ADOLESCENT SOCIAL AND EMOTIONAL WELLBEING IN ABU DHABI: SOCIO-CULTURAL DETERMINANTS OF MENTAL HEALTH AND THEIR RELATIONSHIP TO HELP-SEEKING BEHAVIOUR IN EDUCATIONAL SETTINGS: A MIXED METHOD EXPLORATION.

A Thesis submitted by

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ABSTRACT

This thesis is an investigation into adolescent social and emotional wellbeing, exploring socio-cultural determinants of mental health and their relationship to help-seeking behaviour in educational settings, and involved two studies. Study 1 examines school counsellor perspectives and Study 2, the adolescent experience. The research explores the prevalence of mental health difficulties experienced by young people aged 15 to 18 years (N = 333), using the Strengths and Difficulties Questionnaire (Goodman, Meltzer & Bailey, 1998), and the Health of the Nation Outcome Scales (Growers, et al., 1998). Adolescent wellbeing is measured using the Brief Multidimensional Student Life Satisfaction Survey (Bickman, et al., 2010), and attitudes to help-seeking are examined utilising the Beliefs about Psychological Services (Ægisdóttir & Gerstein, 2009). A focus group of school counsellors (N = 23) provided quantitative and qualitative data, contributing the nature, incidence and impact of mental health difficulties, and impediments to accessing psychological services in educational settings.

Key findings indicate both gender and cultural background influence wellbeing, mental health, and beliefs about psychological services. Impediments to help-seeking include parental perceptions of mental health, and perceived lack of confidentiality, while students report high levels of shame, stigma, and lack of family support. Students present with levels of need which align to international prevalence rates for emotional, conduct and peer difficulties, and report the lowest levels of life satisfaction in the domains of school experience and where they live. The practical implications of these findings are relevant to school leaders, school counsellors, adjunct specialist psychological services, families, and adolescents. It is evident that schools should provide access to mental health support services, the nature of which should reflect presenting needs, be delivered in a manner that integrates socio-cultural factors and belief systems, sensitive and responsive to the international “third-culture” experienced by many adolescents in the UAE. Working within this context will improve outcomes, reduce the long-term impact of emerging mental health difficulties, and promote wellbeing in the UAE.

Key words:
Mental Health, Adolescent, United Arab Emirates, Well-being, Help-seeking

CERTIFICATION OF THESIS

This Thesis is entirely the work of *Kathrine Anne McMillan* except where otherwise acknowledged. The work is original and has not previously been submitted for any other award, except where acknowledged.

Principal Supervisor: Associate Professor Gavin Beccaria

Associate Supervisor: Professor Peter McIlveen

Student and supervisors' signatures of endorsement are held at the University.

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Keep close, those who act as both anchor and sail during your doctoral voyage.

Dr Jennifer Donovan, 2015

Wise and fortuitous words, which resonated then and have become a touchstone since. I have indeed been blessed to have the support, encouragement, and guidance of so many, those who have held me steady in stormy seas and kept me close hauled in a fresh breeze. I am profoundly grateful to my supervisors, Professor Peter McIlveen and Associate Professor Gavin Beccaria, whose immense knowledge and patient guidance throughout the duration of this journey helped me maintain my heading and overcome a crisis of confidence. I acknowledge the generous assistance of Lois Skinner who proofread and edited this work, and the financial support of the Australian Commonwealth Government through the Research Training Program Fee Offset scheme.

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Fair winds and a following sea ~ the red sky of evening heralds.

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Abbreviations

Abbreviation	*Explanation*
AD	Abu Dhabi
ADEK	Abu Dhabi Education and Knowledge
ADHD	Attention Deficit Hyperactivity Disorder
AED	(United) Arab Emirates Dirham (currency)
ASD	Autism Spectrum Disorder
BAPS	Beliefs about Psychological Services
BMSLSS	Brief Multidimensional Students' Life Satisfaction Survey
BESD	Behaviour Social and Emotional Disorders
CBT	Cognitive Behaviour Therapy
CD	Conduct Disorder
CDC	Centre for Disease Control (USA)
DSM-IV	Diagnostic Statistical Manual – IV
GCC	Gulf Cooperation Council
HoNOSCA	Health of the Nation Outcomes Scales Child & Adolescent
MoE	Ministry of Education (UAE)
POD	People of Determination
SEND	Special Educational Needs and Disabilities
SDQ	Strengths and Difficulties Questionnaire
TCK	Third Culture Kid
UAE	United Arab Emirates
UK	United Kingdom
WHO	World Health Organisation

CHAPTER 1: INTRODUCTION

"Understanding the human mind is one of the greatest challenges facing us today."
HE Sheikh Nahyan bin Mubarak Al Nahyan
2015Child Behaviour and Mental Health Conference,
United Arab Emirates: Abu Dhabi.

At a time when "madness" was considered the result of demonic or spiritual possession, with those afflicted feared and ostracised by society, it was the Islamic world that pioneered the moral treatment of patients with mental illness. Building the first psychiatric hospital in Bagdad in 705 AD and conceiving treatments such as occupational therapy, music therapy and meditation, their compassionate and holistic approach was in sharp contrast to that witnessed across Medieval Europe and the Far East (Grmek & Fantini, 1988; O'Donnell, 2012). The progressive approach to treatment in the Middle East was led by seminal figures such as Arab doctor Ishaq bin Imran (d. 908 AD), who advocated for the mentally ill, researched psychosomatic treatments and challenged archaic beliefs. Rather than attributing depression to possession or a lack of faith, he described it as "melancholia which affects the soul through fear and sadness, sadness defined by the loss of what one loves, and fear the expectation of misfortune" (Thomas, 2012, p.1).

This enlightened approach to provision for those with mental illness may have been a result of Muslim beliefs that promote inclusion and consider care for the mentally ill as a religious obligation. This sentiment is reflected in the Quranic verse, "do not give the property with which Allah has entrusted you to the feeble-minded, but feed and clothe them with this property and speak kindly to them", Surat an-Nisa` 4:5. However, in the Arabian Gulf region and wider Middle East, despite the guidance of religious scripts, the reality is that cultural sensitivities and stigma persist. This has resulted in a lack of coordinated mental health policy, a scarcity of accurate data or research into psychiatric morbidity, insufficient access to specialist mental health services and a range of cultural impediments to help-seeking (Eapen & Ghubash, 2004; Sayed, 2003; Thomas & Altareb, 2012; Thomas, 2014). Increasingly, governments and communities are recognising that there must be provision for those experiencing mental illness, alongside a robust strategy

for promoting mental health and a sense of well-being, factors essential in maintaining productive individuals, healthy communities, and cohesive societies.

It is important to highlight that the concept of mental health does not always correlate with mental ill-health or mental health difficulties. Often qualified by the addition of the descriptor well-being, mental health is a broader notion. From a medical perspective mental health is not simply the absence of mental illness but an indicator of social, emotional, and physical wellness, influenced by the wider contexts within which a child or young person lives. Public Health England (2016) defines mental wellbeing as children and young people's happiness, life satisfaction and positive functioning. The UK Equalities Act 2010 (Lockwood, Henderson, & Thornicroft, 2012) takes a legal view, seeking to define when a mental health problem becomes a disability. Within this context, to demonstrate the presence of mental illness, one would have to show that it has a significant impact on everyday life, presents persistent challenges to the individual, has lasted at least 12 months, or is likely to recur. The Department for Education UK (2014) in their Special Educational Needs and Disability (SEND) Code of practice, focus on defining mental health by the expression or manifestation of difficulties, citing challenging, disruptive or disturbing behaviours which may reflect underlying mental health difficulties such as anxiety or depression, self-harming, substance misuse, attention deficit, hyperactivity, attachment or eating disorders.

Gladerisi et al. (2015, p. 231) offered a new definition, broad and inclusive, recognising individual self-regulation within context of developmental and social cultural constructs, defining mental health as:

> A dynamic state of internal equilibrium, which enables individuals to use their abilities, in harmony with universal values of society. Basic cognitive and social skills; ability to recognise, express and moderate one's own emotions, as well as empathise with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components to mental health, which contribute, to varying degrees, to the state of internal equilibrium.

This current research project recognises the presence of and need for multiple and dynamic definitions of mental health and well-being, and acknowledges cultural variations and sensitivities. It takes the view that mental health is not merely the absence

of illness, but the presence within adolescent population of the personal attributes and interpersonal skills required to achieve a sense of internal equilibrium as described by Gladerisi. Using these skills and attributes will enable children and young people to maintain "a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (World Health Organisation [WHO], 2005a, p.19). Taking into account the medical, legal and social definitions, while maintaining a broad and inclusive view of mental health, this research seeks to identify indicators of mental illness, expressions of mental health and establish levels of wellbeing and life satisfaction in adolescents.

For 11 years, my husband and I have lived in Abu Dhabi, capital of the United Arab Emirate (UAE), raising our own three 'third culture kids'. During this period, we have had the opportunity to bear witness to a gradual but clear shift in community attitudes towards inclusion of individuals with physical, intellectual or behavioural disorders. Parents are more aware of their children's right to education and are advocating for the provision of support services and school places. This is in sharp contrast to a time, not that long ago, when parents had little option but to keep their children at home because of insufficient or inadequate services (Bradshaw, Tennant & Lydiatt, 2004). Progress has been supported by a range of UAE government initiatives, starting with the 2006 Federal Law No.29, concerning the Rights of People with Disabilities, which provides equal rights and opportunities for those with disabilities to education, health care and rehabilitation. More recently, a 2017 Federal Decree mandating a change of title, referring to those formerly known as "people with disabilities", to People of Determination (POD), along with a range of initiatives established to ensure equitable and active participation, and full engagement in the community, have been put in place. The commitment of the UAE to the National Agenda of Inclusion was highlighted, and celebrated, in March 2019 when Abu Dhabi hosted the World Games of the Special Olympics.

However, less progress has been seen in acknowledging and accommodating mental health needs, and the country remains without a strategic mental health policy, despite the reported development of a new mental health act, which was expected to come into effect in early 2018 but is yet to be released. A seminal development, indicative of increased awareness and the intention to better meet the needs of those experiencing mental health

difficulties occurred in July 2018, in the northern emirate of Dubai. The Dubai olice announced that they were releasing a new policy to decriminalise failed suicide attempts, a move that would provide psychological support rather than fines and imprisonment for those who attempt but fail to die by suicide (Ramahi, 2018). "Suicide is not something shameful, it is a response to suffering", expressed Dr Wyne of the mental health clinic Lighthouse Arabia and while praising the new policy as a very positive step towards changing perceptions and ensuring those suffering access appropriate support, it was unclear if other Emirates intended to release similar policies (cited in Ramahi, 2018).

On 7th November 2020, the UAE announced significant changes to personal and family laws in the UAE. Progressive changes are reflected in new regulations, effective immediately, in matters of divorce, inheritance, alcohol use, non-married non-related people living together, the inclusion of a Good Samaritan law and more robust punishments for men who abuse or harass women. No longer will Islamic (Sharia) Law be applied to all residents, individuals can now employ laws of their home country. Significantly, suicide and attempted suicide will be decriminalised which will enable police and the judicial system to take action to ensure mental health support is provided rather than prosecution (Reynolds, Jarallah, & Al Nowais, 2020).

Current literature published in English relating to mental health in the UAE predominantly arises from quantitative or qualitative research conducted in clinical settings or with college and university students. A mixed method approach has been rarely employed. Themes explored have included prevalence and risk factors, eating disorders, help-seeking, depression, and culturally sensitive interventions to support those experiencing difficulties. In this research project both quantitative and qualitative data will be utilised, using a sequential explanatory design. The qualitative data will enable a deeper understanding of socio-cultural belief structures, challenges, and perspectives, which when correlated with the quantitative data will facilitate detailed exploration and understanding of the current challenges experienced by adolescents in educational settings.

Research specifically undertaken within international education settings is sparse, yet worthy of individual exploration given the experiences of a young person being educated within the "third culture". Third Culture Kids (TCK), was a term first used by researchers John and Ruthe Useem, who in the 1950s applied it to the experience of American children working and living abroad (Pollock & Van Reken, 2001). They

considered a TCK as one who had lived for a significant amount of time in one or more culture, and integrated these with their birth culture, thus creating the third culture. Given the predominance of expatriates, and the multicultural, multinational and multilingual settings offered within international schools in the UAE, it is imperative to consider the experience of both expatriate TCK, and the impact for UAE Nationals, of the creation of their own third culture, at least within the confines of their educational setting. Implications of this on mental health, wellbeing and counselling approaches are explored in more detail within Chapter 3.

At the time of writing this thesis the global community find themselves in the midst of a pandemic. The metalanguage of Covid-19 pervades all aspects of our daily lives, the media, workplace and social interactions. Shielding, social isolation, physical distancing, quarantine, school closures, distance education, “bubbles”, remote working, vulnerable groups, and high-risk conditions. Both short, and long-term impacts of these new constructs will be felt by our children and adolescents, the depth and nature of which will take time to fully understand. What has been seen in Abu Dhabi, with schools closed for children aged 12-15 years for over 9 months, and for adolescents 15 and above for 5 months followed by 50% in school attendance on a rotation for an additional 4 months. is increased need for social and emotional support. Given the context of Covid-19, understanding the socio-cultural impediments, and nuances of gender and nationality, to accessing counselling and mental health support have never been more critical. The findings of this research will enable educational settings to make informed decisions regarding the nature and mode of support and the possibilities of tele-therapy and online support to overcome some of those socio-cultural impediments to adolescent help seeking.

1.1 Problem to be Addressed

Mental health in childhood and adolescence is necessary for optimal social, emotional, and psychological development, the maintenance of productive relationships, successful communication and learning, and the ability and motivation to adapt to and overcome personal challenges (WHO, 2005b). Unfortunately, an estimated one in five adolescents experience a diagnosable mental illness (WHO, 2005a), the presence of which results in compromised physical and psychological well-being, poorer educational attainment, and reduced employment prospects (Goodman, Joyce & Smith, 2011).

Recognising that mental health and wellbeing are central to long term social and emotional, personal, and academic success, research suggests that mental ill-health in adolescence is indicative of later outcomes, and that 50% of all ill health emerges by age 14 and 75% by age 18 (Murphy & Fonagy, 2012). A study by Merinkangas et al. (2010) in the United States found that the lifetime prevalence of an adolescent aged 13-18 years experiencing any mental health disorder was 46.3%, and their lifetime prevalence of experiencing a severe disorder was 21.4%. In their report, Truth Hurts, research by the UK Mental Health Foundation (2006), found that 1 in 12 children and adolescents engage in self-harming behaviours. Australian research reports that 1 in 4 young people aged 16-24 have a mental health condition, including substance misuse disorders (Australian Bureau of Statistics, 2008, p.9). The degree, nature, and frequency of the presentations of ill health in these populations is alarming. According to the WHO (2005a), most disorders which emerge in adolescence will persist into adulthood, making mental illness the single greatest economic health burden worldwide. According to the 2005 United Arab Emirates Global School-based Student Health Survey (WHO, 2005c), 13% of UAE school students aged 13 to 15 indicated that they had seriously considered attempting suicide. This speaks to levels of anxiety and stress related disorders, with 15% reporting that they experience loneliness and depression most of the time. Furthermore, it is a particularly alarming statistic given that more than 68% of surveyed students (15 612) were from the UAE, Gulf Cooperation Council (GCC) and Arab nations, most of whom would also identify as Muslim, and would be aware that suicide is illegal in many countries and contrary to Islamic values.

Adolescent access to mental health services in the UAE is complicated by cultural beliefs that influence help-seeking behaviours, and the availability of high-quality services or clinicians specialised to work with this age group. Sayed (2015 p. 661) acknowledges these challenges, given a community and culture where “most patients and families inflicted by psychological problems …have a mind-set that attributes a condition to the “evil eye” or demonic possession”. Further, he explores the perception that psychotherapy is all about talk, and less effective that use of pharmaceutical interventions, suggesting that seeing a counsellor or psychotherapist would be a weakness and shameful act that may cause disgrace to a family (Sayed, 2015). Therefore, for Emirati and many other GCC or Arab adolescents or their families, there are significant

impediments to recognising, acknowledging then seeking help for mental health difficulties.

1.2 Purpose of the Present Research

This project aims to explore the mental health and wellbeing of adolescents attending international schools in the emirate of Abu Dhabi, comparing the experiences of individuals in relation to their expatriate or Emirati status. Further, this research seeks to identify potential correlations between culture, nationality, presentation, protective factors, and the likelihood of accessing support, in an effort to inform community education, improve provision and facilitate positive outcomes. Data collected from school counsellors will provide further insight into rates of presentation to school based mental health services, as compared to prevalence identified in the anonymous student survey.

The research design, utilising a mixed method approach, intends to develop understanding of adolescent wellbeing, clarify existing cultural and social practices, and ultimately result in conclusions and recommendations that inform social action. The mixed method design will provide a strong evidence base and rationale for recommendations relating to the prevalence and nature of need and provision of interventions amendable and accessible to adolescents.

The objective of the quantitative aspects of this research is to gather data on the prevalence of a range of mental health difficulties experienced by adolescents, using a survey containing a series of screening tools which identify emotional, conduct, hyperactivity, and social problems, compared to the prevalence of students presenting to school counsellors by need type as reported by counsellors. Collecting qualitative data through open-ended survey questions allows adolescents and counsellors to expand upon personal experiences, beliefs, attitudes, and perceptions, which will deepen analysis and lead to more informed evaluations and assumptions. Integrating the quantitative and qualitative data and taking a sequential explanatory mixed method approach enables the researchers to explore themes in a manner that would not be possible if only one data collection method were employed.

The target audience for this research are those who work in educational settings, leading counselling provision, pastoral care, or as mental health and student wellbeing advocates. School governors and educational leadership of private international schools would benefit from reviewing themes that emerge, the risk and protective factors that

exist for their students in the UAE, and reflecting upon the suggested recommendations for provision and support that arise as a result of the research. In addition, mental health specialists across the Emirates will be well positioned to utilise the data gathered on prevalence and presentation of mental health difficulties as well as attitudes expressed in relation to help-seeking preferences to inform their provision in clinical settings.

1.3 Research Questions

The intention of this research project is to establish recommendations and guidelines to enhance the quality, appropriateness and accessibility of support and intervention in schools that meet the specific needs and socio-cultural preferences of Emirati and expatriate adolescents. To inform these recommendations, accurate data relating to the nature and prevalence of mental health needs, cultural beliefs around help-seeking and levels of life satisfaction is required. Therefore, this research project seeks answers to answer the following broad questions, posed to both adolescents and school counsellors via survey instruments:

1. What are the levels of self-reported wellbeing and mental health in the sample of adolescents?
2. What is the incidence of mood disorders, eating disorders, substance misuse and self-harm reported by adolescents?
3. Are levels of reported mental illness and inclination to seek support influenced by socio-cultural or religious factors?
4. What social, emotional, educational, and societal implications of mental health disorders are reported by adolescents living in Abu Dhabi, and how do the experiences of locals and expatriates differ?
5. What impediments to help seeking do counsellors working with adolescent populations report and what are the key issues and challenges they face in delivering services and support?

1.4 Structure of the Thesis

Utilising a mixed method research design and seeking to build understanding of the interplay between socio-cultural perspectives, help-seeking, the nature, and presentation of mental health in the UAE, is enhanced by integrating a range of perspectives. To this end, conclusions will be rigorously and critically evaluated to maintain awareness of how a viewpoint may advance certain beliefs and perspectives while undermining others, particularly important given the examination of cultural influences and mental health

within this research. This research recognises the social and cultural context of mental health difficulties, and embraces the concept of "mental health's, rejecting any notion of an objective, defined, regulated – or even a subjective, phenomenological, liberated – view of mental health" (Tudor, 1996, p. 231).

1.4.1 Chapter 1 Introduction

Chapter 1 will address the challenges and difficulties experienced in the region in relation to mental health, highlighting the purpose for this research and selected research questions.

1.4.2 Chapter 2 Mental Health

Chapter 2 will address three relevant domains of mental health; adolescence, "Third Culture Kids" and mental health in Arab Cultures and in the UAE. This chapter will review relevant literature and explains the nature of adolescent cognitive, emotional and psychosocial development and establishes the link between emergent mental health difficulties and long-term implications for mental health and wellbeing. The experience of being a Third Culture Kid, and how that impacts personal character strengths and traits, experience of mental health difficulties and propensity to access support. Finally, this chapter will examine literature exploring the history of provision for mental health in the region, cultural factors influencing help-seeking trends and beliefs around mental ill health, which impact upon community and individual outcomes.

1.4.3 Chapter 3 Methodology

The methodological approach for this research will be detailed in chapter 3, providing the rationale for the selected research design, highlighting the value of utilising a mixed method design within this research.

1.4.4 Chapter 4 Study 1: School Counselling in the UAE

This chapter demonstrates the nature of mental health difficulties experienced by adolescents and frequency of presentation to counselling services. Further, it explores counsellor perceptions of cultural factors and family engagement with specialist services and barriers to help-seeking. Important considerations are given to safeguarding and child protection concerns held by counsellors, in relation to neglect and abuse experienced and reported by adolescents.

1.4.5 Chapter 5 Study 2: The Adolescent Experience

The adolescent experience chapter quantifies the frequency, nature, and impact of mental health difficulties on social, emotional, and cognitive functioning. It explores beliefs about psychological services and help-seeking and provides recommendations for school-based provision to increase accessibility and impact, ultimately seeking to improve long-term outcomes.

1.4.6 Chapter 6 General Discussion and Recommendations

This chapter includes discussion relating to the main findings, significance and contribution of the research, and the theoretical, methodological, and practical implications for policy and provision in the UAE. Furthermore, it examines limitations, and recommendations for potential future research.

1.4.7 Chapters 7 and 8 References and Appendices

To close the thesis refences will be provided and relevant documents utilised in the research, including the participant information and consent forms, copies of the survey instruments and student information publications.

1.5 Researcher's 'insider' position

For 10 years I have been employed by Aldar Academies, now Aldar Education. Initially providing learning support in one school, I have progressed to leading strategic initiatives to enhance inclusion, counselling and safeguarding across our group of 19 schools. This 'insider' view enabled me to witness the challenges adolescent, families, counsellors and senior school leadership face first-hand, I have heard the voices of adolescents expressing their hatred of themselves, the pleas of parents desperate to access psychological help but unable to afford services and the desperation of counsellors unable to reach students who obviously need help but resist. The benefit of this position is that I have been able to formulate this research, asking probing questions informed by presenting needs and challenges witnessed, motivated to clarify the impediments and barriers to help-seeking in order that as an educational entity we can effectively address or remove these barriers to facilitate equitable and accessible access to help. However, there are potential drawbacks to this 'insider view', primarily the potential for bias based on pre-existing experience, if preconceptions or assumptions were to influence the content and focus of the survey questioning, either by inclusion or omission. Similarly Eurocentric views may adversely impact the data gathering phases due to cultural and

religious assumptions. The potential for both drawbacks has been mitigated by both my supervisors reviewing the content of the survey and challenging my assumptions and findings based upon the data gathered, and through the process of having the Aldar Education Head of Arabic language independently examine the content and tone of questioning to confirm no personal bias is evident.

CHAPTER 2: MENTAL HEALTH

2.1 Mental Health in Adolescence

The transition from child to adult is marked by the adolescent phase, a time of significant change in physical, cognitive, social, emotional, and interpersonal domains. Adolescents seek independence and self-direction, and develop an awareness of more complex societal, cultural, and ethical dilemmas, often alongside increased social and academic stressors. They face challenges, including violence, risk taking behaviours, increasingly complex and often sexual relationships, substance use and misuse. This dynamic leaves them vulnerable to developing externalising and internalising behaviours such as anxiety and depression (Chow, 2016). This is compounded by the fact that most lifelong mental health illnesses emerge during the adolescent years (Merikangas et al., 2010). Long-term mental health and wellbeing can be influenced by the nature and timeliness of support and intervention accessed during adolescent years (Kessler et al., 2007 a) which speaks to the importance of understanding the adolescent experience and being aware of challenges that may present.

2.1.1 Adolescent Psychosocial, Emotional and Cognitive Developmental

It is important to recognise the unique phase adolescence represents in an individual's life, its implications on both the identification and nature of intervention for mental health issues, and on efforts to develop protective factors and support, accessible and amenable to adolescents. Adolescence, defined as a period of human growth between childhood and adulthood, in and of itself poses many challenges to the individual, and include:

1. Achievement of biological and sexual maturation
2. The development of personal identity, rights and responsibilities
3. The development of intimate sexual relationships with an appropriate peer
4. Establishment of independence in the context of sociocultural environment

Christine & Viner (2005, pp. 301-304)

While an individual's progression through adolescence may appear a relatively straightforward developmental process, it is influenced by both external challenges and the emergence of inherent mental illnesses, many of which impair the individual's capacity to demonstrate skills necessary to maintain wellbeing and make informed decisions on help-seeking should that be necessary. Table 1 illustrates the range of

maturational processes which occur during the adolescent period and some of the challenges which present.

Table 1

Adolescent Development

	Biological	*Psychological*	*Social*
*Early Adolescence * 9 -14 yrs*	Early puberty (girls: breast bud and pubic hair development, start of growth spurt; boys: testicular enlargement, start of genital growth).	Concrete thinking but early moral concepts, progression of sexual identity development (sexual orientation); reassessment of body image.	Emotional separation from parents; start of strong peer identification; early exploratory behaviours (smoking, violence).
*Mid Adolescence * 15 -17 yrs*	Girls: mid-late puberty and end of growth spurt; menarche; development of female body shape. Boys: mid-puberty, spermarche and nocturnal emissions, voice breaks; start of growth spurt.	Abstract thinking, but self still seen as 'bullet proof', growing verbal abilities, identification of law with morality; start of fervent ideology (religions, political).	Emotional separation from parents; strong peer identification; increased health risk (smoking, alcohol, etc); heterosexual peer interest; early vocational plans.
*Late Adolescence *18 – 21 yrs*	Boys: end of puberty; increase in muscle bulk and body hair.	Complex abstract thinking; identification of difference between law and morality; increased impulse control; further development of personal identity; further development of rejection of religious and political ideology.	Development of social autonomy; intimate relationships; development of vocational capability and financial independence.

Note: Age ranges are indicative only and will vary based on the individual. Adapted from McIntosh, Helms & Smyth eds., (2003). Forfor and Arneils's Textbook of Paediatrics. 6th ed. Edinburgh: Churchill Livingstone, pp.1757-68.

2.1.2 Adolescent Mental Health and Wellbeing

Mental health, irrespective of an individual's age is a broad concept which relies at least in part, upon the individual's capacity to maintain a sense of wellbeing, experiencing a sense of control and purpose, and taking responsibility for one's experiences and responses to them. However, for adolescents who need support during this phase, accessing help can be hindered by the adolescent way of thinking, which represents a belief that adults cannot have an understanding of how a young person feels, in addition to their temporarily reduced capacity to understand the impact of their behaviour on others. Furthermore, adolescent perception of mental health may vary from individual to individual and is vulnerable to and influenced by cultural and community values and expectations.

Keyes (2006) identified three broad components of mental health relevant to the adolescent experience:

1. Emotional well-being: happiness, interest in life and satisfaction.
2. Psychological well-being: liking most parts of one's personality; being good at managing the responsibilities of family life, having good relationships with others and being satisfied with one's own life.
3. Social well-being: positive functioning and having something to contribute to society (social contribution), feeling part of a community (social integration), believing that society is becoming better for all people (social actualisation) and that the way society works make sense (social coherence).

Given the range of factors which reflect mental health, and that a sense of wellbeing is central to success in academic, social, emotional and physical domains, it is important to have in place a system that identifies those experiencing distress or difficulty and a range of resources available to support and intervene once a need is established.

2.1.3 Mental Health Disorders of Adolescence

In addition to adolescence being a time of challenge, growth and opportunity for self-discovery and empowerment, it is also a time that marks the emergence of many mental health disorders and difficulties. Research by Merikangas et al. (2010) examined the lifetime prevalence of mental health disorders in USA, using a sample of 10123 adolescents aged 13-18 years, and applying Diagnostic Statistical Manual 4 (DSM IV) criteria. The research found the median age of onset for particular mental health

difficulties in adolescents, included “6 years for anxiety, 11 years for behaviour, 13 years for mood disorders and 15 years for substance use disorders” (Merikangas et al., 2010, p. 287). Data collected by the researchers indicated the following.

1. Most common conditions were anxiety (31.9%), behaviour disorders (19.1%), mood disorder (14.3%) and substance use disorders (11.4%).
2. 40% of participants who met criteria for one disorder also met criteria for another lifetime disorder.
3. Prevalence of disorders with severe impairment was 22.2% (11.2% with mood disorders, 8.3% with anxiety disorders, and 9.6% with behaviour disorders).

(Merikangas et al., 2010, p.980)

The World Mental Health Survey, which utilised the WHO Composite Diagnostic Interview (Version 3) to obtain DSM-IV and International Classification of Diseases 10th Edition (ICD-10) diagnosis, examined prevalence, distribution and patterns of treatment of mental health disorders across 85000 surveys across 28 countries, including representation from Africa, Americas, Europe, Asia and the Pacific. Data which emerged from the review of this survey by Kessler et al. (2007 b), indicated that approximately half of all lifetime mental disorders start by the mid-teens and that three quarters of lifetime mental health disorders start by the mid 20’s. In relation to the onset of Attention Deficit Hyperactivity Disorder (ADHD), the surveys established that 80% of all lifetime presentation begins between 4-11 years, and Conduct Disorder (CD) and Oppositional Defiance Disorder (ODD) emerge between 5-15 years. Analysis of treatment patterns suggested that those disorders that emerge later in life are often secondary disorders, and that early treatment or intervention for primary disorders generally reduces the severity-persistence of disorders and may prevent the emergence or onset of secondary disorders (Kessler et al., 2007).

A summary of the research examined, indicating the median age of onset of mental health disorders is detailed in Table 2.

Table 2

Onset of mental health disorders

Disorder		*Median Age of Onset*
Impulse Control Disorders	ADHD	7-9 years
	Oppositional Defiant Disorder	9-14 years
	Conduct Disorder	9-14 years
	Intermittent Explosive Disorder	13-21 years
Anxiety Disorders	Phobia / Separation Anxiety Disorder	7-14 years
	Panic Disorder, Generalized Anxiety Disorder, Post-Traumatic Stress Disorder	25-53 years
Mood Disorders	Depression, Bipolar Disorder, Seasonal Affective Disorder	25-45 years
Substance Disorders	Drug and Alcohol Misuse	18-29 years
Psychotic Disorders	Psychosis	16-24 years
	Schizophrenia	15-35 years

(Kessler et al., 2007)

With regard to sociodemographic differences in presentation, research suggests that females experience a higher prevalence of anxiety and mood disorders, whereas males have a significantly higher risk of substance use and impulse control disorders (Kessler, 2005; Bor, Dean, Naiman, Hayatbaskhsh, 2014).

Median age of onset for individual mental health disorders in adolescence varies according to research data. However, what is clear across research examined, is that more than 50% of lifetime mental health illnesses emerge during the adolescent years, and that intervention during this time has the potential to reduce the severity of difficulties experienced, and may prevent the onset of secondary or comorbid mental health disorders (Kessler et al, 2007; Merikangas et al., 2010; Patel, Flisher, Hetrick & Gorry, 2007).

2.1.4 Psychological Interventions for Adolescents

Identifying interventions and support appropriate for adolescents requires an understanding of adolescent coping behaviours. Coping is defined as "cognitive and behavioural efforts to manage external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 141). In

adolescents, effective coping skills represent a protective factor, mitigating the impact of generalised pressures such as stress and anxiety, and emergent mental health disorders. Chow (2016) cites approach strategies (information seeking, solution focused, problem solving) and withdrawal or avoidant strategies (emotional, diversional, or defensive thinking) as the two primary coping methods employed by adolescents. Effective coping has been found to reduce stress and resulted in more positive adjustment, whereas ineffective coping may result in a deterioration of wellbeing and mental health (Ebata & Moos, 1991). Research by Heran-Stabl, Stemmler & Peterson, 1995) established that adolescents who are more willing to seek help or are more proactive in addressing their own difficulties achieve improved outcomes and adapt to challenges more readily and positively. The implications for psychological interventions with adolescents, are that any strategies employed must account for those who have both avoidant and approach coping styles, and overcome the adolescent scepticism about the veracity of any guidance provided from an adult.

In addition to coping strategies, other protective factors can have a positive impact on mental health in adolescents, including:

1. Sense of connection
2. Low levels of conflict
3. Encouragement of expression
4. Consistent and engaging parenting styles
5. Parents and friends who model healthy behaviour
6. Zero tolerance towards bullying

(Patel, Flisher, Hetrick & Gorry 2007)

Employing a strengths-based approach is recommended by Chow (2016 p. 35), who purports that shifting the focus to "understanding clients' holistic functioning, helping them resolve their own problems by instilling hope, exploring their strengths and cultivating community resources", is an appropriate and effective approach with adolescent clients.

2.1.5 Summary

Adolescence is a time of growth and transformation, some of that change may be the emergence of mental health illnesses and behavioural or emotional challenges that impact on social and academic achievement and emotional wellbeing. Adults working and interacting with adolescents, be they in a familial, educational or context need to

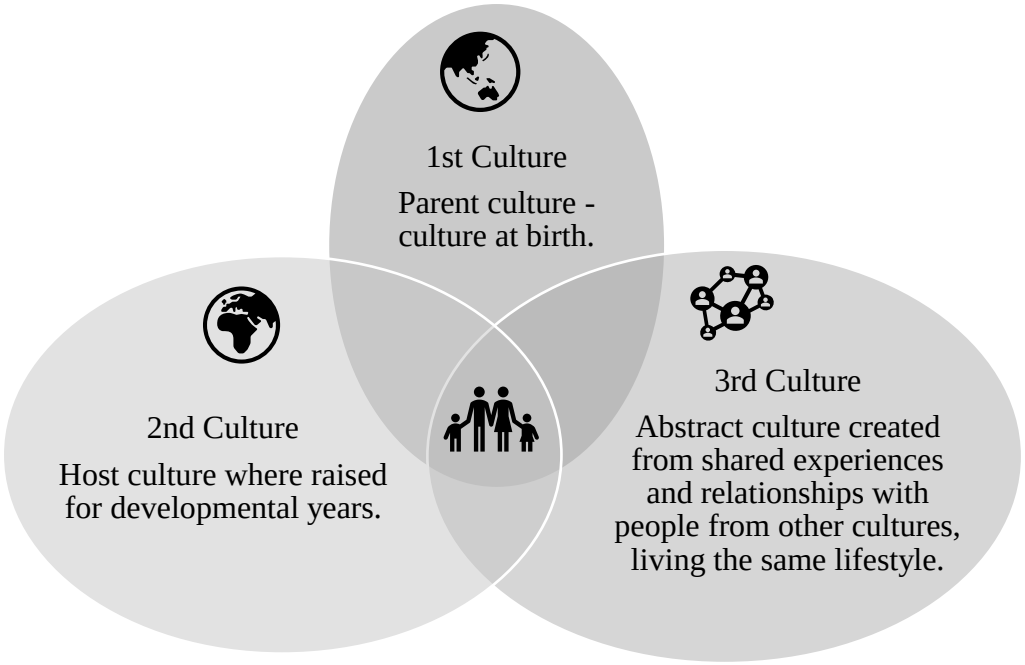
understand the developmental and cognitive changes and the risk factors that may contribute to the emergence of mental health difficulties. They need to be proactive in enhancing protective factors, which may develop skills and resilience to protect the individual, to varying degrees, from experiences that increase the likelihood of and severity of impact of mental health and personal challenges. Early identification and early intervention offer the best chance of improved long-term outcomes and reduce the risk of secondary mental health difficulties developing.

2.2 Mental Health of Third Culture Adolescents

Third Culture Kids (TCK) are those that find themselves for "a significant part of their developmental years, in a culture other than their parents or home culture" (Pollock & Van Reken, 2001, p. 19), and as a result develop a unique set of character traits (See figure 1). Their character strengths, areas of difficulty and challenge arise from growing up amidst cultures, often within multilinguistic, and multicultural contexts (Pollock & Van Reken, 2009). Provision for TCK in counselling settings should be informed by an understanding of the vulnerabilities of this cohort to a range of mental health difficulties including depression, anxiety, identity and personality disorders (Dahl, 2018).

Figure 1

Third Culture Kids (Pollock & Van Reken, 2001; Van Reken 2010).



2.2.1 Third Culture Kids in the UAE

> "… in reality, they are more like the contrasting coloured strands of thread woven together into a tapestry. As each strand crosses with a contrasting or complementary colour, a picture begins to emerge, but no strand alone tells the full story"
> (The Third Culture Kid Experience: Growing Up Among Worlds, Pollock & Van Reken, 2009, p.78).

The third culture has been described as "a created culture that is neither the 'home' nor the 'host' culture; it is a culture between two cultures", (Walters & Auton-Cuff, 2009, p755) and it is within the conceptualisation of this third culture that the unique experiences of non-UAE-national and international expatriate adolescents lie.

Many nations rely upon an expatriate workforce to enhance capacity in developing industries, complement existing professionals or address deficiencies in labour markets. Military families are deployed across the world, often for extended deployments. Multinational companies transfer knowledge and expertise around the world to strengthen or expand their business and staff capacity, and as they do so many bring trailing wives or husbands, and children. In the UAE, despite increased efforts towards Emiratisation, and the inclusion of Emirati men and women in the workforce, there will continue to be a reliance upon or motivation to attract the expertise and experience of expatriate professionals and labour due to the nation's rapid expansion, gaps in local expertise and skill set and limited Emirati workforce (Paulo, Loney & Lapão, 2019; Fattah & Omar, 2020). In 2018 the UAE's population was estimated by the World Bank to be 9.543 million, with Emiratis making up only 11.48% of the total population. Of the expatriate workforce, 27.5% were Indians, 12.7% Pakistanis, 5.6% Filipinos, 4.3% Egyptians, and 38.5% others predominantly from Europe, America, Asia, Australia, and Russia (World Bank, 2018). The experience of expatriate life, and being a TCK, is similar here to that experienced in other developed nations.

