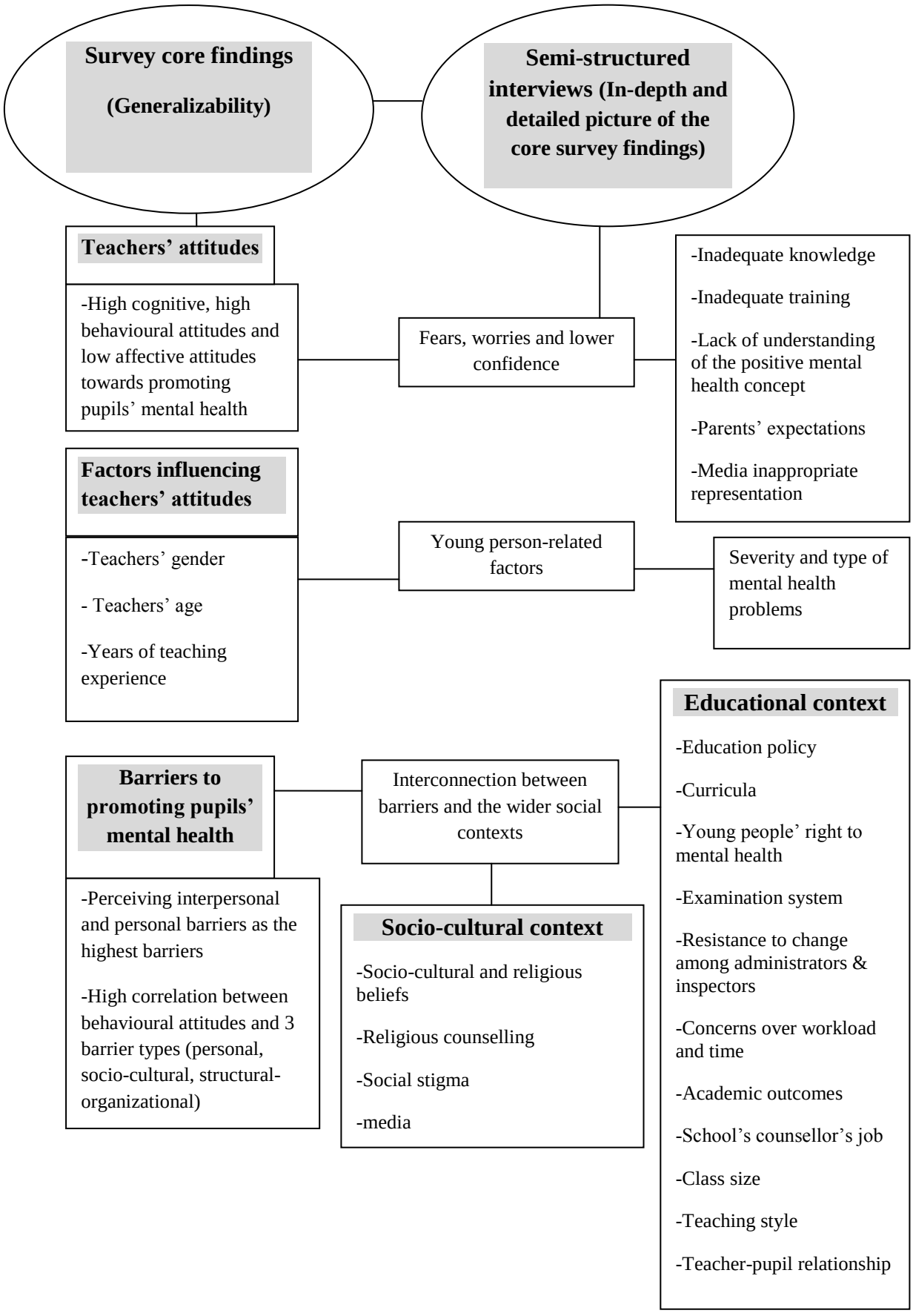


Figure 7.1 **Overall core findings of the current study**

The interconnections between teachers' attitudes and the educational context, which were seen clearly through the current study, could be a good example of the correlation between structural-organisational barriers and teachers' behavioural attitudes towards the implementations of promotional processes. It is unsurprising that teachers may be feel stressed, over-worked and disempowered, and that there is no room for them to recognise pupils' mental health within the educational system adopts in Kuwait. Such feelings could be normal if one consider the nature and the policy of the education system in Kuwait. It has a number of features that could hinder teachers in having positive attitudes towards promoting pupils' mental health. First, it adopts an extensive and demanding academic curriculum to be covered in limited time, with an examination system based on memorisation. Second, it places power in the hands of administrators and inspectors to control the educational process, where they consider the academic achievements of pupils as the only evaluation standard for teachers, and they resist change in this domain. Third, the educational system has no effective education policy or legislation to promote pupils' mental health. Finally, schools tend to have large class sizes and the teaching style is predominantly of the traditional 'by rote' type, discouraging the use of creative and technological approaches in teaching. Thus, the application of pupils' mental health promotion in Kuwaiti education seems to be a significant challenge, with the process associated with designing and adopting such a framework necessitating a great deal of reform of the education policy and system in Kuwait.

7.5 The limitations of the study

All research faces various limitations. Accordingly, investigators are required to make decisions and prioritise what they view as being valuable when seeking to gain insight into and comprehension of certain phenomena. Thus, it is fundamental that limitations are recognised and understood; these may be found in the data collection tool design or the approach itself, or otherwise in regard to access, availability, place and time, or administrative or cultural barriers.

One of the limitations recognised in the current research concerns the study context, in terms of place and time, with the research carried out across four Kuwaiti provinces, thus demanding travel between areas and further difficulties in establishing contact with and access to participants. Thus, so as to ensure that access to both schools and teachers could be gained, permission was sought from the MOE in Kuwait as well as from administrative

educational authorities. However, this meant the time available for gathering data was reduced, which also meant the number of interviews was limited.

Additionally, the distribution within the school environment was problematic in a number of different ways. Firstly, teachers worked within a number of different schools located in different places; secondly, introduction was necessary, followed by a request for teachers be involved in the research; and thirdly, not all teachers were willing to participate on a particular day, which meant wasted journeys and time.

There was another limitation related to the survey utilised for the research. It is recognised that the survey would have been more accurate and dependable had there been greater emphasis on the research phenomenon itself, which could have been achieved had there been a preliminary interview carried out beforehand, targeting a small number of teaching staff. This could have provided greater insight into the reasons behind teachers' actions.

One limitation faced relates to cultural considerations. Mental health issues are not familiar topics for Kuwaiti pupils and teachers because of the social stigma and the misconceptions around mental health in Arab and Gulf countries; consequently, participants' responses could be affected by that cultural stigma (Al-Thakeb, 1985). To overcome this problem, the researcher attempted to ensure that all participants understood the aim of the study, how the data would be used, and to whom it would be reported.

A further limitation relates to the research sample. In focusing on investigating teachers' attitudes and perceptions, a number of key individuals, including mental health counsellors, Ministry of Education mental health professionals, policymakers, parents and pupils, were excluded. Accordingly, future work should ensure that the views of all involved are garnered and taken into account (Alradaan, 2010).

Additionally, there is another limitation related to the study sample. The researcher was planning to choose a sample for the qualitative stage. The plan was to select a sample of two groups; one including teachers who show strong attitudes and another comprised of those teachers who showed less favorable attitudes towards promoting pupils' mental health in the survey in the quantitative stage, and meet them separately in order to examine in depth the factors behind their differences in attitude. Unfortunately, selecting such samples was out of the researcher's control once factors such as socio-cultural issues, the demands of the

education system, the need to obtain administrators' agreement, teachers' hectic timetables, and the sensitivity of the interview topic were taken into account.

Another limitation relates to the lack of awareness among some teachers of the topic of mental health and promoting pupils' mental health, which made it difficult for them to reflect on and relate their experiences and attitudes. One way to overcome this difficulty was to reduce the amount of scientific terminology used in the interviews and employ language which could be understood. Using semi-structured interviews gave the opportunity for more interaction, providing room for any questions from the participants.

The researcher was also faced with a problem of time in conducting the study. Methods of data collection required consideration of periods of school vacations as well as teachers' daily schedules. Before conducting the interviews, the researcher asked teachers first to suggest convenient times. The school administrations were also requested to allow more flexibility, in order to make the participants feel more comfortable about reducing their teaching schedule on the day of the interviews.

Furthermore, although interviews were selected owing to the benefits of the approach, discussed earlier, it is nevertheless understood that this study tool has various limitations. Carrying out interviews in Kuwait was problematic owing to the dominance of a positivistic or scientific approach in the country's research culture. Accordingly, a number of contextual factors were experienced while conducting the interviews, such as cultural and religious issues, and timetable constraints. For instance, male teachers could not be freely interviewed owing to the cultural belief that a woman should not be left alone with a man; open rooms needed to be used for interviewing male participants, which may have impacted on the responses given.

Comprehending the study limitations is known in the educational research field to reduce the risks inherent in generalising the results garnered through the study's qualitative phase. Accordingly, this study positions the findings in the correct context, meaning they are more valid. This is appropriate to the research approach utilised, the aim of which was not to make sweeping generalisations; the study was far more concerned with gaining in-depth insight into the studied phenomenon. Nevertheless, despite the fact that generalisation was not considered to be an aim of the study's qualitative phase, it is recognised that what has been

established and learned may apply in other similar contexts, as highlighted by Lincoln & Guba (1985). In sum, the aforementioned limitations should all be taken into account and are all viewed as being important, and can therefore be incorporated within any future researches and studied in-depth.

A final limitation may relate to the possibility of utilising other methods to collect data in the current study, such as observation, analysis diaries, group interviews or focus groups, which might have been in various ways suitable to achieving the aims of the study. However, taking the socio-cultural and religious considerations into account was important here. For example, the researcher could not conduct group interviews or focus group because teachers could not be interviewed at the same time, given the restrictive timetable they follow in school (cover for classes could not be provided *en masse*) and the fact that male teachers and female teachers cannot be gathered in the same place, considering the religious principles of Islam. Also, the researcher could not have utilised observation or diaries in the study due to the sensitivity of the mental health issues and the limited possibility to talk about these issues with people living in an Arab and Islamic culture, especially females who are less free to talk about their feelings with others.

7.6 Implications of the current study

The results of the current study carry a range of theoretical as well as practical implications for mental health promotion in schools in Kuwait, with a view to education reform. These implications should be understood against the limitations inherent in context-sensitive approaches that account for cultural and social factors, such as those highlighted in the current study.

7.6.1Theoretical implications

The present research's theoretical implications possess potential for developing the theoretical assumptions held about promoting pupils' mental health in Kuwait's schools and teachers' attitudes in this area.

The current study challenge the 'psychological' and the 'individualistic' concept of the term 'attitude', that has been presented in psychological studies on attitudes as a matter of liking and accepting or disliking and rejecting. The results of the current study argue against the simple assumption that once teachers hold positive feelings towards promoting pupils' mental

health, promotional process will take place. Rather, it shows that teachers' attitudes towards promoting pupils' mental health are complicated and context-dependent, and they not an aspect that can be easily understood in isolation from the wider circumstances. Whereas teachers show positive ethos towards promoting pupils' mental health, they appear to be constrained by different educational practice, cultural, and structural issues, which lead them to adopt certain intentions. Therefore, the current study delivers additional support for the social constructivist view of attitudes as being reactive to a number of factors in numerous socio-cultural contexts (Eiser, 1994; Brockington *et al*., 1993).

Accordingly, and based on the multi-dimensional (three component) model of attitudes utilised in the current study, the findings provide evidence that promoting pupils' mental health in schools is about more than what teachers feel about promoting pupils' mental health. Teachers' attitudes could be measured by three components, namely cognitive (what teachers know), affective (what teachers feel), behavioural intentions (what teachers are ready to do). However, the current study highlights that teachers' attitudes towards promoting pupils' mental health are more about behavioural intentions than cognitive knowledge or the emotions teachers show. In the context of this study, it should be highlighted that, since its objective was to analyse the attitudes of middle-school teachers with regard to the promotion of pupils' mental health; rather, the emphasis of this research was placed upon the way in which attitudes are established and shaped, and how attitudes and beliefs about mental health inform and influence behaviour. However, a number of different behavioural tools could be utilised to predict teachers' behavioural intentions in this area.

Additionally, teachers' readiness to show behavioural intentions towards promoting pupils' mental health was found in the current study to be affected by various barriers they perceive. Therefore, it would not be fair to assign blame to the teacher by only concentrating on their reluctance to participate in promotion processes. Several contextual circumstances and factors need to be taken into account in order to ensure that teachers' attitudes and perceptions are understood, rather than engaging in simplistic 'victim blaming' (Ingstad & Whyte, 1995). Thus, the implication here is that policymakers should not underestimate the impact of those contextual factors on teachers' attitudes if pupils' mental health promotion is to be realistic and practically implemented.

Moreover, the current study challenges the negative understanding of the mental health concept. It argues that teachers are conceptualising mental health concept within a medical

context and as a lack of mental illness accompanied by widely negative associated perceptions. The study supports the worldwide awareness of mental health and its global positive conceptualisation, affecting the way in which mental health has been defined with respect to young people. For instance, the Mental Health Foundation's definition of 'young people's mental health' has been adopted by the Department for Education and Skills (2001) in the UK, which highlights the belief that young people are considered to be mentally healthy if they are able to establish and maintain good relationships, succeed in playing and learning, progress through good psychological development, and develop good morals. Teachers' understanding of and familiarity with the positive term of mental health, which views mental health issues as alterable problems that could be recovered from by additional support and early recognition, remains to be low or absent by the findings of the interviews. Such lack was clearly a cause of the fears reported by teachers, as were the personal, interpersonal, socio-cultural and organisational-structural barriers explained previously, which have a significant impact on undermining teachers' readiness to promote pupils' mental health. This means that teachers need to be well-equipped with knowledge and skills to view the mental health of pupils as more than an absence of mental illnesses symptoms, deviation from norms or disruptive behaviour. They need to be aware what the signs of mental illness could be, and should not be alarmed by mental concerns. Most important here is that teachers' early recognition of these mental health problems could help in minimizing the impact of these problems and helping to prevent potential severe problems. Such awareness among teaching staff can be raised through knowledge and training courses in the area of pupils' mental health, through media content, and with rewarded activities and programmes arranged by society and education leaders for that purpose. Teachers' attitudes towards promoting pupils' mental health is shown to be critical, because their support of young people can be a protective factor that can prevent young people from developing severe mental health problems, by recognising early the signs of mental health problems among pupils. Therefore, there is a need for teachers' understanding of mental health to be altered from the pathological to the positive concept. This different understanding and conceptualisation of mental health concept could further affect the ways in which they are able to identify and recognize these problems among pupils (Rogers & Pilgrim, 2005). Thus, this study provides a foundation for the educators to deal with the misconceptions of teaching staff relating to young people in the context of mental health-related illnesses. Further research is required to explore teachers' conceptualizations of mental health issues and how

they understand the mental health concept, mental health problems and illness, and factors in mental health.

7.6.2 Practical implications

The current study contains a range of practical implications for reforming policy and developing practice in the field of promoting pupils' mental health in school in Kuwait, with a suggestion to reform the educational system, encouraging the provision of teacher training programmes and education in the area of pupils' mental health issues, and designing strategies to encourage complementary teamwork to promote pupils' mental health.

This study challenges the current policy and practice of promoting pupils' mental health in the schools of Kuwait. It argues against the 'deficit model' of promoting mental health undertaken Kuwait's schools, providing evidence to support the 'asset model' of promoting mental health, focusing on protective factors, empowerment and encouraging individuals' levels of self-esteem, resulting in lesser dependence on professional services (Masten & Reed, 2005). Based on this model, young people's mental health is conceptualised as a positive term within the context of resiliency, where mental health can be enhanced and young people can cope even if they are experiencing mental health issues, especially if they get support (Werner & Smith, 1992; O'Grady & Metz, 1987).

Unfortunately, the choice of promoting pupils' mental health under the asset model does not exist within the context of schools in Kuwait, at least in cultural-ideological terms, since several barriers to empowerment are related to the socio-cultural and educational context. As the study shows, teachers conceptualise promoting pupils' mental health as a special area under the remit of on-site mental health professionals and school counsellors appointed by the Ministry of Education (Alradaan, 2007). This reactive policy for attending to pupils' mental health in Kuwait's schools may lead educators - particularly teachers - to situate the promotion of pupils' mental health within a medical and professional area, putting responsibility in the hands of designated specialist staff, but also disempowering teachers from becoming involved, and mitigating against effective partnership between the people of education and people of mental health in addressing pupils' mental health issues. This is reflected in teachers' feelings of having little or no role and responsibility in promoting pupils' mental health (Repie, 2006).

Changing the conception of mental health to a more positive view is a multi-faceted and long-term undertaking, so the current study calls for initial steps to be taken to reform the policy of promoting pupils' mental health in Kuwait schools by shifting away from the more conventional pathological perspective, towards a wide-ranging ecological and interactive position that addresses mental health issues among all pupils, not only those who are diagnosed with problems (Adelman & Taylor, 2010). To accomplish this, school teachers must truly believe in young people's innate capacity for change and resilience against stresses, in order to create a supportive environment that taps into resilience and promotes pupils' mental health (Mills, 1991; Lifton, 1993). The starting point for creating classrooms and schools and programmes that tap into pupils' capacities is the deep belief of all staff that every young person is resilient. This means that every teacher and adult must be equipped with the awareness, knowledge, and skills that allow them to connect this knowledge to what they do in the classroom to promote their pupils' mental health (Bernard, 1996). Thus, the study implies the need to adopt practices that looks beyond a problem-oriented strategy, to those adopted in many Western countries. However, educators and policy makers need to be careful when adopting any new strategy. They should consider constructing the policy based on the national Kuwaiti ethos and the ethos of the education process as understood in the Kuwaiti social, cultural and Islamic context, rather than borrowing a new policy based on a different context's assumptions about the mental health concept and promoting mental health in schools.

Additionally, the current study highlights the impact of the socio-cultural context on teachers' attitudes towards promoting pupils' mental health, as it addressed the influence of religious and cultural beliefs on the way that parents approach their children's mental problems, and consequently their co-operation and communication with teachers in this area. This connection suggests the potential for harnessing cultural values to develop the promotion of pupils' mental health within Kuwait, by raising social awareness and establishing anti-stigma programmes and co-operation across schools and communities, between teachers and parents. Thus, the current study highlights the need for all involved to attend to socio-cultural issues apparent within a specific context, i.e. being context-sensitive when establishing any process of mental health promotion in schools (Fullan, 2002: 2008). This includes acknowledging the impact of the media on people's views of mental illness and those affected by it, through their generally negative representations. This same influence will impact on teachers and their attitudes to pupils with mental health issues. This factor has been highlighted by the

interviews in this study, and demands further study as part of a comprehensive view of the context of mental health promotion in Kuwait's schools.

The holistic approach inherent in such context-sensitivity clearly points to the importance of collaborative teamwork to ensure the effective promotion of pupils' mental health, an issue raised by the teachers in this study. Because of the lack of communication and co-operation between teachers and mental health professionals, schools counsellors, parents and other members of school staff, a significant interpersonal barrier is in place that could hinder the promotion of pupils' mental health. The study encourages good school ethos and wide-ranging partnerships to ensure equal opportunities and well-defined policies for promoting pupils' mental health in schools (Rowling, Martin & Walker, 2008; Atkinson & Hornby, 2002). Pupils' mental health is everyone's business, and should not be confined to school-based specialists or merely be the concern of outside agencies and mental health professionals (Weare, 2000). Developing effective teamwork can tackle a number of mental health-oriented objectives, such as the promotion of academic, behavioural, contextual, emotional and social systems that promote mental health in young people, whilst also pursuing the reduction of barriers to this process (Greenberg *et al*., 2003; Paternite, 2004).

A key finding of the study was therefore how important it is that teachers have a sense of responsibility towards their role in promoting pupils' mental health. This requires their empowerment to act in collaboration with other members of a mental health team, valued by mental health professional colleagues. Structurally, implementing a multi-disciplinary approach of this kind could help to achieve a great deal of continuous support for mental health promotion within schools (Paternite, 2004). Therefore, the success of any initiatives to promote pupils' mental health depends on teachers considering promoting pupils' mental health to be a key part of their job, rather than something additional. Embedding the idea of mental health promotion in the culture of teaching will push teachers to take on these responsibilities, and connect them with the school as a whole. Hargreaves argues that, 'local cultures give meaning, support and identity to teachers and their work. Physically, teachers are often alone in their own classroom, with no other adults for company, psychologically, they never are' (p. 165). Moving mental health promotion from a marginal to a key part of the culture of the school, and allowing teachers to influence policy through their unique knowledge will encourage participation and reduce the sensation that policy is something 'imposed' by the Ministry of Education, for which teachers are not responsible.

As part of this shift, this study argues for a reform of the education system's focus in Kuwait, away from the heavy prioritisation of exams and specified academic outcomes, towards social outcomes, helping to support students with mental health needs, and remove barriers to their learning. As well as the prescriptive demands of the curriculum, the means by which teachers are assessed should be changed, from a results-driven to 'whole-person' assessment of how pupils progress. This would free teachers to be more creative and responsive in their classroom, making them more able to include the promotion of mental health, and encourage a more rounded view of pupils' achievements. In short, the social, political and cultural elements of schooling must all be considered (Hargreaves *et al.*, 1998). This study presents evidence that education system needs to be more flexible, giving schools and educational authorities greater freedom over instructional choices. This would allow the use of diverse teaching approaches to meet the needs of all pupil, freeing up time and learning space where teachers can feel less pressured, meaning the promotion of pupils' mental health would be welcomed by them.

As the foregoing practical recommendations and warnings imply, change is best managed on an incremental and flexible basis. Policy should not be imposed through dramatic or uniform approaches, since it must be responsive to specific contexts, and teachers must have the opportunity to integrate the process and its values into their practice. Stern and Keislar (1977), in their extensive review of attitudes and attitude change in teachers discovered that attitudes of teachers can be altered, though certain attitudes are more resistant to change than others. They argue that allowing teachers to express their concerns, and taking their views into account, would facilitate the adoption of new perspectives. This study calls for the perspectives of teachers in Kuwaiti schools to be taken into account by policymakers prior to the adoption of any changes regarding the education system. Further, given the wide variety of agents involved in the promotion of pupils' mental health, the view of administrators, learners, parents and others should be included, and their understanding sought.

As well as policy and structural consideration, material and training aspects should be assessed as part of implementing the promotion of pupils' mental health. This study demonstrates the need to provide teaching staff with professional facilities such as educational and training courses, information sources, targeted support for teachers' mental health, and material recognition of the effort, knowledge, determination and time management needed to put the promotion process into practice. Stern and Keislar (1977)

argue that changing teachers' attitudes, as with participants in any programme, must be made rewarding.

Dealing with the concerns of teachers about adopting mental health promotion among pupils requires the publication of a strategy by curriculum developers and education policymakers in Kuwait. Curriculum planners should consider various approaches to ensure the curriculum is more attractive and absorbing, and should further enable teachers to customise teaching for all pupils. In this way, various approaches, such as designing a curriculum that addresses mental health may be adopted. Nind and Weare (2009) recommend that this type of curriculum needs to integrate the development of all pupils' social and emotional skills within all subject areas; supplying mental health education and information can also raise pupils' awareness of and ability to cope with such issues, promoting their emotional, mental and physical well-being (Department for Children, Schools and Families, 2010). Because of their unique position in delivering such a curriculum to pupils (Woolfson *et al.*, 2007) teachers should be consulted in its design. This will also help to ensure that the curriculum is realistic in terms of the time and resources required to apply it in the classroom, and facilitate the design and deployment of training programmes tailored to the specific needs of teachers in this area.

That teachers are well informed and motivated around mental health issues in school was confirmed as important by the responses given in this study, an insight applicable both to Kuwait and to teachers in other countries and contexts. Their attitudes and knowledge profoundly affect their skills in recognising early signs of mental health problems among pupils. Training courses to target mental health awareness, as distinct from behaviour management, will make teachers better able to identify and support pupils with mental health issues (Chazan, 1993; Cooper, 1989; Bowers, 1996). Such courses should not be offered only to teachers in active employment, but also those at college and university. Piland (1999) argues that the failure to equip teachers with reasonable knowledge about pupils' mental health issues during their college education could limit their knowledge of such issues, leading teachers to deal with them negatively. Therefore, education in this area must begin before graduation (Teacher Training Agency, 2005). However, it is not realistic to expect the availability of training workshops alone to produce the improvements needed. Change should harness the wider culture of schools, involving all staff, in particular leaders, equipping them to monitor and evaluate each other's work, and to disseminate good practice from other education contexts (Fullan, 2002). The importance of such involvement for administrators,

inspectors and head teachers can be seen in teachers' view that the roles and responsibilities of teachers will not be considered valuable unless administrators are educated and knowledgeable about the mental health of pupils.

7.6.3 Methodological implications

Methodologically, the mixed approach utilised in the current study is supported by Snape and Spencer (2003), who suggest that it can ensure a suitable 'fit' between the research questions posed and the study approaches utilised. Adopting the mixed-methodological approach allowed the researcher to explore teachers' perceptions of promoting pupils' mental health in more detail than could be captured by using a single approach (Creswell & Plano Clark, 2007). Additionally, the current study concurs with the arguments of Kiki & Miller (1986), Levitt (2001) and Ajzen and Fishbein (1980), that it is not possible to directly observe attitudes, beliefs or perceptions; rather, they need to be deduced by considering what people feel and say, and the ways in which they behave in regard to their beliefs. Individuals' perceptions and attitudes also need to be considered as responsive to, and dependent on, context, within specific socio-cultural environments, and their investigation should not be restricted to a reductive positivist interpretation. Also, the use of a mixed-methodological approach demonstrates how attitudes and perceptions relate to and affect teachers' practice in the classroom, validating Silverman's argument that there are areas of social reality which cannot be measured merely by statistics, including attitudes, experience and interpretations (Silverman, 2006) (see Chapter 4).

In regard to the approach itself, the utilisation of a mixed-methodology strategy in the present research has proved to be extremely valuable, in contrast to dependence on a positivistic-scientific framework, the most prevalent strategy in Kuwait. The study provides evidence that utilising a single quantifiable instrument may suppress participants' subjectivities and deprive them of the chance to have their voices heard. The study highlights the richness and the effectiveness of mixed-methodology research approaches in exploring the complexity of participants' attitudes and perceptions. This has connotations for what I term the 'researcher-researched relationship', since in adapting this type of flexible approach allows researchers to establish a more detailed and comprehensive picture of participants' views. In this respect, the current study has initiated an opportunity for researchers within Kuwaiti education to follow this example, to implement appropriate mixed-methodology strategies, especially for

studies requiring both in-depth knowledge and data concerning the event under examination, where the qualitative and quantitative aspects may be combined within one study. This richness has facilitated the current study in considering the phenomena from a number of different perspectives, enabling the interpretation and review of data to be improved and further enriched. This emphasises that researchers in Kuwait should implement more flexible strategies rather than depending on a fixed approach, which may (whether consciously or not) be set up to twist the phenomena under examination to ensure the researcher's expectations are fulfilled. The current study has provided the foundations and opened opportunities for the implementation of a mixed-methodology approach within the context of the educational environment in Kuwait. This may assist other researchers in this same context, helping to provide answers to questions that could not be answered through the use of one individual strategy, by providing a clear and in-depth image concerning social phenomena.

Moreover, the utilisation of interviews in the current study has proven to be significantly valuable, with qualitative data analysis providing an in-depth understanding of the views of teachers, despite the relatively small number of participants. It would not have been possible to garner so deep an understanding through the implementation of a survey approach alone, owing to the restricted space for the subjects to communicate their views and opinions. The present research has questioned whether attitude surveys and the results of such can be an adequate foundation for the promotion of mental health amongst pupils. Other researchers in Kuwait are thus invited to examine the possibility of implementing various context-rich data collection methods, such as diaries, focus groups, group interviews, reflective journals, and autobiography, all of which could help to analyse teachers' attitudes. As emphasised by Silverman (2006) and Snape & Spencer (2003), these have the potential to establish greater knowledge of the complex and interwoven strategies linked with attitudes, practices and personal experience. My argument for adopting the mixed-methodological position does not aim to denigrate the scientific mode of inquiry or the experimental research design popular in Kuwait for educational research. Rather, it encourages educational researchers there to take the challenge to adopt other paradigm of inquiry and therefore cater for what can be called the 'multi-dimensionality' of social phenomena, instead of relying so heavily on one approach.

7.7 Conclusion

The current study stresses the need for understanding that the mental health of young people is not a private concern; rather, it should be a subject for public consideration and seen as a part of young people's overall well-being (Adelman & Taylor, 2006). In order to achieve such a standing, there must be a philosophical change in how young people's mental health is approached. That increased importance be placed on mental health promotion is a demanding change, given how the majority of agencies working with and around young people operate. It would necessitate a mutual vision and understanding of what mental health promotion means and involves, and also what outcomes can be expected — not only for those directly involved but also for those affected on a wider scale (Adelman & Taylor, 2006). Markedly, the teachers in this study also recognised that there is a need to see commitment across the communities, which would help to enhance teachers' own levels of commitment to the initiative.

Following the current study, it is clear that teachers' views are not the only consideration in promoting of pupils' mental health and the success thereof. Success would not be prevented should teachers possess negative views, nor would positive views guarantee success. Thus, it is important to conduct subsequent research to ensure an adequate number of factors linked with schools, teachers and young individuals, and the interconnections between them, are considered in regard to their impact on mental health promotion amongst young people.

It is the hope of this researcher that this study's results may help to direct education reform towards alternative approaches. As opposed to focusing solely on meeting academic achievement standards, there is a need to consider enhancement through improving educational quality in Kuwait. In fact, the promotion of mental health amongst pupils is not concerned only with understanding mental health; rather, it is centred on educational reconstruction, social change, and school policy reform. Nevertheless, such change should be regarded as multi-faceted and thus be focused on the number of interlinked aspects that shape both agency and structure (Power, 1992).

Lastly, the study suggests further research is conducted into the adoption of the promotional process within the education system in Kuwait. Such studies would have ample opportunity to critically deliver direction and assistance in the formulation of policies, which would ultimately help in the promotion of mental health. Accordingly, change flourishes in a

cooperative and co-ordinated environment, with good levels of prepared and trained staff, all of whom should hold positive attitudes and perspectives concerning the promotion of mental health, with such professionals also afforded the right resources - administrative, educational, financial and political. It should be emphasised that change takes time and should be an on-going process. As noted by Bennett, Crawford & Riches (1992), it should be taken into account that change is not only centred on the design and adoption of new approaches and policies, but also places value on personal approaches, through which individuals may aim to impose structural and cultural change, and react to it. Any studies subsequently carried out by this researcher will certainly take into consideration such recommendations.

References

Adelman, H. & Taylor, L. (2006). Mental Health in Schools and Public Health. *Public Health Rep*. *Association of Schools of Public Health*, *121*(3), 294–298.

Adelman, H. S. & Taylor, L. (1999). Mental health in schools and system restructuring. *Clinical Psychology Review*, *19*(2), 137-163. Ainsworth, M. D., Blehar, M.C., Waters, E. & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Adelman, H. S. & Taylor, L. (2000). Promoting mental health in schools in the midst of school reform. *Journal of School Health, 70*(5), 171-178.

Adelman, H. S. & Taylor, L. (2010). *Engaging learners, preventing problems, and improving schools.* Corwin: Sage Publications.

Ainsworth, M. D., Blehar, M.C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Ajzen, I. (2005). *Attitudes, personality, and behaviour* (2nd ed.). Milton-Keynes, Berkshire: Open University Press.

Ajzen, I. (1991). The theory of planned behaviour. *Organizational Behaviour and Human Decision Processes*, *50*(2), 179-211.

Ajzen, I. & Fishbein, M. (1980). *Understanding attitudes and predicting social behaviour.* Englewood Cliffs, NJ: Prentice-Hall.

Akin-Little, K., Little, S. & Delligatti, N. (2004). A preventative model of school consultation: Incorporating perspectives from positive psychology. *Psychology in the Schools*, *41*(1), 155-162.

Al-Abdulghafoor, F. (2000). *The development of education in Kuwait* (Arabic). Kuwait: Al-Falah Press.

Al-Abdullah, Y. (2003). *The history of education in the Arabian Gulf (1913-1971)* (Arabic). Paper presented at the Conference of Education in the Arabian Gulf, Doha.

Al-Ansari, B. (1994). *The impact of the Iraqi aggression on the personality traits of Kuwaiti students of both sexes.* Paper presented at the International Conference of Iraqi Aggression on Kuwait: Centre of Gulf and Desert Studies (Arabic). Kuwait.

Al-Ansari, E, A., Emara, M, M., Mirza I. A. & El-Islam, M. F. (1989). Schizophrenia in ICD-10: A field trial of suggested diagnostic guidelines. *Comprehensive Psychiatry, 30,* 416-419.

Albarracin, D., Johnson, B. T., Zanna, M. P. & Kumkale, G. T. (2005). Attitudes: Introduction and scope. In D. Albarracin, B. T. Johnson & M.P. Zanna (Eds.), *Handbook of attitudes* (pp. 3-20). Hillsdale, NJ: Lawrence Erlbaum.

Ali, A. Y. (1996). *The meaning of the Holy Qur'an*. Beltsville: MD, Amana Publication.

Al-Issa, I. (2000). *Mental Illness in the Islamic World*. London: International University Press.

Allport, G. W. (1935). Attitudes. In C. Murchison (Ed.), *Handbook of social psychology* (pp.789-844). Worchester, MA: Clark University Press.

Al-Maleh, H. (2009). Mental health and the importance of the media - Psychological awareness (Arabic). A seminar hold at the University of Damascus, Faculty of Education, 17-18 / 3 / 2009.

Al-Mosawy, M. (1992). *Kuwait and development* (Arabic). Dar Al-Maaref Press, Alexandria: Egypt.

Al-Rashidi, B. (1995). *The war and the psychology of society (Arabic).* Al Amiri Diwan Press: Kuwait.

Al-Radaan, D. (2010). Young people and their Teachers' perceptions of mental health in the secondary schools: A predictable future vision of the mental health education in the state of Kuwait schools. A paper presented at the Student Annual Conference of Education Research, 18th May, Exeter University, UK.

Al-Radaan, D. (2007). The effectiveness of a group cognitive and behavioural counselling program to enhance social skills in reducing social anxiety, shyness and lack of self-confidence cases among group of Kuwaiti middle school pupils in the State of Kuwait. Unpublished MA thesis, Faculty of Education, Kuwait University, Kuwait.

Al-Rowaie, O. (2001). Predictors of attitudes toward seeking professional psychological help among Kuwait University students. Doctoral Dissertation, Virginia Polytechnic Institute and State University. Retrieved July 22, 2010, from http://www.scholar.lib.vt.edu/theses/available/etd-12192001-172305.

Al-Sahel, R. (1989). Group Counselling Therapy as a Technique to Modify the Undesirable School Behaviour (School Phobia) Of Children At Elementary School Level In The State Of Kuwait. Unpublished PhD. Thesis at University of Wales.

Al-Saraf, Q. (1994). The effects of the Iraqi invasion on the emotional aspects of the Kuwaiti secondary school students in the general system. Paper presented at the Second International Conference on Iraqi Aggression on Kuwait. Al Amiri Diwan Press: Kuwait.

Al-Thakeb, F. (1985). The Arab family and modernity: evidence from Kuwait. *Current Anthropology, 26,* .575-580.

Al-Turkait, F. & Ohaeri, J, U. (2008). Psychopathological status, behaviour problem, and family adjustment of Kuwaiti children whose fathers were involved in the first Gulf War. *Child and Adolescent Psychiatry and Mental Health, 2*(12), 1-12.

Ames, C. (1992). Classrooms: Goals, structures, and student motivation. *Journal of Educational Psychology, 84*, 261-271.

Anderson, K, N. & Anderson, L. E. (1995). *Mosby's Pocket Dictionary of Nursing, Medicine and Professions Allied to Medicine* UK Eden. London: Mosby.

Antonovsky, A. (1979). *Health, stress and coping*. San Francisco: Jossey-Bass.

Appleton, P. (2000). Tier 2 CAMHS and its interface with primary care. *Advances in Psychiatric Treatment, 6*, 388–396.

Atkinson, M. & Hornby, G. (2002). *Mental health handbook for schools*. London: Routledge Falmer.

Babcock, N. L. & Pryzwansky, W. B. (1983). Model of consultation: Preferences of educational professions at five stages of service. *Journal of School Psychology, 21*, 359-366.

Bagozzi, R. P. & Burnkraut, R. W. (1985). Attitude organization and the attitude-behaviour relationship: A reply to Dillon and Kumar. *Journal of Personality and Social Psychology, 49*, 47-57.

Bailey, S. (1999). Young People, mental illness and stigmatization. *Psychiatric Bulletin, l23*, 107-110.

Balton, K. (2002). Avoiding school exclusions: Rethinking support and the curriculum. *Improving Schools, 5*(2), 10–21.

Barker, L. & Adelman, H. (1994). Mental health and help-seeking among ethnic minority adolescents. *Journal of Adolescence, 17*(3), 251-263.

Bartley, M. (Ed.). (2006). Capability and Resilience: Beating the Odds. London: University College London. Department of Epidemiology and Public Health.

Bartley, M., Schoon, I., Mitchell, R. & Blane, D. (2007). Resilience as an asset for healthy development. UCL. Retrieved April 2012, from http://www.ucl.ac.uk/capability and resilience/resilienceasanassetforhealthydevelopment.doc.

Baxter, J. (2002). Creative partnerships: Public and voluntary services working together. *Educational Psychology in Practice, 18*(1), 63-72.

Belfer, M. (2005). Child and adolescent mental health around the world: challenges for progress. *Journal of Indian Association for Child and Adolescent Mental Health, 1*(1), 31-36.

Bell, J. (1993). *Doing your research project: A guide for first-time researchers in education and social science* (2nd ed.). Buckingham, Philadelphia: Open University Press.

Bennett, N., Crawford, M. & Riches, C. (1992). *Managing change in education: individual and organizational perspectives*. London: Paul Chapman.

Bernard, B. (1996). Resilience Research: A foundation for Youth Development. New Designs for Youth Development. Summer 1996, pp. 4–10.

Biesta, G. J. J. (2005). *What 'what works' won't work. Evidence based practice and the democratic deficit of educational research.* Paper presented at the annual meeting of the American Research Association, Montreal: Canada.

Birch, S.H. & Ladd, G.W. (1997). The teacher-child relationship and children's early school adjustment. *Journal of School Psychology, 35*, 61-79.

Bowers, T. (1996). Putting the ‘E’ back in ‘EBD’, *Emotional and Behavioural Difficulties*, 1 (1), 8–13.

Breckler, S. J. (1984). Empirical validation of affect, behaviour and cognitions distinct components of attitudes. *Journal of Personality and Social Psychology, 47,* 191 – 205.

British Educational Research Association. (2004). BERA, *Revised ethical guidelines for educational research.* Retrieved October 28, 2010, from http://www.bera.ac.uk/publications/guides.php.

Brockington I., Hall, P., Levings, J. & Murphy, C. (1993.) The Community's Tolerance of the Mentally Ill. *British Journal of Psychiatry, 162*, 93–99.

Bryman, A. (1988a). *Quantity and Quality in Social Research*. London: Routledge.

Bryman, A. (2008). *Social Research Methods.* Oxford: Oxford University Press.

Bryman, A. & Gramer, D. (2001). Quantitative Data Analysis with SPSS Release 10 for Windows: A Guide for Social Scientist. London: Routledge.

Burgess, R.G. (2002). *The ethics of educational research*. London: Routledge

Burke, R. (2002). Classroom management and discipline: Closing the gap between research and practice. Paper presented at the 2002 Alternative Education Summit, Columbus, OH.

Burke, R. J., Greenglass, E. R. & Schwarzer, R. (1996). Predicting teacher burnout over time: Effects of work stress, social support, and self-doubts on burnout and its consequences. *Anxiety, Stress, and Coping, 9*(3), 261-275.

Capey, M. (1997). *Counselling for pupils and young adults: examples of what LEAs and schools provide.* Slough: Education Management Information Exchange, NFER.

Celnick, A. (2002). Ethics in the field. In D. Burton (Ed.), *Research training for social scientists (pp. 97-108)*. London: Sage Publications.

Chandra, A. & Minkovitz, C. (2007). Factors that influence mental health stigma among 8th grade adolescents. *Journal of Youth and Adolescence, 36*, 763 -774.

Chazan, M. (1993). Integration of students with emotional and behavioural difficulties. *European Journal of Special Needs Education, 8*(3), 261–274.

Cherryholmes, C. (1992). Notes on pragmatism and scientific realism. *Educational Researcher, 21*, 13-17.

Chew-Graham, C. A., Rogers, A., Yassin, N. (2003). I wouldn't want it on my CV or their records': medical students' experiences of help-seeking for mental health problems. *Medical Education, 37*(10), 873– 880.

Child and Adolescent Mental Health Services (2008). *Children and young people in mind: the final report of the National CAMHS Review.* Retrieved November 25, 2011, from http://www.dh.gov.uk/en/publications.

Clare, A. & Maitland, J. (2004). *A mental health reader* (First draft) Unpublished, YJB.

Clarke, G., Hawkins, W., Murphy, M. & Sheeber, L. (1993). School-based primary prevention of depressive symptomatology in adolescents: Findings from two studies. *Journal of Adolescent Research, 8,* 183-204.

Close-Conoley, J. & Conoley, C. W. (1991). Collaboration for child adjustment: Issues for school- and clinic-based child psychologists. *Journal of Consulting and Clinical Psychology, 59*, 821-829.

Coffey, A. & Atkinson, P. (1996) *Making Sense of Qualitative Data Analysis: Complementary Strategies.* Thousand Oaks CA: Sage Publications.

Cohall, A., Cohall, R., Dye, B., Dini, S., Vaughan, R. & Coots, S. (2007). Overheard in the halls: What adolescents are saying, and what teachers are hearing about health issues. *Journal of School Health, 77*(7), 344-350.

Cohen, L. & Manion, L. (1994). *Research methods in education*. Oxon: Routledge.

Cohen, L., Manion, L. & Morrison, K. (2000). *Research Methods in Education (5th ed.).* Oxon: Routledge Falmer.

Cohen, L., Manion, L. & Morrison, K. (2007). *Research methods in education*. (6th ed.). London: Routledge.

Cohen, P., Kasen, S., Brook, J. & Struening, E. (1991). Diagnostic predictors of treatment patterns in a cohort of adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, *30*, 989-993.

