What are the barriers to accessing psychological therapy in Qatar: A concept mapping study

A thesis submitted in partial fulfilment of the requirements of the University of the West of England, Bristol for the degree of Professional Doctorate in Counselling Psychology

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Abstract

**Background:** Mental health problems are highly prevalent throughout the world; however, all too frequently individuals do not receive treatment. Psychological therapy is a potentially successful intervention but barriers to its access, which are likely to be country specific, could be better understood.

**Aims:** The aim of this paper was to identify the perceived barriers to accessing psychological therapy for people living in Qatar from the perspective of clinicians and policymakers involved in designing and delivering mental health care.

**Method:** A mixed methodology known as concept mapping was used to investigate the views of mental health clinicians and policymakers. Concept mapping invites participants to first brainstorm the issue, in this case potential barriers to accessing psychological therapy in Qatar (qualitative data). Participants then sort barriers into groups (clusters) and rate each barrier in terms of perceived importance (quantitative data). Differences between the views of the two participant groups were also observed.

**Results:** 15 clinicians and 11 policymakers took part in the study. They generated a total of 251 potential barriers that were consolidated into 80 statements. A nine-cluster concept map was produced from the results of all 26 participants. These clusters were labeled as; Stigma, Impact of the family, Cultural implications, Stigma impacting on reality, Cross-cultural Therapy, Workforce and training, Local (mis)understanding of therapy, Structural problems within the country and East meets West. The individual level barriers of stigma, family and culture were rated as being more important than organizational level barriers.

**Conclusions:** There are numerous barriers to accessing psychological therapy in Qatar. All participants rated barriers relating to the individual as having a greater impact on individual’s access to therapy than organization level barriers.
Addressing these barriers is likely to require a multi-faceted response involving health policy as well as political and sociological level changes. The views of service users and their families also need to be explored.
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A: Introduction to the thesis

A.1 Introduction
People experience mental health difficulties throughout the world. Successful treatments (psychological, pharmacological or a combination of both) are available but are frequently inaccessible or underutilised. The barriers that prevent people accessing treatment can vary between different cultures, societies and countries. One country where considerable development is currently occurring is Qatar, a small Gulf State in the Middle East.

A.2 Study Aims and Objectives
Given the potential existence of numerous barriers to accessing psychological therapy in Qatar, the main aim of this study was to better identify those considered the most important, or most significant at preventing access. The barriers were considered from the perspective of two groups of important stakeholders involved in mental health services; clinicians and policy makers. A secondary aim was to investigate the similarities and differences in the views of these two groups. To achieve these aims I set the following major objectives:

1. Identify all the possible barriers in Qatar as perceived by clinicians and policymakers.
2. Use concept mapping to create groupings of these barriers to create a manageable dataset.
3. Identify which of these barriers are felt to be the most significant (important) at preventing people accessing psychological therapy.
4. Statistically compare the ratings of importance given to each set of barriers by the two groups of participants.

A.3 Contribution of the thesis
The need to understand the barriers that prevent people from accessing psychological therapies has frequently been discussed in the international literature. Some may be unique to a given country or society whilst others
prove more general. Given that health services are currently undergoing considerable development in Qatar, it is timely to attempt to understand what might prevent residents of Qatar from successfully accessing the care.

This study provides a novel observation of the relationships between potential barriers that prevent people accessing psychological therapy. It is also the first study to show the relative importance of barriers, as perceived by the participants. Based on the results of this study, future planning of interventions to address the identified issues could occur within Qatar. The findings may also offer guidance to other developing countries that are looking to build on their current mental health provision.
Chapter 1: Introduction and background

1.1 Introduction

In this chapter I begin by giving some context about the Middle Eastern country of Qatar where this study is set. This is important, as it is a small country that many people know little about. I move on to addressing the global need to treat mental health difficulties as well as the gap that exists between those in need of treatment and those that successfully receive it. In order to try to understand this unmet need I discuss some of the barriers to accessing treatment in developed and then developing countries. I then give further context around mental health problems and healthcare provision in Qatar where this study was based and explain the context behind the conceptualisation of this piece of research in relation to my doctoral studies in counselling psychology. Finally I consider the aims and objectives of the study.

1.1 The context of Qatar

Qatar is a small country of approximately 12,000 square kilometres. It is located in the Gulf of Arabia, shares a land border with Saudi Arabia. Most of the population live in Doha, the capital city. Qatar is a member of the Gulf Coorporation Council (GCC), a regional intergovernmental political and economic union that consists of the Arab states of the Persian Gulf (Saudi Arabia, Kuwait, Bahrain, United Arab Emirates and Oman). Each of these nations are undoubtedly unique, however they share many important commonalities; language, religion, history, culture and political economies. Qatar specifically is a hereditary constitutional monarchy with a government appointed by the Head of State (Emir).

1.1.1 Population

Global inward migration of working age adults is a feature of GCC countries where rapid urbanisation and ambitious infrastructure projects require a work force that the countries’ population alone cannot support (Mirkin, 2004). This
means that the population of Qatar has changed substantially since the
discovery of its oil and gas fields. In the last 12 years it has quadrupled to
around 2.2 million, with 87% of the population now being expatriates on short-
term work contracts (Qatar Statistics Authority Bulletin Labour Force Statistics
2012). Indeed, Qatar has the largest expatriate to citizen ratio in the world. The
demographic population of this Arab region is therefore mixed and complex but
dominated (56%) by individuals from the Asian subcontinent (India, Nepal, Sri
Lanka, Pakistan and Bangladesh) working as unskilled labor migrants. Consequent-
ly, women account for only around a quarter of the population. The
Central Intelligence Agency’s 2015 World Factbook reported that Qatar has the
world’s largest gender imbalance, with an estimated 4.15 males (age 15-64) to
every one female. The rest of the expatriate population typically consists of
those from other Arab nations (e.g. those from Egypt, Jordan, Iran and Lebanon
together totals 10% of the population) and then smaller numbers (1%) of
individuals from each ‘western’ country such as the UK, USA and Canada who
typically occupy senior management position.

To live in Qatar you are required to have a ‘residents permit’, unless, of course,
you are a Qatari national. These permits are only issued to those that have an
in-country sponsor (normally their employer) who is responsible for their visa or
legal status. This sponsorship system is called Kafala (QSA, 2012). As you cannot
remain in the country without a valid visa, losing your job would likely result in
having to leave the country at very short notice. Many families must leave the
country on retirement of the employed ‘sponsoring’ member, which can create
particular challenges for relocation particularly given the current instability in
the region. Adsul et al (2011) found that unskilled labour migrants are generally
younger and healthier than the host population of the country they reside in,
however they also tend to have poorer living and working conditions and can be
vulnerable to exploitation and abuse.

Qatar is a high-income economy, mainly due to its large natural gas and oil
reserves and overseas investments. It is considered to have one of the highest
per capita incomes in the world (IMF, 2017). This is based on Gross Domestic
Product (GDP) and Purchasing Power Parity (PPP), the later taking into account the relative cost of living and inflation rates. For context, the 2017 GDP per capita of the UK is £34,686 and Qatar’s is £105,791. It is important to note that GDP per capita calculations do not count immigrant workers in Qatar (87% of the population), as they are not considered ‘residents’ by the government. There are therefore considerable limitations to the usefulness of these statistics as they paint a misleading picture of what life is like for the majority of Qatar’s population. Qatar is considered to have a skewed income distribution as it has a high per-capita GDP whilst the majority of its population have a low level of income. It has been reported that a typical Qatari-local household earns approximately £14,000 a month (Ministry of Development Planning and Statistics (MDPS) 2014). There are limited published statistics on the average income of unskilled labour migrants (who make up the majority of the population) but it can frequently be under £200 a month (Al-Maskari et al., 2011). A recent telephone survey conducted by Gray and Khaled (in press) suggested that almost a third of Qatari nationals earned over $19,228 (approx. £15,000) per month whilst just under half of the labour migrants sampled reported that they earned more than $550 (approx. £420) per month.

It is worth noting that as GDP is an economic indicator of the macro-social context of countries (World Bank, 2008) it has often been used in health systems research. There is substantial evidence from developed and developing countries (Myer et al., 2008) that lower socio-economic status (SES) is associated with an increased occurrence of mental disorders. Countries with higher GDP may be more likely to score highly on health related measures, such as life expectancy; therefore, GDP is often used as a determinant of a person’s quality of life (Janssen, Kunst, & Mackenbach, 2006). However, these findings need to be considered whilst baring in mind the specific context of Qatar. Although the country may seem to be well developed in terms of its economy, this does not automatically mean that its healthcare system is. Furthermore, Suphanachaimat et al. (2015) suggested that labour migrants tend to be infrequent users of a host country’s healthcare system because of fear of
deportation due to illness. This may mean that a large proportion of the individuals living in Qatar do not have adequate access to psychological support.

1.1.2 Religion and Culture
Qatar is a Muslim-majority country with Islam as the state religion. The CIA (2015) factbook reports that 77.5% of the population are Muslim, 8.5% Christian and 14% other. This is comparative to other countries in the Middle East that are experiencing significant growth and migration, such as the UAE, Kuwait and Bahrain. Other Middle Eastern countries such as Iran, Iraq and Yemen report rates as high as 99% of the population being Muslim. Due to the large expatriate population, other religions are accepted and practiced in Qatar. For example, there are a number of Christian churches where the large Filipino (Christian) community will typically meet, however these are typically segregated outside of the main city of Doha.

As a result of Qatar’s regional Islamic heritage, the country is governed by a mixture of civil and Sharia Law. This results in laws that are significantly different to Western countries, for example, it is illegal to be pregnant or have children outside of marriage but Islamic polygamy is allowed. Living in an Islamic society brings with it certain customs that non-Muslim expatriates must consider. For example, dressing conservatively (covering shoulders and knees) in public is advised for women and men. Although the call to prayer can be heard around the country it does not tend to impact on opening times of places unlike, for example, Saudi Arabia.

The traditional culture of Qatar is that of a typical collectivist Arabic society (Al-Haj, 1987; Barakat, 1993). These communities historically value collective good over the individual, and social stability over social change. They tend to adhere strictly to social morals and values as well as the principles of gender segregation (Hall, 1981). There is often pressure on individuals to accommodate the expectations of others, most significantly, their family members (Okasha, 2003). This societal preference for the group over individuals is reflected in the high regard placed on families. The good of the family comes before the good
of the individual, and a problem is viewed as a problem of the entire family (Al-Krenawi & Graham, 1996).

The Islamic religion and culture also has an impact on gender roles, especially within the family. In many Arab societies, a woman’s social status is strongly linked to being married and rearing children, especially boys (El Saadawi, 1995). Arranged marriages occur frequently, and women are expected to devote much of their time to caring for their family. Traditionally it is uncommon for women to have a career outside of the home although some do and it is becoming more frequent and accepted. Because of the perception that one’s behaviour is a representation of a person’s wider family, it is felt that behaving in an appropriate way prevents a family from being disgraced. Maintaining a family’s honor is often one of the core values of Arabic societies (Barakat, 1993). In Qatari culture the concept of honor is still the basis for, and regulator of, social interactions (Lay, 2005).

1.1.3 Beliefs and values
The Qatari population can be said to be traditionally Muslim; their beliefs and values are strongly influenced by the Qur’an and very few alternative discourses are available. Qatari children, like many Muslim children, are taught about Islam and the Qur’an from an early age, often attending their local mosque or having a private tutor for weekly lessons. Qatar is typically not a literary culture, the Qur’an is read and re-read. It is therefore unsurprising that beliefs about physical and mental health are influenced by what individuals know best; religious teachings from the Qur’an. Islam often explains mental illness or personal problems as a possession by spirit (‘jinn’; metaphysical beings with an occasional ability to interfere with human functioning) (Aloud, 2004). The solution is for a traditional healer to exorcise the spirit, through reading Quran, prayers, playing music, dancing, and beating spirits out of the person’s body, which then frees the person (Al-Krewani & Graham, 1997). Islamic-based beliefs and values can therefore also have an impact on accessing health services. For example, the religious authority figures and traditional healers can take the place of using specialist ‘westernised’ services (Al-Krewani et al., 2004; El-Islam, 2005; Loewenthal et al., 2001).
This traditional view of illness is commonly the only discourse available in conventional Arabic societies. Whilst younger generations are increasingly exposed to Western rationality through the media, travel and education, there can still be family pressure to subscribe, at least in part, to traditional beliefs and values.

1.1.4 Language
Although the country of Qatar is officially Arabic speaking, English, with variable fluency, is commonly spoken as a second language by a vast proportion of the population. Given the large number of nationalities working in the health systems, the formal language of the health systems is English, which means that everything is communicated in both Arabic and English and that official documentation is written in English and Arabic e.g. consent forms. A large number of staff members working in health services have English as a foreign language; for example, a recent work force review found that only a minority of nurses working in the psychiatry department spoke Arabic fluently (Thomas et al., 2015).

1.2 Mental health problems: A global challenge

1.2.1 Prevalence
The World Health Organisation (WHO) reports that 25% of the global population will experience a mental health disorder at some point in their lives (WHO Atlas, 2014). For example, Kessler et al. (2005) reported that 46.4% of Americans will meet the criteria of a DSM-IV disorder during their lifetime. Specifically, the lifetime prevalence of major depressive disorder (MDD) was reported as 20.8% and anxiety disorders as 28.8%. Another indicator of the significance of mental health problems is from the Global Burden of Disease study where depression was found to be the second leading cause of burden as measured using ‘years lived with disability (YLD’s, the years of productive life lost due to disability), only ‘lower back pain’ caused a greater burden to individuals (Whiteford et al, 2013).
To date, well-designed mental health epidemiology studies, using validated assessment tools are rare in the Arab Region (Okasha et al., 2012; Tahriki et al. 2009). Work that has been undertaken suggests rates similar to the rest of the world (Karem et al., 2006). For example, Al-Otaibia et al., (2007) had 2,320 patients attending primary care in Kuwait complete the Beck Depression Inventory. The authors found that 37.1% screened positive for depressive symptoms. ‘Depressive disorder’ was more prevalent among women than men, young people than old and more common among highly educated individuals, working participants, married individuals, and parents with three or more children. In Qatar, Bener, Ghuloum, and Abou-Saleh (2011) surveyed 1,660 Qatari nationals attending a primary care centre to estimate the prevalence of mental disorder. These authors observed that around a quarter of the sample had a mental disorder, rates comparable to those seen in the USA. In this study, risk factors also included being female, better educated and younger. A further study based in Qatar (Bener, Gerber & Sheikh, 2012) examined the prevalence of psychiatric disorders in women post partum. These authors reported that in a sample of 2,091 women, 19% had a depressive disorder. Other data collected for a collaborative project across 50 countries led by the Institute of Health Metrics and Evaluation in the USA suggested that mental disorder was the leading cause of disability in the state of Qatar (IHME, 2010).

1.2.2 Burden
Mental illness is deadly; for example, people with major depression have an overall increased risk of mortality 1.4 times greater than that of the general population because of physical health problems associated with mental disorders (such as cancer, diabetes, and HIV infection) as well as the serious consequences such as suicide. Leaving mental health problems untreated is also expensive (Layard report, 2006). It can cost a developed country up to 4% of GDP in lost productivity and disability (OECD, 2012).

In addition to economic factors, it is important to consider the debilitating nature of personal and social burdens. Depression, for example, affects most aspects of everyday functioning (Judd et al., 2000; Lecrubier, 2001). Relationships with significant others are often impacted. This can lead to marital
distress (Dudek et al., 2001) and troubled parent-child relationships (Ingram, 2001).

1.2.3 Cultural variances in mental illness
Some authors have observed that the way mental illnesses are viewed, reacted to, and expressed is different across cultures (Department of Health and Human Services, 1999). This is unlike physical disorders, which are mostly expressed and diagnosed in the same way the world over. Given the diversity of Qatar’s population, it may be helpful to understand how the symptoms of mental illness are conveyed amongst different cultures. The World Health Organisation (WHO) is one such body that has tried to better understand the similarities and differences in the way mental illness is expressed in varying cultures. One example of this is the development of the Standardised Assessment of Depressive Disorders (SADD; WHO, 2000). This suggests that the core symptoms of depression are common across cultures but factors such as guilt and low self-esteem are more characteristic of depression in Western nations. A focus on the physical (somatisation) is also more common is some cultures than others (Keedwell, 2008). For example, expression of emotion in front of authority figures (e.g. doctors) is considered a taboo in countries such as Japan and China.

The DSM-V has attempted to foster a greater cultural sensitivity towards diversity in its latest update. It identifies three cultural concepts; *cultural syndromes, cultural idioms of distress* and *cultural explanations of distress*. It acknowledges that some syndromes are less localised than previously thought, and instead have tended to be identified by different names across cultures rather than being different concepts entirely.

The DSM-V includes a ‘*cultural formulation interview guide*’ that was designed to help clinicians assess cultural factors influencing patients’ perspectives of their symptoms and treatment options. It includes questions about patients’ background in terms of their culture, race, ethnicity, religion or geographical origin (Lewis-Fernández, Aggarwal, Hinton, Hinton, & Kirmayer, 2015). The APA suggests that this interview guide provides an opportunity for individuals to define their distress in their own words. This is then related to how others
(including medical professionals), who may not share their culture, could be viewing their problems.

It may be commonplace in counselling or clinical psychology to consider carefully a person’s social and cultural background but the fact that it is necessary to explicitly encourage the medical profession to do so, implies this has not always been the case for all clinicians. This suggests a growing recognition that cultural variances within mental health diagnoses exist and must be attended to in order to successfully provide person-centred care (Aggarwal, Desilva, Nicasio, Boiler, & Lewis-Fernández, 2015).

1.2.4 Treatment
Treatment for mental illness typically involves pharmacological or psychological interventions, or a combination of both (APA, 2006; Davidson, 2010; NICE, 2009, 2011, 2014; Pilling et al., 2011). The UK is one country that has successfully established care pathways for various mental health problems within a state provided health care system (the National Health Service, NHS) that is free at the point of entry. These care pathways have been set out by the UK Government’s Department of Health and (in England) the National Institute for Clinical Excellence (NICE) and are based on the best available evidence from the research literature, ideally meta-analyses of randomised controlled trials.

1.2.4.1 Pharmacological therapy
Two of the main drug treatments available to treat mental health problems are antidepressants and antipsychotics. Antidepressants are prescribed for depression based on evidence that they increase the levels of neurotransmitters (noradrenaline, dopamine and serotonin) in brain areas such as the prefrontal cortex, hippocampus, amygdala and thalamus (Willner et al., 2013). Antipsychotics are prescribed when an individual presents with psychosis or mania. They exert their effect via the blockade of post-synaptic dopamine receptors.

Despite the significant body of literature that highlights the positive impact medication can have on managing symptoms of mental illness (Andersen et al., 2008; Barnes et al., 2011; Goodwin, 2003) medication is commonly perceived in
a negative light with some individuals preferring a non-pharmacological treatment. Reasons for this include potential side effects of the medication and believing that the medication is addictive. Historically, medication has been the first line of treatment for mental illness because of its cost and ease of access. Psychological therapy, on the other hand, can often be more difficult to access and costly due to the resources it requires. Health services have however, begun to acknowledge that one size does not fit all and that service users benefit from being offered a choice of treatments.

1.2.4.2 Psychological therapy
In the UK NHS system, psychological treatment is generally provided by clinicians trained in a range of treatment modalities (e.g. counselling/clinical psychologists), or a specific model (e.g. cognitive behavioural therapists). With less severe mental health disorders, a stepped care model is typically applied with less intensive interventions such as group or computerised treatments, being offered first (Bower & Gilbody, 2005). Where necessary, clients will be ‘stepped up’ to a more intensive intervention, typically one-to-one psychological therapy over a longer period of time.

Psychological therapy is also available to clients presenting with more severe difficulties who may be receiving services from a multidisciplinary community team or on an inpatient ward. In these cases the length of treatment may be longer with clients sometimes being seen weekly for up to a year.

1.2.4.3 Treatment choices
Good clinical practice would suggest that the choice of what treatment a person receives is made by the clinician and service user together and should be based upon on a number of elements, including; the duration of the episode and the trajectory of symptoms, any previous episodes and response to treatment, the person’s likelihood of adherence to treatment and any potential adverse effects and importantly, a person’s treatment preference and priorities. Ivanecka (2015) used concept mapping to try to understand what factors influenced the treatment choices of individuals diagnosed with depression. She found that a client’s insight in to their difficulties, their emotional states, the external views
they hear about depression (stigma) and their doctor’s advice all influenced their treatment choices.

1.2.5 Addressing the unmet need

Since the 1980s, studies have shown that a large proportion of individuals with mental health problems do not receive any treatment, pharmacological or psychological (Bebbington, 2000; Goldburg et al., 1988; Messias et al., 2007; Wells et al., 1992). A large European multi-site study (Alonso et al., 2007) used a cross-sectional survey of representative samples of the adult general population to look at rates of unmet need. Approximately 6% of the sample was defined as being in need of mental health care (defined as living with a disabling mental health problem for at least 12 months, or using services in a period of 12 months). Of this population in need of care, nearly half (48%) reported no formal healthcare use. In comparison, only 8% of people with diabetes reported no use of services for their physical condition.

In order to tackle this need for treatment for mental health problems, some developed health systems have attempted to role out evidence-based psychological interventions on a large scale. An example of this is the Improving Access to Psychological Therapies (IAPT) program in England. The aim is to provide short-term, stepped care psychological therapy (predominantly CBT) to a large number of clients with the premise that the service will essentially pay for itself (Layard & Clark, 2014). Recent increases in the provision of CBT for depression has also occurred in Australia (The Better Access Initiative, e.g. Pirkis et al., 2011) and Japan (Ono et al., 2011).

Given Qatar’s decision to model the development of their mental health care services on those found in the UK, it is encouraging to read Sudak’s (2015) report of global academics acknowledging that they could learn from the UK based IAPT program to develop the provision of psychotherapeutic treatments in countries such as America. This suggests that there may be grounding in Qatar’s potentially biased decision to replicate a UK system of mental health care. Despite IAPT’s perceived success (Clark et al., 2009; Layard & Clark, 2014),
criticisms remain and there are still significant barriers to accessing psychological treatment worldwide.

1.3 Barriers to accessing psychological treatment
Some barriers to accessing psychological treatment are the same whether the country is developed or developing. Others are unique to developing countries or those that are not Western, such as Middle East Arab countries (Fairburn & Patel, 2014; Gearing et al., 2013; Saxena et al., 2007). Here I will outline some of the barriers reported in the literature in each of these environments.

1.3.1 Barriers in developed countries
The term ‘developed countries’ refers to a country that has a highly developed economy and advanced technological infrastructure relative to other less industrialized nations. Mohr et al. (2006) investigated barriers to accessing psychotherapy in an American primary care population. The authors’ factor analysis identified practical barriers including cost of therapy, time constraints, transportation difficulties and childcare problems. Emotional barriers included discomfort taking about personal issues, concerns about being seen while emotional, talking about private topics with a stranger and concerns about what others (friends, family) would think. Further analysis found that practical barriers were significantly more prevalent than emotional barriers. Mohr et al. (2010) developed this list of barriers further and used factor analysis to collapse 27 items into eight groups; stigma, lack of motivation, emotional concerns, negative evaluation of therapy, misfit of therapy to needs, time constraints, participation restrictions and availability of services.

Although Mohr and colleagues work (2006, 2010) represented some of the first attempts to systematically evaluate perceived barriers to receiving psychological therapy, it only represents those at the individual or personal level. There are other barriers that exist at the systemic level. One example of this is the limited availability of specialist mental health services. For instance, the studies that ‘prove’ the IAPT programme works involved therapists who are highly qualified. In reality, the number of these therapists in resource rich
countries is still not sufficient (Fairburn & Patel, 2014). Another systemic factor limiting access to psychological therapy in some developed countries such as the USA is the emphasis on pharmacotherapy in primary care guidelines (Collins et al., 2004) contributing to limited access. The relationship between primary care and mental health services can also serve as a barrier given the gatekeeping role general practitioners (GPs) often play. Practitioners who lack an understanding of best evidence-based treatment for mental health problems contribute to access being delayed or prevented (Collins et al., 2004; Kendrick et al., 1996).

There are further barriers at the individual level that Mohr et al. (2010) did not mention. For example, perceived severity also plays a part in whether a client engages in treatment, as do the consequences and controllability of symptoms (Brown et al., 2001). In addition Bell et al. (2011) found the most frequent reason that an individual did not disclose symptoms of depression to their general practitioner (GP) was a concern that they would be prescribed antidepressants.

### 1.3.2 Barriers in developing countries

The definition of a ‘developing country’ has been harder to universally agree upon. Generally they are felt to have a less developed industrial base and a lower Human Development Index (HDI) relative to other countries. This includes countries in Africa, Asia and the Middle East, in turn they are said to have a ‘developing health system’. One challenge to effectively implementing psychological treatment in developing health systems is having an appropriately qualified work force. Patel et al. (2004) reported that in most developing countries there is, at best, one psychiatrist and one mental health nurse per 100,000 population, with the number of psychologists even less. In contrast, developed EU countries such as the UK have an average of 13 psychiatrists, 52 mental health nurses and 4 psychologists per 100,000 population (WHO, 2008). This lack of qualified professionals is compounded by the migration of appropriately trained staff to countries providing higher incomes (Pond & McPake, 2006) and an absence of local training institutions. The consequence
of this is that the treatment gap (the number of people with a illness who do not get treatment for it) frequently exceeds 75% in many parts of the world (Kohn, Saxena, Levav, & Saraceno, 2004). One reason for this is that there simply are not the numbers of adequately trained therapists in these countries required to meet the need. In fact, Fairburn and Patel (2014) argue that the current model of training therapists is not scalable to the populations requiring treatment.

Patel, Chowdhary, Rahman, and Verdeli (2011) discussed three separate projects that developed and evaluated psychological therapy in low resource countries (Pakistan, Uganda, India). The barriers they felt were most important to overcome in order to improve access to evidence based psychological therapies were the lack of skilled human resources and the cultural acceptability and appropriateness of therapy. The authors concluded that in order to meet need, therapy could be provided by more available and affordable members of the community who received relatively short training and continuous supervision by well-qualified mental health professionals. The authors also reported that it was possible to make cultural adaptations to psychological therapies developed in high-income western countries. Adaptations included modifying the language used (for example, using simplified scripts in the local dialect, removing psychiatric labels like ‘depression’ and using religious idioms) and an emphasis on involving others (friends, family) in the person’s treatment and recovery.

Other barriers that were encountered during the development of the interventions discussed by Patel et al (2011) included; communities being unfamiliar with the use of ‘talking’ treatments for health problems, doubts around confidentiality, the stigma associated with mental health problems, low motivation of the health workers, and low adherence due to cost and time of travel.
1.3.3 Barriers in Middle East Arab countries

Countries within the Gulf Coorporation Council (GCC) in the Middle East can still be said to have developing health care systems, but often have sufficient funding available to plan and build new services. Being young nations that have experienced considerable growth over a short period of time, it is important to look at what specific barriers exist in these unique countries in order to facilitate successful implementation.

Gearing et al. (2013) carried out a systematic review of mental health studies completed in Middle East Arab countries. As part of this the authors aimed to identify barriers to implementing and adapting psychological interventions originally devised in developed health care systems. From their review they reported a total of 78 barriers. They grouped these in to three sets; cultural context, community and systems and clinical engagement process. I have set out the barriers they outlined in Table 1:

Table 1 – Gearing et al.’s (2013) barriers to implementing psychological interventions in Middle East Arab countries

| Cultural Context (42/78) | Beliefs/Values (13/78) | • Gender – females must be accompanied  
|                          |                      | • Preference for traditional healers  
|                          |                      | • Negative consequences on individual and family  
| Community and systems (21/78) | Stigma (6/78) | • Social shame about mental illness  
|                          |                      | • Social shame about using services  
|                          | Etiological differences (6/78) | • Social status of family in the community  
|                          | Language (1/78) | • Marital prospects  
|                          | Access (9/78) | • Mental illness caused by external origins – Will of God or Evil spirits  
|                          | Availability (5/78) | • Need for translators  
|                          | Clinical Treatment | • Financial contributions  
|                          |                      | • Women cannot access without men  
|                          |                      | • Bad transportation  
|                          |                      | • Misdiagnosis of mental health needs  
|                          |                      | • Lack of professional training  
|                          |                      | • Complicated referral process  
|                          |                      | • Lack of community based service providers  
|                          |                      | • Insufficient resources  
|                          |                      | • Lack of availability of services  
|                          |                      | • Lack of understanding of diagnosis  

<table>
<thead>
<tr>
<th>Engagement process (15/78)</th>
<th>Expectations (7/78)</th>
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<tbody>
<tr>
<td>Therapeutic Alliance (2/78)</td>
<td>- Lack of understanding of treatment goals</td>
</tr>
<tr>
<td></td>
<td>- Lack of understanding of the nature of treatment</td>
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<tr>
<td></td>
<td>- Preference for medical model</td>
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<tr>
<td></td>
<td>- Patient mistrust of mental health services</td>
</tr>
<tr>
<td>Appropriateness of treatment (3/78)</td>
<td>- Inappropriate treatment e.g. generalised not specialised</td>
</tr>
<tr>
<td></td>
<td>- Culturally incongruent methods of treatment</td>
</tr>
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It is worth noting that these findings were part of a wider review and that the authors did not report how these groupings were formulated. It does however, offer a useful organising framework for illustrating potential barriers; these are elaborated below.