Dahl (2018), in article for Gulf News, cites clinical and health psychologist Dr Sarloos, who describes TCK in Dubai as "unique…fortunate to be exposed to different cultural influence…more flexible, adaptive and thus find it easier to adapt to changing environments". However, he also contends that as children combine and create their new culture, a third culture, they can experience "a more complex experience of the world and thus the self or identity, ...complexity in the brain (which) can sometimes lead to conflict,

or even neurological stimulation and psychological disorders" (Dahl, 2018). Those families he works with in a clinical setting present with difficulties which exemplify the experience of some TCK. He cites the experience of an Emirati mother who placed her children in an international school, but now as they become more westernised, the family experiences increasing stress and arguments at home. Similarly, a child is struggling to establish an identity within her international school, with a Moroccan father who "values religion and emotional character" and Dutch mother who is "non-religious, rational and tries to supress her emotions", they speak only to their daughter in English and "make little effort to understand each other's traditions". The experience for a young Syrian woman is equally complex, diagnosed with depression and post-traumatic stress disorder, she is conflicted, missing her "true identity and culture associated with her ravaged home", while she "wants to assimilate new values that would liberate her from the past" (Dahl, 2018).

2.2.2 Implications of being a Third Culture Kid

The development of a young person's identity, personality, and belief systems are a result of a subtle interplay between multiple factors, including for example, genetics, ethnicity, family structure, parental personalities, and social class (Aetna, 2019). Combined with environmental and contextual influences such as living as an expatriate, children and young people raised within one or more cultures experience outcomes perceived and both beneficial and detrimental. The implications of being a TCK are complex, both profound and subtle. Many TCK experience positive self-esteem based on their open mindedness, understanding of the world and confidence interacting with various cultures and languages and frequently report feeling a sense of responsibility to counter narrow minded views (Aetna, 2019). The shared experiences of TCK raised in expatriate communities often results in them gravitating towards others with a similar history in later life, and indeed seeking it out for themselves as they form their own families.

> I sometimes wonder whether my life would be different if I had grown up in one place. I wonder what it would be like to have lived in a house where there were ruler marks beside a doorframe, documenting each of my childhood growth spurts; to have a friend who has known me since nursery; not to feel like a tourist, wandering around with a map in a country that I'm supposed to embrace as my own. Being rootless has given me a sense of

> freedom. I feel grateful for the experiences I've had, and I am proud to feel, above all, like a citizen of the world. The possibilities for the future are endless. The sense of being at home anywhere, yet feeling that home is nowhere, is part of who I am.
>
> Ndela Faye, 2016

Being a TCK brings opportunities, challenges, experiences, and perspectives that many who have a mono-culture cultural experience during their early development do not experience. Researchers have identified several benefits of spending adolescence as a TCK, including the development of:

- Broad worldview, one which recognises multiple viewpoints and through their experience value diverse perspectives (Moore & Barker, 2012).
- Multi-dimensional view of the world developed because of both observation and authentically participating in what are often intimate experiences within other cultures and family traditions (Pollock & Van Reken, 2009).
- Interpersonal and cultural sensitivity with heightened awareness of and respect for societal norms, and cultural tradition (Pollock & Van Reken, 2009).
- Cultural intelligence, competency in engaging effectively with peers across ethnic, national, or organisational cultures (Lyttle et.al, 2011).
- Adjustment, capacity for managing change and transitions is heightened (Selmer & Lauring, 2014).
- Extended exposure to native languages, enable TCK to reach a level of cultural knowledge, familiarity and communication not otherwise achieved (Tokuhama-Espinisa, 2003).

Conversely, researchers have also identified a range of challenges which emerge for TCK's, including:

- Confused values and politics, particularly when experiencing collectivist versus individualistic cultures (Pollock & Van Reken, 2009).
- Development of personal identity in new environments is more complex for TCK as they merge their beliefs and behaviours (Hervey, 2009) and may experience dysfunctional identity development impacting academic and socio-emotional functioning (Walters& Auton-Cuff, 2009).

- Disconnection from home culture, wherein TCKs may lack knowledge and understanding of the home country, city or family, or experience difficulty relating to cultural sense of humor or language traditions, something that can be ameliorated through use of technology to remain connected to family, friends and cultural or national traditions (Pollock & Van Reken, 2009).
- Transition to adulthood may bring difficulties in developing a sense of identity, and potential to feel a lack of belonging (Hervey, 2009).
- Reduced emotional affect and hesitation to form relationships, most notable for female TCKs, is a consequence of a disproportionate focus on adjusting to return to home culture rather than creating a sense of belonging (Walters & Auton Cuff, 2009 in Limberg & Lambie, 2011).

2.2.3 Counselling and Mental Health Support for Third Culture Kids

School counsellors working in international schools, and those that work with TCK re-entering their home country, as is the case for UAE nationals raised for many years abroad and now returning to Abu Dhabi, have an ethical responsibility to deliver culturally responsive programmes that promote a school climate that is responsive and holistically meets the needs of all students and the school community (Courtland, 2001). Developing an understanding of multicultural counselling issues, including maintaining an awareness of personal beliefs and attitudes towards other cultures, is considered essential when providing services in international settings (American School Counsellor Association, 2010).

The individual experiences of a TCK can be impacted upon by the stability of the family within their expatriate setting, the willingness of parents to embrace the culture and experiences offered within the host country, and the level of connectedness maintained to the home country during the time spent distanced from it (Pollock & Van Reken, 2009). Consideration for counselling services and evaluation of increased risk factors is a necessary part of provision for non-UAE national adolescents in international schools in the UAE, and beyond.

Counsellors may take into account factors relating to adolescents cognitive and emotional development, for example that teenage TCK are more mature than non-TCK, but in late high school and their early 20’s may take longer to focus their aspirations and

career goals (Cottrell & Useem, 1993), which may have an impact on their capacity to make informed subject choices in secondary school. Depression is comparatively prevalent among TCK (Cottrell & Useem, 1993) and they may experience heightened stress and grief as a consequence of the relocation experience (Oesterreich, 2004). Hoersting's research (2010) found that TCK experience greater difficulty establishing a sense of belonging and attachment, which has a significant impact on the stability of one's self esteem and identity. Mental health specialists and counsellors in schools may explore these issues as possible causal factors with young people who present with anxiety, depression and issues with identity.

Research has identified that TCK are particularly vulnerable during transition phases, which may include the time leading up to a return to their "home" culture, or for those transitioning between expatriate settings. Plamondon (2008) established that the sense of identity and well-being of TCK is directly and negatively affected by repatriation, with the severity of the effect of repatriation also depending on the degree of cultural and linguistic differences between the TCK's place of recent residence and place of repatriation. Similarly, UAE nationals who have spent some time abroad with their family, often in Canada and America, will also be vulnerable during their reintroduction. The impact of the stress and adjustment of transition is often seen in distortion of psycho-social development which can impact school performance, establishment of social connections and feeling a lack of connectedness. Counsellors are recommended to create as a sense of comfort and safety to mitigate and uncertainty or trepidation that emerges (Limberg & Lambie, 2011), and wherever possible utilise the support students offer each other simply by being together with people who have had similar experiences (Hervey, 2009). Limberg and Lambie (2011) summarise the presentation of needs and behaviours and possible support strategies in Table 3.

Table 3

TCK Descriptors, Observable Cues, and Potential School Counselling Strategies

General Descriptors	*Observable Cues*	*School Counselling Strategies*
Strengths Expanded worldview Adaptable Cross Cultural relationships Often multilingual	**Transition Stage** Resistance to make friends Overconfident of academic skills Constant comparison to old school Bragging about previous experiences	**Transition Stage** Orientation with family Fact sheet for teachers Teacher meeting / training
Common impacts of Transition Identity development issues Lack of sense of belonging Commonly experience grief / loss Friendship & relationship issues Reverse culture shock	**Entering Stage** Decline in grades Frequent absences Parents enable poor behaviour due to own guilt Isolate themselves or only interact with people who speak same first language	**Entering Stage** Buddy programme Friendship Circle Group International day / Diversity week
Common impacts of Transition	**Leaving stage** Increase in poor behaviour/ discipline Withdrawal from friendship groups or extra-curricular activities Parent against school Decrease in academic performance	**Leaving stage** Farewell book Time to say goodbye Visits / online

2.2.4 Summary

Counsellors are recommended to develop a holistic understanding of each student, taking into account the unique characteristics and experiences of TCK's living within their third culture, and importantly in preparation for or when receiving those transitioning back into their first culture, to ensure therapeutical approaches meet the needs and are culturally informed (Limberg & Lambie, 2018). The transition phases are of particular importance, given the additional social, emotional, and academic vulnerabilities at these times. Counsellors who engage in culturally aware practice and have well developed counselling and therapeutic skills are best positioned to identify the presentation of unhelpful behaviours or traits which are a result of being a TCK, and use their character strengths to mitigate any adverse long-term impact.

2.3 Mental Health in Arab Cultures and in the UAE

The literature and research relating to wellbeing and mental health in the UAE and Middle East, the influence of Islam and Arab culture on the expression of mental health and mental illness, and culturally appropriate interventions and support for those experiencing difficulties, identifies key issues which provide the context for this current research project. In addition, they build a case for the necessity of further specific research, particularly in adolescent populations, conducted in educational settings. Literature specific to the UAE highlights cultural issues and spiritual beliefs unique to this region of the Arabian Gulf, and speak to the value, indeed necessity of research which provides a greater understanding of socio-cultural risk and protective factors, family and community attitudes and values which impact the propensity of young people seeking help when the need arises.

2.3.1 Mental Health in Arab Cultures

The WHO defines mental health, as not the absence of illness, rather it is a positive and productive state of well-being (WHO, 2005a). However, defining mental health across cultures or in universal terms presents challenges and applying Eurocentric or ethnocentric understandings to adolescents in a Middle Eastern context is likely to result in less reliable diagnosis and may be incompatible with regional culture and values (Al-Darmaki & Sayed, 2009). Cultural variations in definitions of mental health influence views of what constitutes normality versus abnormality, whether mental disease is

considered naturalistic or supernatural, if it is a consequence of fate or evil sources and impacts upon selection of appropriate treatment options (Paniagua & Yamada, 2013).

The Arab world consists of the 22 member countries of the Arab League, and includes countries in both North Africa (Egypt, Algeria, Sudan, Morocco, and Libya) and the Middle East (Saudi Arabia, Iraq, Syria, Yemen, Oman, Bahrain, Jordan, Lebanon, Kuwait, Qatar, Palestine and the UAE). Developing policy and facilitating access to psychiatrists and psychologists for mental health disorders in the Arab world is challenged due to localised cultural sensitivities, the dichotomy between Arab cultures and the community of Islam, attitudes towards mental health and a lack of social support services (Sayed, 2003; Eapen & Ghubash, 2004; Thomas & Altareb, 2012; Ashencaen Crabtree, 2008). Research conducted by Jaalouk, Okasha, Karam, and Okasha (2012) identified that across the Arab world, nine of the twenty countries for which information was available did not have mental health legislation or mental health policy, nor was their expenditure sufficient to promote mental health services. In fact, of the six member countries of the Cooperation Council for the Arab States of the Gulf (GCC), Saudi Arabia, Kuwait, Qatar, Oman, UAE, and Bahrain, only Qatar has a national strategy. In addition to a lack of policy guiding the treatment and care of those experiencing mental health difficulties, the practice of seeking counselling or any psychological help is stigmatised in Arab culture, and disclosure of personal or emotional issues to outsiders is not only discouraged but is also seen as a weakness of the individual (Ahammed & Cherian, 2014).

Thomas and Furber (2015), in their research on culturally and spiritually attuned psychotherapy in the UAE, cite commonly held metaphysical and spiritual explanations for mental ill health in the Arabian Gulf region, including *jinn* (sentient – unseen creatures who coexist with humans and have the potential to lead to abnormal behaviours), *'ain* (evil-eye), *hasad* (envy) and *sihr* (sorcery). They examined the role of traditional healers who offer 'Quran-based interventions … for what we might consider depressive symptom: fatigue, vague aches and pains, sadness, and lack of motivation" (Thomas & Furber, 2015, p. 71). The authors speak to the patient benefits of integrating traditional indigenous healing as a complementary therapy to mainstream psychotherapy.

2.3.2 Mental Health in the UAE

Since unification of the emirates in 1971 into the nation state, the UAE, the country has experienced rapid industrialisation and modernisation, and maintained a progressive

approach to economic, cultural, health, educational and infrastructure development, however mental health provision remains inadequate (Al-Darmaki & Yaaqeib, 2015). Despite the existence of a mental health plan embedded within the UAE general health policy (WHO, 2011), and the intention to release a Mental Health Act in early 2018, there remains no independent mental health policy in place. In the last 10 years, efforts to integrate mental health into primary health care facilities have been hampered by a lack of mental health professionals, with rates of 0.3 psychiatrists, 0.51 psychologists and 0.25 social workers per 100,000 head of population (WHO, 2011) and waiting times of over 2 months to access public facilities (Abed, 2014). Schools struggle to identify specialised clinics to refer students and their families dealing with mental health issues or special educational needs, and in practice assessments and provision recommendations are frequently provided by those who are not fully qualified educational psychologists, and rarely able to communicate with a student or family in the native language (Arabic) of many students. Ewen (2015, p.187) argues that "should those not appropriately trained be employed for the purpose (of educational psychologist consultation), even if educated to degree standard with some knowledge of psychology and its application, children could potentially be put at risk and the UAE's international reputation threatened". Where need outstrips the availability of services, compromises are inevitable, however both in educational and clinical contexts fully qualified and experienced mental health professionals remain at a critical shortage. Furthermore, a general lack of attention to mental health has resulted in an absence of legislation, inadequate licencing of clinical specialists, a shortage of qualified mental health professionals, and insufficient undergraduate and postgraduate psychology programmes (Al-Damaki & Yaageib, 2015; Al-Shihabi, 2011; Badawi, 2012; Rizvi & Bell, 2014).

Protecting clients who do seek psychological services and maintaining the integrity of professional psychological practice also presents challenges. Within the UAE there is currently no one licensing body to monitor credentials and qualifications, so psychologists regularly claim specialisms for which they hold no specific qualifications, for example there is nothing stopping those with a psychology degree who work in an educational setting claiming "Educational Psychologist" status. Furthermore, within the UAE there is no established ethical codes of practice for psychologists, with practitioners left to conduct themselves in line with codes from their home regulatory bodies (for example the ethical code as laid down by the British Psychological Society for UK

expatriate specialists) or as they feel personally appropriate (Al Serkal, 2015). Even in the event that an ethical code for psychologists were established in the UAE, there is no regulatory body to oversee or administer it. Al Serkal explains that while there is a licencing procedure for clinical psychologists, "organisational, educational, forensic or sport psychologist credentials are not being monitored … and there is no license for such subspecialties, one is left to practice as one sees fit, without being held to any standard of ethics except one's own" (Al Serkal, 2015, p. 246). An enduring challenge is the impact of the historical process for UAE nationals who having graduated with a psychology degree were employed as psychologists in major UAE government hospitals, working under the supervision of doctoral level psychologists from other Arab countries. However, "the number of clinical psychologists as defined by the APA and other licencing bodies was not enough … so non-doctoral psychologists by default became eligible to practice as clinical psychologists" (Haque and Al Kindi, 2015, p. 30) and counsellors with no training in professional counselling (Al Damarki, & Yaageib, 2015). These factors perpetuate a context which contributes to community scepticism of the value and professional quality of many existing mental health services, which does little to help overcome sociocultural and religious beliefs around help-seeking.

Al Mazrouei (2014a, p. 1), in commentary on attitudes towards mental health in the UAE, states that many Emiratis and Muslims "view severe mental health disorders … as 'madness' and look at depression and anxiety as an indication of a lack of faith". In fact, according to Sharia principles and UAE law, suicide is considered "a social evil by those who lack self-esteem" (Al Moosa, 2012, p. 2). This is further evidenced in the UAE Penal Law (No. 3 of 1987), Article 335, which stated that a person who attempted to commit suicide but fails, is committing a punishable offense with a maximum 6 months in jail if convicted. Regulations released in November 2020 have now decriminalised suicide and suicide attempts opening the way for those experiencing distress to access specialised services and support rather than be prosecuted (Reynolds, Jarallah, & Al Nowais, 2020). The implications of such cultural beliefs, laws, and changes to laws are profound, not only for those experiencing mental health issues, but for the community that is put at risk by those individuals not receiving appropriate care and treatment.

It has only been in the last 10 years, that academics, health professionals, and government entities in the UAE have begun to conduct research that explores the sensitive issues relating to mental health in this country and culture. However, to date

research has predominantly focused on university and post graduate student participants (Aveyard, 2015; Al Darmaki, 2011; Al-Krenawi, Graham, Dean & Eltaiba, 2004; Hamdan, 2009; Thomas & Altareb, 2012), or on children in clinical settings (Eapen, Al Gazali, Bin Othman, & Abou Saleh, 1998; Eapen, Essa Jakka, & Abou-Saleh, 2003; Eapen, & Ghubash, 2004; Khamis, 2011). Although these influential researchers have begun to shape understanding of mental health in the UAE, their reliance upon participants in these two relatively narrow cohorts is a limitation. The lack of any adolescent specific, school-based survey of mental health needs in Abu Dhabi is concerning, for without accurate measures and empirical data, policy decisions, the establishment of support services and community education are potentially ill-informed (Osman & Afifi, 2010).

In response to shortcomings identified in research conducted for the WHO Mental Health Atlas (WHO, 2011), during 2013 the Dubai Health Authority conducted a survey of 1,289 students aged 14-18 in 20 schools (16 private and four public). This was the first survey of its kind in the UAE, covering a mix of nationalities with a participant sample from both public and private school sectors. The research found that one in five students had elevated levels of depression and that those experiencing symptoms of heightened anxiety, and therefore at risk of developing more significant mental health needs, equated to 17.5 per cent of pupils (Ismail, 2013). In Abu Dhabi, no similar research conducted on adolescents in educational settings can be located, however the data from university and clinical research confirms that prevalence, risk, and age of onset is similar to international norms (Ashencaen Crabtree, 2008; Lambert, 2008). Clinical studies and research urged further large-scale studies of mental health in adolescent populations to confirm these predictive findings (Eapen, Essa Jakka & Abou-Saleh, 2003; Ismail, 2013).

Responding to increasing concern about the happiness and wellbeing of children and adults, the Dubai Knowledge and Human Development Authority (KHDA) partnered with the South Australian Government for a five-year project, to implement the first ‘Dubai Student Wellbeing Census’ for Grades 6 to 9 (Year 7 to Year 10), expanding in 2018 to include Grades 10 to 12, (Years 11 to 13, the final year in UK Curriculum schools). Support for these initiatives is supported at the highest levels, with His Highness Sheikh Mohammed bin Rashid Al Maktoum, Vice President and Prime Minister of the UAE and Ruler of Dubai, stating that “we will seek to create a society

where our people's happiness is paramount, by sustaining an environment in which they can truly flourish." Contributing to a general understanding of life satisfaction, happiness and wellbeing, the 2018 census which surveyed 95 874 students in Dubai, 68% who report to living all or most of their lives in the UAE, found that 54% felt highly connected to adults at school, 75% to adults at home and 76% to close friends. Declines in wellbeing were noted in both first and second census years, from Grade 6 to Grade 10. Based on nationality the groups reporting the highest rates in wellbeing domains included Arabs for perseverance, Indian for happiness and Western for having the least worries (KHDA, 2019). The census does not offer the detail on students presenting with behaviours indicative of depression or anxiety that the initial 2013 survey did, however it does highlight that 46% of students do not feel highly connected to adults at school, and that 20% of students in Grades 10-12 are unsatisfied with life.

2.3.3 Counselling in Arab Nations

For those of Arab heritage experiencing mental health distress, they seek help from family or religious leaders who act as a form of social support, and often in place of professional psychological services (Al-Krenawi & Graham, 2016). Arabs are strongly oriented towards the collective, the family, and have a strong sense of fatalism in relation to wellbeing. Emotional and psychological difficulties are routinely attributed to "God's will", and therefore beyond an individual's control (Hamda, 2009), a belief system which results in symptom tolerance and a reduced inclination to seek help (Hamid & Furnham, 2013). In addition, there is a belief that disclosure of mental health difficulties could be the result of a lack of faith, an act of family disloyalty in disclosing that there was such an affliction within the family (Abddabbeh & Nydell, 1993). Research has found that even within the collective of Arab cultures, there are marked distinctions in the willingness to seek help in relation to nationality, faith, gender and education levels influence the inclination to access counselling (Balesh, Gamst, Meyers, Karabetian & Elias, 2018).

In an interview in 2012, Psychologist Linda Sakr, a Muslim Iraqi-Jordanian born in Dubai, explained why taboo exists in Arab cultures, and the Gulf specifically.

> I believe the taboo is twofold; first of all, Arab tradition regards doctors, religious figures or family members as the proper alleviators of distress and illness. Most of my Arab Muslim clients would have seen a religious figure before they come to see me. Western counselling and psychotherapy techniques rely on client self-disclosure, sharing with the therapist the client's

> internal states, life circumstances, interpersonal relationships, and emotions. This technique is founded on the Western democratic belief that self-expression is a basic right for all people and that is a part of everyday life. However, within the framework of Arab culture, self-expression to strangers is discouraged and only permitted to the family. Family reputation and honour is of primary importance. They tend to avoid revealing personal problems in a way to save face. Disclosing family conflict could be viewed as a form of betrayal. Secondly, there is a widespread view that those who go to therapists are considered 'crazy' or 'insane,' and so people fear the stigma around that label.
>
> Baidas (2012, p. 448)

Given the context and complexity of mental health provision in Gulf states and Arab nations, a culturally sensitive, flexible, and informal approach to therapy is recommended (Lambert, 2008). Utilising a systemic and solution-focused approach with female college students was found to "accommodate culture, religion, and the gender and social hierarchy within the society through the use of family members and intermediaries" (Lambert, 2008, p 101). Furthermore, Lambert found that for effective and well utilised counselling services, confidentiality was critical, with many students expressing that they would not seek help from an Emirati Counsellor given the close interfamilial relationships that exit between tribes and families, expressing a preference for non-nationals.

2.3.4 Help-Seeking

Exploring the help-seeking trends of those experiencing mental health difficulties, provides insight into cultural values and fears that hinder young people and their families from accessing the support they need and highlights implications for research. Ahammed and Cherian (2014) identified that Emiratis remain wary of seeking help because values considered important in Arab societies rarely align to Western counselling paradigms. In an interview for the Khaleej Times, Dr Ahmed, Senior Specialist Psychiatrist at the Dubai Health Authority suggests that families may reject Western counselling or psychotherapy because mental illness is a matter of faith. He stated that "this is a sensitive issue, but in our (Emirati) culture, many tend to turn to healers for mental cases because they think it may have something to do with being possessed by bad devils, having weak faith in God or being affected by black magic" (Chawdhury, 2010, p. 1).

There is often a disconnect between the medical definition, versus cultural or religious understandings of mental illness and mental health. Hamdan (2009) suggests that methodological difficulties defining mental health within cultural contexts contributes to a lack of culturally relevant research instruments, an over reliance on scales designed for use in other cultures and mistrust of the health profession in some communities. The reliability and validity of assessment tools utilised by Educational Psychologists in the UAE for example, causes some difficulty, both linguistically and culturally. In this case, psychologists must evaluate if administering an assessment tool which has been standardised in Western populations and delivered in English, maintains validity when used for a child whose preferred language is Arabic and who belongs to an Arab cultural background. Taking these factors into account during the administration, diagnostic evaluation and recommendation phases of the assessment are crucial to ensure that judgements made are as accurate as possible (Bailey & Uzsayilir, 2015). Some of these challenges can be mitigated in an educational assessment by accounting for knowledge that could not be reasonably expected given the cultural context, integrating nonverbal measures which allow for examination of a child's cognitive potential where language demands are reduced or eliminated, as well as taking cultural knowledge into account. Bailey and Uzsayilir (2015) recommend that all assessment judgements be substantiated by qualitative information to minimise the potential for error. By applying these recommendations, it would be anticipated that families and schools will place greater importance on the assessment process, value the data and recommendations for therapy, treatment or intervention and over time reduce the scepticism and stigma surrounding such diagnostic assessments.

Research by Eapen and Ghubash (2004) investigated Emirati parental attitudes toward seeking help for children, finding that only 37% would access specialist services. Sayed (2003) identified that there was a tendency for parents to assume guardianship of an individual with mental health needs rather than seek medical or psychological attention and risk the patient revealing family secrets. In addition, there are a significant number of culturally sensitive issues which are often comorbid with mental health needs and may contribute to the unwillingness of young people to declare the need for psychological or emotional support. Examples include the taboo of child abuse, the illegality of homosexuality and suicide, the attribution of child disabilities to the mother, consanguinity, polygamous and gender segregated familial dynamics, and fear that their

Islamic values may not be respected, and spiritual disorders dismissed, for example demonic possession by 'Jinn' (Haque & Keshavarzi, 2013; Ahammed & Cherian, 2014; Thomas & Furber, 2015).

A prevailing practice in seeking support for psychological disturbance is to engage the services of a religious healer, a "Mutawwa". Until 1971 and the unification of the Emirates, these traditional healers were the only treatment options available (Al-Darmaki, 2011), driving away the "evil spirit" or "evil eye". Treatment includes the use of traditional medicine, prayers and reading the Qur'an, reinforcing the common belief that mental illness is a sign of weakness and lack of faith that can be cured by religious devotion (Sayed, 2015). Studies undertaken by Thomas and Furber (2015), which involved interviewing UAE traditional Mutawwa, revealed that demand for their services, usually to treat depressive symptoms such as sadness, loss of motivation, fatigue was increasing. The most common treatment was recitation of the Quran and sayings of the Prophet over the person; however, in rare cases, the use of light, often symbolic beatings to encourage the departure of spirts with ill intent were employed. It is common that when a family member experiences extreme psychosis or mental disturbance that families will attend hospitals and receive a referral for psychological services, however families often consider this the last option (Sayed, 2015). Implications of this cultural approach and family preference are significant, in that it can delay treatment and overlooks the value of earlier intervention and counselling or psychotherapy which may have addressed the issues earlier and more effectively, resulting in less severe and potentially more difficult to treat outcomes.

2.3.5 Culture: Health, Illness and Healing

Culture is the shared meanings and feelings, beliefs, and values of a group (Valsiner, 2007) and shapes how people express their symptoms, whether they seek help and what form of psychological intervention is most effective. Culture influences interactions between the participant and researcher, between an individual presenting in mental distress and the mental health professional, and factors including coping styles, how much stigma is attached to their needs, and the meaning that is attributed to the illness (Office of the Surgeon General, 2001).

In order to raise awareness of contextual factors relating to race, ethnicity, culture, religion or regional origin, the DSM–5 (American Psychiatric Society, 2013) has been updated to incorporate descriptors of cross-cultural variations in the presentation of

mental health difficulties and includes more detailed information on cultural concepts of distress. This builds upon the DSM-IV (American Psychiatric Society, 1994, p. 324) which acknowledged that in terms of mental health, culture can influence the "experience and communication of symptoms" providing the example of Middle Eastern cultures where depression is more often experienced as "problems of the heart". The interrelation between culture and mental health is profound, and it is essential that researchers and clinicians appreciate the subtle and complex interplay between the two.

Acknowledging cultural idiosyncrasies within the UAE is important, both for evaluating the generalisability of research findings which arise in one Emirate, and when planning mental health education or support. Eapen, Mabrouk, and Bin-Othman (2006) suggest that changing sociocultural foundations, witnessed as conflicts between liberalisation and traditionality in the UAE, may result in psychological adjustment difficulties, particularly in female adolescents where the conflicts are expressed as eating disorders. Shulte and Thomas (2013) have conducted extensive research into links between depressive symptoms, body dissatisfaction and disordered eating in males and females in the UAE. In subsequent research Thomas (2014) raises the proposition that the very nature of the traditional clothing worn by Emirati women, the long, black and loose fitting abaya, can act as both a protective and risk factor given its ability to both conceal weight loss and weight gain.

In the UAE, the way that an adolescent expresses their mental health issues may be influenced by cultural preference towards reporting physical illness rather than psychological distress. Somatisation in Arab cultures is well documented, defined as the expression of emotional problems in bodily ailments, where individuals are more likely to report a "physical symptom" associated with mental illness rather than an emotional need itself (Sayed, 2003; Sayed 2015), and it is often when physical symptoms present that health care is sought. Research in the Kingdom of Saudi Arabia to establish the prevalence of somatisation and psychological disorders in primary care patients found that one or more psychological disorders were experienced by half of the sample, and somatisation evident in 16% of those, more commonly in women (Alqahtani & Salmon, 2008). Psychologist Linda Sakr elaborates, providing some explanation for why a physical expression of ill health is preferable to acknowledging, let alone seeking help for psychological support.

> In order to avoid the stigma, a person who is still able to withstand the distress, such as in emotional or neurotic disorders, tends to avoid behavioural and verbal displays. Instead, it is displayed in physical symptoms over which the person is assumed to have no control. This, I have noticed is another factor that contributes to the high frequency of physical symptoms of depression and anxiety among Arabs. Unlike Westerners, Arabs tend not to pathologise behaviour. Only extreme cases are considered to be junoon (madness), while other manifestations of distress are considered normal. For instance, anxiety and depression among women may be considered part of their femininity. Ruminations and cleanliness rituals are sometimes considered part of the cultural and religious attitude that conservative Muslims hold toward cleanliness – they usually perform cleanliness rituals five times a day before each prayer. The emotional component of a client's symptoms is seldom enough to bring him or her to therapy; it is the behaviour that is decisive in seeking treatment.
>
> Baidas, (2012, p. 449)

It is important that practitioners do not discount or minimise reports of physical pain, and essential that counsellors understand the connection between the physical and psychological expressions of mental ill-health. Kendell (2001) states that "pain and suffering have bodily, psychological, sociocultural dimensions…. (and) even when suffering is not caused by biological or observable circumstances, it is an embodied experience … even if suffering does not originate from illness or pain, it can make us feel ill" (Bueno-Gomez, 2077, p7). Raja and Dougherty's (2005) research established that the emotional experience is influenced and altered by psychological factors, highlighting the connection between pain and mental health. Therefore, somatisation can be considered psychological illness and pain expressed as physical symptoms, in addition to more intensely experiencing the distress associated with the physical symptoms.

Research has established some associations between the type of physical pain or symptoms experienced by an individual and specific mental health disorders, summarised by Harris (2007) in Table 4. Irrespective of the country of origin of the participant cohort, the connection between psychological illness or distress and the experience of that illness as pain is evident. And although somatisation exists, it is important not to jump to somatisation as the first assumption, hence careful assessment and diagnosis is important.

Table 4

Mental Illness expressed as Physical Symptoms

Type of Mental Illness	*Type or Nature of Pain Expressed*	*Researchers*	*Country of Research*
Depression	Musculoskeletal pain	Hallstrom & Possee, 1998	Scandinavia
Anxiety	Headaches (high frequency)	Zwait. et al., 2003	Iran
Panic Disorder	Chest pain	Demiryoguran et. al. 2006	Turkey
Borderline Personality Disorder	Lower back pain	Yap. et. al., 2003	Singapore
Psychiatric Disorders	Jaw and facial pain	Sheeb & Otakpoor, 2005	Nigeria
Neurotic Problems	Pelvic Pain	Dellenback & Haerunger, 1996	France
Post Traumatic Stress Disorder	Chronic limb pain Chronic back pain	Beckham. et. al., 1997	USA

Harris (2007)

A cross cultural study by the WHO study found that an average of 19.7% of patients presenting with somatic symptoms including body, stomach and head pain, sleep and digestive disturbance, found the origin to be psychological distress (Gurie, Simon, Ustun & Goldberg, 1997). Studies from the Gulf Cooperation Council (GCC) region obtained similar results, Qatar 12.2%, UAE 12% and Saudi Arabic 19% however also indicate that rates of somatisation in the Middle East are likely to be underreported (Bener et al., 2010a). Sayed (2003) suggests somatisation is a physical expression of mental illness, but also akin to self-medication which relieves the symptoms of the causal problems. Given the tendency of Arabs to report physical illness rather than mental health issues one must consider the potential under-attribution of prevalence data.

Harris (2007) cites research by Garralda (1999) who established that for those experiencing pain as a result of, or in parallel with a mental health disorder, Cognitive Behaviour Therapy (CBT) offers an effective treatment, with positive outcomes within child and adolescent populations. However, CBT can be less effective in communities and cultural groups which maintain worldviews which differ to Western societies,

particularly those relating to family, collectivist versus individualistic societies, and constructs such as individuality, spirituality and traditional healing (Bennett, Flett & Babbage, 2016). CBT has been measured to have a positive effect when adapted to the community within which it is being utilised for example Australian research by Bennett-Levy et. al (2014) within Aboriginal communities, established that CBT was very effective, when adapted to take the social and cultural context into account and integrate visual imagery. Similarly, in Maori populations CBT was found to be effective when adapted to integrate the concepts of 'connectedness, spirituality, extended family, and metaphor' experienced within this traditional culture (Bennett, Flett & Babbage, 2016. p.1).

In contrast, Lin et al. (2019) proposes as an effective alternative, Acceptance and Commitment Therapy (ACT). The authors purport that this approach assists clients to be open to experiencing pain (be it physical or psychological in origin), aware of behavioural response options to that pain, and ultimately to make changes to behaviours which align with personal values. It is proposed as an effective therapeutical approach to managing chronic pain, and integrates well with cultural values prevalent in Muslim societies. Tanhan (2019) suggests that within Muslim communities one commonality between ACT and Muslim belief structures is that of being present, mindful, and aware of the human being within a given experience. He cites the alignment of therapeutical and faith perspectives in the way ACT and Muslims interpret pain, accepting that difficult, painful, or unpleasant experiences are natural, inevitable and a part of life and existence (Tanhan, 2019).

Therefore, counsellors who consciously integrate culturally relevant therapies for students, taking into account religious values and belief systems, will empower students to manage both the psychological origin of the pain, and the pain itself. Counsellors should consider the value of CBT, ACT and Mindfulness Based Cognitive Therapy (MBCT), which are evidence based in adolescent cohorts and the treatment of depression, anxiety and addictions, and offer an alternative for counsellors to select from based on the needs and world view of the presenting student.

Research in the field of culturally and spiritually attuned psychotherapy highlights the importance, and potential, of working with the traditional healing approaches found in the UAE, purporting that integrating belief systems and treatment methodologies, particularly given their "non-invasive nature", may "optimise the accessibility of

psychological therapies and perhaps help ensure their cultural appropriateness" (Thomas & Furber, 2015, p. 72). Acknowledging the importance of religiosity as a sociocultural phenomenon in the UAE, and wider Gulf region, and its positive impact on wellbeing and mental health is important. Thomas and Furber (2015) examined the correlation between depression, well-being and religiosity in Saudi school children (8-11 yrs.), school aged Kuwaitis, and Emirati college students in the UAE, and found a correlation between subjective wellbeing and religiosity, and an inverse relationship between depression and religiositity. Practitioners in the UAE are urged to consider the value of secular psychotherapies, and developing spiritually and culturally attuned versions of cognitive and metacognitive approaches (Thomas & Furber, 2015). Those who recruit and employ counsellors into educational settings should be mindful of the advantages for adolescents in terms of therapeutic outcomes, when counsellors demonstrate multicultural counselling competencies.

2.3.6 Risk Factors in the UAE

Understanding what constitutes risk and protective factors for adolescents in the UAE helps inform recommendations intended to address mental health issues. The Centre for Disease Control (CDC) and World Health Organisation (2010) conducted research into the nature of protective factors and mental health behaviours which impact adversely upon adolescents in the UAE. The survey of 15,790 private and public-school students, identified that an alarming number of adolescents participate in risk taking behaviours, for example 46% were in a physical fight in last 12 months, 9.8% had smoked or used tobacco in the last 30 days and 38.4% were overweight. Furthermore, responses raised concern over the wellbeing and mental health of these young people, including that only 49% report their parents knew what they did in their free time, 6.4% said they had no close friends and felt lonely most of the time and 12.6% had attempted to commit suicide in the last 12 months. The CDC and WHO exploration of risk factors for wellbeing of adolescents in the UAE highlights concerning social and cultural patterns of behaviour which, in combination with stigma and apathy towards seeking help and a lack of specialised mental health professionals, potentially place adolescents at considerable risk of adult mental health issues.

Living in the UAE, rated second only to Finland in the 2017 World Economic Forum standings for the safest country in the world, and being a nation adhering to conservative Islamic values and strict Sharia laws, one may assume that drugs and

alcohol are less prevalent and therefore pose less of a risk to adolescents. However, the reality is that access to prescription, illicit and illegal substances endure with their use and misuse becoming more widespread. According to Wanigaratne and Al Ghaferi (2015, p. 133) the most commonly misused substances in the UAE are alcohol, heroin and hashish, with increasing usage attributed to the "rapid pace of development, the erosion of traditional family and cultural structures, as well as proximity to countries that produce drugs". In 2002, the National Rehabilitation Centre was developed to serve the Emirati population, providing care for those with addictions and comorbid psychiatric disorders. In a 10-year retrospective patient study it was found that 54% were aged 20-29 years, 56% were referred from the emirate of Abu Dhabi as compared to the next most prevalent Dubai at 17%, and that since 2009 there had been a dramatic increase in the misuse of prescription drugs and polysubstance misuse (Wanigaratne and Al Ghaferi, 2015). Given the scarcity of mental health services, poor regulation of mental health professionals prescribing medications and stigma of seeking help, the possible correlation between the age of onset of mental health difficulties, tendency towards self-medication, and potential for clinically endorsed over medication, cannot be overlooked.