Cooper, P. (1989). Emotional and behavioural difficulties in the real world: A strategy for helping junior schoolteachers cope with behavioural problems. *Maladjustment and Therapeutic Education, 7*(3), 178–185.

Corrigan, P. W. & Kleinlein, P. (2005). The impact of mental illness stigma. In P. W. Corrigan (Ed.), *On the stigma of mental illness. Practical strategies for research and social change* (pp. 11- 44). Washington, DC: American Psychological Association.

Crawford, S. & Caltabiano, N. J. (2009). The School Professionals' Role in Identification of Youth at Risk of Suicide. *Australian Journal of Teacher Education, 34*(2), 28-39.

Creswell. J. W. (2003). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches*. (2nded) London: Sage Publications.

Creswell, J. W. (2009). *Research design, qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, CA: Sage Publications.

Creswell, J. W. & Plano Clark, V. L. (2007). *Designing and conducting mixed methods.* Thousand Oaks, CA: Sage Publications.

Crotty, M. (2003). *The foundations of social research: Meaning and perspective in the research process*. London: Sage Publications.

Cutcliffe, J. R. & Hannigan, B. (2001). Mass media, "monsters" and mental health clients: The need for increased lobbying. *Journal of Psychiatric and Mental Health Nursing*, *8*(4), 315–321.

Darlington, Y. & Scott, D. (2002). *Qualitative Research in Practice: Stories from the field*. Australia: Allen & Unwin: Sydney.

Davidson, J. (2008). *Children and Young People in Mind: The Final Report of the National CAMHS Review*. DfCSF & DoH.

Delamont, S. (1992). *Fieldwork in Educational Settings: Methods, Pitfalls and* Perspectives. Lewes: Falmer Press.

Department for Children, Schools and Families (2010). Children's Rights and Participation Team. The United Nations Convention on the right of the child: How legislation underpins Implementations in England; Further Information for the Joint committee on Human Rights. London: DCSF.

Department for Education and Employment (2001). *Promoting Children's Mental Health within Early Years and School Settings*. Nottingham: DfEE Publications.

Department for Education and Skills (2004). *Every Child Matters*. London: DfES.

Department of Health (2004). *National Service Framework for Children, Young People and Maternity Services: The Mental Health and Psychological Well-being of Children and Young People*. London: DoH.

Department of Health and Aged Care (2000). *Promotion, Prevention and Early Intervention for Mental Health: A Monograph.* Canberra: Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care.

Dillon, W. R. & Kumar, A. (1985). Attitude organization and the attitude-behaviour relation: A critique of Bagozzi and Burnkant's reanalysis of Fishbein and Ajzen. *Journal of Personality and Social Psychology, 49(1),* 33-46.

Dogra, N., Parkin, A., Gale, F. & Frake, C. (2002). A Multidisciplinary Handbook of Child and Adolescent Mental Health for Front-Line Professionals. London: Jessica Kingsley Publishers.

Dryfoos, J. G. (1994). *Full-service schools: A revolution in health and social services for children, youth, and families*. San Francisco: Jossey-Bass.

DSM-IV. (1994). *The Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). American Psychiatric Association: Washington, DC.

Dwyer, S.B., Nicholson, J.M., Battistutta, D. & Oldenburg, B. (2005). Teachers' knowledge of children's exposure to family risk factors: accuracy and usefulness. *Journal of School Psychology, 43*, 23–38.

Eagly, A. H. & Chaiken, S. (1993). *The psychology of attitudes*. Fort worth, TX: Harcourt Brace Jovanovich.

Edney, D. R. (2004). Mass Media and Mental Illness. London: Routledge.

Eiser, J. R. (1994). *Attitudes, chaos and the connectionist mind*. Oxford: Blackwell.

Elias, M. J., Gara, M., Ubriaco, M., Rothbaum, P. A., Clabby, J. F. & Schuyler, T. (1986). Impact of preventive social problem solving intervention on children's coping with middle- school stressors. *American Journal of Community Psychology, 14,* 259-275.

El-Islam, M. F. (1994). Cultural aspects of morbid fears in Qatari women. *Social Psychiatry and Psychiatric Epidemiology*, *29,* 137-140. Brockington. El-Islam, M. F., Mohsen, M. Y. A., Demerdash, A. M. & Malasi, T. H. (1983). Life events and depression in transit populations. *International Journal of Social Psychiatry*, *29*: 13-20.

El-Islam, M. F. (2000). Mental illness in Kuwait and Qatar. In: Al-Issa I. (Ed.) *Al-Junun: Mental illness in the Islamic world*. (pp. 121-138) Madison CT: International Universities Press.

El-Islam, M. F. (2006). The socio-cultural boundaries of mental health: experience in two Arabian Gulf countries. *World Cultural Psychiatry Research Review: Official Journal of World Association of Cultural Psychiatry (pp. 143-146).* Retrieved March 20, 2011, from http://www.Wcprr.org/Pdf/juloct06143146.pdf.

Erikson, E.H. (1971). *Identity: Youth and Crisis*. London: Faber & Faber.

Erlandson, D. A., Harries, E. L., Skipper, B. L. & Allen, S. D. (1993). *Doing naturalistic inquiry: a guide to methods*. Newbury Park, CA: Sage Publications.

Ernest, P. (1994). *An introduction to research methodology and paradigms*. The research support unit: University of Exeter.

Esterberg, K.G. (2002). *Qualitative methods in social research.* McGraw-Hill companies: Boston.

Evers, W., Tomic, W. & Brouwers, A. (2004). Burnout among teachers. *School Psychology International, 25*(2), 131-148.

Farmer, E., Burns, B., Phillips, S., Angold, A. & Costello, E. (2003). Pathways into and through mental health services for children and adolescents. *Psychiatric Services, 54*, 60–66.

Fazio, R. H. & Zanna, M. P. (1981). Direct Experience and attitude-behaviour consistency. In L. Berkowitz (Ed.), *Advances in experimental social psychology*, *14*, 161-202. New York: Academic Press.

Fishbein, M. & Ajzen, I. (1975). *Beliefs, attitudes, intention, and behaviour: An introduction to theory and research*. Reading, MA: Addison-Wesley.

Flay, B. R. (2002). Positive youth development requires comprehensive health promotion programs. *American Journal of Health Behaviour*, 26(*6)*, 407–424.

Flick, U. (2006). *An introduction to qualitative research* (3rd ed.). London: Sage Publications.

Ford, T., Sayal, K., Meltzer, H. & Goodman, R. (2005). Parental concerns about their child's emotions and behaviour and referral to specialist services: General population survey. *British Medical Journal, 331*, 1435– 1436.

Fox, P. & Avramidis, E. (2003). An Evaluation of an Outdoor Education Programme for Students with emotional and behavioural difficulties. *Emotional and Behavioural Difficulties*, *5*(4), 267-283.

Franzoi, S. L. (1996). *Social psychology.* Iowa: Brown & Benchmark.

Freeman, J. (1994). Some emotional aspects of being gifted. *Journal For the Education of the Gifted, 17(2)*, 180-197.

Fullan, M. (2002). The change leader. *Educational Leadership*, 59(8), 16-20.

Funk, M. (2005). *Child and adolescent mental health policies and plans*. World Health organization: Geneva.

Fullan, M. (2008). School leadership's unfinished agenda. *Education Week, 27*(31), 36-41.

Gallichan, D. J. & Curle, C. (2008). Fitting square pegs into round holes: the challenge of coping with attention-deficit hyperactivity disorder, *Clinical Child Psychology and Psychiatry*, *13*(3), 343-363.

Ghubash, R. & Eapen, V. (2009). Postpartum mental illness: perspectives from an Arabian Gulf population. *Psychol Rep, 105*(1), 127-136.

Giannakaki, M. S. (2005). Using mixed-methods to examine teacher's attitudes to educational change: The case of the Skills for Life strategy for improving adult literacy and numeracy skills in England. *Educational Research and Evaluation*, *11*(4), 323-348.

Goldman, R.K., Botkin, M.J., Tokunaga, H. & Kuklinski, M. (1997). Teacher consultation: Impact on teachers' effectiveness and students' cognitive competence and achievement. *American Journal of Orthopsychiatry, 67*(3), 374-384.

Gowers, S. G., Thomas, S. & Deeley, S. (2004). Can Primary Schools Contribute Effectively to Tier 1 Child Mental Health Services? *Clinical Child Psychology and Psychiatry*, *9*(3), 419-425.

Greenberg, M., Weissberg, R., O'Brien, M., Fredericks, L., Elias, M. & Resnik, H. (2003). Enhancing school-based prevention and youth development through coordinated social, emotional, and academic learning. *American Psychologist, 58*, 466-474.

Gross, R. & Mcllveen, R. (1996). *Abnormal psychology.* London: Hodder and Stoughton.

Guba, E. G. & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). London: Sage Publications.

Hallam, S. (2009). An evaluation of the Social and Emotional Aspects of Learning (SEAL) programme: promoting positive behaviour, effective learning and well-being in primary school children. *Oxford Review of Education, 35(3),* pp. 313-330.

Han, S. & Weiss, B. (2005). Sustainability of teacher implementation of school-based mental health programs. *Journal of Abnormal Child Psychology, 33*(6), 665-679.

Haque, A. (1998). Psychology and Religion: Their Relationship and Integration from Islamic Perspective. *The American Journal of Islamic Social Sciences, 15*, 97–116.

Haque, A. (2005). Mental health in Malaysia. In Z. A. Ansari, M. N. Noraini & A. Haque (Eds.), *Contemporary issues in Malaysian psychology*. (pp. 19–39). Malaysia: Thomson learning.

Hardy, L. (2008). Children at risk. *American School Board Journal, 193*(12), 17-21.

Hargreaves, A. (1994). *Changing teachers, changing times: Teachers' work and culture in the postmodern age*. London: Cassell.

Hargreaves, A., Liberman, A., Fullen, M. & Hopkins, D. W. (Eds.). (1998). *International handbook of educational change.* Dordrecht: Kluwer Academic Publishers.

Hastings, R. & Brown, T. (2002). Coping strategies and the impact of challenging behaviours on special educators' burnout. *Mental Retardation, 40*(2), 148-156.

Health and Welfare Canada (1988). *Mental Health for Canadians: Striking a Balance*. Ottawa: Supply and Services Canada.

Health Education Authority (1998). *Mental Health Promotion: A quality of framework*. London: HEA.

Herrman, H., Saxena, S. & Moodie, R. (2005). Promoting mental health: concepts, emerging evidence, practice: a report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. Geneva, World Health Organization Press.

Hiday, V. A., Swartz, M. S., Swanson, J. W., Borum, R. & Wagner H. R. (1999). Criminal victimization of persons with severe mental illness. *Psychiatric Services, 50,* 62–68.

HM Government (2003). *Every Child Matters: Green Paper*. Retrieved July 24, 2011, from http://www.everychildmatters.gov.uk/files/EBE7EEAC90382663EDD5BBF24C99A7AC.pdf.

Hodgson, R, Abbasi, T. & Clarkson, J. (1996). Effective mental health promotion: a literature review. *Health Education Journal, 1*, 55–74.

Hogg, M. & Vaughan, G. (2005). *Social Psychology* (4th ed.). Essex: Pearson Education Limited, Prentice Hall.

Hottentot, E. I. (2000). *Print media portrayal of mental Illness: An Alberta study. Draft*. Edmonton: Alberta Mental Health Board Consumer Advisory Council. Retrieved July, 2010 from http://www.blackwell-synergy.com/links/doi/10.1046/j.1365-2850.2001.00394.

Ingstad, B. & Whyte, S. R. (Eds.). (1995). *Disability and culture.* Berkeley: University of California Press.

Jackson, D.A. & King, A.R. (2004). Gender differences in the effects of oppositional behaviour on teacher ratings of ADHD symptoms. *Journal of Abnormal Child Psychology, 32*, 215–224.

Janos, P. M., Fung, H. C. & Robinson, N. (1985). Self-Concept, Self-Esteem, and Peer Relations Among Gifted Children who feel ‘’Different’’. *Gifted Child Quarterly, 29(2)*, 78-82.

Jenkins, R. (2001). Making psychiatric epidemiology useful: the contribution of epidemiology to government policy. *Acta Psychiatrica Scandinavica*, *103*, 2–14.

Johnson, B. & Turner, L. A. (2003). Data collection strategies in mixed methods research. In Tashakkori, A. & Teddlie, C. (Eds.), *Handbook on mixed methods in the*

behavioural and social sciences (pp. 297-320). Thousand Oaks, CA: Sage Publications.

Johnson, R. B. & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher, 33* (7) 14-26.

Kaltiala-Heino, R., Murttunen, M., Rantanen & P., Rimpela, M. (2003). Early puberty is associated with mental health problems in middle adolescence. *Social Science and Medicine, 57*(6), 1055-1064.

Kam, C. M., Greenberg, M. T., Kusche, C. A. (2004). Sustained effects of the PATHS Curriculum on the Social and Psychological Adjustment of Children in Special Education. *Journal of Emotional and Behavioural Disorders, 12*(2), 66-78.

Kataoka, S., Zhang, L. & Wells, K. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry, 159(9),* 1548-1555.

Kazdin, A. E. (1993). Adolescent mental health: Prevention and treatment programs. *American Psychologist, 48,* 127-141.

Kearl, M. C. & Gordon, C. (1992). *Social Psychology: Shaping identity, thought and conduct.* MA: Allyn & Bacon: Boston.

Keyes, C. (2002). The mental health continuum: from languishing to flourishing in life. *Journal of Health and Social Behaviour, 43*, 207–222.

Khalaf, S. & Hammoud, H. (1983). The emergence of the oil welfare state: The case of Kuwait. *Dialectical Anthropology*, *12*(3), 343-357.

Kidger, J., Gunnell, D., Biddlle, L., Campbell, R. & Donovan, J. (2010). Part and parcel of teaching? Secondary school staff's views on supporting student emotional health and well-being. *British Educational Research Journal*, 36(6), 919-935.

Kiki, J. & Miller, M. L. (1986). *Reliability and validity in qualitative research*. Beverly Hills: Sage Publications.

King, K.A., Price, J.H., Telljohann, S.K. & Wahl, J. (1999). High school health teachers' perceived self-efficacy in identifying students at risk for suicide. *Journal of School Health, 69*(5), 202-207.

Kitchener, B., A. & Jorn, A., F. (2002). Mental health first aid training for the public: evaluation of effects on knowledge, attitudes and helping behaviour. *BMC Psychiatry, 2(10),* 147-244.

Kothandpani, V. (1971). Validation of feeling, belief, and intention to act as three components of attitude and their contribution to prediction of contraceptive behaviour. *Journal of Personality and Social Psychology,* 19, 321-333.

Krosnick, J. A., Judd, C. M. & Wittenbrink, B. (2005). The measurement of attitudes. In D. Albarracin, B. T. Johnson & M.P. Zanna (Eds.), *The handbook of attitudes* (pp.21-76). New Jersey: Lawrence Erlbaum Associates publishers.

Kuwait Constitution (2012). *The Diwan of His Highness Sheikh Jaber Mubarak Al-Hamad Al-Sabah*. Retrieved May 2, 2012, from: http://www.pm.gov.kw/en/state_Of_Kuwait/kuwaitConstitution.jsp.

Kvale, S. (2007). *Doing interviews*. London: Sage Publications.

LaPiere, R. T. (1934). Attitudes versus actions. *Social Forces, 13*, 230- 237.

Lee, V. E., Dedrick, R. F. & Smith, J. B. (1991). The effect of the social organization of schools on teachers' efficacy and satisfaction. *Sociology of Education, 64*, 190-208.

Levitt, K.E. (2001). An analysis of elementary teachers' beliefs regarding the teaching and learning of science. *Science Education, 86,* 1-22.

Lewis, R. (2001). Classroom discipline and student responsibility: The students' view. *Teaching and Teacher Education, 17,* 307–319.

Lifton, R. (1994). The protean self: Human resilience in an age of fragmentation. New York, NY: Basic Books.

Likert, R. (1932). A technique for the measurement of attitudes. *Archives of Psychology, 22,* 1-55.

Lincoln, Y. S. & Guba, E.G. (1985). *Naturalistic inquiry*. Beverley Hills, CA: Sage Publications.

Lines, D. (2002). *Brief counselling in schools*. London: Sage Publications.

Link, B. G. & Phelan, J. C. (1996). Understanding socio-demographic differences in health: the role of fundamental social causes. *American Journal of Public Health, 86,* 471–472.

Loades, M. & Mastroyannopoulou, K. (2010). Teachers' Recognition of Children's Mental Health Problems. *Child and Adolescent Mental Health, 15*(3), 150–156.

Local Government Information Unit & Children's Services Network (2007). *Fundamental Health: Children's Mental Health: A guide*. London: LGIU & CSN.

Loeber, R., Green, S. M. & Lahey, B. B. (1990). Mental health professionals' perception of the utility of children, mothers, and teachers as informants on childhood psychopathology. *Journal of Clinical Child Psychology, 19,* 136-143.

Long, M. (2000). *The Psychology of education.* London: Rutledge.

Lusterman, D. D. (1985). An ecosystemic approach to family-school problems. *American Journal of Family Therapy, 13,* 22-30.

Luthar, S. (1991). Vulnerability and resilience: A study of high-risk adolescents. *Child Development, 62,* 600-616.

Lynch, T. & Spence, D. (2007). A qualitative study of youth living with Crohn's disease, *Gastroenterology Nursing: The Official Journal of the Society of Gastroenterology Nurses and Associates, 31*(3), 224.

Lynn, C., McKay, M. & Atkins, M. (2003). School social work: Meeting the mental Health needs of students through collaboration with teachers. *Children & Schools, 25*(4), 197-209.

Maehr, M. L. & Midgley, C. (1996). *Transforming school cultures*. Boulder, CO: Westview.

MacDonald, G. & O'Hara, K. (1998). Ten *Elements of Mental Health, its Promotion and Demotion: Implications for Practice.* Glasgow: Society of Health Education and Health Promotion Specialists.

Maniadaki, K., Sonuga-Barke, E.J.S. & Kakouros, E. (2003). Trainee nursery teachers' perceptions of disruptive behaviour disorders; the effect of sex of child on judgements of typicality and severity. *Child: Care, Health & Development, 29*(6), 433–440.

Marland, M. (2001). School management and pupil care. *Pastoral Care in Education, 19*(4), 25-34.

Marshall, C. & Rossman, G. B. (1995). *Designing qualitative research*. Thousand Oaks, CA: Sage Publications.

Maslach, C. & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Occupational Behaviour, 2*, 99-113.

Masten, A.S. & Reed, M.J. (2005). Resilience in Development. In C.R. Snyder & S.J. Lopez (Eds.). *Handbook of Positive Psychology*. New York: Oxford University Press.

Maxwell, J. A. (1996). *Qualitative research design: An interactive approach*. Thousand Oaks, CA: Sage Publications.

Mbarak, R. (2005). Art and New Media. Strategies for an multiculturalism. Retrieved June, 2012, from: http:// www.wsa-conference.org/presentation/ricardombarak.pdf.

Meldrum, L., Venn, D. & Kutcher, S. (2009). Mental health in schools: how teachers have the power to make a difference. *Health and Learning magazines, 8, 3-5.*

Meltzer, H., Gatward, R., Goodman, R. & Ford, T. (2000). *The mental health of children and adolescents in Great Britain.* London: The Stationery Office.

Mental Health Foundation (1999). *Bright Futures: Promoting children and young people's mental health*. London: MHF.

Mental Health Foundation (1999a). *The big picture: Promoting children and young people's mental health*. London: MHF.

Mental Health Foundation (2005). *Life Impacts: Childhood and Adolescent Mental Health, Understanding The Lifetime Impacts*. London: MHF.

Merriam, S. B. (1998). *Qualitative research and case study applications in education* (Rev. Ed.). San Francisco: Jossey-Bass.

Mertens, D. M. (2005). Research and evaluation in education and psychology (2nd ed.). London: Sage Publications.

Midgley, C., Feldlaufer, H. & Eccles, J. S. (1989). Change in teacher efficacy and student self-and task-related beliefs during the transition to junior high school. *Journal of Educational Psychology, 81*, 247-258.

Miles, M. B. & Huberman, A. M. (1994). *Qualitative data analysis* (2nded.). London: Sage Publications.

Mills, R. (1991). A new understanding of self: The role of affect, state of mind, self-understanding, and intrinsic motivation. Journal of Experimental Education 60(1), 67-81.

Mind (2001). *Children, young people and mental health*. Fact sheet. London: Mind. National Children's Bureau. Peer Support Forum Briefing Papers. Available online at www.ncb.org.uk/psf/publlications.asp?dep=26.

Ministry of Education (2008). The national report of the State of Kuwait 2004-2008. Presented at the 4th session of the International Conference on Education, Geneva.

Ministry of Education (2009). *The Guide for Mental Health Counsellor in the Schools of Kuwait.* Kuwait. Ministry of Education publication: the department of social and mental services.

Modood, T. (1999). Anti-essentialism, multiculturalism and the 'recognition' of religious groups. *The Journal of Political Philosophy, 6*(4), 378-399.

Moliner, P. & Tafani, E. (1997). Attitudes and social representations: A theoretical and experimental approach. *European Journal of Social Psychology, 27(6),* 687-702.

Moor, S., Ann, M., Hester, M., Elisabeth, W.J., Robert, E., Robert, W. & Caroline, B. (2006). Improving the recognition of depression in adolescence: can we teach the teachers? *Journal of Adolescence, 30(1),* 81–95.

Morgan, A. (2008). Discussion and implications. In: Currie, C. et al. (Eds.). Young people's health in context. Health Behaviour in School-aged Children study: international report from the 2001/2002 survey. Copenhagen, WHO Regional Office for Europe.

Morgan, A. & Ziglio, E. (2006) Foreword in M. Bartley (ed.) *Capability and Resilience: Beating the Odds*. London: University College London.

Morgan, D. (2007). Paradigms lost and pragmatism regained: methodological implications of combining qualitative and quantitative methods. *Journal of Mixed Methods Research, 1*(1), 48-76.

Mukalel, M. & Jacobs, F. (2005). *Beyond cultural and religious biases: Asian Indians and mental health issues.* Retrieved September 14, 2010, from http://www.naswnyc.org/Asian Indian Mental Health Issues.htm.

Murray, C. & Pianta, R. (2007). The importance of teacher-student relationships for adolescents with high incidence disabilities. *Theory Into Practice, 46*, 105- 112.

Murray, C. J. L. & Lopez, A. D. (1996). Evidence-based health policy: Lessons from the Global Burden of Disease Study. *Science, 274,* 740-743.

NCH the children's charity (2007) *Literature Review: Resilience in Children and Young People*. London: NCH: The Children's Charity.

Neil, A. L. & Christensen, H. (2007). Australian school-based prevention and early intervention programs for anxiety and depression: a systematic review. *Medical Journal of Australia, 186*(6), 305–308.

Nelson, E. & While, D. (2002). Constraints to pastoral care for distressed children: Opinions of head teachers. *Pastoral Care in Education, 20*(3), 21-28.

NHS Health Advisory Service (1995). *Child and adolescent mental health services together we stand the commissioning, role and management of child and adolescent mental health services*. London: HMSO.

Nind, M. & Weare, K. (2009). Evidence and outcomes of school based programmes for promoting mental health in children and adolescents. *Paper presented at the European Conference of Educational Research, 28-30 September 2009, Vienna.*

Norwich, B. (1998). Research methods in educational psychology: Traditional and new paradigm. *Educational and Child Psychology*, *15*(3), 8-14.

Nowacek, E.J., McKinney, J.D. & Hallahan, D.P. (1990). Instructional behaviours of more and less effective beginning regular and special educators. *Exceptional Children, 57*, 140-149.

O'Grady, D. & Metz, J. R. (1987). Resilience in high-risk children. *Journal of Pediatric Psychology, 12*, 3-23.

Office for Standards in Education (2005). Personal, Social and Health Education in Secondary Schools. Retrieved October 27, 2011, from http://www.ofsted.gov.uk/assets/ 3828.doc.

Osgood, C. E., Suci, G. J. & Tannenbaum, P. H. (1975). *The measurement of meaning*. Illinois: The University of Illinois Press.

Ostrom, T. M. (1969). The relationship between the affective, behavioural and cognitive components of attitude. *Journal of Experimental Social Psychology*, *5*, 12-30.

Pallant, J. (2005). *SPSS survival manual: A step by step guide to data analysis using SPSS version 12*. Berkshire: Open University Press.

Paternite, C. & Johnston, T. (2005). Rationale and strategies for central involvement of educators in effective school-based mental health programs. *Journal of Youth and Adolescence, 34*, 41-49.

Paternite, C. E. (2004). Involving educators in school-based mental health programs. In K. E. Robinson (Ed.), School-based mental health: Best practices and program models (pp. 6–1 – 6–21). Kingston, NJ: Research Institute, Inc.

Paternite, C, E., Weist, M.D., Burke, R. & Flaspohler, P. (2008). Mental health issues in schools. *Encyclopaedia of counselling, 1,* 288 -293. New York: Sage.

Patton, G.C., Glover, S., Bond, L., Butler, H., Godfrey, C. & Di Pietro, G. (2000). The Gatehouse Project: A systematic approach to mental health promotion in secondary schools. *Australian and New Zealand Journal of Psychiatry*, *34*,586-593.

Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods* (2nd ed.). Newbury Park, CA: Sage Publications, Inc.

Patton, M. Q. (2000). *Qualitative Research and Evaluation Method.* London: Sage Publications.

Pianta, R. C. (1999). *Enhancing relationships between children and teachers.* Washington, DC: American Psychological Association.

Pianta, R. C. & Steinberg, M. (1992). Teacher-child relationships and the process of adjusting to school. *New Directions for Child and Adolescent Development, 57,* 61-80.

Piland, R. (1999). *The 1999 Classroom Teacher Survey*. Butler County Mental Health Board: Fairfield, OH.

Pinfold, V., Toulmin, H., Thornicroft, G., Huxley P., Farmer, P. & Graham, T. (2003). Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools. *British Journal of Psychiatry*, *182*, 342-346.

Pottick, K., Lerman, P. & Micchelli, M. (1992). Of problems and perspectives: Predicting the use of mental health services by parents of urban youth. *Children and Youth Services Review*, *18*, 363-378.

Poulou, M. & Norwich, B. (2000). Teachers' Perceptions of Students with Emotional and Behavioural Difficulties: severity and prevalence. *European Journal of Special Needs Education*, *15*(2) 171–187.

Power, S. (1992). Researching the impact of education policy: Difficulties and discontinuities. *Journal of Education Policy*, *7*(5), 493-500.

Pring, R. (2000). *Philosophy of educational research* (2nd ed.). London: Continuum.

Punch, K. F. (2005). Introduction to Social Research-Quantitative & Qualitative Approaches. Thousand Oaks, CA: Sage Publications.

Purkey, W. W. & Aspy, D. (1988). The mental health of pupils: Nobody minds, nobody cares? *The Person-Cantered Review*, *3*, 41-49.

Rabinow, B. A. (1960). A training program for teachers of the emotionally disturbed and socially maladjusted. *Exceptional Children*, *26*, 287-293.

Rappaport, J. (1977). *Community Psychology: Values, Research and Action*. New York: Holt, Rinehart and Winston.

Radnor, H. (1994). Collecting and analysing interview data in educational research. Monograph Series 3, Exeter: School of Education (Exeter University).

Reddy, R., Rhodes, J. E. & Mulhall, P. (2003). The influence of teacher support on student adjustment in the middle school years: A latent growth curve study. *Development and Psychopathology*, *15*, 119-138.

Reiko, M. (2008). Common misconceptions and attitudes toward psychology and mental health: a Malaysian Context. *Health Education Journal*, *1*, 55–74.

Repie, M. S. (2006). A school mental health issues survey from the perspective of regular and special education teachers, school counsellors, and school psychologists. *Education and Treatment of Children, 28*(3), 279-298.

Ritchie, J. & Lewis, J. (2003). *Qualitative research practice.* London: Sage Publications.

Roaf, C. & Bines, H. (1989). *Needs, rights and opportunities*. London: Flamer Press.

Robson, C. (2002). *Real World Research*. Oxford: Blackwell.

Roeser, R. W. & Midgley, C. (1997). Teachers' views of issues involving students' mental health. *The Elementary School Journal*, *98*(2), 115-133.

Rogers, A. & Pilgrim D. (2005). A *Sociology of Mental Health and Illness*. Maidenhead : McGraw-Hill.

Rogers, C. (1961). *On Becoming a Person: A Therapist's View of Psychotherapy*. London: Constable.

Rogoff, B. (1998). Cognition as a collaborative process. In W. Damon, D. Kuhn & R. S. Siegler (Eds.), *Handbook of child psychology, 2,* 679-729. Toronto: John Wiley & Sons.

Rogoff, B. (2003). *The cultural nature of human development.* New York: Oxford University Press.

Rones, M. & Hoagwood, K. (2000). School-based mental health services: A research review. *Clinical Child and Family Psychology Review*, *3*(4), 223-241.

Rose, D. (1998). Television, madness and community care. *Journal of Community & Applied Social Psychology*, *8*(3), 213–228.

Rosenberg, M. J. & Hovland, C. I. (1960). Cognitive, affective and behavioural components of attitudes. In C. I., Hovland & M. J., Rosenberg (Eds.), *Attitude organisation and change: An analysis of consistency among attitude components* (pp. 1-14). New Haven, CT: Yale University Press.

Rosenhan, D. L. & Seligman, M.E. P. (1989). *Abnormal psychology (2nd Ed.).* New York: Norton.

Rothì, D. M. & Leavey, G. (2006). Mental health help-seeking and young people: A review. *Pastoral Care*, *24*, 4–13.

Rothì, D. A., Leavey, G. & Best, R. (2008). On the front-line: Teachers as active observers of pupils' mental health. *Teaching and Teacher Education, 24* (5), 1217–1231.

Rothì, D. M., Leavey, G., Chamba, R. & Best, R. (2005). *Identification and management of pupils with mental health difficulties: A study of UK teachers' experiences and views*. London/Birmingham, England: Barnet, Enfield & Haringey Mental Health Trust/NASUWT. Retrieved June 21, 2010, from http://www.playfieldinstitute.co.uk

Rowling L., Martin G. & Walker L. (Eds.) (2008). *Mental health promotion and young people: concepts and practice* (pp. 258-265). Sydney: McGraw Hill.

Rubin, H. & Rubin, I. (2005). *Qualitative interviewing: The art of hearing data* (2nd ed.). London: Sage publications.

Rutter, M., Maughan, B., Mortimore, P. & Ouston, J. (1979). *Fifteen thousand hours: Secondary schools and their effects on children*. Cambridge, MA: Harvard University Press.

Rutter, M. & Smith, D J. (1995*). Psychological Disorders in Young people, time trends and their causes*. John Wiley & Sons Ltd: UK.

Sanford, M. N., Offord, D. R.; Boyle, M. H., Peace, A. & Racine, Y. A. (1992). Ontario child health study: Social and school impairments in children aged 6 to 16 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, *31*, 60-67.

Sayal, K. (2006). Annotation: Pathways to care for children with mental health problems. *Journal of Child Psychology and Psychiatry, 47*, 649–659.

Sayed, M.A. (2003). Conceptualization of mental illnesses within Arab Cultures: Meeting challenges in cross-cultural setting. *Social Behavioural and personality, 31*(4), 333-342.

Schlegel, R. P. (1975). Multidimensional measurement of attitude towards smoking marijuana. *Canadian Journal of Behavioural Science, 7*, 387-396.

Schlegel, R. P. & DiTecco, D. (1982). Attitudinal structures and the attitude behaviour relation. In M. P., Zanna, E. T., Higgins & C. P. Hermand, (Eds.), *Consistency in social behaviour*: The Ontario symposium (vol. 2, pp.17-50). Hillsdale, NJ: Erlbaum.

Schwandt, T. A. (2000). Three epistemological stances for qualitative inquiry: Interpretivism, hermeneutics, and social constructivism, In N.K. Denzin & Y. S. Lincoln (Eds.), Handbook of qualitative research (2nd ed.), (pp.189-213). Thousand Oaks: Sage publications.

Seale, C. (1999). Quality in qualitative research. *Qualitative enquiry, 5(*4), 465-478.

Secker, J. & Platt, S. (1996). Why media images matter. In Philo, G. (Ed.), *Media and Mental Distress.* Longman, London.

Seligman, M. E. P. & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55,* 5-14.

Shanley, D.C., Reid, G.J. & Evans, B. (2008). How parents seek help for children with mental health problems. *Administration in Policy and Mental Health and Mental Health Services Research, 35*, 135–146.

Silverman, D. (2000). *Doing Qualitative Research: A Practical Handbook.* London: Sage Publications.

Silverman, D. (2006). *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction* (3rd ed.). London: Sage Publications.

Smart, L. & Wegner, D. M. (1999). Covering Up What Can't Be Seen: Concealable Stigma and Mental Control, *Journal of Personal and Social Psychology, 77* (3), 474-486.

Smith, E. R. & Mackie, D. M. (2007). *Social Psychology* (3rd ed.). New York: Psychology Press.

Smith, M. (2002). Stigma. *Advanced in Psychiatric Treatment, 8*, 317-323.

Snape, D. & Spencer, L. (2003). The foundations of qualitative research. In J. Ritchie & J. Lewis (Eds.), *Qualitative research practice: A guide for social science students and researchers* (pp. 1-23). London: Sage Publications.

Soliman, A. M. (1993). Choice of helpers, types of problems and sex of helpers of college pupils. *International Journal for the Advancement of Counselling, 16* (2), 67-79.

Stahlberg, D. & Frey (1996). *Attitudes: Structure, measurement and functions.* In M. Hewstone, W. Stroebe & G. Stephenson (Eds.), *Introduction to social psychology* (2nd ed.), (pp. 205-275). Oxford: Blackwell.

Stake, R. E. (1995). *The art of case research.* Thousand Oaks, CA: Sage Publication.

Stanger, C. & Lewis, M. (1993). Agreement among parents, teachers, and children on internalising and externalising behaviour problems. *Journal of Clinical Child Psychology*, *22*, 107–115.

Steckler, A., McLeroy, K. R., Goodman, R. M., Bird, S. T. & McCormick, L. (1992). Toward integrating qualitative and quantitative methods: An introduction. *Health education quarterly*, *19*(1), 1-8.

Stern, C. & Keislar, E. R. (1977). Teacher attitudes and attitude change: A research review. *Journal of research and Development in Education, 10(2)*, 63-76.

Strauss, A. & Corbin, J. M. (1990). *Basic of Qualitative Research: Grounded Theory Procedures and Techniques*. Newbury Park: Sage Publication.

Suhrcke, M., Pillas, D. & Selai, C. (2007). Economic aspects of mental health in children and adolescents. In: WHO. *Social cohesion for mental well-being among adolescents*. WHO/HBSC Forum 2007 (pp. 43-64). Copenhagen: WHO Regional Office Europe.

Surgeon General (2000). Report on the Surgeon General's Conference on Children's Mental Health (2000): *A National Action Agenda*. Washington, DC: Department of Health and Human Services.

Sutherland, K. S., Wehby, J. H. & Copeland, S. R. (2000). Effect of varying rates of behaviour-specific praise on the on-task behaviour of students with EBD. *Journal of Emotional and Behavioural Disorders, 8*, 2-8, 26.

Taher, H. & Al-Mosawy, M. (1995). *Mental health from the ancient Greece to modernization* (Arabic). Kuwait: Al-Falah Press.

Tashakkori, A. & Creswell, J.W. (2007). Exploring the nature of research questions in mixed methods research. *Journal of Mixed Methods Research, 1*, 207-211.

Tashakkori, A. & Teddlie, C. (1998). *Mixed Methodology: Combining Qualitative and Quantitative Approaches*. London: Sage Publications.

Tashakkori, A. & Teddlie, C. (2003). *Handbook of mixed methods in social and behavioural research*. Thousand Oaks: Sage Publication.

Teacher Training Agency. (2005). *Handbook of Guidance.* London: TTA.

Tew, J. (2005). Core Themes of Social Perspectives. In J. Tew (Ed.) *Social Perspectives in Mental Health: Developing Social Models to understand and Work with Mental Distress*. London: Jessica Kingsley Publishers.

Thurstone, L. E. (1931). The measurement of social attitudes. *Journal of Abnormal and Social Psychology, 26*, 249-269.

Triandis, C. A., Adamopoulous, J. & Brinberg, D. (1984). Perspectives and Issues in the study of Attitudes and Attitudes Change in Special Education: Theory and Practice. (pp. 21-40) VA: The Council of Exceptional Children.

Tudor, K. (1996). *Mental health promotion: paradigms and practice*. London: Routledge.

United Nations (1989). The United Nations Convention on the Rights of the Child. Retrieved February 20, 2010, from http://www.unicif.org.

Wahl, O. F. (1995). Media madness: Public images of mental illness. New Jersey: Rutgers University Press.

Wahl, O. F. (2003). Depictions of mental illness in children's media. *Journal of Mental Health, 12*, 249-258.

Walter, H., Gouze, K. & Lim, K. (2006). Teachers' beliefs about mental health needs in inner city elementary schools. *Journal of the American Academy of Child & Adolescent Psychiatry, 45*(1), 61-68.

Waxman, R. P., Weist, M. D. & Benson, D. M. (1999). Toward collaboration in the growing education-mental health interface. *Clinical Psychology Review, 19*, 239-253.

Weare, K. (2000). *Promoting mental, emotional and social health: A whole school approach*. Routledge: London.

Weare, K. (2004). *Developing the Emotionally Literate School*. London: Sage Publications.

Weisberg, R.P., Caplan, M. & Sivo, PJ. (1989). A new conceptual framework for establishing school-based social competence promotion programs. In L.A. Bond & B.E. Compas (Eds.), *Primary prevention psychopathology, 12: Primary prevention and promotion in the schools*, (pp. 255-296). Newbury Park, CA: Sage Publications.

Weist, M., Sander, M., Walrath, C., Link, B., Nabors, L., Adelsheim, S., Moore, E., Jennings, J. & Carrillo, K. (2005). Developing Principles for Best Practice in Expanded School Mental Health. *Journal of Youth and Adolescence*, 34 (1), 7 - 13.

Wellington, J. (2000). *Educational research: Contemporary issues and practical approaches*. London: Continuum.

Wells, J., Barlow, J. & Stewart-Brown, S. (2003). *A systematic review of universal approaches to mental health promotion in school*s. *Health Education, 103,* 197-220.

Wentzel, K. R. (1991). Social competence at school: Relation between social responsibility and academic achievement. *Review of Educational Research, 61,* 1-24.

Werner, E. E. & Smith, R. S. (1992). *Overcoming the odds*. Ithaca, NY: Cornell University Press.

WHO (2001). *Mental health: strengthening mental health promotion. Factsheet no. 220.* Geneva, World Health Organization.

WHO (2001c). *Mental health: new understanding, new hope*. *The world health report.* Geneva, World Health Organization.

WHO (2005). *The health of children and adolescents in Europe. Fact sheet Euro/06/05,* World Health Organization, Copenhagen.

Wicker, A. W. (1969). Attitude versus actions: The relationship of verbal and overt behavioural responses to attitude objects. *Journal of Social Issues, 25*(4), 41-78.

Wilson, P. (2003). *Young minds in our schools: a guide for teachers and others workings in schools.* London: Young Minds.

Woolfson, R., Woolfson, L., Mooney, L. & Bryce, D. (2007). Young people's views of mental health education in secondary schools: a Scottish study. *Child: care, health, and development, 35*(6), 790-798.

World Federation for Mental Health (2003). *Emotional and behavioural disorders of children and adolescents*. Baltimore, MD: WFMH.

Wyn, J., Cahill, H., Holdsworth, R., Rowling, L. & Carson, S. (2000). MindMatters, a whole-school approach promoting mental health and wellbeing. *Australian and New Zealand Journal of Psychiatry*, *34*, 594–601.

Yager, Z. & O'Dea, J. A. (2005). The role of teachers and other Educators in the prevention of eating Disorders and Child Obesity: What Are the Issues? *Eating Disorders*, *13*(3), 261–278.

Yin, R. K. (2003). *Case study research: design and methods*. (3rd ed.). Thousand Oaks, CA: Sage Publications.

YoungMinds (1996). *Mental health in your school: a guide for teachers and others working in schools*. London: Jessica Kingsley.

Zwaanswijk, M., Verhaak, P. F. M., Bensing, J.M., Van der Ende, J. & Verhulst, F.C. (2003). Help-seeking for emotional and behavioural problems in children and adolescents: A review of recent literature. *European Child and Adolescent Psychiatry*, *12*, 153–161.

Appendix (I)

Map of Kuwait

http://www.lonelyplanet.com/maps/middle-east/kuwait/

Appendix (II)

Map of Arab Peninsula

http://www.lonelyplanet.com/maps/middle-east/kuwait/

Appendix (III): The study survey

*"*Middle school teachers' attitudes and perceptions about promoting pupils' mental health in the State of Kuwait*"*

Dear teacher,

This study aims to ascertain the attitudes and perspectives of middle school teachers in regard to their role in enhancing the mental health of students in the context of Kuwait. The overall purpose of this survey is to gather data that may facilitate deeper understanding and awareness of the factors concerning mental health promotion across schools, and accordingly establish the elements that could potentially undermine or support the implementation of the pupils' mental health promotion process in Kuwait.

It is essential that the responses provided are honest and sincere, and that they are your own and not those of colleagues or other influential individuals or entities. Importantly, no judgement is made about whether specific standpoints are in themselves preferable or correct. Moreover, so as to ensure anonymity and confidentiality, personal identification will not be necessary. However, should you be willing to be interviewed in relation to the study context, please do advise of this by providing your details at the end of the survey.

Please provide one response to each of the statements, according to the scales and criteria detailed.

Part one: Background information:

Please put a tick where appropriate:

1. Gender: ☐ Male ☐ Female

2. Age Group:

☐ 21-25 ☐ 26-30 ☐ 31-35 ☐ 36-40 ☐ 41-45 ☐ 46-50

3. Years of teaching experience:

☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ 16-21 ☐ more than 20

4. Level of education:

☐ Diploma ☐ BA ☐ Master ☐ PhD

Part Two: Teachers' attitudes towards promoting pupils' mental health.

Please consider the statements made in the following section and accordingly highlight the degree to which you either agree or disagree by utilising the scale. Answers are neither correct nor incorrect; they need only be honest.