### 1.3.3.1 Cultural context

Cultural beliefs about the etiology of mental illness may have the consequence that religious leaders and/or traditional healers are approached in preference to specialist ‘westernized’ services (Al-Krewani et al., 2004; El-Islam, 2005; Loewenthal et al., 2001). Al-Krewani and Graham (2000) suggested that Arabic populations could view psychiatrists, nurses, psychologists and other mental health professionals as a single unit that fails either to recognise or to respect religious values. The authors also reported that staff can be viewed as lacking genuineness and empathy, and service users have difficulty establishing trust.

One suggestion (El-Islam, 2005) for overcoming this barrier is to educate the traditional healers/faith leaders about the nature of psychiatric symptoms and their presentation and the process of appropriate referral to specialist care so traditional and modern care providers could work together to support an individual. Another barrier relating to cultural customs is the need for some women to have a male family member chaperone to access and receive services (Al-Krenawi & Graham, 1999).

The beliefs and values of Arabic populations can differ substantially from other societies and what is considered acceptable in one culture may be considered unacceptable and open to stigmatization in another (Abdullah & Brown, 2011; Dardas & Simmons, 2015). Stigma surrounding mental illness remains an issue
worldwide, with 55% of mental health promotion and prevention programmes aimed at combating stigma (WHO Atlas, 2014). It can play a large part in preventing individuals seeking help (e.g. Barney et al., 2006). Specific examples in Arab countries include a perceived risk of damage to their family’s reputation and social status (Shalhoub-Kevorkian, 2005) and a view that a mental health diagnosis might impact on the marriage potential of females (Al-Krenawi & Graham, 1999; Shalhoub-Kevorkian, 2005).

Another barrier can be language, with differences between the service user and the professional’s native language inhibiting effective communication (Al-Krenawi & Graham, 1999). This finding is not limited to developing health care settings as Griner and Smith’s (2006) meta-analysis of culturally adapted mental health interventions showed. They concluded that interventions conducted in the native language were twice as effective as those in English for non-English speakers. They concluded that ideally, clients should be matched to therapists of the same race and ethnicity (Lam and Sue, 2001). When matched, clients are less likely to drop out of therapy (Campbell and Alexander, 2002). Griner and Smith (2006) also concluded that interventions targeted to a specific cultural group were four times more effective than interventions provided to groups consisting of clients from a variety of cultural backgrounds.

1.3.3.2 Community and systems
Middle Eastern countries also experience barriers to accessing psychological therapy at the systemic level, specifically accessibility and availability (Gearing et al., 2014). As with other developed and developing countries, clinical resources can be insufficient to meet need. Lack of professional training (Shalhoub-Kevorkian, 2005) and complex referral pathways (Al-Krenawi & Graham, 1999) exacerbate these issues. Other barriers in these countries include personal financial constraints (Eapen & Ghubash, 2004; Karam et al., 2006), and insufficient local transportation (Eapen & Ghubash, 2004).

1.3.3.3 Clinical engagement process
The final group of barriers that Gearing and colleagues identified were those relating to the concept of psychological therapy. The expectations of clients
presented several barriers, including a lack of understanding of diagnosis, treatment goals and the nature of the psychological treatment (Al-Krenawi & Graham, 1999; Murray et al., 2006) and a preference for a more medical approach Al-Krenawi et al., 2001; Al-Krenawi, Graham & Kandah, 2000; Schwartz et al., 2002). Further barriers in this grouping were clients not trusting mental health services generally (Eapen & Ghubash, 2004) and inappropriate treatment being offered given a person’s diagnosis (Schwartz et al., 2002; Shalhoub-Kevorkian, 2005).

Barriers to accessing psychological therapy will inevitably vary from country to country given the different health care systems available. It is therefore important to understand the specific circumstances surrounding the study population currently under investigation.

1.4 Health care services in Qatar
Qatar has a predominantly socialised system of health care, with residents being able to access services for little or no cost. Hamad Medical Corporation (HMC) is the principle provider with eight hospitals in the country. There is currently one psychiatric hospital with up to 80 inpatient beds available for those over 14 years old. Inpatient beds for children with mental health problems or developmental disorders are available at the main ‘rehabilitation hospital’.

Other private options exist for those with health insurance, who are willing to pay or hold a Qatari passport. This is because Qatari nationals currently have any health bills paid for by the Government, whether received in or outside of the country. Although recent volatility in the oil and gas markets have meant healthcare costs, like other government expenditure, receives increasing scrutiny for nationals, and as services are established at great expense in country there is increasing pressure to use them. Mental health services in non-Government funded hospitals or clinics are limited to outpatients with a Psychiatrist as sole provider thereby propagating pharmaceutical treatment. Some populations may access psychological assessment and therapy via
therapists working in international schools and Universities in the country. There are some therapists that work privately from their own homes with referrals being made informally by ‘word of mouth’ and who are not overseen by the State. Recently, a centre has opened providing specialist outpatient and residential care for addictive disorders for Qataris. It advertises itself as a wellbeing and recovery center for guests rather than patients or clients. The only accessible information about it is on one website where its role in treating mental health and addiction problems is not publicized.

1.4.1 The Qatar national mental health strategy
This document was published in December 2013 by the Supreme Council of Health (now the Ministry of Public Health), one of the government bodies in Qatar. It outlined modernisation of mental health services in Qatar within five years and highlighted the role of evidence-based practice as a central step in the provision of services. The strategy states that it has been developed using the best available research from around the world but tailored specifically to the needs of Qatar. In reality, the models of service provision suggested are most similar to NHS services in the UK, unsurprising as the consultants and civil servants involved in its development and many of the psychiatrists working in the country were most familiar or sympathetic to the UK National Health systems. This potential bias towards a UK service needs to be borne in mind.

Following the publication of the strategy, a team from the UK was invited to Qatar in 2015 to review how implementation was progressing (Kendall et al., 2015). As a result of this review, care pathways and clinical protocols were suggested, developed from England’s National Institute for Clinical Excellence (NICE) guidelines. The review also noted that although psychological interventions are central to delivering evidence based mental health care, there were frequent reports of a lack of their availability.

1.4.2 A context for suicide
Mental illness can be life threatening with depression being one of the greatest risk factors for suicide (Cheng et al., 2000). For example, in the United States of America in 2011 almost 40,000 people died by suicide and in 2014 almost one million attempted suicide (CDC, 2014). In this American sample suicide is the
second most common cause of death for young people (aged 15-24) and men are four times more likely to take their own lives than women. There are no existing data on rates of successful suicide; attempted suicide and para suicide in Qatar and suicide prevention isn’t once mentioned in the Qatar national mental health strategy. The suggested reason for this is that Islam strictly forbids suicide and it is considered a criminal act under Sharia Law. The authors felt that by avoiding mentioning suicide the report may be better received by stakeholders. This can make facilitating access to a safe environment and assessing for suicidal ideation challenging for health professionals. One suggestion of how to potentially adapt practice to manage this was made by Hedayat-Diba (2000) who recommended that for Muslim patients, staff ask about the passive expression of suicidal ideation instead, framing the question as “do you wish that God would let you die?” rather than asking if the individual has thoughts of killing themselves.

1.4.3 Migration and mental illness
The majority of the population in Qatar are not local and migration is known to be a risk factor for mental disorder. A systematic review of the rates of depression and anxiety in labour migrants by Lindert et al (2009) suggested a prevalence rate of 20% and 21% respectively. A recent study within the GCC had similar findings. Al-Maskari et al (2011) undertook a cross-sectional survey in labor camps in the UAE and found that 25.1% of their participants met the cut off score for depression. This is considerably higher than the global point prevalence of depression, which is thought to be around 4.5% (Ferrari et al., 2013). In another study, a sample of labor migrants in Kazakhstan (Central Asia) were found to have point-prevalence rate of 6.2% for depression (Ismayilova et al., 2014). Depression was more prevalent among female, younger, and non-married migrants, as well as among migrant workers with higher levels of education. Marital status was a significant protective factor for depression, particularly among female migrant workers.

1.5 The current study
The literature discussed above suggests that there is a real need to understand potential barriers to accessing psychological therapy in the Middle Eastern
country of Qatar in order to potentially improve the wellbeing of its population. Improving out understanding could be beneficial for possible service users, clinicians providing therapy services and policy makers planning future service delivery.

It is also necessary to understand the position that this study was conceptualized from. It was undertaken as part of my professional doctorate in counseling psychology undertaken between 2010 and 2017 at the University of the West of England. At the time of the research project (2015-2017) I was a trainee-counseling psychologist studying in the UK but living predominantly in Qatar. It is therefore important to consider how these multiple identities may have impacted on the current piece of research.

1.5.1 Counselling psychology in the UK
The UK has recognised the discipline of counselling psychology since 1982 when the British Psychological Society (BPS) first established the ‘Counselling Psychology Section’. Divisional status was awarded in 1994. Nielsen and Nicholas' (2016) overview of counselling psychology in the UK explains that the profession holds a humanistic value base with influences from counselling psychology in the USA and European psychotherapy. It therefore has a strong focus on the therapeutic relationship whilst adhering to the scientist-practitioner model of professional practice.

The BPS Division of Counselling Psychology explains:

at the centre of counselling psychology lies an inquisitive, reflexive and critical attitude that acknowledges the diversity of ontological and epistemological positions underlying all forms of therapeutic approaches and techniques. It is a stance that holds a humanistic and relational value system, which aims at the exploration, clarification and understanding of clients’ world-views, underlying assumptions and emotional difficulties that emerge out of our interaction with the world and others. (BPS, 2012, p15).
This definition may not be dissimilar to how the discipline of clinical psychology would define itself and it can be said that differentiating between clinical and counselling psychology is challenging (Nielsen & Nicholas, 2016).

1.5.2 Diversity and multiculturalism within counselling psychology
Moller (2011) argued that the unique identity of counselling psychology in the UK could be strengthened by emphasising diversity and multiculturalism; a philosophy more firmly held by counselling psychologists in the USA (Fouad et al., 2004). This could be achieved, in part, by putting “the onus on the trainees and trainers to challenge any personal values that may lead to a prejudicial response to any client” (Moller, 2011 p.13). Moller also suggests that this commitment to diversity could create an important research focus within the profession. The field of counselling psychology in the USA has contributed significantly to the multi-cultural movement in psychology and education, evidence of this can be seen in the APA (2003) guidelines on Multicultural Education, Training, Research, Practice and Organisational Change for Psychologists. Despite this, many would argue that progress is slow and there is still much work to be done in the area. Likewise, although American counselling psychology literature has a history of championing multicultural research (Buboltz, Deemer, & Hoffman, 2010), the findings do not naturally translate to the UK or the rest of the world.

1.5.3 The Internationalisation of counselling psychology
Improving the acceptance and awareness of diversity and multiculturalism in the profession is closely linked to the internationalisation of the discipline in the USA. Heppner et al (2008) defined this in the (American) Handbook of Counseling Psychology as

“the inclusion of cross-national and cross-cultural perspectives in the predominant Western perspectives of counseling [sic] practice and research as traditionally operationalized in the United States” (p. 68)
Addressing this issue is timely. Global migration has never been higher (International Migration Organisation’s World Migration Report, 2015). This has resulted in individuals no longer living within stabilised, clearly defined local cultures (Hermans & Hermans-Konopka, 2010). This is indeed true for myself. This meeting of cultures, traditions, values, and practices does not however mean that understandings of differences are shared. This extends to the understanding of mental health, psychology and counselling. As Cheung (2000) expresses it:

“The meaning of counseling [sic] may seem obvious to American psychologists. The understanding of its meaning by American clients is assumed. In another cultural context, however, counseling may imply a different nature of relationship to both the provider and the recipient. Counseling needs to be deconstructed in the context of the culture in which it is offered. (p. 124).

Simply adopting a multicultural approach, as defined by Heppner (2009) above, may not be sufficient. A number of authors (e.g. Hwang, 2009) have argued that the discipline is still rooted in American ideals, principles and philosophical beliefs. Cheung (2000) questions whether the applicability of counselling psychology theory and practice outside of the USA has been fully considered. This is not to say that the discipline shouldn’t and hasn’t taken off in other countries. In some non-Western countries (for example, Taiwan, Hong Kong, mainland China) the teaching and practice of counselling and psychology has grown substantially in just the past couple of decades (Wang & Heppner, 2009). As a trainee-counselling psychologist living in Qatar and completing a placement in their state provided health service it provided me the opportunity to see this first hand. My placement supervisor was a UK trained counselling psychologist who originated from Sudan and studied undergraduate psychology in Egypt. She frequently discussed how she found the UK profession of counselling psychology a well-placed discipline for working in a non-western country. She mirrored the views reported by Moller (2011) that the profession’s focus on
being a discipline that continually considers an individual’s context and background facilitated this internationalisation.

1.5.4 Study rationale
From my personal experiences of the mental health systems within Qatar, exploring Qatar’s mental health policy and reading the existing literature on barriers to accessing psychological therapy I wished to explore what the potential barriers are in a unique country such as Qatar. It also fitted in with my interest in the transferability of the counselling psychology discipline from the UK to other cultures and societies. Indeed, one way of considering whether there is indeed an issue in the transferability is to consider the barriers to accessing psychological therapy in a non-western country. Investigating this may also shed light on how the discipline of counselling psychology could develop in countries where it is not currently prioritised.

Findings from the literature review above suggest that there are potentially numerous barriers that prevent access to psychological therapy in Qatar. Therefore, the main aim of this study was to better identify those considered the most important, or most significant at preventing access. There are a number of different stakeholder groups that are well placed to help identify such barriers including clinicians, service users, family and carers of service users and individuals that work at a managerial or policy-development level. There were a number of reasons why service users and carers were not involved in the current study. Firstly, there was the potential need for an interpreter in order to get the best quality data and to ensure that participants fully understood the tasks they were required to complete. Secondly, the ethical requirements involved in gaining approval to undertake the study would have been complex, if not impossible in a limited time frame. Finally, there was a research project being completely concurrently that was interviewing service users and their carers meaning that they might have felt overburdened from being asked to take place in multiple studies concurrently. It was therefore felt that this study would be best placed to consider the views of two other
important stakeholder groups involved in mental health services; clinicians and policymakers.

The primary aim of this study was therefore to investigate what clinicians and policymakers felt were the barriers to accessing psychological therapy in Qatar. Using these two groups as the participants also allowed the similarities and differences in the views of these two groups to be investigated. This became the study's secondary aim. To achieve these aims I set the following major objectives:

1. Identify all the possible barriers in Qatar as perceived by clinicians and policymakers.
2. Use concept mapping to create groupings of these barriers to form a manageable dataset.
3. Identify which of these barriers are felt to be the most significant (important) at preventing people accessing psychological therapy.
4. Statistically compare the ratings of importance given to each set of barriers by the two groups of participants.

What follows is an outline of the methodology developed to address these aims and objectives.

1.6 Summary
Mental disorders are a global problem that often require treatment with psychological therapy. Qatar is a developing country in the beginning stages of implementing a mental health care system based on models from the UK. This includes recognition of the need to develop therapy services. However, it is clear from this literature review that many potential barriers to accessing psychological therapy in Qatar could exist. In order to successfully develop services there is a timely need to understand what some of these barriers could be.
Chapter 2: Methodology

2.1 Introduction

Concept mapping is a mixed methods approach that allows the exploration of views held by multiple stakeholders around a carefully defined topic. In this study, participants were chosen from two stakeholder groups who were experienced in issues surrounding psychological therapy in Qatar; clinicians providing therapy (Group one) and individuals working at a policy or managerial level (Group two).

In this chapter I set out my rationale for selecting concept mapping as the most effective methodology for investigating the barriers to accessing psychological therapy in Qatar. I then outline the six stages of concept mapping that guided the development of the project, data collection, analysis, and interpretation of the results. Finally I reflect on my own position, giving context to the project as myself as the lead researcher.

2.2 Potential methods of investigation

To successfully achieve the aims of a study it is necessary to chose the most appropriate research method for the question being asked. There are various methodological frameworks that can be used to address a research question. Which framework is chosen will affect all stages of the research process, from the choice of methods, through presentation of findings to what the research can claim to find. The primary aim of this study was to identify the most important barriers to accessing psychological therapies for individuals living in Qatar from the perspective of clinicians and policy makers. A secondary aim was to investigate the similarities and differences in the views of these two groups.

Research methodologies are grounded in philosophical assumptions about the nature of knowledge (‘epistemology’). There are three main types of research
methodology; quantitative, qualitative and mixed methods (the combination of both quantitative and qualitative). Quantitative research is generally perceived to be positivist, with the premise being that there is a ‘truth’ out there waiting to be discovered (Murphy et al., 1998). The goal of such research is statistical probability and results that can be generalised to a larger population. Qualitative research exists within the interpretive or social constructionist paradigm. This stresses that perceptions and experiences are socially, culturally, historically, and linguistically produced. It aims to produce detailed descriptions and in-depth understanding of experience, or phenomena but does not claim generalisability (Finlay, 2006).

The third type of methodology, mixed methods, is grounded in a pragmatic (realism) philosophy. Pragmatism refers to the idea that we come to know the world through the practicality or usefulness of concepts. It is seen as offering “a productive approach to evaluating real world knowledge” (Cornish and Gillespie, 2009, p7). It sees knowledge as a tool for action (Rorty, 1982). Like social constructionism, it is pluralistic, accepting a variety of competing interests and forms of knowledge. However it is also non-relativist and action-orientated; meaning knowledge can be evaluated by reference to its ability to facilitate successful action, the primary reality. This makes mixed methods highly relevant to health services research (Tashakkori & Teddlie, 2010) and for this reason this methodology will now explored in greater depth.

### 2.2.1 Mixed methods

Mixed methods has been defined by Tashakkori and Creswell (2007) as:

“Research in which the investigator collects and analyses data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study or program of inquiry” (p.4).

Mixed-methods are more than simply collecting both quantitative and qualitative data and indicates that data is integrated at some stage of the research process. Tashakkori and Teddlie (1998) argue that the use of both
qualitative and quantitative methodologies in a single piece of research can enrich study findings in ways that using a single methodology could not. When combined, quantitative and qualitative data complement each other and yield a more complete analysis. Results can be considered more generalizable whilst still allowing the researcher to gain a deeper understanding of the phenomena being studied. This is advantageous in multidimensional, complex areas of research interest, such as health services research (Tashakkori & Teddlie, 2010).

2.2.1.1 Why mixed methods?
A mixed methodology was chosen due to its pragmatic grounding. Firstly there was a pressing need to address the research question proposed. Mixed methods enables researchers to understand complex realities using data from multiple perspectives to combine and present practical information. Specifically, in this study, it was anticipated that there are many barriers to accessing psychological therapies and identifying the barriers that are perceived to be the most and least important would help target interventions and policy development within the country. Using a mixed methodology allowed me to explore such complex ideas during a relatively short time.

2.2.1.2 Mixed methods techniques
There are a number of different methodological techniques that can be considered to be a mixed-methodology. There are a number of these that have been previously used to explore participants’ opinions and perceptions in mental health services, including; Delphi-technique, Q-methodology (Wallis, Burns & Capdevila, 2009), and concept mapping (Ivaneka, 2015).

2.2.1.2.1 Delphi-technique
The Delphi method was originally developed by an organisation known as the RAND Corporation in the 1950s in order to forecast the influence of technology on warfare (Dalkey & Helmer, 1963). It is used when theory or knowledge of an area is lacking, but where ‘experts’ are thought to hold relevant information. The process seeks to move towards a position of relative consensus and its ultimate goal is to find a solution to a query or a problem. To achieve this,
sequential questionnaires are answered anonymously by a panel of ‘expert’ participants. The questioning takes place in rounds, and after each round of questions, an anonymous summary of the responses is fed back to the group. Individual participants may then decide to keep their original answers or to change their opinion in the subsequent round of voting. One advantage of this approach to gathering the views of a group of participants is that it is not face-to-face, and therefore avoids one participant dominating the group discussion and subsequently influencing others’ voting. In general, the range of answers decreases and the group converges towards a consensus opinion over the course of several rounds.

Although the Delphi method is designed to explore the views of the participating experts, it is only possible to the extent that would allow identification of a solution they all agree with. In the current study, I expect to identify a large number of different barriers, which may make it difficult for participants to reach a consensus. As I also wish to compare the views of two participant groups, it would not be the best-fit methodology for the research questions I am looking to answer.

2.2.1.2.2 Q-methodology
This technique was developed by Stephenson (1953) who was interested in revealing the subjectivity in any given situation. It aims to place participants at the centre of the research process and attempts to represent the perspective of the participants rather than the researchers. This methodology consists of a technique known as ‘Q-sort’, which involves participants arranging cards of statements about a topic into a predetermined grid, and then ranking them according to a scale relevant to the research question (e.g. from agree to disagree). Q-methodology focuses on the meanings people make or ‘constructions’ of a topic rather than the ‘constructors’ (participants). This focus means that Q-methodology is suited to topics that are socially contested or debated (Stainton Rogers, 1995). Its goal is to identify the different subjective perspectives on the issue rather than identifying the common conceptual understanding. As the focus of this technique is the systematic study of
subjectivity, it would not be the best placed methodology to answer the research questions proposed here.

2.2.1.2.3 Concept mapping
Concept mapping is considered to be a mixed methodology because it allows participants to brainstorm ideas in qualitative interviews that they then organise and rate. Multivariate statistical analysis is then used to (quantitatively) explore the relationships between ideas and concepts. Results can be formed into maps, which can then be used to plan actions or interventions (Kane and Trochim, 2007). Concept mapping has several notable characteristics relevant for addressing problems in complex health care settings. Firstly, it is purposefully designed to integrate input from multiple sources with differing levels of expertise or interest. It then uses sophisticated and rigorous multivariate data analyses to create a series of maps that visually depict the composite thinking of the group. These maps then have the potential to constitute a framework or structure that can immediately be used to guide action planning, program development or evaluation and measurement.

2.2.1.2.3.1 The phenomenology of concept mapping
Ponterotto (2005) positions concept mapping between post-positivism and constructivism paradigms. This fits with quantitative research tending to be associated with the positivist paradigm and qualitative research with social constructionism. Concept mapping makes use of standardised procedures and an impartial researcher (post-positivist) but is also based on the constructivist assumption that social reality is relative and that people construct things differently. Ponterotto argues that there is such thing as reality, but this is ever changing and based on one’s actions. The aim of concept mapping is to portray these different constructs, especially when involving different populations as participants. Forgas (1979) suggests that the analytic approach that anchors concept mapping represents the best fit of the various cognitive structures of participants.
2.2.2 Why concept mapping?

Concept mapping was chosen as the best mixed methodology for the research question proposed for a number of reasons. Firstly, it fits well with the field of research. In fact, Rosas and Kane’s (2012) pooled analysis of concept mapping studies found that the areas of research that most frequently used this methodology were public health orientated.

Secondly, concept mapping blends qualitative and quantitative methods in a complementary and cumulative manner meaning that data is integrated at multiple points of the process. Other mixed methodologies can result in the two types of data being connected but still distinct. Concept mapping combines qualitative and quantitative methods in ways that challenge the distinction between the two, which suggests they may be more deeply intertwined (Kane & Trochim, 2007). Furthermore, I felt that the data generated from this technique produces more credible data as it allows for individually created items, which are then considered through group collective consensus. It required participants to help generate the units for analysis as well as categorize them. It also facilitated analysis about how themes related to each other – an element that is often neglected in many qualitative methodologies. Concept mapping, unlike the analysis of interviews using thematic analysis for example, generates a well-defined set of quantitative results (Kane and Trochim, 2007). These can then be used to statistically analyse the differences in views across various stakeholder groups involved in a project.

Participant involvement in all stages of the research process is becoming an essential component of credible academic work (e.g. Thornicroft & Tansella, 2005, Telford & Faulkner, 2004). Involving participants in multiple parts of the process, including data analysis, is a considerable strength of the concept mapping methodology. Indeed by using purely qualitative methods, Bedi and Alexander (2009) explained that researchers often inadvertently examine the participant’s perspective through their own lens, thereby blurring researcher and participant boundaries. Concept mapping avoids this by allowing clients to categorise the content they provide.
2.2.3.1 Limitations of concept mapping

Despite these strengths, concept mapping methodology presents similar challenges to those encountered with other qualitative methods. Sample sizes are relatively small and non-randomised and it requires a labour intensive process. There is also the possibility of participant burden given the complexity of the tasks they are required to undertake. Unlike other interview-based methods, participants are required to be able to read and write in English as well as having proficient verbal English skills. It is possible that participants who have English as a second, or third language as do many in Qatar, may find the data sorting and ranking tasks a challenge (Rachlis et al., 2013).

2.3 Methods

2.3.1 Concept mapping procedure: an overview

The term ‘concept map’ can refer to any visual representation of relationships between different ideas or concepts. The type of concept mapping being used in this project however refers to a sophisticated mixed-methods analysis (Trochim, 1989b). Trochim (1989a) defined the process of concept mapping as consisting of 6 stages;

1. Preparation,
2. Generation,
3. Structuring,
4. Representation,
5. Interpretation and
6. Utilisation

(cf Jackson & Trochim, 2002; Trochim, 1989b; Trochim, Cook, & Setze, 1994). Each of these phases will now be considered in more detail.

2.3.1.1 Phase one: Preparation

The first phase involves the planning of the research question and deciding which participant group(s) to approach. This occurs in the early stages of the project and is born out of informal discussions with potential participants, meetings with academic supervisors and reviewing the existing literature. The
stakeholder groups (in this case clinicians and policymakers) were pragmatically selected to allow for completion of the project within the scheduled time frame but still accessing the views of the people closely involved in promoting access to psychological therapies. This stage also involves choosing the computer software to use, gaining ethical approvals, creating a recruitment plan and choosing data collection methods.

2.3.1.1.1 Computer software

It is important to make a decision about which software package to use early on in the process of concept mapping due to differences in data collection modes, and also in the maximum number of statements allowed. I chose to use a software package known as Ariadne (Severens, 1995). Ariadne was chosen as it is widely used in peer-reviewed concept mapping research, (for example; de Vries et al., 2014; Hargreves & Crozier, 2013; van Grieken et al., 2013) and available for free from the software developer.

The software package works by performing two types of quantitative, multivariate data analysis; principal component analysis and cluster analysis (Severens, 2012). The raw data can also be exported to other statistical software such as SPSS for Windows, allowing analysis of the differences in mean scores across the two participant groups using analysis of variance (ANOVA).

2.3.1.1.2 Ethical approvals

Before starting recruitment, I sought ethical approval from the University of the West of England Research Ethics Committee (reference number HAS/16/03/120). As some of the participants worked for Hamad Medical Corporation (HMC) I also completed the necessary ethical application from their Medical Research Centre (MRC) in order to include individuals working in HMC in my recruitment (reference number MRC1341/2016).

2.3.1.1.3 Participant recruitment

There are two participant groups in this study; mental health clinicians (Group one) and individuals working at the policy making/organisational level (Group
two). These groups were chosen as they represented important stakeholders that held experience of what barriers to accessing psychological therapy might exist in Qatar. There were a number of reasons why the views of service users and their carers were not explored in this study. Firstly another piece of research was being carried out in the country at the same time with these participant groups making recruitment from the same population group challenging. Furthermore, it was recognised that practical challenges such as the requirement for interpreters and issues with gaining ethics to undertake research with patients made the possibility of recruiting this participant group in a limited time frame unfeasible. It was also felt that clinicians and policymakers would bring their experiences of a wide variety of participants and this might offer greater insight into potential barriers, given the diverse population of Qatar.

I used a purposive sampling method, recruiting participants using the snowballing (chain referral sampling) technique (Biernacki & Waldorf, 1981). Ideally, I would have used a random sampling technique to select a representative sample of participants from a larger defined population as this would allow for greater generalization of the concept map to the larger population. However, given that such a sampling method is often unfeasible (due to the large number of people required in the population groups), a purposive sampling method that considers the similarities and differences to the wider population (e.g., in this case culture or experience) was chosen. This is known as intuitive or analytical generalizability (Stake, 1994).

In Group one I aimed to recruit participants with experience of working with clients seeking psychological therapy in Qatar. This included those working privately as well as in health care settings within Qatar. This involved approaching personal contacts that knew other therapists that might be interested in taking part, requesting that they passed my contact details on (Biernacki & Waldorf, 1981). As Qatar is a small country consisting of close-knit communities, I expected this to be an effective recruitment strategy. I recruited
therapists with a variety of theoretical backgrounds, qualifications, age, and client group experiences (children, adults, couples and families).

I used the same methodology to recruit participants to Group two. These were individuals who have had input into mental health services in Qatar at an organisational or policy level, for example providing consultancy to the development of the mental health strategy. Again I approached personal contacts that work or have worked within these roles and may have known others eligible to take part.

