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Focus Groups Investigating Mental Health Attitudes and Beliefs of Parents and Teachers in South Lebanon: Are They Culturally Determined?

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Abstract

Introduction: The wars that Lebanon had endured led to a devastating number of deaths, injuries, and displacements. Such tragedies have detrimentally affected its civilians psychologically. **Purpose:** To identify knowledge, attitudes, and practices of teachers and parents concerning child/adolescent mental health. **Method:** Using purposeful sampling, five focus groups were conducted with teachers and parents of students from elementary, middle, and secondary levels in two private hub schools in South Lebanon. **Results:** A total of 27 teachers and 18 parents participated separately in focus groups. Three themes emerged: (a) Mental health care is a priority for overall health, (b) Mental illness is a cultural taboo, and (c) There is a need for better education and cultural understanding about mental health. **Discussion:** This is the first study in Lebanon directly targeted at parents' and teachers' mental health concerns. Such findings will add to transcultural nursing knowledge about the importance of mental health care.

Keywords

psychiatric/mental health, adolescents, maternal/child, focus group analysis

Introduction

For over three decades, the Lebanese population has experienced periods of armed conflict and occupation. In 1975, a civil war embroiled the country into mass violence and destruction lasting for more than 15 years. This war resulted in many deaths, injuries, mass destruction to infrastructure, and displacement of more than one million civilians (Bouckaert & Houry, 2007). Not only do such man-made disasters result in political and economic turmoil but they also unfortunately scathe those who witness them psychologically (Farhood & Dimassi, 2012; Farhood, Dimassi, & Lehtinen, 2006). People residing in South Lebanon live with either the consequences of previous wars or the threat of new ones. Farhood et al. (2006) found that 97.7% of a studied sample in the South had experienced, witnessed, or heard of war-related traumatic events, from which 29.3% had post-traumatic stress disorder (PTSD). If left undetected or untreated, these psychological and interpersonal problems may evolve into chronic behavioral and developmental obstacles (Yoon, Steigerwald, Holmes, & Perzynski, 2016).

Studies that particularly focused on children living in war zones have similarly found that this population is at great risk of developing PTSD and symptoms of psychological distress, including shouting, arguing, talking rapidly or loudly, and difficulty sleeping (Bobich, 2011; Farhood, 2013). These findings were even found among preschool children who were directly or indirectly exposed to war traumas (Thabet, Karim, & Vostanis, 2006).

In many Lebanese villages, mental illness is believed to be either an outcome of familial defect or the "action of evil maneuverings." These negative beliefs result in the perception of the mentally ill as recluses. This stigmatization denies the compassion and support traditionally offered to the physically ill in Lebanese society. This study therefore aimed to determine the knowledge of and attitude toward mental illness among schoolteachers and parents, the first persons to discover and deal with psychiatric issues in children. This information could be used in the formulation of programs for in-service training, management, and service delivery on mental health issues in schools and in the community; it can also add to existing international data with the same focus.

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Building culturally fit psychoeducational skills and promoting mental health education for the classroom and home helps support good mental health and recognition of mental illness, if any, in caregivers themselves (i.e., parents/guardians and teachers) and children or adolescents. Acceptance of mental illness may not be the same among different cultures. Cultural values are known to affect people's perception of their conditions and associated therapeutic interventions (Wolf, Zoucha, McFarland, Salman, & Dagne, 2016).

Despite the need emerging from different studies conducted in the South (Farhood & Dimassi, 2012; Farhood et al., 2006; Karam et al., 2006) research examining the knowledge, practice, and attitudes toward mental health among these communities is scarce (Karam et al., 2007). For Lebanese, the concept of mental health has been traditionally appended to insanity or "majnoun" in Arabic (Youssef & Deane, 2006). Therefore, stigma is considered as a major barrier to care and potential solutions (Aloud, 2004; Corrigan, 2004; Henderson, Evans-Lacko, & Thornicroft, 2013). It is worth noting that in Lebanon, although the prevalence of mental disorders has significantly been found to be high, with 17% having at least one *Diagnostic and Statistical Manual of Mental Disorders–Fourth edition*/Composite International Diagnostic Interview disorder in 12 months (Karam et al., 2008), treatment-seeking behavior is considerably low, as indicated in the World Health Organization world mental health surveys (Wang et al., 2007). Kreuter et al. (2003) indicated that factors such as beliefs, individualism, collectivism, familial role, and spirituality might be associated with health-related behaviors. This highlights the importance of encouraging health educators to recognize cultural factors within a specific population and integrate them in interventions aimed at changing behaviors.