The implications for young people of poorly managed mental health issues on emotional, social and academic outcomes is well documented (Lundy, Silva, Kaemingk, Goodwin & Quan, 2010; Owens, Stevenson, Hadwin & Norgate, 2012) and it is therefore of the greatest importance to facilitate timely and accurate diagnosis followed by the provision of appropriate support to ensure positive outcomes for students. Acknowledging the efforts of regional researchers to establish morbidity in the UAE, the exploration of literature and research clearly indicates a lack of explicit data on adolescent populations. Although establishing adult trends and prevalence in young children can be predictive to a certain extent, ultimately it is essential to explore cohort specific information. The community is calling for more research to guide intervention offered by mental health practitioners and inform those designing public health and educational prevention programmes (Al Mazrouei, 2014b). They urge the education community in particular to include specific mental health education within a whole school approach to mental health promotion and mental illness prevention, explaining that the educational environment offers ideal opportunities for prevention and intervention.

2.3.7 Screening Tools for Mental Health in Young People

"Screening is the process of collecting data to decide whether more intensive assessment or intervention is necessary. Implicit in screening is the notion that the student's difficulties may go unnoticed" (Salvia, Ysseldyke & Bolt, 2007, p. 29). Generally, through a brief process of evaluating current functioning, conducted either through observation, interview or completion of a questionnaire, the intention is to identify early signs of minor problems that may over time become worse, or to identify students who are at risk of developing a problem later in life. Early identification enables intervention to be put in place, which may reduce the impact of difficulties experienced (Hoff, Peterson, Strawhun & Fluke, 2015). There are a wide range of screening tools that evaluate mental health, academic, social, cognitive, behavioural, emotional, and physical functioning, however, they differ in their reliability, validity, cost, administration time, ease of analysis, interpretation of results and administrator qualification requirements.

Employing these screening tools in clinical settings is routinely part of the triage or baseline assessment and subsequently administered throughout therapy to monitor impact. However, in schools and educational settings, their value is often overlooked, predominantly utilised solely by those in special education to evaluate relative strengths and difficulties and inform the development of Individual Education Plan or Behaviour Intervention Plan targets. Value exists in using school-wide screening to monitor trends and inform school development priorities and interventions, in addition to more targeted standardised screeners on smaller at-risk cohorts or individuals.

It is important to ensure that with any use of screening tools, inventories, or questionnaires that they are culturally appropriate and that their use contributes in a positive way to improving outcomes for children and adolescents. Al Heeti, Hamid and Al Ghorani (2012) suggest that considering the internationalisation of psychology there is a need to establish the efficacy of Western measurement tools in other geographic areas. Their research examined the validity of administering the Irrational Beliefs Inventory (IBI) with Arab populations. They administered the Beck Depression Inventory-II, General Health Questionnaire and IBI to the main and cross-validation samples of undergraduate students from the UAE University, to investigate the internal consistency, concurrent validity, and factor structure of the IBI. Findings suggest that significant correlations were evident for the Worrying and Problem Avoidance components, with internal consistency calculated by Chronbach's alpha and test-retest correlation measures

within acceptable limits. However, the Demand and Approval, Emotional Irresponsibility and Rigidity subscales need improvement (Al Heeti, Hamid & Al Ghorani, 2012). Their work highlights the importance of testing instruments for validity when applying to cultural contexts not initially part of the development and standardisation process.

Deighton, Croudace, Fonagy, Brown and Wolpert (2004) conducted a review of the suitability and availability of mental health and wellbeing measures for use with children and adolescents. Each was evaluated in terms of cost, time to administer, clinical use, validity and reliability, with conclusions drawn about the relative merits of each. Eleven were identified as meeting the criteria that they were intended to be completed by children, had been validated in adolescent or child contexts and resulted in a broad measure of mental health, wellbeing, and quality of life, and included:

1) Achenbach System of Empirically Based Assessment
2) Beck Youth Inventories
3) Behaviour Assessment System for Children
4) Behavioural and Emotional Rating Scale
5) Child Health Questionnaire
6) Child Symptom Inventories
7) Health of the National Outcome Scale for Children and Adolescents
8) Kidscreen
9) Paediatric Symptom Checklist
10) Strengths and Difficulties Questionnaire
11) Youth Outcome Questionnaire

Significantly, the authors note that none of the instruments (at the time of their research) had been tested for bias or differential performance in those of different ethnic or cultural backgrounds, which has implications for their use in the UAE and wider Middle Eastern region (Deighton, Croudace, Fonagy, Brown & Wolpert, 2004).

Examination of the validity of each screening tool for application in this research and more broadly, in the UAE, considered the degree to which the tool was developed for use in adolescent populations, reliability when administered in multicultural and / or bilingual cohorts, relevance for data collection considering research questions, cost and availability. Where research was available, the tools were examined for content validity

(comprehensiveness of the instrument), construct validity (internal consistency of items measured) and concurrent reliability (correlation between other tests of same measures).

The Achenbach System of Empirically Based Assessment (ASEBA) offers a range of questionnaires examining behaviour (adaptive and maladaptive) and exploring functioning of the individual measured against age norms. Of merit is the addition of a multicultural family assessment module which enables health providers to compare the results of screening both child and adult. Multicultural norms have been established for a range of syndromes, ages, and genders. This recognition that scores may change based on the culture of an individual is important when making therapeutical or treatment decisions based on self or parent rated evaluations (Achenbach, 2019). The cost of the ASEBA is around $500 USD for a computer scored kit with multicultural supplement making it an affordable option for administration in educational settings.

The Beck Depression Inventory (BDI) is a measure of depression, with high reliability in discriminating those that do and do not meet the diagnostic criteria for the disorder. It has been translated into 17 languages and has been used extensively, and reliably across the Middle East. Arabic versions have been utilised with student populations (N = 824) in research conducted by Al-Musawai (2001) and Al Turkait and Ohaeri (2010). Al Ansari (2006) developed an Arabic language adaptation of The Beck Depression Inventory II, and evaluated internal consistency, finding that use of this tool is viable in Arabic populations. A review by Wang and Gorenstein (2013) found that despite the use and adaptation of the BDI information on cross cultural comparability was not present. Their research identified that construct validity varied across language versions and that differences in expression and experience of depression in different cultures/races likely contributed to significant differential item functioning values on some items when comparing Turkish and American students with same levels of depression. They argue that “before a true cross-cultural difference can be acknowledged, more find grained analysis should be conducted to ascertain the sources of this dissimilarity” (Wang & Gorenstein, 2013. p.429). The cost is $145 USD for the kit, however for widescale screening of students in education settings an instrument that identifies vulnerabilities to a range of behavioural and mental health difficulties may be more beneficial. For this research, the BDI was excluded due to this limitation.

The Behaviour Assessment System for Children (BASC) is utilised to monitor behaviour and emotional status in children and adolescents, and reports concurrent

reliability is high when evaluated alongside such assessments as the ASEBA and the Conners' Teachers Rating Scale (Tan, Reynolds & Kamphaus, 2007). However, Nezafat, Chanda and Gladstone (2019) questioned claims of cross-cultural validity, claiming that translation and back translation followed by subsequent administration does not constitute cross-cultural appropriateness. They argue that "the realities and day-to-day life of children in different settings might be quite different", citing that despite the use of the same Arabic version in Palestine and Kuwait, the results may be non-comparable due to variables in life experiences of young people living in the two countries and the way questions were understood by parents (Nezafat, Chanda & Gladstone, 2019. p. 9). Therefore, use of the Arabic version of the BASC should be used with caution, and consideration of contextual and administrative factors. In terms of affordability and generalised application, the English version costs $650 USD for the hand scored instrument and 25 forms, making it expensive to administer as a screening tool across school cohorts.

The Behavioural and Emotional Rating Scale (BERS) provides a measure of a child's inter and intrapersonal strengths, competencies at school and family engagement. Taking a strengths-based approach, the tool takes 10-15 minutes and by rating a Likert scale, can be administered as a screening tool for groups. Standardisation of an Arabic version of the scale was examined by Al Khurinej and Al Mutairi in 2020, finding that factors were stable and highly reliable, and that validity for use by practitioners with Arabic speaking clients or families was confirmed. There is much about this tool that would lend itself to screening in educational settings, however, is limited by the cost of $250 USD for 25 tests. Counsellors would benefit from integrating it into their admission evaluation of students, establishing a baseline of competencies upon which to build therapy and personalised mental health support plans.

The Child Health Questionnaire measures health-related wellbeing and quality of life for those aged 1-18 years and has been translated into Arabic and modified for administration with Arabic speaking children (Madi et. al., 2004). Researchers translated and modified the questionnaires, administering to a sample of 75 children with rheumatoid arthritis in Saudi Arabia, and established reliability and validity for use with Arab children. The limits of this questionnaire lie with its focus on examining the impact of illness on quality of life, factors beyond the scope of this research. For those

examining a population of young people who do present with health disorders or diagnosis, the questionnaire is available free to download.

The Health of the Nation Outcome Scales Child & Adolescent (HONOSCA) are widely used in clinical settings, administered at admission, when reviewing progress during treatment and upon discharge to measure patient mental health. Manderson and McCune (2003) found it to be a reliable measure, producing reasonable gender/age outcomes such as boys scoring higher on disruptive or aggressive behaviours and lower on emotional symptoms, and younger children higher on language problems and lower on self-injury. Studies have found benefits in administration due to its brief nature and ease of administration, however express some questions around the instruments failure to integrate contextual factors (Pirkis. et al., 2005). Usually administered in clinical settings, there is value to integration into the research to capture through self-report, broad indicators of wellbeing and difficulty.

Kidscreen offers parent and self-report administration and examines the wellbeing and functioning of a child or adolescent. It measures health-related quality of life, across social, behavioural, physical, and emotional domains. No research can be found to confirm validity in administration of translations into Arabic, however research into cross cultural usage across 13 European countries found acceptable levels of validity and reliability (Ravens-Sieberer et. al., 2007). Examining similar domains, the Youth Outcome Questionnaire evaluates adolescent functioning to identify presenting intrapersonal, interpersonal, somatic, social, and behavioural difficulties. Reliability and validity have been established, with high internal consistency, test-retest reliability and concurrent validity with other screening tools (Ridge et.al, 2009). At a cost of $100 USD potential use as a screening tool in educational settings warrants further research.

The Paediatric Symptoms Checklist (PSC) enables clinicians to conduct psychosocial screening of young children in educational and health settings to achieve early identification of emerging psychosocial problems. Strong predictive validity has been established through examination of rates of positive clinical diagnosis following a positive PCS when screening for psychosocial difficulties, and internal consistence and criterion-related validity were established for use within educational settings in research by Liu, et.al. (2019). This widely used tool is available in Arabic but no research to establish validity of this version could be found. The limitations for this research are that

validity has only been established to age 16 years, so does not cover the full range of adolescent participants.

The Strengths and Difficulties Questionnaire (SDQ) identifies social, emotional, and behavioural problems in children and adolescents. Used internationally, this freely accessible screening tool has been translated into 80 languages, although not all have been validated. It offers a reliable tool for evaluating the self-reported prevalence of personal strengths and difficulties. As a screening instrument which integrates positive attributes alongside areas of difficulty it facilitates taking a strength-based approach to interventions when used to guide therapeutic interventions and use in educational settings (Rousseau, et. al., 2007). Research by Almaqrami and Shuwail (2004) tested the validity of the Arabic version of the self-report in Yemen, finding strong factor and concurrent validity and concluding that validity had been established for use in Arabic and Arab populations. While the administration of screening tools in this research will be conducted in English, it is relevant that it has been reliably used in Arabic cultural contexts and maintained validity.

Where evidence emerges of a specific disorder, it is beneficial to use a standardised assessment tool intended to measure the specific area of presenting difficulty. However as with the broader screening tools, few have been cross-culturally evaluated. The Screen for Child Anxiety Related Disorders (Brimaher, Brent, Chiappette, Bridge, Monga & Braugher, 1999), is commonly used for evaluating anxiety disorder in children aged 8-18 years, and identifies a propensity towards anxiety disorders as measured by the DSM-IV, however has not been evaluated cross-culturally. Similarly, Krentz and Arthur reviewed a number of tools which screen for eating disorders, however call into question the validity of assessments such as the Eating Attitudes Test (EAT), Eating Disorders Inventory (EDI) and the Bulimia Investigation Test – Edinburgh (BITE) due to their lack of attention to cultural norms relating to food and body image (Krentz & Arthur, 2008).

Following due consideration of the relative merits of available screening tools, including cost and affordability, administration in an international and culturally diverse setting, examining adolescent wellbeing and mental health, and presented in an online format in an educational setting, the following two tools were selected for this research.

1. The Strengths and Difficulties Questionnaire (SDQ), self- report behavioural screening questionnaire for children aged 3-17 years, which investigates psychological attributes including emotional symptoms,

conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behaviour (Goodman, Meltzer & Bailey, 1988).

2. The Health of the Nation Outcome Scales Child and Adolescent (HoNOSCA) evaluates the social functioning and health of young people experiencing mental health difficulties, measuring social functioning, behaviour, impairment, symptoms and impact (Growers, Harrington, Whitton, Beevor, Lelliot & Wing, 1998).

The SDQ will form the primary data set given its established reliability and validity within the context and intended mode of administration, while the HONOSCA client-rated form will provide additional commentary due to its application beyond the usual clinical setting administration. In addition, adolescent participants will complete two screening tools to measure life satisfaction and attitudes towards mental health services to further establish wellbeing and inform therapeutic recommendations:

1. The Brief Multidimensional Students' Life Satisfaction Scale – PTPB version **(**BMSLSS-PTPB) measures overall youth life satisfaction, in addition to satisfaction with self, family life, friendships, where you live and school (Athay, Kelley & Dew-Reeves, 2012).
2. The Beliefs about Psychological Services (BAPS) (Ægisdóttir & Gerstein, 2009) measures attitudes towards psychologists and accessing psychological or mental health support by exploring 3 subscale scores, Intent, Stigma Tolerance and Expertness.

2.3.8 Protective Factors in Educational Settings

Research has confirmed strong links between school connectedness and academic achievement, motivation, self-efficacy and feelings of belonging (Shochet, Dadds, Ham & Montague, 2006; Bond, Butler, Thomas, Carlin, Glover, Bowes & Patton, 2007; Seigman, 2011) and highlighted a predictive link between school connectedness and future mental health problems. Shochet, Dadds, Ham and Montague (2006) conducted research intended to identify if there was a link between school connectedness and its impact on general mental health, future depressive and anxiety related symptoms. They administered the Children's Depression Inventory, Strengths and Difficulties Questionnaire and Spence Children's Anxiety Scale, twice within an 18-month interval, and found a distinct correlation between low levels of connectedness with depression and anxiety, a more significant association between adolescent depressive symptoms and

school connectedness than previously understood. Furthermore, the predictive value of levels of connectedness indicated vulnerability to depression for boys and girls, anxiety for girls and general functioning for boys (Shochet, Dadds, Ham & Montague, 2006).

Intended to examine associations between social relationships and school engagement with mental health, substance use and educational achievement 2-4 years later, research by Bond et al., (2007) identified that experiencing both social connectedness and connectedness to school during adolescence are protective factors and result in more positive outcomes for individuals. Furthermore, schools are urged to increase protective factors by facilitating connectedness, as evidenced in a commitment to school, a belief that school is important, secure relationships with teachers and peers in addition to feelings of belonging and opportunities to be involved. Connectedness improves an individual's achievement and mental health (Bond, Butler, Thomas, Carlin, Glover, Bowes & Patton, 2007). This research correlates with the findings of previous cross-sectional studies, validating the proposition that school intervention programs which promote wellbeing and connectedness would benefit the international student community in the UAE.

In response to international research and growing evidence which speaks to the incidence of mental health difficulties in children and youth, governments across the world are working more closely with education regulatory bodies and providers, to more effectively meet the needs of children and young people. This acknowledges the role schools play in promoting wellbeing, reducing stigma, identifying, and responding to mental health concerns. Increasingly, communities are recognising that early intervention can prevent issues escalating, and improve long-term outcomes for individuals and community services. The state of New South Wales, Australia, announced in January 2018 that the Department of Education will overhaul the Personal Development, Health and Physical Education curriculum for 5 – 16-year olds, integrating specific mental health lessons. Teaching will include a focus on developing skills to cope with life's stresses, overcoming adversity, dealing with loss and death; it will challenge misconceptions about mental health, provide education on the relationship between violence and drug abuse, and examine mental health difficulties including anxiety, suicide and depression.

Similarly, the UK's Transforming Children and Young People's Mental Health Provision: A Green Paper (Department for Education, 2017; Department of Health

&NHS England 2015), calls for pivotal reforms that build on earlier 'Future in Mind' initiatives. These include provision of funding for Mental Health Support Teams linked to schools, a requirement that every school have a Designated Senior Lead for mental health and working with the National Health Service to reduce waiting times for children and adolescents to access specialist services. The UK position is unequivocal:

> Children with a persistent mental health problem face unequal chances in life. This is one of the burning injustices of our time. It is our collective duty to ensure that we take action to promote and protect the mental wellbeing of our children. The impact of mental health problems on children and young people's lives is significant. The evidence shows that children and young people with mental health problems are more likely to have negative life experiences early on, that can damage their life chance as they grow towards adulthood.
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> Department of Health and Department for Education (2017, pp. 9-10)

2.3.9 School Based Support Services and Complementary Interventions

Considering the limited number of specialist mental health resources within the community and absence of telephone support or help lines, and taking into account religious and cultural challenges adolescents face when attempting to access mental health support, it is evident that schools represent an important protective factor for young people. Not only are they well placed to identify emerging mental health needs, provide timely intervention and support and engage with families to facilitate access to external specialists, but they are able to deliver broad skills-based student training that can help them develop skills and strategies to cope with challenges.

Programmes that develop resilience, emotional intelligence, conflict resolution and self-regulation skills have been found to be highly effective at developing an individual's capacity to manage feelings, emotions; and responses in a productive and health manner (Cefai et al., 2015). When implemented in school settings, ideally as part of a whole school approach and following a bespoke curriculum, benefit has been experienced in the broadest of terms. For example, in response to persistent social, cultural and economic challenges in Europe, including racism, terrorism, immigration and recession, and with a growing understanding of the impact of such factors on young people and their mental health, a resilience curriculum was developed by academics representing 6 European

universities. The resulting curriculum framework, RESCUR: Surfing the Waves, covered following key skills:

1. Developing communication skills
2. Establishing and maintaining healthy relationships
3. Developing a growth mindset
4. Developing self-determination
5. Building on strengths
6. Turning challenges into opportunities

The curriculum was developed to "equip young children with the skills they need to manage the 'tests of life' and overcome any obstacles they face on the way, (it) places the onus of responsibility on the individual in coping with, and continue to grow in the face of, adversity" (Cefai et al., 2015, p. 4). The authors argue that teaching the skills of resilience impacts educational practice as a whole, resulting in improved outcomes as the wider curriculum and school community recognise and value resilience education as central to preparing students for success and challenge.

This curriculum framework offers one example of resilience education in educational settings. Another increasingly common approach to building coping skills is the teaching of mindfulness in educational settings. Mindfulness is "mostly used to refer to a way of 'being', which has prescribed characteristics, activities and programs designed to cultivate this way of being, as well as ancient meditation techniques rooted in various religions" (Albrecht, Albrecht, & Cohen, 2012, p.1). Australian researchers from RMIT University, examining student perspectives on learning mindfulness in school, found that globally there are more than 30 different mindful programmes, and that nearly 50% of children in UK regularly engage in mindful activities within school. Students who completed a 10-week mindfulness programme, which integrated activities such as meditation, mindful eating and "pausing"' to respond not react, expressed that their awareness and sense of wellness was enhanced. They shared positive sentiments, including now having a deeper connection to friends, family and the environment, being more able to resolve conflicts positively, feeling a greater sense of calm, happiness, confidence and trust with an overall "heightened state of awareness of body, mind and emotions" (Ager, Albrecht & Cohen, p. 910, 2015).

Initial implementation of mindfulness across schools in Dubai and Abu Dhabi was tempered by the concerns of some school leaders, that its connection to Buddhist

philosophies may make it a culturally sensitive issue and therefore contrary to UAE values and not to be discussed in school. However, with the support of regulatory entities, these concerns were overcome and schools across the Emirates are now integrating mindfulness programmes to help students develop the skills to manage stress, anxiety, and interpersonal interactions. Barack (York Al-Karam & Haque, 2015, p. 226), speaks to the contribution school-based mindfulness programmes have been shown to make, including that they "significantly reduce stress levels and increase concentration, attention, cognitive performance, body/self-awareness, emotional regulation, communication skills and empathy". Smiling Minds (2018), the Australian not for profit organisation committed to enhancing the wellbeing and mental health of children and adolescents, cite recent research that speaks to the urgency of need to respond to this crisis for our youth, indicating that "1 in 4 secondary students and 1 in 7 primary school students (in Australia) experience a mental illness (Telethon Youth Institute & University of Western Australia), 1 in 10 teenagers has engaged in self-harm, 1 in 13 have contemplated suicide, 1 in 40 have attempted suicide and 2 in 5 young people have tried elicit substances, and that according to the Australian Bureau of Statistics (2018), Australia has the highest suicide rate for 13 years and a 50% increase in suicides amongst young women since 2006. Mindfulness is proven to lead to better emotional and self-regulation, attention, and memory which can result in reductions in levels of stress, depression and anxiety and an increase in effective social and academic skills and self-esteem, therefore offering a protective and proactive intervention and lifelong strategy for maintaining health and wellbeing.

Another school-based programme which has contributed to the responsiveness of schools is Mental Health First Aid (MHFA), developed in Australia in 2000 by nurse Betty Kitchener and Professor Tony Jorm (Kitchner & Jorm, 2019). When implemented, MHFA raises staff awareness and skills to identify when a student is exhibiting signs of mental distress. Early identification promotes timely referral to school counsellors and also empowers class teachers, pastoral leads or form teachers to 'administer' the mental health first aid and build supportive relationships, in turn promoting connection and a sense that school is a place of care, compassion and support. The programme offers a comprehensive and proven strategy to develop capacity at a school level to respond to presenting need as early as possible, and conveys responsibility for students' mental health lays with every adult within the school. This is particularly helpful where there

may be insufficient access to counsellors or where a student feels more comfortable reaching out to a trusted adult of the same culture, religion or language background.

Considering that many young people may choose not to avail themselves of support within the school setting, or may experience distress outside school hours or during holidays, it is worthwhile considering the role of technology as a potential means to offer treatment and education for youth about mental health. Successful use of technology has been established through research into the effectiveness of cognitive behavioural therapy delivered online, which achieved symptom reduction in anxiety, depression, eating disorders and risk-taking behaviour in young people (Nunes, Daly, Rao, Borntrager, Chambers, Rohner & Sujan, 2010: Glasheen & Campbell, 2008). Furthermore, the authors established that new technology including video modelling, anonymous response and feedback systems/therapy, interactive whiteboards, and client-generated stories in therapy, cyber-counselling, virtual reality and avatars and haptic technology has proven very effective with adolescents.

Edwards-Hart and Chester (2010) published literature which examined the help-seeking behaviour of adolescents who use the internet to access information about mental health, and suggest that knowing where adolescents seek help when distressed enables practitioners to better meet their needs. They identified that internet-based psychotherapy has become increasingly common, with cognitive behavioural therapy the most often used online approach to treat such afflictions as panic disorders, post-traumatic stress disorder, suicide prevention, depression and anxiety (Edwards-Hart & Chester, 2010). They report many benefits, including improved accessibility when physical resources are scarce or difficult to consistently access, or when stigma may be associated with attendance – situations which are both evident in the UAE. However, challenges in employing this approach are raised, including the inability to read nonverbal communication cues and the heightened risk of cultural misunderstanding (Edwards-Hart & Chester, 2010).

Research by Young, Richards and Gunning (2012) evaluated the effectiveness of two online mental health resources, designed specifically for young people in response to identified needs for information, awareness raising and de-stigmatisation. They presented concerning statistics suggesting that only 22% of young people with significant mental health needs received treatment by specialist child and adolescent mental health specialists, with many relying on internet-based services, which highlights the need for

access to reliable, informative and trustworthy information. Given the complexity of providing and facilitating direct client counsellor contact as a result of cultural impediments, integrating technology into plans for school-based counselling and support services may offer potential benefits. Furthermore, it is clear that barriers exist that impede young people from accessing treatment for mental health needs and that online resources may help overcome such concerns as confidentiality, stigma and trust in the provider (Young, Richards & Gunning, 2012).

The use of Apps, accessible on android and smart phones offer not only an opportunity to access online support but do so without limitations of accessibility, resulting in targeted and timely support, often at very low or no cost (e.g., Smiling Mind App). In Australian research into the use and efficacy of apps in accessing mental health support and the dissemination of mindfulness interventions, Mani, Kavanagh, Hides, and Stoyanov (2015) stated that a recent survey found, 39% of young people reported using the internet to seek information about a mental health problem (Burns, Davenport, Durkin, Luscombe & Hickie, 2010). They further asserted that an outcome of widespread acceptance of e-technologies offers an advantageous and preferable medium to improve the well-being of young people (Christensen & Hickie, 2010). While similar research has not been conducted into the inclination of Arab populations to use similar online media and e-technologies, they would offer a means to access confidential, anonymous support which could address cultural issues of stigma and accessibility.

2.3.10 Summary

There are a wide range of barriers to mental health provision within UAE culture, many of which will need to be overcome in order that consistent, high quality mental health support to be accessible for children, adolescents and adults experiencing distress or difficulty. Sayed (2015) provides a salient summary of presenting difficulties in the UAE, which include:

1. Limited availability of competent mental health community resources.
2. The use of interpreters and translators in psychotherapy.
3. The role of the family – family honour and presence as emotional support.
4. Seeking help viewed as a family decision.
5. The perceived role of religion.
6. Cultural impact on the expression of emotions.

7. Confusion of role expectations and the client-therapist relationship.
8. Expressing psychological problems in form of physical concerns.
9. Stigma of mental illness.
10. Malpractice and the absence of standard practice.

Sayed (2015 p. 663-664)

A range of therapeutic and preventative strategies have effectively been employed within educational settings, many of which offer insight into which may be effective approaches given the importance of mental health and wellbeing as both protective factor and predictor of long-term health and success, and taking into account the socio-cultural context and complexity of the UAE. Therefore, in response to these identified impediments, research which examines the experiences and mental health presentations of adolescents in educational setting, and explores preventative programmes that work effectively and sensitively within the socio-cultural context is necessary. This research has the potential to improve outcomes in the short term, and importantly will be vital to inform discussions about how schools and communities begin to destigmatise psychological services and promote the concept of mental health in its broadest terms.

Following a detailed review of the literature and research available (in English language medium), relating to adolescent mental health, psychological interventions and patterns of help seeking, framed within the context of Arab and 'Third' cultures in the Middle East, the proposed research questions remain pertinent and the value and contribution of insight gained as a result of their exploration beneficial.

What are the levels of self-reported wellbeing and mental health in the sample of adolescents?

1. What is the incidence of mood disorders, eating disorders, substance misuse and self-harm reported by adolescents?
2. Are levels of reported mental illness and inclination to seek support influenced by socio-cultural or religious factors?
3. What social, emotional, educational, and societal implications of mental health disorders are reported by adolescents living in Abu Dhabi, and how do the experiences of locals and expatriates differ?
4. What impediments to help seeking do counsellors working with adolescent populations report and what are the key issues and challenges they face in delivering services and support?

CHAPTER 3: METHODOLOGY

This chapter outlines the research paradigm and my personal and professional rationale for undertaking this doctoral research. Mental health and a positive sense of wellbeing are foundational in empowering individuals to lead productive, successful, and fulfilling lives, but for many these can remain elusive. A systematic review and meta-analysis of research into prevalence rates of common mental disorders worldwide 1980-2013, found that "on average one in five (17.6%) experienced a common mental disorder within the past 12 months and 29.2% across their lifetime" (Steel, Marnane, Iranpour, Chey, Jackson, Patel, Vikram & Silove, 2014, p.476). Recognising that the majority of these mental health difficulties emerge during adolescence highlights the importance of early identification and intervention during this period in an individual's life, and speaks to the role educational settings can have as both protective and supportive factors.

3.1 Personal Perspective

Interest in child and adolescent mental health and wellbeing has been a field of academic, professional and personal interest for me over the last 25 years, theoretically and academically underpinned by bachelor's degrees in Arts and Education, master's degrees in both Special Education, and Counselling and Guidance, and postgraduate skills-based certifications and specialisations. Combined, this academic and professional development endeavours to provide a solid and broad knowledge base in the theories of child and adolescent development, significance of mental health and wellbeing, and skills of identification and intervention for children and adolescents experiencing cognitive, social, emotional, physical, behavioural or psychological challenges or impediments to learning. Working with children from 6 months to 18 years of age, as teacher, carer, counsellor, and special educator provides an opportunity to observe first-hand, the process and impact of developmental change, recognise emerging difficulties and disorders, and intervene to improve outcomes. Personal experience supporting my own three daughters through their challenging adolescent years, further enhanced the intimacy of my understanding and empathy for experiences and mental health challenges experienced by themselves or their peers. It also highlighted some of the systemic and environmental impediments to help-seeking the existed in the UAE.

An academic interest was sparked upon arrival in the UAE in June of 2008, where it became increasingly evident that mental health provision for children and adolescents was insufficient, inadequate, or inappropriate, both within clinical and educational

settings. Over subsequent years, the opportunity to interact more intimately with Emirati families in both social and professional contexts heightened my awareness of, and sensitivity towards, their cultural and religious values and perspective. Many of these values and beliefs had a positive impact on the sense of community and belonging young people experience, but others that spoke to stigma, secrecy, and denial of mental health needs. Remaining cognisant of the cultural sensitivities surrounding mental illness, the research design was heavily influenced by the need to maintain the highest levels of anonymity and confidentiality, ultimately with an anonymous online questionnaire selected. The desire to gather data on the prevalence of need came in response to familial and organisational denials that there were any students or children in need of mental health support, in addition to a lack of UAE based research or literature on effective school-based interventions given resistance to help-seeking among some cultural groups.

Upon employment with Aldar Academies in 2010, there was one part-time counsellor in one of the secondary schools, working 2 days a week, the impact of which was negligible and did little to address prevailing beliefs about counselling and mental health within the school or wider community. Over the following two years, due to regulatory requirements that school counsellors where required for school licencing, all schools were staffed with a highly qualified and experienced counsellor, someone whose core specialism and experience was working with children and adolescents in educational or clinical settings. There was some initial organisational resistance to the need for a counsellor in the primary settings, based on preconceptions that young children did not experience the degree, frequency or range of mental health difficulties, stressors, or risk factors. However, presenting evidence of the impact on academic, social, and emotional development of child mental health difficulties, supported by data and analysis of presenting need in the schools resulted in the appointment of counsellors across all Academies schools. The commitment Aldar Academies counsellors make to promoting student wellbeing is evident in the range and quality of programmes implemented across the school, initiatives to build student coping skills, sense of connectedness, resilience and conflict resolution and communication skills. In addition to seeing students for individual counselling, a proactive and preventative mind-set prevails utilising group sessions, peer mentor development and regular skill and capacity building workshops. These are designed to provide students the best opportunity, as young as possible, to develop the capacity to recognise and articulate their emotions, respond rather than react

in situations where they feel distress or discomfort and be resilient in the face of life's inevitable challenges and disappointments. This investment in early intervention will result in young adults who may otherwise have developed mental health difficulties, increase individual coping skills which will decrease the frequency or intensity of challenges that may emerge. In some cases, it is likely this proactive rather than reactive approach may prevent some mental health illnesses emerging at all.

3.2 Research Paradigm

As stated, this research takes a view of mental health, recognising the social and cultural context and nuances of expression and perception of mental health. Furthermore, it is set within the pragmatic paradigm, "oriented towards solving practical problems in the "real world" rather than on assumptions about the nature of knowledge" (Feilzer, 2010, p. 8). In terms of data analysis, empirical research will be conducted in a natural context, maintaining the ontological perspective that reality is the practical impact and outcome of ideas, aligned with an epistemology that aims to identify practical solutions to identified challenges.

3.3 Mixed Methods

The methodological approach to this research centres on a mixed method approach, the advantage of which, as described by Hanson, Creswell, Clark, Petska and Creswell (2005, p. 224) is that it "allows researchers to simultaneously generalise results from a sample to a population and gain a deeper understanding of the phenomenon of interest". A sequential explanatory approach to data collection will be taken, with priority given to the quantitative data, which will be gathered first and the results of which will inform themes explored in the gathering of qualitative data, utilising the qualitative data to explain the quantitative results (Creswell, 2003). Thus, data collection will take two primary forms, which align with a mixed methodology approach, an anonymous online survey of each participant group followed by confidential responses to open-ended questions gathering qualitative data.

3.4 Research Survey

Selecting an appropriate methodology and development of survey instrument requires identification of the most appropriate and effective approach that addresses potential cultural, social, and religious impediments, results in the greatest number of respondents, and provides the anonymity and confidentiality required.

Ritter and Valerie (2007) suggest that online surveys offer a wide reaching and cost-effective data collection alternative. Ethical considerations such as informed consent, confidentiality, anonymity and data handling require the researcher to carefully ensure that participants are, despite the online medium, adequately briefed on purpose, process and intended outcomes of the research (Ritter & Valerie, 2007). Anonymous online questionnaires have been found to be an effective way to engage young people in research (Riva, Teruzzi & Anoli, 2003; Buchanan, 2003). This is particularly the case when the content may be personal or the participant hesitant to speak about topics of a sensitive social, cultural, or religious nature (Fouladi, McCarthy & Moller, 2002). Enabling adolescents to participate without fear of stigma, social judgement or potential negative outcomes is an important and necessary consideration in the context of Abu Dhabi and in relation to the sensitive topics being discussed.

Therefore, developing an appropriate questionnaire for use in the UAE requires cultural sensitivity, and the inclusion of assessments which integrate health questions to evaluate potential somatisation, cultural questions to establish attitudes and beliefs, and the use of a number of standardised questionnaires that gauge mental health and wellbeing. Additionally, it is important to ensure that the nature of the questionnaire is not unwieldy and time consuming, which would potentially result in incomplete submissions and/or be overly challenging from a language perspective for those for whom English is an additional language.

The decision to administer the survey in English reflects the age of students, duration of education in an English-speaking setting and ability level of participants. All students in the cohort surveyed have been educated in the primary language of English, for a minimum of 2 years. The curriculum delivered within the participants current setting is UK A Level or International Baccalaureate, both of which require a high level of receptive and expressive English. Furthermore, the level of English used in all screening tools is simple and accessible, and validated on adolescents within the age range of participants. One amendment to the language used within a screening tool was made, replacing the term counsellor for psychologist, as counsellor is the term children are familiar with in their school setting, a recommendation made by the test developers. Where documents were provided in Arabic, namely the participant information for informed consent, and parental consent forms, they were done so to ensure families were

able to understand the content with accuracy, given their levels of literacy and English language skills are more varied.

3.5 Implementation Matrix

The research is structured around two parallel and complementary studies which provide a holistic view of the experiences of both adolescents and those who provide psychological support services in their educational settings. The implementation of the data collection phase of the research is summarised below, and highlight the integration of quantitative data alongside qualitative data collection and subsequent analysis. Exemplar research questions are provided alongside anticipated outcomes of the various phases of the data collection process.

3.5.1 Study 1: School Counsellors

Study 1 engages School Counsellors across international schools in Abu Dhabi, collating qualitative and quantitative data on the nature of adolescent's mental health difficulties experienced, and the frequency with which those experiencing these challenges present for counselling. In addition, counsellors provide contextual information on the rate adolescents are the subject of safeguarding and child protections concerns, the willingness of families to seek and access specialist services on behalf of their child and the quality of such services.

Study 1 provides the contextual framework and comparative data from which to explore and contrast the adolescent self-reported experience. Quantitative research questions include:

- What difficulties do students experience that bring them to counselling?
- To what degree do cultural background, religion, gender, age impact student willingness to engage with counselling?

Anticipated outcomes of these questions include a deeper understanding the disorders or difficulties students present with, the frequency of presentation and the impact of socio-cultural factors on propensity to seek help. The qualitative research questions include:

- What reasons do students give for choosing not to access counselling?
- What reasons do parents give for not providing consent to their child accessing counselling?
- How do you reduce the stigma of mental health issues?
- What programmes have been implemented to enhance wellbeing?

These questions will provide a deeper understanding of what support programmes are effective in educational settings in the UAE, counsellor perception of cultural factors or aspects of faith that are impediments to adolescents seeking support from the counsellor, and levels of family engagement when referrals to external services are made.

3.5.2 Study 2: Adolescents

Study 2 gathered qualitative and quantitative data from adolescent participants attending international schools, establishing levels of subjective life satisfaction and well-being, the presence or experience of mental health difficulties or disorders such as anxiety and depression, and the impact on their lives. In addition, beliefs about psychological services and inclinations and impediments to seek or accept help are explored, considering the potential impact of culture, faith, and gender.

Quantitative data has been drawn from screening tools and questionnaires which include the Strengths and Difficulties Questionnaire, Health of Nation Outcome Scales Child & Adolescent, Student Life Satisfaction Scale and the Beliefs about Psychological services survey. These screening tools will provide data which speaks to the incidence and nature of mental health difficulties experienced by students and their sense of life satisfaction. Furthermore, it will highlight factors which influence student's propensity to access services when needed.

Qualitative data is gathered through questioning to better understand and more deeply examine the reasons a student would not seek help from counsellor, and actions that a counsellor or the educational system could take to make it easier for them to do so. Through this process it will be possible to gain a deeper understanding of socio-cultural and contextual factors which present impediments to students accessing support and inform recommendations for amelioration actions.