The average number of participants in concept mapping studies varies depending on the mode of data collection. Rosas and Kane (2012) found that for face-to-face collection, the average number was 62 participants. These authors reported that the internal reliability of results increased with a larger sample size and suggest that the clustering task should be completed by a minimum of 20 participants. Trochim (1989a) suggested having between 10 and 20 participants to ensure a variety of opinion and ensure data saturation. Severens (2012) reported that the minimum number of participants needed to successfully use concept mapping is 8-10. Fewer than this and concept mapping has little added value compared to other methods. Severens also explains that there is no upper limit to the number of participants whilst Jackson and Trochim (2002) recommended that 15 participants should complete the sorting tasks. Given the variation in these proposed sample sizes, I initially aimed to recruit a total of 25-30 participants; 15 clinicians and 10 to 15 policymakers.

I aimed to use the same participants for both the second and third stages of the process (generation and structuring). Trochim (1989a) found that participants better understood the notion of concept mapping when they had taken part in all of the stages. However, there is flexibility to access new participants at the third stage if the individuals used to generate items are unavailable or unwilling to take further part in the study and/or there are new participants willing to take part.
2.3.1.1.4 Data collection mode

Rosas and Kane (2012) found that most concept mapping projects involved a combination of data collection methods (for example, focus groups, interviews, over the telephone and via emails) as this allows participants more flexibility, and reduces the burden of taking part in the study. In line with this, I aimed to predominantly use face-to-face meetings or group sessions to collect data, but when necessary collect data using web-based means. Group sessions have the advantage of allowing participants to communicate with each other and increase the free association of concepts and ideas. These however can be logistically difficult to organise particularly with busy professionals so I planned in addition to gather statements through one-to-one interviews or via telephone or email.

I undertook the majority of the data collection for the third stage face to face, allowing participants the chance to ask any questions they might have. When this was not possible, participants were able to submit their clustering responses online via a personalised link to the Ariadne web based programme.

2.3.1.1.5 Developing the research question

The focal question in concept mapping research is an open-ended question that participants are able to freely discuss and brainstorm potential answers to. The question needs to be specific enough that participants did not produce too many different statements that are difficult to cluster together. However, if too narrow this could prevent participants expressing their own points of view. In this study, all participants were asked the following question:

“What are the barriers to accessing psychological therapy in Qatar? In other words, what makes it hard for people to access psychological therapy in Qatar?”
2.3.1.2 Phase two: Generation of ideas

The second phase of concept mapping methodology involves generating statements to answer the research question. In this study, the statements were produced via interviews with participants. They were cross-referenced with the literature and informal fieldwork/corridor conversations’ to ensure that no potential statements were missed out. This technique has been completed in previous concept mapping studies such as Ries et al (2008).

Participants were required to brainstorm as many answers to the research question as possible. Brainstorming can be defined as trying to think of as many responses, solutions or approaches as possible, without labelling them as right or wrong. This premise was the same, regardless of data collection mode (individual, group, telephone or email). I transcribed all the interview recordings and where necessary used a simple content-analysis to reduce sentences into ‘statements’ (Jackson and Trochim, 2002). Statements can be defined as short sentences, which should be clear, singular and understandable and are phrased so that they answer the research question. Duplicate responses were then discarded. Trochim (1989a) advises a maximum of 100 statements and Ariadne software allows a maximum of 98 but recommends between 40 and 70 statements. Therefore, where necessary, similar items were condensed in to one item. This final set of statements form the basis of phase three.

2.3.1.3 Phase three: Structuring

The third phase, known as structuring, consists of two tasks. Participants were provided with a pile of cards with one statement (formed in phase 2) on each card as well as a unique ‘case record form’ (CRF) to record their answers. They then completed the following two tasks.

a) Independently organising the list of statements and sorting them into piles based on perceived similarity (clustering). Participants were also asked to assign titles to each of the groups based on whatever they feel was most appropriate. This was done to help eliminate researcher-labelling bias.
Participants had to use all statements and create between two and ten piles with a maximum of 40 statements per pile.

b) Statements were re-sorted based on usefulness or relevance to answering the research question (prioritising). This is done using a 1-5 Likert-type Scale. In this study one represented the ‘least important’ barriers, two ‘somewhat important’ barriers, three, ‘moderately important’ barriers, four, ‘very important’ barriers and five the ‘most important’ barriers. All items must be sorted in to five equal piles that sit under each heading.

Once complete, the participant handed or sent back the CRFs ready for data entry and analysis. Alternatively, when participants felt they had sufficiently proficient IT skills, a link was sent in an email, which allowed participants to complete the task directly on the Ariadne software package.

The rationale for sorting statements into equal piles in the prioritising task was that participants in concept mapping studies can be reluctant to rank statements with a low priority score (Kane and Trochim, 2007) given that all statements were created during the brainstorming sessions. Requiring equal piles of statements in the prioritising task therefore creates a better picture of the relative value of statements. It can however make the task more challenging for participants who wished to give more statements higher priority scores.

2.3.1.4 Phase four: Representation

In this phase, each participant’s sorted and rated data were entered into the Ariadne computer software. This program analysed the data using predetermined multivariate statistical techniques. It created a concept map (with a horizontal and vertical axis) where the statements are positioned with the distance between them representing how often participants sorted them together into the same cluster. A concept map is therefore a graphical illustration of the relationships among statements. An example can be seen in Figure 1. In this, each of the dots represents a statement and each of the boxes
represents a cluster. In this example the clusters are labelled with their given title underneath the box.

Figure 1: Example of a concept map produced by Ariadne computer software (Kikkert et al., 2006; used with permission of the publisher)

From the concept map that was produced during this phase of the procedure, I could identify common themes related to the statements and label the axes to represent the breadth of the theme that the statements lie on. At this stage of the analysis several concept maps were produced, consisting of between 2 and 18 clusters.

Another part of this phase involved using the data collected from the prioritising task to calculate the mean relative importance ranking for each statement (and cluster). It was possible to contrast the perceptions from the two stakeholder groups to look for similarities and differences in their views. This was achieved by entering the data into SPSS and carrying out analysis of variance (ANOVA).
2.3.1.5 Phase five: Interpretation
Stage five of the concept mapping technique (interpretation) required me to work with a small group of participants and members of the research team to select the most meaningful cluster solution. It is important to note that there is no single correct number of clusters or a set of mathematical decision criteria to help determine the final cluster solution (Kane and Trochim, 2007). Instead the selection was based on a combination of expert judgement and participant feedback. Clusters were then named based on their content, much like ‘themes’ in qualitative data analysis (Braun and Clarke, 2006). Titles provided by the participants helped guide these.

2.3.1.6 Phase six: Utilization
The final stage involved discussing the findings and considering how they may best inform the original research question. The dissemination of the findings to those that may benefit, such as organisations that provide mental health services, was also considered at this stage.

2.3.2 Information collected about participants
I collected informed consent from all participants as well as their preferred contact details if they wished to consider taking part in the second element of the study. They were also required to complete a short questionnaire to collect descriptive data including age, gender, ethnicity, qualifications, job and the number of years in that job. This form can be seen in appendix 9.
2.3.3 Study Procedures

2.3.3.1 Recruitment of participants

I aimed to recruit individuals who provide psychological therapy in Qatar within a variety of clinical settings including adults, couples and child and families (group one) and those who have worked within mental health care services at the policy setting, organisational or systemic level (group two).

2.3.3.1.1 Inclusion criteria: Group one: mental health clinicians

The following inclusion criteria were used to recruit participants to group one:

• Be able to speak, read and write in fluent English AND
• Be a provider of psychological therapy/counselling in Qatar OR
• have provided psychological therapy/counselling in Qatar in the last three years

2.3.3.1.2 Inclusion criteria: Group two: individuals working at policy/organisational level

The following inclusion criteria were used to recruit participants to group two:

• Be able to speak, read and write in fluent English AND
• Work at a managerial level having input into policy around mental health in Qatar OR
• Provide consultation to organisations in Qatar that run mental health services OR
• Have worked in the above roles within the last three years

I initially approached personal contacts and explained to them my recruitment aims. I invited them to pass on my contact details and a flyer to anyone they felt may be eligible to take part in the study. If an individual expressed interest in taking part, I either meet with them face-to-face to give them the written information sheet or discussed the study on the telephone and subsequently emailed the documents to them. Potential participants had received the participant information sheet at least 24 hours before written consent was taken. At the start of the interview, two copies of the consent form were
signed, with the participant retaining a copy. If the interview took place via the telephone, participants were required to return the signed copy of the consent form by email. If data was gathered via email, a signed copy of the consent was also be returned via email.

2.3.3.2 Data collection

2.3.3.2.1 Phase 2: Generation

I carried out the interview or focus group in a private room at a location that suited the individual(s) such as their office on clinical premises or University campus. I also collected data via email responses. The interview consisted of filling out the demographic data and completing a taped dialogue lasting up to 30 minutes. This amount of time was necessary to ensure that all possible answers to the research question had been thought of. At the end, I asked participants if they were willing to take part in the second element of the study, the sorting and prioritising task. Contact details were recorded separately if they agreed. If participants did not agree to take part in the second element, it did not influence their involvement in the first part of the study. Finally, the interviews were then transcribed with the participant’s responses being anonymised.

After all the interviews had been completed and transcribed, I extracted the statements that answered the research question. Where participants’ answers did not entirely fit as a statement that answered the focus question necessary I conducted a simple thematic analysis (Braun and Clark, 2006), i.e., reducing the text data into manageable summary statements (Krippendorff, 1980; Weber, 1990).

2.3.3.2.2 Phase 3: Structuring

The next section of data collection consisted of the clustering and prioritising tasks. For this part, I contacted the participants who agreed to take part in the second element and when possible, arranged a convenient time and place to meet and complete the tasks on paper. Alternatively, participants were able to
discuss the task face-to-face or on the telephone and then complete it in their own time. It was also possible to send, via email, a link to completing the tasks online so that answers were recorded directly on to the software program.

Where necessary, data gathered in this stage were then inputted into the Ariadne software program for analysis using the following steps.

2.3.3.3 Data analysis
Concept mapping data analysis involved the following steps:

1. Data entry
2. Multivariate analyses
   a. Principle component analysis
   b. Cluster analysis
3. Generation of a concept map
4. Analysis of variance of prioritising data

2.3.3.3.1 Data entry
Data from phase three of concept mapping (the structuring task) were entered into Ariadne, the specialised software package chosen for the project. This involved entering one participant’s answers (the card numbers) into each row of a table, with columns representing groups or piles. Although the statistical analysis is undertaken by the computer program rather than directly by the researcher, it is important to understand what it is that it is doing as this aids the interpretation of outputs.

2.3.3.3.2 Multivariate analyses
In the first part of the analysis the software performs, data from the clustering task is used to calculate a distance matrix, where each column and each row represents one statement from the set (similar to a correlation matrix). Each value in the matrix is calculated by dividing the number of participants that put the two particular statements in the same group, by the total number of participants (Severens, 2012). The values in the matrix therefore represent the participants’ overall perception of how related each statement is to every other
statement in the set. Higher values in the distance matrix indicate that a larger proportion of the sample placed the two statements in the same group (cluster), i.e. they thought that the two statements were related (Kane and Trochim, 2007).

2.3.3.3.2.1 Principle Component Analysis

The software then reduces the dataset using principal component analysis (PCA). PCA is a technique for translating the distances (or in this case the correlation) between items or other entities into coordinates in a multi-dimensional space. It identifies a set of principal components, and assigns values for every item on each component (Jackson, 2005; Pallant, 2001; Quinn & Keough, 2002). The components are dimensions, or themes, that run through the data, each capturing a proportion of the variance within the dataset. The variance is largest for the first dimension and gradually decreases for every subsequent one. In PCA, each statement is assigned a value for each of the dimensions, based on the ‘average’ distances of statements to each other. Each dimension identified in the PCA is described by an eigenvalue, which indicates the proportion of variance explained by the dimension (Jolliffe, 2002). These values are used to decide the number of dimensions that will be used in further analysis, which in concept mapping is cluster analysis.

The purpose of a concept map is to graphically demonstrate the relationships between statements, and to aid the visual interpretation of these. For this reason a concept map is typically displayed on a two-dimensional graph (Kane and Trochim, 2007) with its axes representing the first two dimensions identified by PCA. Adding any further dimensions would make it visually impossible to interpret to the human eye, reducing the usefulness of the result.

It was not possible to access the data produced by the PCA analysis but given the rigor and reliability of the computer software (de Vries et al., 2014; Hargreves & Crozier, 2013; van Grieken et al., 2013, 2014) I was confident that there were no errors in this part of the analysis.
2.3.3.2.2 Cluster Analysis

The next part of data analysis involves the Ariadne software producing a cluster analysis of the statements using the coordinates of the items from the PCA. This then partitions the PCA configuration into non-overlapping clusters in a two-dimensional space. This agglomerative (bottom-up) hierarchical cluster analysis therefore groups together the individual data points into clusters of statements that represent similar concepts. This cluster analysis creates a number of different cluster solutions, the simplest being a two-cluster solution, the most complex being an eighteen-cluster solution and because no criteria exist for determining the appropriate number of clusters, it is up to the researchers to examine the concept maps produced and choose the final cluster solution themselves.

2.3.3.3 Generation of the final concept map

A concept map is essentially a scattergram where statements are represented as dots. The observed distance between any two dots (statements) represents how often participants had placed them in the same group, i.e. how related they were perceived to be. It therefore visually symbolises the relationships between statements. The dimensions (the x-axis and y-axis) can be thought of as a continuum of a theme used by participants when grouping the statements. The axes can be interpreted from the items that score on them and therefore labeled, to add further understanding to the visual representation of the data.

Further to this, the prioritization scores are entered for each participant. The scores for the whole group (participants from Group one and Group two) are used to calculate average ratings for each item and cluster. I also calculated the standard deviation and 95% confidence interval for each cluster. Another potential way of analysis this data would have been to use bootstrap estimates of the confidence intervals. Although this is now seen as a potentially more accurate method of reporting the precision of the population values calculated (Wright, London & Field, 2011), I chose to use standard confidence intervals as Chernick (2008) recommends the use of bootstrapping only for sample sizes over 50.
The average cluster scores based on the prioritization data are shown on the *Concept Map* as the thickness of the outline around each cluster; the thicker the outline, the higher the average priority given to the statements in that cluster. An example of this can be seen in Figure 1.

### 2.3.3.3.4 Analysis of variance of prioritising data

The final stage of analysis required data to be extracted from the Ariadne software and transferred into SPSS. It was then possible to analyse significant differences between the priorities given to each cluster by the two participant groups. To do this, T-tests were performed to examine differences in the mean importance of each cluster between the clinician and policymaker groups.

### 2.3.3.4 Participant Consent

Information sheets conforming to UWE guidelines, were approved by the university institutional ethics board and HMC institutional research board. I provided these to the potential participant and gained their consent before the interview began. My contact details, as well as those of a different member of the study team were available on request so that any questions from participants could be answered if necessary.

### 2.3.3.5 Data Handling

All data were handled in accordance with the requirements of the Data Protection Act, 1998. All data were stored on a secure academic computer database on a password-protected file. Study participants were unidentifiable by name or any other confidential information.

In particular:

- Any information collected was only used for the purposes of the project.
- Only information that was essential for the proper conduct of the project was collected.
• Due diligence was exercised to ensure information was accurate and kept up to date.

• Information was retained only for as long as is necessary to complete the project process.

• Copies of the information were not transferred to any person or organisation outside the research team, either within or outside the UK or Qatar.

• Appropriate technical measures will be taken to prevent unauthorised or unlawful processing of information, and accidental loss, destruction of, or damage to the information.

2.4 Reflexivity

The conception of this piece of research came from my transition from living, working and studying in the UK to living in Qatar. In February 2014 I moved with my husband and 6-month old daughter to Doha, the capital city of Qatar. I arrived on maternity leave but with a plan to try to find therapy related work in due course. Given that the country was being promoted as one with a rapidly developing health system and a new mental health strategy, I was shocked by the reality of the support available for mental health problems. As a clinician, it was next to impossible to get a job. As a Mum, talking to other Mums with experiences of post-natal depression, it was next to impossible to find suitable support. As a white, Western woman, I was very much a minority. I could only imagine how the majority of the population of Qatar may experience mental illness and support for this.

In time, I became aware of the Doha Professionals Resource (DPR) Group, essentially a group of approximately 30 expatriate professionals all with backgrounds in the provision of therapy. I was relieved to find a group of like-minded individuals, all of who shared my concern with the current level of service provision in the country. We frequently discussed the way things were across various settings and potential future developments. Notably, the existence of this group was kept under the radar of the local authorities.
When it came to restarting this doctorate in 2016 I wanted to make sure the research element was something that was achievable within Qatar, yet also had real world value. Understanding the issues that prevented people accessing support for mental health problems in Qatar remained an unknown to my mind. I felt that if we had a better understanding of these, Qatar as a country and society could perhaps ensure that the needs of its residents would be met more effectively in the future.

As a trainee-counselling psychologist I was interested in the barriers to accessing psychological therapy specifically. This helped channel my research question to address this particular element of treatment.

My choice of methodology was certainly influenced by the fact that researchers are typically drawn to research methodologies that fit their personality and epistemological inclinations. Having previously used concept mapping I was drawn to its ‘pragmatic’ nature. Professionally, I am both a researcher and a clinician so mixed methods felt well matched to these two paradigms; allowing me to sit with both ‘hats’ on rather than choosing one (qualitative) or the other (quantitative). Furthermore, I was aware that for results to have an impact in Qatar, they have to be simple and meaningful (i.e. quantitative because of its generalizability). I feel that my choice of using a mixed-methods approach was therefore an attempt to hang on to the interpretative stance of my profession, counselling psychology (i.e. the qualitative), whilst also producing work that was both realistic and meaningful.

2.5 Summary

This study aimed to address the research question by utilizing a mixed methods approach known as concept mapping, to produce a conceptual model of the barriers to accessing psychological therapy in Qatar. This method was chosen because it produces easily interpretable, meaningful results whilst still maintaining the richness of data associated with qualitative research. Concept mapping facilitates the involvement of multiple stakeholder groups throughout
the study. This study was designed to begin to understand some of the barriers to accessing therapy in Qatar and how they might be worked with during future service planning.
Chapter 3: Results

3.1 Introduction
The aim of this study was to use concept mapping to gain a better understanding of the barriers to accessing psychological therapy in Qatar. A further aim was to compare the perspectives of two different groups of participants, clinicians providing psychological therapy and individuals working at the policy or organisational level. To achieve my objectives I collected statements from participants during brainstorming focus groups or interviews where they answered the question “What are the barriers to accessing psychological therapy in Qatar?” Participants then sorted the statements into order of importance from 1, (least important) to 5, (most important). The previous chapters justify the choice of concept mapping for achieving the aims and objectives of this study.

In this chapter I present the findings of this mixed methods study in four parts. In section 3.2 the recruitment of participants is reported including a participant flow diagram. Section 3.3 outlines the results of the brainstorming, including the characteristics of the participants involved in this part of the study. Section 3.4 outlines the prioritising and clustering elements of the study. The characteristics of the participants involved in this part are presented. Section 3.5 presents the data analysis using the Ariadne software program. This section also explains how the number of clusters was decided upon.

3.2 Recruitment
I recruited participants for both groups using a purposive sampling method, recruiting participants mainly using the snowballing (chain referral sampling) technique. I designed a flyer that I would distribute if necessary to support recruitment but found this type of recruitment was not necessary. Diagram 2 is a CONSORT flow chart that outlines my recruitment through the project.
Figure 2: CONSORT flow chart of participants through the study
3.2.1 Recruitment of group 1 (clinicians)
For this group of participants I began recruitment using chain referral sampling. This involved approaching personal contacts that knew other therapists that might be interested in taking part, requesting that they passed my contact details on (Biernacki & Waldorf, 1981). To reach my recruitment target of fifteen clinicians I attended meetings held by the Doha Professional Resource (DPR) group where I presented the study and invited those interested to contact me.

There were two participants in the clinician group that I approached who were unwilling to participate, one due to time constraints and one because of a lack of understanding about the confidential nature of research.

3.2.2 Recruitment of group 2 (policymakers)
I recruited to this group of participants using chain referral sampling. This time I approached personal contacts that knew individuals involved in mental health services at the organisational level or responsible for policy development. Again I asked for them to pass on my contact details to other individuals that may be eligible and willing to take part. It is not possible to report the number of participants that received my contact details but did not get in touch.

3.3 Brainstorming
This part of the study involved participants from both the clinician and policymaker groups brainstorming statements that answered the question: “What are the barriers to accessing psychological therapy in Qatar?” A number of methods were used to collect this data including interviews, focus groups and written lists of statements communicated to me via email.

The majority of the sixteen participants attended as part of a focus group. I held three focus groups, each with three participants (56.3%). Four participants took part via email (25.0%) and I held one-to-one interviews with three participants (18.8%).
It was decided to stop recruitment of this brainstorming stage at sixteen participants as the research team felt that data saturation was complete, as participants were not generating any additional items. This decision was supported by cross-referencing the list of statements produced by participants with barriers reported in the literature.

### 3.3.1 Statement reduction procedure

From the brainstorming sessions, a total of 251 statements were produced. Each statement created in the brainstorming session was subsequently written on to a separate piece of paper. I then sorted the statements, placing identical ones together and similar ones in groups. Where I was unsure of how best to collate statements I discussed the issues further with my supervisors until a consensus was reached. I also eliminated statements that were irrelevant to the focus question. As much as possible, the exact words of the participants were preserved. When I reached a total of 80 statements it was agreed that any further reduction of statements would result in loss of meaning of the items created in the brainstorming sessions. This fitted with Trochim’s (1989a) recommendation that a maximum of 100 statements are used for concept mapping.

### 3.3.2 Participant characteristics

Table 3.1 shows the characteristics of the sixteen participants that completed the brainstorming task; data for all participants together are presented as well as breaking them down into the two participant groups. Ten were clinicians (group one) and six were policymakers (group two). The participants in group one were, in general, younger, had fewer years of experience in mental health (14 years vs. 28 years) and more likely to be female (70% vs. 33%) than group two. Both groups had a similar ratio of ethnicity, 30-40% from Middle Eastern countries and 60-70% from Western countries.
<table>
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</tr>
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<td>1 (6.3%)</td>
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<td>30-39 years</td>
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<td>40-49 years</td>
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<td><strong>Gender</strong></td>
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<tr>
<td>Male</td>
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<td>Female</td>
<td>7 (70%)</td>
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<td>Private provider of healthcare</td>
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<td>1.35</td>
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### 3.4 Prioritising and clustering

Twenty-six participants undertook the prioritising and clustering tasks; fifteen clinicians and eleven individuals that work at the policy level. Eight of those who
took part in the brainstorming part also undertook this task, seventeen new participants undertook just this task.

Twenty-two participants completed the task face-to-face and four online via a unique link sent in an email. Because participants either completed to task with me face-to-face or directly onto the Ariadne computer software, there were no missing data that needed to be managed.

### 3.4.1 Participant characteristics
The characteristics of the participants that undertook the prioritising and clustering tasks are presenting in Table 3.2. Again, totals are presented as well as breaking them down into the two participant groups. The majority were female, aged between 40 and 60 with at least a Masters level qualification. Seventeen of the participants were from western countries whilst seven were from countries defined as the ‘Middle East and North Africa’. Looking at the two groups separately, group one were, in general, younger, had fewer years of experience in mental health (15 years vs. 20 years) and more likely to be female (80% vs. 46%) than group two. This shows similar characteristics to the two groups used in the brainstorming section. It was not possible to test any differences in the participant groups statistically because the samples were not powered sufficiently to identify statistical differences so it would be likely that it would produce type 2 errors.
Table 3: Descriptive statistics of participants in the clustering and prioritising tasks

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<td>3 (27.3%)</td>
<td>7 (26.9%)</td>
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<td>Western Countries</td>
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<td>17.1</td>
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<td>SD</td>
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<td>8 (53.3%)</td>
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<td>Private provider of healthcare</td>
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<td>2 (7.7%)</td>
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<td>SD</td>
<td>3.7</td>
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</table>
3.5 Data Analysis

3.5.1 Data entry
Data collected face-to-face were inputting into the Ariadne computer program under each unique participant identification number. Where participants undertook the task directly online, additional data inputting was not required.

3.5.2 Concept Maps
In order to better understand the relationships between multiple statements, I needed to create a concept map. Firstly I wanted to investigate the relationships between the statements based on how participants grouped them together in to clusters. One way of achieving this was to use the Ariadne computer program to undertake a principle component analysis (PCA) followed by a cluster analysis. At this stage, the results from all participants (i.e. the clinicians and the policymakers) are analysed together. Although this analysis is undertaken by the computer program rather than directly by the researcher, it is important to understand what it is doing as this aids the interpretation of the output.

3.5.2.1 Principle Component Analysis (PCA)
The purpose of a concept map is to graphically demonstrate the relationships between statements, and to aid their visual interpretation. Each dimension (the x-axis and the y-axis) can be thought of as a continuum of a theme used by participants when grouping the statements, and can be labelled accordingly (for instance, personal vs. organisational aspects).

After the Ariadne computer software completes the PCA it produces a ‘point map’ where each statement is represented as a dot. On this the distance between statements represent how often they have been sorted together, the closer together the items, the more frequently participants had grouped them together. This point map can be seen in Figure 3.2. It represents a first step to understanding how participants felt the statements fitted together.
3.5.2.2 Cluster Analysis
In order to develop my understanding of the relationships between statements I wanted the statements that statistically represented similar concepts to be grouped together. I therefore requested that the Ariadne computer software completed a cluster analysis. With my data it was possible to create a number of different cluster solutions, the simplest being a two-cluster solution, the most complex being an eighteen-cluster solution.

3.5.3 Cluster Map Creation
An essential part of the final analysis was choosing which solution is the most meaningful and understandable. To do this I brought together a small consultation team made up of one supervisor and one participant. At this meeting we started by looking at the solution with only two clusters and at each step (addition of cluster) we discussed whether the split of the cluster was conceptually interpretable. We decided upon a nine-cluster solution. Fewer clusters than this and it was felt that important distinctions were lost, while those with more clusters were felt to be difficult to interpret and split apart statements that did in fact relate to each other.

At this meeting, we also decided on the names of the clusters. Where possible we retained titles suggested by participants. Participant generated titles
included those of ‘Stigma’, ‘Impact of the family’, ‘Cultural implications’, ‘Workforce and training’ and ‘Structural problems within the country’. We also discussed the possible titles of the x-axis and y-axis. The x-axis was clearer to interpret with clusters on the ‘west’ end of the axis being related to issues at the organisational level and those at the ‘east’ end being related to the individual. Therefore the labels ‘organisational’ and ‘individual’ were decided upon. We found it more difficult to interpret the y-axis but concluded that the clusters nearer the ‘southern’ end of the axis related to issues that were internal, i.e. occurring within one’s self or mind. For example, the barrier that is at the lowest end of the y-axis is about internalising the stigma associated with accessing psychological therapy. On the other hand, those statements near the ‘northern’ end of the y-axis related more to what was happening between people, for example the experience of cross-cultural therapy between a therapist and a client. This axis was therefore labelled Intrapersonal-to-Interpersonal.

A final part of the analysis was using the data from the prioritising task to calculate the relative importance of each cluster. They are represented visually on the Concept Map as the thickness of the outline around each cluster; the thicker the outline, the higher the average score of importance that was given to the statements in that cluster. Figure 4 shows the cluster map with cluster and axis labels.
Figure 4: Final 9-cluster concept map solution
Cluster labels refer to the following:
1 – Stigma
2 – Impact of the family
3 – Cultural implications
4 – Stigma impacting on reality
5 – Cross-cultural Therapy
6 – Workforce and training
7 – Local (mis)understanding of therapy
8 – Structural problems within the country
9 – East meets West

I also calculated the standard deviation and 95% confidence interval for each cluster.

Tables 4.1 to 4.9 show the sets of statements included in each cluster in order of mean preference score. Preference scores are between 1 (least important) to 5 (most important).

**Cluster 1: Stigma**

This cluster is made up of seventeen items and emerged as the most important cluster with a mean importance score of 3.37. Table 4.1 shows the mean scores of each item in the cluster. The statements all relate to elements of stigma, including self-stigma (e.g. “a fear of being labelled”) and society stigma (e.g. “some behaviours that may benefit from therapy are unacceptable/illegal in Qatar (e.g. suicide”). The cluster is located towards the personal end of the x-axis and slightly towards the intrapersonal end of the y-axis.

**Table 4.1: Cluster 1 – Stigma**

<table>
<thead>
<tr>
<th>Statements</th>
<th>Mean importance score</th>
</tr>
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<tbody>
<tr>
<td>9 - The stigma associated with mental illness</td>
<td>4.35</td>
</tr>
<tr>
<td>42 - A lack of understand of mental health problems</td>
<td>4.12</td>
</tr>
<tr>
<td>11 - A fear of being labeled</td>
<td>4.12</td>
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Cluster 2: Impact of the family

This cluster contains nine statements and had the second highest importance rating (3.31). Table 4.2 shows the mean scores of each statement included. They cover a range of issues relating to the impact of the family on a person’s ability to access psychological therapy. The cluster is positioned close to Cluster 1: Stigma and Cluster 3: Cultural Implications on the concept map. It is on the individual end of the x-axis and located in the middle of the intrapersonal-to-interpersonal y-axis.