A. Teachers' cognitive response to promoting pupils' mental health.

5=strongly agree 4=agree 3=undecided 2=disagree 1=strongly disagree

N	Statements	SA	A	U	D	SD
1	A mentally healthy person is someone who can cope with, adjust to life's stressors, and adapt to changes.	5	4	3	2	1
2	Somebody with a mental health problem, which is temporary, would not be said to have a mental illness.	5	4	3	2	1
3	The majority of people who experience mental health problems can recover if they get help early on.	5	4	3	2	1
4	Mental health problems that are not recognised early can become more severe.	5	4	3	2	1
5	Young people have the right and the need to be mentally healthy.	5	4	3	2	1
6	Schools hold a unique position in positively affecting the mental health of pupils.	5	4	3	2	1
7	Teachers play an influential role in recognising pupils with mental health problems.	5	4	3	2	1
8	It is not teachers' job to promote pupils' mental health in the classroom.*	5	4	3	2	1
9	Promoting pupils' mental health means supporting pupils to strengthen their positive mental health.	5	4	3	2	1
10	Promoting pupils' mental health means enhancing individual knowledge and skills to foster their mental health.	5	4	3	2	1
11	Teachers are expected to assume some responsibility in the early recognition of pupils' mental health problems.	5	4	3	2	1
12	Promoting pupils' mental health required teachers to have specific training skills.	5	4	3	2	1
13	Promoting pupils' mental health requires teachers to have adequate knowledge in mental health issues.	5	4	3	2	1
14	Promoting pupils' mental health has a positive impact on their social well-being.	5	4	3	2	1
15	Referring pupils with mental health problems for appropriate early support reduces their risk of developing mental health problems.	5	4	3	2	1
16	Having pupils with mental health problems in my class impedes the learning of other pupils.*	5	4	3	2	1
17	Promoting pupils' mental health has a positive impact on their academic achievement.	5	4	3	2	1

B. Teachers' affective response towards promoting pupils' mental health

1. If a pupil with mental health problems were about to join my class, I would feel: :

Not comfortable	1	2	3	4	5	Very comfortable
Very negative	1	2	3	4	5	Very positive
Not optimistic	1	2	3	4	5	Very optimistic
Not interested	1	2	3	4	5	Very interested
Unhappy	1	2	3	4	5	Very happy

2. Recognising pupils' mental health problems makes me feel: :

Not comfortable	1	2	3	4	5	Very comfortable
Very negative	1	2	3	4	5	Very positive
Not optimistic	1	2	3	4	5	Very optimistic
Not interested	1	2	3	4	5	Very interested
Unhappy	1	2	3	4	5	Very Happy

3. Dealing with pupils' mental health problems in my classroom makes me feel:

Not comfortable	1	2	3	4	5	Very comfortable
Very negative	1	2	3	4	5	Very positive
Not optimistic	1	2	3	4	5	Very optimistic
Not interested	1	2	3	4	5	Very interested
Unhappy	1	2	3	4	5	Very happy

4. Managing a class which includes pupils with mental health problems makes me feel:

Not comfortable	1	2	3	4	5	Very comfortable
Very negative	1	2	3	4	5	Very positive
Not optimistic	1	2	3	4	5	Very optimistic
Not interested	1	2	3	4	5	Very interested
Unhappy	1	2	3	4	5	Very happy

5. Promoting pupils' mental health makes me feel:

Not comfortable	1	2	3	4	5	Very comfortable
Very negative	1	2	3	4	5	Very positive
Not optimistic	1	2	3	4	5	Very optimistic
Not interested	1	2	3	4	5	Very interested
Unhappy	1	2	3	4	5	Very happy

C. Teachers' behavioural response towards promoting pupils' mental health.

5=strongly agree	**4=agree**	**3=undecided**	**2=disagree**	**1=strongly disagree**

N	**If I have or recognise a pupil with mental health problems in my class, I will.....**	SA	A	U	D	SD
1	Accept responsibility for promoting pupils' mental health in my class.	5	4	3	2	1
2	Increase my knowledge about mental health issues and how they affect pupils.	5	4	3	2	1
3	Hope his/her problems will go away.*	5	4	3	2	1
4	Be willing to implement a positive mental health curriculum.	5	4	3	2	1
5	Engage in developing training in the appropriate skills to recognise and deal with pupils with mental health issues.	5	4	3	2	1
6	Co-operate with the school administration in decision-making concerning pupils' mental health.	5	4	3	2	1
7	Be willing to work with mental health professionals in order to address emotional/ behavioural issues in my classroom.	5	4	3	2	1
8	Co-operate with the parents of pupils with mental health problems.	5	4	3	2	1
9	Suggest to the head teacher to move pupils with mental health issues to another class.*	5	4	3	2	1
10	Be aware of the mental health services available for my pupils in the school.	5	4	3	2	1

Part Three: Teacher's perceptions about barriers to promoting pupils' mental health.

5=strongly agree	**4=agree**	**3=undecided**	**2=disagree**	**1=strongly disagree**

N	**To what degree does each item represent a barrier to your participation in promoting pupils' mental health?**	SA	A	U	D	SD
1	Lack of awareness about my role and responsibility regarding pupils' mental health.	5	4	3	2	1
2	Inadequate knowledge and personal education about pupils' mental health issues.	5	4	3	2	1
3	Inadequate training to recognise the early signs of pupils' mental health problems.	5	4	3	2	1
4	Teachers' negative attitudes towards mental health issues.	5	4	3	2	1
5	Concerns over workload and time limits.	5	4	3	2	1
6	Lack of partnership between specialists (e.g. counsellors, educational psychologists) and teachers regarding pupils' mental health.	5	4	3	2	1
7	Lack of information resources related to pupils' mental health.	5	4	3	2	1
8	Absence of an educational policy which expects teachers to be responsible in promoting pupils' mental health.	5	4	3	2	1
9	Inadequate funding.	5	4	3	2	1
10	Curriculum, pedagogy and the examination system.	5	4	3	2	1
11	Lack of partnership between parents and teachers.	5	4	3	2	1
12	Resistance among administrators and inspectors.	5	4	3	2	1
13	Social stigma around talking about mental health problems and labelling.	5	4	3	2	1
14	Alternative cultural and religious beliefs about the ways of healing mental health problems.	5	4	3	2	1
15	School culture and ethos (social view of school and schooling).	5	4	3	2	1
16	Inappropriate media representations of mental health problems.	5	4	3	2	1

- Could you please mention any other barriers to teachers' role in promoting pupils' mental health?

- .....
  .....

- What changes would you recommend for promoting pupils' mental health in the classroom?

- .....
  .....

Dear Colleague,

I might like to conduct an interview with you to discuss your views on some aspects of promoting pupils' mental health. Please tick the following choice to show whether you agree to this further contact.

Yes [ ] No [ ]

Name: Your phone number: Your e- mail:

The personal details of the researcher, including telephone number and email address, are provided below, should there be any need to change or cancel an appointment or even to ask questions. You can also provide your own contact details should you wish to do so.

My phone Number: 99744487.

My e-mail: dafa201@ex.ac.uk.

Thank you for your co-operation and interest.

Appendix (IV): Protocol of the Semi- Structured Interviews

The semi-structured interviews aimed to elicit and elaborate on the participants' perceptions about their understanding of some mental health concepts, their role in promoting pupils' mental health, awareness, knowledge, and training skills, and their perceptions of barriers and changes involved in promoting pupils' mental health. The order in which the questions are presented in this protocol does not imply that interviews were conducted in the same sequence, since the participants' abilities to articulate their views about certain issues provided outlets for some probing or minor questions, leading to further discussion. The questions sometimes unfolded without probing, and some questions were added, varied or their wording and order modified. The following sections represent the themes the interviews addressed.

Understanding and perceptions of some mental health concepts

- If I say 'mental health', what do you understand by this term?
- What comes to mind if I say 'mental illness'?
- What do you think has led you to forming these opinions?
- In your view, would somebody with a mental health problem be said to have a mental illness? Does the severity make difference?
- Do you think that people who experience mental health problems can overcome these problems? How?
- How do you know if pupils have mental health problems?

Teachers' role and school's role in promoting pupils' mental health

- What does 'promoting mental health' mean?
- How is 'promoting mental health' related to your pupils and your school?
- Do you think that all pupils have the right to be mentally healthy?
- To what extent do you think schools are resourced and ready for promoting pupils' mental health?
- If you recognise a pupil with a mental health problem, what role and responsibility would you as a teacher have in responding to his/her problem?

- In your view, is it a part of your job to recognise or deal with pupils' mental health problems? If not, whose responsibility should be?

- In your view, to what extent could the idea of teachers having a responsibility in promoting pupils' mental health be acceptable in Kuwaiti schools today?

- In your opinion, are there any common socio-cultural beliefs regarding mental health issues in Kuwaiti society could have impact on the implementation of prompting pupils' mental health in Kuwait's school?

- From your point of view, to what extent could the media's representation of mental health issues in Kuwaiti society affect teachers' attitudes towards the implementation of prompting pupils' mental health in Kuwait's schools?

- What does promoting pupils' mental health make you feel? For example, including pupils with mental health problems in your class, or dealing with pupils having mental health problems?

- In your opinion, what are the factors related to teachers or young people that could have an impact on teachers' perceptions about promoting pupils' mental health?

Awareness, knowledge, and training skills

- In you view, do regular teachers have adequate awareness and knowledge about promoting pupils' mental health? What are the appropriate ways to increase teachers' knowledge and awareness about pupils' mental health issues?

- In your opinion, what sort of training do they need? Is it general training in pupils' mental health or are there particular areas they need to be trained in?

- Do you think that a lack of teacher' knowledge and training skills regarding pupils' mental health issues could affect teachers' attitudes towards promoting pupils' mental health?

- Are you ready to participate in any training workshops or educational courses related to promoting pupils' mental health?

- In your opinion, does the process of promoting pupils' mental health imply specific requirements to be implemented in practice?

- In what way does promoting pupils' mental health benefit pupils?

- In your opinion, to what extent would the delivery of a mental health education curriculum by teachers to their pupils be acceptable?

Perceptions of barriers to and changes needed for promoting pupils' mental health

- What are the barriers that you feel limit your taking up of this responsibility?
- Are there any changes that should be made to put the promotion of pupils' mental health into practice in Kuwait's schools?

Appendix (V): Reliability of the scales

- Reliability for the attitudes scale in the pilot study

Cronbach's Alpha	No. of Items
.870	35

Item Statistics

	Mean	Std. Deviation	N
c1	3.0522	1.34265	479
c2	4.2965	.76249	479
c3	4.2693	.66951	479
c4	4.2860	.66253	479
c5	4.3215	.73537	479
c6	4.5073	.69023	479
c7	4.4092	.70829	479
c8	4.3403	.68384	479
c9	4.1253	.77956	479
c10	4.2568	.69880	479
c11	4.3194	.68169	479
c12	4.0731	.95991	479
c13	4.1628	.79919	479
c14	4.2109	.85778	479
c15	4.2756	.84540	479
c16	4.3820	.72187	479
c17	4.3967	.66066	479
c18	4.1670	.88294	479
A1	2.9144	1.23198	479
A2	3.4656	1.14364	479
A3	3.5219	1.23200	479
A4	3.5491	1.25311	479
A5	3.9228	1.02290	479
B1	4.2463	.76663	479
B2	4.1670	.79570	479
B3	4.1190	.89655	479
B4	4.0292	.80997	479
B5	4.3257	.73353	479
B6	4.0438	.90568	479
B7	3.9896	.89273	479
B8	4.1232	.79187	479
B9	4.2150	.74717	479
B10	4.2589	.73453	479
B11	4.0292	.93244	479
B12	4.2651	.74222	479

- Reliability test for the barriers scale in the pilot study

Reliability Statistics

Cronbach's Alpha	No. of Items
.871	32

Item Statistics

	Mean	Std. Deviation	N
c1	3.0522	1.34265	479
c2	4.2965	.76249	479
c3	4.2693	.66951	479
c4	4.2860	.66253	479
c5	4.3215	.73537	479
c6	4.5073	.69023	479
c7	4.4092	.70829	479
c8	4.3403	.68384	479
c9	4.1253	.77956	479
c10	4.2568	.69880	479
c11	4.3194	.68169	479
c13	4.1628	.79919	479
c14	4.2109	.85778	479
c15	4.2756	.84540	479
c16	4.3820	.72187	479
c17	4.3967	.66066	479
c18	4.1670	.88294	479
A1	2.9144	1.23198	479
A2	3.4656	1.14364	479
A3	3.5219	1.23200	479
A4	3.5491	1.25311	479
A5	3.9228	1.02290	479
B1	4.2463	.76663	479
B2	4.1670	.79570	479
B3	4.1190	.89655	479
B4	4.0292	.80997	479
B7	3.9896	.89273	479
B8	4.1232	.79187	479
B9	4.2150	.74717	479
B10	4.2589	.73453	479
B11	4.0292	.93244	479
B12	4.2651	.74222	479

- Reliability of the attitudes scale after conducting the factor analysis and excluding items C12, B5, B6)

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.862	.871	32

Item Statistics

	Mean	Std. Deviation	N
c1	3.0522	1.34265	479
c2	4.2965	.76249	479
c3	4.2693	.66951	479
c4	4.2860	.66253	479
c5	4.3215	.73537	479
c6	4.5073	.69023	479
c7	4.4092	.70829	479
c8	4.3403	.68384	479
c9	4.1253	.77956	479
c10	4.2568	.69880	479
c12	4.0731	.95991	479
c13	4.1628	.79919	479
c14	4.2109	.85778	479
c15	4.2756	.84540	479
c16	4.3820	.72187	479
c17	4.3967	.66066	479
c18	4.1670	.88294	479
A1	2.9144	1.23198	479
A2	3.4656	1.14364	479
A3	3.5219	1.23200	479
A4	3.5491	1.25311	479
A5	3.9228	1.02290	479
B1	4.2463	.76663	479
B2	4.1670	.79570	479
B3	4.1190	.89655	479
B4	4.0292	.80997	479
B7	3.9896	.89273	479
B8	4.1232	.79187	479
B9	4.2150	.74717	479
B10	4.2589	.73453	479
B11	4.0292	.93244	479
B12	4.2651	.74222	479

*C stands for cognitive item and B for behavioural intention item.

- Reliability test for the attitudes scale after employing the factor analysis and excluding Ba5 and Ba6.

Reliability Statistics

Cronbach's Alpha	No of Items
.835	18

Item Statistics

	Mean	Std. Deviation	N
Ba1	1.8410	.91105	478
Ba2	1.8828	.79495	478
Ba3	1.8787	.86021	478
Ba4	1.9372	.85183	478
Ba7	1.9121	.83717	478
Ba8	2.0084	.88780	478
Ba9	1.8619	.81249	478
Ba10	1.8598	.79781	478
Ba11	1.9791	.94923	478
Ba12	2.0084	.84918	478
Ba13	2.1883	1.03912	478
Ba14	2.2259	1.03158	478
Ba15	2.1862	1.09547	478
Ba16	2.1883	1.07677	478
Ba17	2.0628	.96709	478
Ba18	2.0377	1.03129	478
Ba5	1.7029	.72369	478
Ba6	1.7385	.78550	478

*Ba stands for barrier.

Appendix (VI): An example of testing normality of the data that subjected to ANOVA

Teaching years of experience Categories

Case Processing Summary

	Teaching years of experience	Cases					
		Valid		Missing		Total	
		N	Percent	N	Percent	N	Percent
cognitive dimension	1-5	194	100.0%	0	.0%	194	100.0%
	6-10	92	100.0%	0	.0%	92	100.0%
	11-15	95	100.0%	0	.0%	95	100.0%
	16-21	62	100.0%	0	.0%	62	100.0%
	above 20	36	100.0%	0	.0%	36	100.0%

Tests of Normality

	Teaching years of experience	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
		Statistic	df	Sig.	Statistic	df	Sig.
Cognitive Dimension	1-5	.061	194	.080	.975	194	.002
	6-10	.105	92	.014	.946	92	.001
	11-15	.139	95	.000	.927	95	.000
	16-21	.118	62	.033	.957	62	.031
	above 20	.150	36	.039	.902	36	.004

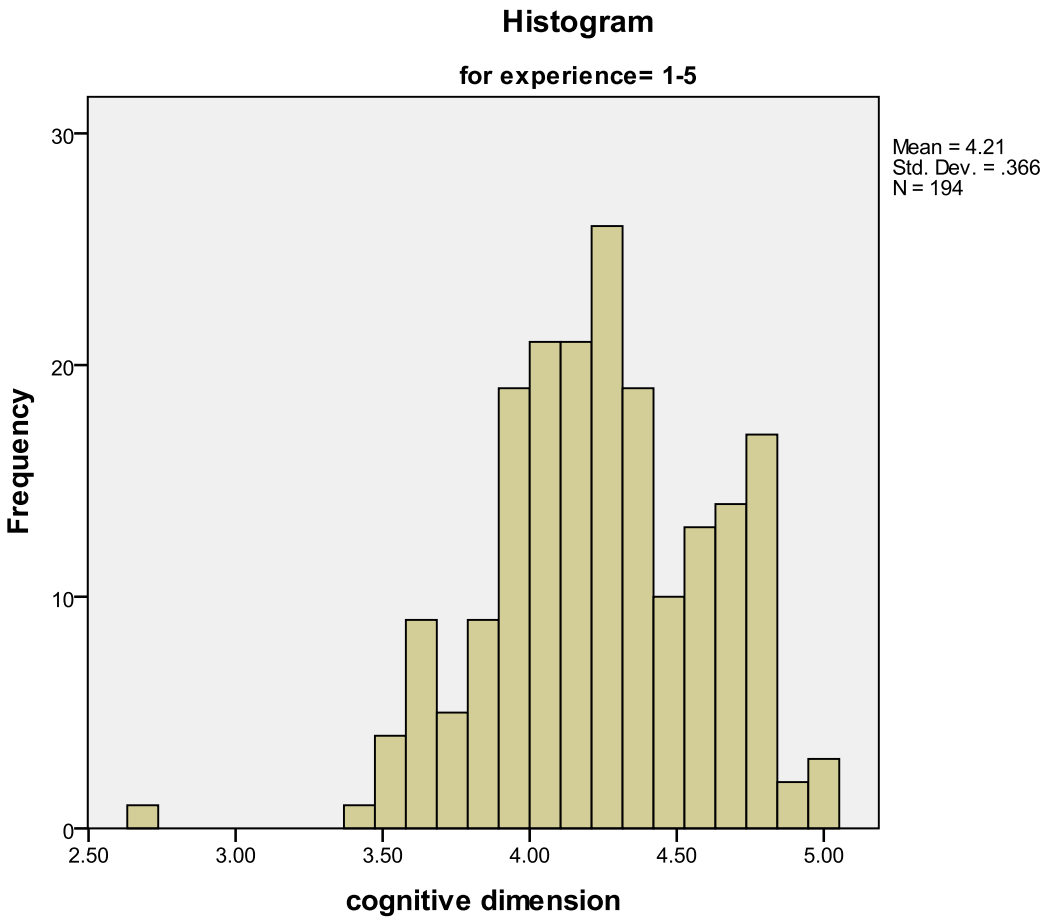
a. Lilliefors Significance Correction

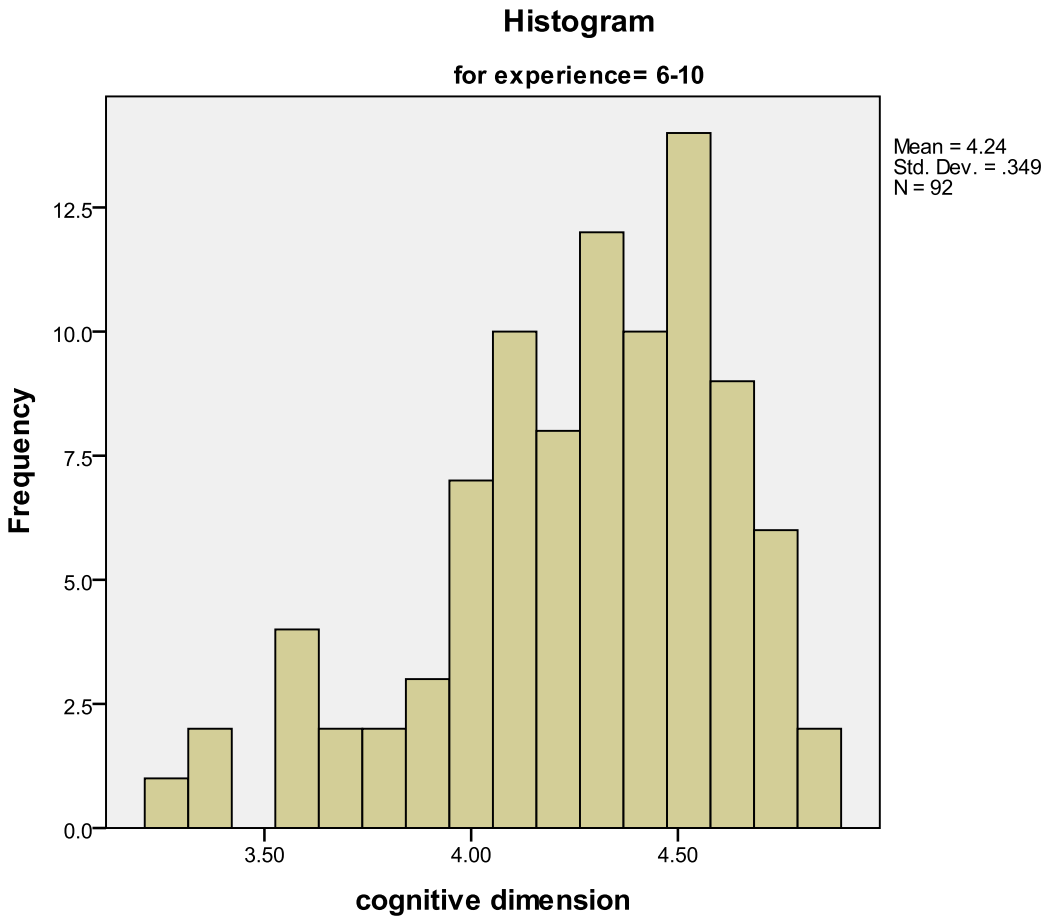
Descriptives

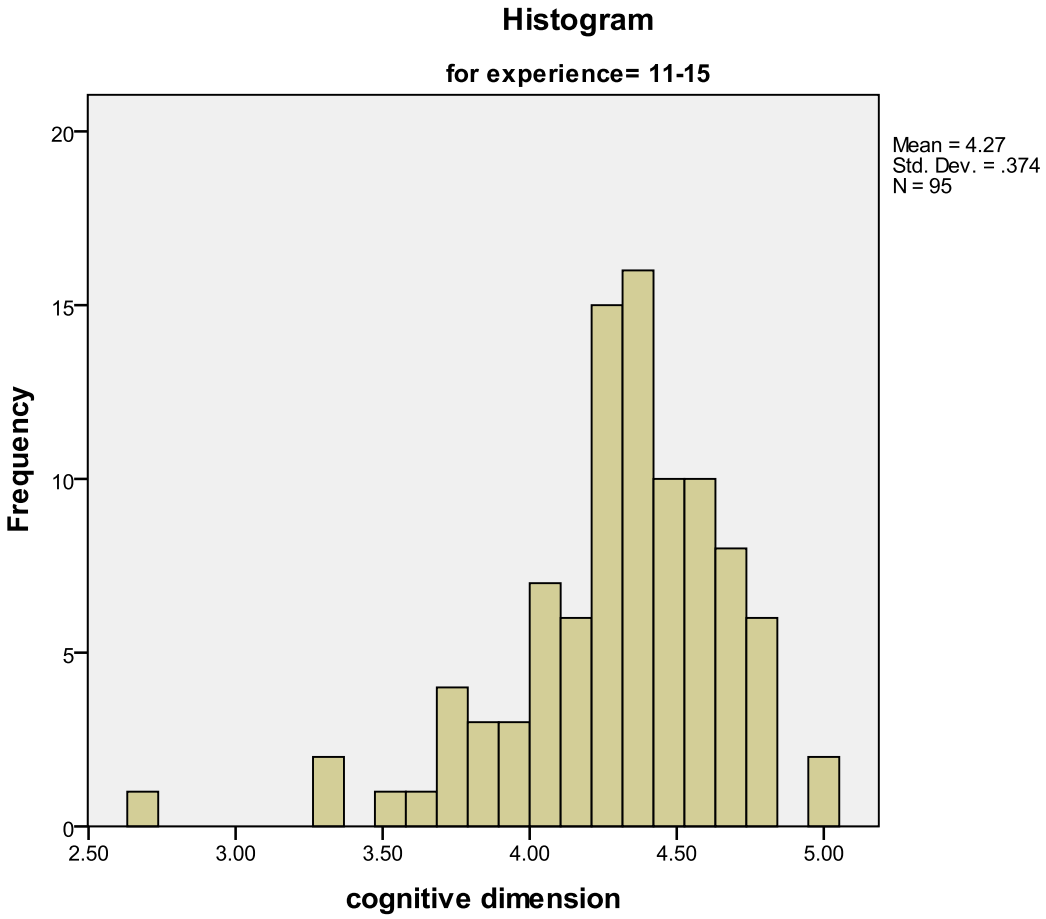
	Teaching years of experience			Statistic	Std. Error
cognitive dimension	1-5	Mean		4.2130	.02630
		95% Confidence Interval for Mean	Lower Bound	4.1611	
			Upper Bound	4.2648	
		5% Trimmed Mean		4.2215	
		Median		4.2105	
		Variance		.134	
		Std. Deviation		.36638	
		Minimum		2.68	
		Maximum		4.95	
		Range		2.26	
		Interquartile Range		.54	
		Skewness		-.350	.175
		Kurtosis		.580	.347
	6-10	Mean		4.2426	.03637
		95% Confidence Interval for Mean	Lower Bound	4.1703	
			Upper Bound	4.3148	
		5% Trimmed Mean		4.2609	
		Median		4.3158	
		Variance		.122	
		Std. Deviation		.34885	
		Minimum		3.26	
		Maximum		4.79	
		Range		1.53	
		Interquartile Range		.47	
		Skewness		-.802	.251
		Kurtosis		.303	.498
	11-15	Mean		4.2726	.03834
		95% Confidence Interval for Mean	Lower Bound	4.1965	
			Upper Bound	4.3487	
		5% Trimmed Mean		4.2972	
		Median		4.3158	
		Variance		.140	
		Std. Deviation		.37366	
		Minimum		2.68	
		Maximum		4.95	
		Range		2.26	

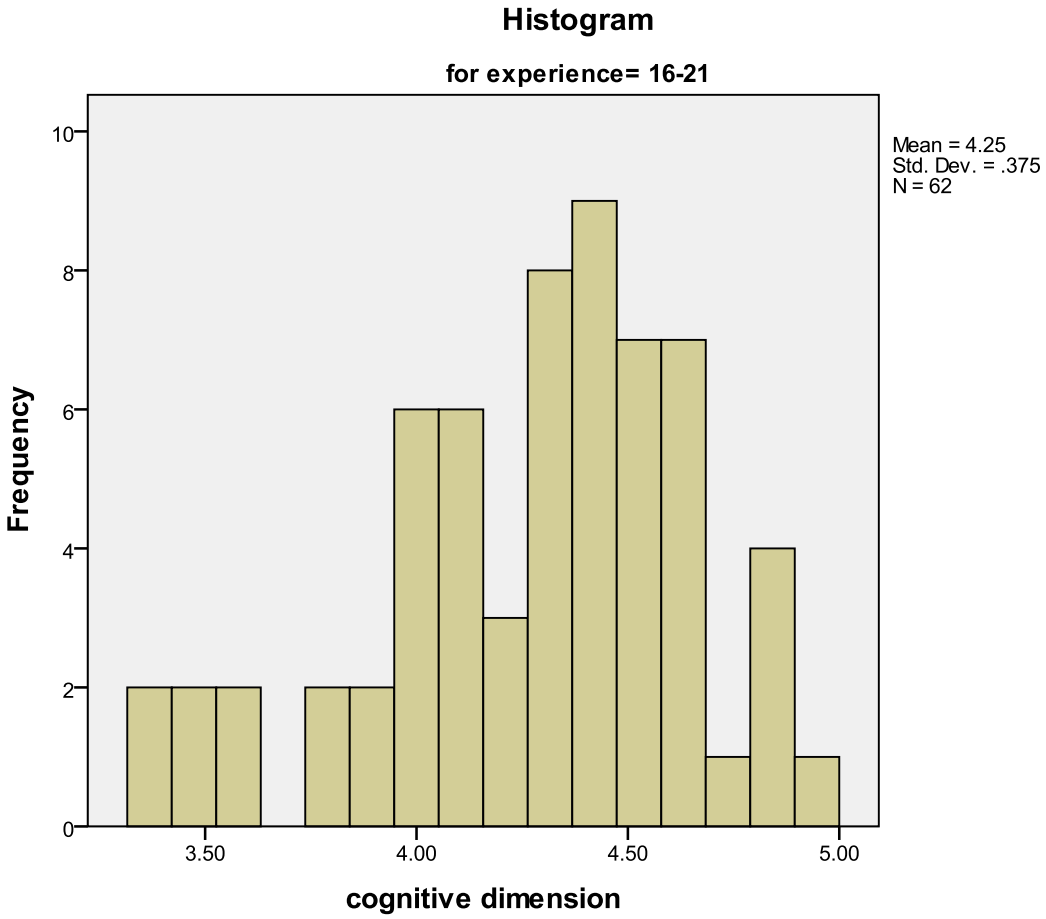
		Interquartile Range		.42	
		Skewness		-1.230	.247
		Kurtosis		3.002	.490
	16-21	Mean		4.2504	.04768
		95% Confidence Interval for Mean	Lower Bound	4.1551	
			Upper Bound	4.3458	
		5% Trimmed Mean		4.2626	
		Median		4.3158	
		Variance		.141	
		Std. Deviation		.37540	
		Minimum		3.37	
		Maximum		4.95	
		Range		1.58	
		Interquartile Range		.47	
		Skewness		-.583	.304
		Kurtosis		-.034	.599
	above 20	Mean		4.1184	.05831
		95% Confidence Interval for Mean	Lower Bound	4.0000	
			Upper Bound	4.2368	
		5% Trimmed Mean		4.1433	
		Median		4.1842	
		Variance		.122	
		Std. Deviation		.34988	
		Minimum		3.11	
		Maximum		4.68	
		Range		1.58	
		Interquartile Range		.37	
		Skewness		-1.240	.393
		Kurtosis		2.439	.768

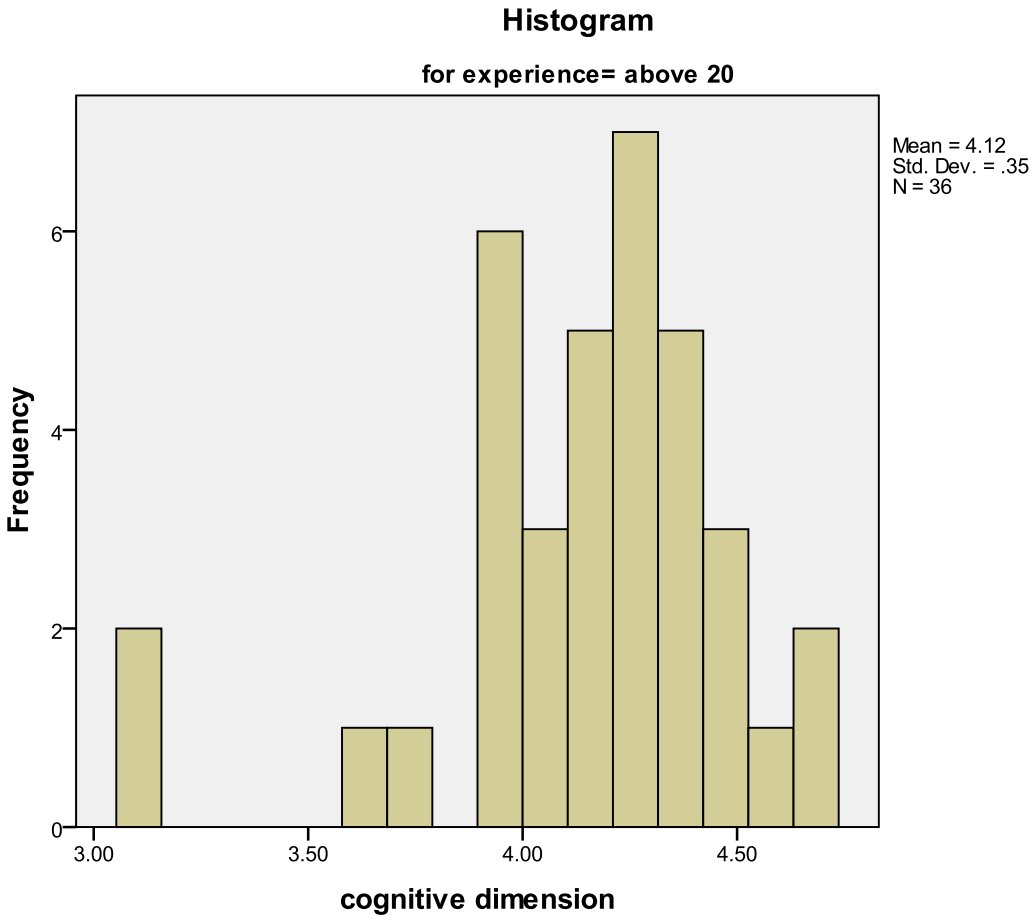
Histograms


Histogram
for experience= 1-5
Mean = 4.21
Std. Dev. = .366
N = 194
Frequency
30
20
10
0
2.50
3.00
3.50
4.00
4.50
5.00
cognitive dimension


Histogram
for experience= 6-10
Mean = 4.24
Std. Dev. = .349
N = 92
Frequency
12.5
10.0
7.5
5.0
2.5
0.0
3.50
4.00
4.50
cognitive dimension


Histogram
for experience= 11-15
Mean = 4.27
Std. Dev. = .374
N = 95
Frequency
20
15
10
5
0
2.50
3.00
3.50
4.00
4.50
5.00
cognitive dimension


Histogram
for experience= 16-21
Mean = 4.25
Std. Dev. = .375
N = 62
Frequency
0
2
4
6
8
10
3.50
4.00
4.50
5.00
cognitive dimension


Histogram
for experience= above 20
Mean = 4.12
Std. Dev. = .35
N = 36
Frequency
0
2
4
6
3.00
3.50
4.00
4.50
cognitive dimension

Stem-and-Leaf Plots

```
Cognitive dimension Stem-and-Leaf Plot for
Teaching years of experience= 1-5

 Frequency    Stem & Leaf

     1.00 Extremes    (=<2.68)
     3.00       34.277
     7.00       35.2277777
     7.00       36.3333888
     5.00       37.33888
    16.00       38.4444449999999999
     9.00       39.444444444
    21.00       40.000000000000055555555
    21.00       41.00000000000555555555
    26.00       42.11111111111111166666666666
    19.00       43.1111111111166666666
    10.00       44.2222222277
    13.00       45.2222222222777
    14.00       46.33333888888888
    17.00       47.33333333333333338
     2.00       48.49
     3.00       49.444

 Stem width:       .10
 Each leaf:       1 case(s)
```

```
Cognitive dimension Stem-and-Leaf Plot for
Teaching years of experience= 6-10

 Frequency    Stem & Leaf

     3.00 Extremes    (=<3.3)
     4.00        3.5555
     4.00        3.6677
     8.00        3.88899999
    16.00        4.0000000111111111
    21.00        4.222222222333333333333
    27.00        4.444444444445555555555555555
     9.00        4.666777777

 Stem width:      1.00
 Each leaf:       1 case(s)
```

Cognitive dimension Stem-and-Leaf Plot for
Teaching years of experience= 11-15

```
 Frequency    Stem & Leaf

     4.00 Extremes    (=<3.5)
     7.00        3.6666777
     4.00        3.8899
    13.00        4.0000000111111
    31.00        4.22222222222222233333333333333333
    20.00        4.44444444445555555555
    14.00        4.66666666777777
     2.00        4.99

 Stem width:      1.00
 Each leaf:       1 case(s)
```

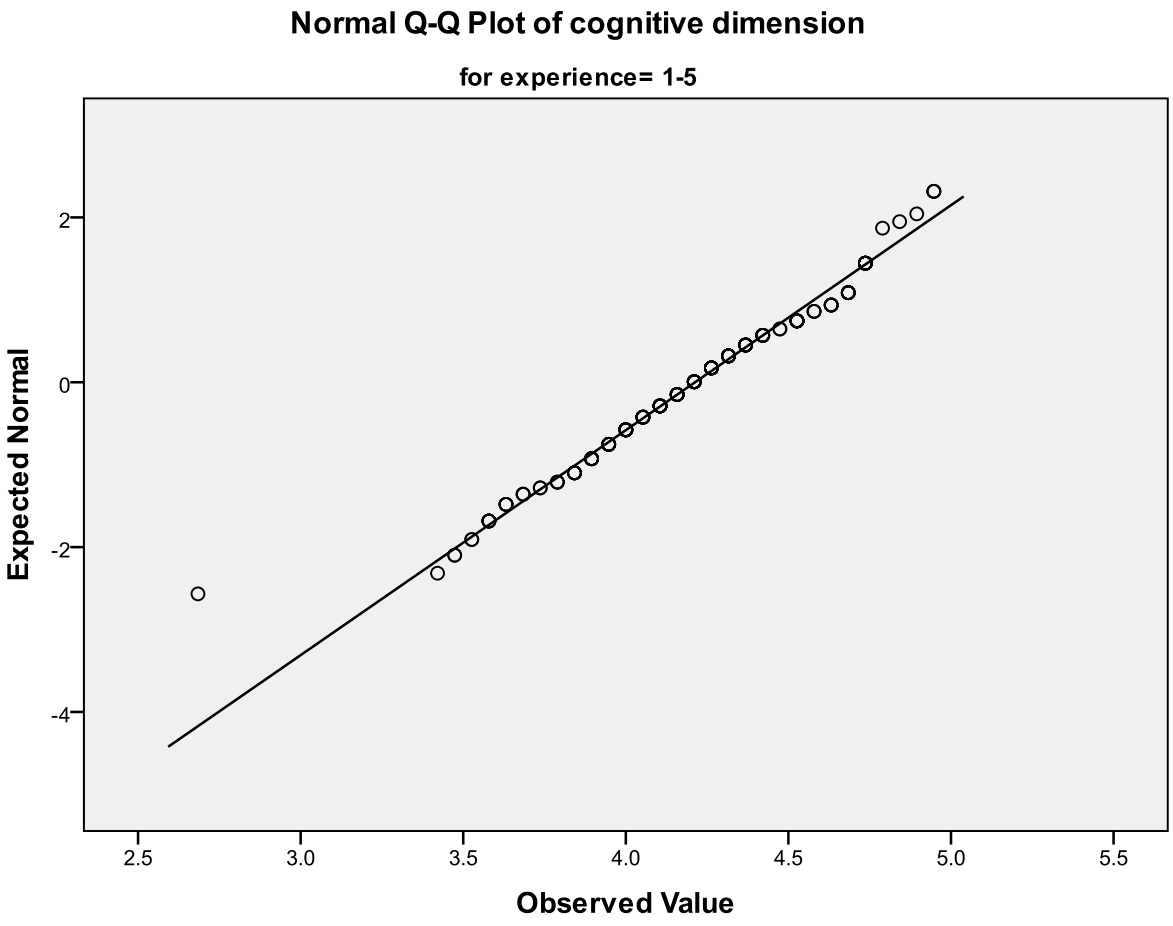
Cognitive dimension Stem-and-Leaf Plot for
Teaching years of experience= 16-21

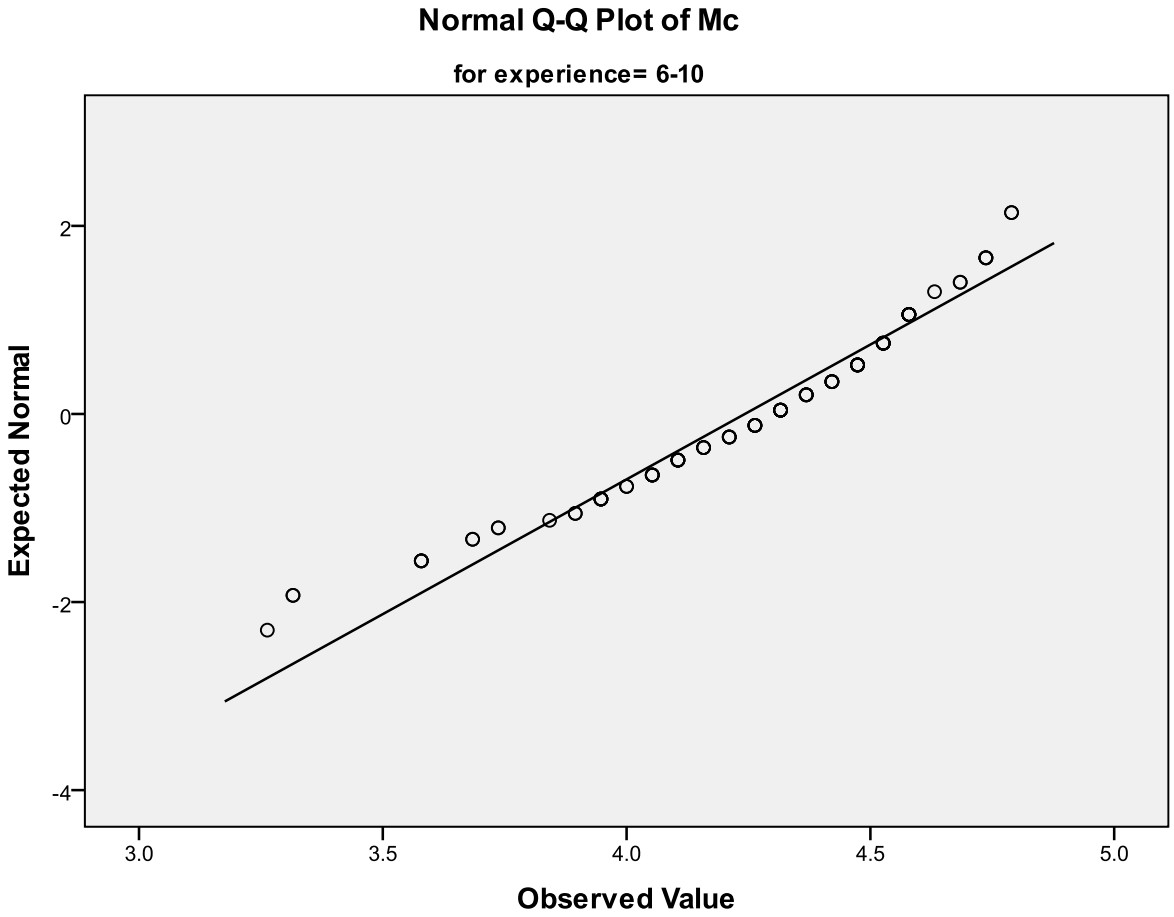
```
 Frequency    Stem & Leaf

     2.00        3.33
     4.00        3.4455
     2.00        3.77
     6.00        3.889999
     9.00        4.000011111
    12.00        4.222223333333
    20.00        4.44444444444445555555555
     3.00        4.677
     4.00        4.8889

 Stem width:      1.00
 Each leaf:       1 case(s)
```

