



Graduate School of Education

**What are in Learning Disability (LD) and Attention Deficit Hyperactivity Disorder (ADHD) names? An exploration of LD and ADHD labels in primary mainstream schools in Jeddah, Saudi Arabia**

Submitted by Hatim Hamdi H Algraigay to the University of Exeter  
As a thesis for the degree of  
Doctor of Education in Special Needs and Inclusive Education  
June 2019

This thesis is available for Library use on the understanding that it is copyright material and that no quotation from the thesis may be published without proper acknowledgement.

I certify that all material in this thesis which is not my own work has been identified and that no material has previously been submitted and approved for the award of a degree by this or any other University.

Signature: .....

## **Abstract**

The objective of the present study was to explore the strength and drawbacks of Learning Disability (LD) and Attention Deficit Hyperactivity Disorder (ADHD) labels on labelled children, general students and general teachers in the context of primary schools in Jeddah, Saudi Arabia.

The study provided background information of the Saudi context regarding SEN in general and a historical overview of LD and ADHD programmes in particular. Also, it assessed the provisions provided to students with LD and ADHD. Two theories were highlighted in this study, labelling theory (Becker, 1963) and stigma theory (Goffman, 1963). These theories were linked to current research on the phenomenon of labels. Relevant and prior literature to the phenomenon of labels were provided and evaluated to shed light to the scope and gap of this study.

A mixed-method design was chosen to serve the research agenda posed by the study. An explanatory sequential design was adopted in which quantitative data were gathered first, followed by qualitative data. A closed-ended questionnaire was distributed to LD parents, LD teachers, ADHD parents and ADHD teachers. Of these, 153 completed questionnaires were received. The aim of the questionnaires was to gain a general and broad picture of the phenomenon of labels. Then, in-depth information and comprehensive understanding were obtained by interviewing a purposeful sample of two LD and two ADHD teachers in primary schools and four parents of children with LD and ADHD. The total number of interviewees were eight.

The quantitative findings indicated that participants perceived stigma, lower self-esteem and potential adverse effects of informal labels on children with LD and ADHD. Thus, information collected from the quantitative phase supported the researcher in interpreting and integrating some of the perceptions and practices of participants concerning labels that appeared later on in the qualitative phase. Finding indicated that there large effects on labelled children, their parents and teachers. General teachers seemed to have crucial role in exercising and distributing stigma to children labelled with LD and ADHD. The present study

concluded with answering all the research questions, proposing some recommendations for parents, teachers, policy makers and future research.

## **Acknowledgement**

I am strongly grateful to All-Mighty God, Allah, who provided me with power, patience, and determination to accomplish my project.

At the end of this project, I would like to extend my thanks and appreciations to the following people who helped me to make my project a truly unique experience, through their support and help. This thesis would not be completed without the constant supports, productive discussion and useful feedback from both supervisors Dr Christopher Boyle and Dr Alison Black.

I owe a very important debt to my father Dr Hamdi Algraigay, and my mother Amenah Algraigay for their supplications and unconditional love during this challenged journey of learning. My Warmest thanks to my beloved sister and brothers, namely, Bushra, Dr Abdualrahamn, Moaath, Abdulbari, Asim and Ahmed for their persistent encouragements. All of you, my darling family, have thought on me, and you haven't left me alone.

I owe my deepest gratitude to my wife Somaih Algraigay, for her sacrifices, unconditional love, support and encouragement despite the responsibilities she has. I would like to show my greatest appreciation to my son Adi, my daughter Besan for their patience and unforgettable love they gave me.

# Table of Contents

<b>Abstract</b> .....	<b>2</b>
<b>Acknowledgement</b> .....	<b>3</b>
<b>Chapter One</b> .....	<b>9</b>
<b>Introduction</b> .....	<b>9</b>
<b>1.1 Introduction</b> .....	<b>9</b>
<b>1.2 Overview</b> .....	<b>9</b>
<b>1.3 Nature of the Problem</b> .....	<b>12</b>
<b>1.4 Rationale of the Study</b> .....	<b>14</b>
<b>1.5 Structure of the Thesis</b> .....	<b>15</b>
<b>Chapter Two</b> .....	<b>17</b>
<b>Background of the Saudi Context</b> .....	<b>17</b>
<b>2.1 Introduction</b> .....	<b>17</b>
<b>2.2 Saudi SEN Historical Overview</b> .....	<b>17</b>
<b>2.3 Saudi SEN Policy</b> .....	<b>19</b>
<b>2.4 Reflection on Saudi SEN Policy</b> .....	<b>21</b>
<b>2.5 Learning Disability</b> .....	<b>22</b>
2.5.1 Saudi Learning Disability Programme (SLDP).....	22
<b>2.6 ADHD</b> .....	<b>25</b>
2.6.1 ADHD in Saudi Arabia .....	25
<b>2.7 Summary</b> .....	<b>27</b>
<b>Chapter Three</b> .....	<b>28</b>
<b>Literature Review</b> .....	<b>28</b>
<b>3.1 Introduction</b> .....	<b>28</b>
3.1.1 Process of Searching the Literature Review.....	29
<b>3.2 Learning Disability</b> .....	<b>31</b>
3.2.1 Definitions and Concepts .....	31
3.2.2 Models of Disability and Dyslexia .....	34
<b>3.3 ADHD</b> .....	<b>35</b>
3.3.1 Concept and Definition.....	35
3.3.2 Models and Interventions of ADHD.....	37
<b>3.4 Labelling Theory</b> .....	<b>39</b>
<b>3.5 Who Has the Power to Label Children with Special Needs?</b> .....	<b>41</b>
<b>3.6 Types of Labelling</b> .....	<b>45</b>
3.6.1 Features of Informal Labelling .....	46
3.6.2 Features of Formal Labelling .....	48
<b>3.7 Strength of Labels</b> .....	<b>49</b>
<b>3.8 Negative Consequences of Labelling</b> .....	<b>51</b>
3.8.1 Stigma Theory.....	52
3.8.2 Stigma as a Negative Consequence of Labelling .....	53
3.8.3 Stigma Management, Teachers' and Students' Roles.....	55
3.8.4 Effects of Labels on Self-Esteem, Self-Perception and Children's Sensitivities ...	56
3.8.5 Discrimination and Social Disadvantages.....	57
3.8.6 Effects of Labels on Children's Behaviours .....	57
3.8.7 Effects of Labels on Teachers and Professionals.....	58
3.8.8 Effects of Labels on Parents and Peer Relationships.....	59
<b>3.9 Summarising Previous Research Related to the Current Study</b> .....	<b>61</b>
<b>3.10 Aim of the Study and Research Questions</b> .....	<b>63</b>
<b>3.11 Summary of the Chapter</b> .....	<b>64</b>

<b>Chapter Four</b> .....	<b>65</b>
<b>Methodology</b> .....	<b>65</b>
<b>4.1 Introduction</b> .....	<b>65</b>
<b>4.2 Philosophical Assumptions</b> .....	<b>65</b>
4-2-1 Positionality .....	67
<b>4.3 Research Design</b> .....	<b>68</b>
4.3.1 Quantitative Phase (First Phase).....	71
4.3.1.1 Sample.....	71
4.3.1.2 Method.....	74
4.3.1.3 Data Collection Procedure and Analysis.....	77
4.3.2 Qualitative Phase (Second Phase).....	79
4.3.2.1 Sample.....	79
4.3.2.2 Method.....	80
4.3.2.3 Data Collection Procedure and Analysis.....	82
<b>4.4 Trustworthiness</b> .....	<b>85</b>
<b>4.5 Ethical Issues</b> .....	<b>86</b>
<b>Chapter Five</b> .....	<b>88</b>
<b>Quantitative Findings</b> .....	<b>88</b>
<b>5.1 Introduction</b> .....	<b>88</b>
<b>5.2 Reliability of the Quantitative Analysis</b> .....	<b>88</b>
<b>5.3 Demographics Information</b> .....	<b>90</b>
<b>5.4 Descriptive Analysis of Whole Scales</b> .....	<b>92</b>
<b>5.5 Descriptive Analysis of Scales Item by Item</b> .....	<b>94</b>
5.5.1 Stigma.....	94
5.5.2 Self-Esteem .....	99
5.5.3 Informal and Formal Labels .....	103
5.5.4 Potential Outcomes of Labels .....	108
5.5.5 Effects of Labels on Teachers and School Staff.....	112
<b>5.6 Summary of the Chapter</b> .....	<b>116</b>
<b>Chapter Six</b> .....	<b>118</b>
<b>Qualitative Findings</b> .....	<b>118</b>
<b>6.1 Introduction</b> .....	<b>118</b>
<b>6.2 General Information about Labelled Students</b> .....	<b>119</b>
<b>6.3 Knowledge and Experience</b> .....	<b>121</b>
6.3.1 Understanding of the LD Label .....	121
6.3.2 Understanding of the ADHD Label.....	123
6.3.3 Involvement in Workshops.....	124
<b>6.4 Strength of ADHD and LD Labels</b> .....	<b>125</b>
<b>6.5 Hiding Difficulties</b> .....	<b>127</b>
6.5.1 Hiding Difficulties at School .....	127
6.5.2 Hiding Difficulties at Home.....	129
6.5.3 Why Labelled Students Hide their Difficulties .....	130
6.5.4 Acknowledgment of Disability .....	131
<b>6.6 Stigma</b> .....	<b>132</b>
6.6.1 Occurrence of Stigma .....	132
6.6.2 Sources of Stigma.....	134
6.6.3 Stigma Outcomes .....	135
<b>6.7 Potential Drawbacks Resulting from Labels</b> .....	<b>136</b>
6.7.1 Effects of Labels on Social Skills .....	136
6.7.2 Effects of Labels on Self-Esteem.....	138
6.7.3 Effects of Labels on Academic Aspects.....	140
6.7.4 Effects of Labels on Teachers .....	142

6.7.5 Effects of Labels on Children and Parents.....	143
<b>6.8 Informal Labels .....</b>	<b>144</b>
6.8.1 Use of Pejorative Words .....	144
6.8.2 Effects of Informal Labels .....	146
<b>6.9 Effects of the Resource Room.....</b>	<b>147</b>
6.9.1 Effects of the Resource Room on Students.....	147
6.9.2 Effects of the Resource Room on General Teachers .....	150
<b>6.10 Labels in the Future.....</b>	<b>151</b>
6.10.1 Use of Labels in the Future.....	151
6.10.2 Suggestions for Alternative Labels .....	153
<b>Chapter Seven .....</b>	<b>155</b>
<b>Discussion Chapter.....</b>	<b>155</b>
<b>7.1 Introduction .....</b>	<b>155</b>
<b>7.2 LD and ADHD Knowledge and Experience among Teachers and Parents .....</b>	<b>157</b>
7.2.1 Misunderstanding and Misperception of LD.....	157
7.2.2 Misunderstanding and Misperception of ADHD .....	159
7.2.3 Teachers' and Parents' Involvement in Training and Workshops.....	162
<b>7.3 Strength of ADHD and LD Labels.....</b>	<b>165</b>
<b>7.4 Occurrence and Features of Stigma Attached to Labelled Students .....</b>	<b>168</b>
7.4.1 LD and ADHD Labels.....	169
7.4.2 Informal Labels and Negative Connotations .....	172
7.4.3 Power and Motivation .....	173
<b>7.5 Effects of Pulling Out Programmes .....</b>	<b>175</b>
<b>7.6 Students' Reactions: 'Hiding Difficulties'.....</b>	<b>177</b>
<b>7.7 Future of LD and ADHD Labels .....</b>	<b>179</b>
<b>Chapter Eight.....</b>	<b>183</b>
<b>Conclusion.....</b>	<b>183</b>
<b>8.1 Introduction .....</b>	<b>183</b>
<b>8.2 Summary of the Study.....</b>	<b>183</b>
RQ 1 How do primary school teachers and parents view and perceive ADHD and LD labels?.....	184
RQ 1-A- How do primary school teachers and parents perceive the strengths of applying ADHD and LD labels to children? .....	185
RQ 1-B- How do primary school teachers and parents of children with LD and ADHD perceive the negative impacts of these labels? .....	186
RQ 4 What do primary school teachers and parents predict regarding the future of ADHD and LD labels?.....	187
<b>8.3 Contribution of the Study.....</b>	<b>188</b>
<b>8.4 Limitations and Strengths of the Study.....</b>	<b>191</b>
<b>8.5 Implications and Recommendations .....</b>	<b>192</b>
8.5.1 Parents.....	192
8.5.2 Teachers .....	193
8.5.3 Policy Makers.....	194
8.5.4 Scholars and Future Research .....	195
<b>8.6 Personal Reflection .....</b>	<b>195</b>
<b>References .....</b>	<b>197</b>
<b>Appendices .....</b>	<b>216</b>

## Table of table

Table 1 (Summary of the number of participants) .....	73
Table 2 (type of questionnaire scales) .....	75
Table 3 (Summary of questionnaires piloting).....	77
Table 4 (Details of the Interview Participants) .....	80
Table 5 (Braun and Clarke's Thematic Analysis Process).....	84
Table 6 (Reliability of Scales) .....	89
Table 7 (Summary of Demographics Information of Participants).....	90
Table 8 (Scoring the questionnaire).....	92
Table 9 (the mean of all scales).....	94
Table 10 (Responses of Stigma Attached to LD Label).....	96
Table 11 (Responses of Stigma Attached to ADHD Label).....	98
Table 12 (Responses of Children' with LD Self-esteem).....	101
Table 13 (Responses of Children' with ADHD Self-esteem).....	103
Table 14 (Responses of Informal and Formal Labels Attached to children with LD).....	105
Table 15 (Responses of Informal and Formal Labels Attached to children with ADHD).....	107
Table 16 (Responses of Potential Outcomes of the LD Label).....	109
Table 17 (Responses of Potential Outcomes of the ADHD label).....	111
Table 18 (Responses of the Effects of the LD Label on Teachers and School Staff) .....	112
Table 19 (Responses of the Effects of the ADHD label on Teachers and School Staff) .....	115
Table 20 (Table of qualitative themes) .....	119
Table 21 (Research Questions and Related Findings) .....	155

## Table of Figures

Figure 1 (Explanation of all Figures) .....	118
Figure 2 (Theme of General Information) .....	120
Figure 3 (Theme of knowledge and Experience).....	122
Figure 4 (Theme of Strength of ADHD and LD labels) .....	126
Figure 5 (Theme of Hiding Difficulties) .....	128
Figure 6 (Theme of Stigma).....	133
Figure 7 (Theme of Potential Drawbacks Resulting from Labels).....	137
Figure 8 (Theme of Informal Labels).....	145
Figure 9 (Theme of Effects of the Resource Room) .....	148
Figure 10 (Theme of Labels in the Future).....	152
Figure 11 (Relationship between traits, labelling and stigma theories).....	191

## Table of Appendices

<b>Appendix 1 (Questionnaires for All Participants- English version)</b> .....	216
<b>Appendix 2 (Questionnaires for All Participants- Arabic version)</b> .....	230
<b>Appendix 3 (Interview Questions - English Versions)</b> .....	264
<b>Appendix 4 (Interview Questions – Arabic version)</b> .....	268
<b>Appendix 5 (Example of Interview Transcripts)</b> .....	273
<b>Appendix 6 (Ethical form Gained from the University of Exeter)</b> .....	274
<b>Appendix 7 (Permissions of Ministry of Education in Saudi Arabia)</b> .....	291
<b>Appendix 8 (Permission from Schools’ Principals)</b> .....	294
<b>Appendix 9 (Information Sheet to Participants and Consent form of Questionnaires)</b> .....	295
<b>Appendix 10 (The Label used in some Saudi Resource Room)</b> .....	301
<b>Appendix 11 (Code of Interviews)</b> .....	302



# Chapter One

## Introduction

### 1.1 Introduction

This chapter opens with an overview of the labelling of children with Special Educational Needs (SEN). In addition, the chapter will explain the nature of the problem and the rationale behind conducting this research.

### 1.2 Overview

In the field of SEN, it has been argued that labelling children with SEN helps with the provision of appropriate learning opportunities and extra support as well as increasing awareness and understanding of certain disabilities (Gillman, Hayman, & Swain, 2000; Lauchlan & Boyle, 2007). Labels might be necessary in order to gain access to funding and support. Educational rationales and justifications are considered as one of the essential reasons why children might be labelled as having a disability. However, as Boyle (2014) illustrates, the reality can be well intended, but also can be negative if applied in an inappropriate way.

Since words and phrases can powerfully configure the perceptions of people and society (Platteel, 2003), SEN advocates should focus on how to use the power of language to help children with SEN. Attributing labels to children can potentially have negative impacts on them, their parents and general teachers. In other words, labelling children with SEN may be harmful, since it affects their lives, their relatives and their educational and employment prospects. Stigmatisation, exclusion and discrimination are potential consequences of labelling people, and stigmatisation has been linked to labels (Algraigray & Boyle, 2017; Lauchlan & Boyle, 2007). The debate about whether assigning labels to children is helpful or harmful is still ongoing (Arnold, 2017). Although the issue of labelling is not new in international contexts and literature, exploring it in the context of Saudi Arabia might contribute novel findings to international knowledge.

Several possible reasons for labelling children with SEN or disabilities have been suggested. Davidson et al. (2008) argued that individuals are characterised and hierarchised by the medical industry and professionals through the observation and examination process. It can be reasonably argued that medical professionals in the

SEN field created labelling to open resources for labelled children and eventually lead to the exclusion of children with SEN from society (Arishi & Boyle, 2017; Hacking, 1999; Lauchlan & Boyle, 2007, 2014). Thus, the outcomes of the discursive process of medical science, including diagnosis and interventions, are the basis for classifying children with SEN.

Gillman et al. (1997) argued that the classification of children with SEN is based on children's problems and difficulties. Harris (1995) claimed that classification and labelling came about through medical science and the diagnostic process. Professionals build classifications and classify children with SEN according to rigorous criteria and formal knowledge – for instance, Attention Deficit Hyperactivity Disorder (ADHD), which is diagnosed by applying criteria in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2013). However, this classification is not always accurate, several studies have criticised the diagnostic system and its fallibility (Gillman & Tomson, 1998; Gillman et al., 2000). An example of the fallibility of the diagnostic system process is that 60% of children labelled with SEN receive an ambiguous diagnosis (Sutcliffe & Simons, 1993; NHS, 2013). Another support here might be the gender disparity in ADHD diagnosis across the lifespan (Rucklidge, 2010). Wood et al (2019) indicated that the DSM-5 expanded the criteria for ADHD widely from the previous DSM-IV, which was seen as possible reason contributed false-positive diagnosis. In more details, the DSM-5 increased the required age of symptom onset and decreased the required number of symptoms for adults and older adolescents (Lewandowski & Lovett, 2014). One final example of the fallibility of diagnostic system is that 15% to 30% of college students evaluated for ADHD overreport traits and symptoms of ADHD (Wood et al, 2018; Harrison & Edwards, 2010). These criticisms and challenges of the DSM can be likely to persist in the decades if it is left without solutions (NHS, 2013). The continuous use and fallibility of labels should be reconsidered. Thus, since labelling is suspected of being fallible, I argue that attributing labels to children could affect their academic and emotional development.

The medical model has prevailed in the SEN field as the essential instrument for characterising and classifying individuals with disabilities (Gillman et al., 1997). It has been claimed that professionals label and classify people with disabilities

through individualising techniques and normalising judgements (Harpur, 2012). In other words, classifications of children with SEN are largely established by those professionals who manage the disability industry, not by people with disabilities themselves. Labels and classifications are believed to be helpful for creating opportunities, such as extra resources and support, and it has been argued that children who are not labelled can be overlooked (Gillman et al., 2000). Labels are also believed helpful in building legislative support for children with SEN (Gold & Richards, 2012; Algraigray & Boyle, 2017), but would these children not be provided with legislative support if they were not labelled? By this yardstick, the word 'dyslexia' refers not to difficulties with reading and writing but to the extra time given to children or to other supportive approaches for teaching literacy. To extend this analogy, it is as if the term 'physical disability' generates images of lifts, wheelchairs, mobility assistance and 'extra resources', instead of the nature of the disability itself. Despite the claim that opening resources and building legislative support were considered to be positive of labels, they might be questionable. Accordingly, there is a need to question other positive points behind the establishment of labels.

As illustrated in the literature review chapter, LD and ADHD are two fields with complex definitions, diagnoses, interventions and labels. For example, there is no one agreed-upon definition of LD worldwide (Sideridis, 2007; Tunmer & Greaney, 2010). Similarly, there is no one exact definition of ADHD (Wheeler, 2007). Such ambiguity regarding the definitions and diagnostic labels of LD and ADHD raises some questions about their effects. In the UK, for example, recommendations have been made to narrow the definitions of LD types. Terms such as dyslexia or 'specific learning difficulties' (SpLD) are preferable over simply referring to a child as having an LD (British Dyslexia Association, 2007; British Psychological Society, 1999). The criteria for diagnosis in the UK such as phonological functions, verbal memory and processing (Rose, 2009), can vary by region to region. In contrast, the Saudi educational system is based on the US system (Alquraini, 2010; Ministry of Education, 2015), where LD has been adopted. However, since LD in the Saudi context corresponds to SpLD in the UK, this thesis will use LD in terms of data collection and participants. Using LD might make the thesis clearer and more easily

comprehensible for researchers and readers. However, there is no difference in ADHD terminology between the UK and Saudi contexts.

Exploring whether LD and ADHD labels are harmful or helpful might best be achieved by using labelling theory (Becker, 1963) and stigma theory (Goffman, 1963) as lenses. According to Neuman (2002, p. 52), 'theory frames how we look at and think about a topic ... directs us to the important questions, and suggests ways for us to make sense of data'. Theoretical frameworks thus serve to orientate how we look at the social world by providing a collection of concepts and forms of explanations (Neuman, 2002). Exploring LD and ADHD labels from two different theoretical frameworks might allow the researcher to achieve a deeper understanding of both conditions and meet the objectives of this research.

### **1.3 Nature of the Problem**

While the issue of labelling has been studied carefully in international contexts, comparatively fewer studies have been conducted in Saudi Arabia to investigate both the drawbacks and advantages of labelling people with SEN generally, and ADHD and LD in particular. Thus, exploring the phenomenon of labels in the Saudi context is needed to fill the existing scholarly gap. One may ask why LD and ADHD were selected in this study rather than any other SEN categories. The answer to this question is that numerous studies have indicated substantial comorbidity between ADHD and LD (Reason, 1999; Tabassam & Grainger, 2002). Although it was a dated finding, nearly one-third of students with LD are considered to have ADHD (Robins, 1992). Similarly, an Australian National Health and Medical Research Council report indicated coexisting LD in 10–90% of students with ADHD, while coexisting ADHD occurred in 41–80% of students with LD (Carmichael et al., 1997). One more recent sign of the comorbidity between LD and ADHD can be the fact that some Saudi LD teachers deal with ADHD students (MOE, 2016). This might be because some ADHD symptoms are likely to be exhibited by LD students. One other reason of why LD teachers deal with ADHD students can be the shortage of teachers who are qualified with ADHD. Thus, the comorbidity between ADHD and LD justifies the selection of both categories in this research.

Another reason behind choosing LD in this study is that some of the potential consequences of labels such as stigma and exclusion cannot be detached from societies. In other words, stigma is a product of social and cultural relations (Goffman, 1963). Therefore, it can be said that culture and society play a crucial role in shaping labels. In the Saudi context, children with LD are the largest group of children with SEN who have opportunities for inclusion in mainstream schools. When a large number of children with LD are included in mainstream settings, they have opportunities to socialise and interact with other, typically developing children. Thus, stigma and other negative connotations might be observed more with respect to LD children. In more detail, approximately 25,000 students with LD are included in mainstream settings in Saudi Arabia. Statistics from the Ministry of Education (MOE) (2016) about Riyadh (the capital of Saudi Arabia) show that among 8,923 students with SEN, 4765 (53.3%) have been labelled with an LD. Therefore, choosing LD as a category to explore the issue of labelling provided this research with more knowledge and greater understanding.

Regarding the selection of ADHD as another category used to explore the issue of labelling, ADHD was recently introduced by the MOE (2017) to mainstream settings. Under the new ADHD system, only 10 schools in the Kingdom of Saudi Arabia provide ADHD services in mainstream settings – two schools in each of the five major cities (Riyadh, Jeddah, Dammam, Aseer and Hail) (MOE, 2016). In the Saudi context, there is no preparation for ADHD teachers or qualified staff at Saudi universities (Algraigay, 2015). Thus, teachers specialised in LD and autism are assigned to teach students with ADHD. Generally speaking, schools, teachers and students have little to no experience with ADHD students due to a lack of preparation. Thus, their practices and daily actions towards children with ADHD should be explored. In this study, understanding ADHD in the Saudi context contributed to a deeper understanding of labelling. Although his study was revealed before the formal establishment of ADHD in Saudi Arabia, Al-Mousa (2008) stated that 12.6% of Saudi children have ADHD, which is approximately two times greater than the international estimation of ADHD prevalence. On the other hand, Statistically, LD are the most common SEN category in Saudi Arabia (MOE, 2016). As such, children with either categories have greater opportunities for inclusion in mainstream settings, which in turn increases their opportunities to interact with

other students, where the issue of labels can be noticed. Thereby, the products of both labels and social interactions were best explored in this study by selecting both ADHD and LD. These are the justifications of why both LD and ADHD were selected in the present study.

It should be noted that while the nature of the problem, i.e., the negative impacts of labels, has been demonstrated in international studies, no such studies have been conducted in Saudi Arabia. One may ask why it was worth studying labelling in the Saudi context. The answer is that Saudi Arabia is very different – in terms of culture, language, education, collective thought, and lifestyle, therefore, perceptions about ADHD and LD – from other national contexts in which labels have been explored, such as the US, Australia and the UK. This is important, since labelling practices are likely contextually bounded (Goffman, 1963), i.e., practices/experiences in one context may be very different from those in other contexts. It is again worth noting that the consequences of labels such as stigma and exclusion cannot be detached from society. As the aforementioned number of ADHD and LD are seen as the two highest categories, perceptions about those two labels might be very much linked within social relationships. Hence, it was prudent to explore Saudi parents' and teachers' perceptions about these labels, especially given its current lack of consideration in the Saudi literature despite the high percentages of children in Saudi Arabia who have ADHD or LD.

#### **1.4 Rationale of the Study**

This research stems from the researcher's previous academic and professional experience. The researcher completed his bachelor's degree in the Education School at King Abdulaziz University in Jeddah in the field of 'learning disability'. This qualified him to begin his profession when he received a school placement in the last semester of his undergraduate degree. He then completed his Master's degree in ADHD intervention and diagnosis programmes. In addition, he conducted a study in which he investigated whether labelling is helpful for children with SEN by reviewing the international literature. Several drawbacks as well as advantages regarding labelling in the UK were found (Gillman, Hayman, & Swain, 2000; Lauchlan & Boyle, 2007). The researcher perceived, via first-hand experience, that cultures and societies play a crucial role in shaping labels, and therefore

perceptions might also play a significant role in teachers' practices. Thus, conducting this study in the Saudi context might be worthwhile since it lacks from studies specifically aimed to explore the issues of labelling. Exploring parents' and teachers' perceptions about labels, and investigating teachers' and parents' perceptions towards them, provided a better and deeper understanding of the labelling phenomenon. Taking teachers' perceptions and views about labelling into account in this research was based on the fact that Saudi SEN teachers have great responsibilities in diagnosing, designing individual educational plans (IEP) for, and teaching SEN students (MOE, 2016). Therefore, they were likely to be more knowledgeable about their students. Furthermore, since parents experience the symptoms and associated difficulties of their children's ADHD and LD in everyday life, they too have more knowledge and experience about their children. Hence, the researcher believed it vital to explore teachers' and parents' perceptions regarding ADHD and LD labels.

Another justification for conducting this research was the lack of essential ADHD services and programmes in Saudi Arabia alongside the lack of relevant literature. The aforementioned high number of LD programmes and services should be accordant with the number of research studies that focus on LD. Exploring this issue from different angles (parents' and teachers' perceptions) may provide a more in-depth understanding of ADHD and LD labels. Therefore, the aim of this research was to explore SEN teachers' and parents' perceptions towards ADHD and LD labels in the Saudi context. By using closed-ended questionnaires and semi-structured interviews, a mixed method approach was applied to the exploration of the effects of LD and ADHD labels based on teachers' and parents' perceptions. To the best of the author's knowledge, this study was the first to explore parents' and teachers' perceptions about LD and ADHD labels in Jeddah, Saudi Arabia. This study might offer an in-depth understanding and provide insights to teachers, parents and authorities about the effects and benefits of LD and ADHD labels in the Saudi context.

## **1.5 Structure of the Thesis**

The introduction in this chapter introduces readers to this thesis through an overview of the topic, the nature of the problem, and rationale of the study and

research questions. Chapter two, which is context of the study, offers background of the context where this research was conducted. It provides a history of Special Educational Needs (SEN) in Saudi Arabia. It highlights the current provision addressed to children with Learning Disability (LD) and Attention Deficit Hyperactivity Disorder (ADHD).

The literature review in chapter three critically offers relevant literature to the discipline of labels. It demonstrates the complexities around LD and ADHD terms and definitions in different contexts. Additionally, it discusses the labelling theory and how labels are attributed to children. It highlights the strength of labels, alongside with the negative outcomes. Stigma theory, teachers and students' roles in stigma are reviewed.

Chapter four describes the methodological assumptions of this study and the researcher. It includes the research's paradigm, ontological and epistemological philosophies. The methodological choices of the study are presented alongside research design, sampling, methods, data analysis and the ethical considerations. Quantitative findings in chapter five associates with results from the first phase of this thesis. It introduces how the validity and reliability of those findings are established. Also, it provides a descriptive analysis of all scales as whole, and a descriptive analysis of all scales item by item.

Chapter six reports the qualitative findings of the second phase. It presents the findings according to themes and sub-themes. Discussion chapter associates the main findings revealed from both quantitative and qualitative phases to answer the research questions of the thesis. Moreover, it links the yielded findings with an extensive literature in line with both labelling and stigma theories. Finally, an overall conclusion in chapter eight provides an overview of this study and how the objectives were addressed. It illustrates the contribution to knowledge and theories. Also, it draws the implications and recommendations for teachers, parents, policy makers and the future scholars.



## Chapter Two

### Background of the Saudi Context

#### 2.1 Introduction

This chapter provides essential and basic information related to special educational needs in Saudi Arabia. It begins by explaining the historical overview of SEN in general, how it has evolved over time and the way the Saudi SEN policy is used to derive and to guide SEN services. In addition, it highlights the current provisions for both LD and ADHD categories as they are the main focus of this research. The penultimate section offers an overview of ADHD in the Saudi context, its history and how the current provisions are implemented, and the chapter concludes with a summary of challenges related to ADHD.

#### 2.2 Saudi SEN Historical Overview

In 1953, unofficial services began in Saudi Arabia through individual initiatives taken by people, such as Alhusain, Almufda and Alswaid, who were blind and learned the Braille alphabet from visitors to Saudi Arabia to teach reading and writing skills to blind students (Almoussa, 2008; Allothman, 2014; Alshahrani, 2014). However, parents were generally fully responsible for providing their children with education services, which could be viewed as insufficient in meeting the children's needs. In 1958, the first special education programme that provided services for blind students was established and funded by a private organisation, and the programme was offered during the evening (Aldabas, 2015). Some policy makers and educational agencies were persuaded by these initiatives to eventually found education institutions that serve people with visual impairments (Afeafe, 2000).

In 1960, the Institute of Light, 'Al-Noor Institute', was established by the Ministry of Education (MOE) to educate male individuals with poor vision, visual impairment or blindness, and it was the first special education school organised by the government (Aldosari, 2013; Almoussa, 2010; Aldabas, 2015). In 1962, the Special Education Division was established by the MOE. The aim of this department was to improve and to provide vocational education and academic skills for students with visual impairments, hearing impairments and intellectual disabilities (Almoussa, 2010; Alshahrani, 2014; Aldabas, 2015). In 1964, two special education institutes for students with hearing impairments were founded. A few years later in 1971, the

first institute for students with intellectual disabilities was established (Aldosari, 2013). In 1974, the MOE established the General Secretariat of Special Education (GSSE), which was previously called the General Directorate of Special Education Care (Aldosari, 2013). The GSSE had many departments, and each department focused on a specific category.

The departments served students with intellectual disabilities, hearing and speech impairments, including difficulty hearing, visual impairments, including those with low vision ability, learning disabilities, physical and health impairments, autism, ADHD and multiple disabilities (MOE, 2018). A recent study was conducted by Bin Battal (2018) in which 12 categories of SEN in Saudi Arabia were identified. He found that the following categories are used for students with disabilities in Saudi Arabia: specific learning disabilities, speech or language impairments, intellectual disabilities, emotional disturbances, hearing impairments, visual impairments, orthopaedic impairments, other health impairments, autism, traumatic brain injury, developmental delays and multiple disabilities (Bin Battal, 2018). Some of these classifications are questionable because they were not listed on the MOE's official websites, such as orthopaedic impairments. Progress in educating those with SEN continued, and in the 1990s, some students with SEN began to be educated in a mainstream setting on a very limited scale (Almoussa, 2010).

In the past, students with LD were educated in mainstream schools with no appropriate provisions; however, in 1996, the Saudi Learning Disabilities Programme (SLDP) was implemented in 12 primary schools supervised by 12 teachers specialising in LD (MOE, 2016). Special education services dramatically expanded throughout Saudi Arabia, and in 2006, the SLDP was implemented in 728 boys' and 498 girls' primary schools to serve 15,038 students (Alnaim, 2016). The Department of Learning Disability's 2016 annual report indicates that there are 1631 SLDPs for boys and 826 SLDPs for girls, serving 24,951 students in total. This dramatic growth of the SLDP in schools indicates the increase in attention paid to learning disabilities, which justifies the significance of this research.

In contrast, it could be argued that inadequate attention has been paid to ADHD as it lacked any acknowledgment from the MOE as a formal category for several years (Almoussa, 2008). In 2014, official ADHD programmes were established by the

MoE, which aimed to include children with ADHD in a mainstream setting with appropriate support and scaffolding (Algraigray, 2015). ADHD programmes were initially launched in five main cities. Each city has two schools with ADHD diagnosis and intervention units to serve both girls and boys. Latest annual report from the department of special education in Riyadh (2019) indicated that the number of ADHD programmes has been expanded where 21 ADHD programmes run in Riyadh mainstream settings. Although Almousa (2008) estimated that ADHD in Saudi Arabia affected 12.6% of school-aged children, this large number of students lacked any formal educational services or provisions in Saudi schools before 2014. Due to the late establishment of official ADHD services, there are challenges and drawbacks, which are described at the end of this chapter.

Despite the unprecedented attention from the MOE towards the SEN field, some people with SEN still lack a fully inclusive education (Almousa, 2010). After official SEN services were provided nearly 60 years ago, there was a propensity to exclude children and people with SEN from public schools (Alquraini, 2010); however, in recent years, there have been fundamental reforms in terms of educating those with SEN, including student placement, educational equipment and resource rooms. In terms of inclusion in the Saudi education system, there are two types of inclusive education for students with SEN. The first type of inclusion in mainstream schools includes targeted categories, such as learning disabilities, physical impairments and behavioural and emotional disturbances, including ADHD, communication problems, difficulty hearing and low vision ability. Students in these categories attend mainstream schools. On the other hand, some categories are included in mainstream schools through special classes or self-contained classes, such as students who are blind or deaf or those who have intellectual disabilities or autism (Bin Battal, 2018).

### **2.3 Saudi SEN Policy**

This section introduces Saudi SEN policies and explains how the current provisions are shaped and influenced by these policies. Policies with a specific regard to both learning disability and ADHD categories are examined.

Three laws concerning children and adults with SEN have been created by the MOE due to the extreme needs for the enhancement of SEN services (Alquraini,

2010). These regulations have facilitated establishing and advancing special needs services in Saudi Arabia. In 1987, the Legislation of Disability emerged as the first piece of legislation for students with special needs in Saudi Arabia (Aldabas, 2015). The Legislation of Disability contains important criteria that ensure the equality of people with disabilities. It also includes several articles that define impairments and describe how interventions, provisions, assessment procedures and diagnoses should be used to determine eligibility for special education services. The Legislation of Disability, as the first piece of legislation for people with disabilities in Saudi Arabia, could be criticised for its ambiguities. The Legislation of Disability is broad regarding issues of inclusion in mainstream schools. It does not mention whether people with disabilities should be educated in special settings or in mainstream settings. One possible reason behind the absence of inclusion in the Legislation of Disability can be the claim that this policy had been established before the Salamanca statement was held (UNESCO, 1994). For example, based on the clause 'eligibility for special education services', it could be understood that people with disabilities should be educated in special settings rather than in mainstream settings. The initial version of the Legislation of Disability does not mention inclusion or inclusive education and instead refers to 'rehabilitation services' (Alquraini, 2010, p. 140).

In 2000, the Saudi Arabian government created a second law, the Disability Law. This law ensures that any person with a disability can access appropriate rehabilitation free of charge (Aldabas, 2015). Alquraini (2010) stated that this law ensures that individuals with disabilities have the right to access special education and rehabilitation services. This law raises a question regarding the meaning of the term 'appropriate', which is somewhat ambiguous. In other words, it does not clarify whether 'appropriate' refers to a special or to a mainstream educational setting. In addition, it does not specify the criteria to be used to determine whether a special or a mainstream setting is appropriate for those with disabilities. In its use of language, the Disability Law is vague in terms of the settings in which people with disabilities in Saudi Arabia should be educated.

One year later, a third law was introduced under different names used by different studies in 2001. Alquraini (2010, 2013) referred to the third law as the Regulations

of Special Education Programmes and Institutes (RSEPI), whereas Aldabas (2015) referred to it as the Rules and Regulations of Special Education Programmes (RRSEP) (Ministry of Education, 2002). The issues related to the first and second policies have not been avoided by the more recent RSEPI or RRSEP. One potential reason inclusion is not mentioned in these Saudi laws is that the Salamanca Statement in 1994 was not taken into consideration during the establishment of these laws. The RRSEP, or the RSEPI, was introduced after reviewing old US laws, such as the Education for All Handicapped Children Act (EHA) in 1975 and the Individuals with Disabilities Education Act (IDEA) in 1990, which is viewed as a major drawback of Saudi special needs laws (Alquraini, 2010). As such, this is considered one fundamental challenge in addressing SEN in Saudi Arabia because Saudi laws have been interpreted and reviewed based on old international laws, such as the EHA in 1975.

It would have been more effective if the RRSEP, or RSEPI, was based on the most recent SEN laws and statements at that time, which have a marked tendency to enhance services and language related to inclusion and integration. Another critique might level up to the RRSEP, or RSEPI is that Saudi schools seem to be unsuccessful to act according to these rules on their actions of assessments, diagnosis and interventions (Al-Nahdi, 2007). Arguably, the schools' failure in complying with these rules led to the existing gap between policy and practices in the Saudi schools.

## **2.4 Reflection on Saudi SEN Policy**

One critique of SEN Saudi policy is that some people with disability issues are still educated without any consideration of the laws. For example, choosing the type of provision and education, such as a special or an inclusive setting, are determined without considering the policies. As Alquraini (2010, p. 140) noted, these laws are 'not practised in the real world with students with disabilities'. In fact, the consequences of overlooking some fundamental issues related to those with SEN are caused by Saudi policies and international policies as well. Several local policies in some countries are likely based on or even indicate that some common international policy was used, such as the EHA (1975), Education for All (EFA) and the Salamanca Statement (UNESCO, 1994). Examining the latter two policies

might explain why Saudi SEN policies overlook some important issues related to people with SEN. Although, the Saudi government was one of the 92 governments and 25 international organisations were signatories to the policy, implementing the Salamanca statement is questionable. Succinctly, the EFA represents an international commitment to ensuring that all individuals receive a basic education of good quality. Still, the EFA does not emphasise a basic education that addresses specific children's needs, such as those with disabilities; rather, it is a comprehensive commitment that aims to benefit individuals, families, communities and countries (Department for International Development/HM Treasury, 2006).

Alternatively, the Salamanca Statement has a strong focus on the development and enhancement of inclusive education. The emphasis and declaration of the right to an inclusive education and basic education in both the Salamanca Statement and the EFA have encouraged countries to legitimise provisions, interventions, rights to education and inclusive education for those with disabilities; however, it has been claimed that some of the main reasons for preventing the implementation of inclusive education are the conceptualisation of and contradictions between inclusive education and the EFA (Miles & Singal, 2010). The initial vision of the EFA has been viewed as broad and ambitious, and Miles and Singal (2010) indicated that the use of the word 'all' has led to neglecting issues related to disabilities and to students viewed as the poorest and the most disadvantaged. Since then, there is no policy has been introduced.

## **2.5 Learning Disability**

Because LD was one category under investigation during this study, it is important to highlight how LD services and programmes function in the Saudi context. Several programmes, aims and challenges are discussed in this chapter. An initial examination of the LD services in Saudi Arabia is important as it furthers the understanding of LD.

### **2.5.1 Saudi Learning Disability Programme (SLDP)**

It is important to describe the key features of the SLDP as well as the way the current provisions are implemented. As indicated in section (2.2 Saudi SEN Historical Overview), the Department of Learning Disability's (2016) annual report

shows that there are 1631 SLDPs for boys and 826 SLDPs for girls, serving 24,951 students (girls and boys in Saudi mainstream schools). These programmes aim to identify students with LD in a mainstream setting, to determine their LD symptoms and to design an individual education plan (IEP) for each student (Alnaim, 2016). Although the services provided to children with LD have been developed since its establishment and the number of students were expanded, there are some drawbacks attached to these services. One of these drawbacks is the lack of a multidisciplinary team. It has been stated that identifying LD and designing an IEP should be done not only by LD teachers but also by a multidisciplinary team (Almoady et al., 2013). Based on his research on LD diagnosis and intervention in Saudi Arabia, Alnaim (2016) indicated that the diagnosis process for students with LD suffers from the lack of a multidisciplinary team, and he stated that the identification process begins with screening and referral steps. Rather than applying sophisticated tests, LD teachers review the list of all students who are retaking courses, basically identifying those who passed or failed courses.

Alternatively, the referral step takes place when LD teachers ask the mainstream teachers for a list of students who might have LD. Alnaim (2016) found that the number of nominated students by referral letters is large, whereas the number of appointed students by screening is low. Algamdi (2010) justified this issue by mentioning the commitment of the MOE to reducing the percentage of repetition and students who retake courses. If a student has a LD but did not retake courses or was not on the referral list, he/she is more likely not to be diagnosed because these are the main methods used to compose a list of students for LD programmes (Alnaim, 2016). Once the process of collecting names is completed, LD teachers apply specific approaches to list students with a higher priority and to refer others to the waiting list. Interviewing students, evaluating students' work and reviewing students' portfolios are the most common approaches that are used by LD teachers. Then, two types of diagnostic tests are used (Alnaim, 2016). First, the academic test is used by all LD teachers because it is the main and the compulsory test of the SLDP. Second, some LD teachers adopt the development test, which is informal because it requires specialists to apply it. The academic test is planned and designed by LD teachers only and is not studied carefully (Alnaim, 2016).

Therefore, LD teachers adopt the developmental test alongside the compulsory academic test because the latter might not identify some academic problems.

Both diagnostic tests need to be enhanced because they are neither accurate nor standardised. According to Alhabib (2006), one of the crucial issues in the LD discipline in Saudi Arabia is the paucity of the standardised diagnostic test. Consequently, unstandardised and inaccurate diagnostic tests affect LD teachers' judgements. Alnaim (2016, p. 140) stated that 'the results of this identification cannot always be trustworthy'. After these diagnostic tests are applied, students are registered in the SLDP. Alnaim (2016, pp. 17-18) summarised some conditions required to register a student in the SLDP:

1. A student has a clear discrepancy between their abilities and academic achievement in reading, writing, speech and mathematical inference. Additionally, a student has disorders in one of the psychological processes, such as memory, attention and thinking.
2. The difficulty must not be caused by mental retardation or a behavioural disorder or any other reasons that are related to lacking appropriate educational or parental circumstances.
3. Regular educational services must be found as not suitable or ineffective for supporting these students, which necessitates providing special education services.
4. Assessment is applied by a multidisciplinary team.

In reality, some of these conditions are either unclear or have not been implemented accurately. For example, several Saudi studies indicate that one of the most fundamental challenges for Saudi SEN in general and LD in particular is that diagnostic procedures are not multi-team implemented (Alnaim, 2016; Alquraini, 2011; Aldabas, 2016). When students have gone through these sequential procedures and have met the above conditions, they will receive LD provisions, such as an IEP and access to the resource room. The IEP states all educational services that are appropriate to match the students' needs, their strengths and their weakness as well as the goals expected to be attained, which are based on the multidisciplinary team's recommendations (Alnaim, 2016). However, due to their lack of involvement, parents should pay more attention to IEP regulations (Hanafi & Alraies, 2008).



Another fundamental provision designed for LD is the resource room which is staffed with a LD teacher who is qualified and trained in LD. Students with LD can attain access to the resource room for a time not exceeding 50% of their normal school day. While students with LD spend half their time in the resource room for academic skills, the mainstream classroom aids in the development of their social and communication skills (Almoady et al., 2013; Alnaim, 2016); however, there are several challenges in the field of LD that affect the delivery of appropriate provisions for students with LD. Along with the lack of team-based diagnostic assessments, Almousa (2008) asserted that the paucity of specialists in LD is one major barrier as it leads to seeking help from poorly qualified staff.

## **2.6 ADHD**

ADHD is the second category that was studied during this research. It is therefore important to highlight the historical services provided for ADHD in the Saudi context. The penultimate section offers an overview of ADHD challenges related to intervention and diagnosis in Saudi Arabia, and the section concludes with a summary of the chapter.

### **2.6.1 ADHD in Saudi Arabia**

As illustrated earlier, there is no mention of ADHD services or programmes prior to 2015 in the MOE's official documents or websites. Insufficient attention has been paid to ADHD without any acknowledgment from the MOE as a formal category for several years (Almousa, 2008). In 2015, the Saudi MOE established ADHD programmes in five major cities: Riyadh, Jeddah, Dammam, Asir and Hail. As an initial step, these five ADHD programmes were launched only in primary schools, and the next step was to serve students with ADHD at all education stages (MOE, 2017). Because they have only recently been established, there are insufficient sources and studies regarding how ADHD programmes are implemented. After searching several databases, such as PsycINFO, Google Scholar, Arabic databases of Saudi universities and the MOE, a paucity of information was found on current ADHD programmes in Saudi Arabia.

There is no clear or obvious guide on the Saudi MOE websites that indicate how students with ADHD can be diagnosed and can receive an intervention. Although Almousa (2008) reported that 12.6% of school-aged students have ADHD, this percentage seems to be questionable. First, Almousa (2008) did not provide any

clarification for this ratio, such as whether these students were actually diagnosed with ADHD or received medication treatment. Second, he reported this percentage before official ADHD services were established. Also, the MOE has not provided any statistical information about ADHD students yet.

The aim of the Saudi ADHD programme is to educate and to provide ADHD students with appropriate knowledge and educational skills that reach the maximum extent of their potential and prepare them to be socially included (MOE, 2017). These programmes are implemented in a mainstream school setting, where students with ADHD receive their education in regular classes and resource rooms. Students with ADHD have access to resource rooms for a time not exceeding 50% of their school day, and mainstream classrooms support the development of their social and communication skills. The ADHD resource room is staffed by a regular teacher and a teacher specialising in behavioural issues; however, it has been indicated that some teachers who are qualified in LD and autism have been involved in teaching students with ADHD (Algraigray, 2015).

Because ADHD programmes in Saudi Arabia have recently been established, there are challenges and barriers that could negatively affect the implementation of ADHD services. Algraigray (2015) discussed the barriers to address ADHD in the Saudi context, which are summarised in six main points:

- 1- There is a lack of an ADHD diagnosis specialist, diagnosis centres and qualified staff members.
- 2- There are inaccurate diagnostic tools, which have been adopted from other countries because the most contemporary tools are not appropriate and not compatible with the Saudi culture.
- 3- There is a negative attitude and a lack of awareness among mainstream teachers and parents.
- 4- Structures and locations of schools where students with ADHD are educated is another barrier to current ADHD programmes. Only two programmes in each city minimises the opportunities for students with ADHD to receive basic services.
- 5- Along with the paucity of ADHD programmes, they are not fully equipped with educational resources that help sustain students' attention and meet their needs.
- 6- Another significant challenge is the absence of a clear policy, teachers' guidance and ADHD educational intervention guidelines. Even the new ADHD policy in Saudi Arabia seems ambiguous and unclear.

## 2.7 Summary

This chapter reviewed the SEN services previously implemented in Saudi Arabia as well as how Saudi SEN policies are implemented and reflections on the issues. Also, it introduces the LD' services in the Saudi Arabia. The SLDP has been investigated, and a summary of SLDP challenges and barriers has been provided. Finally, an overview of ADHD has been provided along with an explanation of the way Saudi ADHD programmes operate followed by a discussion of the impediments and challenges of current ADHD programmes. Regarding this thesis, it is important to note that the research took place in boys' schools and that the interviewees were male. However, the respondents to the questionnaires may have been male or female since the questionnaires were distributed online to parents of children with LD and ADHD, as it will be illustrated more in (section 4.3.1.1).

# Chapter Three

## Literature Review

### 3.1 Introduction

The act of labelling people has persisted for many years, and thus labelling in the SEN context is not solely a contemporary concept. Some labels can indicate much about the personality of someone who is labelled (Boyle, 2014). In addition, labelling can be considered a form of classification. In the case of SEN, it is the process of assigning children or conditions to a general category or to a certain position in a class system (Hobbs, 1975; Sowards, 2015). Labelling is treated as an original construct that can describe accepted or unaccepted actions or behaviours (Riddick, 2000).

Throughout the history of special education, concerns and debates have arisen regarding the use of labels to identify and to define those with disabilities (Thomson, 2012). It has been argued that labelling and identifying people with disabilities helps in providing appropriate learning opportunities and extra support (Gillman et al., 2000, Lauchlan & Boyle, 2007). In other words, it is necessary that people with disabilities should be labelled to be eligible for SEN services (Sowards, 2015). For example, to be entitled to special educational services in accordance with the U.S. Individuals with Disabilities Education Act, children should be labelled using one of 13 categories that identify a disability. In the Saudi education system, students should be classified into one of 10 categories of SEN to receive SEN services and support (MOE, 2018). However, in their summary of arguments and counterarguments related to labelling, Lauchlan and Boyle (2007) pointed out that assigning labels to children and people with disabilities could be harmful as it affects their social lives and educational futures. Also, stigmatisation, exclusion and discrimination are some potential consequences of labelling children with disabilities. Therefore, the concept of labelling in the special needs field is controversial and remains under debate.

This section begins with how the process of searching the literature was conducted. Also, it provides an overview of both LD and ADHD definitions and concepts. It is important to note that these topics are not the focus of the current study. However, providing an overview could further the understanding of the main phenomena

under investigation, which are ADHD and LD labels. This section also explains the labelling theory, how deviance is introduced and the power of labels. In addition, types of labels, the significance of labels and the negative consequences of labels are examined. Furthermore, the stigma theory is explained in the stigma section, which is believed to be one negative consequence of labels. The penultimate section offers an overview regarding the effects of labelling people with disabilities in general and those with ADHD and those with LD in particular. This chapter ends with research aims and the research questions.

### **3.1.1 Process of Searching the Literature Review**

As mentioned in the previous chapter, the dramatic grown number of LD programmes in Saudi Arabia should be consistent with research and studies that concerned issues of LD, such as labelling and its consequences. Similarly, the recent establishment of ADHD programmes needs adequate research to ensure the successful implementation of those programmes, maintain them developed based on a scientific rationale. Thus, searching the discipline of labelling children with LD and ADHD in this research has gone through several steps. The process of reviewing the previous research began with examining the Saudi, Gulf Cooperation Council countries, and other Arabic databases. For example, databases in the Saudi universities, databases of the ministries of education in the GCC. The keywords used in this step was labelling children with special needs, labelling and disabilities, labelling and ADHD, stigma and disabilities, stigma and learning disabilities, stigma and ADHD. The results indicated that, as mentioned in chapter two, there is a lack of studies on ADHD and LD labels in the Saudi context. The vast majority of studies on SEN in Saudi Arabia have examined SEN in general (Almosa, 2008; Alquraini, 2010; Aldabas, 2015), and others have focused on the perception and knowledge of LD interventions and identifications (Alnaim, 2016; Alnaim, 2015; Al-Ahmadi, 2009). In addition, few studies have been conducted on the ADHD label, and most have focused on the aetiology, prevalence, teachers' perceptions and knowledge of diagnosis and interventions (Alkahtani, 2013; Alqahtani, 2010; Algraigay, 2014; Abed et al., 2014; Taleb & Ferheen, 2013; Homidi et al., 2013; Alhamed et al., 2008). Some research in the Saudi context and

other Arab contexts, such as Kuwait, briefly examined labelling related to SEN (Alnaim, 2016; Alqalaf, 2015; Aldaihani, 2011; Altamimi, 2016).

The second step of searching the literature of this thesis was investigation of the international databases, scholarly books, peer-reviewed journal through ProQuest, SAGE journal, Wiley Online library and google scholar. The keywords used in this step were similar the ones used in the first step. Other keywords were used such as labelling theory, labelling theory and disability, labelling theory and ADHD, stigma theory, stigma theory and learning disability, stigma theory and dyslexia, stigma theory and ADHD, stigma theory and labelling theory, specific learning difficulties and stigma theory, specific learning difficulties and labelling theory. The results of this step can be divided into four groups. First, some studies regarding labelling theory and stigma theory were concerned with crime. For example, the work entitled with crime and criminology conducted by White et al (2017), and the work of Hebl et al (2018) entitled with A Stigma Lens for Considering What Targets Can Do. Second, there are several studies regarding labelling and stigma were concerned with ill mental. For example, the study of Hayward et al. (1997) entitled with stigma and mental illness. Also, the research of Link and Phelan (2006) focuses on stigma and public health implication. One more example is the study of Huggett et al. (2018) concentrates on the experience of stigma by people with mental health problem. The third type of studies considered labelling and stigma theories were associated with discipline of homosexuality, such as the work of Walker (2019), Herek (2004) and King (2019). The fourth results of searching the issue of labels and stigma was related to special needs and disabilities. Most of the studies used in the literature below were related to the discipline of disabilities.

Although there is some recent research were reviewed and criticised, there are some justification of why dated studies were used too. One possible reason is the core of this research which are labelling and stigma theories were established in 1963. Second, because of the focus of this study was on special needs and disability, several studies in some disciplines implemented both theories were excluded, such as crime, mental health problems and homosexuality. Third, there is lack of studies regarding the issue of labels and stigma attached to children with special needs in the Saudi literature as well as the international ones.

Both steps of searching the literature of this thesis were useful in pointing out the general results regarding the phenomenon of labelling children with LD and ADHD. Additionally, those two steps were helpful in determining the gap of the existed literature regarding this phenomenon.

## **3.2 Learning Disability**

This section aims to illustrate the current theoretical concerns regarding LD in terms of concepts and definitions. Definitions of LD are explained in three contexts: the UK, the US and Saudi Arabia. The way LD and dyslexia are viewed based on medical and social models and the way related identifications and interventions are conducted are also explained.

### **3.2.1 Definitions and Concepts**

The field of LD is a highly complex discipline, which includes various arguments and contradictions regarding several issues, such as definitions, diagnosis, labels, etc. Terminological differences are common when this phenomenon is studied because many researchers adopt different terms. As mentioned, in this research, LD is used as it is applied in Saudi Arabia. Until now, there has been no universally agreed upon definition of LD even worldwide (Sideridis, 2007; Tunmer & Greaney, 2010). A report written by Reiss and Brooks (2004) categorised the definitions of LD into several types, including Advocacy Definitions, Consortium Definitions, Practitioner Definitions and Research Definitions. It seems that one potential reason for multiple LD definitions is that those who provide definitions have several aims in mind (Alnaim, 2015). Thus, if the aim is allocating services and resources, the definition might be shaped according to the IQ-discrepancy model, whereas if the aim is identifying underlying psychological elements, numerous definitions can be generated (Armstrong & Squires, 2015).

Generally, several definitions have considered difficulties in spelling and reading words fluently as prime factors (Rose, 2009). Difficulties with aspects of phonological functions, such as verbal memory and processing, are valid symptoms of LD regardless of the intellectual abilities of students (Rose, 2009). Nevertheless, intellectual abilities play a significant role in defining LD. As mentioned, there are two dominant definitions of dyslexia in the UK, mainly those

provided by the British Psychological Society (BPS) and British Dyslexia Association (BDA), which both prefer to adopt the term 'dyslexia'. It is important to note that in the UK, LD can be referred to other terms, such as 'specific learning difficulties' (SpLD). It has been suggested that SpLD includes other sub-categories, such as dyslexia, dyspraxia, dyscalculia and ADHD (Turner, 1997; Wedell, 2001). On one hand, the BPS (1999, p. 8) has stated a working definition of dyslexia as:

'Dyslexia is evident when accurate and fluent word reading and/or spelling develops very incompletely or with great difficulty. This focuses on literacy learning at the "word level" and implies that the problem is severe and persistent despite appropriate learning opportunities. It provides the basis for a staged process of assessment through teaching'.

On the other hand, the BDA Management Board (2007) defines dyslexia as follows:

'Dyslexia is a specific learning difficulty that mainly affects the development of literacy and language related skills. It is likely to be present at birth and to be life-long in its effects. It is characterised by difficulties with phonological processing, rapid naming, working memory, processing speed, and the automatic development of skills that may not match up to an individual's other cognitive abilities. It tends to be resistant to conventional teaching methods, but its effect can be mitigated by appropriately specific intervention, including the application of information technology and supportive counselling' (BDA, 2007, online).

According to Reid (2016), the BPS is not interested in stating a causal explanation of dyslexia. Alternatively, it seems to focus on determining the characteristics of a lack of language development and persistent issues. These issues are more apparent and valued in the BPS definition than any other elements, such as the overall ability of children. It could be argued that despite neglecting the causes, the BPS definition includes several characteristics that are common in other special needs categories, such as slow reading and students with autism, because students in these categories experience persistent language development problems (Alnaim, 2016). Due to its broad inclusivity, it has been claimed that the BPS definition is insufficient in determining special and appropriate interventions because it does not clarify or differentiate between the different reading difficulties that different students experience (Elliott & Gibbs, 2008).



In contrast, the BDA definition is more extensive because it addresses several problems related to dyslexia, including its characteristics, age, causal factors and interventions (Alnaim, 2016). The reason for the more in-depth BDA definition refers to the extensive scope of the aims and tasks of the BDA. The interests of the BDA are not restricted to addressing one element of issues related to dyslexia; rather, it aims to address this discipline using a comprehensive approach.

It has been found that children with dyslexia and children with low reading skills are taught in reading classes using the same methods. In other words, difficulties with literacy skills can be addressed by appropriate instruction without examining the existence of dyslexia or LD (Elliott & Gibbs, 2008; Elliott & Grigorenko, 2014). This leads to the argument that dyslexia does not exist in a proportionate and consistent form in all cases, which means there is no clear-cut line (Rose, 2009). Several indications of the condition were proposed by Rose (2009), such as mental calculation, personal organisation and lack of focuses. However, if these indications emerge or exist individually, they might be not crucial indications of the presence of dyslexia. Elliot (2009) also questioned the approach of using both dyslexia and reading difficulty. Elliot (2009, p. 2) suggested that 'most definitions - including I suspect the one in this report - simply describe children who have difficulty learning to read and write. We've known for generations there are plenty of such kids in society. They do need special help - but what they don't need is some pseudo-medical label. It's just really woolly thinking'.

Another context that is considered in this research is the US context because the Saudi instruction approach follows the definition of the U.S. Office of Education (1977), which is the most common definition of LD as 'a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, speak, read, write, spell, or to do mathematical calculations'. The term includes conditions such as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia and developmental aphasia. The term does not include children with learning disabilities that are primarily the result of visual, hearing or motor handicaps, mental retardation, emotional disturbance or those of environmental, cultural or economic disadvantage (U. S. Office of Education, 1977, p. 65083).

Another definition of LDs is found in the Individuals with Disabilities Education Act of 1997 (IDEA, 1997) and in the Individuals with Disabilities Education Improvement Act of 2004 (IDEA, 2004). They define LD as:

“A disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations. Such term includes such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. Such term does not include a learning problem that is primarily the result of visual, hearing, or motor disabilities, or mental retardation, or emotional disturbance, or of environmental, cultural, or economic disadvantage” (IDEA, 2004, para 1).”

The Saudi MOE (2002) defines LD similarly to the U.S.:

‘Disorders in one or more of the basic psychological processes involved in understanding or using spoken and written language which is manifested in disorders in listening, thinking, talking, reading, writing, spelling, or arithmetic and it is not due to factors related to mental retardation, visual or hearing impairments, or educational, social, and familial factors’ (MOE, 2002, p. 9).

The Saudi and U.S. definitions do not give in-depth information about characteristics, accurate causes or appearance time. Rather, they list factors that can be excluded from the causes of LD. The Saudi LD definition could be criticised by the fact that the culture, language and education system were not taken into consideration. In other words, ‘the US experience of Learning Disability should not be copied exactly in the SLDP’ (Alnaim, 2016, p. 32).

### **3.2.2 Models of Disability and Dyslexia**

Although this subsection does not specifically relate to the scope of the current study, it is important to discuss the current issues involving dyslexia and LD. There are two predominant models of disabilities that have appeared in the last fifty years, which are the medical and social models (LoBianco & Sheppard-Jones, 2007).

Initially, dyslexia was considered a neurological issue; hence, adopting medical views to explain it seemed to be appropriate and acceptable (Bury, 2000). Although using the medical model is still a dominant approach to explaining the causes of dyslexia, Ferrell (2004) suggested that there are three approaches to explaining dyslexia. First, a biological approach indicates that the impairment has genetic

origins. Second, the cognitive approach considers shortcomings in processing. Finally, the behavioural approach considers poor literacy skills. Based on a medical model, dyslexia is explained in terms of a disability experienced by individuals with dyslexia resulting from diseases or health issues that can be cured by professional intervention. Thus, the medical model might influence labelling and categorising people and children with special needs, which is explained later in this chapter.

On the other hand, the social model was a central approach used by the British Disability Movement (Hasler, 1993). The social model claims that 'it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society' (UPIAS, 1976, p. 14). The social model considers the relationship between people and society that might be affected by being labelled as disabled. In other words, using the social model is an attempt to shift the focus from shortcomings caused by impairments to limitations caused by environments and cultures (Oliver, 1996). For dyslexia in particular, the social model argues that social segregations linked with dyslexia might not be associated with impairments themselves but rather with societies' approaches to impairments (Burner & Mercer, 2004). Although dyslexia is caused primarily by biological causes, not by social oppression, social factors can also have an impact (Bury, 2000).

### **3.3 ADHD**

This section provides an overview of the current theoretical concerns regarding ADHD in terms of concepts and definitions. It also explains how ADHD is viewed by medical and social models and how related identifications and interventions are conducted.

#### **3.3.1 Concept and Definition**

Although, there is increased research on ADHD, agreeing on an exact definition can be somewhat problematic and controversial (Wheeler, 2007). This is because ADHD is considered an interdisciplinary topic that involves medicine, sociology and education (Wheeler, 2007). These disciplines investigate ADHD from different aspects, such as its aetiology and intervention strategies, which leads to more disagreements and disputes (Baldwin & Cooper, 2007). A considerable number of

studies suggested that ADHD is a medical disorder. It has been suggested that ADHD is 'a neurobehavioral developmental disorder' (Ahonen et al., 1994, p. 168), 'a disorder underlying biological cause' (Munden & Arcelus, 1999, p. 9) and 'an internationally recognised medical condition of brain dysfunction' (Kewley, 2005, p. 11). Thus, the biomedical aetiology and treatment of ADHD is positioned predominantly in the academic and professional literature (Visser & Jehan, 2009; Wheeler, 2010). The latest DSM-5 defines ADHD as 'a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development' (American Psychiatric Association, 2013). ADHD is defined by three behavioural characteristics: inattention, hyperactivity and impulsiveness (Wheeler, 2010). Inattention could be observed when a child seems to have difficulties listening or fails to complete given tasks (Kendall, 2000). Hyperactivity can be observed when a child shows developmentally inappropriate levels of vocal or motor activities (Barkley, 2014). Impulsiveness is noted when a child speaks, acts or excessively reacts without thinking (Kewley, 2010). It has been emphasised that all three symptoms must be present in two or more environments, such as school and home (CHADD, 2013).

Unlike LD, there is no terminological difference between the concept of ADHD in the Saudi, UK or U.S. context. The differences between these contexts involve the diagnosis and the prevalence of ADHD. An ADHD diagnosis is done by a clinician using one of two types of diagnostic criteria. According to Wheeler (2007), Europe and the UK use the International Classification of Disease (ICD-11). The U.S. and Saudi Arabia, as has been mentioned by the Saudi MOE (2018), adopt the Diagnostic and Statistical Manual of Mental Disorder (DSM-5) system, which is also used in other countries, such as Australia (American Psychiatric Association, 2013); however, there is no universal definition of ADHD in Saudi Arabia. The Saudi MOE's definition and that of the ADHD Society, which is a governmental society, are different.

The MOE defines ADHD as 'a neurological and behavioural disorder in brain cells in the lipids, skin and blood cells that are more likely to be caused by genetic factors. Symptoms between the fifth and ninth years of age gradually increase. Symptoms have been manifested in the form of inattention, planning and

deficiencies in accomplishing normal functions' (MOE, 2018); however, the ADHD Society defines ADHD as 'a neurodevelopmental disorder affecting children that leads to hyperactivity, impulsiveness and inattention that continue until puberty in different forms and symptoms' (AFTA, 2018). Thus, the precise definition of ADHD is still under debate.

Another fundamental issue of the ADHD debate is centred on its veracity, or whether ADHD exists or not, which has been the focus of several studies (Maras & Redmayne, 1997; Barkley, 1998; Timimi et al., 2004; Remschmidt, 2005). Although there are indications that ADHD is under-diagnosed, under-treated or over-diagnosed (Timimi, 2005; Wheeler, 2010), many scholars, fields and disciplines agree ADHD exists (Wheeler (2007).

### **3.3.2 Models and Interventions of ADHD**

Although these disputes are outside the scope of this research, it is worthwhile to briefly examine some perspectives, mainly medical, social and educational ADHD intervention. The biomedical aetiology and treatment of ADHD is positioned predominantly in the academic and professional literature (Visser & Jehan, 2009; Wheeler, 2010). Thus, considering ADHD in this study will contribute to the coexisting literature because it is difficult to contextualise ADHD within a single framework (Visser & Jehan, 2009). The common understanding of ADHD symptoms displayed by children diagnosed with ADHD and their responses is the heterogeneity of the symptoms and responses. Therefore, it is difficult to determine the most efficient and successful intervention strategy for each child. There are numerous types of intervention adopted to treat children diagnosed with ADHD. Medical, social and educational interventions are discussed in this section.

First, the medical standpoint views ADHD as a brain dysfunction (Visser and Jehan, 2009); thus, the basic treatment intervention is medication. Stimulant medications are used because they positively affect attention span, academic achievement and social skills (DuPaul & Stoner, 2014). It has been claimed that the use of these psycho-stimulants leads to positive changes in children's behaviours. To illustrate, Wheeler (2007) reported that 70% of children given these drugs were described to

be more focused and less aggressive, and she reported that 90% of U.S. children diagnosed with ADHD are treated by medication therapy. In the UK, it has been reported that approximately 20% of children with ADHD receive medical intervention (Cooper & Bilton, 2013); however, there is controversy regarding the use of medical interventions for ADHD. The biomedical use of intervention is dominantly positioned in the academic literature, which leads to the first critique. Educational staff, such as teachers, may believe that ADHD is only a neurological development disorder; therefore, they may believe they do not play a crucial role in ADHD treatment. In Sweden, for example, teachers consider medications to be the sole approach to ADHD treatment (Hjorne & Saljo, 2004). Another example can be the Saudi context where teachers were found to feel that they are not responsible for dealing with children who have been diagnosed with ADHD (Algraigray, 2015). Social and educational interventions are also used to treat children who display ADHD symptoms. Unlike the medical viewpoint, the social and educational standpoint consider ADHD an educational issue that results in some behaviours in the classroom but not a true disorder (Visser & Jehan, 2009). Social and educational advocates believe that even non-ADHD children may exhibit some behavioural problems in the classroom. Thus, from this perspective, educational approaches that seek to address the dominant issues are the most efficient ways to help children with ADHD (Cooper & Hughes, 2007). There are several suggestions for classroom strategies to support children who display ADHD symptoms. Such activities should be designed to provide children with more opportunities to participate in structured corporal and verbal activities (Cooper & Biton, 2013). Brevity, variety and structured activities are some proposed approaches (Goldstein (1998). Teaching social skills to children with ADHD is essential because they suffer from social ineptness (DuPaul & Stoner, 2014). Nevertheless, social and educational types of ADHD interventions are not without drawbacks. One major criticism of implementing these activities is that the observed behaviour changes might be not generalised to other situations (Cooper & Hughes, 2007). In other words, the observed behaviour changes while interventions take place in small settings may not carry over to mainstream classrooms. Thus, some studies have suggested that social and educational interventions might be more effective if they are combined with medical intervention (Wheeler, 2007; Cooper & Biton, 2013).

This discussion regarding ADHD diagnosis, prevalence and types of interventions reveals one common feature, which is that ADHD could be considered one of the most controversial topics of the SEN categories. The abundance of ADHD disagreements and disputes in international studies affect ADHD services in Saudi Arabia in terms of the paucity of services, diagnosis and intervention programmes.

### **3.4 Labelling Theory**

This section explains labelling theory, which is a theoretical perspective applied to understand mental illness and deviance. Also, the section aims to illustrate how people are labelled and considered deviant according to two approaches of this theory. Becker (1963) explained that the indispensable aspect of someone or something being deviant is that deviance is created by a society in which specific standards are established, and those who break these standards are considered outsiders. To understand the labelling process, there is a necessity to investigate how children with special needs come to be considered deviant as well as how societies assign a deviant label to undesirable children. In addition, there is a necessity to explore how deviance is associated with children with special needs. Becker (1963) argued that there are some approaches to labelling people deviant. However, this research focused on two of Becker's approaches that can be applied to people with special needs. It is important to note that terms such as deviance and outsider are articulated by labelling theory. Although some wrong connotations might be implied from these terms, using other terms would not help the researcher of this study to discuss labelling theory sufficiently.

The first approach to defining someone as deviant is based on statistics in which deviance is introduced as anything that significantly contradicts the norm. If this approach is used, 'to be left-handed or redheaded is deviant because most people are right-handed and brunette' (Becker, 1963, p. 4). If deviance is introduced as something dissimilar to the average, this approach might include height, function, behaviour, etc. When applying this to special needs, words such as 'hugely', 'greater' and 'significantly' are mentioned. For example, special education needs in England have been defined legally in the latest Code of Practice, which articulates that there are 'significantly greater difficulties in learning than the majority of others of the same age' (DfE & DoH, 2014, p. 16).

Two debated concepts emerge when this approach is applied to children with special needs: normality and abnormality. In brief, these two concepts are directly linked to body dysfunction. According to Terzi (2004, p. 142), 'causes of disability are attributable primarily to individual biological conditions, which depart from normal human functioning and determine handicap in terms of disadvantages'. It has been argued that societies have entitled some groups to create definitions of normality and abnormality according to body dysfunctions. Then, these created definitions are considered true and are adopted by societies (Mendez et al., 1988). As is explained in the next section, declarations by professionals, such as medical professionals, and their diagnosis outcomes are constructed by the status of validity and accuracy because they are dominant discourses in society (Gillman et al., 2000). Thus, because society seems to establish the difference between normal and abnormal people, children with special needs are likely to be considered abnormal or deviant, as their activities and potentials are defined by their body dysfunctions. When applying this specifically to ADHD as an example, ADHD and the use of medication to treat it have become universal and prevalent, and some behaviours that were once considered normal are now considered deviant, such as hyperactivity or inattention (Simoni, 2015).

The second approach that Becker (1963) adopted to define deviance is based on pathological aspects. In other words, the second approach is based on medical analogy. Becker (1963) claimed that people can be considered deviant when their human organisms work inefficiently due to a bodily dysfunction. As mentioned, medical science and associated outcomes, such as diagnoses, classify and define children with special needs in accordance with their disabilities. Disabilities are viewed as different from abilities and are ultimately considered to be negative (Harpur, 2012). The medical view of defining people as deviant is more influential than the statistical view, and it can be considered discriminatory and abusive (Becker, 1963). Becker (1963) explains that the extent to which labelling and classification are applicable varies because it tends to be applied more to some children than others. Children with special needs are vulnerable to professionals in power who label them through legal activities and consolidated medical science outcomes. In other words, classifying individuals who have a disability carries a



powerful legal pedigree. The incentive for the current classification of disabilities in the U.S. could have been acquired from the Civil War pension scheme (Blanck, 2008). The Disability Discrimination Act 1995 in the UK and the Human Rights Act in Canada are two other examples of legal activity related to disabilities. Thus, the use of phrases such as disability and impairments and consequently classifying individuals is vigorously entrenched (Harpur, 2012). These labels and classifications are potentially more influential because they are provided by professionals in power. In other words, they are given a legitimacy and thus a currency to operate within 'the system' (Algraigray & Boyle, 2017). Labels would be scientifically invalid and less reliable if they were given by laypeople.

Therefore, the labelling theory has been established as a crucial theoretical tool to deeply understand deviance and how it is conceptualised. The labelling theory is relevant to this study as it highlights the process of labelling and how people are defined based on society's perceptions of them. Thus, this theory was used in this study as a lens to serve the research agendas.

### **3.5 Who Has the Power to Label Children with Special Needs?**

Before exploring who has the power to establish labels for children with special needs, it is important to shed light on the medical and social models of disability because they can provide an in-depth understanding of who can create these labels. First, the medical model, as implied by its name, is medical in nature and views a disability as a defect and a sickness that should be cured and treated by a medical intervention (Kaplan, 1999). In accordance with this viewpoint, if a disability is managed, then any issues are treated or are improved in some way with treatments. Second, the social model contends that a disability is influenced by exclusion, social discrimination and oppression (Thomas, 2004). The advocates of this model believe that the environment disables people. Based on this view, social discrimination is perceived as the most crucial problem experienced by children with special needs (Kaplan, 1999). It is important to define both impairment and disability. The World Health Organisation (WHO) defines both terms as follows:

'Impairment: in the context of health experience, an impairment is any loss or abnormality of psychological, physiological, or anatomical structure or function'.