Table 4.2: Cluster 2 – Impact of the family

<table>
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<th>Mean importance score</th>
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<tr>
<td>30 – Fear of bringing shame on family</td>
<td>4.19</td>
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<td>12 – A fear of having your or family member’s chances of getting married affected</td>
<td>3.96</td>
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<td>20 – Qatar is a small community – fear of being recognised or bumping in to therapist</td>
<td>3.46</td>
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16 – The law still criminalises seek help for ‘haram’ behaviours (e.g. suicide) 3.42
40 – Services are only accessed when the family can’t cope any longer 3.23
15 – Therapy is seen as sharing family secrets rather than speaking with someone neutral 3.15
73 – Group work isn’t possible as people don’t want to talk in front of others 2.88
69 – Showing need/dependency on others is shameful 2.81
39 – Men don’t see therapy as for them 2.65

Cluster 3: Cultural implications
The third cluster shown in table 4.3 consists of nine statements with a mean importance score of 3.21. The statements all relate to the impact that culture can have on people accessing psychological therapy in Qatar. This includes the impact of Islamic, as well as collectivist, culture. It is situated on the far right of the map, just above Cluster 2: Impact of the family. It is located at the individual end of the x-axis and slightly within the interpersonal side of the intrapersonal-to-interpersonal axis.

Table 4.3: Cluster 3 – Cultural implications

**Cluster 3: Cultural implications (mean importance score 3.21)**

<table>
<thead>
<tr>
<th>Statements</th>
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<td>13 - A belief that problems should be dealt with within the family</td>
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<tr>
<td>14 - The needs of the family are put before own needs (collectivist culture)</td>
<td>3.54</td>
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<tr>
<td>75 - Issues of anxiety, depression, trauma are not concepts discussed within the culture</td>
<td>3.46</td>
</tr>
<tr>
<td>7 - People hold traditional explanations of mental illness such as 'evil eye' or possessed by spirits</td>
<td>3.35</td>
</tr>
<tr>
<td>65 - A reliance on what is in the Qur’an rather than newer understanding about how the mind works</td>
<td>3.27</td>
</tr>
<tr>
<td>71 - Everything is 'God's willing' - In'shallah</td>
<td>3.23</td>
</tr>
<tr>
<td>38 - The expected presence of a male member of the family in therapy sessions preventing women expressing themselves openly</td>
<td>3.00</td>
</tr>
<tr>
<td>8 - People access traditional healers for treatment of mental illness</td>
<td>2.85</td>
</tr>
<tr>
<td>56 - A person’s cultural baggage might unconsciously impact on their behaviour</td>
<td>2.38</td>
</tr>
</tbody>
</table>
**Cluster 4: Stigma impacting on reality**

This ‘cluster’ consists of just one statement, the fear of losing one’s job because of having therapy. Although it is just one statement it is still technically known as a cluster in accordance with Trochim’s concept mapping technique. It is situated below Cluster 1: Stigma, on the concept map, at the intrapersonal end of the intrapersonal-to-interpersonal axis and towards the individual end of the organisational-individual x-axis.

Table 4.4: Cluster 4 – Stigma impacting on reality

<table>
<thead>
<tr>
<th>Statements</th>
<th>Mean importance score</th>
</tr>
</thead>
<tbody>
<tr>
<td>23... - Fear of losing job because of having therapy</td>
<td>3.19</td>
</tr>
</tbody>
</table>

**Cluster 5: Cross-cultural therapy**

The fifth cluster consists of three items with a mean importance score of 2.94. It is situated at the intrapersonal end of the intrapersonal-to-interpersonal axis whilst in the middle of the organisational-to-individual axis. The statements all refer to potential barriers as a result of therapist and client being from differing cultures from each other.

Table 4.5: Cluster 5 – Cross-cultural therapy

<table>
<thead>
<tr>
<th>Statements</th>
<th>Mean importance score</th>
</tr>
</thead>
<tbody>
<tr>
<td>34 - Therapists lack therapeutic abilities to deal with cultural diversity</td>
<td>3.15</td>
</tr>
<tr>
<td>51 - The difficulty in successfully delivering culturally sensitive psychological therapies</td>
<td>2.96</td>
</tr>
<tr>
<td>45 - A concern that therapists don’t understand traditional/cultural explanations</td>
<td>2.69</td>
</tr>
</tbody>
</table>
Cluster 6: Workforce and Training

Cluster six contains thirteen statements with a mean importance score of 2.90. It contains statements related to the workforce providing psychological therapy, the training of therapists, as well as the training of other professionals around mental health and therapy. It sits at the organisational end of the organisational-to-individual axis above Cluster 8, “structural problems within the country”. It is located towards the interpersonal end of the y-axis.

Table 4.6: Cluster 6 – Workforce and training

<table>
<thead>
<tr>
<th>Statements</th>
<th>Mean importance score</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 - No licensing/registration for private therapists in place</td>
<td>3.62</td>
</tr>
<tr>
<td>4 - There are not enough therapists</td>
<td>3.58</td>
</tr>
<tr>
<td>1 - No psychologist/therapist training programs in Qatar</td>
<td>3.35</td>
</tr>
<tr>
<td>6 - No clear international training route for therapists/psychologists</td>
<td>3.19</td>
</tr>
<tr>
<td>(like for medical training)</td>
<td></td>
</tr>
<tr>
<td>50 - Other professionals not understanding what therapists do</td>
<td>3.00</td>
</tr>
<tr>
<td>3 - Therapists have to be found through word of mouth - can't advertise</td>
<td>2.96</td>
</tr>
<tr>
<td>5 - Therapists are not necessarily well trained</td>
<td>2.96</td>
</tr>
<tr>
<td>18 - Difficulty in recruiting psychologists/therapists to work in Qatar</td>
<td>2.96</td>
</tr>
<tr>
<td>49 - Some psychiatrists have negative views of therapy</td>
<td>2.77</td>
</tr>
<tr>
<td>28 - Language barriers - many different languages spoken in Qatar</td>
<td>2.62</td>
</tr>
<tr>
<td>57 - Being a therapist/psychologist isn't a desirable career for a Qatar</td>
<td>2.46</td>
</tr>
<tr>
<td>i local</td>
<td></td>
</tr>
<tr>
<td>24 - Unethical private practice – e.g. therapists seeing client</td>
<td>2.15</td>
</tr>
<tr>
<td>groups they aren’t qualified to see</td>
<td></td>
</tr>
<tr>
<td>63 - Therapists are anxious about who they see</td>
<td>2.08</td>
</tr>
</tbody>
</table>

Cluster 7: Local (mis)understanding of therapy

The seventh cluster is made up of four statements that refer to how the population in Qatar understand psychological therapy. Its mean importance score is 2.85 and it is located in the centre of the intrapersonal-to-interpersonal axis towards the organisational end of the organisational-to-individual axis.
Table 4.7: Cluster 7 – Local (mis)understanding of therapy

**Cluster 7: Local (mis)understanding of therapy (mean importance score 2.85)**

<table>
<thead>
<tr>
<th>Statements</th>
<th>Mean importance score</th>
</tr>
</thead>
<tbody>
<tr>
<td>44 - A lack of understanding of what therapy is</td>
<td>3.50</td>
</tr>
<tr>
<td>17 - Lack of understanding of confidentiality</td>
<td>3.35</td>
</tr>
<tr>
<td>36 - Qatar not yet in the right place for accepting psychological services (new country)</td>
<td>2.46</td>
</tr>
<tr>
<td>64 - People in Qatar aren’t used to an appointment based system instead of turning up and being seen</td>
<td>2.08</td>
</tr>
</tbody>
</table>

**Cluster 8: Structural problems within the country**

This cluster consists of 22 statements; the largest of the clusters. All statements relate to the care services within the country (e.g., a lack of joined up working between services) or government level issues (e.g., no national level education about what mental health problems). The mean importance score is 2.65. It is situated at the organisational end of the organisational-to-individual axis, close to cluster 6 – workforce and training and cluster 7 – local (mis)understanding of therapy.

Table 4.8: Cluster 8 – Structural problems within the country

**Cluster 8: Structural problems within the country (mean importance score 2.65)**

<table>
<thead>
<tr>
<th>Statements</th>
<th>Mean importance score</th>
</tr>
</thead>
<tbody>
<tr>
<td>35 - No national level education about what mental health problems</td>
<td>3.62</td>
</tr>
<tr>
<td>33 - Limited community based services</td>
<td>3.58</td>
</tr>
<tr>
<td>48 - Medical model and paternalistic care still prevails</td>
<td>3.42</td>
</tr>
<tr>
<td>53 - A lack of joined up working between services</td>
<td>3.27</td>
</tr>
<tr>
<td>52 - Inequalities in minority populations e.g. LGBT, multiple disabilities or older adults</td>
<td>3.12</td>
</tr>
<tr>
<td>54 - A lack of care pathways for specific diagnoses</td>
<td>2.96</td>
</tr>
<tr>
<td>27 - Lack of research into what therapy works here</td>
<td>2.92</td>
</tr>
<tr>
<td>2 - Lack of anti discriminatory legislation</td>
<td>2.81</td>
</tr>
<tr>
<td>26 - A person’s job takes priority in Qatar which may interfere with attending therapy sessions</td>
<td>2.81</td>
</tr>
<tr>
<td>62 - Unclear referral processes</td>
<td>2.65</td>
</tr>
<tr>
<td>19 - Mental health and therapy is not prioritised by Government</td>
<td>2.65</td>
</tr>
<tr>
<td>68 - People don't trust the government or police</td>
<td>2.54</td>
</tr>
<tr>
<td>37 - A lack of data on the use of services (epidemiology)</td>
<td>2.46</td>
</tr>
<tr>
<td>72 - There is nobody in Qatar permanently driving the need for</td>
<td>2.35</td>
</tr>
</tbody>
</table>
psychological therapies

77 - Experts' pushing their own agendas not considering the needs of the population 2.35
22 - Therapy isn't covered under private health insurance 2.35
21 - Cost – of private therapy, transport to appointments etc 2.27
78 - Under 18's need to have parental consent to access treatment 2.19
67 - Some services are seen as only being accessible if you are taken there by police or doctors 2.12
29 - No interpreters available 2.08
43 - Employment/HR issues e.g. only full time work available or not able to have 2 jobs 2.08
31 - Logistical difficulties: traffic, transport issues etc. 1.62

Cluster 9: East meets West

The final cluster consists of two statements, both referring to the clash of cultures between the ‘East’ and the ‘West’. The mean importance score is 2.37. It is located in the middle of the organisational-to-individual axis and towards the interpersonal end of the intrapersonal-to-interpersonal axis.

Table 4.9: Cluster 9 – East meets West

<table>
<thead>
<tr>
<th>Cluster 9: East meets West (mean importance score 2.37)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Statements</strong></td>
</tr>
<tr>
<td>41 – Therapy is a Western concept</td>
</tr>
<tr>
<td>55 – The local population feel hostile towards expatriates ‘taking over their country’</td>
</tr>
</tbody>
</table>

3.6 Comparisons between the two stakeholder groups

Differences between the cluster mean importance scores for each participant group were tested using independent-sample T-tests. The results of these are set out in Table 5, which also displays means, standard deviations and 95% confidence intervals. No significant differences were found for the first eight clusters. There was a significant difference between the mean importance score for the clinician group compared to the policymaker group in Cluster 9, titled East meets West. Clinicians scored the items in the cluster significantly higher (mean 2.60, SD 0.81) than the policymakers (mean 2.05, SD 0.47), t (23) = 2.20, p=0 .04. This represents a large Cohan’s d effect size of 0.83.
There were small differences in the order that the two groups ranked the clusters with policymakers ranking cluster four - ‘stigma impacting on reality’ as more important than clinicians and clinicians ranking cluster seven, ‘local (mis)understanding of therapy’ as more important than policymakers did. However, it is important to consider the standard deviations and 95% confidence intervals when considering the rankings. If the standard deviation figure is large it suggests that the participants did not agree on the rating for a statement or cluster. These reveal that in fact there was little difference between the importance ratings for the first four clusters (stigma, impact of the family, cultural implications, and stigma impacting on reality). This was true for both the clinician and policymaker groups.


<table>
<thead>
<tr>
<th>Cluster</th>
<th>All Participants (n=26)</th>
<th>Group 1 – Clinicians (n=15)</th>
<th>Group 2 – Policymakers (n=11)</th>
<th>T-test result (p-value)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rank</td>
<td>Mean (SD)</td>
<td>95% CI</td>
<td>Rank</td>
</tr>
<tr>
<td>1 – Stigma</td>
<td>1</td>
<td>3.37 (.50)</td>
<td>3.17 – 3.57</td>
<td>1</td>
</tr>
<tr>
<td>2 – Impact of the family</td>
<td>2</td>
<td>3.31 (.55)</td>
<td>3.09 – 3.53</td>
<td>2</td>
</tr>
<tr>
<td>3 – Cultural implications</td>
<td>3</td>
<td>3.21 (.59)</td>
<td>2.97 – 3.45</td>
<td>3</td>
</tr>
<tr>
<td>4 – Stigma impacting on reality</td>
<td>4</td>
<td>3.19 (1.39)</td>
<td>2.63 – 3.75</td>
<td>4</td>
</tr>
<tr>
<td>5 – Cross-cultural Therapy</td>
<td>5</td>
<td>2.94 (.98)</td>
<td>2.54 – 3.36</td>
<td>7</td>
</tr>
<tr>
<td>6 – Workforce and training</td>
<td>6</td>
<td>2.90 (.46)</td>
<td>2.71 – 3.09</td>
<td>6</td>
</tr>
<tr>
<td>7 – Local (mis)understanding of therapy</td>
<td>7</td>
<td>2.85 (.40)</td>
<td>2.69 – 3.01</td>
<td>5</td>
</tr>
<tr>
<td>8 – Structural problems within the country</td>
<td>8</td>
<td>2.65 (.71)</td>
<td>2.36 – 2.94</td>
<td>8</td>
</tr>
<tr>
<td>9 – West meets East</td>
<td>9</td>
<td>2.37 (.73)</td>
<td>2.08 – 2.66</td>
<td>9</td>
</tr>
</tbody>
</table>

Table 5: Independent samples T-test analysis comparing the mean importance scores of the two stakeholder groups.
3.7 Summary

Concept mapping consists of two elements; brainstorming statements and prioritising and grouping these statements into clusters. For the brainstorming task I recruited 16 participants who came up with 251 statements before data saturation was achieved. These were condensed down to 80 statements, each representing a barrier to accessing psychological therapy in Qatar. For the prioritising and clustering tasks 26 participants in total were recruited, 15 clinicians and 11 policymakers, predominantly using a snowballing approach. These participants grouped these statements into nine clusters, the most important ones being stigma, impact of the family, cultural implications, and stigma impacting on reality.
Chapter 4: Discussion

4.1 Introduction
The aim of this study was to investigate the barriers to accessing psychological therapy in Qatar as perceived by two groups of stakeholders; clinicians and policymakers. A secondary aim was to compare the views of these participant groups. Using concept mapping, I identified a total of 80 barriers that could be grouped into nine clusters. In this discussion I interpret the results of this concept mapping project and examine my findings in the context of the existing evidence.

I begin by discussing each cluster created by the concept mapping procedures and how they relate to current literature. Within this I consider the differences and similarities in stakeholders views. Next I consider what the results of the concept map may mean when considered as a whole. I move on to discussing the challenges I faced around recruitment as well as potential limitations of the present study. Finally I consider future recommendations for research in this area before summarising.

4.2 The nine groups of barriers to accessing psychological therapy in Qatar
The main result from using the concept mapping methodology is a quantitative map that reveals how participants perceive the interrelationships between and amongst items whilst also assigning values to the ideas and concepts originally brainstormed. This visual representation of the data therefore constructs a basis for further discussion, interpretation and possible future action.

The final concept map chosen had nine clusters. This number of clusters was consistent with other concept mapping studies. Rosas and Kane (2012) found that in an analysis of 65 studies, the average number of clusters formed was 8.93 (SD= 1.55).
I will now address each cluster individually from those rated the most important thought to those considered less important before addressing the findings overall, reflecting on the context provided in the specific clusters.

4.2.1 Cluster 1: Stigma

This cluster came out with the highest score of all the clusters, suggesting it was seen as the most important barrier to accessing psychological therapy in Qatar. It consists of 17 statements, including “the stigma associated with mental illness”, “a lack of understand of mental health problems”, “a fear of being labelled”, “fear of discrimination from family, friends & others” and “some behaviours that may benefit from therapy are unacceptable/illegal in Qatar (e.g. suicide/drug and alcohol problems)”. The title ‘stigma’ reflects that all the barriers expressed in these statements are linked to the stigma associated with mental illness. This finding that stigma was seen as one of the biggest barriers stopping people access psychological therapy in Qatar is perhaps not unsurprising. For example, the World Health Organization (2001) identified stigma of mental illness as one of the key barriers to effective treatment globally due to its negative impact on an individual’s help seeking behaviour.

Link and Phelan (2001) conceptualised stigma as the negative attitudes, emotions or behaviours towards people that belong to a certain subgroup (for example, having a specific illness or displaying a certain behaviour), based on that subgroup characteristic. There are predominantly two types of stigma; public-stigma (views and attitudes towards others) and self-stigma (internalising public prejudice and directing it towards oneself) (Rüssch, Angermeyer, & Corrigan, 2005). Holding these views leads to stereotypes, which can be defined as ‘a set of beliefs about members of a group that typically represent society’s shared beliefs about that group’. Such stereotypes around mental health can include beliefs such as a person with mental illness is violent and dangerous as well as beliefs related to the causes of their mental health problem(s) (Corrigan et al., 2002). For example, Pescosolido et al., (2010) explained that stereotypes
may include beliefs that mental illness is brought about by a person’s action or inaction or are due to moral character flaws.

Globally, mental health problems have long attracted stigma, more so than physical health problems (Piner & Kahle, 1984). People experiencing mental disorders are more likely to be seen as responsible for causing their illness than those with a physical problem (Corrigan et al., 2000). Such attitudes have historically resulted in discriminatory behaviour such as being less able to rent housing (Page, 1977) or get a job (Bordieri & Drehmer, 1986) therefore perpetuating self-stigma. Western countries now have substantial disability legislation that protects individuals from such discriminatory behaviours, however, the damage has already been done and these attitudes and beliefs are still frequently held by the general population (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). Unfortunately 22% of countries (31% of the world’s population) still do not have any laws in place relating to mental health (Saxena et al., 2007) whilst Al-Krenawi et al. (2004) found that most Arab countries have no documented mental health policies. This is true in Qatar and may go someway to explaining why stigma features so highly as a barrier; no legal protection exists and the fear of discrimination is real.

It is important to remember that stigma has a further impact on the individual experiencing a mental health problem, given that the internalization of negative views has been linked to low self-esteem, self-blame, and negative emotional states (Link et al., 1987). The stress of concealing one’s mental illness may also compound the person’s issues and therefore their ability to access psychological therapy. The significance of the on-going impact of stigma is reflected in the fact that 55% of mental health promotion and prevention programmes globally are aimed at tackling stigma (WHO Atlas, 2014). These programmes often involve elements of stigma reduction theory as proposed by (Corrigan & Penn, 1999). This predominantly involves contact and education. Contact involves video or direct in-person contact with people experiencing mental illness whilst educational approaches aim to provide factual information about mental illness and recovery in order to replace inaccurate stereotypes and beliefs and to
increase positive attitudes. A meta analysis of RCT’s addressing programs that tackle stigma (Griffiths, Carron-Arthur, Parsons, & Reid, 2014) concluded that there is an evidence base to inform the roll out of programs for improving personal stigma among members of the community but that more work is required to develop interventions that are effective in reducing perceived and internalized stigma. It is encouraging to read that there may be interventions that could be rolled out to address stigma and that this is a potential way forward to meeting the psychological needs of those living in Qatar.

Although Griffiths et al’s meta-analysis suggests that anti-stigma campaigns can work, it is important to be aware of over-generalisation between specific cultures (Dardas and Simmons, 2015). Culture no doubt influences stigma, as what may be considered acceptable in one society may be considered unacceptable and open to stigmatisation in an other. A small number of studies have looked at stigma in specific Muslim populations. For example, Weatherhead and Daiches (2010) interviewed 14 Muslim participants living in Britain about their understanding of mental illness. One of the themes they identified was ‘barriers’, which included feeling ashamed or stigmatised if they needed to access services, and that professional services were only for very serious issues. Similarly, Youssef and Deane (2006) found that Arabic-speakers in Australia cited shame and stigma as one of the major hindrances to accessing services and that they tended to view psychological disorders as a test from God, God’s will, or a form of punishment for sin. Al-Krenawi (2005) explained that Arab patients experiencing mental illness often somaticize their psychiatric symptoms to avoid others (including the public, family and friends) having negative reactions towards their illness. Gilat et al. (2010) found that when a member of an Arab family shows symptoms of mental illness, mental health practitioners were turned to in only 11% of their cases. The authors explained that it can take months and even years for some Arab families to accept that the person with mental illness needs professional psychiatric care.

It is obvious that stigma remains an issue across different cultures worldwide, however there is a need to think about the specific context in which it exists in
Qatar. The results from this current study offer some insight into this. For example, the impact of ‘public stigma’ on accessing psychological therapy appears to be one of most important barriers with statements such as ‘a fear of being labelled’ and ‘fear of discrimination from family, friends and others’ scoring very highly on the importance scale. Another context specific barrier to note is ‘some behaviours that may benefit from therapy are unacceptable/illegal in Qatar (e.g. suicide)’. This suggests that the stigma around mental illness goes far deeper than just the views of friends and family as it implies that the Qatari government and its wider society hold extremely negative views of individuals experiencing mental health problems. Addressing this barrier would not be easy and would require a substantial and well-coordinated shift across the whole country.

4.2.2 Cluster 2: Impact of the family

The cluster that came out with the second highest importance ranking was ‘impact of the family’. This consists of nine statements which were felt to all relate to how a person’s family created barriers to accessing psychological therapy. These include ‘fear of bringing shame on family’, ‘a fear of having your or family member’s chances of getting married affected’, and ‘Qatar is a small community – fear of being recognised or bumping in to therapist’. The cluster is located in-between the ‘stigma’ cluster and the ‘cultural implications’ cluster on the concept map, indicating that the ‘impact of the family’ is closely linked to both of these other concepts. It is located at the far end of the organizational-to-individual x-axis because the items refer to barriers that are related to an individual’s personal processes.

It is perhaps not surprising that this cluster is located close to the ‘stigma’ cluster because beliefs linked to stigma are frequently related to perceptions about the individual’s extended family. Indeed, Goffman (1963), an eminent sociological researcher with an interest in mental health stigma, originally called this ‘courtesy stigma’ and it refers to the prejudice and discrimination that is extended to individuals because of their link to a person with a stigmatising
characteristic. It has subsequently been referred to as ‘family stigma’ (Corrigan, Watson, & Miller, 2006; Phelan, Bromet, & Link, 1998; Wahl & Harman, 1989). As with public-stigma and self-stigma, family-stigma can have a significant impact on a person and their family’s well-being. It can cause lowered family esteem, embarrassment, disgrace, secrecy, isolation, mistrust, anger, inability to cope, despair and helplessness (Östman & Kjellin, 2002; Veltman, Cameron, & Stewart, 2002).

It is essential to consider the importance of the family in the context of Arabic societies. There is a societal preference for the group over individuals and this is reflected in the high regard placed on families. The good of the family comes before the good of the individual, and a problem is viewed as a problem of the entire family (Al-Krenawi & Graham, 1996). Extrapolating this, one’s behaviour is a reflection of the extent that their family upholds social values, norms and expectations (Erickson & Al-Timimi, 2001). The extended family is typically the main social unit and also plays a pivotal role in caring for those who are ill, mentally or physically (Okasha, 2003, 2012). It is therefore uncommon for elderly members of the family to receive care from someone outside of the family (Abdullah, 2016; Bergman, Bodner, & Cohen-Fride, 2013). Okasha (2003) noted that Arab family members contribute a great deal to the care of their relatives experiencing mental health problems, which influences “illness behaviour, illness pattern and illness management” (p. 42). The enmeshed nature of these close relationships suggest that the thoughts, feelings and behaviours of the person with mental illness can be significantly influenced by those of their extended family. This supports the current findings regarding the considerable role that the family plays in an individual’s accessing of psychological therapy.

Dalky (2012) reviewed the international literature around family members’ perceptions of caring for relatives with mental illness, concluding that culture significantly influences stigma perception within families. Despite clear links between culture and stigma towards mental health in general very little work has been undertaken addressing family stigma from cultural perspectives. The
author concluded that further work in this area is necessary, especially in Arabic populations where stigmatization and the family are very important concepts. Research specifically undertaken with Arabic populations that has studied family members experiences of mental illness is scarce. One study conducted by Kadri et al (2004) studied 100 Moroccan family members whose relatives had a diagnosis of schizophrenia. The results revealed that 86.7% of family members reported hard lives and 72% reported psychological suffering and poor quality of life perceived to be a result of their family member’s diagnosis (Kadri et al., 2004). This authors concluded that despite the belief that traditional societies are more supportive of the weak and the sick, stigma is a major burden on the family, in addition to that of the illness the relative is experiencing. Clearly further research is necessary with Arabic populations to augment the findings of this isolated study.

To understand this cluster further it is necessary to consider how Arabic families specifically view psychotherapy within mental health care services. For example, Budman, Lipson, and Meleis (1992) expressed the opinion that therapy is discouraged as it constitutes disclosure of personal problems to outsiders and therefore show the family in a negative light. This view, although potentially dated, was shared by participants in this study and formed the basis of the statement “therapy is seen as sharing family secrets rather than speaking with someone neutral” which falls into the current ‘impact of the family’ cluster. To address these negative perceptions of therapy El-Islam (2005) proposed that family members should be involved in an individual’s therapy to the extent that they are considered ‘co-therapists’. Indeed Erikson and Al-Timimi (2001) and Nobles and Sciarra’s (2000) studies with Arab-Americans suggest that family or systems approaches yield better therapeutic results because of the cultural emphasis on groups. However the reality of these proposals warrants further unpacking. There is often a focus in Arabic societies on preserving the greater good and wellbeing of the family by maintaining face, guarding, and upholding reputation (Okasha, 2003). Thus, in our study many participants identified instances in which the family could be stigmatised if an individual member of that family was shown to be experiencing a mental illness.
Participating in therapy involves engagement and often being physically present in contexts where it is known a stigmatising illness is managed. This is less easy to ‘hide’ in a small country like Qatar and consequently, the family may work to maintain their isolation in order to prevent their health needs becoming apparent to the wider community. Such strategies of managing stigma have been described as attempts at ‘passing’ (Goffman, 2009) and act to obscure or to mask what is perceived as being a family weakness or problem. Attempting to engage family as ‘co-therapists’ or, in the case of systemic therapy, patients receiving treatment, may be difficult because it would involve challenging societal norms around preserving family status (Barakat, 1993; Lay, 2005).

In contrast, Masalha (1999) argued that it might be best not to involve the family in therapy for Arab clients. He noted that the focus of therapy with Western clients was often establishing relationships with significant others. He compared this to the focus of therapy with non-Western populations, which was often on helping them to discover their individuality and process the burdens of family obligations they may carry. To date there is no empirical evidence looking at whether it is beneficial or detrimental to involve a client’s family in the therapy process. Further exploration of how clients and their family members feel about these different types of treatment may reveal how best to incorporate psychological therapy into an individual’s treatment package in the future. This is particularly crucial give that little work has been done with Arabic clients living in traditional Arabic societies. Addressing stigma was not something that was adequately explored in the Qatar National Mental Health Strategy whilst this current study suggests that beginning to address family stigma in Arabic populations may also represent a necessary step forward to supporting individual’s access to psychological therapy in Qatar.

4.2.3 Cluster 3: Cultural implications
Castillo (1997) declared that culture is an inherent part of mental (ill)health in that it both influences, and is an integral part of, an individual’s state of being. This third cluster consists of nine statements that relate to the specific culture of Qatar as an Arabic, collectivist society. The statements either refer to the
impact of Islamic concepts (e.g. ‘people access traditional healers for treatment of mental illness’ and ‘a reliance on what is in the Qur'an rather than newer understanding about how psychological difficulties’) or the impact of being a collectivist culture where family and honor are cornerstones of an individuals’ way of life (e.g. ‘a belief that problems should be dealt with within the family’ and ‘the expected presence of a male member of the family in therapy sessions preventing women expressing themselves openly’). The cluster is located just above the ‘impact of the family’ cluster on the concept map, suggesting that the two concepts are closely linked. In fact there are a number of statements that could be located in either the family or the culture cluster. It is situated at the far end of the organizational-to-individual x-axis because the items refer to barriers that are related to an individual’s personal processes.