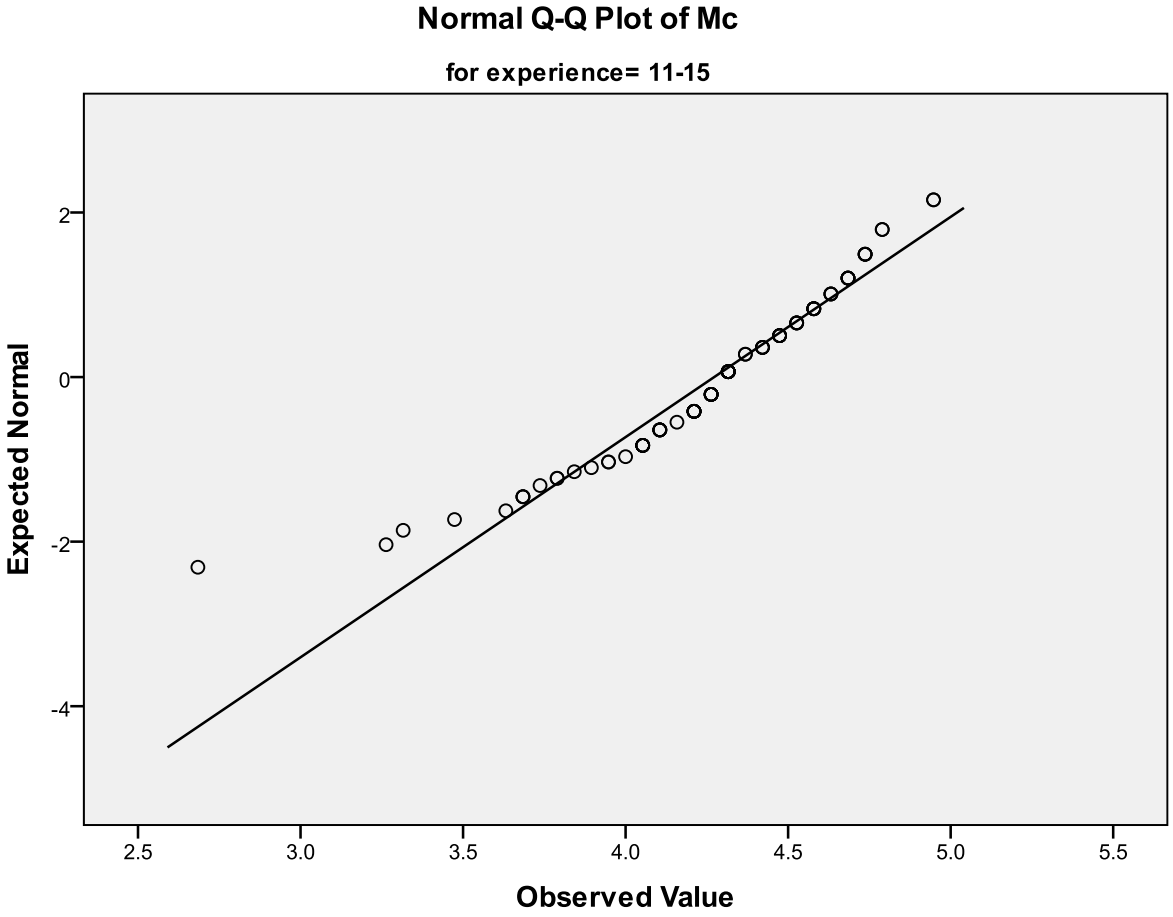
Cognitive dimension Stem-and-Leaf Plot for
Teaching years of experience= above 20

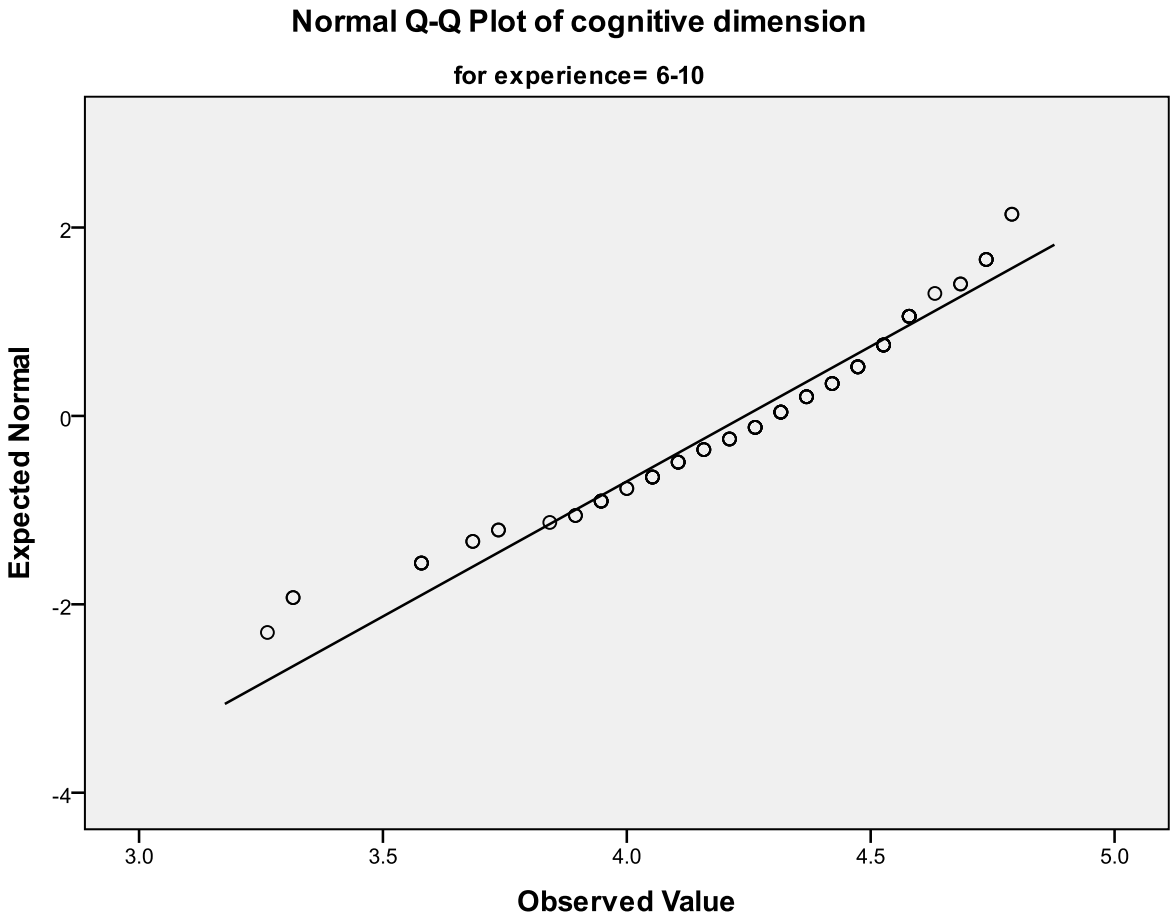
```
 Frequency    Stem & Leaf

     2.00 Extremes    (=<3.11)
     1.00       35.7
     1.00       36.8
      .00       37.
     3.00       38.999
     3.00       39.444
     3.00       40.055
     5.00       41.00005
     7.00       42.1111666
     5.00       43.11166
     3.00       44.277
     1.00       45.2
     2.00       46.88
 Stem width:       .10
 Each leaf:       1 case(s)
```

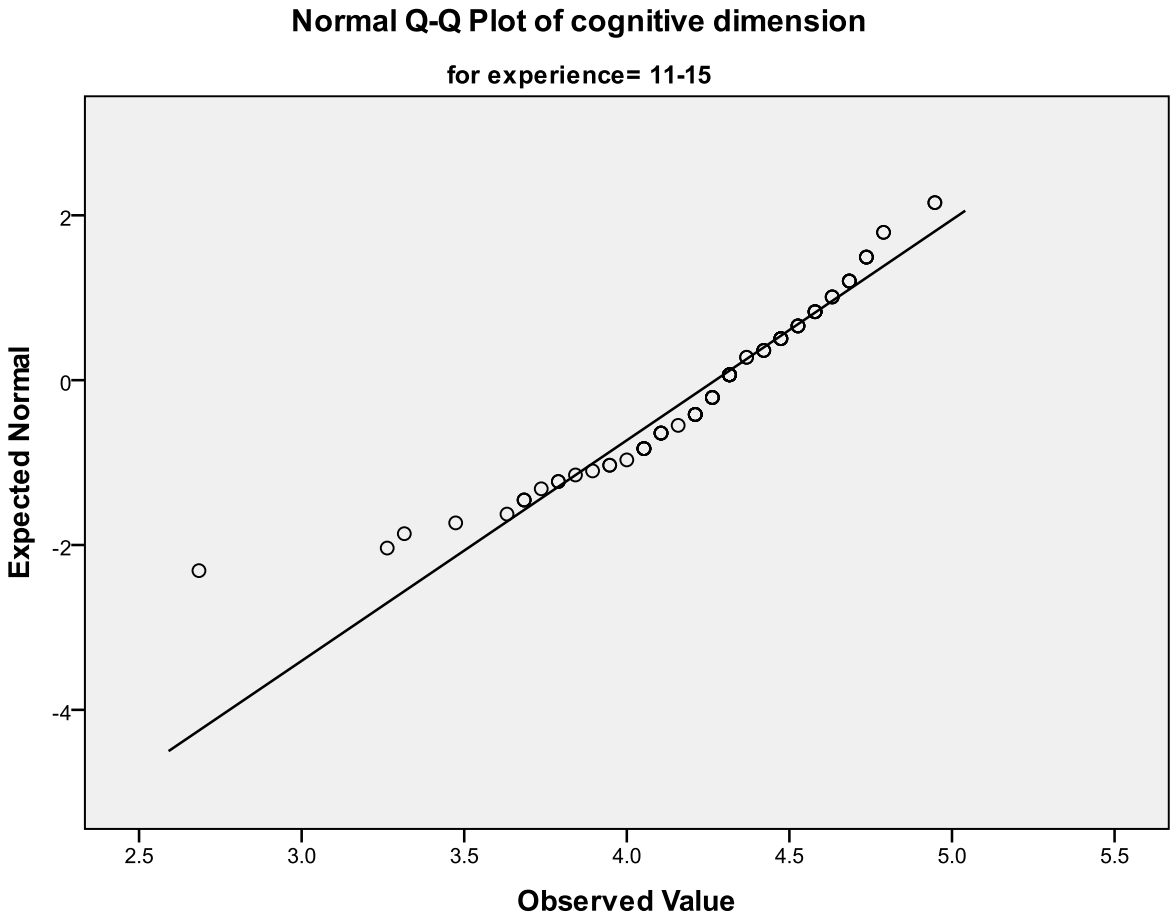
Normal Q-Q Plots

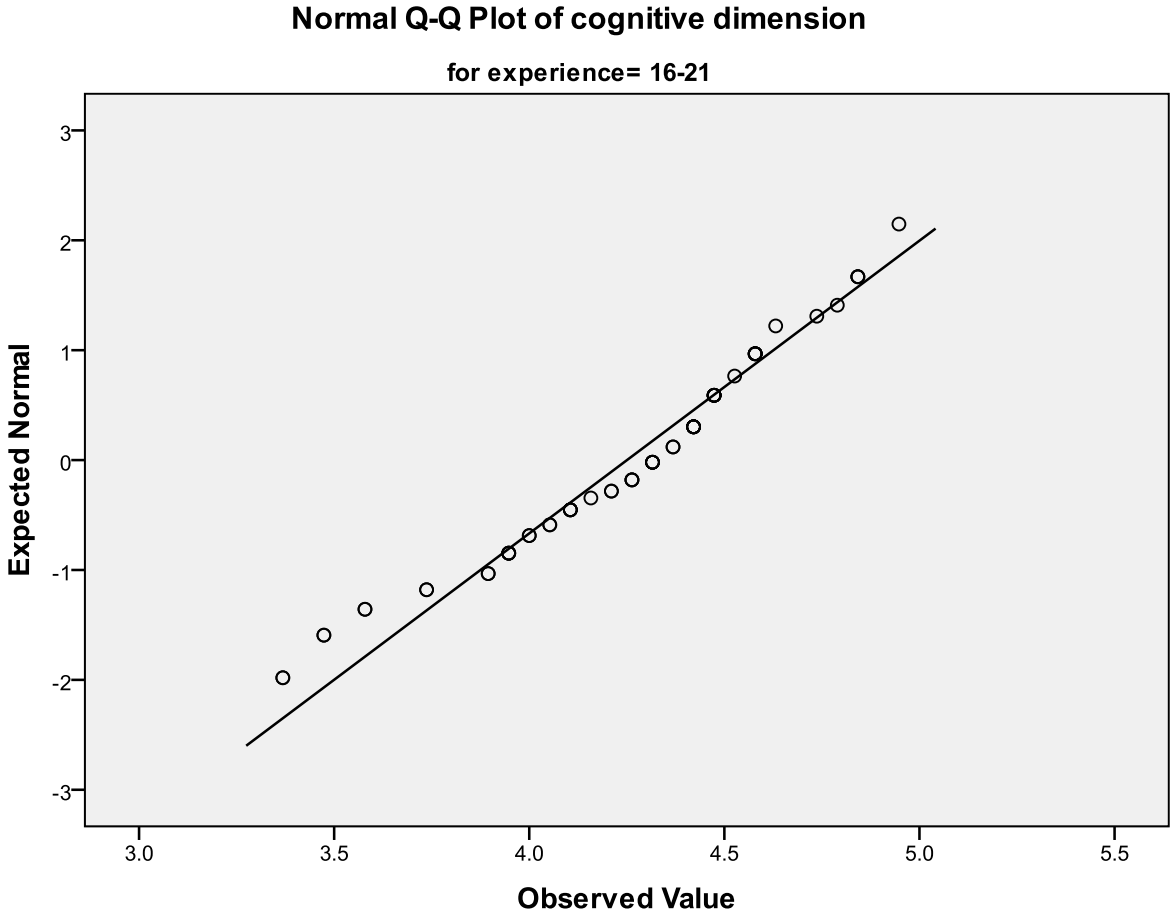


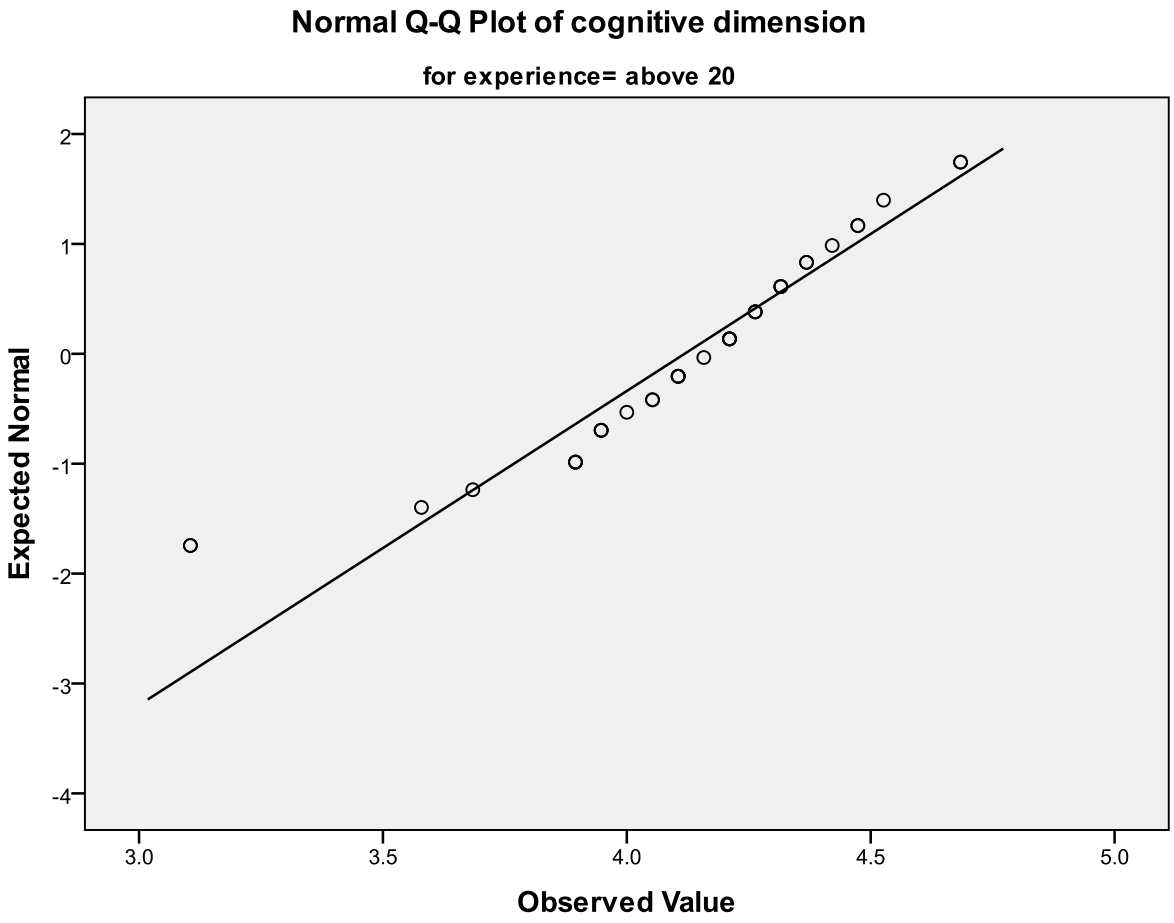

Normal Q-Q Plot of Mc
for experience= 6-10
Expected Normal
2
0
-2
-4
3.0
3.5
4.0
4.5
5.0
Observed Value


Normal Q-Q Plot of Mc
for experience= 11-15
Expected Normal
2
0
-2
-4
2.5
3.0
3.5
4.0
4.5
5.0
5.5
Observed Value

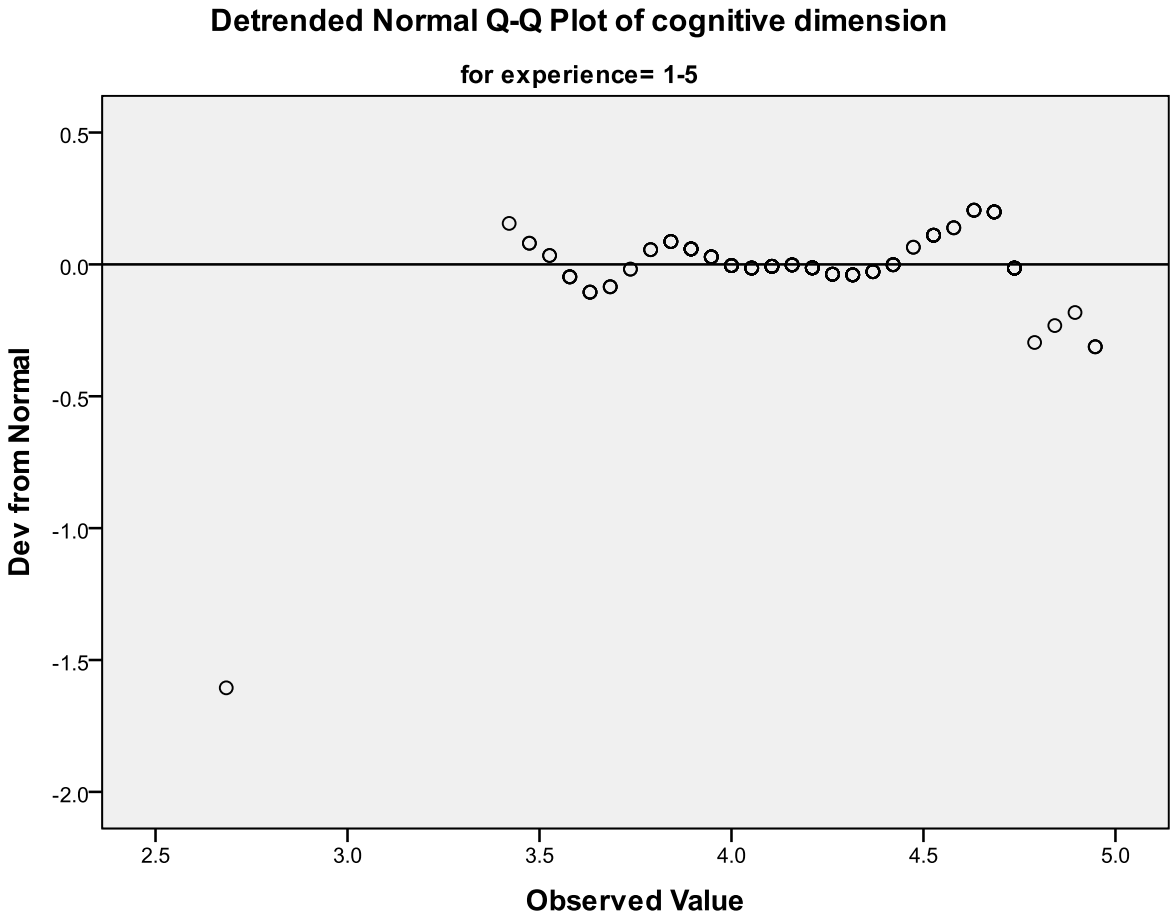

Normal Q-Q Plot of cognitive dimension
for experience= 6-10
Expected Normal
2
0
-2
-4
3.0
3.5
4.0
4.5
5.0
Observed Value

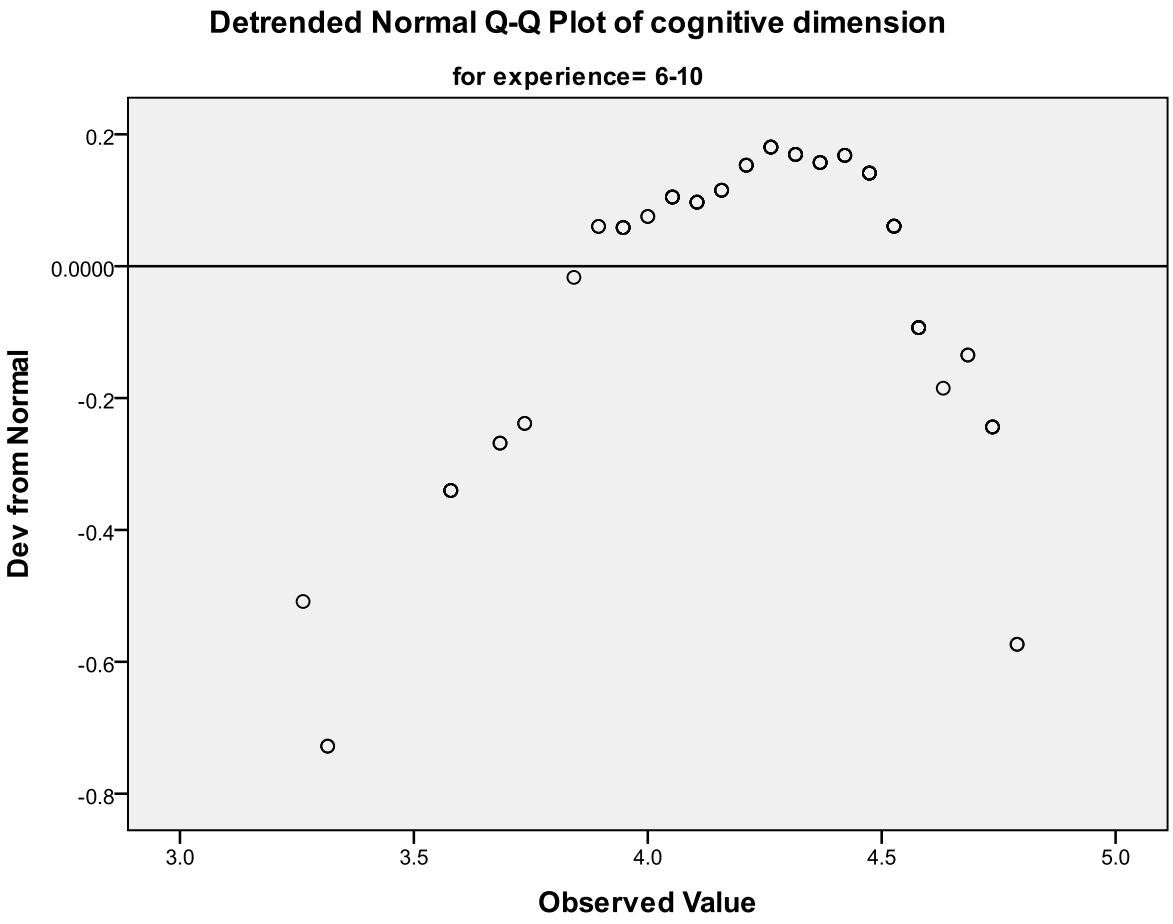

Normal Q-Q Plot of cognitive dimension
for experience= 11-15
Expected Normal
2
0
-2
-4
2.5
3.0
3.5
4.0
4.5
5.0
5.5
Observed Value

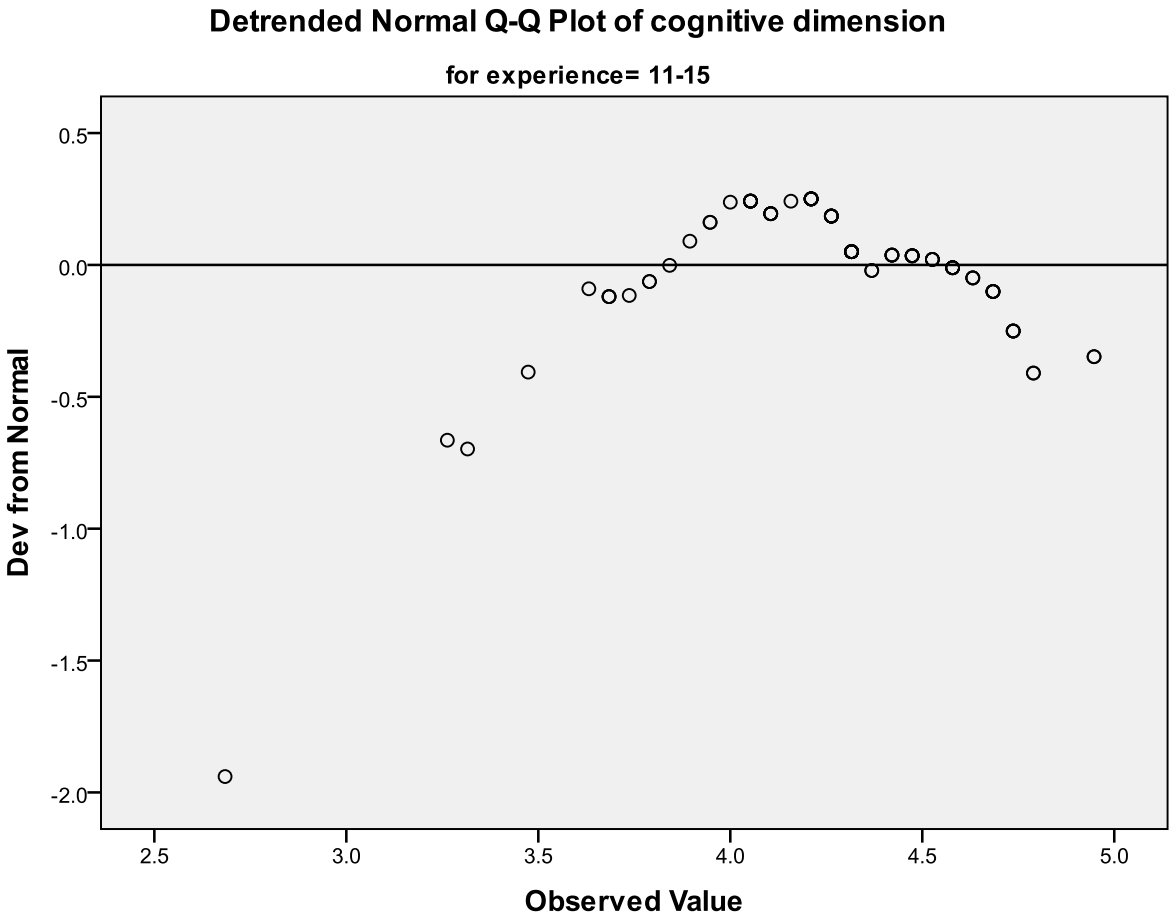

Normal Q-Q Plot of cognitive dimension
for experience= 16-21
Expected Normal
3
2
1
0
-1
-2
-3
3.0
3.5
4.0
4.5
5.0
5.5
Observed Value

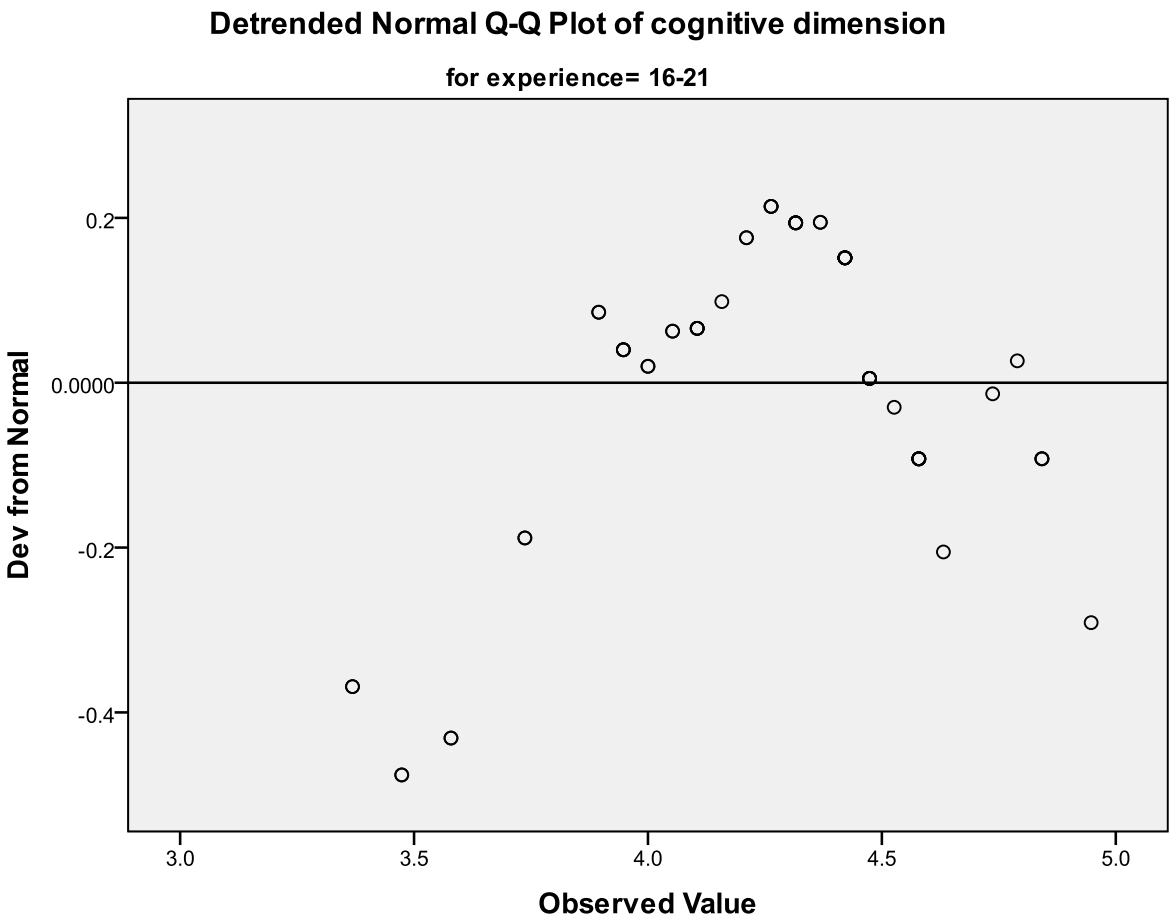

Normal Q-Q Plot of cognitive dimension
for experience= above 20
Expected Normal
2
1
0
-1
-2
-3
-4
3.0
3.5
4.0
4.5
5.0
Observed Value

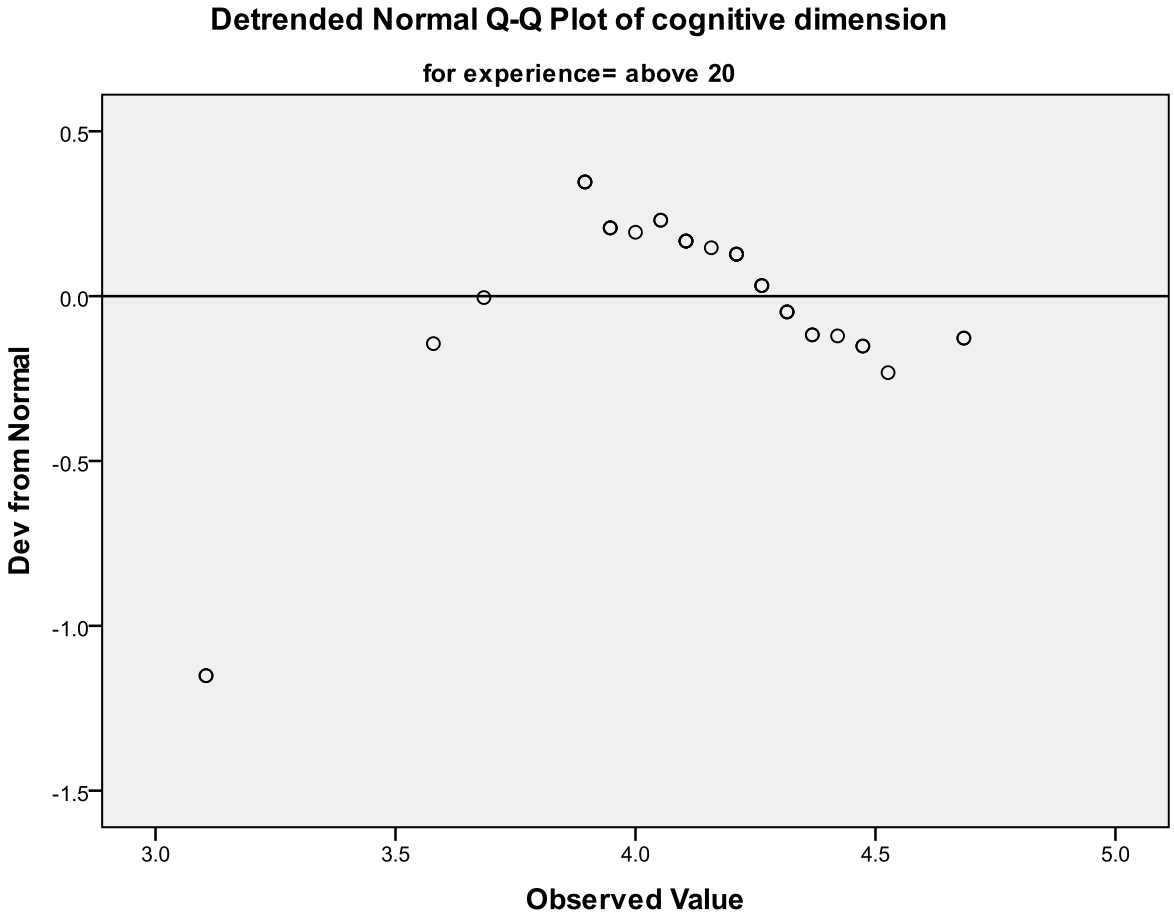
Detrended Normal Q-Q Plots

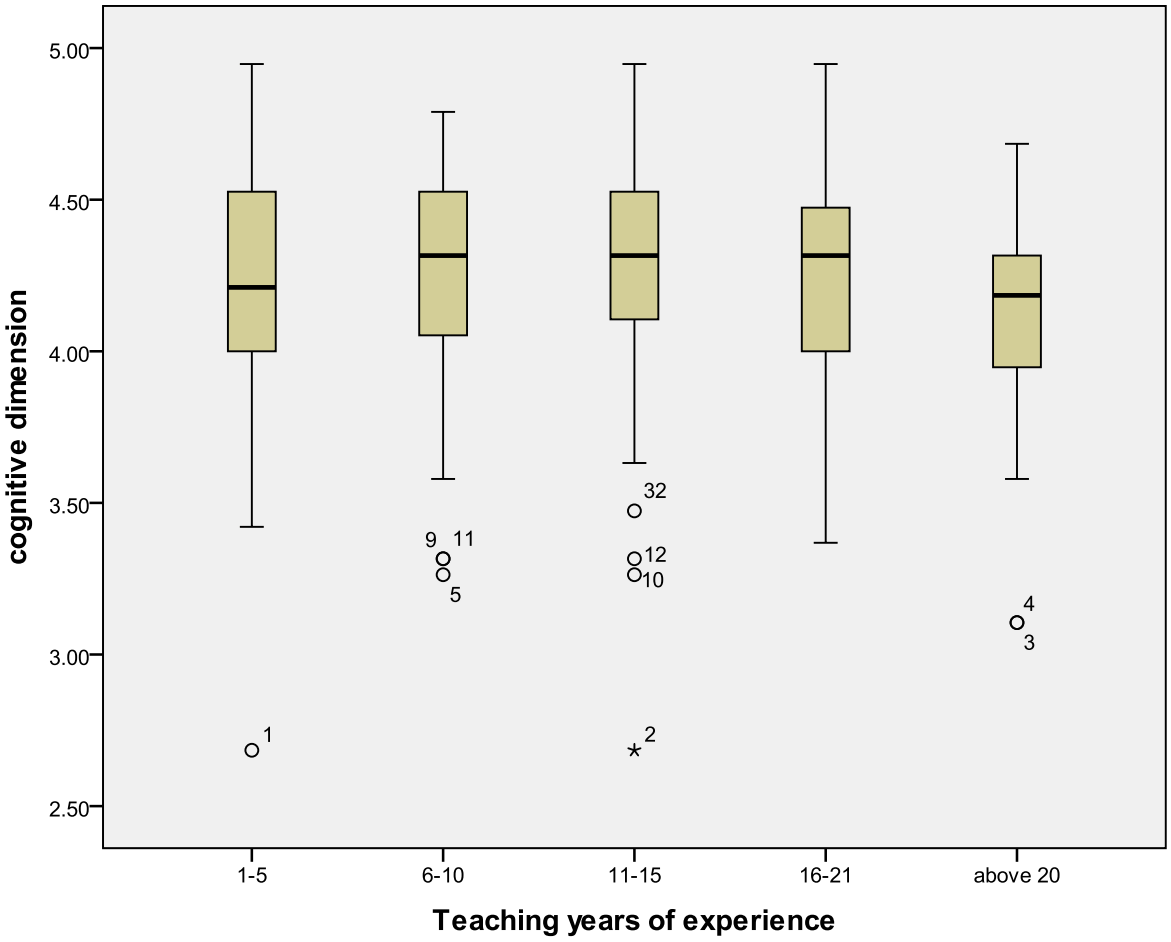



Detrended Normal Q-Q Plot of cognitive dimension
for experience= 6-10
Dev from Normal
0.2
0.0000
-0.2
-0.4
-0.6
-0.8
3.0
3.5
4.0
4.5
5.0
Observed Value


Detrended Normal Q-Q Plot of cognitive dimension
for experience= 11-15
Dev from Normal
0.5
0.0
-0.5
-1.0
-1.5
-2.0
2.5
3.0
3.5
4.0
4.5
5.0
Observed Value


Detrended Normal Q-Q Plot of cognitive dimension
for experience= 16-21
Dev from Normal
0.2
0.0000
-0.2
-0.4
3.0
3.5
4.0
4.5
5.0
Observed Value


Detrended Normal Q-Q Plot of cognitive dimension
for experience= above 20
Dev from Normal
0.5
0.0
-0.5
-1.0
-1.5
3.0
3.5
4.0
4.5
5.0
Observed Value


5.00
4.50
4.00
3.50
3.00
2.50
cognitive dimension
9
11
5
32
12
10
4
3
1
2
1-5
6-10
11-15
16-21
above 20
Teaching years of experience

Appendix (VII):

The Ethical Approval from the University of Exeter

STUDENT HIGHER-LEVEL RESEARCH

UNIVERSITY OF EXETER

Graduate School of Education

Certificate of ethical research approval

STUDENT RESEARCH/FIELDWORK/CASEWORK AND DISSERTATION/THESIS
You will need to complete this certificate when you undertake a piece of higher-level research (e.g. Masters, PhD, EdD level).

To activate this certificate you need to first sign it yourself, and then have it signed by your supervisor and finally by the Chair of the School's Ethics Committee.

For further information on ethical educational research access the guidelines on the BERA web site: http://www.bera.ac.uk/publications/guidelines/ and view the School's statement on the GSE student access on-line documents.

READ THIS FORM CAREFULLY AND THEN COMPLETE IT ON YOUR COMPUTER (the form will expand to contain the text you enter). **DO NOT COMPLETE BY HAND**

Your name: Dalal Alradaan

Your student no: 570026789

Return address for this certificate:

Degree/Programme of Study: 4 years PhD

Project Supervisor(s): Dr. Hazel Lawson and Professor Brahm Norwich

Your email address: dalalpy@hotmail.com

Tel: 07510301018

I hereby certify that I will abide by the details given overleaf and that I undertake in my dissertation / thesis (delete whichever is inappropriate) **to respect the dignity and privacy of those participating in this research.**

I confirm that if my research should change radically, I will complete a further form.

Signed: Dalal **date:** 13/12/2010

Dalal ALRadaan

NB *For Masters dissertations, which are marked blind, this first page must* ***not be included*** *in your work. It can be kept for your records.*

Chair of the School's Ethics Committee
updated: July 2010

Appendix (VIII): Informed Consent Form

Title of the study: 'Middle school teachers' attitudes and perceptions about their role in promoting pupils' mental health in the State of Kuwait'

1. Purpose of the study

The purpose of this study is to explore teachers' attitudes towards their role as promoters of pupils' mental health, their perspectives about barriers to implementing the promoting process and changes required to put promoting pupils' mental health in practice. Generally and most importantly, the study outlines a vision to attain the ambition of applying a mental health curriculum in the middle schools of Kuwait.