CHAPTER 4: STUDY 1 SCHOOL COUNSELLING IN ABU DHABI

In recent years, schools in Abu Dhabi have been required to have a counsellor on staff to gain approval for their school license, however it is at the school's discretion how their counsellors are deployed and the nature of their role. For some it will be providing academic guidance and pastoral care, for others delivering curriculum based personal development programmes or delivering individual or group therapy, yet others will be tasked to monitor attendance and manage parent communications around truancy and behaviour. The nature of the role would depend upon the identified needs in the school, the experience, qualifications, and capacity of the counsellor, all of which are eminently variable within the UAE. School counsellors with qualifications and experience in counselling and/or social work are well positioned to identify needs across their student population and provide support and intervention necessary to improve outcomes and ameliorate difficulties experienced. Their contribution of both quantitative and qualitative data to this research is profound, and will seek to establish what the impediments to help seeking are and what key issues and challenges they face in delivering services and support. When correlated with that provided by students provides insight into how provision can be enhanced to be more accessible, culturally informed, and effective for students in need.

4.1 Research Question

This research anticipates that despite being located in an international school, with both expatriate and Emirati students, counsellors working with an adolescent population that experiences broadly the same range of mental health needs, at similar prevalence rates as would be seen in other countries. Within this context it would be expected that counsellors will report such factors as Arab culture and Islam as influencing adolescent help seeking for mental health needs, and the presence of gender trends would be a reasonable assumption. Utilising a mixed method approach and surveying both adolescent and counsellors enables parallel views to emerge, taking a holistic and multi perspective view from which to explore impediments to help seeking. To confirm and or challenge these assumptions, the following research questions were developed and presented to counsellors as part of a mixed method survey, with counsellor participants asked for example to rate presenting adolescent needs alongside an opportunity to report personal experiences and views in relation to help seeking impediments and share strategies they implement to mitigate.

Question 1 - What are the levels of self-reported wellbeing and mental health in the sample of adolescents?

Question 2 - What is the incidence of mood disorders, eating disorders, substance misuse and self-harm reported by adolescents?

Question 3 - Are levels of reported mental illness and inclination to seek support influenced by socio-cultural or religious factors?

Question 4 - What social, emotional, educational, and societal implications of mental health disorders are reported by adolescents living in Abu Dhabi, and how do the experiences of locals and expatriates differ?

Question 5 - What impediments to help seeking do counsellors working with adolescent populations report and what are the key issues and challenges they face in delivering services and support?

Qualitative and quantitative data gathered from the counsellors will help establish the veracity of trends which emerge from the adolescent data and provide context for the recommendations for provision which arise as an outcome of the research.

4.2 Method

Counsellors were surveyed using an online medium, utilising the CreateSurvey package, to establish the prevalence of need types presenting for counselling and provide qualitative information on relevant aspects including perceptions of socio-cultural impediments to help-seeking, engagement with external services and effective strategies implemented in educational settings to minimise impediments and enhance accessibility to students.

4.2.1 Participant

Participants for this study were school counsellors, all of whom meet the qualification requirements for approval by ADEK, reside in the emirate of Abu Dhabi and are employed by private international schools. School counsellors do not belong to any professional body in the UAE, as there is currently no licencing system, despite the intention to develop a Social Care Licence regulated by the Department of Community Development, under which counsellors may register in the future. Both quantitative and qualitative data was gathered from each participant group.

The participant sample of N = 23 counsellors is representative of the broader counsellor experience within Abu Dhabi (57.5% of international schools represented within the counsellor network N = 40, and 39% of the wider international school

community N = 59). It is not possible to establish the total number of school counsellors in the UAE or Abu Dhabi, and therefore the percentage of counsellor participants, due to the absence of any professional organisation nor registration requirement, and that many schools, particularly those offering American curriculum, have more than one counsellor employed within the school. The participants include those working across a range of international curriculum, and those from varying national and cultural backgrounds and genders. There is diversity represented in the length of practice in counselling and the length of time employed in the UAE.

School counsellor participants are all members of the Abu Dhabi School Counsellors Network. There are 38 regular members, who lead mental health provision and support in schools which deliver British, American, Canadian, and International Baccalaureate curriculum. Their levels of experience vary, as do the cohorts of students they work with and the length of time they have worked with adolescents in the UAE or wider Gulf - Middle East region. Counsellor demographics are shown in Table 5.

Table 5

Counsellor Participant Demographic Summary

	Less than 1 year	*1-3 years*	*4-6 years*	*7-10 years*	*10-20 years*
Years counselling in educational or clinical settings.		4	3	9	7
Years counselling in the UAE	2	10	10	1	

Twenty-three respondents, three males and twenty females

4.2.2 Researcher Participant Relationship

As a longstanding member of the Abu Dhabi Counsellors Network, I am known to participants, yet in a collegial capacity only. However, in relation to the 7 Aldar Academies Counsellors, who were also members of the network, there was a more direct relationship in that my role also included coordination, mentoring, and facilitating peer supervision. The pre-existing relationship with both groups did not have an influence on the research, and required no specific ethical consideration, given participation was

anonymous and voluntary, withdrawal at any time was without penalty and there was no conflict of interest.

4.2.3 Participant Recruitment Process

Participants were recruited in November 2017 via a face-to-face presentation and information meeting held during the regular Abu Dhabi School Counsellor Network meeting at New York University Abu Dhabi. An introductory email with detailed participant information and the survey link was emailed out to all members of the network with the December minutes. No incentives were provided to participants and the survey opened on 24th November 2017. Once the return of surveys had stalled, a reminder email was sent out to the Network in early January, resulting an additional 4 respondents and the decision was taken to close the survey as there had been no new returns for the preceding 10 days. Quantitative and qualitative data was collected simultaneously utilising the same survey instrument.

Of the counsellor participants, 4 work with students aged 4-10 years, 7 work with students aged 11-19 and 12 indicated they work with students aged 4-19 years. Therefore 82% of counsellors work directly with adolescent clients in the UAE. The feedback from the 4 counsellors working with primary aged students will not be excluded as the data they provide speaks to the needs presenting, and cultural considerations delivering mental health services in the UAE.

4.2.5 Procedure

4.2.5.1 Ethics and Approvals

Ethics approval for this research was obtained from the Human Research Ethics Committee through the University of Southern Queensland and conducted in compliance with the National Health and Medical Research Council (NHMRC) National Statement on Ethical Conduct in Human Research, 2007 (Updated 2015). This project adheres rigorously to the principles of ethical research, namely informed participant consent, voluntary participation and the right to withdraw, confidentiality, secure storage of data, and that research outcomes are meaningful, contribute to knowledge and understanding, and inform practice.

4.2.5.2 Recording and Data Transformation

The survey was developed using the CreateSurvey package, which facilitated the use of a range of question types, integration of skip logic and the capacity for results to be filtered, cross-tabulated and exported as raw data to SPSS, Excel or in plain text.

4.2.5.3 Data Collection / Identification Procedures

The survey link was made available to all members of the Abu Dhabi school counsellor network and participants and contained no exclusion criteria, given that members of the network already meet the primary criteria of being in post in an international school providing direct counselling to students. School counsellors completed the anonymous online survey, which explored the nature and prevalence of disorders that students present to counselling, anecdotal experiences of students who have expressed concerns about social stigma and the challenges of service provision in Abu Dhabi. The survey was accessible online for 9 weeks (encompassing the winter school holiday period). The timing of the administration of the survey was determined by the dates of scheduled meetings, availability of a session to present the general themes of the research and provide follow up information to enable members an opportunity to review and then participate as they wished. Initially qualitative data collection took priority, underpinned by the opportunity for counsellors to provide open-ended quantitative feedback or additional clarification embedded within the survey.

Opportunities were given for quantitative information to be provided, illustrating salient points, or providing context or clarity to the quantitative information. For example, information on what counsellors do to reduce stigma, the response of external specialists when referrals occur, what the most significant impediments to provision are and what programmes have been effective in meeting student needs in their schools.

The following sample questions provide an indication of the broad fields of exploration.

- What mental health difficulties do students present with most frequently?
- Does the nature of the mental health difficulty differ in relation to gender or culture?
- How closely do you work with the school nurse to identify students presenting with somatic symptomology who may benefit from counselling?
- To what degree are families reported to support the counselling process, and follow up with specialist support when recommended?

The survey explored the frequency students present with various need types through closed questions measured by Likert ratings and open-ended questions to gather qualitative data relating to challenges and experiences with regard to help-seeking and parent engagement, enabling both qualitative and quantitative analysis, as shown in Table

6. School counsellors were requested to provide responses based on a Likert scale for questions relating to the frequency need types present, indicating a presentation weekly, monthly, termly etc. Whilst it was not explicitly requested that counsellors refer to intake data to confirm this prevalence, the questioning assumes that each counsellor was able to distinguish trends of attendance and reflect accordingly. This approach was selected rather than requesting numbers of attendees across a term or year due to the variance that would inevitably occur depending if data included only those with external formal diagnosis as compared to those that present with a need type based on the professional judgement of the counsellor. Given the difficulty in attending and accessing assessment services, as established in the literature review, it was considered that utilising findings based only on data at intake may be skewed.

Table 6

Counsellor Sample Survey Questions

Survey Section	*Rating*	*Sample Questions / Statements*	*Question / Statement Form*
Student Difficulties	6-point Likert scale 23 questions	What is the frequency students present to counselling for the following difficulties? Loss / Grief Self -Harm What other difficulties do students present with?	Closed and Open
Help-seeking	7 questions	What reasons do students give for choosing not to access or continue counselling? What reasons do parents give for choosing not to consent to their child accessing counselling? To what degree do the following impact on a student's willingness to access counselling: Cultural background Religion	Closed and Open
Services	5-point Likert scale 6 questions	What programmes have you implemented in your school that are most successful? What do you do to promote the counselling service in your school? How do you reduce the stigma of mental health difficulties?	Open
Referral to External Services	4 questions	Do families access external specialist if referred? Have you referred a student for suicidal ideation? What could be done to support you in your role as school counsellor?	Open and Closed
Demographics	3 questions	What is your gender? How long have you worked in the UAE? How many years have you been counselling?	Closed

4.2.4 Data Analysis

4.2.4.1 Data Analysis

Analysis began by identifying the patterns and trends as highlighted by the quantitative data set. For example, gathering objective data on the frequency young people present to counselling for a range of mental health needs (grief or loss, self-harm, anxiety, eating disorders etc) and subjective data on their perception of the degree of influence such factors as gender, religion or cultural background have on help-seeking. This data was examined in detail using statistical analysis looking at incidence, frequency, socio-cultural and gender correlates. The quantitative survey data gathered using the online survey was cross tabulated and filtered by themes, to enable examination and comparison of data from subgroups of respondents.

Themes were derived by first identifying key words or phrases expressed in each of the responses to the open ended questions and were grouped initially based on these features. Responses were then colour coded and further refined into themes that could be quantified and ordered from most to least prevalent, for example questions probing reasons students don't seek help from counsellors centred around stigma and perception as being weak, and lack of trust of confidentiality. Comments were quoted directly were relevant within the findings and recommendations sections as appropriate.

4.2.4.2 Validity and Methodological Integrity

Methodological integrity requires the presence of both fidelity (adherence to the topic and nature of inquiry) and utility (achieving the goals of the research by employing appropriate measures and methods which answer the research questions). Implementing a mixed method design, which values the insight gained by integrating multiple perspectives, achieved through examination of both qualitative and quantitative data underpins the methodological integrity of this research. Furthermore, it achieves the fundamental principle of mixed research, that being to combine qualitative and quantitative methods and approaches that have complementary strengths while excluding weaknesses inherent in singular design methods (Johnson & Turner, 2003).

Qualitative data contributed by the counsellors authentically represents the experience of counsellors in relation to their day-to-day interactions with students and families within educational settings using direct quotes and references throughout the data presentation and analysis, while qualitative measures capture the frequency and

nature of presenting need without interpretation or extrapolation, correlated where appropriate with the quantitative student data.

The validity of qualitative data is interrogated in relation to the five types of validity identified by Maxwell (1992). Descriptive validity is maintained through the accuracy of representation of the written qualitative data provided directly by participants in the survey tool, interpretative validity emerges from the correlation of themes and interpretation which provides an understanding of common experiences and theoretical validity is evident in the consistency between research findings and data provided by the counsellor participants corroborated by that gained through the student survey. The final types of validity, evaluative and generalisability, are achieved by the convergence of quantitative data within the mixed method design and correlations with other regional research findings respectively.

Findings and recommendations arising from the analysis of qualitative and quantitative counsellor and student data are provided alongside detailed descriptions of contextual factors influencing the setting of the study, participant information and the nature of questions asked, and data collected. This has enabled findings to be presented with clarity and accuracy, and discrepancies examined and reconciled. To further validate and support recommendations and research findings, data tabulations are provided within the data analysis section, alongside triangulation across the student, counsellor qualitative and quantitative data, with points of convergence and divergence explored.

4.3 Results

4.3.1 Quantitative Survey Data

School counsellors were surveyed to gain qualitative data on a range of factors relating to their provision of counselling services for young people within their schools. Establishing the usage of counselling service and capturing the experience and understanding of those tasked with meeting the needs of adolescents, provides a picture of need and exploration of impediments including the quality of external services, the interplay between mental health needs and child protection and safeguarding concerns and the engagement of families. Establishing the counsellor – school-based usage of services as compared with the adolescent responses to the mental health difficulties experience will highlight the gap between adolescent self-reported need and the usage of

school-based services to address that need. Quantitative data is presented in Table 7, with further explanatory narrative integrated into the qualitative data section.

Table 7 *Student Presentation to School Counsellors by Frequency and Need Type*

Presenting Need	*Daily*		*Weekly*		*Monthly*		*Termly*		*Rarely*		*Never*	
	n	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*
Inability to Maintain Friendships	1	4.3%	12	52.2%	7	30.4%	3	13%	0	0%	0	0%
Conflict with Peers / Fighting	8	34.8%	11	47.8%	4	17.4%	0	0%	0	0%	0	0%
Anxiety	7	30.4%	11	47.8%	5	21.7%	0	0%	0	0%	0	0%
Anger / Aggression	9	39.1%	10	43.5%	4	17.4%	0	0%	0	0%	0	0%
ADHD	7	30.4%	9	39.1%	3	13%	3	13%	1	4.4%	0	0%
Special Educational Needs	5	21.7%	6	26.1%	3	13%	5	21.7%	3	13%	1	4.3%
Bullying	4	17.4%	3	13%	11	47.8%	2	8.7%	3	13%	0	0%
Depression	5	21.7%	5	21.8%	9	39.1%	2	8.7%	1	4.3%	1	4.3%
Difficult Transitions (UAE / School)	2	8.7%	1	4.3%	8	34.8%	8	34.%8	1	4.3%	3	13%
Non-suicidal self-injury / self-harm	1	4.3%	5	21.7%	7	0.4%	3	13%	3	13%	4	17.4%
Parental neglect	1	4.3%	2	8.7%	7	30.4%	7	30.4%	5	21.7%	1	4.3%
Loss / Grief	1	4.3%	5	21.7%	2	8.7%	10	43.5%	5	21.7%	0	0%
Divorce / Family Breakdown	4	17.3%	3	13%	6	26.1%	9	39.1%	1	4.3%	0	0%
Somatisation	1	4.3%	5	21.7%	2	8.7%	6	26.1%	5	21.7%	4	17.4%
Obsessive Compulsive Behaviours	2	8.7%	0	0%	2	8.7%	5	21.7%	11	47.8%	3	13%
Life threatening Illness (self/others)	0	0%	0	0%	1	4.3%	9	39.1%	11	47.8%	2	8.7%
Physical / Sexual Abuse	1	4.3%	0	0%	4	17.4%	6	26.1%	10	43.4%	1	8.7%
Eating Disorders	0	0%	2	8.7%	3	13%	7	30.4%	10	43.5%	1	4.35%
Substance Misuse	1	4.3%	0	0%	4	17.4%	6	26.1%	2	8.7%	10	43.5%
Suicidal Ideation	1	4.3%	2	8.7%	5	21.7%	4	17.4%	7	30.4%	4	17.4%
Absenteeism / School Avoidance	0	0%	4	17.4%	8	34.8%	4	17.4%	6	26.1%	1	4.3%
Risk Taking Behaviours	1	4.3%	0	0%	3	10%	4	17.4%	6	26.%1	9	39%

In addition to the presentation of the above-mentioned disorders counsellors expressed a range of other needs which impact upon student engagement and wellbeing within school. Sexuality, transgender and body image issues were reported by two counsellors, which within the context of the UAE are highly sensitive and at times problematic presentations given the illegality of both homosexuality and sex outside of marriage, both prosecutable offenses bringing fines, jail and or deportation.

Counsellors also report that acculturation and "cultural confusion whereby students misunderstand cultural cues or send mixed messages" (Counsellor 11), including "too much inappropriate horseplay among males primarily" (Counsellor 14) also pose challenges for students and counsellors within international educational settings. In the international schools within Abu Dhabi it is particularly complex given the interplay between UAE nationals and an expatriate culture predominantly made up of (TCK, those who are raised for a significant part of their childhood in a culture other than that on their passport or that of their parents (Pollock & van Reken, 2001). TCK's are often characterised as having broad world views despite lacking a personal cultural identity, are adept at building relationships and often multi-lingual, in contrast to many UAE nationals who within their school and social setting interact with expatriates and TCK, while often constrained by more insular, traditional and conservative expectations in their home. Exploring if counselling services in an expatriate international setting for TCK reaches beyond the remit of this research, however, does factor into considerations of help seeing trends and what recommendations for provision arise following data analysis.

A recurrent theme in the qualitative feedback was the prevalence of test anxiety, concern regarding revision strategies, time management and a "lack of fulfilment and school stress coming from family expectations and a lack of emotional engagement". Perhaps this speaks to the competitive nature of the international school environment and the predominance within the parental cohort of high achievers with a strong commitment to academic achievement as a pathway to university and post graduate employment and success. One could potentially extrapolate that the parental commitment to paying school fees within the private schools setting may act as an additional source of pressure, or expectation conveyed from parent to child.

Responses to questions relating to the frequency of child protection and safeguarding concerns revealed that 43% of counsellors have a student present to counselling experiencing neglect, and 47% emotional abuse. Given the correlation

between protective and risk factors and the emergence of mental health needs, it is concerning that the frequency of students experiencing neglect and emotional abuse within their home environment is so prevalent. 34.75% of counsellors indicate that students present with self-harm on a weekly-monthly basis. Self- harm, or non-suicidal self-injury is a response to mental distress, anger, frustration, or emotional pain and requires counsellors to both report to the designated safeguarding lead as it represents a risk to self, alongside provision of alternate coping strategies. Physical abuse is reported by 34.78% of counsellors as a weekly-monthly occurrence, and 17.39% sexual abuse. The frequency with which counsellors have students present with these life experiences speaks to levels of trauma in the adolescent community. Importantly it also highlights the need for counsellors to have a robust skill set in responding to safeguarding and child protection concerns, delivering appropriate therapies, and accessing professional supervision themselves.

Counsellors were requested to provide information on their experience of what impediments exist that inhibit students from seeking help or maintaining engagement in school-based counselling services, and the impediments or rationale that parents provide counsellors when declining assistance (Table 8). Responses suggest that a parental belief that assistance is not needed is the most frequently provided explanation of non-engagement in services. Following within the student cohort, was shame (53%) and stigma (43%) which influences student willingness to reach out, and for parents it was privacy (56%) and stigma (47%). Explanations for these results are likely to stem from a lack of awareness of what constitutes a mental health need and what support or services are available to assist which underpin the belief that there is no problem, or that no assistance is required beyond the family to resolve it. That concerns around shame, privacy and stigma are held by both parent and student cohorts is unsurprising given the lack of trust in confidentiality, and the belief that family and faith are the primary factors in addressing difficulties.

Table 8

Impediments to Help-seeking

	Reasons students give for not seeking help		*Reasons parents provide for not seeking help.*	
	n	%	n	%
Not needed	13	56.52%	14	60.87%
Shame	13	53.52%	8	34.78%
Privacy	9	39.13%	13	56.52%
Stigma	10	43.48%	11	47.83%
Religion	3	13.04%	4	17.39%
Lack of Time	6	26.09%	3	13.04%
Lack of family support	9	39.13%	3	13.04%
Accessing external services	8	34.78%	6	13.04%
Costs of external services	2	0%	4	26.09%

To further examine trends in counselling service access and influences which should be considered in developing and enhancing provision, counsellors identified cultural background, gender and age as the most significant factors impacting access to services (Table 9). Religion was identified as an insignificant influence on engagement in services, which causes contemplation of the difference between Arab culture and Islamic religion, two distinct and influential paradigms in the region.

Table 9

Factors impacting student engagement in school-based counselling services

Degree	Factor							
	Cultural Background		*Religion*		*Gender*		*Age*	
	n	*%*	*n*	*%*	*n*	*%*	*n*	*%*
Not at all	*2*	*8.7%*	*4*	*17.39%*	*4*	*17.39%*	*3*	*8.7%*
Insignificantly	*4*	*17.39%*	*8*	*34.78%*	*3*	*13.04%*	*5*	*21.74%*
Mild but definitely	*8*	*34.78%*	*4*	*17.39%*	*9*	*39.13%*	*11*	*47.83%*
Moderately	*5*	*21.74%*	*5*	*21.74%*	*6*	*26.09%*	*3*	*13.04%*
Severely	*4*	*17.39%*	*2*	*8.70%*	*1*	*4.35%*	*2*	*8.70%*

One of the challenges for families supporting a child with a mental health difficulty, and for school counsellors and school pastoral teams, is the scarcity of support services and mental health professionals. Frequently there are extended waiting periods for services and assessments, additionally there are significant financial costs due to inequitable coverage as few psychological services are covered by UAE health insurers. For example, for Emiratis accessing Thiqa Insurance they are entitled to weekly services with a psychiatrist or psychotherapist, however most insurance plans for expatriates do not cover psychiatric treatment or psychological services (AXA Gulf, Alliance Insurance and Green Crescent). Where there are annual limits applied, they range in aed (Arab Emirates Dirham – currency) from 1500 aed (Abu Dhabi National Insurance Company Silver tier), to 3500 aed (Daman Comprehensive Plan). Given an assessment with a psychologist ranges from 5000 – 7000 aed, broadly equivalent to $1900 - $2670 AUD) and an hour session is in excess of 800 aed ($300 AUD), appropriate provision is often not affordable therefore inaccessible (Khalaf, 2016).

Counsellors were asked to indicate the frequency of a family following up on a referral to external services when requested to do so by the school counsellor, and the frequency of an external specialist contacting the counsellor to engage with the school following a family visit, with the view to ensuring a comprehensive and integrated treatment and support plan taking into account the challenges experienced in the educational settings (Table 11). Responses from the counsellor participants indicated that families usually follow up on referrals and specialists usually contact school counsellors. Whilst this is positive to some extent, it is worrying that one third, 30.44% of specialists do not or rarely engage with schools during the assessment and therapy planning or implementation and nearly 1 in 10 families referred to specialists do not follow up. These factors result in a student whose needs meet the threshold for professional psychological intervention not receiving services.

Table 10

Referrals to Specialist External Agencies

	Family taking up referral to specialist external agency		Frequency of specialist external services contacting counsellor	
	n	*%*	*n*	*%*
Never	*0*	*0%*	*1*	*8.7%*
Rarely	*2*	*8.7%*	*10*	*21.74%*
Usually	*11*	*47.83%*	*8*	*47.83%*
Often	*7*	*30.43%*	*2*	*13.04%*
Always	*3*	*13.04%*	*2*	*8.70%*

In summary, the quantitative counsellor data suggests that the most common support needs students present with are behavioural, conduct, social and emotional difficulties. Counsellors regularly have students disclose emotional abuse or neglect, and the perception that help is not needed, shame, confidentiality and stigma are the most common impediments to help-seeking. Furthermore, counsellors identified student age and gender as less of a factor influencing a student's capacity and willingness to reach out for assistance, than religion and cultural background.

4.3.2 Qualitative Survey Data

Counsellors were surveyed to gather qualitative data utilising open ended questioning, to deepen understanding of the quantitative data and to establish any additional factors or experiences they felt were relevant to the scope and field of research. Opportunities to provide this feedback related to student difficulties, impediments to help-seeking and accessing support, engagement with external services, parental concerns and what counsellors can and are doing to mitigate these contextual challenges.

Guided by the method described by Braun and Clarke (2006), thematic data analysis of the qualitative data was undertaken to identify themes at a semantic level and followed a six-phase approach. Interpretation of the data using thematic analysis began with transcription and familiarisation, reading through all responses to each question to gain a high-level overview of emerging similarities in responses. This was followed by the generation of codes, the classification and transformation of segments of data to facilitate analysis. Initially colour coding responses similar in content or nature, for example, stigma, religious views, and confidentiality, then combining into themes, in this

case, impediments to help-seeking experienced by students. Identification of themes was achieved by reviewing then grouping responses, for example to the question what could be done to make it easier to seek help from a counsellor, all responses fell into five themes:

- Encouragement from parents, family or support from friends
- Having a relationship with the counsellor outside of direct counselling
- Confidence in confidentiality, trust and quality of advice
- Access to counselling without others knowing
- Education for self or others about what counselling offers

A review of the themes to confirm they work both within the specific question and across the whole data set was undertaken and finally naming and producing a definition of each theme was completed. Coding for this research was conducted by the researcher. No statements were removed from the coding process, however where they were an outlier and did not align to any mutually held views they were reviewed separately to the emerging themes. Qualitative responses were reviewed thoroughly and presented with transparency. Matrices aid data analysis and visually highlight these trends and patterns.

Presenting Difficulties

In addition to the need types identified in the quantitative responses, counsellors shared that additional difficulties exist which can be allocated to three broad categories; exam anxiety, study skills, organisation and time management; internet and social media addiction and difficulties; and body image, self-esteem and sexuality.

One counsellor at an all through (FS1 – Year 13) British curriculum school, and Muslim American, shared her experiences and concerns in relation to sexuality, transgender issues, religious beliefs, and homosexuality today in Abu Dhabi.

> "As a part of overall growth and development, coming into one's own identity, especially sexual, has been clouded by the need to be in line with cultural and religious beliefs that are held by others, and not necessarily the individual and or their families. Youth today are under enormous amount of stress and experience anxiety as they try to explore their sexual identities in a restrictive environment. The overall effect of hiding who one is, manifests itself in destructive behaviours that result in self-harm or risky behaviours, including alcohol use and smoking. These provide an outlet for exploring in a safe environment, feelings and questions that would help them develop and mature into healthy

> young adults with positive sexual identities given appropriate support and ways to deal with who they identify as" (TP 6/2019).

She shares that the experience for young people who are exploring sexuality can be further complicated by the mixed messages they receive from adults within their family, community, or school.

> "Furthermore, these destructive behaviours are often engaged in by adults, and youth are aware of them. Although they may be considered 'haram' (meaning forbidden by Allah (God), it is also well known many adults don't practice what they preach, which ultimately impacts how youth react to those who insist they don't engage in these behaviours. We had an experience at our school where sexual abuse of a son was kept secret, and later parents finding out their son prefers homosexual relationships and/or is displaying sexual behaviour the parents consider feminine, caused considerable conflict within the family and community" (TP 6/2019).

Impediments to help-seeking and accessing support services

A broad area of challenge experienced and shared by a number of counsellors were limitations arising from student and parent education, what can and cannot be taught to students (as per ADEK guidance for education relating to sensitive issues) and the illegality of some of the behaviours students engage in (sex outside of marriage, homosexuality, suicide, alcohol consumption under 21 years of age). Quantitative data suggested that the primary reason for students not accessing services (56.52%), and parents not accepting or seeking help for their child (60.87%) was the perception that it was not needed, despite the guidance of the school counsellor and school.

Counsellors identified "irrational thoughts and beliefs and lack of family support", "shame associated with counselling and parents not willing to consent for younger children", and "parents being obstacles to their wanting help or acknowledging they need help due to social stigma, social status, religious views on mental health, privacy and confidentiality they feel will not be adhered to". Counsellors acknowledged the limits placed upon them by educational regulators, on what they can teach or discuss with students in lessons or information sessions, contributed to the atmosphere of secrecy surrounding these behaviours, and impacted on a student's capacity to recognise when they were experiencing difficulty and to be informed as to when and to whom they should seek help. While some schools with predominantly expatriate student bodies deliver

cursory of drug, alcohol and relationship education to senior students traveling overseas or returning home for university, for the majority it remains a significant challenge. Not only is parental approval, gender specific information and delivery in conjunction with the school nurse required, along with ensuring that aspects of illegal behaviour are not discussed or condoned, but in many cases educational leaders prefer to refrain from delivery of any topics deemed too sensitive. Recent initiatives through the MoE My Identity curriculum has started to integrate explicit teaching on mental health, wellbeing, happiness, personal and social responsibility and identification of people in the community who can assist, however it lacks the depth of information around specific mental health needs such as eating disorders, self-harming, suicidal ideation to have a clear impact, particularly on adolescent students or vulnerable populations.

Engagement with external services

Quantitative data indicates that clinical services usually contact the counsellor or school (47.83%) and that most families follow up on a referral recommendation (47.83%). The feedback from counsellors was mixed and largely dependent on the initiative of the counsellor, quality of the clinic and at times cost point of services families availed themselves of. "We are very selective about where we send those students, but cost is the highest factor", "excellent, the response was instant, and an appointment made very quickly. The family felt reassured and very supported", "services have been mostly good, but this has required a lot of work from my end before the referral to clearly communicate to the external agency exactly what the referral is for and what the student needs". However, some shared less satisfaction, "services have been disappointing, we have had cases where police have gotten involved even though it should have been declared a mental health concern and a student had to be detained and taken to court", and "we have not been satisfied because the student did not show any progress'.

The quality and accessibility of services is impacted by the financial limitation's families experience, and all too often the less expensive services employ less experienced or competent therapists and psychologists enabling them to pay reduced salaries and therefore reduce costs to families. Counsellors need to work within this dynamic and refer to clinics that are trusted but are also affordable, forging relationships with providers at all levels to lift the accountability and nature of services rendered which

results in better and more coordinated and consistent care for the students and advice for the family.

Parental concerns

Counsellors confirm that most parental concerns fall into three primary categories, confidentiality, questioning need for services and privacy. Confidentiality is the cornerstone of ethical practice for mental health providers, and central to the development of trust in the formation of a therapeutic relationship between counsellor and client. In most schools, children in primary school require parental consent to access services, while in high school or secondary school students deemed capable of making informed decisions on their own behalf can assent to counselling. Many, particularly British curriculum schools, apply the Frazer competencies, formerly referred to as the Gillick principle (Gillick, 1984), which states that the right to make a decision on any particular matter concerning the child shifts from parent to the child when sufficient maturity is demonstrated to ensure the child is capable of making their own and a well-informed decision. If an adolescent was considered unable to make a decision for themselves, either due to a cognitive delay, special educational need or mental health disorder parents would be engaged in the process and provide consent on their child's behalf.

In general terms confidentiality would be maintained for the student, and by the counsellor, except in cases where the student is perceived a risk to self or others, where abuse, neglect or any other child protection concern is held, or if the counsellor were legally compelled. This is explained before counselling begins and is generally stated in school counselling policies. In the event that information did need to be passed on, the student would be informed first so that the counsellor could work with them to manage the situation in a way that respected the feelings and needs of the child or adolescent. Counsellors expressed concerns stating that, "parents worry about a paper trail and that others within the school may see their child going to the counsellor and talking about it", "there are systemic trust issues and concerns that those providing the service belong to their community (ethnic)" and "the status of the family (for example a VIP or member of the royal family, or staff member's child) also affects them allowing their child to access services".

With respect to parents accepting their child needs mental health support, it can be challenging to distinguish if parent perceptions are the result of a lack of awareness or information relating to mental health disorders and appropriate responses, or if denial

relates more to potential shame and stigma should they have a child with a mental health need. Such attitudes are shared by the counsellors, stating that "some parents express that there is no need for counselling and that their children are fine", while others "don't feel there is a problem therefore refuse to seek counselling or allow their child to continue working with the counsellor".

Privacy links closely with concerns relating to confidentiality, specifically how and when a child may access counselling, who may observe this and what the consequences may be, for example gossip among staff and/or students. "Often it is the location of the counsellor's office that contributes shame associated with lack of privacy, ducking in the door, and then just stopping if someone sees them coming too often is especially common in secondary school". Many schools and counsellors try to address issues of privacy by giving thought to the location of the counsellor room, providing an email booking system or a self-referral box where students can leave a message or note to the counsellor. These along with "providing a proactive counselling programme to reach all students, and having students see counselling/wellbeing as part of the school culture reduces stigma, as does reinforcing that everyone can use some help at times".

Counsellor initiatives to mitigate contextual challenges

Within educational settings counsellors are well placed to deliver proactive and preventative mental health interventions, alongside school initiatives that raise the profile of wellbeing, give students skills to manage life's stresses and be resilient in responding to them. Efforts by counsellors to reduce stigma, build relationships and demonstrate positive effects of self-care and mental health are diverse and largely align to school priorities, delivery of curriculum aligned to personal, social or emotional growth or in response to areas of need which emerge throughout the school year.

Raising awareness of mental health and wellbeing within the school setting by "educating parents through communication and workshops" about "the importance of mental health and wellbeing", running "awareness campaigns at school", "encouraging children to talk about how they are feeling", and holding regular "assembly presentations", for example addressing vaping, use of social media, and managing stress in preparation for examinations.

Explaining clearly what the counselling service offers within school is critical, with counsellors expressing that "word of mouth and thematic displays work well", as does "maintaining an open-door policy", "making ourselves familiar to students throughout the

school from new student orientations and assemblies" and "promoting the counsellors as student advocates and someone that is an adult that cares". To ensure parents are informed, use of "pamphlets, brochures, newsletter pieces", along with "coffee mornings and presence at parent teacher conferences… and meet the tutor evenings for parents".

Ensuring students get information even if they do not attend counselling can be achieved by "addressing common issues on a larger scale to reduce the feelings of individuals suffering" and "having counsellors involved in universal, proactive programmes with a focus on wellbeing, for example hosting a mental health week". Stigma can be reduced by "using words that have fewer threatening connotations. Stress and coping strategies seem less threatening than anxiety and depression. I talk about parenting options rather than behaviour modification", "not writing down notes in front of them (students)" and "training senior students as wellbeing and peer mentors".

Ultimately there was consensus regarding the need for counsellors to be a central part of the school community and for students to "get to know" the counsellor by "mingling and creating a friendly atmosphere among students", "being seen and participating in school wide events and themes", "spend time with students during lunch and interact in the Post-16 area (upper secondary communal area)", have "chat and do activity sessions", or "run a lunchtime club or extra-curricular activity".

Counsellors recognise the need to raise awareness and acknowledge that whole school or class-based interventions (prosocial support programmes) are beneficial to all students, and through delivery provide an opportunity to build relationships with students. In the event that a student needs individual support there is a familiarity and level of trust already in place which results in more timely and effective provision. Counsellors are using a range of programmes that underpin these efforts, which among others include the MindUp programmes, Mindfulness, Peer Mentoring, Positive Psychology interventions.

Therapeutic interventions utilised with adolescent populations

School counsellors report using a range of psychotherapy modalities and therapeutic interventions in their work with students, reporting that many employ a holistic approach rather than align staunchly to a theoretical position on mental health. Most counsellors employ a theoretical framework within which they interpret feelings, thoughts, and behaviours to enable students to address the challenges they are experiencing and develop strategies to manage in the future. In summary the predominant approaches utilised include:

- Psychodynamic Theory – by focusing on past events, traumas, and relationships one can understand one's self enabling treatment and healing to occur.
- Behavioural Theory – considers behaviour as learned, and therefore unwanted or destructive behaviours are addressed through positive or negative reinforcement.
- Cognitive Theory – is present focused, purporting that peoples thinking can change feelings and associated behaviours, it is oriented towards problem solving and is the basis of Cognitive Behaviour Therapy.
- Humanistic Approach - is also present focused and facilitates the achievement of potential rather than focusing on past or negative behaviours, often associated with client-centred therapy (taking control of your own destiny) and existential therapies (self-determination and responsibility).
- Holistic / Integrative Therapy – integrates aspects of different theories and focuses on what provision is best suited to the adolescents needs and problem they are facing.

Counsellors utilise a variety of programmes which integrate these approaches or theories both with individual students, and to teach wellbeing and self-regulation skills to student cohorts. Counsellors deliver Mindfulness, Peer Mentoring, and Positive Education programmes, alongside Responsive Classrooms in primary and weekly social emotional tutorials in secondary to groups of students. Others deliver psychosocial support programmes as a class-based intervention, which helps all students and provides general support, as well as identifying students who need further support and referral for individual counselling. For individuals Counsellor #10 utilises positive psychology interventions, the MindUp programmes, and yoga. Counsellors should feel empowered to utilise therapeutical interventions that are selected based on the needs of the young person and offered ongoing professional development to continue to enhance the range of modalities available to them.

4.4 Discussion

The counsellors, who are trained and experienced mental health professionals, provide observations of the incidence, prevalence, presentation, and limitations of counselling in international schools, which offer an important and alternate perspective to

that given by students. The quantitative and qualitative data may explain potential under or over reporting of some items on the student data and offer some explanation as to the rationale behind why there may be a difference between data sets. Students may either, lack the self-awareness or vocabulary to recognise and explain their feelings or experiences, or it may be that cultural or religious forces lead them to somatisation or minimisation of the impact of their mental health in line with their familial or cultural expectations. In either case, the counsellor data provides important comparative, contextual and explanatory data.

The information gathered from participants is adequate to provide sufficient qualitative and quantitative data to enable broad analysis and generalisation of experiences, particularly when cross referenced to the student feedback and screening data collected. While this research has been conducted exclusively with counsellors and adolescents within private schools in Abu Dhabi, given the number of UAE nationals within private schools, and that counsellors across their careers in Abu Dhabi often have work experiences in both public and private schools, broad themes arising from this research could reasonably be applied to both settings. Confirmatory research would be necessary to examine the experience of students and counsellors in public schools, and potentially replicate the findings and validate recommendations of this research to both settings.