'Disability; in the context of health experience, a disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being' (Oliver, 2017, p. 3).

The Disabled People's International's (DPI) definitions of the terms are as follows:

'Impairment: is the functional limitation within the individual caused by physical, mental or sensory impairment'.

'Disability: is the loss or limitation of opportunities to take part in the normal life of the community on an equal level with others due to physical and social barriers' (Oliver, 2017, p. 4).

When defining disability, the social model postulates that it 'is not the individual's impairment which causes disability (impairment → disability) or which is the disability (impairment = disability), and it is not the difficulty of individual functioning with physical, sensory or intellectual impairment which generates the problem of disability' (Thomas, 1999, p. 14). The social model contends that disabilities come from social barriers that are not linked to bodily dysfunction. Both impairments and disabilities seem to be defined ambiguously using different approaches. Oliver and Barnes (1986) argued that the social model defines impairment as a deficit that relates solely to sensory and physical impairment; however, Riddick (2001) viewed phonological difficulties as impairments that might be considered functional problems. According to Norwich (2009, p. 6), 'if an impairment can be a difficulty in some function, then it is likely that it can also be influenced by environmental factors and not just physical structural ones'. Thus, scholars of the social model differentiate between the concepts of impairment and disability, which creates a causality between society and disabilities, a problem that needs more consideration (Terzi, 2004).

Based on the medical model, it is difficult to recognise why society discriminates against people with disabilities if there were no relation at all with a, perhaps wrongly perceived, initial state which they share (Algraigray, & Boyle, 2017). Terzi remarked, 'True, this needn't be a causal relation, but this does not exclude it, either' (2004, p. 150). One significant criticism appear here is that the social model does not consider the aspect of impairment. Arguably, when societies perceive

barriers and discrimination against children with disabilities as aspects that might be overcome and thus as non-existent, then how can the experiences of children with impairments be understood? It has been claimed that the social model overlooks the important difficulties that impairments can generate, including restricting activities and the potential to perform different functions (Terzi, 2004). Also, this model can be criticised for its constant expression of personal tragedy, especially regarding impairments (Terzi, 2004).

On the other hand, the medical model indicates that impairments cause disabilities when impairments are associated with diseases, illnesses and genetic disorders (Bury, 2000). In accordance with this model, medical interventions and rehabilitation professionals are required to cure disabilities (Kaplan, 1999). The medical model has been criticised for its attempt to treat all disorders and issues using the same approach while neglecting and overlooking the fact that some disabilities are generated by social and cultural aspects. Therefore, the medical model includes internal contradictions because it contends that disabilities should be cured solely by medical interventions (Algraigay & Boyle, 2017); however, Thomas (2004) asserted that some scholars who adhere to the medical model acknowledge that some disabilities occur due to social and cultural factors.

To understand who controls establishing labels for children with special needs, it has been acknowledged that the medical model has been dominant in the special needs discipline as a crucial tool for classifying children with special needs (Gillman et al., 1997). For example, it is widely postulated that the concept of ADHD has been positioned largely within the realm of medical and scientific discourse (Visser & Jehan, 2009). This is because the main causality of ADHD is considered exclusively from a biomedical viewpoint (Visser & Jehan, 2009), and thus the essential intervention is solely medical-based. Therefore, other discourses that criticise the medical basis of ADHD have been overlooked and neglected (Graham, 2008). Because the biomedical discourse is dominant, it is adopted by other professionals related to the medical profession. One such example is dyslexia, for which teachers and psychologists adhere to the medical model when they attempt to understand why children have some difficulties in reading and writing (Visser & Jehan, 2009).

While the difference between disability and impairment remain ambivalent, it has been argued that professionals classify and identify people with special needs by individualising approaches and normalising judgements (Foucault, 1977). Labels and classifications of children and people with special needs are largely created by professionals in the disability field—not by children or people with special needs themselves (Harpur, 2012). When the medical science approach and its outcomes, such as diagnoses, are applied in the special needs field, professionals have the power and the authority to label and to classify children and people with special needs because medical science is considered an essential tool used to do so.

These medical classifications and labels often include a sense of rationality and neutrality because they are established by rigorous and prestigious professionals, such as doctors, who have historically been authoritative in the hierarchy of professions; however, it is crucial to analyse the biological causes of disabilities to eliminate or to at least minimise the overuse of medical classifications and labels that rely on the dysfunctions of children and people with special needs. Although this was not the aim of this research, shedding light on the shortcomings of medical labels is important in reducing the dominance of biomedical discourses. According to Powell (2003), children are selected to be checked and diagnosed based on their teachers' subjectivities and assumptions regarding children. In other words, diagnosis processes are based on inaccurate and subjective assumptions that all children learn similar things in similar ways or at a similar pace. These assumptions have been observed in many standardised diagnosis tests that require children to work through a common curriculum. Also, the standardised diagnosis tests and their outcomes are not neutral or objective facts: they are simply suggestions that are established and introduced by professionals (Gillman et al., 2000).

Ho (2004) explained that these diagnoses are intentionally used to discriminate against children who are diagnosed as having impairments and to direct their future educational and employment opportunities. Some labels are implemented to control children with SEN and to exclude them from mainstream schools and to place them in segregated environments where they will be able to receive *appropriate support* (Algraigray & Boyle, 2017). This is sometimes based on no legitimate evidence, which seems to suggest that appropriate support can and

should be provided in a mainstream school (Boyle et al., 2011). As Hacking (1999) explained, these classifications are socially shaped, and children's behaviours and social interactions might be shaped and formed by these classifications as well. It is important to note that the consequences of labels, such as stigma and exclusion, cannot be detached from societies (Algraigray & Boyle, 2017).

A further examination of Becker's theory may be helpful. As Becker (1963) stated, deviance from the norm is constructed and shaped by society or the community to determine which range of behaviours can be regarded as acceptable or not. People who break these rules are segregated and regarded as outsiders, and behaviours may therefore be influenced by socially developed labels and classifications as well as those that are created by professionals (Becker, 1963); however, in some cases, these labels are useful in identifying students' needs and obtaining supportive resources, as they can be considered an 'admission ticket' (Zuriff, 1996, p. 403). Various studies have indicated that labelling children and young people with SEN has some advantages (e.g. Lauchlan & Boyle, 2007; Algraigray & Boyle, 2017). In addition, Hacking (1999) claimed that biomedical discourse as an indispensable approach to classifying and labelling children with special needs is not only clinically based. It has been argued that the labels and classifications could be divided into two types: formal labels established by professionals and other labels constructed by teachers and children with special needs themselves (Oliver & Barnes, 1998). The next section explains these two types of labels as well as how teachers perceive them.

### **3.6 Types of Labelling**

Students who struggle academically can experience two possible types of labelling. The first potential type is that students are officially assessed by professionals to determine whether they meet the required criteria to receive special educational services. In the U.S. educational system, for example, if students meet the criteria, they will be classified and labelled using one of the 13 specific categories of disabilities that have been established by federal education regulation (Sowards, 2015). The official labels are based on the institutional system, which identifies students by using the administrative instruments of the educational system (Simoni, 2015). The second type is being informally labelled by teachers and

students with negative as well as artificial words (DeRoche, 2015). Different schools' contexts were reported to use informal labels for children with special needs, such as Japanese schools (Kayama & Haight, 2018) and Scottish schools (Maguire et al.2019). Kelly and Norwich (2004, p. 418) described some of these informal labels as "thick, stupid, slow, spastic and spaz". This labelling process takes place on a daily basis when teachers notice some behaviours that are problematic and react in a way that unintentionally labels students (Simoni, 2015). Unfortunately, regardless of the labelling process, all labels include several assumptions. In other words, when students are labelled, societies are displaying and sharing beliefs and assumptions about those being labelled (Sowards, 2015). Therefore, it is important to explain and to simplify how both types of labelling occur within and outside educational settings.

### **3.6.1 Features of Informal Labelling**

Although this section elaborates on informal labelling that can occur for both ADHD and LD, some features of informal labelling can be applied to both categories. In other words, features of labelling ADHD informally might be similar to features of labelling LD informally. According to Simoni (2015), some students are labelled with ADHD informally. Before discussing the types, it is important to note that teachers might not be aware of the fact that they are 'othering' students, but the labelling process nonetheless occurs. The first type of informal labelling is spectacle labelling, which is based on other students recognising that a particular student is an 'other'. Many teachers adopt this informal labelling technique to manage and to maintain their classes. For example, some teachers use colours that refer to students' disruptive behaviours. When a student misbehaves or is disruptive, his/her name is positioned on the corresponding colour, and all students in the class can see the colour chart. Therefore, the child placed on a certain colour is viewed as an 'other'. It could be claimed that a common characteristic of ADHD is being disruptive, and thus these students can be assigned this label in the class; however, Simoni (2015, p. 123) stated that 'as noted by labelling theory, children who are outside the bee hive or whom receive a less favourable colour may internalise the label and see themselves as outside the group'. To link this with the labelling theory, Bernburg (2019) mentioned that the notion of informal labels is in

the core of labelling theory, as it accentuates that formal labels affects people development to facilitate stigma in other informal setting. It has been claimed that deviance or outsider might be encouraged by others by using informal labelling (Covington, 1984). Informal labels that position students in certain role are dangerous as they 'get cemented over time with repeated usage until they are seen as the social identity of that student' (Collins & Ferri, 2016, p 12). Thus, deviance can be constructed as a label based on others' mistrust and suspicion during interactions. In other words, informal labels could be created, shaped and affected by others' beliefs of those who deviate from the role of 'normal'.

The second type of informal labelling is spatial reformation. For example, teachers reorganise the class to closely observe disruptive students or those who exhibit ADHD symptoms. This might occur when a teacher moves a student's seat near his/her desk. Another example is placing overachieving students with students who display ADHD symptoms. In both examples, teachers unintentionally label students because other classmates realise that the ADHD student is different and thus should be observed by teachers or by overachieving students to complete tasks successfully. It could be argued that other students might not consider these students deviant but rather students who require support in an unharmed way; however, Simoni (2015) argued that this is still a mechanism used to label students when undesirable behaviours occur often over the academic year.

This might be more obvious in 'pull-out' programmes where children are called from special classes, such as resource rooms, for teaching. It has been claimed that grouping and separating children for learning based on their educational performances is problematic because non-labelled students 'bear witness' to this process (Osterholm et al., 2011, p. 7). Even those who believe that a LD label is a relief due to a former and previous misunderstanding of differences suggest that spatial and physical grouping and separation from non-labelled students is disheartening and disappointing because it is a form of informal labelling (Barga, 1996). Students with LD experience some types of informal labelling as well. Students with LD have a sense of being different due to the issues they face in performing literacy tasks in classrooms. Students with LD are frustrated and are viewed as others when they are pulled from mainstream classrooms to resource rooms, or to the 'stupid trailer' (Arceneaux, 2006, p. 89).

### 3.6.2 Features of Formal Labelling

In contrast to informal labelling, which mainly occurs to an indirect extent, the formal labelling process takes place with the support of a rational legal authority (Thomson, 2012). In special education, formal labelling involves identifying individuals or groups of students according to a category attributed to them (Smith & Luckasson, 1992). For example, students who have been diagnosed with behavioural disorders might eventually be labelled as having emotionally disorders (Thomson, 2012). With formal labels, teachers are aware that they are classifying students via the official labelling process. Simoni (2015) argued that the formal labelling process begins with designing an Individual Educational Plan (IEP) for students. Once an IEP is assigned, there are some subtle and obvious modifications, such as extra time and large folders with all the student's assignments. It is easy for other students to recognise that a student is different when he/she carries a folder with 'IEP' written in large letters. Therefore, the concept of 'othering' is apparent (Covington, 1984). Deviant labels that initiate the concept of othering and stigmatising markers are fundamental to labelling theory (Bernburg, 2019). Another problematic issue associated with an IEP and also linked with formal labelling is based on the fact that some IEPs include behavioural aides. The behavioural aide supports students in maintaining their concentration on lessons and ensures they have all important requirements for their assignments. Behavioural aides are a positive form of support; however, they are an obvious sign to all students in the classroom that a student is treated differently, and thus the label is assigned (Simoni, 2015).

It is significant to note that although the features of official and unofficial labelling might be different, the outcomes and consequences can be similar (Osterholm et al., 2007). More importantly, informal labelling should be recognised as fundamental type of labelling along with formal labelling. Although this section does not aim to determine which type of labelling is more powerful, the consequences of official labelling might be more influential because the formal labelling procedure is created and constructed by the administrative organisation and a rigorous legal system (Simoni, 2015).



### 3.7 Strength of Labels

It can be argued that special needs and disability labels can be beneficial for students. Lauchlan and Boyle (2007) summarised several positive aspects of assigning labels to students with special needs. According to them, classifications and labels lead to treatment because they open doors for resources. The acquisition of labels might create more opportunities, such as extra resources that are not otherwise obtained if students have not been labelled (Gillman et al., 2000; DeRoche, 2015). One critique can be found with this claim. Students' difficulties might be addressed even without assigning labels. As Lauchlan and Boyle (2007, p. 37) stated, 'the failure to label a child as dyslexic did not necessarily mean that the child's difficulty went unaddressed'.

According to Lauchlan and Boyle (2007), the second potential advantage of assigning labels to students is based on the assumption that labelling leads to increased awareness of and promotes the understanding of certain difficulties. Although it is not fully understood, the label 'dyslexia' is widely known. ADHD is another example that is widely recognised as a specific issue in educational settings. It has been argued that increasing awareness might lead to increasing tolerance, which helps teachers and professionals determine how students face certain difficulties (Gross, 1994). The counterargument is that labels can be difficult to eliminate, even if the labelled student succeeds in other educational or vocational aspects. Thus, labels can remain with students throughout their lives (Lauchlan & Boyle, 2007).

Furthermore, decreasing ambiguities and enabling clear communication amongst professionals can be another advantage of assigning labels to students. Lauchlan and Boyle (2007) argued that for professionals in special education, labels are often used because they support professionals in sharing complicated information. Arceneaux (2006) found some positive aspects of being labelled with LD. In terms of the students, Arceneaux (2006) claimed that labels can lead to a sense of belonging to a group and a sense of appreciation. It has been claimed that many successful students credit dyslexia as the reason behind their achievements (Arceneaux, 2006). Also, some students prefer to be labelled with dyslexia and other specific learning disabilities 'as differences in learning styles rather than a disability' (Arceneaux, 2006, p. 55). This might be because dyslexia is easily

understood by many people as difficulties in reading skills, while specific learning disabilities or specific learning difficulties are not immediately obvious (Boyle, 2014).

Being labelled can provide comfort to children and families. Some people seek to attach a label to their difficulties because it provides information and an explanation for their issues (Lauchlan & Boyle, 2007). Being labelled with LD as a formal name, for example, can provide a child with a sense of relief because it leads to eliminating other stigmatization alternatives (Arceneaux, 2006). Applying this claim to the dyslexia label, children may have a sense of relief because dyslexia is viewed as a socially valid label that provides them with the knowledge and support they need (Taylor et al., 2010). Also, the sense of relief that some children have after being labelled with dyslexia is potentially due to the fact that the dyslexia label replaces other negative or informal labels, such as 'stupid' (Kelly & Norwich, 2004, p. 418). Therefore, students seem to be comfortable and even welcome the label of dyslexia (Riddick, 2000, Taylor et al., 2010).

Furthermore, Riddick (1995b) found that a label is viewed as helpful because it supports the children and because those close to them understand their educational problems. As mentioned, with the dyslexia label, children no longer perceive that they are 'stupid'; instead, they believe that the label facilitates their understanding of the difficulties they experience academically. Another advantage of the LD label is the help and support students receive from others. Arceneaux (2006, p. 86) stated that 'sometimes the help can be in terms of actual benefits that they received, and at other times it is the emotional support that they got from the others'. Although the LD label can cause students to believe that they have a lower potential, which is harmful, labels can lead to alternative goals and inspirations (Arceneaux, 2006).

In terms of the ADHD label, it has been claimed that it has no significant effect on peer rating and that it is a helpful label (Cornett-Ruiz & Hendricks, 1993). Toone (2006) criticised this claim for several reasons. First, Cornett and Hendricks (1993) might have minimised the influence of the ADHD label on their participants as they emphasised that children with ADHD are similar to other children. Unlike Cornett and Hendricks (1993), Toone (2006, p. 38) found a significant impact of the ADHD label as his participants 'were only told that the child in the video had ADHD. No other information about the disorder was provided'. Thus, the results of Cornett and

Hendricks' (1993) study would have been different if they did not emphasise that children with ADHD are similar to others. Second, Toone (2006, p. 21) found issues related to the phrasing of Cornett and Hendricks' (1993) questions, such as 'the questions on the scale related to "how well this child would get along with peers, the likelihood that the child would complete tasks, and the child's disposition". These areas are positive areas to assess but fail to measure how the respondent would interact with the child and what personal feelings the respondent has towards the labelled child'. Third, Toone (2006) questioned the lack of the effect of the ADHD label found by Cornett and Hendricks (1993) and stated that it might be due to the fact that actual symptoms are more salient than a label.

Similarly, Riddick (2000) found that children with dyslexia felt negatively affected by other children, though not because of the label; rather, they were negatively affected by their salient performance, such as poor reading or handwriting or when they often finished their tasks late. Therefore, children seem to be unacquainted, especially those in grades 3-6, 'participants of Cornett' and Hendricks' study', and thus they are likely to be unaware of the label, though they are aware of the actual symptoms of ADHD and dyslexia disorders.

By stating the aforementioned strengths of label, individuals seeking for labels might have other motivations for being labelled. Wood et al (2019) indicated that involving symptom exaggeration leads to false diagnosis. It has been claimed that it is not difficult for an individual to learn to describe the symptoms of ADHD (Harrison et al., 2007). Wood et al (2019, p. 2) articulated 'pull toward incentives accruing from the diagnosis has spawned concern about malingering or feigning the diagnosis to reap certain benefits'. Thus, assigning labels to children with ADHD and LD has disadvantages. In the next section, negative consequences of labelling are discussed with a specific focus on stigma, self-esteem, low expectations of teachers and professionals, discrimination and social distance.

### **3.8 Negative Consequences of Labelling**

This section examines the potential consequences when labels are assigned to individuals by agents of social control or other channels, such as the educational system or the medical field. Riddick (2000) claimed that assigning a dyslexia label to children is thought to be negative and might lead to negative experiences for individuals who are labelled. Individuals who believed that dyslexia is a

characteristic were less likely to reveal information about their dyslexia. One possible reason for this is that dyslexia continues to attract an unjustified stigma, which influences the development of a constructive relationship of labelled individuals with others (Morris & Turnbull, 2007). It is important to begin with the stigma theory, as it might highlight how stigma occurs when such a label is assigned.

### **3.8.1 Stigma Theory**

Stigma is a notion developed within the social psychology discipline, and it is particularly well-demonstrated by Goffman (1963). Stigma is succinctly defined as a discrediting trait or sign that might negatively affect individuals. Therefore, stigmatisation occurs when an individual who has a discredited attribute is hugely discredited by others due to that attribute (Goffman, 1963). Individuals are defined in accordance with their discrediting attribute. According to Thornicroft (2006), stigma is established due to a universal human tendency to eliminate danger. Thus, stigmatisation is not direct towards individuals but towards those who are believed to pose a threat or are understood to be different from the norm. Stigmatisation is conducted in a process of labelling that involves assigning a label or category (formal or informal) that attaches the stigma to an individual (Gwernan-Jones et al., 2016). For example, pupils diagnosed with ADHD are more likely to be stigmatised by their classmates once the label is assigned. Also, they might be stigmatised due to ADHD traits, which include an inability to sufficiently concentrate and to remain seated in classrooms (Unnever & Cornell, 2003).

This approach to creating a stigma indicates the mechanisms of discrimination illustrated by Goffman (1963). Labelled children or family behaviours might be understood as manifestations of a stigmatised trait, while similar behaviours from non-labelled children or their families would not be regarded similarly. For example, a reward provided by family to their children for good behaviour might be seen by teachers as an example of how parents are spoiling their children (Gwernan-Jones et al., 2016). Therefore, a stigma of mental disorders, such as ADHD, can have more influence than the disorder itself. In other words, some people with mental disorders prefer not to participate in treatments due to the associated stigma, which might lead to a decrease in self-perception, negative stereotypes and discrimination (Corrigan, 2004). Examples of how stigmas affect individuals with

SEN in general and those with ADHD and LD in particular are provided in the next section.

### **3.8.2 Stigma as a Negative Consequence of Labelling**

The effect of biological causal explanations on emotional activities and the tendency for social distance is a controversial issue. It has been assumed that attributions of medical causes decrease the stigma linked to mental health issues by decreasing assumptions that people are personally accountable and thus avoiding blame, while sympathy and the public's tendency to help increase (Corrigan, 2004; Connolly, 2011). These assumptions hold true for those with intellectual disabilities (Panek & Jungers, 2008); however, this is not always the case for all individuals whose disabilities are associated with biomedical causes. For example, ADHD has been extensively researched and studied biologically, and patients have their own distinctive experiences with stigmas.

According to Arkin (2012), individuals with ADHD are found to be less competent in areas such as social acceptance and close friendships than those without the label. In other words, the 'presence of an ADHD label is more influential on perceived social interactions and skills than it is on actual skills, abilities, or self-esteem' (Arkin, 2012, p. 43). Therefore, stigma is a consequence of an interplay between labels, stereotypes and social rejection (Toye et al, 2019). Teachers have also demonstrated more negative attitudes towards children with ADHD in the presence of a label (Koonce et al., 2004). The stigmatising outcomes of an ADHD label have also been identified in the perceptions of service providers. It has been found that subsequent interactions and communications with children can be changed as a result of applying a label (Arkin, 2012). In other words, assigning the label can cause providers to attribute a biomedical dysfunction to ADHD symptoms, while the home environment is largely considered the cause of ADHD in the absence of the label (Dryer et al., 2006).

On the other hand, a learning disability is a more stigmatised concept than other types of disabilities (Arceneaux, 2006). Those with LD experience many effects of stigmas as they have a sense of being different from others, such as when they encounter issues in performing literacy tasks and thus are pulled from the classrooms (Arceneaux, 2006). As mentioned, other types of formal or informal labelling can lead to stigmatisation. Evidence shows that stigmatisation might take

place in the absence of official labelling (Riddick, 2000). For example, being allocated to certain reading groups or being pulled from regular classrooms are sources of stigmas for children with LD (Arceneaux, 2006).

Other features of stigmas associated with LD can be identified when distinguishing between social identity and personal identity. According to Goffman (1963), social identity is a collective category that people are placed into by others, whereas personal identity is a group of characteristics that comprises an individual's personality. Therefore, LD, similar to other disabilities, have a variety of negative stereotypes surrounding them. First, a personal identity related to LD is based on the formal definition of LD, which is that individuals have significant difficulties or lower achievement in some academic areas, such as reading, writing and mathematical skills (Arceneaux, 2006). Thus, students with LD are stigmatised by significant underachievement. Second, some students with LD are stigmatised by other negative connotations or stereotypes linked to underachievement, such as laziness or stupidity. These negative connotations or stereotypes are viewed as social identity. Indeed, laziness is one of the most repeated stereotypes for individuals with LD (Arceneaux, 2006). An important aspect of a stigma is the role of either a hidden or a visible disability.

Goffman (1963) stated that a stigma refers to discrediting traits or symptoms according to others. LD and dyslexia are different from physical disabilities, for which physical signs are visible to all. Students with LD can be stigmatised by others due to a visible underachievement, such as poor spelling or an inability to complete tasks on time (Riddick, 2000). In some cases, a stigma cannot be attributed to labelling, such as when the severity of a disability leads to a stigma. In other words, the severity of a disability and visible signs can be stigmatised and 'labels can encapsulate or distil the stigmatization that already exists' (Riddick, 2000, p. 655). Thus, it might be difficult to determine whether a label or a visible symptom causes a stigma; however, even if the severity or visible symptoms are more influential in creating a stigma than a label, formal or informal labels usually accompany the signs.

### **3.8.3 Stigma Management, Teachers' and Students' Roles**

Teachers can play a significant role in contributing to or minimising stigmas in an educational setting. It has been claimed that teachers seemed to not fully recognise a stigma and stigmatised students, since they lack from effective training and lack of adequate knowledge of ADHD symptoms (Gwernan-Jones et al., 2016; Lee, 2008, Hong, 2008). Previous studies that were conducted in the Saudi context found that teachers' lack of knowledge and training affected them to deal with ADHD students (Abed et al., 2014; Algraigray, 2015; Al-Kahtani, 2013). Teachers are more likely than others to expect students with this diagnosis to perform poorly in class (Shifrer, 2013). In other words, teachers have lower expectations for labelled students than non-labelled students in classrooms (Johnson, 2016). It has been claimed that teachers can positively engage and treat children with ADHD if they are well prepared and adequately knowledgeable about ADHD (Goldstein et al., 2011). Thus, teachers' dealing and practices that based on insufficient knowledge or training might be facilitate teachers' role in stigma.

Another stigma management approach is individualistic and is associated with students themselves. Conceptualising issues related to LD is deeply rooted in an individual's type of disability or failure to achieve a social expectation (Dudley-Marling, 2004). This is linked to an individual's biology or actions rather than the societal context in which the problem is viewed. As Goffman (2009) suggested, stigmatised people attempt to appear normal by hiding their stigmatised symptoms from others. Arceneaux (2006) suggested that the individualistic approach to stigma management is to shift the focus of how individuals are perceived. Individuals manifest their behaviours to meet others' expectations. This stigma management approach involves how people cope in accordance with their self-interests, although Arceneaux (2006) claimed that individuals should embrace their discrediting traits rather than hiding them. This approach emphasises disclosing and embracing information related to identity. As mentioned, many successful students attribute their achievements to dyslexia (Arceneaux, 2006).

It could be argued that stigma management approaches are difficult to implement. Gwernan-Jones et al. (2016) indicated that increasing teachers' knowledge of

stigmas related to ADHD is not necessarily sufficient in reducing stigmas. In other words, based on an examination of stigma levels for people with mental illnesses over the past 40 years, it is clear that stigmas have increased in some ways despite substantial societal understanding, and interventions established to decrease stigmas have yielded unexpected effects (Pescosolido et al., 2008). It has been argued that there are complex elements other than a lack of teachers' knowledge that contribute to stigmas. These complicated elements include the stigmatised, the stigmatiser, disorder traits or symptoms, social identity, social network characteristics and treatment system (Pescosolido et al, 2008). Managing or minimising stigma with existing labels is complex, and thus it might be worthy to claim for labels that are alleviated and harmless (Algraigray & Boyle, 2017).

#### **3.8.4 Effects of Labels on Self-Esteem, Self-Perception and Children's Sensitivities**

Before investigating the effects of labels on self-esteem, defining self-esteem is crucial. According to Sowards (2015, p. 9), self-esteem can be defined as 'confidence in one's own worth or abilities; self-respect'. Self-esteem is related to a person's ability and potential. It has been reported that students with LD and ADHD have significant issues associated with self-esteem or self-perception (Smith & Nagle, 1995). Students with LD have been reported to achieve lower scores academically than the average of their peers, and thus they would also present poor self-efficacy and a negative attributional style for academic purposes (Tabassam & Grainger, 2002). A study conducted by Taylor et al. (2009) on the impact of labelling on self-esteem showed that having the SEN label might negatively influence children's self-esteem because unlike the dyslexia label, the SEN label provides very little explanation regarding their difficulties. Also, the SEN label negatively impacts children's self-concepts as it targets interventions that are not as obtainable and available to those with less specified labels. Thus, a lack of self-concept and a sense of being rejected may contribute to the development of additional emotional issues (Georgiadi et al., 2012). When emotional issues are added to being labelled with LD, these issues impede social and academic development (Sowards, 2015). When labels affect children's self-esteem, their



sensitivities can be affected. Children in both special and mainstream settings are sensitive to the negativity linked to labels (Kelly & Norwich, 2004).

Thus, it is not surprising that some children with ADHD tend to rate their behaviours in a positive way (Toone, 2006). Some labelled children have a tendency to refuse to acknowledge their actual behaviours or issues because they are sensitive to and aware of the negative connotations of their behaviours. Although this is more prevalent in older children, most pupils are aware of the negative connotations of LD (Kelly & Norwich, 2004).

### **3.8.5 Discrimination and Social Disadvantages**

According to Sowards (2015, p. 9), social disadvantage or social distance is 'an unfavourable circumstance that reduces the chances of success or effectiveness of making and maintaining social relationships. Labels can lead to social distance and exclusion from society (Gillman et al., 2000). It has been reported that people with dyslexia have their own experience with discrimination, social disadvantage and exclusion (Morris & Turnbull, 2007). The label of dyslexia could be viewed as synonymous with personal identity, which controls perceptions of exclusion (Riddick, 2000). As labels contribute to stigmatisation, it has been argued that stigmatisation might lead to discrimination (Lauchlan & Boyle, 2007). Connolly (2011) discussed the relationship between stigma and social distance and stated that the most apparent feature of behavioural stigma is the desire of labelled people for social distance. Labels have been emphasised as a significant mechanism in increasing differences between 'us' and 'them', which also generates discrimination (Connolly, 2011). Similarly, children labelled with ADHD experience difficulties in dealing with their peers. It has been reported that children with ADHD are likely bullied by their peers, who are likely to be less friendly once the label is attached (Unnever & Cornell, 2003). Thus, children with labels experience social difficulties and discrimination in accordance with Backer's (1963) theory and with Goffman's (1963) assertion that the way people perceive individuals with labels is influential in the way those who are labelled outwardly present themselves.

### **3.8.6 Effects of Labels on Children's Behaviours**

One potential outcome of labels is that children who are stereotyped become what others perceive them to be (McMahon, 2012). Labelling theory suggests that people who are labelled unintentionally change their behaviours to meet the

negative connotations and stereotypes aligned with the label. Labelled people may believe that the label refers to undesirable behaviours, which means they are unequal to others and deserve to be excluded (Link et al., 2004). Kelly and Norwich (2004) reported that some formal labels are not recognised by pupils. Labels that are likely to have negative connotations are recognised frequently by students, such as 'stupid'. This is because these terms are likely to be heard on a daily basis through interactions with others. The term LD is also perceived as a negative term by children in England (Kelly & Norwich, 2004). Arguably, while labelled children are not aware of some formal labels, they are likely to be aware of the negative connotations attached to labels (Kelly & Norwich, 2004). Thus, when they constantly experience the effects of negative connotations, children might continue exhibiting negative behaviours based on the expectations of others. Because these behaviours are believed to be negative from the viewpoints of others, such as peers or teachers, students with labels may feel it is normal to exhibit the negative behaviours. One reason for this assumption could be that individuals with intellectual disabilities might be blamed less for difficulties they face in the presence of a label (Connolly, 2011).

### **3.8.7 Effects of Labels on Teachers and Professionals**

Labels not only affect children but also affect teachers and professionals. One potential concern with assigning labels to children is how the label might affect teachers' expectations. Teachers might construct different expectations of these students and might unintentionally react differently to them. Gibbs and Elliott (2015) indicated that labels such as dyslexia were associated with differences in teachers' efficacy beliefs. According to Simoni (2015), teachers shape expectations according to students' records and what they hear about students. Thus, teachers are likely to construct and to develop their own perceptions of students, which might in turn impact children's behaviours and academic achievements (Eisenberg & Schneider, 2007). Several studies have shown that teachers have lower expectations in all aspects for children with labels than for those without labels. Thelen et al.'s (2003) results were similar to previous studies, and they found that teachers' expectations of labelled students were lower than those without labels. The ADHD label also has an effect on teachers' expectations. Koonce et al. (2004) found that children with ADHD were rated to have more attention issues than non-

labelled children. An earlier study conducted by Cornett-Ruiz and Hendricks (1993) found that behaviours typical of students with ADHD play crucial roles in influencing teachers' ratings. Thus, teachers' impressions of future achievements were more negative for students who demonstrated ADHD symptoms than for those who did not. In other words, ADHD symptoms might be more influential in teachers' expectations than labels.

It is important to determine whether both general education teachers and special education teachers are influenced negatively by labels. A study conducted by Fox and Stinnett (1996) showed that general and special education teachers were provided with a vignette describing a situation with a male child with behavioural issues. There were no significant differences between general and special education teachers in their ratings of the child described in the vignette. Three different labels were used in their study: conduct disorder, socially maladjusted and serious emotional disorder. It was reported that all teachers rated the child labelled with a serious emotional disorder more negatively than children with other labels.

Another area that has been studied is whether professionals, such as psychologists, physicians and social workers, are affected by labels. Fairbanks and Stinnett (1997) examined the effect of labels on acceptable behavioural treatment approaches. None of the three studied labels, ADHD, LD or behaviour disorder, affected school psychologists' or social workers' ratings of acceptable treatment approaches. Labels might not have an effect on professionals because they rated labelled students positively. One possible reason is that professionals receive specific training on aspects of labels. For example, professionals are likely to have training in ADHD diagnosis and interventions. It has been claimed that the education and training that professionals receive might decrease the effects associated with labels during rating (Toone, 2006). Thus, professionals, teachers and parents should all be educated regarding how using labels may have negative impacts on labelled individuals.

### **3.8.8 Effects of Labels on Parents and Peer Relationships**

Another aspect of concern is the potential negative effect of the ADHD label on peer relationships. It is crucial to note that there is no consensus on whether

labelling children has negative impacts on peer relationships (Toone, 2006). Cornett-Ruiz and Hendricks (1993) also examined the effect of the ADHD label on peer ratings. They found that stereotypical ADHD behaviours and the ADHD label had crucial, negative impacts on peer ratings. A previous section questioned and criticised the findings of Cornett-Ruiz and Hendricks (1993). For example, an issue with the phrasing of some questions and a lack of an explanation provided to participants were discussed. Negative impacts on peer interactions can be mediated by educating children with ADHD because education reduces the negative impact of label (Toone, 2006).

Other studies also examined the effects of labels on peer ratings, such as the study conducted by Thelen et al. (2003), who indicated that labelled peers were rated lower on scales assessing interpersonal achievements than peers without labels. After investigating how children interacted with other children labelled with ADHD, Harris (1990, 1992) indicated that children without labels were less friendly, talked less and were likely to rate labelled peers negatively on tasks. A study conducted by Toone (2006) also showed that school-aged children reported that they would be less likely to have friendships with ADHD-labelled children than those without labels.

In a study on informal labelling, Arceneaux (2006) also examined how the LD label influences social relationships among peers. Arceneaux (2006) claimed that the problem of LD is not associated with social interaction as an obvious issue. Thus, LD is a minor stigma. Although it is a minor stigma, there are issues that threaten social relationships and interactions with children with LD. One participant indicated that a child with LD might be affected by his/her disability in more ways than academically. Arceneaux (2006) found that children with LD had many issues with peer interactions and relationships.

Another area that has been examined is the impact of labels on parents. A study conducted by Eisenberg and Schneider (2007) showed that some parents might have misreported the diagnosis results of their children. In other words, if some parents misreport the ADHD diagnosis due to fear of embarrassment or stigmatisation, negative perceptions of ADHD may be the cause. The findings also indicate that parents' perceptions of ADHD diagnoses were likely to be more negative than those of teachers. The results have been justified by the assumption that parents might have more negative perceptions of ADHD as they are less

knowledgeable of the condition (Eisenberg & Schneider, 2007). Also, children with ADHD may behave and complete tasks more poorly in the home environment than they do in the school environment, especially because schools are usually better educationally equipped than homes (Eisenberg & Schneider, 2007). DeRoche (2015) indicated that most of parents were found to be ambivalent about the negative effects of receiving labels, although they were aware about the benefits of ADHD label. Parents were ambivalent since the social implications regarding ADHD label are unclear.

### **3.9 Summarising Previous Research Related to the Current Study**

To date, in the Saudi context, few studies have indirectly addressed the issue of labelling children with LD and ADHD. Despite the fact that many studies have made considerable contributions, they have addressed the issue of this study in very few paragraphs, where some limitations require future studies. As mentioned in section (3.1.1), the majority of studies on special needs in Saudi Arabia have examined special needs in general. Others have concentrated on the perception and knowledge of LD, others have focused on the aetiology, prevalence, teachers' perceptions and knowledge of diagnosis and interventions. Some studies, mostly conducted in the USA and the UK, touch on the issue of labelling, but this study seems to be the first one conducted in the Saudi context.

Although those studies conducted in the UK and USA have considerably contributed to knowledge, some omissions and limitations were found. For example, Sowards (2015), Simoni (2015), Osterholm et al. (2011), Kayama and Haight (2018) Maguire et al. (2019) have indicated that children with disability can be labelled informally in school contexts. Notwithstanding the fact that several ways of informal labels were stated, approaches of informal labels in the UK, USA, Japan and Scotland are likely to be different from the Saudi context. As mentioned earlier, Saudi Arabia is different from these countries in terms of language, culture, education system and lifestyle, which can play role in distributing informal labels among children. Moreover, those studies seem to fail in examining the relationship between formal and informal labels, how informal labels can impact labelled children in line with labelling and stigma theories. Issues such as the role of informal labels and negative connotations in facilitating stigma attached to labelled children were not addressed. In addition, previous studies seem to be limited from

examining the relationship between informal labels and teachers' role in enhancing stigma attached to children with LD and ADHD. Thus, this study attempted to fill the gap and address the limitations and omissions attached to previous studies. Examining the relationship between formal and informal labels in line with both labelling and stigma theories is one aim of this study.

Among exiting research regarding stigma, many have indicated that children with special need in general, and those with LD and ADHD have their experience with stigma because of the labels (Corrigan, 2004; Ohan et al. 2011; Arkin, 2012, Gwernan-Jones et al. 2016). Some research attempted to discover how stigma can be facilitated between teachers (GLee, 2008; Hong, 2008; pescosolido et al, 2008; Gwernan-Jones et al., 2016; Toye et al. 2019). Those studies examined teachers' knowledge about ADHD as one fundamental element in distributing stigma. Although they contributed to knowledge of teachers' role in stigma, however, limiting teachers' knowledge as only one element to explore stigma seems to be insufficient. pescosolido et al, (2008) indicated that stigma is complicated issue which needs more sophisticated aspects for further exploration. They suggested that stigma should be examined based on stigmatised person, stigmatiser, disorder traits and social identity. Therefore, this study attempted to examine teachers' role in facilitating stigma attached to students based on aspects such as teachers' understanding to terminology of LD and ADHD, informal labels and negative connotations, power and motivation of teachers. This exploration will be in line with both labelling and stigma theories. So far, previous studies were limited from exploring teachers' role in stigma through more than teachers' knowledge.

Another issue relates to stigma is the management of concealing the stigmatised traits. Concealing stigma was suggested by Goffman (1963) to minimise the effect that stigmatised people can be potentially received. Several studies indicated that hiding stigmatised traits is difficult to implement (Newheiser and Barreto, 2014; Gwernan-Jones et al, 2014; Thompson and Lefler, 2016; Ditchman, 2016). However, this might be the case for children with ADHD. The findings from these studies considered ADHD cannot be generalised to other categories, such as LD. Therefore, this research aims to examine the approach of concealing stigma as an approach suggested by Goffman (1963) for both children with LD and ADHD.

Although some studies indicated that students with LD or dyslexia can minimise their stigmatised traits by hiding their difficulties (Alexander-Passe, 2015; Mueller, 2019), their abilities to do so might be questionable. Arguably, if children with LD or dyslexia can conceal their some their difficulties, others visible signs such as withdrawing to resource room cannot be hidden from peers and general teachers. Therefore, the current study aims to investigate whether the approach of hiding difficulties is applicable to the verities numerous of LD and ADHD. This examination will be in line with stigma theory.

### **3.10 Aim of the Study and Research Questions**

This study aimed to explore whether LD or ADHD labels are beneficial for children labelled as such in the Saudi context. The exploration was based on perceptions about LD and ADHD by teachers in primary schools and parents of children with either condition. Another objective of the study was to investigate how labels impact general teacher practices as well as student reactions towards labelled children. Determining whether teachers' and parents' perceptions about LD and ADHD can help children avoid the negative consequences of these labels was another important goal, i.e., Examining the relationship between formal and informal labels, how do formal and informal labels affect labelled children, their teachers and their classmates, and how can teachers' and parents' perceptions regarding these labels mitigate any negative impacts labelled children might face?. This study aims also to examine teachers' role in facilitating stigma attached to students based on aspects such as teachers' understanding to termonlogy of LD and ADHD, informal labels and negative connotations, power and motivation of teachers. Investigating the approach of concealing LD and ADHD difficulties to minimise the stigma is another objective of this study.

In addition to these aims, this research attempted to answer the following research questions:

1- How do primary school teachers and parents view and perceive ADHD and LD labels?

1-A- How do primary school teachers and parents perceive the strengths of applying ADHD and LD labels to children?

1-B- How do primary school teachers and parents of children with LD and ADHD perceive the negative impacts of these labels?

2- What do primary school teachers and parents predict regarding the future of ADHD and LD labels?

### **3.11 Summary of the Chapter**

This chapter has begun with an overview of LD definitions and concepts, and it illustrates other relevant theoretical concerns, such as models of LD and their associated intervention types. Then, the ADHD concept and definition and models and interventions of ADHD are explained. The current chapter also examines the labelling theory as well as who has the authority to create labels. Types of labels, features of each type and positive aspects of labels have been discussed. Negative consequences of labels, such as stigma and discrimination, have been examined as well. The penultimate section reflects on the consequences of LD and ADHD labels, and the chapter concludes with summarising the previous studies relates to research topic and the emerged research questions.



# Chapter Four

## Methodology

### 4.1 Introduction

This chapter provides a description of the research philosophy and methodology. It explains how the mix method design is adopted in detail. Each section of quantitative and qualitative phases has several sub-sections that discuss topics such as the sample, method, piloting work, procedure of collecting data and how data were analysed. The trustworthiness and credibility of qualitative phase are described in detail. This chapter concludes by discussing the ethical issues of the current study.

### 4.2 Philosophical Assumptions

Social realities can be approached in several different ways in educational research. The diversity of educational research is a fundamental feature, and different types of research require different methods (Pring, 2004). Positivist, interpretivist and critical paradigms are three distinctive examples of how realities can be explored and examined in the social sciences (Willis, 2007; Cohen et al., 2007; Crotty, 2015). The word paradigm refers to 'a comprehensive belief system, world view, or framework that guides research and practice in a field' (Willis, 2007, p. 8). The importance of paradigms lies in how they facilitate the researcher in structuring his or her perceptions as well as in configuring the paradigm's subsequent components, such as ontology, epistemology and methodology (Carr & Kemmis, 1986; Dossin & Lincoln, 1994). Thus, improving the fit of the paradigm or philosophical assumptions is fundamental to any educational study. Choosing the appropriate paradigm for research allows for determining the research procedure, including the structure, notions, methodology, data gathering and data analysis (Crotty, 2015).

Between the two essential philosophical assumptions, the positivism assumption is appropriate when the research aims to investigate objects scientifically by gathering numerical data through quantitative methods, such as a questionnaire. The ontological and epistemological assumptions of the positivism claim that reality or knowledge is singular where the researchers should be objective and independent from that being searched (Crotty, 2015). On the other hand, the

interpretivist (constructivism) assumption is suitable when the research aims to deeply explore social realities by gathering qualitative data and interpretations through the qualitative method, which includes semi-structured interviews and observations. According to Pring (2004), relativism states that reality is not singular; however, reality is constructed by subjective experiences. The social world can only be understood from individuals' views who are part of the phenomena being explored (Johnson & Onwuegbuzie, 2004). The interpretivist (constructivism) paradigm holds that meanings are constructed by individuals because they are involved in the work they interpret (Creswell, 2013). Constructivism epistemology states that truth and meaning are not found but constructed (Crotty, 2015). A disagreement over the ontological and epistemological assumptions of the two paradigms are described as paradigm war. Purists are found in both paradigms where researchers believe to adopt one and neglect the other (Johnson et al, 2007). However, this research was informed by the mixed method approach 'explanatory sequential design'. Thus, none of the purists traditional paradigm was used, instead, pragmatist assumption was used. In educational, social, and behavioural disciplines, mixed methods research is considered as methodological pluralism (Johnson & Onwuegbuzie, 2004) that appears the third movement of research, after the positivist and interpretivist paradigms.

Pragmatism is a philosophy that denies the debates between both paradigms and concentrates on research benefits (Klingner and Boardman, 2011). In other words, pragmatism rejects the theoretical argument on the ontological level (truth and knowledge), and it considers reality as what best works in practice (Rorty, Putnam, Conant, & Helfrich, 2004). pragmatic researchers focus on answering their research questions, rather than focusing on stating the differences between traditional approaches and methods. Pragmatism assumptions believe that research should be mixed in the methodology level to provide researchers with the best chances to answer their research questions (Johnson & Onwuegbuzie, 2004). Pragmatic researchers have more opportunities rather than forcing on one believe or decision (Tashakkori & Teddlie, 1998). By adapting the pragmatism approach, researchers can demonstrate their epistemological assumptions by combining both quantitative and qualitative approaches to answer their research questions (Johnson et al. 2007).

Looking at the aims and research questions of this study, both objectivity and subjectivity were needed. Quantitative methods allowed me to examine how and why things happen (Bryman, 2012). On the other hand, qualitative methods provided and developed depth understanding of the phenomenon under study (Mertens, 2014). Therefore, mixed research aims to respect fully the wisdom of both quantitative and qualitative, in the meantime, it also seeks a workable solution for all research questions (Johnson & Onwuegbuzie, 2004). I believe that research should concentrate on the complexity of the phenomenon of LD and ADHD labels, the research questions, and the study's purposes and aims rather than being focused on the debates between paradigms and assumptions. This belief was represented and reflected during the period when data and information were collected and analysed. I was based on the literature and my professional experience to recognise some related facts and advantages of the issue of LD and ADHD labels.

#### **4-2-1 Positionality**

It might be important to state my positionality while I conducted this research. The beliefs and experiences I have had should be explicit through reflexive comments. The way of examining the research process of this study according to my positionality can be described as reflexivity (Bourke, 2014). It has been stated 'reflexivity involves a self-scrutiny on the part of the researcher; a self-conscious awareness of the relationship between the researcher and an "other" (Bourke, 2014, p. 2). When a researcher is being reflexive about his or her own positionality, he or she should 'reflect on how one is inserted in grids of power relations and how that influences methods, interpretations, and knowledge production' (Sultana, 2007. P, 376). When researcher acknowledge his or her positionality should not be necessary mean abandoning the research, rather 'it can strengthen our commitment to conduct good research based on building relations of mutual respect and recognition' (Peake & Trotz, 1999. P, 37).

My positionality can be described as student who was previously selected from the school administration to represent my class in the academic competition in several occasions. I was selected as I was highly achiever students in math and science. Later, I was grouped with other gifted students to represent the school in public

academic competition. I understand and I am aware of the fact that I was grouped and considered in somehow as gifted child. However, I lack any understanding of how to be labelled by disability label, such as LD or ADHD. I lack from how children who are diagnosed with LD and ADHD experience their academic and social life differently. Although my experience was twenty years ago, I wanted to explore the issue of labelling on children with LD and ADHD. Considering these limitations in my positionality, and paucity in Saudi literature, I decided to conduct a mixed method research. This led to increase my interests in exploring the perceptions held by LD teachers, ADHD teachers and parents of children with LD and ADHD. As this study used qualitative approach in the second phase, it has been argued that 'the nature of qualitative research sets the researcher as the data collection instrument. It is reasonable to expect that the researcher's beliefs' (Bourke, 2014, p. 2). In other words, bias can exist in all research (Smith & Noble, 2014). However, and as it will be explained in section (4.4), I did my best effort to minimise and balance the potential bias by establishing specific criteria, such as credibility and confirmability (Lincoln & Guba, 1985).

### **4.3 Research Design**

This study was a two-phase study in which a mixed methods design (both quantitative and qualitative inquiries) was used to answer the research questions. A mixed methods design allows the researcher to obtain in-depth information and a thorough understanding of the phenomena under investigation. It allowed the researcher of this study to use words to provide meanings to numbers and to use numbers to provide meanings to words (Johnson et al., 2007). Qualitative research can be conducted to obtain a deep understanding of the phenomena under study, whereas quantitative research can be adopted to determine why a certain issue occurs and how (Mertens, 2010; Bryman, 2012). Adopting either a quantitative or qualitative approach alone could prevent researchers from obtaining an in-depth understanding and a clear image of the phenomena under investigation. Thus, the mixed methods approach was adopted because one research method might be insufficient, and the other research approach can enhance the first approach (Creswell & Clark, 2011). An explanatory sequential design was used in which gathering quantitative data was conducted first and gathering qualitative data was

conducted second (Creswell, 2012).

It has been claimed that a mixed methods approach is the best fit for the pragmatic paradigm (Rossman & Wilson, 1985; Tashakkori & Teddlie, 2003), which is practical and 'pluralistic' and is concerned only with the research problem and the multi-research methods used to address the issue. Regardless of methods adopted, having an extensive answer to all my research questions was fundamental. As mentioned in chapter two, the phenomenon of LD and ADHD labels seemed to lack from depth exploration in the Saudi context. Thus, using both quantitative and qualitative provided different data and information. It could be said that this thesis is largely qualitatively positioned because the researcher aimed to obtain an in-depth understanding of parents' and teachers' perceptions of ADHD and LD labels by adopting both quantitative and qualitative inquiries. The explanatory sequential design allowed the researcher to gain general picture about the issue of ADHD and LD labels in the first phase (quantitative), and to have depth exploration and an extensive understanding in the second phase (qualitative). To ensure that the second, qualitative phase was the essential phase of this study, the qualitative results were examined in more detail than the quantitative results (Creswell, 2012). Hence, the main aim of the quantitative method was not to generalise or to test hypotheses but to provide a background for the issue at hand to explore it more deeply in the second phase using the qualitative method (Creswell, 2012).

Creswell (2012, p. 543) argued that the explanatory sequential design is most useful when the researcher aims to capture the best of both quantitative and qualitative data in which the researcher 'obtains quantitative results from a population in the first phase, and then refines or elaborates these findings through an in-depth qualitative exploration in the second phase'. The explanatory sequential design offers enormous potential for generating new ways of understanding the complexities and contexts of social experiences. It can also help qualitative researchers who seek to develop constructivist epistemologies and to engage with complex methodological issues, especially for questions of interpretation and explanation (Mason, 2006). Adopting the explanatory sequential design for this study helped the researcher gain a better understanding and exploration of LD and ADHD labels by adopting different methods based on the

research questions (Johnson et al., 2007).

Another reason behind choosing the explanatory sequential design was that mixed research allows the researcher to explore information that would have been overlooked if only a qualitative or quantitative method had been adopted (Dörnyei, 2007). Conducting an explanatory sequential design study provided the researcher with a better understanding of the research questions than any single method (Creswell, 2012; Robson, 2011). This design provided a better opportunity to build on the strengths of both the qualitative and quantitative approaches. The explanatory sequential design in which combining two or more research methods, such as interviews and questionnaires in the present study, with different strengths and weaknesses helped the researcher to increase the adequacy of the interpretations by adopting a multi-level analysis (Dörnyei, 2007, Johnson & Christensen, 2008). In addition, adopting this design was based on the researcher's belief that an in-depth exploration of the perceptions of teachers and parents of labels is needed because a lack of studies has been conducted on the LD and ADHD labels phenomena in the Saudi context.

Another reason for adopting this design was that it helped the researcher return to participants for a second round of qualitative data collection, as the questionnaire asked whether they were willing to participate in the second phase (Creswell, 2012). In addition, this design enhanced the credibility of the study by applying triangulation which different methods for gathering data were used (Robson, 2011). According to Golafshani (2003), triangulation may include multiple or different methods of data collection and data analysis.

Thus far, justifications for adopting an explanatory sequential design for the present study have been provided; however, conducting a mixed methods research design in the education field has disadvantages. There were a number of potential challenges associated with implementing the explanatory sequential design. It has been indicated that a design with a two-phase approach requires considerable time to conduct, particularly for analysing the quantitative data to design and to implement the second instrument, which is the interview (Creswell, 2012). For this research, there was sufficient time to implement the quantitative phase, to analyse the data and to conduct the interviews.

In addition, it has been claimed that it may be difficult to determine which quantitative results need to be further explained (Creswell, 2009). Although this was thought to be a disadvantage initially, based on the results from the quantitative phase, the results that required further explanation in the second phase were clear. This study began with the collection and analysis of quantitative data. Then, based on the quantitative phase, it was followed by the qualitative phase by determining which results from the first phase required further explanation for an in-depth understanding. According to Creswell (2012), these separate phases make the explanatory design straightforward to describe, implement and report.

### **4.3.1 Quantitative Phase (First Phase)**

#### **4.3.1.1 Sample**

It is widely known that for quantitative research, a large sample is selected using probability techniques, whereas for qualitative studies, smaller samples are selected through non-probability or purposive techniques (Wellington, 2000). In the present study, selecting a large number of participants through probability techniques was not needed in the quantitative phase because generalisation was not the aim. The priority of this study was the qualitative phase, the second phase, where the essential aim was deep exploration. Thus, convenience sampling or opportunity sampling was used in the first quantitative phase (Cohen et al., 2007). This technique involved selecting the nearest or most convenient participants to serve as respondents and continuing the procedure until the required sample size was obtained (Cohen et al., 2007).

A convenience sample is used when participants are viewed as captive audiences. This research was carried out in Saudi Arabia, specifically in mainstream primary schools in Jeddah, which is the second largest city and a major urban centre of western Saudi Arabia. Choosing Jeddah was based on several reasons. First, Jeddah is one of the five cities in Saudi Arabia that has launched ADHD programmes in its mainstream schools (Algraigray, 2015). Jeddah also has a number of LD programmes in a mainstream setting. Hence, both categories were available to conduct this research. Second, by choosing Jeddah, the researcher ensured his familiarity with the study context, as he has worked as a teacher in a

primary school for one year and has had many training placements while studying for his bachelor's degree. Hence, the researcher has remained up-to-date with changes occurring in primary schools in Jeddah. This prolonged engagement helped the researcher achieve credibility for the current study (Lincoln & Guba, 1985). In addition, choosing Jeddah as a study context helped the researcher implement and apply the sample technique, which was convenience sampling, which involved selecting the nearest or most convenient participants to serve the research agendas.

Furthermore, ADHD and LD teachers and parents of children with ADHD and LD were targeted participants in this study, and there are no clear statistics regarding their number. The statistical information provided by the MOE regarding ADHD and LD only includes the number of programmes in the schools. According to the latest information on LD in Jeddah, the number of LD programmes in Jeddah was 152 (MOE, 2016). As mentioned, the MOE stated that there are only two ADHD programmes in Jeddah. Thus, the researcher simply selected participants who were convenient to access because the population or total number was unknown. Other sampling techniques, such as probability random sampling, which requires clear explanations of the population, could not be implemented effectively. It has been claimed that although purposive techniques are often linked with qualitative instruments, they might be used in either qualitatively or quantitatively oriented research, and they are also used in mixed methods studies (Tashakkori & Teddlie, 2003).

Also, convenience sampling 'saves time and spares the researcher the effort of findings less amenable participants' (Cohen et al., 2007, p. 144). Yet, the convenience sampling technique in which participants are willing to be involved in a study was appropriate for the first quantitative phase. Participants indicated their willingness to be involved in the first phase through the provided information sheet and consent form from schools' principals. Therefore, the researcher had 153 completed questionnaires from a) parents of children with a label of ADHD or LD and b) mainstream primary school teachers of ADHD and LD students. These teachers were involved in teaching students with ADHD and LD in both mainstream classrooms and resource rooms, where students spend half their day (MOE, 2017). The researcher prepared to visit all schools where students with ADHD were included (two schools). Also, he visited a number of mainstream schools where LD



students were included. The aim of the visits was to introduce myself as a researcher, explain the study's purposes and receive help from teachers to distribute the questionnaires. ADHD and LD teachers were provided with access to the online questionnaires, and they distributed them to parents. Also, the researcher revisited the MOE and met the LD teachers' supervisors, who helped distribute the online questionnaire through WhatsApp. Ultimately, 153 responses were received from all participants.

As shown in Table 1, 42 LD parents and 91 LD teachers completed the online questionnaire. The number of parents seemed low when compared with the number of LD programmes, which was 152, whereas the number of teachers seemed to be acceptable compared to the 152 LD programmes in Jeddah schools. The low number of LD parents was acceptable because the aim was not to generalise data that requires a representative sample of the whole population. According to Cohen et al. (2007), a probability sample, which was not used in this study, is useful if researchers aim to make a generalisation because it seeks representativeness of a wider population. On the other hand, a non-probability sample deliberately avoids representing the whole population because generalisation is not the research aim. Fifteen ADHD parents and five ADHD teachers participated in this study, which seemed to be acceptable because the number of ADHD programmes in Jeddah was two when the data collection of this study took place. The five ADHD teachers comprised the total number of ADHD teachers in Jeddah who were involved in teaching children with ADHD in a mainstream setting.

**Table 1 (Summary of the number of participants)**

Type of Participants	Number of Participants
LD Parents	42
ADHD Parents	15
LD Teachers	91
ADHD Teachers	5
Total Completed Questionnaires	153

#### 4.3.1.2 Method

During the first quantitative phase of this study, a closed-ended questionnaire was distributed online to a) parents of children with a label of ADHD and LD and b) both ADHD and LD primary school teachers (see Appendix 1). The closed-ended questionnaire has a number of advantages. Neuman (2002) stated that a closed-ended questionnaire is straightforward and quick for respondents to answer, which enables the researcher to easily code it and analyse it. As there is an extreme lack of studies on ADHD and LD labels in the Saudi context, the questionnaire items were adapted to cover most labelling issues from the literature that were related to the research questions. Slang, jargon and abbreviations were avoided in the questions. Also, ambiguity, emotional language, leading questions, overlapping and unbalanced response categories were avoided (Pallant, 2005).

The aim of the questionnaire was to gain a general and a broad picture of the phenomena under exploration. In particular, the aim was to obtain a broad understanding of the consequences of the labels ADHD and LD. Quantitative data was gathered by distributing a questionnaire to a large number of participants (153 participants). The main part of the questionnaire included statements and asked participants to rate their agreement with the statements. The questionnaire items were divided into six separate sections (see Table 2). The first section asked for personal information, such as questions about qualifications. The second section included statements adapted from Arceneaux's (2006) research to measure stigmas of students with LD. This scale was adapted for the present study to include measures of stigmas for students with ADHD as well. The third section included statements adapted from the Rosenberg Self-Esteem scale (1979). Some statements for this scale were adapted to measure the fourth section, which measured the potential impacts of informal and formal labelling on children's socialisation. The final two sections measured the effects of labels on children's behaviours and the expectations of teachers. Statements in these sections were composed based on the literature review to answer the research questions (see Table 2).

A four-point Likert scale was used because it provided the researcher with a wide range of possible scores and enhanced the statistical analysis (Pallant, 2010.). According to Johns (2012), a Likert scale is universally applicable as it provides

response options covering the negative to positive dimensions of specific issues. Considering the research questions, this scale was appropriate; however, a closed-ended questionnaire is not without disadvantages. Cohen et al. (2007, p. 248) stated that 'it may take two or three months to devise it, pilot it, refine it and set it out in a format that will enable the data to be processed and statistics to be calculated'. A closed-ended questionnaire can also restrict participants from giving their opinions and views regarding ADHD and LD labels; hence, semi-structured interviews filled the gap by allowing the participants to do so. The researcher followed Cohen et al.'s (2007) advice regarding minimising the drawbacks of the questionnaire. First, leading questions and questions that require sophisticated responses were avoided. Also, questions that use negative and double negative phrasing were avoided to make the questions clear to participants.

**Table 2 (type of questionnaire scales)**

<b>Questionnaire section</b>	<b>Nature</b>	<b>Example of statements</b>
Stigma scale	Adapted from Arceneaux (2006)	My child tends to hide his school work from other family member or sibling
Self-esteem of labelled children	Adapted from: -Rosenberg Self-Esteem scale (1979) -Created by the thesis' author based on the available literature	Regardless his disability, I think that Attention Deficit Hyperactivity Disorder label minimises my child ability to do things as most non-labelled students can do
Informal and formal labelling consequences on a children's scale	Adapted from: -Rosenberg Self-Esteem scale (1979)	I think that my child gets bullied by other peers because he always goes to resources room
Potential Outcomes	Adapted from: -Rosenberg Self-Esteem scale (1979) -Created by the thesis' author based on the available literature.	Students with Attention Deficit Hyperactivity Disorder tend to change their behaviour to match the negative stereotypes of ADHD label
Effects of Labels on Teachers and Schools' Staffs	Created by the thesis' author based on the available literature.	Teachers treat my child differently once he receives the Learning Disability label

***Piloting the questionnaire***

Piloting questionnaires is crucial because it has several functions, such as increasing the validity and reliability of the questionnaires (Oppenheim, 1992). Piloting thus provides feedback on the clarity of items, the validity of the

questionnaires, the response categories and layout, whether the questionnaire is too long or too short, etc. (Cohen et al., 2007). Validity can be defined as the degree to which a questionnaire measures what it is designed to measure (Pallant, 2010). As shown in Table 2, stigma, self-esteem of labelled children and informal and formal labelling consequences scales have been designed and used in many studies, and thus they can be considered validated instruments to measure the components of labels (Rosenberg, 1979; Arceneaux, 2006). The effects of labels on children and teachers' expectations scales were created and adapted from the literature on ADHD and LD labels. Several versions were sent to the thesis supervisors for their feedback to ensure validity. The final English version was translated into Arabic by an official certified office that specialises in translation, and the accuracy of words and items of all four questionnaires were checked (see Appendix 2). Then, the questionnaires were also checked by two native Arabic colleagues at the University of Exeter who were completing PhD degrees in special needs. Small amendments were suggested for some items to ensure that participants answered clearly.

Next, all four questionnaires were distributed to participants for the pilot stage; however, ten responses were received for only three of the surveys. No response was received for the ADHD parent questionnaire. Because all the surveys are similar in terms of what the scales aimed to measure, the three piloted questionnaires seemed to be sufficient for the piloting stage (see Table 3). Some questions were added to the piloted version. For example, participants were asked whether the items were clear and how much time was required to answer the questionnaires. Also, one open-ended question was added to provide them with an opportunity to add any comments regarding the items. Overall, seven participants stated that the questionnaires were clear, and three participants stated that the questionnaires were not clear, though no information was provided regarding which items needed to be amended. Thus, the participants did not mention any major issues in completing the questionnaires.

The reliability of questionnaires is another significant element to measure. As is stated in detail in the quantitative findings chapter, reliability refers to the extent to which results are consistent over time (Golafshani, 2003). Cronbach's alpha, which

is one of the most common tools used in SPSS software to test internal consistency, was adopted. All questionnaires scored higher than 0.7 in SPSS for all items. The internal reliability for each scale was also established to ensure that the items of each scale functioned as intended. All scores and their details are explained in section (5.2 Reliability of the Quantitative Analysis).

**Table 3 (Summary of questionnaires piloting)**

<b>Questionnaire types</b>	<b>Number of responses</b>	<b>Time to answer the questionnaire</b>	<b>Items are clear and there is no need for change</b>	<b>Items are not clear and there is a need for change</b>	<b>Comments provided</b>
Teachers of LD	3	6-9 mins	3	-	No comments
Parents of children with LD	6	6-9 mins	4	2	No comments
Teachers of ADHD	1	6-9 mins	-	1	No comments
Parents of children with ADHD	No response	-	-	-	No comments

#### **4.3.1.3 Data Collection Procedure and Analysis**

Collecting the first round of quantitative data required several stages. Initially, the researcher visited the MOE in Jeddah to obtain permission for data gathering. Also, the researcher had been given a list of all school names and details of locations and communication types in Jeddah. There are only two schools that run ADHD programmes in their mainstream setting, so both schools were selected. However, the number of LD programmes in Jeddah was 152 (MOE, 2016). Determining the number of schools and both LD and ADHD programmes did not determine the number of participants. Thus, and as mentioned in section (4.3.1.1 Sample), A convenience sample approach was used to recruit the participants of the study as the researcher chosen those who were convenient to access because their population or total number was unknown.

During the first quantitative phase, data were analysed using statistical software (SPSS) version 24. Most items in the questionnaires were positively worded and were scored according to a four-point Likert scale. The Likert scale ranged from 1,

strongly disagree; 2, disagree; 3, agree and 4, strongly agree; however, some items in each questionnaire were negatively worded to help the researcher avoid acquiescence bias. Reversing some items was intended to reduce the effects of response styles. Swain et al (2008) indicate that adding negative words such as 'not' or 'un', is strategy to change the item without changing substantially item wording. In this research, this approach was used in which the negative items were converted into different items before the data analysis was conducted. Also, the scoring of the negative worded items was reversed before reporting data in this thesis.

The quantitative analysis in this phase was descriptive (Pallant, 2010). Descriptive statistics were obtained using mean and standard deviation (SD), which allowed the researcher to determine the average of all given responses (Pallet, 2010). The main aim of the descriptive analysis was to obtain a general picture of ADHD and LD labels and to determine which issues needed to be explained further in the second phase.

As is stated in detail in the quantitative findings chapter, all questionnaires were analysed descriptively. Mean and SD were used to indicate the level of agreement of the responses a specific item received. Scales of six labels in the questionnaires (general information, stigma, self-esteem, informal and formal labels, potential outcomes and future expectations) were generated to determine teachers' and parents' perceptions regarding ADHD and LD labels. Then, data for each scale were closely examined to achieve an in-depth understanding of certain topics and items for ADHD and LD labels.

Descriptive statistics were selected in this study rather than inferential statistics such as analysis of variance, for example, for several reasons. First, conducting a descriptive statistic helped the researcher to gain general information about the issue of LD and ADHD labels in the first phase (quantitative). In other words, the results of the descriptive analysis allowed the researcher to establish the frame of the second phase (qualitative). Descriptive statistics helped the researcher to summarize the overall trends or agreement level in the data and provide an understanding of how varied the scores may be (Creswell, 2012). The questionnaires were distributed to obtain a quantitatively analysable background

as well as general information related to ADHD and LD labels according to teachers' and parents' perceptions and views.

One may argue that one way ANOVA test, an example of inferential statistics should have been conducted to compare between parents and teachers. However, these statistics tests were not applicable and would not help the researcher to answer the research questions. The purpose of this study was not to compare between groups such as teachers and parents or ADHD and LD. The aim of this study was to deeply explore the issue of labelling from different angles.

To ensure the safety and privacy of data, all results were kept on a private laptop and a private disk computer at the University of Exeter. Copies were saved in the OneDrive of the University of Exeter and other locations, which is explained in the ethical section.

### **4.3.2 Qualitative Phase (Second Phase)**

#### **4.3.2.1 Sample**

During the qualitative second phase of this study, specific persons were selected intentionally from those who stated their willingness in the first phase to participate in the interviews. The aim was to generate information that could not be obtained via other sampling choices (Creswell, 2012). A purposeful sampling technique was used because the purpose of the research questions was to obtain an in-depth understanding of parents' and teachers' perceptions of LD and ADHD. To achieve this objective, specific persons were selected intentionally and purposefully. As mentioned, the researcher liaised to cooperate with the local authority in Jeddah to facilitate the process of meeting participants, following the procedure that has been adopted by the MOE.

Participants who stated their willingness to participate were contacted by the researcher, and interview times, dates and locations were agreed upon. 12 participants from the first phase agreed to participate in the second qualitative phase. I contacted all the 12 participants to liaise the locations where the interview will be held. Two LD parents and one ADHD parents did not respond to my contacts. Participants in the second phase were from Jeddah. As shown in Table 4, the participants included four parents whose children were diagnosed with LD and ADHD and were included in a primary mainstream setting (two parents of children with LD and two with ADHD). Also, four ADHD and LD teachers from

different primary mainstream schools in Jeddah participated in the interview phase. Thus, the total number of participants was eight male parents and teachers alongside to one piloted interview. Only male participants were chosen due to the cultural and educational policies, which limited accessibility to female schools in Saudi Arabia. Participants were selected to ensure a diverse sample of participants (teachers and parents) and types of labels (LD and ADHD). These elements were mentioned in the questionnaire, and thus the researcher ensured the interview sample covered the elements.

The small number of participants is suitable for qualitative research to provide the depth and breadth of the data needed (Liamputtong & Ezzy, 2005). The researcher deliberately chose a small purposeful sample in the second phase from those who stated their willingness to participate in the questionnaire (first phase) to obtain an in-depth understanding of the issue at hand because generalisation and testing findings were not the aims of the present study. Hence, a purposeful sample helped answer the research questions. Also, this sample procedure helped the researcher obtain a deep understanding of how a specific set of participants experienced the phenomenon under investigation (Maykut & Morehouse, 1994).

**Table 4 (Details of the Interview Participants)**

No	pseudonyms names	Roles	Type on interview	Location of the interview
1	Khalid	LD teacher	Piloted	School
2	Ammar	LD teacher	Actual	School
3	Omer	LD teacher	Actual	Coffee shop
4	Ahmed	LD parent	Actual	School
5	Adi	LD parent	Actual	School
6	Aati	ADHD teacher	Actual	School
7	Sameer	ADHD teacher	Actual	School
8	Hazim	ADHD parent	Actual	His work
9	Fahad	ADHD parent	Actual	His house

#### 4.3.2.2 Method

During the second qualitative phase of the present study, semi-structured interviews were conducted. According to Kajornboon (2005), interviews allow the researcher to gain an in-depth understanding of participants' views. Considering the research questions, using interviews as a tool was appropriate for attaining highly personalised data. In the present study, the perceptions of ADHD and LD



teachers and parents were viewed as personal data (Seidman, 2013). Another justification for conducting semi-structured interviews in the current study was that they are frequently used in the qualitative phase of a mixed methods design when the central phenomenon is associated with perceptions (Kajornboon, 2005). In addition, this type of interview allowed the researcher to prompt participants and to probe more deeply into a given situation. During the semi-structured interviews, the order of the questions was changed based on the direction of the interview and on participants' responses, allowing the researcher to ask additional questions (Kajornboon, 2005).

There were other justifications for adopting semi-structured interviews, which have been demonstrated by Gray (2004). First, semi-structured interviews allow the researcher to understand the participants' views regarding their perceptions of ADHD and LD labels because interviews are appropriate tools to provide participants with opportunities to express their views and feelings. Second, this method allowed the researcher to investigate different opinions among the participants. This tool also helped the researcher expand and deepen the exploration of issues that arose during the first quantitative phase. Questionnaire' statements that achieved very high or very low mean scores were selected to be deeply explored through the interviews. Further details can be found in the next Quantitative Findings chapter.

The interview questions were designed to answer the research questions and to deeply explore issues that emerged from the questionnaire as well as previous studies (see Appendix 3). Supervisors of the current study were consulted several times; hence, feedback and comments were taken into consideration. Similar to the first phase, the interview questions were translated. The final English version was translated into Arabic by a certified office that specialises in translation, and the accuracy of words and items of all interview questions were checked (see Appendix 4). Then, the interview questions were forward-backward translated to English. Then, the English version of the interview questions were checked by two native Arabic colleagues at the University of Exeter who were completing PhD degrees in special needs. No changes were suggested by the colleagues.

As research tools, interviews have drawbacks. One disadvantage is that the researcher may not be able to manage and analyse data properly because they are voluminous and the process is time-consuming (Marshall & Rossman, 2010). As is discussed in more detail, both manual and computer software methods were used to analyse the qualitative data adequately. Researcher bias is another weakness of interviews (Liamputtong & Ezzy, 2005), which was overcome by using both quantitative and qualitative methods in which the triangulation technique was used.

### ***Piloting the interview***

To ensure the translations of the interview questions were clear, one pilot interview with a LD teacher was conducted. The clarity of the questions, the time required to answer the questions and the wording of the questions after translation were checked. The interview lasted nearly 30 minutes, and no major changes were suggested. Thus, the interview questions were well-prepared for data gathering. Because the interview questions explored similar issues of ADHD and LD labels, such as stigma and self-esteem, one piloted interview seemed sufficient for the pilot stage. The researcher would have conducted another piloted interview if a major change was suggested.

### **4.3.2.3 Data Collection Procedure and Analysis**

After the questionnaires were completed by participants, some of those who stated their willingness to participate were chosen to be a part of the interviews. As mentioned, the interview schedules were agreed upon between the researcher and the participants, and locations, dates and times were set. All interviews were conducted in school settings except for two interviews with ADHD parents, who were interviewed in their homes based on their preference. As stated in the ethics section, permission was obtained from the participants to record the interview. The interviews lasted between 30 to 45 minutes depending on the circumstances and the general atmospheres. The interviews were conducted in the Arabic language for simplicity and to achieve an in-depth understanding of personal feelings and perceptions rather than participants having to translate their complex thoughts because Arabic was the mother language of the participants. This allowed the interviewees to express their views and perspectives related to the phenomena under investigation more freely and without any linguistic obstacles. Using the

Arabic language during interviews provided the freedom for participants to express and to illuminate their views, experiences and perceptions in their own words without any language difficulties. According to Randor (2001), considering a comfortable and easy language to use when conducting interviews is crucial in any field of research. Furthermore, it is important to ensure the simple flow of interviews, and hence question prompts were used to open and to create discussions with interviewees.

Translating transcripts of interviews before analysing themes leads to a loss of in-depth meanings and concepts structured by the context. It has been claimed that 'the advantage of not needing to render idioms into English or translate expressions in ways that lose their immediacy, power and context is an important step towards a consistent interaction with the text that forms the data' (Madang & lee, 2005, p. 5). The data were collected in the Arabic language and were not translated into English until the analysis stage because immersion in the original Arabic data provided the researcher with a better understanding. In addition, some concepts and terminology in the original data might be less comprehensive and understandable if the analysis process takes place after translation into English.

MAXQDA, which is a computer software programme, was used because it supported the researcher in the data analysis by providing an accurate, rigorous and transparent view of the data (Welsh, 2002). A manual analysis was also conducted at the final stages of analysing the qualitative data. Analysing qualitative data by adopting a combination of both manual and computer-assisted methods helped the researcher achieve better results than any single method of analysis (Welsh, 2002). Data were converted from an audiotape recording to text files. A thematic analysis was used in which the processes of coding generation, searching for themes and defining and naming the themes were conducted (Braun & Clarke, 2006). Using a thematic analysis helped the researcher organise and explain data in rich detail. The thematic analysis was also adopted because it has flexible and adaptable approaches of analysis that lead to embellishing and refining essential elements of large data and obtaining a consolidated description and explanation of data (Braun & Clarke, 2006). Unexpected findings were generated using a thematic analysis through an in-depth exploration of ADHD and LD labels (Creswell, 2012).