This study aimed to identify knowledge, practices, and attitudes of teachers and parents toward mental health and illness through focus groups conducted uniquely with teachers and parents of students. Results from these focus groups may, in turn, feed into culturally fit awareness and educational sessions that meet the needs of parents, teachers, and experts. Results of this study will help in informing the practice of mental health in Lebanon to provide culturally congruent health care.

Method

Study Overview

This study employed a qualitative design. Data were primarily obtained through focus groups, along with observation and field notes. Focus groups were conducted in Arabic by a qualitative researcher. Participants answered open-ended, nondirectional questions. The interviewer used the probing technique to elicit additional information (see Table 1). All focus groups were audiotaped. This study obtained ethical approval from the American University of Beirut Institutional Review Board and approvals from both schools.

Table 1. Focus Group Questions and Probes (English Version).

Questions
1. What is your opinion about mental health?
2. Describe a child/student whom you think is facing a mental health issue.
3. How do you deal with him or her?
4. Why do you think people become mentally ill?
5. What measures can be taken to become mentally healthy?
6. What does it mean to you to suffer from a mental disorder?
7. What behavior(s) indicate a mental issue/concern?
8. What are the available mental health services for your child/student? Are they accessible?
9. How do you cope with life stressors?
10. How do you deal with issues/concerns in the classroom/home environment?
11. What are the challenges or threats to your well-being and that of your child/student?
Probes
1. Tell me more about that.
2. Could you please give example(s)?
3. Could you explain that?

Participants

A purposeful sample of teachers and parents was recruited via announcements from two schools in the area. These two schools were chosen because they have been considered as hub schools that attract students of different sociocultural backgrounds from different towns and villages in the south of Lebanon. The town was selected based on availability of venue, size, and results from previous mental health assessments reflecting high psychiatric morbidity such as anxiety, depression, and PTSD prevalence (Farhood & Dimassi, 2012; Farhood, Dimassi, & Strauss, 2013; Farhood et al., 2006). Exclusion criteria for participation in each focus group included the following: individuals not currently employed as teachers, or nonparents/guardians, and individuals under the age of 18 years.

Procedure for Data Collection

After receiving institutional review board approval, a letter from the principal investigator explaining the purpose of the study was addressed to each school director. This letter was preceded by a meeting with school directors whereby the principal investigator also explained the aims of the study. In each school, all of the teachers were recruited through the school's director and asked to attend a meeting with the researchers, who explained to them the purpose of the study and focus groups. It is worth noting that focus groups are the most convenient approach used to collect data for such a sensitive topic of inquiry (Speziale, Streubert, & Carpenter, 2011). The teachers were then asked to voluntarily register their names with the director's secretary if they were interested in participating. Parents

were recruited through letters sent by the schools' directors in which the purpose and content of the study were explained. The letters emphasized that participation is voluntary and that at any time they could decline or withdraw from the focus group session without obligation. All participants were asked to read and sign a consent form delineating their agreement to participate in the study and their approval to be audiotaped.

Each focus group, comprising 6 to 10 participants, was formed based on maximum variation sampling. Maximum variation sampling provides maximum efficacy for the naturalistic approach (Lincoln & Guba, 1985). The great heterogeneity in individual cases that may arise from small samples with maximum variation is intriguing since it captures core experiences and central aspects (Patton, 1990). Heterogeneity in the current study was reflected in sociocultural backgrounds, religious backgrounds, number of children, and educational levels.

Five audiotaped focus groups were conducted separately with teachers and parents/guardians. Before commencing with the focus group session, participants were reminded about the purpose of the study and focus group, and that participation is voluntary. At the beginning of these sessions, surveys were administered to collect basic demographic information about age, religion, marital status, place of residence, number of people living in the house, educational level, current working status, and monthly income. Focus group sessions took place in a quiet room chosen by the each school's director, respectively. Each session took approximately 60 to 75 minutes.