The relative importance of this cluster is perhaps unsurprising, give that an individual’s culture is frequently referenced as a barrier to accessing mental health services. This is true in developed countries such as America (e.g. Borowsky et al., 2000; Cooper-Patrick et al., 1999) as well as in low-income developing countries such as India or Uganda (e.g. Patel, Chowdhary, Rahman, & Verdeli, 2011). Understanding that a person’s culture will inevitably shape their beliefs and values is a first step when interpreting the meaning of this cluster. In Muslim cultures, individuals tend to be guided by Islam and the Qur'an. This cluster contained six statements that related specifically to the impact Islam and the Qur'an can have on accessing psychological therapy. These were; ‘Issues of anxiety, depression, trauma are not concepts discussed within the culture’, ‘People hold traditional explanations of mental illness such as 'evil eye' or possessed by spirits, ‘A reliance on what is in the Qur'an rather than newer understanding about how the mind works’, ‘Everything is 'God's willing' - In'shallah’, ‘People access traditional healers for treatment of mental illness’, and ‘A person's cultural baggage might unconsciously impact on their behaviour’. These statements fit with the findings from existing literature with Middle Eastern Arabic populations. For example, specific cultural beliefs about the etiology of mental illness can lead to religious authority figures and
traditional healers being consulted rather than specialist ‘westernised’ practitioners (Al-Krenawi et al., 2004; El-Islam, 2005; Loewenthal et al., 2001).

A further cultural implication is that in the region, social structures are family focused and still typically male dominant. Women, particularly in Muslim societies, can continue to be socially constructed as powerless, subservient and submissive (Al-Haj, 1987). The impact this has on an individual’s willingness to access psychological therapy was expressed in three of the statements in this cluster; ‘The expected presence of a male member of the family in therapy sessions preventing women expressing themselves openly’, ‘A belief that problems should be dealt with within the family’, ‘The needs of the family are put before own needs (collectivist culture)’. Clearly some of these statements could have fitted into the ‘impact of the family’ cluster. In fact the ‘impact of the family’ cluster sits juxtaposed between the stigma and culture cluster, illuminating that family could be the mediating influence between the two. In other words, the reason that stigma has such resonance in this society is because the family, not the individual, is pre-eminent within the culture.

4.2.4 Cluster 4: Stigma impacting on reality

This cluster consists of just one statement: ‘the fear of losing your job as a result of having therapy’. The title ‘stigma impacting on reality’ was proposed as it captures the local situation that this statement refers to. The location of the cluster on the concept map highlights that the statement is closely linked to other statements relating to stigma. It is the ‘lowest’ statement on the intrapersonal-to-interpersonal y-axis symbolising that it is an internal conflict that creates this particular barrier to accessing psychological therapy in Qatar.

Western literature suggests that historically, concern about losing your job because of a mental health diagnosis has been a realistic fear (Bordieri & Drehmer, 1986). Legislation now prevents this from legally happening in developed countries. No such legislation has yet to be put in place in Qatar,
leaving residents there potentially vulnerable to discrimination based on their mental and physical health.

The prospect of losing your job also has a more specific context in Qatar because of the specific Kafala labour laws in place in the country. These apply to anyone living and working in Qatar who is not a Qatari national (i.e. approximately 90% of the population). If an individual loses their job they are (nearly instantly) required to leave the country, along with their family who will be under their sponsorship. It is very difficult to change jobs within the country so losing a job can also mean losing your family home and your children’s education systems.

The significance of this cluster can be understood by considering Maslow’s (1954) historic theory of human motivation commonly known as the ‘hierarchy of needs’. In Qatar, engaging in psychological therapy has the potential to affect the most essential requirements for human survival, our ‘physiological’ and (economic) ‘safety’ needs, not just interpersonal needs that relate to ‘love and belonging’ and ‘esteem’. The misunderstanding of mental illness and its treatment therefore potentially reaches beyond having a purely psychological impact on the majority of individuals living in Qatar. Separate employment law applies to Qatari nationals so this cluster does not apply to this demographic. This difference between populations will be considered in more depth in the limitations section.

4.3.5 Cluster 5: Cross-cultural therapy

The fifth cluster comprised of three statements; ‘therapists lack therapeutic abilities to deal with cultural diversity’, ‘the difficulty in successfully delivering culturally sensitive psychological therapies’ and ‘a concern that therapists don’t understand traditional/cultural explanations’. The title ‘cross-cultural therapy’ was given to this cluster as it was felt that all statements were referring to the impact of receiving therapy from a professional who comes from a different culture to the client (Sue et al., 1982). This is locally very important, given that
the population in Qatar is extremely diverse, and mismatched with the work force currently providing psychological therapy within the country.

Cross cultural therapy and culturally relevant counselling competences are not new (e.g. Sue et al., 1982; Sue, Arredondo, & McDavis, 1992), indeed they are part of American Psychological Association guidelines for ethical practice (APA, 2002). Collins and Arthur (2010) suggest a framework for cross-cultural therapy, which includes developing attitudes, knowledge, and skills across the three domains (a) cultural self-awareness of their own assumptions, values and biases, (b) awareness of the cultural identities of clients or understanding the worldview of clients, and (c) culturally sensitive working alliances. This framework aims to support therapists to acknowledge the significance of a client’s individual identity whilst offering a clear and concrete set of tools with which to navigate culture-infused practice.

Despite the history behind practicing in this manner, this cluster in the current study suggests that there is still concern about a therapist’s ability to work cross-culturally. Brown (2009) argues that the concept of a therapist being ‘culturally competent’ proves problematic because the emphasis is on understanding the ‘other’ using generalisations that rarely fit the individual client. She argues that for a therapist to truly be culturally competent they must “attune to the component parts of the person’s tapestry of self “(p. 345), in other words, consider the intersectionalities of an individual (Marshall, 2004). Nonetheless, it is important for a therapist to be aware of specific cultural beliefs, values and scripts because even if an individual exhibits behaviour inconsistent with the ‘cultural norms’, it is important to consider what this means (Brown, 2009).

It would be interesting to establish whether concerns about therapist ability to work cross culturally were shared by clients and family members or if this is a barrier perceived only by clinicians and policymakers. It could be that a therapist’s angst about not being able to work cross-culturally creates a self-fulfilling prophecy (Brown, 2009). Perhaps this then acts as a barrier to
accessing psychological therapy from the clinician’s point of view, but is not something that client’s themselves are aware of or concerned with. Further investigation of the client’s point of view is required to understand this cluster more clearly.

4.2.6 Cluster 6: Workforce and Training
The sixth cluster consisted of 13 statements and is located at the organisational end of the x-axis. It was named ‘workforce and training’ because all statements referred to the workforce and training of clinicians providing psychological therapy in Qatar. There were also two statements that referred to other professionals (‘other professionals not understanding what therapists do’ and ‘some psychiatrists have negative views of therapy’) but it was felt that the title still captured the meaning of these statements.

The statements in this cluster that were identified as the most important barriers to accessing psychological therapy all referred to a lack of therapists and local barriers to growing this workforce. Most significantly there are currently no psychologist or therapist training programs in Qatar and no licensing/registration in place for private therapists. This is thought to be because the healthcare system is still relatively new and mental health and psychological therapy has not been sufficiently prioritised. Furthermore, the Qatari Government finds the lack of clarity around professional training routes confusing and has historically found it easier to ignore the development of the profession. The reasons behind this lack of prioritization are likely to be a complex combination of the barriers presented here including stigma and culture. As a result, there are not enough therapists in Qatar to ensure adequate access to therapy.

This barrier is not new and a lack of therapists exists the world over, although the problem is greater in low and middle-income countries (Demyttenaere et al., 2004; Fairburn & Patel, 2014). Eaton et al's., (2011) systematic review of scaling up mental health services to address the treatment gap highlighted the
current lack of documented examples of successfully developed services. Successful scaling up of services occurs when decision makers and political leaders understand the issues, recognise their importance and prioritise action to address mental health needs. Plans need to be feasible and adequately resourced. Although Qatar has a plan for growing its mental health services, the statements in this cluster potentially question its feasibility. Country specific barriers such as ‘no psychologist/ therapist training programs in Qatar’ and ‘no licensing/registration for private therapists in place’ inevitably exacerbate the global issues surrounding inadequate human resources. Fairburn and Patel (2014) meanwhile discuss potential ways in which therapist training can be scaled up to match the unmet need. One possibility is ‘web-centred training’ (Fairburn & Cooper, 2011), which could be an appropriate solution in Qatar given the current lack of educational provision for therapists and psychologists. They remain concerned however that it is unachievable given the intensity of therapist time (resource) required. Further concerns included the lack of experts available to give workshops to train future therapists and insufficient qualified therapists experienced enough to provide supervision.

The education, or rather lack of, for other professionals appears to be another barrier that requires addressing in order to facilitate successful access to psychological therapy in Qatar. Again, this isn’t a country or culturally specific barrier, as Richards et al (2004) found that general practitioners who had undertaken mental health education and training more frequently suggested non-pharmacological treatments than those that had not.

The views of psychotherapy held by psychiatrists trained in and working with an Arabic population is not something that has been explored in the literature. It may be helpful in the future to look at the views that other professionals involved in the care of people with mental health problems (psychiatrists, nurses, general practitioners) hold. Colleagues working at HMC’s Psychiatry Department are about to undertake a survey of attitudes of staff members around stigma. This might shed some light on whether the statements mentioned in this cluster are justified. It has been proposed that one way to
address misunderstandings around mental health problems might be to run a Mental Health First Aid (Kitchener & Jorm, 2002; 2004, 2006) training program for staff.

4.2.7 Cluster 7: Local (mis)understanding of therapy

The seventh most important cluster consists of four statements that refer to how the population in Qatar understands psychological therapy. These were ‘a lack of understanding of what therapy is’, ‘a lack of understanding of confidentiality’, ‘Qatar is not yet in the right place for accepting psychological services (it is a new country)’ and ‘people in Qatar are not used to an appointment based system instead of turning up and being seen’. Its location towards the organisational end of the organisational-to-individual axis suggests that these barriers reflect issues around the context of services (therapy). The title ‘local (mis)understanding of therapy’ refers to barriers created by the local population not understanding the processes surrounding the intervention compared to individuals frequently exposed to the concept of therapy. Not being used to an appointment based system is not an issue unique to psychological therapy in Qatar, as other allied health professions such as physiotherapy can experience the same ‘turn up and be seen’ mentality. It may be because the country’s health care system is used to operating out of hospitals, an issue Saraceno et al highlighted in their 2007 report. This barrier might also be linked to holding a non-Western concept of time. Masalha’s (1999) reflected on providing psychotherapy in an Arab village in Israel and noted that he frequently had to repeatedly educate his patients about the value of time and keeping appointments. In contrast he had found that this was second nature to patients living in Western societies.

The statement ‘a lack of understanding of confidentiality’ was, at times, mirrored in my recruitment. One potential participant from a GCC country was not happy to be involved because they were concerned that their responses would not be kept confidential. As this potential participant works in the field
of therapy provision, it was concerning to hear this worry but it highlighted the very real fear that some individuals in Qatar have about maintaining family secrets and saving face.

4.2.8 Cluster 8: Structural problems within the country

This cluster was the largest formed, consisting of 22 statements. These all referred to the limitations within the care services in the country (for example, ‘a lack of joined up working between services’, ‘limited community based services’ and ‘a lack of care pathways for specific diagnoses’) or government level issues (for example, ‘no national level education about what mental health problems are’, ‘Inequalities in minority populations e.g. LGBT, multiple disabilities or older adults’ and ‘lack of anti discriminatory legislation’). It is situated at the organisational end of the organisational-to-individual axis, close to cluster six -workforce and training and cluster seven-local (mis)understanding of therapy. The large number of statements within this cluster emphasises just how many barriers there are in relation to the organisational structures within Qatar.

The statements in this cluster are generally issues unique to Qatar. The same was found in the study undertaken in Sudan by Ali and Agyapong (2016). Their similar exploration of barriers to mental health service utilisation in Sudan, found that one of the main barriers was the cost of medications, especially as they are often required long term. In Sudan, psychiatric medications are not included on private health insurance plans, nor are there any government provision of support. This has resulted in a country specific barrier to accessing support and care for mental health problems for those living in Sudan.

The Qatar specific barriers reported in the current study were, however, not all that conceptually dissimilar to those reported by Saraceno et al (2007) as occurring in low and middle-income countries. This included the complexity of and resistance to decentralisation of mental health services, the challenges of implementation of mental health care in primary-care settings, and the
frequent scarcity of public-health perspectives in mental health leadership. These are all significant and multifaceted issues that require addressing at a national, government level. Saraceno and colleagues concluded that improvement in access to mental health care required greater attention at the political, leadership, planning and advocacy level.

This sentiment was echoed by Saxena et al (2007) who explained that adequate financial resources in a country was not enough to ensure development of services, this must be matched by political will. This view was reflected in the present study in a number of statements in this cluster, namely “mental health and therapy is not prioritised by Government”, “there is nobody in Qatar permanently driving the need for psychological therapies”, “Experts' pushing their own agendas not considering the needs of the population” and “a lack of data on the use of services (epidemiology)”. These statements all reflect a current lack of prioritization of mental health care in Qatar, this is despite the existence of a National Mental Health Strategy that is supposed to be close to completion.

The statements within this cluster emphasize the need for services in Qatar to be locally relevant, i.e. consider the needs of the diverse population. This is supported by Eaton et al (2007) who concluded, “Services should be both evidence-based and locally relevant, ensuring that they take into account all aspects of existing systems”. These authors reminded us that there is often little published information in either government or scientific literature about the use and need of services in developing countries. This can limit the improvement of local services as it makes it hard to monitor development. For example, I have been here for three years now and am still not aware of many of the services available within the country. No directory of local services exists and knowledge tends to be shared purely by word of mouth. The frequent migration of individuals in the country complicates this as knowledge becomes easily lost. This lack of awareness of services also exists within the current health care services. For example, during the fieldwork, I came across several nurses who were unaware that there were psychiatrists working within the
Accident and Emergency services at HMC, in an office around the corner from their nurses’ station.

Growing community services might offer a solution to some of the other barriers I have explored. For example, it could influence the stigma associated with accessing these services and the misunderstanding of confidentiality.

**4.2.9 Cluster 9: East meets West**

The final cluster consists of two statements, ‘therapy is a Western concept’ and ‘the local population feel hostile towards expatriates ‘taking over their country’. The title East meets West was given because it was felt that both statements referred to the meeting, or perhaps clashing, of East and West.

It scored the lowest rating of importance suggesting that other clusters were felt to represent more substantial barriers to accessing psychological therapy than the clashing of cultures within the country. It is interesting therefore that this cluster was the only one where the views of clinicians and policymakers differed statistically significantly; policymakers viewing it as less important than clinicians did. We could hypothesise that this is because clinicians are immersed in this ‘culture clash’ whilst completing day-to-day clinical work and it is something they are attuned to reflect upon more than those working at a policy level. Again it would be interesting to explore whether service users and their families also share these views and perceptions about culture clash creating barriers to therapy.

This cluster brings us back to the issues originally presented around the internationalisation of counselling psychology. This refers to the transferability of the counselling psychology discipline, developed in western countries, to practice in non-western cultures. The identification of the statements included in this barrier suggests that the profession does need to be mindful of these potential barriers.
4.3 What do these nine clusters mean?

4.3.1 The most important clusters

In the present study, participants rated statements that related to stigma, culture and the family as the most important. This finding paralleled the systematic review conducted by Gearing et al (2014) in which over half of the papers referenced barriers to implementing and adapting psychological interventions originally devised in developed health care systems as related to ‘cultural context’ (Table 1). The current findings give important credibility to the results that Gearing and colleagues present, especially as their paper gave little context behind how they reached their conclusions. Many of the items listed in Table 1 feature in the first three clusters. The close proximity of these three clusters to each other on the concept map helps us see visually just how closely interlinked the three concepts are considered to be. Indeed there were numerous times when participants wanted to place statements in two or all of these clusters. This finding suggests the need to consider stigma, family and culture almost collectively when reviewing how barriers to psychological therapy in Qatar may be overcome. For example, these findings would suggest that any anti-stigma campaign would need to have a strong focus on addressing the views of the wider family and community and acknowledge how influenced an individual may be by the concerns of others.

Given the relative importance attributed to stigma in the current study, it could be argued that one of the first steps that Qatar needs to take to address the barriers to psychological therapy would be an anti-stigma campaign aimed specifically at a family-orientated, collectivist culture. As discussed by Gronholm et al (2017), when deciding upon a stigma focused public health programme, a number of decisions need to be made in advance, including; the scope of mental disorders to include, the level of intervention, whether to tackle whole populations or target specific groups and which type of stigma to tackle (e.g. structural, self-stigma or courtesy). The current study would support the argument for focusing anti-stigma work in Qatar on ‘courtesy stigma’. Given that most anti-stigma campaigns have targeted health professionals, law
enforcement officers, and young people (Gronholm et al, 2017) considerable work may be needed to successfully develop an intervention aimed at family members. Ungar, Knaak and Szeto (2016) suggests a helpful place to start would be to use qualitative interviews or ethnography to understand the target group (i.e family and wider community) and the context of their views and beliefs regarding the stigmatised group. Importantly, for an intervention to successfully reduce stigma and discrimination, a long-term, sustained commitment is required (Sartorius, 2010). The impact of any anti-stigma campaign should be evaluated using a measure such as the Mental Illness Knowledge Scale (MAKS, Evans-Lacko et al, 2011).

One example of mental health anti-stigma campaigns being run in the Arab region is the ‘Standing for Psychological Education and Awareness in Kuwait” campaign which works predominantly through social media sites such as facebook. It is unclear whether any evaluation of this campaign will occur but perhaps its mere existence suggests that the region is starting to open up to having long-standing views challenged.

4.3.2 An overarching narrative

The collective results presented in this thesis depict an interesting overarching story. They suggest that Qatar (as a country, culture and society) needs to solve multiple problems both in order and yet side-by-side. Broadly these problems fall in to two categories; organisational and individual issues. My findings propose that as a first step, cultural attitudes, including those of a stigmatising and discriminatory nature, need to shift. These issues were consistently ranked as most ‘important’ by participants; suggesting the need to tackle cultural attitudes first. Once this shift occurs, it is likely that the number of individuals wishing to access services will increase. When this happens the country will then need to rethink the infrastructure in order to successfully manage this shift. Once this infrastructure exists, policy makers and key government organisations may be better placed to evaluate what would be the best
approaches to supporting individuals with mental health problems and which services would best meet the needs of the population.

Addressing the initial cultural attitudes is likely to require a multi-faceted response involving health policy as well as political and sociological level changes. Developing and running an anti-stigma campaign may be one of the ways change may start to occur. Despite this potential way forward, we must acknowledge that Individuals in important positions within the country must also want change to occur for this type of response to be realised.

4.3.3 Driving change forward

Anti-stigma campaigns often sit within public health infrastructures rather than mental health services specifically. I feel that the findings from the current study suggest that as many different stakeholder groups as possible should be engaged with in the development of any intervention. Stigma is always a complex issue but it feels further complicated in Qatar because of the significant role family and wider communities play for an individual. I feel that the potential development of such interventions would benefit from involvement from psychologists whose focus is often on carefully considering the unique, intersectional context of an individual.

One other finding from this study suggests further caution is needed when developing potential interventions to address stigma or other service level changes. I identified that both policymakers and clinicians in the country felt that the clash between Western and non-Western cultures could act as a barrier to people accessing psychological therapy. This suggests that successful change would likely benefit from the involvement of non-Western psychologists rather than simply having Western psychologists come in to the country. As ever, this is easier said than done and the complexities of this suggestion are highlighted in the organisational level clusters (‘workforce and training’ and ‘structural issues within the country’).
4.4 Personal reflections

As a non-Western counselling psychologist I have found this project has given me a wider understanding of my profession and where it could sit within global mental health service development. I have found myself agreeing with Moller’s (2011) suggestion that the profession needs to champion diversity and multiculturalism in the way counselling psychologists practice. The fact that this study found that culture was considered one of the most important barriers emphasises the need to carefully consider the unique, intersectional context that each client comes from. I feel that the findings support an argument that Western trained counselling psychologists might also be well placed to start to gently challenge some of the negative attitudes that arise because of the environment in which people live in Qatar and their current provision of psychological therapy. Perhaps it may help the country to recognise that it needs to develop local therapy training programs that champion some of the values the profession of counselling psychology holds.

I will now move on to discuss recruitment during this study, issues this raised, other limitations of the current study as well as the direction of future research.

4.5 Recruitment

I aimed to recruit a sample of participants that was representative of the populations from which they came. I recruited to target for both of the groups within the time scale set. Participants were recruited from a range of cultural backgrounds in line with the population in Qatar. Seven (27%) of my overall sample were from countries in ‘Middle East and North Africa’, Seventeen (65%) were from ‘western countries’.

The demographics of the two groups used in the brainstorming and those involved in the clustering and prioritising tasks were similar. In both samples the differences in the demographics of the clinician group compared to the policymakers group were felt to be representative of the sample from which they were being drawn. For example, the policymaker group were typically older and more likely to be male than the clinician group. This is similar to
other studies that have compared the views of clinicians and policymakers using concept mapping (e.g. Green and Aarons, 2011).

As expected, recruitment to the policymaker group was more challenging than for the clinician group, mainly due to the smaller population that they were being drawn from. Additionally, I was relying simply on ‘word of mouth’ for this participant group, as there were no specific meetings that I could attend and recruit from. It was difficult to find out from other sources, e.g. online searches, who exactly worked in policy related roles in the country and obtaining contact details was only possible when I was introduced through other personal contacts. This lack of local awareness about who the senior individuals working in the country are may reflect how mental health and psychological therapy continues to be viewed within the country.

It is also worth noting that of the three Qatari nationals I found to approach (covering both participant groups), one did not respond, one was concerned about confidentiality and one declined to take part because of time constraints. The lack of understanding about the confidential nature of research by one clinician was particularly concerning. It did nonetheless mirror the literature around Arabic-populations lacking trust in services and client-professional confidentiality (Youssef & Deane, 2006).

4.6 Limitations of the study

This study was limited by its sample size and it cannot be viewed as representing all psychological therapy clinicians working in mental health in Qatar or all individuals involved in policy development. It also does not consider the views of service users or their family and carers. Given that the findings here suggest that the views of the family are extremely important to understanding barriers to accessing psychological therapy in Qatar, this could limit the reliability of our interpretations. Another challenge with trying to include the views of service users is that these individuals have, by definition, overcome any potential barriers to successfully access psychological therapy. Perhaps what would be more beneficial would be accessing individuals who do
let barriers stop them from receiving services. Doing so would inevitably require more creative ways of recruiting, especially within a bureaucratically complex country such as Qatar.

Another problem with this study is that it is not clear what the participants considered as the target client population when undertaking the tasks. The diversity of the population in Qatar means that what might be a barrier for one individual might not be for another. For example, “fear of losing your job because of having psychological therapy” may not have the same implication for a Qatari national compared to a migrant/expatriate worker living temporarily in Qatar. Another issue is that the participants in this study worked with a variety of clinical populations accessing psychological therapy for different reasons. I did not ask participants to undertake the tasks bearing specific mental health problems in mind. I therefore cannot be sure that all participants were considering the same conditions, which again may impact on the findings, and conclusions I have made.

The nature of the data collection method must also be considered. Participants were self-reporting perceived barriers and as Crawford et al (2002) suggested, this is often part of a ‘sense-making’ strategy by the individuals. These authors investigated barriers to implementing evidence-based practice from the perspective of mental health nurses in the UK. They suggested that rather than the barriers suggested being concrete and to be taken at face value, participants in fact, socially construct them. They suggested that the barriers reported in their study;

“represent a meticulously constructed and intelligently flexible set of strategies for limiting the impact of evidence-based practice upon practice” (p. 296)

Checkland, Harrison, and Marshall (2007) also argued that the identification of barriers does not necessarily lead to effective change within a system. They suggest that there can be an overemphasis on change where it is always seen as good and desired, whilst barriers can, and should, be removed.
Of a similar vein to the presumption that the statements participants gave were concrete and factually correct, is the premise that participants felt able to speak freely during both parts of my data collection. Although this is true of any piece of qualitative research it feels particularly significant in a country where there can be a lack of freedom of speech. For example, one English web-based news channel (Doha News) can no longer be accessed from within the country due to Government censorship. As a result, when working in Qatar, there can be a constant pressure to ‘say the right thing’. This is reflected in the barrier ‘stigma impacting on reality’. Participants in this study may have felt pressure to say the ‘right thing’ during their involvement with the study, which inevitably impacts on the reliability of the data. I have also needed to reflect on my personal feeling of needing to ‘report the right thing’ when analysing, reporting and discussing the data in this thesis.

Another limitation to the current study may be the choice of methodology. An alternative mixed-methods approach that I could have used is Q-methodology (Stephenson, 1953). This also places participants at the centre of the research process and attempts to represent the perspective of the participants rather than the researchers. However, it differs from concept mapping because the aim of the sorting task in Q-methodology is to find groups of people who have similar sorting patterns, who share the same viewpoint on the topic. Its goal is to identify the different subjective perspectives on the issue rather than to identify the common conceptual understanding. I chose to use concept mapping instead of Q-methodology because I felt that the current research question was aimed at the conceptual rather than an individual level. However, if I had used Q-methodology, it could perhaps have provided a deeper understanding of the variety of subjective viewpoints held in regards to the research question.

This fits with another limitation of the current project, which is the fact that I am a white, western female expat reflecting on an Arabic, non-western, male dominated world. A Muslim woman may interpret the results I’ve presented
here quite differently. Saying that, making sure my samples represented a
diverse a population as possible and constantly discussing my findings with
Muslim women and men working in the field should hopefully mean that my
data is as valid as possible.

4.7 Recommendations for future research
To improve access to psychological therapy in Qatar, it is important to
understand what might be preventing individuals receiving treatment for their
mental illness. The current study considered what clinicians and policymakers
felt but did not attempt to establish the views of service users and their family
members. This is an important next step to building on our understanding of barriers.

Further work could also be done on the predictive validity of these barriers on a
patient’s willingness to access treatment. These sorts of data would provide a
more rigorous understanding of the implications that the different types of barriers outlined in this project.

As mentioned previously, it would be beneficial to expand our understanding of
the stigmatising views held by individuals in Qatar. Breaking this down further in
to public, self and family-stigma could help with future planning for successful
anti-stigma campaigns and interventions. It may be that an intervention such as
‘mental health first aid’ would benefit the population. This is aimed at raising
awareness at the prevalence of mental health problems and promoting the best
ways to help support an individual who is in crisis, get the treatment they
require.

4.8 Summary
This is the first study to explore what some of the barriers to accessing
psychological therapy are in Qatar, a small but significant country in the Arabian
Gulf. In this thesis I have described and discussed an exploratory study that
considered the views of clinicians and policymakers involved in mental health
care within Qatar. The findings offer some understanding of how therapists and
commissioners view the social, cultural and psychological barriers preventing access to psychological therapies in Qatar.

It has the potential to influence policy in the area, for example it may be necessary to take an initial focus on tackling mental health stigma. These findings could also assist managers when making decisions about service development and how best to meet the needs of patients and their families. Finally, the findings may also provide valuable information for other countries in the region looking to develop mental health services and particularly when offering psychological therapies.
Chapter 5: Article submitted for publication

5.1 Journal Choice

I chose to submit the paper based on my thesis to the Journal of Mental Health (JMH). I studied previous editions of the journal’s publications to get a sense of what sort of articles they publish and found numerous articles that reported findings from non-Western countries, all with a focus on mental wellbeing. Furthermore, the journal has an international editorial board including academics from China and Israel. I also considered the impact factor of the journal when choosing where to submit so that I knew that my article had a realistic chance of being put forward for peer review. The JMH’s impact factor is currently 1.69, which, from previous experience of publishing research articles, I felt was in the right range for my current study.

The paper was submitted for publication on the 3rd June 2017 and at the time of writing is out for peer-review.
ABSTRACT

Background: Mental health problems are highly prevalent throughout the world; however, all too frequently individuals do not receive treatment. Psychological therapy is a potentially successful intervention but barriers to its access could to be better understood. Barriers are likely to be country specific.

Aims: The aim of this paper was to identify the perceived barriers to accessing psychological therapy for people living in Qatar from the perspective of clinicians and policymakers involved in designing and delivering mental health care.

Method: A mixed methodology known as concept mapping was used to investigate the views of mental health clinicians and policymakers. Concept mapping invites participants to first brainstorm the issue, in this case potential barriers to accessing psychological therapy in Qatar (qualitative data). Participants then sort barriers in to groups (clusters) and rate each barrier in terms of perceived importance (quantitative data). Differences between the views of the two participant groups were also observed. The data were analysed using principle component analysis, cluster analysis, descriptive statistics and t-tests.

Results: 15 clinicians and 11 policymakers took part in the study. They generated a total of 251 potential barriers that were consolidated into 80 statements. A nine-cluster concept map was produced from the results of all 26 participants. These clusters were labeled as; Stigma, Impact of the family, Cultural implications, Stigma impacting on reality, Cross-cultural Therapy, Workforce and training, Local (mis)understanding of therapy, Structural problems within the country and East meets West. The individual level barriers of stigma, family and culture were rated as being more important than organizational level barriers. The only statistically significant difference found between the views of clinicians and policymakers was that clinicians rated the East meets West cluster as more important than policymakers did.