Braun and Clarke's (2006) approach to analysing qualitative data was adopted. This approach has several steps, including familiarising oneself with data, creating initial codes, searching for themes, reviewing themes, defining themes and generating the report (see Table 5). In the first step, all audio-recorded interviews were transcribed by the researcher by listening to them several times. This helped the researcher transcribe the audio recordings accurately and furthered the understanding of and immersion in the data. This step also included careful readings of the transcripts to obtain a deep understanding, which was suggested by Creswell (2012). Using MAXQDA helped the researcher write memos and notes in different colours regarding general and basic ideas of data to organise them into files.

During the second step of Braun and Clarke's (2006) approach to analysing qualitative data, initial codes were generated and created for each line of the transcripts. For trustworthiness purposes, two pages of one transcript were given to one PhD student at the University of Exeter. She was asked to generate initial codes to ensure that another way of coding was available to the researcher. One supervisor of this thesis was also given copy, who suggested another type of coding. Obtaining other opinions in generating initial codes allowed for removing any potential bias and subjectivity, which are core features of qualitative studies. Ultimately, nearly 705 codes were generated during this stage (see Appendix 11).

**Table 5 (Braun and Clarke's Thematic Analysis Process)**

<b>Phase</b>	<b>Description of the process</b>
1-familiarizing yourself with your data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2-generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3-searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4-reviewing themes	Checking if the themes work in relation to the coded extracts (level 1) and the entire data set (level 2), generating a thematic 'map' of the analysis.
5-defining and naming themes	Ongoing tells, generating clear definitions and names for each theme.
6-producing the report	The final opportunity for analysis, selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

See Braun and Clarke (2006, p. 87).

The third stage of Braun and Clarke's approach involves finding and searching for themes. Based on a high number of initial codes and after several readings of and immersion in the data, the process of searching for themes included combining, deleting and collapsing codes. At the end of this stage, initial themes and sub-themes were found. In the following stage, the generated themes and sub-themes were reviewed and refined. Some themes and sub-themes were combined for more meaningful and rich of data and extracts. The researcher focused on how codes were linked to sub-themes and how sub-themes were associated with themes. Some codes were deleted, collapsed and combined with others for more expressive and meaningful findings.

After several reviews of the themes, the researcher obtained an understanding of the main concept of the qualitative data as well as how each theme was linked to the research questions. During this step, definitions and names were assigned to all themes and sub-themes related to ADHD and LD labels. At the final stage of the thematic analysis, the researcher wrote the report of the qualitative findings. As is explained in greater detail in the qualitative chapter, the report of the findings was divided based on the main themes and sub-themes.

#### **4.4 Trustworthiness**

Ensuring trustworthiness is a significant element of qualitative studies. According to Lincoln and Guba (1985, p. 20), trustworthiness is linked to 'how [the] inquirer [can] persuade his or her audiences that the research findings of an inquiry are worth paying attention to'. This can be established based on specific criteria, such as credibility and confirmability (Lincoln & Guba, 1985). Credibility in qualitative research is an essential criterion for achieving trustworthiness. Credibility can be established using several approaches, such as triangulation, prolonged engagement and member checks. Triangulation was applied in this study using questionnaires and interviews. Two different types of participants (teachers and parents) were involved in this study, which allowed the researcher to explore ADHD and LD labels from different perspectives. Using triangulation helped the researcher improve the validity and reliability of the research findings (Golafshani, 2003). As mentioned, the researcher was familiar with the context of this study because he had worked in Jeddah (context); hence, he was up-to-date on issues related to special needs in general. This prolonged experience helped the

researcher achieve credibility for the current study (Lincoln & Guba, 1985). As mentioned, analysing qualitative data involved a member check in which two PhD students were given copies of an interview transcript to create initial codes. This contributed to developing and increasing the credibility of the research. Thus, triangulation, prolonged engagement and member checks provided and enhanced the credibility of this study, which led to trustworthiness.

Confirmability was used to ensure the trustworthiness of the generated results and to avoid and to overcome bias (Lincoln & Guba, 1985). To validate the qualitative findings data, a summary of the findings was provided to interviewees over the telephone to reflect on what they said during their interviews and to determine whether there was a need for changes or additions. Seven of eight participants responded that they agreed with the provided summary. One participant did not answer and comment to the summary. Thus, by ensuring credibility and confirmability using different techniques, trustworthiness was established.

#### **4.5 Ethical Issues**

In the present study, ethics were a primary consideration and at the forefront of the researcher's agenda. Before data collection, ethical approval for the research was granted by the Human Research Ethics Committee at the University of Exeter (see Appendix 6). The ethical approval included all details about participants, their personal details and their data protections. The information sheet for participants and school principals and consent forms were approved by the Graduate School of Education as well. The researcher liaised with the MOE in Jeddah to obtain permission for school visits, which is a prerequisite of research in Saudi Arabia (see Appendix 7). After permission was obtained, the MOE provided the researcher with a list of all mainstream primary schools in Jeddah where students with labels of ADHD and LD were included.

The researcher contacted the principals of all the schools and informed them that the MOE granted permission to conduct the study and then asked them to facilitate the study. An information sheet was given to all principals to inform them of the study purposes (see Appendix 9). They were asked to undertake the initial contact with teachers and parents to inform them of the study by giving them an information sheet. The information sheet contained a link to the questionnaire, which participants accessed directly. An online link to the questionnaires was also

provided to school principals via WhatsApp, which contained the researcher's contact details if more information was needed. Approved consent forms and information sheets were distributed to all participants in both Arabic and English to ensure they were fully aware of the details of the proposed study (see Appendix 9). As mentioned, the respondents to the questionnaires may have been male or female since the questionnaires were distributed online to parents of children with LD and ADHD. The researcher has no contact information about parents unless he liaised with the schools' principals. Hence, this is the reason how female parents may have been responded to the questionnaires.

In addition, for the second qualitative phase, verbal permission was obtained before each interview took place. Permission was obtained from participants to record interviews by phone. They were informed that their participation was completely voluntary and not compulsory, which means they had the right to withdraw at any stage of the interview. All audio-recorded files and analysis files were kept on a private laptop with a password that only the researcher could access. There were also other ethical considerations involved in reporting the data. For example, data were reported honestly without any changes, and the names of the participants were reported anonymously to ensure they cannot be identified.

## Chapter Five

### Quantitative Findings

#### 5.1 Introduction

As stated in the Methodology chapter, the current research is mostly qualitatively oriented; however, the four closed-ended questionnaires were distributed to achieve a quantitatively analysable background as well as general information related to ADHD and LD labels according to teachers' and parents' perceptions and views. The aim of the closed-ended questionnaires was to answer the first research question: 1- How do primary school teachers and parents view and perceive ADHD and LD labels?

This chapter begins with a calculation of the reliability of the quantitative findings and how reliability was ensured. It explains how this study used Cronbach's alpha for all questionnaires and each scale in each questionnaire. It is followed by a descriptive analysis of the mean of all scales and the personal information of all participants of the current study. **Stigma, self-esteem, formal and informal labels, potential outcomes of labels and Effects of Labels on Teachers and Schools' Staff** are also discussed in this chapter. Each section presents the descriptive findings according to the participants' types.

#### 5.2 Reliability of the Quantitative Analysis

Reliability is introduced as 'the degree to which the items that make up the scale are all measuring the same underlying attribute' (Pallant, 2016, p. 6). Pallant (2016) stated that internal consistency can be measured in several ways. Cronbach's alpha is the most commonly used technique using SPSS software. In this study, and as shown in Table 6, each questionnaire has six scales: personal information, stigma, self-esteem, informal labels, potential outcomes and effects of labels on teachers and school staff. Therefore, Cronbach's alpha was used to assess the internal reliability of each scale. Field (2013) argued that if the questionnaire contains different scales, Cronbach's alpha should be used separately for each scale. Thus, it was applied separately for each scale as well as for all items together.



*Table 6 (Reliability of Scales)*

Questionnaire types	Scale	Number of Items	Cronbach's alpha value
<b>LD Parents</b>	Stigma	10	.633
	Self-Esteem	5	.534
	Informal Labels	10	.701
	Potential Outcomes	5	.452
	Effects of Labels on Teachers and Schools' Staffs	9	.884
	<b>Cronbach's alpha value of all items</b>	<b>39</b>	<b>.874</b>
<b>ADHD Parents</b>	Stigma	6	.503
	Self-Esteem	4	.385
	Informal Labels	10	.609
	Potential Outcomes	5	.387
	Effects of Labels on Teachers and Schools' Staffs	9	.815
	<b>Cronbach's alpha value of all items</b>	<b>34</b>	<b>.767</b>
<b>LD Teachers</b>	Stigma	10	.610
	Self-Esteem	6	.769
	Informal Labels	8	.542
	Potential Outcomes	5	.717
	Effects of Labels on Teachers and Schools' Staffs	8	.704
	<b>Cronbach's alpha value of all items</b>	<b>37</b>	<b>.851</b>
<b>ADHD Teachers</b>	Stigma	6	.676
	Self-Esteem	6	.584
	Informal Labels	4	.766
	Potential Outcomes	4	.837
	Effects of Labels on Teachers and Schools' Staffs	7	.680
	<b>Cronbach's alpha value of all items</b>	<b>27</b>	<b>.888</b>

As shown in table 6, some scales have a sufficient and acceptable value of alpha ( $\geq .7$ ); however, some scales, such as the stigma scale, in all questionnaires have a value less than (.7). Kline (2013) mentioned that a value below .7 can be realistically trusted when the scale deals with diverse and psychological constructs. Thus, as the scales can be considered psychologically oriented, a lower alpha value is acceptable. Field (2013) stated that the value depends on the number of

items on the scale, which means the more items on the scale, the higher the value. Pallant (2016) claimed that when the number of items on the scale is 10 or fewer, the value can be quite small. As shown in table 6, the low value of some scales such as **Self-Esteem** in ADHD parents' questionnaire, might be due to the number of items, which is 10 or fewer, or the low number of participants who completed the questionnaires.

### 5.3 Demographics Information

This section describes the personal information of all participants who completed the four questionnaires. The information for parents is different from teachers. In other words, both questionnaires for LD and ADHD parents contained three questions: educational level, workshop involvement and school levels of their children. The questionnaires for both ADHD and LD teachers included four questions: educational level, workshop involvement, years of experience and school levels of their students (see Table 7).

**Table 7 (Summary of Demographics Information of Participants)**

Questionnaire types	Items	scale	Frequency	Percent
LD Parents	Educational level	Primary school	5	11.9
		Intermediate school	4	9.5
		High school or diploma	12	28.6
		Bachelor degree	18	42.9
		Postgraduate degree	3	7.1
		<i>Total</i>	42	100
	Involvement in training and workshops	Yes	6	14.3
		No	36	85.7
		<i>Total</i>	42	100
	School level of children	Low elementary 1-3	21	50
Upper elementary 4-6		15	35.7	
Both levels		6	14.3	
<i>Total</i>		42	100	
<b>Total completed questionnaires</b>			<b>42</b>	
ADHD Parents	Educational level	Intermediate school	2	13.3
		High school or diploma	8	53.3
		Bachelor degree	3	20
		Postgraduate degree	2	13.3
		<i>Total</i>	15	100
	Involvement in training and workshops	Yes	2	13.3
		No	13	86.7
		<i>Total</i>	15	100
	School level of children	Low elementary 1-3	11	73.3
		Upper elementary 4-6	3	20
Both levels		1	6.7	
<i>Total</i>		15	100	
<b>Total completed questionnaires</b>			<b>15</b>	

<b>LD Teachers</b>	Educational level	Bachelor degree	80	87.9
		Postgraduate degree	11	12.1
		Total	91	100
	Involvement in training and workshops	Yes	81	89
		No	10	11
Total		91	100	
Years of Experience	1-5 years	25	27.5	
	6-10 years	35	38.5	
	11 years or more	31	34	
	Total	91	100	
School levels of students	Low elementary 1-3	17	18.7	
	Upper elementary 4-6	3	3.3	
	Both levels	71	78	
	Total	91	100	
<b>Total completed questionnaires</b>			<b>91</b>	
<b>ADHD Teachers</b>	Educational level	Bachelor degree	4	80
		Postgraduate degree	1	20
		Total	5	100
	Involvement in training and workshops	Yes	5	100
		No	0	0
Total		5	100	
Years of Experience	1-5 years	3	60	
	6-10 years	1	20	
	11 years or more	1	20	
	Total	5	100	
School levels of students	Low elementary 1-3	1	20	
	Upper elementary 4-6	0	0	
	Both levels	4	80	
	Total	5	100	
<b>Total completed questionnaires</b>			<b>5</b>	
<b>Completed questionnaires for all participants</b>			<b>153</b>	

As shown in table 7, approximately half of LD parents were qualified with bachelor and postgraduate degrees, whereas the other half had primary, intermediate and high school degrees. The vast majority of LD parents (85.7%) stated that they were not involved in training or workshops related to LD. Half stated that their children were in lower grades in primary schools or younger children classes. One third of ADHD parents were qualified with bachelor and postgraduate degrees. Two-thirds of them were qualified with intermediate and high school degrees. Similar to LD parents, most ADHD parents (86.7%) were not involved in training or workshops related to ADHD. Nearly three quarters of their children were in lower primary school grades.

As shown in table 7, most LD teachers (87.9%) were qualified with bachelor's degrees, while the rest held postgraduate degrees. The majority were involved in training and workshops related to LD. Approximately one-third of LD teachers had worked for 11 years or more. The years of experience for the other two-thirds were between 1-10 years. Nearly three quarters of teachers taught children in both lower

and higher grades in primary schools. Furthermore, most ADHD teachers were qualified with bachelor's degrees. All had been involved in training and workshops related to ADHD. Most (80%) had 1-10 years' experience in teaching children with ADHD in both lower and higher grades in primary schools.

#### 5.4 Descriptive Analysis of Whole Scales

Since the Likert scale had a range on each item from 1 (Strongly Disagree) to 4 (Strongly Agree), it was decided to divide this range into four equal sections (see Table 8). This divisions applies to the mean scores of each group of participants on the whole scale and each scale. On these scales, a high score indicates a negative perception towards the statements. Whereas a low score indicates a positive perception towards these statements.

**Table 8 (Scoring the questionnaire)**

cales	Strongly disagree (DS)	Disagree (D)	Agree (A)	Strongly Agree (SA)
<b>Mean score</b>	<b>1.00-1.75</b>	<b>1.76-2.50</b>	<b>2.51-3.25</b>	<b>3.26-4.00</b>

Table 9 shows that out of the 5 subscales, most were in agree levels of agreement. When the overall mean for the four groups of participants on each subscale are compared (see Table 9), all subscales were on the agree level. This suggests that participants perceived high level of stigma on children labelled with LD and ADHD, negative perceptions of the self-esteem, and they perceived informal labels negatively, perecievd potential outcomes of labels, and they perceibved negative effects on teachers and schools' staffs. The 'agree' means were distributed mainly for most parents and teachers and between type of labels. This indicates that the negative perceptions were not concentrated on one group of participants, or on one type of labels, but were more common in certain scales.

All participants on the **stigma** scale were in the agree level. The highest mean of **stigma** scale was observed in the LD teachers with a score of 2.94, indicating that they perceived the potential stigma attached to children who were labelled with LD. Also, LD parents, ADHD parents, and ADHD teachers achieved mean scores around 2.6 indicating that these participants also perceieved potential stigma attached to children with LD and ADHD. Similarly, all participants on the **self-**

**esteem** scale were in the agree level. The two highest means the **self-esteem** scale were for ADHD parents (2.90) and LD parents (2.88) indicating that these participants agreed with these statements and perceived low self-esteem of children with LD and ADHD. Also, the other two groups, LD teachers and ADHD teachers had mean scores in the agree range (2.76 and 2.67 respectively) showing that they perceived low self-esteem. Regarding the **informal labels** scale, all categories of participants were in the agree range (see Table 9), the ADHD teachers mean score was the highest (2.80). This suggests that the ADHD teachers and other categories had negative perception towards the informal labels regarding ADHD.

The mean score of the **potential outcomes** were in the agree range in parents' questionnaires. The highest two score were for the ADHD parents and LD parents (2.71 and 2.58 respectively), indicating that parents perceived high negative outcomes on labelled children. However, LD and ADHD teachers achieved low scores (2.50 and 2.40 respectively) showing that teachers disagreed with these statements and perceived no negative outcomes of labels on children.

Finally, the high mean scores for the **effects of labels on teachers and school staff** scale were in the ADHD teachers' and ADHD parents' questionnaires with scores of 3.06 and 2.86 respectively, indicating that they agreed with statements, showing that they perceived negative effects on teachers and school staff due to the ADHD label. However, the lowest means in the same scale were in the LD parents' and LD teachers' questionnaires with scores of 2.42 and 2.48 respectively, indicating disagreement with these statements and did not particularly perceived effects of LD label on teachers and school staff (see Table 9).

Regarding the standard deviation, most of scales were fairly around 0.5 (see Table 9). The highest SD was noticed in the scale of **Effects of Labels on Teachers and Schools' Staff** in the LD parents' questionnaire with score of .617, indicating that this scale had the widest spread of responses. Whereas the lowest SD was observed in the scale of **stigma** in LD teachers' questionnaire with a score of .348, indicating that this scale had the smallest spread of responses, where most of them were on the 'agree' and 'strongly agree' ranges. More details are presented in describing the scales item by item.

**Table 9 (the mean of all scales)**

<b>Scale</b>	<b>Type of Participant</b>	<b>Overall Mean</b>	<b>SD</b>	<b>Level of agreement</b>
<b>Stigma</b>	LD Parents	2.63	.384	A
	ADHD Parents	2.66	.443	A
	LD Teachers	2.94	.348	A
	ADHD Teachers	2.53	.491	A
Overall Mean Score of the Scale		<b>2.69</b>	-	<b>A</b>
<b>Self-Esteem</b>	LD Parents	2.88	.513	A
	ADHD Parents	2.90	.489	A
	LD Teachers	2.76	.603	A
	ADHD Teachers	2.67	.565	A
Overall Mean Score of the Scale		<b>2.80</b>	-	<b>A</b>
<b>Informal Labels</b>	LD Parents	2.60	.480	A
	ADHD Parents	2.59	.416	A
	LD Teachers	2.64	.412	A
	ADHD Teachers	2.80	.541	A
Overall Mean Score of the Scale		<b>2.66</b>	-	<b>A</b>
<b>Potential Outcomes</b>	LD Parents	2.58	.511	A
	ADHD Parents	2.71	.465	A
	LD Teachers	2.50	.511	D
	ADHD Teachers	2.40	.518	D
Overall Mean Score of the Scale		<b>2.55</b>	-	<b>A</b>
<b>Effects of Labels on Teachers and Schools' Staff</b>	LD Parents	2.42	.617	D
	ADHD Parents	2.86	.556	A
	LD Teachers	2.48	.469	D
	ADHD Teachers	3.06	.458	A
Overall Mean Score of the Scale		<b>2.71</b>	-	<b>A</b>

## **5.5 Descriptive Analysis of Scales Item by Item**

### **5.5.1 Stigma**

The current theme descriptively illustrates the quantitative findings associated with stigma. Table 10 and Table 11 present the mean and standard deviation of the **stigma scale** of LD parents, LD teachers, ADHD parents, and ADHD teachers. This scale represents their views and perceptions regarding stigmas attached to their children.

#### ***The LD label***

As shown in Table 10, on the items of LD parents' perceptions of stigma, the mean scores were in the agree range for eight items, but in the 'disagree' range for two items. The items with the highest mean were on items 5, 8 and 9, with scores of

(3.00, 2.92 and 2.88 respectively), indicating that LD parents agreed that their children tended to avoid writing notes to them, avoid spelling in front of family members, hide and not discuss their difficulties with others to avoid the potential stigma. However, the lowest mean scores of LD parents (2.28) were obtained from items 3 and 4, indicating that parents did not perceive of stigma attached to their LD children when hiding schoolwork from parents and other family members. Also, LD parents' mean score on items 1, 2, and 7 were in the agree range, indicating agreement with these statements and perceived stigma when their children tended to hide their difficulties from parents and other family members to avoid the potential stigma.

Similarly, the mean scores of all items in LD teachers' perceptions of stigma were in the 'agree' range, and one item on the strongly agree range (Table 10). The highest mean was on item 9 with mean score of (3.29) indicating that teachers strongly perceived stigma when students avoid telling others about their disability to justify their poor academic performance. In addition, items 4 and 10 had a mean score above 3.0, indicating that LD teachers agreed with statements and perceived stigma when students avoid reading at loud and avoid acknowledging their difficulties. Items 2 and 3 with mean score of (2.61 and 2.75 respectively), indicating that LD teachers agreed that stigma attached to labelled children when they hide their difficulties from them or other peers. Furthermore, items 1, 5, 6, 7 and 8 in the LD teachers' perceptions of stigma were in agree range, indicating that LD teachers agreed with items and perceived stigma attached to LD students when they avoid spelling in front of them, hide difficulties from others, and avoid writing notes to others and teachers.

As reported in Table 10, on the other hand, the highest SD (.944) in the LD parents questionnaire was observed for item 3, indicating that this item had the widest spread of responses, where the extreme choices of strongly disagree and strongly agree attracted a fairly large percentage of responses. This shows a significant variation in LD children's unwillingness to show their schoolwork to their parents.

**Table 10 (Responses of Stigma Attached to LD Label)**

Items	Mean	Std. Deviation	Range of responses
<b>LD Parents</b>			
1-my child tends to hide his difficulties from others	2.57	.859	A
2-My child tends to discuss his difficulties with other peers	2.57	.673	A
3-My child tends to hide his school work from me	2.28	.944	D
4-My child tends to hide his school work from other family member or sibling	2.28	.863	D
5-My child tends to avoid writing notes to me	3.00	.662	A
6-My child tends to avoid writing notes to other family members	2.80	.671	A
7-My child tends to avoid spelling in front of me	2.57	.859	A
8-My child tends to avoid spelling in front of other family members	2.92	.777	A
9-My child tends to not tell others about his disability to justify his academic poor performances.	2.88	.771	A
10-My child tends to not acknowledge his disability in order to avoid the negative stereotypes about LD label	2.69	.840	A
<b>LD Teachers</b>			
1-Students with Learning Disability tend to hide their difficulties from others	2.94	.672	A
2-Students with Learning Disability tend to hide their school work from me	2.61	.741	A
3-Students with Learning Disability tend to hide their school work from other peers	2.75	.672	A
4-Students with Learning Disability tend to avoid reading loudly in front of me	3.02	.774	A
5-Students with Learning Disability tend to avoid writing notes to me	2.86	.702	A
6-Students with Learning Disability tend to avoid writing notes to other peers	2.95	.648	A
7-Students with Learning Disability tend to avoid spelling in front of me	2.94	.779	A
8-Students with Learning Disability tell me about their disability to justify their academic poor performances	2.86	.871	A
9-Students with Learning Disability tend to not tell others about their disability to justify their academic poor performances	3.29	.691	SA
10-Students with Learning Disability tend to not acknowledge their disability in order to avoid the negative stereotypes about Learning Disability label	3.07	.805	A



However, the smallest SD (.662) in the LD parents' questionnaire was observed for item 5, indicating that this item had the smallest spread of responses, where there are few extreme choices (0 % strongly disagree and 9% strongly agree). This shows a uniform response that LD children were reluctant to write notes to their parents. Similarly, and as shown in Table 10, items 1, 3, 6 and 9 in the LD teachers' questionnaire were around .672 because the responses 'agree' and 'strongly agree' had a high rate. This indicates a high level of variations in LD students' unwillingness to demonstrate their difficulties and to write notes to teachers and peers.

Mostly, LD teachers and parents of children with LD indicated that there was a potential stigma that would be attached to their students because the overall mean score of this scale was 2.94 (see Table 9). Therefore, further exploration regarding the features, occurrences, outcomes and roles of stigma are needed in the interview, which is the second phase.

### ***The ADHD label***

As shown in Table 11 below, on the items of ADHD parents' perceptions of **stigma**, the mean scores were in the 'agree range for four items, but in the 'disagree' range for two items. Item 2 in the ADHD parents' scale of stigma was the highest mean score (3.06), indicating that ADHD parents agreed with item and perceived stigma attached to their children when they discussed their difficulties with peers. The mean score for item 5 was in the agree range (2.86), indicating that ADHD parents agreed with item and perceived stigma attached to their children when they avoided unacceptable behaviour in front of parents. Also, the mean scores for items 1 and 3 were in the agree range, indicating that ADHD parents agreed with these statements and perceived stigma attached to their children when they hid difficulties from peers and parents. However, the mean score for items 4 and 6 were in the disagree range, indicating that parents do not perceive stigma attached to their ADHD children when they openly displayed unacceptable behaviour in front of other family members or siblings or when they avoided unacceptable behaviour in front of parents. (see Table 11).

Regarding the items of ADHD teachers' perceptions on **stigma**, the mean scores of four items were in the 'agree range, one item in the 'strongly disagree' range and

only one item in the 'disagree' range. As reported in Table 11, the highest mean score (3.0) was observed for item 1, indicating that all ADHD teachers agreed with item and perceived stigma attached to ADHD children when they discussed their difficulties with peers. Also, The mean score for items 3 , 4 and 6 were in the 'agree' range (2.80), indicating that ADHD teachers agreed that stigma is attached to ADHD students when they hide difficulties from others and do not acknowledge their difficulties to avoid the negative stereotypes of the ADHD label. In contrast, the lowest mean score (1.60) was for item 5, indicating that ADHD teachers strongly disagreed and did not particularly perceived stigma attached to students when they do not tell others about their disability to justify their unaccepted behaviours (see Table 11 for more details).

**Table 11 (Responses of Stigma Attached to ADHD Label)**

Items	Mean	Std. Deviation	Range of responses
<b>ADHD Parents</b>			
1-My child tends to hide his difficulties from others	2.66	.617	A
2-My child tends not discuss his difficulties with other peers	3.06	.717	A
3-My child tends to hide his school work from me	2.66	1.046	A
4-My child tends to hide his school work from other family member or sibling	2.46	.915	D
5-My child tends to be shy in displaying unaccepted behaviour in my presence	2.86	.833	A
6-My child tends to not be shy in displaying unaccepted behaviour in front of other family members or sibling	2.22	.774	D
<b>ADHD Teachers</b>			
1-Students with Attention Deficit Hyperactivity Disorder tend to hide their difficulties from others	3.00	0.0	A
2-Students with Attention Deficit Hyperactivity Disorder tend to hide their school work from me	2.40	.894	D
3-Students with Attention Deficit Hyperactivity Disorder tend to hide their school work from other peers	2.80	.447	A
4-Students with Attention Deficit Hyperactivity Disorder tend to be shy in displaying unaccepted behaviour in my presence	2.60	1.140	A
5-Students with Attention Deficit Hyperactivity Disorder tend to not tell others about their disability to justify their unaccepted behaviours	1.60	.894	SD
6-Students with Attention Deficit Hyperactivity Disorder tend to not acknowledge their disability in order to avoid the negative stereotypes about this label	2.80	.863	A

Regarding standard deviation on the items of ADHD parents' perceptions of stigma, as reported in Table 11, item 1 was .617 because eight ADHD parents (of 15 parents) responded 'agree' and one responded 'strongly agree', whereas there was no 'strongly disagree' response. This indicates a significant variation in ADHD children in sharing their difficulties with parents. In contrast, item 3 was 1.046 because ADHD parents' responses varied regarding whether their children tended to hide schoolwork from them. Similar results are presented in the ADHD teachers' perception of stigma, as the SD of item 4 was 1.14 because they were extremes in responses due to different opinions regarding children who do not openly display unacceptable behaviours in their presence (see Table 11). Overall, ADHD parents and ADHD teachers perceived the potential stigma attached to ADHD students, although they tended to disagree on some items.

### **5.5.2 Self-Esteem**

The current theme descriptively illustrates the quantitative findings associated with self-esteem. Table 12 and Table 13 present the mean and standard deviation of the self-esteem scale of LD parents, LD teachers, ADHD parents, and ADHD teachers. This scale represents their views and perceptions regarding the self-esteem of children with LD and ADHD.

#### ***The LD label***

As shown in Table 12, the mean score of most items of LD parents' perceptions of **self-esteem** were in the 'agree' range, but only one item was in the 'disagree' range. The highest mean score (3.19) was observed for item 1, indicating that LD parents agreed with statement and perceived low self-esteem for their children because the LD label has negative effects on the child's self-satisfaction. The mean score for item 2 was 3.02, indicating that LD parents agreed with the statement and perceived low self-esteem for their children because the LD label minimises their children's ability to perform the way most non-labelled students can perform. Also, items 4 and 5 had a mean score of 2.97 and 2.90 respectively, which indicates that LD parents perceived a low level of self-esteem for their children because the LD label makes children more likely to fail and to feel useless and frustrated. In contrast, item 3 had the lowest mean score (2.28), indicating that LD parents disagreed with this statement and did not perceived LD label makes children feel that their children can be proud of their achievements.

Regarding LD teachers' perceptions of **self-esteem** scale, however, five items were in the 'agree' range, whereas, one item was on the 'disagree' range (see Table 12). In more details, the highest mean score (3.17) was observed for item 1, indicating that LD teachers agreed with statement and perceived a low level of self-esteem for LD students because the LD label has negative effects on students' self-satisfaction. The mean score for item 2 (2.83) was in the 'agree' range indicating that LD teachers agreed with the statement and perceived low level of self-esteem for LD students because the LD label minimises their abilities. Items 3, 4, and 6 were in the agree range, indicating that LD teachers agreed with these statements and perceived a low level of self-esteem for LD students because the LD label minimises students' abilities, makes them more likely to fail and makes them feel frustrated and useless, and effect of LD label on the social skills of students. However, the lowest mean score (2.28) was observed for item 5, showing that LD teachers disagreed with statement and did not perceived an effect of LD label on the academic development.

Regarding standard deviation, the highest SD (.994) was on 3 in the LD teachers' questionnaire (see Table 12). This indicates this item had the widest spread of responses. In contrast, the smallest SD was observed in item one in the LD parents' questionnaire equalled .772. This indicates that this item had the smallest range of responses, as they agreed or strongly agreed that the LD label negatively affected their children's self-satisfaction.

Overall, LD parents perceived a low level of self-esteem for their children due to the LD label, as the overall mean score was 2.88. similarly, LD teachers mean score was in the 'agree' (2.76). This suggests that the LD teachers had negative perception of LD label on children' self-esteem (see Table 9). Therefore, more details regarding how the LD label can affect on children' self-esteem are needed in the second phase of this study.

**Table 12 (Responses of Children' with LD Self-esteem)**

Items	Mean	Std. Deviation	Range of responses
<b>LD Parents</b>			
1-Regardless his disability, I think that Learning Disability label has negative effects on my child' self-satisfaction	3.19	.772	A
2-Regardless his disability, I think that Learning Disability label minimises my child ability to do things as most non-labelled students can do	3.02	.949	A
3-Regardless his disability, labelling my child with Learning Disability, makes me feel that he has much to be proud of.	2.28	.863	D
4-Regardless his disability, I think that Learning Disability label makes my child more likely to fail	2.97	.811	A
5-Regardless his disability, I think that the Learning Disability label makes my child feels useless and frustrated	2.90	.932	A
<b>LD Teachers</b>			
1-Regardless the disability, I think that Learning Disability label has negative effects on students' self-satisfaction	3.17	.837	A
2-Regardless the disability, I think that Learning Disability label minimises students' abilities to do things as most non-labelled students can do	2.83	.909	A
3-Regardless the disability, I think that the Learning Disability label gets students feel useless and frustrated	2.70	.994	A
4-Regardless the disability, I think that Learning Disability label makes students more likely to fail	2.61	.951	A
5-Beside the effects of the disability, Learning Disability label does not impede the academic development of labelled student'.	2.28	.792	D
6-Beside the effects of the disability, Learning Disability label impedes the social skills development of labelled student'.	2.51	.807	A

**The ADHD label**

In the response of ADHD parents regarding **self-esteem**, as illustrated in Table 13, three of two items were in the 'strongly agree' range, but only one item was in the 'disagree' range and one item in the 'agree' range. In more details, the highest mean score (3.33) was for item 3, indicating that ADHD parents strongly agreed with the statement and perceived a low level of self-esteem because they believed ADHD made their children more likely to fail. Also, the mean score of item 2 (3.26) revealed that parents perceived low self-esteem for their children because the ADHD label minimises their children's ability to perform the same as most non-labelled students perform. Item 1 had a high mean score (2.93), indicating that

parents agreed with the item and perceived a low level of self-esteem because they believed that the ADHD label has negative effects on their children's self-satisfaction. In contrast, item 4 had the lowest mean score (2.06), indicating that parents disagreed with item and did not particularly perceived a low level of self-esteem for the effect of the ADHD label on children's frustration and uselessness.

Comparably, on the items of ADHD teachers' perceptions of **self-esteem**, the mean scores were in 'agree range for five items, but in the 'disagree' range for one item. The highest mean score in the ADHD responses to this scale (3.0) was observed for item 1, indicating that ADHD teachers agreed with the item and perceived a low level of self-esteem because the ADHD label has negative effects on students' self-satisfaction. The mean score for items 2, 3, and 6 was 2.60, indicating that ADHD teachers agreed with these statements and perceived a low level of self-esteem for students because the ADHD label makes students feel frustrated, minimises their abilities and impedes the development of students' social skills. However, the lowest mean score (2.40) was noticed in item 5, showing that ADHD teachers did not perceived low self-esteem since they disagreed that ADHD label does not impede the students' academic development.

Notably, the highest SD was observed on item 3 in the ADHD teachers' questionnaire, which equalled 1.140 because ADHD teachers gave different responses to statements that the ADHD label makes children feel useless and frustrated. Similarly, the SD of item 5 in same questionnaire was 1.140, indicating that this item had the widest range of responses. This indicates a significant variation in ADHD teachers' perceptions of the effects of the ADHD label on students' academic development (see Table 13).

Overall, ADHD teachers perceived a low level of self-esteem for students with ADHD because there were potential negative effects of the ADHD label as the overall mean score was 2.90. Closely, ADHD parents perceived a low level of self-esteem for their children due to the ADHD label because the overall mean score was 2.80 (see Table 9). Thus, more understanding regarding the effects of ADHD label on children' self-esteem is needed in the second phase of this study.

**Table 13 (Responses of Children' with ADHD Self-esteem)**

Items	Mean	Std. Deviation	Range of responses
<b>ADHD Parents</b>			
1-Regardless his disability, I think that Attention Deficit Hyperactivity Disorder label has negative effects on my child' self-satisfaction	2.93	.883	A
2-Regardless his disability, I think that Attention Deficit Hyperactivity Disorder label minimises my child ability to do things as most non-labelled students can do	3.26	.798	SA
3-Regardless his disability, I think that Attention Deficit Hyperactivity Disorder label makes my child more likely to fail	3.33	.816	SA
4-Regardless his disability, I think that the Attention Deficit Hyperactivity Disorder label does not make my child feel useless and frustrated	2.06	.798	D
<b>ADHD Teachers</b>			
1-Regardless the disability, I think that Attention Deficit Hyperactivity Disorder label has negative effects on students' self-satisfaction	3.00	.707	A
2-Regardless the disability, I think that Attention Deficit Hyperactivity Disorder label minimises students' abilities to do things as most non-labelled students can do	2.60	.894	A
3-Regardless the disability, I think that the Attention Deficit Hyperactivity Disorder label makes students feel useless and frustrated	2.60	1.140	A
4-Regardless the disability, I think that Attention Deficit Hyperactivity Disorder label makes students more likely to fail	2.80	1.095	A
5-Beside the effects of the disability, Attention Deficit Hyperactivity Disorder label does not impede labelled student' academic development	2.40	1.140	D
6-Beside the effects of the disability, Attention Deficit Hyperactivity Disorder label impedes labelled student' social skills development	2.60	.894	A

### **5.5.3 Informal and Formal Labels**

The current theme descriptively illustrates the quantitative findings associated with **informal and formal labels**. As shown in Table 14 and Table 15, the mean and standard deviation of this scale in LD parents', LD teachers', ADHD parents', and ADHD teachers' questionnaires are illustrated.

#### ***The LD label***

As shown in Table 14, on the items of LD parents' perceptions of **informal and formal labels**, the mean scores were in 'agree range for six items, but four item

was in the 'disagree' range. The highest mean score (2.83) was on item 2, indicating that LD parents agreed with item and perceived that the LD label impedes the social skills development of their children. Item 4 and 10 mean scores were in the 'agree' range (2.80). This suggests that the LD parents perceived that the LD label makes their children feel less intelligent than others. Also, LD parents agreed that informal labels, such as 'stupid' and 'thick', are assigned to their children. However, the mean score of item 3 was 2.43, indicating that LD parents did not perceive effects of the LD label on their children's friendships. The mean score of item 6 and 7 were 2.40 and 2.23, indicating that LD parents disagreed with these statements and did not particularly perceived negative effects of informal labels because their children are not bullied when they have extra time and support to finish given tasks. For further details see table 14.

Similar to LD parents, five items of LD teachers' perceptions of **informal and formal labels** were in the 'agree' range, and three were in the 'disagree' range. The highest mean score (3.03) was observed in item 6, indicating that LD teachers agreed with the item and perceived bullying of students when they demonstrated poor academic performance. Their responses were comparable with items 3, 4 and 8 with mean score of (2.92, 2.84 and 2.85 respectively), indicating that LD teachers agreed that children were labelled by informal words, and perceived bullying of students when they visit the resource room or when they were given extra time. The mean score of item 5 was in the 'agree' range (2.76). This suggests that the LD parents perceived bullying of students when they were given extra support to finish tasks. However, the mean scores of items 1, 2 and 7 were (2.32, 2.15 and 2.19 respectively), indicating that LD teachers disagreed with items and did not perceive that the LD label affects students from having friendship, makes students feel smarter than students without labels or does not cause students to be bullied by others at school.



**Table 14 (Responses of Informal and Formal Labels Attached to children with LD)**

Items	Mean	Std. Deviation	Range of responses
<b>LD Parents</b>			
1-Beside the effects of his disability, Learning Disability label does not impede my child' academic development	2.57	.914	A
2-Beside the effects of his disability, Learning Disability label impedes my child' social skills development	2.83	.960	A
3-Regardless his disability, Learning Disability label affects my child from having friendship	2.42	.966	D
4-Regardless his disability, Learning Disability label makes my child less smart than others without labels	2.80	.943	A
5-I think that my child gets bullied by other peers because he always goes to resources room	2.61	.882	A
6-I think that my child gets bullied as he is always given extra time compared to others in mainstream classroom to finish the given tasks	2.40	.989	D
7-I think that my child gets bullied as he is always given extra support compared to others in mainstream classroom to finish the given tasks	2.23	.849	D
8-I think that my child gets bullied by others when he demonstrates poor academic performance	2.73	.885	A
9-Regardless his disability, Learning Disability label does not make my child get bullied by others outside the educational setting	2.45	.889	D
10-My child is always labelled by words such as "stupid or thick" instead of Learning Disability label	2.80	.943	A
<b>LD Teachers</b>			
1-Regardless the disability, Learning Disability label affects students from having friendship	2.32	.907	D
2-Regardless the disability, Learning Disability label makes students smarter than students without labels	2.15	.758	D
3-Students with Learning Disability label get bullied by others because they always go to resources room	2.92	.859	A
4-Students with Learning Disability label get bullied as they are always given extra time compared to others in mainstream classroom to finish the given tasks	2.84	.773	A
5-Students with Learning Disability label get bullied as they are always given extra support compared to others in mainstream classroom to finish the given tasks	2.76	.789	A
6-Students with Learning Disability label get bullied by others when they demonstrate poor academic performance	3.03	.674	A
7-Regardless the disability, Learning Disability label does not make students get bullied by others inside the school	2.19	.921	D
8-Students with Learning Disability are always labelled by words such as "stupid or thick" instead of LD label	2.85	.1028	A

On the other hand, the highest SD (1.028) was observed for item 8 in the **LD teachers'** questionnaire, indicating that this item had the widest range of

responses. This shows a significant variation in LD teachers' perceptions of the use of pejorative and informal words.

Overall, LD parents and teachers agreed on the effects of LD label on social skills development of children, labelled students were affected by many features of informal labels, such as pejorative words, resource rooms and extra time and support. Thus, more information regarding these agreed items and particularly the effects of formal and informal labels on children with LD are needed in the second phase of this study.

### ***The ADHD Label***

As shown in table 15, seven items of the ADHD parents' perceptions of **informal and formal labels** were in the 'agree' range, one item was in strongly 'agree' range, and two items were in the 'disagree' range. The mean score of items 1 and 2 were 2.60, indicating that ADHD parents perceived the ADHD label impedes their children's academic and social skills development. The mean score of item 3 was 2.20, indicating that ADHD parents disagreed with the item and perceived no effects of the ADHD label on their children's friendships, which is in contrast to their responses to item 2. The mean score of item 4 was 3.00, indicating that ADHD parents perceived no effects of the ADHD label because it makes their children smarter than others without labels. Their responses were contradicted by item 10 because it had the highest mean score (3.40), indicating that ADHD parents agreed that their children were labelled with pejorative and informal labels, such as 'noisy' and 'naughty'. Items 6 and 7 had mean scores of (2.73, and 2.53, respectively) indicating that ADHD parents agreed with these items and perceived bullying of their children because they are given extra time and support to complete tasks in a mainstream classroom. However, the mean score of item 5 was (2.33), indicating that ADHD parents did not perceive effects of the resource room on their children.

**Table 15 (Responses of Informal and Formal Labels Attached to children with ADHD)**

Items	Mean	Std. Deviation	Range of responses
<b>ADHD Parents</b>			
1- Beside the effects of his disability, Attention Deficit Hyperactivity Disorder label does not impede my child' academic development	2.60	.985	A
2-Beside the effects of his disability, Attention Deficit Hyperactivity Disorder label impedes my child' social skills development	2.60	.910	A
3-Regardless his disability, Attention Deficit Hyperactivity Disorder label affects my child from having friendships	2.20	.941	D
4-Regardless his disability, Attention Deficit Hyperactivity Disorder label makes my child smarter than others without labels	3.00	.925	A
5-I think that my child gets bullied by other peers because he always goes to resources room	2.33	.975	D
6-I think that my child gets bullied as he is always given extra time compared to others in mainstream classroom to finish the given tasks	2.73	.883	A
7-I think that my child gets bullied as he is always given extra support compared to others in mainstream classroom to finish the given tasks	2.53	.990	A
8-I think that my child gets bullied by others when he demonstrates unaccepted behaviours	2.93	.883	A
9-Regardless his disability, Attention Deficit Hyperactivity Disorder label does not make my child get bullied by others outside the educational setting	2.60	.632	A
10-My child is always labelled by words such as "noisy and naughty" instead of the Attention Deficit Hyperactivity Disorder label	3.40	.632	SA
<b>ADHD Teachers</b>			
1-Regardless the disability, Attention Deficit Hyperactivity Disorder label affects children from having friendship	2.40	.894	D
2-Students with Attention Deficit Hyperactivity Disorder label get bullied by other peers because they always go to resources room	3.00	.707	A
3-Students with Attention Deficit Hyperactivity Disorder label get bullied as they are always given extra time compared to others in mainstream classroom to finish the given tasks	3.00	.707	A
4-Student with Attention Deficit Hyperactivity Disorder label get bullied as they are always given extra support compared to others in mainstream classroom to finish the given tasks	2.80	.447	A

As shown in table 15, on the items of ADHD teachers' perceptions of **informal and formal labels**, three items were in the 'agree' range and other one item was in the

'disagree' range. In more details, the mean score of item 1 was 2.40, indicating that ADHD teachers did not perceived effect of ADHD label on children's friendships. In contrast, item 4 mean score was in the 'agree' range (2.80), suggesting that the LD parents agreed with the item that children get bullied as they are always given extra support to finish the given tasks. Similarly, items 2 and 3 had the highest mean scores (3.00), indicating that ADHD teachers perceived the effects of resource rooms and providing students with extra time compared to others. Regarding the SD, the score in item 4 equal (.447), which indicates that this item has the smallest spread of responses. There are no responses on the extreme choices (0% strongly disagree and 0% strongly agree).

Overall, ADHD teachers tended to agree that ADHD students were affected by many features of informal labels, such as resource rooms, extra time and extra support, as the overall mean score of this scale was 2.80. similarly, ADHD parents perceived the effects of the informal and formal labels of ADHD on their children, as the overall mean score of this scale was 2.59 (see Table 9). Based on the above finding of informal labels for ADHD category, it might be significant to explore the relationship between pejorative labels and formal labels in the second qualitative phase.

### **5.5.4 Potential Outcomes of Labels**

The current theme descriptively illustrates the quantitative findings associated with the **potential outcomes of labels**. The mean and standard deviation of this scale in LD parents', LD teachers', ADHD parents' and ADHD teachers' questionnaires are illustrated (see tables 16 and 17).

#### ***The LD Label***

As shown in Table 16, four items of the ADHD parents' perceptions of **potential outcome** were in the 'agree' range, one item was in the 'disagree' range. In the LD parents' responses, item 1, and 2 had mean scores of (2.69 and 2.66 respectively). These indicate that LD parents agreed with these items and perceived that the LD label affected students negatively as they changed their academic performance to match the negative connotations of LD, or leads others to treat their children differently. Item 4 and 5 had mean scores of (2.69 and 2.66 respectively), indicating that LD parents agreed with these statements and perceived LD label leads their children avoiding interacting with others as they were treated differently. However,

item 3 had mean score of (2.42) indicating that LD parents did not perceive LD label makes their children feel isolated from others or not invited by others to play. What was notable is the SD deviation of item 3 was 1.015, indicating that this item had the widest range of responses, where the choices of disagree has a fairly large percentage of responses (31%).

Similarly, in LD teachers' responses, three items had mean scores in the 'agree' range, indicating that LD teachers perceived the potential outcomes of labels, such as avoiding interactions with others, changing academic performance negatively and being treated differently (Table 16). On the other hand, items 3 and 5 were in the 'disagree' range, showing that LD teachers did not perceive LD label makes students isolated from others, and did not treat students more differently than those non labelled who show similar academic problems. Overall, LD parents and teachers perceived potential and negative outcomes of labels on labelled students as the overall mean scores of these scales were 2.58 and 2.50 respectively (see Table 9).

**Table 16 (Responses of Potential Outcomes of the LD Label)**

Items	Mean	Std. Deviation	Range of responses
<b>LD Parents</b>			
1-My child tends to change his academic performance to match the negative connotations of Learning Disability label	2.69	.811	A
2-I think that my child is treated differently by others when they know he has Learning Disability label	2.66	.845	A
3-Regardless his disability, Learning Disability label does not make my child isolated from others, or not invited by others to play	2.42	1.015	D
4-My child tends to avoid interacting with others because his worries of being stigmatised	2.57	.940	A
5-Other peers treat my child with Learning Disability more differently than non-labelled students who show similar academic issues	2.52	.943	A
<b>LD Teachers</b>			
1-Students with Learning Disability tend to change their academic performance to match the negative connotations of LD label	2.54	.734	A
2-I think that labelled students are not treated differently by others once the Learning Disability label is attached	2.53	.655	A

3-Regardless the disability, I think that LD label makes students isolated from, or not invited by others to play	2.35	.779	D
4-Students with Learning Disability tend to avoid interacting with others because of their worries of being stigmatised	2.56	.748	A
5-Other peers treat students with Learning Disability more differently than non-labelled students who show similar academic issues	2.50	.807	D

### ***The ADHD Label***

As shown in table 17, all items of ADHD parents on the scale of **potential outcome of labels** were in the agree range. Items 2, 3, 4 and 5 had mean scores of (2.73, 2.66, 2.53, and 2.66 respectively). This indicates that ADHD parents agreed with these items and perceived that ADHD label lead to different treatment to their children or leads to feeling of isolation or lead peers to treat their children differently than non-labelled students with similar academic issues. Item 1 had the highest mean score (2.93), indicating that ADHD parents perceived that the ADHD label affected students negatively as they changed their behaviours to match the negative connotations of ADHD.

The SD of item 5 equalled 1.046, indicating that it had the widest range of responses, as the extreme choices of strongly disagree and strongly agree had fairly similar percentages (20%). However, the smallest SD (.593) was observed for item 1, indicating that this item had the smallest range of responses, where there are few responses for extreme choices (0% strongly disagree and 13.3% strongly agree).

In contrast to the ADHD parents, most items of the ADHD teachers' perceptions of **the potential outcomes** of the ADHD label were in the disagree range. For example, the mean scores of item 1 and 3 were in the disagree range, indicating that ADHD teachers disagreed with some of these outcomes, such as being isolated and changing behaviours negatively. The lowest mean score (2.20) was for item 4, indicating that ADHD teachers disagreed with the item perceived no effects of the ADHD label on students' interactions with others. However, item 2 was in the agree range indicating that ADHD teachers perceived potential outcomes of ADHD label, such as others treat students with ADHD label more

differently. As shown in table 17, this item had the smallest SD (.447), as 80% of ADHD teachers responded to the statement with 'disagree'.

**Table 17 (Responses of Potential Outcomes of the ADHD label)**

Items	Mean	Std. Deviation	Range of responses
<b>ADHD Parents</b>			
1-My child tends to change his behaviour to match the negative connotations of Attention Deficit Hyperactivity Disorder label	2.93	.593	A
2-I think that my child is treated differently by others when they know he has Attention Deficit Hyperactivity Disorder label	2.73	.798	A
3-Regardless his disability, Attention Deficit Hyperactivity Disorder label does not make my child isolated from others, or not invited by others to play	2.66	1.046	A
4-My child tends to avoid interacting with others because his worries of being stigmatised	2.53	.915	A
5-Other peers treat my child with Attention Deficit Hyperactivity Disorder more differently than non-labelled students who show similar behavioural issues	2.66	.899	A
<b>ADHD Teachers</b>			
1-Students with Attention Deficit Hyperactivity Disorder tend to change their behaviour to match the negative stereotypes of ADHD label	2.40	.547	D
2-Other peers treat student with Attention Deficit Hyperactivity Disorder more differently than non-labelled students who show similar behavioural issues	2.60	.547	A
3-Regardless the disability, Attention Deficit Hyperactivity Disorder label makes students isolated from others, or not invited by others to play	2.40	.894	D
4-Students with Attention Deficit Hyperactivity Disorder tend to avoid interacting with others because their worries of being stigmatised	2.20	.447	D

Overall, ADHD parents perceived the effects of the ADHD label on children since the overall mean score of these scales were 2.71. however, ADHD teachers did not perceive effects on labelled students (see Table 9). Accordingly, comprehensive exploration about the effects of labels on social aspects, such as changing behaviours to match the negative connotations of labels are worthy in the second qualitative phase.

### 5.5.5 Effects of Labels on Teachers and School Staff

The current theme descriptively illustrates the quantitative findings associated with **the effects of labels on teachers and school staff**. It is divided into four sub-sections, LD parents, LD teachers, ADHD parents and ADHD teachers, according to participant types.

#### *The LD Label*

According to table 18, on the items of LD parents' responses on this scale, most mean scores were in the disagree range. For example, the mean scores of items 1, 3, 4 and 5 were around 2.42, indicating that LD parents perceived no effects of the LD label on teachers' treatment of their children, being withdrawn to the resource room or being given extra time and support. Similarly, items 6, 7 and 8 were around 2.28, indicating that LD parents did not perceive effect of label on teachers and psychologists. However, the highest mean score (2.80) was observed on item 9, suggesting that the LD parents agreed that the LD label had not helped their children in developing their social skills.

In contrast to LD parents, five of LD teachers' responses on this scale were in the agree range. As presented in table 18, the mean score of items 1, 3 and 4 were around 2.57, indicating that LD teachers perceived mainstream teachers treated children differently once they received the LD label or once they received extra support and time.

**Table 18 (Responses of the Effects of the LD Label on Teachers and School Staff)**

Items	Mean	Std. Deviation	Rnage of responses
<b>LD Parents</b>			
1-Teachers treat my child differently once he receives the Learning Disability label	2.42	.830	D
2-Teachers treat my child differently once he accesses the resources rooms	2.54	.832	A
3-Teachers treat my child differently once he receives extra support compared to other peers	2.47	.772	D
4-Teachers treat my child differently once he receives extra time compared to other peers	2.42	.769	D
5-Teachers treat my child who has Learning Disability label more differently than non-labelled students who show similar academic issues	2.38	.794	D
6-Schools staffs treat student with Learning Disability more differently than non-labelled students who show similar academic issues	2.21	.870	D



7-Psychologists treat my child differently when they know he has the LD label	2.28	.969	D
8-I think that assigning Learning Disability label has helped my child in developing his academic aspects	2.23	.957	D
9-I think that assigning Learning Disability label has not helped my child in developing his social skills	2.80	.890	A
<b>LD Teachers</b>			
1-Mainstream teachers treat children with Learning Disability differently once they receive the LD label	2.57	.858	A
2-Mainstream teachers do not treat children with Learning Disability differently once they access the resources rooms	2.39	.772	D
3-Mainstream teachers treat children with Learning Disability differently once they receive extra support compared to other peers	2.59	.802	A
4-Mainstream teachers treat children with Learning Disability differently once they receive extra time compared to other peers	2.57	.790	A
5-Mainstream classroom teachers treat students with Learning Disability more differently than non-labelled students who show similar academic issues	2.40	.881	D
6-Other school staffs treat students with Learning Disability differently when they know students have the LD label	2.20	.809	D
7-I think that assigning Learning Disability label has helped children in developing their academic aspects	2.75	.807	A
8-I think that assigning Learning Disability label has not helped children in developing their social skills	2.63	.850	A

Similarly, the mean score of item 7 was in the agree range (2.75), indicating that LD teachers perceived LD label helpful in developing students' academic aspects. However, LD teachers perceived LD label not helpful in developing students' social skills. The mean score of item 2 was 2.39, indicating that LD teachers perceived that mainstream teachers do not treat children with LD differently once they access the resource rooms. The lowest mean score (2.20) was observed for item 6, indicating that LD teachers disagreed that school staff does not treat students with LD differently when they know students have the LD label.

Overall, LD teachers tended to perceive the effects of the LD label on mainstream teachers and other school staff members because the overall mean score of this scale was 2.48. Similarly, LD parents perceived no effects of the LD label on

teachers and other school staff's treatment of their children as the overall mean score of this scale was 2.42 (see Table 9). Looking back to the informal label scales responses concerned with resource room, it seems to contradict the responses here in this scale. Thus, this contradictions between responses need to be explored in the second phase.

### ***The ADHD Label***

As shown in Table 19, all items of ADHD parents' perceptions of **the effects of labels on teachers scale** were in the 'agree' range. For example, the mean score of items 1, 2, 4, and 5 were 2.86, 3.06, 2.86, and 3.00 respectively, indicating that ADHD parents agreed with these items and perceived that teachers are affected by the ADHD label because they treat their children differently once they receive the label, when they are educated in resource rooms and when they receive extra time and support compared to peers with similar behavioural issues. The highest mean score (3.13) was for item 6, indicating that ADHD parents perceived the effects of the ADHD label on school staff because they treat their children differently than non-labelled students with similar behavioural issues. Regarding SD in ADHD parents' items, the smallest (.639) was for item 6, indicating that this item had the smallest range of responses because the choices of strongly disagree and disagree had low percentages (0% and 13.3%, respectively).

Similarly, the responses of ADHD teachers, most items were in agree and strongly agree ranges, and one item in the disagree range (see Table 19). For example, the two highest mean scores, 3.40 and 3.60, were observed for items 4 and 5, respectively, indicating that ADHD teachers strongly agreed and perceived that mainstream teachers and other school staff treat children with ADHD differently in comparison with non-labelled students with similar behavioural issues. Also, the mean score of items 1 and 3 was 3.20, indicating that ADHD teachers perceived that mainstream teachers treat children with ADHD differently once they receive the ADHD label or once they receive extra time compared to peers. The mean score of items 2 and 7 were 2.60, indicating that ADHD teachers perceived that mainstream teachers treat children with ADHD differently when they go to a resource room, and did not perceive that assigning the ADHD label has not helped children in developing their social skills. The lowest mean score (2.20) was observed for item 6, indicating that ADHD teachers disagreed that assigning the

ADHD label has not helped children in academic development, which is compatible with previous answers. On the other hand, in the ADHD teachers' responses, the highest SD (1.140) was observed for item 2, indicating that this item had the widest range of responses. Whereas the smallest SD (.447) was observed for items 6 and 7, indicating that these items had the smallest range of responses, where there are few responses for extreme choices (see Table 19).

Overall, ADHD teachers and parents perceived that the ADHD label and other features of labels, such as extra time and support given to ADHD students, affect mainstream teachers and other school staff's treatment of students as the overall mean score of these scales were 3.06 and 2.86 respectively (see Table 9). Based on the above results, more details about the effects of labels on teachers and academic staff are needed in the second qualitative phase.

**Table 19 (Responses of the Effects of the ADHD label on Teachers and School Staff)**

Items	Mean	Std. Deviation	Range of responses
<b>ADHD Parents</b>			
1-Teachers treat my child differently once he receives the Attention Deficit Hyperactivity Disorder label	2.86	.990	A
2-Teachers treat my child differently once he accesses the resource rooms	3.06	.883	A
3-Teachers treat my child differently once he receives extra support compared to other peers	2.73	.798	A
4-Teachers treat my child differently once he receives extra time compared to other peers	2.86	.915	A
5-Teachers treat my child who has Attention Deficit Hyperactivity Disorder label more differently than non-labelled students who show similar behavioural issues	3.00	.755	A
6-School staffs treat student with Attention Deficit Hyperactivity Disorder more differently than non-labelled students who show similar behavioural issues	3.13	.639	A
7-Psychologists treat my child differently when they know he has the Attention Deficit Hyperactivity Disorder label	2.66	.975	A
8- I think that assigning Attention Deficit Hyperactivity Disorder label has helped my child in developing his academic aspects	2.73	.883	A
9-I think that assigning Attention Deficit Hyperactivity Disorder label has not helped my child in developing his social skills	2.66	.975	A
<b>ADHD Teachers</b>			

1-Mainstream teachers treat children with Attention Deficit Hyperactivity Disorder differently once they receive the ADHD label	3.20	.836	A
2-Mainstream teachers do not treat children with Attention Deficit Hyperactivity Disorder differently once they access the resources rooms	2.60	1.140	A
3-Mainstream teachers treat children with Attention Deficit Hyperactivity Disorder differently once they receive extra time compared to other peers	3.20	.836	A
4-Mainstream teachers treat children with Attention Deficit Hyperactivity Disorder more differently than non-labelled students who show similar behavioural issues	3.40	.547	SA
5-Other school staffs treat children with Attention Deficit Hyperactivity Disorder differently when they know students have the ADHD label	3.60	.547	SA
6-I think that assigning Attention Deficit Hyperactivity Disorder label has helped children in developing their academic aspects	2.20	.447	D
7-I think that assigning Attention Deficit Hyperactivity Disorder label has not helped children in developing their social skills	2.60	.447	A

## 5.6 Summary of the Chapter

It might be important to shed lights to the main quantitative findings that emerged in the first phase in order to deeply and comprehensively explore them in the second qualitative phase. What was the biggest concerns for all participant is the high level of stigma attached to children. For example, LD parents perceived the highest level of stigma attached to their children when they avoid writing notes to them. Thus, questions such as how stigma occurs to children, and what is main sources and outcomes of stigma needs to be answered.

Second, since the overall mean of self-esteem scales were 2.80 (see Table 9), LD and ADHD labels had an effects on all type of participants to perceived low level of self-esteem for children labelled with LD and ADHD. Thus, it might be significant to explore how and why these labels affect the self-esteem of children in the interview phase. Third, some items in informal labels scale were reported to have high mean score in this chapter. For example, ADHD teachers had perceived high level use of informal labels and pejorative words towards children with ADHD. Issues such as the relationship between pejorative words and formal labels, effects of informal labels, who and how are pejorative words used in the school contexts.

In addition, ADHD teachers and ADHD parents perceived high level of impact of ADHD label on teachers (as mentioned in Table 9). For example, ADHD parents perceived that teachers are highly affected by the ADHD label because they treat their children differently once they receive the label, when they are educated in resource rooms. Therefore, the interview phase should explore the effects of resource room on general teachers, general students and how general teachers get affected by LD and ADHD labels.

Bringing these background and general information about LD and ADHD labels gained from the first quantitative phase into the interview enabled the researcher to probe more comprehensively into the issues of labels. During the semi-structured interviews, I might discover and explore the complexities surrounding the ADHD and LD labels that achieved background information in prior phase, by interviewing different participants.

# Chapter Six

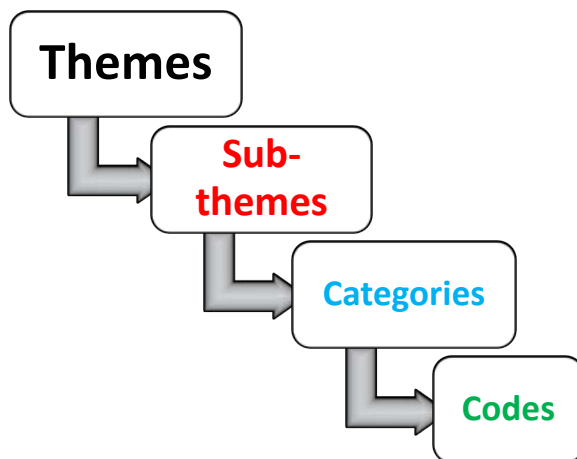
## Qualitative Findings

### 6.1 Introduction

This chapter presents the qualitative results from the semi-structured interviews. As described in the previous chapter, the participants of the study included two LD teachers, two LD parents, two ADHD teachers and two ADHD parents. As stated in table 20, nine themes associated with sub-themes are explained. These themes are related to ADHD teachers, ADHD parents, LD teachers and LD parents. The themes also indicate participants' views on ADHD and LD labels.

Before explaining the themes, a diagram is presented to simplify the results of each theme. As shown in Figure 1, each diagram entitles with the theme name (in Black colour), and it divided into sub-themes (in Red colour). Each sub-theme is divided into a category (in Blue colour), and each category has some codes (in Green colour). It is important to mention that all names in this chapter are pseudonyms (see 4.5 Ethical Issues).

*Figure 1 (Explanation of all Figures)*



**Table 20 (Table of qualitative themes)**

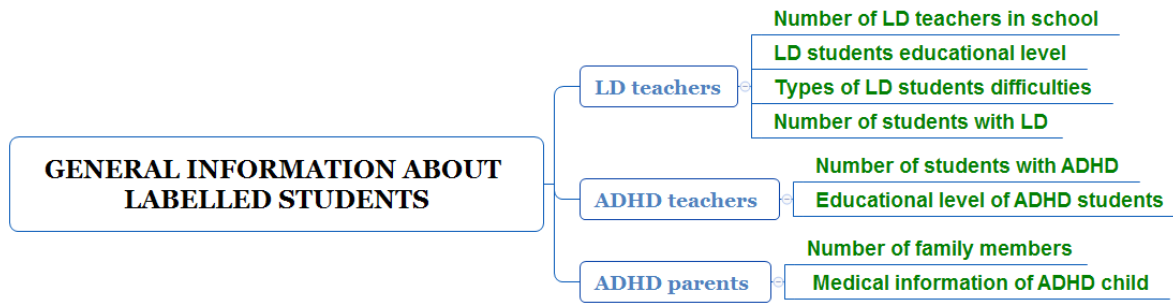
<b>Themes</b>	<b>Sub-themes</b>
<b>General information about labelled students</b>	<ul style="list-style-type: none"> <li>➤ <b>Number of students with LD.</b></li> <li>➤ <b>Number of students with ADHD.</b></li> </ul>
<b>Knowledge and experience</b>	<ul style="list-style-type: none"> <li>➤ <b>Involvement in workshops.</b></li> <li>➤ <b>Understanding of LD label.</b></li> <li>➤ <b>Understanding of ADHD label.</b></li> </ul>
<b>Positives of current labels</b>	<ul style="list-style-type: none"> <li>➤ <b>Positives of LD label.</b></li> <li>➤ <b>Positives of ADHD label.</b></li> <li>➤ <b>Factors make labels beneficial.</b></li> </ul>
<b>Hiding difficulties</b>	<ul style="list-style-type: none"> <li>➤ <b>Hiding at school.</b></li> <li>➤ <b>Hiding at homes.</b></li> <li>➤ <b>Why labelled students hide their difficulties.</b></li> <li>➤ <b>Acknowledgment of disability.</b></li> </ul>
<b>Stigma</b>	<ul style="list-style-type: none"> <li>➤ <b>Occurrence of stigma.</b></li> <li>➤ <b>Source of stigma.</b></li> <li>➤ <b>Stigma outcomes.</b></li> </ul>
<b>Potential drawbacks resulting from labels</b>	<ul style="list-style-type: none"> <li>➤ <b>Effect of labels on social skills.</b></li> <li>➤ <b>Effects of labels on self-esteem.</b></li> <li>➤ <b>Effects of labels on academic performance.</b></li> <li>➤ <b>Effects of labels on teachers.</b></li> <li>➤ <b>Effects of ADHD label on children and parents.</b></li> </ul>
<b>Informal labels</b>	<ul style="list-style-type: none"> <li>➤ <b>Use of pejorative words.</b></li> <li>➤ <b>Effects of informal labels.</b></li> </ul>
<b>Effects of resources room</b>	<ul style="list-style-type: none"> <li>➤ <b>Effects of resources rooms on students.</b></li> <li>➤ <b>Effects of resources rooms on general teachers.</b></li> </ul>
<b>Label in future</b>	<ul style="list-style-type: none"> <li>➤ <b>Use of labels in the future.</b></li> <li>➤ <b>Suggestions to alternative labels.</b></li> </ul>

## **6.2 General Information about Labelled Students**

This section briefly states the findings related to general information regarding labelled children. As shown in Figure 2, information was gathered for three categories: LD teachers, ADHD teachers and ADHD parents. All LD teachers reported in the interview data that only one LD teacher is responsible for teaching at least 13 students with LD in the school. LD teachers stated that LD students are in lower and higher grades. Both LD teachers reported that LD students' difficulties are found mainly in language and writing, and some have mild difficulties in math; however, one LD teacher stated that LD students are divided in resource rooms

into two different types. Some LD students are educated according to one Educational Plan (EP), and others are educated according to a dual EP in which the LD teacher takes two LD students with similar difficulties and abilities and designs an EP plan for them.

**Figure 2 (Theme of General Information)**



It was indicated that this is a new policy introduced by the MOE, which it requires a tremendous amount of work to mediate between two similar students. He stated the following:

*‘A Dual Educational Plan is a new policy set by the Ministry of Education. It requires me to find two similar students in their difficulties to set up an EP. I always try to mediate between their ability and skills. You know, LD students have different and unique needs. It is a lot of work, and I am not sure of it’ (Ammar).*

Similar to LD teachers, both ADHD teachers stated that one ADHD teacher taught 13 students with ADHD. They expressed that their students were in lower and higher grades. Both ADHD teachers stated that the educational levels of their students were between moderate and severe in all academic aspects.

Both ADHD parents mentioned that their children with ADHD were twins with brothers. They indicated that their diagnosed children were educated in different schools and classes than their twins. One ADHD parent said his child with ADHD was educated in a different school than his brother, and he believed that the ADHD child relied on his brother to learn and to progress. Another ADHD parent mentioned that his child with ADHD was educated in a different and lower class than his twin. He stated that school acceptance was conditional on medicinal treatments.



## 6.3 Knowledge and Experience

This theme attempts to identify all participants' understandings of both LD and ADHD concepts and any involvement in workshops. The current theme is classified by participant group, namely ADHD teachers, ADHD parents, LD teachers and LD parents (see Figure 3). All children/students of the interviewed parents and teachers were included in mainstream schools. Hence, their views regarding some subthemes, such as involvement in workshops, are likely to be similar.