The focus group session started with a grand tour question followed by probing for every idea, such as: *What is your opinion about mental health and what is your understanding of mental health? Tell me more about it*. *Give me more examples*. *Can you elaborate more on it?* Participants were asked to answer and provide examples. Saturation within focus groups for each question was sought. Saturation is reached when no new ideas would surface (Cohen, Kahn, & Steeves, 2000). Furthermore, knowing that it is possible that participants in focus groups may choose to give socially pleasing answers (Lincoln & Guba, 1985), the investigator in the current study clarified—at the beginning of each session—that she is concerned about individuals' *actual* thoughts, feelings, and experiences. In order to prevent group think, the moderator paid special attention to the group dynamics throughout data collection. Furthermore, equivalence, internal consistency, and validity of the process were maintained by one moderator, who led the discussion with one group and across groups. Other researchers who were present during the interview were recording important nonverbal behaviors of participants that input helped in the data analysis process. A qualitative researcher transcribed the data verbatim and communicated regularly with other team members as the analysis proceeded.

Pseudonyms were used to protect participants' identities. Knowledge, attitudes, and practices regarding mental health and mental illness were therefore sought; needs and issues predominantly faced by parents and teachers regarding personal and student mental health were additionally examined.

The researchers chose to do the data analysis in English in order to have very thick description and to target English language journals. The researchers who were bilingual (English and Arabic) made sure to maintain the conceptual equivalence of what participants said during the focus groups by reviewing the translation and back translation executed by translators. No problems were perceived because the English version mirrored a technically and conceptually precise translated communication of the interviews conducted (Larkin, de Casterlé, & Schotsmans, 2007; Squires, 2009).

Data Analysis

A thematic analysis method described by Braun and Clarke (2006) was used to guide the analysis. The analysis process followed a five-step approach. First the qualitative researcher explained the method of data analysis to group members and played the role of gate keeper at the data analysis level. Then, all team members familiarized themselves with the data through repeated readings of the focus group data. Next, an initial common list of ideas and coding was generated after comparing notes with all researchers involved; the list was supported by excerpts from the focus groups interviews. Then, the different codes were sorted into potential themes. Afterward, the list of themes was refined after thorough discussions among researchers. Last, the themes were defined and named.

Results

Sample Characteristics

Our sample consisted of 27 teachers (60.0%) and 18 parents (40.0%). Among those parents, 13 were mothers (72.2%) and five were fathers (27.8%). The majority was female (91.1), below 50 years of age (95.6%), married (82.2%), and employed (72.7%). Our sample was heterogeneous in terms of religious backgrounds, whereby 75.6% were Christian, 17.8% were Muslim, and 6.6% were Druze. Approximately half had below college education (48.9%); the rest had either completed college or graduate studies (40.0% and 11.1%, respectively). The group of parents had children from different school levels (elementary, middle, and secondary).

Major Themes Identified

Three main themes emerged from the data process from both groups (teachers and parents):

1. Mental health care is a priority for overall health and there is a need for mental health awareness and services in the region.

All parents and teachers highlighted the need for having greater mental health awareness and services. They all mentioned that mental health is as important as any other health condition because it has a direct impact on the individual's quality of life and interaction with others. All participants mentioned the need to have mental health awareness similarly to the awareness campaigns that are done for vaccination or breast cancer. Despite the fact that mental health is not a common topic for discussion in Lebanon, all participants highlighted the need to know more about it as if they were waiting for an opportunity to convey this concern.

P: . . . for me mental health is extremely important. It affect our daily life, our professional life. Mental health affects everything . . .

T: . . . mental health was neglected in our region but now people are more aware about it. It is increasing and the more it is increasing people become aware about it . . .

T: We need to prepare our children for mental health like we prepare them for physical health . . . we vaccinate our children for physical health and we need to watch their mental health as well . . .

Parents and teachers expressed the need to know more about mental health causes and symptoms. It seems that parents and teachers had great curiosity toward this topic.

P: . . . to tell you the truth we do not know what is mental health precisely, we know it in general. It is something essential and since longtime no one gave it any attention . . .

T: . . . they used to hide mental illness and this affected people a lot and our society. There is no understanding of mental health in our society and we need to know it better . . .

P: . . . if your mental health is good then physically you would feel good . . .

2. Mental illness is a cultural taboo associated with fear of social isolation and stigmatization.

Participants without exception complained that people in Lebanon and in the region still consider mental health problems as a taboo, which should never be discussed openly. They all mentioned their fear of being labeled as "mentally ill," for it can lead to social isolation and stigmatization. Teachers in specific mentioned that this stigmatization prohibits them from highlighting any suspected symptom or mental health concerns to parents.

P: . . . if you tell someone that you seek mental health they stop talking to you . . .

P: . . . people here think that if you are mentally sick this means you are mad and they stop talking to you . . .

T: . . . most people if they want to seek mental health they go outside our region in order not to be labelled by others . . .