2. Procedures to be followed

Your involvement in this research will include completing a questionnaire, which will take no more than 10 minutes of your time. There is the potential for you to be involved in an interview should you wish. Interviews are expected not to exceed 40 minutes in duration. Interviews will be recorded, and thereafter stored securely.

3. Discomforts and Risks:

Involvement in this study comprises no risks, although it should be noted that some questions posed may be considered personal, and it is possible that some interviewees would prefer not to answer them. While stressing the value of honest and fulsome responses, the interviewer wishes to emphasise that you are entirely free to choose not to answer any uncomfortable questions.

4. Benefits:

- **a.** You may develop a deeper insight into yourself and your views.
- **b.** You may become more aware of the attitudes and beliefs you hold that may impact on your instructional practices.
- **c.** The research results may be adopted to deliver a skills training programme for teachers, geared towards facilitating the effective promotion of mental health amongst students.

5. Statement of Confidentiality:

The researcher is the only individual who will know your identity. Should the study undergo publication, no personal data able to identify you will be detailed.

6. Your Right to Ask Questions:

At any point in the process you have the right to questions relating to the study, either through direct contact with the researcher or otherwise through telephone or email. My phone no is: 99744487. My e-mail is: dafa201@ex.ac.uk.

7. Compensation:

No compensation is offered for your involvement in this research process.

8. Voluntary participation:

There is no obligation for you to participate in this research; your involvement is voluntary. Accordingly, you may choose to end your involvement at any stage simply by advising the investigator of your intention to do so. Moreover, there is no obligation to answer any questions you do not wish to.

9. Data ownership:

The data you provide is owned by you personally and nobody else, and so you have the right to request access or details relating to any such information and copies thereof. If such a request is not made, the data will be destroyed following the completion of the study. Moreover, during the conducting of the research, the investigator will provide you with draft transcripts, thus providing you with the opportunity to correct any factual inaccuracies or to otherwise suggest changes be made to comments or understanding, or to otherwise provide alternative statements.

Should you consent to participating in this study and to all that has been outlined above, please show your agreement by signing your name below. A copy of this consent form will be provided, which you may then keep for your own records.

Thank you for giving me your time.

Participant Signature *Researcher's Signature*

Date *Date*

Appendix (IX): Sample of analysing and coding the emerged themes from interviews

Sample (1) of Interview Script

I started the interviews by explaining the purpose of my research and developing trust relationships with the participants. Then, I asked permission to audio tape the interviews, to use the obtained data for research purposes. The interviewed participants were given assurances about the confidentiality and the privacy of the data.

-Researcher: If I say 'mental health', what do you understand by this term?

-Interviewee S/S: To have good mental health is to be happy, not bored with your life. It entails focusing on your life and your work, and doing your best to achieve your goals.

-Researcher: So you think that the concept of mental health is associated with achieving life goals; could achievement lead people to be mentally healthy?

-Interviewee S/S: Yes, to some extent, because once a person has achieved at least some of his goals in life, he will feel satisfied, happy and relieved, and will be encouraged to do his best to face life's pressures and uphold his responsibilities in life.

-Researcher: Are there any other meaning, in your opinion?

-Interviewee S/S: Personally, I think that mental health is one's ability to distinguish between right and wrong. It is what leads a person to develop himself in spite of pressures around him. It has the meaning of creating a balance.

-Researcher: What comes to mind if I say 'mental illness'?

-Interviewee S/S: Mental illness is something that prevents a person from living normally within his family, work and society.

-Researcher: I see what you mean. What else?

-Interviewee S/S: Mental illness is to feel lacking in energy and experiencing extreme tiredness with no ability to overcome your stresses. It is like functioning unusually. sometimes stupidly and crazily.

-Researcher: So, you think that mental illness is linked to these feelings?

-Interviewee S/S: Sometimes, a mentally ill person can lose his desire to live, and attempt suicide. I've heard lots of stories about people who killed themselves because they were

experiencing mental health disorders - especially famous people. Once they became old and felt that people were no longer interested in watching their work, they felt sad and lonely.

-Researcher: I see. What else?

-Interviewee S/S: People who experience mental health problems might be hospitalised. It is not a simple matter; it is something wrong with one's mind. If we lose our minds, how can we live normally in this stressful life?

-Researcher: Do you think that people who experience mental health problems can overcome them?

-Interviewee S/S: Yes, if their mental problem is not serious. I know one person who was diagnosed with depression, but he still functioning normally in his life. If these people were supported and provided with sympathy and help early, I think that they might be able to cope effectively, because their problems are temporary and might be treated.

-Researcher: Does this require them to have some kind of particular ability?

-Interviewee S/S: This depends on the extent of their awareness, and what skills they have. For example, if they are aware of the importance of seeking advice and support from specialists, they will be definitely able to cope with their problems. What they need is only to understand, accept and trust themselves and ask for help and talk about their problems.

-Researcher: So, who is the "mentally healthy person" in your opinion?

-Interviewee S/S: In my opinion, we can say that a person is mentally healthy when we feel that he is happy and has no problems. A mentally healthy person is one who can adjust to life's stresses, have the ability adapt to changes rather than just giving up, letting their problems become worse.

-Researcher: What do you think has led you and others to form these opinions about mental illness?

-Interviewee S/S: I think it is the impact of the media. The way that the media presents mental health issues negatively gives people incorrect assumptions about mental health issues. The image of mentally ill people represents danger, crime and violence.

-Researcher: In your opinion, how does the media represents mental health issues?

-Interviewee S/S: In fact, the media feeds these images of the mentally ill. The media represent these people in an awful way that nonetheless convinces people to believe it. Maybe these are realistic images, maybe not. However, it is scary. Mental health issues bring to my mind those crazy, dangerous people with messed-up hair, smelling bad, having an ugly appearance, being dressed inappropriately and homeless. I hope that I do not face anything like this in my class.

-Researcher: Does media has an impact on public understanding of mental health issues?

-Interviewee S/S: Yes. I believe that the media has an impact on forming public awareness of mental health issues, and with all of the inappropriate ways that the media presents images of mentally ill people, you can imagine how people conceptualise mental health issues, and consequently deal with mentally ill people.

-Researcher: From your point of view, what other factors could affect people's understanding of mental health issues?

-Interviewee S/S: In a conventional society like Kuwait, I think that there are some common cultural beliefs or religious beliefs which might affect the way that people understand mental health issues.

-Researcher: Would you please give examples of some of these beliefs?

-Interviewee S/S: These beliefs are linked to Arabic and Islamic culture. For example, people in the past, and even now, have considered mental health problems to be the result of the 'evil eye' or 'touch of jinn', and have held that a traditional healer is able to drive the 'evil eye' away. Many people here in Kuwait believe that experiencing mental health problems is a test from God, given to certain people to understand their level of belief in God. If their children have mental health problems, this means that God is testing them through their children. They think that God, 'Allah', is testing people's level of religiosity, patience and confidence in Allah; those who succeed in this test will get a very great reward in the hereafter. As a result, people need to face their problems without complaining, increase their prayers and strengthen their deep relationship with Allah, as this is the only way to heal their problems. I believe that people are still affected by these cultural and religious beliefs in dealing with children and their mental health problems.

-Researcher: To what extent do you think that these beliefs could affect parents?

-Interview S/S: I think that these some parents might seek help from religious and traditional healers instead of seeking help from professionals. Then, parents also might continue treating their children through those healers in spite of the fact that many of them believe that their children need to go to mental health specialists. One explanation could be the healers' desire to secure parents' endowments, as they convince parents that their child has a 'jinn touch'or 'evil eye', and that they should keep coming to them or their child may die. What normally happens is that these religious healers provide some blessed water and recite from the holy book, the Qur'an. Traditional healers provide incense and medicines based on herbs to treat people with mental health problem. I still remember a story from one of my cousins, whose daughter was suffering from a mental health problem. The teachers informed her father that his daughter was not participating in the class activities, not interacting with her peers and teachers, and spent most of her time alone in the school. Thereafter, her father prevented her from going to school, and hid her in the house. He did not allow her to sit with us when we visited. Sometimes I could hear her hysterical screaming. He sought the help of some of the healers, and they told him that his daughter was a demoniac or had a 'touch of jinn'. The healer hit her and used his traditional tools to treat her. Her case got worse until she lost her appetite and ability to sleep. Then finally she died.

-Researcher: Do you think that if your cousin had had sufficient awareness that his daughter was experiencing mental health issues, he would have sought help from those religious and traditional healers?

-Interviewee S/S: I believe that if he was aware of the mental health issues, I think he would not have taken her to those healers, and he probably would have sought specialist advice. No one would have reason to make their children lose their lives.

-Researcher: What might cause pupils' mental health problems?

-Interviewee S/S: Some mental health problems emerge as inherited problems from their parents or any one who had mental illnesses in their family. However, some circumstances related to family feuds, divorce, drug and alcohol addiction among parents, could result in pupils experiencing some mental health problems.

-Researcher: Have you ever recognised mental health problems among your pupils in the class?

-Interviewee S/S: Yes. I have. I have recognized many such instances.

-Researcher: How do you know that they have mental health problems?

-Interviewee S/S: The task might seem to be easy, but in fact, teachers might find it difficult to recognise these sorts of problems. Sometimes, teachers judge low achievement by pupils, not paying attention in lessons, disturbing the class, or any alteration in a pupil's behaviour, such as being aggressive in the class or in the playground, as evidence of mental health problems. And they could be wrong.

-Researcher: If you recognise any mental health problem, do you think that you are able to deal with it?

-Interviewee S/S: Even if we recognise any mental health problem, we are not equipped with sufficient knowledge or skills to deal with mental health issues among pupils.

-Researcher: What does 'promoting pupils' mental health' mean to you?

-Interviewee S/S: Personally, I think that promoting pupils' mental health is supporting pupils not only when they need support in difficult times, but also before they experience problems. It is building a strong relationship with teachers; it is important in times when they feel that they need help, that they can receive it from their teachers.

-Researcher: Is this type of relationship important?

-Interviewee S/S: Yes. This relationship can give teachers the chance to be closer to their pupils, understand them more and recognise early on any changes that may emerge in their mental health. This relationship could have a positive impact on teachers' satisfaction with their class' academic performance, and consequently mean improvements in the teachers' evaluation reports.

-Researcher: What else do you understand by the phrase 'promoting pupils' mental health'?

-Interviewee S/S: It means to provide them with support, knowledge and the necessary skills they might need to cope with stressful situations.

-Researcher: In your opinion, do you think that you are well equipped to provide this support for them?

-Interviewee S/S: Not at all. I think that we need to be well educated in the area of pupils' mental health issues and trained well to deal with pupils' mental health needs and problems.

This training and education needs to be within school plans and policy. Unfortunately there is no policy set within the educational system in Kuwait that would oblige them to take up this responsibility.

-Researcher: So, you think that setting a policy would be beneficial?

-Interviewee S/S: Establishing policies supporting pupils' mental health promotion should be viewed as obligatory, and so there is the need for the Ministry of Education to establish policy and legislation to ensure promotion and awareness. Even if we have limited support, poor resources, and low salaries, I think that our responsibility is a sense of humanity.

-Researcher: Is promoting pupils' mental health a part of your job?

-Interviewee S/S: Yes. Although I believe that treating pupils' mental health issues is a specialist activity that a mental health professional should deal with, I think that teachers have a critical role in this responsibility. This responsibility starts after they accept a job in the field, and swear at their graduation to do their best to support their pupils, both emotionally and academically.

-Researcher: So, whose responsibility is it?

-Interviewee S/S: Perhaps many teachers believe that promoting pupils' mental health is not their responsibility..... Maybe they are right. Personally, I think that it should rest with mental health counsellors in schools. However, I also believe that teachers' significant position requires them to participate in this responsibility, since pupils' mental health is crucial and affects academic achievement.

-Researcher: In your view, what are the issues that could prevent teachers from taking on this responsibility?

-Interviewee S/S: Training and knowledge are critical when you ask teachers to participate in this responsibility. Also, the degree of the mental health problems is important here. Teachers might not be able to support these pupils in their classes. For example, if a pupil's problems are less serious and do not threaten the teacher's safety, they might be able to support them.

-Researcher: Are there any other issues?

-Interviewee S/S: The first impression I get if you say to me 'promoting pupils' mental health' is of additional roles being added to our instructional routine as teachers - roles such

as preparing teaching plans and tools, checking attendance, controlling pupils in the morning queue, etc. We will be asked to do something extra, which could lead to feelings of not being able to provide as much time for supporting pupils' academic achievement. How can I pay attention to such mental health issues among my pupils if at the same time I am required to do so many other tasks? One of them is teaching a large number of classes, besides taking part in administrative affairs. School administrators need to reduce these pressures that come from massive teaching demands.

-Researcher: What else?

-Interviewee S/S: I think that teachers' levels of education are important here. Better educated teachers are more knowledgeable and aware about pupils' mental health issues, because when they study more, they will be more open-minded and will have read in different areas.

-Researcher: If you recognise a pupil with a mental health problem, what role and responsibility would you as a teacher have in responding to his/her problem?

-Interviewee S/S: As a teacher, if I recognise a pupil with mental health problems, I will try to open a dialogue with this pupil and talk with him about his problem. A teacher needs to be careful in his approach, and ask him indirectly about his problem, in a way that does not cause harm or embarrassment for this pupil. The teacher should attempt to form a closer relationship with him. However, this closeness should not be sudden matter. Teachers need to build strong relationships with their pupils from the beginning of the year, so that pupils can feel comfortable, encouraged and confident when they talk to their teachers about their problems. Then, the role of the counsellors comes into play; if I cannot help the pupil. I can ask for help from counsellors in school, by transferring the pupil to them.

-Researcher: What about the media?

-Interviewee S/S: I assume that teachers are affected by the way that the media present people with mental health issues. How teachers feel about pupils' mental health issues correlates with what they believe. Personally, what I normally know about mentally disturbed people is that they can be violent and dangerous. Sometimes, I feel scared when I hear that some pupil has shown signs of these mental difficulties in other teachers' classes. I don't like to talk about it. I hope I will not face it in my class. Before you ask teachers to participate in the responsibility of promoting pupils' mental health, the media need to

change their representation of these mental health issues and act to raise public awareness of them.

-Researcher: In your opinion, what is the effect of common socio-cultural and religious beliefs on teachers' attitudes towards pupils' mental health issues today?

-Interviewee S/S: I think that these beliefs lead pupils' parents to seek help from religious and traditional healers, which may result in dealing wrongly with their children's mental problems, and these problems getting worse. Some parents also hide their children's mental problems to avoid social stigma. In addition, parents might fear transferring their children to the professionals in the psychiatric hospital, since everything will be documented, and their children will be labelled as having mental problems. In such cases, how can teachers support those pupils, seeing as they have no idea about their mental health problems? Thus, these beliefs decrease the level of communication between parents and teachers.

-Researcher: What else?

-Interviewee S/S: I believe that families have a critical role in promoting their children's mental health. Family is an important information resource for teachers regarding a child's mental health.

-Researcher: What responsibility does the family have in this domain?

-Interviewee S/S: We need to consider the family's role before the school's role; then we can think about co-operation between school and home.

-Researchers: What else?

-Interviewee S/S: I believe that families have a critical role in promoting their children's mental health. Family is an important information resource for teachers... It depends on how much families pay attention to their children; supporting them, devoting time to discussing their concerns will bring up mentally healthy pupils who are able to deal with their stresses, or at least talk about them and ask for help. Other families consider their children's mental health issues as private matters and teachers are not thought to be qualified or allowed to deal with them. So, teachers will refuse to deal with these children's mental health problems. As a result, teachers will feel more restricted in addressing pupils' mental health issues.

-Researcher: In your opinion, does the process of promoting pupils' mental health demand additional requirements for it to be implemented in practice?

-Interviewee S/S: Training first. Unfortunately, there is a lack of information sources, like booklets, brochures or books for teachers to acquire more information related to pupils' mental health. I know that we have counsellors; however, their role is not effective in schools. We noticed that the only thing they usually do is to refer those pupils to specialists if the situation gets worse. I think that schools are not adequately equipped yet. Sometimes, if we recognise that any pupil has mental health problems, we feel that we need to know more about his problem, but sources are poor or sometimes not available at all.

-Researcher: What is your view of how is training should be?

-Interviewee S/S: Once we have the appropriate training and knowledge courses relevant to what can help us to be able to recognise mental health problems among our pupils in the classroom and support them, we will be more self-confident and able to participate in the promoting process. If they are serious about their training and educational courses, they should plan and organize them carefully, and they should be continuous. I think that promoting pupils' mental health should be a comprehensive and gradual process. I mean by comprehensive that it should involve of all the members of schools, parents and community in this business. We need a united work. And gradual means that once the process has been evaluated and proved to be successful, we can move towards applying these promoting processes in all schools. I think that training needs to be approached in two ways: mental health issues in general, and training specialised in a certain area of mental health. You do not want teachers to feel bored, and that these issues are hard, which could lead them to feel uncomfortable towards these issues.

-Researcher: Are there any other requirements you can think of?

-Interviewee S/S: It is not easy to ask people to change suddenly. You have to convince them that there are worthwhile reasons for change. Administrators in schools and inspectors need to be convinced of the importance of these process and their demands so that they can assist teachers to overcome any difficulties they will face in achieving this goal. They need to be more flexible with teachers, especially with those who have pupils' with mental health concerns in their classes.

-Researcher: In what way does promoting pupils' mental health benefit pupils?

-Interviewee S/S: Promoting pupils' mental health could benefit the whole society. If we have mentally healthy pupils, this will impact on their families and their future. It also could reduce the emergence of mental health problems. Pupils who find their teachers and school staff caring about them, showing empathy towards them, supporting them, listening to them and respecting their feelings and concerns, will be more self-confident to face stressors in life.

-Researcher: Would you please explain more about these benefits?

-Interviewee S/S: This in turn might be reflected in their feelings towards others, so that they will show empathy towards their peers who are experiencing mental health problems.

-Researcher: What else?

-Interviewee S/S: If they feel mentally healthy, they will be functioning healthily and able to achieve better academically.

-Researcher: Are there any negative outcomes from promoting pupils' mental health?

-Interviewee S/S: When you ask teachers to recognize pupils' mental health problems, you are asking them to take time from their original teaching time, which is required to cover the curriculum. This will make the task hard for teachers.

-Researchers: Do you believe that pupils have a right to be mentally healthy?

-Interviewee S/S: I think that being mentally healthy is the right of all people around the world. Just like any adult in society, I think that young people have the right to live normally. Even if they have mental health problems, they have the right to live without any stigma. I think that this is their right, and accords with the demands of our religion, which emphasizes that all human beings are equal.

-Researcher: How does dealing with and recognising pupils with mental health problems make you feel?

-Interviewee S/S: It leads me to feel uncomfortable and unable to deal with such pupils.

-Researcher: From a practical point of view, are you ready to accept any changes to participate in promoting pupils' mental health process?

-Interviewee S/S: What do you mean by changes?

-Researcher: I mean if you are asked to participate in educational courses or training workshops regarding pupils' mental health issues, for example.

-Interviewee S/S: I am happy to accept my responsibility regarding promoting pupils' mental health, but I do need support from the school's head teacher and administrators. Also, I need information sources regarding pupils' mental health issues. These materials should not be limited to written information sources. There should be practical information sources provided for teachers, for example, training programmes. The area of pupils' mental health issues is wide, and we need to know more about it before any promoting processes are undertaken. Knowledge will assist us to understand pupils' mental health issues more. Also, we will feel more confidence in discussing and sharing their concerns and asking for advice if they recognize our knowledge in this area.

-Researcher: In your view, to what extent do you think that delivering a mental health curriculum to pupils would be acceptable?

-Interviewee S/S: I'm ready to deliver this sort of curriculum. However, the curriculum in our schools is so extensive and we have to cover it within a certain time. I think it will be too difficult to specify time in which to teach such a curriculum. I think that the administration of school will refuse to apply this curriculum. They will only understand it as an extra work and this might be the point of view of all teachers. You need to ask teachers whether they agree, and how they recommend delivering this curriculum, because they are the people who are going to do the teaching. In my view, teachers will not accept any extra curriculum, or if they do, the outcomes will not be accomplished, since they will teach the curriculum without any interest in it.

-Researcher: What should be the nature of this mental health curriculum?

-Interviewee S/S: I suggest that this type of curriculum be included in the general topics of other school subjects. I think that pupils need a curriculum that can provide them with information they need to raise their awareness of mental health issues they might face and how to overcome their stresses, and handle their job stresses.

-Researcher: What are the appropriate ways to increase teachers' knowledge and awareness about pupils' mental health issues?

-Interviewee S/S: Many teachers are able to recognise that some kinds of misbehaviour could be a sign of serious mental health problems, but equally could not. However, teachers

are not yet equipped with all the skills and knowledge necessary for all the demands such a task. One should start practically, by focusing on the main staff members who have the most contact with pupils – teachers - and provide ongoing support once they have been equipped with the necessary knowledge and skills to promote pupils' mental health in their classroom, first.

-Researcher: Are there any other barriers?

-Interviewee S/S: How teachers feel about pupils' mental health issues is correlated with what they believe. Personally, what I normally know about mentally disturbed people is that they can be violent and dangerous. Sometimes, I feel scared when I hear that some pupil has shown signs of these mental difficulties in other teachers' classes.

-Researcher: Are there any other barriers you can think of?

-Interviewee S/S: In exams, only one format is used, and this can only demonstrate the level of memorisation of the text. Thus, we need to think about alternative forms of evaluation and assessment, and the examination system, considering other areas of pupils' lives when evaluating their academic achievement.

-Researcher: In what ways do you think that school curricula could be a barrier to the implementation of promoting pupils' mental health?

-Interviewee S/S: The curricula are full of useless information. They need to be updated and focus on the important themes required for effective learning. The curriculum should be condensed and freed from unnecessary information, and made less boring. It should include flexible and supportive activities. When you ask teachers to recognize pupils' mental health problems, you are asking them to take time from their original teaching time, which is required to cover the curriculum.

-Researcher: Would you please explain these extra roles more?

-Interviewee S/S: If I am to think about promoting the mental health of pupils, I immediately think I will need to take on additional roles to the usual teaching routine. We will be required to carry out extra activities and tasks, which is likely to result in a lack of time being directed towards pupils' academic attainment. How can mental health issues be afforded attention when there are other tasks to be carried out?

-Researcher: In your view, how far could the idea of teachers having a role in promoting pupils' mental health be acceptable in Kuwaiti schools today?

-Interviewee S/S: Personally, I believe in the important role of teachers in promoting pupils' mental health. I think that this idea will be acceptable among teachers in Kuwaiti schools, if all barriers are reduced and appropriate facilities provided.

-Researcher: Do schools have adequate finance to put this process into practice?

-Interviewee S/S: Head teachers and administrators of schools usually receive an annual budget for their schools from the Ministry of Education in Kuwait and they always report that this budget barely satisfies the financial needs of schools. Personally, I don't think that they will spend a major part of this budget on mental health issues. Their excuse will be that mental health counsellors are already appointed in schools. I think that we need more funding to be able to provide what teachers need to take part in this promoting task. Kuwait is a rich country and it should be a priority to finance projects and school approaches related to promoting pupils' mental health.

-Researcher: In your opinion, are there any changes that should be made to put the promotion of pupils' mental health into practice in Kuwait's schools?

-Interviewee S/S: If we want teachers to feel more comfortable in dealing with pupils' mental health issues, society's view of mental health should be changed. I think that the media has a significant role in this. The media can raise awareness among teachers, parents and even among members of the community of the role of schools, in how school could affect pupils' mental health and maybe teachers' role in this more specifically. The process should be practical more than about giving speeches.

-Researcher: Would you like to see any other changes?

-Interviewee S/S: Teachers need to be educated and equipped with the appropriate skills to deal with pupils' mental health issues, but not only teachers. A whole range of teamwork is needed, and each member of school staff should participate. Communication with parents is important to achieve this goal. There is the need to change policymakers' thoughts and beliefs if the right approach is to be selected and adopted, as such individuals being able to make decisions concerning teaching staff, schools and pupils. Memorisation seems to be prioritised within the educational system, meaning individuals are forced to neglect their interests and instead follow labour choices. Pupils' mental health policies should be

implemented as early as possible, such as from nursery age, as doing so at a stage of advanced education may be problematic.

Sample (2) - Interview Script

-Researcher: If I say 'mental health', what do you understand by this term?

-Interviewee H/M: Personally, I think that mental health means not suffering from any kind of mental disorder. It means to behave appropriately and normally.

-Researcher: What else?

-Interviewee H/M: As you know, people experiencing mental health issues are unable to live normally or function well in their life.

-Researcher: What comes to your mind if I say 'mental illness'?

-Interviewee H/M: It is experiencing mental issues that require asking for psychiatric help and medicine. Briefly, mental illness is being sad and lost. It is an illness which could lead others to lose control on their behaviour and they might behave unconsciously and maybe aggressively. Mental illness is a serious problem and it might not be treatable.

-Researcher: Do you think that people who experience mental health problems can overcome these problems?

-Interviewee H/M: Yes, Sometimes mental health problems are less serious and if a person can evaluate the situation and think more logically, they might recover from mental health problems, especially if they get support and guidance.

-Researcher: So, who is the 'mentally healthy person' in your opinion?

-Interviewee H/M: I think that the mentally healthy person is one who is not suffering from any mental health issues. A mentally healthy person needs to be completely mentally healthy and be able to live happily and normally.

-Researcher: What do you think has led you and others to form these opinions about mental illness?

-Interviewee H/M: The misconceptions and stereotypes they hold about mental health issues derived from the stories they heard from their family and cousins when they were children. These stereotypes could strength the stigma around mental health issues. As a result, if they experience any mental health issue, they will feel embarrassed to talk about it with anyone because they are scared of being labelled.

-Researcher: Who else has a role in affecting the public's assumptions and beliefs about mental health issues?

-Interviewee H/M: The Media. Many people feel scared of mentally ill people, they call then crazy and they avoid dealing with them. They see them behaving aggressively in movies and sometimes killing others. Personally and according to what we usually hear and see through media, I see that mentally ill people are scary people. The media have a vital effect. Nowadays, you can travel to any place in the world through computers and your TV remote control. People spend huge amount of time using computers, reading newspapers and watching TV. Surely what we perceive from different media streams has its impact on our lives.

-Researcher: From your point of view, what other factors could affect public understanding of mental health issues?

-Interview H/M: They believe that mental problems are the result of a lost soul and attraction to the devil. People can cope with these mental health problems through a deep relationship with their God and by seeking help from religious healers, which could give hope of relief through God, 'Allah'.

-Researcher: As a teacher, do you think that these beliefs affect parents?

-Interviewee H/M: Parents for example might be affected by these beliefs and take their children who have mental health problems to those healers. Then, they will not communicate with and inform their children's teachers, counsellors and social workers about their problems. Because parents are hiding them, children suffer even among family and cousins. Some parents could avoid seeking help from the school counsellor because they don't want their children to feel stigmatized and ashamed before their teachers and peers. They are scared of acquiring social stigma; they are concerned that others will know about their children's mental problems.

-Researcher: What else?

-Interviewee H/M: Yes I believe it will affect the partnership between parents, mental health counsellors and teachers. Teachers might need to be aware of any change in pupils' behaviour that may point to mental health problems. If there is no co-operation with teachers and professional in schools, those pupils will not get the chance to be treated early. Some parents believe that teachers should not be involved, because they don't have the right

or the experience to do so. Parents can be in contact with school regarding their children's problems, which could result in updating parents with any recognised signs of mental problems and help to maintain their mental health.

-Researcher: Have you ever recognised mental health problems among your pupils in the class?

-Interviewee H/M: Yes. I have recognised many of these mental health problems.

-Researcher: How do you know that they have mental health problems?

-Interviewee H/M: With almost no mental health background, we might sometimes explain some unusual behaviour among pupils as mental health problem and we could be wrong. For example, a shy pupil or a very active pupil might be labelled with mental health issues, rather than being supported, due to the real necessity for teachers to acquire skills and knowledge in the area of pupils' mental health.

-Researcher: So, if you recognise any mental health problem, do you think that you are able to deal with it?

-Interviewee H/M: No, I don't think I have sufficient skills to deal with these problems.

-Researcher: In your opinion, what causes pupils' mental health problems?

-Interviewee H/M: It could be the consequence of some bad environmental issues surrounding those pupils related to their family or friends. On other hand, the support of family, school and others could strengthen this person in the face of their stressors.

-Researcher: Can you explain more?

-Interviewee H/M: Let's talk about school. Sometimes school can be a good support for pupils when it shows care for pupils' concerns. Teachers could play a significant role here. They can in this case build a good relationship with their pupils and encourage them to talk about their academic as well as mental health issues.

-Researcher: What does 'promoting pupils' mental health' means to you?

-Interviewee H/M: It has the meaning of supporting pupils on all levels, academically and emotionally. School already provides mental health intervention for pupils with diagnosed

disorders, through counsellors. Counsellors follow up on those pupils. And we are supporting them academically.

-Researcher: To what extent do you think schools are resourced and ready for promoting pupils' mental health?

-Interviewee H/M: I think that schools need to set new policies and regulations for school staff regarding their role in promoting pupils' mental health and providing training courses for teachers, besides conducting intervention counselling programmes. I think that all members of school staff should work collaboratively. Schools need to support teachers to reach this goal, as they are doing the hardest job in this educational system - teaching.

-Researcher: As a teacher, what kind of support you are looking for in order to participate in this promoting task?

-Interviewee H/M: Teachers need to be supported morally and materially. If you want them to achieve the goal of promoting pupils' mental health, you need to provide them with rewards. The task could be hard because teachers have a lot of teaching demands, which could not leave a room for teachers to recognise pupils' mental health problems. Administrators and head teachers may be less informed about the daily practices of promoting pupils' mental health, and the processes that teachers need to follow in their classrooms. So they need to be involved in these processes. There should be a change in order to implement promoting pupils' mental health and we are looking to this change. However, this change is the responsibility of the Ministry of Education; we cannot make the change ourselves.

-Researcher: Do you think that promoting pupils' mental health is a part of your job and responsibility as a teacher?

-Interviewee H/M: It is important to keep in mind that the teacher's primary job is to teach, not to become a psychologist or a social worker as well. A teacher's job becomes more difficult if given the additional tasks the new education system demands, meeting the required standards that pupils need to achieve. Yes, it could be a part of my job and responsibility, yet it is not my job. I think that school counsellors and professional have the adequate skills and experience to do that better than us.

-Researcher: In your opinion, whose responsibility is it to promote pupils' mental health?

-Interviewee H/M: The government and social institutions are responsible for dealing with the mental health issues of pupils, not only schools or professional entities. Accordingly, there is the need to encourage the participation of local communities, businessmen, parents, etc.

-Researcher: In your view, what issues might discourage teachers from taking part in this responsibility?

-Interviewee H/M: Firstly and lastly, it is teachers' lack of training skills and knowledge in the area of pupils' mental health.

-Researcher: Are there any other issues, in your opinion?

-Interviewee H/M: Media needs to play a vital role in educating public about these issues in order to reduce public unawareness about mental health.

-Researcher: What else?

-Interviewee H/M: Teachers with long experience might be able to deal with pupils' mental health issues because they saw some cases through their teaching. Also, if teachers have an advanced education degree, they will be more educated about these issues. I think that old teachers might be more patient about promoting pupils' mental health; however, they might be too inactive to participate effectively. You know, they may have lost their passion, because they have become stressed by their teaching job.

-Researcher: If you recognise a pupil with a mental health problem, what role and responsibility would you as a teacher have in responding to his/her problem?

-Interviewee H/M: Personally, the first thing I would do is talk about it with the school counsellor. Then I will see if there is anything I can do to support this pupil. It is unfair to be asked to do others' work. In fact, I feel happy to partuicipate in this responsibility, but I feel anxious to do it.

-Researcher: From your point of view, are there any issues related to the social context in Kuwait that could impact on teachers' attitudes towards prompting pupils' mental health in schools?

-Interviewee H/M: Yes, the media has a crucial impact on how teachers will deal with pupils' mental health problems, as many teachers feel scared and not able to guarantee those pupils' reactions in different situations. Nevertheless, these beliefs might produce more sympathy and support from teachers of pupils. Teachers might avoid pupils with mental health problems because they are scared that an 'evil touch' will be transferred to them, as they believe. This may be reflected in the amount of support teachers will provide to pupils. Nevertheless, these beliefs might result in more sympathy and support from teachers of pupils.

-Researcher: In your opinion, does the process of promoting pupils' mental health have requirements for it to be implemented in practice?

-Interviewee H/M: By being reasonably knowledgeable and skilled in this area, it will be possible for teachers to understand their pupils' mental health issues. Also, it will be easy for teachers to assist their pupils confidently in reducing the effects of their mental problems on their academic progress.

-Researcher: In what way does promoting pupils' mental health benefit pupils?

-Interviewee H/M: It is possible that if peers recognise that teachers are paying particular attention to some pupils, they will label them as having mental health problems.

-Researcher: What else?

-Interviewee H/M: Although promoting pupils' mental health could contribute to pupils getting better support, it might lead teachers to be busier than they already are and affect the other children, especially the talented pupils; these gifted pupils may feel frustrated.

-Researchers: Tell me, do you believe in pupils' right to be mentally healthy?

-Interviewee H/M: I believe that all people are equal, so all young people are equal and have the right to be respected and valued. Their right to live mentally healthy is equal to their right to live physically healthy or the right to education.

-Researcher: What does promoting pupils' mental health and dealing with pupils' mental health issues make you feel?

-Interviewee H/M: Personally, I would like to participate in recognising pupils' mental health problems, however, I feel scared of these mental health issues. In addition, teachers

will spend extra time on this issue, which could lead them to feeling stressed and uncomfortable. Administrators and head teachers may be less informed about the daily practices of promoting pupils' mental health, and the processes that teachers need to follow in their classroom. So I feel as a teacher that I need to be involved in these training and education courses. We are ready to help our pupils. In the end, teachers will take on the whole responsibility, and will be blamed for anything that happens. In my opinion, if head teachers, administrators and inspectors are interested in this process, they will share the responsibility with teachers, which will result in teachers being interested and feeling more comfortable and happy about this process.

-Researcher: From a practical point of view, are you ready to accept any changes to participate in promoting pupils' mental health?

-Interviewee H/M: Yes, I will accept any changes regarding pupils' mental health because I believe that it is a part of our responsibility to participate in this process. A teacher's personality is critical, as not just any one can work as a teacher. However, we need to be supported in what we will do, in terms of recognising early signs of mental health problems, supporting pupils with mental health problems, overcoming stresses or even teaching a mental health curriculum. We need the support of head teachers, inspectors, social workers, and counsellors. Sometimes it might require help from mental health professionals, to learn how to deal with mental health issues. In particular, head teachers' support may be considered among the most important, as they need to be flexible and open-minded about the demands of promoting pupils' mental health process. It is a matter of teamwork. It is a task for all members of the school. Everyone should work together to ensure the benefits of the promoting processes.

-Researcher: What about if you are asked to participate in educational courses or training workshops regarding pupils' mental health issues?

-Interviewee H/M: Yes, I'm ready and happy to do that because these courses will increase our awareness and responsibility in the area of pupils' mental health.

-Researcher: In your view, how far could the idea of teachers having a role in promoting pupils' mental health be acceptable in Kuwaiti schools today?

-Interviewee H/M: I think the idea will not be too much accepted because you are asking them to do extra tasks; you need to support them and be flexible with them. Head teachers

need to show more flexibility and more interest in learners' social and emotional - as well as academic - development. Teachers' preparation notebooks are the main concern of inspectors and head teachers alike. There is no flexibility regarding the preparation of lessons and teaching plans. There is uncertainty concerning how permission will be given to discuss mental health issues.

-Researcher: From your point of view, to what extent do you think that delivering this sort of curriculum would be acceptable?

-Interviewee H/M: I do not think that this idea will be acceptable in the beginning. However, they might show their interested later. You need first to start with programmes to raise teachers' awareness of their role in this area. Schools need to encourage staff to work as an effective team, as each member has obligations towards promoting pupils' mental health. We have not taught or delivered such mental health topics before, or planned any lessons including this content. Personally, I normally try to change my mode during teaching so that I can wake pupils who are not paying attention, or slow down to allow pupils to catch up with me. Sometimes, I do my best to recognise all pupils' attention levels. However, I have never discussed pupils' mental health issues. You need to support teachers financially.

-Researcher: Do schools have adequate finance to put this process in practice?

-Interviewee H/M: I think that any new policy implemented needs financial support. Teachers need to be rewarded also. Their job is hard and the salaries they receive are low. Why they do not raise our salaries if they are asking us to perform extra tasks?

-Researcher: So, you think that a policy should be set to oblige teachers to promote pupils' mental health in schools?

-Interviewee H/M: People in charge of education need to set a new policy to promote pupils' mental health in schools. However, policymakers need to consider the teachers' role very seriously when they make decisions relating to pupils, because this will be instrumental in increasing teachers' feelings of responsibility and commitment. Applying any policy or programmes to promote pupils' mental health needs to suit our society, culture and morals. Professionals, researchers and universities should be utilised as much as possible to make use of their skills and knowledge, with programmes and policies

concerned with enhancing the mental health of pupils taking into account moral and cultural considerations.

-Researcher: In your opinion, what sorts of training do teachers they need?

-Interviewee H/M: Of course we need more training in mental health issues before we are asked to show our responsibility. We need training that covers most of pupils' mental health issues and our mental health issues, as teachers could face stressors in their teaching jobs. Teachers need to be trained to overcome their problems before they are asked to help their pupils to do that.

-Researcher: What are the barriers that you feel limit your responsibility in this area?

-Interviewee H/M: There is the pressing need to establish new evaluation criteria, with movement away from memorisation, which may help in passing tests but not in long-term success for future citizens. Evaluation should consider group work and activities emphasising learning effectiveness and flexibility, and ensuring there is the time to recognise the health issues of pupils.

-Researcher: Are there any other barriers, in your opinion?

-Interviewee H/M: The massive curriculum that teachers are required to cover might be another significant barrier. There should be a change in these curricula. What we learnt in university is completely different from what we are doing in schools. In practice, teaching is very different from the theory taught at university. Essentially, it is a competition to fill pupils' minds with the most knowledge and information in preparation for tests and examinations, and attendance levels. There is no additional time or space for emotional and social considerations. Ultimately, high grades and academic attainment are most important, but this results in poorly prepared citizens.

-Researcher: In your opinion, are there any changes that should be made to put the promotion of pupils' mental health into practice in Kuwaiti schools?

-Interviewee H/M: From my point of view, I think that change is the nature of life. We cannot refuse it. However, I think that in order to move towards the promoting process from the current status, we need to make sure that all personnel among school staff, including teachers, believe in the necessity of this process, and then we should work to overcome barriers that could limit the implementation of promoting processes. First of all,

overcrowding in classrooms means the identification of pupils' mental health issues is near-impossible. Around 20 or fewer pupils per class is ideal, meaning that mental health statuses can be recognised by teachers and issues handled and overcome effectively. Speeches are of somewhat limited value and only a short-term method; processes need to be practical and consider the devising and implementation of clear plans and rules, with the necessary facilities and resources provided to facilitate change.

-**Researcher: Do any other changes come to mind?**

-Interviewee H/M: Personally, I think that parents also can share the responsibility and lend a hand in promoting pupils' mental health within school. The media again need to accept their role in raising public awareness about mental health issues and reduce stigma around them. Especially, religious counselling, or what can be seen as using religion as an alternative way of dealing with mental health problems, could play a role in increasing social awareness of mental health issues, and how to deal with and accept their associated problems and people having these problems.

(1) Codes based on the breaking down, reducing, simplifying, and categorising the data derived from the transcript interviews (highlighted data in the previous transcripts).