### 6.3.1 Understanding of the LD Label

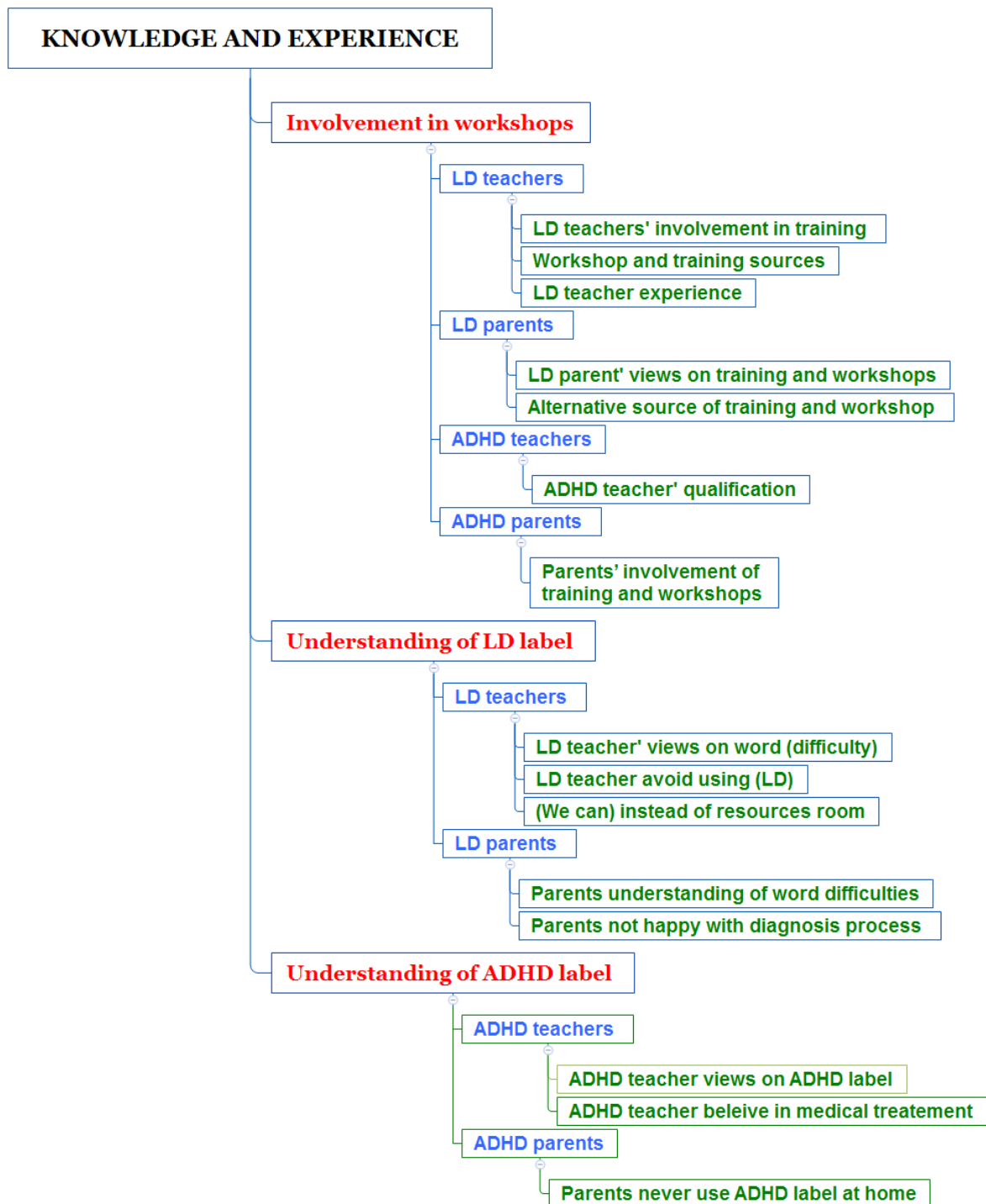
While it is a common acknowledgement that the Saudi education system adopts the U.S. system in terms of terminology (MOE, 2002) it seems that both learning disabilities and learning difficulties are used interchangeably and simultaneously in Saudi schools. In terms of understanding the LD label, both LD teachers indicated that LD refers to shortcomings or difficulties in learning. They expressed their understanding of LD as some difficulty that prevents children from learning and from overcoming their difficulties easily. Also, they stated that the word 'difficulty' refers to the other possibilities, such as children having obstacles to learning. The two LD teachers expressed their understanding as follows:

*'When you hear the word 'difficulty', it means that children have barriers that impede them from being successful and smart like their peers. It can also be explained as children having problems they cannot solve or overcome easily. There are no other explanations'. Ammar.*

*'I think that learning difficulties is a phrase that means there is something difficult to learn'. Omer.*

Furthermore, one LD teacher indicated that general students have a negative understanding of the LD label. He stated that general students feel that labelled children are unsuccessful. He explained that this feeling might be more noticeable in general students in higher grades, whereas those in lower grades might not be fully aware of the interpretations. He stated that *'I think children in higher grades have more negative explanations about the term LD. They are affected more deeply'. Omer.*

Figure 3 (Theme of knowledge and Experience)



Both LD teachers revealed they are not affected by the LD label and they do not treat children differently based on the label. They used different words instead of LD. For example, Ammar used the term 'we can' in the resource room. Another LD teacher used another non-labelled door for his resource room. Both teachers

indicated that they only used the term 'LD' while supervision or inspections took place. One teacher described his situation as follows:

*'My resource room has two doors. One is hidden from students with no label. I mean there is no LD title. I always use the one without the label. I can't remove the label from the main door; otherwise, I will face issues with my supervisor, so I don't use the main door unless supervisors observe my lesson'. Omer.*

Similar to LD teachers, both LD parents indicated their understanding of LD as a difficulty that prevents their children from learning and progressing positively. Both explained that LD has a generalisation in which it means that children have difficulties in most or all skills, whereas they actually have difficulties in few skills. Therefore, both parents criticised the diagnosis of their children and the style of learning adopted by teachers. Adi (LD parent) stated his concern about the LD label:

*'The problem here is how teachers judge my child due to difficulties in learning, whereas the truth is, he has issues with letters and writing. It's not logical to use the term 'learning difficulties', which means he suffers from difficulties in all lessons. It's not reasonable. Maybe the problem is the wrong style of teaching used by teacher. Maybe'.*

### **6.3.2 Understanding of the ADHD Label**

One ADHD teacher revealed his views about the ADHD label and stated that it is unnecessary to label children to solve a simple disorder. He indicated that children's difficulties might be addressed without labelling and notifying all school staff and students. He articulated that:

*"ADHD is not a severe or profound disability. It's a simple disorder that can be resolved without telling all school teachers and students about the group suffering from ADHD. You know, instead of supporting them, we harm them by labelling. No one wants anybody to know about his problems'. Sameer.*

The second ADHD teachers shared a similar understanding of ADHD and emphasised that medical treatment is helpful because it helps students reduce their impulsiveness and hyperactivities. One teacher indicated that some parents refused medical treatment because they were not aware of the advantages of medical treatments. He stated that

*"When children with ADHD are treated medically, their behaviour and impulsiveness are reduced considerably. Unfortunately, some parents*

*totally refuse the medical treatment because they do not believe in it. They refuse medicine or drugs'. Aati.*

Both ADHD parents expressed that they are not embarrassed of the label and that they always attempt to reduce the negative outcomes of label. They stated that they are concerned about the potential reactions of others towards labels. Therefore, both parents emphasised that they have never used the label at home or in other contexts outside schools. One ADHD parent stated:

*'I've never used ADHD at home, but not because we are shy about it. I am not shy about the label itself. I always look for ways to minimise the effects of the label from teachers, students and outside the school'. Fahad.*

### **6.3.3 Involvement in Workshops**

The participants' involvement in workshops differed. For instance, both LD teachers explained that they are involved regularly in workshops and training provided by the MOE. Both LD teachers have been involved in workshops through their services, which is more than eight years. They also acknowledged that they used social network sites, such as Twitter and WhatsApp groups, to contact many LD teachers and supervisors with which they shared information and experiences. They expressed that the workshops and training mainly focused on EPs and diagnoses. One LD teacher stated:

*'I not only attend formal workshops and training, but I use Twitter to improve myself in LD. You know, I can contact so many teachers who have great information and experience. They are useful. Sometimes, I ask questions in the WhatsApp group, and many answers and good advice are shared straightway. We share our experiences'. Omer.*

Both ADHD teachers indicated that they are highly involved in training and workshops provided by the MoE because the ADHD programmes were established recently in Saudi Arabia. Because their bachelor's qualifications were in behavioural disorders, which does not include a specialisation in ADHD, both teachers explained that workshops focused on aetiology, symptoms, characteristics and designing EPs for children with ADHD. One ADHD teacher stated the following:

*'The Ministry of Education provides workshops that focus on EP, reasons that ADHD occurs, characteristics and information to determine how to deal with children. It's really helpful. You know, I didn't receive a degree specialising in ADHD. The workshops helped my career'. Sameer.*

All LD and ADHD parents indicated their lack of involvement in workshops and training provided by the MOE because most workshops are provided to teachers. They stated that there were workshops provided by teachers in schools, which were not helpful because they presented simple topics, such as definitions and concepts. Therefore, all ADHD and LD parents acknowledged that they were not interested in attending workshops. Alternatively, they used other sources of knowledge and information. Social network sites, such as following sites of professionals and specialists on Twitter, were mentioned by all parents as sufficient and trusted sources. One LD parent stated:

*'I haven't attended any workshops organised by the Ministry of Education because they neglect us. They focus more on teachers. But, I attended some of those in schools presented by LD teachers. For me, it wasn't that helpful because they talked about basic things. So, I am not interested in attending anymore. I follow specialists on LD on Twitter. Very useful'. Adi.*

#### **6.4 Strength of ADHD and LD Labels**

This theme aims to highlight the positive aspects of the ADHD and LD labels in accordance with LD teachers, LD parents, ADHD teachers and ADHD parents' views (see Figure 4). Both LD teachers revealed that having and allocating support to LD students is conditional on a label. They indicated that the LD label helps them choose the learning style and helps in designing EPs according to students' needs, and it allows students to join the resource room. Thus, both LD teachers indicated that labelled students are in better positions than those without a label with similar difficulties. They also mentioned that the LD label would be more beneficial for students if it is associated with a high level of teacher and student awareness. One LD teacher stated:

*'The current policy requires us to label students. It helped me choose students for the resource room, set up an EP for them and teach them using different approaches from the general class. Students wouldn't have been provided with services if they didn't have labels, so those with the LD label are better off than those without it, at least when they start their EPs'. Omer.*

Similarly, both LD parents indicated that the LD label allowed their children to receive academic scaffolding in resource rooms. They also mentioned that the LD

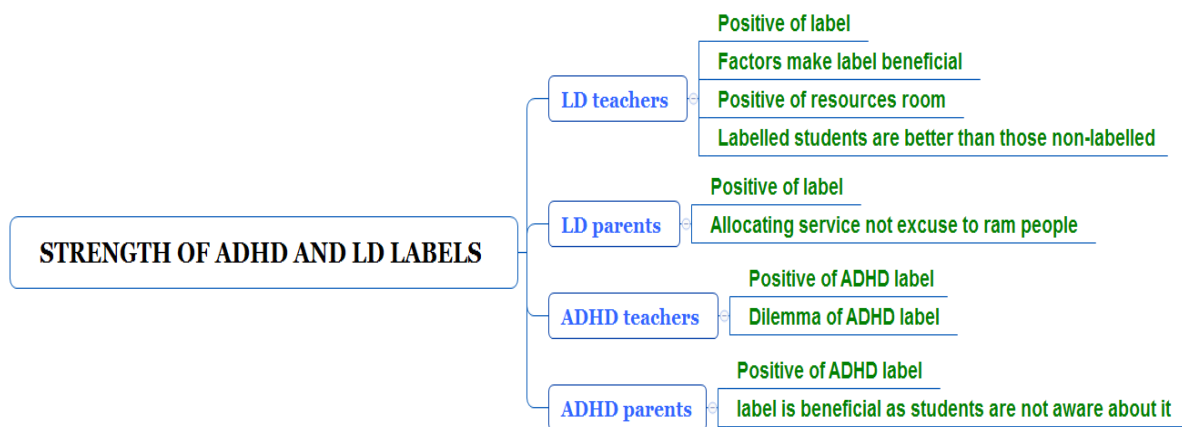
label only helped their children academically, and it overlooked the emotional and psychological aspects. Both parents revealed that it was not rational to label children and to harm them psychologically to allocate academic services. One LD parent explained:

*'It is not a good reason to label my child, highlighting his shortcomings to everyone in school in order to choose the appropriate academic support. I think it is not difficult for teachers or for the Ministry of Education to allocate services with other positive labels'. Adi.*

One ADHD parent made similar statements. He mentioned that the ADHD label helped him determine the exact issues his child suffered from, which eventually helped him find the appropriate treatments. Thus, he believed that children with the ADHD label have more opportunities than those without the label. He mentioned that he is not concerned about the label, but he is concerned about finding the best way to solve his child's problems and behaviours. He stated:

*'Me—as a father—I think the ADHD label helped me choose the best way to cure my child. It helped me understand the type of issues my child has, so a label is not as important as finding suitable ways to support my child'. Hazim*

**Figure 4 (Theme of Strength of ADHD and LD labels)**



Another ADHD parent stated that his ADHD child is not aware of the concept of ADHD. Hence, he believed that the ADHD label has not affected his child socially, emotionally or academically. He stated:

*'My child is still a small boy. He is eight years old. I don't think he understands the concept of ADHD or what it means or refers to. He*

*cannot think deeply about the negative stereotypes of the ADHD label, so right now, it hasn't harmed my child'. Fahad.*

Both ADHD teachers mentioned that the ADHD label was helpful in determining the educational services and effective medical treatments for children with ADHD. One ADHD teacher stated that the label might be a good explanation for unacceptable behaviours in classrooms because general teachers would not have accepted certain behaviours from other children without labels. Another ADHD teacher described a dilemma at his school in which some general teachers with lower awareness might not help ADHD students sufficiently. He indicated that the ADHD label helped children join the resource room with a special teacher, but other psychological aspects are neglected in mainstream classrooms with general teachers:

*'I think the ADHD label helped me and students as well, but sometimes, general teachers who have a very low level of awareness ignore labelled children. They don't support them, and they always want to send them to the resource room. Thus, students will be supported by special teachers and neglected in front of their peers. It's difficult for me judge whether a label is totally useful'. Aati.*

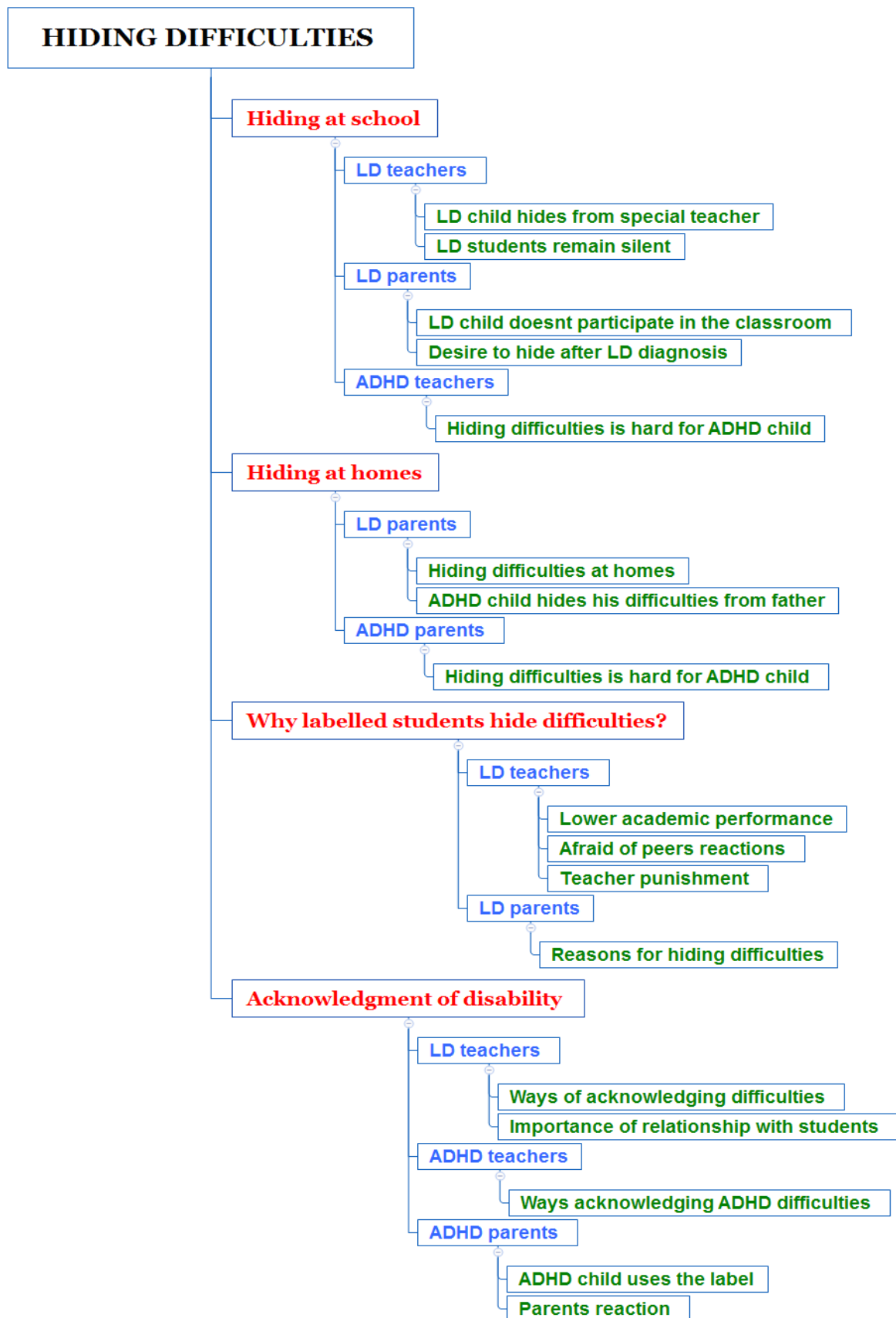
## **6.5 Hiding Difficulties**

This theme attempts to explain how students with ADHD and LD hide their difficulties. It encompasses four subthemes: hiding difficulties at school, hiding difficulties at home, reasons for hiding difficulties and instances in which students acknowledge their difficulties. (See Figure 5)

### **6.5.1 Hiding Difficulties at School**

This study showed that students with ADHD and LD hide their difficulties at school in different ways. For instance, one LD teacher stated that some children with LD hide from him at school during assemblies and break times. He expressed that LD students desire to not be seen by their peers while they are talking with a LD teacher.

Figure 5 (Theme of Hiding Difficulties)





He admitted that he struggled with calling students to the resource room. Thus, he always provided the general teachers with his timetable so they could ask LD students to go to the resource room. He also mentioned another feature of hiding difficulties at school in which students with LD remained silent when certain tasks were given in front of their peers. He articulated:

*'Unfortunately, some issues with the LD label are linked to me. Some students hide themselves from me in the school halls and during break time. You know, sometimes I find it difficult to call them to resource rooms. I don't want peers to see me when I take them. I always ask general teachers to refer them to me'. Ammar.*

One LD parent shared similar thoughts regarding hiding difficulties at school. He was informed by general teachers that his child never wanted to participate in class, especially when tasks were given in front of others. The LD parent stated that his child started to hide his difficulties after he knew he was diagnosed with LD:

*'The reading and writing teacher told me that my child always hides his written work from others. I think this happened after he was diagnosed with LD. I mean after he knew he has a LD'. Adi.*

On the other hand, ADHD teachers shared different views about hiding difficulties at school. For example, one ADHD teacher indicated that ADHD students do not attempt to hide academic work, but they always attempt to hide the label. They do not want anyone to know they have ADHD or that they are going to the resource room. In terms of their behaviours, he stated that ADHD students cannot hide their behaviours due to a lack of behaviour management:

*'They cannot hide their behaviours. It's difficult for them to control their behaviours. They would be normal if they controlled their behaviours'. Aati.*

### **6.5.2 Hiding Difficulties at Home**

Both LD parents indicated one feature of hiding difficulties at home. They mentioned that their children attempt to hide their difficulties from their brothers and sisters. The parents said that their LD children hide their homework because they are concerned they will have less play time. One LD parent stated that he rewards his children based on their achievement on homework; thus, a lower achiever might be punished by less play time:

*'Yes, he does. Sometimes he doesn't want his brothers to know whether he did the homework or not because I always give extra time for play to the kids who finish their homework'. Ahmed.*

One ADHD parent described a different feature of hiding difficulties at home. He indicated that his child always hides the 'school daily notes' from his parents, where special and general teachers write notes about him each day. He acknowledged that his child deliberately hides these notes when he displayed unacceptable behaviour in school. Similar to ADHD teachers' views, an ADHD parent indicated that his child cannot hide his unacceptable behaviours because he suffers from lack of behaviour control. He stated:

*'He cannot hide his behaviours. It is out of his hand. He cannot control this, but he always hides his notes from his teachers. He hides the notebook when he does unacceptable things in school. Sometimes, he gives me his notebook when nothing is written. He is doing this on purpose [laughter]'. Hazim.*

### **6.5.3 Why Labelled Students Hide their Difficulties**

Both LD teachers indicated various and similar reasons for hiding difficulties. For instance, they stated that a lack of self-appreciation is a major reason for hiding difficulties. Also, they mentioned that a lack of awareness among general students, teachers and societies have impacted LD students. Therefore, LD students are concerned about other people's reactions and being stigmatised by peers. One LD teacher added that students with LD hide their difficulties due to their concerns of being punished by general teachers. In addition, he mentioned that a lack of knowledge and the academic shortcomings of LD students are likely to be reasons for hiding difficulties:

*'Yes, they hide their difficulties. For example, they avoid participating in the classroom as they are not confident in themselves. They believe they are always wrong, so they avoid participating in front of others. Sometimes, they don't have enough knowledge to participate or to answer teachers' questions'. Omer.*

Similarly, both LD parents indicated that a lack of confidence and concerns of failure are possible reasons that LD children hide their difficulties. Also, both parents believed that their children always hide difficulties because they want to avoid teachers' punishments and peers' reactions, such as laughing and stigma.

Hence, they do not want to be viewed as less capable than others in the classroom.

One LD parent stated:

*'As I said, he hides some homework and written notes because he avoids the punishment of teachers, and he doesn't want anyone to laugh at him. You know, this is normal in primary school stages. He wants to be successful, so he doesn't like those reactions by teachers and peers'. Ahmed.*

#### **6.5.4 Acknowledgment of Disability**

In contrast to hiding difficulties, the participants indicated that there are instances in which labelled students acknowledge their difficulties. For example, one LD teacher mentioned expressions that refer to acknowledging difficulties, such as *'I don't know', 'I forget', 'it is hard for me' and 'I can't understand'* (Omer). He explained that these expressions are indirect ways to acknowledge difficulties. Another LD teacher indicated that some factors help students acknowledge their difficulties. He mentioned that teachers should have a good relationship with students so they can talk about their difficulties. A good relationship with students might increase their desire to come to the resource room to learn and receive help. He articulated:

*'I think that the teacher should not begin the academic work with students before starting to consolidate this relationship because it is important in the academic aspect as it reflects positively on students. This makes students come to the resource room based on their desire to engage with you and receive academic help. Thus, they can tell you anything that is difficult for them'. Ammar.*

Both ADHD teachers indicated that students with ADHD acknowledge their difficulties when they are bored in classrooms or resource rooms. For example, they might say *'I can't understand' or 'it is difficult'* (Aati). Both teachers stated that some children exploit the label to leave the classroom because some general teachers allow them to leave. Both teachers justified this claim by stating that general teachers have a low awareness and prefer to send ADHD students out of the classroom. One ADHD teacher articulated:

*'They are smart in exploiting the label. They exploit things for their favour. They tell teachers they have ADHD or they can't understand or sometimes deliberately disrupt teachers so they will send them out of the class. I am sorry to say this, but some teachers can't wait to hear those words. They get them out right way'. Sameer.*

Similarly, both ADHD parents indicated that their children acknowledge their difficulties when parents compare them with other family members. Comparisons sometimes take place when doing homework and other school tasks. Thus, the parents stated that their children acknowledge difficulties because they are concerned they will have less play time. Also, one ADHD parent stated that acknowledgement might be a way to justify unacceptable behaviour or to avoid punishment. He articulated:

*'Once I reprimand him for any unaccepted behaviour, he tells me about his disorder. I know he is doing this to avoid my punishment, like giving him less time to play or playing in the garden. Honestly, I would not be surprised if he uses this at school. He is good at these things'. Hazim.*

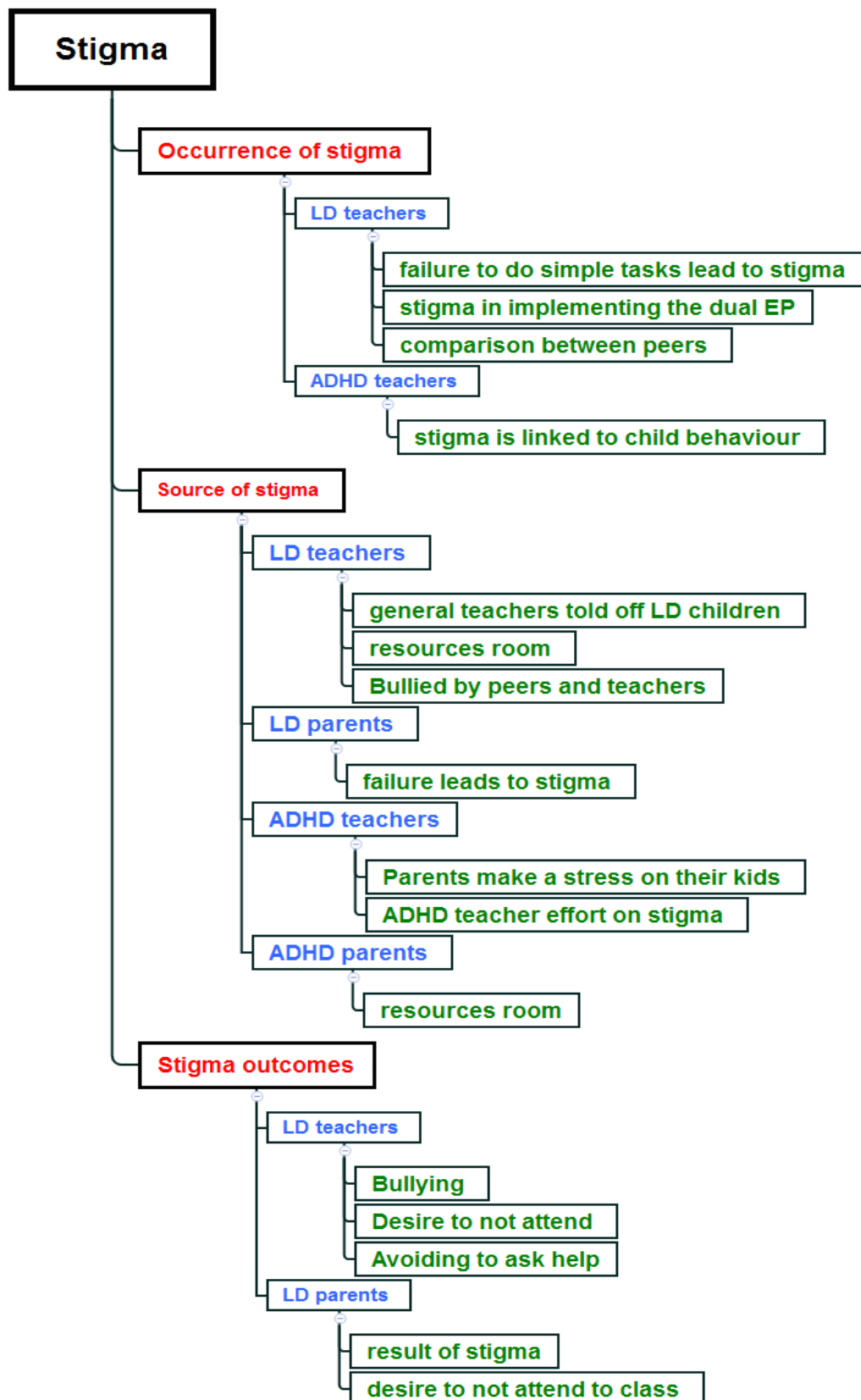
## **6.6 Stigma**

This theme attempts to explain how stigma is associated with children with ADHD and LD. It includes four subthemes: occurrence of stigma, source of stigma, stigma outcomes and solving stigma (see Figure 6).

### **6.6.1 Occurrence of Stigma**

Both LD teachers stated that stigma might occur when LD students fail to accomplish the given tasks, especially easy tasks. Peers stigmatise LD children when they fail their tasks. One LD teacher acknowledged that stigma occurs when he visits mainstream classrooms to observe LD children and to support them in some tasks. He also mentioned that LD children experience stigma when a dual EP is implemented in the resource room. This occurs when one LD child accomplishes the given task while another fails to do so. Both LD teachers stated that a comparison between peers is another feature of stigma. Both mentioned that general teachers ask successful students to support LD students in some tasks, which leads to stigma and laughter from peers. One LD teacher believed that the comparison might be more harmful when teachers implement both encouragement of peers and punishment. Simple encouragement, such as allowing students to leave the class early based on their academic achievement, is highly effective.

Figure 6 (Theme of Stigma)



One LD teacher articulated:

*'Some LD children compare themselves with other peers, like "why is that child is better than me? Or why he can do this and I can't? Why can he leave the class early to play"? These types of encouragement are used with primary school children. Peers stigmatise these children who have less encouragement. Unfortunately, LD children always receive less encouragement than others'. Ammar.*

Both ADHD teachers mentioned that stigma occurs when ADHD children show unacceptable behaviours, such as hyperactivity, which they believed cannot be controlled by ADHD children. Both stated that stigma cannot be eliminated until unacceptable behaviours are also eliminated. One ADHD teacher added that medical treatment can significantly reduce unacceptable behaviours and thus reduce the stigma for children with ADHD. He articulated:

*'It is important to use prescription drugs. This will help them control their behaviours, so others will not stigmatise them because there are no bad behaviours. Stigma will not occur without reasons. It happens due to ADHD children's behaviours'. Aati.*

Another ADHD teacher justified the occurrence of stigma by the fact that ADHD programmes have been recently introduced in mainstream schools by the MOE. Thus, general teachers and students do not have a sufficient awareness of interacting with ADHD students. They do not accept ADHD children's behaviours, and they laugh and stigmatise them. He said:

*'ADHD programmes are new in public schools, so general teachers do not have enough information or a full understanding of ADHD. Thus, they are not interested in dealing with ADHD students. Some general teachers are happy when ADHD children leave the class to go to the resource room'. Sameer.*

### **6.6.2 Sources of Stigma**

All LD teachers and parents revealed that lower academic achievement is an important source of stigma. They mentioned that lower achievement can lead to other sources of stigma. For instance, general teachers reprimand children when they show lower academic achievement. One LD teacher stated:

*'It is common here in the school that general teachers reprimand children when they fail to finish their tasks. Teachers yell and shout at students with LD in the classes'. Ammar.*

All LD teachers, ADHD teachers and ADHD parents stated that the resource room is another source of stigma for both LD and ADHD students. As mentioned, one

LD teacher indicated that stigma can be occur in the resource room when a dual EP is implemented with two LD children. Both LD teachers stated that supporting LD children through peers or teachers in the classroom can be another source of stigma. One ADHD teacher admitted that the resource room supports children academically, but it harms them in other psychological aspects. Hence, he mentioned that sometimes, he does not call ADHD children to the resource room to increase self-esteem. He added that not all children with ADHD are affected by stigma and that those in higher grades might experience a high level of stigma because they are aware of more words and labels. He said:

*'I am aware that I do sacrifice academic aspects when I don't call them to the resource room, but you know, you have to do this when you aim to minimise stigma. Some of them don't understand words they hear from peers, especially those in lower grades, whereas students in higher grades know and are aware of harmful words'. Aati.*

Another ADHD teacher expressed that ADHD children are stigmatised by peers when teachers reprimand them. He added that some parents exacerbate their ADHD children's situations because they demand their children to progress positively. He articulated:

*'As some parents suffer from a lack of knowledge and information about ADHD, they cause stress for their kids. They say to their kids that they were diagnosed with ADHD because they have a big problem and that this is their issue'. Sameer.*

### **6.6.3 Stigma Outcomes**

All LD teachers and parents revealed that stigma affects children's education. For instance, both LD teachers mentioned that stigma leads students to not attend resource rooms and schools. They stated that stigma exacerbates children's problems and causes them to suffer from both academic difficulties and low self-esteem. Both LD teachers indicated that students would not accomplish their academic tasks because they were afraid of stigma and punishment. One LD teacher stated:

*'I think the LD child has a sense when he is doing certain task he will fail in front of his peers, which leads to being stigmatised and proving he is stupid'. Ammar.*

Another LD teacher said: *'Stigma and laughter make children feel that they are less than others and that they will be reprimanded and punished by teachers'. Omer.*

Both LD teachers explained a potential dilemma that occurs for LD children. Children are stigmatised by peers if they ask for help; however, they suffer from academic difficulties if they do not ask for help. Similarly, one LD parent indicated that his child does not have severe difficulties in reading and writing that prevent him from participating; however, his child is concerned about failure if he does certain tasks. The parent articulated:

*'When I ask teachers whether my child participates in lessons, they answered no. He doesn't. I think this is not because he has severe difficulties but because he is afraid of his peers' reactions. You know, they laugh and stigmatise him'. Adi.*

Despite the occurrences of stigma and its many features, both LD teachers explained their efforts to reduce its effects. One LD teacher indicated that the effect of stigma can be minimised by increasing general teachers' awareness of LD and how they should deal with children in classrooms. He mentioned that he provided various workshops to teachers and speeches to students in schools regarding LD. Another LD teacher indicated another approach to reducing stigma by explaining to general students the positive aspects and strengths of LD children. He said:

*'My reactions always stop them from laughing. I always explain to them that LD children are better in other aspects, such as sports. I show them some correct homework done by LD children. I think it's a helpful way to reduce stigma'. Omer.*

## **6.7 Potential Drawbacks Resulting from Labels**

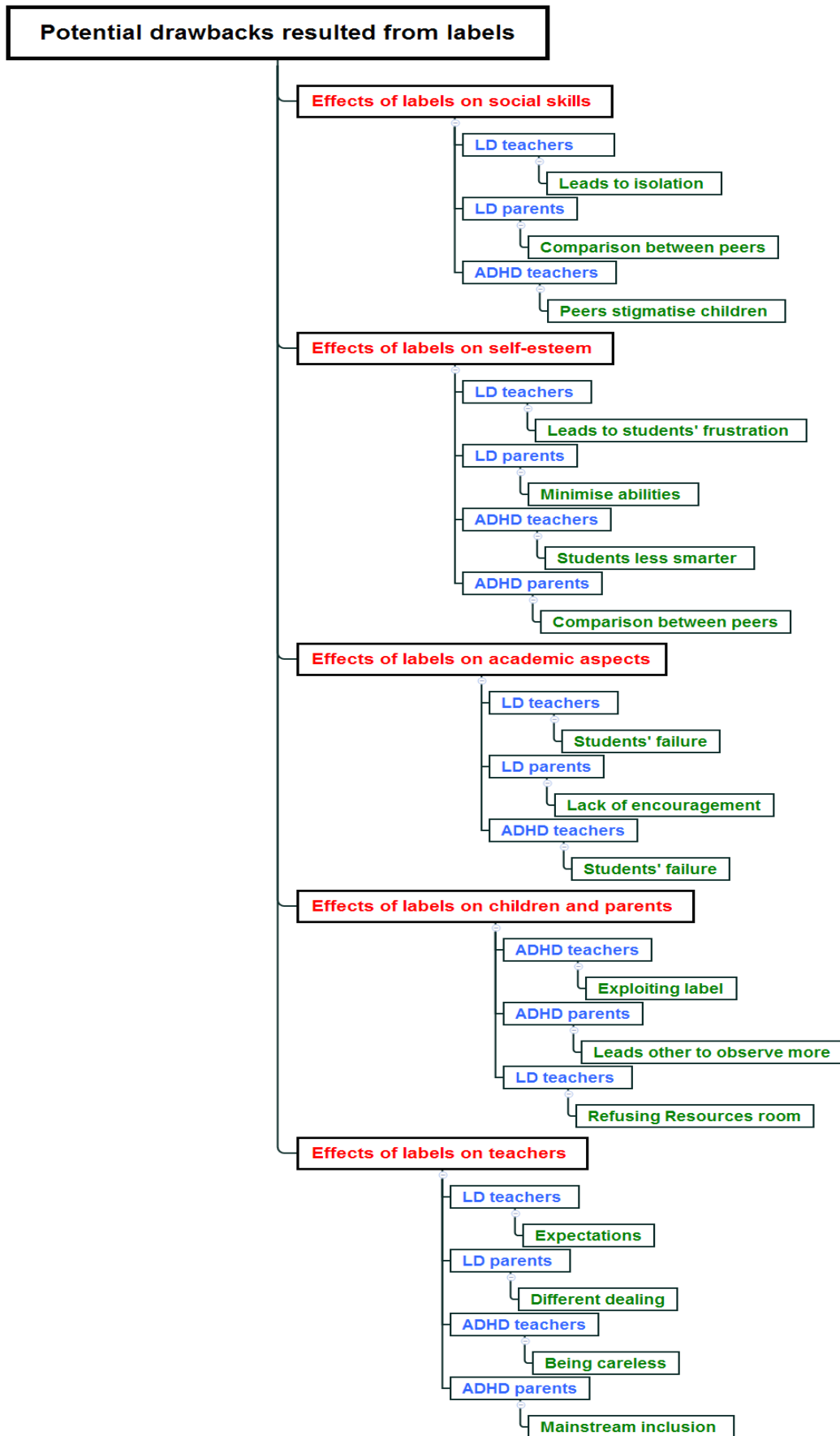
The current theme attempts to explain the potential drawbacks resulting from LD and ADHD labels. It encompasses five subthemes: effects of labels on social skills, effects of labels on self-esteem, effects of labels on academic aspects, effects of labels on teachers and effects of labels on children and parents (see Figure 7).

### **6.7.1 Effects of Labels on Social Skills**

All LD teachers and parents acknowledged that the LD label affects children socially. For instance, they mentioned that the LD label leads to a lack of social participation because students fear being stigmatised. Both LD teachers believed that the label allows others to stigmatise and to laugh at labelled children; thus, they prefer to be isolated.



Figure 7 (Theme of Potential Drawbacks Resulting from Labels)



One LD teacher indicated that a reason for social distance might be the lack of general students' awareness. Once LD children show academic difficulties, others' reactions are never to support or to help them; they laugh and stigmatise them. He said:

*'Also, students do not justify it to their peers when they show difficulties. Rarely do you notice support towards those children, whereas they laugh at them, so LD children do not want anyone to know about their difficulties because they are concerned they will laugh'. Ammar*

Similarly, one LD parent stated that stigma occurred on a daily basis for LD students, which causes them to be distant from others because labels affect their self-confidence. Also, one ADHD teacher mentioned that some general students do not have a desire to accept ADHD children with a high level of impulsivity and hyperactivity. Thus, peers stigmatise ADHD students, who ultimately desire to be distant from participating with others. He articulated:

*'In terms of social aspects, when peers are aware of some visible behaviour, like being hyperactive and impulsive, they won't allow ADHD children to participate with them. They always laugh at them and bully them, so ADHD students prefer to leave them'. Aati.*

### **6.7.2 Effects of Labels on Self-Esteem**

Both LD teachers emphasised that the LD label affects children's self-esteem because the label is used on a daily basis, such as during lessons in resource rooms. Both mentioned that children with LD are susceptible to low self-esteem as they experience the effects of the label and stigma every day. Both stated that the LD label affects children's abilities. Although some are knowledgeable, they fail to complete the given tasks, especially when they are asked in front of peers in the classroom. One LD teacher noticed that some LD children completed certain tasks successfully in the resource room, whereas they failed to do so in the mainstream classroom. He explained that students with LD fear failure as they might be stigmatised by students and punished by teachers:

*'I noticed some of them finished tasks twice and three times in the resource room, but when they were asked to do similar tasks in front of peers in the classroom, they failed. I am sure they knew how to answer and complete the tasks, but they were afraid because they face a bad experience every day if they fail, such as being laughed at or reprimanded by teachers'. Omer.*

Similarly, both LD parents indicated that the LD label leads to low self-confidence because their children believe that they are less than others. One LD parent admitted that he accepted his child being labelled and then being educated in the resource room as he had believed it is helpful. He added that he regretted enrolling his child in resource rooms due to the harm to his child's self-esteem. He articulated:

*'You know, at the beginning, I thought having a label and be included in the resource room is good for my child. But I found something else. He is psychologically broken. He feels less than others. I regretted allowing him to go to the resource room'. Ahmed.*

One ADHD teacher shared a similar idea that the ADHD label and its outcomes, such as entering the resource room, lead to low self-esteem, especially when disadvantageous actions come from general teachers in the classrooms. He added that labelling some children means differentiating between them negatively in others' eyes, which leads to labelled children having no confidence in their abilities. He stated that labelled children have a lack of self-esteem because they experience the outcomes of labels on a daily basis from teachers and peers. Therefore, he acknowledged that he did not tell some general teachers about some labelled children as he believed that they might exacerbate children's situations. He articulated:

*'Now, I have two children diagnosed with ADHD. They are involved in the resource room. I didn't tell their general teachers about them. They deal with them like their peers, but I am sure if I tell teachers about their diagnosis, they will deal with them differently or at least neglect them'. Sameer.*

Another ADHD teacher indicated that the ADHD label does not affect children's self-esteem because some labelled children are not aware of the label's meaning. He stated that labelling a child means providing help and support to match their needs to overcome their academic and behavioural drawbacks. He added that non-labelled children who show similar behaviours would be more affected regarding self-confidence because without a label, they do not know the aetiology or the appropriate social and medical treatments. He said:

*'I don't think the label affects children's self-esteem because with a label, they will have an EP to help them solve their academic and social issues, and they progress well and improve. But when they are left without a label or diagnosis, their self-esteem will be affected as they*

*don't have a clue what's going on. No label means no reasons, no treatment and no academic help'. Aati.*

Furthermore, both ADHD parents stated similar points regarding how the label affects children's self-esteem. One ADHD parent mentioned that his child linked the ADHD label with his negative behaviour and academic shortcomings. Thus, his child's self-esteem was affected negatively by the label because he was treated differently by teachers and peers. The parent added that he sometimes regretted telling teachers about his child's label:

*'When it comes to self-esteem, the ADHD label harmed my child because he was always treated badly by teachers and classmates. I think if I didn't tell teachers about his disorder, I would find another way to deal with it, like, yah he is normal. All kids like playing and moving'. Fahad.*

Another ADHD parent discussed a comparison between family members that affected his child's self-esteem. He clarified that once his child was labelled, they became highly careful in terms of assigning academic and even home tasks. Therefore, the child with ADHD was always assigned less tasks than his brother, which led him to feel that he is less than his brother. The parent admitted that his child is aware of this comparison, which affects his self-esteem. He stated that:

*'His brother always takes trash and recycling outside, but we cannot ask my child with ADHD to do so because we are concerned about him. When both did similar unaccepted behaviours, the normal child gets a more severe punishment than his brother. I am not sure if we are doing this right, but he realised we care too much about him and he is less than his brother'. Hazim.*

### **6.7.3 Effects of Labels on Academic Aspects**

After explaining the effects of ADHD and LD labels on social skills and self-esteem, participants discussed the related effects of LD and ADHD on academic aspects. For instance, both LD teachers stated that because LD children's social skills and self-esteem are affected, they are likely to be affected academically. Both LD teachers explained that the LD label makes children likely to fail because it lowers children's self-confidence. One LD teacher mentioned that even some undiagnosed children show academic shortcomings, but their confidence might be better than those with the LD label because they are not stigmatised by peers or suffer from low self-esteem. He articulated:

*'I think the harm of the label starts with children's self-esteem. When it is broken, you cannot expect him to progress well in the classroom. There are students who show similar difficulties, but at least their self-confidence is higher than those who experience the effect of the label every day'. Ammar.*

One ADHD teacher indicated that labelled children understand the concept of ADHD as having lower abilities than others, and their level of self-esteem is lower than others, which eventually leads to academic failure. He stated that the existence of a label means the existence of lower self-confidence, which makes students likely to fail. He expressed that:

*'It is something related to the label. You can't separate the label from low self-esteem. Children view the ADHD label negatively. They believe they will never succeed because they are labelled and go to the resource room'. Sameer.*

Similarly, both LD parents stated that academic failure might result from children's concerns of being stigmatised if they perform certain tasks. One LD parent mentioned that children's understanding of the label LD plays a role in their academic achievements. When children are labelled in lower grades, they are not aware of the negative connotation, which leads them to avoid potential harm to their self-confidence academically. Those who are labelled in higher grades are aware of the associated negative stereotypes, which affects their self-esteem and ultimately affects them academically. He said:

*'I see that children who start LD programmes in their early school stages, like year 1 and year 2, they benefit from the resource room because they don't understand what LD means and is linked to. But those who start quite late, like year 4 and 5, they will spend more time in resource room, and the more they stay, the more they experience bad outcomes due to the label'. Ahmed.*

Another LD parent mentioned a lack of encouragement in school as an important reason for students' failure. He explained that encouragement should be higher or at least equivalent to the potential harms they experience due to the label. He stated that his child progressed better at home than in school due to an abundance and a variety of desired encouragement at home. He articulated:

*'I know my child does better at home because I provide him with all the encouragement he needs. Sometimes, I encourage him to play games or ride his bike. Sometimes, we go to a theme park, but teachers don't have those ways to encourage him, so his progress is slow'. Adi.*

#### 6.7.4 Effects of Labels on Teachers

All types of participants in the current study indicated that LD and ADHD labels have an impact on general teachers. They mentioned that general teachers deal differently with labelled students, such as neglecting them in classrooms and after diagnosis processes. Participants stated that general teachers believe that they are not responsible for teaching diagnosed children when special teachers and resource rooms are available in schools. Thus, one LD teacher revealed that a high number of students are referred to resource rooms by general teachers. He added that general teachers always reprimand LD children, raising their voices and being careless in managing them. Also, one LD parent indicated significant differences in general teachers' treatment of his child after being diagnosed with LD, although his child showed difficulties before the diagnosis:

*The following quotes express participants' voices: 'General teachers are careless, treating LD children differently, because they believe teaching them is not their duty. They believe that teaching these kids is the duty of special teachers'. Ammar (LD teacher).*

*'Yes, there are big differences in the ways teachers deal with my child before and after diagnosis. They want me to feel my child is sick. They want me to understand that learning is hard for him. My child had difficulties in writing since he started primary school, but he was diagnosed this year'. Adi (LD parent).*

*'They are careless. They stop asking students even simple requests like sitting in their seats. They believe ADHD children can't cope in mainstream settings'. Sameer (ADHD teacher).*

*'Class teachers cannot wait for any poor behaviour from my child. They kick my child out of the class. They believe a special teacher is responsible for teaching my child. I am sure there are other students with similar behaviours, but they deal with my child differently because he has ADHD'. Fahad.*

Furthermore, one LD teacher indicated that his work was insufficient to solve the existed problem. He mentioned that he is overloaded with many duties because he always aims to increase general teachers' awareness, which makes him less focused on working with children.

*He articulated: 'It's interesting when you get so many students referred to the resource room by general teachers. I can't diagnose all of them, and I can't set EPs and teach them. In the meantime, I present lectures to teachers explaining my work, the resource room and LD in general. I*

*feel my efforts are not enough to alleviate the problem. It's really huge'. Ammar.*

Not only are teachers affected by labels, but head teachers also reported being influenced by labels. Both ADHD parents mentioned that they faced difficulties in registering their children in mainstream settings. Head teachers often reject ADHD children in mainstream schools because they have a certain limit for students with ADHD. Parents stated that schools were forced to accept their children after they proved their children received medical treatment to the MOE. One ADHD parent articulated:

*'The head teacher refused to accept my child because he said he accepted ADHD children more than enough. Then, I brought my child's medical report of treatments to the local authority, and they gave me a letter addressed to the head teacher. He finally accepted him'. Fahad.*

#### **6.7.5 Effects of Labels on Children and Parents**

Both ADHD teachers expressed that children with ADHD rely on the label to justify their unacceptable behaviours or academic shortcomings. Both teachers stated that ADHD children exploit general teachers' carelessness to leave the classroom.

One ADHD teacher said: *'Some of them use the label in his favour, use it as good reason for his behaviour. Also, they clearly say to teachers they have ADHD to leave the classroom and play with others'. Sameer.*

Furthermore, both ADHD parents indicated that the label is used outside schools and might stay with their children for their life. One ADHD parent hoped his child could change schools to allow him to make new friendships rather than socialising with those who stigmatised him in school and outside school. The parent added that he regretted enrolling his child in the ADHD group because the label makes him different in which all. He articulated:

*'When I take my child in the afternoon, his peers come to me and say your child did this thing and that thing. Labels made him easy to be observed and judged by everyone'. Hazim.*

Similarly, one LD teacher expressed that parents are shocked when they are informed that their children are diagnosed with LD. He justified their shock as the belief that LD means an unsuccessful education for their children, and they are likely to fail, causing stigma and other negative actions. He acknowledged that some parents rejected the diagnosis and ultimately refused to enrol their children in the resource room. He said:

*'Some parents never signed to enrol their kids in the resource room. Some of them told me why they didn't sign. They were concerned about the future of their kids and relationships with others. Bear in mind that some parents believe that LD threatens their children's learning'. Omer.*

## **6.8 Informal Labels**

The current theme aims to explain the use of informal labels in schools and their effects on students. It encompasses two subthemes: the use of pejorative words and the effects of informal labels (see Figure 8).

### **6.8.1 Use of Pejorative Words**

All participants reported that pejorative words are used in schools by teachers and students to label children. All LD teachers and parents mentioned words such as 'stupid', 'thick' and 'can't understand' as commonly used by teachers and students. Both LD teachers indicated that these words have more effects on students than formal labels because they point out shortcomings in a derogatory way, which all lower and higher grades students are aware of. Both LD teachers articulated:

*'Those words are dangerous. They affect students more than LD. Children in years 1 and 2 might be unaware of LD, but surely they understand what stupid means'. Ammar.*

*'I always hear those words. Some general teachers say them to me, like, please take him, he will not benefit in my class. Sometimes they say them publicly. All students hear'. Omer.*

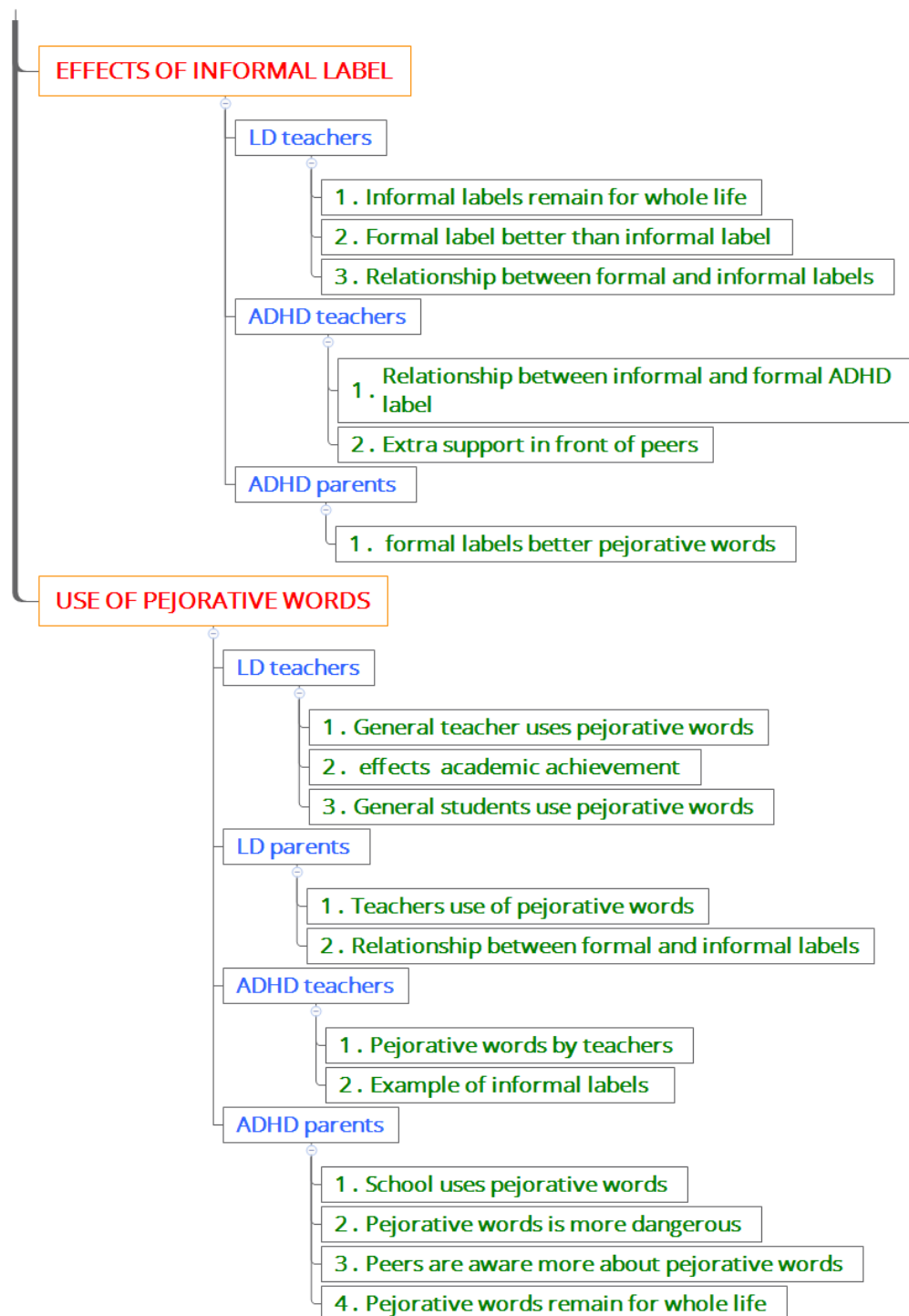
Similarly, both LD parents mentioned that informal words spread quickly among students, which might affect other parents. One LD parent stated that other parents ask general teachers to not allow their children to sit next to LD children. Another LD parent articulated that children not only call his son 'stupid', they also call the resource room the 'stupidity room'. He said:

*'I attended the school's opening day. I heard one parent ask teachers to move his son to the front of class because stupid children always sit in the back. He believed children in resource rooms are stupid. I think he heard it from his son, and his son heard it from a teacher'. Adi.*



Figure 8 (Theme of Informal Labels)

## INFORMAL LABELS



Furthermore, all ADHD parents and teachers reported that words such as ‘crazy’, ‘naughty’, ‘mentally retarded’ and ‘trouble maker’ are used in schools by teachers and students. One ADHD teacher indicated that general teachers used those words to students as potential consequences if they fail or miss homework. He explained that these words describe students’ dysfunctions, which are spoken loudly to punish students.

*He said: ‘Most young children in lower grades can’t understand ADHD, but they understand words like mentally retarded or crazy. Some teachers ask students to deliver papers between classes, so one came to me and said this is from my teacher for the room of crazy students’.*  
Aati.

One ADHD parent indicated that these words remain for children’s entire lives because formal labels might be understood as academic terms. Those words are highly understandable to students, who use them even outside schools.

*He articulated that: ‘I still remember my classmates who were labelled by words like mentally retarded and crazy. I forgot their actual names. We used to say them even after we met long time after primary school’.*  
Hazim.

### **6.8.2 Effects of Informal Labels**

Both LD teachers mentioned that pejorative words might stay with children for a long time because students use and understand them, while the LD label is used but some do not understand it. They added that a formal label also might remain for a long time, but they claimed they did not encounter them in their childhood. Therefore, both LD teachers preferred using a formal label, although they affect students as well. One LD teacher articulated:

*‘I think words like ‘stupid’ remain for a long time, as I still remember my friends in school who were labelled by those names. There were no resource rooms or special teachers, so I can’t say formal labels stick with children, but they might’.* Ammar.

Similarly, one ADHD parent stated he preferred a formal label rather than an informal label, which is widely used outside schools; however, the participants indicated that pejorative words are supported and advanced by formal labels. They mentioned that students created disrespectful words after formal labels were attached to students with ADHD and LD. One ADHD teacher added that pejorative words are used by ADHD students when extra support is given to them in the

classroom, such as 'can't understand'. The following quotes are linked to the relationship between formal and informal labels.

*'I think LD as a label helped students create other bad words, like 'stupid' and 'thick'. They believed that the 'stupidity room' is only for stupid kids'. Ammar (LD teacher).*

*'Those words were attached to my child after he got the LD label. I haven't heard them before'. Ahmed (LD parent).*

*"'Naughty'" and other similar words came after the essential label, which is ADHD, but they are used because everyone understands them'. Sameer (ADHD teacher).*

*'It is normal that other related words are linked to the main concept, so 'crazy' and 'mentally retarded' are linked to ADHD. This is how children understand them'. Hazim (ADHD parent).*

## **6.9 Effects of the Resource Room**

The current theme attempts to explain the effects of the resource room on labelled students and general teachers. As shown in Figure 9, this theme is divided into two subthemes: effects of the resource room on students and effects of resource room on general teachers.

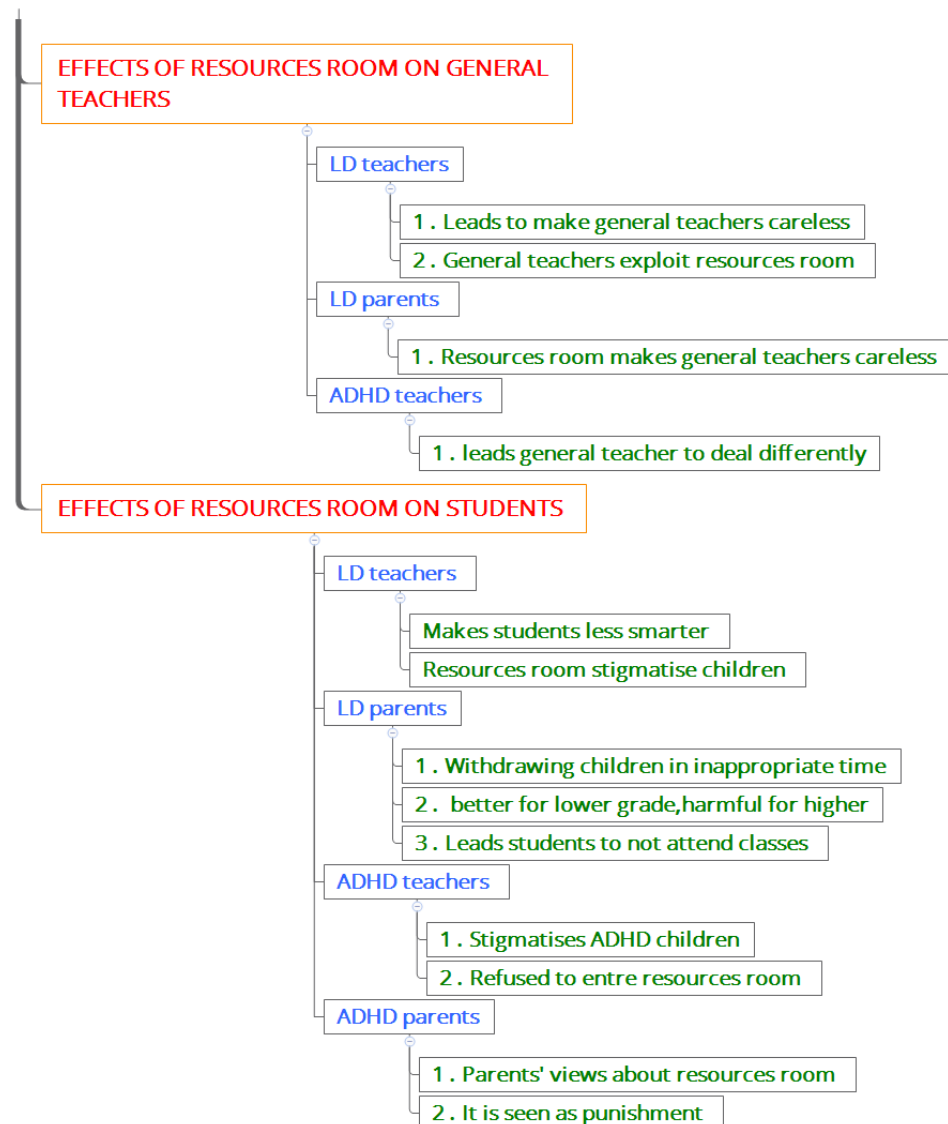
### **6.9.1 Effects of the Resource Room on Students**

All LD teachers and parents indicated that the resource room stigmatised children with LD. Both LD teachers mentioned that the resource room can be considered by other students as the 'stupidity room' where 'stupid' children are taught. General students feel they are smarter than those in the resource room because they do not have academic difficulties. Thus, LD children are stigmatised and disparaged by peers. One LD teacher said:

*'I can see that general children believe in themselves more. They think they are smarter than those who go to the 'stupidity room'. They are better because they always finish their academic tasks correctly'. Omer.*

Figure 9 (Theme of Effects of the Resource Room)

### EFFECTS OF RESOURCES ROOM



Both LD parents expressed that the LD label shaped general students’ thoughts on students educated in the resource room. They mentioned that ‘LD’ as a term has been understood as something difficult and not easy to overcome. Thus, words like ‘stupid’ and ‘thick’ are used for those who are educated in the resource room. Also, they mentioned that the ‘stupidity room’ is used to refer to the resource room, which stigmatises children with LD. One LD parent articulated:

*‘They laugh at my child because he goes to the “stupidity room” as they believe, so my child is ‘stupid’. If you visit school, you will see learning difficulties is written on the front door of resource room. Children understand the word difficult as something really hard’. Ahmed.*

Moreover, both LD parents mentioned that withdrawing their children from the main class to the resource room is problematic. They expressed that the LD teacher comes and calls LD children to follow him to the resource room in front of their peers. Thus, parents said that their children feel less than others in the class because the LD teacher is believed by peers to be a special teacher for children who have academic difficulties. Consequently, both LD parents stated that the resource room affected their children because it allows others to stigmatise them. They added that their children have less desire to attend school or at least to attend lessons in the resource room. One LD parent said:

*'General teachers claimed that they are effectively working with the LD teacher. In fact, no. The LD teacher comes to the classroom and asks for LD kids to go to the resource room while everyone is watching. He doesn't ask to play or to go somewhere else. No, he asks them to go to the LD room. It is harmful'. Adi.*

Both LD parents acknowledged that the resource room is intended to be useful; however, its name affects children with LD because the label is understood differently by peers. Both parents stated that the LD label overshadowed the positive aspects of the resource room. One LD parent mentioned:

*'Honestly, I had asked the LD teacher to enrol my child in the resource room because I thought it is academically helpful. But I found something else. I didn't expect these negative points. I mean laughter and stigma. If the resource room did not have a name that children understand as negative, my child would have gained more help'. Ahmed.*

Similarly, one ADHD teacher mentioned that although the resource room positively affects academic aspects, it affects children psychologically because it allows others to stigmatise them. He admitted that he deliberately avoids bringing children to the resource room because self-confidence and self-esteem are more important than academic satisfaction. He articulated that:

*'I know it's academically helpful, but I can't call them to the resource room on a daily basis. It harms them. Others will laugh, or they will feel they have less abilities. I always scarify by academic aspects. I think when children are confident and stable psychologically, they are better academic achievers'. Sameer.*

Another ADHD teacher expressed that the resource room might be viewed derogatorily by general students. He explained that the school includes students with different types of disabilities, such as autism, ADHD and mental retardation.

Some general children are not familiar with or aware of all terminologies; however, they are aware that the resource room is a common denominator for all categories with lower abilities. Thus, some ADHD students have a low desire to attend lessons in the resource room because they are concerned about others' reactions, such as laughter and stigma. He articulated:

*'You know, some of them are still kids. They don't understand words like autism, ADHD and mental retardation. By the way, those groups are included in this school. Kids are aware that there is a small room downstairs called the resource room where everyone with lower abilities goes'. Aati.*

One ADHD parent expressed that his child feels the resource room is a sort of punishment he always receives from teachers because he is taken from his friends and is isolated. The parent added that the resource room frightens his child and that he has less enthusiasm for school.

*He said: 'He gets scared of it. He understands that the teacher uses this room to isolate him. He can't play, can't talk and must stay 40 minutes in front of one teacher under his control. He doesn't like it at all'. Hazim.*

### **6.9.2 Effects of the Resource Room on General Teachers**

All LD teachers, LD parents and ADHD teachers expressed that the resource room affects general teachers in dealing with children educated in the resource room. Both LD teachers clarified that general teachers neglect children in the resource room for several reasons. First, general teachers believe that they are not responsible for teaching those who are in the resource room with special teachers. Second, general teachers have a high workload in which the number of students in the classroom is always above 30 students. Thus, they consider their responsibilities are only to those who stay in the classroom. General teachers have different reactions towards labelled students, such as neglecting them during in-class participation, reprimanding them and treating them differently. Both LD teachers mentioned that even some non-labelled students show academic difficulties, but general teachers seem to care more about them than those labelled and educated in the resource room. Both LD teachers articulated the following:

*'In fact, he teaches more than 30 children in the class. Two or three of them have difficulties, so he feels they are obstacles in his work. Here, he deals with them like he doesn't accept them, sometimes reprimanding them or not allowing them to participate. These actions occur because they go to the resource room'. Omer.*

*'It's funny when some students without a label have academic problems and general teachers work hard with them, care about them. When labelled students have similar difficulties, they are careless with them because they go to the resource room with a special teacher'. Ammar.*

## **6.10 Labels in the Future**

The current theme aims to explore participants' views regarding LD and ADHD labels in the future. It encompasses two subthemes: the use of labels in the future and suggestions for changing labels (see Figure 10).

### **6.10.1 Use of Labels in the Future**

All participants indicated that labels should be changed to positive labels that can be understood positively. They mentioned that the current labels describe certain shortcomings or dysfunctions in children; thus, these labels are understood negatively. For example, both LD teachers stated that the word 'difficulty' in the term LD plays a significant role in shaping the meaning of LD. Ammar (LD teacher) stated:

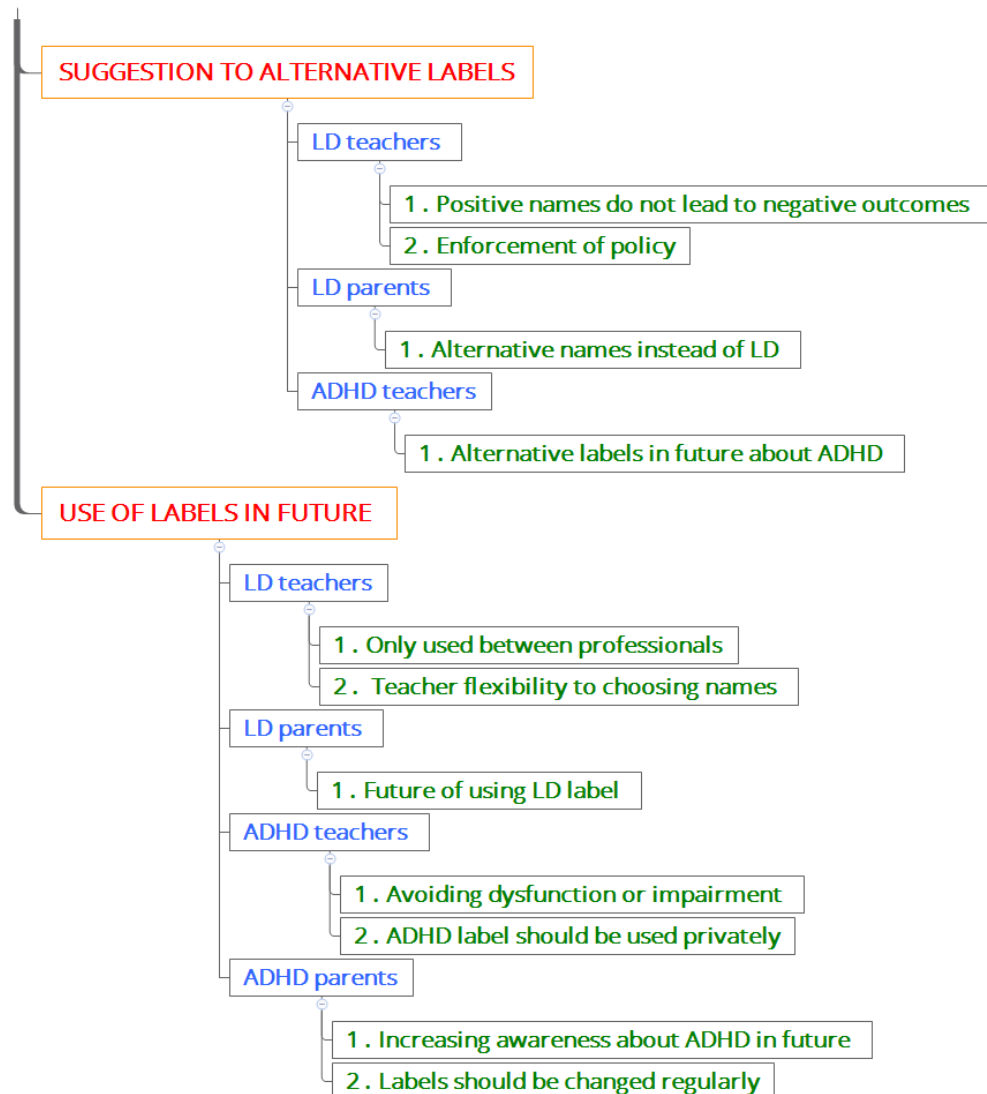
*'I hope in the future labels will be changed to contain positive meanings that children understand positively. The current label has the word 'difficulty', which is always understood as something difficult'.*

Both LD teachers suggested that labels should be used between professionals and specialists. Children should not have access to the labels. They claimed that special teachers are more knowledgeable of children's situations; thus, they should be given the flexibility to use other more positive labels.

Both LD teachers mentioned that they are not satisfied with the current labels but are forced by policy to use them. One LD teacher articulated: *'I think we should be given opportunities to use other positive labels. We know so much about these children. I know what names they like and dislike'. Ammar.*

Figure 10 (Theme of Labels in the Future)

## LABELS IN FUTURE



Similarly, both LD parents emphasised that labels should not include negative words that allow others to interpret them negatively and to disparage labelled children. They indicated that in the future, children’s dignity should be considered, and labels should not describe their shortcomings. One LD parent claimed that changing labels to have a positive connotation increases children’s and general teachers’ awareness because positive labels cannot be interpreted negatively. He added that some informal labels might disappear gradually due to this change. He expressed that changing labels to have positive connotations would not prevent providing services to children.



He articulated: *'I believe that when a formal label is changed to a label that saves children's dignity and does not include negative words, peers' awareness is likely to increase, and bad words will not be used. I don't think my child would have been affected if he had been labelled by positive words'. Ahmed.*

All ADHD teachers and parents shared similar thoughts regarding the future of using ADHD labels. They expressed that the ADHD label describes the exact symptoms of children who show hyperactivity, inattention and impulsiveness. They mentioned that the ADHD label manifests children's dysfunctions, which affects teachers' and children's attitudes and thoughts. They emphasised that ADHD should be changed to a more positive label that contains a positive meaning, which might contribute to increasing teachers' and children's awareness. They suggested that the label should not be used publicly. One ADHD parent claimed that services and support can be provided to children with positive labels. ADHD teachers and parents stated their suggestions in the following quotes:

*'Labels shouldn't be used by general teachers, students or even janitors in the school. This is not useful. It affects children badly. Not only should labels be changed to positive words, but they must also be used between special teachers and highly private. It's like banking information. Not everyone knows what that child is labelled with'. Sameer.*

*'It's not difficult for those in the MoE to find positive words to effectively help children with a lack of attention. Future labels shouldn't describe or explain children's disorders and dysfunctions. I am saying this to raise peers' and teachers' awareness'. Aati.*

*'Positive words are important in shaping others' feelings. With the current labels, I can't imagine positive attitudes towards my son because he is labelled and diagnosed with ADHD. I couldn't get my child's acceptance in public schools till I forced them to accept the label and he took medicine. It's not logical. They can look for other words and get academic support delivered to my child'. Hazim.*

### **6.10.2 Suggestions for Alternative Labels**

Participants of the current study suggested alternative labels to LD and ADHD. For instance, one LD teacher has recently begun using 'we can' with a positive logo in his resource room because he believes that LD has broad effects on teachers, labelled children and their peers (see Appendix 10). As mentioned in the second theme, another LD teacher used an alternative door to his resource room (door

without the LD label); however, both teachers admitted that they kept the LD label on their resource rooms because they are observed by supervisors during school inspections. Furthermore, one LD teacher suggested that the resource room could be referred to as a classroom for remedial lessons because many students use this approach to learning outside the schools. The teacher claimed that high-achieving students have studied remedial lessons in their homes with private teachers. Thus, this phrase is unlikely to be understood or interpreted negatively, especially because it is used by most children. He explained:

*'I'd say up to 80% of smart and successful students have worked with private teachers in their homes in the evening to study remedial lessons. They are helped and supported to strengthen some skills, so I haven't come across someone stigmatising them due to studying remedial lessons. This is another example of positive names'. -Omer.*

Similarly, both LD parents suggested labels, such as educational services and remedial lessons instead of 'resource room' as well as capable children instead of LD children, which do not include obvious negative meanings. They claimed that these labels are more general and therefore draw attention away from children's difficulties and shortcomings. Labels such as supportive room and remedial lessons were also suggested by both ADHD teachers. One LD student's parent stated:

*'For names like educational services, it is hard for kids in primary school to interpret it negatively. Both high- and low-achieving children need educational support and help. It's also hard for kids to create other informal words based on educational services. The use of the word 'Stupid' resulted from some sort of previous label, such as difficulty'. - Ahmed.*

# Chapter Seven

## Discussion Chapter

### 7.1 Introduction

The preceding two chapters highlighted several themes associated with the complexities of ADHD and LD labels in the Saudi context, according to teachers' and parents' perceptions. Each theme in these chapters elaborated and developed an understanding of various issues tied to both labels. All themes discovered in the first phase (quantitative) were explored deeply in the second phase (qualitative). This chapter, therefore, draws on key findings from the themes outlined in previous chapters as they relate to the theoretical framework and earlier literature review. It is also important to discuss how the findings from the themes are linked to the research questions in the current study. As shown in table 21, eight themes emerged from the two phases. Accordingly, the present chapter is organised in such a way to discuss the main discussion points by these themes.

**Table 21 (Research Questions and Related Findings)**

Research questions	Key findings	
	Quantitative	Qualitative
<b>1-How do primary school teachers and parents view and perceive ADHD and LD labels?</b>	This question succeed in providing general picture about the phenomenon of LD and ADHD labels mainly in the quantitative phase.	
<b>1-A- How do primary school teachers and parents perceive the strengths of applying ADHD and LD labels to children?</b>	<b>Theme (1) LD and ADHD knowledge and experience among teachers and parents</b>	
	1- Parents have a low rate of workshop attendance and training. 2- Teachers had a high rate of workshop attendance and training.	1- Parents' lack of involvement in workshops. 2- Alternative sources of workshops and training. 3- Different and negative understanding of LD and ADHD concepts among teachers and parents.
	<b>Theme (2) Strength of ADHD and LD labels</b>	
		Findings from the current study revealed some positive points of ADHD and LD labels in academic respects.

<p><b>1-B- How do primary school teachers and parents of children with LD and ADHD perceive the negative impacts of these labels?</b></p>	<p><b>Theme (3) Occurrence and features of stigma attached to labelled students.</b></p>	
	<p>1- In the quantitative findings, all types of participants showed high frequencies of stigma occurred to children labelled with LD and ADHD.</p>	<p>1- The qualitative findings reported how stigma occurs in schools. 2- Several sources of stigma, such as resource rooms, labels, teachers and students, were highlighted. 3- The qualitative findings revealed several outcomes of stigma, such as bullying, school absenteeism, and students prefer to not ask teachers for help.</p>
	<p><b>Theme (4) Social and academic effects of LD and ADHD labels on teachers and students.</b></p>	
	<p>1- The quantitative findings emphasized that a high number of labelled children were affected in terms of their self-esteem. 2- It was found that labels affected students in terms of social and academic aspects generally.</p>	<p>1- The qualitative findings reported that labels affect children in social participation. 2- The findings emphasized that negative outcomes were due to labels, not academic underachievement or unaccepted behaviours. 3- The qualitative findings reported that labels have impacted students academically.</p>
	<p><b>Theme (5) Usage and effects of informal labels</b></p>	
	<p>1-The quantitative finding reported some features of informal labels such as extra time, support and pejorative words such as stupid and naughty.</p>	<p>1- The qualitative findings reported that informal labels are used by teachers and students. 2- Teachers were reported to have a significant role in distributing and using informal labels for several reasons, such as threatening or punishing students. 3- The qualitative findings highlighted the danger of informal labels and its potential outcomes.</p>
	<p><b>Theme (6) Effects of pulling out programs</b></p>	
	<p>1- Participants indicated that pulling out of programmes, such as resource rooms, affected children with LD and ADHD labels. For example, children in resource rooms get bullied by other peers.</p>	<p>1- The qualitative findings reported that resource rooms affected general teachers, general students and labelled students in several respects.</p>
<p><b>Theme (7) Students' reactions: 'hiding academic and behavioural difficulties'</b></p>		

	1- Parents and teachers indicated some hiding of academic and behavioural difficulties among labelled children.	1- The qualitative findings indicated two types of hiding difficulties, at home and at school. 2- Also, why labelled children hide their difficulties was indicated. 3- How students acknowledge their difficulties was indicated.
<b>4-What do primary school teachers and parents predict regarding the future of ADHD and LD labels?</b>	<b>Theme (8) Future of ADHD and LD labels</b>	
		1- It has been suggested that ADHD and LD labels should be changed to positive labels. 2- Participants suggested alternative labels to LD and ADHD. 3-Also, participants suggested that labels should be used only by professionals and teachers who are involved in dealing with labelled children.

## **7.2 LD and ADHD Knowledge and Experience among Teachers and Parents**

### **7.2.1 Misunderstanding and Misperception of LD**

One of the key results from the present study was the negative and different understandings of the LD label. Parents and teachers expressed their understanding of LD as difficulties that prevent children from learning and from overcoming these difficulties easily. The word ‘difficulties’ in the LD label has been understood negatively, and it seems to have sense of generalisation. Perhaps, teachers perceived that children labelled with LD had difficulties in most learning skills. The findings from the current study agreed with the notion that the LD concept is still misperceived and misunderstood. The phenomenon of teachers’ lack of understanding about the concept of LD was studied by several researchers, each of whom regarded the LD concept as a controversial issue (Alnaim, 2016; Hudson et al., 2007; Tansey & Ní Dhomhnaill, 2002; Washburn et al., 2011).

Tansey and Ní Dhomhnaill (2002) distributed questionnaires to 69 teachers in the UK regarding their attitudes about dyslexia. The results indicated that 81% of the teachers had an ambiguous notion of dyslexia. Also, Washburn et al. (2011) developed a questionnaire aimed at exploring teachers’ knowledge of basic language concepts and LD, which was distributed to 185 teachers in the US. Their results showed that more than 81% of the teachers considered dyslexia to be a

visual deficit by which students with LD saw letters and words backwards. Washburn and colleagues explained that their findings supported the notion that dyslexia was still misunderstood and misperceived, as they found variation in teachers' knowledge of dyslexia.

A recent study conducted by Alnaim (2016) was aimed at identifying Saudi primary teachers' perspectives regarding LD. Alnaim indicated an extensive overlap between teachers' perceptions of LD. In other words, teachers perceived the concept of LD in different ways, such as by discrepancy notions, exclusionary criteria, symptoms of academic problems and developmental issues. Alnaim indicated that teachers also perceived LD as carelessness, slow learning and underachievement. Therefore, similar findings from previous studies of teachers' perceptions of LD, the findings of the current study are consistent with the notion that the LD concept is still misperceived and misunderstood.

There are several reasons why teachers misunderstand the concept of LD, one of which may be attributable to controversies about and the abundance of LD concepts. Several studies concluded that there was no universally agreed-upon definition of LD (Reiss & Brooks, 2004; Sideridis, 2007; Tunmer & Greaney, 2010). In the Saudi context, it has been acknowledged that the Saudi education system follows the US system in terms of terminology, with the term 'learning disability' in official use. However, the findings of the current study suggest that the terms 'learning disabilities' and 'learning difficulties' are used both interchangeably and simultaneously in Saudi schools. Therefore, controversies surrounding LD concepts and definitions might be one reason why Saudi teachers misunderstand the LD concept.

The second potential reason why teachers lack understanding of LD might be how LD is practised and implemented in Saudi schools. Accordingly, the present study questioned general classroom teachers' practices concerning LD students. General teachers were found to refer a large number of lower-achieving students to LD teachers in resource rooms. Arguably, the practices of general teachers could lessen the time of LD teachers since they need to diagnose all referral students. Alnaim (2016) argued that referring large numbers of students might disturb LD teachers' understandings. Since according to the findings from the present study,

nearly one-half of students in general classrooms are referred to resource rooms, LD teachers may struggle to differentiate between students with LD, slow learners, lower achievers and careless students. Therefore, the practices of general classroom teachers might affect LD teachers' perceptions and understanding of LD concepts.