P: . . . since long time no one gave it any interest . . .

T: . . . there is no understanding of mental health in our society because people are afraid of mental health . . .

T: . . . if you tell parents that your child needs mental health they get mad at you and they report you . . .

Parents and teachers talked about mental health stigma as major hindering factors for people to seek psychiatric care or even to accept feedback from teachers. Teachers in specific talked about parents' fear of mental health as a major barrier for accepting it.

3. There is a need for better education and cultural understanding about mental health care.

Parents and teachers insisted that knowledge about mental health care needs to be disseminated among civilians of that region. More information about mental health consequences particularly about causes, early symptoms, and contributing factors was requested. Teachers mentioned that during their academic preparation, they are given very meager notions of mental health. Most of what they know about mental health stems from their professional experience. Both groups mentioned the need for awareness sessions about early recognition and symptoms.

P: . . . in our society we know little about mental health, we need to know more about it . . .

P: . . . I think it is as important as physical health I even think that they are closely interrelated . . .

T: . . . during our academic preparation they told us a bit about mental health, but what I know comes from my experience with students . . . we need more understanding of mental health . . .

T: . . . there are many things that we do not know about mental health that we would like to know . . . as teachers it is important for us to know in order to help our students and their parents

Parents and teachers asked for mental health awareness campaigns to enhance people's knowledge about mental health care and needs. Teachers requested more preparation about mental health issues in their academic preparation.

T: . . . there should be a clear cut definition of mental health, we need to know what is it . . . all people need to understand about mental health

P: . . . Mental health is like any other physical condition like diabetes for example but why people do not like to talk about it? Why there is this fear? . . .

Discussion

Based on the analysis process of the focus group sessions, three main themes were subsequently derived, which reflect the needs of parents and teachers from South Lebanon. It is interesting to note that to our knowledge, this is the first study to implement a qualitative strategy that investigates individuals' voiced concerns about negative mental health attitudes and beliefs, which could aid in the development of interventions. Most of the current literature has only assessed the efficacy of these interventions by comparing participants' responses preintervention and postintervention (Guzmán et al., 2015), or by comparing the treatment group's responses with those of the controls (Tol et al., 2012; Tol et al., 2014). Therefore, due to the paucity of existent literature, we rather sought to discuss empirical evidence that supported the importance of addressing the themes that emerged in the current study.

Mental Health Care Is a Priority for Overall Health and There Is a Need for Mental Health Awareness and Services in the Region

Participants highlighted the pressing need to have more awareness and services about mental health. These results correlate with the existing literature, which has consistently found a positive correlation between continuous exposure to war and rates of psychiatric symptoms (de Jong et al., 2001; Demyttenaere et al., 2004; Johnson & Thompson, 2008). In fact, several studies that were similarly conducted on the South Lebanese population found that witnessing trauma was a significant predictor of PTSD, depression, or their co-occurrence (Farhood & Dimassi, 2012; Farhood et al., 2006; Farhood, Fares, Sabbagh, & Hamady, 2016; Farhood & Noureddine, 2003). Although examining the prevalence rates of psychiatric symptoms was not our focus for the current study, these findings accentuate the need for relevant mental health care services in populations exposed to war traumas and continuous threats.

War-related trauma has been found to be intergenerationally transmitted (Klarić et al., 2008), even across three generations (Lev-Wiesel, 2007). In fact, children of war veterans with PTSD exhibited significantly more developmental, behavioral, and emotional problems (Klarić et al., 2008). Similarly, unhealthy family functioning, specifically in the inability of the family to experience adequate emotional responses and to effectively solve problems, was observed in these families (Miller & Jordans, 2016). These findings accentuate the need to examine children's mental health needs in the context of their parents', even years after the occurrence of war events and traumas. Alternatively, the need for parents themselves to examine their children's mental health, just as they would monitor their physical health, has been highlighted by one of the teachers in our study.

The need for mental health care among children in our region deserves even further scrutiny because exposure to trauma may have a vast influence on children's physical, psychological, and interpersonal development (Yoon et al., 2016). Moreover, if children's social, emotional, and behavioral difficulties are not addressed, their capacity to learn and excel in school could be impeded (Strøm, Schultz, Wentzel-Larsen, & Dyb, 2016). This was specifically observed in a national mental health intervention conducted on students from first to third grade in Chile; those whose mental health needs were met demonstrated better behavioral and academic outcomes compared with those whose needs were not (Guzmán et al., 2015). The multifaceted consequences of children's mental and psychological concerns have similarly been indicated by one of the parents in our focus groups who explained how unmet mental health needs can affect everything.