Threats to validity in this mixed method design emerge in the data collection, analysis and interpretation phases, however, are mitigated by managing researcher perspectives, excluding interpretation without correlation between quantitative and qualitative findings and upholding a clear parameters of researcher engagement in both the data collection and interpretation phases. Links are identified and maintained between current research literature both within the Middle East region and internationally, providing some contextual relevance for those practicing with Arab and/or Muslim clients irrespective of their service provision, in addition to informing recommendations for services within the UAE and Gulf region.

In response to the key questions of this thesis and themes explored through this research, counsellors reported students accessing counselling services do so with a range of need types which are impacting on their levels of wellbeing and mental health. The percentage of counsellors that indicated students presenting with mood disorders on a daily or weekly basis was 78% for anxiety, and 43% for depression. For disorders that

were less common, but presenting on a monthly basis, counsellors reported 13% for eating disorders, 17% for substance misuse, and 21% for self-harming behaviours. 21% of counsellors have students present with suicidal ideation on a monthly basis. It is important to recognise that these are the conditions and experiences which lead a student to present to counselling services and are not necessarily indicative of the level of need, in fact one could extrapolate that there are significant differentials between those experiencing for example anxiety, depression, eating disorders and substance misuse and those presenting for assistance, particularly when taking into account the reported concerns regarding confidentiality and associated impediments to help-seeking.

When exploring if levels of reported mental illness and inclination to seek support were influenced by socio-cultural or religions factors, the qualitative data from counsellors suggests that 39% felt the degree to which cultural background influenced help-seeking was moderate to severe, 30% felt the influence of both religion and gender were moderate to severe, and only 21% felt age had a moderate to severe influence over inclination to seek help.

Counsellors report a range of services that vary in terms of cost, waiting times, quality of services as measured by impact and effectiveness of interventions, the qualifications and expertise of those delivering services and clinical engagement with school practitioners. Where services provide the best services, with the most positive and sustained impact, schools have built relationships with individual clinicians, made direct referrals to specific services and who have been proactive in the following up on a regular basis. Where the impact of external services is less successful, there are usually factors including lack of parental consistency in taking the student to services, or poor quality and ineffective therapy. Indeed, there are reported cases of clinicians offering services beyond their qualifications, and those delivering therapy without adequate supervision or accountability, which when such concerns are identified by the school and shared with families usually result in a rapid change of service provider, or more commonly a withdrawal from services altogether. Within educational settings counsellors report a range of holistic and individual therapeutical approaches being utilised to reach both those students who engage with counselling services and the broader population who may need or benefit from support but who are reluctant due to concerns around confidentiality or privacy. Counsellors report that the effectiveness of school-based services,

particularly when occurring alongside high-quality external services produce the best outcomes for the higher need or more complex cases.

Educators and those working in the field of child development or psychology recognise that low levels of mental health and wellbeing have a direct influence on educational engagement and outcomes, social interactions and peer support, and an increase in the presentation of health disorders either as somatisation (21% of counsellors report weekly somatic presentation of students) or enduring physical illness which occurs as a direct result of poorly managed mental disorders. Within secondary private schools, counsellors report that the majority of students presenting are expatriate females, with under presentation of UAE and Gulf nationals and boys, the reason for which will emerge from themes that will be further explored within the student data.

Parent education has been identified by counsellors as both a major impediment to students accessing support, but also an area of significant potential to address some of the challenges in reaching all students who need support. Some schools invite visiting specialists to speak with school parent communities, for example Dr Adrian Harrison (Child and Educational Psychologist) of Kids First has done a series of presentations on the psychological impacts of online media on adolescent mental health and wellbeing, and Dick Moore a UK Mental Health First Aid trainer is regularly brought out by schools to deliver training to staff, but also share his story with parents and students of losing a son to suicide. Parents, particularly those of Arab cultures are less aware of the signs their child may be experiencing mental health difficulties, less knowledgeable about support services and less inclined to accept or seek help when needed, one counsellor sharing that "we find that parents need as much psychoeducation as students" (Counsellor #26). Here in lies the potential, that by engaging with parents in the school setting and empowering them to recognise their role in ensuring their child's social and academic potential is not impacted by such factors as stress, anxiety, or depression or the expressions of such conditions such as self-harming and eating disorders over time the inclination to seek help in the early stages will produce more positive outcomes.

> I try to use words that have a less threatening connotation. Stress and coping strategies seem less threatening than anxiety and depression. I talk about parenting options rather than behaviour modification (Counsellor #13).

Inadequate resourcing, both human and physical was also identified as impediments to student access to services, with many counsellors stating that they were unable to meet

the needs of students due to time constraints and timetable limitations. Staffing of counsellor to students in many schools was greater than 1:1000 which left little time to deliver the proactive or preventative group or assembly sessions after meeting the needs of scheduled 1:1 sessions. For schools to be licenced in Abu Dhabi, they are mandated to have a counsellor, however in private schools there are no guidelines or requirements based on the number of students. As a result, in some schools the required (single) counsellor is in post, but demand exceeds capacity. Counsellors felt that only "through a whole school approach to mental health and wellbeing" (#10), which is "fully supported by the senior leadership team" (#22), would optimal provision be achieved for their students and community.

Reflective of levels of need and challenges accessing services both within the school and community, are the increasing numbers of local initiatives and support groups are becoming established in Abu Dhabi, highlighting the need for accessible services and dispelling myths around mental health. These groups seek to increase accessibility to support, reduce stigma and promote mental health wellbeing as being as important as physical health and wellbeing. They advocate that open discussions around stress management, anxiety and depressions should be as commonplace as those about the need for weight management, exercise, and sleep. One such example is Darkness into Light, which began in 2009 in Ireland, as a walk-in memory of those who ended their lives by suicide, starting before dawn and walking into the light to raise funds for mental health care and raise community awareness. A group of volunteers brought the walk to Abu Dhabi in 2016, and has been run annually since, alongside a range of weekly support events and networks that seek to "create a world where suicide, self-harm and stigma have been replaced by hope, self-care and acceptance" (Maria Kelly, 2019).

In summary, counsellors view their role in school as central to providing for the needs of students in crisis who present to their service, pivotal in addressing stigma and building a strong community that recognises and values the importance of wellbeing and mental health alongside physical, and in reaching out to secure effective and high-quality external services for their students and their families. They state their effectiveness would be enhanced with increases in the number of counsellors in schools, and a whole school top down commitment to student wellbeing as core to school values.

CHAPTER 5: STUDY 2 THE ADOLESCENT EXPERIENCE

Adolescence is a period of significant change. Maturity emerges in both physical and emotional domains, within the context of often increasing and more complex social and academic stressors. Critically, adolescence is also the time where many mental health difficulties emerge, witnessed as destructive internalising or externalising behaviours, thoughts, or emotions. The impact of these behaviours on academic, social, and mental health is profound. In many clinical and educational settings, provision for adolescents is all too often based on the historical experience, theoretical assumptions, or the preconceptions of adult decision makers. The quantitative and qualitative data gathered in this research provides detailed and first-hand personal information about adolescent experiences, beliefs, concerns, and difficulties, and inform recommendations for school-based provision that meet the needs of these young people.

5.1 Method

Students were surveyed using the online survey tool, CreateSurvey. The survey administered screening tools that identify indicators of need types, strengths and difficulties, attitudes towards accessing psychological services and provide insight into perceptions of socio-cultural impediments to help-seeking.

5.1.1 Participants

Abu Dhabi, the largest of the 7 Emirates and capital of the UAE, has 253,000 students, 73% of whom are expatriates and 23% Emiratis (2018/2019 Academic year) which represents 65% of all students in the Emirate (Abu Dhabi Education & Knowledge, 2019). Within this multinational cohort adolescent participants will be drawn from students aged 15-18 years, limited to those attending Aldar Academies secondary schools in Abu Dhabi. Aldar Academies is an educational group offering high quality education delivering the British, American Massachusetts and International Baccalaureate curricula, with students of over 90 nationalities, including both expatriates and UAE nationals. Within the Academies' schools that have secondary provision, Al Ain Academy, Al Yasmina Academy, Al Bateen Academy and Al Mamoura Academy, there were 640 students aged 15 and above who fell into the participant target group (at the time of data collection). Those electing to participate represent 53% of potential participants (n = 340), as seen in Table 11. English language is the primary language of

instruction and students had sufficient expressive and receptive levels to engage with the research questions and screening tools.

Table 11

Potential Adolescent Participants

School	*Males aged 15-19 years*	*Females aged 15-19 years*	*Total students aged 15-19 years*
Al Ain Academy	31	25	56
Al Bateen Academy	187	118	305
Al Mamoura Academy	-	18	18
Al Yasmina Academy	138	123	261

Note. All students meeting participant age criteria in each school.

As detailed in Table 12, there were marginally more males than females that participated in the survey, approximately one third were UAE nationals and two thirds other expatriates and the majority of adolescents were of Muslim faith.

Table 12

Actual Adolescent Participants

	Number of Adolescents	*% of Total Participants n=333*
Male	181	54.5%
Female	152	45.6%
UAE National	116	34.8%
Other GCC Arabs	8	2.4%
Expatriate	209	62.7%
Muslim	193	57.9%
Other Religion	140	42%

5.1.2 Researcher Participant Relationship

As Group Head of Inclusion and Safeguarding for Aldar Education, of which Aldar Academies represents one group of schools, I may be known to some of the students in the participant group, given periodic presence in the schools to support school based special educational needs coordinators and counsellors, families and students with

learning support needs. However, this contact would be transient and superficial, therefore the researcher may be known to students but not be considered to have any pre-existing relationship.

5.1.3 Participant Recruitment Process

Participants were recruited between January and March 2018 via a series of face-to-face presentations and information meetings held with each form group, as part of their regular school assembly. This presentation outlined the nature and intention of the research and survey, matters of informed consent, confidentiality and right to withdraw. Student questions were answered, and contact details distributed along with participant information and parental consent forms. Posters explaining the purpose of the research project were displayed within common rooms. No incentives were provided for participants. The survey opened to students on 21st January 2018 and closed on 31st March once all form teachers had confirmed all students with approval to participate had done so, and a further 10 days had lapsed in case any participants changed their mind. Quantitative and qualitative data was collected simultaneously utilising the same survey instrument.

5.1.4 Participant Selection or Sampling

A purposive sampling approach was taken in gathering data from participants, based on meeting the criteria of age (15-19 years) and attending one of the Aldar Academies secondary schools. Those students outside of these parameters were ineligible to participate and were therefore excluded. Quantitative data was gathered from the participants in the first instance, arising from the standardised screening questionnaires included in the survey. Qualitative data was collected via open ended and semi structured questions integrated into the survey tool. By taking this approach, participants were able to provide additional observations, share experiences and preferences, concerns, and attitudes, alongside their responses to the quantitative screening questions.

5.1.5 Design

Selecting standardised assessment and self-report screening tools which quantify behaviours and experiences indicative of the absence or presence of mental health difficulties, in a culturally appropriate and sensitive manner, requires evaluation of both language and content. Previously explored concerns about somatisation and the range of cultural presentations of mental ill-health influence the selection of screening tools and development of the survey instrument, requiring the inclusion of assessments which

include health questions to evaluate potential somatisation, qualitative cultural questions to establish attitudes and beliefs, and standardised questionnaires that provide the qualitative data on prevalence and incidence. Furthermore, to ameliorate concerns participants may have with maintaining confidentiality, an anonymous online survey was utilised to administer the combined questionnaires.

Following due consideration of these factors, four assessment tools that have been adapted and evaluated for use in Arabic settings and/or standardised using culturally diverse participant samples were selected.

5.1.5.1 Strengths and Difficulties Questionnaire

The Strengths and Difficulties Questionnaire (SDQ) (Goodman, Meltzer & Bailey, 1988) is a self- report behavioural screening questionnaire for children aged 3-17 years, and investigates psychological attributes including emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behaviour. Scoring of these domains helps identify mental health difficulties and their impact on emotions, behaviour, and social interactions. The questionnaire has been translated into Arabic and demonstrated to have maintained validity and reliability. Whilst it will not be administered in Arabic in this survey, that validity and reliability were maintained speaks to its use in Arabic speaking populations akin to those found in the UAE. Data can be evaluated in several ways:

- Total difficulties score – measured by combining the sum of each individual scales
- Externalising score – measured by combining the conduct and hyperactivity scales.
- Internalising score – measured by combining the emotional and peer problems scales.
- Individual scale scores – evaluating each conduct, hyperactivity, emotional and peer problem scale separately.

The developers recommend that evaluating individual scale scores may be of more value in high risk groups, whereas in community samples evaluating the amalgamated scales providing the externalising and internalising scores may be more appropriate. In this research it is the latter that will be utilised for the collective sample, and participants that present with elevated amalgamated scores and therefore are considered a risk group, the four scales will be explored individually (Goodman, Meltzer & Bailey, 1988).

Participants rate statements as not true, somewhat true, or certainly true, and are further explored in Table 13. Statements are phrased as "I statements", focusing on beliefs and feelings as opposed to characteristics, for example:

- I get very angry and often lose my temper
- I am kind to younger children
- I have many fears, I am easily scared
- I finish the work I am doing, my attention is good

5.1.5.2 Brief Multidimensional Students' Life Satisfaction Scale – PTPB version

The Brief Multidimensional Students' Life Satisfaction Scale – PTPB version **(**BMSLSS-PTPB) (Athay, Kelley & Dew-Reeves, 2012) is a measure of youth life satisfaction. This instrument gathers data on overall life satisfaction, alongside domain specific responses, such as satisfaction with self, family life, friendships, where you live and school. Participants respond using a 5-point Likert scale rating from 'very satisfied' to 'very dissatisfied'. Questions include 'how satisfied or dissatisfied are you with your friendships', or 'how satisfied or dissatisfied are you with yourself', see Table 13. The Brief MSLSS was developed as an abbreviated version of the Multidimensional Students' Life Satisfaction Scale, the original 40-item measure, offering an instrument that can be used in time sensitive contexts. A score of greater than 4.2 for the BMSLSS-CEPI is considered high (high satisfaction) and a score of less than 30 is considered low (low satisfaction,) as calculated by average of the sum of scores (Athay, Kelley & Dew-Reeves, 2012). This instrument has been effectively used in culturally diverse populations and will enable correlation between student mental health and reported well-being and life satisfaction.

5.1.5.3 Health of the Nation Outcome Scales Child and Adolescent Mental Health

The Health of the Nation Outcome Scales Child and Adolescent (HoNOSCA) (Growers, Harrington, Whitton, Beevor, Lelliot & Wing, 1998) was developed in 1992 by the United Kingdom Royal College of Psychiatrist's/Psychiatrists' Research Unit to evaluate the social functioning and health of young people experiencing mental health difficulties. Widely used in clinical settings in UK and Australia, it is an instrument with 12 items, measured on a 5-point scale of severity, which measures social functioning, behaviour, impairment, and symptoms. Clinicians, parent and the child or adolescent each complete their form and results are compared. Administration guidance suggests the

client-rated HoNOSCA should be administered every time a clinician-rated HoNOSCA is completed, to act as a comparison (generally at assessment or admission, at the review point and finally at discharge). In addition, there is an impact supplement which provides information relating to the length of time difficulties have been present and the degree of interference the difficulty has on aspects of life including education, leisure, social and familial contexts.

The HoNOSCA 'client rated' self-report form will be utilised in this research to give adolescents and additional opportunities to provide contextual and experiential information alongside the SDQ. Furthermore, it provides an opportunity to evaluate such experiences as non-accidental self-injury (self-harm / suicidal ideation) and non-organic somatic symptoms, aspects of Emirati and Arab adolescent presentation that need to be sensitively explored within this cultural context.

Summarised further in Table 13, the self-report form includes a series of direct questions which establish the overall functioning of the adolescent within the domains of self, home, and school, including for example:

- Have you experienced difficulties keeping up with your usual educational abilities?
- Have you been in a low or anxious mood, troubled by fears, obsessions, or rituals?
- Have you been troubled by a lack of satisfactory friendships or bullying?
- Have you done anything to harm or injure yourself on purpose?

One amendment to the HoNOSCA was undertaken for use in this research, as advised by the Aldar Academies Head of Arabic and Islamic Studies, requested by Aldar Academies Director of Education and confirmed by research supervisory team. Question 4, "have you had problems as a result of your use of alcohol, drugs or solvents" has been replaced by "have you felt peer pressure to use illegal substances"? Administration of the initial question 4 would have asked adolescents to admit to illegal activities which is inappropriate given the legal and moral codes applied in the UAE. This change will be taken into account when evaluating the data arising from the survey, however is not anticipated to impact the validity of the screening tool.

5.1.5.4 Beliefs about Psychological Services

The Beliefs about Psychological Services (BAPS) (Ægisdóttir & Gerstein, 2009) was developed out of a need to refine two previously developed survey instruments that

measure common positive and negative attitudes towards psychologists and accessing psychological support. The BAPS has 17 statements, including both positive, 'it is good to talk to a counsellor because everything you say is confidential', and negatively worded questions, for example 'going to see a counsellor means I am a weak person', as seen in Table 13. The developers recommend use of the 3 subscale scores, Intent, Stigma Tolerance and Expertness, which gives more detailed information than use of a totalled score. The BAPS has been used in research which replaced the terms psychologists and psychological services with mental health counsellor and mental health counselling without negative impact on reliability or factor structure (Ægisdóttir, O'Heron, Hartong, Haynes & Linville, 2011). The current survey will be adjusted for use in this research by replacing psychologist with 'school counsellor' as this is the title familiar to the students completing the survey. No impact on reliability is anticipated.

The combination of these tools and integration into the survey will enable a culturally sensitive and thorough exploration of presenting difficulties, and their impact on relationships, wellbeing, and life satisfaction.

After meeting all administrative requirements, submitting all regulatory applications, and gaining approval, participants were secured. Following full disclosure and informed consent, and confirming their right to withdraw, adolescent participants completed the anonymous online survey. The survey integrates standardised screening tools including the Strengths and Difficulties Questionnaire (Goodman, Meltzer & Bailey, 1998), Health of the Nation Outcome Scales Child and Adolescent Mental Health (HoNOSCA) (Growers, et al., 1998), and the Brief Multidimensional Student Life Satisfaction Survey (Bickman, et al., 2010; Diener, Emmons, Larsen & Griffin, 1985). The final section explores attitudes to help-seeking, which offers an opportunity for participants to share their experiences and thoughts on social and cultural factors, and integrates the Beliefs about Psychological Services (Ægisdóttir & Gerstein, 2009) in addition to broad demographic data (age, gender, nationality, number of years in the UAE).

5.1.6 Procedure

5.1.6.1 Data Collection

Identified challenges of data collection that informed the research and data collection design, include issues of confidentiality, anonymity, accessibility, convenience, and applicability for adolescent populations. Research supports the use of self-report

measures and screening tools with adolescents. Deighton, Croudace, Fonagy, Brown & Wolpert (2004) completed a review of eleven individual child or adolescent mental health measurement tools and established that self-report measures offer a practical means to explore mental health, and an effective way to gather both quantitative and qualitative data. For these reasons data is collected utilising a questionnaire administered via an online survey, integrating self-report screening tools, demographic information and open-ended questions to gather qualitative data which offer a cost and time effective means to gather confidential, accurate and standardised data on adolescent populations.

Given the number of participants, pre-existing academic commitments and complexity of timetabling student's access to computers to complete the online survey during the school day, access was facilitated by the form teachers for each of the year groups to complete the survey at a time and day convenient with the teacher and student. As a result, the duration of data collection was 2 ½ months, from 21st January to 31st March, with majority of individual response times ranging between 8 - 15 minutes.

The research questions which underpin the formulation of the survey can be broadly categorised as those which identify:

- Mental health difficulties, and the frequency they are exhibited/experienced.
- Wellbeing and concept of self, and the influence of socio-cultural factors.
- Inclination to seek help, and the nature of help sought.
- Factors influencing decision not to seek help.

In addition to demographic data, and questions relating to accessibility of and barriers to help seeing, the online survey will utilise research questions drawn from the four standardised assessment tools, as previously discussed, and shown in Table 13.

Table 13

Sample Questions from Survey and Self Report Assessment Tools

Survey Section	*Self-Report Standardised Screener / Rating*	*Sample Questions / Statements*	*Question / Statement Form*
Strengths and Difficulties	Yes 3-point Likert scale 25 questions	I am restless, I cannot stay still for long. I worry a lot. I have one good friend or more.	Closed
Health and Wellbeing	Yes 5-point Likert scale 13 questions	Have you been troubled by disruptive behaviour, physical or verbal aggression? Have you done anything to injure or harm yourself? Have you been troubled by relationships in your family?	Closed
Life Satisfaction	Yes 5-point Likert scale 6 questions	How satisfied or dissatisfied are you with your family life? How satisfied or dissatisfied are you with yourself? How satisfied or dissatisfied are you with your overall life?	Closed
Life Satisfaction Impact Statement	Yes 4-point Likert scale 10 questions	How long have these difficulties been present? Do the difficulties distress you? Do the difficulties interfere with your everyday life?	Closed
Help-seeking	Yes 7-point Likert scale 10 statements 3 questions	I would be willing to confide my intimate concerns to a counsellor. Going to the counsellor means I am a weak person. What reasons may cause you not to seek help from a counsellor?	Closed and Open
Demographics	No 5 questions	How long have you lived in the UAE? What is your gender? What is your religion?	Closed

Note. Questions are indicative of the nature or remaining questions of the subset.

5.1.7 Data Analysis

5.178.1 Recording and Data Transformation

The survey was developed using the CreateSurvey package, which enabled the use of a range of question types, skip logic and result in an online survey presented in a manner that would be appealing and accessible for adolescents. Survey results using this package can be filtered, cross tabulated and exported as raw data to SPSS, Excel or in plain text.

5.1.7.2 Data Analysis

Mixed method analysis of the data generated is undertaken using a sequential explanatory design, that being where the qualitative data provides opportunity for deeper exploration of the themes emerging from the quantitative data analysis. Quantitative data were analysed using the IBM SPSS Statistics (SPSS) version 26 package to extract reliability and correlation data, in addition to quantifying the incidence of various factors as evidenced in the scored survey responses, for example the prevalence of participants meeting the HoNOSCA self-report criteria for behavioural problems or the SDQ criteria for emotional problems. Participant qualitative data was collated in excel spreadsheet format and coded to identify themes within the narratives provided. Commentary included in the qualitative themes were selected and integrated to further illustrate information which emerges within the quantitative data set.

Review of the data set highlighted 7 cases that did not meet the criteria for inclusion, namely that there was evidence of deliberate mischief (repeated identical responses throughout entire survey) or where insufficient time was taken to complete the survey (less than 201 seconds). Cases removed include cases 36, 37, 39, 181, 189, 204 and 330, resulting in total data sample of n333.

5.1.7.3 Addressing the Research Questions

This research anticipates that adolescents in the UAE will express prevalence rates for mental health disorders or difficulties that align with international trends. There is a relative absence of data examining adolescent beliefs around psychological services and the differences that exist in relation to culture, faith and/or gender. This makes it challenging to predict to what degree the assumed impediments (cultural and community stigmas relating to mental illness and help seeking) are experienced and subsequently expressed by the adolescents. To confirm and or challenge this premise, research

questions (1-4 of 5) were developed and means to assess them devised, as summarised in Table 14.

Table 14

Research Questions and Data Gathering

Question Number	*Research Question*	*Mode of Data Gathering*
1	What are the levels of self-reported wellbeing and mental health in the sample of adolescents?	Strengths & Difficulties Questionnaire HoNOSCA Screen Life Satisfaction Survey
2	What is the incidence of mood disorders, eating disorders, substance misuse and self-harm reported by adolescents?	Strengths & Difficulties Questionnaire HoNOSCA Screen Counsellor Survey
3	Are levels of reported mental illness and inclination to seek support influenced by socio-cultural or religious factors?	Beliefs about Psychological Services survey. Adolescent Survey Questions
4	What social, emotional, educational and societal implications of mental health disorders are reported by adolescents living in Abu Dhabi, and how do the experiences of locals and expatriates differ?	Strengths & Difficulties Questionnaire Adolescent Survey Questions
5	What impediments to help seeking do counsellors working with adolescent populations report and what are the key issues and challenges they face in delivering services and support?	Counsellor Survey Questions

The mixed method design facilitates quantitative data gathering through screening tools embedded within the survey structure, alongside qualitative commentary from the integrated open-ended questioning. No parametric analysis has been undertaken, as the intent of this research was not to make strong inferences but explore trends within the socio-cultural context experienced by adolescents.

5.1.7.4 Ethics and Approvals

Ethics approval for this research was obtained from the Human Research Ethics Committee through the University of Southern Queensland and conducted in compliance

with the National Health and Medical Research Council (NHMRC) National Statement on Ethical Conduct in Human Research, 2007 (Updated 2015). In addition, approval to conduct the research with student participants attending Aldar Academies was granted by the CEO and Director of Education. This project adheres rigorously to the principles of ethical research, namely informed participant and parental consent, voluntary participation and the right to withdraw, confidentiality, secure storage of data, and that research outcomes are meaningful, make a contribution to knowledge and understanding and inform practice.

With regard to this research, and the nature of its focus on the experiences of adolescents, due and careful consideration was given to possible psychological and social risks, with strategies to minimise possible risk and negative outcomes put in place. These included the ability to withdraw participation at any time, access to a counsellor post research, maintenance of anonymity and using culturally sensitive questioning strategies.

5.1.7.5 Validity and Methodological Integrity

Methodological integrity, essentially the quality of research conducted when utilising a mixed method design, challenges the researcher, according to Creamer (2018), to use the technical language associated with the three methods, qualitative quantitative and mixed methods. Furthermore, Creamer posits that the quality of research undertaken relies upon engaging with multiple perspectives and standpoints which integrate in a meaningful way, utilising both qualitative and quantitative data and analytical procedures. As detailed in chapter 6, methodological integrity requires the presence of both fidelity (adherence to the topic and nature of inquiry) and utility (achieving the goals of the research by employing appropriate measures and methods which answer the research questions), both of which have been applied in the examination of student responses to the survey and data subsequently collected.

Qualitative data contributed by the adolescent cohort provides insight into the attitudes and experiences of students and elaborates on their beliefs about psychological services and help-seeking and is provided as direct quotes and references which elaborate on the information established via the quantitative data set.

As was the case for the counsellor data, Maxwell's (1992) test of validity is applied, with descriptive validity achieved through direct quoting statements provided by adolescents as gathered through the survey tool and interpretative validity evident in the correlation and interpretation of themes to establish common experiences. Theoretical

validity is evident in the consistency between research findings and data provided by the student participants corroborated by that gained through the counsellor survey. The remaining validity measure, that research is evaluative and generalisable, is achieved by the convergence of quantitative data within the mixed method design and correlations with other regional research findings respectively.

The participant sample of 333 adolescent students is representative of the broader adolescent experience within Abu Dhabi and includes those from varying national and cultural backgrounds, religions and genders, and for expatriates, diversity in the length of time they have resided in the UAE. Data gathered from participants is adequate to provide sufficient qualitative and quantitative data to enable broad analysis and generalisation of experiences, particularly when cross referenced to the counsellor data collected.

Assuring validity requires that the research instruments accurately and without bias, measure the factors intended. Construct validity will be maintained in the current research by using previously standardised, translated, and tested mental health questionnaires, each offering its own internal validity. In addition, to improve content validity and reduce bias, and as recommended by Foxcroft, Paterson, Le Roux & Herbst (2004) a panel of experts, knowledgeable individuals in Islamic principles, Arab traditions and mental health have reviewed the survey and provided guidance prior to the testing phase. The development of the surveys will be informed by the Best Practice in Cross Cultural Surveys Guidelines (Survey Research Centre, 2010), which include guidance specific to survey design, adaptation, translation and testing to avoid the potential that bias may invalidate data.

Use of standardised mental health questionnaires contributes to validity, given their standardisation on culturally diverse populations and subsequent use in many countries and across multicultural contexts. However external generalisability may be difficult to demonstrate unless a sample of students are surveyed from another school/curriculum or from the public-school system. At present, this is beyond the scope of this research, however if the socio-cultural makeup of the participant group is similar, the efficacy of generalisation could be argued across similar socio-cultural cohorts found in Abu Dhabi international private schools.

As stated in Chapter 6, threats to validity exist in the data collection, analysis and interpretation phases, however, are mitigated by minimising interpretation that cannot be

substantiated by the quantitative and qualitative findings and by providing clear descriptions of researcher engagement in both the data collection and interpretation phases. Links are maintained between current English language research literature within the Arabian Gulf, Middle East and internationally, providing contextually relevant recommendations for those practicing with Arab and/or Muslim clients. As is the case with the counsellor data, adolescent findings and recommendations are provided alongside detailed descriptions of contextual factors influencing the setting of the study, the nature of questions asked, and data collected which results in findings presented with clarity and accuracy, and discrepancies examined and reconciled.

5.2 Results

5.2.1 Quantitative Survey Data

Adolescents who participated in the online survey provided responses to a series of questions that explored their state of wellbeing, and inclination to seek help. As previously detailed in table 13 which provides the breakdown of the cohort, there were 9% more male participants than female, approximately one third were UAE Nationals, and 60% of adolescent respondents identified as being of Muslim faith.

Data from each survey was be explored individually before correlation across surveys to identify key themes and vulnerabilities to inform recommendations for counselling and mental health services.

5.2.1.1 Strengths and Difficulties Questionnaire

The Strengths and Difficulties Questionnaire (SDQ) (Goodman, Meltzer & Bailey, 1988) investigates psychological attributes including emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behaviour. It can identify adolescents who present with behaviours or beliefs indicative of mental health difficulties and reflect the degree to which they impact on emotions, behaviour, and social interactions. For the purposes of this research, data provided in the high – very high degree of difficulty domains will be examined, as these students based on their self-reporting fall into the most vulnerable cohort (Table 15). These students would likely benefit most from intervention, education, and support to minimise the impact on their emotional wellbeing and academic performance.

Table 15

Strengths and Difficulties – Total Difficulties

	High	*% High Degree of Difficulties*	*Very High*	*% Very High Degree of Difficulties*
Male	14	7.7%	15	8.2%
Female	15	9.8%	23	15.1%
UAE National	10	8.6%	15	12.9%
Other GCC Arabs	1	12.5%	1	12.5%
Other Expatriate	18	12.8%	22	15.7%

Note: Scores are aggregated and represent the total sum of emotional, conduct, hyperactivity peer problems and prosocial scores, further explored in the tables below. Percentage reflects prevalence within each cohort, for example 15 individuals, 8.2% of all male's report very high degree of difficulties.

UAE Nationals report a high – very high degree of difficulty predominantly in the domains of emotional problems (22.4%) and conduct problems (22.3%). However, as illustrated in Table 16, when compared to the reported very high overall difficulties, non-UAE expatriates (Gulf Arab others and other expatriates) report 15%, compared to UAE nationals 7.5%. Therefore, while it is important that initiatives targeting UAE nationals focus on developing resilience and skills to manage behavioural and emotional concerns, it is the non-UAE national cohort that report the most significant overall difficulties and will require holistic interventions taking into account their TCK/expatriate status and lived experience.

Table 16

Strengths and Difficulties – UAE Nationals

	High	*% High Degree of Difficulty /(Strength for Prosocial scale)*	*Very High*	*% Very High Degree of Difficulty /(Strength for Prosocial scale)*
Emotional Problems	11	9.4%	16	13%
Conduct Problems	15	12.9%	11	9.4%
Hyperactivity	7	6%	12	10.3%
Peer Problems	10	8.6%	9	7.7%
Prosocial	21	18%	11	9.4%

Data collected through the SDQ, suggests that males report the lowest prevalence of high-very high difficulties, while female and expatriate adolescents experience the greatest overall high-very high difficulties. However, when examined as individual sub-scales by gender (Tables 17 and 18), unique profiles of need and difficulty emerge which can inform the nature and extent of interventions and support put in place to ameliorate contributing factors.

Table 17

Strengths and Difficulties – Males

	High	*% High Degree of Difficulty / Strength*	*Very High*	*% Very High Degree of Difficulty / Strength*
Emotional Problems	17	9.3%	12	6.6%
Conduct Problems	13	7.1%	20	11%
Hyperactivity	7	3.8%	16	8.8%
Peer Problems	18	9.9%	12	6.6%
Prosocial	32	17.6%	21	11.6%

Males reported a high – very high degree of difficulty predominantly in the domains of conduct problems (17.2%) and peer problems (16.5%). Research suggests that 20% of adolescents that have a conduct disorder such as oppositional defiant disorder and 10% who experience anxiety also present with ADHD – hyperactivity (Fayyad,

Sampson & Hwang, 2017), therefore it is unsurprising that 11.6% of males also report hyperactivity as a difficulty they experience.

Table 18

Strengths and Difficulties – Females

	High	*% High Degree of Difficulty / Strength*	*Very High*	*% Very High Degree of Difficulty / Strength*
Emotional Problems	10	6.5%	35	23%
Conduct Problems	15	9.8%	7	4.6%
Hyperactivity	12	7.8%	15	9.8%
Peer Problems	18	11.8%	20	13.1%
Prosocial	12	7.8%	7	4.6%

Females report a high – very high degree of difficulty predominantly in the domains of emotional problems (29.5%) and peer problems (24.9%). The WHO (2019, p.1) reports that adolescents experiencing emotional disorders may have mood changes, emotional outbursts and 'emotion-related' physical symptoms including headaches and nausea, further stating that "depression is the fourth leading cause of illness and disability among adolescents aged 15-19 years". As to the greater prevalence of very high difficulties reported in female participants (23% versus 6.6% reported by male participants), this correlates with international research and prevalence rates. Childmind Institute (Steingard, 2019) suggest that prior to puberty boys and girls experience similar rates of mood disorders (3-5%), however by mid-adolescence females are twice as likely as males to be diagnosed, and in adulthood prevalence rises to 14-20% of females.

Of similar difficulty irrespective of gender were reported levels of hyperactivity, presenting a very high degree of difficulty for 8.8% of respondent males, and 9.8% of females, representing 31 of the 333 participants and an average prevalence of 9.4%. This is higher than that found in a 2015 systematic review of research into the epidemiology of ADHD in Arab countries (Alhraiwil, Househ, Al-Shehri & El-Metwally, 2015), which found the prevalence of hyperactivity type ADHD at 1.4-7.8%. The research also established that rates of ADHD decrease with age, suggesting that student self-reporting in this adolescent sample n333, may be influenced by the self-report versus parent or teacher rating scales. Potentially self-reporting may offer a more accurate reflection of

the experience of the adolescent as compared to observations of parent or teacher; however, it may also reflect an over sensitivity of the participants. Further examination of these factors would be advantageous.

Important to note are the responses which indicate significant differences in difficulties experienced by each gender. Looking at the two most reported 'very high' impact difficulties, 36% of males experience very high levels of conduct and/or hyperactivity problems, and 55% of females report experiencing very high levels of emotional and/or peer problems. The implications of this are significant for preventative social, emotional, and behavioral education interventions, suggesting that skill building for boys around self-regulation, and relational communication for girls, may have more of an impact than generic pastoral or wellbeing provision. Gender specific interventions are not commonly delivered, and yet the data arising from this tool suggests that the very high levels of impact and the very specific gender experiences warrant school initiatives to be more responsive, personalised, and gender specific.

In summary, adolescent participants report difficulties in a range of domains that have a direct impact on social, emotional, and academic functioning. The SDQ clearly establishes priority areas for interventions, namely conduct for males, emotional difficulties for females and experienced equally by gender, hyperactivity, peer, and interpersonal difficulties. Furthermore, it reinforces the importance of reviewing each presenting adolescent as likely experiencing more than one difficulty or disorder. Counsellors understanding rates of comorbidities, and connections between disorders, and accounting for that in evaluations of need will result in more holistic provision. This has the potential to have a greater likelihood of reducing the impact of the difficulty and preventing it from developing into more severe presentations.

5.2.1.2 Brief Multidimensional Students' Life Satisfaction Scale – PTPB version

The Brief Multidimensional Students' Life Satisfaction Scale – PTPB version **(**BMSLSS-PTPB) (Athay, Kelley & Dew-Reeves, 2012) is a measure of youth life satisfaction and explores overall life satisfaction, alongside domain specific responses, such as satisfaction with self, family life, friendships, where you live and school.

It is important to explore the view adolescents have of their own lived experience, their place and space in time and the stability of their connection to family, peers, school, and community. The BMSLSS-PTPB offers insight into adolescent perceptions and

experiences which inform the types of support that may be necessary across individual cohorts and domains of satisfaction (Table 19).

Table 19

Student's Life Satisfaction Scale - Very Satisfied

	Male	*Female*	*UAE National*	*Other GCC Arabs*	*Other Expatriate*	*Muslim*	*Other Religion*
Family Life	57%	48%	52%	37%	54%	55%	49%
Friendships	48%	48%	45%	50%	49%	48%	48%
School Experience	13%	16%	11%	12%	16%	15%	14%
Yourself	38%	19%	34%	25%	27%	32%	26%
Where you live	50%	38%	56%	50%	38%	53%	32%
Overall life	43%	30%	38%	37%	36%	41%	32%

On all except 1 measure (school experience) males report equal or higher satisfaction as compared to female peers. The lack of satisfaction and wellbeing experienced by females in this cohort requires the attention of counsellors, pastoral teams, and school leadership (Table 20). For so few to be experiencing a state of high life satisfaction may be indicative of deeper causes of dissatisfaction relating to educational opportunities, limitations due to gender or religion, or a lack of self-determination as an expatriate adolescent. Levels of satisfaction with school experience are notably lower than all other measures for all cohorts, ranging between 11-16% of students reporting high levels of satisfaction, with the lowest reported by UAE Nationals (11%) and GCC Arabs (12%). These factors require further exploration to establish what strategies could be employed to address these shortcomings.