A third possible reason why teachers lack an understanding of LD might be the LD label itself. It has been argued that labels, words and phrases powerfully configure people's perceptions and understandings (Platteel, 2003). Even though labels such as LD may be helpful in describing behaviours or characteristics, they remain difficult to understand (Lauchlan et al., 2017). Moreover, since LD, dyslexia and other labels may contain negative, socially developed meanings (Algraigray & Boyle, 2017), it could be argued that the LD label itself exacerbates teachers' misunderstanding and misperception of LD.

Inadequate preparation at the pre-service level may be another cause of teachers' lack of understanding of the LD concept (Washburn et al., 2011). Although this point will be discussed in more detail in section (7.2.3 Teachers' and Parents' Involvement in Training and Workshops), it is worth mentioning here that inadequate follow-up training might also affect teachers' understandings of LD.

### **7.2.2 Misunderstanding and Misperception of ADHD**

Similar to the LD label, the ADHD label was also differently and negatively understood by teachers and parents in this study. Teachers believed that medical treatment should be used to resolve and manage ADHD. In contrast, parents rejected the idea of medical treatment as the only way to manage ADHD in their children. This disagreement in terms of parents' and teachers' perceptions is not a new issue in the field of ADHD. Other studies have demonstrated that teachers and parents have inadequate knowledge about ADHD (Abed et al., 2014; Algraigray, 2015; Al-Kahtani, 2013; Barbaresi & Olsen, 1998; Kos, 2008; Sciotto et al., 2000). Sciotto et al. (2000) found that teachers had a low rate of knowledge (48%) regarding ADHD. Additionally, although teachers were found to be knowledgeable about the main characteristics of ADHD, they had inadequate knowledge about interventions and causes. Another study by Al-Kahtani (2013) distributed a scale

(KADDS) to 429 Saudi teachers with the aim of exploring their knowledge about ADHD. Al-Kahtani found that teachers were less knowledgeable about diagnosing and characterising ADHD. Al-Kahtani explained that teachers thought more about some elements of treating ADHD, such as 'Reducing dietary intake of sugar or food additives is generally effective in reducing the symptoms of ADHD' (2013, p. 965), than others. Kos (2008) found that Saudi teachers believed ADHD to be a medically well-founded condition that adversely affected students' capacity to be successful in their education.

Abed et al. (2014) used a mixed methodology to examine knowledge and beliefs about ADHD as held by male and female Saudi teachers. The researchers revealed that the teachers were knowledgeable about general characteristics of ADHD; however, they lacked knowledge about ADHD treatment, diagnosis and intervention. Most of the teachers affirmed the medical diagnosis and intervention, since they believed that proper treatment would increase their students' concentration and help them to manage their disruptive behaviour and increase academic achievement (Abed et al., 2014). The findings from the present study are in line with the results from this and the other studies. Arguably, if teachers are adequately and accurately knowledgeable about ADHD, they could effectively and positively engage in the process of diagnosis, intervention and teaching of children with ADHD (Al-Kahtani, 2013; Goldstein et al., 2011). So long as teachers have inadequate knowledge about ADHD, their practices for managing children with ADHD are likely to be ineffective. This might seem alarming, since teachers are frequently involved in ADHD diagnosis, referral and intervention and may be the first to recognise and symptoms of ADHD in the classroom (Snider et al., 2003). Thus, teachers' practical experiences and role in managing children with ADHD are more likely to be negatively affected by insufficient knowledge (Vereb & DiPerna, 2004).

Saudi teachers might lack knowledge about ADHD for several reasons. First, they are not specialised in detecting ADHD but rather in detecting autism. However, it is important to note that ADHD programmes were officially launched in Saudi Arabia in 2015, and it has been shown that teachers who attend specialised



courses about ADHD have a higher level of knowledge about the condition (Abed et al., 2014).

A lack of follow-up training or workshops for teachers concerning ADHD might be another cause of insufficient knowledge. Follow-up training especially has been linked to a higher level of knowledge (Abed et al., 2014). Jerome et al. (1994), for instance, found that 90% of teachers who had inadequate knowledge about ADHD had been given insufficient opportunities to specialise in ADHD. Section (7.2.3 Teachers' and Parents' Involvement in Training and Workshops) discusses issues regarding involvement in workshops and training as a potential cause of teachers' lack of knowledge.

Teachers' reliance on medical treatment and intervention may be another cause of their lack of understanding of ADHD. In line with other studies, such as those by Abed et al. (2014) and Kos (2008), the findings from the present study indicate that Saudi teachers believe ADHD to be solely a neurological developmental disorder. Thus, they might believe that they do not have the responsibility for ADHD treatment. Algraigray (2015) found that teachers had very little experience in diagnosis programmes, since they were not involved in any diagnosis work. Hjerne and Saljo (2004) identified a similar issue in Sweden, where teachers considered medication to be the sole way of treating ADHD. Therefore, teachers' misunderstanding of ADHD may be related to their belief that they are not responsible for diagnosing or managing the condition in their students.

Notably, ADHD, as a pseudo-medical label, refers to myriad behaviours in need of modification, accommodation and management; the label can also entail negative, socially constructed connotations (Algraigray & Boyle, 2017). Such complexity might exacerbate teachers' misunderstanding of ADHD. Hence, inadequate preparation and follow-up training, over-reliance on the medical view of ADHD and the myriad behaviours associated with the ADHD label all seem to adversely affect teachers' knowledge about ADHD. It is important to mention that teachers who have adequate knowledge about ADHD are likely better prepared to teach and assist students with ADHD (Al-Kahtani, 2013; Goldstein et al., 2011).

### **7.2.3 Teachers' and Parents' Involvement in Training and Workshops**

One of the key findings from the present study was the high level of involvement by teachers in workshops and training: 89% of LD teachers indicated involvement in workshops and training, provided by the MOE, which focused on Individual Educational Plan (IEP) and diagnosis. Likewise, all ADHD teachers indicated involvement in workshops provided by the MOE. These workshops focused on the aetiology, symptoms and characteristics of ADHD, as well as on designing IEP for children with ADHD. Moreover, both LD and ADHD teachers used Twitter and WhatsApp groups to share information and experiences. Despite their heavy involvement in workshops and training, the teachers raised some issues, e.g., the workshops and training seemed to be more theoretical than practical.

The findings from the present study indicate that teachers preferred to use WhatsApp groups to contact their supervisors and colleagues directly for some issues, such as designing IEP and teachings. It can be argued, that the provided workshops and training were similar to university preparations insofar as both lacked practical instruction about, for example, teaching skills. In term of ADHD, there is no special preparation at Saudi universities. To support this claim, Hussain (2009) distributed a survey to 160 LD teachers regarding their views about preparation programmes. Although the results found these programmes to be effective in general, the teachers rated the programmes as ineffective for addressing practical issues. Alnaim (2016) also suggested a gap between LD teachers' preparation programmes and real practices in Saudi schools. Due to this issue, alongside ineffectual workshops, teachers are increasingly reliant on social network sites for more practical advice and answers to their inquiries. The gap between teachers' preparations and real-life practices is evident not only in the Saudi system.

Studies from the US, such as those by Wasburn-Moses (2005) and Lovingfoss et al. (2001), found that preparation programmes lack coverage of practical issues, such as pedagogy, paperwork and student issues. Likewise, Miller and Losardo (2002) found teacher preparation programmes to be inadequate in practical areas, including working with families and managing children's behaviour. As discussed in sections (7.2.1 Misunderstanding and Misperception of LD and 7.2.2

Misunderstanding and Misperception of ADHD), deficient preparation programmes and follow-up training might contribute to teachers' lack of knowledge about LD and ADHD. That said, the issue is not the availability of teacher preparation programmes and follow-up training but rather their nature. It has been argued that providing teachers with effective training is indispensable to the LD and ADHD programme's perfection, since training is associated with successful and higher-quality implementation (Dusenbury et al., 2003).

Another key finding from the present study was the lack of parental involvement in workshops and training. It was revealed that more than 85% of parents of children with LD or ADHD have not been involved in any workshops or training programmes. This can be attributed to the claim that most workshops and training run by the MOE are provided to teachers, not parents. That said, some workshops are provided by teachers to parents; however, most parents are not satisfied with these workshops, as they are basic in nature and fail to garner parents' interest. Hence, the findings of this study have revealed a lack of parental involvement in general, and a lack of involvement in workshops and training in particular.

Similarly, Alshammari (2017) found that Saudi parents considered teachers to be a barrier to participation because of ineffective or inconsistent communication. Likewise, Alobaid (2018) revealed that the biggest impediment to parental involvement in Saudi education were the schools themselves. Saudi schools were shown to be ineffective in communicating with parents, especially regarding invitations to and the efficacy of workshops and other sessions intended for parents. Arguably, the lack of parental involvement might result in an insufficient level of knowledge and understanding of their children's disabilities. In this respect, Alnahdi (2007) claimed that a high level of parental involvement with schools improved children's academic performance and behaviour and helped parents obtain more comprehensive information about their children.

Although most parents care about their children's education (Epstein, 2001; Hornby, 2011), their involvement in workshops and training is still lacking. One possible cause of this discrepancy is the educational level of parents (Alshammari, 2017). The findings of the present study showed that nearly 48% and 66% of parents of children with LD or ADHD, respectively, had an educational level lower

than a bachelor degree. Thus, it can be said that the higher the level of parents' education, the higher their tendency to be involved in school events, workshops and educational programmes for their children. Another possible cause of a lack of parental involvement might be that parents actively avoid communicating directly with teachers regarding their children's difficulties and behaviours (Alshammary, 2017). Several studies have indicated that lower academic performance and behavioural issues hinder parents from becoming more involved with schools (Hornby & Lafaele, 2011; Nokali et al., 2010; Seligman, 2000). When parents believe that their children are progressing well, they might be more encouraged to involve themselves in school activities.

Another important cause of a lack of parental involvement is directly related to the location of schools. Parents prefer schools that are located near to their jobs or homes: the farther away the school, the less involved parents are likely to be in school activities. In Jeddah, where this study was conducted, only two schools provide ADHD programmes in mainstream settings. Arguably, then, should the number of schools providing ADHD programmes increase, parental involvement should increase accordingly (Hornby, 2011). The aforementioned causes of a lack of parental involvement has led parents to use social network sites as an alternative means of obtaining information and participating.

The findings of the present study indicate that nearly all parents and teachers use alternative, often online, sources of information, such as social network sites. This trend raises some important points. Both teachers and parents desire to be informed and increase their understanding about LD and ADHD, especially given the lack of appropriate and accessible workshops and training. This desire, coupled with the complexities and contradictions inherent to notions of LD and ADHD, lead teachers and parents to rely on online sources of information. Tansey and Ni Dhomhnaill (2002) reported that 91% of teachers who responded to their questionnaire would attend special workshops and training if they were available online. More specifically, Alnaim (2016) reported that Saudi teachers were keen on attending online courses provided by some disability centres in Saudi Arabia.

It has been claimed that e-learning communities have progressively considered social networks, such as Twitter, to be effective tools for establishing and distributing large amounts of information and knowledge compared with traditional learning methods (Rosell-Aguilar, 2018; Huberman et al., 2008; Kassens-Noor, 2012; McFedries, 2007). As a social network, Twitter increases independent learning by enabling the rapid and frequent exchange of short messages (Jamieson, 2009). Therefore, it has been suggested that e-learning, including social networks, should be an important component for learning (Yang & Lu, 2001). Arguably, parents and teachers use Twitter because it provides substantial knowledge and information better than do traditional social networks (Kassens-Noor, 2012). Twitter also allows users, such as parents and teachers, to follow and communicate with well-known scholars and official organisations. That said, parents and teachers might follow people on Twitter who post senseless or wrong information, since not all accounts are credible or reliable. Therefore, although Twitter has a number of advantages in terms of general learning and education (Rosell-Aguilar, 2018), the MOE should still address the lack of adequate workshops and training.

### **7.3 Strength of ADHD and LD Labels**

One of the key results from the present study was that both ADHD and LD labels have advantages. It was found that LD and ADHD labels help students to find and receive educational support and services. However, the findings also indicated that LD and ADHD harmed or overlooked children, emotionally and psychologically. These findings are consistent with those of Lauchlan and Boyle (2007), Gillman et al. (2000) and Arceneaux (2006), all of whom suggested that labels can pose obstacles to receiving services and educational opportunities.

Although labels have been used for and served academic purposes for decades, the findings from the present study highlight the negative effects of labels on emotional and psychological aspects of children. Thus, the persistent claim that labels open the door to resource is questionable. Children's learning difficulties and misbehaviours can be addressed without attributing labels to them that could adversely affect them emotionally. The perseverance of the belief that assigning labels to children is solely an approach to gaining support is disappointing

(Lauchlan et al., 2017). Even if the idea that a label leads to the provision of support is accepted, the practice of labelling does not represent what a label is supposed to do. In other words, labels are supposed to represent the behavioural content and characteristics of the labelled children. For example, in the term 'learning disability', the prefix *dis* is a Latin root which means *not* or *without*. Thus, disability as a term can be interpreted as 'not having ability' (Gold & Richards, 2012). Similarly, the prefix *dys* in the term 'dyslexia' means abnormal or bad. As another example, the term 'attention deficit hyperactivity disorder' indicates a set of behaviours that require intervention, accommodation and specialised teaching approaches. And yet, even these terms do not fully capture the abilities of labelled children. Therefore, labelling children with a particular label does not provide all the required information to teachers (Kelly & Norwich, 2004).

Arguably, labels seem to be poorly advertised labelled children who have been found not to be accordant to the labels (Arishi et al., 2017). In other words, the practice of assigning labels is unlikely to be consistent with real labelled children's situations and will invariably affect their self-esteem and attached stigma. As stated in the findings of the present study, labels are associated with lower self-esteem, stigma and adverse effects on students and teachers. It has been argued that those who rely exclusively on labels to provide support and provisions sometimes inadvertently attach stigma and negative stereotypes to children, since they fail to think beyond the labels (Boyle, 2014). Concentrating solely on labels can lead to a lack of educational quality and accomplishment, since aspects beyond labels might be affected, such as self-esteem and other emotional expects. For example, the concept of SEN has come to include and construct exclusionary practices within education. If this was indeed the aim for establishing the concept of SEN, then it could be argued that this aim has been achieved.

Norwich (2009) argued that by applying the term SEN, children are inevitably regarded negatively, which in turn leads to the perpetuation of adverse labelling. One more caveat to the persistent claim that labels open the door to resource is an argument made by Haywood (1997), who claimed that labels can be impossible to escape even when a labelled person attains some success in his or her life. Therefore, labels affect children not only in their education contexts, but spill over

into mainstream society as well, leading to possible social exclusion (Gillman et al., 2000). In response to the claim that SEN classifications and labels are used for educational purposes, it might be argued that labelling proceeds well beyond educational contexts regardless of its initial purpose (Norwich, 2009). Additionally, if individuals with SEN are labelled solely for educational reasons, it is almost impossible to change or remove the labels at a later point, even when the labelled person no longer requires the same level of support. Therefore, labels remain attached to children outside their schools and can continue to affect their accessibility to educational and career opportunities in the future (Ho, 2004).

Although labels have been used for many years to provide for children who are labelled with ADHD and LD, they have not been supported with educational equity (Lachlan & Boyle, 2007). It is clearly not logical to identify and label people negatively in order to provide them with support, especially where supportive provisions are given without labelling. It might seem a cynical approach to provide equal educational chances by first obligating children to be labelled and classified (Ho, 2004). Indeed, if labels do *not* lead to improved education, then their value would be legitimately questioned. Despite the persistent claim that labels open the door to resources, would children not be provided with support and legislative aid if they were not labelled? This section is not intended to answer this question, but rather to use it to critique the claim that labels were established to lend legislative support to children.

Another claim made in support of labels is that labelling may lead to increased understanding among students about the nature of their disorder and provide them with comfort, which could in turn lead to increased self-esteem (Riddick, 2010). One possible limitation of Riddick's (2010) study is that it concentrated solely on pupils with dyslexia, which means that findings from the study are not generalisable to all categories of children with different disabilities (Lauchlan & Boyle, 2007). Furthermore, the very argument that the dyslexia label provides children and their parents with comfort is questionable. Arishi et al. (2017), for instance, criticised the argument by claiming that the relief provided to children via the label did not lead to improved opportunities. After assigning dyslexia label to children, did their literacy skills improve, did they become keen and enthusiastic to work hard upon

having the label, or did they have feelings of helplessness and inescapably about their difficulties that led to depreciate their attempts. Those who focus exclusively on the dyslexia label to bring relief to children and their parents often fail to think beyond this purpose to the emotional and psychological welfare of the children (Lauchlan & Boyle, 2014). Therefore, if labels do not lead to improved education and do not consider labelled children's psychological and emotional needs, then the value of labels is legitimately questioned. The following sections of this chapter discuss some effects of labels and, further, the argument that labels fail to proceed beyond their academic purposes.

#### **7.4 Occurrence and Features of Stigma Attached to Labelled Students**

Quantitative findings from the present study showed that teachers and parents gave a high mean score to stigma, as they perceived a high level of stigma to be attached to children with LD and ADHD. Additionally, both parents and teachers thought that stigma was more likely to occur to students in school contexts. For example, students were stigmatised whenever they wrote notes to parents and teachers, discussed their difficulties with peers, or showed poor academic performance and unacceptable behaviours. One of the key qualitative findings, on the other hand, indicated that general teachers were considered significant sources of stigma. General teachers engage in some negative practices, such as threatening children with resource rooms in front of their peers, loudly telling them to go to resource rooms, and reprimanding them based on poor academic performance and unacceptable behaviours.

Prior studies have noted that children with ADHD and LD experience a high level of stigma from peers based on their abilities and behaviours (Al-Ahmadi, 2009; Arceneaux, 2006; Arkin, 2012; Morgan et al., 2010; Riddick, 2000; Shifrer et al., 2013). These studies indicated that children were stigmatised once they were labelled according to their academic shortcomings and misbehaviours. Also, in reviewing the literature, data were found to support the significant role teachers' play in contributing to or minimising stigmas in an educational setting. Since teachers lack knowledge regarding ADHD (Hong, 2008), some studies have reported that teachers have lower expectations about students with ADHD, i.e., they expect the students to perform poorly (Jonson, 2016; Shifrer, 2013). However,



teachers' lack of knowledge is not the only complex element which contributes to stigma; other factors, such as the stigmatised, the stigmatiser, and disorder traits or symptoms, are also involved (Pescosolido et al., 2008). As the present study demonstrated that teachers were sources of stigma who played a crucial role in its perpetuation, it might be worth discussing teachers as stigmatisers. Also, in line with stigma and labelling theories, the teachers' role in perpetuating stigmas will be discussed from different angles, such as the LD and ADHD labels, academic difficulties and misbehaviours, the negative connotation of both labels and teachers' motivations as stigmatisers.

#### **7.4.1 LD and ADHD Labels**

To deeply investigate teachers as fundamental sources of stigma, it is crucial to examine whether teachers perpetuate stigma based on LD and ADHD labels or on academic difficulties and misbehaviours of children. One key finding of the present study is that poor academic and behavioural outcomes are a source of stigma. Several reports have shown that poor academic achievement is seen as the primary criterion for LD labels (Bradley et al., 2007; Fletcher et al., 2005). This means that children who display poor academic performance and behavioural issues might be stigmatised regardless of the appropriate labels. This argument may be in line with Goffman's (1963) definition of stigma as discrediting traits that may negatively influence individuals. Stigma is associated with deviance, which describes prejudicial activities and negative actions towards people with undesirable characteristics. Also, the significance of poor academic performance and misbehaviours to stigma can be linked to labelling theory.

Becker (1963) considered deviance to be associated with those who break roles and standards created by societies. Possibly, poor academic performance and misbehaviours might be the original basis for stigmatising children. Labels are likely to be assigned to individuals who break roles by showing poor academic performance and unacceptable behaviours (Becker, 1963). In other words, labels are less likely to be attributed to people who do not break those roles or who at least do not show poor academic performance or misbehaviours. Therefore, when children do show poor academic performance or misbehave, teachers adopt different approaches to help and support them. For example, students who perform

poorly in mainstream classrooms are likely to be referred to resource rooms for diagnosis and teaching (Alnaim, 2016). Teachers have also been shown to treat children more negatively when they exhibit behavioural problems, such as hyperactivity (Dobbs & Arnold, 2009). Thus, poor academic achievement and misbehaviours can lead to stigma regardless of labels. Riddick (2010) argued that it is not always the case that labels lead to stigma, since stigmatisation can occur in the absence of labels. Although some student referrals are subjectively established based on, e.g., academic achievement and behaviour, and ultimately students are diagnosed on the basis of discordant criteria (Fletcher et al., 2005), teachers are likely to be influenced by children's educational and behavioural outcomes to apply stigmas to them.

As noted above, regardless of outcomes and behaviours, labels themselves can result in stigma. The findings from this study indicated that general teachers and students deal with labelled students differently than they do non-labelled students with similar academic and behavioural issues. These results are similar to those from prior studies, which revealed that teachers deal with labelled students differently regardless of the labels themselves. For example, a study conducted by Dobbs et al. (2004) found that even when labelled children behave appropriately, teachers give them more commands and reprimands, since these children always misbehave. In other words, labels seem to establish a history for each labelled child for his or her poor academic and behavioural outcomes, and hence negative treatment will continue even when he or she behaves. Fox and Stinnett (1996) found that teachers judged the severity of ADHD behaviours, such as disruptiveness, to be higher than the severity of the same behaviours when expressed by those without labels. The labels themselves lead to increased negative expectations about the severity of children's academic and behavioural problems (Ohan et al., 2011), with some arguing that labels automatically lead to stigma (Riddick, 2010).

In line with labelling theory (Becker, 1963), labels may generate stigma by changing the perceptions of others, including teachers, and by validating stratifications. Thus, labels are one possible factor that facilitates the teachers' role in perpetuating stigma. As I discussed earlier, labels such as ADHD refer to several symptoms and

characteristics about which teachers must be sufficiently knowledgeable and adequately trained and prepared in order to work with labelled children appropriately. Yet, teachers in this study were found to be totally lacking in terms of preparation and training in practical aspects of teaching students with ADHD which in turn allowed them to perpetuate stigma through their interactions with labelled children, such as loudly telling them to go to resource rooms and reprimanding them based on poor academic performance and misbehaviours.

Another aspect of labels that contributes to the teachers' role in perpetuating stigma is their reliance on medical knowledge. The findings from the present study indicated that parents perceived the LD label to mean unsuccessful learning by their children, making them more likely to fail and ultimately leading to their and their children's stigmatisation. In line with stigma theory, Goffman (1963, p 29) described courtesy stigma as 'the individual who is related through the social structure to a stigmatized individual'. Parents of children with (and stigmatised by) LD and ADHD might also experience negative attitudes by the public, including shame, stereotyping and stigma (Larson & Corrigan, 2008). It has been claimed that the power of stigma could be reduced by shifting culpability for poor academic performance and misbehaviour to biology (Martin et al., 2007). Parents were reported to have successfully resisted stigma by deploying medical causes of academic and behavioural issues, which were accepted by others, such as teachers (Farrugia, 2009). The significance of teachers' perceptions towards children with disorders such as ADHD should not be underestimated, since the effects of these perceptions might extend beyond school settings and into homes (Ohan et al., 2011). Teachers are likely to be trusted and regarded by parents as a desirable source of advice on childhood disorders, such as ADHD (Pescosolido et al., 2008).

It could be argued that parents deploy medical causes not just to reduce the chance that their children will be stigmatised but also to decrease the effects of stigma should it occur. However, it is not always the case that stigma is reduced by medical knowledge. When teachers rely on medical causes of some conditions, such as ADHD and dyslexia, as the results have shown, they might feel they are no longer responsible for dealing with children who have been labelled with ADHD or dyslexia

(Algraigray, 2015; Hjerne & Saljo, 2004). Due to their lack of knowledge, teachers appear to be influenced by labels into engaging in negative practices towards labelled students, such as overlooking or referring them for evaluation in resource rooms. Thus, although the deployment of medical knowledge by parents might minimise stigma or its effects, it could also facilitate the teachers' role in perpetuating stigma.

#### **7.4.2 Informal Labels and Negative Connotations**

The second factor that might facilitate the teachers' role in perpetuating stigma is the use of informal labels and the negative connotations surrounding them. The findings from the present study showed that pejorative words are often used for children with LD and ADHD. Words such as stupid, thick, crazy and troublemaker have been used by both students and teachers, especially when labelled students fail or disregard their homework. Prior studies have indicated that pejorative words are also used to describe children who have been formally labelled (Kelly & Norwich, 2004; Osterholm et al., 2007; Simoni, 2015). Notably, teachers often label students informally when they do not finish their homework, as the results have shown, and it is commonly agreed that all students occasionally disregard their homework or make mistakes in class. Yet, not all students are labelled informally. Forgetting to complete homework is not a rational excuse to label students with pejorative words. Thus, students who are labelled informally might already have been labelled formally. Also, resource rooms, as one type of informal label, were found to have a negative influence on teachers and students. The findings from this study indicate that general teachers neglect children who are sent to resource rooms. This is because general teachers believe they are not responsible for teaching these students – it is the duty of special teachers. When students are labelled formally, assumptions and beliefs about them are shared (Sowards, 2015).

Negative connotations can be generated by the symbols of formal labels, which can be seen as an element of stigma (Link & Phelan, 2001). The LD label, for example, can communicate negative connotations and stereotypes among general teachers (Shifrer, 2013). Another example is the ADHD label, which increases the severity of problems and leads teachers to perceive behaviours as more disruptive and hyperactive (Ohan et al., 2011). The concept of stereotype has been

associated with stigmatisation and social distance (Osterholm et al., 2011). When children are labelled informally by pejorative words, negative beliefs about them might be both generated and shared. Thus, the teachers' role in stigma may be facilitated by their use of informal labels and negative stereotypes, since these shape teachers' perceptions about labelled children. As noted above, teachers' attitudes and perceptions about labelled children cannot be underrated, as these might shape teachers' practices as well (Ohan et al., 2011). Yet, teachers' lower expectations for labelled students are associated with *their own* perceptions and attitudes, not with students' underachievement (Shifrer, 2013). Although teachers might be unaware that their use of pejorative words and informal labels generates negative stereotypes about children, it nonetheless enhances their role in perpetuating stigma. While the significance of the teachers' role in perpetuating stigma and how it might influence other children is outside the scope of this section, it might be the case that when teachers stigmatise some children in front of others, as the findings of this study have shown (e.g., using informal labels, withdrawing labelled children from classrooms, sending these children to resource rooms – all in the presence of other children), negative stereotypes and connotations are perpetuated among the whole student body, including other teachers and students.

#### **7.4.3 Power and Motivation**

Another element that could facilitate the teachers' role in perpetuating stigma is the power of teachers to assign labels to children. People interested in stigmatising others typically have three motivations to do so: keeping people down, in or away (Link & Phelan, 2014). Keeping people away is defined as 'avoidance of disease or deviations from the organism's normal (healthy) appearance' (2014, p. 25). Deviation includes behavioural anomalies that can strongly motivate stigmatisers to keep some people away through the stigma process. This approach seems similar to labelling theory, whereby, as mentioned, specific roles and standards are created, and those who break those roles are seen as deviants or outsiders (Becker, 1963). In investigating teachers' motivations in stigmatising students, it is important to note that many are often unaware they are doing so. However, their daily practices might convey stigma or support existing stigmatised actions. The authority of labels is grounded within school contexts, where teachers possess

more motivation and power than do parents to enhance stigma (Riddick, 2010; Shifrer, 2013).

The findings from the present study suggest that general teachers refer a large number of students to resource rooms. In some cases, nearly one-half of students in classrooms are referred to special teachers in resource rooms for diagnosis and evaluation. This finding is similar to that of a prior study conducted by Alnaim (2016) in which a large number of students were referred by classroom teachers. Often, when teachers refer children for SEN diagnosis and evaluation, their motivation is revealed (Bradley et al., 2007) – that is, the motivation to enforce a stigma begins with the possession of approaches to transform differences in a widely structured environment, such as via labels or diagnosis (Shifrer, 2013). Teachers in school contexts are motivated towards ‘othering children’, as they have the power to refer students to resource rooms. In the Saudi context, the process of diagnosing children with LD starts with general teachers’ observations and academic records and outcomes. General teachers refer those with lower academic achievement to resource rooms for evaluation and diagnosis. General teachers play a crucial role at the beginning of a child’s referral and diagnosis, as they best leverage from their power to serve their interests. Arguably, teachers have several motivations to stigmatise children with LD and ADHD. First, labels such as LD and ADHD provide little cost for teachers in their professions. Shifrer (2013) argued that LD labels minimise teachers’ responsibilities towards students. Thereby, teachers can refer students with lower academic achievement to resource rooms to reduce their classroom workload. In addition, some teachers might lack sufficient knowledge about teaching students with diverse abilities and may thus prefer to refer these students for special education evaluation and diagnosis. Ho (2004) explained that some teachers were not prepared to deal with children with multiple backgrounds and learning approaches. Teachers may believe that these children need more attention than they can provide in mainstream classrooms. Teachers might also believe that these children will hinder them from teaching the other students effectively in the classrooms. Therefore, the teachers might be motivated to refer these children for diagnosis and evaluation elsewhere.

The present section discusses the teachers' role in perpetuating stigma with respect to three different elements: labels, negative connotations, and power and motivation. Alongside another element, teachers' lack of knowledge, there are other elements that can shed light on the argument that teachers leverage from labels and negative stereotypes to practice stigma. The next section discusses the effects of pulling out programmes, such as the resource room, and how it might contribute to stigma.

### **7.5 Effects of Pulling Out Programmes**

One of the major findings from the present study were the effects of pulling out programmes, such as withdrawing children to resource rooms. It was found that resource rooms affect general students' beliefs towards those educated in these rooms. Resource rooms are viewed by general students as stupidity rooms in which 'stupid and thick' students are educated. It was also found that resource rooms affect children psychologically, as they are a source of stigma. This finding is similar to those of prior studies by Osterholm et al. (2011) and Somaily et al. (2012), which indicated that resource rooms are related to views about the supposed inferiority of children educated in them. Those educated in resource rooms appear to be more susceptible to emotional issues compared with peers in mainstream classrooms (Bryan et al., 2004).

Pulling out programmes are considered one type of informal label, i.e., as spatial reformation (Simoni, 2015). Grouping or withdrawing children based on their academic achievements is an obvious example of labelling theory. Children sent to resource rooms are those who challenge the roles of teachers and schools, whose primary task is to ensure sufficient academic achievement and acceptable behaviour. Students with LD and ADHD are sent to resource rooms to help them improve their academic performance; however, students with LD are withdrawn from mainstream classrooms on a daily basis, while other students can remain. Consequently, withdrawn students are considered to be different by their classmates, which is a mechanism of informal labelling. Although resource rooms play a crucial role in improving the academic skills of children (Somaily et al., 2012), they overlook children's social and emotional skills.

One negative aspect of resource rooms is that withdrawing children from mainstream class is noticeable by other classmates, who are not necessarily aware of formal labels. The findings from this study indicate that children in lower primary school grades might not be aware of some formal labels, such as ADHD. However, they might be aware of other, visible informal labels, such as resource rooms. While formal labels create beliefs and assumptions (Sowards, 2015), informal labels can include more negative assumptions and beliefs shared by those who are aware of these labels.

Another example of informal labelling is the extra time and effort required for writing tasks compared to other students. Writing is problematic for many students with LD because it includes spelling, grammar and concentration. When teachers give students certain tasks that must be accomplished within a certain amount of time but give more time to students with LD, the results can be problematic. Teachers might not be aware of their actions, but general students will perceive of students with LD as 'others'. Although giving extra time to students with LD is common due to their lower academic achievement, it occurs in front of the other students throughout the academic year, which is notable. Osterholm et al. (2011) indicated that withdrawing children from mainstream classes is problematic since classmates are witnesses. If we assume informal labelling to be one type of label in general, resource rooms and other informal labels can spill over into mainstream society, resulting in more exclusion (Gillman et al., 2000).

In other words, both formal and informal labels lead to exclusionary practices and stigmatisation by teachers and students. It has been argued that including children with disabilities in mainstream settings is needed to diminish social and physical differences and thereby ensure equal education for everyone (Osterholm et al., 2011). However, when children with LD and ADHD spend up to 50% of their school day in resource rooms (MOE, 2017), social and physical differences are unlikely to be minimised. Pulling out programmes seem to contradict one of the objectives of inclusion by minimising some children's presence in general classes.



## 7.6 Students' Reactions: 'Hiding Difficulties'

As mentioned, students labelled with LD and ADHD experience many negative consequences, such as stigma, discrimination and stereotypes. These children are reported to experience such consequences from other students as well as from general teachers, as shown in this study. Unfortunately, however, children labelled with LD and ADHD react to such negative consequences by concealing their difficulties.

One of key findings from the present study was that many students attempt to conceal their difficulties. Students with LD were found to conceal their difficulties in school settings in several ways. For example, they attempt to hide from special teachers and avoid participating in classrooms. Teachers and parents perceived lower academic achievement, experiencing stigma from peers and teachers, and teachers' reprimanding as reasons why many students hide their difficulties. Parents indicated that their children attempted to conceal their difficulties after they were diagnosed with LD. However, teachers and parents indicated that it was hard for children with ADHD to hide their misbehaviour because it was unintentional. Thus, stigmatised children, who face discrimination and negative connotations, prefer to conceal rather than acknowledge their difficulties. Goffman (1963) argued that concealing difficulties was a primary coping strategy: 'because of the great rewards in being considered normal, almost all persons who are in a position to pass will do so on some occasion by intent' (p. 74).

Hiding difficulties has been suggested as one possible approach to decreasing stigma and other negative consequences. Stigmatised individuals often anticipate that concealing their stigmatised traits will allow them to make a better public impression about themselves (Brrreto et al., 2006) and thereby increase social acceptance and belonging (Newheiser & Barreto, 2014). However, younger children who conceal their difficulties might face considerable side effects and high future costs, such as anxiety, depression, stress and loss of authenticity (Meyer, 2003; Newheiser & Barreto, 2014). Taken together, concealing difficulties is a complicated strategy aimed at reducing stigma and increasing social acceptance; however, it also leads to inauthenticity and negative well-being. Arguably, those who conceal difficulties still internally experience stigma and other negative effects.

One may wonder why other children who show similar difficulties are not labelled and, ultimately, not stigmatised. This may be because some children are better at concealing their difficulties and thus avoid labels and stigma brought on by, for example, being sent to special teachers and resource rooms. As shown in the findings, some children attempt to hide themselves from special teachers, or at least try not to be seen with special teachers. When children deliberately conceal their labels or other relative indications, it is obvious that their differences and unique needs are neglected (Lauchlan & Boyle, 2007). Also, when children seek to hide their labels and yet still fail to decrease their stigma, they might believe that attributing labels is not safe. Therefore, concealing stigmatised traits or labels is likely to be maladaptive (Newheiser & Barreto, 2014), which might in turn lead some children to develop different ways, such as acknowledging their difficulties.

The findings from the present study propose that some children with LD and ADHD acknowledge their difficulties by stating clearly that they 'cannot understand'. In some cases, such as with students with ADHD, teachers have mentioned that these students cannot control their behaviour and therefore cannot hide their difficulties. When stigmatised children reveal their difficulties to their teachers, they attempt to shift the issues from themselves. In other words, these children might acknowledge their difficulties as an excuse to avoid or at least lessen blame and stigma (Connolly, 2011). This might be similar to how parents deploy medical justifications for their children's academic and behavioural issues to reduce stigma (Farrugia, 2009). Unfortunately, acknowledging difficulties often fails to eliminate the attached stigma. Thus, neither revealing nor concealing difficulties (Goffman, 1963) eliminates or reduces stigma.

Prior studies by Meyer (2003) and Newheiser and Barreto (2014) identified several drawbacks of concealing stigmatised traits that lead to other negative consequences. In addition, revealing difficulties might be used by children to exploit their label. The findings from the present study revealed that some children acknowledged their difficulties in order to avoid lessons. One may ask how teachers allow labelled children to leave classrooms. They may do so because they do not feel responsible for working with labelled children. Another possible exploitation of labels by children to leave classroom refers to their beliefs of labels:

Children might believe that the label means undesirable behaviour and lower academic achievement, which would in turn mean they are unequal to their peers and deserve to be segregated (Link et al., 2004). Arguably, the issue is not whether revealing or concealing difficulties works better in reducing stigma, since both approaches fail to do so. On the contrary, the issue is that labels are assigned to children without considering beyond the labels (Boyle, 2014). When children fail to decrease their stigma and other negative consequences by either revealing or concealing difficulties, the attribution of labels is not safe and can in fact be harmful.

This discussion on the effects of labels has revealed some important points. According to Boyle (2014, p. 3), investigating whether labels are beneficial 'seem[s] to always be a poor second to the somewhat engrained human obsession of categorisation'. As many bureaucratic systems operate in this way, labels, whether beneficial or harmful, are unavoidable (Boyle, 2014). Labels were proposed to determine the support and help that children need. Considering the discussion, the drawbacks of labelling seem to outweigh its advantages. In other words, labels are no longer considered a productive aspect in the lives of labelled individuals (Riddick, 2000). It has been argued that labels do not always provide pedagogic support (Daniels, 2006). One dilemma that has been highlighted by Norwich (1999) is that stigmatisation and other negative connotations are likely to exist when children are identified or labelled; however, if they are not labelled, then they do not have accessibility to resources. Another dilemma is the continuous use of labels despite the harm they inflict on students, parents and general teachers, such as the failure to reduce stigma. The next section will discuss the future of LD and ADHD labels and will make some relevant suggestions.

## **7.7 Future of LD and ADHD Labels**

Participants in the present study indicated that the current labels, LD and ADHD, describe shortcomings and dysfunctions in children. They suggested that these labels should be changed to more positive ones. LD and ADHD teachers indicated that they had used some words instead of formal labels, such as 'we can'. They also suggested some other labels that can be used in school contexts, such as remedial lessons. The debate over the benefits and drawbacks of labels is ongoing. However, the present study highlighted several drawbacks of labels and how they

influence teachers to use and facilitate stigma. Although labels were claimed to have positive points, such as opening doors to resources and provisions (Lauchlan & Boyle, 2007), they nonetheless failed to provide all required information to teachers (Kelly & Norwich, 2004). Arguably, the labels LD and ADHD have enhanced the ideology of dysfunctions. The LD label refers to learning difficulty, which facilitates the meaning of hardness in learning. ADHD, another example, refers to several behaviours, such as lack of attention and hyperactivity. Similarly, the term 'disabled' enhances the ideology of ableism (Harpur, 2012). Therefore, these terms and definitions conceptualise labelled children by making them different based on dysfunctions. Consequently, these children have experienced several drawbacks and negative effects (Harpur, 2012).

The common sentiment about such labels is not that they secure appropriate provisions for labelled children; rather, their negative connotations receive most of the attention. In addition, these labels seem to neglect differences among children, which in turn facilitates assumptions about homogeneity in which there is no chance of determining frameworks to adopt diversity in learning and teaching approaches. Therefore, the main issue with LD and ADHD labels are their negative impacts. Lauchlan et al. (2017) viewed it as disappointing that negative labels based on irrational beliefs persist but that many children will be overlooked if these labels are diminished. This section does not argue for eliminating labels; however, it does aim to contribute to arguments made in prior work that have suggested less severe labels (Algraigray & Boyle, 2017). Ho (2004) stated that 'Pathologizing learning difference may be unnecessary or even counterproductive if we presume that all children learn in their unique ways. It is more productive to design flexible curricula that can accommodate learning diversity' (p. 86). As this study showed, many labels have negative prefixes, which has led others to understand them negatively and, more importantly, has facilitated stigmatisers, such as teachers, to perpetuate stigma. It might, therefore, be a good time to replace these labels with less severe, more neutral alternatives. Negative stereotypes and pejorative words were argued to be enhanced and facilitated by formal labels which highlight the dysfunctions of students.

Although labels are unavoidable (Boyle, 2014), there is a need to consider the negative impacts associated with labels for individuals and to replace them with more neutral alternatives. For instance, Norwich (2009) suggested that labels should be assigned to children according to the different levels of support they receive. The Scottish education system, for example, replaced the term 'SEN' with 'additional support needs' (ASN) (William et al., 2009). ASN has a much broader definition of support needs based on children's needs, including issues of bereavement or educational difficulties, 'which would not normally be related to special educational needs' (Algraigray & Boyle, 2017, p. 11). Another example can be found in the United Arab Emirates, where they recently established the term 'people of determination' (The Official Portal of UAE, 2019). In 2010, 'people with special needs' was replaced by 'people with disability', which was itself replaced by 'people of determination' in 2017. This term is in use for education opportunities, rights, care, training and rehabilitation. The term 'people of determination' is used in UAE policies and rules of inclusive education. For example, Quality Standards of Services for People of Determination in Government and Private Institutions use this term (The Official Portal of UAE, 2019). In addition, the General Entertainment Authority in Saudi Arabia began to use the term 'people of determination' instead of 'people with disability' since its establishment in 2016 (General Entertainments Authority, 2019). The term 'people of determination' seems to be more neutral than the term 'people with special needs'.

Determination here does not refer to a limitation but rather to high intention and supreme purpose. To the best of this researcher's knowledge, no study has thus far been conducted to measure the effects of the label 'people of determination'. It is also unclear whether children with ASN in Scotland experience exclusionary practices. However, it might be argued that if terms that highlight children's difficulties and misbehaviour are eliminated, then the consequences of exclusionary practices might also be removed (Algraigray & Boyle, 2017). It might be cynical that children with LD and ADHD who are stigmatised by their labels are asked to conceal their difficulties (Goffman, 1963) and to resist the negative connotations of labels while society and teachers are asked to have positive attitudes and undertake positive actions without changing the labels. Persistence in doing so, might be highly demanded, more consumed time and importantly leaving labelled children to suffer from the negative consequences of labels. One

may argue that changing the current labels might lead to increased ambiguities and lack of clear communications among professionals. However, there is no obvious agreement among professionals about how classifications and labels are decided (Lauchlan & Boyle, 2007). Also, the current system of assigning particular labels to children does not provide the required information to teachers (Kelly & Norwich, 2004).

# Chapter Eight

## Conclusion

### 8.1 Introduction

The objective of this chapter is to conclude the thesis by providing a summary of the study and its results. The chapter evaluates the importance of this thesis by illustrating its contributions, its strengths and its limitations. The chapter will recommend some actions regarding the phenomenon of LD and ADHD labels. Finally, the chapter will end with the author's reflections and personal learning experiences gained during the journey of composing this thesis.

### 8.2 Summary of the Study

The current study aimed to explore the advantages and drawbacks of LD and ADHD labels on labelled children, general students and general teachers. This exploration was based on teachers and parents of children who were labelled with LD and ADHD in primary mainstream schools in Jeddah, Saudi Arabia.

The study began with a background of the Saudi context regarding SEN in general and a historical overview of LD and ADHD programmes in particular. It evaluated the provisions given to children labelled with LD and ADHD and also assessed the SEN policy in the Saudi context. Furthermore, the study reviewed the existing literature and provided critiques of the field of SEN and labelling of children with LD and ADHD. It also highlighted relevant theories regarding the phenomenon of labelling and illustrated how these theories are implemented in the field of LD and ADHD labels. Labelling theory (Becker, 1963) and stigma theory (Goffman, 1963) in particular were linked to current research on the phenomenon of labels.

A mixed-method design was adopted to answer the research questions posed by the study. In particular, an explanatory sequential design was used in which quantitative data were gathered first, followed by qualitative data. This approach allowed the researcher to obtain a deep understanding as he used words (qualitative phase) to give meanings to numbers (quantitative phase), and vice versa. Combining the quantitative and qualitative approaches provided the researcher with enhanced opportunities to build on the strengths of each approach. A closed-ended questionnaire was distributed to parents of children with LD and

ADHD and LD and ADHD teachers in primary schools in Jeddah. The aim of the questionnaires was to gain a general and broad picture of the phenomenon of labels. Then, in-depth information and understanding were obtained by interviewing a purposeful sample of four LD and ADHD teachers in primary schools and four parents of children with LD and ADHD. In addition, eight semi-structured interviews were conducted to answer the research questions and serve the research agenda. Trustworthiness and credibility for the qualitative findings were established, and validity for the quantitative findings was verified.

The quantitative findings indicated a high mean score in general, which suggested that participants perceived stigma, lower self-esteem and potential adverse effects of informal labels on children with LD and ADH and on their general teachers as well. Thus, information collected from the quantitative phase about LD and ADHD teachers' and parents' perceptions supported the researcher in interpreting and integrating some of their perceptions and practices concerning labels that appeared later on in the qualitative phase. Nine themes emerged from the qualitative findings that together answered the research questions. How the findings are linked to the research questions is discussed below.

### **RQ 1 How do primary school teachers and parents view and perceive ADHD and LD labels?**

This research question was answered by the Quantitative Findings in the first phase. As mentioned, the aim of this phase was to obtain a general, broad picture of the phenomenon of labels. Thus, the questionnaire contained five sections besides personal information. The first section concerned stigma attached to children with LD and ADHD. LD parents, ADHD parents and ADHD teachers perceived a slight stigma attached to children labelled with LD and ADHD; whereas LD teachers perceived a severe stigma attached to children diagnosed with LD. The second section concerned the self-esteem of labelled children. All types of participants perceived lower self-esteem in children due to LD and ADHD labels. In the third section, which was concerned with informal labels, LD parents, ADHD parents and LD teachers perceived slight effects of pejorative words and informal labels on children; whereas ADHD teachers perceived severe effects on children. The fourth section pertained to the potential outcomes of labels, in which participants perceived children to have negative outcomes in social and academic



skills. The final section concerned the effects of labels on teachers. ADHD teachers and parents perceived severe effects on general teachers regarding the ADHD label. Therefore, I argue that the first phase succeeded in providing the general information needed about LD and ADHD labels, which in turn allowed this information to be deeply explored and integrated with the data that emerged in the second phase.

**RQ 1-A- How do primary school teachers and parents perceive the strengths of applying ADHD and LD labels to children?**

Building from the quantitative results, two themes emerged from the qualitative findings to answer the second research question. The first was the knowledge and experience of teachers and parents regarding LD and ADHD labels. Parents had a lack of involvement in workshops and training about the difficulties their children suffer from. Although they were used as an alternative source of training, the workshops allowed parents to understand the complexities surrounding their children's disability. Parents had negative and different understandings about the concepts of LD and ADHD. Due to the lack of a single, agreed-upon definition of LD and ADHD, parents' lack of training and knowledge about both terms exacerbated and negatively shaped their perceptions regarding those labels.

On the other hand, teachers were found to attend a large number of workshops and training regarding LD and ADHD. However, their involvement in workshops was insufficient to cover the gap between theoretical preservice preparations at universities and actual practice. ADHD teachers especially were not prepared with special courses in their preservice preparation. Worse, preservice preparation was not followed by more practical workshops and training at the in-service level. In other words, labelling and its associated consequences, such as stigma, cannot be isolated from social and practical relations nor attributed only to labels (Shifrer, 2013). Therefore, the nature of teachers' preparations and the workshops they attended aggravated their understandings of LD and ADHD. Arguably, the ultimate results of their preparations shaped their actual practices with labelled children.

The second theme that answered this research question were the advantages of ADHD and LD labels. It was found that labels have some positive effects on the academic performance of children. However, the claim that labels can open up

resources to labelled children is questionable. It is not rational to attribute to children labels that manifest their dysfunction and shortcomings in order to allocate resources for them. Notwithstanding the positive aspects of labels, when compared with negative aspects, the claim that labels are advantageous is neither logical nor supported. Even if this claim is solely intended to provide labelled children with appropriate provisions that match their needs, these children are still not provided with educational equity. Questioning this theme presented the answer to the third research question.

### **RQ 1-B- How do primary school teachers and parents of children with LD and ADHD perceive the negative impacts of these labels?**

Five themes emerged from the qualitative findings that answered this research question (See Table 21). Some of these themes were combined in the discussion to make the argument clearer and more rational. The first theme was the occurrence and features of stigmas attached to labelled children. Labelled children were stigmatised by their peers and teachers based on their academically lower achievement and misbehaviours. I argued that stigma was a complicated issue and linked it only to the lack of teachers' knowledge and understanding. In line with labelling and stigma theories (Becker, 1963; Goffman, 1963), I discussed the teachers' role in facilitating and enhancing stigma. The teachers' role as stigmatiser was discussed in terms of the labels themselves, informal and negative connotations, and the power of teachers in school contexts. Although stigma was claimed to be linked with lower academic achievement and misbehaviours, I argued that labels aggregated teachers' practices towards labelled children, since non-labelled children who display similar issues have not experienced stigma.

Teachers' reliance on medical knowledge of LD and ADHD have facilitated their role as stigmatisers. Informal labels were argued to be another element that facilitated teachers' role as stigmatisers. I argued that informal labels and negative stereotypes were likely associated with formal labels rather than with lower academic achievement or misbehaviours. Teachers' motivations and power in school contexts were considered as an element that plays a crucial role in teachers' stigma practices. In line with labelling theory, I argued that teachers have set rules in schools, and students who break them get referred to resource rooms. Teachers

practised their power by referring a large number of students to resource rooms for SEN evaluations. While teachers have insufficient knowledge and lack preparation, they prefer to refer students for evaluation, since they lack the necessary and required skills to deal with labelled children. Those three elements together facilitated teachers to enhance their roles as stigmatisers.

Another qualitative theme that answered the third research question was the effect of pulling out programmes. Similar to formal labels, I argued that resource rooms as one type of informal label were supposed to be helpful academically. However, they have found to be harmful on the psychological aspects of children. Children who are withdrawn to resource rooms are likely to be neglected and overlooked by general teachers. It has been argued that inclusive education was proposed to diminish the social and physical differences between children with disabilities by ensuring equal accessibility to general education. However, I argued that these differences are not likely to be minimised, since such children are withdrawn from mainstream classes for one-half of their school days. Furthermore, concealing stigmatised difficulties was proposed as an effective approach to minimising the stigma attached to children (Goffman, 1963). I argued that this approach seemed to be maladaptive for two reasons. First, if children are able to conceal their difficulties, they might then pay a high cost in terms of other negative side effects, such as depression and inauthenticity. Second, concealing stigmatised difficulties is not always the right way, since some children, ADHD children for example, cannot control their misbehaviours. Ultimately, when children have the desire to hide their difficulties but nonetheless fail to decrease their stigma, attributing labels to them is not safe, despite its claimed advantages. This argument shed light on the future of using labels and answered the final research question.

#### **RQ 4 What do primary school teachers and parents predict regarding the future of ADHD and LD labels?**

Considering the effects of labels and the previous qualitative themes that addressed the third research question, this study also questioned the future of labels. The fourth research question concerned the future of labels based on themes that emerged from the qualitative findings. I argued that current labels and definitions conceptualise labelled students' differences based on their

dysfunctions. Thus, the claimed goal that labels open up resources does not work. These labels facilitate beliefs about homogeneity and diminished opportunities for adapting to a diverse framework and teaching styles. Therefore, more neutral labels were suggested to replace current labels. I argued that the current labels' prefixes have facilitated others to understand them negatively. Although labels were claimed to be unavoidable, I argued that they could be more positive. Examples from some countries were evaluated, such as the Scottish education system, where ASN is used, and the UAE, which has adopted the term 'people with determination'. I am not arguing for the adoption of these new terms; however, I do argue for the possibility of selecting positive, or at least neutral, alternatives. This might be less costly, more realistic and more applicable than asking labelled, stigmatised children to hide their difficulties while expecting teachers and society at large to have positive attitudes towards them.

### **8.3 Contribution of the Study**

This study has contributed to knowledge, theory and methodology. Before this research, previous studies suggested that teacher's knowledge and understanding of LD and ADHD is fundamental factor. However, this study indicated that the issue of labelling is complicated but should not be solely attributed to labels. By considering labelling and stigma theories in this study, other factors such as teachers' lack of knowledge, teachers' understanding of terms, informal labels, power and motivation of teachers should be considered as well. Therefore, this study contributes to the existing knowledge of labelling and stigma by providing more factors that enhance stigma. The negativity associated with LD and ADHD in their terms, negative connotations, stereotypes, power and motivations were related to teachers' roles in stigma.

In line with labelling theory, the study indicated that informal labels and pejorative words are associated with attributing formal labels. Pulling out programmes, as one feature of informal labels, have negatively impacted general teachers, general children and labelled children. This study contributed to knowledge by explaining the relationship between resource room and teachers' exclusionary practices. Resource room as an example of pulling out programmes prevents the implementation of effective inclusion of children with special needs. Including children with special needs in mainstream setting was established to diminish

social, academic and physical differences and therefore ensure equal education for children. However, the way that pulling out programmes are implemented in Saudi schools does not enhance the idea of inclusion. When nearly half of mainstream class students are transferred to and thereby spend up to 50% of their school day in resource room not only contradict the objective of inclusion. Rather, it facilitates teachers and general students to perpetuate stigma.

This work contributes to existing knowledge about labelling by exploring two different categories of disability: LD and ADHD. Doing so expanded our understanding of labels and its associated negative outcomes. Studying one category would have prevented the acquisition of wider knowledge about the phenomenon of labels. Some issues of the LD label might be different from issues of the ADHD label, such as the inability to conceal stigmatised difficulties by children labelled with ADHD. To the best of my knowledge, the present study is the first to have been conducted in the Saudi context on the phenomenon of LD and ADHD labels. Thus, this new understanding of labels should help to improve and minimise the effects of labels in Saudi Arabia.

Theoretically, the present study offered an analytical approach in which both labelling and stigma theories were combined and used as lenses. In line with labelling theory (Becker, 1963), schools set rules, and those students who break the rules are labelled. Once children are labelled, they experience several effects, such as negative stereotypes, stigma, social distance and different treatment from teachers. Based on the findings of this study and in line with labelling theory, pejorative words and negative stereotypes are linked with formal labels. The prefixes and terms of LD and ADHD highlight students' difficulties and misbehaviours, which in turn lead teachers and other students to understand them negatively. Therefore, an important insight gained from this study is that the more negativity a label has, the more negative stereotypes and pejorative words are established and used to describe it. This might be more likely to occur while teachers have lack of knowledge and lack of effective preparations programs, as the finding suggested.

The insights gained from stigma theory have extended our knowledge of stigma and how teachers' roles are facilitated. However, the findings reported here shed

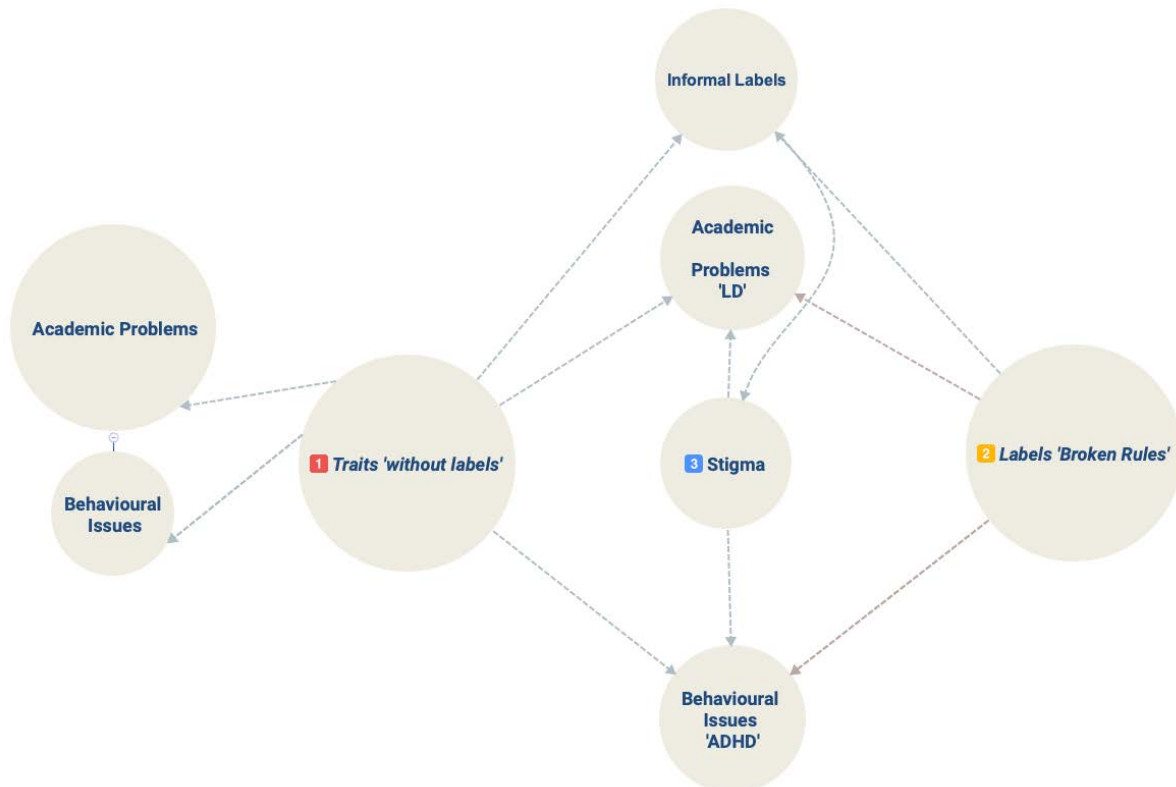
new light on the ineffectiveness of concealing stigmatised difficulties and behaviours. Goffman (1963) indicated that concealing stigmatised difficulties and behaviours might decrease the level of stigma. The present study suggested that this approach is maladaptive and inappropriate for primary school children labelled with LD and ADHD in the Saudi context. Concealing stigmatised difficulties has side effects on children, such as losing authenticity, depression and anxiety. Furthermore, children who are diagnosed with ADHD cannot control their misbehaviours, and it is therefore difficult for them to conceal their stigmatised behaviours. In addition, children with LD are stigmatised when they are withdrawn to resource room. Concealing resource room as stigmatised trait seems difficult. Therefore, concealing stigmatised traits can be hard to do for children with LD and ADHD. This approach cannot be implemented with all stigmatised traits, especially these are imposed to students, such as pulling out programmes. Concealing stigmatised traits is beyond the children ability, especially those in primary schools. Thus, this study was useful in expanding our understanding of how concealing stigmatised difficulties and behaviours is ineffective for labelled children in primary school.

The insights gained from both labelling and stigma theories in this study indicated relationship between both theories and traits (see Figure 11). The link between both theories elucidates the process of stigmatising children with LD and ADHD. First, traits or symptoms should break set of rules and standards in schools. Findings from this study suggested that not all academic or behavioural traits are labelled. Some children who show academic problems or behavioural issues have not been diagnosed and thereby not labelled. The findings also suggested that non labelled children who display academic problems and behavioural issues have not experienced stigma. Second, stigmatised traits are perpetuated by formal labels, informal labels and its negative connotations. When children are labelled by their academic problems and behavioural issues they are no longer considered as individuals but as part of outsider groups. This new understanding should help to reconsider labels in the field of special needs and disabilities in general, and LD and ADHD in particular.

Lastly, the present study contributed a methodology to the study of labels. As mentioned in the Methodology chapter, some scales of the questionnaires were

created by the researcher to examine the potential outcomes of labels and the effects of labels on teachers and school staff. These scales were created based on the available literature, and their validity to measure what they were supposed to measure was ensured. Future researchers can use this scale in the field of labelling of children with disabilities.

**Figure 11 (Relationship between traits, labelling and stigma theories)**



#### 8.4 Limitations and Strengths of the Study

Although the current study achieved its goals, it was exposed to the risk of subjectivity from both the participants and the researcher. However, as mentioned in the Methodology chapter, every effort was made to avoid subjectivity by conducting validity, trustworthiness and credibility checks. Further, the present study was conducted to explore teachers' and parents' perceptions and views regarding LD and ADHD labels in primary schools in Jeddah. It would have been even more valuable if the study had considered labelled children's perceptions. However, limited time and space concerns forced the exclusion of this topic. The most important limitation is that the number of ADHD participants was low. However, as I explained earlier, only two schools in Jeddah run inclusive education

programmes for children with ADHD. Thus, the short number of participants was based on the small number of schools.

Notwithstanding the relatively limited sample, the present study employed a wide range of participants: LD parents, LD teachers, ADHD parents and ADHD teachers. This in turn allowed me to more deeply understand the phenomenon of labels from different perspectives. In addition, using two different methods of data collection provided me with enhanced opportunities to build on the strength of each tool. Lastly, exploring the effects of labelling children from two different categories of disabilities gave the study more insights and deeper understanding. Thus, the major strength of the present study was its diversity of participants, methods, the use of two relative theories regarding the phenomenon and categories of disabilities.

## **8.5 Implications and Recommendations**

The current study offered substantial information regarding the complexities surrounding LD and ADHD labels based on the perceptions of teachers and parents. Thus, I can offer several implications and recommendations for teachers, parents, policy makers and future researchers in the field of labelling. The following implications and recommendations should be considered to minimise the effects of labels and teachers' role in perpetuating stigma, as well as to develop future research.

### **8.5.1 Parents**

Findings from the present study indicated that parents lack knowledge and training concerning the difficulties their children face. As a result, they understood LD and ADHD labels negatively. Since specialised workshops and training were insufficiently provided to parents by the MOE, parents should seek out alternative sources, such as social network platforms. This might compensate for deficiencies and allow parents to use more open and wider sources of information, such as specialists and specialised centres for disabilities, which have verified Twitter accounts.

Furthermore, parents should be aware of the drawbacks of labels and how their children can suffer as a consequence. They should also be aware that they might



be affected by labels as well. Thus, their level of participation with schools and level of knowledge and information about the difficulties their children face might alleviate some of the potential negative impact they could receive. As parents in this study sought to register their children in resource rooms, parents in general should consider the negative impacts of resource rooms and labels besides their positive points. As parents were reported to deploy medical reasons to teachers in order to minimise blame on them or their children, parents in general should be aware that this approach might lead teachers to neglect responsibility for their children.

### **8.5.2 Teachers**

The quantitative and qualitative findings highlighted teachers' negative understandings of both LD and ADHD labels. This was attributed to the nature of preservice preparations and to a lack of in-service follow-up training and workshops. Thus, teachers should be more involved in practical follow-up training and should further develop their knowledge by using online sources and social network sites.

Teachers were found to refer a large number of children for SEN evaluation and diagnosis in resource rooms. This led to disruptions in the work of LD teachers, since they need to diagnose all referred children and could ultimately struggle to distinguish between students with LD, slow learners, lower achievers and careless students. Thus, teachers must rethink their approach of referring children to resource rooms and should consider that not everyone who demonstrates academic difficulties should be withdrawn to resource rooms.

Teachers were reported to rely on medical causes of ADHD, which made them feel like they were not responsible for working with children with ADHD. Thus, teachers should minimise reliance on medical sources and rethink other intervention types, such as behavioural and academic intervention. Teachers should remember that they are responsible for working with children diagnosed with LD. Teachers should also be aware that having the labels of LD or ADHD should not hide the strengths of labelled children.

The findings from this study indicate that LD and ADHD teachers have provided ineffective or insufficient workshops to parents and general teachers. This has led

to a lack of parental involvement, since parents are not interested in attending these sessions. Special teachers (LD and ADHD) should engage in and motivate parents by providing more effective and practical workshops to initiate parental involvement. Special teachers should also consider general teachers by organising workshops that addressed to their lack of awareness and misperceptions about labels and resource rooms.

### **8.5.3 Policy Makers**

The present study found only two schools in Jeddah that run mainstream ADHD programmes. This low number of schools has led to a lack of parental involvement and made including children with ADHD more difficult. Thus, policy makers should consider increasing the number of schools to facilitate more inclusive education for children with ADHD. Furthermore, both phases of this study found that ADHD teachers were not qualified with specialised preparations in Saudi universities. Although teachers were provided with follow-up workshops and training, these follow-ups were concerned more with theoretical issues about ADHD than practical ones. Policy makers should consider these limitations and establish more effective preparation programmes to qualify ADHD teachers. Follow-up training should focus more on the practical issues of LD and ADHD to enhance teachers' practices. Parents were found to have neglected workshops that did not address their concerns. The MOE should consider parents as fundamental partners and support them in dealing with their children.

As mentioned earlier, general teachers had more resilience and authority in referring children to resource rooms for evaluation and diagnosis. As mentioned in chapter two, general teachers have the authority to refer students by reviewing the list of students who retook courses or failed. Policy makers should rethink the policy of referring children and consider clear mechanisms for the implementation of pulling out programmes. Better implementation might minimise the large number of students referred to resource rooms. More importantly, findings from both phases identified several drawbacks of LD and ADHD labels on labelled children, their parents and general teachers. The MOE should take into consideration these negative effects and rethink these labels. As discussed in the Discussion Chapter, addressing children's needs by labelling them with harmful labels, thereby leading

them to negatively experience their associated impacts, and asking teachers and others to have positive attitudes and practices is unrealistic. Thus, policy makers should consider less costly and more applicable solutions, such as using more neutral labels. Examples were mentioned from different educational systems internationally to demonstrate the possibility and timeliness of such a change.

#### **8.5.4 Scholars and Future Research**

Although the present study provided substantial information and deep understanding about the effects of LD and ADHD labels, it also suggests some pathways for future studies. Since this was the first study conducted in the Saudi context, it might serve as the foundation and background for future studies in the field of labelling. Future studies should consider larger, randomised, controlled trials in order to have the option to generalise the results to wider and more representative samples in the Saudi context. The study should also be repeated, considering other cities and different factors that would contribute to knowledge about labelling issues in the Saudi context.

Since this study did not include labelled and general children's perceptions, considerable more work will need to be done to explore the phenomenon of labels from other angles. More broadly, research is also needed to determine general students' roles in stigma and other negative effects of labels. Exploring general and labelled children's perceptions could lead to significant insights in the study of labels. Finally, this research raised the question about the use of more neutral labels in Scotland and UAE. Terms like 'additional support needs' and 'people of determination' have been introduced internationally. Examining the use of both terms and whether they are beneficial or harmful could shed important light on the field of labelling.

#### **8.6 Personal Reflection**

Conducting this study in four years' time was challenging (and interesting) in many aspects. From this journey of learning, I emerged into an educational-philosophical paradigm in which I familiarised myself with ontological, epistemological and methodological assumptions. As a result, I had opportunities to adopt the appropriate methodology to conduct this study, to answer the research questions, and to meet the study's other objectives. Via the type of learning I received, in

which professionalism was key, I had the chance to link theoretical knowledge about labelling with actual practices in the Saudi context. Conducting this study on a diversity of participants, methods and categories of disabilities allowed me to obtain a broad understanding of the phenomenon of labels, since I conducted extensive readings. In addition, gathering the data, as an essential requirement of this study, granted me wider knowledge and information regarding the Saudi system and policies of special education. Throughout this study, I acquired helpful skills, which I learned using several software programmes to organise and analyse the data. Importantly, these skills will help me throughout my future academic career. Therefore, the considerable knowledge, experience and transferrable skills I have obtained have encouraged me to continue conducting additional research in the fields of labels and special needs in particular.

## References

- Abed, M., Pearson, S., Clarke, P. and Chambers, M. (2014) 'Saudi Arabian teachers' knowledge and beliefs about ADHD', *Journal of the International Association of Special Education*, 15(1) 67-75.
- Afeafe, M. Y. (2000). Special education in Saudi Arabia. Retrieved from <http://www.khayma.com/education-technology/PrvEducation3.htm>. Access date: 09/11/2018.
- Alexander-Passe, N. (2015). The dyslexia experience: Difference, disclosure, labelling, discrimination and stigma. *Asia Pacific Journal of Developmental Differences*, 2(2), 202-233.
- Al Hamed, J. H., Taha, A. Z., Sabra, A. A., & Bella, H. (2008). Attention deficit hyperactivity disorder (ADHD) among male primary school children in Dammam, Saudi Arabia: Prevalence and associated factors. *J Egypt Public Health Association*, 83(3-4), 165-182.
- Al-Ahmadi, N. A. (2008) *Teachers' perspectives and attitudes towards integrating students with learning disabilities in regular Saudi public schools* (PhD thesis). Retrieved from ProQuest Thesis and Dissertation Global. (Accession No 3371476).
- Aldabas, R. A. (2015). Special education in Saudi Arabia: History and areas for reform. *Creative Education*, 6(11), 1158-1167.
- Aldaihani, M. (2011). *A comparative study of inclusive education in Kuwait and England*. (Ph.D. thesis, University of Birmingham, Birmingham). Retrieved from <http://etheses.bham.ac.uk/1547/>.
- Aldosari, M. S. (2013). The differences in the levels of stress between fathers and mothers of children with intellectual disabilities in Saudi Arabia. (Doctoral thesis). Retrieved from ProQuest Thesis and Dissertation Global. (Accession No 3605397).
- Alfaiz, H. S. (2006). *Attitudes of elementary school teachers in Riyadh, Saudi Arabia toward the inclusion of children with autism in public education* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (UMI NO. AAT 3262967).
- Algraigay, H. & Boyle, C. (2017). The SEN label and its effect on special education. *Educational and Child Psychology*, 34(4), 70-79.
- Algraigay, H. (2015). *Teachers' and parents' knowledge and perceptions regarding challenges and opportunities of setting up diagnosis and interventions programmes for pupils with ADHD in Saudi Arabia*. Unpublished dissertation. University of Exeter, Exeter.
- Alkahtani, K. D. (2013) 'Teachers' knowledge and misconceptions of attention deficit/hyperactivity disorder', *Psychology*, 4 (12), 963-969.
- Almoady, S., Bokhary, Y., Alhawas, M., Almayah, S., & Alabdullatif, S. (2013). *The guidebook for teachers of learning disabilities*. Riyadh: Ministry of Education.
- Almosa, N. (2008). *The journey of special education in the Kingdom of Saudi Arabia from isolation to inclusion*. Dar Alqalam. Dubai, UAE.
- Al-Mousa, N. (2010). The experience of the Kingdom of Saudi Arabia in mainstreaming students with special educational needs in public schools (a success story). The Arab Bureau of Education for the Gulf States, Saudi Arabia: Riyadh.

Al-Nahdi, G. H. (2007). The application of the procedures and standards of assessment and diagnosis in mental education institutes and programs as regards Regulatory Principles of Special Education Institutes and Programs in Saudi Arabia. *Unpublished Master's thesis*. King Saud University, Saudi Arabia, Riyadh.

Alnaim, F. (2015). Approaches for the identification of dyslexia. *International Journal of Advances in Science Engineering and Technology*, 3(2), 67-69.

Alnaim, F. (2016). *Identification strategies in the Saudi Learning Disabilities Programme: Primary teachers' perspectives* (Doctoral dissertation). Retrieved from ProQuest Thesis and Dissertation Global. (Accession No 10806424).

Alobaid, M. A. (2018). *Parental participation in the education of students with learning disabilities in Saudi Arabia* (PhD). Retrieved from ProQuest Thesis and Dissertation Global. (Accession No 10928161).

Alothman, A. (2014). *Inclusive education for deaf students in Saudi Arabia: Perceptions of school principals, teachers and parents* (Doctoral thesis, University of Lincoln, England). Retrieved from <http://eprints.lincoln.ac.uk/19026/>.

Alqahtani, M. M. (2010). Attention-deficit hyperactive disorder in school-aged children in Saudi Arabia. *European Journal of Pediatrics*, 169(9), 1113-1117.

Alqallaf, B. (2015). The social participation of children identified as having moderate learning difficulties/slow learning and the different ways of assessing such children in Kuwait and England (a comparative study) (PhD thesis). Retrieved from: <https://ore.exeter.ac.uk/repository/handle/10871/19281>.

Alquraini, T. (2010). Special education in Saudi Arabia: Challenges, perspectives, Future possibilities. *International Journal of Special Education*, 254(3), 139-147.

Alquraini, T. (2012). Factors related to teachers' attitudes towards the inclusive education of students with severe intellectual disabilities in Riyadh, Saudi. *Journal of Research in Special Educational Needs*, 12(3), 170–182.

Alquraini, T. (2013). Legislative rules for students with disabilities in the United States and Saudi Arabia: A Comparative Study. *International Interdisciplinary Journal of Education*, 2(6), 1-14.

Alshahrani, M. M. (2014). Saudi educators' attitudes towards deaf and hard of hearing inclusive education in Jeddah, Saudi Arabia. (Doctoral thesis). Retrieved from ProQuest Thesis and Dissertation Global. (Accession No 10028491).

Alshammari, M. (2017). Parents' involvement and perspectives towards the quality of teaching: a review of related literature. *International Journal of Education*, 9(2), 16-33.

Altamimi, R. (2016). Understanding dyslexia implications of the identification of and support for children with dyslexia in Kuwaiti primary schools. (PhD thesis). Retrieved from ProQuest Thesis and Dissertation Global. (Accession No 10761647).

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing. Retrieved from: <https://www.psychiatry.org/psychiatrists/practice/dsm>.

- Arceneaux, A. D. (2006). *It doesn't make any sense: Self and strategies among college students with learning disabilities*. (PhD thesis). Retrieved from: <https://mospace.umsystem.edu/xmlui/handle/10355/4467>.
- Arishi, L., Lauchlan, F., Boyle, C. (2017). Inclusive education and the politics of difference: Considering the effectiveness of labelling in special education. *Educational and Child Psychology, 34*(4), 9-19.
- Arkin, J. (2012). *What's in a name? The influence of an ADHD-inattentive type label on perceived social competence as viewed by mental health professionals and teachers*. PhD dissertation). Retrieved from ProQuest Thesis and Dissertation Global. (Accession No 3535710).
- Armstrong, D., & Squires, G. (2015). *Key Perspectives on dyslexia: An essential text for educators*. Routledge, Oxfordshire, England; New York.
- Arnold, C (2017), Labels, literacy and the law. Implications for EP practice post-school in the UK. *Educational and Child Psychology, 34*(4), 50-59.
- Baldwin, S. (2000). Living in Britain: Why are so many amphetamines prescribed to infants, children and teenagers in the UK? *Critical Public Health, 10*(4), 453-462.
- Barbaresi, W., & Olsen, R. (1998). An ADHD educational intervention for elementary schoolteachers: A pilot study. *Developmental and Behavioral Pediatrics, 19*(2), 94-100.
- Barga, N. K. (1996). Students with learning disabilities in education: Managing a disability. *Journal of Learning Disabilities, 29*(4), 413-421.
- Barkley, R. A. (2014). *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment*. Guilford Publications. New York.
- Barkley, R.A. (1998). *Attention-deficit hyperactivity disorder (2nd Ed.)*. New York: Guilford Press.
- Barreto, M., Ellemers, N., & Banal, S. (2006). Working under cover: Performance-related self-confidence among members of contextually devalued groups who try to pass. *European Journal of Social Psychology, 36* (3), 337–352.
- Battal, Z. M. B. (2016). Special education in Saudi Arabia. *International Journal of Technology and Inclusive Education, 5*(2), 880-886.
- Becker, H. S. (1963). *Outsiders: Studies in the sociology of deviance*. New York: Simon and Schuster.
- Bernburg J.G. (2019) Labeling Theory. In: Krohn M., Hendrix N., Penly Hall G., Lizotte A. (eds) *Handbook on Crime and Deviance*. Handbooks of Sociology and Social Research. Springer, Cham
- Biederman, J., & Faraone, S. (2005). Attention-deficit hyperactivity disorder: a selective overview. *Biological Psychiatry, 57*(11), 1215-1220.
- Blanck, P. (2008). The right to live in the world: Disability yesterday, today, and tomorrow. *Texas Journal on Civil Liberties and Civil Rights, 13*(2), 367–431.