Data	Codes
Good mental health, happy, not bored with your life- to achieve your goals- feel satisfied-happy-relieved-face and adjust life's pressures- ability to distinguish between right and wrong- creating a balance- adapt to changes- not giving up- evaluate the situation- think more logically- get support and guidance- able to live happily and normally.	**M.H Concept**
Still functioning normally- supported and provided with sympathy and help early- able to cope effectively- temporary- might be treated- less serious.	**M. H Pro**
Something prevents a person from living normally- lacking in energy- experiencing extreme tiredness- no ability to overcome stresses- functioning unusually- lose his desire to live- killed themselves- no longer interested- felt sad and lonely- might be hospitalised- something wrong with mind- unable to function well in life- medicine- lose control- behave unconsciously- aggressively- might not be treatable.	**M. ill**
Inherited problems- family feuds, divorce, drug and alcohol addiction among parents- combination of genes and environmental factors surrounding young people.	**M.H.P Cause**
Being aware- enhance skills to cope- seeking advice- ask for help- support- understand -accept - trust themselves- supporting pupils all times- building strong relationship with teachers to give teachers- be close to understand pupils more and recognise early changes- supporting pupils on all levels, academically and emotionally.	**P.M.H Mean**

Not equipped-no sufficient knowledge and training skills-specialist activity- teachers have a critical role and significant position to promote pupils' maintain emotionally and academically- counsellors should rest with mental health-teacher's primary job is to teach- school counsellors and professional have the adequate skills and experience to do that better than us.	**Role of T**
School can be a good support- shows care apply curriculum-train and educate pupils and teachers- school already provides mental health intervention for pupils with diagnosed disorders through counsellors- it is the responsibility of the Ministry of Education.	**Role of Sc**
Need to be well educated and well trained in the area (difficult to recognise these sorts of problems-teachers judge low achievement, less attention, disturbing the class, alteration in a pupil's behaviour, aggressive behaviour as mental health problems) - need for plans, legislation and policy establish by the Ministry of Education to ensure promotion and awareness- teachers might not be able to support if there are barriers- more flexibility from administration- support.	**Req**
Time from their original teaching time- slow other pupils' learning-affect progressing of gifted pupils- lead pupils to feel being respected and valued, raised self-esteem and confidence- affect learning and social relationships positively-showing empathy and support for other pupils-benefit pupils in more academic achievement.	**Out**
Feel happy to participate in this responsibility, but I feel anxious to do it.	**Mixed F**
Happy to accept my responsibility.	**Positive F**
Hope not to face anything like class-degree of severity-feeling scared when hearing that some pupil has shown	**Negative F**

signs of these mental difficulties in other teachers' classes- viewing mentally ill people are scary people- become stressed by their teaching job and not interested in any other extra tasks.	
Ask counsellors for help in appropriate time- ready to deliver this sort of curriculum- teach the curriculum without any interest in- feel as a teacher that there is a need to be involved in these training and education courses- ready to help their pupils- will accept any changes regarding pupils' mental health because they believe that it is a part of our responsibility to participate- courses will increase their awareness and responsibility in the area of pupils' mental health.	**Behav**
Media presents mental health issues negatively- image of mentally ill people represents danger, crime and violence- media feeds these images- represent these people in an awful way (messed-up hair, smelling bad- ugly appearance- being dressed inappropriately- homeless)- Arabic and Islamic culture beliefs of mental health- evil eye' or 'touch of jinn'- traditional healer is able to drive it away- mental health problems is a test from God testing level of religiosity, patience and confidence in Allah- face their problems without complaining- increase their prayers and strengthen their deep relationship with Allah- father prevented her from going to school, and hid her in the house- parents to seek help- avoid social stigma- fear of documented in the psychiatric hospital- misconceptions and stereotypes they hold about mental health issues derived from the stories they heard from their family- scared of being labelled- mental health problems are result of a lost soul and attraction to the devil.	**Barr- Socio &Cult**

Less knowledge and training in the area- no mental health background- unable to recognise mental health issues among pupils and deal with it- less confident- job pressured-fears to talk about mental health issues.	**Bar. Per**
Parents opposite- considering teachers as unqualified or allowed to deal with their children mental health issues- mental health counsellors are already appointed in schools- counsellors don't consider teachers' views- lack of communication with counsellors and social workers- lack of partnership with parents regarding pupils' mental health issues.	**Bar. I nter**
Additional roles added to instructional routine- something extra- no much time for supporting pupils' academic achievement- large number of classes- administrative affairs- school inspectors- massive teaching demands- extensive curriculums- examination system based on memorisation of the text- higher bodies evaluation based on pupils' achievement grades- lack of information sources- resistance of administration for change- school budget barely satisfies the financial needs of schools- useless information in curriculums.	**Bar. Struc**
Better educated teachers are more knowledgeable and aware about pupils' mental health issues- more open-minded- more years of experience lead to ability to deal with problems- pupils' severity and type of mental health problems.	**Fact**

Forming public awareness- teachers need to open a dialogue and build relationship- being close to pupils lead them feel comfortable and confident, media representation for mental health issues need to be changed- family role in preventing- co-operation between school and home- government and social institutions are responsible for dealing with the mental health issues of pupils-anti stigma programs- avoid counting only on religious counselling.	**Chang. Soc**
United team and work collaboratively- pupils' mental health need to be everyone's business- set new policy and regulations for schools and teachers to participate in the area- rewards- raise awareness- support- hearing voices.	**Chang. Pol**
Providing education and training in comprehensive and gradual process- multi-agencies team- mental health curriculum be included in the general topics of other school subjects- flexible and supportive activities- flexible administration-support teachers morally and materially- administrators and inspectors need to be more flexible and open-minded about the demands of promoting pupils' mental health process- new evaluation criteria- reform educational system- around 20 or fewer pupils per class is ideal- provide space for learning.	**Change. Org & Stru**
Change suddenly not what is not required-teachers need to be aware and convinced with change- rewarded- supported to raise their commitment-young people's right to live mentally healthy- teachers' commitment to participate in the responsibility(humanitarian and religious).	**Change. Te. Comm**

(2) Analytical themes related to area of teachers' perceptions about promoting pupils' mental health		
(A) **Teachers' understanding and perceptions about mental health (Major themes)**	**Sub-themes**	**Codes**
Understanding of mental health concept 'Terminological Issues'	-Perspectives on mental health concept. ➢ Absence of mental illness. ➢ Negative feelings. ➢ Balance in life. ➢ Distinguishing right and wrong. ➢ Achieving goals. -Perspectives on mental health problems. ➢ Meaning of mental health problems. ➢ Possibility of recovery. ➢ Temporary. -Perspectives on mental illness ➢ Medicine ➢ Hospitalisation ➢ Severe symptoms ➢ Long-lasting -Perspectives on the causes of mental health problems ➢ Biological ➢ Psychological ➢ Environmental ➢ Interaction between multiple factors	**M.H Concept** **M. H Pro** **M. ill** **M.H.P Cause**
Perceptions of promoting pupils' mental health	-Perceptions of the meanings of promoting pupils' mental health -Perceptions of teachers' role -Perceptions of school role	**P.M.H Mean** **Role of T** **Role of Sc**

Perceptions of the requirements	-Awareness (responsibility & role) -Training skills -Knowledge	**Req** Req. Aw Req. Tr Req. Know
Perceptions of the outcomes	-Social and psychological benefits -Social and psychological problems - Academic benefits -Academic problems	**Out** Out. Soc Out. Soc Out. Ac Out. Ac
(B) **Teachers' feelings about promoting pupils' mental health** **(Major themes)**	**Sub-themes**	**Codes**
Mixed feelings	-Positive feelings ➢ Feel comfortable ➢ Feel interested ➢ Feel happy	**Positive F**
	-Fears ➢ Feel uncomfortable ➢ Feel uninterested ➢ Feel unhappy ➢ Feel scared ➢ Feel anxious	**Negative F**
(C) **Teachers' intentional behaviours** **(Major theme)**	➢ Ready to engage ➢ Willing to be educated, trained and aware	**Behav**

(2) Analytical themes related to teachers' views of the socio–cultural context regarding promoting pupils' mental health		
Socio–cultural context (Major theme)	**Sub-themes**	**Codes**
A. Contradictory religious beliefs	➢ Experiencing mental health problems is a test from God ➢ Experiencing mental health problems is a punishment from God	Socio- Re
B. Views about different social contexts	-Community ➢ Lack of awareness and negative views ➢ Social stigma and labelling ➢ Fear of people with mental health problems ➢ -Family ➢ Parenting styles ➢ Relationships ➢ Parents' opposition ➢ Family socioeconomic status -School ➢ School social view ➢ Teacher-pupil relationships ➢ Peer relationships	Socio-Com Socio-F Socio-S

(2) Analytical themes related to teachers' perceptions about barriers to promoting pupils' mental health		
Teachers' perceptions about barriers to promoting pupils' mental health (Major theme)	**Sub-themes**	**Codes**
Personal barriers	➢ Teachers' negative attitudes ➢ Lack of awareness about teachers' role and responsibility	**Bar. Per**

	➢ Lack of teacher training ➢ Lack of teachers' knowledge about mental health issues	
Interpersonal barriers	➢ Lack of partnership between parents and teachers ➢ Resistance among administrators and inspectors ➢ Lack of partnership between specialists and teachers	**Bar. I nter**
Socio-cultural barriers	➢ Social stigma and labelling ➢ Alternative cultural and religious beliefs. ➢ School culture and ethos (social view of schooling) ➢ Inappropriate media representations of mental health problems	**Barr-Socio &Cult**
Structural-organizational barriers	➢ Lack of information resources ➢ Concerns over workload and time limits ➢ Absence of an educational policy ➢ Inadequate funding ➢ Curriculum, pedagogy and examination system	**Bar. Struc**

(3) Analytical themes related to teachers' perceptions about change		
Teachers' perceptions about changes (Major theme)	**Sub-themes**	**Codes**
Societal awareness	➢ Beliefs ➢ Family ➢ Media ➢ Society ➢ Social organizations ➢ Schools ➢ Government ➢ Action not words	**Chang. Soc**
Policies and regulation	➢ Education policy ➢ Laws& regulations ➢ Involving teachers, pupils & parents ➢ Educational research	**Chang. Pol**

	➢ Policymakers' views ➢ Cultural perspectives ➢ Early identification ➢ Time ➢ Administration	
Organizational& structural changes	➢ Class size ➢ Curriculum, pedagogy& examination system ➢ Support	**Change. Org & Stru**
Teachers' commitment	➢ Non-resistance ➢ Support ➢ Attitudes and beliefs ➢ Training ➢ Personality ➢ Collaboration ➢ Involving teachers ➢ Flexibility	**Change. Te. Comm**

Appendix (X) Samples of interviews scripts in Arabic

''نموذج من مقابلات المدرسين والمدرسات''

نموذج رقم(1):

الباحثة:ماذا يعني مفهوم" الصحة النفسية" بالنسبة إليك؟

س \س:الصحة النفسية هي أن يعيش الفرد بسعادة وأن لا يشعر بالملل من حياته. وقد يحمل مفهوم الصحة النفسية أن يركز الفرد على عمله ويؤدي مهامه في العمل والحياة وأن يفعل ما بوسعه ليحقق أهدافه لأنني أعتقد أن الفرد الذي يحقق لو جزء من أهدافه في الحياة, فإن ذلك سيشعره بالرضى والسعادة والراحة ويحفزه على أن يبذل أقصى جهده لمواجهة الضغوط وتحمل المسؤوليات في هذه الحياة....بنظري الشخصي الصحة النفسية هي قدرة الفرد على خلق التوازن في الحياة. إنها قدرة الفرد على أن يفرق بين الخطأ والصواب الذي يمكنه من أن يطور من نفسه رغم ضغوطات الحياة من حوله. الصحة النفسية هي قدرة الفرد على عدم جعل ما حوله من ضغوطات يؤثر على سير حياته وآداء وظائفه نحو أسرته وعمله وعلاقاته بالآخرين.

الباحثة:إذا ماهو "المرض العقلي" بنظرك؟

س \س: المرض العقلي هو ان تكون شخص غير اجتماعي و هو إحساس الفرد بفقدان الأمل..... وقد يكون الإصابة بالمرض العقلي هو الإحساس الفرد بأنه ضائع ومكتئب وإحساسه بأنه يتصرف بشكل غير عادي وهو أن يشعر الفرد أنه مختلف عن الباقين وهو أن الاحساس بعدم التوازن فقد الرغبة بالعيش... إنه الإضطراب الذي يمنع الفرد من التعايش الصحيح في محيطه العائلي والوظيفي والمجتمعي . شخصيا" أشعر أن استخدام مصطلح "المريض العقلي" بحد ذاته يبعث على الخوف في نفوس الآخرين. المرض النقسي هو حالة مرضية وقد تكون حادة ومزمنة... وتتطلب تناول العقاقير الطبية وأحيانا" الايداع بالمستشفى .

الباحثة:وفي اعتقادك كيف تكونت لديك هذه الفكرة او لدى الآخرين عن المريض العقلي؟

س\س: نعم. أعتقد أنه تأثير وسائل الإعلام.....فالطريقة التي تصور بها وسائل الإعلام المختلفة الأمور النفسية بالصورة السلبية, يعطي الناس الانطباع الخاطىء عما يتعلق بالأمور النفسية والمرضى العقليين. فالخطر والعنف والجريمة هي الصورة التي يظهرها الاعلام عن هؤلاء المرضى. وقد ترتبط فعلا" هذه التصورات السلبية بقوة باتجاهات الناس السلبية نحو الأمور الخاصة بالصحة النفسية. في الحقيقة فإن وسائل الإعلام تغذي هذه التصورات لدى الناس بأن هؤلاء الأشخاص الذين يعانون من الأمراض النفسية هم أشخاص مجانين.خطرين.....منكوشي الشعر....ذو رائحة كريهة ...وشكلهم قبيح..... يرتدون الملابس البالية والمقطعة..... ويمشي هائما" على وجهه بالطرقات وينام بها أحيانا".. يثيرون الضحك....وقد يمثلون خطورة على الآخرين. للإعلام تأثيره على تكون الوعي لدى الآخرين حول الامور المتعلقة بالصحة النفسية...ومع كل هذه الصور الغير المناسبة للمرض النفسي والأشخاص الذين يعانون منه لك أن تتصور كيف يستوعب الناس مفاهيم الصحة النفسية والتعامل مع الأمور النفسية.

الباحثة :إذا أنت ترى أن هناك إختلاف بين المرض العقلي والمشكلة النفسية؟هل لك أن تحدثني بالمزيد عن هذا؟

س\س: نعم. فالناس ترى أن أي شخص لديه مشكلة نفسية تتعلق في تغير المزاج أو الإحساس بالضغط النفسي من جراء الضغوطات الحياتية فهو مريض عقلي يحتاج لمراجعة مستشفى الطب النفسي وأنه يجب على الآخرين الحذرمن التعامل معه وأنه يفضل عدم التعاون معه. برأيي الشخصي أن هذا غير صحيح...فالمريض العقلي درجة مرضه متقدمة وقد يتطلب الأمر تلقيه العقاقير المهدئة وقد يتجاوزالأمر إلى إيداعه بمستشفى الطب النفسي وقد لايتشافىمن المرض....وقد يستغرق المرض العقلي العلاج لفترة طويلة.... بينما قد يعاني بعض الأشخاص من مشكلات نفسية بسيطة التي لم تصل لدرجة حادة من المرض ويستطيعون بالرغم منها العيش بصورة طبيعية بحيث يصعب بها يمكنهم آداء واجباتهم والتزاماتهم والحفاظ على علاقاتهم نحو عملهم وأسرهم ومجتمعهم... والخ .

الباحثة:هل تعتقدأنه بإمكانية الأفراد الذين يعانون من مشكلات نفسية أن يتغلبوا على مشكلاتهم ؟

س\س: نعم ....هم قادرين على ذلك...إذا استمروا بالعمل على اكتشاف أنفسهم..لان درجة مرضهم ليست حادة...وبالتالي ما يحتاجونه هو ان يفهموا أنفسهم ويتقبلوا انفسهم ويثقوا بقدراتهم. وهذا يعتمد بالدرجة الأولى على مدى الوعي لدى الشخص بطبيعة مشكلته النفسية التي يعاني منها وطرق التعامل معها واهمية طلب المساندة والدعم من الآخرين.

الباحثة: إذن من هوالشخص الصحيح نفسيا" بنظرك؟

س\س: برأيي الشخصي.... الفرد يكون سليم نفسيا" إذاكان يشعر بالسعادة والقدرة على موازنة الأمور .... وهو الشخص الذي لديه القدرة على التكيف مع ما حوله من تغيرات وضغوط حياتية....بينما يفقد القدرة على مثل هذا النوع من التكيف.... الشخص الذي يعاني من مشكلة نفسية.....لأن أهم ما في الموضوع هو التكيف مع الضغوط والقدرة على مواجهة تحديات الحياة فمثلا" لو واجهتهم الصعوبات والتحديات فهم يفكرون بمنطقية وعقلانية بحيث أنهم لا يدعون هذه الضغوط تؤثر على تعاطيهم الصحيح مع الحياة ويفكرون بالحلول المناسبة ويستشيرون ذوي الخبرة والإطلاع للاستفادة منهم بالتغلب على مشكلاتهم النفسية.....ولا يستسلمون لليأس....

الباحثة: من وجهة نظرك الخاصة..... في مجتمع تقليدي كالمجتمع الكويتي المتمسك بتقاليده ومبادئه الدينية..... هل تؤثرالمعتقدات الاجتماعية والدينية والثقافية السائدة في هذا المجتمع على مفهوم الأفراد للصحة النفسية والمشكلات النفسية ؟

س\س:نعم....في مجتمع كالمجتمع الكويتي أعتقد أن هناك تأثير كبير لبعض المعتقدات السائدة على الطريقة التي يفهم بها الناس المشكلة النفسية وأسبابها وطرق التغلب عليها....

الباحثة: هل لك أن تشرح لنا كيف يكون هذا التأثير ؟

س\س: نعم..هناك بعض من المعتقدات الدينية والتقليدية الخاصة بطبيعة الثقافة العربية والإسلامية تؤثر على فهم الناس للمشكلات النفسية.... والكويت طبعا" جزء من هذه الثقافة...فمثلا" يعتقد الكثير من الناس هنا في الكويت وبعض الدول العربية والإسلامية أن الإصابة بالأمراض النفسية ماهو إلا نتيجة إختبار الإله " الله" للناس.... .... فالله يختبرهم بأبناءهم... كي يرى مستوى إيمانهم ومستوى صبرهم على هذا البلاء.... أو على الأقل هذا ما يحاول هؤلاء الأشخاص الذين يعانون

من المشكلات والأشخاص المحيطين بهم إقناعهم به..فإن أظهروا قوة إيمانهم بالرضى والصبر والتحمل ومواجهة هذه المشكلات وعدم التأفف منها والشكوى والإكثار من العبادة والتقرب من الإله" الله"..فإنهم سوف يفوزون برضا الله في الدنيا والحياة الآخرة ... وهذ التقرب بنظرهم الوسائل الوحيدة للتخلص من المشكلات النفسية.....وهذا بدوره قدينعكس على طريقة فهمه لمشكلاتهم أو مشكلات أبنائهم النفسية والتعاطي معها.

الباحثة: كمعلم في المدرسة ومن خلال ملاحظتك....إلى أي حد مثل هذه المعتقدات تؤثر على توجه بعض أولياء الأمور لطلب المساعدة من المدرسة في حالة ملاحظة أن أبنائهم يعانون من مشكلات نفسية؟

س\س: هذه المعتقدات الدينية تجعلهم يتوجهون لطلب المساعدة والعلاج من رجال الدين المعالجين والمتدينين او المعالجين التقليديين في المجتمع بدلا" من التوجه إلى المتخصصين من المرشدين والمعالجين النفسيين ... مما قد يجعل الأمور يسوء أحيانا" ويؤخر من التشافي بالمرض أو حتى زيادة حدته فبعض الحالات يستمر التعامل بعلاجها بالطرق الدينية والتقليدية بالرغم من حقيقة أن مثل هذه الإضطرابات قد تحتاج لتناول عقاقير طبية .. ما يحدث عند هؤلاء المعالجين الدينيين هو أنه يطلب الناس منهم بأن يقوموا بقراءة الآيات القرآنية عليهم أو حتى إعطائهم المياه المباركة التي تمت قراءة بعض الآيات عليه..... اعتقادا" منهم أن هذه هي وسائل الشفاء من المرض النفسي...أما لدى المعالجين التقليديين فإن الأمر يختلف فالمعالجين هنا يقدمون الأدوية المصنوعة من الأعشاب وانواع البخور المتخصصة في مثل هذه الأمور ....لأن المعالج التقليدي هنا يوهم الناس بأن ما أصاب ابنائهم هو مس من الجن أو الأرواح الشريرة أو العين التي قد تؤدي بوفاتهم إذا لم يستمروا بالعلاج لديهم و عليهم أن يستمروا بتقديم العطاء المادي في كل مرة يزورون المعالج الشعبي أو التقليدي..... وهذه أمور موجودة في كثير من الثقافات وخاصة الثقافة العربية أو الإسلامية لا يمكن ان ننكر تأثيرها على فهم الناس لحقيقة المرض النفسي والمشكلات النفسية وكيفية التعاطي معها وعلاجها... فمن الحوادث التي لازالت عالقة في ذاكرتي هو احد أقاربي كان لديه بنت تعاني من مشكلة نفسية اكتئاب على ما اذكر عندما اكتشفت المعلمة أن الطالب لا تتفاعل مع محيطها بالمدرسة ..مع معلماتهم وزملاؤهم.. وان لديها بعض الهلاوس السمعية.. فقام الأب بحرمانها من المدرسة وإخفاءها عن الآخرين وكان يخفيها في كل زيارة عائلية ومن ثم زادت معاناتها وكنا نسمع صراخها وحالتها الهستيرية وعرضها على أحد المعالجين الشعبيين الذي قام بتشخيص حالتها بمس من الجن وكان يقوم بضربها بالعصا ظنا" منه بأن الجن يخرج منها بالضرب... وكان يعالجها بالبخور والادوية الشعبية وزادت هذه الوسائل حالتها النفسية سوءا"وزادت حدة المرض لديها بعد أن زاد عليها مستوى الاكتئاب ورفضت الطعام والشراب والنوم... حتى فقدت حياتها...فأنا أعتقد أن لو كان لدى قريبي هذا أي نوع من الوعي بضرورة طلب الدعم من المتخصصين بالصحة النفسية أو لو كان لديه الوعي بأن ما تعانيه بنته هو إكتئاب نفسي لما فقد هذه البنت... وأن اللجوء لمثل هذه الأساليب التقليدية لعلاج المشكلات النفسية قد لا يجدي نفعا"... فهذا المثال قد يوضح تأثر الناس بالمعتقدات الثقافية الموروثة... هذه المعتقدات تؤثر بشكل كبير على الأهل ...فبعضهم يتعمد إخفاء الإضطرابات النفسية لأولادهم ولا يتوجهون لطلب المساعدة من ألآخرين. .. وخاصة المدرسين أو المرشدين النفسيين والأخصائيين النفسيين في المدرسة حتى لا يتم تحويل ابنائهم للطب النفسي ويفتح لهم ملفات هناك تؤثر على سجلاتهم المدنية في الدولة أو حتى أحيانا" عند التقدم للزواج لأن المجتمع هنا لا يرحم أبدا"... وفي مجتمع كمجتمع الكويت... مجتمع صغير وقليل السكان وجميع أفراده معروفين ومتعارفين ...يصعب إخفاء مثل هذه الحقائق وهي تنتشر بسرعة.. وقد لا يتمكنوا من الحصول على العمل بسب إصابتهم بالمرض النفسي ولخوفهم من وصمة العار التي قد تلازمهم مدى الحياة وتسبب لهم الحرج مع الآخرين ... فبعضهم يؤمن بأن طلب المساعدة يجلب وصمة العار التي قد تؤثر عليه وعلى أبنائه بالمجتمع عندما يوصم أبنائهم بالمرض النفسي ... فقد يكون كذلك السبب الرئيسي من عدم طلب المساندة

هو قلق الأهل من أن يكون مشكلات أبنائهم النفسية محور أحاديث المدرسين أو حتى المرشدين النفسيين أو الأخصائيين الاجتماعيين وعندما يقول الآخرين بأن ما حدث لأبنائهم هو عقاب من الله.... ". فتأثير هذه المعتقدات الثقافية واضح في الرعب الي يصيب أولياء الامور من إيمانهم بأن أولادهم سوف يوصمون بالعار وصمة العار من المرض النفسي وإمكانية ان يعرف الآخرون أن أبنائهم لديهم مشكلات نفسية وخوفهم على مستقبل ابنائهم بسبب ما قد يوثق بالسجل المدني لهم في الدولة وتأثيرذلك على مستقبلهم بتضائل فرص حصولهم على وظيفة جيدة مما قد يعيق من قيام المعلم بدوره بشكل فعال في تحقيق الصحة النفسية للطالب.

الباحثة: هل لاحظت أن هناك بعض الطلبة لديهم مشكلات نفسية ؟

س\س: نعم. لقد لاحظت الكثير من الحالات.

الباحثة: وكيف تعرف أنهن يعانون من مشكلات نفسية؟

س\س: قد يبدو الأمر سهلا" ولكن الحقيقة قد يواجه المدرسين صعوبة في ملاحظة مثل هذه الأمور... أحيانا" يحكم المعلمين على الطالب الذي لديه انخفاض في درجات تحصيله العلمي أوحتى التغير السلوكي كالميل للسلوك العدواني في الفصل أو ساحة اللعب أو حتى عدم الانتباه بالفصل انه يعاني من مشكلة نفسية وأن هذه ما هي إلا مؤشرات لمعاناة الطالب من مشكلة نفسية وقد لايكونوا ع صواب... وحتى لو لاحظنا هذه المشكلات وتأكدنا منها فنحن كمعلمين لا نعرف كيف نتصرف...كيف نتعامل مع الطالب... فنحن لسنا على القدر الكافي من المعلومات والتدريب فيما يختص بالأمور النفسية للطالب والتعامل مع احتياجاته النفسية ....وهذه بنظري أمور بالقيام بمسؤوليتنا ودورنا كمعلمين بما يخص الأمور النفسية للطالب.

الباحثة: برأيك ما هو سبب المشكلات النفسية التي يعاني منها بعض الطلبة؟

س\س: ليس كل أسباب المشكلات النفسية تعود للورثة ... فهناك أسباب تعود لشخصية الطالب فقد يكون شخصيته ضعيفة وليس لديه صفات تحمل للضغوط مثلا"...كما أنه قد ترجع معاناة الطالب من المشكلات النفسية إلى عوامل متعلقة بالأسرة كالطلاق و التشاجر بين الوالدين إدمان بعض الوالدين على الخمر أو المخدرات مما ينعكس على التسبب ببعض المشكلات النفسية للطلبة كالقلق. أيضا" ضغوطات الامتحانات قد تؤثر على صحة الطالب النفسية إذا كان الطالب ليس لديه القدر الكافي من الوعي للتعامل مع هذا النوع من الضغوط.

الباحثة::ماذا يعني مفهوم " تحقيق الصحة النفسية للطالب" بالنسبة لك؟ في نظرك....لأى مدى نستطيع أن نقول أن المدارس مهيأة ومستعدة للقيام بدورها اتجاه تحقيق الصحة النفسية للطالب؟

س\س: بإعتقادي الشخصي أن تحقيق الصحة النفسية قد يتم من خلال بناء علاقة قوية بين الطالب ومعلميه بالدرجة الاولى بحيث أنه يمكنه ان يجدوا المساعدة من معلميهم في الوقت الذي يحتاجون إلى مساعدتهم... لأن هذه العلاقة القوية تمكن المعلم من فهم الطالب بصورة أكبر والتقرب اليه وملاحظة التغيرات التي قد تطرأ عليه وعلى حالته النفسية أول باول ...بحيث في حالة وجود أي مؤشرات للمشكلة النفسية فإن المعلم سيقوم بملاحظتها مبكرا" ....ثم ياتي بعد ذلك دور تدريب المعلمين على التعامل مع احتياجات الطلبة ومشكلاتهم النفسية وتثقيفهم ورفع مستوى وعيهم بذلك وتثقيفهم بأهمية دعم الطلبة فيما يتعلق بأمورهم النفسية... والذي يجب ان تتبناه المدارس كجزء من خططها وسياسيتها التربوية.

الباحثة: على حد علمك هل توجد سياسة تربوية أو قانون ينص أو يلزم المعلم بالمساهمة بتحقيق الصحة النفسية للطالب في مدارس الكويت ؟

س\س: من سوء الحظ... لا يوجد سياسة أو حتى قانون يلزم المعلم بالمساهمة بتحقيق الصحة النفسية للطالب هنا بالكةيت بل على العكس أن ما هو متعارف عليه هو أن الأمور النفسية للطالب من إختصاص المرشدين النفسيين.. القانون هنا في المدارس ينص على ان الطالب الذي يعاني من مشكلات نفسية يحول للمرشد النفسي بالمدرسة وان المسئولية هنا مسؤولية المرشد النفسي بتقديم المساندة والمساهمة في حل مشكلاتهم...

الباحثة: إذن هل برأيك عدم وجود سياسة تربوية تنص على التزام المعلمين بدورهم ومسؤوليتهم بتحقيق الصحة النفسية للطالب قد يكون من المعوقات لتحقيق الصحة النفسية للطالب؟

س\س:على الرغم من أنني اسلفت ان الالتزام يجب ان يكون نابع من الاحساس بالمسئولية الانسانية قبل الالتزام بالقانون والسياسة التربوية والتزاماتها...إلا انني أرى أن وجود سياسة تربوية تعززمن دور المعلمين وشعورهم بالمسئولية أكثر بتحقيق الصحة النفسية للطالب. ولا يجب أن يكون صياغة مثل هذه السياسات اختياري بل على العكس يجب أن يكون من شيء أساسا"...وبالتالي يجب لأن تكون هناك سياسة واضحة وتصيغها وزارة التربية وتنص على التزامات للوصول لهذا الهدف.

الباحثة: هل ترى أن ملاحظة الصحة النفسية للطالب وتحقيق صحته النفسية هو جزء من وظيفتك كمعلم؟: بمعنى آخر..هل تعتقد أن ملاحظة مشكلات الطالب النفسية والتعامل مع هذه المشكلات هو جزء من وظيفة كمعلم؟

س\س: نعم. أعتقد أن المعلم له دوره في هذا الصدد وعليه مسؤولية فهو قد أقسم على آداء الأمانة عند التخرج ومراعاة طلبته وتقديم العون لهم أكاديميا" ومعنويا" مهم ...قد لا يكون هناك نص حرفي مكتوب يدعو إلى ملاحظة المشكلات النفسية للطالب في المدرسة..ولكن تظل المساهمة في تحقيق الصحة النفسية للطالب مشروطة بتقديم التدريب الكافي والمعلومات والمساندة من الإدارة وتخفيف الأعاء على المعلم والضغوطات عليه والمتطلبات من العمل المدرسي...وكذلك على التعاون معه ومع أفراد طاقم العاملين بالمدرسة من مرشدين نفسيين واخصائيين إجتماعيين وإدارة مدرسية....بالإضافة إلى درجة المرض النفسي نفسها عند الطالب.... إذا كانت حالته حادة ومصاب بأمراض نفسية حادة ...في هذه الحالة لا يمكن للمعلم سوى المساندة وعلى الدخرين من الإختصاصيين أن يقوموا بدورهم في هذه الحالة.... أما المشكلات النفسية التي لا يشكل صاحبها أي خطر علينا كمعلمين .....فهنا يستطيع المعلم أن يقدم الدعم والمساندة والمتابعة مع الآخرين في المدرسة وخارجها... وأحيانا تقديم العون بتعلم طرق ومهارات التغلب على هذه المشكلات التي يعاني منها الطلبة... فتحقيق الصحة النفسية للطلبة هو جزءمن عمل المعلم لوجود العلاقة الوطيدة بين الآداء الأكاديمي للطالب و استقرار حالته النفسية.. ... وقد يجهل الكثير من المعلمين كما قلت سابقا" دورهم ومسؤوليتهم في هذا الشأن لنقص الوعي بينهم.

الباحثة : برأيك لمن تعود المسؤلية في تحقيق الصحة النفسية للطالب في المدرسة؟

س\س: قد يرى معظم المعلمين انهم ليسوا مسؤولين عن تحقيق الصحة النفسية لطلبتهم.... وقد يكونون على حق... فلا توجد قوانين أو سياسة تربوية للمدارس هنا في الكويت تلزمهم بالمساهمة في تحقيق الصحة النفسية للطالب....فهم يرون

أنها وظيفة المرشد النفسي والأخصائي الاجتماعي بالمدرسة....وأنه ليس جزء من واجبهم أو وظيفتهم القيام بذلك فهم مضغوطين بما يوكل إليهم من مهمات ومتطلبات متعلقة بالتدريس وتحضير الامتحانات ورصد الدرجات وغيره من المتطلبات التدريسية بالإضافة إلى الكم المكثف من المناهج الدراسية.... ولكن بالنسبة لي شخصيا" فانا أعتقد أن تحقيق الصحة النفسية هو مسؤولية جميع أفراد الطاقم العاملين في المدرسة من معلمين و مرشدين نفسيين وأخصائيين اجتماعين.. وبالنبة لنا كمعلمين.....فتحقيق الصحة النفسية هو جزء من مسؤولياتنا كمعلمين فنحن أقسمنا بالتخرج أن نراعي الطالب ماديا" ومعنويا" وقد يكون الدعم المادي مقصود به أكاديميا" والدعم المعنوي هو الدعم النفسي... فنحن كمعلمين مطالبون بأن نلاحظ حالة الطالب النفسية والمشكلات النفسية التي قد يعاني نها وملاحظة اي من الأعراض التي تصاحب هذه المشكلات ...لأن الملاحظة والاكتشاف المبكر لمثل هذه المشكلات يقلل من تطورها لأمراض نفسية مزمنة....ومن المعروف أن الطالب يقضي معظم وقته بالمدرسة و أن المعلم هو أكثر الأشخاص إحتكاكا" مع الطالب....فمن باب أولى أن يكون هو المصدر الأساسي في الحصول على معلومات تخص الطالب اكاديميا" ونفسيا".... فملاحظة الصحة النفسية للطالب فهي جزء من مسؤوليته... نظرا" لقربه من الطالب.....وقد لا يكون لدى المعلم المهارات والمعلومات الكافية فيما يخص الأمور النفسية للطالب والتعامل مع المشكلات النفسية للطلبة ولكن من الواجب على المعلم أن يبدي نوع من الاهتمام اتجاه ملاحظة الصحة النقسية لطلبته..... وقد يكون من أهم الأشياء التي قد يساهم بها بهذا الصدد هو عند ملاحظة أي من الأعراض التي قد تشير لمعاناة الطالب من مشكلة نفسية عليه ان يساند الطالب ويفتح باب حوار معه ليستفسر عن الأسباب ويدعم الطالب فإذا كانت المشكلة بسيطة يقوم بحلها مع الطالب وإن لم يتمكن من حلها عليه بطلب المساندة من المرشدين النفسانيين بالمدرسة والأخصائيين الاجتماعين وتحويل الطالب لهم .... وأعتقد أن هذا متوقع... فبالنهاية قد نؤمن كمعلمين بأنه قد تكون المسؤولية الأولية لتحقيق الصحة النفسية للطالب للمختصين في هذا المجال وهي ليست من واجبنا ولكن من جهة أخرى فإن الصحة النفسية هي مكون رئيسي ومهم يؤثر على إنجاز الطالب الأكاديمي....إن الأمر برأيي الشخصي ليس مجرد إلتزامات تلزم المعلم بالمسؤولية إنما هي حس المسؤولية الإنسانية.

الباحثة: إذا لاحظت مشكلة نفسية لدى أحد الطلبة .. كيف تتجاوب مع مشكلة هذا الطالب بما تمليه عليك مسؤوليتك و دورك كمعلم؟

س\س: هناك طرق عديدة يستطيع المعلم بها المساهمة بتحقيق الصحة النفسية لطلبته..... فالمعلم عليه أن يلاحظ أي تغير على آداء آداء طلبته الأكاديمي ومدى انتباهم بالفصل وسلوكياته سواء بالسلب أو الإيجاب....حتى يتمكن المعلم من الإقتراب من هؤلاء الطلبة في حالة ملاحظته لأي مشكلة نفسية عليهم .. من خلال بناء علاقة مع الطلبة مشجعة لهم ليسمحوا للمعلم أن يشاركهم همومهم ومشاكلهم ... والمعلم هو المسئول خلق الجو المشجع والداعم منذ البداية وفتح باب الحوار مع الطالب والتحدث معه في حالة وجود مشكلة نفسية... إن مثل هذه العلاقات المشجعة لا تعود على الطالب بالفائدة النفسية وتخفيف المعاناة النفسية ممن يعانون من مشكلات فقط بل تشجعهم على التحصيل العلمي الأكثر وكذلك تعود على المعلم بدعم عطائه الأكاديمي بالحصول على نتائج مرضية لآداء طلبته... ولكن يظل عامل الوقت المسموح للمعلم به بان يقوم بهذه المساهمة فهو محاط بإدارة تملي عليه متطلبات إدارية وأكاديمية وتدريسية كثيرة لا يجد أحيانا الوقت الكافي لأن يفرغ منها... و لأهمية دور المعلم في الملاحظة المبكرة للأعراض قد يسهم في تقليل حدة المرض النفسي وعدم تطور المشكلة النفسية .. على التربويين أن يراعوا المعلم أولا"..فمثلا" إذا أردنا للمعلم أن يقوم بالمساهمة في تحقيق الصحة النقسية للطالب علينا أن نخفف من أعبائه التي تضغطه نفسيا"... قبل أن نطلب منه ملاحظة الصحة النفسية للطالب... فالمعلم إذا أتيحت له الظروف المادية التشجيعية والمعنوية وتوافرت له المعلومات الكافية والتدريب سيقوم بدوره

ومسؤوليته بتحقيق الصحة النفسية للطلبة... فالمعلمين هم من أقرب الأشخاص للطالب في المدرسة..وعلى المعلم أن يدرك أن علاقته بطلبته لها تأثيرها الواضح على صحة الطالب النفسية وأن العلاقة السلبية قد تودي بنتائج سلبية فالطالب يحتاج إلى أن أن تكون هذه العلاقة يملؤها المحبة والتاطف والدعم والتقرب من الطالب والإحساس بمعاناته وهمومه ومشاركته نجاحاته....فمتى كان هذا المعلم قادر عى بناء علاقة على ها النحو فإن الطالب سوف يشعر بالأمان وسوف يتوجه لمعلمه إذا أحس بوجود مشكلة والمعلم كذلك سوف يشعر بهذه المشكلة ويكتشفها مبكرا" لقربه من الطالب....

الباحثة: من وجهة نظرك الشخصية.. هل تؤثر المعتقدات الدينية والاجتماعية والثقافية السائدة والصورة التي تقدمها وسائل الاعلام عن المرض النفسي في المجتمع الكويتي على تحقيق الصحة النفسية بالمدارس بالكويت؟

س\س: المدرس هو جزء من المجتمع وفرد من أفراده فهو يتأثر لحد كبير بما ترسمه وسائل الإعلام من صورة للمرض النفسي والشكل الذي تظهر به الاشخاص الذين يعانون من مشكلات نفسية... فحينما نطلب من المعلم أن يساهم بدوره بتحقيق الصحة النفسية للطالب وملاحظة حالته النفسية والمشكلات النفسية واكتشاف هذه المشكلات وأعراضها مبكرا" لابد أن لا ننكر حقيقة أن بعض المعلمين قد يشعرون بالخوف من الأمور النفسية هذه أو حتى الحديث عنها متاثرين بالإعلام ... فلك أن تتخيل كيف يتصور الناس المرض النفسي والمريض النفسي بعد الطريقة التي يظهر بها الاعلام المريض النفسي ومفهوم المشكلة النفسية ...وأنت هنا تطلب منهم هنا أن يساهموا في تحقيق الصحة النفسية للآخرين.. لذا لابد من تغيير الصورة التي تظهر بالإعلام عن المرض النفسي برفع مستوى الوعي لدى المعلمين والطلاب كذلك وتثقيفهم علميا" بالدورات التدريبية والكورسات التعليمية عن إمكانية العلاج ووسائل واساليب المساندة المطلوبة والمناسبة لهؤلاء الطلبة حتى لا يشعر المعلمين بخوف من التعامل مع الطلاب الذين يعانون من مشكلات نفسية أو من يظهرون مؤشرات تضعهم في خطر المعاناة من المرض النفسي... لأن المعلم قد يكون لديه الرغبة الداخلية بالمساندة لهؤلاء الطلبة ولكنه يشعر بالخوف.. وهذه بدورها يؤثر على اتجاهات المعلم حو تحقيق الصحة النفسية للطلبة من قبل المعلمين.... وهذا الخوف ناتج عن ما يسمعه ويراه من وسائل علام وما يؤمن به بعض أفراد المجتمع من أن المريض النفسي إنسان يشكل خطورة على من هم حوله وأن التعامل مع اصحاب المشكلات النفسية هم أشخاص خطيرين ويجب تجنب التعامل معهم....

الباحثة: حسنا" هذا بالنسبة لتأثير الإعلام وماذا عن دور المعتقدات الدينية والثقافية على مدى مساهمة المعلم بدوره بتحقيق الصحة النفسية للطلبة؟

س\س: المعتقدات الدينية تجعل اولياء الأمور يتجهون إلى طلب المساعدة من رجال الدين والمعالجين التقليديين مما قد يسبب التأخر بالتعاطي مع المشكلة النفسية بالشكل الصحيح وقد يسوء الحال وتتحول المشكلة إلى إضطراب يصعب علاجه ويستغرق وقت طويل وبالتالي يؤثر على نفسية الطالب.. كذلك المعتقدات الاجتماعية والخوف من وصمة العار وما قد يوثق بالسجل المدني عن مرضهم النفسي و تضائل فرص الحصول على وظيفة او زواج في المستقبل نتيجة لذلك قد يقود الوالدين والعائلة لإخفاء لمشكلات ابنائهم النفسية ونجد الكثير منهم يفضل مراجعة العيادات النفسية الخاصة حيث لا تؤيد زيارات أبنائهم بالسجلات الرسمية للدولية كما هو الحال في مستشفيات الطب النفسي وإدارة الخدمة النفسية بوزارة التربية.. فالأهل يخفون إضطرابات ومشكلات أولاده النفسية عن المعلمين والمرشدين النفسين بالمدرسة...فالمعلم هنا ليس لديه فكرة أن هذا الطالب يعاني من مشكلة نفسية وهو قد لا يظهر عليه ذلك لأن في بعض الأحيان الطلبة لا يظهر عليهم المرض كأعراض خارجية....فبالتالي كيف يساند المعلم الطالب في مشكلاته النفسية.... حيث أن اللجوء لمثل هذه الوسائل

من المعالجة الدينية والتقليدية والخوف من وصمة العار... لا تمكن المعلم من مشاركة الطالب بحل المشكلة ومساندته وتعيق عمله في المساهمة بتحقيق الصحة النفسية للطالب...

الباحثة: إذن أنت هنا تؤكد دور التعاون بين الأسرة والمدرسة لنتمكن من تحقيق الصحة النفسية للطالب؟

س\س: نعم. للأسرة الدور الكبير والفعال فهي المؤسسة الاجتماعية المهمة التي يجب أن يؤكد دورها قبل دور المدرسة ويجب هنا ان يتم التعاون بين البيت و المدرسة لنتمكن من تحقيق الصحة النفسية للطالب...فبعض الأسر قد تسبب المشكلات النفسية لابنائها بينما أسر أخرى قد تساندهم بالتغلب على المشكلات النفسية وتحمي من هم في خطر من المشكلات النفسية فمثلا" الأسرة التي تعاني من جود المشاكل والاختلافات بين افرادها وخاصة الوالدين قد تزيد فيها فرص إصابة أبنائها بالمشكلات النفسية... كما ان الأسرة التي تحرص على تكاتف افرادها وتماسكهم وتساند أفرادها وتقضي وقت من الحوار معهم بوجودعلاقات قوية بين افرادها تثمر عن ابناء أصحاء نفسانيين واثقين من أنفسهم يدركون كيفية التعمل مع مشكلاتم والتغلب عليها ومنفتحين للتعامل مع الآخرين وخاصة المعلمين لإخبارهم بهمومهم على الاقل في حالة هذه الأسر سيجد المعلم الاسرة المساندة والمتعاونة التي يمكن التعاون معها فيما يخص صحة ابنائها النفسية مما يسهل المهمة على المعلم. وهذا يعتمد على طبيعة أولياء الأمور فهناك أولياء امور لا يسمحون لنا بالتدخل بأمور أبنائهم النفسية... ويعدونها شئوون شخصية ومناطق محظورة لا يمكن الخوض بها وهذا ينعكس بدوره على تفاعل المعلم والمرشد النفسي بالمدرسة والأخصائي الاجتماعي مع مشكلة الطالب النفسية وقد لا يعيرها اهتماما" خوفا" من التعرض لأي نوع من المضايقة او الشكوى من قبل أولياء الأمور والنتيجة لذالك هو التسبب من كل الأطراف والأسرة والوالدين بشكل أخص بتدهور المشكلة وجعلها أكثر سوءا.... وهنا يأتي دور المشاركة التعاون بين المتخصصين بالمدرسة من مرشدين واخصائيين اجتماعيين واختصاصي علم النفس بالمدرسة وإدارة الخدمة النفسية بالمدرسة مع المدرس ... دور هذا التعاون في الاسهام في التعامل كفريق عمل متكامل للتعامل معأي مشكلة نفسية قد يمر بها الطلبة مشكلة الطالب النفسية ... لأن التعاون بينهم يزيد من الأفراد الداعميين للطالب والمساندين له مما يشعره بالأمن والراحة والطمأنينة التي قد تدفعه للتحدث بمزيد مما يخص مشكلته النفسية ويساهم في التقليل من الضغوطات التي قد تسسبها المشكلة عليه ويساهم أيضا" بمساعدته على التغلب على مشكلته النفسية بشكل أسرع بسبب التفاهم بين هؤلاء المختصين ومعلميه ومشاركة المعلومات الخاصة به بينهم مما يدعم المساهمة في تحقيق صحته النفسية حيث أن النقص في هذه المشاركة والتعاون والمساهمة المشتركة في المسئولية بين هؤلاء المختصين قد تكون من أهم المعوقات الت قد تبطىء من تحقيق الصحة النفسية للطالب.