Conclusions: There are numerous barriers to accessing psychological therapy in Qatar. All participants rated barriers relating to the individual as having a greater impact on individual’s access to therapy than organization level barriers.
Addressing these barriers is likely to require a multi-faceted response involving health policy as well as political and sociological level changes. The views of service users and their families also need to be explored.

**Declaration of interest:** The authors declare no conflicts of interest.

**Keywords:** barriers, psychological therapy, concept mapping, mental health
INTRODUCTION

The World Health Organisation (WHO) reports that 25% of the global population will experience a mental health disorder at some point in their lives (WHO Atlas, 2014). Evidence-based psychological treatments are key to the successful management of a variety of mental health problems globally (WHO, 2016). There is, however, a significant treatment gap between the number of people requiring treatment and those who actually receive it. In many parts of the world as many as three quarters of the people who could potentially benefit from treatment go without. (Kohn et al., 2004). While a lack of resources often plays a significant part in this treatment gap (Lora et al., 2012; Fairburn & Patel, 2014), coherent mental health policies along with realistic plans for their local implementation are also essential in order to successfully develop services. However a third of all countries worldwide still have no such policy or plan in place (Saxena et al., 2007).

This treatment gap is not simply to do with a lack of clinicians or services in middle and low-income countries, as a similar disparity exists in high-income countries such as the USA. For example Kessler et al (2005) showed that despite a significant increase in treatment availability between 1990 and 2003, most people with a mental disorder in the USA still did not receive treatment. This situation is unlikely to have changed substantially since then. Other barriers to accessing mental health services clearly exist therefore. Amongst the barriers to accessing psychotherapy that have been identified are: stigma (Saxena, et al., 2007), poor mental health literacy and a preference for self-reliance (Gulliver, Griffiths, & Christensen, 2010), a lack of motivation, negative evaluation of therapy, the misfit of therapy to needs, time constraints, participation restrictions and availability of services (Mohr et al., 2006, 2010).

Other challenges to accessing psychological therapy exist at an organizational level. Saraceno et al (2007) investigated the barriers to improving mental health services in low and middle-income countries, finding continued resistance to the decentralisation of services, particularly primary-care based, prevented many individuals accessing the mental health care they need. This
tended to be due to a historical reliance on large, centralised hospitals and a lack of specialist support for overburdened primary-care workers. The authors concluded that government level attention to politics, leadership, planning, advocacy and participation is required to begin to address these complex barriers.

While barriers to accessing psychological therapy exist globally, they are not identical between countries. Within Middle East Arab countries, Gearing et al. (2013) reported a total of 78 barriers that they grouped into three sets; cultural context, community and systems, and clinical engagement process. Barriers relating to cultural context included beliefs and values such as having a preference for seeing traditional healers (Al-Krewani et al., 2004; El-Islam, 2005). In addition, the impact of stigma was experienced in terms of social shame about mental illness and using services, as well as fear of bringing shame on one’s family, (Shalhoub-Kevorkian, 2005) and concerns that women might impair their marriage potential (Al-Krenawi & Graham, 1999; Shalhoub-Kevorkian, 2005). Barriers relating to community and systems included issues associated with access and availability to mental health services (Al-Krenawi & Graham, 1999; Shalhoub-Kevorkian, 2005), whilst clinical engagement process barriers referred to issues such as a lack of understanding of the nature of psychological therapy (Al-Krenawi & Graham, 1999; Murray et al., 2006) and a preference for a medical approach (Al-Krenawi et al., 2001).

Qatar, a small country located in the Gulf of Arabia, is one Middle Eastern country where mental health services are currently undergoing considerable development as the population grows and the country matures. Qatar has a ‘National Mental Health Strategy’ in place (Supreme Council of Health, 2013), which outlined the modernisation of mental health services in Qatar over a five-year period. It highlighted the role of evidence-based practice as a central step in the provision of services. In order to successfully scale up these mental health services nationally, the barriers to accessing treatment, and in particular psychological therapy, need to be identified. As mental health care services are typically embedded in many different systems, an important way of identifying
Those barriers is by investigating the views of different stakeholders involved in the delivery and design of mental health care services in Qatar (Green & Aarons, 2011). These stakeholder groups include those individuals who are directly involved (service users and clinicians) but also program managers and policy makers. The input from multiple levels of stakeholders must be considered for positive, sustained implementation of mental health services to take place (Ferlie & Shortell, 2001).

This current study aimed to investigated the views of two different stakeholder groups, both of whom were seen to be crucial to the process of implementing change (Green & Aarons, 2011) and were thus well placed to provide valuable insights into potential barriers to accessing psychological therapy; clinicians providing psychological therapy (group one) and individuals working in policy and service development (group two). Service users were not approached in this study as their views were being studied separately.

METHODS
Study context/setting
This study was conducted across mental health services (public and private) and governmental policy making organizations in Qatar.

Participants
We recruited participants using a chain referral sampling technique (Biernacki & Waldorf, 1981), a purposive sampling method. There were two participant groups: in the first we recruited clinicians who were either currently providing psychological therapy privately or in public health care settings within Qatar or who had done so within the last three years. Recruitment involved approaching therapists who might be interested in taking part and requesting that they passed on the contact details for the researcher (EB) within their networks (Biernacki & Waldorf, 1981). We used the same methodology to recruit participants to group two: individuals who have had input into designing or influencing mental health services in Qatar at an organisational or policy level, for example providing consultancy to the development of the mental health
strategy. Again we approached potential participants who worked, or had previously worked within these roles, and then invited them to introduce others eligible to take part.

Inclusion criteria: for both participant groups, the ability to speak, read and write in fluent English was required as the data capture methods demanded understanding of descriptive concepts. For the policymaker group a further requirement was experience within the last three years in providing input into policy around mental health at a strategic level in Qatar either to the government, or to provider organisations.

**Study Design**
This project involved concept mapping, a mixed methods approach that uses qualitative procedures (in this case interviewing), to generate statements; these are then extracted, ranked, clustered, and ultimately analysed using quantitative methods. From the conversion to numerical data it produces a visual representation of the inter-relationships between ideas on a given topic. This methodology has been widely used across mental health and health services research (e.g. Johnsen, Biegel, & Shafran, 2000), and is especially appropriate when researchers are seeking to describe and quantify the underlying structures of a phenomenon as experienced by the participants (Kunkel & Newsom, 1996). The approach recognises that groups may hold different views to each other and acknowledges the added value that this can bring when interpreting results. For example, using concept mapping in this study allowed us to assess the level of agreement between clinicians and policymakers with regards to the perceived barriers to accessing psychological therapy.

**Procedures**
The term ‘concept map’ can refer to any visual representation of relationships between different ideas or concepts. The type of concept mapping used in this project refers to a sophisticated mixed-methods analysis first developed by
Trochim, (1989b). It consists of two parts, the *generation* of statements and the *structuring* (prioritising and clustering) of these statements.

**a) Generating the statements.** In the first part of this process, we asked participants the following question; ‘*what are the barriers to accessing psychological therapy in Qatar?*’ Participants were required to generate as many statements as possible that they felt answered it. We collected this data either through small focus groups, one-to-one interviews or via email. This variety of approaches maximised the potential for participants to be involved. Once all brainstorming sessions were complete, statement consolidation took place, eliminating duplicates and merging similar statements. This final list of statements formed the basis of the second part of the process.

**b) Structuring the statements.** We invited both those participants who had taken part in the brainstorming task as well as others who were new to the process to meet face-to-face, or, if they preferred, to undertake the tasks online. Participants were then provided with each individual statement and asked to perform two separate tasks: ranking the importance of each statement (prioritising) and putting the statements that seem to go together into groups (clustering). The prioritising task involved placing an equal number of statements under one of five headings representing a one to five Likert-type scale with one representing the ‘least important’ barriers, and five being the ‘most important’ barriers. The clustering task required participants to sort the statements into clusters based on their perceived similarity. In order to avoid researcher-labelling bias, participants were then asked to assign a descriptive title to each of the clusters. Participants were asked to use all the statements and create between two and ten clusters with a maximum of 40 statements in each cluster (Severens, 2012).

**Recruitment**

Recommended minimum numbers of participants for a successful cluster analysis vary: Trochim (1989a) recommended between 10 and 20 participants while Severens (2012) suggested a minimum of eight to ten participants.
However, as Rosas and Kane (2012) found that that the internal reliability of results increased with a larger sample size, they advised a minimum of 20 participants. We therefore aimed to recruit between ten and fifteen participant for each group.

Analysis

All of the data were entered into a specialist computer software program called Ariadne (Severens, 2012), which facilitated data analysis using a combination of multivariate statistical techniques, specifically principle component analysis (PCA) and cluster analysis. As part of this analysis, a concept map (with a horizontal and vertical axis) was generated with statements being positioned on the map with the distance between them representing how often participants sorted them together into the same group. A concept map is therefore a graphical illustration of the relationships among statements.

Ethics

Ethical approval was obtained from the University of the West of England Research Ethics Committee prior to recruitment starting\(^1\). We also sought approval from Hamad Medical Corporation’s (HMC) Medical Research Centre (MRC) Institutional Review Board (IRB) in order to recruit individuals working in HMC\(^2\).

Reflexivity

We are aware that as a research team we are viewing this project through our own ‘Western’, secular lens and all data are partial (Annandale, 1998). Two of the authors (EB and AT) are both migrant expatriate workers (in common with approximately 88% of the healthcare workforce) and lived in Qatar for a number of years. RC has not and acted as an external supervisor for the project.

RESULTS

\(^1\) HAS/16/03/120
\(^2\) MRC1341/2016
Sample characteristics

The Generation task. Sixteen participants (ten clinicians and six policy makers) took part in the brainstorming task, with the majority of participants (nine) attending one of three focus groups that were held. Four participants took part via email and three participants were interviewed individually. Table 1 shows the characteristics of the sixteen participants that completed the brainstorming task. Recruitment for this first phase of data collection ceased at sixteen participants as participants were not generating any additional items and it was therefore clear that data saturation had been reached (Holloway & Wheeler 2010). This decision was supported by cross-referencing the list of statements produced by participants with barriers reported in the existing literature.

The participants in group one (clinicians) were, in general, younger, had fewer years of experience in mental health, and were more likely to be female than participants in group two (policymakers). Both clinicians and policymakers had a similar ratio of ethnicity, 30-40% from Middle Eastern and North African (MENA) countries and 60-70% from Western countries.

The Structuring task. Twenty-six individuals (fifteen clinicians and eleven policymakers) participated in the prioritising and clustering tasks, eight of whom had also been part of the structuring tasks, and with seventeen new participants only taking part in the second phase of data collection. Demographic characteristics of participants in this phase of data collection are provided in Table 2. The majority were female, aged between 40 and 60 with at least a Masters level qualification. 17 of the participants originated from the West and 7 from MENA countries.

Group one (clinicians), were, in general, younger, had fewer years of experience in mental health and more likely to be female than group two (policymakers), similar characteristics to the two groups who participated in the generation task.
Statement generation and card sort

From the brainstorming sessions a total of 251 statements were produced. By combining similar statements and removing duplicates, this was reduced to 80 distinct statements by EB. These can be seen in Table 3.

Data analysis.

A team of three (EG, AT and a participant) analysed the data using the following process:

1) Similarities matrix. The first part of data analysis used the results from the clustering task to calculate a similarities matrix, where each column and each row represented one statement from the set (similar to a correlation matrix). Each value in the matrix was calculated by dividing the number of participants that placed the two particular statements in the same group, by the total number of participants (Severens, 2012). The values in the matrix therefore represented the collective overall perception of how related each statement is to every other statement in the set and with higher values in the similarity matrix indicating that a larger proportion of the sample placed the two statements in the same group or cluster (i.e. they thought that the two statements were related (Kane and Trochim, 2007)).

2) Cluster map creation. Based on this similarities matrix, a number of different cluster solutions were carried out in order to define specific clusters of statements that best fitted the data. This ranged from the simplest two-cluster solution to the most complex eighteen-cluster solution. For each possible solution a concept map was generated, and beginning with the two clusters solution, each additional cluster solution was evaluated in terms of the extent to which it fitted the data in terms of meaning and conceptual interpretation. Having examined this range of all the possible cluster solutions, a nine-cluster map seemed to be the most meaningful interpretation of the data.

3) Cluster descriptions and ratings. Finally, each cluster in the final solution was given a name, where possible, retaining the titles suggested by participants.
These nine clusters were labelled: *Stigma, Impact of the family, Cultural implications, Stigma impacting on reality, Cross-cultural Therapy, Workforce and training, Local (mis)understanding of therapy, Structural problems within the country* and *East meets West*. Figure 1 shows the final cluster map solution. The themes that each of the clusters represents are described below. Labels that best described the x and y-axes were also identified.

**INSERT FIGURE 1 ABOUT HERE**

The cluster titled *stigma* contains seventeen items and emerged as the most important cluster (mean importance score of 3.37). The statements all relate to elements of stigma, including self-stigma (e.g. “a fear of being labelled”) and societal stigma (e.g. “some behaviours that may benefit from therapy are unacceptable/illegalt in Qatar (e.g. suicide”). The *impact of the family* cluster contains nine statements and had the second highest mean importance rating (3.31). It covers a range of issues relating to the impact family can have on access to psychological therapy for example “a fear of bringing shame on the family”. The third cluster consists of nine statements with a mean importance score of 3.21. The statements all relate to the impact that culture can have on people accessing psychological therapy in Qatar. This includes the impact of Islamic, as well as collectivist, culture. The fourth cluster was titled *stigma impacting on reality* and consists of just one statement, the fear of losing one’s job because of having therapy. The title was chosen because it captures the local situation that the statement refers to.

The fifth cluster, *cross-cultural therapy* consists of three items with a mean importance score of 2.94. The statements all refer to potential barriers as a result of therapist and client being from differing cultures to each other. Cluster six, *workforce and training*, contains thirteen statements with a mean importance score of 2.90. It includes statements related to the workforce providing psychological therapy, the training of therapists, as well as the training of other professionals involved in mental health and therapy. The seventh cluster, *local (mis)understanding of therapy*, is made up of four
statements that refer to how the population in Qatar understands psychological therapy, for example, not understanding confidentiality and the required attendance at weekly, scheduled appointments. It had a mean importance score of 2.85. The eighth cluster, *structural problems within the country*, consists of 22 statements; the largest of the clusters. Its mean importance score is 2.65 and all statements relate to the care services within the country (e.g. “a lack of joined up working between services”) or government level issues (e.g. “no national level education about what mental health problems”). The final cluster, *East meets West*, consists of two statements, both referring to the clash of cultures between the ‘East’ and the ‘West’; “Therapy is a Western concept” and “the local population feel hostile towards expatriates ‘taking over their country’”. The mean importance score is 2.37.

Clusters were placed in rank order according to their mean importance score. Standard deviations and 95% confidence intervals, however, revealed little difference between the importance ratings for the first four clusters, and these could therefore be deemed to be of similar importance. This was consistent when both clinician and policymaker groups were examined independently as well as together.

**INSERT TABLE 3 ABOUT HERE**

**Comparison of the two stakeholder groups**

Differences between cluster mean importance scores for each participant group were tested using independent-sample T-tests. No significant differences were found for the first eight clusters. There was a significant difference between the mean importance score for the clinician group compared to the policymaker group in Cluster 9, titled *East meets West*. Clinicians scored the items in this cluster significantly higher (2.60) than the policymakers (2.05) ($t = 2.13$, df = 23, $p = 0.04$)

**DISCUSSION**
This study aimed to identify the perceived barriers to accessing psychological therapy for mental health concerns in the State of Qatar. We considered the views of two different stakeholder groups; clinicians providing psychological therapy and individuals working in policy or strategic development positions. Using concept mapping, we identified a total of 80 barriers that could be grouped into nine clusters.

Overall, participants rated statements that related to stigma, culture and the family as the most important. This finding parallels a systematic review (Gearing et al., 2014) in which over half of the papers identified barriers to implementing and adapting psychological interventions originally devised in developed health care systems, as being related to ‘cultural context’. These three barrier clusters emerged in close proximity on the concept map, suggesting that they are closely related. Indeed, some of the items in the cultural implications cluster could be (re)located in either the cluster related to family and/or to culture. The impact of the family cluster sits juxtapositioned between the stigma and culture clusters, illustrating that the family could be the mediating effect between the two. Within this interpretation, the reason that stigma has such resonance in this culture is because in Qatar it is the family and not the individual that dominates society.

El-Islam’s (2008) review of the literature examining the influence that Arabic culture has on mental illness concluded that cultural beliefs and practices can be crucial in shaping an individual’s perception and management of mental health problems. The findings of our current study offer further insight into why accessing psychological therapy for managing mental health problems in Arabic culture may be resisted. To address this El-Islam (2005) proposed that family members should be involved in an individual’s therapy to the extent that they are considered ‘co-therapists’. This proposal warrants further unpacking because there is often a focus in Arabic societies on preserving the greater good and wellbeing of the family by maintaining face, guarding, and upholding reputation (Okasha, 2003). Thus, in our study many participants identified instances in which the family could be stigmatised if an individual member of
that family was shown to be experiencing a mental illness. Participating in therapy involves engagement and often being physically present in contexts where it is known a stigmatising illness is managed. Consequently, the family may work to maintain their isolation in order to prevent their health needs becoming apparent to the wider community. Such strategies of managing stigma have been described as attempts at ‘passing’ (Goffman, 2009) and act to obscure or to mask what is perceived as being a family weakness or problem. To attempt to engage family as ‘co-therapists’ may be difficult because it would involve challenging societal norms around preserving family status (Barakat, 1993; Lay, 2005). Further work is required to explore this.

On the other side of the concept map to the stigma, culture and family clusters were those that related to organisational factors; workforce and training and structural problems within the country. These included a number of barriers that related to Qatar-specific issues with providing psychological therapy. For example, currently there are no psychologist or therapist training programs in Qatar and no licensing for therapists making it very difficult to work independently in private practice. Those few working in the public sector come with a range of backgrounds and qualifications and therefore services are varied and scarce. This barrier is not new and a lack of therapists exists the world over, while registration or licensure is far from universal (Fairburn & Patel, 2014). However, the combination of scarcity, inconsistency and stigma in Qatar undoubtedly compounds problems around access to therapy and thus consequently requires strategic intervention if the country’s Mental Health Strategy is to be realised.

We found considerable agreement between clinicians and policymakers about which were the most important barriers. We might have expected that the stakeholders from a policy, organisational or systemic perspective may have different views from the clinician groups. For example, they may have been more aware of bureaucratic structures and contractual agreements that would act as barriers (Hasenfeld, 2009). This similarity of views may reflect the recent
resolve to incorporate psychological therapies as part of the strategic design of mental health services in the State.

LIMITATIONS
This study was limited by its sample size and it cannot be viewed as representing all psychological therapy clinicians working in mental health in Qatar or all individuals involved in policy development. It also does not consider the views of service users or their family and carers or the wider general public within Qatar. Given that the findings here suggest that the views of the family are extremely important to understanding barriers to accessing psychological therapy in Qatar, this could limit the reliability of our interpretations. Another problem with this study is that it is not clear what the participants considered as the target client population when undertaking the tasks. The diversity of the population in Qatar means that what might be a barrier for one individual might not be for another. For example, “fear of losing your job because of having psychological therapy” may not have the same implication for a Qatari national compared to a migrant/expatriate worker living temporarily in Qatar. Another issue is that the participants in this study worked with a variety of clinical populations all of whom accessed psychological therapy for different reasons. As we did not ask participants to undertake the tasks bearing specific mental health problems in mind, we therefore cannot be sure that all participants were considering the same mental health conditions. This, again, may impact on the findings and conclusions we have made.

CONCLUSIONS
The findings from this study offer some understanding of how therapists and commissioners view the social, cultural and psychological barriers preventing access to psychological therapies in Qatar. It has the potential to influence policy in the area and to assist managers when making decisions about service development and how best to meet the needs of patients and their families. Findings may also provide valuable information for other countries in the region looking to develop mental health services and particularly when offering psychological therapies.
Chapter 6: References


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https://doi.org/10.1080/13674670512331335686
Appendix 1: Ethics application to UWE UREC

APPLICATION FOR ETHICAL REVIEW OF RESEARCH INVOLVING HUMAN PARTICIPANTS

This application form should be completed by members of staff and PhD/Prof Doc students undertaking research which involves human participants. U/G and M level students are required to complete this application form where their project has been referred for review by a supervisor to a Faculty Research Ethics Committee (FREC) in accordance with the policy at [http://www1.uwe.ac.uk/research/researchethics](http://www1.uwe.ac.uk/research/researchethics). For research using human tissue, please see separate policy, procedures and guidance linked from [http://www1.uwe.ac.uk/hls/research/researchethicsandgovernance.aspx](http://www1.uwe.ac.uk/hls/research/researchethicsandgovernance.aspx).

Please note that the process takes up to six weeks from receipt of a valid application. The research should not commence until written approval has been received from the University Research Ethics Committee (UREC) or Faculty Research Ethics Committee (FREC). You should bear this in mind when setting a start date for the project.

APPLICANT DETAILS

<table>
<thead>
<tr>
<th>Name of Applicant</th>
<th>Ellie Brown</th>
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<tr>
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<td>Contact postal address</td>
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<td>Name of co-researchers (where applicable)</td>
<td>Prof Richard Cheston, Dr Nic Hooper</td>
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FOR STUDENT APPLICANTS ONLY

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<th>Name of Supervisor/Director of Studies</th>
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<tr>
<td>Detail of course/degree for which research is being undertaken</td>
<td>Prof Doc in Counselling Psychology</td>
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</table>
Supervisor’s/Director of Studies’ email address
Richard.Cheston@uwe.ac.uk

Supervisor’s/Director of Studies’ comments
Please note the supervisor must add comments here. Failure to do so will result in the application being returned.

For student applications, supervisors should ensure that all of the following are satisfied before the study begins:
The topic merits further research;
The student has the skills to carry out the research;
The participant information sheet is appropriate;
The procedures for recruitment of research participants and obtained informed consent are appropriate.

PROJECT DETAILS

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DETAILS OF THE PROPOSED WORK

Aims, objectives of and background to the research
The World Health Organisation (WHO) reports that 25% of the global population will experience a mental health disorder at some point in their lives (WHO Atlas, 2014). Psychological treatment is an established part of mental health care in countries with developed health systems. In other countries mental health services are less well established. Qatar in the Middle East is one such country where they are committed to developing services, having recently adopted a ‘national mental health strategy’ (Supreme Council of Health, 2013). The implementation of this plan is still in its infancy so we are well placed to investigate what key the barriers and facilitators to accessing psychological therapy in Qatar might be. This understanding should aid successful development of mental health services in the country.

The input from multiple levels of stakeholders must be considered for positive, sustained implementation of mental health services to take place (Ferlie & Shortell, 2001). Two such stakeholder groups are clinicians providing psychological therapy and individuals working in policy and service development. These participants are well placed to provide valuable insights in to what the barriers and facilitators to accessing services could be (Colucci et al, 2015). They are also crucial in terms of implementing change (Green & Aarons, 2011). In this study I aim to investigate what the facilitators and barriers to accessing psychological therapies in developing health systems are. I will achieve this by using a methodology known as concept mapping to compare and collate the views
of two major stakeholder groups; those working at the policy and organisational level and those who work at the clinical level (privately and government employed).

The findings from this study could help therapists and policy makers better understand how accessing psychological therapies is viewed in Qatar. It may influence policy in the area and help managers make decisions about service development and patient needs. Findings may also provide valuable information for other countries in the region looking to develop mental health services.

**Research methodology to be used**

You should explain how you plan to undertake your research. A copy of the interview schedule/questionnaire/observation schedule/focus group topic guide should be attached where applicable.

I will use a methodology known as concept mapping to compare and collate the views of two major stakeholder groups. This mixed-methods technique has two parts:

**Part 1:**
The first part of data collection involves a taped interview. I will carry out this out in a private room at a location to suit the individual such as their office on clinical premises or University campus. The interview will consist of filling out demographic data (age, gender, ethnicity, qualifications, job, number of years in that job) and completing a taped dialogue lasting up to 45 minutes. At the end, I will ask participants if they are willing to take part in the second element of the study, the sorting and prioritising task. Contact details will be recorded separately if they agree. If participants do not agree to take part this will not influence their involvement in the first part of the study.

The interview will consist of participants being asked the question ‘what are the facilitators and barriers to accessing psychological therapy in Qatar?’ i.e. “What makes it hard for people to access therapy in countries with developing health systems” and “What would help people to access therapy in countries with developing health systems”. They will be required to produce as many statements as possible that they feel answer these questions. Following this the interview will then be transcribed and data analysed thematically and a list of statements generated. These statements are then compiled and form the basis of the second part of the process.

**Part 2:**
Using the data (statements) gathered above, participants who expressed willing are invited to perform two individual, written tasks: 1 – ranking the importance of each statement (prioritising) and 2 – putting the statements that seem to go together into groups (clustering). These results are then analysed using a specialist software package. This creates a concept map, which depicts the importance and relations of the statements as viewed by the participants. From this, I can draw conclusions about what factors impact on access to therapy.

**SELECTION OF PARTICIPANTS**

Will the participants be from any of the following groups? (*‘x’ as appropriate)*

- [ ] Children under 18*
- [ ] Adults who are unable to consent for themselves
- [ ] Adults who are unconscious, very severely ill or have a terminal illness
- [ ] Adults in emergency situations
- [ ] Adults with mental illness (particularly if detained under Mental Health Legislation)
- [ ] Prisoners
- [ ] Young Offenders
Healthy Volunteers (where procedures may be adverse or invasive)
Those who could be considered to have a particularly dependent relationship with the investigator, e.g. those in care homes, medical students
Other vulnerable groups
XX None of the above

*If you are researching with children please provide details of completed relevant safeguarding training.

If any of the above applies, please justify their inclusion in this research.

I am looking to recruit two groups of healthy participants and do not consider the procedures to be adverse or invasive.

Please explain how you will determine your sample size/recruitment strategy, and identify, approach and recruit your participants. Please explain arrangements made for participants who may not adequately understand verbal explanations or written information in English

In this section, you should explain the rationale for your sample size and describe how you will identify and approach potential participants and recruit them to your study.

Sample size:
There will be 2 participant groups in this study:
1. 15 mental health clinicians
2. 10 - 15 individuals working at policy setting/organisational level

These sample sizes are based on recommendations by Trochim (1989), the curator of the concept mapping methodology. He suggests having between 10 and 20 participants to ensure a variety of opinion and ensure data saturation. I anticipate that it will be more challenging to recruit individuals who work at the organisational level given this is a smaller population. For this reason, the recruitment targets are smaller for this group. I aim to use the same participants for both elements of data collection. Trochim (1989) found that participants better understood the notion of concept mapping when they had taken part in all of the stages of the methodology. There is however flexibility for me to access new participants at the third stage if the individuals used to generate items are unavailable or unwilling to take further part in the study.

Recruitment strategy:
I will aim to recruit individuals who provide psychological therapy in Qatar (group 1) and those who have worked within mental health care services at the policy setting or organisational level (group 2). I will initially approach personal contacts and explain to them my recruitment aims. I will invite them to pass on my contact details to anyone they feel may be eligible to take part in the study (snowballing methodology; Biernachki & Waldorf, 1981). If an individual expresses interest in taking part, I will meet with them face-to-face or via telephone to discuss the study and give them the written information sheet. Potential participants will be asked to take a minimum period of 24 hours in which to consider taking part. After this, I will collect written consent for those participants still wishing to take part in the study.

After approaching initial contacts I will ask them to pass on my details and a flyer about my study to others they feel may be eligible to take part.

Inclusion criteria:
Adequate understanding of English (verbal and reading) to allow them to
undertake the task.

Purposive sampling favouring inclusion of people from the following groups:
Group 1 – e.g. providers of psychological therapy to people living in Qatar
Group 2 – e.g. those working at a managerial level, which involves having input to policy around mental health; those providing consultation to organisations in Qatar that run mental health services.

What are your arrangements for obtaining informed consent whether written, verbal or other? (where applicable, copies of participant information sheets and consent forms should be provided)

Consent. After face-to-face, telephone or email contact has been made with potential participants, they will be given or sent a copy of the Participant Information sheet and the consent form (see attachments). At the start of the appointment two copies of the consent form will be signed, with the participant retaining a copy.

What arrangements are in place for participants to withdraw from the study?
Participants will be informed that they are free to withdraw at any time from the study, without giving a reason and without consequence.

If the research generates personal data, please describe the arrangements for maintaining anonymity and confidentiality (or the reasons for not doing so)

Given the type of analysis undertaken, it is not expected that any reported data will be personally identifiable. Consent forms and participant demographic CRF’s will be kept in a locked filing cabinet on UWE premises for six years after the end of the study. During the study, any confidential information will be kept in a locked filing cabinet in HMC’s Medical Research Centre.

Please describe how you will store data collected in the course of your research and maintain data Security and protection.

All data collected during the study will be anonymised. Each case record form (CRF) and interview transcript will be identified through a participant number with all the data about the person being linked to that number rather than to a personal identifier. A list of participant identification numbers and participant names will be kept separately to the other data collected during the study in a password-protected file, and will not be accessed by anyone else. All data collected as part of this study will be kept securely for a period of six years after the end of the study after which time it will be destroyed.