- Bourke, B. (2014). Positionality: Reflecting on the research process. *The qualitative report*, 19(33), 1-9.
- Boyle, C. (2014). Labelling in special education: Where do the benefits lie? In A. Holliman (Ed.) *The Routledge international companion to educational psychology* (pp.213–221). London: Routledge.
- Boyle, C., Scriven, B., Durning, S. & Downes, C. (2011). Facilitating the learning of all students: The 'professional positive' of inclusive practice in Australian primary schools. *Support for Learning*, 26(2), 72–78.
- Bradley, R., Danielson, L., & Doolittle, J. (2005). Response to intervention. *Journal of Learning Disabilities*, 38(6), 485-486.
- Bradley, Renée, Louis Danielson, and Jennifer Doolittle. (2007). Responsiveness to Intervention: 1997 to 2007. *Teaching Exceptional Children* 39(5), 8–12.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.
- British Dyslexia Association. (2006). *Definition of Dyslexia*. Retrieved from: <http://www.bdadyslexia.org.uk/educator/what-are-specific-learning-difficulties>.
- Bryan, T., Burstein, K. and Ergul, C. (2004) The Social-Emotional Side of Learning Disabilities: A Science-Based Presentation of the State of the Art. *Learning Disability Quarterly*, 27 (1): 45-51.
- Bryman, A. (2012). *Social research methods*. Oxford: Oxford University Press, New York.
- Bury, M. (2000). On chronic illness and disability. *Sociology of Health and Illness*, 4(2), 176-183.
- Carmichael, P., Adkins, Gaal I., Hutchins, P., Levey, McCormack, J., Oberklaid, F., Pearson, C., & Storm, V. (1997). Attention deficit hyperactivity disorder. National Health and Research Council, Australia.
- Carr, W., & Kemmis, S. (1986). *Becoming critical: Education, knowledge and action research*. Australia: Deakin University Press.
- Chamberlain, S., & Sahakian, B. (2006). Attention deficit hyperactivity disorder has serious and immediate implications. *Educational Journal*, 94 (4), 35-37.
- Cohen, L., Manion, L., and Morrison, K. (2007). *Research methods in education*. London: Routledge.
- Collins, K., & Ferri, B. (2016). Literacy education and disability studies: Reenvisioning struggling students. *Journal of Adolescent & Adult Literacy*, 60(1), 7-12
- Connolly, T. (2011). *The influence of diagnostic labels on stigma toward people with schizophrenia and intellectual disability*. (PhD thesis). Retrieved from ProQuest Thesis and Dissertation Global. (Accession No U635316).
- Cooper, P. and Bilton, K. (2002). *Attention deficit/ hyperactivity disorder: A practical guide for teachers* (2nd ed.). London: Routledge.



- Cooper, P., & Bilton, K. M. (2013). *Attention deficit hyperactivity disorder: A practical guide for teachers*. London: Routledge.
- Cornett-Ruiz, S., & Hendricks, B. (1993). Effects of labelling and ADHD behaviours on peer and teacher judgments. *The Journal of Educational Research*, 86(6), 349-355.
- Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, 59(7), 614-625.
- Corrigan, P. W., Watson, A. C., Warpinski, A. C., & Gracia, G. (2004). Implications of educating the public on mental illness, violence, and stigma. *Psychiatric Services*, 55(5), 577-580.
- Cottrell, J. M. (2014). The definition, identification, and cause of specific learning disabilities: A literature review. All Graduate Plan B and other Reports: Utah State University. Retrieved from: <https://digitalcommons.usu.edu/gradreports/434/>.
- Covington, J. (1984). Insulation from labelling: Deviant defences in treatment. *Criminology*, 22(4), 619-644.
- Creswell, J. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches*. (3rd ed.). London: Sage publications Ltd.
- Creswell, J. W. (2012). *Educational research: Planning, conducting and evaluating quantitative and qualitative research* (4th ed.) Boston: Pearson Education, Inc.
- Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches*. London: Sage Publications Ltd.
- Creswell, J. W., & Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd ed.). London: Sage Publications Ltd.
- Crotty, M. (2015). *The foundations of social research: Meaning and perspective in the research process*. London: Sage Publications Ltd.
- Daniels, H. (2006). The dangers of corruption in special needs education. *British Journal of Special Education*, 33(1), 4-9.
- Denzin, N., & Lincoln, Y. (Eds). (1994). *Handbook of qualitative research*. Thousand Oaks, CA: Sage Publication.
- DeRoche, C. (2015). Labels in education: the role of parents and parental cultural capital in acquiring diagnoses and educational accommodations. *Canadian Journal of Education*, 38(4), 1-24.
- DfE and DoH (2014). Special educational needs and disability code of practice 0-25. Retrieved from: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/342440/SEND\\_Code\\_of\\_Practice\\_approved\\_by\\_Parliament\\_29.07.14.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/342440/SEND_Code_of_Practice_approved_by_Parliament_29.07.14.pdf)
- Directorate General of Special Education [DGSE]. (2018). *Department of ADHD (Arabic)*. Retrieved from: <http://departments.moe.gov.sa/EducationAgency/RelatedDepartments/SPECIAL EDUCATION/Pages/AttentionDeficit.aspx>.

- Ditchman, N., Kosyluk, K., Lee, E. J., & Jones, N. (2016). How stigma affects the lives of people with intellectual disabilities: An overview. In *Intellectual Disability and Stigma* (pp. 31-47). Palgrave Macmillan, London.
- Dobbs, J., & Arnold, D. H. (2009). Relationship between preschool teachers' reports of children's behavior and their behavior toward those children. *School Psychology Quarterly, 24*(2), 95-105.
- Dörnyei, Z. (2007). *Research methods in applied linguistics: Quantitative, qualitative, and mixed methodologies*. England, Oxford University Press.
- Dryer, R., Kiernan, M. J., & Tyson, G. A. (2006). The effects of diagnostic labelling on the implicit theories of attention-deficit/hyperactivity disorder held by health professionals. *Behaviour Change, 23*(3), 177-185.
- Dudley-Marling, C. (2004). The social construction of learning disabilities. *Journal of Learning Disabilities, 37*(6), 482-489.
- Duhaney, L.M. & Salend, S.J. (2010). History of special education. In P. Peterson, E. Baker & B. McGaw (Eds.) *International encyclopaedia of education* (3rd edn), (pp.714–720). Oxford: Elsevier.
- DuPaul, G. J., & Stoner, G. (2014). *ADHD in the schools: Assessment and intervention strategies*. New York, Guilford Publications.
- Dusenbury, L., Brannigan, R., Falco, M., & Hansen, W. B. (2003). A review of research on fidelity of implementation: implications for drug abuse prevention in school settings. *Health education research, 18*(2), 237-256.
- Eisenberg, D., & Schneider, H. (2007). Perceptions of academic skills of children diagnosed with ADHD. *Journal of Attention Disorders, 10*(4), 390-397.
- El Nokali, N. E., Bachman, H. J., & Votruba-Drzal, E. (2010). Parent involvement and children's academic and social development in elementary school. *Child development, 81*(3), 988-1005.
- Elliott, J. (2009 April 7th). Thousands of children diagnosed with dyslexia. *The Telegraph*. Retrieved from <https://www.telegraph.co.uk/education/educationnews/5120280/Thousands-of-children-wrongly-diagnosed-with-dyslexia.html>.
- Elliott, J. G. (2005). Dyslexia: Diagnoses, debates and diatribes. *Special Children, 169*, 19-23.
- Elliott, J. G., & Gibbs, S. (2008). Does dyslexia exist? *Journal of Philosophy of Education, 42*(3-4), 475-491.
- Elliott, J. G., & Grigorenko, E. L. (2014). *The dyslexia debate* (No. 14). New York, Cambridge University Press.
- Epstein, J.L. (2001). *School, family and community partnerships*. Boulder, CO: Westview Press.
- Executive, S. (2004). Education (additional support for learning) (Scotland) Act 2004. *Edinburgh: Scottish Executive*. Retrieved from: <https://www2.gov.scot/Publications/2005/05/11112347/23484>.

- Executive, S. (2009). Education (additional support for learning) (Scotland) Act 2009. *Edinburgh: Scottish Executive*. Retrieved from: <https://www.legislation.gov.uk/asp/2009/7/contents>.
- Fairbanks, L. D., & Stinnett, T. A. (1997). Effects of professional group membership, intervention type, and diagnostic label on treatment acceptability. *Psychology in the Schools*, 34(4), 329-335.
- Farrell, M. (2004). *Special educational needs: A resource for practitioners*. London, SAGE Publications.
- Farrugia, D. (2009). Exploring stigma: Medical knowledge and the stigmatisation of parents of children diagnosed with autism spectrum disorder. *Sociology of Health & Illness*, 31(7), 1011-1027.
- Field, A. (2013). *Discovering statistics using IBM SPSS statistics*. Los Angeles: Sage.
- Fletcher, J. M., Coulter, W. A., Reschly, D. J., & Vaughn, S. (2004). Alternative approaches to the definition and identification of learning disabilities: Some questions and answers. *Annals of Dyslexia*, 54(2), 304-331.
- Fletcher, Jack M., Carolyn Denton, and David J. Francis. (2005) Validity of Alternative Approaches for the Identification of Learning Disabilities: Operationalizing Unexpected Underachievement. *Journal of Learning Disabilities* 38(6), 545–52.
- Fogel, L. S., & Nelson, R. O. (1983). The effects of special education labels on teachers' behavioural observations, checklist scores, and grading of academic work. *Journal of School Psychology*, 21(3), 241-251.
- Foster, G., & Ysseldyke, J. (1976). Expectancy and halo effects as a result of artificially induced teacher bias. *Contemporary Educational Psychology*, 1(1), 37-45.
- Foucault, M. (1977). *Discipline and punish: The birth of the prison*. New York, Random House, Inc.
- Fox, J. D., & Stinnett, T. A. (1996). The effects of labelling bias on prognostic outlook for children as a function of diagnostic label and profession. *Psychology in the Schools*, 33(2), 143-152.
- Frith, U. (1999). Paradoxes in the definition of dyslexia. *Dyslexia*, 5(4), 192-214.
- Fuchs, D., & Fuchs, L. S. (2006). Introduction to response to intervention: What, why, and how valid is it? *Reading Research Quarterly*, 41(1), 93-99.
- Georgiadi, M., Kalyva, E., Kourkoutas, E., & Tsakiris, V. (2012). Young children's attitudes toward peers with intellectual disabilities: Effect of the type of school. *Journal of Applied Research in Intellectual Disabilities*, 25(6), 531-541.
- Gibbs, S., & Elliott, J. (2015). The differential effects of labelling: how do 'dyslexia' and 'reading difficulties' affect teachers' beliefs. *European Journal of Special Needs Education*, 30(3), 323-337.
- Gillman, M. & Tomson, D. (1998) what's in a name? Reflecting on diagnosis. *Context: a magazine for family therapy and systemic practice and 'thinking families', for family therapy and general practice*, 41, 3–4.

Gillman, M., Heyman, B. & Swain, J. (2000). What's in a name? The implications of diagnosis for people with learning difficulties and their family carers. *Disability & Society*, 15(3), 389–409.

Gillman, M., Swain, J., & Heyman, B. (1997). Life history or 'case' history: the objectification of people with learning difficulties through the tyranny of professional discourses. *Disability & Society*, 12(5), 675-694.

Glazzard, J. (2010). The impact of dyslexia on pupils' self-esteem. *Support for Learning*, 25(2), 63-69.

Goffman, E. (2009). *Stigma: Notes on the management of spoiled identity*. United State of America, Simon and Schuster, Inc.

Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report*, 8(4), 597-606.

Gold, M.E. & Richards, H. (2012). To label or Not to label: The Special education question for African Americans. *Educational Foundations*, Winter-Spring 2012. 26 (1), 143-156.

Goldstein, S. (1998). *Managing attention deficit hyperactivity disorder in children: A guide*. Hoboken, NJ, US, John Wiley & Sons.

Goldstein, S., Naglieri, J., & DeVries, M. (2011). *Learning and Attention Disorders in Adolescence and Adulthood: Assessment and Treatment* (2nd ed.). New Jersey; John Wiley & Sons.

Graham, L. J. (2008). From ABCs to ADHD: The role of schooling in the construction of behaviour disorder and production of disorderly objects. *International Journal of Inclusive Education*, 12(1), 7-33.

Gray, D. E. (2004). *Doing research in the real world*. London: SAGE Publications.

Gross, J. (1994). Asperger syndrome: A label worth having? *Educational Psychology in Practice*, 10(2), 104-110.

Gwernan-Jones, R., Moore, D. A., Cooper, P., Russell, A. E., Richardson, M., Rogers, M. Garside, R. (2016). A systematic review and synthesis of qualitative research: The influence of school context on symptoms of attention deficit hyperactivity disorder. *Emotional and Behavioural Difficulties*, 21(1), 83-100.

Hacking, I. (1999). *The social construction of what? Place of publication*. Harvard University Press. New York: Harvard University Press.

Hanafi, A., & Alraies, T. (2008). Special education teachers' perceptions about preparing the individual educational programme and the obstacles to apply it in some special educational centres and programs in Saudi Arabia. *Journal of Psychological Counselling*, 22(1), 6-12.

Harpur, P. (2009). Sexism and racism, why not ableism? Calling for a cultural shift in the approach to disability discrimination. *Alternative Law Journal*, 34(3), 163-167.

Harpur, P. (2012). From disability to ability: Changing the phrasing of the debate. *Disability & Society*, 27(3), 325-337.

- Harris, P. (1995). Who am I? Concepts of disability and their implications for people with learning difficulties. *Disability & Society*, 10(3), 341-352.
- Harrison, A. G., & Edwards, M. J. (2010). Symptom exaggeration in post-secondary students: Preliminary base rates in a Canadian sample. *Applied Neuropsychology*, 17(2), 135-143.
- Harrison, A. G., Edwards, M. J., & Parker, K. C. (2007). Identifying students faking ADHD: Preliminary findings and strategies for detection. *Archives of Clinical Neuropsychology*, 22(5), 577-588.
- Hasler, F. (1993). *Developments in the disabled people's movement: Disabling barriers, enabling environments*. London: Sage Publication.
- Hayward & Jenifer A. Bright, P. E. T. E. R. (1997). Stigma and mental illness: A review and critique. *Journal of Mental Health*, 6(4), 345-354.
- Haywood, H.C. (1997). Interactive assessment, in R. Taylor (Ed.) *Assessment of individuals with mental retardation* (pp.108–129). San Diego, CA: Singular Publishing Group.
- Hebl, M. R., Moreno, C., & King, E. B. (2018). A Stigma Lens for Considering What Targets Can Do. In *The Oxford Handbook of Workplace Discrimination*.
- Herek, G. M. (2004). Beyond "homophobia": Thinking about sexual prejudice and stigma in the twenty-first century. *Sexuality Research & Social Policy*, 1(2), 6-24.
- Hjorne, E., & Saljo, R. (2004). "There Is Something About Julia": Symptoms, Categories, and the Process of Invoking Attention Deficit Hyperactivity Disorder in the Swedish School: A Case Study. *Journal of language, identity, and education*, 3(1), 1-24.
- Hjorne, E., & Saljo, R. (2004). 'There is something about Julia': Symptoms, categories, and the process of invoking attention deficit hyperactivity disorder in the Swedish school: A case study. *Journal of Language, Identity, and Education*, 3(1), 1-24.
- Ho, A. (2004). To be labelled, or not to be labelled: That is the question. *British Journal of Learning Disabilities*, 32(2), 86–92.
- Hobbs, N. (1975). *The Futures of Children: Categories, Labels, and their Consequences: Report of the Project on Classification of Exceptional Children*. San Francisco: Jossey-Bass.
- Homidi, M., Obaidat, Y., & Hamaidi, D. (2013). Prevalence of attention deficit and hyperactivity disorder among primary school students in Jeddah city, KSA. *Life Science Journal*, 10(3), 280-5.
- Hong, Y. (2008). Teachers' perceptions of young children with ADHD in Korea. *Early Child Development and Care*, 178(4), 399-414.
- Hornby, G. (2011). *Parental involvement in childhood education: Building effective school-family partnerships*. Springer Science & Business Media. New Zealand; Christchurch.
- Hornby, G., & Lafaele, R. (2011). Barriers to parental involvement in education: An explanatory model. *Educational Review*, 63(1), 37-52.
- Huberman, B.A., Romero, D.M., & Wu, F. (2009). Social networks that matter: Twitter under the microscope. *First Monday* 14, (1–5).

- Hudson, R. F., High, L., & Al Otaiba, S. (2007). Dyslexia and the brain: What does current research tell us? *The Reading Teacher*, 60(6), 506-515.
- Hughes, C. A., & Dexter, D. D. (2011). Response to intervention: A research-based summary. *Theory into Practice*, 50(1), 4-11.
- Hughes, L., & Cooper, P. (2007). *Understanding and supporting children with ADHD: Strategies for teachers, parents and other professionals*. London, Sage Publication.
- Huggett, C., Birtel, M. D., Awenat, Y. F., Fleming, P., Wilkes, S., Williams, S., & Haddock, G. (2018). A qualitative study: experiences of stigma by people with mental health problems. *Psychology and Psychotherapy: Theory, Research and Practice*, 91(3), 380-397.
- Hussain, O. A. (2009). *Evaluation of Preparation Program for Teachers Specialising in Learning Disabilities in Saudi Arabia*. (PhD). Retrieved from ProQuest Thesis and Dissertation Global. (Accession No 3390815).
- IDEA. (2004 ). Identification of specific learning disabilities. U.S. Department of Education, Special Education Programs. Retrived from: <http://idea.ed.gov/explore/view/p/%2Croot%2Cregs%2C300%2CA%2C300%252E8%2Cc%2C10%2C>.
- Jamieson P (2009) The serious matter of informal learning. *Planning for Higher Education* 37(2), 18–25.
- Jennifer Dobbs, David H. Arnold \* & Greta L. Doctoroff (2004) Attention in the preschool classroom: the relationships among child gender, child misbehavior, and types of teacher attention, *Early Child Development and Care*, 174(3), 281-295.
- Jerome, L., Gordon, M., & Hustler, P. (1994). A comparison of American and Canadian teachers' knowledge and attitudes towards Attention Deficit Hyperactivity Disorder (ADHD). *Canadian Journal of Psychiatry*, 39(9), 563–567.
- Johns, R. (2010) Survey question bank: method fact sheet 1. Likert items and scales. Retrieved from: [https://www.sheffield.ac.uk/polopoly\\_fs/1.597637!/file/likertfactsheet.pdf](https://www.sheffield.ac.uk/polopoly_fs/1.597637!/file/likertfactsheet.pdf).
- Johnson, B., & Christensen, L. (2008). *Educational research: Quantitative, qualitative, and mixed approaches*. London, Sage Publication.
- Johnson, B., & Christensen, L. B. (2004). *Educational research: Quantitative, qualitative and mixed approaches (2nd ed)*. Boston, USA: Pearson Education.
- Johnson, J. R. (2016). *Do education and personal relationships reduce the stigma of those labelled?* (PhD thesis). Retrieved from Rowan Digital Works (accession No 2352).
- Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher*, 33(7), 14–26.
- Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a definition of mixed methods research. *Journal of Mixed Methods Research*, 1(2), 112–133.
- Kajornboon, A. B. (2005). Using interviews as research instruments. *E-journal for Research Teachers*, 2(1). Retrieved form: <http://www.culi.chula.ac.th/research/e-journal/bod/annabel.pdf>.

- Kaplan, D. (1999). The definition of disability: Perspective of the disability community. *Journal of Health Care Law & Policy*, 3, 352-364.
- Kassens-Noor, E. (2012). Twitter as a teaching practice to enhance active and informal learning in higher education: The case of sustainable tweets. *Active Learning in Higher Education*, 13(1), 9-21.
- Kayama, M., & Haight, W. (2018). Balancing the stigmatization risks of disability labels against the benefits of special education: Japanese parents' perceptions. *Children and Youth Services Review*, 89, 43-53.
- Kelly, N. & Norwich, B. (2004). Pupils' perceptions of self and of labels: Moderate learning difficulties in mainstream and special schools. *British Journal of Educational Psychology*, 74(3), 411-435.
- Kendall P. C. (2000). *Childhood disorders*. UK, Psychology Press.
- Kewley, G. (2010). *Attention deficit hyperactivity disorder: What can teachers do?* Abingdon, Oxon, Routledge Publication.
- King, M. (2019). Stigma in psychiatry seen through the lens of sexuality and gender. *BJPsych International*, 1-4.
- Koonce, D. A., Cruce, M. K., Aldridge, J. O., Langford, C. A., Sporer, A. K., & Stinnett, T. A. (2004). The ADHD label, analogue methodology, and participants' geographic location on judgments of social and attentional skills. *Psychology in the Schools*, 41(2), 221-234.
- Kos, J. M. (2008). What do primary school teachers know, think, and intend to do about ADHD? Paper presented at the *British Educational Research Association Conference*. Edinburgh, Scotland. Retrieved from: [https://research.acer.edu.au/tll\\_misc/8](https://research.acer.edu.au/tll_misc/8).
- Kos, J., Richdale, A., & Jackson, S. (2004). Knowledge about attention deficit hyperactivity disorder: A comparison of in-service and preservice teachers. *Psychology in the Schools*, 41(5), 517-526.
- Larson, J. E., & Corrigan, P. (2008). The stigma of families with mental illness. *Academic psychiatry*, 32(2), 87-91.
- Lauchlan, F. & Boyle, C. (2007). Is the use of labels in special education helpful? *Support for Learning*, 22(1), 36-42.
- Lauchlan, F. & Boyle, C. (2014). To label or not to label: Is this the question? Commentary on Bishop, D.V.M. Ten questions about terminology for children with unexplained language problems. *International Journal of Language and Communication Disorders*, 49(4), 399-400.
- Lauchlan, F., Boyle, C., Gibbs, S & Resing, W (2017). Guest Editorial: Labelling and diagnosis. *Educational and Child Psychology*, 34(4), 5-8.
- Lee, K. (2008). ADHD in American early schooling: From a cultural psychological perspective. *Early Child Development and Care*, 178(4), 415-439.
- Leech, K. (2004). 'Can mainstream cope with all our children?' *The Times Educational Supplement*, 9th January 2004.

- Lewandowski L. J., Lovett B. J. (2014). The new Diagnostic and Statistical Manual of Mental Disorders, DSM-5: Implications for accommodations requests. *Bar Examiner*, 83(1), 42-54.
- Liamputtong, P., & Ezzy, D. (2005). *Qualitative research methods* (2nd ed.). South Melbourne, VIC: Oxford University Press.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage Publication.
- Link, B. G., & Phelan, J. (2014). Stigma power. *Social Science & Medicine*, 103, 24-32.
- Link, B. G., & Phelan, J. C. (2006). Stigma and its public health implications. *The Lancet*, 367(9509), 528-529.
- LoBianco, A. F., & Sheppard-Jones, K. (2007). Perceptions of disability as related to medical and social factors. *Journal of Applied Social Psychology*, 37(1), 1-13.
- Lovingfoss, D., Molloy, D. E., Harris, K. R., & Graham, S. (2001). Preparation, Practice, and Program Reform: Crafting the University of Maryland's Five-Year, Multicategorical Undergraduate Program in Special Education. *The Journal of Special Education*, 35(2), 105-114.
- Luz Méndez, C., Coddou, F., & Maturana, H. R. (1988). The bringing forth of pathology. *The Irish Journal of Psychology*, 9(1), 144-172.
- Maguire, R., Wilson, A., & Jahoda, A. (2019). Talking about learning disability: promoting positive perceptions of people with intellectual disabilities in Scottish schools. *International Journal of Developmental Disabilities*, 65(4), 257-264.
- Maras, P., & Redmayne, T. (1997) 'Helicopter children' and 'butterfly brains'. ADHD: perceptions, issues and implications. *Educational and Child Psychology*, 14(1), 39-49.
- Marshall, C., & Rossman, G. B. (2010). *Designing qualitative research*. Singapore, Sage Publication.
- Martin, Jack K., Bernice A. Pescosolido, Sigrun Olafsdottir, and Jane D. McLeod (2007). "The Construction of Fear: Americans' Preferences for Social Distance from Children and Adolescents with Mental Health Problems." *Journal of Health and Social Behavior* 48(1), 50-67.
- Mason, J. (2006). Mixing methods in a qualitatively driven way. *Qualitative Research*, 6(1), 9-25.
- Maykut, P., & Morehouse, R. (1994). *Beginning qualitative research: A philosophic and practical guide*. London: The Falmer Press.
- McFedries P (2007) Technically speaking: All a-Twitter. *IEEE Spectrum* 44(10), 84-89.
- McMahon, S. E. (2012). Doctors diagnose, teachers label: The unexpected in pre-service teachers' talk about labelling children with ADHD. *International Journal of Inclusive Education*, 16(3), 249-264.
- Mendez, C.L., Coddou, F., & Maturana, R.H. (1988). The bringing forth of pathology. *The Irish Journal of Psychology*, 9(1), 144-172.
- Mertens, D. (2010). *Research and evaluation in education and psychology* (3rd ed.). London: Sage Publication.



Mertens, D. (2014). *Research methods in education and psychology. Integrating diversity with quantitative and qualitative approaches*. London: Sage.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129(5), 674-697.

Miles, S., & Singal, N. (2010). The education for all and inclusive education debate: Conflict, contradiction or opportunity? *International Journal of Inclusive Education*, 14(1), 1-15.

Miller, P. S., & Losardo, A. (2002). Graduates' Perceptions of Strengths and Needs in Interdisciplinary Teacher Preparation for Early Childhood Education: A State Study. *Teacher Education and Special Education*, 25(3), 309-319.

Ministry of Education (2016). Guidance of Learning Disability programs 2016-2017. Retrieved from:

<https://www.moe.gov.sa/ar/Documents/%D8%AF%D9%84%D9%8A%D9%84%20%D8%A8%D8%B1%D8%A7%D9%85%D8%AC%20%D8%B5%D8%B9%D9%88%D8%A8%D8%A7%D8%AA%20%D8%A7%D9%84%D8%AA%D8%B9%D9%84%D9%85%201437>.

Ministry of Education (2017). The Department of Learning disability. Retrieved from: <https://departments.moe.gov.sa/EducationAgency/RelatedDepartments/boysSpecialEducation/The%20departments/Learning%20Disability%20Management/Pages/default.aspx>.

Ministry of Education. (2016). Statistical information about general education. Retrieved from: <https://www.moe.gov.sa/ar/Pages/StatisticalInformation.aspx>.

Ministry of Education. (2016). The development of special education. Retrieved from: <http://departments.moe.gov.sa/EducationAgency/RelatedDepartments/boysSpecialEducation/Pages/VisionandMission.aspx>.

Ministry of Education. (2018). The departments of special education. Retrieved from: <https://departments.moe.gov.sa/EducationAgency/RelatedDepartments/boysSpecialEducation/The%20departments/Pages/default.aspx>.

Ministry of Education. (2019). The departments of special education. Retrieved from: [https://edu.moe.gov.sa/Riyadh/Departments/FemaleAffairsEducationalAssistant/sp\\_g/Pages/default.aspx](https://edu.moe.gov.sa/Riyadh/Departments/FemaleAffairsEducationalAssistant/sp_g/Pages/default.aspx).

Moberg, S. (1995). Impact of teachers' dogmatism and pessimistic stereotype on the effect of EMR-class label on teachers' judgments in Finland. *Education and Training in Mental Retardation and Developmental Disabilities*, Vol 30(2), 141-150.

Morgan, Paul L., Michelle Frisco, George Farkas, and Jacob Hibel. 2010. "A Propensity Score Matching Analysis of the Effects of Special Education Services." *Journal of Special Education* 43(4), 236-54.

Morris, D. K., & Turnbull, P. A. (2007). The disclosure of dyslexia in clinical practice: Experiences of student nurses in the United Kingdom. *Nurse Education Today*, 27(1), 35-42.

Mueller, C. (2019). Adolescent understandings of disability labels and social stigma in school. *International Journal of Qualitative Studies in Education*, 32(3), 263-281.

Neuman, L. W. (2002). *Social research methods: Qualitative and quantitative approaches*. Edinburgh, Pearson Education Limited.

Newheiser, A. K., & Barreto, M. (2014). Hidden costs of hiding stigma: Ironic interpersonal consequences of concealing a stigmatized identity in social interactions. *Journal of Experimental Social Psychology*, 52, 58-70.

NHS (2013) *News Analysis: Controversial Mental Health Guide DSM-5*. Retrieved from: <https://www.nhs.uk/news/mental-health/news-analysis-controversial-mental-health-guide-dsm-5/#conclusion>.

Norwich, B. (2009). How compatible is the recognition of dyslexia with inclusive education? In G. Reid (Ed.), *The Routledge companion to dyslexia* (pp. 177–192). New York, NY: Routledge/Taylor & Francis Group.

Norwich, B. (2009). How compatible is the recognition of dyslexia with inclusive education? In G. Reid (Ed.). *The Routledge Dyslexia Handbook*. London: Routledge.

Ohan, J. L., Visser, T. A., Strain, M. C., & Allen, L. (2011). Teachers' and education students' perceptions of and reactions to children with and without the diagnostic label "ADHD". *Journal of School Psychology*, 49(1), 81-105.

Oliver, M (1996) Understanding Disability: From Theory to Practice. *The Journal of Sociology & Social Welfare*: Vol. 23 (3), Article 24. Retrieved from: <https://scholarworks.wmich.edu/jssw/vol23/iss3/24>.

Oliver, M. (1996b) A Sociology of Disability or a Disablist Sociology?, in: L. BARTON (Ed.) *Disability and Society: emerging issues and insights* (Longman, New York).

Oliver, M. (2017). Defining impairment and disability. *Disability and Equality Law*, 3. P39-45.

Oliver, M., & Barnes, C. (1998). *Disabled people and social policy: From exclusion to inclusion*. London, Addison Wesley Longman.

Oppenheim, A. N. (1992). *Questionnaire design, interviewing and attitude measurement*. London: Pinter Publishers Ltd.

Osterholm, K., Nash, W. R., & Kritsonis, W. A. (2011). Effects of labelling students 'learning disabled': Emergent themes in the research literature 1970 through 2000. *FOCUS on Colleges, Universities & Schools*, 6 (1) p1-11.

Pallant, J. (2010). *SPSS survival manual: A step by step guide to data analysis using SPSS for Windows (version 12)*. London: Open University Press.

Panek, P. E., & Jungers, M. K. (2008). Effects of age, gender, and causality on perceptions of persons with mental retardation. *Research in Developmental Disabilities*, 29(2), 125-132.

Peake, L., & Trotz, D. A. (1999). *Gender, ethnicity and place: Women and identity in Guyana*. London: Routledge.

Pescosolido, B. A., Jensen, P. S., Martin, J. K., Perry, B. L., Olafsdottir, S., & Fettes, D. (2008). Public knowledge and assessment of child mental health problems: findings from the national stigma study-children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 47(3), 339–349.

- Pescosolido, B. A., Martin, J. K., Lang, A., & Olafsdottir, S. (2008). Rethinking theoretical approaches to stigma: A framework integrating normative influences on stigma (FINIS). *Social Science & Medicine*, 67(3), 431-440.
- Platteel, A. (2003). *Marketing: Inventing a different marketing language*. Rotterdam: Episode Publishers.
- Pring, R. (2004). *Philosophy of educational research*. London; New York: Continuum.
- Randor, H. A. (2002). *Researching your professional practice doing interpretive research*. Buckingham: Open University Press.
- Reason, R. (1999). ADHD: A psychological response to an evolving concept (Report of the working party of the British Psychological Society). *Journal of Learning Disabilities*, 1(32), 85-91.
- Reid, G. (2016). *Dyslexia: A practitioner's handbook*. Chichester, West Sussex, John Wiley & Sons.
- Reiss, M., & Brooks, G. (2004). *Developmental dyslexia in adults: A research review*. London, Institute of Education.
- Remschmidt, H. (2005). Global consensus on ADHD/HKD. *European Child and Adolescent Psychiatry*, 14(3), 127-137.
- Riddick, B. (1995). Dyslexia: Dispelling the myths. *Disability & Society*, 10(4), 457-474.
- Riddick, B. (2000). An examination of the relationship between labelling and stigmatisation with special reference to dyslexia. *Disability & Society*, 15(4), 653-667.
- Robins, P. M. (1992). A comparison of behavioral and attentional functioning in children diagnosed as hyperactive or learning disabled. *Journal of Abnormal Child Psychology*, 20(1), 65-82.
- Robson, C. (2011). *Real world research: A resource for social scientists and practitioners-researchers*. Massachusetts: Blackwell Publishing, Australia.
- Rorty, R., Putnam, H., Conant, J., & Helfrich, G. (2004). What is pragmatism? *Think*, 3(8), 71-88.
- Rose, J. (2009). Identifying and teaching children and young people with dyslexia and literacy difficulties: an independent report. Retrieved from: [https://dera.ioe.ac.uk/14790/7/00659-2009DOM-EN\\_Redacted.pdf](https://dera.ioe.ac.uk/14790/7/00659-2009DOM-EN_Redacted.pdf).
- Rosell-Aguilar, Fernando (2018). Twitter: A Professional Development and Community of Practice Tool for Teachers. *Journal of Interactive Media in Education* 6(1), 1-12.
- Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press.
- Rossmann, G. B., & Wilson, B. L. (1985). Numbers and words: Combining quantitative and qualitative methods in a single large-scale evaluation study. *Evaluation Review*, 9(5), 627-643.

- Rowland, A. S., Lesesne, C. A., & Abramowitz, A. J. (2002). The epidemiology of attention-deficit/hyperactivity disorder (ADHD): A public health view. *Mental Retardation and Developmental Disabilities Research Reviews*, 8(3), 162-170.
- Rucklidge, J. J. (2010). Gender differences in attention-deficit/hyperactivity disorder. *Psychiatric Clinics*, 33(2), 357-373.
- Runswick-Cole, K., & Hodge, N. (2009). Needs or rights? A challenge to the discourse of special education. *British Journal of Special Education*, 36(4), 198-203.
- Ryan, J., & Thomas, F. (1991). *The politics of mental handicap* (revised ed). London: Free Association Books.
- Schachar, R. J., Tannock, R., Cunningham, C., & Corkum, P. V. (1997). Behavioural, situational, and temporal effects of treatment of ADHD with methylphenidate. *Journal of the American Academy of Child & Adolescent Psychiatry*, 36(6), 754-763.
- Science and Technology Committee. (2009). Evidence Check 1: Early Literacy Interventions. Second Report of Session 2009–10. London: The Stationery Office Limited.
- Sciutto, M., Terjesen, M., & Bender, A. (2000). Teachers' knowledge and misperceptions of Attention-Deficit/Hyperactivity Disorder. *Psychology in the Schools*, 37(2), 115-122.
- Seidman, I. (2012). *Interviewing as qualitative research: A guide for researchers in education and the social sciences*. New York, Teachers College Press.
- Seligman, M. (2000). Conducting effective conferences with parents of children with disabilities. New York: Guilford.
- Shifrer, D. (2013). Stigma of a label: Educational expectations for high school students labelled with learning disabilities. *Journal of Health and Social Behaviour*, 54(4), 462-480.
- Shifrer, Dara, Rebecca Callahan, and Chandra Muller. (2013). Equity or Marginalization? The High School Course-taking of Students Labeled with a Learning Disability. *American Educational Research Journal* 50(4), 656–82.
- Sideridis, G. D. (2007). International approaches to learning disabilities: More alike or more different? *Learning Disabilities Research & Practice*, 22(3), 210-215.
- Simoni, Z. R. (2015). *The ADHD medication process model: A qualitative investigation of teaching pedagogies, ideal student behaviour, labelling processes, and attitudes towards ADHD medication*. (Doctoral thesis). Retrieved from ProQuest Thesis and Dissertation Global. (Accession No 3700363).
- Smith, D. S., & Nagle, R. J. (1995). Self-perceptions and social comparisons among children with LD. *Journal of Learning Disabilities*, 28(6), 364-371.
- Smith, J., & Noble, H. (2014). Bias in research. *Evidence-based nursing*, 17(4), 100-101.
- Snider, V. E., Busch, T., & Arrowood, L. (2003). Teacher Knowledge of Stimulant Medication and ADHD. *Remedial and Special Education*, 24(1), 46–56.
- Söder, M. (1989). Disability as a social construct: The labelling approach revisited. *European Journal of Special Needs Education*, 4(2), 117-129.

Somaily, H., Al-Zoubi, S., & Bani Abdel Rahman, M. (2012). Parents of students with learning disabilities attitudes towards resource room. *International Interdisciplinary Journal of Education*, 1(1), 1-5.

Sowards, A. K. (2015). Labeling: Student Self-Esteem and the Stigma of a Label (master dissertation). Retrieved from: Marshall Digital Scholar. (Accession No 976).

Stanovich, K. E. (2005). The future of a mistake: Will discrepancy measurement continue to make the learning disabilities field a pseudoscience? *Learning Disability Quarterly*, 28(2), 103-106.

Sultana, F. (2007). Reflexivity, positionality and participatory ethics: Negotiating fieldwork dilemmas in international research. *ACME: An international E-journal for Critical Geographies*, 6(3), 374-385.

Sutcliffe, J. & Simons, K. (1993) *Self advocacy and people with learning difficulties*. Leicester: NIACE.

Swain, S. D., Weathers, D., & Niedrich, R. W. (2008). Assessing three sources of misresponse to reversed Likert items. *Journal of Marketing Research*, 45(1), 116-131

Tabassam, W., & Grainger, J. (2002). Self-concept, attributional style and self-efficacy beliefs of students with learning disabilities with and without attention deficit hyperactivity disorder. *Learning Disability Quarterly*, 25(2), 141-151.

Taleb, R. A. A., & Farheen, A. (2013). A descriptive study of attention deficit hyperactivity disorder in Sabia City, Saudi Arabia. *International Journal of Current Research and Review*, 5(11), p36-41.

Tansey, A. and Ni Dhomhnaill, G. (2002). The Perceptions and Practices of Primary School Teachers with Regard to Dyslexia. *LEARN Journal of the Irish Learning Support Association*, 24(1), 13-20.

Tashakkori, A., & Teddlie, C. (1998). *Mixed methodology: Combining qualitative and quantitative approaches*. Thousand Oaks, CA: Sage Publications LTD.

Tashakkori, A., & Teddlie, C. (2003). *Handbook of mixed methods in social and behavioural research*. Thousand Oaks, CA, USA: Sage Publications.

Taylor, L. M., Hume, I. R., & Welsh, N. (2010). Labelling and self-esteem: The impact of using specific vs. generic labels. *Educational Psychology*, 30(2), 191-202.

Terzi, L. (2004). The social model of disability: A philosophical critique. *Journal of Applied Philosophy*, 21(2), 141-157.

The Official Portal of the UAE Government (2019). Retrieved from: <https://www.government.ae/en/information-and-services/social-affairs/special-needs>.

The Reggio Emilia approach (no date). Retrieved from: <http://www.reggiochildren.it/identita/reggio-emilia-approach/?lang=en>.

Thelen, R. L., Burns, M. K., & Christiansen, N. D. (2003). Effects of high-incidence disability labels on the expectations of teachers, peers, and college students. *Ethical Human Sciences and Services*, 5(3), 183-193.

Thomas, C. (1999). *Female forms: Experiencing and understanding disability*. Buckingham, Open University Press.

Thomas, C. (2004). How is disability understood? An examination of sociological approaches. *Disability & Society*, 19(6), 569-583.

Thomson, M. M. (2012). Labelling and self-esteem: Does labelling exceptional students impact their self-esteem? *Support for Learning*, 27(4), 158-165.

Thompson, A. C., & Lefler, E. K. (2016). ADHD stigma among college students. *ADHD Attention Deficit and Hyperactivity Disorders*, 8(1), 45-52.

Thornicroft, G. (2006). *Shunned: Discrimination against people with mental illness*. New York, Oxford University Press.

Timimi, S. (2005). *Naughty boys: Anti-Social behaviour, ADHD and the role of culture*. New York: Palgrave Macmillan.

Timimi, S. and 33 co-endorsers. (2004). A critique of the International Consensus Statement on ADHD. *Clinical Child and Family Psychology Review*, 7(1), 59-63.

Toone, J. (2006). Effects of the diagnostic label 'ADHD' on peer judgment (master dissertation). Retrieved from ProQuest Thesis and Dissertation Global. (Accession No 1441172).

Toye, M. K., Wilson, C., & Wardle, G. A. (2019). Education professionals' attitudes towards the inclusion of children with ADHD: the role of knowledge and stigma. *Journal of Research in Special Educational Needs*, 19(3), 184-196.

Tunmer, W., & Greaney, K. (2010). Defining dyslexia. *Journal of Learning Disabilities*, 43(3), 229-243.

U. S. Office of Education. (1977). Assistance to states for education of handicapped children: Procedures for evaluating specific learning disabilities. *Federal Register*, 42, 65082–65085.

U.S. Individual with Disabilities Education Act. Retrieved from: <https://sites.ed.gov/idea>.

Unnever, J. D., & Cornell, D. G. (2003). Bullying, self-control, and ADHD. *Journal of Interpersonal Violence*, 18(2), 129-147.

Vallance, R. J., Madang, P., & Lee, M. H. (2005). QSR NVivo 7 as an aid towards analytic rigour when researching in non-English languages and cultures. In *6th International Strategies in Qualitative Research conference*. Retrieved from: <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.580.8286&rep=rep1&type=pdf>.

Vaughn, S., Linan-Thompson, S., & Hickman, P. (2003). Response to instruction as a means of identifying students with reading/learning disabilities. *Exceptional Children*, 69(4), 391-409.

Vereb, R. and DiPerna, J. (2004) 'Teachers' knowledge of ADHD, treatments for ADHD and treatment acceptability: an initial investigation', *School Psychology Review* 33(3), 421–428.

Visser, J., & Jehan, Z. (2009). ADHD: A scientific fact or a factual opinion? A critique of the veracity of attention deficit hyperactivity disorder. *Emotional and Behavioural Difficulties*, 14(2), 127-140.

- Vivian, D., & O'Leary, K. D. (1984). Effects of the label 'hyperactive'. *Psychology in the Schools*, 21(3), 356-359.
- Walker, A. (2019). "I'm Not like That, So Am I Gay?" The Use of Queer-Spectrum Identity Labels Among Minor-Attracted People. *Journal of homosexuality*, 1-24.
- Wasburn-Moses, L. (2005). Preparing Special Educators for Secondary Positions. *Action in Teacher Education*, 27(3), 26-39.
- Washburn, E. K., Joshi, R. M., & Binks-Cantrell, E. S. (2011). Teacher knowledge of basic language concepts and dyslexia. *Dyslexia*, 17(2), 165-183.
- Wellington, J. (2000). *Educational research: Contemporary issues and practical approaches*. London: Continuum.
- Welsh, E. (2002). Dealing with Data: Using NVivo in the Qualitative Data Analysis Process. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 3(2). doi:<http://dx.doi.org/10.17169/fqs-3.2.865>
- Wheeler, L. (2007). *Attention deficit hyperactivity disorder (ADHD): Identification, assessment, contextual and curricular variability in boys at KS1 and KS2 in mainstream schools*. Retrieved from ProQuest Thesis and Dissertation Global. (Accession No 10085542).
- Wheeler, L. (2010). Critique of the article by Visser and Jehan (2009): ADHD: a scientific fact or a factual opinion? A critique of the veracity of attention deficit hyperactivity disorder. *Emotional and Behavioural Difficulties*, 15(3), 257-267.
- White, R., Haines, F., & Asquith, N. L. (2017). *Crime & criminology*. Oxford University Press, Melbourne.
- Williams, T., Lamb, B., Norwich, B., & Peterson, L. (2009). Special educational needs has outlived its usefulness: A debate. *Journal of Research in Special Educational Needs*, 9(3), 199-217.
- Willis, J. W. (2007). *Foundations of qualitative research: Interpretive and critical approaches*. London: Sage Publications.
- Wood, W. L., Lewandowski, L. J., & Lovett, B. J. (2019). Profiles of Diagnosed and Undiagnosed College Students Meeting ADHD Symptom Criteria. *Journal of attention disorders* 1(2) 1-11
- Yang B and Lu D (2001) Predicting academic performance in management education: An empirical investigation of MBA success. *Journal of Education for Business* 77(1), 15–20.
- Zuriff, G. E. (1996). The myths of learning disabilities: The social construction of a disorder. *Public Affairs Quarterly*, 10 (4), 395–405.

# Appendices

## Appendix 1 (Questionnaires for All Participants- English version)

### Survey for parents of children with Attention Deficit Hyperactivity Disorder (ADHD)

Thank you for your participation in this research by completing this questionnaire for primary school teachers of students with ADHD. Answering this questionnaire will not take more than six minutes. The study aims to explore perceptions and perspectives of teachers and parents of students with (A) Learning Disability (LD) and (B) ADHD regarding ADHD and LD labels. This study is approved by the Graduate School of Education at the University of Exeter. Thus, the information that you provide will be kept completely confidential and will remain anonymous. No names will be used in any report. All data from this questionnaire will be used for this study only and it will be deleted after the study is completed. In addition, it would be helpful to follow up some questionnaire with interviews. At the end of the questionnaire, there is a space to write your contact details if you want to do so.

If you have any questions about this study please contact:

The researcher

Hatim Algraigay

Phone number: UK 00447414557525 Saudi 00966553999580

Email address: [hhha202@exeter.ac.uk](mailto:hhha202@exeter.ac.uk) or [h.haa111@hotmail.com](mailto:h.haa111@hotmail.com)

Supervisors:

Dr Alison Black [A.E.Black@exeter.ac.uk](mailto:A.E.Black@exeter.ac.uk)

Dr Christopher Boyle [C.Boyle2@exeter.ac.uk](mailto:C.Boyle2@exeter.ac.uk)

### Section One

**Please tick or circle the appropriate items that best represents you**

#### 1- Are you

- A parent of child with Learning Disability
- A parent of child with Attention Deficit Hyperactivity Disorder
- A teacher of children with Learning Disability
- A teacher of children with Attention Deficit Hyperactivity Disorder

#### 2- Educational level

- Primary school
- Intermediate school
- High school or diploma
- Bachelor degree
- Postgraduate degree

#### 3- Have you ever involved in training courses or workshops about the disability your child has?

- Yes
- No

#### 4- How many children do you have?

- 1
- 2
- 3
- 4
- 5 or more

#### 5- Age of your child with Attention Deficit Hyperactivity Disorder

- 6
- 7
- 8
- 9
- 10
- 11
- 12 or more

#### 6- School level of your child

- Low elementary grades 1-3
- Upper elementary grades 4-6
- Both levels

### Second Section

This section aims to indicate whether you agree or disagree with the statements by selecting a score to represent your perceptions and views on stigma.

Please tick the following statements by using the following scale:

1= strongly disagree

2= disagree



3= agree

4=strongly agree

- 1- **My child tends to hide his difficulties from others**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 2- **My child tends not discuss his difficulties with other peers**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 3- **My child tends to hide his school work from me**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 4- **My child tends to hide his school work from other family member or sibling**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 5- **My child tends to be shy in displaying unaccepted behaviour in my presence**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 6- **My child tends to not be shy in displaying unaccepted behaviour in front of other family members or sibling**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

### Section Three

This section aims to indicate whether you agree or disagree with the statements by selecting a score to represent your perception and views on self-esteem and labels

Please tick the following statements by using the following scale:

1= strongly disagree

2= disagree

3= agree

4=strongly agree

- 1- **Regardless his disability, I think that Attention Deficit Hyperactivity Disorder label has negative effects on my child' self-satisfaction**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 2- **Regardless his disability, I think that Attention Deficit Hyperactivity Disorder label minimises my child ability to do things as most non-labelled students can do**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 3- **Regardless his disability, I think that Attention Deficit Hyperactivity Disorder label makes my child more likely to fail**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 4- **Regardless his disability, I think that the Attention Deficit Hyperactivity Disorder label does not make my child feel useless and frustrated**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

### Section Four

This section aims to indicate whether you agree or disagree with the statements by selecting a score to represent your perception and views on formal and informal labels.

Please tick the following statements by using the following scale:

1= strongly disagree

2= disagree

3= agree

4=strongly agree

- 1- **Beside the effects of his disability, Attention Deficit Hyperactivity Disorder label does not impede my child' academic development**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 2- **Beside the effects of his disability, Attention Deficit Hyperactivity Disorder label impedes my child' social skills development**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 3- **Regardless his disability, Attention Deficit Hyperactivity Disorder label affects my child from having friendships**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 4- **Regardless his disability, Attention Deficit Hyperactivity Disorder label makes my child smarter than others without labels**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

- 5- I think that my child gets bullied by other peers because he always goes to resource room  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 6- I think that my child gets bullied as he is always given extra time compared to others in mainstream classroom to finish the given tasks  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 7- I think that my child gets bullied as he is always given extra support compared to others in mainstream classroom to finish the given tasks  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 8- I think that my child gets bullied by others when he demonstrates unaccepted behaviours  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 9- Regardless his disability, Attention Deficit Hyperactivity Disorder label does not make my child get bullied by others outside the educational setting  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 10- My child is always labelled by words such as “noisy and naughty” instead of the Attention Deficit Hyperactivity Disorder label  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

### Section Five

This section aims to indicate whether you agree or disagree with the statements by selecting a score to represent your perception and views on potential behaviours resulted from labels.

Please tick the following statements by using the following scale:

1= strongly disagree

2= disagree

3= agree

4=strongly agree

- 1- My child tends to change his behaviour to match the negative connotations of Attention Deficit Hyperactivity Disorder label  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 2- I think that my child is treated differently by others when they know he has Attention Deficit Hyperactivity Disorder label  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 3- Regardless his disability, Attention Deficit Hyperactivity Disorder label does not make my child isolated from others, or not invited by others to play  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 4- My child tends to avoid interacting with others because his worries of being stigmatised  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 5- Other peers treat my child with Attention Deficit Hyperactivity Disorder more differently than non-labelled students who show similar behavioural issues  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

### Section Six

This section aims to indicate whether you agree or disagree with the statements by selecting a score to represent your expectations.

Please tick the following statements by using the following scale:

1= strongly disagree

2= disagree

3= agree

4=strongly agree

- 1- Teachers treat my child differently once he receives the Attention Deficit Hyperactivity Disorder label  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 2- Teachers treat my child differently once he accesses the resource rooms  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 3- Teachers treat my child differently once he receives extra support compared to other peers  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 4- Teachers treat my child differently once he receives extra time compared to other peers  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

- 5- **Teachers treat my child who has Attention Deficit Hyperactivity Disorder label more differently than non-labelled students who show similar behavioural issues**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 6- **School staffs treat student with Attention Deficit Hyperactivity Disorder more differently than non-labelled students who show similar behavioural issues**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 7- **Psychologists treat my child differently when they know he has the Attention Deficit Hyperactivity Disorder label**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 8- **I think that assigning Attention Deficit Hyperactivity Disorder label has helped my child in developing his academic aspects**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 9- **I think that assigning Attention Deficit Hyperactivity Disorder label has not helped my child in developing his social skills**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

This is the end of the questionnaire. Thank you for your time in completing it.

I will be carrying out face to face interviews with primary school teachers of students with a learning disability to gain deeper understanding about your perceptions regarding learning disability' label. The interview will take up to 40 mins, and your participation will be highly appreciated. If you wish to participate, please write your contact details, as I will contact you confidentially. This is, of course, optional.

**Name:**

**Email:**

**Phone Number:**

### **Survey for parents of children with Learning Disability (LD)**

Thank you for your participation in this research by completing this questionnaire for primary school teachers of students with ADHD. Answering this questionnaire will not take more than six minutes. The study aims to explore perceptions and perspectives of teachers and parents of students with (A) LD and (B) Attention Deficit Hyperactivity Disorder (ADHD) regarding ADHD and LD labels. This study is approved by the Graduate School of Education at the University of Exeter. Thus, the information that you provide will be kept completely confidential and will remain anonymous. No names will be used in any report. All data from this questionnaire will be used for this study only and it will be deleted after the study is completed. In addition, it would be helpful to follow up some questionnaire with interviews. At the end of the questionnaire, there is a space to write your contact details if you want to do so.

#### **Section One**

**Please tick or circle the appropriate items that represent yourself**

**1- Are you**

- A parent of child with Learning Disability  
 A parent of child with Attention Deficit Hyperactivity Disorder  
 A teacher of children with Learning Disability  
 A teacher of children with Attention Deficit Hyperactivity Disorder

**2- Educational level**

- Primary school  
 Intermediate school  
 High school or diploma  
 Bachelor degree  
 Postgraduate degree

**3- Have you ever involved in training courses or workshops about the disability your child has?**

- Yes  
 No

**4- How many children do you have?**

- 1  2  3  4  5 or more

**5- Age of your child with Learning Disability**

6 7 8 9 10 11 12 or more

**6- School level of your child**

- Low elementary grades 1-3  
 Upper elementary grades 4-6  
 both levels

**Section Two**

This section aims to indicate whether you agree or disagree with the statements by selecting a score to represent your perceptions and views on stigma.

Please tick the following statements by using the following scale:

1= strongly disagree

2= disagree

3= agree

4=strongly agree

**1- My child tends to hide his difficulties from others**

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**2- My child tends to discuss his difficulties with other peers**

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**3- My child tends to hide his school work from me**

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**4- My child tends to hide his school work from other family member or sibling**

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**5- My child tends to avoid writing notes to me**

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**6- My child tends to avoid writing notes to other family members**

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**7- My child tends to avoid spelling in front of me**

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**8- My child tends to avoid spelling in front of other family members**

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**9- My child tends to not tell others about his disability to justify his academic poor performances.**

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**10- My child tends to not acknowledge his disability in order to avoid the negative stereotypes about LD label**

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**Section Three**

This section aims to indicate whether you agree or disagree with the statements by selecting a score to represent your perception and views on self-esteem and labels.

Please tick the following statements by using the following scale:

1= strongly disagree

2= disagree

3= agree

4=strongly agree

**1- Regardless his disability, I think that Learning Disability label has negative effects on my child' self-satisfaction**

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**2- Regardless his disability, I think that Learning Disability label minimises my child ability to do things as most non-labelled students can do**

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**3- Regardless his disability, labelling my child with Learning Disability, makes me feel that he has much to be proud of.**

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

4- **Regardless his disability, I think that Learning Disability label makes my child more likely to fail**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

5- **Regardless his disability, I think that the Learning Disability label makes my child feels useless and frustrated**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

#### **Section Four**

This section aims to indicate whether you agree or disagree with the statements by selecting a score to represent your perception and views on formal and informal labels

Please tick the following statements by using the following scale:

1= strongly disagree

2= disagree

3= agree

4=strongly agree

1- **Beside the effects of his disability, Learning Disability label does not impede my child' academic development**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

2- **Beside the effects of his disability, Learning Disability label impedes my child' social skills development**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

3- **Regardless his disability, Learning Disability label affects my child from having friendship**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

4- **Regardless his disability, Learning Disability label makes my child less smart than others without labels**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

5- **I think that my child gets bullied by other peers because he always goes to resource room**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

6- **I think that my child gets bullied as he is always given extra time compared to others in mainstream classroom to finish the given tasks**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

7- **I think that my child gets bullied as he is always given extra support compared to others in mainstream classroom to finish the given tasks**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

8- **I think that my child gets bullied by others when he demonstrates poor academic performance**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

9- **Regardless his disability, Learning Disability label does not make my child get bullied by others outside the educational setting**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

10- **My child is always labelled by words such as "stupid or thick" instead of Learning Disability label**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

#### **Section Five**

This section aims to indicate whether you agree or disagree with the statements by selecting a score to represent your perception and views on potential behaviours resulted from labels

Please tick the following statements by using the following scale:

1= strongly disagree

2= disagree

3= agree

4=strongly agree

1- **My child tends to change his academic performance to match the negative connotations of Learning Disability label**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

2- **I think that my child is treated differently by others when they know he has Learning Disability label**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**3- Regardless his disability, Learning Disability label does not make my child isolated from others, or not invited by others to play**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**4- My child tends to avoid interacting with others because his worries of being stigmatised**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**5- Other peers treat my child with Learning Disability more differently than non-labelled students who show similar academic issues**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

### **Section Six**

This section aims to indicate whether you agree or disagree with the statements by selecting a score to represent your expectations

Please tick the following statements by using the following scale:

1= strongly disagree

2= disagree

3= agree

4=strongly agree

**1- Teachers treat my child differently once he receives the Learning Disability label**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**2- Teachers treat my child differently once he accesses the resource rooms**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**3- Teachers treat my child differently once he receives extra support compared to other peers**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**4- Teachers treat my child differently once he receives extra time compared to other peers**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**5- Teachers treat my child who has Learning Disability label more differently than non-labelled students who show similar academic issues**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**6- Schools staffs treat student with Learning Disability more differently than non-labelled students who show similar academic issues**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**7- Psychologists treat my child differently when they know he has the LD label**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**8- I think that assigning Learning Disability label has helped my child in developing his academic aspects**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**9- I think that assigning Learning Disability label has not helped my child in developing his social skills**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

This is the end of the questionnaire. Thank you for your time in completing it

I will be carrying out face to face interviews with primary school teachers of students with learning disability to gain deeper understanding about your perceptions regarding learning disability' label. The interview will take up to 40 mins, and your participation will be highly appreciated. If you wish to participate, please write your contact details, as I will contact you confidentially. This is, of course, optional.

**Name:**

**Email:**

**Phone Number:**

## **Survey for primary school teachers who teach students with Attention Deficit Hyperactivity Disorder (ADHD)**

Thank you for your participation in this research by completing this questionnaire for primary school teachers of students with ADHD. Answering this questionnaire will not take more than six minutes. The study aims to explore perceptions and perspectives of teachers and parents of students with (A) Learning Disability (LD) and (B) ADHD regarding ADHD and LD labels. This study is approved by the Graduate School of Education at the University of Exeter. Thus, the information that you provide will be kept completely confidential and will remain anonymous. No names will be used in any report. All data from this questionnaire will be used for this study only and it will be deleted after the study is completed. In addition, it would be helpful to follow up some questionnaire with interviews. At the end of the questionnaire, there is a space to write your contact details if you want to do so.

### **Section One**

#### **Please tick or circle the appropriate items that represent yourself**

**1- Are you**

- Parent of child with Learning Disability
- Parent of child with Attention Deficit Hyperactivity Disorder
- Teacher of children with Learning Disability
- Teacher of children with Attention Deficit Hyperactivity Disorder

**2- Educational level**

- Bachelor degree
- Postgraduate degree

**3- Have you ever involved in training courses or workshops about the disability you deal with?**

- Yes
- No

**4- Years of experience or services**

- 1-5 years
- 6-10 years
- 11 years or more

**5- School level of your students**

- Low elementary grades 1-3
- Upper elementary grades 4-6
- Both levels

### **Section two**

This section aims to indicate whether you agree or disagree with the statements by selecting a score to represent your perceptions and views on stigma

Please tick the following statements by using the following scale

1= strongly disagree

2= disagree

3= agree

4=strongly agree

**1- Students with Attention Deficit Hyperactivity Disorder tend to hide their difficulties from others**

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**2- Students with Attention Deficit Hyperactivity Disorder tend to hide their school work from me**

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**3- Students with Attention Deficit Hyperactivity Disorder tend to hide their school work from other peers**

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

**4- Students with Attention Deficit Hyperactivity Disorder tend to be shy in displaying unaccepted behaviour in my presence**

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

5- **Students with Attention Deficit Hyperactivity Disorder tend to not tell others about their disability to justify their unaccepted behaviours**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

6- **Students with Attention Deficit Hyperactivity Disorder tend to not acknowledge their disability in order to avoid the negative stereotypes about this label**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

### **Section Three**

This section aims to indicate whether you agree or disagree with the statements by selecting a score to represent your perception and views on self-esteem and labels

Please tick the following statements by using the following scale

1= strongly disagree

2= disagree

3= agree

4=strongly agree

1- **Regardless the disability, I think that Attention Deficit Hyperactivity Disorder label has negative effects on students' self-satisfaction**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

2- **Regardless the disability, I think that Attention Deficit Hyperactivity Disorder label minimises students' abilities to do things as most non-labelled students can do**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

3- **Regardless the disability, I think that the Attention Deficit Hyperactivity Disorder label makes students feel useless and frustrated**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

4- **Regardless the disability, I think that Attention Deficit Hyperactivity Disorder label makes students more likely to fail**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

5- **Beside the effects of the disability, Attention Deficit Hyperactivity Disorder label does not impede labelled student' academic development**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

6- **Beside the effects of the disability, Attention Deficit Hyperactivity Disorder label impedes labelled student' social skills development**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

### **Section Four**

This section aims to indicate whether you agree or disagree with the statements by selecting a score to represent your perception and views on formal and informal labels

Please tick the following statements by using the following scale:

1= strongly disagree

2= disagree

3= agree

4=strongly agree

1- **Regardless the disability, Attention Deficit Hyperactivity Disorder label affects children from having friendship**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

2- **Students with Attention Deficit Hyperactivity Disorder label get bullied by other peers because they always go to resource room**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

3- **Students with Attention Deficit Hyperactivity Disorder label get bullied as they are always given extra time compared to others in mainstream classroom to finish the given tasks**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

4- **Student with Attention Deficit Hyperactivity Disorder label get bullied as they are always given extra support compared to others in mainstream classroom to finish the given tasks**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

### **Section Five**

This section aims to indicate whether you agree or disagree with the statements by selecting a score to represent your perception and views on potential behaviours resulted from labels



Please tick the following statements by using the following scale

1= strongly disagree

2= disagree

3= agree

4=strongly agree

1- **Students with Attention Deficit Hyperactivity Disorder tend to change their behaviour to match the negative stereotypes of ADHD label**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

2- **Other peers treat student with Attention Deficit Hyperactivity Disorder more differently than non-labelled students who show similar behavioural issues**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

3- **Regardless the disability, Attention Deficit Hyperactivity Disorder label makes students isolated from others, or not invited by others to play**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

4- **Students with Attention Deficit Hyperactivity Disorder tend to avoid interacting with others because their worries of being stigmatised**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

### Section Six

This section aims to indicate whether you agree or disagree with the statements by selecting a score to represent your expectations

Please tick the following statements by using the following scale

1= strongly disagree

2= disagree

3= agree

4=strongly agree

1- **Mainstream teachers treat children with Attention Deficit Hyperactivity Disorder differently once they receive the ADHD label**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

2- **Mainstream teachers do not treat children with Attention Deficit Hyperactivity Disorder differently once they access the resource rooms**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

3- **Mainstream teachers treat children with Attention Deficit Hyperactivity Disorder differently once they receive extra time compared to other peers**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

4- **Mainstream teachers treat children with Attention Deficit Hyperactivity Disorder more differently than non-labelled students who show similar behavioural issues**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

5- **Other school staffs treat children with Attention Deficit Hyperactivity Disorder differently when they know students have the ADHD label**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

6- **I think that assigning Attention Deficit Hyperactivity Disorder label has helped children in developing their academic aspects**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

7- **I think that assigning Attention Deficit Hyperactivity Disorder label has not helped children in developing their social skills**

4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

This is the end of the questionnaire. Thank you for your time in completing it. I will be carrying out face to face interviews with primary school teachers of students with learning disability to gain deeper understanding about your perceptions regarding learning disability' label. The interview will take up to 40 mins, and your participation will be highly appreciated. If you wish to participate, please write your contact details, as I will contact you confidentially. This is, of course, optional.

Name:

Email:

Phone Number:

## Survey for primary school teachers who teach students with Learning Disability (LD)

Thank you for your participation in this research by completing this questionnaire for primary school teachers of students with learning disability. Answering this questionnaire will not take more than six minutes. The study aims to explore perceptions and perspectives of teachers and parents of (a) students with (LD) and (b) Attention Deficit Hyperactivity Disorder regarding (ADHD) and LD labels. This study is approved by the Graduate School of Education at the University of Exeter. Thus, the information that you provide will be kept completely confidential and will remain anonymous. No names will be used in any report. All data from this questionnaire will be used for this study only and it will be deleted after the study is completed. In addition, it would be helpful to follow up some questionnaire with interviews. At the end of the questionnaire, there is a space to write your contact details if you want to do so.

### Section One

Please tick or circle the appropriate items that represent yourself

#### Are you

- Parent of child with Learning Disability
- Parent of child with Attention Deficit Hyperactivity Disorder
- Teacher of children with Learning Disability
- Teacher of children with Attention Deficit Hyperactivity Disorder

#### 1- Educational level

- Bachelor degree
- Postgraduate degree

#### 2- Have you ever involved in training courses or workshops about the disability you deal with?

- Yes
- No

#### 3- Years of experience or services

- 1-5 years
- 6-10 years
- 11 years or more

#### 4- School level of your students

- Low elementary grades 1-3
- Upper elementary grades 4-6
- Both levels

### Section Two

This section aims to indicate whether you agree or disagree with the statements by selecting a score to represent your perceptions and views on stigma

Please tick the following statements by using the following scale:

1= strongly disagree

2= disagree

3= agree

4=strongly agree

#### 1- Students with Learning Disability tend to hide their difficulties from others

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

#### 2- Students with Learning Disability tend to hide their school work from me

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

#### 3- Students with Learning Disability tend to hide their school work from other peers

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

#### 4- Students with Learning Disability tend to avoid reading loudly in front of me

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

#### 5- Students with Learning Disability tend to avoid writing notes to me

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

#### 6- Students with Learning Disability tend to avoid writing notes to other peers

- 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

#### 7- Students with Learning Disability tend to avoid spelling in front of me

- 4 (Strongly Agree) ○ 3 (Agree) ○ 2 (Disagree) ○ 1 (Strongly Disagree)
- 8- **Students with Learning Disability tell me about their disability to justify their academic poor performances**
- 4 (Strongly Agree) ○ 3 (Agree) ○ 2 (Disagree) ○ 1 (Strongly Disagree)
- 9- **Students with Learning Disability tend to not tell others about their disability to justify their academic poor performances**
- 4 (Strongly Agree) ○ 3 (Agree) ○ 2 (Disagree) ○ 1 (Strongly Disagree)
- 10- **Students with Learning Disability tend to not acknowledge their disability in order to avoid the negative stereotypes about Learning Disability label**
- 4 (Strongly Agree) ○ 3 (Agree) ○ 2 (Disagree) ○ 1 (Strongly Disagree)

### Section Three

This section aims to indicate whether you agree or disagree with the statements by selecting a score to represent your perception and views on self-esteem and labels.

Please tick the following statements by using the following scale:

1= strongly disagree

2= disagree

3= agree

4=strongly agree

- 1- **Regardless the disability, I think that Learning Disability label has negative effects on students' self-satisfaction**
- 4 (Strongly Agree) ○ 3 (Agree) ○ 2 (Disagree) ○ 1 (Strongly Disagree)
- 2- **Regardless the disability, I think that Learning Disability label minimises students' abilities to do things as most non-labelled students can do**
- 4 (Strongly Agree) ○ 3 (Agree) ○ 2 (Disagree) ○ 1 (Strongly Disagree)
- 3- **Regardless the disability, I think that the Learning Disability label gets students feel useless and frustrated**
- 4 (Strongly Agree) ○ 3 (Agree) ○ 2 (Disagree) ○ 1 (Strongly Disagree)
- 4- **Regardless the disability, I think that Learning Disability label makes students more likely to fail**
- 4 (Strongly Agree) ○ 3 (Agree) ○ 2 (Disagree) ○ 1 (Strongly Disagree)
- 5- **Beside the effects of the disability, Learning Disability label does not impede the academic development of labelled student'.**
- 4 (Strongly Agree) ○ 3 (Agree) ○ 2 (Disagree) ○ 1 (Strongly Disagree)
- 6- **Beside the effects of the disability, Learning Disability label impedes the social skills development of labelled student'.**
- 4 (Strongly Agree) ○ 3 (Agree) ○ 2 (Disagree) ○ 1 (Strongly Disagree)

### Section Four

This section aims to indicate whether you agree or disagree with the statements by selecting a score to represent your perception and views on formal and informal labels

Please tick the following statements by using the following scale:

1= strongly disagree

2= disagree

3= agree

4=strongly agree

- 1- **Regardless the disability, Learning Disability label affects students from having friendship**
- 4 (Strongly Agree) ○ 3 (Agree) ○ 2 (Disagree) ○ 1 (Strongly Disagree)
- 2- **Regardless the disability, Learning Disability label makes students smarter than students without labels**
- 4 (Strongly Agree) ○ 3 (Agree) ○ 2 (Disagree) ○ 1 (Strongly Disagree)
- 3- **Students with Learning Disability label get bullied by others because they always go to resource room**
- 4 (Strongly Agree) ○ 3 (Agree) ○ 2 (Disagree) ○ 1 (Strongly Disagree)
- 4- **Students with Learning Disability label get bullied as they are always given extra time compared to others in mainstream classroom to finish the given tasks**
- 4 (Strongly Agree) ○ 3 (Agree) ○ 2 (Disagree) ○ 1 (Strongly Disagree)

- 5- Students with Learning Disability label get bullied as they are always given extra support compared to others in mainstream classroom to finish the given tasks  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 6- Students with Learning Disability label get bullied by others when they demonstrate poor academic performance  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 7- Regardless the disability, Learning Disability label does not make students get bullied by others inside the school  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 8- Students with Learning Disability are always labelled by words such as “stupid or thick” instead of LD label  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

### Section Five

This section aims to indicate whether you agree or disagree with the statements by selecting a score to represent your perception and views on potential behaviours resulted from labels. Please tick the following statements by using the following scale:

1= strongly disagree

2= disagree

3= agree

4=strongly agree

- 1- Students with Learning Disability tend to change their academic performance to match the negative connotations of LD label  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 2- I think that labelled students are not treated differently by others once the Learning Disability label is attached  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 3- Regardless the disability, I think that LD label makes students isolated from, or not invited by others to play  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 4- Students with Learning Disability tend to avoid interacting with others because of their worries of being stigmatised  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 5- Other peers treat students with Learning Disability more differently than non-labelled students who show similar academic issues  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

### Section Six

This section aims to indicate whether you agree or disagree with the statements by selecting a score to represent your expectations.

Please tick the following statements by using the following scale:

1= strongly disagree

2= disagree

3= agree

4=strongly agree

- 1- Mainstream teachers treat children with Learning Disability differently once they receive the LD label  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 2- Mainstream teachers do not treat children with Learning Disability differently once they access the resource rooms  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 3- Mainstream teachers treat children with Learning Disability differently once they receive extra support compared to other peers  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 4- Mainstream teachers treat children with Learning Disability differently once they receive extra time compared to other peers  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

- 5- **Mainstream classroom teachers treat students with Learning Disability more differently than non-labelled students who show similar academic issues**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 6- **Other school staffs treat students with Learning Disability differently when they know students have the LD label**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 7- **I think that assigning Learning Disability label has helped children in developing their academic aspects**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)
- 8- **I think that assigning Learning Disability label has not helped children in developing their social skills**  
 4 (Strongly Agree)  3 (Agree)  2 (Disagree)  1 (Strongly Disagree)

This is the end of the questionnaire. Thank you for your time in completing it.

I will be carrying out face to face interviews with primary school teachers of students with learning disability to gain deeper understanding about your perceptions regarding learning disability' label. The interview will take up to 40 mins, and your participation will be highly appreciated. If you wish to participate, please write your contact details, as I will contact you confidentially. This is, of course, optional.

**Name:**

**Email:**

**Phone Number:**

## Appendix 2 (Questionnaires for All Participants- Arabic version)

### إستطلاع رأي آباء الطلاب ذوي صعوبات التعلم

شكراً لكم على مشاركتكم في هذا البحث عن طريق إتمام هذا الإستبيان الموجه لآباء الطلاب ذوي صعوبات التعلم. سوف يستغرق إتمام هذا الإستبيان تقريباً ستة دقائق. تهدف هذه الدراسة إلى إكتشاف آراء ووجهات نظر أساتذة و آباء الطلاب الذين يعانون من (أ) صعوبات التعلم و (ب) إضطراب تشتت الإنتباه و فرط النشاط حول تسميات هذين الاضطرابين. هذه الدراسة معتمدة من كلية الدراسات العليا للتربية بجامعة إكستر. لذلك سيتم الإحتفاظ بالمعلومات الخاصة بكم في سرية تامة كما انها ستظل غير مسمّاة حيث لن يتم إستخدام أسماء في أي من التقارير الخاصة بالدراسة. البيانات الناتجة عن هذا الإستبيان مقصودة لإستخدامها في الدراسة فقط و سيتم حذفها بعد إنهاء الدراسة. بالإضافة إلى ذلك، سيكون من المفيد لنا إذا قمتم بإجراء بعض المقابلات الشخصية بعد إتمام الإستبيان كما يوجد حيز مخصص في نهاية الإستبيان لكتابة تفاصيل الإتصال بكم إذا رغبتم في ذلك.