It is crucial to consider teachers' beliefs and perceptions concerning students' mental health prior to the implementation of any intervention program (Whitley, Smith, & Vaillancourt, 2013). Moreover, given the vast influence that teachers have on children's development, and the numerous associations that have consistently been found between academic and psychosocial development, efforts that address this need should also address teachers' mental health needs and concerns (Whitley et al., 2013). In addition, one cannot disregard the massive role that parents have on their children's psychological functioning. Studies have found that children of mothers who experienced poor psychological functioning were more likely to exhibit posttraumatic stress symptoms after exposure to war traumas (Laor, Wolmer, & Cohen, 2001; Qouta, Punamäki, & El Sarraj, 2003; Thabet, Tawahina, El Sarraj, & Vostanis, 2008), especially children from younger age groups (Farhood, 2013). Conversely, mothers' parenting style and coping strategies employed during conflict could fortunately cultivate resilience and psychological well-being in their child (Qouta, Punamäki, & El Sarraj, 2008). Knowing the detrimental impact of exposure to military conflict on mental health wellness, including teachers', parents', and children's, both universal and targeted interventions that seek to enhance children's mental health well-being should additionally target teachers' and families' mental health literacy (Thabet et al., 2008).

Mental Illness Is a Cultural Taboo Associated With Fear of Social Isolation and Stigmatization

Another major theme that emerged was the fear of being labeled as a mentally ill or "majnoun" that would almost inevitably evoke stigma. Stigma associated with mental illness is not an uncommon occurrence. In fact, studies have found that stigma associated with mental illness outweighs

that associated with physical disorders (Lai, Hong, & Chee, 2001). Falk referred to this as the "ultimate stigma" (as cited in Saxena, Thornicroft, Knapp, & Whiteford, 2007). In a study conducted on eighth graders, children were more likely to hold negative attitudes toward pictures of adults labeled as "mentally ill" compared with those labeled as "physically disabled." Furthermore, as many as 30.3% of teens reported that they were not willing to use mental health services, of which 65% had moderate to high stigma (Chandra & Minkovitz, 2006). The influence of fear of stigma on seeking mental health services has similarly been observed in our study, whereby one teacher mentioned that if one needs to seek professional help, he or she would most likely go outside the region to avoid being labeled by others.

It is worth noting that in Arab culture—including Lebanese culture—although family members are renowned for the support that they offer toward each other in times of stress, they can also be very intolerant and disappointed with a member's behavior (Youssef & Deane, 2006). Meleis and Hattar-Pollera argued that the family could simultaneously act as a barrier to better coping with stress and a source of stress (as cited in Youssef & Deane, 2006). The family, therefore, plays an integral role in shaping fundamental values and beliefs and in molding attitudes toward help-seeking behaviors. Help seeking could be influenced by perceived repercussions such as family dishonor (Youssef & Deane, 2006). An individual's mental illness is thus regarded as a private family matter, and help-seeking behaviors require a collaborative family effort (Heath, Vogel, & Al-Darmaki, 2016). Any form of professional intervention is perceived as a violation of family boundaries, which could subsequently harm the individual's and family's reputation (Bhui et al., 2003; Hamdan, 2009). Psychiatrists are thereby perceived as "the end of the line" resort for treatment of mental problems, and those who resort to such mental health professionals' care are thought of as "mad" (Youssef & Deane, 2006). The relationship between mental health seeking and family dishonor has also been highlighted in this study by one of the teacher's, which clearly indicated that if a teacher tells the parents their child needs to seek mental help, the teacher would most likely be scolded on.

Knowing that it is common for students to perceive that individuals in their lives often ridicule the use of formal mental health services, it is important to involve parents and teachers in those programs that aim at promoting mental health literacy (Chandra & Minkovitz, 2007). Moreover, it is essential to investigate children's and adolescents' *subjective* stigma experiences identified through their perceptions of family members' and school staff's interactions with them. In a qualitative study conducted in a mid-Western U.S. city (Moses, 2010), approximately half of the adolescents reported experiencing stigmatization exhibited through distrust, avoidance, pity, and gossip. Moreover, approximately one third reported experiencing stigmatization by school staff, which was expressed through fear, avoidance, dislike, and belittlement of their academic capabilities (Moses, 2010). It is interesting to note that in the current study, although mental health stigma emerged as a major concern voiced by parents and teachers, these individuals may have unconsciously endorsed stigmatizing attitudes and beliefs such that they may unknowingly be inflicting them on their children or students. It could be insightful to simultaneously examine *adolescents'* perceptions, and *parents'* and *teachers'*, to understand how stigma influences children's relationships with their parents and teachers and vice versa.