What risks (eg physical, psychological, social, legal or economic), if any, do the participants face in taking part in this research and how will you AddRESs these risks?

There could be a small risk of psychological harm due to the personal nature of the research topic. These risks are anticipated to be minor and unlikely.

Are there any potential risks to researchers and any other people impacted by this study as a consequence of undertaking this Research that are greater than those encountered in normal day to day life?

Describe any health and safety issues including risks and dangers for both the participants and yourself (if appropriate) and what you will do about them. This might include, for instance, arrangements to ensure that a supervisor or co-researcher has details of your whereabout and a means of contacting you when you conduct interviews away from your base; or ensuring that a ‘chaperone’ is available if necessary for one-to-one interviews.

Please check to confirm you have carried out a risk assessment for your research x

There are no particular risks anticipated, other than the potential to become upset by a particular question. This is deemed unlikely, and sources of support will be available.
Risk to researcher carrying out one-to-one interviews away from own base. Please see completed risk assessment.

How will the results of the research be reported and disseminated?
*Please indicate in which forms and formats the results of the research will be communicated.*

(Select all that apply)
- ☒ Peer reviewed journal
- ☒ Conference presentation
- ☐ Dissertation/Thesis

12. WILL YOUR RESEARCH BE TAKING PLACE OVERSEAS?

This project aims to recruit participants who have had experience of working in, or providing consultation to health care services in Qatar. All participants will have sufficient verbal and written English to allow participation, as this is an inclusion criterion in the study. We do not anticipate there to be any cultural, legal or political issues.

Data protection will be handled in the same manner it would in the UK, following the principles of GCP. When anonymised data is sent between Qatar and supervisors in the UK, we will use our UWE email addresses, which are considered secure.

I will be adhering to UWE’s code of conduct covering research, which will mean I am covered by UWE indemnity insurance.

I will be seeking ethical approval or a ‘letter of no objection’ from HMC’s Medical Research Centre in Qatar. I am in consultation with the MRC and await their guidance on this.

13. Are there any other ethical issues that have not been addressed which you would wish to bring to the attention of the Faculty and/or University Research Ethics Committee?

*This gives the researcher the opportunity to raise any other ethical issues considered in planning the research or which the researcher feels need raising with the Committee.*

No.

**CHECKLIST**

**Please complete before submitting the form**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
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<tbody>
<tr>
<td>Is a copy of the research proposal attached?</td>
<td></td>
</tr>
<tr>
<td>Have you explained how you will select the participants?</td>
<td></td>
</tr>
<tr>
<td>Is a participant information sheet attached?</td>
<td></td>
</tr>
<tr>
<td>Is a participant consent form attached?</td>
<td></td>
</tr>
<tr>
<td>Is a copy of your questionnaire/topic guide attached?</td>
<td></td>
</tr>
<tr>
<td>Have you described the ethical issues related to the well-being of</td>
<td></td>
</tr>
</tbody>
</table>
participants?

Have you described fully how you will maintain confidentiality?

Have you included details of data protection including data storage?

Where applicable, is evidence of a current DBS (formerly CRB) check attached? 

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
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</table>

Is a Risk Assessment form attached? (HAS only)

<p>| | |</p>
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</table>

Have you considered health and safety issues for the participants and researchers?

<p>| | |</p>
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<th></th>
<th></th>
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</thead>
</table>

---

DECLARATION

The information contained in this application, including any accompanying information, is to the best of my knowledge, complete and correct. I have attempted to identify all risks related to the research that may arise in conducting this research and acknowledge my obligations and the right of the participants.

<table>
<thead>
<tr>
<th>Principal Investigator name</th>
<th>Ellie Brown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supervisor or module leader name (where appropriate)</th>
<th>Prof Richard Cheston</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>

The signed form should be submitted electronically to Committee Services: researchethics@uwe.ac.uk and email copied to the Supervisor/Director of Studies where applicable together with all supporting documentation (research proposal, participant information sheet, consent form etc).

For student applications where an electronic signature is not available from the Supervisor we will require an email from the Supervisor confirming support.

Please provide all the information requested and justify where appropriate.

For further guidance, please see http://www1.uwe.ac.uk/research/researchethics (applicants’ information)
Appendix 2: Ethics approval from UWE UREC

Dear Ellie

Application title: What are the facilitators and barriers to accessing psychological therapies in developing health systems: A concept mapping study.

Your ethics application was considered by the Faculty Research Ethics Committee and, based on the information provided, has been given ethical approval to proceed.

You must notify the committee in advance if you wish to make any significant amendments to the original application using the amendment form at http://www1.uwe.ac.uk/research/researchethics/applyingforapproval.aspx

Please note that any information sheets and consent forms should have the UWE logo. Further guidance is available on the web: http://www1.uwe.ac.uk/aboutus/departmentsandservices/professionalservices/marketingandcommunications/resources.aspx

The following standard conditions also apply to all research given ethical approval by a UWE Research Ethics Committee:

1. You must notify the relevant UWE Research Ethics Committee in advance if you wish to make significant amendments to the original application: these include any changes to the study protocol which have an ethical dimension. Please note that any changes approved by an external research ethics committee must also be communicated to the relevant UWE committee.
2. You must notify the University Research Ethics Committee if you terminate your research before completion;

UWE REC REF No: HAS/16/03/120
31st March 2016

UWE REC REF No: HAS/16/03/120
31st March 2016
3. You must notify the University Research Ethics Committee if there are any serious events or developments in the research that have an ethical dimension.

Please note: The UREC is required to monitor and audit the ethical conduct of research involving human participants, data and tissue conducted by academic staff, students and researchers. Your project may be selected for audit from the research projects submitted to and approved by the UREC and its committees.

Please remember to populate the HAS Research Governance Record with your ethics outcome.

We wish you well with your research.

Yours sincerely

[Signature]

Dr Julie Woodley
Chair
Faculty Research Ethics Committee

c.c. Prof Rik Cheston
Appendix 3: Ethics application to HMC’s MRC

Initial Application for Clinical Research Form
Medical Research Center, HMC Doha-Qatar

Form used to obtain approval to conduct research and if required to submit a complete and comprehensive application for IRB review and approval to initiate research.

Application Forms must be submitted electronically. DO NOT PDF OR SCAN FORMS FOR SUBMISSION. Save, Rename & Submit

Rename the file with form name, a reference & version date i.e. New_Protocol_05Study_07Jun15 i.e. ICF_QoStudy_07Jul15

The MRC or the IRB, as appropriate, will issue a study # after submission has been received

Form Completion Instructions: Only shaded areas can be edited. These appear on the electronic form as shaded but not when printed. Where indicated, TICK BOXES to indicate an affirmative answer. TEXT FIELDS are blank and appear indicated: TICK BOXES to indicate an affirmative answer.

TEXT FIELDS are blank and appear indicated; DROP DOWN MENUS are blank and appear indicated. Where appropriate, use curser to “choose” highlight area, use mouse & click left-side button to open and make selection. Date format is d/mmm/yy. Ensure responses are provided for ALL FIELDS.

Date Form Completed: 12-May-16

Planned Start Date*: 12-May-16
Planned Enrollment End Date*: 12-Dec-16
Planned Study End Date*: 12-Jan-17

Section 1.0 Study Information

A. Research Summary
Please provide a response for ALL that apply below

Is the Proposed Study Original Research? (Generating NEW data or source data that is NOT PRE-EXISTING) ☐ Yes ☐ No

Type PhD Dissertation / Research ☐ Yes ☐ No

Protocol Title
What are the barriers to accessing psychological therapy in Qatar: A concept mapping study

Principal Investigator* Prof Annie Topping

Contact Information Phone 66643073 Email ATopping@hamad.qa

Mailing Address

Sponsored? None Provide Detail:
Funded? No Provide Detail:

*To Declare Roles & Responsibilities for this Research Study, refer to the MRC’s ‘Scheme of Delegation List’ and submit with this application

B. Research Abstract
In the shaded area below, give a VERY BRIEF SUMMARY of the proposed research. DO NOT cut & paste aims, literature review, histories or background as to why the research is being conducted. DO NOT provide academic theory from a funding application or PhD dissertation. Leave at this content for the appropriate protocol section, in your attached PROTOCOL (Refer to the Protocol Template).

Describe WHAT the research question is, WHAT procedures are being done to answer that question & WHO it is doing it to, in 10 sentences or less.

Summarize the primary research objective including the planned enrollment, very basic INCLUSION CRITERIA, procedures, anticipated risks and safety concerns, and projected outcome(s) or if it is merely a data review (no enrolment of human beings).

Our study is organised by researchers at the University of the West of England as part of a professional doctorate in counselling psychology. The aim of the study is to find out what people think the barriers are to accessing psychological therapies in Qatar.

The World Health Organisation (WHO) reports that 25% of the global population will experience a mental health disorder at some point in their lives. Psychological treatment is an established part of mental health care in countries with developed health systems. In other countries mental health services are less well developed. Qatar in the Middle East is one such country where they are committed to developing services, having recently adopted a national mental health strategy. The implementation of this plan is still in its infancy so we are well placed to investigate what key the barriers to accessing psychological therapy in Qatar might be. This understanding should aid successful development of mental health services in the country.

In this study we aim to investigate what the barriers to accessing psychological therapies in Qatar are. We will achieve this by using a methodology known as concept mapping to compare and collate the views of two major stakeholder groups; those working at the policy and organizational level and those who work at the clinical level (privately and government employed).
Initial Application for Clinical Research Form
Medical Research Center, HMC Doha-Qatar

Form used to obtain approval to conduct research and if required to submit a complete and comprehensive application for IRB review and approval to initiate research.

Application Forms must be submitted electronically. DO NOT PDF OR SCAN FORMS FOR SUBMISSION. Save, Rename & Submit. Rename the file with form name, a reference & version date (i.e. New_Protocolo_IQStudy_07Jul15 i.e. ICF_IQStudy_07Jul15)

The MRC or the IRB, as appropriate, will issue a study # after submission has been received.

Form Completion Instructions:

- Only shaded areas may be edited. These appear on the electronic form as shaded but not when printed. Where indicated: TICK BOXES to indicate an affirmative answer. TEXT FIELDS are blank and appear shaded to fill out, type in response. There is a character max limit including text fields. Do not exceed character max limit.
- DROP DOWN MENUS- use cursor to “choose” highlight area, use mouse & click left-side button to open and make selection. Date format is d/mm/yy. Ensure responses are provided for ALL FIELDS.
- PROVIDE RESPONSE FOR ALL THAT APPLY BELOW: * Give the best estimate for the following
- * To Declare Rules & Responsibilities for this Research Study, Refer to the MRC's 'Scheme of Delegation List' and submit with this application.
- * Give the best estimate for the following

Section 1.0 Study Information

A. Research Summary

- Is the Proposed Study Original Research? (Generating NEW data or source data that is NOT PRE-EXISTING?)
  - [ ] Yes
  - [x] No

Type PhD Dissertation / Research Phase NA If Other:

- MRC Study # Pending
- Protocol Title
- 580 Character Limit
- What are the barriers to accessing psychological therapy in Qatar: A concept mapping study
- Principal Investigator
- Prof Annie Topping
- 200 Character Limit
- Contact Information
- Phone 66643073
- Email ATopping@hamad.qa
- Mailing Address
- 100 Character Limit
- Sponsored? None
- Provide Detail
- Funded? No
- Provide Detail

B. Research Abstract

In the shaded area below, give a VERY BRIEF SUMMARY of the proposed research. DO NOT cut & paste aims, literature review, histories or background as to why the research is being conducted. DO NOT provide academic theory from a funding application or PhD dissertation. Leave all this content for the appropriate protocol section, in your attached PROTOCOL (Refer to the Protocol Template).

Describe WHAT the research question is, WHAT procedures are being done to answer that question & WHO it is doing it to, in 10 sentences or less. Summarize the primary research objective including the planned enrollment, very basic INCLUSION CRITERIA, procedures, anticipated risks and safety concerns, and projected outcome(s) if it is merely a data review (no enrollment of human beings). Our study is organised by researchers at the University of the West of England as part of a professional doctorate in counselling psychology. The aim of the study is to find out what people think the barriers are to accessing psychological therapies in Qatar.

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Initial Application for Clinical Research Form

2. If recruiting subjects, provide the quantity of individuals that will be screened in order to identify ELIGIBILITY FOR INCLUSION in the research and the quantity that will need to be ENROLLED AS PARTICIPANTS in the research below.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>HMC Planned Screening #</th>
<th>HMC Planned Enrollment #</th>
</tr>
</thead>
<tbody>
<tr>
<td>England, UK</td>
<td>10</td>
<td>7</td>
</tr>
</tbody>
</table>

☐ Tick if subjects will be ENROLLED into the research, BUT the research IS NOT doing anything physical to the subject. For example, there are no clinical interventions; no specimens are being collected specifically for research purposes. (This DOES NOT include the use of aliquots of bio-specimens that have been collected as part of clinical diagnosis, treatment or for diagnostic testing)

3. Will Subjects be SCREENED prior to enrollment as participants in the research? *Checking for Eligibility* ☐ Yes ☐ No

☐ If YES above, describe below HOW participants will be SCREENED PRIOR TO ENROLLMENT into the research study?

Potential participants will be asked if they meet eligibility criteria, i.e. can they read and write English fluently and do they either provide psychological therapy or had input into policy around psychological therapy provision.

4. How long AFTER APPROVAL to commence research will subject screening and/or enrollment begin?

<table>
<thead>
<tr>
<th>Duration of Participation</th>
<th>For the duration of the interview</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>*If space needed, complete an addendum and include in the ‘Attachment Summary Form’ with this application</td>
</tr>
</tbody>
</table>

5. Intended Study End Date

<table>
<thead>
<tr>
<th>Site PI</th>
<th>Email</th>
<th>SCH Assurance#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ellie Brown</td>
<td><a href="mailto:elliebrown@gmail.com">elliebrown@gmail.com</a></td>
<td>Faculty Research Ethics Committee</td>
</tr>
</tbody>
</table>

Total Planned across ALL SITES Enrollment# 30
Total Planned at HMC Enrollment# 7

B. External Collaborators & Multi-Site Studies (may continue on next page)

1. Is the research a multi-site study or involve collaboration with an EXTERNAL investigator or institution? ☐ Yes ☐ No

2. If subjects are being recruited at sites other than HMC or the research is a multi-center international study, provide the TOTAL quantity of individuals that will be ENROLLED AS PARTICIPANTS in the research below.

Total Planned at HMC Enrollment# 7

3. Does the proposed research ALREADY HAVE approval letter(s) from collaborator institutions? ☐ Yes ☐ No ☐ NA

☐ If YES to Above, include copies of the relevant compliance letters with this application.

4. Provide details for EACH external collaborator in the table below

*If more space is needed, complete an addendum and include in the ‘Attachment Summary Form’ with this application

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Site PI</th>
<th>Email</th>
<th>SCH Assurance#</th>
<th>Project Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of the West of England, UK</td>
<td>Ellie Brown</td>
<td><a href="mailto:elliebrown@gmail.com">elliebrown@gmail.com</a></td>
<td>Faculty Research Ethics Committee</td>
<td>Data analysis</td>
</tr>
</tbody>
</table>

C. Participant Risk Profile

1. Will individuals that can be identified as a member of any of the vulnerable populations listed below be enrolled in the research study? *If YES to Above*

☐ Newborns/Infants
☐ Children
☐ Cognitively Impaired
☐ Disabled
☐ Economically Disadvantaged
☐ Pregnant Women/ Fetuses
☐ Prisoners
☐ HMC Employees
☐ Other 30 Character Limit

☐ If Yes, Tick All That Apply Below

☐ If NO, Tick All That Apply Below

☐ If YES to Above, Refer to the MRC for Translation Services; List ALL Languages Below

2. Are NON-ENGLISH® resources & informed consent utilized by the site in the conduction of the study? ☐ Yes ☐ No

☐ *If YES to Above, complete the following:

3. How people will be NOTIFIED OR APPROACHED to consider being a research subject in this study?

☐ NA

☐ Doctor Referral(s)
☐ Posters/roll-ups(s)
☐ Handouts(s)
☐ Ads
☐ Direct - In Clinic/Hospital(s)
☐ Researcher's/PI's Patient Pool
☐ Other 30 Character Limit

☐ Through word of mouth, contacts of contacts (snowballing method)

☐ NA

☐ Other

☐ NA

☐ NA

4. Describe the CONSENT PROCESS procedures (When, Where, How, by Whom) below.

☐ NA

5. Describe HOW LONG potential participants will have to decide on participation below.

☑ Participants will have at least 24 hours to decide. They will have until recruitment finishes to decide (i.e. approximately 3 months)
Initial Application for Clinical Research Form

6. Describe how subjects will be SCREENED FOR ELIGIBILITY for the study below.
   | Yes | No | NA |
--- | --- | --- | ---
Potential participants will be asked if they meet eligibility criteria, i.e. can they read and write English fluently and do they either provide psychological therapy or had input into policy around psychological therapy provision.

7. Describe how subjects will be ENROLLED into the research study below.
   | Yes | No | NA |
--- | --- | --- | ---
Participants will be asked to complete a consent form and participant demographics form.

8. If participants withdraw their consent from study participation indicate what happens to their data?
   | Yes | No | NA |
--- | --- | --- | ---
If OTHER is marked, be sure to specify details below & in the protocol.

9. If participants withdraw their consent from study participation indicate what happens to their specimens?
   | Yes | No | NA |
--- | --- | --- | ---
If OTHER is marked, be sure to specify details below & in the protocol.

Section 4.0 Risk Assessments (may continue on next page)

A. Safety - Risk Ratio & Oversight
1. Do research activities present LITTLE or NO RISK of harm to the research participants?
   | Yes | No | NA |
--- | --- | --- | ---

2. Do anticipated adverse events or risk of harm expected as a result of taking part in the proposed research EXCEED the types of risk that a person NOT participating in the research could reasonably expect or experience in daily life or in the receipt of clinical care?
   | Yes | No | NA |
--- | --- | --- | ---

3. If the proposed research is reporting to multiple IRBs for this study, does EACH IRB have a valid assurance filed with the Supreme Council of Health (SCH)?
   | Yes | No |
--- | --- |
If NO, Provide Details Below 300 Character Limit

4. Have any of the researchers ever been suspended/removed from any research activities in the past?
   | Yes | No | NA |
--- | --- | --- | ---
*If Yes, Refer to the MRC for current policy.

B. If YES to the use of Medical Procedure(s) (may continue on next page) | NA |
--- |
Tick All That Apply Below: If Other is Checked, Include Detail in Shaded Fields:

- Clinical Controls/Placebo/Blinding
- Clinical/ Surgical Procedures
- Emergency Response
- Experimental Drug(s)
- Experimental Treatment(s)
- Biopsy
- Bio-specimen Collection
- Clinical Interviews/ Assessments
- Diagnostic Testing
- X-Ray/MRI
- Det or Vitamin Supplements
- Environmental Controls (Temperature, Sleep, Food, etc)
- Other

1. Indicate below what medical intervention(s) will be performed ON the subject for the sole purpose of the proposed research.
   | Yes | No | NA |
--- | --- | --- | ---

2. Provide details below for the procedures indicated above, a brief description of WHAT specific drug or treatment the subject will be required to take and WHY specific medical procedures will be done to them for the proposed research.
   | 500 Character Limit |
--- |

C. If YES to the use of Specimens & the Collection of Bio-specimens | NA |
--- |
Tick All That Apply Below: If Other is Checked, Include Detail in Shaded Fields:

- Blood/Plasma
- Bone Marrow
- Amniotic Fluid/ Fetal Tissue
- Tissue/Skin
- DNA/RNA-Other
- Tumor
- Surgical Biopsy-Other
- Saliva
- Urine/Stool
- Other

1. Indicate below WHAT bio-specimens are being collected FROM the subject for the sole purpose of the proposed research.

2. Provide details below for the specimens indicated above, a very brief description of WHY the specimens will be collected and HOW they will be used. For example, to extract DNA or RNA, to identify biomarkers for disease, diagnosis, genetic tests, etc.

D. If YES to the use of collection of Personal Identifiable Information in the Research | NA |
--- |
1. Describe below WHAT identifiable information is being collected, and WHY it needs to be used and stored for research.

E. If YES to the use of Registries, Medical Records/Charts, Patient Files or Hospital Databases | NA |
--- |
1. Describe below WHICH specific resources will be used to collect information for the purpose of the proposed research.

2. Describe below HOW you have ACCESS & PERMISSION to use the resources for the purpose of the proposed research.

3. Describe below WHY the information is being collected from these resources for the purpose of the proposed research.
Initial Application for Clinical Research Form

4. Describe below WHAT information is being collected from these resources for the purpose of the proposed research.

F. If YES to the use of Questionnaires, Surveys, Interviews or Scripts

1. Indicate below HOW information is being obtained FROM the subject for the sole purpose of the proposed research. NA

   Tick All That Apply Below

   [☐] Questionnaire/Survey  [☐] Interviews/Scripts  [☐] Group Discussions/Scripts  [☐] Online Survey  [☐] Other

   Provide details in shaded field below details for EACH ticked above, HOW these will be administered to the subjects.

G. If YES to the use of Coding and/or De-identification of Identifiable Information

1. Describe below specifically HOW the data will be coded or de-identified for the sole purpose of the proposed research.

H. Data Management & Control

   All Shaded Fields Below have a 200 Character Limit unless otherwise specified

1. Indicate below HOW study data will be collected for the proposed research.

   Tick All That Apply Below

   [☐] Study Forms  [☐] Study Database  [☐] Study Web-Based/App  [☐] Other

   Provide a COPY of the questionnaires, surveys, etc with this submission.

2. Describe below WHERE and HOW the study data is physically stored. Transcribed interviews will be stored on a password protected computer. Consent forms will be stored in locked cabinet

3. Describe below WHO controls access to the study data.

   Elite Brown - PhD student and researcher

4. Describe below WHO has access to the study data.

   Prof Annie Topping

5. Describe below HOW the study data is accessed.

   Password to open files on computer

6. Will subject identifiers be shared outside of HMC? If YES describe below WHO the study data is shared.

   Yes [☐] No [☐]

7. Will the study data be transferred or shared outside of HMC? If YES describe below HOW this will happen.

   Anonymised data will be shared with supervisors at the University of West of England via secure password to open files on computer

I. Data Monitoring

1. Below provide details of WHO and HOW subject safety/ risk issues will be reviewed & evaluated

   Risk assessment undertaken as part of University of the West of England ethics submission

   For example, usually referred to as a safety monitoring plan, includes oversight for the review of subject safety and other outcomes that could require changes to the protocol to ensure the safety of the participants continuing in the research (DOES NOT include IRB oversight)

   500 Character Limit

   30 Character Limit Per Entry

   As needed

   Yes [☐] No [☐]

   No [☐]

   Section 5.0 Research & Document Summary

A. Study Snapshot

   Below Check a Box for ALL That Apply to the Proposed Research

   [☐] Subjects Receiving Investigational Drug/Treatment  [☐] Randomizing  [☐] Blinded

   [☐] Subjects Receiving Treatment/ Intervention as part of Clinical Care

   [☐] Bio-specimen Collection/Analysis/Storage  [☐] Comparative Research (Monitoring Standard of Care/ Outcomes)

   [☐] Behavioral/ Educational Intervention(s)

   [☐] Data Coordinating Activities Only (Data Accrual/ Cleaning/ Analysis/ Publication preparation)

   [☐] Other (Summarize below 200 character limit)

B. Research Document Summary

   Below Check a Box for ALL That Apply to THIS Research & provide a COPY of EACH with the Submission

   [☐] Protocol  [☐] Focus Group(s)  [☐] Advertisement(s)

   [☐] Informed Consent Form - ICF(s)  [☐] Interview(s)  [☐] Brochure(s)

   [☐] Case Report Form - CRF(s)  [☐] Patient Diary  [☐] Handout(s)

   [☐] Data Collection Sheet(s)  [☐] Questionnaire(s)  [☐] Poster/Roll Up(s)

   [☐] Other  [☐] Other
Initial Application for Clinical Research Form

- Investigator’s Brochure (IB)
- Survey(s)
- Referral(s)
- Other
- Packet Inserts (Drugs/Devices)
- Script(s)
- Other

Tick to indicate that an ‘Attachment Summary Form’ is attached to this application. List must be organized in a manner conducive to review & the electronic files named to support identification of a file without having to open the file.

Section 6.0 Principal Investigator (PI) Authorization

- Electronic Declaration: By ticking box applicant indicates there is evidence on file of review & approval by PI. The MRC or HMC may request documentation at anytime without notice, failure to provide may result in closure/suspension of research.
- Tick box if ANYONE involved in the proposed research is a member of RSAC for this research proposal
- Tick box if ANYONE involved in the proposed research is a member of the IRB of record for this research proposal
- Tick box if the MRC’s ‘Conflict of Interest Form’ has been completed

Tick to Indicate Form Completed by
Name: Prof Annie Topping
Phone: 66643073
Email: ATopping@hamad.qa
Appendix 4: Approval from HMC’s MRC

Ref No.: MRC1341/2016
Date: 06 November, 2016

Prof. Anne Elizabeth Topping
Assistant Executive Director of Nursing (CF)
Nursing Research

Dear Prof. Anne,

Research Protocol 16039/16: "What are the facilitators and barriers to accessing psychological therapies in developing health systems: A concept mapping study?"

The above titled Research Proposal submitted to the Medical Research Center has been approved to be conducted in HMC provided that the continuing approval from the Institutional Review Board (IRB) is renewed as per the committee terms. The Research Center has acknowledged the IRB approval letter dated 31 October, 2016-30 October, 2017.

This research study should be conducted in full accordance with all the applicable sections of the Rules and Regulations for Research at HMC and you should notify the Medical Research Center immediately of any proposed changes in study conduct that may affect the resource utilization at HMC. It is the Principal Investigator's responsibility to obtain review and continued approval if there is any modification to the approved protocol.

A study progress report should be submitted bi-annually and a final report upon study's completion.

We wish you all success and await the results in due course.

Yours sincerely,

Prof. Ibrahim Al Janahi
Executive Director of Research
Medical Research Center

Cc:
1. Ellie Brown (Principal Investigator)
Appendix 5: Research protocol

What are the barriers to accessing psychological therapies in Qatar: A concept mapping study

Study protocol – Version 1 27.01.16

Background and theoretical framework

Current evidence for the treatment of mental health problems in developed health systems
The World Health Organisation (WHO) reports that 25% of the global population will experience a mental health disorder at some point in their lives (WHO Atlas, 2014). For example, Kessler et al (2005) reported that 46.4% of Americans will meet the criteria of a DSM-IV disorder during their lifetime. Specifically, the lifetime prevalence of major depressive disorder (MDD) was reported as 20.8% and anxiety disorders as 28.8%. Mental illness is deadly; being responsible for approximately 28% of disease morbidity worldwide, compared to 6% being caused by cardiovascular diseases (Vos et al, 2010). Leaving mental health problems untreated is also expensive. It can cost a developed country up to 4% of GDP in lost productivity and disability (OECD, 2012). Treatment of MDD involves pharmacological or psychological interventions, or a combination of both (NICE, 2009, Pilling et al, 2011).

To address the needs of this population, developed health systems have attempted to role out evidence-based psychological interventions on a large scale. An example of this is the Improving Access to Psychological Therapies (IAPT) program in England. The aim is to provide short-term, stepped care psychological therapy (predominantly cognitive behavioural therapy (CBT)) to a large number of clients with the premise that this service will essentially pay for itself (Layard & Clark, 2014). Recent increases in the provision of CBT for depression has also occurred in Australia (The Better Access Initiative, e.g. Pirkis et al, 2011) and Japan (Ono et al, 2011). Also worth noting is that academics from outside the UK have acknowledged they could learn from the IAPT program to develop their own provision of psychotherapeutic treatments in countries such as America (Sudak, 2015). Improving the access to psychological therapy globally is therefore an area of priority for health systems. Despite IAPT’s perceived success (Clark et al, 2009; Layard & Clark, 2014), criticisms remain and in developed countries there are still significant barriers to accessing psychological treatment.

Barriers to accessing treatment for mental health problems in developed countries
One barrier at the systemic level is the limited availability of specialist mental health services. For example, the studies which ‘prove’ the IAPT programme works involved
therapists who are highly qualified. In reality, the number of these therapists in resource rich countries is still not sufficient and in low-resource countries, they barely exist at all (Fairburn & Patel, 2014). Fairburn and Patel argue that the current model of training therapists is not scalable to the populations requiring treatment. Another systemic factor limiting access to psychological therapy in some developed countries such as the USA is the emphasis on pharmacotherapy in primary care guidelines (Collins et al, 2004). The relationship between primary care and mental health services can also serve as a barrier given the gatekeeping role GPs often play. Practitioners that lack an understanding of evidence-based treatment for mental health problems can result in access being delayed or prevented (Collins et al, 2004; Kendrick et al, 1996)

Other barriers exist at the individual level. These include a desire to handle the problem on one's own and a lack of awareness of available treatment (Christiana et al, 2000). Perceived severity also plays a part in whether a client engages in treatment, as do the consequences and controllability of symptoms (Brown et al, 2001). Bell et al (2011) found the most frequent reason that an individual did not disclose symptoms of depression to their GP was a concern that they would be prescribed antidepressants.