### القسم الأول

قم بوضع علامة (صح) أمام الإجابة الأمثل لوصف حالتك أو تطويقها بدائرة

1- هل أنت

- أب لطفل يعاني من صعوبات التعلم
- أب لطفل يعاني من إضطراب تشتت الإنتباه و فرط النشاط
- مدرس لأطفال يعانون من صعوبات التعلم
- مدرس لأطفال يعانون من إضطراب تشتت الإنتباه و فرط النشاط

2- مستوي التعليم

- شهادة إبتدائية
- شهادة إعدادية/ متوسطة
- شهادة ثانوية/ دبلومة
- شهادة جامعية/ بكالوريوس
- شهادة دراسات عليا

3- هل شاركت قبل ذلك في دورات تدريبية أو ورش عمل حول الإضطراب الذي يعاني منه طفلك؟

- نعم
- لا

4- كم لديك من أبناء؟

- 1
- 2
- 3
- 4
- 5 أو أكثر

5- كم من العمر يبلغ طفلك الذي يعاني من صعوبات التعلم؟

- 6
- 7
- 8
- 9

- 10
- 11
- 12 أو أكبر

6- مستوى طفلك الدراسي

- الصفوف الابتدائية الدنيا 1-3
- الصفوف الابتدائية العليا 4-6
- كلتا المرحلتين

القسم الثاني

يهدف هذا القسم إلى تحديد إتفاقتك أو عدم إتفاقتك مع الجمل التالية عن طريق إختيار درجة معينة لتمثيل آرائك و وجهات نظرك حول هذا تسمية صعوبات التعلم وعلاقته بوصمة الناتجة عنه

من فضلك قم بإختيار جملة من الجمل التالية عن طريق إتباع هذا الميزان:-

1= أعارض بشدة

2= أعارض

3= أتفق

4= أتفق بشدة

1- يفضل طفلي ذو صعوبات التعلم إلى إخفاء الصعوبات التي تواجهه عن الآخرين

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

2- يفضل طفلي ذو صعوبات التعلم إلى مناقشة الاكاديمية مشاكله مع أقرانه

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

3- يميل طفلي ذو صعوبات التعلم إلى إخفاء واجباته المدرسية مني

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

4- يميل طفلي ذو صعوبات التعلم إلى إخفاء واجباته المدرسية من أقرانه أو إخوته أو أقرانه

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

5- يميل طفلي ذو صعوبات التعلم إلى تجنب القراءة بصوت مرتفع امامي

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

6- يميل طفلي ذو صعوبات التعلم إلى القراءة بصوت مرتفع امام من أقربائه أو إخوته او اقرانه الاخرين

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

7- يميل طفلي ذو صعوبات التعلم إلى عدم كتابة الملاحظات الموجهة لي

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

8- يميل طفلي ذو صعوبات التعلم إلى عدم كتابة الملاحظات الموجهة لأقربائه أو إخوته او اقرانه الاخرين

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

9- يميل طفلي ذو صعوبات التعلم إلى تجنب الانشطة الاملائية امامي

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

10- يميل طفلي ذو صعوبات التعلم إلى تجنب الانشطة الاملائية امام أقربائه أو إخوته او اقرانه الاخرين

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

11- يخبرني طفلي ذو صعوبات التعلم عن إعاقته كتبريرٍ ضعف مستواه الاكاديمي

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)



○ 1 (أعارض بشدة)

- يخبر طفلي ذو صعوبات التعلم أقرانه الآخرين عن إعاقته كتبريرٍ ضعف مستواه الأكاديمي 12

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

- يميل طفلي ذو صعوبات التعلم عن عدم التصريح بإعاقته كي يتجنب المفاهيم السلبية والشائعة والمرتبطة بصعوبات التعلم 13

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

### القسم الثالث

يهدف هذا القسم إلى تحديد إتفاقتك أو عدم إتفاقتك مع الجمل التالية عن طريق إختيار درجةٍ معينة لتمثيل آرائك و وجهات نظرك حول تقدير الذات والثقة بالنفس مع وجود التصنيف والتسمية

من فضلك قم بإختيار جملةٍ من الجمل التالية عن طريق إتباع هذا الميزان:-

1= أعارض بشدة

2= أعارض

3= أتفق

4= أتفق بشدة

1- بغض النظر عن الإعاقة ، أنا أرى أن تسمية طفلي بصعوبات التعلم يؤثر سلباً على رضاه الذاتي

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

2- بغض النظر عن الإعاقة ، أنا أرى أن تسمية طفلي بصعوبات التعلم يقلل من قدرته على القيام بالأشياء التي يتمكن معظم الأطفال غير المشخصين بهذا الإضطراب من فعلها

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

3- بغض النظر عن إعاقته ، تصنيف وتسمية طفلي بصعوبات التعلم يجعلني أشعر بأنه ليس لديه شيء يفخر به

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

4- بغض النظر عن إعاقته، أنا أرى أن تسمية وتلقيب طفلي بصعوبات التعلم تزيد من احتمالية فشله

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

5- بغض النظر عن إعاقته، أنا أرى أن تسمية وتلقيب طفلي بصعوبات التعلم تجعله عديم القيمة أو تؤدي إلى إحباطه

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

#### القسم الرابع

يهدف هذا القسم إلى تحديد إتفاقتك أو عدم إتفاقتك مع الجمل التالية عن طريق إختيار درجة معينة لتمثيل آرائك و وجهات نظرك حول التسميات والتصنيفات الرسمية و غير الرسمية.

من فضلك قم بإختيار جملةٍ من الجمل التالية عن طريق إتباع هذا الميزان:-

1= أعارض بشدة

2= أعارض

3= أتفق

4= أتفق بشدة

- مع وجود تأثير الاضطراب، أنا أرى أن تسمية وتصنيف صعوبات التعلم لا يُعيق التطور الاكاديمي لطفلي المصنف بهذا الاضطراب 1

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

- مع وجود تأثير الاضطراب، أنا أرى أن تسمية وتصنيف صعوبات التعلم يُعيق تطور المهارات الاجتماعية لطفلي المصنف بهذا الاضطراب 2

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

- بغض النظر عن تأثيرات الإعاقة، أنا أرى بأن تسمية وتصنيف طفلي بصعوبات التعلم يؤثر على محاولاته في تكوين صداقات 3

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

- بغض النظر عن تأثيرات الإعاقة، أنا أرى بأن تسمية وتصنيف طفلي بصعوبات التعلم يجعله أقل ذكاء من أولئك الذين ليس لديهم أي تسمية 4  
اولقب لاي إعاقة

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

- أعتقد بان طفلي ذو صعوبات التعلم يتعرض للتهكم والسخرية من أقرانه بسبب تردده المتكرر على غرفة المصادر 5

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

- أعتقد بان طفلي ذو صعوبات التعلم يتعرض للتهكم والسخرية من أقرانه بسبب حصوله الدائم على وقتٍ أكثر من باقي الطلاب في الفصل 6  
لإنهاء المهام الاكاديمية المطلوبة منه

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

- أعتقد بان طفلي ذو صعوبات التعلم يتعرض للتهكم والسخرية من أقرانه بسبب حصوله الدائم على دعمٍ أكثر من باقي الطلاب في الفصل لإنهاء 7  
المهام الاكاديمية المطلوبة منه

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

- أعتقد بان طفلي ذو صعوبات التعلم يتعرض للتهكم والسخرية من الطلاب الآخرين عند ظهور ضعفه الاكاديمي 8

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

- بغض النظر عن تأثيرات الإعاقة، أنا أرى أن تسمية طفلي بصعوبات التعلم لا تعرضه للتهكم والسخرية من الآخرين داخل البيئة التعليمية او 9  
المدرسة

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

- يوصف طفلي ذو صعوبات التعلم دائماً بكلماتٍ مثل "مهمل وبليد" بدلاً من وصفه بطفلي يعاني من صعوبات التعلم 10

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

#### القسم الخامس

يهدف هذا القسم إلى تحديد إتفاقتك أو عدم إتفاقتك مع الجمل التالية عن طريق إختيار درجةٍ معينة لتمثيل آرائك و وجهات نظرك حول تصرفات ابنك المحتملة و الناتجة عن تشخيصه.

من فضلك قم بإختيار جملةٍ من الجمل التالية عن طريق إتباع هذا الميزان:-

1=أعارض بشدة

2=أعارض

3=أتفق

4=أتفق بشدة

1- يميل طفلي ذو صعوبات التعلم إلى تغيير مستواه الأكاديمي ليتماشى مع بعض المفاهيم السلبية والشائعة المرتبطة بهذا الإضطراب

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

2- اعتقد أن الآخرين يتعاملون بطريقة مختلفة أو سلبية مع طفلي ذو صعوبات التعلم عند معرفتهم بأنه ملقب بهذا الإضطراب

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- بالرغم من تلك الإعاقة، أظن أن تسمية طفلي بصعوبات التعلم تجعله منعزلاً عن الآخرين أو تمنعهم من دعوته إلى اللعب معهم 3

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- يميل طفلي ذو صعوبات التعلم إلى تجنب التعامل مع الآخرين بسبب قلقه من سخريتهم له على لقب صعوبات التعلم 4

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- اعتقد أن الآخرين يتعاملون مع طفلي ذو صعوبات التعلم بطريقة أكثر اختلافاً وبشكل أكثر سلبية من الطلبة الآخرين الغير مصنفين بهذا 5  
الاضطراب والذين لديهم نفس المشاكل الأكاديمية

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

#### القسم السادس

يهدف هذا القسم إلى تحديد إتفاقتك أو عدم إتفاقتك مع الجمل التالية عن طريق إختيار درجة معينة لتمثيل توقعاتك.

من فضلك قم بإختيار جملة من الجمل التالية عن طريق إتباع هذا الميزان:-

1=أعارض بشدة

2=أعارض

3=أتفق

4=أتفق بشدة

1- يتعامل الأساتذة العاديين في فصولهم بطريقةٍ مختلفةٍ او سلبية مع طفلي بسبب تسميته بصعوبات التعلم

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

2- يتعامل الأساتذة العاديين في فصولهم بطريقةٍ مختلفةٍ او سلبية مع طفلي المصنف بصعوبات التعلم النشاط بسبب ترده المتكرر على غرفة المصادر

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- يتعامل الأساتذة العاديين في فصولهم بطريقةٍ مختلفةٍ او سلبية مع طفلي المصنف بصعوبات التعلم بسبب حصوله على دعم اكاديمي أكثر من 3 باقي أقرانه لانهاء المهام الاكاديمية

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- يتعامل الأساتذة العاديين في فصولهم بطريقةٍ مختلفةٍ او سلبية مع طفلي المصنف بصعوبات التعلم بسبب حصوله على وقتٍ أكثر من باقي 4 أقرانه لانهاء المهام الاكاديمية

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- يتعامل الأساتذة العاديين في فصولهم مع طفلي ذو صعوبات التعلم بطريقة أكثر سلبية او مختلفة عن الطلاب غير المصنفين بالإضطراب والذين يعانون من المشكلات الأكاديمية ذاتها بسبب انه مصنف بهذا الاضطراب

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

6- يتعامل موظفو المدرسة مع طفلي ذو صعوبات التعلم بطريقة مختلفة او سلبية عندما يعرفون انه مصنف بصعوبات التعلم

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

7- يتعامل الأطباء النفسيون بطريقة مختلفة مع إبني عندما يعرفون انه مصنف بصعوبات التعلم

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- أظن أن تسمية إبني بصعوبات التعلم ساعده على تطوير قدراته الأكاديمية 8

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- أظن أن إعطاء إبني لقب او تسمية صعوبات التعلم لم يساعده على تطوير مهاراته الاجتماعية 9

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

إنتهى هذا الإستبيان. شكراً لكم على تخصيصكم الوقت لإتمامه.

سوف أقوم بإجراء مقابلات شخصية وجهاً لوجه مع أولياء امور الطلاب الذين يعانون من صعوبات التعلم لأكتسب فهماً أعمق لأرائكم ووجهات نظركم حول تسمية بصعوبات التعلم. ستستغرق المقابلة 40 دقيقة و ستحتل مشاركتكم بكل التقدير. إذا رغبتم في المشاركة فرجاءاً قوموا بكتابة تفاصيل الإتصال الخاصة بكم و سأقوم بالتواصل معكم في سرية تامة. هذه الخطوة إختيارية.

الإسم:

البريد الإلكتروني:

رقم الهاتف:

إستطلاع رأي المعلمين المدارس الإبتدائية المختصين بتدريس الطلاب ذوي صعوبات التعلم

شكراً لكم على مشاركتكم في هذا البحث عن طريق إتمام هذا الإستبيان تقريبا ستة دقائق. تهدف هذه الدراسة إلى إكتشاف آراء ووجهات نظر أساتذة و آباء صعوبات التعلم. سوف يستغرق إتمام هذا الإستبيان تقريبا ستة دقائق. تهدف هذه الدراسة إلى إكتشاف آراء ووجهات نظر أساتذة و آباء الطلاب الذين يعانون من (أ) صعوبات التعلم و (ب) اضطراب تشتت الإنتباه و فرط النشاط حول تسميات هذين الاضطرابين. هذه الدراسة معتمدة من كلية الدراسات العليا للتربية بجامعة إكستر. لذلك سيتم الإحتفاظ بالمعلومات الخاصة بكم في سرية تامة كما انها ستظل غير مسماة حيث لن يتم إستخدام أسماء في أي من التقارير الخاصة بالدراسة. البيانات الناتجة عن هذا الإستبيان مقصودة لإستخدامها في الدراسة فقط و سيتم حذفها بعد إنتهاء الدراسة. بالإضافة إلى ذلك، سيكون من المفيد لنا إذا قمتم بإجراء بعض المقابلات الشخصية بعد إتمام الإستبيان كما يوجد حيز مخصص في نهاية الإستبيان لكتابة تفاصيل الإتصال بكم إذا رغبتم في ذلك.

### القسم الأول

قم بوضع علامة (صح) أمام الإجابة الأمثل لوصف حالتك أو تطويقها بدائرة

1- هل أنت

- أب لطفل يعاني من صعوبات التعلم
- أب لطفل يعاني من اضطراب تشتت الإنتباه و فرط النشاط
- مدرس لأطفال يعانون من صعوبات التعلم
- مدرس لأطفال يعانون من اضطراب تشتت الإنتباه و فرط النشاط

2- مستوي التعليم

- شهادة جامعية/ بكالوريوس
- شهادة دراسات عليا

3- هل شاركت قبل ذلك في دورات تدريبية أو ورش عمل حول الإضطراب الذي تقوم بتدريس الطلبة المصابين به؟

- نعم
- لا

4- كم هي عدد سنوات الخبرة؟

- 1-5 سنوات
- 6-10 سنوات
- 11 سنة او أكثر

5- المستوى الدراسي للأطفال الذين تقوم بتدريسهم

- الصفوف الإبتدائية الدنيا 1-3
- الصفوف الإبتدائية العليا 4-6
- كلتا المرحلتين

### القسم الثاني

يهدف هذا القسم إلى تحديد إتفاقتك أو عدم إتفاقتك مع الجمل التالية عن طريق إختيار درجة معينة لتمثيل آرائك و وجهات نظرك حول هذا تسمية صعوبات التعلم وعلاقته بوصمة الناتجة عنه

من فضلك قم بإختيار جملة من الجمل التالية عن طريق إتباع هذا الميزان:-

1= أعرض بشدة

2= أعارض

3= أتفق

4= أتفق بشدة

1- يفضل الطفل ذو صعوبات التعلم إلى إخفاء الصعوبات التي تواجهه عن الآخرين

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

2- يفضل الطفل ذو صعوبات التعلم إلى مناقشة مشاكله الأكاديمية مع أقرانه

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

3- يميل الطفل ذو صعوبات التعلم إلى إخفاء واجباته المدرسية مني

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

4- يميل الطفل ذو صعوبات التعلم إلى إخفاء واجباته المدرسية من أقربائه أو إخوته أو أقرانه

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

5- يميل الطفل ذو صعوبات التعلم إلى تجنب القراءة بصوت مرتفع أمامي

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

6- يميل الطفل ذو صعوبات التعلم إلى القراءة بصوت مرتفع أمام أقربائه أو إخوته أو أقرانه الآخرين

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

7- يميل الطفل ذو صعوبات التعلم إلى عدم كتابة الملاحظات الموجهة لي

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)



○ 1 (أعارض بشدة)

8- يميل الطفل ذو صعوبات التعلم إلى عدم كتابة الملاحظات الموجهة لاقراءه الاخرين

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

9- يميل الطفل ذو صعوبات التعلم إلى تجنب الانشطة الاملائية امامي

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

- يخبرني الطفل ذو صعوبات التعلم عن إعاقته كتبريرٍ ضعف مستواه الاكاديمي 10

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

- يخبر الطفل ذو صعوبات التعلم اقرانه الاخرين عن إعاقته كتبريرٍ ضعف مستواه الاكاديمي 11

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

- يميل الطفل ذو صعوبات التعلم عن عدم التصريح بإعاقته كي يتجنب المفاهيم السلبية والشائعة والمرتبطة بصعوبات التعلم 12

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

### القسم الثالث

يهدف هذا القسم إلى تحديد إتفاقتك أو عدم إتفاقتك مع الجمل التالية عن طريق إختيار درجةٍ معينة لتمثيل آرائك و وجهات نظرك حول تقدير الذات والثقة بالنفس مع وجود التصنيف والتسمية

من فضلك قم بإختيار جملةٍ من الجمل التالية عن طريق إتباع هذا الميزان:-

1= أعارض بشدة

2= أعارض

3= أتفق

4= أتفق بشدة

1- بغض النظر عن الإعاقة ، أنا أرى أن تسمية الطفل بصعوبات التعلم يؤثر سلباً على رضاه الذاتي

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

2- بغض النظر عن الإعاقة ، أنا أرى أن تسمية الطفل بصعوبات التعلم يقلل من قدرته على القيام بالأشياء التي يتمكن معظم الأطفال غير المشخصين بهذا الإضطراب من فعلها

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

3- بغض النظر عن إعاقته، تصنيف وتسمية الطفل بصعوبات التعلم يجعلني أشعر بأنه ليس لديه شيء يفخر به

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

4- بغض النظر عن إعاقته، أنا أرى أن تسمية وتلقيب الطفل بصعوبات التعلم تجعله عديم القيمة أو تؤدي إلى إحباطه

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

5- بغض النظر عن إعاقته، أنا أرى أن تسمية وتلقيب الطفل بصعوبات التعلم تزيد من احتمالية فشله

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

6- مع وجود تأثير الاضطراب، أنا أرى أن تسمية وتصنيف صعوبات التعلم لا يُعيق التطور الأكاديمي للطلبة المصنفين بهذا الاضطراب

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

7- مع وجود تأثير الاضطراب، أنا أرى أن تسمية وتصنيف صعوبات التعلم يُعيق تطور المهارات الاجتماعية للطلبة المصنفين بهذا الاضطراب

- 4 (أتفق بشدة)
- 3 (أتفق)

- 2 (أعارض)
- 1 (أعارض بشدة)

#### القسم الرابع

يهدف هذا القسم إلى تحديد إتيافاك أو عدم إتيافاك مع الجمل التالية عن طريق إختيار درجة معينة لتمثيل آرائك و وجهات نظرك حول التسميات التصنيفات الرسمية و غير الرسمية.

من فضلك قم بإختيار جملةٍ من الجمل التالية عن طريق إتباع هذا الميزان:-

1= أعارض بشدة

2= أعارض

3= أتفق

4= أتفق بشدة

1- بغض النظر عن تأثيرات الإعاقة، انا أرى بان تسمية وتصنيف الطلبة بصعوبات التعلم يؤثر على محاولاتهم في تكوين صداقات

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- بغض النظر عن تأثيرات الإعاقة، انا أرى بان تسمية وتصنيف الطلبة بصعوبات التعلم يجعلهم أذكى من أولئك الذين ليس لديهم أي تسمية او لقب لاي إعاقة

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- أعتقد بان الطلبة ذوي صعوبات التعلم يتعرضون للتهكم والسخرية من أقرانهم بسبب ترددهم المتكرر على غرفة المصادر 3

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- أعتقد بان الطلبة ذوي صعوبات التعلم يتعرضون للتهكم والسخرية من أقرانهم بسبب حصولهم الدائم على وقتٍ أكثر من باقي الطلاب في 4 الفصل لإنهاء المهام الاكاديمية المطلوبة منهم

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- أعتقد بان الطلبة ذوي صعوبات التعلم يتعرضون للتهكم والسخرية من أقرانهم بسبب حصولهم الدائم على دعم أكثر من باقي الطلاب في 5 الفصل لإنهاء المهام الأكاديمية المطلوبة منهم

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- أعتقد بان الطلبة ذوي صعوبات التعلم يتعرضون للتهكم والسخرية من الطلاب الآخرين عند ظهور ضعفهم الأكاديمي 6

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- بغض النظر عن تأثيرات الإعاقة، أنا أرى أن تسمية الطفل بصعوبات التعلم لا تعرضه للتهكم والسخرية من الآخرين داخل البيئة التعليمية او المدرسة

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- يوصف الطالب ذو صعوبات التعلم دائماً بكلماتٍ مثل "مهمل وبليد" بدلاً من وصفه بطفلٍ يعاني من صعوبات التعلم 8

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

#### القسم الخامس

يهدف هذا القسم إلى تحديد إتفاقتك أو عدم إتفاقتك مع الجمل التالية عن طريق إختيار درجةٍ معينة لتمثيل آرائك و وجهات نظرك حول تصرفات الطالب المحتملة و الناتجة عن تشخيصه.

من فضلك قم بإختيار جملةٍ من الجمل التالية عن طريق إتباع هذا الميزان:-

1=أعارض بشدة

2=أعارض

3=أتفق

4=أتفق بشدة

1- يميل الطالب ذو صعوبات التعلم إلى تغيير مستواه الأكاديمي ليتماشى مع بعض المفاهيم السلبية والشائعة المرتبطة بهذا الإضطراب

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

2- اعتقد أن الآخرين لا يتعاملون بطريقة مختلفة أو سلبية مع الطلبة ذوي صعوبات التعلم عند معرفتهم بانهم ملقبون بهذا الإضطراب

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- بالرغم من تلك الإعاقة، أظن أن تسمية الطالب بصعوبات التعلم يجعله منعزلاً عن الآخرين أو يمنعهم من دعوته إلى اللعب معهم 3

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- يميل الطالب صعوبات التعلم إلى تجنب التعامل مع الآخرين بسبب قلقه من سخرتهم له على لقب صعوبات التعلم 4

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- اعتقد أن الآخرين يتعاملون مع الطلبة ذوي صعوبات التعلم بطريقة أكثر اختلافاً وبشكل أكثر سلبية من الطلبة الآخرين الغير مصنفين بهذا 5  
الاضطراب والذين لديهم نفس المشاكل الأكاديمية

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

#### القسم السادس

يهدف هذا القسم إلى تحديد إتفاقتك أو عدم إتفاقتك مع الجمل التالية عن طريق إختيار درجة معينة لتمثيل توقعاتك.

من فضلك قم بإختيار جملةٍ من الجمل التالية عن طريق إتباع هذا الميزان:-

1= أعارض بشدة

2= أعارض

3= أتفق

4= أتفق بشدة

بصعوبات التعلم 1- يتعامل الأساتذة العاديين في فصولهم بطريقةٍ مختلفةٍ او سلبية مع الطلبة بسبب تسميتهم

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

2- لا يتعامل الأساتذة العاديين في فصولهم بطريقةٍ مختلفةٍ او سلبية مع الطلبة المصنفين بصعوبات التعلم النشاط بسبب ترددهم المتكرر على غرفة المصادر

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- يتعامل الأساتذة العاديين في فصولهم بطريقةٍ مختلفةٍ او سلبية مع الطلبة المصنفين بصعوبات التعلم بسبب حصولهم على وقتٍ أكثر من باقي أقرانهم لانتهاء المهام الاكاديمية

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- يتعامل الأساتذة العاديين في فصولهم بطريقةٍ مختلفةٍ او سلبية مع الطلبة المصنفين بصعوبات التعلم بسبب حصولهم على دعم أكاديمي أكثر من باقي أقرانهم لانتهاء المهام الاكاديمية

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- يتعامل الأساتذة العاديين في فصولهم مع الطلاب المصابين بصعوبات التعلم بطريقةٍ أكثر سلبية او مختلفة عن الطلاب غير المصنفين بالإضطراب والذين يعانون من المشكلات الاكاديمية ذاتها بسبب وجود تسمية هذا الاضطراب

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

6- يتعامل موظفو المدرسة مع الطلاب المصابين بصعوبات التعلم بطريقةٍ مختلفةٍ او سلبية عندما يعرفون انه مصنف بصعوبات التعلم

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- أظن أن تسمية الطالب بصعوبات التعلم ساعده على تطوير قدراته الأكاديمية6

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- أظن أن إعطاء الطالب لقب او تسمية صعوبات التعلم لم يساعده على تطوير مهاراته الاجتماعية7

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)

إنتهى هذا الإستبيان. شكراً لكم على تخصيصكم الوقت لإتمامه.

سوف أقوم بإجراء مقابلاتٍ شخصيةٍ وجهاً لوجهٍ مع معلمي الطلاب الذين يعانون من صعوبات التعلم لأكتسب فهماً أعمق لأرائكم ووجهات نظركم حول تسمية بصعوبات التعلم. ستستغرق المقابلة 40 دقيقة و ستحتل مشاركتكم بكل التقدير. إذا رغبتم في المشاركة فرجاءاً قوموا بكتابة تفاصيل الإتصال الخاصة بكم و سأقوم بالتواصل معكم في سريةٍ تامة. هذه الخطوة إختيارية.

الإسم:

البريد الإلكتروني:

رقم الهاتف:

### إستطلاع رأي لآباء الأطفال المصابين بإضطراب تشتت الإنتباه وفرط النشاط

شكراً لكم على مشاركتكم في هذا البحث عن طريق إتمام هذا الإستبيان الموجه لآباء الطلاب المصابين بإضطراب تشتت الإنتباه وفرط النشاط. سوف يستغرق إتمام هذا الإستبيان تقريبا ستة دقائق. تهدف هذه الدراسة إلى إكتشاف آراء ووجهات نظر أساتذة و آباء الطلاب الذين يعانون من (أ) صعوبات التعلم و (ب) إضطراب تشتت الإنتباه و فرط النشاط حول تسميات هذين الاضطرابين. هذه الدراسة معتمدة من كلية الدراسات العليا للتربية بجامعة إكستر. لذلك سيتم الإحتفاظ بالمعلومات الخاصة بكم في سريةٍ تامة كما انها ستظل غير مسمّاة حيث لن يتم إستخدام أسماء في أي من التقارير الخاصة بالدراسة. البيانات الناتجة عن هذا الإستبيان مقصودةٌ لإستخدامها في الدراسة فقط و سيتم حذفها بعد إنهاء الدراسة. بالإضافة إلى ذلك، سيكون من المفيد لنا إذا قمتم بإجراء بعض المقابلات الشخصية بعد إتمام الإستبيان كما يوجد حيز مخصص في نهاية الإستبيان لكتابة تفاصيل الإتصال بكم إذا رغبتم في ذلك.

#### القسم الأول

قم بوضع علامة (صح) أمام الإجابة الأمثل لوصف حالتك أو تطويقها بدائرة

1- هل أنت

- أب لطفل يعاني من صعوبات التعلم
- أب لطفل يعاني من إضطراب تشتت الإنتباه و فرط النشاط
- مدرس لأطفالٍ يعانون من صعوبات التعلم
- مدرس لأطفالٍ يعانون من إضطراب تشتت الإنتباه و فرط النشاط

2- مستوى التعليم

- شهادة ابتدائية
- شهادة إعدادية/متوسطة
- شهادة ثانوية/ دبلومة
- شهادة جامعية/ بكالوريوس
- شهادة دراسات عليا

3- هل شاركت قبل ذلك في دورات تدريبية أو ورش عمل حول الإضطراب الذي يعاني منه طفلك؟

○ نعم

○ لا

4- كم لديك من أبناء؟

○ 1

○ 2

○ 3

○ 4

○ 5 أو أكثر

5- كم من العمر يبلغ طفلك الذي يعاني من اضطراب تشتت الإنتباه وفرط النشاط؟

○ 6

○ 7

○ 8

○ 9

○ 10

○ 11

○ 12 أو أكبر

6- مستوي طفلك الدراسي

○ الصفوف الإبتدائية الدنيا 1-3

○ الصفوف الإبتدائية العليا 4-6

○ كلتا المرحلتين

### القسم الثاني

يهدف هذا القسم إلى تحديد إتفاقتك أو عدم إتفاقتك مع الجمل التالية عن طريق إختيار درجة معينة لتمثيل آرائك و وجهات نظرك حول هذا اللقب او التسمية.

من فضلك قم بإختيار جملةٍ من الجمل التالية عن طريق إتباع هذا الميزان:-

1= أعارض بشدة

2= أعارض

3= أتفق

4= أتفق بشدة

1- يفضل إبني إخفاء الصعوبات التي تواجهه عن الآخرين

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

2- يفضل إبني عدم مناقشة مشاكله مع أقرانه

○ 4 (أتفق بشدة)

○ 3 (أتفق)



- 2 (أعارض)
- 1 (أعارض بشدة)

3- يميل إبي إلى إخفاء واجباته المدرسية مني

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

4- يميل إبي إلى إخفاء واجباته المدرسية من أقرائه أو إخوته

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

5- يخجل إبي من إظهار ممارسته لتصرف غير مقبول أثناء وجودي

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

6- يخجل إبي من إظهار ممارسته لتصرف غير مقبول أثناء وجود أقرابه أو إخوته

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

7- يخبرني إبي المصاب باضطراب تشتت الإنتباه وفرط النشاط عن إعاقة كتبرير لسلوكه الغير مقبول

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

8- لا يخبرني إبي المصاب باضطراب تشتت الإنتباه وفرط النشاط عن إعاقة كتبرير لسلوكه الغير مقبول

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

9- يفضل إبي عدم الإقرار بإعاقة ليتجنب الصور النمطية السلبية المنتشرة حول لقب اضطراب تشتت الإنتباه وفرط النشاط

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

### القسم الثالث

يهدف هذا القسم إلى تحديد إتفاقاتك أو عدم إتفاقاتك مع الجمل التالية عن طريق إختيار درجة معينة لتمثيل آرائك و وجهات نظرك حول تقدير الذات والثقة بالنفس مع وجود التصنيف والتسمية

من فضلك قم بإختيار جملة من الجمل التالية عن طريق إتباع هذا الميزان:-

1=أعارض بشدة

2=أعارض

3=أتفق

4=أتفق بشدة

1- بغض النظر عن إعاقة إبني، أنا أرى أن إضطراب تشتت الإنتباه وفرط النشاط يؤثر سلباً على رضاه الذاتي

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

2- بغض النظر عن إعاقة إبني، أنا أرى أن إضطراب تشتت الإنتباه وفرط النشاط يقلل من قدرته على القيام بالأشياء التي يتمكن معظم الأطفال غير المشخصين بهذا الإضطراب من فعلها

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

3- بغض النظر عن إعاقة، تصنيف إبني كطفلٍ يعاني من إضطراب تشتت الإنتباه وفرط النشاط يجعلني أشعر بأنه ليس فخورا

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

4- بغض النظر عن إعاقة أنا أرى أن تسمية وتلقيب ابني بإضطراب تشتت الإنتباه وفرط النشاط تزيد من احتمالية فشله

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

5- بغض النظر عن إعاقة أنا أرى أن تسمية وتلقيب ابني بإضطراب تشتت الإنتباه وفرط النشاط لا تجعله عديم القيمة أو تؤدي إلى إحباطه

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

### القسم الرابع

يهدف هذا القسم إلى تحديد إتفاقاتك أو عدم إتفاقاتك مع الجمل التالية عن طريق إختيار درجة معينة لتمثيل آرائك و وجهات نظرك حول التسميات والتصنيفات الرسمية و غير الرسمية.

من فضلك قم بإختيار جملةٍ من الجمل التالية عن طريق إتباع هذا الميزان:-

1=أعارض بشدة

2=أعارض

3=أتفق

4=أتفق بشدة

1- بغض النظر عن تأثيرات الإعاقة التي يعاني منها إبنى فأنا لا أرى أن تسميته وتلقيبه بإضطراب تشتت الإنتباه وفرط النشاط يُعيق تطوره العلمي والدراسي

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

2- بغض النظر عن تأثيرات الإعاقة التي يعاني منها إبنى فإن تسميته وتلقيبه بإضطراب تشتت الإنتباه وفرط النشاط يُعيق تطور مهاراته الإجتماعية

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

3- بغض النظر عن تأثيرات الإعاقة التي يعاني منها إبنى فإن تسميته وتلقيبه بإضطراب تشتت الإنتباه وفرط النشاط يؤثر على محاولاته في تكوين صداقات

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

4- بغض النظر عن تأثيرات الإعاقة التي يعاني منها إبنى فإن تصنيفه وتسميته كطفلٍ يعاني من إضطراب تشتت الإنتباه وفرط النشاط يجعله أذكى من أولئك الذين لا يعانون من هذه الإعاقة

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

5- أظن أن إبنى يتعرض للتهكم والسخرية من أقرانه بسبب تردده المتكرر على غرفة المصادر

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

6- أظن أن إبنى يتعرض للتهكم والسخرية من أقرانه بسبب حصوله الدائم على وقتٍ أكثر من باقي الطلاب في الفصل لإنهاء المهام الاكاديمية المطلوبة منه

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

7- أظن أن إبي يتعرض للتهكم والسخرية من أقرانه بسبب حصوله الدائم على دعم أكثر من باقي الطلاب في الفصل لإنهاء المهام الأكاديمية المطلوبة منه

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

8- أظن أن إبي يتعرض للتهكم والسخرية من الطلاب الآخرين عندما يقوم بتصرفاتٍ غير مقبولة

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

9- بغض النظر عن إعاقته أنا أرى أن تسمية إبي بإضطراب تشتت الإنتباه وفرط النشاط لا تعرضه للتهكم والسخرية من الآخرين خارج البيئة التعليمية

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

10- يوصف إبي دائماً بكلماتٍ مثل "مزعج و شقي" بدلاً من وصفه بطفلي يعاني من اضطراب تشتت الإنتباه وفرط النشاط

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

#### القسم الخامس

يهدف هذا القسم إلى تحديد إتفاقتك أو عدم إتفاقتك مع الجمل التالية عن طريق إختيار درجةٍ معينة لتمثيل آرائك و وجهات نظرك حول تصرفات إبنك المحتملة و الناتجة عن تشخيصه.

من فضلك قم بإختيار جملةٍ من الجمل التالية عن طريق إتباع هذا الميزان:-

1= أعارض بشدة

2= أعارض

3= أتفق

4= أتفق بشدة

1- يميل إبي إلى تعديل سلوكه ليتماشى مع المفاهيم السلبية والشائعة المرتبطة بإضطراب تشتت الإنتباه وفرط النشاط

- 4 (أتفق بشدة)

- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

2- أظن أن إبني يلقي معاملةً مختلفةً أو سلبيةً من الآخرين عند معرفتهم بأنه ملقب بإضطراب تشتت الإنتباه وفرط النشاط

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

3- بالرغم من تلك الإعاقة، لا أظن أن تسمية ابني بإضطراب تشتت الإنتباه وفرط الحركة يجعله منعزلاً عن الآخرين أو يمنعهم من دعوته إلى اللعب معهم

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

4- يميل إبني إلى تجنب التعامل مع الآخرين بسبب قلقه من سخريتهم له على لقب إضطراب تشتت الإنتباه وفرط الحركة

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

5- يقوم أقران إبني المصاب بإضطراب تشتت الإنتباه وفرط النشاط بالتعامل معه بطريقةٍ تختلف عن الطلاب غير المصابين بهذا الإضطراب و الذين ربما يعانون من مشكلات سلوكية مشابهة بسبب انه ملقب بهذا الاضطراب

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

#### القسم السادس

يهدف هذا القسم إلى تحديد إتفاقتك أو عدم إتفاقتك مع الجمل التالية عن طريق إختيار درجةٍ معينة لتمثيل توقعاتك.

من فضلك قم بإختيار جملةٍ من الجمل التالية عن طريق إتباع هذا الميزان:-

1= أعارض بشدة

2= أعارض

3= أتفق

4= أتفق بشدة

1- يتعامل الأساتذة بطريقةٍ مختلفة أو سلبية مع إبني بسبب تسميته بالإصابة بإضطراب تشتت الإنتباه وفرط النشاط

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)

○ 1 (أعارض بشدة)

2- يتعامل الأساتذة بطريقةٍ مختلفةٍ او سلبيةٍ مع إبي بسبب تردده المتكرر على غرفة المصادر

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

3- يتعامل الأساتذة بطريقةٍ مختلفةٍ او سلبيةٍ مع إبي بسبب حصوله على مساعدة اكااديمية من المعلمين أكثر من باقي أقرانه

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

4- يتعامل الأساتذة بطريقةٍ مختلفةٍ او سلبيةٍ مع إبي بسبب حصوله على وقتٍ أكثر من باقي أقرانه

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

5- يتعامل الأساتذة مع إبي المصاب بإضطراب تشتت الإنتباه وفرط النشاط بطريقةٍ تختلف عن الطلاب غير المصابين بالإضطراب ولكن يعانون من المشكلات السلوكية ذاتها بسبب انه ملقب بهذا الاضطراب

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

6- يتعامل موظفو المدرسة مع الطلاب المصابين بإضطراب تشتت الإنتباه وفرط النشاط بطريقةٍ تختلف عن الطلاب غير المصابين بالإضطراب و لكن يعانون من المشكلات السلوكية ذاتها بسبب تسميته بهذا الاضطراب

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

7- يتعامل الأطباء النفسيون بطريقةٍ مختلفةٍ مع إبي عندما يعرفون انه مصنف بإضطراب تشتت الإنتباه وفرط النشاط

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

8- أظن أن وصف إبي بلقب مصاب بإضطراب تشتت الإنتباه وفرط النشاط قد يساعده على تطوير قدراته الأكاديمية

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

9- أظن أن إعطاء إبي بلقب مصاب بإضطراب تشتت الإنتباه و فرط النشاط لم يساعده على تطوير قدراته الأكاديمية

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

إنتهى هذا الإستبيان. شكراً لكم على تخصيصكم الوقت لإتمامه.

سوف أقوم بإجراء مقابلاتٍ شخصيةٍ وجهاً لوجهٍ مع والدي الطلاب الذين يعانون من اضطراب تشتت الإنتباه و فرط النشاط لأكتسب فهماً أعمق لأرائكم و وجهات نظرکم حول تسمية اضطراب تشتت الإنتباه و فرط النشاط. ستستغرق المقابلة 40 دقيقة و ستحظى مشاركتكم بكل التقدير. إذا رغبتكم في المشاركة فرجاءاً قوموا بكتابة تفاصيل الإتصال الخاصة بكم و سأقوم بالتواصل معكم في سريةٍ تامة. هذه الخطوة إختيارية.

الإسم:

البريد الإلكتروني:

رقم الهاتف:

**إستطلاع رأي لمعلمين المدارس الإبتدائية المختصين بتدريس الطلاب الأطفال المصابين باضطراب تشتت الإنتباه و فرط النشاط**

شكراً لكم على مشاركتكم في هذا البحث عن طريق إتمام هذا الإستبيان الموجه لأساتذة المدارس الإبتدائية المختصين بتدريس الطلاب المصابين باضطراب تشتت الإنتباه و فرط النشاط. سوف يستغرق إتمام هذا الإستبيان تقريبا ستة دقائق. تهدف هذه الدراسة إلى إكتشاف آراء و وجهات نظر أساتذة و آباء الطلاب الذين يعانون من (أ) صعوبات التعلم و (ب) اضطراب تشتت الإنتباه و فرط النشاط حول تسميات هذين الاضطرابين. هذه الدراسة معتمدة من كلية الدراسات العليا للتربية بجامعة إكستر. لذلك سيتم الإحتفاظ بالمعلومات الخاصة بكم في سريةٍ تامة كما انها ستظل غير مسماةٍ حيث لن يتم إستخدام أسماء في أي من التقارير الخاصة بالدراسة. البيانات الناتجة عن هذا الإستبيان مقصودةٌ لإستخدامها في الدراسة فقط و سيتم حذفها بعد إنهاء الدراسة. بالإضافة إلى ذلك، سيكون من المفيد لنا إذا قمتم بإجراء بعض المقابلات الشخصية بعد إتمام الإستبيان كما يوجد حيز مخصص في نهاية الإستبيان لكتابة تفاصيل الإتصال بكم إذا رغبتكم في ذلك.

**القسم الأول**

**قم بوضع علامة (صح) أمام الإجابة الأمثل لوصف حالتك أو تطويقها بدائرة**

1- هل أنت

○ أب لطفل يعاني من صعوبات التعلم

○ أب لطفل يعاني من اضطراب تشتت الإنتباه و فرط النشاط

○ مدرس لأطفالٍ يعانون من صعوبات التعلم

○ مدرس لأطفالٍ يعانون من اضطراب تشتت الإنتباه و فرط النشاط

2- مستوي التعليم

○ شهادة جامعية/ بكالوريوس

○ شهادة دراسات عليا

3- هل شاركت قبل ذلك في دورات تدريبية أو ورش عمل حول الإضطراب الذي تقوم بالتدريس حوله؟

- نعم  
 لا

4- كم هي عدد سنوات الخبرة؟

- 5-1 سنوات  
 6-10 سنوات  
 11 سنة او أكثر

- المستوى الدراسي للأطفال الذين تقوم بتدريسهم 5

- الصفوف الابتدائية الدنيا 1-3  
 الصفوف الابتدائية العليا 4-6  
 كلتا المرحلتين

#### القسم الثاني

يهدف هذا القسم إلى تحديد إتفاقتك أو عدم إتفاقتك مع الجمل التالية عن طريق إختيار درجة معينة لتمثيل آرائك و وجهات نظرك حول هذا تسمية إضطراب تشتت الإنتباه و فرط النشاط وعلاقته بالوصمة

من فضلك قم بإختيار جملة من الجمل التالية عن طريق إتباع هذا الميزان:-

1= أعارض بشدة

2= أعارض

3= أتفق

4= أتفق بشدة

1- يفضل الطفل ذو إضطراب تشتت الإنتباه و فرط النشاط الى إخفاء الصعوبات التي تواجهه عن الآخرين

- 4 (أتفق بشدة)  
 3 (أتفق)  
 2 (أعارض)  
 1 (أعارض بشدة)

2- يفضل الطفل ذو إضطراب تشتت الإنتباه و فرط النشاط الى مناقشة مشاكله مع أقرانه

- 4 (أتفق بشدة)  
 3 (أتفق)  
 2 (أعارض)  
 1 (أعارض بشدة)

3- يميل الطفل ذو إضطراب تشتت الإنتباه و فرط النشاط إلى إخفاء واجباته المدرسية مني

- 4 (أتفق بشدة)  
 3 (أتفق)  
 2 (أعارض)  
 1 (أعارض بشدة)



4- يميل الطفل ذو اضطراب تشتت الإنتباه وفرط النشاط إلى إخفاء واجباته المدرسية من أقرائه أو إخوته

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

5- يخجل الطفل ذو اضطراب تشتت الإنتباه وفرط النشاط من إظهار ممارسته لتصرف غير مقبول أثناء وجوده

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

6- يخجل الطفل ذو اضطراب تشتت الإنتباه وفرط النشاط من إظهار ممارسته لتصرف غير مقبول أثناء وجود أقرابه أو إخوته

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

7- يخبرني الطفل المصاب باضطراب تشتت الإنتباه وفرط النشاط عن إعاقة كتبرير لسلوكه الغير مقبول

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

8- لا يصرح الطفل المصاب باضطراب تشتت الإنتباه وفرط النشاط عن إعاقة لاقربائه الاخرين كتبرير لسلوكه الغير مقبول

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

9- يفضل الطفل ذو اضطراب تشتت الإنتباه وفرط النشاط عدم الإقرار بإعاقة ليتجنب المفاهيم السلبية المنتشرة حول لقب اضطراب تشتت الإنتباه وفرط النشاط

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

### القسم الثالث

يهدف هذا القسم إلى تحديد إتفاقتك أو عدم إتفاقتك مع الجمل التالية عن طريق إختيار درجة معينة لتمثيل آرائك و وجهات نظرك حول تقدير الذات والثقة بالنفس مع وجود التصنيف والتسمية

من فضلك قم بإختيار جملة من الجمل التالية عن طريق إتباع هذا الميزان:-

1= أعارض بشدة

2= أعارض

3= أتفق

4= أتفق بشدة

1- بغض النظر عن الإعاقة ، أنا أرى أن تسمية الطفل بإضطراب تشتت الإنتباه وفرط النشاط يؤثر سلباً على رضاه الذاتي

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

2- بغض النظر عن الإعاقة ، أنا أرى أن تسمية الطفل بإضطراب تشتت الإنتباه وفرط النشاط يقلل من قدرته على القيام بالأشياء التي يتمكن معظم الأطفال غير المشخصين بهذا الإضطراب من فعلها

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

3- بغض النظر عن إعاقة، تصنيف وتسمية الطفل بإضطراب تشتت الإنتباه وفرط النشاط يجعلني أشعر بأنه ليس لديه شيء يفخر به

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

4- بغض النظر عن إعاقة، أنا أرى أن تسمية وتلقيب الطفل بإضطراب تشتت الإنتباه وفرط النشاط تجعله عديم القيمة أو تؤدي إلى إحباطه

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

5- بغض النظر عن إعاقة، أنا أرى أن تسمية وتلقيب الطفل بإضطراب تشتت الإنتباه وفرط النشاط تزيد من احتمالية فشله

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

6 - مع وجود تأثير الاضطراب، أنا أرى أن تسمية وتصنيف اضطراب تشتت الإنتباه وفرط النشاط يُعيق التطور الأكاديمي للطلبة المصنفين بهذا الاضطراب

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- مع وجود تأثير الاضطراب، أنا أرى أن تسمية وتصنيف اضطراب تشتت الإنتباه وفرط النشاط يُعيق تطور المهارات الاجتماعية للطلبة 7 المصنفين بهذا الاضطراب

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

#### القسم الرابع

يهدف هذا القسم إلى تحديد إتفاقتك أو عدم إتفاقتك مع الجمل التالية عن طريق إختيار درجةٍ معينة لتمثيل آرائك و وجهات نظرك حول التسميات والتصنيفات الرسمية و غير الرسمية.

من فضلك قم بإختيار جملةٍ من الجمل التالية عن طريق إتباع هذا الميزان:-

1= أعارض بشدة

2= أعارض

3= أتفق

4= أتفق بشدة

1- بغض النظر عن تأثيرات الإعاقة، أنا أرى بأن تسمية وتصنيف الطلبة باضطراب تشتت الإنتباه وفرط النشاط يؤثر على محاولاتهم في تكوين صداقات

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- بغض النظر عن تأثيرات الإعاقة، أنا أرى بأن تسمية وتصنيف الطلبة باضطراب تشتت الإنتباه وفرط النشاط يجعلهم أذكي من أولئك الذين ليس لديهم أي تسمية اولقب لاي إعاقة

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- أعتقد بأن الطلبة ذوي اضطراب تشتت الإنتباه وفرط النشاط يتعرضون للتهكم والسخرية من أقرانهم بسبب ترددهم المتكرر على غرفة المصادر

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- أعتقد بان الطلبة ذوي اضطراب تشتت الإنتباه وفرط النشاط يتعرضون للتهكم والسخرية من أقرانهم بسبب حصولهم الدائم على وقتٍ أكثر 4 من باقي الطلاب في الفصل لإنهاء المهام الاكاديمية المطلوبة منهم

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- أعتقد بان الطلبة ذوي اضطراب تشتت الإنتباه وفرط النشاط يتعرضون للتهكم والسخرية من أقرانهم بسبب حصولهم الدائم على دعمٍ أكثر 5 من باقي الطلاب في الفصل لإنهاء المهام الاكاديمية المطلوبة منه

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- أعتقد بان الطلبة ذوي اضطراب تشتت الإنتباه وفرط النشاط يتعرضون للتهكم والسخرية من الطلاب الآخرين عندما يقومون بتصرفاتٍ غير مقبولة

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- بغض النظر عن تأثيرات الإعاقة، أنا أرى أن تسمية الطفل بإضطراب تشتت الإنتباه وفرط النشاط لا تعرضه للتهكم والسخرية من الآخرين 7 داخل البيئة التعليمية او المدرسة

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- يوصف الطالب ذو اضطراب تشتت الإنتباه وفرط النشاط دائماً بكلماتٍ مثل "مزعج وشقي" بدلاً من وصفه بطفلٍ يعاني من اضطراب تشتت الإنتباه وفرط النشاط

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

#### القسم الخامس

يهدف هذا القسم إلى تحديد إتفاقتك أو عدم إتفاقتك مع الجمل التالية عن طريق إختيار درجةٍ معينة لتمثيل آرائك ووجهات نظرك حول تصرفات الطالب المحتملة و الناتجة عن تشخيصه.

من فضلك قم بإختيار جملةٍ من الجمل التالية عن طريق إتباع هذا الميزان:-

1=أعارض بشدة

2=أعارض

3=أتفق

4=أتفق بشدة

1- يميل الطالب ذو إضطراب تشتت الإنتباه وفرط النشاط إلى تعديل سلوكه ليتماشى مع بعض المفاهيم السلبية والشائعة المرتبطة بهذا الإضطراب

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

2- اعتقد أن الآخرين لا يتعاملون بطريقة مختلفة أو سلبية مع الطلبة ذوي إضطراب تشتت الإنتباه وفرط النشاط عند معرفتهم بانهم ملقبون بهذا الإضطراب

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

3- اعتقد أن الآخرين يتعاملون مع الطلبة ذوي إضطراب تشتت الإنتباه وفرط النشاط بطريقة أكثر اختلافاً وبشكل أكثر سلبية من الطلبة الآخرين الغير مصنفين بهذا الاضطراب والذين لديهم نفس السلوكيات

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

4- بالرغم من تلك الإعاقة، أظن أن تسمية الطالب بإضطراب تشتت الإنتباه وفرط الحركة يجعله منعزلاً عن الآخرين أو يمنعهم من دعوته إلى اللعب معهم

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

5- يميل الطالب ذو إضطراب تشتت الإنتباه وفرط النشاط إلى تجنب التعامل مع الآخرين بسبب قلقه من سخرتهم له على لقب إضطراب تشتت الإنتباه وفرط الحركة

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

6- يقوم أقران إبني المصاب بإضطراب تشتت الإنتباه وفرط النشاط بالتعامل معه بطريقة تختلف عن الطلاب غير المصابين بهذا الإضطراب و الذين ربما يعانون من مشكلات سلوكية مشابهة بسبب انه ملقب بهذا الاضطراب

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

### القسم السادس

يهدف هذا القسم إلى تحديد إتفاك أو عدم إتفاك مع الجمل التالية عن طريق إختيار درجة معينة لتمثيل توقعاتك.

من فضلك قم بإختيار جملة من الجمل التالية عن طريق إتباع هذا الميزان:-

1=أعارض بشدة

2=أعارض

3=أتفق

4=أتفق بشدة

1- يتعامل الأساتذة العاديين في فصولهم بطريقة مختلفة او سلبية مع الطلبة المصنفين بإضطراب تشتت الإنتباه وفرط النشاط

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

2- يتعامل الأساتذة العاديين في فصولهم بطريقة مختلفة او سلبية مع الطلبة المصنفين بإضطراب تشتت الإنتباه وفرط النشاط بسبب ترددهم المتكرر على غرفة المصادر

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- يتعامل الأساتذة العاديين في فصولهم بطريقة مختلفة او سلبية مع الطلبة المصنفين بإضطراب تشتت الإنتباه وفرط النشاط بسبب حصولهم 3 على وقت أكثر من باقي أقرانهم لانهاء المهام الاكاديمية

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- يتعامل الأساتذة العاديين مع الطالب المصاب بإضطراب تشتت الإنتباه وفرط النشاط بطريقة تختلف عن الطلاب غير المصنفين بالإضطراب والذين يعانون من المشكلات السلوكية ذاتها بسبب وجود تسمية هذا الاضطراب

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)
- 1 (أعارض بشدة)

- يتعامل موظفو المدرسة الاخرين مع الطلاب المصابين بإضطراب تشتت الإنتباه وفرط النشاط بطريقة تختلف عن الطلاب غير المصنفين بالإضطراب والذين يعانون من المشكلات السلوكية ذاتها بسبب وجود تسمية هذا الاضطراب

- 4 (أتفق بشدة)
- 3 (أتفق)
- 2 (أعارض)

○ 1 (أعارض بشدة)

- أظن أن تسمية الطالب بإضطراب تشتت الإنتباه وفرط النشاط ساعده على تطوير قدراته الأكاديمية6

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

- أظن أن إعطاء الطالب لقب او تسمية إضطراب تشتت الإنتباه وفرط النشاط لم يساعده على تطوير مهاراته الاجتماعية7

○ 4 (أتفق بشدة)

○ 3 (أتفق)

○ 2 (أعارض)

○ 1 (أعارض بشدة)

إنتهى هذا الإستبيان. شكراً لكم على تخصيصكم الوقت لإتمامه.

سوف أقوم بإجراء مقابلاتٍ شخصيةٍ وجهاً لوجهٍ مع معلمي الطلاب الذين يعانون من إضطراب تشتت الإنتباه و فرط النشاط لأكتسب فهماً أعمق لأرائكم و وجهات نظركم حول تسمية إضطراب تشتت الإنتباه و فرط النشاط. ستستغرق المقابلة 40 دقيقة و ستحظى مشاركتكم بكل التقدير. إذا رغبتكم في المشاركة فرجاءاً قوموا بكتابة تفاصيل الإتصال الخاصة بكم و سأقوم بالتواصل معكم في سريةٍ تامة. هذه الخطوة إختيارية.

الإسم:

البريد الإلكتروني:

رقم الهاتف:

### **Appendix 3 (Interview Questions - English Versions)**

#### Interview questions for ADHD teachers

- 1- How many children with ADHD do you have in your class? Can you describe his school level? Can you describe your educational level? Have you ever been involved in training courses or workshops about the disability children have?
- 2- What type of training have you received? In what way have they been useful to you, if at all?

Thinking about one of the children with ADHD in your class:

- 3- In what ways does the child attempt to hide his difficulties from others? Does he hide his school work from you?
- 4- Does the child acknowledge his disability to justify any academic difficulties? In What way does the child acknowledge his disability?
- 5- In what way does the child not acknowledge his disability to avoid the negative stereotypes about ADHD label from teachers and peers?
- 6- In what way does the child with ADHD change his academic performance negatively to match the negative stereotypes of ADHD label?
- 7- How does the ADHD label affect the child negatively or positively? Does it cause him to be dissatisfied with himself?
- 8- Do you think that ADHD label minimises the child' ability to do things as most non-labelled students? If yes, in what way can you express it?
- 9- Do you think that the child with ADHD label is more likely to fail? If yes, what do you feel about it? Do you think that the child with ADHD feels useless and frustrated? If yes, in what way does this manifest?
- 10- In which way can ADHD label affect the child behavioural development? Can you manifest both positive and negative effects?
- 11- Do you think that the child with ADHD label gets bullied when he receives extra time and support or when he goes to the resource room? If yes, can you describe how does this happen?
- 12- How do you see resource room, extra time and support affect teachers and school staffs in dealing with children?
- 13- Do you think that supporting the child by teachers or peers in front of others provides a sense of being less than others? If yes, in what way does this manifest?
- 14- Does the school use pejorative labels for the child? If yes, can you give me an example?
- 15- Do you think that the child with ADHD is treated differently by other peers or teachers as he is labelled with ADHD? If yes, what do you feel about it?
- 16- In what way do you think ADHD label is useful for the child in education?
- 17- In what way do you see the use of the ADHD label developing in the future?

There are other sub-questions will be asked according to participants' responses.

#### Interviews questions of parents with LD

- 1- How many children with LD do you have in your class? Can you describe his school level? Can you describe your educational level? Have you ever been involved in training courses or workshops about the disability children have?
- 2- What type of training have you received? In what way have they been useful to you, if at all?

Thinking about one of the children with LD in your class:



- 3- In what ways does the child attempt to hide his difficulties from others? Does he hide his school work from you, such as avoiding writing notes and avoiding reading loudly in front of you or in front of others?
- 4- Does the child acknowledge his disability to justify any academic difficulties? In What way does the child acknowledge his disability?
- 5- Does his disability prevent him from attending certain subjects? Does his disability affect his motivation? In what way does this manifest?
- 6- In what way does the child not acknowledge his disability to avoid the negative stereotypes about LD label from teachers and peers?
- 7- In what way does the child with LD change his academic performance negatively to match the negative stereotypes of LD label?
- 8- How does the LD label affect the child negatively or positively? Does it cause him to be dissatisfied with himself?
- 9- Do you think that LD label minimises the child' ability to do things as most non-labelled students? If yes, in what way can you express it?
- 10- Do you think that the child with LD label is more likely to fail? If yes, what do you feel about it? Do you think that the child with LD feels useless and frustrated? If yes, in what way does this manifest?
- 11- In which way can LD label affect the child behavioural development? Can you manifest both positive and negative effects?
- 12- Do you think that the child with LD label gets bullied when he receives extra time and support or when he goes to the resource room? If yes, can you describe how does this happen?
- 13- How do you see resource room, extra time and support affect teachers and school staffs in dealing with children?
- 14- Do you think that supporting the child by teachers or peers in front of others provides a sense of being less than others? If yes, in what way does this manifest?
- 15- Does the school use pejorative labels for the child? If yes, can you give me an example?
- 16- In what way do you think LD label is useful for the child in education?
- 17- In what way do you see the use of the LD label developing in the future?

There are other sub-questions will be asked according to participants' responses.

#### Interviews questions of parents with ADHD

- 1- How many children do you have? How old is he? Can you describe his school level? Can you describe your educational level? Have you ever been involved in training courses or workshops about the disability your child has?
- 2- What type of training have you received? In what way have they been useful to you, if at all?
- 3- In what ways does your child attempt to hide his difficulties from others? Does he hide his school work from you?
- 4- Does your child acknowledge his disability to justify any academic difficulties? In What way does your child acknowledge his disability?
- 5- How does the ADHD label affect your child negatively or positively? Does it cause him to be dissatisfied with himself?
- 6- Do you think that ADHD label minimises your child' ability to do things as most non-labelled students? If yes, in what way can you express it?
- 7- Do you think that your child with ADHD label is more likely to fail? If yes, what do you feel about it? Do you think that your child with ADHD feels useless and frustrated? If yes, in what way does this manifest?

- 8- In which way can ADHD label affect your child behavioural development? Can you manifest both positive and negative effects?
- 9- Do you think that your child with ADHD label gets bullied when he receives extra time and support or when he goes to the resource room? If yes, can you describe how does this happen?
- 10- How do you see resource room, extra time and support affect teachers and school staffs in dealing with children?
- 11- Do you think that supporting your child by teachers or peers in front of others provides a sense of being less than others? If yes, in what way does this manifest?
- 12- Does the school use pejorative labels for your child? If yes, can you give me an example?
- 13- In what way does your child with ADHD change his academic performance negatively to match the negative stereotypes of ADHD label?
- 14- Do you think that your child with ADHD is treated differently by other peers or teachers as he is labelled with ADHD? If yes, what do you feel about it?
- 15- In what way do you think ADHD label is useful for your child in education?
- 16- In what way do you see the use of the ADHD label developing in the future?

There are other sub-questions will be asked according to participants' responses.

Interviews questions of parents with LD

- 1- How many children do you have? How old is he? Can you describe his school level? Can you describe your educational level? Have you ever been involved in training courses or workshops about the disability your child has?
- 2- What type of training have you received? In what way have they been useful to you, if at all?
- 3- In what ways does your child attempt to hide his difficulties from others? Does he hide his school work from you, such as avoiding writing notes and avoiding reading loudly in front of you or in front of others?
- 4- Does your child acknowledge his disability to justify any academic difficulties? In What way does your child acknowledge his disability?
- 5- Does his disability prevent him from attending certain subjects? Does his disability affect his motivation? In what way does this manifest?
- 6- In what way does your child not acknowledge his disability to avoid the negative stereotypes about LD label from teachers and peers?
- 7- In what way does your child with LD change his academic performance negatively to match the negative stereotypes of LD label?
- 8- How does the LD label affect your child negatively or positively? Does it cause him to be dissatisfied with himself?
- 9- Do you think that LD label minimises your child' ability to do things as most non-labelled students? If yes, in what way can you express it?
- 10- Do you think that your child with LD label is more likely to fail? If yes, what do you feel about it? Do you think that your child with LD feels useless and frustrated? If yes, In what way does this manifest?
- 11- In which way can LD label affect your child behavioural development? Can you manifest both positive and negative effects?
- 12- Do you think that your child with LD label gets bullied when he receives extra time and support or when he goes to the resource room? If yes, can you describe how does this happen?
- 13- How do you see resource room, extra time and support affect teachers and school staffs in dealing with children?
- 14- Do you think that supporting your child by teachers or peers in front of others provides a sense of being less than others? If yes, in what way does this manifest?

- 15- Does the school use pejorative labels for your child? If yes, can you give me an example?
- 16- Do you think that your child with LD is treated differently by other peers or teachers as he is labelled with LD? If yes, what do you feel about it?
- 17- In what way do you think LD label is useful for your child in education?
- 18- In what way do you see the use of the LD label developing in the future?

There are other sub-questions will be asked according to participants' responses.

#### Appendix 4 (Interview Questions – Arabic version)

#### أسئلة مقابلة أولياء أمور الطلبة ذوي صعوبات التعلم

- 1- كم عدد الأطفال لديك؟ كم عمر طفلك المصاب بصعوبات التعلم؟ هل يمكنك وصف مستواه الصفي أو في أي صف يدرس؟ هل يمكنك وصف مستواه التعليمي؟ هل سبق لك أن شاركت في دورات تدريبية أو ورشات عمل حول الأطفال ذوي صعوبات التعلم؟
- 2- ما نوع التدريب الذي تلقيته؟ بأي طريقة كانت مفيدة لك، إذا كانت كذلك على كل حال؟
- 3- بأي الطرق يحاول طفلك إخفاء الصعوبات أو الاضطراب التي يعاني منها من زملائه؟ هل تظن أن طفلك يقوم بإخفاء واجباته المدرسية منك؟ مثل تجنب كتابة الملاحظات أو تجنب القراءة بصوت عالي امامك أو امام الآخرين؟
- 4- هل يميل طفلك ذو صعوبات التعلم بإخبارك عن اعاقته كتبرير لمشاكله الأكاديمية؟ بأي طريقة يقوم طفلك بالإفصاح عن مشاكله الأكاديمية؟
- 5- هل صعوبات طفلك تمنعه من حضور بعض الحصص؟ هل صعوباته تؤثر على تحفيزه؟ إذا كانت الإجابة بنعم، بأي طريقة توضح لي ذلك؟
- 6- بأي طريقة يميل طفلك ذو صعوبات التعلم الى عدم التصريح عن صعوباته حتى يتجنب بعض المفاهيم السلبية المرتبطة بمفهوم صعوبات التعلم من قبل المعلمين أو زملائه؟
- 7- بأي طريقة يقوم طفلك بتغيير ادائه الأكاديمي سلباً حتى يتوافق مع المفاهيم السلبية المرتبطة بمفهوم صعوبات التعلم؟
- 8- كيف يؤثر تصنيف وتسمية صعوبات التعلم على طفلك بشكل سلبى أو إيجابى؟ هل يجعله غير راضٍ عن نفسه؟
- 9- هل تعتقد بأن تصنيف وتسمية صعوبات التعلم يقلل من قدرة طفلك على القيام بالأشياء التي يتمكن معظم الأطفال غير المشخصين بهذا الاضطراب من فعلها؟ إذا كانت الإجابة بنعم، بأي طريقة ممكن تعبر عن ذلك؟
- 10- هل تعتقد بأن تسمية وتلقيب طفلك بصعوبات التعلم تزيد من احتمالية فشله؟ إذا كانت الإجابة بنعم، كيف تشعر بذلك؟ هل تعتقد بأن طفلك الملقب بصعوبات التعلم طفل عديم القيمة أو طفل محبط؟ إذا كانت الإجابة بنعم، بأي طريقة توضح لي ذلك؟
- 11- بأي طريقة تعتقد بأن تسمية صعوبات التعلم يُعيق التطور الاجتماعي لطفلك الملقب به؟ هل بإمكانك أن توضح التأثير السلبى والايجابى لذلك؟
- 12- هل تظن ان طفلك ذو صعوبات التعلم يتعرض للتهكم والسخرية من أقرانه بسبب تردده المتكرر على غرفة المصادر أو بسبب حصوله الدائم على وقتٍ أو دعم أكثر؟ إذا كانت الإجابة بنعم، هل بإمكانك أن توضح كيف يحدث ذلك؟
- 13- كيف تتصور التردد المتكرر على غرفة المصادر أو الحصول الدائم على وقتٍ أو دعم أكثر يؤثر على المعلمين أو منسوبي المدرسة في التعامل مع طفلك؟
- 14- هل تعتقد بان دعم طفلك ذو صعوبات التعلم من المعلمين أو زملائهم يجعلهم اقل ذكاء من أولئك الذين ليس لديهم أي تسمية أو لقب لاي إعاقة؟ إذا كانت الإجابة بنعم، بأي طريقة ممكن توضح لي ذلك؟
- 15- هل تستخدم المدرسة تسميات تحقيرية لطفلك؟ إذا كانت الإجابة بنعم، هل يمكنك أن تعطيني مثالاً؟
- 16- هل تظن ان طفلك ذو صعوبات التعلم يعامل بطريقة مختلفة أو سلبية من قبل اقرانه أو المعلمين عند معرفتهم بأنه ملقب بهذا الاضطراب؟ إذا كانت الإجابة بنعم، كيف تشعر بذلك؟

- 17- ما هي الطريقة التي تعتقد أن بها تسمية وتصنيف صعوبات التعلم مفيد لطفلك في تعليمه؟
- 18- ما هي الطريقة التي ترى بها استخدام تسمية وتصنيف صعوبات التعلم في المستقبل؟

سوف تكون هناك أسئلة فرعية أخرى ستظهر وفقا لردود المشاركين.

### أسئلة مقابلة أولياء أمور الطلبة ذوي فرط الحركة وتشتت الانتباه

- 1- كم عدد الأطفال لديك؟ كم عمر طفلك المصاب باضطراب فرط الحركة وتشتت الانتباه؟ هل يمكنك وصف مستواه الصفي او في أي صف يدرس؟ هل يمكنك وصف مستواه التعليمي؟ هل سبق لك أن شاركت في دورات تدريبية أو ورشات عمل حول الأطفال ذو فرط الحركة وتشتت الانتباه؟
- 2- ما نوع التدريب الذي تلقيته؟ بأي طريقة كانت مفيدة لك، إذا كانت كذلك على كل حال؟
- 3- بأي الطرق يحاول طفلك إخفاء الصعوبات او الاضطراب التي يعاني منها من زملائه؟ هل تظن ان طفلك يقوم بإخفاء واجباته المدرسية منك؟
- 4- هل يميل طفلك ذو فرط الحركة وتشتت الانتباه بإخبارك عن اعاقته كتبرير لمشاكله الاكاديمية؟ بأي طريقة يقوم طفلك بالإفصاح عن مشاكله الاكاديمية؟
- 5- كيف يؤثر تصنيف اضطراب فرط الحركة وتشتت الانتباه على طفلك بشكل سلبي أو إيجابي؟ هل يجعله غير راضٍ عن نفسه؟
- 6- هل تعتقد بأن تسمية اضطراب فرط الحركة وتشتت الانتباه يقلل من قدرة طفلك على القيام بالأشياء التي يتمكن معظم الأطفال غير المشخصين بهذا الاضطراب من فعلها؟ إذا كانت الإجابة بنعم، بأي طريقة ممكن تعبر عن ذلك؟
- 7- هل تعتقد بأن تسمية وتلقيب طفلك باضطراب فرط الحركة وتشتت الانتباه تزيد من احتمالية فشله؟ إذا كانت الإجابة بنعم، كيف تشعر بذلك؟ هل تعتقد بأن طفلك الملقب باضطراب فرط الحركة وتشتت الانتباه طفل عديم القيمة طفل محبط؟ إذا كانت الإجابة بنعم، بأي طريقة توضح لي ذلك؟
- 8- بأي طريقة تعتقد بأن تسمية اضطراب فرط الحركة وتشتت الانتباه يُعيق التطور الاجتماعي لطفلك الملقب به ؟ هل بإمكانك ان توضح التأثير السلبي والايجابي لذلك؟
- 9- هل تظن ان طفلك ذو فرط الحركة وتشتت الانتباه يتعرض للتهكم والسخرية من أقرانه بسبب ترده المتكرر على غرفة المصادر او بسبب حصوله الدائم على وقتٍ او دعم أكثر؟ إذا كانت الإجابة بنعم، هل بإمكانك ان توضح كيف يحدث ذلك؟
- 10- كيف تتصور التردد المتكرر على غرفة المصادر او الحصول الدائم على وقتٍ او دعم أكثر يؤثر على المعلمين او منسوبي المدرسة في التعامل مع طفلك؟
- 11- هل تعتقد بان دعم طفلك ذو فرط الحركة وتشتت الانتباه من المعلمين او زملائهم يجعله اقل ذكاء من أولئك الذين ليس لديهم أي تسمية أو لقب لاي إعاقة؟ إذا كانت الإجابة بنعم، بأي طريقة ممكن توضح لي ذلك؟
- 12- هل تستخدم المدرسة تسميات تحقيرية لطفلك؟ إذا كانت الإجابة بنعم، هل يمكنك أن تعطيني مثالاً؟
- 13- بأي طريقة يقوم طفلك بتغيير ادائه الأكاديمي سلبيا حتى يتوافق مع المفاهيم السلبية المرتبطة بمفهوم اضطراب فرط الحركة وتشتت الانتباه؟

- 14- هل تظن ان طفلك ذو فرط الحركة وتشتت الانتباه يعامل بطريقة مختلفة او سلبية من قبل اقرانه او المعلمين عند معرفتهم بانه ملقب بهذا الاضطراب؟ اذا كانت الإجابة بنعم، كيف تشعر بذلك؟
- 15- ما هي الطريقة التي تعتقد أن بها تسمية وتصنيف فرط الحركة وتشتت الانتباه مفيد لطفلك في تعليمه؟
- 16- ما هي الطريقة التي ترى بها استخدام تسمية وتصنيف فرط الحركة وتشتت الانتباه في المستقبل؟

سوف تكون هناك أسئلة فرعية أخرى ستظهر وفقا لردود المشاركين.

### أسئلة مقابلة معلمى صعوبات التعلم

- 1- كم عدد الأطفال المصابين بصعوبات التعلم الذي لديك في صفك؟ هل يمكنك وصف مستواه الصفي او في أي صف يدرس؟ هل يمكنك وصف مستواه التعليمي؟ هل سبق لك أن شاركت في دورات تدريبية أو ورشات عمل حول الأطفال ذو صعوبات التعلم؟
- 2- ما نوع التدريب الذي تلقيته؟ بأي طريقة كانت مفيدة لك، إذا كانت كذلك على كل حال؟
- فكر في أحد الأطفال المصابين بصعوبات التعلم في صفك:
- 3- بأي الطرق يحاول الطفل إخفاء الصعوبات او الاضطراب التي يعاني منها من زملائه؟ هل تظن ان الطفل يقوم بإخفاء واجباته المدرسية منك؟ مثل تجنب كتابة الملاحظات او تجنب القراءة بصوت عالي امامك او امام الاخرين؟
- 4- هل يميل الطفل ذو صعوبات التعلم بإخبارك عن اعاقته كتبرير لمشاكله الاكاديمية؟ بأي طريقة يقوم الطفل بالإفصاح عن مشاكله الاكاديمية؟
- 5- هل صعوبات الطفل تمنعه من حضور بعض الحصص؟ هل صعوباته تؤثر على تحفيزه؟ اذا كانت الإجابة بنعم، بأي طريقة توضح لي ذلك؟
- 6- بأي طريقة يميل الطفل ذو صعوبات التعلم الى عدم التصريح عن صعوباته حتى يتجنب بعض المفاهيم السلبية المرتبطة بمفهوم صعوبات التعلم من قبل المعلمين او زملائه؟
- 7- بأي طريقة يقوم الطفل بتغيير ادائه الأكاديمي سلبيا حتى يتوافق مع المفاهيم السلبية المرتبطة بمفهوم صعوبات التعلم؟
- 8- كيف يؤثر تصنيف وتسمية صعوبات التعلم على الطفل بشكل سلبى أو إيجابى؟ هل يجعله غير راض عن نفسه؟
- 9- هل تعتقد بأن تصنيف وتسمية صعوبات التعلم يقلل من قدرة الطفل على القيام بالأشياء التي يتمكن معظم الأطفال غير المشخصين بهذا الاضطراب من فعلها؟ اذا كانت الإجابة بنعم، بأي طريقة ممكن تعبر عن ذلك؟
- 10- هل تعتقد بأن تسمية وتلقيب الطفل بصعوبات التعلم تزيد من احتمالية فشله؟ اذا كانت الإجابة بنعم، كيف تشعر بذلك؟ هل تعتقد بأن الطفل الملقب بصعوبات التعلم طفل عديم القيمة او طفل محبط؟ اذا كانت الإجابة بنعم، بأي طريقة توضح لي ذلك؟
- 11- بأي طريقة تعتقد بأن تسمية صعوبات التعلم يُعيق التطور الاجتماعي للطفل الملقب به؟ هل بإمكانك ان توضح التأثير السلبى والايجابى لذلك؟
- 12- هل تظن ان الطفل ذو صعوبات التعلم يتعرض للتهكم والسخرية من أقرانهم بسبب تردددهم المتكرر على غرفة المصادر او بسبب حصولهم الدائم على وقتٍ او دعم أكثر؟ اذا كانت الإجابة بنعم، هل بإمكانك ان توضح كيف يحدث ذلك؟

- 13- كيف تتصور التردد المتكرر على غرفة المصادر او الحصول الدائم على وقتٍ او دعم أكثر يؤثر على المعلمين او منسوبي المدرسة في التعامل مع الطفل؟
- 14- هل تعتقد بان دعم الطالب ذو صعوبات التعلم من المعلمين او زملائهم يجعلهم اقل ذكاء من أولئك الذين ليس لديهم أي تسمية او لقب لاي إعاقة؟ اذا كانت الإجابة بنعم، بأي طريقة ممكن توضح لي ذلك؟
- 15- هل تستخدم المدرسة تسميات تحقيرية للطفل؟ إذا كانت الإجابة بنعم، هل يمكنك أن تعطيني مثالاً؟
- 16- ما هي الطريقة التي تعتقد أن بها تسمية وتصنيف صعوبات التعلم مفيد للطفل في تعليمه؟
- 17- ما هي الطريقة التي ترى بها استخدام تسمية وتصنيف صعوبات التعلم في المستقبل؟

سوف تكون هناك أسئلة فرعية أخرى ستظهر وفقا لردود المشاركين.