الباحثة: بنظرك ماهي المتطلبات اتي يجب توافرها لوضع تحقيق الصحة النفسية ضمن الإطار العملي؟

س\س: حتى يتم وضع تحقيق الصحة النفسية في الإطار العملي و الاخذ به كمنهج في مدارس الكويت لا بد أولا" من تجربته بأحد المدارس وتقييمه ومعرفة نقاط الضعف والقوة به ومن ثم تطبيقه في مدارس الكويت...لأنه ليس من السهل أن تطالب الناس بالتغيير المفاجيء عليك أن تقنعهم بالنتائج أولا". فلا بد أن يكون التغيير تدريجي وشامل.. فلا بد كما أسلفت أن يكون التغيير بحيث يكون الاهتمام بالصحة النفسية هو محور العمل بالمدرسة وفريق العمل بها.. ثم بعد ذلك تسن لوائح تلزم طاقم العاملين بالمدرسة بتحقيق الصحة النفسية للطالب ..فالإدارة المدرسية لابد من أن توافق وأن تساهم بذلك بتذليل العقبات أمام المعلمين والطلبة... الإدارة نفسها يجب ان يتم العمل على رفع مستوى الوعي لديهم بأهمية تحقيق الصحة النفسية للطلبة والمتطلبات اللازمة لذلك.... والمعلمين لا بد أن يكون التركيز بالخطوة التالية عليهم لانهم من أكثر الأشخاص في المدرسة إحتكاكا" مع الطلبة وذلك بتوفيرالتدريب والتعليم المناسب للمعلمين من خلال الدورات التدريبية

والكورسات التعليمية لزيادة وعيهم بالدرجة الأولى و مهاراتهم ومعلوماتهم بالأمور النفسية للطلبة.... لأن أهم ما في هذا الصدد اننا كمعلمين فعلا" لا نملك ما يكفي من المهارات والمعرفة ما يمكننا أن نساهم بهذا الأمر بثقة أكثر.... فمثلا الكثير من كمعلمين يعتقد أن بعض المظاهر السلوكية غير السوية بالمدرسة أو الفصل الدراسي بالخصوص تعني وجود مشكلة نفسية وهي قد لا تكون كذلك..... متى ما حصلنا على التدريب المناسب والمعلومات الكافية من خلال الكورسات التعليمية فيما يتعلق بمساعدتنا كمعلمين لنتمكن من ملاحظة المشكلات النفسية ومؤشراتها لدى الطلبة في الفصل وسوف نكون على قدر من الثقة بالنفس و القدرة على مساندتهم... لأن اي شخص يحتاج لقدر من التدريب والتعليم مما يساعده لتحسين مستواه في حقل عمله.فإذا كانوا جادين فيا يخص الكورسات التدريبية والتعليميةعليهم أن يخططوا وينظموا بشكل جيد على أن يكون هذا التدريب مستمر وليس لمرة واحدة في المشوار التدريسي للمعلم. ..فللأسف لا يوجد مصادر للمعلومات يستفيد منها المعلم في تثقيف نفسه بأمور الصحة النفسية للطالب فلا يوجد كتيبات أو حتى منشورات أو كتب صممت وكتبت بطريقة تربوية مفهومة وسهلة ليحصل من خلالها المعلمون على المعلومات المتعلقة بالصحة النفسية للطالب وحتى لا يتوافر يوجد أشخاص مختصون للاتصال بهم والتعلم منهم كيفية مساعدة ومساندةهؤلاء الطلبة .أعلم أن لدينا مرشدين نفسيين ولكن هؤلاء لا يقومون بدور فعال بالمدرسة..فنحن نلاحظ أن الشيء الوحيد الذي يقومون به هو تحويل الطلبة الذي تسوء مشكلاتهم النفسية إلى المختصين بإعتقادي أن المدرسة ليست مجهزة بالشكل الكافي حتى الآن في بعض الأحيان إذا لاحظنا أي مشكلة نفسية لدى الطلبة فإننا نشعر أننا نحتاج لنعرف الكثير عن مشكلاتهم ولكن مصادر المعلومات المتعلقة بهذه الأمور ضئيلة وقد تكون معدومة وغير متوافرة نهائيا"..

الباحثة: هل تعتقد أن تحقيق الصحة النفسية للطالب قد تعود على الطالب بالنفع أم لا؟

س\س: نعم.... فمن الناحية النفسية والاجتماعية فإن الطالب عندما يجد الآخرين وخصوصا معلمه يبدي الاهتمام به وبمشكلاته النفسية سوف يحسن ذلك من حالته النفسية وثقته بنفسه ومفهومه لذاته لأنه يمكن من فهم نفسه جيدا".. وذلك أن المعلم يقدره ويسانده نفسيا" ويتعاطف معه ويدعمه ويحترم احتياجاته ويستمع إليه ويبني معه علاقة قوية ويساعده في استخدام المهارات والأساليب في حل مشكلاته ....هذا كله بدوره سوف ينعكس على تحسن الحالة النفسية للطالب الذي يعاني من مشكلة نفسية وبناء الجانب الوقائي من المشكلات النفسية والمرض النفسي بتجنب العوامل المؤدية للإصابة بالمرض النفسي...كما أن الطلبة سوف ينعكس بسلوكيات إيجابية لدى معظم الطلبة وذلك بتعاملهم بصورة أكثر إيجابية مع الطلاب الذين لديهم مشكلات نفسية ويساندونه ويتعاطفون معهم.

الباحثة: ومن الناحية الأكاديمية ماذا يفيد تحقيق الصحة النفسية للطالب برأيك؟

س\س: أعتقد أن الطلبة إذا شعروا أن حاجاتهم النفسية مشبعة وأن هناك من يراعي ويساهم في تحقيق صحتهم النفسية فإن ذلك سينعكس بإنجاز أكاديمي من قبل هؤلاء الطلبة لأن هناك من يساندهم ويشاركهم مشاكلهم ومخاوفهم واهتمامتهم . فإني أعتقد أن الطالب المستقر نفسيا" هو شخص قادر على الإنجاز الأكاديمي بشكل أفضل.

الباحثة : إذن أنت تؤمن بحق هؤلاء الطلبة بان يكونوا أصحاء نفسيين؟

س\س: نعم.. أنا أن الصحة النفسية حق للجميع .....لكل فرد في المجتمع الحق في أن يعيش بصحة نفسية جيدة ..والطلبة هم جزء من المجتمع وجزء مهم وفعال في بناء المجتمعات وبناء هذا الجزء والاهتمام به لا يكون من خلال توفير الدعم للصحة البدنية فقط والمادية ... بل من خلال البناء الداخلي أي البناء النفسي....يجب أن يشعر هؤلاء الطلبة بالاستقرار

النفسي ليتمكنوا من الإنجاز الأكاديمي في المدرسة..... فالصحة النفسية جزء مهم وحيوي و لا يتجزأ من الصحة الكاملة للفرد.

الباحثة: "تحقيق الصحة النفسية للطالب" بما يشعرك هذا المصطلح... بمعنى آخر بما يشعرك من أن يطلب منك مدير المدرسة أن تضم طالب يعاني من مشكلات نفسية إلى فصلك أو حتى أن تتعامل مع طالب يعاني من مشكلة نفسية ؟

س\س: بإعتقادي ان تحقيق الصحة النفسية للطلبة بالمدارس قد يغير وجه المجتمع لأنه قد يسهم بتقلل نسبة المصابين بالأمراض النفسية بين صغار السن والطلبة بشكل خاص...مما يقلل بدوره التكاليف في علاج الحالات والمشكلات النفسية من قبل الحكومة.... بالنسبة لي فإنني أشعر بالراحة والتفاؤل لمثل هذا الأمر ولكنني أعتقد أن الامر الذي سوف يقودنا بالشعور بعدم الراحة هو افتقارنا للمعرفة والتدريب الكافي قد يقودنا للشعور بعدم الراحة..

الباحثة: من الناحية العملية هل أنت مستعد لأي تغيير يطلب منك للمساهمة في تحقيق الصحة النفسية؟

س\س: ماذا تقصد بالتغيير هنا؟

الباحثة: أقصد ماذا لويطلب منك أن تشارك في الكورسات التعليمية أو الورش التدريبية الخاصة بالأمور النفسية للطالب مثلا"؟

س\س: نعم.... أنا على استعداد أن أشارك ...لأنه لكي نكون قادرين على مساعدة ودعم الطلبة بالأمور التي تتعلق بصحتهم النفسية فنحن نحتاج إلى أن يكون لدينا خلفية عن الصحة النفسية.. لأن حقل الصحة النفسية والأمور النفسية واسع..ونحن نريد أن نعرف الكثيرعنه قبل أن يبدأ العمل بأي نوع من عملية تحقيق الصحة النفسية هذه...فبمعرفتنا الكثير عن هذه المنطقة سوف يكون بإمكان المعلمين فهم مشكلات طلبتهم النفسية وطبيعتها وطرق التعامل معها...كما أنه يكون من السهل عليهم تقديم العون لهؤلاء الطلبة .لأن المعلم في هذه الحالة لديه خلفية معقولة من المعلومات التي تدخل الثقة بنفسه عندما يستشيره الطالب ويطلب عونه ونصيحته في مثل هذه الأمور.

الباحثة : من وجهة نظرك الشخصية.... هل يمتلك المعلم العادي المعرفة والتدريب اللازم المتعلقين بأمورالصحة النفسية للطالب ؟ وما هي أنسب الطرق التي يمكن اتباعها لزيادة معرفة المعلم ووعيه بما يتعلق بهذا الجانب من وجهة نظرك ؟

ه\م: اعتقد أن المعلمين تنقصهم بالفعل المعرفة المطلوبة و المهارات اللازمة للتعامل مع مشكلات الطلبة النفسية. في رأيي الشخصي إن الطريقة الأنسب لرفع مستوى وعي هؤلاء المعلمين من خلال الكورسات التعليمية للمعلمين والتدريب على المهارات المطلوبة للتعامل مع الأمور النفسية للطالب

الباحثة : بنظرك ما هو التدريب الذي يتطلعون إليه؟....هل هو تدريب من النوع العام؟ أم هناك تدريب من نوع معين؟ هل هناك مواضيع معينة يفضل المعلمين أن يشملها التدريب؟

ه\م: يجب ان تبدأ مثل هذه الكورسات التعليمية وورش التدريب بالمعلومات العامة بما يتعلق بالأمور النفسية للطالب ثم تتدرج إلى الأمور الأكثر تخصص حتى لا يشعر المعلم بالملل والإحساس بالصعوبة من التعامل مع هذه الأمور وينعكس هذا بدوره على اتجاهاتهم نحو القيام بدورهم نحو تحقيق الصحة النفسية للطالب... ومن الأفضل ان يكون هذا التدريب مستمر وبشكل دوري على الأقل لكل ثلاث سنوات حتى يتمكن المعلم أن يلم بالمستجدات للأمور النفسية المتعلقة بالصحة

النفسية للطالبزز على أن تشمل خطط التدريب هذه مديري المدارس والإداريين والمشرفيين الفنيين لأن منهم من ليسوا على معرفة كافية بالأمور النفسية للطالب وما يتطلبه التطبيق العملي لعملية تحقيق الصحة النفسية للطلبة وما يتوجب على المعلمين القيام به... وهذا من باب مراعاة المعلم أيضا" فإن كانت هناك حالات نفسية أو طلبة يعانون من مشكلات نفسية في فصله ... وتكون الإدارة على علم بذلك... يراعى إعطاءه الوقت الكافي للتعامل مع هؤلاء الطلبة ولا يضغط بالمنهج الدراسي أو حتى الجدول في هذه الظروف... لتكون النتيجة شعور المعلم بالراحة وتفهم الآخرين لعمله ومراعاته مما ينعكس على منح المعلم الوقت الكافي لمراعاة الصحة النفسية للطالب..بشكل أكبر....لأن مدى تفهم إدارة المدرسة والمشرفين الفنيين الذين يقيمون ويراقبون عمل المعلم لمتطلبات عملية تحقيق الصحة النفسية للطالب يساهم هنا بشكل كبير في تحقيق التقدم والنجاح كعوائد من هذه العملية..... لأن مدير المدرسة والمشرفين هم المسئولين عن الموافقة للسماح للمعلم الحصول على أي مرونة في الجدول المدرسي أو حتى المنهج المدرسي بما يخدم مراعاة هؤلاء الطلبة ونفسياتهم... فأغلب المعلمين يشعرون بالضيق والضغط من الطريقة التي يتم التعامل بها من قبل إدارة المدرسة الذي بدوره يساهم في نقص الدافع لدى هؤلاء المعلمين للتدريس.. فنحن نشعر أن هؤلاء المدراء والمشرفين الفنين بالمدارس ليسوا على درجة من الكفاءة لقيادة وتوجيه عملية تحقيق الصحة النفسية للطالب لأنهم غير مؤهلون لذلك قد يظهر بعض الجدل والصراعات بين المعلمين والنظار والمشرفين بشأن تنفيذ تحقيق الصحة النفسية عمليا" على ارض الواقع...لأن في الحقيقة ما يقلق هؤلاء المعلمين هي التقارير السنوية لكفاءتهم المهنية وذلك لأهمية هذه التقارير للحصول على الترقيات في السلم الوظيفي...كما أن تقارير الطلبة السنوية تعتمد بالدرجة الأولى على تحصيل الطلبة الأكاديمي بناء على ما يدرس لهم من مواضيع من قبل المدرسين والمعلمين ينظرون لأي أنشطة إضافية أخرى أو خطط لن تدعم تقاريرهم السنوية كمعلمين برايهم.. وبذلك يكون نقص المسؤولية والعمل المشترك بين إدارة المدرسة والمشرفين والمدرسين قد يعيق عملية تحقيق الصحة النفسية .

الباحثة: هل تعتقد أن نقص مثل هذه المهارات والمعرفة للتعامل مع المشكلات النفسية قد تعيق من مساهمةالمعلمين نحو تحقيق الصحة النفسية للطالب.؟

س\س: .نعم لأن امتلاك المعلم لهذه المهارات سوف ينعكس بزيادة ثقة الطلبة بأنفسهم في حال مناقشتهم لأمورهم النفسية وأحلامهم مع معلميهم وطلبهم للنصيحة والدعم منهم...وهذا سوف ينتج بناء أساس صلب يساهم في تطور شخص ناضج برأيي داخل طفل صغير بالنهاية مما يفيده في مستقبله ويحقق توقعات المجتمع عنه ويحرز إنجازات طيبة من الناحية التعليمية...كما أن التدريب على الأمور النفسية للطالب يساعد المعلم على اكتساب الأساليب اللازمة للتعامل مع المشكلات النفسية للطلبة مما ينعكس على توفر الثقة بالنفس بالنسبة للمعلم....برأيي المهارات والمعرفة المطلوبة للتعامل مع هذه المشكلات مهمة.. ومتى ما توافرت ومتى ما حصل عليها المعلم سوف يشعر بمزيد من الثقة بنفسه والراحة لتقديم المساعدة لطلبته..فهي تكسب المعلم المزيد من الصبر للتعامل مع الطلبة الذين يعانون من هذه المشكلات أو من في خطر من المعاناة منها.

الباحثة: وهل هناك معوقات أخرى برأيك قد تؤثرعلى اتجاهات المعلمين نحو تحقيق الصحة النفسية للطالب؟

س\س: نعم..اتجاهات المعلمين السلبية نحو المشكلات النفسية... وما يشعره المعلمين اتجاه ما يسمى بالصحة النفسية وعلم النفس والمريض النفسي..... فمازال هناك العديد من المعلمين الذين لا يستطيعون الشعور بالراحة عند التعامل مع المشكلات النفسية لدى طلبتهم فهم قد يشعرون الرهبة. لذا تجد الكثيرين منهم يتحاشون التعامل مع الطلبة الذين يعانون من

هذه المشكلات النفسية ويفضلون التعامل السطحي وعدم الخوض في التحدث معهم عن أي أمور بعيدة عن متطلبات الدراسة والواجبات المنزلية بل إن البعض الآخر لا يتحدث معهم البتة خوفا" من تلقي رداة فعل سلبية منهم.. فالصورة التي يصور بها الإعلام بها اصحاب المشكلات النفسية قد تظل عالقة بأذهان هؤلاء المعلمين...وهذا بدوره يعطل من إسهام المعلم بتحقيق الصحة النفسية للطالب.

الباحثة: هل هناك معوقات أخرى ؟

س\اس: أن ملاحظة الحالة النفسية للطلبة وملاحظة أمورهم ومشكلاتهم النفسية والعلامات التي قد تشير إلى معاناتهم من مشكلات نفسية قد تتسبب في مزيد من الضغط على المعلم الذي قد يقوم بتدريس أكثر من سبعة حصص يوميا" فأنت تعلم أن جداول المعلمين متغيرة للنقص في طاقم المعلمين بعض الأحيان بسبب غياب بعض المعلمين وهذا قد يؤدي لزيادة الضغط على المعلم ..... فكيف تطلب من المعلم أن يقوم بذلك وهو يشعر بالضغط من كم المتطلبات التدريسية المطلوبة منه والإدارية وإعداد تقارير الطلبة ورصد الدرجات ومراقبة الطابور الصباحي والمراقبة اثناء الفسحة المدرسية... هذا ضغط عمل إضافي يضاف للضغط الموجود اساسا" في عمل المعلم... فكم العمل المطلوب منا كمعلمين قد يكون من العوائق في طريق تحقيق الصحة النفسية للطالب...

الباحثة: هل يعيق الكم المكثف من مواضيع المنهج الدراسي المطلوب من المعلم تغطيتها بوقت معين التقدم نحو تحقيق تحقيق الصحة النفسية للطالب؟

س\اس: نعم .. فأنت تطلب من المعلم جهد إضافي إلى جانب مسئوليته بتغطية هذا المنهج مما لا يسمح به الوقت المتاح له... كما ان القيام بالمساهمة بهذه العملية قد يؤدي لقيام المعلمين بأدوار أخرى مثل الدور الإداري والدور التعليمي المتعارف عليه في فصولهم.

الباحثة: هل بإمكانك ان تشرح لنا هذا الأدوار؟

س\اس: الدور الإداري خاص بإدارة الفصل والتعامل مع المشكلات النفسية للطلبة وملاحظة مشكلاتهم النفسية لأن هذه ليست مهمة سهلة للمعلمين فانت كمعلم قد تواجه صعوبة بإدارة الفصل إذا كان لديك طلبة يعانون من مشكلات بالصحة النفسية وخاصة لو كان هناك لو كان الصف يضم عدد كبير من الطلبة أساسا" لان عليك بالسيطرة عل الوضعوالتحكم به وتنظيمه.... فإذا كنا نناشد المعلم بالمساهمة في دوره بتحقيق الصحة النفسية لابد ان نقلل من عدد الطلبة بالفصل حتى يتمكن المعلم من القدرة على ملاحظة الطلبة ومشكلاتهم النفسية مع عدد معقول من الطلبة في الفصل... فالفصول في مدارسنا تتعدى أعدادها الأربعين طالب ...أما الدور التعليمي فهو يتمثل في في التخلي عن الطرق التقليدية والغير مناسبة المستخدمة هذه الأيام لتقديم وشرح الدروس.....إنهنا بحاجةلاستخدام طرق مستحدثة من التكنولوجيا وخاصة مع المراهقين في مرحلة المتوسطة ممن يعيشون في ثورة تكنولوجية عظيمة.....هذه الطرق التقليدية قد لا تكون مجدية وقد لا تمكن المعلمين من استقطاع وقت كافي لقضائه مع طلبته للتحدث عن اهتماماتهم وهمومهم... بينما الطرق الحديثة توفر له الوقت و مع تحقيق تعليم نوعي جيد للطلبة يحققون منه الاستفدة الضخمة. وبالتالي توفر مساحة لمساهمة المعلم بتحقيق الصحة النفسية للطالب.

الباحثة: إلى أي مدى سوف تكون فكرة ان يطلب من المدرسين أن يساهموا في تحقيق الصحة النفسية للطالب بشكل عملي مقبولة في مدارس الكويت اليوم مثلا" أن يطلب منهم تدريس مقرر للصحة النفسية ؟

س\س: أعتقد أن هذه الفكرة قد تلاقي القبول لدى المعلمين...بالنسبة لي شخصيا" فأنا أؤيد الفكرة لشدة إيماني بدور المعلم بتحقيق الصحة النفسية للطالب فأنا من المشجعين لهذه العملية وأعتقد أن معظم المعلمين سيتقبلون الفكرة إذما توافرت لهم التسهيلات المطلوبة والمساندة ..

الباحثة: هل بإعتقادك الشخصي أن عملية تحقيق الصحة النفسية للطلبة تحتاج للدعم المادي وهل الدعم هذا كافي في المدارس؟أم يقف كعائق نحو وضع تحقيق الصحة النفسيةعلى أرض الواقع؟

س\س: عادة ما يتلقى نظار ومديري المدارس ميزانية سنوية لمدارسهم من وزارة التربية في الكويت وهم دائما" ما يرددون أن هذه الميزانية بالكاد تغطي احتياجات مدارسهم المادية المطلوبة....أنا شخصيا" لا اعتقد أنهم سوف يقومون بتخصيص جزء من هذه الميزانية في الأمور النفسية للطالب واعتقد ان عذرهم سوف يكون أن وزارة التربية قامت بتعيين مرشدين نفسيين بالمدارس وأنهم سوف يطلبون تمويل إضافي ليتمكنوا من توفير ما بيلزم المعلمين ليساهموا بدورهم في تحقيق الصحة النفسية للطلبة..... بإعتقادي أن الكويت دولة غنية وأن من الأولية تخصيص جزء من ميزانيتها لتمويل المشاريع أوالمناهج التي تتبناها بعض المدارس والمتعلقة بتحقيق الصحة النفسية للطلبة وتستفيد من تجارب الدول الأخرى كالمملكة المتحدة واستراليا والولايات المتحدة مثلا" مع الأخذ بالاعتبار أن ليس كل ما طبق في هذه الدول يتناسب مع المعايير الثقافية للدول الأخرى لأنه ما يصلح للتطبيق في الولايات المتحدة قد لا يصلح للتطبيق في المملكة المتحدة مثلا".... وبالنهاية فأن الحالة النفسية للطالب تعتبر جزء مهم من صحته الكلية لها تأثيرها الكبير على إنجازه الأكاديمي.

الباحثة : برأيك الشخصي ما هي هذه التغيرات التي يمكن أن تجعل تحقيق الصحة النفسية حقيقة على أرض الواقع؟ هل بإمكانك ذكر هذه التغيرات ؟

س\س: نعم لنصل إلى مجتمع متعاون لديه حس المساندة والدعم لهؤلاء الأشخاص الين يعانون من المشكلات النفسية أو حتى دعم الآخرين الذين لا يعانون من المشكلات النفسية وتحقيق صحتهم النفسية علينا أن نكون أكثر وعي نحو الأمور النفسية بشكل عام واحتياجات الطلبة النفسية ومشكلاتهم النفسية كمدرسين بشكل خاص. إن نظرة المجتمع للصحة النفسيةيجب أن تتغيرعن طريق وسائل الاعلام وإقامة الندوات والمؤتمرات والبرامج التدريبية والمحاضرات والمهرجانات الخطابية العامة.كما انه يجب تشجيع المرشديين النفسيين الاسلاميين الذين ينتشرون هذه الايام أو ما نسميهم رجال الدين على ممارسة دورهم المهم لزيادة الوعي لدى مراجيعهم بالمشكلات النفسية و تقبل مشكلاتهم واستشارة المتخصصين بالصحة النفسية بالاضافة لهذه الارشادات الدينية ليحصلوا على فائدة اعظم.... ويجب ان يقوم الاعلام بدوره المكثف حيال تحفيز المجتمع على النظرة الايجابية للمشكلات النفسية وكيفية التعامل معها و دور المدرسة بنفس الطريقة التي يغطي بها الاعلام المواضيع الأخرى..ولا ننسى دور الوالدين والأسرى في دعم المدرسة وتسهيل القيام بدورها المساند لتحقيق الصحة النفسية للطلبة.....إنما يفكر به صناع القرار التربوي وواضعي السياسات التربوية والطريقة التي يفكرون بها...مهمة إذا كنا ننظر لتغيير مباشر عليهم أن يغيروا ما يؤمنون به فهم مازالوا ملتصقين بهذا النظام النربوي الذي يركز على حفظ المواد عن ظهر قلب للتسميع بالامتحانات... إن التغيير بأي سياسة عن تحقيق الصحة النفسية يجب أن تكون قدر

الامكان منذ السنوات المبكرة من الحضانة مثلا"..لأنه سوف يكون من السهل بعد ذلك أن تتم في مراحل تعليمية أخرى....كالمرحلة المتوسطة والثانوية..... حجم الفصل كذلك ..إذا كنا ننظر إلى عملية تحقيق صحة نفسية ناجحة فنحن نحتاج أن يكون حجم الفصول معقول... كما أن ما سوف يقدم للطلبة من مناهج نفسية واجتماعية مما توفر لهم معلومات للتغلب على ضغوطهم ومشكلاتهم وترفع من مستوى الوعي لديهم بما قد يواجهونه من مشكلات نفسية هذا النوع من المناهج يجب ان يوفر للمعلم ايضا"....ليساندهم.... للقيام بدورهم بتحقيق الصحة النفسية للطلبة... كذلك إذا أردنا من المعلم أن يهتم بالأمور النفسية للطلبة علينا أن نهتم نحن بصحته النفسية لاننا في بعض الأحيان كمعلمين قد نشعر بالضغط والتعب ونحتاج الدع ولا نجده فالتربويين عليهم ان يهتموا بهذه الناحية ويوفروا الخدمات المناسبة للمعلمين بهذا الشأن... فنحن نعلم أن العقول السليمة تنشأ عقول سليمة.... ومع هذا للأسف المعلميين ليس لديهم الصلاحية لإحداث اي تغييرات في خططهم التدريسية وعليهم أن يتبعوا خطط صارمة من الوزارة وهذا لن يجدي نفعا" إذا اردت هؤلاء المعلمين أن يساهموا بتحقيق الصحة النفسية لطلبتهم...فهم يحتاجون للضوء الأخضر ليصيغوا خططهم التدريسية بما يستوفي احتياجات الطلبة الأكاديمية والاجتماعية والنفسية وكذلك لا ننسى أن الدعم الأول للمعلمين للوصول هذا الهدف هو تزويدهم بالمعرفة والتدريب الكافيين.

نموذج مقابلة(2):

الباحثة:ماذا يعني مفهوم" الصحة النفسية" بالنسبة إليك؟

ه\م: في نظري الشخصي الصحة النفسية مرتبطة بالمرض العقلي ومدى إصابة الفرد به. الصحة النفسية هي خلو الفرد من المرض العقلي.....أي بمعنى آخر متى ما كان الفرد لا يعاني من أي مرض عقلي نستطيع أن نقول أن هذا الشخص لديه صحة نفسية جيدة. لأن المرض العقلي يؤثر على تعاطي الشخص مع أمور حياته وعلاقته مع الآحرين و مسؤولياته ضمن إطار الأسرة والعمل ويجعله غير قادر على العيش بصورة طبيعية.

الباحثة:إذا ماهو "المرض العقلي" بنظرك؟

ه\م: المرض العقلي هو حالة مرضية قد تشمل اضطرابات نفسية حادة في الدرجة قد تتطلب تناول العقاقير والايداع بمستشفى الطب النفسي...هو مرض يفقد الشخص السيطرة على سلوكه وقد يكون واعي بذلك أو لا ... وقد يقوم الشخص بأمور قد تشكل الخطر نحو الآخرين وتهدد حياتهم .. وقد تكون هذه الأمور سلوكية كالاعتداء البدني على الآخرين وبالتالي المرض العقلي درجة مرضية حادة جدا" لا ينفع ترك المريض بها يتعايش مع الآخرين حتى يتشافى بتاتا" من المرض...

الباحثة:وفي اعتقادك كيف تكونت لديك هذه الفكرة او لدى الآخرين عن المريض العقلي؟

ه\م: من المجتمع ..المجتمع هو الذي يدعم هذه التصورات فما كنا نسمعه من الأهل والأسرة والأقارب وما كنا نسمعه من القصص عن هؤلاء الأشخاص المصابين بالأمراض والذين يعانون من مشكلات نفسية وعقلية منذ كنا صغار قد انعكست علينا بتكون وجعلتنا نرى المريض النفسي بأنه الشخص الذي يجب ان تتحاشى التعامل أو حتى الحديث معه....لأننا لا نضمن ردة فعله كما نرى أحيانا" ..... ففي الأفلام يظهر الذين يعانون من مشكلات نفسية يتصرفون بعدائية غير متوقعة وقد يرتكبون جرائم قتل مثلا"...فبالتالي المجتمع ونظرته للمريض النفسي التي قد تكون توارثها افراد المجتمع من أهاليهم على مر الزمن بناء على تجارب وقصص عايشوها أو سمعوا بها يورثونها بدورهم إلى أبنائهم... و الاعلام كذلك يدعم هذه الموروثات الثقافية في المجتمع بتصويره الخاطىء للأشخاص الذين يعانون من الأمراض النفسية... بالنسبة لي شخصيا" أنا قد ارى ان فعلا" هؤلاء الاشخاص قد يسببون الرعب للآخرين بسبب ما يسمعونه من قصص ويشاهدونه من أفلام.

الباحثة :إذا أنت ترى أن هناك إختلاف بين المرض العقلي والمشكلة النفسية؟هل لك أن تحدثني بالمزيد عن هذا؟

ه\م: في نظري المريض العقلي درجة المرض لديه حادة.. يتلقى معها الدواء ومراجعة العبادات النفسية. فالمرض أو الاضطراب العقلي قد يتعذر معه توافق الفرد مع ظروفه و ممارسة الحياة بصورة طبيعية...ولكن المشكلة النفسية هي درجة أخف من المرض لم تصل لدرجة المرض وأنه ممكن أن يتشافى منها الفرد متى ما عمل جاهدا" ليكتشف أنفسهم ويكونون قادرين على التكيف مع هذه المشكلة بفعالية وطلب المشورة مثلا" ....لأن الاخذ بالنصح والقيام باتباع خطط للعلاج مثلا" للتغلب على المشكلة..

الباحثة: إذن من هوالشخص الصحيح نفسيا" بنظرك؟

ه/م: برأيي الشخصي.... الفرد يكون سليم نفسيا" هو الذي لا يعاني من اي اضطراب عقلي أو حتى مشكلة نفسية فحتى المعاناة من مشكلة نفسية تؤثر على صحته الشخص النفسية ولا نستطيع أن نقول عنه صحيح نفسيا" حتى يتشافى كلية... ويكون قادر عى العيش بسعادة وبدون اضطرابات تعيق عيشه الحياة بصورة طبيعية...

الباحثة:هل تعتقدأنه بإمكانية الأفراد الذين يعانون من مشكلات نفسية أن يتغلبوا على مشكلاتهم النفسية؟

ه/م: نعم .... من الامكان ان يتشافون من ذلك في حالة تلقيهم النصح والارشاد المناسب وفي الوقت المناسب لأنهم إذا تجاهلوا مشكلاتهم ولم يطلبوا العون والمساندة مبكرا" من الممكن أن تتفاقم المشكلة وتتدهور الحالة النفسية للشخص ويصاب باضطراب نفسي حاد يصعب معه العلاج البسيط والنصح غلى تناول العقاقير والمكوث بالمستشفى.أنا ارى ان المهم الاكتشاف المبكر للمشكلات النفسية....فالوقاية أفضل من العلاج. ولا ننسى دور الدعم من الأسرة والاصدقاء والوالدين في تخطي المشكلات النفسية..

الباحثة: من وجهة نظرك الخاصة..... في مجتمع تقليدي كالمجتمع الكويتي المتمسك بتقاليده ومبادئه الدينية..... هل تؤثرالمعتقدات الاجتماعية والدينية والثقافية السائدة في هذا المجتمع على مفهوم الأفراد للصحة النفسية والمشكلات النفسية ؟

ه/م:بالتأكيد. لها تأثير خاصة على الكيفية التي يفهم بها الناس المشكلات النفسية والطرق المستخدمة في علاجها ....

الباحثة: هل لك أن تشرح لنا كيف يكون هذا التأثير ؟

ه/م: نعم.. فمثلا" الاسرة في المجتمعات العربية والإسلامية... تمثل الداعم الاول للفرد في السراء والضراء لأن الدين والأعراف التقليدية في هذه الجتمعات تملي على الاسرة لتعزيز دورها بمساندة الفرد ومشاركته في إتخاذ أو الزواج أو قرارات الدراسة مثلا" فهنا لا يهمل دور الأسرة ..ففي حالة معاناة الفرد من مشكلة نفسية فإن الأسرة سوف تتساند لدعمه ومساعدته لإيجاد الحل المناسب وبالتالي سوف ينساق الفرد إلى نصيحتهم مثلا" إما بالذهاب إلى المرشد النفسي المعالج ويحصل على المساعدة المثمرة التي تنعكس على اكتسابه للاساليب المناسبة للتعامل مع مشكلته والتغلب عليها قبل ان تتفاقم المشكلة ..أو الذهاب للمعالجين النفسيين الذين قد يستعملون طرق تقليدية من الرقي بالبيات القرانية والأعشاب وقد يستعمل البعض الماه المباركة...أو الضرب ....وكذلك استخدام طرق السحر لإخراج الروح المصاب أو العين الشريرة من جسد هذا الفرد اللتان قد تسببان المشكلة النفسية. الثقافة الاسلامية أحيانا" ترى أن المشكلات النفسية ناتجة عن التقصير بالواجبات الدينية المفروضة نحو الإله" الله" .. وحتى يتخلص هؤلاء الاشخاص من المشكلات النفسية عن طريق التقرب من الإله"الله" بالعبادة والإكثار من الواجبات الدينية .....وهذا بدوره قد يؤثر على طريقة تعاطيهم مع مشكلاتهم أو مشكلات ابنائهم النفسية.

الباحثة: هل بإمكانك أز تذكر بعض من هذه المعتقدات ؟كمعلم في المدرسة ومن خلال ملاحظتك....إلى أي حد مثل هذه المعتقدات تؤثر على توجه بعض أولياء الأمور لطلب المساعدة من المدرسة في حالة ملاحظة أن أبنائهم يعانون من مشكلات نفسية؟

ه/م: بسبب هذه المعتقدات فإن الأشخاص الذين يعانون من المشكلات النفسية قد يسلكون الاتجاه الخاطىء في العلاج .. مما يؤخر العلاج النفسي الصحيح لهؤلاء الافراد ..فرجال الدين المعالجين والمتدينين او المعالجين التقليديين في المجتمع

قد لا يكون لهم الدراية بدرجة المرض لدى هذا المريض مما يفاقم المشكلة النفسية لديه..... وأولياء الأمور أفراد من المجتمع يتاثرون بهذه المعتقدات فقد يعالجون أبنائهم بهذه الطرق ولا يتواصلون مع المعلمين والمتخصصين في المدرسة من مرشديين نفسيين واخصائيين اجتماعيين وإخطارهم بحالات ابنائهم لأن بعضهم قد يميل لإخفاء مشكلات ابنائهم النفسية لخوفهم من أن ينتشر خبر معاناته للأقرباء من خلال المعلمين بالمدرسة وهذا بدوره قد يجعل الأمور يسوء أحيانا" ويؤخر من التشافي بالمرض النفسي..... قد يتحاشى طلب المساعدة من المدرسة وخاصة المرشد النفسي حتى لا يحس ابنه بوصمة المرض النفسي أمام المعلمين وأقرانه بالفصل والمجتمع بصورة عامة ... وكذلك حتى لا يوثق هذا في سجله المدرسي ويتاثر في حالة انتقاله مثلا" من مدرسة إلى اخرى بحيث لا يقبل بسبب هذا السجل من المعاناة من المشكلات النفسية... بعض اولياء الأمور قد يلجئون إلى مراجعة عيادات خاصة وإخفاء الأمر على المدرسة لأن إذا أخبر المرشد النفسي بهذا الأمر قد يقوم بتحويل الطالب لإدارة الخدمة النفسية بالوزارة التي قد تحوله بدورها إلى عيادات الطب النفسي وتوضع نقطة سوداء بسجله المدني...فكي يتلافى أولياء الأمور ذلك يلتزمون الصمت حيال الامور النفسية لأولادهم بل ويرفضون تدخل العاملين بالمدرسة وخاصة المعلمين بالامور النفسية لأبنائهم... وهذا بدوره يقلل من التعاون بين أولياء الأمور والمدرسين والمرشدين النفسيين والاخصائيين الاجتماعيين الذي قد يعد من أهم المعوقات نحو اسهام المعلم بدوره في تحقيق الصحة النفسية بصورة اكثر فعالية....

الباحثة:كمدرس. هل لاحظت أن هناك بعض الطلبة لديهم مشكلات نفسية ؟

ه\م: نعم. لقد مرت علي بعض الحالات.

الباحثة: وكيف تعرف أنهن يعانون من مشكلات نفسية؟

ه\م: كمعلمين تنقصنا الخبرة لاكتشاف هذه المشكلات بصورة مبكرة كما أننا حتى لو اكتشفنا المشكلات فنحن نفتقر إلى الأساليب المناسبه للتعامل مع هؤلاء الطلبة ... أحيانا" نرى الطالب المنعزل عن الطلبة ولا يتحدث ولايلعب معهم ..طالب يعاني من مشكلة وقد لا يكون بالفعل يعاني من مشكلة نفسية فقد تكون طبيعته وشخصيته كذلك ... مثال آخر ..الطالب الكثير النشاط بالفصل والحركة وكثير الأسئلة قد يكون في نظر المعلم يعاني من مشكلة نفسية أو من فرط النشاط ولكن قد تكون طبيعة الطالب أنه نشط ولديه حيوية ومحب للمشاركة في الفصل... ...أو حتى تكون منصفاته الخجل فنحكم عليه بالمرض النفسي بدل أن نشجعه على تجاوز خجله.... .إنها عملية صعبة جدا" ... تحتاج أن يكون المعلم على قدر من المعرفة والتدريب بحيث يستطيع التعامل مع المشكلات إن وجدت او اكتشافها مبكرا حتى يتمكن من مساعدة الطالب ومساندته حتى لا تتفاقم المشكلة وتزيد حدتها. وقد تشكل المعرفة الكافية والتدريب هنا كعائق يحد من يام المعلم بدوره المطلوب في تحقيق الصحة لنفسية للطالب.

الباحثة: برأيك ما هو سبب المشكلات النفسية التي يعاني منها بعض الطلبة؟

ه\م: العوامل الوراثية هي السبب في الدرجة الأولى.... فالطالب الذي لديه تاريخ في أسرته من المرض النفسي كأن يكون لدى والديه أو أحد الوالدين او أقاربه مشكلات نفسية قد تكون فرصة إصابته بالمرض النفسي أكبر... وكذلك الظروف المحيطة بالبيئة التي يعيش بها الطالب ... من مشكلات بالأسرة ومشكلات تخص علاقاته مع أقرانه وأصدقائه ... والمشكلات التي قد يعانيها من أي ظروف مادية في أسرته أو فالمجتمع قد يتسبب له بالمعاناة نفسيا" لأن ما هو متعارف عليه في مجتمعه من مفهوم للمرض النفسي وما يشعر به الآخرين اتجاه المريض النفسي والتعامل معه بحد ذاته من

العوامل التي تزيد من حدة مرضه النفسي فهذه النظرة من المجتمع والاحساس بوصمة العار قد تدفعه كي لا يبيح بمشكلاته النفسية وتسوء الأمور نتيجة لذلك..... أيضا"الطالب الذي لديه مشكلات مثلا" في كيفية تكوين علاقات صداقة أو زمالة لأنه يفتقر للأساليب الي تساعده على ذلك ... قد يعاني من مشكلات نفسية لأن ليس لديه أصدقاء.....كذلك ضغط الامتحانات والواجبات والمتطلبات المدرسية قد تسبب للطالب الضغط النفسي والمشكلات النفسية ..... وكذلك علاقة الطالب بمعلميه.... كلها عوامل عديدة تؤدي لمعاناة الطالب من مشكلات نفسية وهذه العوامل نفسها أحيانا" قد تتسبب في وقايته من المرض النفسي.