Table 20

Student's Life Satisfaction Scale - Very Dissatisfied

	Male	*Female*	*UAE National*	*Other GCC Arabs*	*Other Expatriate*	*Muslim*	*Other Religion*
Family Life	6%	7.8%	9.4%	0%	5.7%	7.7%	5.7%
Friendships	6.6%	2.6%	6.8%	0%	3.8%	5.6%	5.7%
School Experience	12.7%	13.1%	20.6%	12.5%	8.6%	15.5%	9.2%
Yourself	7.7%	11.8%	12%	0%	8.6%	9.3%	10%
Where you live	8.2%	7.2%	5.1%	12.5%	7.1%	5.6%	10.7%
Overall life	5.5%	9.2%	7.7%	0%	7.1%	7.7%	6.4%

The highest rated level of dissatisfaction across all cohorts was with school experience, ranging from 8.6% for other expatriates, to 20.6% for UAE nationals, equalled only in the GCC Arabs cohort by dissatisfaction with where they live, both rated as 12.5%. When comparing Muslim students (5.7%) with those identifying with other religions (10.7%), the most notable difference in levels of dissatisfaction was where they live, suggesting that non-Muslim adolescent's experience of life in the UAE is not as they would ideally wish it to be. As all non-Muslim students would be expatriates, and therefore Third Culture Kids, it is perhaps not surprising to see less connection with where they live, however it may well be the inherent restrictions on adolescents living in a Muslim, Arab culture such as the UAE. Traditional and conservative values, and laws may be impacting on the adolescent perception of what life opportunities should be available for young adults and adolescents, and therefore happiness.

In summary, the contrast between very satisfied and very dissatisfied is most pronounced between genders, with 13% more boys very satisfied with overall life as compared to girls, and 3.7% more girls very dissatisfied compared to boys. The data indicates that this difference is particularly influenced by very low levels of satisfaction in friendships for girls (2.6%) compared to boys (6.6%) and low levels of satisfaction in themselves for girls (11.8%) almost double the amount of boys (7.7%). UAE Nationals' satisfaction in their experience of school is also noteworthy, with 20.6% very dissatisfied

(compared to 12.5% GCC and 8.6% other expats), from which one could extrapolate is connected to their dissatisfaction in family life 9.4% and where they live 5.1%.

When examined as a whole, of the 333 students 43 (12.9%) indicated they were very dissatisfied with school and 32 (9.6%) with themselves. Such levels of dissatisfaction require further investigation to establish if the apparent correlation between dissatisfaction with yourself and your school holds true. A contrary view may be that poor self-esteem coupled with perceptions of unfulfilling friendships has an impact on overall wellbeing and therefore the school experience.

Satisfaction with life overall was rated as 7.2% very dissatisfied which positions these students as very vulnerable to mental health difficulties, wellbeing concerns and are at risk of disengagement academically, socially, or emotionally. On the contrary, those adolescents reporting very high levels of overall life satisfaction are 37.5% of participants, suggesting these students experience stable and rewarding friendships, home and school life, and have a relatively positive view of themselves. They are likely to have developed the skills of self and emotional regulation, achieving a level of resilience to life's inevitable ups and downs. Utilising these students as peer mentors working alongside counsellors may offer some protective factor to those identified as more vulnerable within the school community.

The implications for provision of counselling services and preventative and proactive interventions is that schools need to recognise the importance of wellbeing and its connection to academic achievement, reinforcing the importance of addressing these difficulties within the educational setting as early as possible. School based pastoral programmes can be utilised to address underlying beliefs or experiences which lead to dissatisfaction and enhance student's sense of belonging and connectedness to school, at the same time as building self-esteem and resilience.

5.2.1.3 Health of the Nation Outcome Scales Child and Adolescent Mental Health

The Health of the Nation Outcome Scales Child and Adolescent (HoNOSCA) (Growers, Harrington, Whitton, Beevor, Lelliot & Wing, 1998) evaluates the functioning and health of young people experiencing mental health difficulties and measures social functioning, behaviour, impairment, and symptoms. The measure establishes the nature of the difficulty, how long the adolescent has experienced these difficulties and the degree of interference on education, leisure, social and family life.

Examining the HoNOSCA provides data on the prevalence and impact of a range of health and social functioning difficulties, and when correlated with the other administered screening tools, provides insight into areas of priority for mental health professionals to address with varying cohorts of students (Table 21).

Table 21 *HoNOSCA – Behaviour Problems Subscale*

	Non-significant	*Mild*	*Moderate*	*Severe*	*% Severe Problems*
Male	135	34	11	1	0.5%
Female	92	40	13	7	4.6%
UAE National	74	28	11	4	3.4%
Other GCC Arabs	5	3	0	0	0%
Other Expatriate	148	43	13	5	2.3%

Note: Scores are aggregated and include behaviours including disruptive/ aggressive/antisocial, overactivity/attention, self-harm and substance misuse.

The majority of respondents (68%) indicate that they experience behaviour problems to an insignificant amount, however 9.6% report moderate to severe difficulties with disruptive, aggressive, antisocial, self-harming, substance misuse or hyperactive behaviours. Concerningly 4.6% of females, compared to 0.5% of males identify with experiencing severe behavioural difficulties. While it is not possible to extrapolate from the HoNOSCA which specific aspect of behaviour difficulty is contributing to the high report rates of females, when considered alongside the frequency of student visits to the counsellor for self-harming, as reported by school counsellors (30% see students on a monthly basis and 22% on a weekly basis) it is likely that a significant number of females with severe difficulties are also those presenting due to behaviours such as self-harming to manage feelings of anxiety, depression or hopelessness.

UAE nationals (6%) and females (5.2%) report significantly higher levels of symptomatic problems, including emotional, somatic, and delusional symptoms, as compared to expatriates and males (Table 22).

Table 22

HoNOSCA – Symptomatic Problems Subscale

	Insignificant	*Mild*	*Moderate*	*Severe*	*% Severe Problems*
Male	150	24	6	5	2.7%
Female	109	25	10	8	5.2%
UAE National	84	19	6	7	6.0%
Other GCC Arabs	6	1	1	0	0%
Other Expatriate	169	25	9	6	2.8%

Note: Scores are aggregated and include behaviours including hallucinations, delusions, non-organic somatic symptoms, and emotional/related symptoms.

Females report severe social problems compared to males at a ratio of 5:1, however the representation is more equally spread when reporting moderate social problems (8% of females and 6% of males) as illustrated in Table 23.

Table 23

HoNOSCA – Social Problems Subscale

	Insignificant	*Mild*	*Moderate*	*Severe*	*% Severe Problems*
Male	143	29	8	1	0.5%
Female	106	32	9	5	3.2%
UAE National	82	25	7	2	1.7%
Other GCC Arabs	6	1	1	0	0%
Other Expatriate	161	35	9	4	1.9%

Note: Scores are aggregated and include behaviours including peer relationships, self-care/independence, family life/relationships and poor school attendance.

There is a strong basis of social wellness that school-based programmes can be built upon, with 70% of UAE Nationals and 77% of expatriates reporting insignificant difficulties in social engagement, relationships, and self-care. This can inform the nature of social interventions delivered by school counselling teams, utilising those

demonstrating a sense of wellbeing to create an environment supportive of those who are not.

Examining the self-reported experience of difficulties, females indicate severe impairment more frequently than males, at a ratio of close to 2:1. In addition 41% of females indicate they experience some degree of impairment, from mild to severe, which impacts academic performance and engagement (Table 24).

Table 24

HONOSCA – Impairment Subscale

	Insignificant	*Mild*	*Moderate*	*Severe*	*% Severe Problems*
Male	131	34	12	4	2.2%
Female	88	46	10	7	4.6%
UAE National	70	32	9	5	4.3%
Other GCC Arabs	7	1	0	0	0%
Other Expatriate	142	47	14	6	2.8%

Note: Scores are aggregated and include behaviours including scholastic/language skills and physical disability.

Despite high rates of dissatisfaction with school experience as measured by the Life Satisfaction Scale, (20.6% UAE national, 12.5% GCC and 8.6% other expatriates), it is positive to note that 60% of UAE Nationals and 68% of expatriates report insignificant impairment arising from academic, communication or physical disabilities. Taking a strength-based approach to addressing impairments which impact school performance and engagement, offers counsellors a viable way to increase school satisfaction by addressing the barriers which result in an impairment.

In summary, on all measures of the HoNOSCA, females report experiencing the most severe problems in the highest frequency. This is in stark contrast to the number of males reporting severe problems as illustrated in Table 25.

Table 25

HoNOSCA – % Participants Reporting Severe Problems

	Impairment	*Social Problems*	*Symptomatic Problems*	*Behaviour Problems*
Male	2.6%	0.5%	2.7%	0.5%
Female	4.6%	3.2%	5.2%	4.6%

The data collected from participants reinforces the need to look at the experience of individual cohorts of our school communities, considering the unique experience and needs of students in relation to their gender, religion, nationality, cultural alignment, and residency status. Gender emerges as a challenge and opportunity across all other defining cohorts.

5.2.1.4 Beliefs about Psychological Services

The Beliefs about Psychological Services (BAPS) (Ægisdóttir & Gerstein, 2009) measures positive and negative attitudes towards psychologists and accessing psychological support, and measures domains of intent, stigma tolerance and expertness. Acknowledging the influence factors such as stigma and perceptions of psychological workers have on inclinations towards help-seeking is important in schools, and essential when offering therapeutical support within educational settings. Frequently counsellors apply Eurocentric therapeutical approaches without due consideration of the social context adolescents find themselves and the often profound or overwhelming influences of their personal belief systems and those of their families and communities when accessing support.

The intent subscale requires responses to six items that establish an individual's willingness and intention to seek help, as seen in Table 26.

Table 26

Beliefs about Psychological Services - Intent

	% Very Positive Beliefs	*Very Positive*	*Positive*	*Somewhat Negative*	*Very Negative*	*% Very Negative Beliefs*
Male	5.5%	10	68	83	20	11%
Female	3.2%	5	68	61	9	5.9%
UAE National	4.3%	5	49	46	16	13.7%
Other GCC Arabs	0%	0	3	5	0	0%
Other Expatriate	4.7%	10	93	93	13	6.2%
Muslim	3.1%	6	80	87	20	10.3%
Other Religion	6.4%	9	65	57	7	5%

Note: Scores for items relating to intent are totalled and include questions such as I would recommend a friend see a counsellor, I would be willing to confide to a counsellor, seeing a counsellor is helpful, and counsellors can help you find solutions to problems.

Participant responses to the questionnaire confirm counsellor qualitative feedback relating to beliefs about the value and appropriateness of accessing psychological services for mental health difficulties, highlighted by 13.7% of UAE national respondents indicating very negative beliefs, in parallel with 10.3% of Muslims reporting very negative beliefs. When examining gender differences, a higher percentage of male's report very negative responses as compared to females, but also higher very positive beliefs, suggesting that the majority of females do not feel as strongly, either positive or negative about accessing psychological services.

Table 27 illustrates the stigma tolerance subscale findings, which asks participants to respond to eight items that reflect the presence of negative views and barriers they may experience towards help-seeking.

Table 27

Beliefs about Psychological Services – Stigma Tolerance

	% Very Positive Beliefs	*Very Positive*	*Positive*	*Somewhat Negative*	*Very Negative*	*% Very Negative Beliefs*
Male	18%	33	105	41	2	1.1%
Female	14%	22	119	20	1	0.6%
UAE National	17%	20	74	20	2	1.7%
Other GCC Arabs	0%	0	7	1	0	0%
Other Expatriate	16%	35	133	40	1	0.4%
Muslim	16%	31	124	36	2	1.7%
Other Religion	17%	24	90	26	1	0.7%

Note: Scores for items relating to stigma tolerance are totalled and include the questions: if I were having a problem my first inclination would be to see a counsellor, counsellors are good to talk to as they don't blame you for your mistakes, I would see a counsellor if I were worried for a long period of time, everything you say is confidential, and if I thought I needed psychological help I would get help no matter who knew I was receiving assistance.

Pleasingly, negative beliefs relating to the stigma of mental health services and accessing support are less strongly expressed by all cohorts, than were in the intent subscale. 76% males and 87% of females report positive to very positive beliefs towards seeking help from psychological services. While only 1.7% of participants express very negative beliefs, when coupled with the 18% of adolescents who identify as having somewhat negative beliefs, the data suggests that approximately 20% of all student participants may experience a barrier to help-seeking arising from concerns around stigma.

The expertness subscale requires responses to four items that measure an individual's perception of psychologist's expertise and the value of psychological services (see Table 28).

Table 28

Beliefs about Psychological Services - Expertness

	% Very Positive Beliefs	*Very Positive*	*Somewhat Positive*	*Somewhat Negative*	*Very Negative*	*% Very Negative Beliefs*
Male	9.9%	18	72	62	29	16%
Female	12.5%	19	69	53	11	7.2%
UAE National	10.3%	12	40	45	47	40%
Other GCC Arabs	12.5%	1	5	2	0	0%
Other Expatriate	11.4%	24	96	68	21	10%
Muslim	9.3%	18	79	70	26	13.4%
Other Religion	13.5%	19	62	35	14	10%

Note: Scores for items relating to expertness are totalled and include questions such as: it is difficult to talk about personal issues with people like counsellors, talking with a counsellor is a poor way to get rid of emotional conflicts, having received help from a counsellor stigmatises a person's life and going to a counsellor means I am a weak person.

The data is interesting because it highlights in certain cohorts a mistrust of the expertness or level of skill / impact that a counsellor offers. 13% of Muslims, 40% of UAE Nationals and 23% of all adolescents indicate very negative views and trust in the skills and qualifications of counsellors and mental health providers. This data suggests that counsellors need to target UAE Nationals and integrate into communications within their school community, explanation of their credentials, areas of specialism and those areas beyond their role and expertise.

Ultimately the beliefs about psychological services suggest an even spread between adolescent willingness to seek help, with 48% expressing positive inclinations versus 51.9% negative. UAE Nationals were the cohort with the highest very negative attitude, with 13.7% indicating they would be unwilling to access psychological services. When examining some of the reason's adolescents would hesitate to seek help from a counsellor, 20% indicated that stigma towards mental health and seeing a mental health professional was a barrier to help-seeking. An additional barrier is the perception of the expertness of counsellors and levels of skill or knowledge that equip them to advise,

guide or support adolescents. 23% of adolescents reported very negative views towards the expertise of counsellors and questions their qualification to advise on matters of metal health.

In summary, following the analysis of the screening tools, The Strengths and Difficulties Questionnaire (Goodman, Meltzer & Bailey, 1988), Brief Multidimensional Students' Life Satisfaction Scale – PTPB version (Athay, Kelley & Dew-Reeves, 2012), Health of the Nation Outcome Scales Child and Adolescent (Growers, Harrington, Whitton, Beevor, Lelliot & Wing, 1998) and Beliefs about Psychological Services (Ægisdóttir & Gerstein, 2009) themes have emerged which provide some insight into the difficulties faced by adolescents, the impact of these challenges and what impediments to help-seeking persist.

Data suggests that our Emirati students require education and support in understanding the role of the counsellor, and what qualifications they have in guiding young people in educational settings. UAE Nationals adolescents report less severe overall difficulties, 12.9% compared to 15.9% of expatriates, however 13% report very high levels of difficulties in areas of emotional regulation and 10.3% with severe hyperactivity (SDQ). High levels of overall life satisfaction vary only marginally between Emiratis (38%) and expatriates (36%), however UAE Nationals are very dissatisfied with their school experience at a much higher rate, 20.6% compared to 8.6% in expatriates (BMSLSS-PTPB). Severe symptomatic problems are reported for 6% of UAE Nationals compared to 2.8% of expatriates (HoNOS-CA) and have more negative views about the expertness of psychological services 40% (compared to 10% of expats), are very negative towards stigma 1.7% (compared to 0.4% for expatriates) and 13.7% have very negative views and are unlikely to access services, compared to 6.2 % of expatriate adolescent participants (BAPS). Understanding the views of Emirati adolescents towards mental health and help seeking emerge with clarity in the qualitative data, and help to explain the notable cultural distinctions in the quantitative data.

5.2.2 Qualitative Survey Data

Alongside administration of the questionnaires, adolescent participants were asked a series of open-ended questions to provide the opportunity for them to share their experiences and beliefs around accessing counselling services, in their own words. These were coded and explored thematically and help explain the data provided in the self-

report screening tools. They provide insightful commentary on personal, familial, and cultural beliefs, fears, and impediments to accessing mental health services in schools.

The question was posed to the adolescent participants, what could be done to make it easier for them to seek help from a counsellor? Responses fell into 5 general themes as detailed in Table 29.

Table 29

Emerging Themes – Removing Impediments to Help-seeking

	Number of respondents
Encouragement from parents, and support from family and friends	20
Having a relationship with the counsellor outside of direct counselling	20
Availability and access to advice with anonymity or without others knowing	19
Confidentiality, trust, and the quality of advice given by the counsellor	12
Education for self or others about what counselling offers and reducing stigma	3

Respondents conveyed that it would be easier for them to seek help from if they felt they had a pre-existing relationship with the counsellor that enabled them to develop trust and confidence in their guidance, as well as familiarity with them personally to ensure they would feel safe and comfortable sharing their difficulties. Effective counsellors address this by ensuring they are visible, accessible, and very much part of the wider school community. Supporting school initiatives such as sport days, whole school productions, completing lunch and break supervision duties, participating in trips and visits are all effective strategies in building relationships and familiarity between counsellor and students. Counsellors are aware of the impact that building trusting relationships outside of the counselling setting has on inclinations to seek help when needed.

> To promote counselling services, it is important being seen and participating in school wide events and themes, so students know I am accessible and open. I speak to year assemblies, spend time with students during lunch and interact in the Post 16 area. I have an open-door policy and am visible by engaging in wellbeing projects (Counsellor 14).

Another theme related to the adolescent's perception that the encouragement and support of parents, family and friends would make seeking help easier, and act as catalyst for help-seeking, as stated by one student, "I might talk to my mom beforehand to check if I really do need to go to a counsellor" (Adolescent #272).

Some students express the preference to have company when reaching out for help in the first instance, as explained by one participant, "I like to deal with problems with people who are closer to me like friends or my parents" (Adolescent #117). This sentiment is echoed by adolescent #21, when asked if they would see a counsellor for help, who simply states "Is the counsellor my dad? Then no!". Counsellors too demonstrate an understanding of the preference for gaining help supported by a peer, as also seen in the data, with one third of respondents indicating they would be more inclined to see a counsellor if a friend came with them.

> The preference among many young people is to seek assistance from family in the first instance, which aligns to the Arab cultural belief that psychological difficulties should and may be the result of a lack of faith or family support (Counsellor TP).

Adolescents provided a range of responses which probed for the impediments experienced when needing or seeking help, summarised by themes in Table 30.

Table 30

Emerging Themes – Impediments to Help-seeking

	Number of respondents
Privacy, confidentiality, and trust	49
Perception of others when you seek help, personal beliefs, and stigma	37
Counselling not needed, belief the individual can fix their own problems	28
External impediments and justifications such as no time	23
Counsellor beliefs, attitudes, and quality of service	20

A significant number of respondents expressed concerns, and a lack of trust in the counsellor's capacity to maintain confidentiality and privacy of content discussed in

sessions. Some participants shared impediments including a belief system which maintains that there are certain things that should not be told to a stranger, while others expressed concern that they may regret telling a counsellor something personal.

> Because people might know. I'm the one always encouraging my friends to see a counsellor when things do go bad and they need to talk because they're scared to admit because they're just scared in general that you are giving private information to a stranger (Adolescent #321).
>
> I may feel that having my secrets with a stranger like a counsellor is not safe, they like to get authorities involved (Adolescent #267).
>
> I'm too scared of people when they look into my eyes, directly to my soul as if they were some devil (Adolescent #143).

Adolescents expressed scepticism about the skills and motivations of counsellors, and their capacity to be culturally sensitive and unbiased.

> Counsellors still have human behaviours even though they have knowledge about human behaviours. Counsellors think more about the money they receive than human emotions because they are human and have greed in them. Counsellors might not have an open mind and understanding due to their own beliefs (Adolescent #8).
>
> It's hard for me to tell someone about what I'm going through, and I feel they don't need to know anything about me. I also feel like counsellors can help but to a certain extent, they don't know or can't relate to what you are going through (Adolescent #110).

Within the qualitative data set, adolescent participants shared a range of fears relating to confidentiality and trust, and the potential that their family or peers would find out what had been discussed. These concerns are underpinned by deeper questions around the skills of a counsellor to provide support that culturally would usually be provided by family. These beliefs frequently act as impediments to help seeking. The perception that they would experience stigma and judgement for having difficulties managing their emotions, social interactions, behaviours, let alone reaching out beyond the family is ever present, particularly within the Gulf Arabs and Emiratis. There is an interplay between Islamic beliefs and Arab culture in the United Arab Emirates, and the qualitative data gathered also highlights that not all individuals and families within the

Arab culture, or who identify as Muslim subscribe to the same beliefs, nor experience impediments solely along cultural and religious lines.

Adolescents express a balanced view and acknowledge the potential benefits of counselling.

> People should understand the risk there is to talk about intimate stuff with other humans, but I would recommend it if it wouldn't physically and mentally affect them in a bad way and it would take things off their chest (Adolescent #8).

Several respondents shared that an impediment to seeking help was their lack of conviction that the counsellor would act in a supportive way and elicit some positive change to address the challenges the student was experiencing. This belief was most common when the adolescent or a peer had reported a negative outcome following engagement with school counselling services.

> I would not seek help because I feel it's a waste of time as they fail to properly address my issues, some problems peers have faced in schools as well (Adolescent #299).
>
> Past experiences and the unnecessary stress that it would put on others is the reasons I may not seek help from a counsellor. It's simply is not worth it in my experience (Adolescent #41).

Similarly, other adolescents' express fears that speaking to a counsellor will result in some action and then potential retribution or negative impacts. This is particularly notable when it relates directly to difficulties or conflicts, they may be experiencing with other teaching staff or aspects of education that are causing stress within their school setting.

> When a teacher is doing something wrong or treating me unjustly, I feel like I have no one to talk to because that teacher might hate me after I complain about him/her. Sometimes I feel like a teacher can't teach properly, and the other students agree with me. I try my best and do all that I can to achieve the highest grades in my subjects, and when the teacher is the one who is causing my grades to slip, I get scared even though the students agree with me (but) they are too scared to tell their parents and complain, so if I am the only person who complains I will look like the one who is lying, then I can't do anything about the fact that my grades are slipping (Adolescent # 49).

What appears to be absent from the adolescent responses when describing reasons they would not seek help, is an understanding of how a counsellor can help them maintain mental health and wellbeing, and the potential for long-term impact on emotional and social wellbeing and academic outcomes should they not seek help. Many express feeling fear and vulnerability in disclosing difficulties, and the risk of not being understood.

> I may not seek help from a counsellor because of the stigma that goes along with it - it's a scary step to first meet with them because they don't know you, so you just put it off (Adolescent #313).
>
> I would not be likely to speak to a counsellor if I personally know I cannot trust them or if they won't understand me because of cultural differences (Adolescent #173).
>
> The illusion that you are an honest and happy person is broken once people know (Adolescent #56).
>
> No, I don't want it. Don't need it no matter how unhappy I am. Don't want to bother anyone else and I don't want to talk to a counsellor (Adolescent #174).

There were a range of suggestions provided by students that they believe would make it easier for students to reach out for assistance. These directly address identified impediments and focus on improving information given about the counsellor and counselling, reducing stigma and initiating more open conversations around emotions and wellbeing.

> Personally, I think schools should show their students that people don't have to go through difficulties alone and that they are in safe hands and won't be judged and feel ashamed of their problems (Adolescent #144).
>
> You need to work on eliminating the stigma – that getting help isn't because you can't deal with it yourself, but rather let us know what they (counsellors) actually do and what a session looks like (Adolescent #313).

Adolescents were articulate in their expression of experience, and it is important that educational leaders recognise the underlying risk to long-term mental health of their students should they not access mental health specialists. School counsellors provide an effective triage and referral route for those presenting with emerging mental illnesses, in addition to individual and group therapeutical interventions. Schools should prioritise,

through their pastoral teams and structures, wellbeing and mental health education and initiatives, and as suggested by one student, “people should ask how a person is more often” (Adolescent #221). Promoting a school culture of self-care, self-awareness and wellbeing would ensure that students recognise the value and importance of mental health while being conducive to help seeking.

5.3 Discussion

Quantitative and qualitative data collected through the administration of the screening tools and the survey provides a detailed picture of the nature of mental health difficulties experienced by adolescents in Abu Dhabi. It provides insight into the factors within self, home, culture, community, and school environment which act as impediments to seeking help.

When compared to research conducted on other populations within the UAE, particularly those with adult participants, the impact of not delivering interventions and facilitating access to mental health care and the development of self-care strategies is evident. For example, in research by Mahmoud and Saravanan (2020) which was undertaken in the northern emirate of Sharjah, the third largest emirate by both size and population, 1.7 million people in 2020 (World Population Review, 2020). Key findings of their adult research compared to that of the adolescent study are presented below in Table 31.

Where the current research utilised screening tools in an educational setting in the Emirate of Abu Dhabi, and the Mahmoud and Saravanan research used a cross-sectional survey in Sharjah, comparing prevalence data provides a basis for projecting long-term outcomes and impact, and the generalisability of the current data set. The Sharjah study found anxiety and depression with higher prevalence rates than other disorders (Mahmoud & Saravanan, 2020), which correlates with the adolescent self-report screening tools, with highest prevalence being emotional disorders, which is inclusive of anxiety and depression, followed by conduct disorders. Of note was the finding that adults seeking support for mental health difficulties were more inclined to access formal mental health services as opposed to traditional healers or non-formal services. This suggests that increasing adult or parental support for students experiencing difficult may ensue, which would be supported by educating adolescents on the symptoms of mental health difficulties and when to seek help.

Table 31

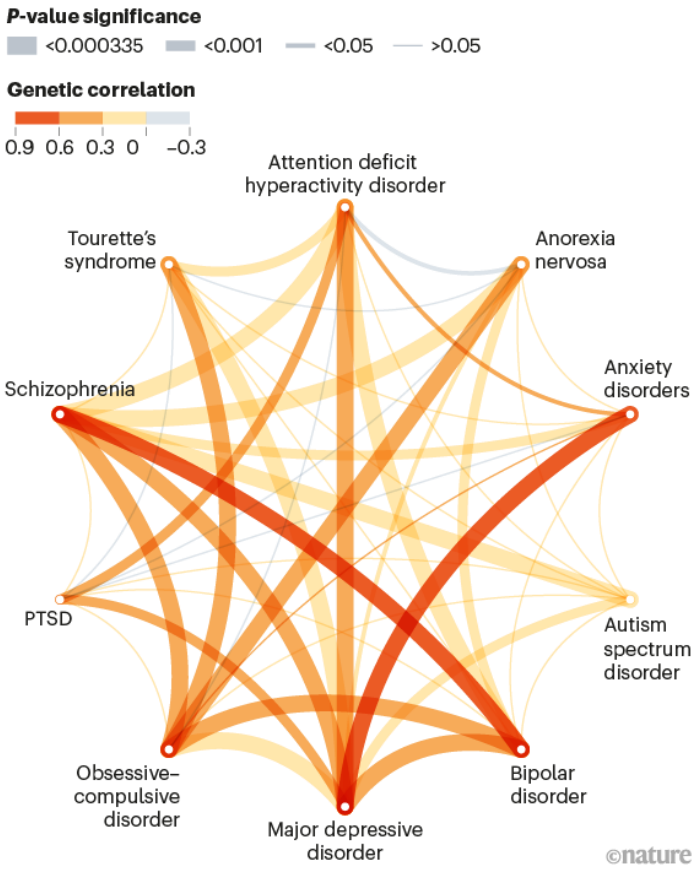
Comparison between Prevalence Data and Help-Seeking Research

	Mahmoud & Saravanan 2020 Sharjah - Adults	*Current research study Abu Dhabi - Adolescents*
Mental Health Disorders *Presenting/reporting Mental Health disorder*	57.2%	41% report very high difficulties on SDQ (emotional, conduct, peer, hyperactivity)
Prevalence *Ratio of Male:Female*	1:1.2 Mental Health Disorder	1:7 report severe behaviour 1:1.6 report severe symptoms (NoNOSCA)
Most prevalent disorders *Adults: presenting Adolescents: reporting high–very high in SDQ*	Anxiety 56.4% Depression 31.5% Post-Traumatic Stress 15.1% Phobic Disorder 10.8%	Emotional Disorder 22%(SDQ) Peer Difficulties 20% (SDQ) Conduct Disorder 16.5%(SDQ) Hyperactivity 15% (SDQ)
Help Seeking *% Seeking help (adults) % Intent to seek help (adolescents)*	80% sought help 57.7% from health professional 42.3% non-health prof.	45% positive – very positive intent to seek help (BAPS)
Perception of Services *% Satisfaction (adults) % Belief in Expertness (adolescents)*	66.2% satisfied with health professional 42.3% satisfaction with non-health professional	13% of Muslims, 40% of UAE Nationals, 23% of all adolescents very negative views / low trust in psychological services (BAPS)

The participant data also indicates the presence of comorbidity, the experience of one or more mental health or medical condition/s presenting at the same time, often to varying degrees of intensity and impact. The mental map illustrated in figure 2, represents a study of 200,000 people diagnosed with a mental health condition, and found the significant majority also experienced secondary and even tertiary associated

and comorbid conditions, for example schizophrenia was significantly correlated with many other disorders, and in contrast Autism Spectrum was mainly correlated primarily with two other conditions, depression and schizophrenia. Given comorbidity findings, it is important to consider that students presenting with one mental health need, may indeed experience multiple disorders or difficulties, each requiring an individual yet holistic response to restore wellbeing. Furthermore, correlations between mental health presentations, special educational needs, behavioural disorders, and difficulties as well as physical manifestations are evident within the data collected from the adolescent participants.

Figure 2 Mental Map



Crespo Facorro, 2018 (as published in Nature Magazine May, 2020).

Considering comorbidity rates as previously described, it is essential that collaboration between pastoral teams, school-based nursing services and school counsellors be established in a structured and holistic manner. To provide early intervention and support for mental health and wellbeing needs, it is essential vulnerable

or at-risk adolescents are identified and support planning be in place as holistically as possible. In this manner improved outcomes will be more readily achieved.

The data highlighted also that 17% of participants report experiencing 'a lot of headaches, stomach aches or sickness', and a further 31% expressing this was somewhat true for them. To the question, 'have you suffered from self-induced vomiting, head/stomach ached with no physical cause', 17.1% of adolescents report a mild but definitely, to a severe impact. While not all illness can be attributed to mental health, it is important that counsellors, when working with Arab cultures, be aware of somatisation. This is a common phenomenon, particularly prevalent within communities where high stigma is associated with mental disorders (El-Rufaie, Abuzeid, Bener & Al-Sabosy, 1999). Research by Bener, Ghuloum & Burghut defined somatisation as "an expression of personal and social distress in the form of bodily complaints" and sought to establish gender differences in the prevalence in Arab cultures (2010, p.1). The researchers surveyed adults presenting at primary care facilities, with no medical evidence for the symptoms reported, and found no significant difference in gender. Somatoform disorders were evident in 24.2% of women and 23.7% of men surveyed, however did establish differences in the nature of the presentation, with backaches most reported by males and headaches by females.

Gender also emerges with notable differences in prevalence, presentation, and inclination to seek help. The data suggests that female adolescents report experiencing severe problems (social, behaviour and symptomatic combined) at rate of 13% compared to 3.7% of males, with 4.6% of females reporting severe behaviour difficulties compared to 0.5% of males (HoNOS-CA). 29.5% of females report very high emotional problems compared to 6.6% males (SDQ), 9.2% of females are very dissatisfied with life compared to 5.5% males (BMSLSS-PTBS), and while females do have a greater belief in the expertness of psychological services (12.5% compared to males at 9.9%), they are less inclined to actually access support, 3.2% females compared to 5.5% males (BAPS).

It is important that school counsellors are mindful of the different incident rates of each gender, and the variation in presentation of mental health distress. Similar themes were explored in 2016 by the UK's National Children's Bureau. They conducted a review of research into gender differences in children and adolescents' mental health and associated trends in help-seeking, identifying the following key points.

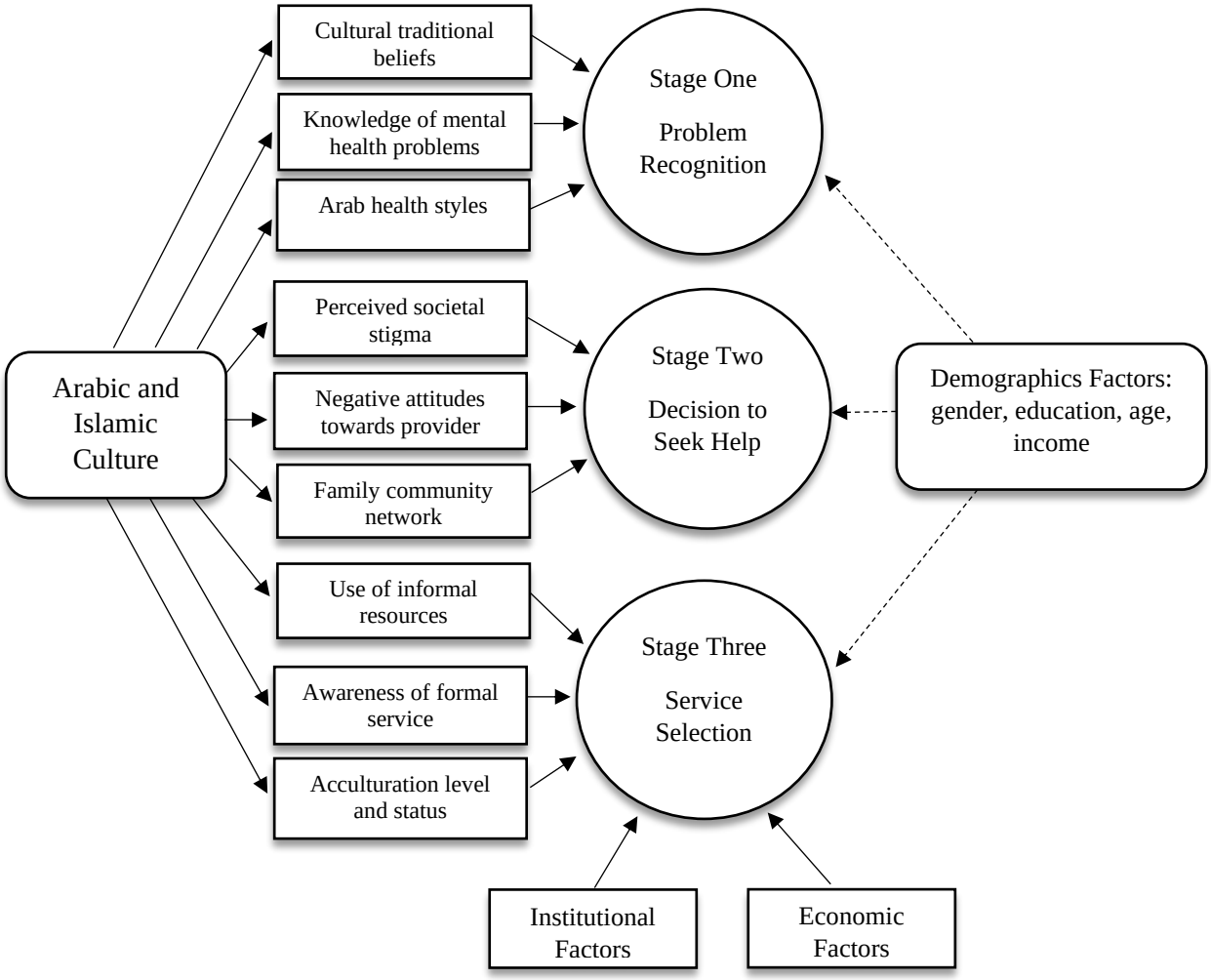
- Girls and young women seek help for emotional and mental health problems more readily than boys and young men; this is facilitated by awareness and understanding about mental health, and emotional competence.
- Concealing information relevant to emotional and mental well-being has negative impacts for young people, and gender is relevant to what young people may keep secret, e.g. risk-taking or gender identity.
- Stigma relating to mental health issues affects young people in general, but young males are among the groups most susceptible to stigma. This has been linked to gender roles.
- Young people consistently prefer to seek help from friends, family, and other informal sources than from professionals. In adolescence, girls begin to seek help from friends and services more, whilst boys remain more dependent on family.
- Gender differences have been observed in what young people seek support for and their preferred sources of support.

Hamblin (2016, p.7)

As has been established in this research, gender differences in help-seeking prevail in the international, expatriate and Arab setting of the UAE, and due consideration is necessary in the formation of intervention programmes and the process by which vulnerable students are identified and referred to specialist services.

In addition to maintaining an awareness of somatisation, comorbidities, and gender differences, it is important to understand the cultural and religious influences that impact help-seeking trends and inclinations. Figure 3 summarises the process by which individuals approach mental health services, interconnected with cultural, and demographic factors. Students will benefit if counsellors can move beyond the simplistic view that a cultural, family or community barrier exists and identify specifically where an adolescent has stalled on their path to seeking help. In doing so counsellors have an opportunity to address that barrier and support a young person to reconcile these internal and societal challenges to access services that are needed to maintain or establish wellbeing and mental health.

Figure 3 Help Seeking Pathways



A model of mental health help-seeking pathways and modifying factors among Arab Muslim populations (Aloud & Rathur, 2009, p.87).

CHAPTER 6: GENERAL DICSUSSION

The implications for young people of poorly managed mental health across emotional, social, and academic domains is well documented (Lundy, Silva, Kaemingk, Goodwin & Quan, 2010; Owens, Stevenson, Hadwin & Norgate, 2012). It is therefore, of the greatest importance to ensure timely and accurate diagnosis of mental illnesses, followed by the provision of appropriate support to achieve positive outcomes, alongside more preventative measures such as promoting wellbeing and self-care. Acknowledging the efforts of regional researchers to establish morbidity in the UAE, the exploration of literature and research (published in English language) clearly indicates a lack of explicit data on adolescent populations, and the absence of student voice in the published research. Although establishing adult trends and prevalence in young children can be predictive to a certain extent, ultimately it is essential to explore cohort specific information, and where possible gather both quantitative data on prevalence contextualized by the shared lived experience, beliefs and attitudes of the adolescent cohort. This research has highlighted the prevalence of need across an adolescent population and offers qualitative and quantitative findings which are likely representative of attitudinal and prevalence trends in other international schools in the UAE.