#### أسئلة مقابلة معلمي فرط الحركة وتشتت الانتباه

- 1- كم عدد الأطفال المصابين باضطراب فرط الحركة وتشتت الانتباه الذي لديك في صفك؟ هل يمكنك وصف مستواه الصفي او في أي صف يدرس؟ هل يمكنك وصف مستواه التعليمي؟ هل سبق لك أن شاركت في دورات تدريبية أو ورشات عمل حول الأطفال فرط الحركة وتشتت الانتباه؟
- 2- ما نوع التدريب الذي تلقيته؟ بأي طريقة كانت مفيدة لك، إذا كانت كذلك على كل حال؟

فكر في أحد الأطفال المصابين باضطراب فرط الحركة وتشتت الانتباه في صفك:

- 3- بأي الطرق يحاول الطفل إخفاء الصعوبات او الاضطراب التي يعاني منها من زملائه؟ هل تظن ان الطفل يقوم بإخفاء واجباته المدرسية منك؟
- 4- هل يميل الطفل ذو فرط الحركة وتشتت الانتباه بإخبارك عن اعاقته كتبرير لمشاكله الاكاديمية؟ بأي طريقة يقوم الطفل بالإفصاح عن مشاكله الاكاديمية؟
- 5- بأي طريقة يميل الطفل الى عدم الإفصاح عن اعاقته لزملائه حتى يتجنب المفاهيم السلبية المرتبطة بمفهوم اضطراب فرط الحركة وتشتت الانتباه من قبل المعلمين وزملائه؟
- 6- بأي طريقة يقوم الطفل بتغيير اداءه الأكاديمي سلبيا حتى يتوافق مع المفاهيم السلبية المرتبطة بمفهوم اضطراب فرط الحركة وتشتت الانتباه؟
- 7- كيف يؤثر تصنيف اضطراب فرط الحركة وتشتت الانتباه على الطفل بشكل سلبي أو إيجابي؟ هل يجعله غير راضٍ عن نفسه؟
- 8- هل تعتقد بأن تسمية اضطراب فرط الحركة وتشتت الانتباه يقلل من قدرة الطفل على القيام بالأشياء التي يتمكن معظم الأطفال غير المشخصين بهذا الاضطراب من فعلها؟ اذا كانت الإجابة بنعم، بأي طريقة ممكن تعبر عن ذلك؟
- 9- هل تعتقد بأن تسمية وتلقيب الطفل باضطراب فرط الحركة وتشتت الانتباه تزيد من احتمالية فشله؟ اذا كانت الإجابة بنعم، كيف تشعر بذلك؟ هل تعتقد بأن الطفل الملقب باضطراب فرط الحركة وتشتت الانتباه طفل عديم القيمة طفل محبط؟ اذا كانت الإجابة بنعم، بأي طريقة توضح لي ذلك؟

- 10- بأي طريقة تعتقد بأن تسمية اضطراب فرط الحركة وتشتت الانتباه يُعيق التطور الاجتماعي للطفل الملقب به ؟ هل بإمكانك ان توضح التأثير السلبي والايجابي لذلك؟
- 11- هل تظن ان الطفل ذو فرط الحركة وتشتت الانتباه يتعرض للتهكم والسخرية من أقرانهم بسبب تردددهم المتكرر على غرفة المصادر او بسبب حصولهم الدائم على وقتٍ او دعم أكثر؟ اذا كانت الإجابة بنعم، هل بإمكانك ان توضح كيف يحدث ذلك؟
- 12- كيف تتصور التردد المتكرر على غرفة المصادر او الحصول الدائم على وقتٍ او دعم أكثر يؤثر على المعلمين او منسوبي المدرسة في التعامل مع الطفل؟
- 13- هل تعتقد بان دعم الطالب ذو فرط الحركة وتشتت الانتباه من المعلمين او زملائهم يجعلهم اقل ذكاء من أولئك الذين ليس لديهم أي تسمية او لقب لاي إعاقة؟ اذا كانت الإجابة بنعم، بأي طريقة ممكن توضح لي ذلك؟
- 14- هل تستخدم المدرسة تسميات تحقيرية للطفل؟ إذا كانت الإجابة بنعم، هل يمكنك أن تعطيني مثالاً؟
- 15- هل تظن ان الطفل ذو فرط الحركة وتشتت الانتباه يعامل بطريقة مختلفة او سلبية من قبل اقرانهم او المعلمين عند معرفتهم بانه ملقب بهذا الإضطراب؟ اذا كانت الإجابة بنعم، كيف تشعر بذلك؟
- 16- ما هي الطريقة التي تعتقد أن بها تسمية وتصنيف فرط الحركة وتشتت الانتباه مفيد للطفل في تعليمه؟
- 17- ما هي الطريقة التي ترى بها استخدام تسمية وتصنيف فرط الحركة وتشتت الانتباه في المستقبل؟

سوف تكون هناك أسئلة فرعية أخرى ستظهر وفقا لردود المشاركين.



## **Appendix 5 (Example of Interview Transcripts)**

*'Dual Educational Plan is a new policy set by the ministry of education, it requires me to find two similar students in their difficulties to set up EP, I always try to mediate between their ability and skills, you know LD students have different and unique needs, it is a lot of work and I am not convinced with it'' (Ammar).*

*'Let me explain this point, when you listen to word difficulty, it means that the child has barrier prevents him to be successful and smart as his peers. It can be explained also as child has something he cannot solve or overwhelm simply, there are no other explanations'' Ammar.*

*'unfortunately, some issues of the LD label are linked to me, some students hide from me in the school' halls and in break time, you know sometimes I found difficult for me when I call them to resource rooms, I don't want peers to see me when I take them, I always ask general teachers to refer them to me'' Ammar.*

*'I think that the teacher should not begin the academic work with students before starting to consolidate this relationship because it is important in the academic aspect as it reflects positively on students. This makes the student come to the resource room with his desire, looking forward to engaging with you in the academic help provided. Thus, he can tell you anything that difficult for him'' Ammar.*

*'some LD children compare themselves with other peers, they say hey teacher, why that child is better than me, or why he can do this and I can't, why he leave the class early to play. Those ways of encouragements are used with primary school children. Here, other peers stigmatise these children who have less encouragement, unfortunately, LD children always receive less than other'' Ammar.*

*'it is common here in the school that general teachers told off children when they fail to finish their tasks. Teachers scream and shout to students with LD in the class'' Ammar.*

*' I think LD child has a sense when he is doing certain task he will fail in front of his peers, which leads to get stigmatised and prove to them he is stupid'' Ammar.*

*'Also, students do not justify their peers when they show difficulties, rarely you notice support towards those children. Whereas, they laugh at them. So, LD children do not want anyone to know about their difficulties as they concerns about laugh'' Ammar.*

*'I think the harm of label starts with children' self-esteem. When it get broken, you cannot expect him to progress well in the classroom. There are students show similar difficulties like LD children do, but at least their self-confidence are higher than those who experience the effect of label every day'' Ammar.*

*'I think words like stupid remain for long time, as I am still remember my friends in school who are labelled by those, there were resource rooms and special teachers, so I can't say formal stick with children, but it might do'' Ammar.*

*'I think LD as label helped students to create other bad words like stupid and thick, they believed that stupidity room only for stupid kids'' Ammar (LD teacher).*

*'general teachers are careless, treating LD children differently, because they believed teaching them is not belong to their duties. They believed that teaching those kids belong to special teachers duties'' Ammar (LD teacher).*

*'It's interesting when you get so many students get referred to resource room by general teachers, I can't diagnose all of them, and I can't set EP and teach them. At the beginning of every academic year, I present some lectures to teachers explaining my work, resource room and LD in general. I feel my efforts is not enough to problem, it really huge'' Ammar.*

*'those words are dangerous, they have affected students more than LD. Children in year 1 and 2 might be not aware about LD, but surely they understand what does stupid mean'' Ammar.*

*‘it’s funny when some students without label have academic problems, and general teachers work hard with them, being cared about them. While labelled students have similar difficulties, but they being careless with them, because they go to resource room with special teacher’* Ammar.

*‘I wish in future label will be changed to contain positive meaning that children understood positively. Current label has word difficulty, which is always understood as something difficult’.*

## **Appendix 6 (Ethical form Gained from the University of Exeter)**

### **COLLEGE OF SOCIAL SCIENCES AND INTERNATIONAL STUDIES**

When completing this form please remember that the purpose of the document is to clearly explain the ethical considerations of the research being undertaken. As a generic form it has been constructed to cover a wide-range of different projects so some sections may not seem relevant to you. Please include the information which addresses any ethical considerations for your particular project which will be needed by the SSIS Ethics Committee to approve your proposal.

Guidance on all aspects of the SSIS Ethics application process can be found on the SSIS intranet:

**Staff:**

<https://intranet.exeter.ac.uk/socialsciences/staff/research/researchenvironmentandpolicies/ethics/>

**Students:**<http://intranet.exeter.ac.uk/socialsciences/student/postgraduateresearch/ethicsaprovalforyourresearch/>

All staff and students within SSIS should use this form to apply for ethical approval and then send it to one of the following email addresses:

[ssis-ethics@exeter.ac.uk](mailto:ssis-ethics@exeter.ac.uk) This email should be used by staff and students in Egenis, the Institute for Arab and Islamic Studies, Law, Politics, the Strategy & Security Institute, and Sociology, Philosophy, Anthropology.

[ssis-gseethics@exeter.ac.uk](mailto:ssis-gseethics@exeter.ac.uk) This email should be used by staff and students in the Graduate School of Education.

<b>Applicant details</b>	
<b>Name</b>	<b>Hatim Algraigay</b>
<b>Department</b>	<b>Graduate School of Education</b>
<b>UoE email address</b>	<b>Hhha202@exeter.ac.uk</b>

### Duration for which permission is required

You should request approval for the entire period of your research activity. The start date should be at least one month from the date that you submit this form. Students should use the anticipated date of completion of their course as the end date of their work. Please note that retrospective ethical approval will never be given.

**Start date:**01/10/2017

**End date:**20/09/2019

**Date submitted:**[Click here to enter a date](#)

### Students only

All students must discuss their research intentions with their supervisor/tutor prior to submitting an application for ethical approval. The discussion may be face to face or via email.

Prior to submitting your application in its final form to the SSIS Ethics Committee it should be approved by your first and second supervisor / dissertation supervisor/tutor. You should submit evidence of their approval with your application, e.g. a copy of their email approval.

Student number

**630046921**

Programme of study

**Other**  
Special Needs and Inclusive Education - EdD

Name of Supervisor(s)/tutors or Dissertation Tutor

**Dr. Alison Black**  
**Dr. Christopher Boyle**

Have you attended any ethics training that is available to students?

No, I have not taken part in ethics training at the University of Exeter

### Certification for all submissions

I hereby certify that I will abide by the details given in this application and that I undertake in my research to respect the dignity and privacy of those participating in this research. I confirm that if my research should change radically I will complete a further ethics proposal form.

**Hatim Algraigray**

Double click this box to confirm certification

*Submission of this ethics proposal form confirms your acceptance of the above.*

### TITLE OF YOUR PROJECT

Exploring SEN teachers' and parents' perceptions and reactions towards ADHD and Learning disability labels in the Saudi context

### ETHICAL REVIEW BY AN EXTERNAL COMMITTEE

No, my research is not funded by, or doesn't use data from, either the NHS or Ministry of Defence.

## MENTAL CAPACITY ACT 2005

No, my project does not involve participants aged 16 or over who are unable to give informed consent (e.g. people with learning disabilities)

## OF THE RESEARCH PROJECT

*Maximum of 750 words.*

It has been argued that assigning labels to children with Special Educational Needs helps with provision of appropriate learning opportunities, extra support and increase awareness and understanding of certain disabilities (Gillman et al, 2000; Lauchlan & Boyle, 2007). The counterargument holds that labelling children with SEN may be harmful, since it affects their lives, their relatives and their educational and employment futures. Exclusion and discrimination are potential consequences of labelling people, and stigmatisation has been linked to labels (Riddick, 2000). It has been claimed that intellectual disability was a more common reason for discrimination than variables linked to stigma, such as gender, race etc (Corrigan et al, 2004).

It has been argued that medical professionals in the SEN field created the labelling that eventually led to the exclusion of children with SEN from society. The outcomes of the discursive process of medical science, including diagnosis and interventions, are the basis for classifying children with SEN (Gillman et al, 2000). Classification of children with SEN is largely based on problems and dysfunctions (Gillman et al, 2000). Classification and labelling came about through medical science and the diagnostic process. Professionals build classifications and classify children with SEN according to rigorous criteria and formal knowledge, such as ADHD which is diagnosed through applying criteria in the latest edition of the DSM “Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013). This classification is not always accurate, and several studies have criticised the diagnostic system and its fallibility. An example of the fallibility of the diagnostic system process is that 60% of children with SEN labels have an ambiguous diagnosis (Sutcliffe & Simons, 1993).

There is a paucity of studies and research in Saudi Arabia that investigate both drawbacks and advantages of labelling people with SEN generally, ADHD and Learning Disabilities in particular.

Saudi Arabia is different from the various contexts where research on labelling has taken place (studies include those in the UK, USA and other European contexts such as Sweden: Backer, 1963; Hjørne, & Säljö. 2004; Lauchlan & Boyle, 2007; Simoni, 2015; Visser & Jehan, 2009) in terms of culture, language, education, collective thought, lifestyle and therefore potentially of perceptions towards SEN labels generally, and in particular labels of ADHD and LD. Labelling practices are contextually bounded and practice/experience in one context may be very different from those in other contexts (Hacking, 1999). Some of the potential consequences of labels such as stigma and exclusion cannot be detached from societies. Culture and societies play crucial role in shaping those labels.

This project will firstly attempt to explore perceptions of about LD and ADHD labels held by a/ parents of children with a label of LD or ADHD, and b/ mainstream primary school teachers who are involved in teaching pupils with a label of ADHD and LD. Secondly, it will also investigate that how parents of children with labels of LD and ADHD and their teachers react towards those labels.

This study will be conducted through a mixed methods design (exploratory sequential design). In the initial phase, a questionnaire that will generate quantitative data, will be adopted to provide the researcher with general and initial information about the phenomena

under investigation through rating scales. There will also be the opportunity to respond to vignettes of children with labels of ADHD/LD (Leighton, 2010).

In the second phase, semi-structured interviews to yield qualitative data will be adopted to access in depth understanding about parents and specialised teachers perceptions about ADHD and LD labels.

The questionnaire of this study will be distributed to approximately 150 parents and teachers, while 8-10 teachers and parents will be involved in the second method (interview). These two methods seek to answer the following four research questions:

- 1- To what extent do SEN primary school teachers and parents react towards ADHD and LD labels?
- 2- How do SEN primary school teachers and parents perceive labels of ADHD and LD?
- 3- How do SEN primary school teachers and parents perceive the potential outcomes and consequences of ADHD and LD labels?
- 4- What are the predictions of SEN primary school teachers and parents regarding the future of ADHD and LD labels?

## **INTERNATIONAL RESEARCH**

This research will be carried out in Saudi Arabia, in particular, mainstream primary schools in Jeddah, which is the second largest city and it is a major urban centre of western Saudi Arabia.

The following sections require an assessment of possible ethical considerations in your research project. If particular sections do not seem relevant to your project please indicate this and clarify why.

## **RESEARCH METHODS**

The study will adopt mixed methods design, in which questionnaire and interview will be used.

A closed-ended **questionnaire** designed for the purpose of this study will be distributed to a/ parents of children with a label of either ADHD or learning disability, and b/ mainstream primary school teachers. Those teachers are involved in teaching children with learning disability and ADHD in Jeddah mainstream primary schools.

The questionnaire items will be created from the literature review to serve and answer the research questions of this study. The aim of the questionnaire is to gain general and broad picture about the phenomena under exploration. In particular, the questionnaire aims to gain broad understanding about the consequences of labels of ADHD and LD. Gathering quantitative through distributing questionnaire to large number of participants (approximately 150 in total, 75 parents of children with labels of ADHD and LD, and 75 mainstream primary schools teachers in Jeddah). The main part of the questionnaire will use statements and ask participants to rate their agreement with the statements. There will also be the opportunity to respond to vignettes of children with labels of ADHD/LD.

The questionnaire will be analysed by using SPSS software. The quantitative design in this phase is descriptive (Pallant, 2010). Descriptive statistics will help me summarize the overall trends or tendencies in the data, and to provide an understanding of how varied the scores might be (Creswell, 2012). Also, descriptive statistics will be obtained by using frequency

analysis which allows me to know how many participants gave each response (Pallant, 2010). To ensure the reliability of this scale, the questionnaire will be piloted by implementing the 'test-retest reliability' scale (Pallant, 2010). Also, the questionnaire will be reviewed by professional colleagues and my supervisors at the University of Exeter to increase the validity of the instrument. The internal consistency also will be assessed by using Cronbach's Alpha in SPSS software (Pallant, 2010).

Semi-structured **interviews** will be adopted in this study to collect in depth qualitative data from 8-10 parents and teachers who will be selected from those who state their willingness in the first phase-questionnaire to participate in the interview. The interview will be designed to answer the research questions and to deeply explore in detail some issues that will have emerged from the questionnaire as well as previous studies. Adopting interviews in this study may provide me with valuable information and deep understanding about teachers' and parents' perceptions and feeling about ADHD and LD labels (Kajornboon, 2005). In addition, using semi-structured interviews might enable me as researcher to probe for any further information, and allow participants to freely express their feelings and perceptions about ADHD and LD labels (Gray, 2013; Kajornboon, 2005).

Interviews will be conducted in Arabic language for the simplicity and for achieving depth personal feeling and perceptions, rather than participants having to translate their complex thoughts since Arabic is the mother language of my participants.

Data will be converted from an audiotape recording to text files through transcription. Thematic analysis will be used in which the processes of coding generation, search for themes and defining and naming the themes will be conducted. The data will be collected in the Arabic language and it will not be translated into English until the analysis stage, as immersion in the original Arabic data might provide the researcher with a better understanding. In addition, some concepts and terminology in the original data might be less comprehensive and understandable if the analysis process takes place after translation into English.

In analysis computer software program such as NVivo will be used since it is likely to support the researcher in the data analysis, providing an accurate, rigorous and transparent view of the data and analysis process (Welsh, 2002). Analysing qualitative data by adopting combination of both manual and computer-assisted method will achieve a better results than any single method of analysis (Welsh, 2002). Thematic analysis will be used to explore answers to the research questions. It is likely themes will initially emerge from the coding, but additionally themes found in the literature review will be searched for in the interview data.

## **PARTICIPANTS**

I hope to have 150 completed questionnaires from a/ parents of children with a label of ADHD or LD, and b/ mainstream primary school teachers of ADHD and LD. These teachers are involved in teaching students with ADHD and LD in "resource rooms". In resource rooms Students spend half of their day in the resource rooms with those teachers. (MoE, 2017).

I will liaise with the Ministry of Education in Jeddah, to get a permission, which is a prerequisite of research in Saudi, to manage my schools' visits. As soon as I receive the

permission, the MoE will provide me with a list of all mainstream primary schools in Jeddah, where students with labels of ADHD and LD are included. Then, I will approach to the principals of all schools, informing them that I have MoE' permission and asking them to facilitate the study. An Information sheet will be given to all principals in order to inform them with this study' purposes. They will be asked to undertake the initial contact with teachers and parents telling them about the study by giving them an information sheet. The information sheet will contain a link to the questionnaire, which participants can access directly. It will also contain my contact details so if they wish to have more information they can contact me.

All who complete the questionnaire will be given the opportunity to indicate if they are willing to take part in phase two of the research (interviews). 8-10 of those participants who have stated their willingness to participate in second phase, will be chosen purposively for the interview. Participants will be selected to ensure a spread of types pf participants (teachers and parents) and types of label (LD and ADHD). Those elements are mentioned in the questionnaire, thus I will attempt to make the interview' sample covered and balanced to those elements. The interviewed participants (teachers and parents) will be male due to the gender of the researcher, as males cannot enter a female's schools.

(It is important to demonstrate the terminological differences between Saudi Arabia and England.

In the Saudi SEN system Learning Disability (LD) is adopted as a label for children who have "Disorders in one or more of the basic psychological processes involved in understanding or using spoken and written language which is manifested in disorders in listening, thinking, talking, reading, writing, spelling, or arithmetic and it is not due to factors related to mental retardation, visual or hearing impairments, or educational, social, and familial factors" (MoE, 2002, p. 9).

In England, the label 'specific learning difficulties' (SpLD) is used for children who have a specific difficulty in one area of learning, such as reading/writing/spelling (dyslexia), Mathematical difficulties (dyscalcula) etc (DfE and DoH, 2014). Thus, LD in the Saudi context corresponds to the tem specific learning difficulties SpLD in the UK. This research will use LD since this study will be implemented in Saudi Arabia, in term of data collection and participants. ADHD is a label which is used in both the UK and Saudi contexts.)

## **THE VOLUNTARY NATURE OF PARTICIPATION**

As mentioned, schools' principals, who have been sent a covering letter by the researcher, will inform potential participants of the study' purposes by supplying them with the researcher's information sheet. Principals are under no compulsion to distribute the information sheet, however they will be informed that permission to conduct the study was gained from the MoE.

The potential participants of this study will be informed clearly that their participation is completely optional. In the first phase (questionnaire), participants will be informed that they are under no compulsion to complete the questionnaire, and can stop at any time for any and no reason. This will be mentioned in the information sheet and on the welcome page of the online questionnaire. The questionnaire will be distributed to teachers and

parents of children with labels of learning disability and ADHD through the information sheet distributed by schools' principals.

The participants of the second phase (interview) will be selected from volunteers. Participants in the first phase will have the opportunity to state their willingness to participate in the interview.

In the last question of the questionnaire, participants will be asked if they wish to participate in the interview at the next stage of this research. Additional information will be given with the last question including Information such as length of interview; the anticipated location where the interview will be held; that the interview may be audio recorded etc. Those who are selected to take part in the interviews will be given an information sheet which will describe the nature of the research and that they have the right to withdraw from the interviews at any time. It will be made clear that participation is completely optional. This will be confirmed orally before the commencement of the interview.

### **SPECIAL ARRANGEMENTS**

There is no need for any special arrangement in this research.

### **THE INFORMED NATURE OF PARTICIPATION**

Participants of this study will be informed by their nature of participation via several methods.

In phase one, parents of children with labels of ADHD and LD, and mainstream primary school teachers of ADHD and LD will be informed by mainstream schools' principals through a formal letter which will include a link to the survey. This letter will clearly explain the aim of this study, what participants will be asked to do, data collection methods, participants' rights during their participation, their rights to refuse answering any questions, confidentiality of their data and their rights to withdraw at any stage of this study without giving any reason. Also, this letter will explain the significance of participants' participation and how answering the questionnaire might be an opportunity to raise their opinions regarding ADHD and LD labels.

Second, a copy of the information sheet will be attached in the first page of the questionnaire by Arabic language to make sure that participants have a second chance to read and understand purpose of study, their role, their nature of participation, and their rights to withdraw or not complete the questionnaire. At the end of the questionnaire, participants will be asked about their willingness to participate in the second phase (interview).

Those who volunteer to be interviewed and are selected will be contacted via email or WhatsApp. Attached to this email will be an information sheet and a consent form. Prior to the interview starting I will ask if they have any further questions. I will collect the signed consent form (and give them a copy to keep for their records).

Prior to beginning the interview I will ensure that oral consent to be recorded is received.



The researcher and supervisor contact details are made obvious on those forms. Also, participants in the interview will be told that they can leave at any time they want during the process of the interview.

#### **ASSESSMENT OF POSSIBLE HARM**

In this research, it is not expected that there will be harm or stress caused by participation for the researcher and the participants. Participants' rights such as confidentiality, anonymity of their information and data, and their rights to withdraw at any stage of the study without giving any reasons will be sufficiently explained to the participants.

#### **DATA PROTECTION AND STORAGE**

The questionnaire will be sent online through the Survey Monkey platform, the researcher will create an account with a secure password, with access given solely to researcher. All completed questionnaires will be deleted from the platform after the study is finished, and the account will be deactivated and removed.

One question on the questionnaire will ask for the name of the school. This is purely for sampling purposes, once the geographic spread of participants has been established responses to this question will be deleted. School names will not be reported.

The participants' names of the interview and their all data and information will be kept confidential. Interview participants will be given pseudonyms. The interview will be recorded digitally, with access given only to the researcher. These audio data will be downloaded to a password protected computer from the recording device then deleted from the device. The interviews will be transcribed immediately, and any reference to real people/places will be changed to a pseudonym. The digital records and transcribed interview will be kept on private files on the researcher' University U drive. Also, completed questionnaires, digital records and transcribed interviews will be kept as well in the research private laptop and private hard disk, which they are secured with password. These files will be deleted 12 months after the completion of my thesis.

#### **DECLARATION OF INTERESTS**

There are no interests to declare. This study is an independent doctorate study with no funding from any specific parties.

#### **USER ENGAGEMENT AND FEEDBACK**

Before conducting the analysis, summary of all interview transcripts will be sent back to the participants for confirmation. Also, interview participants will be informed by the summary of interview' data analysis and findings of this research later.

#### **INFORMATION SHEET**

*The information sheets will be translated into Arabic language, (the participants' language) and it will be given to them by the principal and in the welcome page of the questionnaire. There are 3 information sheets – a/ for the school principals, b/ for potential participants prior to completing the questionnaire, c/ for interview participants. This final information sheet will also be a consent form.*

a/

## Information sheet for schools' principals

### **Title of Research Project**

Exploring SEN teachers' and parents' perceptions and reactions towards ADHD and Learning disability labels in the Saudi context

### **Details of Project**

My name is Hatim Algraigay and I am a doctoral researcher at the University of Exeter. My background is linked to special need field in which I graduated with Bachelor degree in learning disability from KAU in Saudi Arabia. I also have a Masters degree in special educational needs from the University of Exeter. Following to my previous studies, I am carrying out a study is to explore parents and teachers of children with Learning Disability (LD) and Attention Deficit Hyperactivity Disorder (ADHD) perceptions and feelings about these labels. Also, this research aims to explore how those labels might affect students who are labelled in the Saudi mainstream primary schools. The study is based in Jeddah in Saudi, hence why I am writing to you.

I hope to gain the views of parents of children with labels of LD and ADHD, and mainstream primary school teachers of LD and ADHD through a closed-ended questionnaire on their perceptions about ADHD and LD labels.

As you are the principal of the school I would like to ask you to distribute the attached information sheet to any teachers of children with labels of of ADHD and LD, and to parents of children with ADHD and LD. It is expected that willing participants will follow the link on the information sheet to access the questionnaire. Also, your permission to conduct the interview in the school is very much appreciated as it is helpful for me and the participants to find an appropriate location to hold the interviews in.

I have contacted the MoE and they have given permission for me to undertake the study in this way. I also have an ethics certificate from the University of Exeter. You are under no compulsion to distribute the information sheet if you do not wish to. Your assistance is very much appreciated and if you have any questions or concerns about the study, please do not hesitate to contact and discuss with myself or my supervisors.

The researcher

Hatim Algraigay

Phone number: UK 00447414557525 Saudi 00966553999580

Email address: [hhha202@exeter.ac.uk](mailto:hhha202@exeter.ac.uk) or [h.haa111@hotmail.com](mailto:h.haa111@hotmail.com)

Supervisors:

Dr Alison Black [A.E.Black@exeter.ac.uk](mailto:A.E.Black@exeter.ac.uk)

Dr Christopher Boyle [C.Boyle2@exeter.ac.uk](mailto:C.Boyle2@exeter.ac.uk)

b/

Information sheet for participants

Dear parent/teacher

My name is Hatim Algraigay, who is currently studying at the University of Exeter in the UK. I am conducting this study as part of my doctoral research. The main aim of this study is to explore your perceptions and feelings about labels of Attention Deficit Hyperactivity Disorder (ADHD) and Learning Disability (LD) labels, and how they might affect students who are labelled in the Saudi mainstream primary schools. You are kindly asked to voluntarily participate in questionnaire and interview on their perceptions about ADHD and LD labels. Your names and personal information will be kept confidential and all results will be anonymised. Although the results of this research might be published, your names, the names of your/your child's school, or any children will not be used. Although one question asks for the name of your/your child's school this is only for sampling purposes and no reference to the school will be made. Your participation is completely voluntarily, therefore you have the right to stop completing the questionnaire without giving any reasons.

In this research, your participation will be filling out an online questionnaire. The aim of the questionnaire is to have a broad picture and general knowledge about ADHD and LD labels and how those labels might affect children who are labelled. It is expected that the questionnaire will take up to 10 minutes to complete. Your participation is completely voluntary in this study, thus please start filling out the questionnaire below if you wish do so.

If you do wish to participate in this important study please click the link below which will take you to the questionaire:

---

Your participation in this research is very much appreciated. If you have any concern about the study, please do not hesitate to contact and discuss with myself or my supervisors

The researcher

Hatim Algraigay

Phone number: UK 00447414557525 Saudi 00966553999580

Email address: [hhha202@exeter.ac.uk](mailto:hhha202@exeter.ac.uk) or [h.haa111@hotmail.com](mailto:h.haa111@hotmail.com)

For alternative contacts:

Dr Alison Black

[A.E.Black@exeter.ac.uk](mailto:A.E.Black@exeter.ac.uk)

Dr Christopher Boyle

[C.Boyle2@exeter.ac.uk](mailto:C.Boyle2@exeter.ac.uk)

---

c/

Information sheets for interview participants

**Title of Research Project**

Exploring SEN teachers' and parents' perceptions and reactions towards ADHD and Learning disability labels in the Saudi context

**Details of Project**

You have received this information sheet as you expressed your interest in being interviewed after completing a questionnaire for this research.

The main aim of this study is to explore your perceptions and feelings about ADHD and LD labels, and how they might affect students who are labelled in Saudi mainstream primary schools.

The interview will be about your perceptions about ADHD and LD labels.

Any personal information you give will be kept confidential and all names will be anonymised. Although the results of this research might be published, your names, the names of any schools, children and teachers will not be used.

Your participation is completely voluntarily, therefore you have the right to withdraw at any stage of the study without giving any reasons.

In this research, your participation will be interviewing. The aim of the interview is to have an in depth conversations about ADHD and LD labels and how those labels might affect children who are labelled.

I will ask for your permission to digitally record the interview on a secure audio recording device. It is anticipated that the interview will take up to 40 minutes. Interviews will be held in one of the private room in your (child) mainstream school.

If you have any questions do not hesitate to contact me, or my supervisors.

**Contact Details**

The researcher: Hatim Algraigay

Phone number: UK 00447414557525 Saudi 00966553999580

Email address: [hhha202@exeter.ac.uk](mailto:hhha202@exeter.ac.uk) or [h.haa111@hotmail.com](mailto:h.haa111@hotmail.com)

For alternative contacts:

Dr Alison Black [A.E.Black@exeter.ac.uk](mailto:A.E.Black@exeter.ac.uk)

Dr Christopher Boyle [C.Boyle2@exeter.ac.uk](mailto:C.Boyle2@exeter.ac.uk)

**CONSENT FORM**

Consent form for interviews (will be attached to information sheet as laid out above).

I have been fully informed about the aims and purposes of the project.

I understand that:

- there is no compulsion for me to participate in this research project and, if I do choose to participate, I may withdraw at any stage;
- I have the right to refuse permission for the publication of any information about me;
- any information which I give will be used solely for the purposes of this research project, which may include publications or academic conference or seminar presentations;
- If applicable, the information, which I give, may be shared between any of the other researcher(s) participating in this project in an anonymised form;
- all information I give will be treated as confidential;
- The researcher(s) will make every effort to preserve my anonymity.

.....

.....

(Signature of participant)

(Date)

.....

(Printed name of participant)

Hatim Algraigay

.....

(Printed name of researcher)

(Signature of researcher)

One copy of this form will be kept by the participant; a second copy will be kept by the researcher(s).

Your contact details are kept separately from your interview data.

**Data Protection Notice**

*Data Protection Notice - The information you provide will be used for research purposes and your personal data will be processed in accordance with current data protection legislation and the University's notification lodged at the Information Commissioner's Office. Your personal data will be treated in the strictest confidence and will not be disclosed to any unauthorised third parties. The results of the research will be published in anonymised form."*

**SUBMISSION PROCEDURE**

Staff and students should follow the procedure below.

**Post Graduate Taught Students (Graduate School of Education):** Please submit your completed application to your first supervisor. Please see the submission flowchart for further information on the process.

**All other students** should discuss their application with their supervisor(s) / dissertation tutor / tutor and gain their approval prior to submission. Students should submit evidence of approval with their application, e.g. a copy of the supervisors email approval.

**All staff** should submit their application to the appropriate email address below.

This application form and examples of your consent form, information sheet and translations of any documents which are not written in English should be submitted by email to the SSIS Ethics Secretary via one of the following email addresses:

[ssis-ethics@exeter.ac.uk](mailto:ssis-ethics@exeter.ac.uk) This email should be used by staff and students in Egenis, the Institute for Arab and Islamic Studies, Law, Politics, the Strategy & Security Institute, and Sociology, Philosophy, Anthropology.

[ssis-gseethics@exeter.ac.uk](mailto:ssis-gseethics@exeter.ac.uk) This email should be used by staff and students in the Graduate School of Education.

Please note that applicants will be required to submit a new application if ethics approval has not been granted within 1 year of first submission.

#### References:

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub
- Angermeyer, M. C., Matschinger, H., & Corrigan, P. (2004). Familiarity with mental illness and social distance from people with schizophrenia and major depression: Testing a model using data from a representative population survey. *Schizophrenia Research*, 69, 175–182.
- Becker, H. S. ((1963) ). *Outsiders: studies in the sociology of deviance*. New York: Simon and Schuster.: Simon and Schuster.
- Creswell, J. W. (2012). *Educational Research: Planning, Conduction and Evaluating Quantitative and Qualitative Research* (4th Edition ed.). Pearson Eduaction, Inc.
- DfE and DoH (2014) *Special educational needs and disability code of practice 0-25*. [online]. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/342440/SEND\\_Code\\_of\\_Practice\\_approved\\_by\\_Parliament\\_29.07.14.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/342440/SEND_Code_of_Practice_approved_by_Parliament_29.07.14.pdf). Accessed date: 26-08-2017.
- Gillman, M., Heyman, B., & Swain, J. (2000). What's in a name? The implications of diagnosis for people with learning difficulties and their family carers. *Disability & Society*, 15(3), 389-409
- Gray, D. E. (2013). *Doing research in the real world*: Sage.
- Hacking, I. (1999). *The social construction of what?* Place of publication: Harvard University Press
- Hjörne, E., and R. Säljö. (2004). ‘There is something about Julia’ – Symptoms, categories and the process of invoking ADHD in the Swedish school. *Journal of Language, Identity and Education* 3, no.1: 1–24.

- Kajornboon, A. B. (2005). Using interviews as research instruments. *E-journal for Research Teachers*, 2(1).
- Lauchlan, F., & Boyle, C. (2007). Is the use of labels in special education helpful? *Support for Learning*, 22(1), 36.
- Leighton, S. (2010). Using a vignette-based questionnaire to explore adolescents' understanding of mental health issues. *Clinical Child Psychology and Psychiatry*, 15(2), 231-250
- Ministry of Education. (2002). *The rules and law for special education schools and programs in Ministry of Education*. Saudi Arabia: Ministry of Education.
- Ministry of education (2017), the department of Learning disability.[online]. Available at: <https://departments.moe.gov.sa/EducationAgency/RelatedDepartments/boysSpecialEducation/The%20departments/Learning%20Disability%20Management/Pages/default.aspx>. Accessed date: 26/08/2017
- Pallant, J. (2010). *SPSS survival manual: A step by step guide to data analysis using SPSS*.
- Platteel, A. (2003). *Marketing: Inventing a different marketing language*. Rotterdam: Episode Publishers.
- Riddick, B. (2000). An examination of the relationship between labelling and stigmatisation with special reference to dyslexia. *Disability & society*, 15(4), 653-667.
- Simoni, Z. R. (2015). *The ADHD medication process model: A qualitative investigation of teaching pedagogies, ideal student behavior, labeling processes, and attitudes towards ADHD medication*. The University of Alabama at Birmingham.
- SUTCLIFFE, J. and SIMONS, K. (1993). *Self Advocacy and People with Learning Difficulties*. Leicester: NIACE
- Welsh, E. (2002). *Dealing with data: Using NVivo in the qualitative data analysis process*. Paper presented at the Forum Qualitative Sozialforschung/Forum: Qualitative Social Research.
- Visser, J., & Jehan, Z. (2009). ADHD: a scientific fact or a factual opinion? A critique of the veracity of Attention Deficit Hyperactivity Disorder. *Emotional and behavioural difficulties*, 14(2), 127-140.

### CERTIFICATE OF ETHICAL APPROVAL

Title of Project: Exploring SEN teachers' and parents' perceptions and reactions towards ADHD and Learning disability labels in the Saudi context

Researcher(s) name: Hatim Algraigay

Supervisor(s): Christopher Boyle  
Alison Black

This project has been approved for the period

From: 01/10/2017  
To: 20/09/2019

Ethics Committee approval reference:

D/17/18/05



Signature:  
(Dr Philip Durrant, Graduate School of Education Ethics Officer)

Date: 04/09/2017



## **Information sheet of the interviews**

### **Title of Research Project**

Exploring SEN teachers' and parents' perceptions and reactions towards ADHD and Learning disability labels in the Saudi context

### **Details of Project**

You have received this information sheet as you expressed your interest in being interviewed after completing a questionnaire for this research.

The main aim of this study is to explore your perceptions and feelings about ADHD and LD labels, and how they might affect students who are labelled in Saudi mainstream primary schools.

The interview will be about your perceptions about ADHD and LD labels.

Any personal information you give will be kept confidential and all names will be anonymised. Although the results of this research might be published, your names, the names of any schools, children and teachers will not be used.

Your participation is completely voluntarily, therefore you have the right to withdraw at any stage of the study without giving any reasons.

In this research, your participation will be interviewing. The aim of the interview is to have an in depth conversations about ADHD and LD labels and how those labels might affect children who are labelled.

I will ask for your permission to digitally record the interview on a secure audio recording device. It is anticipated that the interview will take up to 40 minutes. Interviews will be held in one of the private room in your (child) mainstream school.

If you have any questions do not hesitate to contact me, or my supervisors.

### **Contact Details**

The researcher: Hatim Algraigay

Phone number: UK 00447414557525 Saudi 00966553999580

Email address: [hhha202@exeter.ac.uk](mailto:hhha202@exeter.ac.uk) or [h.haa111@hotmail.com](mailto:h.haa111@hotmail.com)

For alternative contacts:

Dr Alison Black [A.E.Black@exeter.ac.uk](mailto:A.E.Black@exeter.ac.uk)

Dr Christopher Boyle [C.Boyle2@exeter.ac.uk](mailto:C.Boyle2@exeter.ac.uk)

### **Consent**

I have been fully informed about the aims and purposes of the project.

I understand that:

- there is no compulsion for me to participate in this research project and, if I do choose to participate, I may withdraw at any stage;

- I have the right to refuse permission for the publication of any information about me;
- any information which I give will be used solely for the purposes of this research project, which may include publications or academic conference or seminar presentations;
- If applicable, the information, which I give, may be shared between any of the other researcher(s) participating in this project in an anonymised form;
- all information I give will be treated as confidential;

The researcher(s) will make every effort to preserve my anonymity.

.....  
 (Signature of participant)

.....  
 (Date)

.....  
 (Printed name of participant)

Hatim Algraigay

.....

(Printed name of researcher)

(Signature of researcher)


One copy of this form will be kept by the participant; a second copy will be kept by the researcher(s).

Your contact details are kept separately from your interview data.

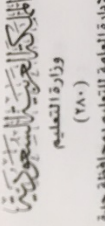
**Data Protection Notice**

*Data Protection Notice - The information you provide will be used for research purposes and your personal data will be processed in accordance with current data protection legislation and the University's notification lodged at the Information Commissioner's Office. Your personal data will be treated in the strictest confidence and will not be disclosed to any unauthorised third parties. The results of the research will be published in anonymised form."*

Appendix 7 (Permissions of Ministry of Education in Saudi Arabia)



وزارة للتعليم  
Ministry of Education



وزارة التعليم  
الإدارة العامة للتعليم بمحافظة جدة  
(٢٨٠)

رؤيتنا : متعلم .. ممتاز بدينه .. منتم لوطنه .. منتج للمعرفة .. مناضح عالمياً .

\* إنهاء تطبيق البحث \*

الاسم	حاتم حمدي حميد القريري	السجل المدني	١٠٦٤٨٠٩٧٢٣
الجنال	٠٥٣٩٩٥٨٠	البريد الإلكتروني	h.haali@hotmail.com
اللمحبة الثقافية	لندن	التخصص	تربية خاصة
الدرجة العلمية	دكتوراه	عينة الدراسة	معلمون
عنوان الدراسة	اكتشاف النتائج السلبية حول تسميات صعوبات التعلم واضطراب فرط الحركة والنشاط الزائد للاطفال في مدارس التعليم العام المرحلة الابتدائية بمدينة جدة		
الموضوع بشأن	إنهاء تطبيق بحث الطالب في تعليم جدة .		

**إلى : سعاده الملتقى الثقافي بسفارة المملكة العربية السعودية لدى المملكة المتحدة .**

**من : مدير عام التعليم بمحافظة جدة .**

السلام عليكم ورحمة الله وبركاته ، وبعد :

إشارة إلى خطاب الباحث ( الموضوع بياناته أعلاه ) ، ( مرفق ) حول رغبته في إبلاغكم عن انتهائه من مرحلة جمع البيانات من خلال عينة الدراسة .

تفيدكم بالتالي :

■ أن الباحث حصل على تسهيل مهمة الباحث في ٢١ / ٢٩ / ١٤٣٩ هـ ، وبدأ جمع المعلومات في ٩ / ٣ / ١٤٣٩ هـ الموافق ٢٨ / ١١ / ٢٠١٧ م ، وأنهى من جمع المعلومات في ١٩ / ٦ / ١٤٣٩ هـ الموافق ٧ / ٢ / ٢٠١٨ م .

■ أفادت جهة عينة البحث أن الباحث قام بتطبيق أداة الدراسة على عينة من المعلمين ؛ حسب الخطاب المرفق .

والسلام عليكم ورحمة الله وبركاته .

**مدير عام التعليم بمحافظة جدة**  
**عبدالله بن أحمد الثقفي**

هاتف ٤٤٤٣٠٥ - فاكس ٤٤٢٤٠٤٠ - الرمز البريدي : ٢١١٥٨

رؤيتنا : متعلم .. معزز دينه .. منتم لوطنه .. منتج للمعرفة .. منافس عالمياً .

" تطبيق البحث "

الاسم	حامد حمدي حميد القرظري	السجل المدني	١٠٦٤٨٠٩٧٢٣
الجوال	٠٥٣٩٩٩٥٨٠	البريد الإلكتروني	h.haal11@hotmail.com
المهنة العلمية	لندن	التخصص	ثرية خاصة
الدرجة العلمية	دكتوراه	عينة الدراسة	معلمون
عنوان الدراسة	اكتشاف النتائج السلبية حول تسميات صعوبات التعلم و اضطراب فرط الحركة و النشاط الزائد للاطفال في مدارس التعليم العام المرحلة الابتدائية بمدينة جدة		
الموضوع بشأن	تطبيق أدوات بحثه في تعليم جدة .		

إلى : سعادة الملحق الثقافي بسفارة المملكة العربية السعودية لدى المملكة المتحدة .  
مسن : مدير عام التعليم بمحافظة جدة .

السلام عليكم ورحمة الله وبركاته

بناء على إفاذتكم ( الموضح بياناته أعلاه ) ، واستجابة لرغبته في تزويدكم بالموافقة بتطبيق بحثه و جمع البيانات المتعلقة بعينة الدراسة .  
نفيدكم أنه لا مانع لدينا بالموافقة بعد دراسة أداة البحث ؛ و ذلك تشجيعاً للبحث العلمي وبما يعود على الوطن بمثل هذه البحوث الميدانية ؛ شاكرين ومقدرين تعاونكم واهتمامكم .  
والسلام عليكم ورحمة الله وبركاته

مدير عام التعليم بمحافظة جدة

عبدالله بن أحمد الثقفي

الاحترام

الكرام قائده مدرسة

السلام عليكم ورحمة الله وبركاته ... وبعد :-

بناءً على خطاب مدير إدارة التخطيط والمعلومات رقم ٢٠١٢٢/١٣ بتاريخ ١٣/١٢/١٤٢٩هـ حول تطبيق أدوات البحث للباحث / حاتم حمدي حميد القريري .  
نأمل منكم تسهيل مهمة الباحث على عينة الدراسة مع أخذ الموافقة من أولياء أمور الطلاب المشاركين في البحث .

ولكم تحياتي وتقديري ،،،،،

مدير إدارة التربية الخاصة

عبد الرحمن بن علي الغامدي

٣ / ٨ / ١٤٤٩ هـ

صورة للتربية الخاصة .



Appendix 8 (Permission from Schools' Principals)

الجمهورية العربية السورية  
وزارة التعليم  
إدارة العامة للتعليم بمحافظة جدة  
القسم الإداري  
٣٢٢٤١

وزارة التعليم  
Ministry of Education

الرقم:  
الملاحظات:

( مشهود )

تشهد إدارة المدرسة بأن الباحث/ حاتم حمدي القريري قام بزيارة المدرسة في ١٤٣٩/٠٢/٠٩ هـ ، وذلك لإجراءات بحثية تتعلق بصعوبات التعلم ، وعلى ذلك تم إعطاءه هذا المشهود للعلم والإحاطة.

والله الموفق

قائد المدرسة  
تركي بن محسن الحميدي  
٢٠١٩

32241@sbmal.org <http://sbmal.sch.sa>

## Appendix 9 (Information Sheet to Participants and Consent form of Questionnaires)



### ورقة المعلومات للمشاركين في الاستبيان

عزيزي المشارك بداية اود ان أقدم لكم نبذة مختصرة عن  
وعنوانه :

العنوان / أثر تسميات وتصنيفات صعوبات التعلم واضطراب تشتت الانتباه  
وفرط الحركة على الأطفال من خلال جهات نظر الإباء والمعلمين.

#### معلومات البحث/

انا اسمي حاتم القريقرى باحث في مرحلة الدكتوراه في جامعة اكستر  
البريطانية. أفديكم بان تخصصي هو صعوبات التعلم حيث انني حاصل  
على درجة البكالوريوس في هذا المجال كما انني حصلت على درجة  
الماجستير في التربية الخاصة من جامعة اكستر البريطانية.  
وامتدادا لتخصصي ومشروعي البحثي فإنني أقوم حاليا بعمل بحث حول  
أثر تسميات وتصنيفات صعوبات التعلم واضطراب تشتت الانتباه وفرط  
الحركة من خلال جهات نظر الإباء والمعلمين. هذه الدراسة سوف تطبق  
في المدارس الابتدائية في مدينة جدة.  
أمل في الحصول على آرائكم حول تسميات وتصنيفات بصعوبات التعلم  
واضطراب تشتت الانتباه وفرط الحركة، من خلال توزيع استبانة مغلقة.

يرجى منك أن تشارك في الاستبيان وهو يقيس تصوراتكم حول أثر تسميات  
وتصنيفات صعوبات التعلم واضطراب تشتت الانتباه وفرط الحركة. سيتم  
الاحتفاظ بأسمائكم ومعلوماتكم الشخصية بكل سرية. على الرغم من أنه  
قد يتم نشر نتائج هذا البحث، فإن أسمائكم، وأسماء المدارس لن  
تستخدم. مشاركتك طوعية تماما، وبالتالي لديك الحق في التوقف عن  
استكمال الاستبيان دون إبداء أي أسباب.  
ومن المتوقع أن يستغرق الاستبيان مدة تصل إلى ٦ دقائق. مشاركتك  
طوعية تماما في هذه الدراسة، لذا يرجى البدء في ملء الاستبيان  
أدناه إذا كنت ترغب في القيام بذلك.  
ان مشاركتك ستسهم في صنع الفرق للأطفال الذين لديهم صعوبات التعلم  
واضطراب تشتت الانتباه وفرط الحركة. مساعدتكم هي محل تقدير كبير  
جدا، وإذا كان لديك أي أسئلة أو استفسارات حول الدراسة، لا  
تترددوا في الاتصال ومناقشة معي أو مع مشرفي الأكاديميين.

الباحث: حاتم القريقرى  
00447414557525

00966553999580

[haha202@exeter.ac.uk](mailto:haha202@exeter.ac.uk)

[h.haa111@hotmail.com](mailto:h.haa111@hotmail.com)

المشرفين:

د. اليسون بلاك

[A.E.Black@exeter.ac.uk](mailto:A.E.Black@exeter.ac.uk)

د. كريستوفر بويل

C.Boyle2@exeter.ac.uk

ارجوا الموافقة على المشاركة في الاستبانة حتى تتم المشاركة

Arabic information sheet to participants and consent form of interviews



## ورقة المعلومات للمشاركين في المقابلة

عزيزي المشارك بداية اود ان أقدم لكم نبذة مختصرة عن هذا البحث وعنوانه:

العنوان / أثر تسميات وتصنيفات صعوبات التعلم واضطراب تشتت الانتباه وفرط الحركة على الأطفال من خلال وجهات نظر الإباء والمعلمين.

معلومات البحث/  
تم توزيع هذه الورقة بناء على رغبتك في اجراء المقابلة. كما تعلم فانا أقوم حاليا بعمل بحث حول أثر تسميات وتصنيفات صعوبات التعلم واضطراب تشتت الانتباه وفرط الحركة من خلال وجهات نظر الإباء والمعلمين. هذه الدراسة سوف تطبق في المدارس الابتدائية في مدينة جدة.

أمل في الحصول على آرائكم حول تسميات وتصنيفات بصعوبات التعلم واضطراب تشتت الانتباه وفرط الحركة، من خلال مقابلة أولياء الامور والمعلمين.

يرجى منك أن تشارك في القابلة وفيها نناقش تصوراتكم حول أثر تسميات وتصنيفات صعوبات التعلم واضطراب تشتت الانتباه وفرط الحركة. سيتم الاحتفاظ بأسمائكم ومعلوماتكم الشخصية بكل سرية. على الرغم من أنه قد يتم نشر نتائج هذا البحث، فإن أسمائكم، وأسماء المدارس لن تستخدم. مشاركتك طوعية تماما، وبالتالي لديك الحق في التوقف عن استكمال الاستبيان دون إبداء أي أسباب. ومن المتوقع أن تستغرق القابلة مدة قد تصل إلى ٤٠ دقيقة

ان مشاركتك ستسهم في صنع الفرق للأطفال الذين لديهم صعوبات التعلم واضطراب تشتت الانتباه وفرط الحركة. مساعدتكم هي محل تقدير كبير جدا، وإذا كان لديك أي أسئلة أو استفسارات حول الدراسة، لا ترددوا في الاتصال ومناقشة معي أو مع مشرفي الأكاديميين.

الباحث: حاتم القريقرى

00447414557525

00966553999580



[hhha202@exeter.ac.uk](mailto:hhha202@exeter.ac.uk)

[h.haa111@hotmail.com](mailto:h.haa111@hotmail.com)

المشرفين:

د. اليسون بلاك

[A.E.Black@exeter.ac.uk](mailto:A.E.Black@exeter.ac.uk)

د. كريستوفر بويل

[C.Boyle2@exeter.ac.uk](mailto:C.Boyle2@exeter.ac.uk)

للسرية:

سوف تكون المقابلة في احدى قاعات المدرسة او أي مكان تفضله. علما  
بانه سوف تسجل المقابلة في اشرطة خاصة بالباحث حرصا على الثقة.  
اود ان أفديكم بانها لن تستخدم لأغراض أخرى غير الاغراض المذكورة  
أعلاه. ولن يسمح لأي طرف اخر للوصول اليها. ومع ذلك سيتم تزويدكم  
بنسخة من المقابلة بحيث يمكنك التعليق عليها وتحريره على النحو  
الذي تراه مناسباً (المرجو إعطاء بريدك الالكتروني ادناه حتى أتمكن  
من التواصل معك لاحقا).

الموافقة:

لقد تم إبلاغي تماما بأهداف المشروع ومقاصده. انا افهم ذلك.  
ليس هناك إجباري بالنسبة لي على المشاركة في هذا المشروع البحثي،  
وإذا اخترت المشاركة، يمكنني الانسحاب في أي مرحلة.  
لدي الحق في رفض الإذن لنشر أي معلومات عني.  
أي معلومات أعطيها سوف تستخدم فقط لأغراض هذا المشروع البحثي،  
والتي قد  
وتشمل المنشورات أو العروض الأكاديمية أو المؤتمرات الدراسية.

المشاركة في هذا المشروع في شكل مجهول الهوية.  
سيتم التعامل مع جميع المعلومات التي أعطيها على أنها سرية؛  
سوف يبذل الباحث قصارى جهده للحفاظ على عدم الكشف عن هويته.  
توقيع المشارك) ( .....  
(التاريخ)  
(الاسم المطبوع للمشارك) (.....)

حاتم القريقرى (اسم مطبوع للباحث)

(توقيع الباحث)

وسيحتفظ المشارك بنسخة واحدة من هذا النموذج؛ سيتم الاحتفاظ بنسخة  
ثانية من قبل الباحث. يتم الاحتفاظ بتفاصيل الاتصال الخاصة بك بشكل  
منفصل عن بيانات المقابلة

## ورقة المعلومات لمدرء المدارس

عززي مدير المدرسة بداية اود ان أقدم لكم نبذة مختصر  
البحث وعنوانه :

العنوان / أثر تسميات وتصنيفات صعوبات التعلم واضطراب تشتت  
الانتباه وفرط الحركة على الأطفال من خلال وجهات نظر الإباء  
والمعلمين.

### معلومات البحث/

انا اسمي حاتم القريقرى باحث في مرحلة الدكتوراه في جامعة اكستر  
البريطانية. أفديكم بان تخصصي هو صعوبات التعلم حيث انني حاصل  
على درجة البكالوريوس في هذا المجال كما انني حصلت على درجة  
الماجستير في التربية الخاصة من جامعة اكستر البريطانية.  
وامتدادا لتخصصي ومشروعي البحثي فإنني أقوم حاليا بعمل بحث حول  
أثر تسميات وتصنيفات صعوبات التعلم واضطراب تشتت الانتباه وفرط  
الحركة من خلال وجهات نظر الإباء والمعلمين. هذه الدراسة سوف تطبق  
في المدارس الابتدائية في مدينة جدة.  
أمل في الحصول على آراء أولياء أمور الأطفال المصنفين بصعوبات  
التعلم واضطراب تشتت الانتباه وفرط الحركة، وايضا معلمهم في  
الصفوف الابتدائية من خلال توزيع استبانة مغلقة.

وبحكم انك مدير المدرسة أود أن أطلب منكم توزيع ورقة المعلومات  
المرفقة على كل من معلمين الأطفال ذوي صعوبات التعلم واضطراب تشتت  
الانتباه وفرط الحركة، وأولياء أمور الأطفال الذين يعانون صعوبات  
التعلم واضطراب تشتت الانتباه وفرط الحركة. ومن المتوقع أن يتبع  
المشاركون الراغبون الرابط على ورقة المعلومات للوصول إلى  
الاستبيان. أيضا، إذنكم لإجراء بعض المقابلات في المدرسة هو محل  
تقدير كبير جدا كما أنه من المفيد بالنسبة لي والمشاركين للعثور  
على الموقع المناسب لإجراء المقابلات.

ولقد تواصلت مع وزارة التربية، وأذنوا لي بإجراء الدراسة بهذه  
الطريقة. كما ان هذه الدراسة معتمدة من جامعة اكستر. توزيع هذه  
الاستبانة هو امر اختياري. مساعدتكم هي محل تقدير كبير جدا، وإذا  
كان لديك أي أسئلة أو استفسارات حول الدراسة، لا ترددوا في  
الاتصال ومناقشة معي أو مع مشرفي الأكاديميين

الباحث: حاتم القريقرى  
00447414557525

00966553999580

[haha202@exeter.ac.uk](mailto:haha202@exeter.ac.uk)

[h.haa111@hotmail.com](mailto:h.haa111@hotmail.com)

المشرفين:

د. اليسون بلاك

[A.E.Black@exeter.ac.uk](mailto:A.E.Black@exeter.ac.uk)

د. كريستوفر بويل

[C.Boyle2@exeter.ac.uk](mailto:C.Boyle2@exeter.ac.uk)



conduct interviews in Arabic

### نموذج موافقة للبحث (مقابلة)

عزيزي المشارك بداية اود ان أقدم لكم نبذة مختصرة عن  
وعنوانه:

العنوان / أثر تسميات وتصنيفات صعوبات التعلم واضطراب فرط  
الحركة والنشاط الزائد على الأطفال من خلال جهات نظر الإباء  
والمعلمين.

تفاصيل المشروع البحثي:

عزيزي المشارك أقدم لك ورقة المعلومات هذه بناء على اهتمامك  
بإجراء المقابلة بعد انتهائك من استبيان السابق.

هذا البحث سيحاول استكشاف تصوراتك واراتك حول تسميات صعوبات  
التعلم واضطراب فرط الحركة والنشاط الزائد وما مدى ضرر هذه  
التسميات على الطلبة في المدارس الابتدائية العامة. سوف تكون  
المقابلة حول تصوراتك واراتك عن تسميات صعوبات التعلم واضطراب  
فرط الحركة والنشاط الزائد.

سيتم الاحتفاظ بأي معلومات شخصية تقدمها بسرية تامة وسيتم إخفاء  
جميع الأسماء. على الرغم من أنه قد يتم نشر نتائج هذا البحث، فإن  
أسمك وأسماء أي مدارس وأطفال ومعلمين لن يتم استخدامها. ستكون  
مشاركتك تطوعية تماما، وبالتالي يكون لديك الحق في الانسحاب في أي  
مرحلة من مراحل الدراسة دون إبداء أي أسباب.

في هذا البحث، سيتم إجراء مقابلة مع مشاركتك. الهدف من المقابلة  
هو إجراء محادثات متعمقة حول تسميات صعوبات التعلم واضطراب فرط  
الحركة والنشاط الزائد وكيف أن هذه التسميات قد تؤثر على الأطفال  
الذين يلقبون بها. أطلب الإذن الخاص بك لتسجيل المقابلة على جهاز  
تسجيل صوتي آمن. ومن المتوقع أن تستغرق المقابلة 40 دقيقة. ستعقد  
المقابلات في إحدى الغرف الخاصة في مدرسة (طفلك).

إذا كان لديك أي أسئلة لا تتردد في الاتصال بي، أو المشرفين  
الدراسيين الخاصين بي:

اسم الباحث: حاتم القريقرى

رقم الجوال: ٠٠٤٤٧٤١٤٥٥٧٥٢٥-٠٠٩٦٦٥٥٣٩٩٩٥٨٠

[hhha202@exeter.ac.uk](mailto:hhha202@exeter.ac.uk) OR [h.haa111@hotmail.com](mailto:h.haa111@hotmail.com)

لاتصالات البديلة:

[A.E.Black@exeter.ac.uk](mailto:A.E.Black@exeter.ac.uk) د. اليسون بلاك

[C.Boyle2@exeter.ac.uk](mailto:C.Boyle2@exeter.ac.uk) د. كريستوفر بويل

أوافق على:

لقد تم إبلاغي تماما بأهداف المشروع البحثي وأهدافه.

انا افهم ذلك:  
\* ليس هناك إجباري بالنسبة لي على المشاركة في هذا المشروع  
البحثي، وإذا اخترت المشاركة، يمكنني الانسحاب في أي مرحلة؛  
ولدي الحق في رفض الإذن بنشر أي معلومات عني.  
\* فإن أي معلومات أعطيها سوف تستخدم فقط لأغراض هذا المشروع  
البحثي، والتي قد تشمل المنشورات أو المؤتمرات الأكاديمية أو عروض  
الندوات إذا كان ذلك ممكنا، المعلومات التي أعطيها، يمكن أن تكون  
مشتركة بين أي من الباحثين الآخرين المشاركين في هذا المشروع في  
شكل مجهول الهوية.  
جميع المعلومات التي أعطيها سيتم التعامل معها على أنها سرية؛  
سوف يبذل الباحث قصارى جهده للحفاظ على عدم الكشف عن هويتي.

.....  
(توقيع المشارك)

.....  
(Date)

.....  
(اسم المشارك)

Hatim Algraigay

(Printed name of researcher)

(Signature of researcher)

وسيحفظ المشارك بنسخة واحدة من هذا النموذج؛ سيتم الاحتفاظ بنسخة  
ثانية من قبل الباحث.  
يتم الاحتفاظ بتفاصيل الاتصال الخاصة بك بشكل منفصل عن بيانات  
المقابلة.

إشعار حماية البيانات  
إشعار حماية البيانات - سيتم استخدام المعلومات التي تقدمها لأغراض البحث وسيتم معالجة  
البيانات الشخصية الخاصة بك وفقا لتشريعات حماية البيانات الحالية وإخطار الجامعة  
المقدمة في مكتب مفوض المعلومات. سيتم التعامل مع بياناتك الشخصية بأقصى قدر من الثقة  
ولن يتم الكشف عنها لأي طرف ثالث غير مصرح به. وسيتم نشر نتائج البحث في شكل مجهول  
الهوية.

**Appendix 10 (The Label used in some Saudi Resource Room)**



## **Appendix 11 (Code of Interviews)**

### **General information (theme)**

#### **LD teachers' general information (sub)**

- 1- number of LD teachers in school 1
- 2- LD students educational level 1
- 3- types of LD students difficulties 2
- 4- number of students with LD 3

#### **ADHD teachers' general information (sub)**

- 1- number of students with ADHD 2
- 2- educational level of ADHD students 2

#### **ADHD parents' general information (sub)**

- 1- number of family members 2
- 2- school acceptance is conditional by medicine treatment 1
- 3- educational and medical information of ADHD child

### **Knowledge and experience (theme)**

#### **Involvement in workshops (sub-theme)**

##### **LD teachers (category)**

- 1- LD teachers' involvement of training and workshops 2
- 2- workshop and training sources 1
- 3- type of workshop and training 1
- 4- LD teacher experience 1

##### **LD parents (category)**

- 1- LD parent' views on training and workshops 4
- 2- alternative source of training and workshop 4

##### **ADHD teachers (category)**

- 1- training and workshops of ADHD teacher 2
- 2- ADHD teacher' qualification 2

##### **ADHD parents (category)**

- 1- parents' involvement of training and workshops 2

#### **Understanding of LD concept (sub-theme)**

##### **LD teachers (category)**

- 1- LD teacher' views on word (difficulty) 9
- 2- Understanding about word LD lower grade students 3 (teachers' views)
- 3- understanding of word LD in higher grade student 2 (teachers' views)
- 4- LD teacher avoid using (LD) 2
- 5- (we can) instead of resource room 3

##### **LD parents (category)**

- 1- parents understanding about resource room 2
- 2- parents understanding of word difficulties 11
- 3- child understanding of word (difficulties) 5
- 4- parents not happy with diagnosis process 3

#### **Understanding of ADHD concept (sub-theme)**

##### **ADHD teachers (category)**

- 1- ADHD teacher views on ADHD label 4
- 2- ADHD teacher believe in medical treatment 4

- 3- parents refuse medical treatment 2
- 4- ADHD teacher views on resource room 3

#### ADHD parents (category)

- 1- ADHD parent is not shy about his child 1
- 2- parents never use ADHD at home 2

### **Positive of current labels (theme)**

#### LD teachers (category)

- 1- positive of label 3
- 2- factors make label beneficial 2
- 3- positive of resource room 1
- 4- labelled students are better than those without(benefit of labe 1

#### LD parents (category)

- 1- positive of label 4
- 2- important) allocating service not excuse to ram people 1

#### ADHD teachers (category)

- 1- positive of ADHD label 5
- 2- dilema of ADHD label ( important memo) 2

#### ADHD parents (category)

- 1- positive of ADHD label according to parents 4
- 2- ADHD child is better than other non-diagnosed 1

### **ADHD child is not aware about the current label (sub-theme)**

#### ADHD parents (category)

- 1- ADHD doesnt has an effects 5
- 2- ADHD child doesnt change his academic performance 2
- 3- ADHD label doesnt minimise child ability 1
- 4- ADHD labels doesnt affect social skill 1

### **Hiding difficulties (theme)**

#### Hiding at school (sub-theme)

#### LD teachers (category)

- 1- LD child hides from special teacher 1
- 2- alternative ways to call LD children to resource room 4
- 3- LD students remain silent 2

#### LD parents (category)

- 1- LD child doesnt participate in the classroom 4
- 2- desire to hide after LD diagnosis 2

#### ADHD teachers (category)

- 1- ADHD child doesnt hide difficulties he desire to not be labelled 1
- 2- hiding difficulities is hard for ADHD child 2
- 3- lower grade ADHD students dont hide from peers 1

#### Hiding at homes (sub-theme)

#### LD parents (category)

- 1- hiding difficulties at homes 2
- 2- encouragement overwhelms hiding difficulties 4

#### ADHD parents (category)

- 1- ADHD child hides his difficulties from father 2
- 2- hiding difficulties is hard for ADHD child 1

### **Why labelled students hide their difficulties (sub-theme)**

#### **LD teachers (category)**

- 1- reasons for hiding difficulties 5
- 2- desire for hiding difficulties 1
- 3- lower academic performance behind hiding difficulties 1
- 4- afraid of peers reactions 2
- 5- LD child afraid from teacher punishment 1

#### **LD parents (category)**

- 1- reasons for hiding difficulties 7

### **Acknowledgment of disability (sub-theme)**

#### **LD teachers (category)**

- 1- types of acknowledging difficulties 6
- 2- importance of relationship with students 3
- 3- benefits of good relationship with LD students 2

#### **ADHD teachers (category)**

- 1- types acknowledging ADHD difficulties 4
- 2- why ADHD acknowledging difficulties to ADHD teacher 2

#### **ADHD parents (category)**

- 1- ADHD child uses the label to justify his difficulties 4
- 2- parents reaction towards acknowledging difficulties 1

### **Stigma (theme)**

#### **Occurrence of stigma (sub-theme)**

#### **LD teachers (category)**

- 1- how stigma occur 2
- 2- failure to do simple tasks lead to stigma 1
- 3- stigma in implementing the dual EP 1
- 4- comparison between peers is more influential 3

#### **ADHD teachers (category)**

- 1- stigma is not linked to label, its linked to child behaviour 1
- 2- why ADHD label stigmatises students 1

#### **Source of stigma (sub-theme)**

#### **LD teachers (category)**

- 1- source of stigma 10
- 2- general teachers told off LD children 1
- 3- stigma occur between 2 LD students 1
- 4- resource room stigmatise LD children 2 "name"
- 5- LD child get bullied by peers and general teachers 2

#### **LD parents (category)**

- 1- sources of stigma 2
- 2- failure leads to stigma 2

#### **ADHD teachers (category)**

- 1- source of stigma 3
- 2- Higher grade students get stigmatised by peers 5
- 3- ADHD label affects parents who stress their kids 1
- 4- ADHD teacher effort on stigma 6



### ADHD parents (category)

- 1- Resource room stigmatises children 1

### Stigma outcomes (sub-theme)

#### LD teachers (category)

- 1- results of stigma ( bullying laughing) 6
- 2- desire to not attend lesson in resoures room 2
- 3- LD children do not ask for help due to stigma 1
- 4- effects of bullying and laughing at school 2

#### LD parents (category)

- 1- result of stigma 2
- 2- desire to not attend to class 3

### LD teachers' views on stigma (sub-theme)

- 1- LD teacher' view to solve stigma 3
- 2- teachers effort on stigma 2

### Potential behaviour resulted from labels (theme)

#### Effect of labels on social skills (sub-theme)

##### LD teachers (category)

- 1- LD label effect on social skills 2
- 2- LD and general teachers efforts on social skills 2
- 3- negative connatations leads to isolation 2
- 4- LD students is isolated 3
- 5- absence of encouragement from society 1
- 6- lower level of society awareness 2
- 7- labels VS reaction of peers 1
- 8- general students behaviour towards LD students 1

##### LD parents (category)

- 1- effects of LD label on social skills 2
- 2- comparison between peers is influential 4
- 3- peers reactions towards label 3

### ADHD teachers (category)

- 1- effect of ADHD label on social skills 1

#### Effects of labels on self-esteem (sub-theme)

##### LD teachers (category)

- 1- effects of LD label on self-esteem 2
- 2- source of pysochological effects 1
- 3- LD label leads to students frustrations 1
- 4- LD label leads to minimise self-expectation 2
- 5- anything might happen if child is broken psychologically 1
- 6- using LD label on a daily basis 1
- 7- supporting children leads students to be shy 1

##### LD parents (category)

- 1- LD label minimising ability 1
- 2- (important) parents wasnt expect the harm of label 1
- 3- LD label leads to frustration 2
- 4- parental higher expectation makes LD child cry 1

### ADHD teachers (category)

- 1- ADHD label dosent affect lower grade children' self-esteem 4
- 2- ADHD label doesnt lead to srustration, non-diagnosis do so 2
- 3- ADHD label frustrates ADHD students 5
- 4- ADHD label minimises children ability 3

- 5- ADHD label doesn't make student less smart 1
- 6- ADHD label doesn't minimise ability 2

#### ADHD parents (category)

- 1- comparing himself with others affect his self-esteem 2
- 2- why comparison affects ADHD child self-esteem 1
- 3- ADHD label minimises child's ability 1

#### Effects of labels on academic aspects (sub-theme)

##### LD teachers (category)

- 1- reasons of students failure 2
- 2- elements impede labels for minimising ability 2
- 3- LD label leads to student's failure 3
- 4- labels exacerbate the child's lower achievement 2
- 5- LD teacher's views on changing academic performances 3
- 6- non-diagnosed students show difficulties 1

##### LD parents (category)

- 1- reasons of LD children failure 6
- 2- lack of encouragement make child less achiever 3

#### ADHD teachers (category)

- 1- ADHD label increases students' failure 5
- 2- ADHD label doesn't lead to students failure 2

#### Effects of labels on teachers (sub-theme)

##### LD teachers (category)

- 1- (important) effects of LD on LD teacher 2
- 2- LD teachers expectations on LD students 1
- 3- teachers views on LD label 2

##### LD parents (category)

- 1- general teachers deal differently with LD kids 3
- 2- why general teachers are careless (parents views 3

#### ADHD teachers (category)

- 1- general teachers are careless with ADHD children 2
- 2- general teachers treat ADHD students differently 2
- 3- general teachers are careless after ADHD students diagnosed 3

#### ADHD parents (category)

- 1- ADHD label makes general teacher careless 5
- 2- parents faced difficulties in registering child in mainstream s 3
- 3- general teachers sent ADHD child out classroom 1
- 4- ADHD label leads general teacher to deal differently 5
- 5- ADHD label minimises general teachers attitudes 2
- 6- ADHD label affects teachers and then he's likely to fail 1

#### Effects of ADHD label on children and peers (sub-theme)

##### ADHD teachers (category)

- 1- ADHD child exploit the label to leave lessons(changing behaviour 3

##### ADHD parents (category)

- 1- peers are observing academic and behavioural of ADHD child 1
- 2- peers talking about my child even outside school 2
- 3- labels stay with child for whole life 1
- 4- parents hope their children to not study with current peers 1

#### Effects of labels on parents (Sub-theme)

##### LD teachers (category)

- 1- effect of LD label on parents (teacher's views) 4

- 2- parents refuse to join their kids in resource room 3
- 3- parents views on label (teacher perspectives) 2

#### ADHD parents (category)

- 1- parent neglects as he told school his child has ADHD 4
- 2- parents' compare ADHD child with other general children 1
- 3- parents' give ADHD child less chances than his normal brother 1

### **Informal labels (theme)**

#### **Effects of informal label (sub-theme)**

##### **LD teachers (category)**

- 1- drawback of formal and informal LD labels 3
- 2- informal labels remain for whole life 2
- 3- formal labels leave person after period of time 1
- 4- reasons for informal label 2
- 5- formal label better than informal label 1
- 6- relationship between formal and informal labels 2

##### **ADHD teachers (category)**

- 1- example of informal labels used in schools by peers 4
- 2- relationship between informal and formal ADHD labels 1
- 3- extra support in front of peers is stigma, as its linked to Rroo

#### ADHD parents (category)

- 1- parents prefer formal labels than pejorative words 1
- 2- parents are affects more by pejorative words than formal ones 1

#### **Use of pejorative words (sub-theme)**

##### **LD teachers (category)**

- 1- general teacher uses pejorative words 5
- 2- use of pejorative words leads LD students not finish their task 1
- 3- general students use pejorative words 1
- 4- results of pejorative words 1

##### **LD parents (category)**

- 1- teachers use of pejorative words 2
- 2- use of pejorative words 4
- 3- educational support makes LD children less smarter than others 2
- 4- relationship between formal and informal labels 2

##### **ADHD teachers (category)**

- 1- pejortative words by teachers 3

#### ADHD parents (category)

- 1- school uses pejorative words 2
- 2- why pejorative words is more dangerous 1
- 3- peers are aware more about pejorative words than formal ones 1
- 4- pejorative words remain with children for whole life 3

### **Effects of resource room (theme)**

#### **Effects of R R on general teachers (sub-theme)**

##### **LD teachers (category)**

- 1- resource room etc make general teachers careless 2
- 2- general teachers exploit resource room 3
- 3- LD teacher' views about general teacher 1
- 4- resource room makes students less smarter 2

#### **LD parents (category)**

- 1- joining resource room makes general teachers careless 2

#### **ADHD teachers (category)**

- 1- resource room change general teacher dealing with ADHD 1

#### **Why general teachers neglect labelled students (sub-theme)**

##### **LD teachers (category)**

- 1- reasons for why general teachers are careless 4
- 2- general teachers are careless with labelled students 3
- 3- example of other names of resource room 2 (understood differently by others)
- 4- drawbacks of resource room 1

#### **Effects of R R on LD students (sub-theme)**

##### **LD parents (category)**

- 1- resource room stigmatise children 7
- 2- time of withdrawing LD children to resource R important 3
- 3- resource R is good for lower grade, but harmful for higher 3
- 4- resource room not problem, LD label is 5
- 5- resource room leads students to not attent classes 2

##### **ADHD teachers (category)**

- 1- resource room stigmatises ADHD children 2
- 2- ADHD child refused to enre resource room 1

##### **ADHD parents (category)**

- 1- resource room is frightening ADHD child 1
- 2- parents' views about resource room 1
- 3- ADHD child feels resource room is punishment 1

#### **Label in future (theme)**

##### **Suggestion to change label (sub-theme)**

##### **LD teachers (category)**

- 1- if labels changed, not effects after long time 3
- 2- enforcement of policy to use label 1
- 3- positives of change names 3
- 4- changing the name of resource room attracts others 4
- 5- positive names cannot lead to negative outcomes 1

##### **LD parents (category)**

- 1- alternative names instead of LD 11

##### **ADHD teachers (category)**

- 1- future of ADHD label 5
- 2- alternative labels in future about ADHD 1

#### **Use of label in future (sub-theme)**

##### **LD teachers (category)**

- 1- LD teachers' views about LD label in future 2
- 2- formal labels should be use between professionals 3
- 3- LD teacher desire for change 2

- 4- LD teacher should be given flexibility to change names 1

#### **LD parents (category)**

- 1- future of using LD label 6

#### **ADHD teachers (category)**

- 1- future labels should not point any dysfunction or impairment 2
- 2- ADHD label should be used privately 5

#### **ADHD parents (category)**

- 1- Parents' views about label in future 2
- 2- general teachers should have full awareness about ADHD in future 1
- 3- labels should be changed regularly 1
- 4- labels are used between some professionals 1