الباحثة: هل يمكن أن تشرح ذلك.. كيف تتسبب مثل هذه العوامل في وقاية الطالب من المشكلات النفسية؟

ه‌م: نعم...فالمعاناة مثلا" من أن بعض الوالدين يعانون من مشكلات قد يضاعف من جهد الطالب للعمل على النجاح لتوفير مناخ مناسب اقتصاديا" واجتماعيا" لإسعاد هؤلاء الوالدين أو توفير من يساعده على الإعتناء بهم بعد أن ينجح ويمتهن وظيفة مثلا"....كذلك المدرسة متى ما وفرت المناخ الوقائي للطالب بمساندتها واهتمامها بحالته النفسية سواء يعاني او لا يعاني من مشكلة من خلال مثلا" دعم العلاقاة بينه وبين معلميه وأقرانه والعاملين بالمدرسة... هذا قد يساند الطالب الذي يعاني من مشكلة نفسية بأنها تزيد من امكانية مقاومته للمرض وتخفف من معاناته وتقليل حدة المشكلة بتوفير الدعم والمساندة.. و قد يقلل فرصة المعاناة من مشكلة نفسية للطلبة الآخرين.. فالظروف البيئية المحيطة قد تكون من اهم اسباب المعاناة من المشكلات النفسية...وقد تكون من العوامل الوقائية من المرض النفسي... فمتى ما كانت الظروف المحيطة للطالب ظروف إيجابية تكون حالته النفسية مستقرة يكون إنجازه الأكاديمي أفضل... في بعض الاحيان تكون المشكلة النفسية نتاج لاجتماع كل من الوراثة والبيئة المحيطة كأن يكون للفرد استعداد وراثي للإصابة بالمرض النفسي وتتواجد ظروف بئية محيطة تعزز قابليتة للاصابة بالمرض النفسي...كما قد تسهم مثل هذه الظروف إن كانت إيجابية في حالة من لديهم استعداد وراثي بالحد من إصابتهم بالمرض النفسي... ولا نستطيع أن نهمل دور الأسرة المتماسكة والخالية من الاضطرابات والمشاحنات والتي تساد أفرادها في الأزمات وتساعدهم على التغلب على مشكلاتهم...والتي تتناقش بواقعية وصراحة أمورها مع كل أفرادها... هذه النوعية من الأسرة قد تكون من العوامل المساعدة التي تسهل عملية تحقيق المعم للصحة النفسية للطالب.. فهي أسر على استعداد لأن تناقش الأمور النفسية لأبنائها مع المعلمين مما يعود بالنفع عليهم... اما الأسر التي تعاني من المشاكل وعدم الترابط بين افرادها هي عامل معيق للمعلم في تحقيق الصحة النفسية لطلبته...فهذه الأسرة لا تسمح بمناقشة الأمور النفسية لأبنائهم ..أو قد لا تهتم بذلك.

الباحثة: ماذا يعني بالنسبة لك مفهوم "تحقيق الصحة النفسية للطالب" ؟ وكيف يمكن ان تقوم المدرسة بهذا الدور؟

ه‌م: بإعتقادي الشخصي أن تحقيق الصحة النفسية قد يتم من خلال بناء علاقة قوية بين الطالب ومعلميه بالدرجة الاولى بحيث أنه يمكنه ان يجدوا المساعدة م معلميهم في الوقت الذي يحتاجون إلى مساعدتهم... لأن هذه العلاقة القوية تمكن المعلم من فهم الطالب بصورة أكبر والتقرب اليه وملاحظة التغيرات التي قد تطرأ عليه وعلى حالته النفسية أول باول ...بحيث في حالة وجود أي مؤشرات للمشكلة النفسية فإن المعلم سيقوم بملاحظتها مبكرا" ....ثم ياتي بعد ذلك دور تدريب المعلمين على التعامل مع احتياجات الطلبة ومشكلاتهم النفسية وتثقيفهم ورفع مستوى وعيهم بذلك.. والذي يجب ان تتبناه المدارس كجزء من خططها وسياسيتها التربوية وان تموله كذلك ....لأن متى ما كانت الصحة النفسية للطلبة جيدة...كلما أشار ذلك إلى وضع المدرسة الجيد كمكان تربوي...

الباحثة: هل ترى أن ملاحظة الصحة النفسية للطالب وتحقيق صحته النفسية هو جزء من وظيفتك كمعلم؟

م١م: قد لا تكون مؤوليته كما قلت بل جزء من مسؤوليته...ولكن متى ما توافرت له الامكانيات من المعرفة والتدريب والعمل والمسؤولية المشتركة بينه وبين الادارة والمختصين سيكون قادر على أن يقوم بتقبل هذا الجزء من المسؤولية ...فهو له موقعه المهم والقريب من الطالب الذي يمكنه من المساهمة بهذا الجزء من المسئولية .. ولكن توافر الشروط السابقة يسهل له القيام بمسؤوليته بفعالية أكثر...

الباحثة: كيف تساهم أنت كمعلم في تحقيق الصحة النفسية لطلبتك؟

م١م: ... تحقيق الصحة النفسية في مدارسنا بالكويت قد يكون واضح وموجود بالفعل من خلال متابعة المرشد النفسي والمتخصصين بالصحة النفسية بالمدرسة فالمرشد النفسي يقوم بمتابعة الحالات التي تحتاج للمتابعة والتي يبلغ عنها من خلال المعلمين أو الأهل فهم يحاولون مساعدته وتقديم الدعم لهم حيث يتم تحويل حالات المشكلات النفسية المتقدمة إلى إدارة الخدمة النفسية بوزارة التربية. أي أن الدور هنا منوط بقسم الارشا النفسي والخدمات النفسية في وزارة التربية في الكويت...وقد لا توكل هذه المهمة لأي من أفراد الطاقم الآخرين في المدرسة للقيام بهذا.. أو حتى قد لا نجد من خلال لوائح وقوانين المدارس في الكويت ما يلزم المدرسة بالقيام أكثر مما تقوم به حاليا" من تسهيل الأمور للمرشد النفسي من متابعة الحالات التي تتطلب متابعة وتحويل الحالات النفسية التي تتطلب التدخلات الإرشادية المتقدمة إلى إدارة الخدمة النفسية بوزارة التربية والتي يشرف عليها متخصصون في العلاج النفسي... فالمهمة هنا مرتبطة بطاقم المرشدين النفسيين بالمدرسة والوزارة ومساندة الأخصائي الاجتماعي بالمدرسة... وإذا طلب من المدارس أن تظهر دورها أو مسؤوليتها...فلابد أن يكون هناك تغير في السياسة المدرسية وصياغة قوانين ولوائح جديدة تملي على المدرسة إلتزاماتها نحو تحقيق الصحة النفسية لطلبتها على المستوى العملي وليس فقط وضع لوائح أو حتى مثلا" توفير دورات تدريبية وتعليمية للمعلمين أو إقرار منهج لتدريس الصحة النفسية للطلبة..أو حتى تطبيق لبعض البرامج الإرشادية بالمدرسة من قبل المرشدين النفسين... فالمدرسة بإمكانها توفير البيئة المناسبة والوقائية من المشكلات والأمراض النفسية .. .. لابد للمدرسة أن تجعل الصحة النفسية محور مقرراتها وأنشطتها المدرسية وسياساتها وقوانينها..نظرا" لأهمية الصحة النفسة للطالب وتأثيرها على تحصيله الأكاديمي... ولكن هذا لا يعني أن لا يكون هناك دور مهم للمدرسة في تحقيق الصحة النفسية للطالب....فالمدرسة لهادورمهم وفعال فالمدرسة يمكن ان تضع بنود ضمن لوائحها تلزم المعلمين بضرورة تأكيد دورهم في تحقيق الصحة النفسية بحيث تشجع المعلم ماديا" أو معنويا" من أجل الاهتمام بملاحظة الصحة النفسية للطالب... وقد يكون الأمر صعب على المعلم في البداية لأن المعلم لديه من المتطلبات الخاصة بالتدريس وإنهاء المقررات المدرسية وإعداد الإمتحانات ورصد الدرجات ما هوكفيل بأن لا يترك له الوقت الإضافي للقيام بالمساهمة بتحقيق الصحة النفسية للطالب... فتحقيق الصحة النفسية في نظري هو تقديم الدعم والمساندة لهؤلاء الطلبة الذين يعانون من المشكلات النفسية وتعلميهم لاكتساب المهارات المناسبة لتجاوز هذه المشكلات وكذلك على المدرسة أت تضع سياسات واضحة يشارك فيها كل العاملين بالمدرسة لتحقيق الصحة النفسية للطالب... لأن الأمر قد لايكون فقط سن قوانين ولوائح تلزم العاملين بالمدرسة بالمساهمة بتحقيق الصحة النفسية للطلبة....وقد يكون في نظري الخطوة الأولى في كل هذا رفع مستوى الوعي لدى المعلمين بأهمية دورهم ومسؤوليتهم يتحقيق الصحة النفسية للطالب بدلا من البدء بسن القوانين أولا"..فالعمل يجب أن يكون كفريق عمل واحد..... فالمدرسة متمثلة بالإدارة والمعلمين والمرشدين النفسيين والأخصائيين الاجتماعيين وكل فرد من العاملين بالمدرسة ها دور مهم بملاحظة الصحة النفسية للطالب وهم يجب أن يعملوا مجتمعين كوحدة واحدة

ليحققوا الأهداف المطلوبة بصورة أكثر فعالية. ... لأن التعامل مع أي مشكلة نفسية للطالب تتطلب التعاون بين كل هؤلاء فمثلا" نحتاج أن نعرف التاريخ الأسري والمرضي والوضع الاجتماعي والإقتصادي للطالب.كما أن على المدرسة أن تعزز الرؤى التي تقول أن المدرسة مؤسسة اجتماعية قبل ان تكون تعليمية... فابناء لعلاقات بين فريق العمل في المدرسة والترابط بين أفراد طاقم العاملين بالمدرسة بصورة قوية ومترابطة كفريق عمل واحد ينعكس على آداء المعلم الذي بدوره ينعكس على العلاقة بين الطالب ومعلمه وكذلك يعطي الطالب الفرصة لبناء علاقات اجتماعية بينه وبين معلمه وأصدقائه وزملاءه بالفصل...وهنا تكون المدرسة مصدر بناء اجتماعي أكسب الطالب القدرة على بناء العلاقات الاجتماعية وتقدير دورها بحياته كما أكسبه الخبرة والمهارات المساعدة على ذلك.

الباحثة: من وجهة نظرك الشخصية.. هل تؤثر المعتقدات الدينية والاجتماعية والثقافية السائدة والصورة التي تقدمها وسائل الاعلام عن المرض النفسي في المجتمع الكويتي على اتجاهات المعلمين في تحقيق الصحة النفسية بالمدارس بالكويت؟

ه\م: نعم يتأثر المعلم بهذه المعتقدات الدينية والاجتماعية فقد يرسم في ذهنه انطباع عن هذا الطالب الذي يعاني من مشكلة نفسية .. على انه مقصر في واجباته الدينية او أنه مثلا" متلبس بالجن او السحر فينعكس هذا بردة فعل عكسية بأن يتحاشى المعلم هذا الطالب والتعامل مع أو مساعدته خاصة إذا كان ملتزم دينيا" أو قد ينعكس إيجابيا" بأن يقدم المعلم ما لديه من مسادة ومن دعم لإعادة هذا الطالب لطريق الصواب الصحيح والهداية بتشجيعه الالتزام بالدين وعدم التقصير بالواجبات الدينية...قد يتاثر بعض المعلمين إيجابيا" بهذه المعتقدات فإذا كان المعلم لا يؤمن بها فقد يتقدم بالنصح والإرشاد للطالب أن لا يتعالج لدى المعالجين الدينيين والتقليديين وينصحه بطلب المساعدة من الاستشارين مما يعود على الطالب بالنفع.

الباحثة: حسنا" هذا بالنسبة لتأثير المعتقدات الدينية والثقافية على مدى مساهمة المعلم بدوره بتحقيق الصحة النفسية للطلبة ماذا عن تأثير الإعلام؟

ه\م: الإعلام له الدور الأكبر نظرا" لتطور وسائل الاتصلات والتكنولوجيا...بحيث اصبح بالإمكان القيام بجولة حول العالم بضغطة زر على الكمبيوتر أو التلفاز ...الإعلام بإمكانه تغذية الصورة السلبية التي تزرعها المعتقدات الدينية و والثقافية والتي يتوارثها الفرد من الأسرة...فالمدرس قد ينتابه الخوف من أصحاب المشكلات النفسية ولا يقدم يد العون لطلبته ممن يلاحظ عليهم مؤشرات لهذه المشكلات لأنه يشعر بأنهم يمثلون خطر يهدد سلامته إذا تعامل معهم...فتلك الصورة التي يبثها الإعلام ترسخ في ذهنه وتسيطر على اتجاهه وسلوكه نحو الطالب الذي يعاني من مشكلة نفسية ...وبذلك لا يستطيع المعلم أن يقوم بدوره ومسؤوليته في المساهمة بتحقيق الصحة النفسية للطالب مما ينعكس على الطالب وعلى تدهور مشكلته النفسيةالتي تؤثر على حياته ودراسته.....فهنا نرى الإعلام وبالتحديد الصورة الغير ملائمة والتي يبثها الإعلام عن أصحاب المشكلات النفسية والمرضى النفسيين وبعض المعتقدات الدينية والثقافية والاجتماعية بإعاقة دور المعلم للمساهمة بتحقيق الصحة النفسية....

الباحثة: بنظرك ماهي المتطلبات اتي يجب توافرها لوضع تحقيق الصحة النفسية ضمن الإطار العملي؟

م١م: أولا" لا بد من وجود قانون يقول ان المعلم عليه جزء من هذه المسؤلية....وله دور في دلك لأنه لا يوجد أي قانون فعلي ينص على هذا ...أعتقد أن لمعلم إن لم يعي ذلك بحسه الإنساني يجب ان يتولى القانون مسئولية اشعاره بذلك... بمعنى ان هناك أشخاص يحتاجون لالتزام مكتوب كي يقوموا بمسئوليتهم...قد لا تكون القوانين احيانا" من الوسال المقنعة بالالتزام بالعمل... وهنا يأتي دور الوعي... لابد من رفع مستوى الوعي لدى المعلمين بموقعهم الحساس و طبيعة عملهم الفريد التي تمكنهم من الاسهام بمهمة تحقيق صحة الطالب النفسية وأن عليهم أن يقدموا هذا الدعم لطالب باقصى جهد يستطيعونه...ثم يتم بعد ذلك تدريبهم وتثقيفهم بما يساعدهم للقيام بهذه المهمة من خلال دورات تدريبية وكورسات تعليمية.

الباحثة: هل تعتقد أن تحقيق الصحة النفسية للطالب قد تعود على الطالب بالنفع أم لا؟

م١م: قد يتعلم الطالب من معلميه من خلال التطبيق العملي لتحقيق الصحة النفسية للطلبة المهارات الاجتماعية اللازمة لبناء العلاقات مع الآخرين ويحسن من حالة الطالب النفسية... سلبيا" من الممكن من خلال ملاحظة المعلمة لطالب لديه مشكلات نفسية والتعامل مع مشكلته ودعمه بصورة ملحوظة أمام الطلبة ان يتعرض هذا الطالب للنعت بلقب المريض النفسي من قبل أقرانه أو المضايقة وإبداء سلوكيات مزعجة إتجاه زميلهم الذي يعاني مشكلة نفسية..... مما قد يدفع الطالب الذي يعاني إلى إخفاء معاناته وبالتالي تطور مشكلته إلى درجة حادة من المرض يصعب معها العلاج ويستغرق وقت طويل يؤثر بدوره على صحته النفسية. لذا يجب على المعلم أن يكون لديه التدريب والمعرفة الكافية للتعامل بحذر في مثل هذه الأمور لكسب ثقة الطالب.

الباحثة: ومن الناحية الأكاديمية ماذا يفيد تحقيق الصحة النفسية للطالب برأيك؟

م١م: حتى لوكان الطلبة يعانونم المشكلات النفسية فمساندتهم ومساعدتهم على تحقيق صحتهم النفسية يساهم بتحسن مستواهم الأكاديمي... وأنهم سوف لن يشعروا بأنهم متأخرين عن أقرانهم.. ولو انني ارى أن من الممكن أن يكون الانشغال في ملاحظة المشكلات النفسية للطلبة ومحاولة مساندتهم سوف يؤثر على الطلبة الآخرين في الفصل....خاصة لمهوبون منهم والنابغين قد يشعرون بالاستياء لأن هذا الجزء من الوقت الذي سوف يخصصلمساهمة المعلم بتحقيق الصحة النفسية يقتطع من زمن الحصة الدراسية..

الباحثة : برأيك لمن تعود المسؤلية في تحقيق الصحة النفسية للطالب في المدرسة؟

م١م: بنظري ... ليس نحن كمدرسين ... أعني المسؤولية مسؤلية المتخصصين بالصحة النفسية...المرشد النفسي بالمدرسة والمعالج والدكتور النفسي خارج المدرس.....ليست مسؤليتنا بل هي قد تكون جزء من مسؤوليتنا كمعلمين...أي نوع م التغيير في المدرسة لابد أن يؤخذ بالاعتبار رأي المعلمين ... فمثلا" أي تطبيق عملي لمساهمة المعلم بتحقيق الصحة النفسية للطالب لابد ان يؤخذ بالاعتبار صوت المعلم..لابد من ان تقنعه بدوره ومسؤوليته وتشجعه عليها ماديا" ومعنويا" حتى تكون العملية مثمرة بالنهاية...ولابد كذلك من تسليحه بالمعرفو والتدريب الكافيين للوصول للهدف المنشود في هذه العملية... لكن بالنهاية نحن نفهم أن استقرار الصحة النفسية للطالب مطلب مهم لتحقيق إنجازه الأكاديمي ولابد من يكون لنا جزء من هذه المسؤولية وليست المسؤولية ككل...

الباحثة : إذن أنت تؤمن بحق هؤلاء الطلبة بان يكونوا أصحاء نفسيين؟

ه١م: نعم. لنا جميعا".. فالصحة النفسية حق للجميع وهؤلاء الطلب هم جيل المستقبل القادم واستثمارات الشعوب تكون في هؤلاء الطلبن فمن باب أولى أن تراعى صحتهم النفسية وتبذل الجهود وتوضع السياسات التي يمكن ان تسهل تحقيق صحتهم النفسية....وهذه الصحة النفسية كما نعلم أنها جزء من صحتهم ككل...

الباحثة: "تحقيق الصحة النفسية للطالب" بما يشعرك هذا المصطلح... بمعنى آخر بما يشعرك من أن يطلب منك مدير المدرسة أن تضم طالب يعاني من مشكلات نفسية إلى فصلك أو حتى أن تتعامل مع طالب يعاني من مشكلة نفسية ؟

ه١م: لا أدري قد يشعرني " تحقيق الصحة النفسية" بشعوري بعدم الراحة والخوف أحيانا" من الأمور النفسية وما يتعلق بها...قد أكون على إيمان بأهميته ولكني أشعر بالخوف عندما يذكرقد يكون بسبب شعوري بصعوبة تحقيق ذلك أو لما قد يتضمنه هذا التحقيق من متطلبات قد تشكل عبء على عاتق المعلمين....إذا طلب مني ذلك فهذا سوف يشعرني بالتشاؤم والخوف وعدم الراحة لأن ذلك سوف يشعرني بأن هناك المزيد من الجهود سوف تبذل والضغوط التي سوف أشعر بها.

الباحثة: من الناحية العملية هل أنت مستعد لأي تغيير يطلب منك للمساهمة في تحقيق الصحة النفسية؟

ه١م:ماذا تقصد بالتغيير هنا؟

الباحثة: هل تعتقد أن لدى المدرسين القدر الكافي من المعرفة الكافية بالأمور النفسية للطلبة.. وماهي برأيك الوسائل المناسبة لزيادة معلوماتهم ووعيهم بهذا الشأن ؟ وهل يؤثر النقص في المعرفة بالأمور النفسية على اتجاهات المعلمين نحو الصحة النفسية؟

ه١م: ليس لدى المعلمين القدر الكافي من المعرفة بالأمور النفسية للطالب...فهم يعانون من هذا النقص بالمعلومة المتعلقة بالأمور النفسية.. وأعتقد من أفضل الطرق لزيادة معلوماتهم هو توفير كورسات وورش تدريبية لهم.. نعم... النقص في المعلومات المتعلقة بالأمور النفسية يؤثر بشكل كبير على قدرة المعلم على ملاحظة المشكلات النفسية للطلبة والتعامل مع المشكلا النفسية.

الباحثة: وماذا لو يطلب منك أن تساهم في الكورسات التعليمية أو الورش التدريبية الخاصة بالأمور النفسية للطالب مثلا"؟

ه١م: نعم أنا سعيد بتقبل مسؤويتي كمعلم إتجاه تحقيق الصحة النفسية للطالب وأنا على استعداد للمساهمة في أي برنامج تدريبي أو ورش عمل قد تساعد في تطبيق تحقيق الصحة النفسية للطلبة في المدارس وجعله حقيقة من الناحية العملية... وإني أود أن أقول اننا كمعلمين لسناعلى قدر كافي من الخبرة والمعرفة والتدريب في الامور النفسية وأننا نحتاج إلى هذا النوع من الكورسات التعليمية والورش التدريبية لتزيد من وعينا وقدرتنا وثقتنا بأنفسنا على تفهم الصحة النفسية للطالب ومتطلباته النفسية وكيفية ملاحظة المؤشرات التي تدل على معاناته من المشكلات النفسية.

الباحثة : من وجهة نظرك الشخصية... هل تعتقد ان المدرسين لديهم القدر الكافي من التدريب لملاحظة أو التعامل مع المشكلات النفسية للطالب...وهل يتطلب الأمر تدريبهم بشكل عام أم في مواضيع معينة؟

ه١م: نعم يعاني المعلمين من نقص شديد في هذه المهارات التدريبية المتعلقة بملاحظة مؤشرات المشكلات النفسية للطلبة والتعامل معهم وتعليمهم الأساليب المناسبة التغلب على مشكلاتهم نعم قد يحتاج المعلمين بالبداية إلى تدريب عام ولكنهم يحتاجون لأن يتدربوا بعد ذلك على المواضيع السابقة**....**

الباحثة:هل ترى أن نقص مثل هذه المهارات للتعامل مع المشكلات النفسية قد تعيق من مساهمةالمعلمين نحو تحقيق الصحة النفسية للطالب؟

ه١م: نعم ...التدريب أمر ضروري لتمكين المعلمين من القدرة على فهم طبيعة المشكلات النفسية للطلبة وكيفي التعامل معها...بعض المعلمين يرون أنه يجب أن يمر المعلم بدورات تدريبية خاصة متعلقة بالأمور النفسية للطلبة حتى لا يشعر أنه في مأزق عندما يجد نفسه أمام طالب يعاني من مشكلة نفسية.. فيعرف كيف يتصرف....وماذا عليه أن يعمل...وكذلك التدريب يجعل المعلم ملم بالطرق اللازمة للاكتشاف المبكر للمشكلات النفسية...فالتدريب يعود على الطالب بالفائدة بأن يساهم في اكتشاف مشكلته النفسية وعلاجها وعدم تطورها وعلى المعلم بزيادة الثقة في نفسه والخبرة بالتعامل مع المشكلات النفسية للطلبة.

الباحثة: وهل هناك معوقات أخرى برأيك قد تؤثرعلى اتجاهات المعلمين نحو تحقيق الصحة النفسية للطالب؟

ه١م: : أن تقوم بالطلب من المدرسين أن يلاحظوا الحالة النفسية للطلبة ومشكلاتهم النفسية قد تقود المعلمين للإحساس بالضغوطات.. لأن هذا كما قلت نوع من التكليف الإضافي يضاف إلى جداولهم المضغوطة...والتكاليف المطلوبة منهم اتجاه الطلبة والمنهج وكذلك التكاليف التي تطلبها منهم الإدارة.....هذا بإعتقادي ينعكس سلبا" على أداء المعلم وعدم شعوره بالراحة اتجاه هذه الأمور النفسية وقد لا يبدون الاهتمام المطلوب نحو الأمور النفسية للطالب ... فهذ بحد ذاته ينعكس بتكون اتجاهات سلبية تضاف إلى الاتجاهات السلبية الموجودة أساسا" لديهم نحو الأمور النفسية....كما ان على التربويين ان يعيروا الكم الهائل والمكثف من المناهج اهتماما" كبير حيث مثل هذه المناهج المكثفة لا تفيد الطالب لأنها حشو للدماغ بينما التعليم النوعي الذي تستخدم به الوسائل التكنولوجية ووسائل متنوعة في تقديم المعلومة للطلبة يثمر عن نتائج تعليمية ممتازة فالوقت الذي يقضيه المعلم بمحاولة تغطية هذه المناهج الطويلة والمكثفة... والامتحانات ورصد الدرجات والاهتمام بإعداد التقارير الشهرية لآداء الطالب....توفر الوقت لتحقيق الصحة النفسية للطالب وهذا يعيق إسهام المعلم بتحقيق الصحة النفسية لطلبته.

الباحثة: هل تعتقد أن وجود سياسة تربوية تنص على إلتزام المعلمين بدورهم ومسؤوليتهم بتحقيق الصحة النفسية للطالب قد يسهل أم يعيق مساهمة المعلمين في تحقيق الصحة النفسية للطلبة؟

ه١م: نعم. كما قلت سابقا" أن هناك الكثير من الناس الذين لا يلتزمون إلا بوجود قانون يلزمهم بالمساهمة بملاحظة الصحة النفسية للطالب ...على الرغم من إيماني بأن الالتزام ينبع من داخل الفرد لكني أؤمن بانه لابد من نص يلزم المعلم بذلك ويخبره بأن هذه المساهمة في تحقيق الصحة النفسية هو جزء من مسؤوليته وعليه ان يرينا اهمامه بهذا الأمر.....

الباحثة: من وجهة نظرك الشخصية.. هل ترى أنه إذا طلب من المعلمين تطبيق تحقيق الصحة النفسية للطلبة عمليا" على أرض الواقع ستكون فكرة مقبولة لديهم؟

م١م: أعتقد أن هذه الفكرة قد لا تلاقي القبول لدى المعلمين..... وقد يبدي المعلمين اهتمامهم بها فقط بالبداية.... ولكن مع عدم مراعاة دعمهم معنويا" ونفسيا" فهذه الفكرة ستواجه الفشل...كذلك المناهج في مدارسنا معقدة جدا" ومكثفة وعلينا أن ننجزها بوقت محدد. اعتقد أنه من الصعوبة جدا" أن نطلب من المعلم أن يخصص وقت لتدريس مثل هذه المناهج ...لأنها تتطلب وقت خاص لها قد لا يكون بالإمكانية استقطاعه من الوقت الأساسي...

الباحثة: هل بإعتقادك الشخصي أن عملية تحقيق الصحة النفسية للطلبة تحتاج للدعم المادي وهل الدعم هذا كافي في المدارس؟أم يقف كعائق نحو وضع تحقيق الصحة النفسيةعلى أرض الواقع؟

م١م: الدعم المادي لعملية تحقيق الصحة النفسية من خلال المدارس من قبل الحكزمة موجود...فالدولة مثلا" وفرت مرشديين نفسانيين في المدارس ومعالجين متخصصين بإدارة الخدمة النفسية بالوزارة..... ولا أعتقد أن الدولة سوف تمانع تقديم دم مادي لجعل عملية مساهمة المعلمين لتحقيق الصحة النفسية بالمدارس حقيقة.... ولكن المطلوب وضع خطط وسياسة لتبني هذا المنهج...مبنية على رأي الباحثين والمتخصصين يجب ان يؤخذ بآرائهم بهذه الخطط والبرامج والاستفادة من الأبحاث التي تقوم بها الجامعات والباحثين بدل من ركن هذه الأبحاث على الأرفف في الجامعات... فبرأيي الشخصي فأنا أعتقد ان الدعم لا يشكل عائق أبدا" لأن ميزانية المدارس عادة ما تكون فائضة عن الحاجة.....

الباحثة: هل تعتقد بأن المدرسة مستعدة للقيام بدورها في تحقيق الصحة النفسية للطالب؟

م١م: لا ...لا يمكن ان نعتبر أن مدارسنا مستعدة بالوقت الحالي لأن تقوم بدورها في تحقيق الصحة النفسية كما هو مطلوب منها.لأن العملية تتطلب وجود بعض الاستعدادات والتغييرات لتتمكن المدارس من ان تؤدي دورها بهذا الصدد على أكمل وجه...

الباحثة : برأيك الشخصي ما هي هذه التغيرات التي يمكن كيف يمكن أن نجعل تحقيق الصحة النفسية حقيقة على أرض الواقع؟ هل بإمكانك ذكر هذه التغيرات ؟

م١م: نعم.. قد نحتاج لبعض التغيرات لنصل بهذا المشروع لأرض الواقع...البداية أولا" بسن القوانين التي تنص على التزام المعلم بدوره بالماهمة بتحقيق الصحة النفسية لطلبته...كذلك يكون التغيير الثاني يتعلق بمسنولى الوعي لدى المعلمين فنحرص على زيادة الوعي لدى المعلمين بدورهم ومسؤوليتهمم اتجاه الصحة النفسية للطالب ....من خلال الندوات والمحاضرات... كما يجب علينا أن نقوم بتسهيل المهمة على المعلمين... بتوفير كورسات تعليمية وتدريبية لتثقيفهم وزيادة معلوماتهم اكسابهم الاساليب المطلوبة لتحقيق اصحة انفسية لطلبتهم..... ولا ننسى دعم الآخرين للمعلم لتشجيعه على الحرص على القيام بدوره بهذا الصدد في كل فعالبة وجدية... وأن يكون هذا الدعم لا يقتصر على الدعم المعنوي فقط بل يتعداه للدعم المعنوي كذلك... كذلك لا بد من تغيير أسلوب التدريس التلقيني التقليدي السائد إلى اساليب أكثر ابتكار تعود الطالب على التفكير النقدي بدلا" من تحفيظه المواد عن ظهر قلب والطلب منه أن يقوم بتسميع هذه المعلومات في ورقة الامتحان....لا بد ان يكون هناك تغيير ويجب أن لا يكون مفاجىء .. بل تدريجي ولكن فعال..تدرس وتقيم به النتائج جيدا" ليتم تفادي الاخطاء به وتعزيز النجاحات.... وعلى المدارس ان تعي دورها في تحقيق الصحة النفسية وأن تقوم بتبني الخطط التي تعزز من دورها.....وقد يكون الأهم من ذلك تغيير نظرة المجتمع للمريض النفسي والاحساس بوصمة العار والتأثر بالمعتقدات الدينية والثقافية في فهم المرض النفسي من خلال خطط تتبناها وسائل الإعلام لتنشر الوعي بين العامة....عن ماهية المشكلات النفسية وطرق التغلب عليها والجهات الصحيحة التي يجب ان يتوجه لها الاشخاص عند الاحساس باي مشكلة نفسية.

Appendix (XI): Arabic copy of the study survey

عزيزي المعلم \المعلمة:

يسعى هذا الاستبيان الذي بين يديك الى استطلاع وجهات النظر والاتجاهات التي يحملها المعلمون في المرحلة المتوسطة حول دورهم في المساهمة في تحقيق الصحة النفسية لطلبة المرحلة المتوسطة.أيا كانت وجهة نظرك و رأيك الذي ستعبر عنه في هذا الاستبيان, فإن مشاركتك بالتعبير عن رأيك الشخصي بصدق وأمانة سيقابله عظيم التقدير و الأثر الكبير في نجاح هذه الدراسة. سيتم التعامل بسرية مع كل البيانات والمعلومات التي ستتوفر من هذا الاستبيان التي سوف تستخدم لغرض الدراسة فقط. ولمزيد من الحرص على السرية والخصوصية فإنه ليس من المطلوب منك ان تذكر معلومات تتناول بيانات شخصية لك.

وفي حالة الرغبة في المشاركة في مقابلة شخصية, يرجى التكرم بتزويدنا برقم هاتفك لنقوم بالاتصال بك.

الجزء الأول:

الرجاء اختيار الاجابة المناسبة مما يأتي:

1. الجنس:

☐ ذكر

☐انثى

2 . العمر:

☐ 21-25 سنة ☐26-30 سنة ☐31-35 سنة ☐36-40 سنة ☐41-45 سنة ☐46-50 سنة

3. سنوات التدريس:

☐ 1-5 سنوات ☐ 6-10 سنوات ☐ 11-15 سنوات ☐ 16-21 سنوات ☐ 20 سنة فأكثر

5. المستوي التعليمي:

☐ الدبلوم ☐ البكالوريوس ☐ الماجستير ☐ الدكتوراة

الجزء الثاني :اتجاهات المدرسين نحو دورهم في تحقيق الصحة النفسية للطلبة:

الرجاء اختيار الاجابة المناسبة

(أ) الاتجاهات المعرفية

(5) أوافق بشدة (4) أوافق (3) لا أدري (2) لا أوافق (1) لا أوافق بشدة

ت	البند	أوافق بشدة	أوافق	لا أدري	لا أوافق	لا أوافق بشدة
1	الشخص الذي يتمتع بصحة نفسية ليس لديه مشكلات نفسية أبدا" *	5	4	3	2	1
2	الشخص الذي يتمتع بصحة نفسية هو الشخص القادر على التغلب والتكيف مع ضغوطات الحياة وتغيراتها المستمرة	5	4	3	2	1
3	غالبية الناس الذين يعانون من مشكلات نفسية يتمكنون من الشفاء منها اذا تم اكتشافها مبكرا"	5	4	3	2	1
4	الشخص الذي لديه مشكلات نفسية مؤقتة لا يطلق عليه مريض نفسي	5	4	3	2	1
5	المشكلات النفسية التي لا يتم اكتشافها وملاحظتها مبكرا" قد تصبح أمراض مزمنة	5	4	3	2	1
6	للمراهق الحق في أن يتمتع بالصحة النفسي وتحقق له.	5	4	3	2	1
7	للمدارس دور فريد وفعال بالتأثير على الصحة النفسية للطلبة بشكل إيجابي	5	4	3	2	1
8	يلعب المعلمون دورا" مؤثرا"في ملاحظة مشكلات الطالب النفسية.	5	4	3	2	1
9	تحقيق الصحة النفسية للطلبة هو جزء من عمل المعلم	5	4	3	2	1
10	تحقيق الصحة النفسية للطالب تعني الدعم المعنوي للطالب لتعزيز صحته النفسية	5	4	3	2	1
11	تحقيق الصحة الفسية للطالب تعني مساعدته على اكتساب المعرفة و المهارات اللازمة لتحقيق التوازن النفسي الايجابي في حياته	5	4	3	2	1
12	المتخصصون بالصحة النفسية مثل المعالجين النفسيين والمرشدين النفسيين والاخصائيون الاجتماعيون هم المسئولون عن تحقيق الصحة النفسية للطالب أكثر من المدرسين	5	4	3	2	1
13	إنه من المتوقع من المعلم ان يبدي نوع من المسئولية اتجاه تحقيق الصحة النفسية للطالب	5	4	3	2	1
14	تحقيق الصحة النفسية للطالب يستلزم سعي المعلم لاكتساب مهارات تدريبية خاصة	5	4	3	2	1

15	تحقيق الصحة النفسية للطالب يتطلب من المعلم التزود بالمعرفة الكافية لأمور الصحة النفسية	5	4	3	2	1
16	تحقيق الصحة النفسية له أثر كبير في اتلوازن النفسي والانفعالي والاجتماعي للطالب	5	4	3	2	1
17	القيام بتحويل الطالب لتلقي العلاج والتدخل في وقت مبكر من بداية المشكلة النفسية يقلل من خطورة تطور المشكلة النفسية الى مرض نفسي مزمن	5	4	3	2	1
18	وجود طلبة يعانون من مشكلات نفسية داخل الفصل يعطل من تقدم العملية التعليمية للطلبة الآخرون	5	4	3	2	1
19	تحقيق الصحة النفسية للطلبة يؤثر ايجابيا" على تقدمهم الدراسي	5	4	3	2	1

(ب) الاتجاهات الشعورية

الرجاء اختيار الاجابة التي تتوافق مع شعورك الحقيقي نحو العبارات التالية :

(5)أشعر بالارتياح جدا" (4)أشعر بالارتياح (3) أشعر بالارتياح قليلا(2) اشعر بالارتياح قليلا" جدا"

(1) لا أشعر بالارتياح أبدا"

الرقم	**العبارة**	أشعر بالارتياح جدا"	أشعر بالارتياح	أشعر بالارتياح قليلا"	أشعر بالارتياح قليلا" جدا"	لا أشعر بالارتياح أبدا"
1	إذا كان هنالك طلبة يعانون من مشكلات نفسية بصدد الانضمام الى الفصل الذي أقوم بتدريسه فإنني سوف	5	4	3	2	1
2	الاهتمام بملاحظة مشكلات الطلبة النفسية يجعلني	5	4	3	2	1
3	التعامل مع مشكلات الطلبة النفسية داخل الفصل يجعلني	5	4	3	2	1
4	إدارة فصل يحوي طلبة يعانون من مشكلات نفسية يجعلني	5	4	3	2	1
5	الاهتمام بملاحظة مشكلات الطلبة النفسية يجعلني	5	4	3	2	1
6	المساهمة في تحقيق الصحة النفسية للطلبة يجعلني	5	4	3	2	1

(ج) الاتجاهات السلوكية

الرجاء اختيار الاجابة المناسبة

(5) أوافق بشدة (4) أوافق (3) لا أدري (2) لا أوافق (1) لا أوافق بشدة

	إذا لاحظت وجود مشكلة نفسية لدى أحد الطلبة في الفصل فإنني سوف.....	أوافق بشدة	أوافق	لا أدري	لا أوافق	لا أوافق بشدة
1	أتقبل مسؤوليتي نحو تحقيق الصحة النفسية للطلبة	5	4	3	2	1
2	أزيد معلوماتي عن الأمور التي تتعلق بالصحة النفسية للطلبة	5	4	3	2	1
3	أدعو للطالب بأن تزول عنه مشكلاته	5	4	3	2	1
4	أكون على ترحيب و استعداد لأن أقوم بإضافة بعض المواضيع المتعلقة بالصحة النفسية للمنهج الدراسي	5	4	3	2	1
5	أقوم بتحويل الطالب للاختصاصية النفسية أو الاختصاصية الاجتماعية بالمدرسة	5	4	3	2	1
6	أقترح على الناظرة أن تنقله من فصلي	5	4	3	2	1
7	أنخرط بالبرامج التدريبية لأتمكن من القدرة على التعامل معه	5	4	3	2	1
8	أتعاون مع إدارة المدرسة في إتخاذها للقرارات المتعلقة بصحة الطالب النفسية	5	4	3	2	1
9	تحقيق الصحة النفسية للطالب يستلزم سعي المعلم لإكتساب مهارات تدريبية خاصة	5	4	3	2	1
10	أكون على ترحيب و استعداد لأن أتلقى مزيد من التدريب من الاختصاصيين بالصحة النفسية لأتمكن من التعامل مع هذا النوع من الطلبة	5	4	3	2	1
11	أتعاون مع والدي الطالب فيما يخص صحته النفسية.	5	4	3	2	1
12	أساويه بالتعامل مع الطلبة الآخرون حتى لو أنه يعاني من مشكلات نفسية	5	4	3	2	1
13	اكون على وعي بخدمات الصحة النفسية المنتوفرة للطالب	5	4	3	2	1

الجزء الثالث: وجهة نظر المعلمون بالعوامل التي تحد من مساهمتهم بتحقيق الصحة النفسية للطالب

الرجاء اختيار الاجابة المناسبة

(5) أوافق بشدة (4) أوافق (3) لا أدري (2) لا أوافق (1) لا أوافق بشدة

	بحسب رأيك كمدرس, لأي درجة تعيق العوامل التالية مساهمة المعلم بتحقيق الصحة النفسية للطالب.....	أوافق بشدة	أوافق	لا أدري	لا أوافق	لا أوافق بشدة
1	نقص الوعي لدى المعلمون بدورهم بتحقيق الصحة النفسية للطالب.	5	4	3	2	1
2	المعرفة الغير كافية بأمور الصحة النفسية التي تخص الطلبة	5	4	3	2	1
3	التدريب الغير كافي على ملاحظة العلامات المبكرة للمشكلات النفسية	5	4	3	2	1
4	اتجاهات المعلمين السلبية نحوالصحة النفسية	5	4	3	2	1
5	ضغوطات ومتطلبات العمل التدريسي	5	4	3	2	1
6	الوقت المحدود والغير كافي في الحصة المدرسية لإعطاء الإهتمام للطلبة الذين يعانون من مشكلات نفسية	5	4	3	2	1
7	قلة التعاون بين المعلم والاختصاصيين (الاخصائية النفسية والاجتماعية, الخدمة النفسية بالوزارة) فيما يتعلق بصحة الطالب النفسية	5	4	3	2	1
8	عدم وجود التزام يلزم المعلم بدعم االبطالب الذي يعاني من مشكلات نفسية	5	4	3	2	1
9	نقص بالمصادر التي تزود المعلم بأمور الصحة النفسية للطلبة	5	4	3	2	1
10	نقص الدعم من المتخصصين في مجال الصحة النفسية للمعلم في هذه الأمور	5	4	3	2	1
11	غياب السياسة التربوية التي تملي على المعلم المسئولية نحو المساهمة في تحقيق الصحة النفسية للطلبة	5	4	3	2	1
12	التمويل المادي الغير كافي لدعم المشاريع التي تساهم في تحقيق الصحة النفسية للطالب في المدارس	5	4	3	2	1
13	ممانعة الإدارات المدرسية لهذه الأمور بالمدرسة	5	4	3	2	1
14	الإحساس بوصمة العار من الإصابة بالأمراض نفسية من قبل نظرة المجتمع	5	4	3	2	1
15	وجود بدائل أخرى لعلاج المشكلات النفسية كاللجوء للطب الشعبي والمعالجين الشعبيين	5	4	3	2	1
16	التصوير السلبي للمشكلات النفسية بوسائل الاعلام	5	4	3	2	1
17	المعتقدات الدينية لعلاج المشكلات النفسية باللجوء الى الرقية ورجال الدين	5	4	3	2	1

18	رفض أولياء الامور لتدخل المعلمين بالأمور النفسية لأولادهم بالمدارس	5	4	3	2	1
19	المدارس لم تصمم أساسا" لتقديم الخدمات النفسية للطلبة	5	4	3	2	1
20	سياسة المدرسة ومبادئها	5	4	3	2	1
21	عدم مراعاة وتوفير خدمات الصحة النفسية للمدرس نفسه للتخفيف من عبء الضغوطات التي يتعرض لها أولا" قبل مطالبته بتحقيق الصحة النفسية لطلبته	5	4	3	2	1

22.برأيك هل توجد عوامل أخرى تعيق مساهمة المعلم بتحقيق الصحة النفسية لطلبته؟

.....
.....
.....

23. ما التغييرات التي تقترحها لتمكين المعلم من المساهمة في تحقيق الصحة النفسية للطلبة في الفصل الدراسي؟

.....
.....
.....

أود أن أشكركم على تعاونكم الطيب...

ملاحظة: قد يتطلب الأمر من الباحث إجراء مقابلة شخصية معك فإذا كنت ترغب في ذلك .... الرجاء ذكر رقم هاتفك أو الايميل الخاص بك لنتمكن من الاتصال بك.