**Treatment for mental health problems in developing health systems**

Many countries can be considered to have a ‘developing’ health system. This includes countries in Africa, Asia and the Middle East; the latter being the focus in the current study. Treatment options in developing countries can be limited and the chance of accessing specialist treatment small due to a lack of qualified professionals. Patel et al (2004) reported that in most developing countries there is, at best, one psychiatrist and one mental health nurse per 100,000 population, with the number of psychologists being even smaller. In contrast, developed EU countries such as the UK have an average of 13 psychiatrists, 52 mental health nurses and 4 psychologists per 100,000 population (WHO, 2008).

There is a paucity of research about the mental health needs of the GCC (Gulf Corporation Council) populations (Okasha et al, 2012; Takriki et al, 2005). That said, Karam et al (2006) reported that the prevalence of mental illness in the Middle East is comparable to other parts of the world, however there are much lower rates of treatment received. Significantly, there is a lack of epidemiological baseline data, which makes it hard to plan for future service provision. Countries within the GCC have developing health care systems, often with sufficient funding available to plan and build new services. Despite these resources to develop services, we do not really know what the barriers to accessing psychological treatments might be in countries such as Qatar.

**Barriers to accessing treatment for mental health problems in developing countries**

Gearing et al (2013) carried out a systematic review of mental health studies completed in Middle East Arab countries. The authors aimed to identify barriers to implementing and adapting psychological interventions originally devised in developed health care systems. The most frequently reported barrier to effective implementation (in 17 out of 22 papers) was acceptability within the cultural context. This included beliefs/values, stigma, etiological differences and language barriers. Additionally, the etiology of mental illness can be understood differently in these cultures, often being attributed to ‘God’s willing’ or evil spirits. I will elaborate on some of these barriers below.

**Beliefs and values**
In Muslim countries there can be a reliance on religious authority figures who take the place of using specialist services that may be perceived as ‘westernized’ (Al-Krenawi et al, 2004; El-Islam, 2005; Loewenthal et al, 2001). Al-Krenawi & Graham (2000) suggested that the Arabic population can view psychiatrists, nurses, psychologists and other mental health professionals as a single unit that discards religious values. They also reported that staff can also be viewed as lacking genuineness and empathy, and being difficult to establish trust with. One suggestion for overcoming this barrier is to educate the traditional healers themselves about the nature of psychiatric symptoms and the process of appropriate referrals to specialist care (El-Islam, 2005).

**Stigma**

Stigma remains an issue worldwide, with 55% of mental health promotion and prevention programmes being aimed at combating stigma (WHO Atlas, 2014). It can play a large part in preventing individuals seeking help (e.g. Barney et al, 2006). Cultural and societal differences exist because what is considered acceptable in one culture may be considered unacceptable and open to stigmatization in another (Gearing et al, 2013). Specific examples in Arab countries include a perceived risk of damage to their family’s reputation and social status (Shalhoub-Kevorkian, 2005) and a view that females might impair their marriage potential (Al-Krenawi & Graham, 1999; Shalhoub-Kevorkian, 2005).

**Shortage of human resources**

Another challenge to effectively implementing psychological treatment in developing health systems is having an appropriately qualified work force. One problem found in developing countries is the migration of appropriately trained staff to countries providing higher incomes (Pond and McPake, 2006). Additionally, Al-Krenawi & Graham (1999) reported that a language barrier between the service user and the professional inhibited effective communication, a finding not limited to developing health care settings (Flores, 2006).

Bhui et al (2007) used their systematic review of cultural competence teaching models to highlight the need to consider the differences between staff members and service users and the impact this can have on the quality of mental health care. However, all studies included in their review were undertaken in North America so the need for ‘cultural competence’ training for staff working in a country such as Qatar remains unknown.

**Current provision in Qatar**

Healthcare for residents is predominantly provided by Hamad Medical Corporation (HMC), the principle public provider for Qatar. Other options for expatriates as well as for Qataris include private hospitals and clinics but mental health services here are limited to outpatients, usually provided solely by Psychiatrists. Counselling services are also available at international schools and Universities in the country. There are some therapists that work privately from their own homes with referrals being made informally by ‘word of mouth’ and not overseen by the State.

**Qatar’s population**

Global migration is prominent in Middle Eastern/GCC countries where rapid urbanization requires a work force that the countries’ population alone cannot support (Mirkin, 2004). This means that the population of Qatar has changed substantially in the last 35 years. It has quadrupled in the last 12 years to around 2.2million, with 87% of the population being non-Qatari nationals in 2010 (Mirkin, 2010). The demographic population of the Arab region is therefore mixed and complex but dominated (56%) by
individuals from the Asian subcontinent (India, Nepal, Sri Lanka, Pakistan and Bangladesh). The rest of the expatriate population typically consists of those from other Arab nations (e.g. those from Egypt, Jordan, Iran and Lebanon together totals 10% of the population) and then smaller numbers (1%) of individuals from ‘western’ countries such as the UK, USA and Canada. This culturally and racially diverse population can make working in Qatar a challenge especially as little is known about which populations currently accesses mental health services. The country is small and most of the population live in Doha, the capital city.

The prevalence of depression within the majority of the Asian population (i.e. single male labourers) has recently been looked at in the UAE. Al-Maskari et al (2011) found that 25.1% of their participants met the cut off score for depression. This is considerably higher than the global point prevalence of depression which is thought to be around 4.5% (Ferrari et al, 2013).

**Aims**

In this study I aim to investigate what the barriers to accessing psychological therapies in developing health systems are. I will achieve this by using a methodology known as concept mapping to compare and collate the views of two major stakeholder groups; those working at the policy and organisational level and those who work at the clinical level (privately and government employed).

**Methods**

Concept mapping is a mixed-methods technique that consists of two parts. In the first part of the process, participants are asked the question ‘what are the f barriers to accessing psychological therapy in Qatar?’ and are required to produce as many statements as possible that they feel answer this question. These statements are then compiled and form the basis of the second part of the process. The same participants are then invited to perform two individual tasks: 1 – ranking the importance of each statement (prioritising) and 2 – putting the statements that seem to go together in to groups (clustering). These results are then analysed using a specialist software package. This creates a concept map, which depicts the importance and relations of the statements as viewed by the participants. From this, I can draw conclusions about what factors impact on access to therapy.

**Participants and setting:**

There will be 2 participant groups in this study:

1. 15 mental health clinicians
2. 15 individuals working at policy setting/organisational level

In the first group I aim to recruit participants who have had experience of working with clients who were seeking psychological therapy in Qatar. I will use a purposive sampling method, using mainly the snowballing (chain referral sampling) technique to access individuals working privately and in health care services within Qatar. This involves approaching contacts who know therapists that may have been interested in taking part (Biernacki & Waldorf, 1981). For example, I am a member of the ‘Doha Profession Resource Group’ which comprises of over 40 therapists who work within a variety of settings across Qatar.
I will use the same methodology to recruit participants to group 2. These will be individuals who have had input into mental health services in Qatar at an organisational or policy level, for example providing consultancy to the development of the mental health strategy. I have a number of personal contacts who work or have worked within these roles who I will be able to approach about taking part in the project. Five have already been provisionally contacted, and all are willing to take part.

**Measures:**
Firstly, demographic information such as age, gender, ethnicity, qualifications, job, number of years in that job will be collected for both groups.

Secondly, qualitative interviews with each participant will explore answers to the question “What are the barriers to improving access to psychological therapy in developing health systems such as Qatar?” i.e. “What makes it hard for people to access therapy in countries with developing health systems” and “What would help people to access therapy in countries with developing health systems”.

**Procedures:**

**Recruitment of participants**
I aim to recruit individuals who provide psychological therapy in Qatar (group 1) and those who have worked within mental health care services at the policy setting or organisational level (group 2). I will initially approach personal contacts and explain to them my recruitment aims. I will invite them to pass on my contact details to anyone they feel may be eligible to take part in the study. If an individual expresses interest in taking part, I will meet with them face-to-face or via a telephone call to discuss the study and give them the written information sheet. Potential participants will be asked to take a minimum period of 24 hours in which to consider taking part. After this, I will collect written consent for those participants still wishing to take part in the study.

I will carry out the interview in a private room at a location to suit the individual such as their office on clinical premises or University campus. The interview will consist of filling out the demographic data and completing a taped dialogue lasting up to 45 minutes. The interview will then be transcribed with the participant’s responses being anonimised. At the end, I will ask participants if they are willing to take part in the second element of the study, the sorting and prioritising task. Contact details will be recorded separately if they agree.

After all the interviews have been completed, I will analyse the data thematically and generate a list of statements. I will contact the participants who agreed to take part in the second element and arrange a convenient time and place to meet and complete the task. If participants do not agree to take part this will not influence their involvement in the first part of the study.

The second part of the task consists of two elements a) participants independently organise the list of statements and sort them into piles based on perceived similarity (clustering) b) statements are sorted based on usefulness or relevance to answering the research question (prioritising). These groupings are recorded on anonimised case report forms, ready for inputting into the concept mapping software.

**Analysis:**
Concept mapping is a mixed-methods approach to data collection and analysis. It is a participatory method that creates a conceptual framework for help understand how a group views a particular topic or aspect of a topic. A concept map is a pictorial representation of a group’s thinking around a given topic, showing how different ideas are related to each other and which ideas are most important, relevant or appropriate.

Trochim (1989) defined the process of concept mapping as consisting of 6 stages:

1) Preparation – the planning of the research question and the participant group(s) to approach
2) Generation – interviewing of participants to elicit data that answers the primary research question. Answers analysed thematically to produce statements
3) Structuring – consists of two stages a) participants independently organise the list of statements and sort them into piles based on perceived similarity (clustering) b) statements are sorted based on usefulness or relevance to answering the research question (prioritising)
4) Representation – each participant’s sorted and rated data are entered into specialised computer software (ARIADNE). Quantitative summaries and visual representations (concept maps) of data are produced
5) Interpretation – qualitative analysis of the concept maps
6) Utilization – discuss findings and consider how they best inform the original research question

My analysis will begin with analysing the interview transcripts using thematic analysis (Braun & Clarke, 2006). The analytic strategy will seek to answer the initial research questions.

Analysis of the data collected in the third stage (Structuring) will be carried out using either Ariadne (Severens, 1995) or Concept Systems, Inc. software.

In both software packages, the 4th stage of analysis, ‘representation’ is the same. It comprises of two types of quantitative analysis; principal component analysis and cluster analysis. It positions the statements on a concept map (with a horizontal and vertical axis) where the distance between them represents how often participants have sorted them together into the same cluster. I can then identify common themes related to the statements and possibly labels the axes to represent the breadth of the theme that the statements lie on. Several concept maps are produced with between 2 and 18 clusters.

Stage 5 of the concept mapping technique (interpretation) allows the most meaningful cluster solution to be selected by the research team. Clusters are named based on their content, much like ‘themes’ in qualitative data analysis. A final stage involves considering the prioritizing data to establish the relative importance of each cluster. The data can be analysed with both participant groups combined but also separately with the two participant groups creating two, potentially different, concept maps. I will also be able to analyse the differences in the items mean scores (statements rated 4 or 5 (important)) using analysis of variance (ANOVA) in SPSS to look at the how the two different participant groups vary. From this, I will be able to draw conclusions about the similarities and differences in the two groups views.
References


Appendix 6: Recruitment flyer

Volunteers needed for a research project!

Are you a counsellor or therapist?

OR

Do you provide input in to the development of mental health services in Qatar?

If you are willing to take part in a short interview and a written task and would like to hear more, then please get in touch!

Email: ellierbrown@gmail.com
Phone: +974 3374 5602
Appendix 7: Participant information sheet

We would like to invite you to take part in our research study. Before you decide to take part, it is important for you to understand why we are doing this study.

Your participation in this study is entirely voluntary. Your medical care will not be affected in any way by deciding to take part or not. If you decide not to carry on with the study or want to withdraw then you will be able to do so and this will not affect you in anyway.

Why are we doing this research?

Our study is organised by researchers at the University of the West of England as part of a professional doctorate in counselling psychology. The aim of the study is to find out what people think the barriers are to accessing psychological therapies in Qatar.

The World Health Organisation (WHO) reports that 25% of the global population will experience a mental health disorder at some point in their lives. Psychological treatment is an established part of mental health care in countries with developed health systems. In other countries mental health services are less well developed. Qatar in the Middle East is one such country where they are committed to developing services, having recently adopted a ‘national mental health strategy’. The implementation of this plan is still in its infancy so we are well placed to investigate what key the barriers to accessing psychological therapy in Qatar might be. This understanding should aid successful development of mental health services in the country.

In this study I aim to investigate what the barriers to accessing psychological therapies in Qatar are. I will achieve this by using a methodology known as concept mapping to compare and collate the views of two major stakeholder groups; those working at the policy and organisational level and those who work at the clinical level (privately and government employed).

What would taking part involve?

The study initially involves undertaking an interview which lasts for approximately 30 minutes. This interview could also be completed over the telephone or the question answered via email. In the first part of the process, you will be asked the question ‘what are the barriers to accessing psychological therapy in Qatar?’ and asked to produce as many statements as possible that you feel answer this question. These statements are then compiled and form the basis of the second part of the process. If
you are willing to take part in the second part you will then be invited to perform two individual paper and pen tasks approximately two months later: 1 – ranking the importance of each statement (prioritising) and 2 – putting the statements that seem to go together in to groups (clustering). This should take no more than about 30 minutes.

What are the possible benefits of taking part?

You will be adding to scientific knowledge about accessing psychological therapies in countries with a developing health care system. Without volunteers like you research of this kind would not be possible. Your participation and contribution is, therefore, invaluable.

What are the possible disadvantages of taking part?

We do not feel that there are many disadvantages to taking part. If, for any reason, you feel distressed after taking part in the research then please let the researcher know and they will be able to help. You can also contact other members of the research team based in the UK whose details are at the bottom of this sheet.

Who will be informed of my participation?

If you decide to take part in the study, then all of the data from the study will be kept confidentially on a password protected computer with only the study team having access to the anonymised data. Your choice to participate or not will not affect your employment status; and your immediate supervisors/managers will not know your participation answers.

Who has funded this study?

This study is being completed as part of a self-funded professional doctorate in counselling psychology

Who has approved this study?

This study has been approved by the University Research Ethics Committee (UREC) at the University of the West of England and the HMC MRC IRB board in Qatar.

What will happen to my data?

All data collected during the study will be anonymised. This means that you will be given a participant number and all the data you provide will be linked to that number rather than to any information that could identify you such as your name, age or gender. A list linking your study number with your name will be kept by the researcher in a password-protected file, and will not be accessed by anyone else. All data collected as part of this study will be kept securely for a period of six years after the end of the study after which time it will be destroyed.

The results of this study will be published in peer-reviewed journals. You will not be able to be identified in any published results. If you decide you would like to be sent a copy of published papers, then please let the researcher know. We aim to recruit 30 participants in total; 15 clinicians and 15 policy makers; with a total of 12 working for HMC.

Further information

If you do decide to take part we will ask you to sign a consent form and we will give you a copy of this information sheet and the consent form to keep. If you undertake the interview over the telephone I will email the documents to you for you to sign and return to me before the interview takes place. If you decide to take part then you are
still free to withdraw from the study at any time. If you decide not to take part or would like to withdraw you do not have to give a reason for doing so.

If you would like to find out more information about the study, then please do get in touch with Ellie Brown (+974 3374 5602) or Prof Annie Topping (+974 6664 3073). If you work for HMC you can contact and you want to talk to someone outside the research team, please contact:

- HMC Medical Research Centre at 4439 2440 or irb@hamad.qa

What do I do now?

We will get in touch with you to arrange a time for you to take part in the research. We will make an appointment to meet in a location that is convenient for you. On arrival, a researcher will be on hand to answer any questions you may have about the study. If you are happy to take part, they will ask you to complete a consent form.

Contact information

**QATAR BASED RESEARCHER**

Ellie Brown  
P: [+974] 3374 5602  
E: elliebrown@gmail.com

**UNIVERSITY OF THE WEST OF ENGLAND**

Richard Cheston  
University of the West of England  
Bristol, BS16 1DD
Appendix 8: Consent form

CONSENT FORM

Participant code: ________________________________

Title of project: What are the barriers to accessing psychological therapies in Qatar: A concept mapping study

Names of researchers: Mrs Ellie Brown, Prof. Richard Cheston, Dr Nic Hooper, Prof Annie Topping

1. I confirm that I have read and understand the information sheet (version 2, dated 08.11.2016) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered to my satisfaction.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

3. I am aware that the results of the study may be presented in research reports, scientific conferences and/or journals. However, the information I provide for the study will remain confidential.

4. I agree for my data to be stored anonymously and that any published quotations or extracts from the research will maintain my confidentiality.

5. I understand that my contact details will be retained so that I can be updated about the outcome of the study.

6. I agree to take part in the above study.

Name of participant __________________ Date ____________ Signature ______________

Name of person taking consent ______________ Date ____________ Signature ______________

When completed: 1 for participant; 1 for researcher site file
Appendix 9: Participant demographics form

Participant Demographics

Project title: What are the barriers to accessing psychological therapies in Qatar: A concept mapping study

Participant number: ....................

1) Gender:
   a. Male
   b. Female

2) Age:
   a. 20-29
   b. 30-39
   c. 40-49
   d. 50-59
   e. 60+

3) Highest academic qualification:
   a. GCSE/A-level/equivalent
   b. Diploma
   c. Degree
   d. Masters
   e. PhD
   f. Other
   g. If other, please give further details: ...........

4) Profession:
   a. Counsellor/psychotherapist
   b. Psychologist
   c. Psychiatrist
   d. Nurse
   e. Other
   f. If other, please provide your job title:

5) Ethnicity: (*see over for definitions)
   a. MENA
   b. Western countries
   c. East & South East Asia
   d. Africa
   e. South Asia

6) How long have you worked in mental health? _________ years

   6a) What population(s) do you currently work with?


7) Where do you work?
   a. HMC
b. School/University

c. Private provider of health care

d. In Qatar but none of the above

e. Outside of Qatar

f. Other

g. If other, please give further details:
.................................................................................................................

8) If you live in Qatar, for how have you been working here? ________ years

*Ethnicity

**MENA** (Middle East and North Africa)

Western countries (Europe, North America and Australia)

**East & South East Asia** (China, Japan, Mongolia, North Korea, South Korea, Taiwan, Indonesia, Malaysia, Singapore, Philippines, East Timor, Brunei, Christmas Island, Cambodia, Laos, Myanmar (Burma), Thailand and Vietnam)

Africa (Sub Saharan)

South Asia (India, Pakistan, Bangladesh, Nepal, Bhutan, Sri Lanka)
## Appendix 10: Final list of 80 statements

**Statements**

<table>
<thead>
<tr>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - No psychologist/therapist training programs in Qatar</td>
</tr>
<tr>
<td>2 - Lack of anti discriminatory legislation</td>
</tr>
<tr>
<td>3 - Therapists have to be found through word of mouth - can't advertise</td>
</tr>
<tr>
<td>4 - There are not enough therapists</td>
</tr>
<tr>
<td>5 - Therapists are not necessarily well trained</td>
</tr>
<tr>
<td>6 - No clear international training route for therapists/psychologists</td>
</tr>
<tr>
<td>(like for medical training)</td>
</tr>
<tr>
<td>7 - People hold traditional explanations of mental illness such as 'evil</td>
</tr>
<tr>
<td>eye' or possessed by spirits</td>
</tr>
<tr>
<td>8 - People access traditional healers for treatment of mental illness</td>
</tr>
<tr>
<td>9 - The stigma associated with mental illness</td>
</tr>
<tr>
<td>10 - There are no 'answers' available yet to tackle stigma</td>
</tr>
<tr>
<td>11 - A fear of being labeled</td>
</tr>
<tr>
<td>12 - A fear of having your or family member's chances of getting married</td>
</tr>
<tr>
<td>affected</td>
</tr>
<tr>
<td>13 - A belief that problems should be dealt with within the family</td>
</tr>
<tr>
<td>14 - The needs of the family are put before own needs (collectivist</td>
</tr>
<tr>
<td>culture)</td>
</tr>
<tr>
<td>15 - Therapy is seen as sharing family secrets rather than speaking with</td>
</tr>
<tr>
<td>someone</td>
</tr>
<tr>
<td>16 - The law still criminalises seek help for 'haram' behaviours (e.g.</td>
</tr>
<tr>
<td>suicide)</td>
</tr>
<tr>
<td>17 - Lack of understanding of confidentiality</td>
</tr>
<tr>
<td>18 - Difficulty in recruiting psychologists/therapists to work in Qatar</td>
</tr>
<tr>
<td>19 - Mental health and therapy is not prioritised by Government</td>
</tr>
<tr>
<td>20 - Qatar is a small community - fear of being recognised or bumping in</td>
</tr>
<tr>
<td>to therapist</td>
</tr>
<tr>
<td>21 - Cost – of private therapy, transport to appointments etc</td>
</tr>
<tr>
<td>22 - Therapy isn't covered under private health insurance</td>
</tr>
<tr>
<td>23 - Fear of losing job because of having therapy</td>
</tr>
<tr>
<td>24 - Unethical private practice – e.g. therapists seeing client groups</td>
</tr>
<tr>
<td>they aren’t qualified to see</td>
</tr>
<tr>
<td>25 - No licensing/registration for private therapists in place</td>
</tr>
<tr>
<td>26 - A person's job takes priority in Qatar which may interfere with</td>
</tr>
<tr>
<td>attending therapy sessions</td>
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<td>27 - Lack of research into what therapy works here</td>
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<td>28 - Language barriers - many different languages spoken in Qatar</td>
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<td>29 - No interpreters available</td>
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<td>30 - Fear of bringing shame on family</td>
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<td>31 - Logistical difficulties: traffic, transport issues etc.</td>
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<tr>
<td>32 - Preference to self medicate</td>
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</tbody>
</table>
33 - Limited community based services
34 - Therapists lack therapeutic abilities to deal with cultural diversity
35 - No national level education about what mental health problems
36 - Qatar not yet in the right place for accepting psychological services (new country)
37 - A lack of data on the use of services (epidemiology)
38 - The expected presence of a male member of the family in therapy sessions preventing women expressing themselves openly
39 - Men don't see therapy as for them
40 - Services are only accessed when the family can't cope any longer
41 – Therapy is a Western concept
42 - a lack of understand of mental health problems
43 - Employment/HR issues e.g. only full time work available or not able to have 2 jobs
44 - A lack of understanding of what therapy is
45 - A concern that therapists don't understand traditional/cultural explanations
46 - Problems are suppressed rather than tackled
47 - Preference to see mental illness as a physical illness (somatization)
48 - Medical model and paternalistic care still prevails
49 - Some psychiatrists have negative views of therapy
50 - Other professionals not understanding what therapists do
51 - The difficulty in successfully delivering culturally sensitive psychological
52 - Inequalities in minority populations e.g. LGBT, multiple disabilities or older adults
53 - A lack of joined up working between services
54 - A lack of care pathways for specific diagnoses
55 – The local population feel hostile towards expatriates ‘taking over their country’
56 - A person’s cultural baggage might unconsciously impact on their behaviour
57 - Being a therapist/psychologist isn't a desirable career for a Qatari local
58 - People perceive that if you are mentally unwell it means you are weak
59 - People perceive that if you need to see a psychologist then you are mad
60 - Clients would prefer to take medication to 'take the problem away' rather than talk
61 - clients are disappointed that therapy doesn’t offer an instant fix
62 - Unclear referral processes
63 - Therapists are anxious about who they see
64 - People in Qatar aren't used to an appointment based system instead of turning up and being seen
65 - A reliance on what is in the Qur’an rather than newer understanding about how the mind works
66 - People are only willing to attend therapy sessions when there is a drama/crisis
67 - Some services are seen as only being accessible if you are taken there by police or doctors
68 - People don't trust the government or police
69 - Showing need/dependency on others is shameful
70 - some behaviours that may benefit from therapy are unacceptable/illegal in Qatar (e.g. suicide)
71 - Everything is 'God's willing' - In'shallah
72 - There is nobody in Qatar permanently driving the need for psychological therapies
73 - Group work isn't possible as people don't want to talk in front of others
74 - Clients don't want to be seen as a patient who is ill
75 - Issues of anxiety, depression, trauma are not concepts discussed within the culture
76 - Society wants to keep mentally ill people away from rest of society
77 - Experts' pushing their own agendas not considering the needs of the population
78 - Under 18’s need to have parental consent to access treatment
79 - Fear of discrimination from family, friends & others
80 - Clients don't want to accept a diagnosis
Appendix 11: Prioritising and clustering data collection sheets

What are the barriers to accessing psychological therapy in Qatar: A concept mapping study.
Thank you expressing an interest in taking part in this study. I am inviting you to complete two tasks that form the last phase of this project:
1) Prioritizing, and
2) Clustering.
Each task should take approximately 15-30 minutes and all you will need is this sheet and a set of cards with statements about barriers to accessing psychological therapy in Qatar (enclosed).
There are no right or wrong answers as we are interested in your own opinions on this issue. Therefore, I would be very grateful if you could complete these tasks on your own, without discussing them with other people.
Once you have completed the tasks, please return the sheet to me or scan/photograph the sheet and email a copy to me. Alternatively you can complete the task online. If you would prefer this method then please let me know and I can send you a link.
Thank you very much for your invaluable help with this research study. If you have any questions or would like to discuss this project further, please contact me.

Kind regards,

Ellie Brown
Researcher
1 The Prioritizing task:

Please sort the cards into five piles, according to how important you think the statements written on them are. Make sure there are 16 cards in each pile. Please use all cards, but remember that each card can only be used once:

- Pile 1 = least important statements
- Pile 2 = somewhat important statements
- Pile 3 = moderately important statements
- Pile 4 = very important statements
- Pile 5 = most important statements

Once you have finished this task, please write the card numbers in the appropriate columns in the table below:

<table>
<thead>
<tr>
<th>No. of Cards</th>
<th>Pile 1: the LEAST important</th>
<th>Pile 2: SOMEWHAT important</th>
<th>Pile 3: MODERATELY important</th>
<th>Pile 4: VERY important</th>
<th>Pile 5: the MOST important</th>
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</thead>
<tbody>
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</table>
2 The Clustering task
This is completely separate from the first task. To complete the clustering task, please put into groups (clusters) the statements that you think go together. I would be very grateful if you could follow the rules below:

1. Please use all cards, but remember each card can only be used once.

2. You can create a **minimum of 2** and a **maximum of 10** groups, and:
   a. Do not put all statements into one group.
   b. Each group must contain more than one card.

3. Please note down the number of each card in each of your ‘groups’ in the table overleaf.

4. Please put a name/label to each group (cluster), as they make most sense to you.

**Table 2: The Clustering task:** Please note down the number of each card as you put them into groups (clusters). There is an additional table on the following page, should you have over 7 clusters.

<table>
<thead>
<tr>
<th>Group label:</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
<th>Group 4</th>
<th>Group 5</th>
<th>Group 6</th>
<th>Group 7</th>
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<tbody>
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<td>Card numbers:</td>
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<tr>
<td>Group label:</td>
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<td>Group 9</td>
<td>Group 10</td>
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Appendix 12: Prioritising and clustering data collection sheets for completion online

What are the barriers to accessing psychological therapy in Qatar: A concept mapping study.
Thank you expressing an interest in taking part in this study. I am inviting you to complete two tasks that form the last phase of this project: 1) Prioritizing, and 2) Clustering.
Each task should take approximately 15-30 minutes and all you will need is to access the webpage via the link sent to you.
There are no right or wrong answers as we are interested in your own opinions on this issue. Therefore, I would be very grateful if you could complete these tasks on your own, without discussing them with other people.
Once you have completed the tasks, the webpage will save these once you press the ‘house’ picture on the bottom right of the page.
Thank you very much for your invaluable help with this research study. If you have any questions or would like to discuss this project further, please contact me.

Kind regards,

Ellie Brown
Researcher
1 The Prioritizing task:

Please sort the cards into five piles, according to how important you think the statements written on them are. Make sure there are 16 cards in each pile. Please use all cards, but remember that each card can only be used once:

- Pile 1 = least important statements
- Pile 2 = somewhat important statements
- Pile 3 = moderately important statements
- Pile 4 = very important statements
- Pile 5 = most important statements

You will need to drag and drop each ‘card’ in to the area you want it to be placed:

![Image showing five piles with labels: least important, somewhat important, moderately important, very important, most important. The areas are placeholders for the cards.]
The Clustering task
This is completely separate from the first task. To complete the clustering task, please put into groups (clusters) the statements that you think go together. I would be very grateful if you could follow the rules below:

1. Please use all cards, but remember each card can only be used once.

2. You can create a minimum of 2 and a maximum of 10 groups, and:
   a. Each group must contain more than one card.

3. Please put a name/label to each group (cluster), as they make most sense to you. This can be done by clicking on the white number that appears when you make a cluster of statements.

You might find this task easier to do AFTER the importance task as by then you are more familiar with the statements and therefore how they might fit together.

If you need a break at any point, please click the ‘house’ picture and your work will be saved. You then need to just follow the same link sent to you to go back in at a later date.