Adolescent perceptions of seeking help within educational settings have been explored in this research, highlighting personal or familial beliefs, cultural and contextual factors which may impede the timely provision of services to students. This insight into the attitudes, experiences and needs of students has the potential to guide how counsellors and schools respond in meeting intervention and therapeutic requirements. Levels of satisfaction with life experienced by adolescents, has been linked to achievement and academic performance (Antaramian & Lee, 2017), highlighting that schools and educational settings should be proactive in raising life satisfaction to enhance academic outcomes. To achieve this, they must embrace their responsibility to promote wellbeing and mental health, which are inextricably linked to life satisfaction, and in doing so improve long-term social and emotional outcomes, to ensure young people's academic potential is realized.

6.1 Main Findings

This mixed method research has collated and analysed quantitative data from adolescent and counsellor participants that confirms adolescents experience mental health

needs at prevalence rates akin to those experienced by adolescents in international settings. In addition, both adolescents and counsellors report similar impediments to help seeking and challenges engaging with specialist mental health services.

Qualitative data provided important insight into the attitudes and beliefs of adolescents and their families, particularly in relation to mental health and wellbeing, help-seeking and confidentiality, in addition to the belief that family is the first and most important support and guidance resource for young people. Counsellor feedback raises the challenges they experience in delivering intervention and therapy due to legal and legislative barriers, affordability and accessibility to external services and community education and understanding of the role of mental health in achieving academic, behavioural, social, and emotional success.

6.1.1 Main Findings: Study 1 Counsellors

23 Counsellors from the Abu Dhabi Counsellors Network volunteered to participate in an anonymous survey to gather quantitative data and qualitative responses, address in topics including the prevalence and degree of impact on adolescents of presenting mental health needs, impediments to help seeking and accepting referrals to external services, and the challenges and opportunities for counselling and therapeutical provision in educational settings offers. Main findings are summarised below.

Counsellors report that the highest areas of need fall into three main categories:

- Intrapersonal: Adolescents present with disorders and difficulties relating to body image, self-esteem, and sexuality.
- Interpersonal: Difficulties managing friendships and family interactions, communication, the internet, social media, and peer interactions leading to addictive or risk-taking behaviours.
- Educational: Adolescents reach out for support and strategies to manage test anxiety, revision, time management, parental expectations, transitions to tertiary settings.

In addition to these broad areas of difficulty, adolescents present with specific mental health disorders. 78% of counsellors report students presenting with anxiety on a weekly basis, and 43% with depression. On a monthly basis 13% have a student seek counselling for eating disorders, 17% for substance misuse, and 21% for suicidal ideation. From a safeguarding and child protection standpoint, on a monthly basis 17% of counsellors have a student experience or disclose sexual abuse, 34% self-harm, 35%

physical abuse and 43% neglect, cases which are reported by the counsellor to the school Child Protection Officer or Designated Safeguarding Lead.

There are similarities in the perceived impediments to help seeking as reported by counsellors, between students and parents. Counsellors consider stigma to be an influence on 47% or parents and 43% of students, a preference to maintain privacy impacts 56% of parents and 39% of students while a belief that the counselling or support is not needed is reported as an impediment impacting 61% of parents and 56% of students. Counsellor #9 expressed that building relationship is necessary to ameliorate some impediments, sharing that "once the student and the parents develop trust it is easier for the counsellor to convince parents and the students to seek help. The relevance of these similarities across the parental and student cohort is that it suggests community education directed at both student and parent cohorts could have a significant impact and offer a protective factor for the well-being of these adolescents.

Summarising impediments, in order of impact, 39% of counsellors reported culture, 30% gender, 29% religion and 21% age as having a moderate to severe influence on inclination to seek help or disclose a mental health need. Pleasingly, despite 61% of counsellors reporting families do not believe there is a need for mental health intervention or external services for their child, 43% of counsellors report that families follow up on referrals. However, it is a concern that only 22% of counsellors report that the external service makes contact with the counsellors often/always, which means that school-based counsellors are not integrated into a holistic or multidisciplinary approach to support and provision for the adolescent. It is necessary given this level of siloed provision, that counsellors engage with and reach out to external services, building relationships as described by counsellor #24 who shares that to achieve this it, "has required a lot of work from my end before the referral to clearly communicate to the external agency exactly what the referral is for and what the student needs".

Despite the challenges and impediments experienced by counsellors, including those imposed by educational regulators and the legal system, they continue to support young people presenting with mental illness and sensitive issues, such as sexual contact outside of marriage, gender identity and homosexuality, suicidal ideation and alcohol use by Muslims or anyone under the age of 21 years, by maintaining a sensitivity to culture and faith, while providing guidance and support that maintains safety and well-being. By raising awareness, addressing stigma, assuring confidentiality, and delivering broad

scale education initiatives such as promoting World Mental health week, counsellors maximise their influence and impact across the school, wherever possible seeking to take a proactive and preventative approach.

In addition to impediments to help-seeking experienced and expressed by the families and adolescents, counsellors too experience challenges to delivering accessible and impactful services. Counsellors shared ways that they felt could better support them to fulfil their roles and responsibilities and included:

- Defining the School Counsellor
  "identify(ing) the school Counselor role amongst other jobs such as social worker, psychologist, mental health counsellor, (and) change that concept at ADEK, (that) all of these specialists (are) the same as social specialist (counsellor #5)".
- Increasing Staffing
  "more staffing, currently there is 1 counsellor for about 1000 students (counsellor #26)".
- Professional Development
  "from reputable trainers that provide best practice for interventions ranging from self-harm, suicide prevention, and clinical practice (counsellor #24)".
- Confidentiality
  "School's supporting the role and adhering to the confidentiality policy and privacy of each student (counsellor #14)".

6.1.2 Main Findings: Study 2 Adolescents

Adolescent qualitative and quantitative data provides important insight into the experience of our students aged 15 years and above, with 333 eligible participants, one third of which are UAE nationals and the remainder expatriate TKC's, contributing to the key findings as summarised below. Adolescents reflected upon their beliefs and attitudes towards psychological services and counsellors, considered the nature and degree of difficulties they experience in social, emotional, and behavioural domains, and shared their levels of satisfaction with themselves, their school, family, friendships and life overall. Collated, the qualitative and quantitative data provides the adolescent perspective, giving voice to their experience, values, and attitudes, making suggestions as to how counselling services could be more accessible and responsive to their needs.

Analysis of the SDQ data representing difficulties indicates trends based on gender, nationality and presenting needs. Males report the lowest high to very high difficulties rate of 6.6%, as compared to females who report 23%. Males experience the most difficulties in the area of conduct (17%) and peer interactions (16%) as compared to females of whom 29.5% report emotional problems and 24% difficulties with peer interactions. UAE Nationals experience high to very high emotional difficulties and conduct difficulties, both reported by 22% of UAE National adolescents. However, when comparing overall difficulties expatriates fare worse, with 15% as compared to 7.5% UAE Nationals expressing high to very high difficulty. Interestingly 9.8% of females as compared to 8.8% of males report very high difficulty due to hyperactivity, although this statistic may require further exploration as this may be skewed based on how males versus females estimate what constitutes high to very high impact.

The HoNOSCA revealed that just under 10% of all adolescents surveyed (9.6%) report experiencing severe disruptive, aggressive, antisocial, self-harming, substance misuse and hyperactive behaviours. When exploring gender trends, 4.6% of females as compared to 0.5% of males report experiencing severe behaviour disorders, which may reflect rates of self-harming, with 30% of counsellors reporting monthly or more adolescent presentation for self-harm. 6% of UAE nationals report severe symptomatic difficulties, which includes the presence of somatisation, an unsurprising figure given that experiencing physical pain as a result of psychological distress is reported in research as more prevalent in Arab cultures.

When collated, some degree of impairment (mild-severe) across combined domains is experienced by 41% of females and 27% of males, further highlighting the need to reflect on gender-based provision to ensure it responds to the unique needs of each group. Most telling is that based on HoNOSCA data, the highest frequency and most severe problems are experienced by females, as illustrated by comparing the female to male scales respectively, impairment 4.6% - 2.6%, social 3.2% - 0.5%, behaviour 4.6% - 0.5% and symptomatic 5.2% - 2.7%. Positively, 68% of adolescents reported behaviour problems to be insignificant, 70% of UAE nationals and 77% of expatriates report insignificant behaviour difficulties with social engagement, relationships, or self-care, correlating with the data from the SDQ. These factors, when taking a strength-based approach to building resilience and capacity across the cohort provides a foundation upon which peer support and intervention programmes can be established.

In terms of life satisfaction, very high life satisfaction is reported by only 43% of males and 30% of females, 38% of UAE nationals and 36% of expatriates, 41% of Muslims and 32% of non-Muslims. 13% more males as compared to females are very satisfied with their overall life, with males higher on all measures (yourself, family, friendships, where you live, school and overall life) except satisfaction with school. Adolescent's reporting being very dissatisfied with aspects of their life include 6.6% of males and 2.6% of females very dissatisfied with their friendships, and 7.7% of males, 11.8% of females, 12% of UAE nationals and 8.6% of expatriates very dissatisfied with themselves. School satisfaction is lower for all cohorts, with only 16% of students, 11% of UAE nationals, 16% of expats reporting high satisfaction, with 8.6% of expatriates and 20.6% of UAE nationals reporting they are very dissatisfied. This highlights that schools need to consider ways they can raise student engagement to increase overall life satisfaction, taking into account the unique needs of UAE nationals, as it is worth considering that on virtually all academic outcomes, higher levels of attainment were achieved by students who reported higher levels of life satisfaction (Antaramian & Lee, 2017).

Understanding impediments to help seeking is essential if schools are to implement measures to ensure services are responses to the needs and concerns of adolescents and their families. The beliefs about psychological services questionnaire highlights the impact of religion, gender, and culture on attitudes towards stigma, expertness and intent to seek help.

When looking at an individual's intent, or willingness to seek help, very positive inclination towards doing so were reported by 6.4% non-Muslims, 5.5% of males, 4.7% of expatriates, 4.3% of UAE nationals, 3.2% of females, and 3.1% of Muslims. Therefore, the inclination to seek help is most impacted by religion and gender more than nationality or culture. However it is important to reflect upon ways to address beliefs which may impact intent, for example adolescent #25 shares "they tell me what to do and I don't like that as I feel I can either run from or solve my own life even it takes a few years", and adolescent #270 who states "I do not believe that counsellors would have the ability to fix or solve any of my personal problems. Other people may want to seek their help". Embedding whole school strategies and open dialogue where concerns can be shared and addressed would have a positive impact.

Whereas stigma produces a very negative beliefs in 1.7% UAE nationals, 1.7% Muslims, 1% males, 0.7% non-Muslims, 0.6% females and 0.4 % of expatriates suggesting in relation to stigma, culture and religion are a greater influence than gender. Finally, very positive attitudes towards the expertness of those providing psychological services are reported by 13.5% non-Muslim, 12.5% females, 11.4% expatriates, 10.3% UAE nationals and 9.9% males, again highlighting gender and religion differentials.

Understanding, acknowledging, and then removing barriers to help-seeking for adolescents is central to the recommendations arising from this research, and where the most impact to long-term mental health can be gained. Three main themes emerge from the adolescent responses, who identify the main impediments as:

- privacy, confidentiality, and trust in the counsellor (31% of respondents)
- stigma and personal beliefs (23% of respondents)
- counselling is not needed (18% of respondents)

When asked for their suggestions to remove or reduce barriers, 27% of adolescent respondents indicated that encouragement from family and support from friends would make a difference. Equally 27% indicated that building a relationship with the counsellor outside of the counselling setting may increase the likelihood they would feel comfortable and reach out when the need emerged. Finally, 25% stated that ensuring anonymity (as opposed to confidentiality) would increase the likelihood they would access services. Interestingly, as this thesis is concluding we find ourselves in the time of Covid-19, students in distance learning and counsellors offering tele-counselling using Microsoft Teams and other online platforms, a medium that future research may establish is preferable due to the anonymity it offers when compared to entering a counselling room from a crowded hallway in the school setting.

Data from the adolescent participants highlights the differences in male and female presentations, best provision is a flexible model, developmentally appropriate and work across cultures and the potential that males underreport distress and are less inclined to seek help. Screening tools remind counsellors that mental illness and/or distress can be exhibited as internalising, externalising or somatic behaviours and impact aspects of life and wellbeing that include academic, social and emotional domains. The value of screening is highlighted as an effective way to identify trends of difficulty or distress, and establish vulnerable individuals or cohorts, particularly when surveys or screening reveals levels of difficulty that do not correlate with the number or needs of presenting students

to counsellors. Finally, the research validates the need to remove Eurocentric views of therapy and the expression of mental distress, and factor the impact and influence of culture or faith, being a TKC, expatriate or national of the country into intervention strategies and therapeutical approaches.

6.2 The Significance of the Research

This research is unique in its focus on an adolescent population, participants drawn from four private international schools located in both regional (1) and urban (3) areas in the emirate of Abu Dhabi, made up of both Emirati and expatriate students, many of whom also fall into the cohort of 'Third Culture Kids'. Gathering both quantitative data on the prevalence of indicators of mental health difficulties or disorders, alongside qualitative data on beliefs about psychological services and life satisfaction, provides invaluable insight into any reticence or reluctance to seek help. Exploring emerging trends in the adolescent data alongside that gathered from counsellors representing 23 schools within the Abu Dhabi region, provides a wider context and confirms that results gathered from the target schools is broadly indicative of adolescent experience across the region.

The World Health Organisation, in their Adolescent Mental Health Fact Sheet (2019) provide a succinct summary of the difficulties and impact of mental health disorders in adolescents worldwide. Data arising from this research into expatriate and Emirati adolescents in the UAE confirms that their experience aligns broadly to international norms and research, and subsequent implications for counselling provision and mental health education.

1. One in six people are aged 10–19 years (worldwide).
2. Mental health conditions account for 16% of the global burden of disease and injury in people aged 10–19 years.
3. Half of all mental health conditions start by 14 years of age, but most cases are undetected and untreated.
4. Globally, depression is one of the leading causes of illness and disability among adolescents.
5. Suicide is the third leading cause of death in 15-19-year-olds.

6. The consequences of not addressing adolescent mental health conditions extend to adulthood, impairing both physical and mental health and limiting opportunities to lead fulfilling lives as adults.

(World Health Organisation, 2019)

Mental health difficulties and disorders, in their immediate presentation have a profound impact on social, emotional, and physical wellbeing, expressed as externalising and / or internalising behaviours. However, it is the long-term and often more subtle implications that may not be appreciated, observed in impaired academic performance, breakdowns in relationships and support structures. With half of all mental health difficulties emerging during adolescence, it is a time of vulnerability, and opportunity. This research highlights how essential it is that educational settings, well placed to identify and respond to emerging needs, address impediments to help seeking and increase their understanding of the lived experience of both UAE National adolescents and those expatriate and Third Culture adolescents.

6.3 Theoretical Implications

The purpose of the research was not to prove or disprove established theories of mental health prevalence in adolescence, value of self-report screening tools, nor impediments to help-seeking, therefore no direct theoretical implications have been identified. However, in broad terms, the research may contribute to the later development of theories which more deeply examine the correlation between adolescent development, triggers for the emergence of mental health disorders and gender, culture, faith, and inclinations to seek help.

The research does highlight the role and influence of family, community and culture as both impediments and protective factors in creating the context within which help seeking and discussion of mental health and wellbeing are normalised and encouraged. And while culture does influence help seeing trends, gender emerges as the predictor of the nature of distress most likely to be experienced.

Data suggests that based on gender, similar prevalence rates of mental distress to international figures being reported, despite the under representation in counselling attendance. The research confirms in this setting as is the case internationally, that some presenting needs are more commonly experienced by boys for example, who are more likely to report experiencing behaviour disorders whereas girls are more likely to report experiencing social and emotional disorders. Therefore, setting aside culture and faith,

schools should anticipate the needs that will be experienced, without considering the numbers of students accessing help to be indicative of distress or need experienced.

Finally, the research does highlight the value of self-reporting through school-based screening for general well-being and levels of life satisfaction, as well as for specific behavioural or mental health difficulties. Future research may result in the emergence of theories which identify ideal timings for such screenings relating to cognitive or emotional development, and future research may explore.

6.4 Methodological Implications

There are methodological implications arising from this research relating specifically to sample size, and recommendations to adapt to facilitate deeper analysis in any subsequent research. The potential sample of adolescent students across the group of schools was 640, resulting in 340 students who voluntarily participated, a return rate of only 53%. Informed consent was gained from parents and students, achieved through presentations to students and information sheets sent to families. However perhaps due to stigma or parental concerns about the themes of the student survey, and despite assurances of anonymity and confidentiality, engagement was less than ideal. To enable more robust evaluation of trends, and exploration of relationships between individual student cohorts, for example to look more closely at the individual experience of cohorts such as Muslim boy, TKC's, or female UAE nationals a larger sample size would be necessary.

6.5 Practical Implications

This research offers recommendations for a wide range of practical implications arising from the findings, broadly broken into domains of community education, counsellor expertise and cultural awareness, therapeutic interventions, adolescent screening.

6.5.1 Community education

Community education is necessary to develop a shared understanding of mental health and wellbeing, and how investing in maintaining both can positively impact the development, and potential outcomes. This education should be directed at the community within which the educational setting is located. Ensuring teachers are skilled in identification, response and referral when at-risk adolescents are identified; integrating wellbeing and Mental Health First Aid training into induction or annual professional

development cycles could be one approach to achieving school wide awareness while upskilling all those who work within the educational setting.

Parent education about mental health conditions, causes, treatments and the importance of early intervention would improve the receptiveness of some families when an adolescent did reach out for guidance, or expressed they were experiencing difficulties or feeling overwhelmed. Many students identified that their parents would be their first point of support, and equally rated parent support to access a counsellor as a significant factor in increasing the likelihood they would seek services and support in school. Providing parents with the knowledge and skills they need to make an informed decision in guiding their child would greatly increase the likelihood of partnerships developing that result in a holistic support and therapeutical network for the young person, and their family. As explained by Dr Tahir (Chaudhary, 2016), in an interview exploring parental attitudes towards help seeking and recognising a mental health need in their child, parental lack of understanding and acceptance is an impediment to young people accessing the support they need.

> "Social stigma is one of the main reasons why parents in the UAE are reluctant to seek help for their teenager's mental health issues. Compounding this issue is the failure of parents, and society in general, to recognise the troubling symptoms in their teenager early enough to adopt interventionist methods. Parents, in as much as they feel proud when their child excels in class and gets a distinction in a subject, also have a hard time accepting the fact that their child has a mental health issue and that it is interfering with their social, academic and professional development. They feel defeated or take it as an ego-bruiser that there is something wrong with their child's outlook or attitude. In other words, they get into denial mode."
>
> Dr Tahir (2016)

Initiatives within schools that develop student understanding about mental health and awareness of self, normalising the discussion of such topics and creating a shared vocabulary and emotional literacy are protective factors. The use of self-report screening tools highlights that many students recognise they are experiencing difficulties, and would consider the need for psychological support however lacked the vocabulary, confidence and/or sense of family support to reach out for parental guidance. The types of community awareness initiatives could take a number of forms, whereby school could

for example use events such as World Mental Health Day, Mental Health Awareness Weeks, Darkness into Light suicide awareness walks to promote the exploration of themes, and create dialogue between all stakeholders.

Community education initiatives are most effective when multilevel, culturally sensitive, and non-judgemental, remain grounded in evidence-based information and recommendations, and conducted to achieve a shared vocabulary, understanding and agenda. Within educational settings, an effective strategy is to clearly state the school's commitment to wellbeing, mental health and safeguarding as a core pillar of the school's values, implying that when families enrol their children they too choose and share this value. Schools that teach emotional literacy, self-regulation, and self-care strategies such as mindfulness from the earliest age means that these skills and dialogue become the norm, and in doing so the culture of the school encourages and invests in wellbeing.

6.5.2 Counsellor expertise and cultural awareness

Much as it is necessary that educators and mental health professionals providing services in their home country remain mindful of cultural beliefs and traditional practices when working with clients from other religious or cultural backgrounds, so too counsellors and teachers working in international settings, contexts where local or regional beliefs and values may differ from their home country or personal perspective, should receive cultural awareness training during the onboarding process. It would be recommended that all counsellors have a minimum level of training in culturally sensitive practice before commencing work in international settings, specifically the Gulf region. Developing an understanding of the significance of the family construct, the importance of societal expectations, the illegality of homosexuality and an awareness of traditional healers and healing is crucial.

It is commonplace in the UAE that counsellors in educational settings are over reliant on Eurocentric therapeutic approaches and benefit from professional development to develop an awareness of the nuances of the tribal, Arab and Muslim influences in the region so that they can effectively integrate traditional beliefs. Further, all counsellors should be aware of the dynamic experienced by adolescent Third Culture Kids, adjusting their approaches and practice accordingly. Acceptance and Commitment Therapy is one approach that may be particularly beneficial by bridging therapeutical needs with cultural beliefs within a historically traditional and patriarchal society.

Regulators frequently overlook the range of professional expertise that falls under the title of school counsellor, and more rigorously monitor the services delivered by these professionals to ensure their remit falls within their professional knowledge and accreditation. For example, the qualifications required to enable approval as a counsellor in s school setting include, Bachelor of Counselling, Bachelor of Social Work or a Bachelor of Psychology (ADEC, 2014), degrees which build relevant knowledge and theoretical understanding, but not all of which equip school counsellors with the practical and theoretical knowledge to provide services as a mental health school counsellor. Schools are required within the ADEK licensing policy (ADEC, 2014; ADEC 2015) to provide students access to a counsellor, however, does not stipulate the remit or skill set of that counsellor. For example, some schools elect to employ a school guidance counsellor who provides career and educational guidance, valuing their contribution to gaining university entrance for students over therapeutic or wellbeing counselling.

Alternately, as school may elect to employ a counsellor to fulfil such roles as monitoring behaviour and attendance, more akin to the local definition of a school social worker. Conversely a school may specifically recruit a counsellor to work in an educational setting to provide mental health and therapeutic services, extending into family counselling, frequently acting as part of school crisis response and pastoral teams. Therefore the quality and nature of counselling in schools varies significantly, with the recommendation being that a counsellor who can provide psychological support and therapeutic interventions and support should be priorities, and where capacity and funding allows add on specific career guidance counsellors and/or social workers. Finally, counsellors in schools should be monitored to ensure their provision does not over-reach their expertise and qualifications. Recent moves to offer licenses to school counsellors are positive, however it is as yet unclear how specific they will be in monitoring or regulating qualifications and services provided to students. Achieving greater representation of male counsellors in the profession, working in the UAE would also benefit students. Given the inclination of male participants to turn to their family for support, and the cultural preference in Arab states for young males to be guided by the eldest brother of father, male counsellors may be more effective working with Arab adolescents, however further research would be required to confirm this finding.

6.5.3 Adolescent Screening

This research, and that of others undertaken in educational settings (Dowdy, Ritchey & Kamphaus, 2010) supports the efficacy of using screening tools and wellbeing surveys to establish individual needs and trends across a school. It is an oversimplification of provision for adolescents to base decisions relating to wellbeing initiatives on curriculum scope and sequence, or common developmental projections, and important that feedback is regularly gathered that take into account localised or contextual influences. Historically, measures of academic achievement were the primary indicator of student success and well-being, however more recently educators have come to understand that academic success is largely dependent on students experiencing emotional mental health, maintaining a sense of well-being, connectedness, and value.

Regular surveys or administration of screening tools promote personal self-reflection and a normalization of discussions relating to mental health and illness, changing the perception that asking for help is a sign of weakness and promoting that reaching out for help as you would for any academic support or for any health and medical concern should also be an excepted part of family and educational interactions. Where the tools administered in this research were targeting adolescent populations, schools should as previously recommended, start emotional literacy education much earlier; younger children can be presented with surveys in visual form, and class practice can integrate regular reviews of emotional state and levels of wellbeing.

Antaramian & Lee (2017) conducted a systematic review of research into the relationship between academic performance and levels of life satisfaction reported by college students. Findings concluded that on virtually all academic outcomes, higher levels of attainment were achieved by students who report higher levels of life satisfaction. Researchers articulated the practical implications of these findings, including the need for educational institutions to regularly conduct life satisfaction assessments, and in doing so identify those vulnerable to poor outcomes and in need intervention. Of the possible support available, those focused on developing an understanding of character strengths including curiosity, hope and gratitude had the most impact on reported life satisfaction (Antaramian & Lee, 2017).

A school system that adopts a regular protocol of screening students will enable the early identification of at-risk students and the provision of intervention either individually or where trends emerge, across a group. Recommended screening tools include a life

satisfaction scale to give an indication of general well-being, in addition to questions that identify both strengths and areas of difficulty, as research suggests that high life satisfaction is an essential component for positive physical and mental health, school engagement and academic achievement. A longitudinal study by Sulio, Thalij, & Ferron (2011) established that wellbeing and life satisfaction offer a protective factor, even when mental health difficulties were present, further supporting the contention that it is important to gain a measure of both the nature and extent of difficulties reported, but also areas of personal or collective strength across a cohort upon which provisions can be built. Taking a strength-based approach for intervention, identifying areas an adolescent is experiencing positive outcomes and feels a sense of control and confidence is more likely to garner community engagement and therefore have the most positive outcomes.

Where schools schedule regular surveys or screening of the student population, either in identified cohorts or across all phases they are well positioned to make informed decisions regarding intervention and education initiatives. Individual students identified as vulnerable can be targeted for small group or individual interventions and where trends are established across a year group, for example boys reporting difficulties in managing anger and aggression in late primary school which likely correlates with increased testosterone as boys enter puberty, may be an ideal time to target sessions teaching self-regulation and healthy ways to express emotions. This may be more effective than trying to address then habitualised behaviours later in adolescence.

6.5.4 Therapeutic Interventions

Counselling psychotherapies commonly used in adolescent populations, though by no means exhaustive, include the following.

- Cognitive Behaviour Therapy (BCT) – examining patterns of thinking, recognising how they impact feelings and actions.
- Dialectical Behaviour Therapy (DBT) – emphasises taking responsibility and managing intense emotions which may often be negative.
- Acceptance and Commitment Therapy (ACT) – accepting inner emotions to commit to progressing in a more positive way.
- Family Therapy – explores patterns of interaction and communication to support positive functioning.
- Group Therapy – utilises group dynamics and interactions with peers to enhance understanding of challenges and improve social or coping skills.

- Interpersonal Therapy (IPT) – addresses problematic relationships and interactions result in individual difficulties.
- Play and/or Art Therapy – uses play or creative materials alongside talk, through which adolescents can verbalise their feelings, manage conflicts and behaviours.
- Psychodynamic Psychotherapy – explores inner struggles and issues to understand and address how they influence current behaviours, feelings, and thoughts.
- Supportive Therapy – provides guidance and scaffolds to help adolescents manage stress, improve self-esteem, and manage challenging behaviours.

(American Academy of Child and Adolescent Psychiatry, 2019)

The majority of counsellor participants in this research report using a holistic approach, employing a range or combination of theoretical and therapeutical approaches depending on the age and interests of the adolescent, as well as the particular difficulties being experienced. Few however, reported considering gender specific interventions and therapeutical approaches that would specifically address the needs or barriers to help seeking, as expressed by males and females in this research, Further research is necessary to trial interventions and therapies which may prove more effective with different gender cohorts.

Adolescents of both gender in this research, expressed barriers to seeking help which focus on stigma, confidentiality, and cultural differences. Adolescent #313 shared that schools "need to work on eliminating the stigma - that getting help isn't because you can't deal with it yourself, but rather let us know what they actually do and what a session looks like", while Adolescent #173 shared that they were not likely to seek help "if I personally know I cannot trust them or they won't understand me because of cultural differences". Considering this commentary, it is evident that while a holistic and flexible, student centred approach to therapies is beneficial, the data would suggest that there is perhaps a lack of consideration to which therapy aligns more effectively with Muslim beliefs and Islamic or expatriate family structures.

Therefore, the need to integrate culturally attuned approaches within educational settings in the Middle East region, or within Arab or Islamic cultures and communities, leads to the recommendation arising from this research that counsellors consider integrating Acceptance and Commitment Therapy (ACT) to benefit adolescent Muslim

populations. Furthermore, while not extensively researched, integrating this behavioural therapy, which utilises being present in the moment, mindfulness and self-acceptance appears to offer beneficial and mutually complementary components, that will also benefit expatriate students and TCK.

Tanhan (2019) has undertaken research into the applicability of Acceptance and Commitment Therapy (ACT) within Muslim populations. His research has established, much as has this current research that Muslims underutilise mental health services and maintain a 'scepticism', a mistrust of traditional psychotherapies and mental health services. A review of literature between 1986 and 2019 confirmed that based on randomised control trials ACT was one of the most effective therapies for Muslims, based on the commonalities identified between ACT and Islam, and its alignment to taking a positive approach to managing mental health distress.

ACT stresses a contextual worldview, whereby one can interpret, influence, and predict psychological states and responses, valuing spirituality and mindfulness and taking a positive psychology stance. It has been researched to have measurable effect for such features of wellbeing, as resilience, academic performance, self-esteem and when targeting diverse populations such as adolescents with mental health needs, the elderly and traumatised groups such as refugees (Tanhan, 2019).

It is possible to identify elements of ACT that closely align to Islam and Muslim beliefs and can be integrated effectively into therapeutic services.

- Conceptualising the nature of the human being as being present in the moment
- Values-based living – ACT identifies and utilises personal values upon which to address psychological difficulties, effectively integrating the religions belief system and structures of Islam and being Muslim.
- Integration of spirituality and faith – ACT and Islam address and acknowledge the role spirituality, faith and religion may take within the definition of a meaningful life, unlike other therapeutical approaches which either dismiss or minimise.
- Interpretation of pain or unpleasant experiences – both ACT and Islam consider these as natural and inevitable, rather than the absence of any emotional difficulty as normal.

- Managing pain or unpleasant experiences – ACT and Islam highlight the potential for learning or understanding gained through the experience of distress or pain, leading to greater meaning and mindfulness in life.

(Tanhan, 2019; Pekan, 2013)

The key tenants of ACT are openness, centredness in the present and engagement through commitment, and helps develop 'psychological flexibility' to overcome mental distress. Made up of six distinct process, they are summarised in Table 32 below, highlighting the applicability of ACT as a culturally sensitive and religiously attuned therapeutical approach.

Table 32

ACT – Keys to Psychological Flexibility & Alignment to Muslim Values

ACT Core Processes	*ACT Process Description*	*Islamic Beliefs and The Holy Qur'an Teachings*
Acceptance & Willingness	An active and aware response to past experiences, without avoidance, allowing for values-based action.	Rather than withdrawing from adverse situations, Muslims are asked to be in the moment (dhikr), take action, persist and be patient.
Cognitive Defusion	Altering the way behaviours are influenced by thoughts or past events by reducing the attachment to those thoughts, thus diminishing the negative impact.	Muslims are guided to maintain perspective on their thoughts and thinking behaviours, and that subsequent actions aspire to achieving a meaningful life, rather than suggesting new thinking styles.
Contact with the Present Moment	Viewing oneself as a 'self as process', remaining non-judgemental and accepting so that behaviours are more flexible and consistent with values.	Allah creates every moment, therefore if people aspire to living fully and experiencing the meaning of life, they must be aware of each moment and its potential.

Self as Context	'I' or self as context, reinforces the understanding that we can be aware of our experiences without investment or attachment to them leading to acceptance, aspects which influence empathy and theory of mind.	Islam requires those of faith to take action to achieve long-term values rather than meet short term self-desires, and teach that one has control over behaviours.
Values	ACT guides conscious choice in areas of life such as family, career, spirituality while challenging self-talk that may result in choices being mad out of avoidance or social compliance, leading to a more enriching, values consistent life.	Islam highlights the temporariness of this world and human life, and importance of building life on the foundation of values. The Islamic concept of judgement day and the ACT metaphor of the tombstone closely align.
Committed Action	ACT promotes commitment to short, medium, and long-term goals. Unlike values, which are more conceptual, concrete behaviour change goals can be more tangible, and if consistent with values consistent can be achieved and lead to sustainable and positive change.	ACT and Islam promotes taking actions and behaving in a social and moral way, that are meaningful and conducive to a values-based life. Building patterns of committed action is a central component of both ACT and Islam, belief in Allah is not enough without taking action, and that action should begin with small steps and permanent change.

(Yavuz in Nieuwsma, Walser & Hayes, 2016)

There is a broad conceptual overlap between ACT and Islam, with the intention that human beings should be conscious in the present moment integrating mindful practice, and persistent in achieving chosen values through behavioural change. ACT therefore can be utilised with Muslim adolescents as a recognised and evidence-based psychotherapy and applied to expatriate cohorts and those who identify as TCK to address similar mental health needs by focusing lesson the faith dimensions and more on self as context (acknowledging the expatriate life experiences and transitions), and goal setting taking into account contextual influences and environment.

Establishing the multicultural counselling competencies, or the lack-there-of, of the school counsellors in Abu Dhabi was not within the remit of this research, however it has been highlighted that few identified using therapeutical approaches that reflect more than a holistic, student-centered approach. While this has value, it is also necessary to provide counsellors with the professional development necessary to enhance or establish the competencies, skill set and awareness required to adequately meet their student's needs.

6.6 Policy Implications

Highlighted in this research are important findings which contribute to the understanding of mental health needs of adolescents, impediments to help-seeking and how these vary depending on cultural or contextual backgrounds. Consideration of the results of this research can contribute in a positive manner to education policy development across the Emirates. Confirmation of prevalence rates of common mental health difficulties experienced by adolescents has been achieved. This validates the use of international figures to inform policy decisions and evaluate the possible outcomes of such. Factoring in adolescent beliefs about psychological services is an essential component in achieving success and a measurable impact of any intervention recommendations for schools. In addition, establishing the nature of impediments highlights the importance of mandated education components of the policy, to ensure that stigma and cultural reticence is addressed.

Three main areas of policy development are recommended.

- Counsellor Expertise (required qualifications, supervision arrangements, ongoing professional development).

- Counsellor Caseload (mandated counsellor to student ratios allowing for group, individual and family therapy, Mental Health First Aid training for identified staff, employee assistance programs).
- Proactive and Preventative Measures (mental health education integrated into school health and wellbeing curriculums, community education).

A review of existing policy in light of these findings establishes that current educational policy does not mandate the inclusion of mental health and wellbeing strategies or professionals into licensing requirements for international schools or inspection frameworks as rigorously as it might.

The ADEK Organising Regulations of Private Schools in the Emirate of Abu Dhabi require schools under Article 58, to "provide counselling services for students as stated in the Private Schools Policies Manual and Guide" (ADEC, 2014) and summarises the expectations as follows:

> Schools shall provide for their students a range of counselling services as appropriate to the students' age and life stage. Schools shall consider the following guidelines to help them develop their practice of guidance services.
> Careers Guidance: Career guidance is intended to prepare students for the next stage of their lives, whether in advanced educational studies or in the world of employment. Career specialist advice is provided either by a dedicated careers teacher or adviser, or by a teacher who has added this area of expertise to their existing commitments.
> Personal Counselling: Many students undergo times when they feel lonely or insecure, lacking in self-esteem or self-confidence. Young people may often feel hesitant to confide in a Parent / Guardian or a teacher with whom they meet daily; and it may be easier for them to do so to a trusted professional counsellor or a social worker, depending on the nature of the concern.
> Academic Guidance: Academic guidance services are part of the curriculum, and mostly focus closely on the academic needs and concerns of individual students. Therefore, teachers are expected to offer guidance and support to students according to their ability and area of expertise. Schools must also employ dedicated professional specialists to offer additional academic guidance services to students.
>
> (ADEK, 2014)

Beyond the education policies and inspection frameworks, such as those developed by the UAE Ministry of Education, the Dubai education regulator KHDA (Knowledge and Human Development Authority) and the Abu Dhabi Education and Knowledge department (ADEK), health sectors may also utilise findings from this research. Some areas of application may be to advocate that insurance covers psychologist assessments and therapy delivered in educational, in addition to clinical settings.

6.7 Limitations and Future Research

It is relevant to note limitations of this research which have been identified, including aspects of the methodology, review of previous research and measurement instruments.

This study specifically focused on the experience of adolescents in the Emirate of Abu Dhabi, due to the lack of information relating to prevalence and barriers to help seeking from psychological services, While the intention was not to generalise beyond this Emirate, it would be reasonable given the similar socio-cultural landscape in nearby Emirates such as Dubai, that educational settings could with confidence apply the findings of this research to inform provision in their own settings. It is acknowledged that voluntary participants from both the counsellor and adolescent cohorts resulted in relatively small sample sizes which did not allow for comprehensive statistical measurement. Despite this, the number of adolescent participants would be considered representative of the population of adolescents across international schools, based on analysis of age, gender, faith and nationality, and trends can be generalised across other educational settings. The number of counsellor participants was sufficient to meet the research aims of validating the trends established in the adolescent survey and provide qualitative context to the emerging challenges and impediments to help seeking.

The literature review and supporting research examined throughout the duration of the research is limited to those released in English. The researcher was unable to identify research published in Arabic, however, cannot confirm that some may be in existence, and potentially relevant to this research, however, remains undiscovered due to language limitations of the researcher. In general, previous research on impediments to adolescent help seeking in an international setting in the UAE and wider Gulf region has not been located. Consequently, this research builds our understanding of these impediments and has the potential to contribute to subsequent research undertaken.