There Is a Need for Better Education and Cultural Understanding About Mental Health Care

The last theme to emerge was the need for mental health literacy. This concern is even more pivotal for children and adolescents, as documented in a study whereby one of the major reasons why these age groups delayed or failed to seek treatment was because they often did not recognize that they had a mental disorder (Gulliver, Griffiths, & Christensen, 2010). Assisting the young in terms of mental health literacy is paramount since they often lack the knowledge and experience to adequately deal with their mental health condition (Jorm, 2012). Thus, providing access to health care services for individuals who need mental health help does not suffice; rather, efforts aimed at increasing mental health literacy in the community should first be implemented in order to promote awareness and acceptance of mental disorders (Jorm, 2012). Most important, by educating parents and teachers about children's mental health, children's home and school environments could subsequently be modified in a way that their mental health is optimized (Hoven et al., 2008). Both parents and teachers in our study concurred that they were relatively naïve about mental health; they believed that such knowledge is as crucial as knowledge of physical health. Thus, community-held educational interventions that address children's and adolescents' mental health needs should simultaneously involve parents and teachers who interact and encounter children the most in their everyday lives so that more supportive and accepting attitudes toward mental health concerns would be endorsed.

Rigor

Guba (1981) and Guba and Lincoln (1994) have identified several terms that describe operational techniques that support the rigor of the study. Credibility was ensured through member checking—that was performed directly at the end of each focus group session—as well as through peer debriefing. Dependability was secured through triangulation of data from teachers and parents. Confirmability was guaranteed through a clear audit trail. This study's rich excerpts that reflect the participants' experience may offer transferability to regions affected by war.

Strength and Limitation

This is the first study in Lebanon that directly spoke with parents and teachers about such a sensitive topic. It is those cultural values, beliefs, practices, and meanings specific to mental health and illness that were found among Lebanese parents and teachers participating in the study that will add to the transcultural nursing knowledge about the importance of mental health care. The subsequent psychoeducational sessions were illuminated by the results of this study. Unfortunately, only the parents and teachers who were present shared their ideas, experiences and feelings about mental health. We believe that parents and teachers who were not included in the study may have similar beliefs and perceptions.

Implication for Practice

The role mental health interventions play in the well-being of conflict-prone communities and the benefits of focus groups for intervention planning are highlighted. Results of this study will illuminate the practice of mental health in Lebanon, which may lead to the development of more culturally congruent health care programs. Moreover, based on the themes discovered in this study, it would be important to design a school-based educational program for parents and teachers in the area where this study was conducted. Nurses with psychiatric background and health care workers in the field of psychiatry in collaboration with teachers and parents at schools need to be involved in the planning and implementation of such a culturally oriented program. Such a program may help in clarifying the taboo concerning mental health in the Lebanese culture. At the international level, health care workers involved in the psychiatric field may benefit from the results of this article to better understand the Lebanese culture regarding mental health. It will also help them in developing a culturally based approach for the Lebanese living in the diaspora which are about 14 million between different continents.

Conclusion

This study highlighted the knowledge, practices, and attitudes of teachers and parents toward mental health in the south of Lebanon. Our findings add to transcultural nursing knowledge related to the Lebanese culture and the mental health perceptions within that culture. These findings could also assist health care providers in Lebanon and abroad. The authors' next step is to conduct an evaluation study of the effectiveness of community-based educational workshop interventions designed based on the themes that had emerged from these focus groups.

Recommendation

Stigma associated with mental illness could be combatted by incorporating mental health services into more mundane settings such as primary health care facilities and, when appropriate, involving a mélange of both modern and traditional healing strategies (Daradkeh, Eapen, & Ghubash, 2005; Patel, Flisher, Hetrick, & McGorry, 2007). Additionally, school officials and leaders could be endorsed with mental health educational programs. Nevertheless, when designing such school-based educational programs, it is crucial to keep in mind that these interventions are not modalities for treatment of psychiatric symptoms, including PTSD, anxiety, and depression. Rather, they can be considered as prevention or early interventions that can only be effective after deliberate planning and piloting (Ertl & Neuner, 2014), as what was sought in the current study.

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