In addition, there are some limitations in relation to the administration of the HoNOSCA. Validity has been established using the self-report adolescent measure however it is generally administered in clinical settings on entry, mid intervention and then upon release from any treatment programmes. In this research we have used it to measure adolescent wellbeing, as experienced at the time of administration. The rationale being that the use of the HoNOSCA was not intended to measure impact of an intervention and therefore the single administration remained a valid way to establish areas of difficulty and strength experienced by the adolescent. It may be worthwhile for future researchers to consider these limitations and amend methodology, participants, measurement instruments or literature reviews accordingly.

Finally, further research is required to identify and test the efficacy of gender specific therapeutical approaches for adolescents, and the impact this may have on willingness to engage with school counsellor or psychological services.

6.8 Conclusion

This research set out to examine levels of adolescent wellbeing and life satisfaction in an international educational setting, exploring trends across gender, culture, faith, and nationality and identifying impediments to help seeking when difficulty or distress emerged. Research questions targeted adolescents, and also counsellors, utilising both quantitative and qualitative information seeking a holistic and comprehensive perspective as possible, and are summarised below.

Research Question 1: What are the levels of reported wellbeing and mental health in the sample of adolescents?

In relation to overall difficulties reported by adolescent participants, females report difficulties in the very high range significantly more frequently than males. Males experience most difficulties in the areas of conduct and peer interactions, whereas for females it is emotional problems and peer interactions which cause the greatest impact. Expatriates report difficulties at a higher rate than UAE nationals. Conversely, 7 out of 10 adolescents report insignificant impact of any behaviour problems on social engagement, relationships, or self-care.

Research Question 2: What is the incidence of mood disorders, eating disorders, substance misuse and self-harm reported by adolescents?

International prevalence rates broadly align with the self-reported data provided by the adolescent participants. The US CDC in 2018 reported that of children and

adolescents aged 3-18 years, 1 in 13 (7.4%) experience a behaviour or conduct disorder, and 1 in 14 (7.1%) are diagnosed with an anxiety disorder. Research by Thomas et al. (2015) confirmed similar prevalence rates of 1 in 14 diagnosed with ADHD, predominantly boys. Data gathered during this research confirms that 1 in 10 adolescents reported experiencing severe aggressive, antisocial, self-harming, substance misuse and hyperactive behaviours, while a third of counsellor's report having a student access services for self- harming in a month. Less commonly presenting are adolescents suffering from eating disorders, who are seen by 13% of counsellors on a monthly basis and those engaging in substance misuse, seen by 20% on a monthly basis. Mood disorders are a common presentation, with 8 out of 10 counsellors on a weekly basis seeing adolescents for anxiety and just under 4 in 10 for depression. One in 5 counsellors have a student express suicidal ideation in a month.

Research Question 3: Are levels of reported mental illness and inclination to seek support influenced by social-cultural or religious factors?

Adolescent participants report socio-cultural factors having a significant impact on help-seeking trends, with influences ranging from parental perceptions and approval to seek and accept support, to experiences of stigma, shame, concerns for anonymity and confidentiality which encompass reticence regarding counselling expertise and impartiality. Students shared that they would not be inclined to seek assistance, even if they recognised the need, "'cause you're seen as weak and people take the 'mick' (Adolescent #134), and expressed fears that "the illusion that you are an honest and happy person is broken once people know (Adolescent #56)".

While the data does not provide explicit evidence of religion having a negative, or indeed positive influence on help- seeking, in the Arab world, faith and culture indelibly interplay. However, the inclination to seek help was seen to be more likely in non-Muslims (6.4%) and males (5.5%) suggesting that gender and religion influence more than nationality or culture. Adolescent reports of mental illness align to expected levels based on international prevalence figures. However, when rating the degree of impact or severity, it is inherently subjective, reliant upon the adolescent's personal definition of severe, mild, or insignificant impact. There is evidence this is influenced by familial and cultural perceptions, based on the qualitative commentary provided in which adolescents question the need for help, or preference to defer to family for support or guidance, for example "I might talk to my mom beforehand to check if I really do need to go to a

counsellor for her (Adolescent #213)", "I like to deal with problems with people who are closer to me, like friends or my parents (Adolescent #90).

Counsellor's experiences indicate culture, followed by gender and religion are the most significant influences on whether a mental health need is disclosed, or help sought. Age was identified by 1 in 5 counsellors as an influence, indicating that as students became older and more mature, they were more inclined to seek support. Some students report barriers that include a lack of understanding about what happens in a counselling session, and that they consider the counsellor to be a stranger, as shared by Adolescent #88 who would choose not to seek help "because there are things that shouldn't be discussed with a stranger like a counsellor".

Research Question 4: What social, emotional, educational, and societal implications of mental health disorders are reported by adolescents living in Abu Dhabi and how do the experiences of locals and expatriates differ?

Data collated from the screening tools confirms that adolescents in Abu Dhabi experience mental health disorders and distress which impact their lives in a range of ways, the nature and degree of which differ depending on gender and nationality 43% of males and 30% of females report high life overall satisfaction, a combination of their experience of friendships, where they live, school and self, which indicates up to 70 % of students experience less than ideal enjoyment and engagement in their lives. A lack of connectedness, and enjoyment of school life is experienced, with 20% of UAE nationals compared to 8.6% of expatriate students reporting very high dissatisfaction. The impact of dissatisfaction in school, and indeed all aspects of life, is reduced academic attainment as established by Antaramian & Lee (2017).

Research Question 5: What impediments to help seeking do counsellors working with adolescent populations report, and what are the key issues and challenges they face in delivering services and support?

Counsellors consider stigma to be a significant influence on the likelihood that an adolescent will seek support to manage emerging mental health disorders or manage emotional distress in 47% of parents and 43% of students. These perceptions are eloquently explained by adolescent #313, who shared the reason they would not seek help from a counsellor was because of "the stigma that goes along with it - it is a scary step to first meet with them because they don't know you so you just put it off." Similarly, concerns relating to privacy, according to counsellors influences 56% of parents and 39%

of students, as one adolescent (#10) shares that they hesitate from accessing help due to "trust issues - people have let me down and didn't keep the things I told them to their self and it's hard to put back my trust for those few people". 61% of counsellors felt that a belief by the parents that the help was not needed highlighted an underlying lack of understanding of how mental health difficulties impact on adolescent wellbeing and achievement. 56% of counsellor reported that students do not feel help is needed, suggesting a lack of self-awareness, acceptance, and the need for enhanced mental health education programmes.

The key issues faced by counsellors delivering services in educational settings fall into broad categories:

- Institutional (resourcing, time, engagement of school senior leaders, holistic approach to mental health and well-being education).
  "Seeking help doesn't mean you are weak. It means you held-it in for so long and you're about to burst (Adolescent #10)".
- Attitudinal (stigma, confidentiality, acceptance of need and counsellor expertise).
  "People need to realize that counsellors are humans and that they do want to help but i think there is a barrier that if you tell them about overly destructive behaviour they will notify your guardian and that provides a disconnect between you and the Counsellor because you will never be able to delve that deep with them (Adolescent #40)".
- Presence (building relationships with student, accessibility, support from peers and engagement of families).
  "Because there are things that shouldn't be discussed with a stranger like a counsellor (Adolescent #88)".

When considering the experiences and prevalence rates of adolescent participant in this study it is notable that themes are similar to those that emerged in a review of research by the UK's National Children's Bureau, which identified the following key points.

- Girls report lower subjective well-being than boys, with the gap appearing to widen throughout adolescence. They express lower satisfaction with themselves.

- Girls and young women are particularly concerned about mental health issues.
- A higher proportion of girls than boys reach the expected level of personal, social and emotional development in early childhood.
- Mental health problems are more frequently identified in school-age boys than girls, and boys are more likely to be identified as having multiple different difficulties.
- The gender gap in the prevalence of diagnosable mental health conditions begins to narrow in adolescence, as emotional problems become more common in girls. By early adulthood, women are more likely to be diagnosed with a mental health condition than men.
- In general, 'internalising' problems (in which distress is directed inwards) are more common among girls and young women than boys and young men, who are more likely to exhibit 'externalising' problems (that manifest through 'acting out').
- Girls and young women are more likely than boys and young men to have depressive disorders and anxiety disorders.
- Conduct disorders are the most common mental health problems identified in children and young people, and are significantly more prevalent in boys than girls.
- High levels of self-harm are evident among girls and young women in particular; however, males aged 15–24 are more likely to die by suicide than females.
- The majority of young people with eating disorders are female.
- Boys and young men are much more likely to be diagnosed with ADHD and autism than girls and young women.

Hamblin (2016, p.6)

The UK, as in Australia and indeed in Middle East, is increasingly recognising of the unique challenges and opportunities adolescence brings in terms of early identification and intervention, skill, and resilience building. So too is the awareness of the necessity to account for gender, religious and cultural trends in the experience of mental illness, tendency to seek help and the effectiveness of the therapeutic approach taken. In the Transforming children and young people's mental health provision: a green

paper (Department for Education, UK, 2017) the government sets out an agenda to provide access for young people to earlier intervention and prevention, faster access to National Health Scheme (NHS) services and raises the role of schools and colleges as a protective and front-line resource. While the same is not yet in place within the UAE, the UK initiative validates the recommendations put forward by the findings of this research.

Awareness of the state of mental health, and in particular adolescent mental health, is becoming more widely recognized in the UAE, and acknowledgement of the need for a coordinated and comprehensive response more urgent. An example of this increased awareness and willingness to have open discussions and reflection is the emergence of mental health and related conferences within the UAE. They provide opportunities for professional dialogue and development for mental health professionals, are reflective of an acknowledgement of the insufficient services and a lack of data on prevalence and need in child, adolescent and adult populations. In 2015 the Gulf Mental and Behavioral Health Society hosted the 1st Schizophrenia Forum in Abu Dhabi, the 2nd UAE Suicide Prevention Conference was held in Dubai, and in Abu Dhabi the 3rd Middle East International Psychology Conference. So too in 2015, the 3rd International Child Mental and Behavioural Health Conference offered those working with adolescent populations, targeted professional development, and workshops. In 2017 the Maudsley International Mental Health Conference was held, expanding in 2018 to include provision for adult services, also in 2018 an International Conference on Addiction and Psychiatry, the 2018 Middle East Psychological Association Conference in Dubai and the first Abu Dhabi Mental Health Conference, which has continued annually. This rapid expansion of opportunities to engage with current research and mental health practices is indicative of professionals and the community urging greater attention to mental health, and a growing concern for young people in the context of this Middle Eastern, Islamic and Arab country.

Perhaps the most salient example of changing attitudes and community efforts to challenge stigma in the UAE, is the return in 2019, for its 3rd consecutive year, of the Darkness into Light walk (postponed in 2020 due to Covid-19). This international event began in Ireland in 2007 and now each May 6th, occurs across many countries of the world where communities wish to show solidarity for those experiencing mental health difficulties. In Abu Dhabi, this community initiative seeks to alleviate the stigma surrounding mental health, and reduce the isolation felt by those struggling and their

families. Events such as this walk along the corniche, and year on year the ever-increasing number of participants, provide a tangible and touching reminder of the numbers of people effected by mental health difficulties in the UAE, the lack of appropriate and accessible mental health services and the need for continued awareness raising and research.

Photo Credit: Laura Brennan – Al Bateen Academy student volunteers. Abu Dhabi, 2019

The WHO, mental health professionals in the UAE and the wider community are calling for more research to guide intervention offered by mental health practitioners and inform those designing public health and educational prevention programmes (Al Mazrouei, 2014b). They urge the education community in particular, to include specific mental health education within a whole school approach to promoting well-being and mental health, explaining that the educational environment offers ideal opportunities for prevention and intervention (Hanif, 2016).

Research into the mental health and wellbeing of adolescents in the UAE is an emerging field, and as such this research makes a valuable contribution to the literature. This is particularly the case as no other research to date has explored adolescent attitudes, perceptions and experiences of mental health and wellbeing in educational settings in Abu Dhabi. This research project has provided detailed information about the nature, prevalence, extent and intensity of mental health issues experienced by adolescents at international schools in Abu Dhabi and shed light on socio-cultural factors that impact upon inclinations towards help-seeking, protective and risk factors. Recommendations arising from this research seek to inform decision making within educational and clinical settings to enhance provision of school based mental health programs to improve well-being for children and young people across the Emirates.

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Appendices

9.1 Appendix A: Aldar Academies Research Information Letter

أكاديميّات الدّار
نرسم مستقبلنا

ALDAR ACADEMIES
SHAPING OUR FUTURE

PARENT COMMUNICATION

Date: 11/27/2017

Subject:
Student participation in well-being research project

Dear Parents,

Aldar Academies is committed to ensuring all students have access to school-based support services and initiatives that enhance their academic attainment and promote well-being. Adolescence can be a particularly challenging time for our young people, as they manage increasing academic, social and emotional demands. For this reason, we are pleased to support this well-being research project, incorporating the views and experiences of our students, aged 15 years and above.

Our Aldar Academies Head of Inclusion, Kate McMillan, is undertaking doctoral research which seeks to examine factors which influence student well-being. Her thesis focuses on adolescent social and emotional well-being, social and cultural determinants of mental health and help-seeking behaviour in education settings. It aims to enhance our understanding of the dynamic relationships between well-being and a range of external factors in order to promote high levels of academic achievement and emotional well-being.

The information gathered through the anonymous online survey will inform provision of appropriate and accessible well-being initiatives and school-based support services tailored to meet the specific needs of our students. We are committed to promoting health and well-being, as we are aware that this will improve academic, social and emotional outcomes for our students, in both the short and long term.

رسالة إلى أوليّاء الأمور

التاريخ: 2017/27/11

الموضوع:
مشاركة الطلّاب في مشروع بحثيّ عن رفاهيّة الطلّاب

حضرة أوليّاء الأمور الأعزّاء،

تلتزم أكاديميّات الدّار بضمان حصول طلّابها جميعهم على خدمات الدّعم المدرسيّ والمبادرات المدرسيّة الّتي ترتقي بتحصيلهم الأكاديميّ وتعزّز رفاهيتهم. يمكن لمرحلة المراهقة أن تكون محفوفة بالتّحدّيات بالنّسبة لفتياننا وفتياتنا، إذ أنّهم يواجهون المزيد من المتطلّبات على الصّعيد الأكاديميّ والاجتماعيّ والعاطفيّ؛ لذا يسرّنا أن ندعم هذا المشروع البحثيّ عن الرّفاهيّة من خلال تقديم وجهات نظر وخبرات طلّابنا، الّذين تتراوح أعمارهم بين 15 سنة وما فوق.

تقوم رئيسة قسم إدماج الطّلبة في أكاديميّات الدّار كيت ماكميلان، بإجراء بحوث الدّكتوراة الّتي تسعى إلى دراسة العوامل الّتي تؤثّر على رفاهية الطلّاب. وتركّز أطروحتها على الرّفاهيّة الاجتماعيّة والعاطفيّة للمراهقين والمحدّدات الاجتماعيّة والثّقافية للصحة العقلية وسلوكيات طلب المساعدة في البيئات التّعليميّة. وتهدف الأطروحة إلى تعزيز فهمنا للعلاقات الدّيناميكيّة بين الرّفاهيّة ومجموعة من العوامل الخارجيّة من أجل تعزيز مستويات عالية من التّحصيل الدّراسيّ والرّفاهيّة العاطفيّة.

إن المعلومات الّتي ستُجمع من خلال مشاركة الطلّاب في استبانة على الانترنت لن تتضمّن أي أسماء، وهي ستساهم في توفير مبادرات ملاءمة تتمحور حول الرّفاهيّة وخدمات الدّعم المدرسيّة والمصمّمة خصيصا لتلبية الاحتياجات المحدّدة لطلّابنا. نحن ملتزمون بتعزيز الصّحّة والرّفاهيّة، لأنّنا ندرك أن ذلك سيؤدّي إلى تحسين النّتائج الأكاديميّة والاجتماعيّة والعاطفيّة لطلّابنا، على المدى القصير والبعيد.

ص.ب. 128484، أبوظبي، الإمارات العربية المتحدة
P.O. Box 128484, Abu Dhabi, United Arab Emirates

أكاديميّات الدّار
نرسم مستقبلنا

ALDAR ACADEMIES
SHAPING OUR FUTURE

نرفق نموذج الموافقة مع هذه الرّسالة على أن نرسل وثيقة المعلومات المفصّلة عبر الإيميل. كما نشجّعكم على قراءة هذه المعلومات ومناقشتها مع أولادكم. في حال موافقتكم على مشاركة أولادكم في الاستطلاع الإلكترونيّ الذي لن يتضمّن أي أسماء، يرجى إعادة نموذج الموافقة إلى أستاذ النماذج أو المرشد التعليمي الذي سيقوم لاحقا بتزويدهم بالرابط الإلكترونيّ. عند بدء الاستبانة، سيطلب من الطّالب تأكيد موافقة وليّ أمره، قبل أن يتمكّن من الانتقال إلى المراحل من الاستبانة.

نثمّن اهتمامكم بمشاركة أولادكم ودعمكم لهذا المشروع البحثيّ المهم.

وتفضلوا بقبول فائق الاحترام

ميشيل فوربس
مديرة المشاريع الخاصّة - أكاديميّات الدّار

Attached to this communication is consent form and a detailed participant information sheet will be emailed to you. We encourage you to read through this information and discuss it with your child. If you consent to their participation in the anonymous online survey, please return the consent form to their Form Tutor or Learning Mentor who will then provide them the link. Upon starting the survey, they will be asked to confirm you have provided consent, before they can proceed through the survey.

We appreciate your consideration of participation, and support of this important research project.

Yours sincerely

Michelle Forbes
Director of Special Projects - Aldar Academies

9.2 Appendix B: Participant Information Sheet and Consent Form – Adolescents

Participant Information for Research Project Survey

Project Details

Title of Project:	Adolescent social and emotional well-being in Abu Dhabi, United Arab Emirates: socio-cultural determinants of mental health and their relationship to help-seeking behaviour in education settings.
USQ Human Research Ethics Approval Number:	H17REA136

Research Team Contact Details

Principal Investigator Details

Kate McMillan
Email: kmcmillan@aldaracademies.com
Mobile: +971 (0) 50 122 6701

Supervisor Details

Associate Professor Peter McIlveen
Email: Peter.McIlveen@usq.edu.au
Dr Stephen Hughes
Email: Stephen.Hughes@usq.edu.au

Description

This project is being undertaken as part of doctoral research into the social and emotional wellbeing of adolescents in Abu Dhabi.

It is widely recognized that a positive state of well-being, and mental health enhances the academic, social and emotional achievement of adolescents. Schools have a unique opportunity to nurture and positively influence adolescent well-being, and a responsibility to provide support when distress or difficulty is experienced. International research suggests that the most effective initiatives to promote well-being and mental health in educational settings are those that are developed with a clear understanding of the student population's needs and challenges faced, while recognizing and appropriately responding to student's cultural and social differences.

The purpose of this project is to deepen our understanding of adolescent well-being and mental health in Aldar Academies. It will incorporate the views and experiences of both adolescent students and mental health professionals in order to explore levels of reported well-being, the nature and prevalence of any difficulties experienced and identify socio-cultural risk and protective factors that influence adolescent attitudes towards help seeking. Information arising as a result of the research will inform provision of effective, culturally sensitive and appropriate support services and initiatives in international schools.

The research team requests your child's assistance because their experiences, insight and contribution are essential in ensuring that support and interventions offered in our schools meet the needs of our students, are accessible, and have a positive impact on academic, social and emotional performance and well-being in both the immediate and longer term.

Participation

Your child's participation will involve completing an anonymous online survey that will take approximately 15 minutes of their time. The survey can be completed at school during form time on a day that is convenient with them.

The survey will include questions drawn from standardized screening tools which explore adolescent strengths, difficulties and well-being, students' life satisfaction and beliefs about psychological services. Questions indicative of those within the screening tools include rating against statements or questions such as 'I care about other's feelings, how satisfied are you with your school experience, have you been troubled by a lack of satisfactory friendships or bullying"?

Your child's participation in this project is entirely voluntary. If they or you do not wish to take part they are not obliged to. If you provide your consent and they decide to take part and later change their mind, they are free to withdraw from the project at any stage. If you do wish to withdraw from this project or withdraw data collected about you, please contact the Research Team (contact details at the top of this form).

Your decision whether your child takes part, does not take part, or to take part and then withdraw, will in no way impact your current or future relationship with the University of Southern Queensland, your school or Aldar Academies.

Expected Benefits

Benefit to participants and the wider school community include greater understanding by counsellors and educational providers about levels of wellbeing and happiness among our students, and the nature and prevalence of mental health difficulties. Your child's contribution will aid understanding of social and cultural influences which impact on why adolescents may or may not seek help, so that our schools can offer the type of support in a manner that adolescents find accessible and beneficial.

Ultimately, your participation will contribute to more effective preventative and early intervention initiatives being offered in educational settings.

Risks

There are minimal risks associated with your child's participation in this project. These include possible heightened awareness of one's state of mind, and the likelihood that participants will consider more deeply their actions, behaviors, feelings and emotions. All questions will be expressed in a culturally sensitive manner. If your child needs to talk to someone about any feelings that may arise, please see the school counsellor, who is able to support and help.

Privacy and Confidentiality

The survey is anonymous and as such, no responses can be attributed to any individual.
Any data collected as a part of this project will be stored securely as per University of Southern Queensland's Research Data Management policy. In the event that a researcher not associated with this project requests access to the anonymous data, it will be considered on a case by case basis and only shared with the approval of the research team.

Consent to Participate

As participants may be aged 15-19 years, we require parental consent for them to participate. Consent can be provided by returning the form attached.

Questions or Further Information about the Project

Please refer to the Research Team Contact Details at the top of the form to have any questions answered or to request further information about this project.

Concerns or Complaints Regarding the Conduct of the Project

If you have any concerns or complaints about the ethical conduct of the project you may contact the University of Southern Queensland Ethics Coordinator on (07) 4631 2690 or email ethics@usq.edu.au. The Ethics Coordinator is not connected with the research project and can facilitate a resolution to your concern in an unbiased manner.

Thank you for taking the time to help with this research project.
Please keep this sheet for your information.

Please return this Statement of Consent
to your child's Learning Mentor or Form Teacher

Statement of Consent

By signing below, you are indicating that you:

- Have read and understood the information document regarding your child's participation in this project.
- You and your child have had any questions answered to your satisfaction.
- Understand that if you have any additional questions you can contact the research team.
- Understand that you or your child are free to withdraw at any time, without comment or penalty.
- Understand that you can contact the University of Southern Queensland Ethics Coordinator on (07) 4631 2690 or email ethics@usq.edu.au if you do have any concern or complaint about the ethical conduct of this project.
- Are the legal guardian of the child that will participate in this project.
- Agree for your child to participate in the project.

Child or Young Person's Agreement to Participate

Name	
Signature	
Date	

Parent's (or Legal Guardian's) Consent for a Child or Young Person to Participate

Name	
Signature	
Date	

9.3 Appendix C: Participant Information Sheet – Counsellors (English & Arabic)

University of Southern Queensland

Participant Information for USQ Research Project Survey and Interview

Project Details

Title of Project:	Adolescent social and emotional well-being in Abu Dhabi, United Arab Emirates: socio-cultural determinants of mental health and their relationship to help-seeking behaviour in education settings.
Human Research Ethics Approval Number:	H17REA136

Research Team Contact Details

Principal Investigator Details

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Supervisor Details

Associate Professor Peter McIlveen
Email: Peter.McIlveen@usq.edu.au
Dr Stephen Hughes
Email: Stephen.Hughes@usq.edu.au

Description

This project is being undertaken as part of Doctoral research into the social and emotional wellbeing of adolescents in Abu Dhabi.

It is widely recognised that a positive state of well-being and mental health enhances the academic, social and emotional achievement of adolescents. Schools have a unique opportunity to nurture and positively influence adolescent well-being, and a responsibility to provide support when distress or difficulty is experienced. International research suggests that the most effective initiatives to promote well-being and mental health in educational settings are those that are developed with a clear understanding of the student population's needs and challenges faced, while recognising and appropriately responding to student's cultural and social differences.

The purpose of this project is to deepen our understanding of adolescent well-being and mental health in Abu Dhabi. It will incorporate the views and experiences of both adolescent students and mental health professionals in order to explore levels of reported well-being, the nature and prevalence of any difficulties experienced and identify socio-cultural risk and protective factors that influence adolescent attitudes towards help seeking. Information arising as a result of the research will inform provision of effective, culturally sensitive and appropriate support services and initiatives in international schools.

The research team requests your assistance because your experiences, insight and contribution are essential in ensuring that support and interventions offered in our schools meet the needs of our students, will be accessible, and have a positive impact on academic, social and emotional performance and well-being in both the immediate and longer term.

The online anonymous survey can be accessed at the following link:

http://www.createsurvey.com/s/elNZXZ/

You will also receive an email inviting you to participate.

Participation

Your participation will involve completion of an anonymous online survey that will take approximately 15-20 minutes of your time.

The survey can be completed at a time and day that is convenient with you.

The survey will gather information on what types of mental health needs student present with, and ask for your comment on such topics as differences in inclination to seek help based on culture, gender or religion, what reasons parents or students give for choosing not to access counselling services, and engagement with external services.

Students aged 15-19 years, will also be completing a survey with questions drawn from standardised screening tools which explore adolescent strengths, difficulties and well-being, life satisfaction and beliefs about psychological services.

At the conclusion of the survey you will be offered the option of volunteering for the follow-up semi structured interview phase of the project. The interview will explore themes which are highlighted as a result of the survey data. Participation in the survey does not require you to participate in the interview, and interviews will be limited to 6 participants.

If you choose to participate in the interview phase, an audio recording will be taken and then transcribed. You will have an opportunity to review and approve the transcription before qualitative data from the interview is incorporated into the research. The audio recording will be deleted once your approval is gained. The transcription will be held anonymously and stored securely and confidentially.

Your participation in this project is entirely voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. You may also request that interview data collected be destroyed. If you do wish to withdraw from this project or withdraw data collected, please contact the Research Team (contact details at the top of this form).

Your decision whether you take part, do not take part, or to take part and then withdraw, will in no way impact your current or future relationship with members of the research team or the University of Southern Queensland.

Expected Benefits

Benefit to participants and the wider school community include greater understanding for counsellors and educational providers of levels of wellbeing and happiness among our students, and the nature and prevalence of mental health difficulties among adolescent populations. Your contribution will aid understanding of social and cultural influences which impact on why adolescents may or may not seek help, so that support can be offered of a nature and in a manner that adolescents find accessible and beneficial.

Ultimately, your participation will contribute to more responsive and effective preventative and early intervention initiatives being offered in educational settings.

Risks

There are minimal risks associated with your participation in this project. These include possible heightened awareness of one's state of mind, and the likelihood that participants will consider some of the challenges facing provision for and protection of adolescents in our schools.

Sometimes thinking about the sorts of issues raised in the survey can create some uncomfortable or distressing feelings. If you need to talk to someone about this please speak to a counselling colleague with whom you case conference, or your professional counselling supervisor.

Privacy and Confidentiality

The survey is anonymous and as such, no responses can be attributed to any individual.

Any data collected as a part of this project will be stored securely as per University of Southern Queensland's Research Data Management policy. In the event that a researcher not associated with this project requests access to the anonymous data, it will be considered on a case by case basis and only shared with the approval of the research team.

Consent to Participate

Consent for participation in the online survey will be indicated at the start of the survey tool. Completion and submission of the survey, implies consent to use the data for the purposes of this research.

Questions or Further Information about the Project

Please refer to the Research Team Contact Details at the top of the form to have any questions answered or to request further information about this project.

Concerns or Complaints Regarding the Conduct of the Project

If you have any concerns or complaints about the ethical conduct of the project you may contact the University of Southern Queensland Ethics Coordinator on (07) 4631 2690 or email ethics@usq.edu.au. The Ethics Coordinator is not connected with the research project and can facilitate a resolution to your concern in an unbiased manner.

Thank you for taking the time to help with this research project.
Please keep this sheet for your information.

9.4 Appendix D: Counsellor Survey

Counsellor Online Survey Content

Thank you for participating in this survey. Your feedback is important. This survey will ask questions about the experiences, beliefs and difficulties experienced by the students you work with in your professional capacity as counsellor.

The purpose of this survey is to help the researcher measure the emotional wellbeing and mental health of adolescents in Abu Dhabi and to identify ways schools could better support students.

I do not anticipate that taking this survey will contain any risk or inconvenience for you. Furthermore your participation is entirely voluntary and you may withdraw at any time.

All information collected will be used for this research and will remain anonymous and confidential. There will be no connection to you specifically in the results or in future publication of the results. Once the study is completed I will be happy to share the results with you should you wish. In the meantime if you have any questions please ask or contact Kate McMillan kmcmillan@aldaracademies.com

The survey has 3 sections and will take about 20 minutes, however there is no rush and you can take as long as you want. By completing and submitting this survey you are communicating your understanding of the purpose of this research and consent to participate. You acknowledge that the information will be used to help us better understand the wellbeing and mental health of our students and to inform the provision of effective and accessible school based mental health programmes and interventions.

Demographic Information

Gender:

Nationality:

How long have you worked in the UAE as counsellor?

What age are the students you work with?

Section 1: Student Difficulties

There are 18 difficulties students may experience. For each, please mark the box indicating the frequency with which students **present** (first attendance only) with the following difficulties -Daily, Weekly, Monthly, Termly, Rarely, Never. It would help us if you answered all items as best you can. Please give your answers on the basis of how things have been for you **in the last 12 months and only indicate frequency of new cases attending your service.**

	Daily	Weekly	Monthly	Termly	Rarely	Never
Loss / Grief						
Divorce / family breakdown or family conflict						

Suicidal ideation						
Self-harm						
Substance misuse – eg drugs, alcohol, solvents, tobacco.						
Risk Taking Behaviours						
Anxiety						
Depression						
Anger / Aggression						
Eating disorders						
Obsessive compulsive behaviours						
Attention deficit and hyperactivity						
Conflict with peers / fighting						
Inability to effectively maintain friendships						
Bullying						
Absenteeism /School Avoidance						
Issues relating to comorbid special educational needs / disability						
Life threatening illness to self, family or peer						
Difficulty transitioning into/out of UAE/school						
Parental neglect						
Physical / sexual abuse						

Are there other difficulties students present with?

Do you have any other comments or concerns about student difficulties?

Section 2: Seeking Help

There are 9 questions. For each question, please check all that apply and provide a comment where indicated. It would help us if you answered all items as best you can.

What reasons do students give for choosing not to access or continue accessing counselling services?	Not needed Shame Privacy Stigma Religion Lack of time Lack of family support Accessing external services Other Comment:
What reasons do parents give for choosing not to give consent for their child to access counselling services?	Not needed Shame Privacy Stigma Religion Lack of time Lack of family support Accessing external services Other Comment:
Is there a difference in a student's willingness to engage in counselling depending on their cultural background?	
Is there a difference in a student's willingness to engage in counselling depending on their religion?	
Is there a difference in a student's willingness to engage in counselling depending on their gender?	
What programmes that you have implemented, do you find most successful in promoting wellbeing and mental health in your school?	
What do you do to promote or advertise your counselling service in your school?	
What do you do to reduce the stigma of mental health issues?	

Do you have any other comments or concerns about patterns of, impediments to or strategies to encourage seeking help?

Section 3: Somatisation and Referrals to External Services

There are 6 questions. For each question, please provide a brief comment where indicated. It would help us if you answered all items as best you can.

How regularly do you observe somatisation (expressing a mental health difficulty as a physical symptom) in students presenting to counselling?	Comment
Is somatisation seen more regularly in particular national or cultural groups, and if so which ones?	Comment
Do you liaise with the school nurse or health services to identify and monitor those students who frequently attend for minor or non-specific illnesses?	Comment
Do families follow up on referrals to external services when recommended?	Comment
Have you referred a student with suicidal ideation to external services?	Yes / No
How would you characterise the support they received by the hospital or doctor to whom they are referred?	Comment

What are the biggest challenges you face in working with adolescents in Abu Dhabi?

Do you have any other comments?

Thank you for participating in this survey. Your answers will help us understand the needs of our students better. If after completing this survey you feel that you would benefit from talking to someone of getting some support with things that are troubling you, please talk to a trusted adult in the school, see the school counsellor or email kmcmillan@aldaracademies.com

If you would like to volunteer to participate in the follow up semi-structured interview phase of the research, please email Kate McMillan on kmcmillan@aldaracademies.com and you will be provided more information and a consent form.

Thank You

9.5 Appendix E: Student Survey

Adolescent Online Survey Content

Thank you for participating in this survey. Your feedback is important. This survey will ask questions about your personal strengths, difficulties, wellbeing, health, and satisfaction with life.

The purpose of this survey is to help the researcher measure the emotional wellbeing and mental health of adolescents in Abu Dhabi and to identify ways our schools could better support students.

I do not anticipate that taking this survey will contain any significant risk or inconvenience for you. Furthermore your participation is entirely voluntary and you may withdraw at any time.

All information collected will be used for this research and will remain anonymous and confidential. There will be no connection to you specifically in the results or in future publication of the results. Once the study is completed I will be happy to share the results with you if you wish. In the meantime if you have any questions please contact Kate McMillan kmcmillan@aldaracademies.com

The survey has 4 sections and will take about 20 minutes, however there is no rush and you can take as long as you want.

Parental consent is required for you to participate.

By completing this survey you are assisting us to better understand the wellbeing, happiness and mental health of our students, and to help us make sure the right support is available and accessible.

Demographic Information

Age:

Gender:

In which country were you born?

How long have you lived in the UAE?

What language do you use to communicate with your family?

Section 1: Strengths and Difficulties

There are 25 statements. For each statement, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely. Please give your answers on the basis of how things have been for you **in the last six months.**

	Not True	Some-what True	Certainly True
I try to be nice to other people. I care about their feelings			
I am restless. I cannot sit still for long			
I get a lot of headaches, stomach aches or sickness			
I usually share with others (food, games, pens, etc)			
I get very angry and often lose my temper			
I am usually on my own. I generally play alone or keep to myself			
I usually do as I am told			
I worry a lot			
I am helpful if someone is hurt, upset or feeling ill			
I am constantly fidgeting or squirming			
I have one good friend or more			
I fight a lot. I can make other people do what I want			
I am often unhappy, down-hearted or tearful			
Other people my age generally like me			
I am easily distracted, I find it difficult to concentrate			
I am nervous in new situations. I easily lose confidence			
I am kind to younger children			
I am often accused of lying or cheating			
Other children or young people pick on me or bully me			
I often volunteer to help others (parents teachers, children)			
I think before I do things			
I take things that are not mine from home, school or elsewhere			
I get on better with adults that with people my own age			
I have many fears, I am easily scared			
I finish the work I am doing. My attention is good			

Do you have any other comments or concerns about your strengths or difficulties?

Section 2: Health and Wellbeing

There are 13 questions. For each question, please mark the box for Not at all, Insignificantly, Mild but definitely, Moderately, Severely. It would help us if you answered all items as best you can, try to be honest. Please give your answers on the basis of how things have been for you **in the last two weeks.**

	Not at all	Insignificantly	Mild but definitely	Moderately	Severely
Have you been troubled by your disruptive behaviour, physical or verbal aggression?					
Have you suffered from lack of concentration or restlessness?					
Have you done anything to injure or harm yourself on purpose?					
Have you had any problems as a result of your use of alcohol, drugs or solvents?					
Have you experienced difficulties keeping up with your educational studies?					
Has any physical illness or disability restricted your activities?					
Have you been troubled by hearing voices, seeing things, suspicious or abnormal thoughts?					
Have you suffered from self-induced vomiting, head/stomach aches with no physical cause?					
Have you been feeling in a low or anxious mood or troubled by fears, obsessions or rituals?					
Have you been troubled by a lack of satisfactory friendship or bullying?					
Have you found it difficult to look after yourself or take responsibility for your independence?					

Have you been troubled by relationships in your family or substitute home?					
Have you stopped attending school?					

Do you have any other comments or concerns about your wellbeing or health?

Section 3: Satisfaction with Life

There are 6 questions. For each question, please mark the box for Very Dissatisfied, Somewhat Dissatisfied, Neither Satisfied nor Dissatisfied, Somewhat Satisfied or Very Satisfied. It would help us if you answered all items as best you can. Please give your answers on the basis of how you feel **right now.**

HOW SATISFIED OR DISSATISFIED ARE YOU WITH …	**Very Dissatisfied**	**Somewhat Dissatisfied**	**Neither Satisfied nor Dissatisfied**	**Somewhat Dissatisfied**	**Very Satisfied**
Your family life					
Your friendships					
Your school experience					
Yourself					
Where you live					
Your life overall					

Do you have any other comments or concerns about your life?

Section 4: Seeking Help

There are 10 questions. For each question, please mark the box for Yes, Possibly or No or write a comment. It would help us if you answered all items as best you can.

	Yes	Possibly	No
Have you ever seen the school counsellor?			
If you were feeling worried, anxious or depressed would you tell someone how you were feeling?			
If you were feeling worried, anxious or depressed would you go to see the school counsellor?			
If you were feeling worried, anxious or depressed would your family agree to you seeing the school counsellor?			
Do you know someone who you think needs to see the counsellor?			
Do you know someone who is harming or planning to harm themselves?			
Do you know someone who is taking risks with substances (tobacco, alcohol, solvents, etc)			
Do you know someone who is taking risks with behaviours (driving, relationships etc)			

If you would not seek help, please explain why?

If you would seek help, please explain who you would go to and why?

Do you have any other comments or concerns about seeking help?

Thank you for participating in this survey. Your answers will help us understand the needs of our students better. If after completing this survey you feel that you would benefit from talking to someone of getting some support with things that are troubling you, please talk to a trusted adult in the school, see the school counsellor or email kmcmillan@aldaracademies.com

If you would like to volunteer to participate in the follow up semi-structured interview phase of the research, please email Kate McMillan on kmcmillan@aldaracademies.com and you will be provided more information and a consent form.

Thank You

9.6 Appendix F: Sample Advertising Material